American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

PCC Chiropractic PC (Applicant)	AAA Case No.	17-21-1202-2478
	Applicant's File No.	2021-0180
- and -	Insurer's Claim File No.	003920000043
	NAIC No.	Self-Insured
Chubb Indemnity Insurance Company (Respondent)		

ARBITRATION AWARD

I, Matthew Summa, 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: Assignor

1. Hearing(s) held on 11/30/2021
   Declared closed by the arbitrator on 11/30/2021

   Michael Zimmerman, Esq. from D'Costa Law, P.C. participated for the Applicant

   Talia Beard, Esq. from Law Office of Jason Tenenbaum, PC participated for the Respondent

2. The amount claimed in the Arbitration Request, **$ 3,280.72**, 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 Assignor, JH, a 43-year-old male, was involved in a motor vehicle accident on 2/3/2020. At issue in this case is $3,280.72 for chiropractic treatment and related services, which were performed on 5/19/2020 through 3/11/2021. A complete breakdown of the bills at issue and the defenses asserted is contained in the body of the award.

4. Findings, Conclusions, and Basis Therefor

This case was decided based upon the submissions of the parties as contained in the electronic file maintained by the American Arbitration Association, and the oral arguments of the parties' representatives. There were no witnesses. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

DOS 5/19/2020 - 6/11/2020 - $393.27
DOS 6/16/2020 - 6/23/2020 - $169.00
DOS 7/14/2020 - 7/30/2020 - $238.36
DOS 9/15/2020 - 9/30/2020 - $104.04

Respondent claims that it never received the above bills. It is well settled that an applicant establishes its prima facie showing of entitlement to no-fault benefits by submitting evidentiary proof that the prescribed statutory billing forms had been mailed, received by the respondent and that payment of no-fault benefits were overdue. Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D. 3d 742, 774 N.Y.S.2d 564 (2d Dept. 2004).

Applicant submits mailing logs showing that these bills were mailed to Respondent on the following dates:

DOS 5/19/2020 - 6/11/2020 - $393.27 - mailed 6/17/2020,
DOS 6/16/2020 - 6/23/2020 - $169.00 - mailed 6/20/2020,
DOS 7/14/2020 - 7/30/2020 - $238.36 - mailed 8/17/2020,
DOS 9/15/2020 - 9/30/2020 - $104.04 - mailed 10/15/2020.

Based upon this evidence, I find that Applicant has established its prima facie case of entitlement to No-Fault compensation for these bills. Since Respondent fails to assert a defense, Applicant is awarded the above bills.

DOS 6/8/2020 - $1,899.89

Respondent issued a timely denial for the above bill claiming that Applicant failed to submit the bill to Respondent within 45 days of the dates of service.

11 NYCRR 65-1.1 states under Proof of Claim as follows: "In the case of a claim for health service expenses, The [EIP] or that persons assignee… shall submit written proof of claim to the company … as soon as reasonably practicable but in no event later then 45 days after the date of services are rendered. … The foregoing time limitations for the submission of proof of claim shall apply unless the [EIP] … submits written proof providing clear and reasonable justification for the failure to comply with such time limitation."

An insurer in a no-fault matter will be precluded as a matter of law from asserting a defense based upon the ground that plaintiff untimely submitted it

claim if such defense is not raised in a timely denial of claim form. See generally, New York and Presbyterian Hospital v. Empire Ins. Co., 286 A.D.2d 322 (2nd Dept. 2001); St. Clare's Hospital v. Allcity Ins. Co., 201 A.D.2d 718 (2nd Dept. 1994). If respondent has preserved such defense in a timely denial of claim form, respondent will still be precluded from proffering such defense as a matter of law unless respondent advised the applicant that "late notice will be excused where the applicant can provide reasonable justification of the failure to give timely notice." See generally, 11 N.Y.C.R.R. 65-3.3(e); See also, Radiology Today, P.C. v. Citiwide Auto Leasing, Inc., 2007 N.Y. Slip Op. 27111 (App. Term 2nd and 11th Jud. Dists. 2007); SZ Medical, P.C. v. Country-Wide Ins. Co., 12 Misc.3d 52 (App. Term 2nd and 11th Jud. Dists. 2006).

The bill at issue for date of service 6/8/2020. According to the NF-10, the bill was received on 8/28/2020, more than 45 days after these dates of service. A timely denial which contains the required statutory language was issued on 9/24/2020.

