American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

WYQNY Chiropractic PC (Applicant)	AAA Case No.	17-20-1165-1796
	Applicant's File No.	300521
- and -	Insurer's Claim File No.	3753522-004
	NAIC No.	22780
Integon General Insurance Corporation (Respondent)		

ARBITRATION AWARD

I, Tracy Morgan, the undersigned arbitrator, designated by the American Arbitration Association pursuant to the Rules for New York State No-Fault Arbitration, adopted pursuant to regulations promulgated by the Superintendent of Insurance, having been duly sworn, and having heard the proofs and allegations of the parties make the following **AWARD:**

Injured Person(s) hereinafter referred to as: injured person-assignor

1. Hearing(s) held on 07/30/2021
   Declared closed by the arbitrator on 07/30/2021

   Neil Menashe, Esq. from Neil Menashe Attorney At Law P.C. participated for the Applicant

   Joseph Iancono, Esq. from Law Offices of Bobbi J. Vilacha participated for the Respondent

2. The amount claimed in the Arbitration Request, **$ 1,056.02**, was AMENDED and permitted by the arbitrator at the oral hearing.

   Applicant amended the amount in dispute to $964.62 in accordance with the fee schedule.

   Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

   The Applicant is the assignee of no-fault benefits from injured person-assignor (BR-M), a 33 year old female passenger who was involved in a motor vehicle accident

on March 1, 2019. Following the accident, the injured person-assignor underwent evaluations and chiropractic treatment performed by Applicant August 26, 2019-October 24, 2019. Respondent denied Applicant's claims contending a lack of medical necessity based upon an Independent Medical Examination performed by Ji Hoon Kim, D.C., L.Ac. on July 31, 2019.

The issue presented on this arbitration is whether the services in dispute were medically necessary?

4. Findings, Conclusions, and Basis Therefor

This hearing was conducted using documents contained in ADR Center. Any documents contained in the folder are hereby incorporated into this hearing. I have reviewed the relevant exhibits contained in the electronic file maintained by the American Arbitration Association and have considered all of the stipulations and arguments presented by both parties at the hearing of this matter. No witnesses appeared or testified.

A health care provider establishes its prima facie entitlement to no-fault benefits by submitting evidentiary proof that the prescribed statutory billing forms were mailed to and received by the insurer and that payment of no-fault benefits is overdue *See Insurance Law § 5106 [a]; 11 NYCRR 65.15 [g];Viviane Etienne Medical Care, P.C. v Country-Wide Ins. Co.*, 25 NY3d 498 (2015).

I find that Applicant established its prima facie entitlement to first person no-fault benefits as proofs of claim were mailed to and received by the insurer and payment of No-Fault benefits is overdue.

Pursuant to both the Insurance Law and the Regulations promulgated by the Superintendent of Insurance, an insurer must either pay or deny a claim for no-fault benefits within 30 days from the date an applicant supplies proof of claim *See, Insurance Law §5106[a]; 11 NYCRR 65.15[g]; Presbyterian Hosp.in City of N.Y. v Maryland Cas. Co.*, 90 NY2d 274, 278 (1997).

Respondent timely issued denials of claims contending that the services at issue were not medically necessary based upon the results of the Independent Medical Examination (hereafter referred to as "IME") performed by Ji Hoon Kim, D.C., L.Ac. on July 31, 2019.

Where a health care provider establishes its prima facie entitlement to no-fault benefits, the burden shifts to the insurer to prove that the medical services were not medically necessary *Nir v Allstate Ins. Co.*, 7 Misc. 3d 544 (2005); *Amaze Medical Supply Inc. v Eagle Insurance Co.*, 2 Misc3d 128(A), 2003 NY Slip Op. 51701(U)(App Term 2d, 11th & 13th Dists.). Respondent bears the burden of production in support of its lack of medical necessity defense, which if established, shifts the burden of persuasion to applicant *See generally, Bronx Expert Radiology, P.C. v. Travelers Ins. Co.*, 2006 NY Slip Op 52116 (App Term 1st Dept. 2006).

A denial of medical expenses based upon a lack of medical necessity must be supported by competent evidence such as an independent medical examination report which sets forth a factual basis and medical rational for an opinion that services were not medically necessary *AJS Chiropractic PC v Mercury Ins. Co.*, 22 Misc3d 133 (A) 2009 NY Slip Op. 50208(U)(App Term 2d & 11th Dists); *Nir v Allstate Ins. Co.*, 7 Misc. 3d 544 (2005).

Where respondent's IME report includes a factual basis and medical rationale for the opinion that further medical treatment is not medically necessary, the burden shifts to the applicant. The insured or the provider bears the burden of persuasion on the question of medical necessity *Bedford Park Medical Practice P.C. v. American Transit Ins. Co.*, 8 Misc3d 1025(A), (Civ. Ct. Kings Co., 2005).

Respondent relies upon the IME of Dr. Kim performed on July 31, 2019 to support its denials. Dr. Kim examined the injured person-assignor and noted present complaints of neck pain, mid and low back pain. Dr. Kim's acupuncture examination revealed a normal tongue, normal pulse and normal complexion and breathing. Dr. Kim examined the injured person-assignor's cervical spine and found no tenderness or spasm and that ranges of motion were all within normal limits. Examination of the thoracic region revealed no tenderness or spasms. The lumbar examination evidenced no tenderness, no spasms and normal ranges of motion. Muscle strength, reflexes and sensation were normal throughout. Cervical compression, distraction, straight leg raises and Kemp's tests were negative. The remainder of the examination was negative. Dr. Kim's impression was of cervical, thoracic and lumbar sprains/strains resolved and no evidence of Qi or blood stagnation. Dr. Kim concluded that no further chiropractic treatment was needed.

