

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Richard S. Obedian MD PLLC
(Applicant)

- and -

Adirondack Insurance Exchange
(Respondent)

AAA Case No. 17-23-1291-7200

Applicant's File No. NF 3733206

Insurer's Claim File No. 210473743-004

NAIC No. 12583

ARBITRATION AWARD

I, Kihyun Kim, 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: the Assignor

1. Hearing(s) held on 09/29/2023, 10/03/2023
Declared closed by the arbitrator on 10/03/2023

Clifford Ryan, Esq. from The Law Office of Thomas Tona, PC participated virtually for the Applicant

Angela Venetsanos, Esq. from Law Office Of Lawrence & Lawrence participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$424.83**, was NOT AMENDED at the oral hearing.
Stipulations WERE made by the parties regarding the issues to be determined.

The parties stipulated Applicant's billing is consistent with the fee schedule.

3. Summary of Issues in Dispute

The issues presented are (1) whether certain claims were properly denied based on a lack of verification under the "120 day rule," and (2) whether Applicant's post-IME cutoff claims were medically necessary.

The Assignor (NA) was a 35-year-old female who was a passenger in an automobile that was involved in an accident on September 2, 2021. Applicant seeks reimbursement in the aggregate amount of \$424.83 for an office evaluation of the Assignor and

corticosteroid injection provided to the Assignor on February 17, 2022, and for an office evaluation of the Assignor conducted, subsequent to the IME cutoff, on August 30, 2022. The IME cutoff became effective on August 28, 2022 based on the orthopedic examination by Pierce J. Ferriter, M.D., conducted on August 11, 2022.

4. Findings, Conclusions, and Basis Therefor

This arbitration was conducted using the documentary submissions of the parties contained in the ADR Center, maintained by the American Arbitration Association. I have reviewed the documents contained therein as of the close of the hearing and such documents are hereby incorporated into the record of this hearing. The hearing was held by Zoom video conference. Both parties appeared at the hearing by counsel, who presented oral argument and relied upon their documentary submissions. There were no witnesses.

At the hearing, the parties stipulated that Applicant's billing is consistent with the fee schedule.

The Assignor was a 35-year-old female who was injured in an automobile accident on September 2, 2021. Following the accident, the Assignor was taken by ambulance to the hospital where she was evaluated, treated and released the same day without admission. The Assignor later sought treatment for her injuries from various providers, who started her on a course of conservative treatment, including medications, acupuncture, and chiropractic care.

On February 17, 2022, Applicant conducted an office evaluation of the Assignor and provided a corticosteroid injection to the left shoulder of the Assignor. Applicant thereafter billed Respondent for its services. Respondent requested additional verification following receipt of Applicant's claims and subsequently denied such claims based upon the "120 day rule," asserting that Applicant failed to provide all of the requested verification within its possession and control to Respondent within 120 days of the initial request.

On August 11, 2022, the Assignor appeared for an orthopedic evaluation with Pierce J. Ferriter, M.D., at the request of Respondent. Dr. Ferriter determined that there was no medical necessity for continued care in his specialty, Orthopedics. On August 23, 2022, Respondent issued a general denial, based on the August 11, 2022 examination by Dr. Ferriter, which advised that further treatment within the Orthopaedic Surgery scope of practice was no longer reasonable and necessary and there was no need for physical therapy, household help, transportation, durable medical equipment, additional diagnostic testing, prescription medications, massage therapy, injections or surgery. Therefore, effective August 28, 2022, No-Fault benefits would be denied for all such expenses.

Subsequent to the general denial, on August 30, 2022, Applicant conducted an office evaluation of the Assignor. Applicant thereafter billed Respondent for its services, and Respondent timely denied Applicant's claims as medically unnecessary based on the August 11, 2022 IME by Dr. Ferriter.

Applicant now seeks reimbursement in the aggregate amount of \$424.83 for an office evaluation of the Assignor and corticosteroid injection provided to the Assignor on February 17, 2022, and for an office evaluation of the Assignor conducted, subsequent to the IME cutoff, on August 30, 2022.

DATE OF SERVICE: 2/17/22

Legal Framework - Tolling/Verification

The general rule regarding payment of claims is set forth in 11 NYCRR §65-3.8(c), which states that, "within 30 calendar days after proof of claim is received, the insurer shall either pay or deny the claim in whole or in part." No-Fault benefits are overdue if not paid within 30 calendar days after the insurer receives proof of claim, which shall include verification of all of the relevant information requested pursuant to 11 NYCRR §65-3.5. *See* 11 NYCRR §65-3.8(a). As such, a claim need not be paid or denied until all demanded verification is provided. *See Nyack Hospital v. General Motors Acceptance Corp.*, 27 A.D.3d 96, 808 N.Y.S.2d 399 (2d Dept. 2005), *mod'd on other grounds*, 8 N.Y.3d 294, 832 N.Y.S.2d 880 (2007).

