

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Island Pain Specialist, PC
(Applicant)

- and -

Integon National Insurance Company
(Respondent)

AAA Case No. 17-19-1141-9687

Applicant's File No. 19-005094

Insurer's Claim File No. 9QINY11111

NAIC No. 29742

ARBITRATION AWARD

I, Charles Blattberg, 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: Eligible injured person

1. Hearing(s) held on 08/20/2021
Declared closed by the arbitrator on 08/25/2021

Michael Maddaloni, Esq. from The Licatesi Law Group, LLP participated by telephone for the Applicant

John Rosillo, Esq. from Rossillo & Licata LLP participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 4,480.37**, was NOT AMENDED at the oral hearing.
Stipulations WERE NOT made by the parties regarding the issues to be determined.
3. Summary of Issues in Dispute

The claimant was the 54 year-old male driver of a motor vehicle that was involved in an accident on 11/15/16. Following the accident the claimant suffered injuries which resulted in the claimant seeking treatment. At issue are services provided by Applicant 7/3/17-1/9/19.

4. Findings, Conclusions, and Basis Therefor

Based on a review of the documentary evidence, this claim is decided as follows:

An applicant establishes a prima facie case of entitlement to reimbursement of its claim by the submission of a completed NF-3 form or similar document documenting the facts and amounts of the losses sustained and by submitting evidentiary proof that the prescribed statutory billing forms [setting forth the fact and the amount of the loss sustained] had been mailed and received and that payment of no-fault benefits were overdue. See, *Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). I find that Applicant established a prima facie case for reimbursement.

The claimant was the 54 year-old male driver of a motor vehicle that was involved in an accident on 11/15/16. The claimant reportedly injured his neck, left shoulder, and low back. There was no reported loss of consciousness. There were no reported lacerations or fractures. There was no reported emergency treatment sought or received. On 11/18/16 the claimant presented to Robert C. Leahy, D.C. and was initiated on chiropractic treatment. On 11/28/16 the claimant presented to Gerard Maggio, L.Ac. with a pink/red tongue with a thin coating and a wiry pulse. The claimant was initiated on acupuncture and cupping. On 12/1/16 the claimant presented to Gregory Bednar, RPAC of Applicant's office with complaints of neck pain, left shoulder pain, low back pain, and left knee pain. The claimant was prescribed Percocet 5-325 and physical therapy; and recommended for cervical epidural steroid injections (CESI) and lumbar epidural steroid injections (LESI). On 12/8/16 the claimant presented to Hasib M. Sarij, M.D. of Applicant's office and was prescribed Morphine Sulfate 15mg and a comprehensive urinalysis/drug screen was ordered. The 12/20/16 cervical spine MRI interpreted by Marc Katzman, M.D. produced an impression of straightening of the normal cervical lordosis, C2/3 broad central subligamentous disc herniation with annular fissure approaching the ventral cord and right-sided foraminal stenosis with impingement of the exiting right C3 nerve root, C3/4 prominent broad central disc herniation compressing the ventral cord with severe central canal stenosis with bilateral foraminal stenosis with impingement of both exiting C4 nerve roots, C4/5 focal central subligamentous disc herniation impressing on the ventral cord and bilateral foraminal disc herniations encroaching on the neural foramina, C5/6 focal central disc herniation impressing on the midline ventral surface of the cord, C6/7 focal central disc herniation impressing on the ventral cord and there are bilateral foraminal disc herniations, impinging on both exiting C7 nerve roots, and C7/T1 focal central subligamentous disc herniation abutting the ventral cord and left with foraminal disc herniation compressing the exiting left C8 nerve root. The 12/20/16 lumbar spine MRI interpreted by Marc Katzman, M.D. produced an impression of levoscoliotic curvature of the lumbar spine, straightening of the normal lumbar lordosis, L1/2 peripheral disc bulging, L2/3 focal right paracentral disc herniation encroaching on the right neural foramen and abutting the traversing right L3 nerve root, L3/4 focal central disc herniation impressing on the ventral thecal sac with central canal narrowing and there is abutment to both traversing L4 nerve roots within the lateral recesses with bilateral foraminal disc herniations right larger than left with impingement of the exiting right L3 nerve root, L4/5 broad central disc herniation compressing the ventral thecal sac with impingement of both traversing L5 nerve roots within the lateral recesses with bilateral foraminal disc herniations impinging both exiting L4 nerve roots, and L5/S1 broad central subligamentous disc