In the instant case, Respondent has preserved its defense in a timely denial of claim form, and such denial contains the requisite language. However, Applicant has rebutted the assertion that the bill was submitted late through a proof which shows it was timely submitted.

Attached to its submission, Applicant includes a mailing log stamped by the USPS, dated 7/20/2020, showing that a correspondence was sent to Respondent regarding a bill for the Assignor, for $1,899.89, for date of service 6/8/2020. I find that this document adequately demomnstrates that the bill at issue was mailed to Respondent within 45 days of the date of service.

It is not the date of the insurer's receipt of a claim form which determines whether the submission of a claim is untimely, but rather the date of the claimant's submission of the claim form. See, New York Diagnostic Medical Care, P.C. v. Geico Casualty Ins. Co., 35 Misc.3d 131(A), 951 N.Y.S.2d 87 (Table), 2012 N.Y. Slip Op. 50681(U),2012 WL 1366750 (App. Term 9th & 10th Dists. Apr. 10, 2012).

Accordingly, I find that this bill was mailed within 45 days of the date of service, Respondent's defense fails, and Applicant is awarded $1,899.89.

DOS 1/27/2021 - $57.30

It is undisputed at the hearing that this bill was paid in full but was paid more than 30 days after the receipt of the bill. Applicant claims it is entitled to attorney's fees on this bill, but the bill was paid prior to the filing of this arbitration. Accordingly, Applicant's claim for attorney's fees is denied.

DOS 11/17/2020 - 12/8/2020 - $139.62

DOS 1/5/2021 - 1/11/2021 - $139.62
DOS 2/23/2021 - 3/11/2021 - $139.62

Respondent timely denied the above bills based upon the independent medical exam (IME) of John Johnson, D.C., conducted on 7/1/2020.The issue presented is whether further treatment was medically necessary.

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).

The purpose of an IME is to permit the insurer to verify the person's injuries, to determine the injured party's condition and to determine if the injured party needs any additional treatment or testing for those conditions and injuries. See, Mangione v Jacobs, 37 Misc 3d 711 (Sup Ct, Queens County 2012). The purpose of an IME is not to determine whether coverage exists but is to permit the insurer to determine the nature and extent of the injured party's injuries, whether the injured party needs additional treatment or testing for those injuries and for how much longer such treatment might be needed. See, Boulevard Multispec Medical, P.C. v. Tri-State Consumer Ins. Co., 43 Misc.3d 802, 805, 982 N.Y.S.2d 864, 867 (Dist. Ct. Nassau Co. 2014).

An IME is a snapshot of the injured party's medical condition as of the date of the IME. It is the opinion of the doctor that based upon the claimant's complaints and the doctor's objective findings at the time the IME is performed the claimant no longer needs medical care or treatment and/or diagnostic testing. The determination that the claimant no longer needs treatment is generally based upon the examining doctor's findings which result in the doctor concluding (1) the claimant has fully recovered from the injuries; (2) the claimant has made as full a recovery as is possible taking into account the nature and extent of the injuries, the claimant's age, preexisting conditions or other factors; and/or (3) additional treatment or testing will not provide any medical benefit to the claimant. See, Amato v. State Farm Ins. Co., 30 Misc.3d 238, 910 N.Y.S.2d 637 (Dist. Ct. Nassau Co. 2010), rev'd on other grounds, 40 Misc.3d 129(A), 975 N.Y.S.2d 364 (Table), 2013 N.Y. Slip Op. 51113(U), 2013 WL 3497906 (App. Term 9th & 10th Dists. July 3, 2013).

Where an IME report provides a factual basis and medical rationale for an opinion that services were not medically necessary, and the provider fails to present any evidence to refute that showing, the claim should be denied. AJS Chiropractic, P.C. v. Mercury Ins. Co., 22 Misc.3d 133(A), 880 N.Y.S.2d 871 (Table), 2009 N.Y. Slip Op. 50208(U), 2009 WL 323421 (App. Term 2d & 11th Dist. Feb. 9, 2009).

In support of the contention further treatment was not medically necessary,

Respondent relies upon the IME of John Johnson, D.C., conducted on 7/1/2020. A review of the examination report reveals that other than complaints of pain and mild tenderness at the lumbar spine, all findings were objectively negative and unremarkable. All ranges of motion were within normal limits, and all tests were negative. Dr. Johnson states that the Assignor's issues are resolved, and no further chiropractic treatment is necessary.