Dr. Kim's report provides a sufficient factual basis and medical rationale for the contention that the services billed were not medically necessary and therefore the burden shifts to Applicant, who bears the ultimate burden of persuasion *See Delta Diagnostic Radiology, PC v. Progressive Casualty Ins. Co*., 21 Misc. 3d 142A (App Term 2d & 11th Jud Dist 2008); *Crossbridge Diagnostic Radiology, PC v. Progressive Casualty Ins. Co*., 20 Misc. 3d 143A (App Term 2d & 11th Jud Dist. 2008).

Applicant relies upon the contemporaneous findings from August 26, 2019 wherein Amram Weiner, D.C. documented moderate to severe subjective complaints of pain in the neck and low back without improvement. Cervical, thoracic and lumbar spasms, tenderness and trigger points as well as joint restriction fixations were noted. Dr. Weiner's evaluation on August 29, 2019 revealed restricted ranges of cervical and lumbar motion, decreased sensation in the L4 dermatome, decreased strength in the upper and lower extremities, positive tests including cervical compression and distraction, shoulder depression, Spurling's, Soto-Hall, straight leg raises, Braggard's Kemp's and Valsalva. To reduce pain and improve range of motion, Dr. Weiner recommended further chiropractic treatment with re-evaluations every 4 weeks. Subsequent chart notes document continued objective findings of spasms, tenderness, joint fixations and trigger points. The re-evaluation of October 2, 2019 documented continued complaints of pain, restricted ranges of motion, albeit slightly improved, positive orthopedic testing, decreased sensation and muscle strength.

After a review of the Record and the arguments of both sides, I am persuaded that at the time of the IME, the injured person-assignor's cervical and lumbar injuries were not yet completely resolved. Relying upon the contemporaneous evaluation findings and chart notes, I find that Applicant has sufficiently refuted the findings and conclusions of Dr. Kim and demonstrated that at the time of the IME, the injured person-assignor was still in need of further treatment.

Applicant's claim is awarded. Any further issues raised in the hearing record are held to be moot and/or waived insofar as not raised at the time of the hearing.

5. Optional imposition of administrative costs on Applicant.
   Applicable for arbitration requests filed on and after March 1, 2002.

   I do NOT impose the administrative costs of arbitration to the applicant, in the amount established for the current calendar year by the Designated Organization.

6. **I find as follows with regard to the policy issues before me:**
   - ☐ The policy was not in force on the date of the accident
   - ☐ The applicant was excluded under policy conditions or exclusions
   - ☐ The applicant violated policy conditions, resulting in exclusion from coverage
   - ☐ The applicant was not an "eligible injured person"
   - ☐ The conditions for MVAIC eligibility were not met
   - ☐ The injured person was not a "qualified person" (under the MVAIC)
   - ☐ The applicant's injuries didn't arise out of the "use or operation" of a motor vehicle
   - ☐ The respondent is not subject to the jurisdiction of the New York No-Fault arbitration forum

Accordingly, the applicant is AWARDED the following:

A.

Medical		From/To	Claim Amount	Amount Amended	Status
	WYQNY Chiropractic PC	**08/26/19 - 10/24/19**	**$1,056.02**	**$964.62**	**Awarded: $964.62**
Total			**$1,056.02**		**Awarded: $964.62**

B. The insurer shall also compute and pay the applicant interest set forth below. 05/14/2020 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant is awarded interest pursuant to the no-fault regulations. See generally, 11 NYCRR §65-3.9. Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30 day month." 11 NYCRR §65-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. However, the regulations toll the accrual of interest when an applicant "does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations." See, 11 NYCRR 65-3.9(c). The Superintendent and the New York Court of Appeals has interpreted this provision to apply regardless of whether the particular denial at issue was timely LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 NY3d 217 (2009).

C. Attorney's Fees

The insurer shall also pay the applicant for attorney's fees as set forth below

As this matter was filed on or after February 4, 2015, this case is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant an attorney's fee, in accordance with newly promulgated 11 NYCRR 65-4.6(d) For claims that fall under the Sixth Amendment to the regulation, the following shall apply: "If the claim is resolved by the designated organization at any time prior to transmittal to an arbitrator and it was initially denied by the insurer or overdue, the payment of the applicant's attorney's fee by the insurer shall be limited to 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon, for each applicant with whom the respective parties have agreed and resolved dispute, subject to a maximum fee of $1,360.00."

D. The respondent shall also pay the applicant forty dollars ($40) to reimburse the applicant for the fee paid to the Designated Organization, unless the fee was previously returned pursuant to an earlier award.

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of New York
SS :
County of Nassau

I, Tracy Morgan, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

08/04/2021
(Dated)

Tracy Morgan

IMPORTANT NOTICE

This award is payable within 30 calendar days of the date of transmittal of award to parties.

This award is final and binding unless modified or vacated by a master arbitrator. Insurance Department Regulation No. 68 (11 NYCRR 65-4.10) contains time limits and grounds upon which this award may be appealed to a master arbitrator. An appeal to a master arbitrator must be made within 21 days after the mailing of this award. All insurers have copies of the regulation. Applicants may obtain a copy from the Insurance Department.

ELECTRONIC SIGNATURE

Document Name: Final Award Form
Unique Modria Document ID:
2fbdef224ed51cf44e517d91161ff253

Electronically Signed

Your name: Tracy Morgan
Signed on: 08/04/2021