herniation on the ventral thecal sac with impingement of both traversing S1 nerve roots within the lateral recesses with bilateral foraminal disc herniations impinging both exiting L5 nerve roots. On 1/4/17 the claimant underwent upper extremities EMG/NCV testing that suggested evidence consistent with left C5, C6 radiculopathies. On 2/1/17 the claimant underwent lower extremities EMG/NCV testing that suggested evidence consistent with bilateral S1 radiculopathy. On 3/1/17 Dr. Sarij performed CESI under fluoroscopic guidance and an epidurogram. On 3/27/17 Mr. Bednar prescribed oxycodone HCL 15mg. During the 5/8/17 follow-up conducted by Dr. Sarij it was noted the claimant had to discontinue massage therapy and acupuncture due to being on blood thinners. On 7/17/17 Applicant conducted a comprehensive urinalysis drug/toxicology screening. On 3/21/18 the claimant was required to present to Vijay Sidhwani, D.O. for an Independent Pain Management Examination (IME) that was purportedly negative and Respondent determined "Per an independent physical exam, no-fault Pain Management benefits are terminated effective 04/16/18. Health services, other necessary expenses and loss of earnings from said date forward, pertaining to this loss, related to and comparable with this specialty will not be paid." At issue are services provided by Applicant 7/3/17-1/9/19.

DOS 7/3/17

Under the current No-Fault Regulations, the Mandatory Personal Injury Protection Endorsement requires that written proof of claim must be submitted as soon as reasonably practicable, but in the case of health service expenses no later than 45 days after the services were rendered. 11 NYCRR Section 65-1.1 requires that:

"The...time limitations for the submission of proof of claim shall apply unless the eligible injured person or that person's representative submits written proof providing clear and reasonable justification for the failure to comply with such time limitations."

Furthermore, 11 NYCRR Section 65-3.3(e) requires that:

"When an insurer denies a claim based upon the failure to provide timely written notice of claim or timely submission of proof of claim by the applicant, such denial must advise the applicant that late notice will be excused where the applicant can provide reasonable justification of the failure to give timely notice.

Respondent timely denied the \$2,795.00 bill for date of service (DOS) 7/3/17 advising "Amended Regulation 68 requires bills must be submitted no later than 45-days after the services are rendered. Late submission will be excused if reasonable justification can be provided." The denial specified Applicant's non-compliance with the 45 day rule (11 NYCRR Section 65-1.1) and further provided that the time limitation may be extended upon proof providing a clear and reasonable justification for this non-compliance. *SZ Medical PC v. Country-Wide Insurance Co.*, 12 Misc 3d 52, 817 NYS 2d 851 (App Term 2d and 11th Dists, 2006).

Respondent contends that Applicant's bill was not received until 9/8/17, 67 days after the date the services were performed, and that no reasonable justification for the

untimely bill was provided. Respondent's denial form herein communicated, as required by the No-Fault Regulations, that late submission of the proof of claim would be excused where an applicant can provide a reasonable excuse for the late submission, see *Park v. Zurich American Ins. Co.*, 32 Misc.3d 127(A), 2011 N.Y. Slip Op. 51836(U) (App. Term 2nd, 11th and 13th Jud. Dists. 2011); *Delta Diagnostic Radiology, P.C. v. Interboro*, 25 Misc.3d 143(A), 2009 N.Y. Slip Op. 52222(U) (App. Term 2nd, 11th and 13th Jud. Dists. 2009); *Radiology Today, P.C. v. Citwide Auto Leasing, Inc.*, 15 Misc.3d 92, 2007 N.Y. Slip Op. 2711 (App. Term 2nd Dept. 2007), Respondent is not precluded from defending its denial.

Applicant uploaded a letter dated 9/1/17 that was prepared by Hasib Mikael Sarij, M.D. of Applicant's office. It states that the claim (which he indicates was for "Date of Service: 7/17/2017") was originally timely submitted to Geico "according to the insurance information we received from the patient", that "Geico denied the claim as the member is inactive" and they "contacted the patient and obtained the updated insurance information." The letter also states "[f]or your verification please see attached Geico's EOB as proof of timely filing" but Geico's EOB was not attached. In AAA Case No.: 19-1149-5801 (where DOS 4/10/17-8/22/17 were at issue) Applicant uploaded the 10/6/19 affidavit of mailing of Benjamin Silberstein who identifies himself as the "Billing Supervisor of Island Pain Specialist, PC." but goes on to state "[i]t is standard billing practice to generate bills for services performed by Diagnostic Chiropractic, PC." He states that he "personally mailed the bills for [the claimant] date of service 04/10/2017- 8/22/2017 to Geico." He also generally states "I have reviewed our records and confirmed that the bills were mailed to Geico." Applicant's counsel argued that the claimant told Applicant that he was insured by Geico and there was no reason not to believe him or investigate further.