This examination presented a cogent medical rationale as to why further benefits were terminated. Accordingly, the burden now shifts to Applicant, who bears the ultimate burden of persuasion. See, Bronx Expert, supra.

Applicant submits a rebuttal form the treating chiropractor David Keiler, D.C., dated 10/7/2021. Dr. Keiler provides a detailed breakdown of the treatment and testing he performed on the Assignor. He also addresses the medical records from other treating providers. Dr. Keiler begins his discussion of the post IME medical records by noting the numerous positive findings contained in the exam reports from Omar Ahmed, M.D., the treating orthopedist. Dr. Keiler then provides a list of the various positive testing contained in the record. Specifically, I note positive EMG/NCV testing and positive findings on computerized range of motion testing from July of 2020. Additional positive tests continue throughout the course of treatment. Dr. Keiler then highlights his own chiropractic treatment notes, showing complaints of pain and tenderness.

Where the IME report submitted by the insurer sets forth a factual basis and medical rationale for the conclusion that the assignor's injuries were resolved and that the treatment which is the subject of the claim lacked medical necessity, the report submitted in opposition must meaningfully refer to and rebut the IME findings. Premier Health Choice Chiropractic, P.C. v. Praetorian Ins. Co., 41 Misc.3d 133(A), 981 N.Y.S.2d 638 (Table), 2013 N.Y. Slip Op. 51802(U), 2013 WL 5861532 (App. Term 1st Dept. Oct. 30, 2013). A review of these medical records, which are contemporaneous to the IME and the treatment at issue, reveals the Assignor was still in significant distress. The rebuttal from Dr. Keiler meaningfully rebuts the determination by Dr. Johnson and demonstrates that the Assignor still required continued treatment. Accordingly, Respondent's defense fails, and Applicant is awarded the above bills.

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**	**Status**
	PCC Chiropractic PC	**05/19/20 - 06/11/20**	**$393.27**	**Awarded: $393.27**
	PCC Chiropractic PC	**06/16/20 - 06/23/20**	**$169.00**	**Awarded: $169.00**
	PCC Chiropractic PC	**06/08/20 - 06/08/20**	**$1,899.89**	**Awarded: $1,899.89**
	PCC Chiropractic PC	**07/14/20 - 07/30/20**	**$238.36**	**Awarded: $238.36**
	PCC Chiropractic PC	**09/15/20 - 09/30/20**	**$104.04**	**Awarded: $104.04**
	PCC Chiropractic PC	**11/17/20 - 12/08/20**	**$139.62**	**Awarded: $139.62**
	PCC Chiropractic PC	**01/05/21 - 01/11/21**	**$139.62**	**Awarded: $139.62**

	PCC Chiropractic PC	**01/27/21 - 01/27/21**	**$57.30**	**Denied**
	PCC Chiropractic PC	**02/23/21 - 03/11/21**	**$139.62**	**Awarded: $139.62**
Total			**$3,280.72**	**Awarded: $3,223.42**

B. The insurer shall also compute and pay the applicant interest set forth below. 04/29/2021 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Pursuant to the no-fault regulations, Applicant is awarded interest running from the above-referenced date. 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).

The interest on a bill that was not denied or delayed for additional verification starts accruing 30 days after the bill is received. Allowing 5 days for mailing, interest will run from the following dates for these bills:

DOS 5/19/2020 - 6/11/2020 - $393.27 - interest 7/22/2020,
DOS 6/16/2020 - 6/23/2020 - $169.00 - interest 7/25/2020,
DOS 7/14/2020 - 7/30/2020 - $238.36 - interest 9/21/2020,
DOS 9/15/2020 - 9/30/2020 - $104.04 - interest 11/19/2020.

For all other bills, interest shall be calculated based upon the filing date of 4/29/2021.

C. Attorney's Fees

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

The insurer shall pay the applicant an attorney's fee pursuant to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D). In accordance with newly promulgated 11 NYCRR 65-4.6(d). "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.

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 Queens

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

12/10/2021
(Dated)

Matthew Summa

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:
77f91028a7863d54e326dea80b984ff9

Electronically Signed

Your name: Matthew Summa
Signed on: 12/10/2021