Respondent's counsel stated that the 9/1/17 letter was never sent to Respondent and that it was first received with the filing of this arbitration. It is noted that no proof of mailing was uploaded and the 9/1/17 letter is not referenced in Mr. Silberstein's 10/6/19 affidavit of mailing. Respondent's counsel also stated that Mr. Silberstein references some but not all DOS (including the one at issue here). It is noted that while Mr. Silberstein provides a range of DOS he does not specifically identify any bill either in terms of amount or type of service performed. Respondent's counsel noted that some bills for this claimant were somehow timely sent to Respondent prior to 9/1/17. Respondent's counsel also noted that no bills addressed to Geico were submitted, no indication when any bills were submitted to Geico was provided and no denial(s) from Geico were submitted. It is noted that the 9/1/17 letter only indicates the bills were timely mailed to Geico and states that Geico's denial is attached when it wasn't. Respondent's counsel also noted that the claimant's NF-2 dated 12/1/16, that was part of Applicant's submission, contains Respondent's policy and claim number. It is noted that there are several methods to identify an insurance company using just a policy number. Respondent's counsel also noted that Respondent's Assignment of Benefits dated 12/1/16, that was also part of Applicant's submission, contains the name (Alan Rodriguez, Esq.), address, and contact information for the claimant's counsel who they could have contacted regarding the claimant's insurance carrier.

I find that the vague explanation proffered by Applicant in its letter of 9/1/17 is insufficient to justify or excuse its delay for failing to provide Respondent with timely submission of proof of claim. Applicant essentially claims that on some date the claimant provided the wrong insurance information, on some date the bill was mailed to Geico, on some date Geico issued a denial, on same date the claimant provided the correct insurance information, and then the bill was sent to Respondent. In the 9/1/17 letter Dr. Sarij states "please see attached Geico's EOB as proof of timely filing" when it was not attached. Dr. Sarij also references a \$2,795.00 bill for DOS 7/17/17 when the correct DOS for the bill at issue is 7/3/17. As noted by Respondent's counsel no bills addressed to Geico were submitted, no indication when any bills were submitted to Geico was provided and no denial(s) from Geico were submitted. Mr. Silberstein's 10/6/19 affidavit of mailing lacks detail and no contemporaneous documents were provided. Mr. Silberstein's 10/6/19 affidavit of mailing does not address the bill at issue. Also as noted by Respondent's counsel the claimant's NF-2 dated 12/1/16, that was part of Applicant's submission, contains Respondent's policy and claim number. Applicant has not offered a reasonable excuse for a late submission. And even if Applicant had submitted proof that the 9/1/17 letter was sent to Respondent prior to this arbitration I note that while 11 NYCRR § 65-3.5(l) requires an insurer to maintain standards for their determinations that bills have been submitted late, the Regulations do not require that such standards be disclosed to providers, but rather are subject to review by the State. I uphold Respondent's denial.

DOS 5/2/18-12/12/18

As to these bills the burden has shifted to the Respondent as they have raised a medical necessity defense. In order to support a lack of medical necessity defense Respondent must "set forth a factual basis and medical rationale for the peer reviewer's determination that there was a lack of medical necessity for the services rendered." See, *Provvedere, Inc. v. Republic Western Ins. Co.*, 2014 NY Slip Op. 50219(U) (App. Term 2nd, 11th and 13th Jud. Dists. 20140. 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). As a general rule, reliance on rebuttal documentation will be weighed in light of the documentary proofs and the arguments presented at the arbitration. Moreover, the case law is clear that a provider must rebut the conclusions and determinations of the IME/peer doctor with his own facts. *Park Slope Medical and Surgical Supply, Inc. v. Travelers*, 37 Misc.3d 19 (2012).

An IME report asserting that no further treatment is not medically necessary must be supported by a sufficiently detailed factual basis and medical rationale, which includes mention of the applicable generally accepted medical/professional standards. *Carle Place Chiropractic v. New York Central Mutual Fire Ins. Co.*, 19 Misc.3d 1139(A), 866 N.Y.S.2d 90 (Table), 2008 N.Y. Slip Op. 51065(U), 2008 WL 2228633 (Dist. Ct. Nassau Co., Andrew M. Engle, J., May 29, 2008).

Respondent timely denied the 5/2/18-12/12/18 services at issue based on the 3/21/18 Independent Pain Management Examination (IME) conducted by Vijay Sidhwani, D.O.

After reviewing the claimant's history, treatment, and medical records, Dr. Sidhwani conducts what appears to be a thorough examination. Dr. Sidhwani documents the claimant's then current complaints as pain in his left shoulder, neck and lower back (stating the pain radiated down his left leg). Examination of the upper and lower extremities revealed manual muscle strength and deep tendon reflexes were normal; but "sensation **decreased** to light touch along the lateral aspect of the left upper extremity and over the entire left lower extremity in all dermatomes tested." Left shoulder ranges of motion were **restricted** in all planes (quantified). Examination was negative for tenderness. Drop Arm test and Apprehension tests were negative. Neer's Impingement sign was negative. Hawkin's Impingement sign was negative. Cervical range of motion was within normal limits in all planes (quantified). Examination was negative for tenderness. Compression and Spurling's tests were negative. Lumbar ranges of motion were **restricted** in flexion, extension, and bilateral lateral flexion (normal in bilateral rotation). Examination was negative for tenderness. Straight leg raising was negative. Sitting Lasegue's test was negative. Patrick's test was negative. Dr. Sidhwani's diagnosis was status-post MVA, left shoulder sprain resolved, cervical sprain and strain resolved, and lumbar sprain and strain resolved. Dr. Sidhwani concluded "Based on the findings of my examination of the claimant today, further causally related Pain Management treatment or physical therapy is not reasonable or medically necessary. From a Pain Management viewpoint, the claimant will no longer benefit from any further Pain Management follow-up or physical therapy at this time. In addition, there is no need for any further diagnostic testing, special transportation, nerve block injections, injections, household help, durable medical equipment/supplies or prescription medication from a Pain Management perspective. The claimant's left shoulder, neck and back have reached a therapeutic endpoint to treatment. The subjective complaints are not substantiated by objective findings. Manual muscle testing and reflexes were normal which means the claimant is neurologically intact. However, range of motion testing and sensory testing are passive and completely subjective. While the claimant may be complaining/experiencing other medical conditions or musculoskeletal ailments I did not find that his limited range of motion in the planes tested nor his sensory deficits were related to his present complaints."

Where the Defendant insurer presents sufficient evidence to establish a defense based on lack of medical necessity, the burden shifts to the Plaintiff which must then present its own evidence of medical necessity (see Prince on Evidence section 3-104, 3-202). *West Tremont Medical Diagnostic PC v. Geico*, 13 Misc.3d 131, 824 N.Y.S. 2d 759.

During the 5/2/18 follow-up examination conducted by Mubushar Raza, N.P. of Applicant's office the claimant presented with complaints of neck and lower back pain rated 9/10 (without taking medication). "The neck pain described as sharp and aching. The neck pain radiates down the left arm and down into the left fingers. Patient states he has been experiencing numbness into the arm. The neck pain aggravated by ADL. The neck pain alleviated with medication. The lower back pain described as sharp and aching pain. The lower back pain radiates down to the buttocks and legs. The lower back pain aggravated by walking, bending and lifting. Medication is helping alleviate 50% of the pain." It has been noted that the claimant suffers thrombotic thrombocytopenic purpura (TTP) (*blood disorder in which platelet clumps form in small blood vessels*) that has produced DVT and caused postponing CESI and LESI. Nurse Raza continued the

claimant on oxycodone HCL and prescribed Zanaflex as a muscle relaxant. Toxicology screenings to continue. Subsequently the claimant would also be prescribed Gabapentin and Lidocaine 5% ointment. As of the 1/9/19 follow-up examination (last date of service in evidence here) conducted by Nurse Raza it was noted "Patient is due in for neck and lower back pain. The lower back pain is described as aching and sharp pain. The lower back pain radiates into the bilateral hips and legs and causing numbness in b/l feet. The lower back pain is alleviated by medication. The neck pain is described as aching and sharp pain. The neck pain radiates into the bilateral shoulders and down the arms w/numbness and numbness in the b/l hands, but more so into the left hand. Pain is aggravated lifting or bending. Medications is helping relieve about 50% of the pain." Examination revealed tenderness throughout the entire spine and lumbar pain was elicited on AROM. Kemp's test was positive. The claimant was recommended to continue stretching and home core exercise.

I am convinced by the thorough and credible IME report by Dr. Sidhwani that the claimant's injuries had resolved by the date of the cut-off thereby justifying the termination of his pain management benefits on 4/16/18 (more than 17 months after the MVA). I find the most thorough evaluation provided regarding this treatment was in fact the IME by Dr. Sidhwani which establishes no further pain management was necessary. I find that the examination performed by Dr. Sidhwani formed a complete and accurate picture of the condition of the eligible injured person as of 3/21/18. As a result, based upon the documentation in evidence, Respondent has sustained its burden of proof.

DOS 6/5/18 and 1/9/19

As to the \$650.00 bill for DOS 6/5/18 and the \$92.98 bill for DOS 1/9/19 Respondent did not submit a denial. Respondent contends that these bills were not received prior to the request for arbitration. Applicant submitted photocopies of postage labels but nothing that would indicate any of them were for these bills. As Applicant did not submit specific proof of mailing of these bills, they are dismissed without prejudice.

Accordingly, the **\$650.00 bill for DOS 6/5/18 and the \$92.98 bill for DOS 1/9/19 are dismissed without prejudice.** All other claims are denied.

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 claim is DENIED in its entirety

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

09/15/2021
(Dated)

Charles Blattberg

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:
77da8fdaa45cc1316e34005e6daa66d1

Electronically Signed

Your name: Charles Blattberg
Signed on: 09/15/2021