11 NYCRR 65-3.5 (c) mandates that the insurer is entitled to receive all items necessary to verify the claim directly from the parties from whom such verification was requested. The insurer has 15 business days from the date it receives the prescribed verification forms to seek additional verification from an Applicant. *See* 11 NYCRR 65-3.5 (b). Thereafter, "at a minimum, if any requested verification has not been supplied to the insurer 30 calendar days after the original request, the insurer shall, within 10 calendar days, follow up with the party from whom the verification was requested, either by telephone call, properly documented in the file, or by mail. At the same time the insurer shall inform the applicant and such person's attorney of the reason(s) why the claim is delayed by identifying in writing the missing verification and the party from whom it was requested." *See* 11 NYCRR 65-3.6 (b).

The Fourth Amendment to 11 NYCRR 65-3, which is applicable to claims for medical services rendered on or after April 1, 2013, introduced the following provision, articulated under §65-3.5(o):

An Applicant from whom verification is requested shall, within 120 calendar days from the date of the initial request for verification, submit all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply. The insurer shall advise the applicant in the verification request that the insurer may deny the claim if the applicant does not provide within 120 calendar days from the date of the initial request either all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply.

11 NYCRR §65-3.5(o). In relation to this new provision, 11 NYCRR §65-3.8(b)(3) was amended so as to confer upon the insurer the right to deny a claim for non-compliance with §65-3.5(o). In pertinent part, the amendment to §65-3.8(b)(3) states the following:

[A]n insurer may issue a denial if, more than 120 calendar days after the initial request for verification, the applicant has not submitted all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply, provided that the verification request so advised the applicant as required in section 65-3.5(o).

Upon receipt of a verification request, it is incumbent upon the Applicant to respond. (*Dilon Medical Supply Corp v. Travelers Insurance Company* , 7 Misc. 3d 927, 796 N.Y.S.2d 872 (N.Y.

Civ Ct. Kings County 2005); *Westchester County Medical Center v. N.Y. Central Mutual Fire Ins. Co.*, 262 A.D.2d 553, 692 N.Y.S.2d 665 (2nd Dep't1999); *Canarsie Chiropractic, P.C. v. State Farm Mutual Automobile Ins. Co.*, 27 Misc. 3d 1228(A), 2010 NY Slip Op 50950(U) (N.Y. Civ Ct. Kings County 2010)). On the other hand, it has been held that a response to a verification request that is "arguably responsive" places the burden to take further action upon the respondent. *See All Health Medical Care, P.C. v. Gov't Empls. Ins, Co.*, 2 Misc.3d 907 (N.Y. City Civ. Ct. 2004); *see also, Media Neurology, P.C. v. Countrywide Ins. Co.*, 21 Misc.3d 1101 (N.Y. City Civ. Ct. 2005). The Court, in *Canarsie Chiropractic, P.C. v. State Farm Mut. Auto. Ins. Co.*, 911 N.Y.S.2d 691 (Table), 27 Misc. 3d 1228(A)(Civ. Ct. Kings Cty. 2010), expressed, "[N]either party may ignore communications from the other without risking its chance to prevail in the matter." *Id.*

It should also be noted that "[i]f the provider objects to the request for verification, then the issue of whether the requested verification was material and the objection were proper are preserved and become questions of fact for the trier of fact. If the insurer can establish it had a reasonable, good faith, factual basis for requesting the verification, then the failure of the claimant-provider to furnish the material will result in the dismissal of the action. If the insurer cannot establish a reasonable, good faith, factual basis for requesting the verification, then the insurer will be required to pay the claim." *Victory Medical Diagnostics, PC v. Nationwide Property and Casualty Ins. Co.*, 36 Misc.3d 568, 576, 949 N.Y.S.2d 855, 862 (Dist. Ct., Nassau Co., 2012).

Analysis - Verification/120 day rule - Office/Injection - DOS 2/17/22

In the present case, Applicant billed Respondent in the aggregate amount of \$337.03 under codes 99213-25, 20611-LT and J1040-LT for an office evaluation of the Assignor and corticosteroid injection provided to the Assignor on February 17, 2022. The bill was received by Respondent on March 15, 2022. Respondent thereafter mailed Applicant an initial request for additional verification, dated March 22, 2022, for Applicant's claim stating, in pertinent part, the following:

Please submit the corresponding supply invoice documenting your original purchase price for CPT Code J1040 (DepoMedrol/methylprednisolone acetate).

The request also included the requisite regulatory language advising that, "Per New York State Regulation 68- C, section 65-3.5, "an applicant from whom verification is requested shall, within 120 calendar days from the date of the initial request for verification, submit all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply. Failure to do

so may result in denial of claim." Respondent subsequently mailed Applicant a similar follow-up request for additional verification, dated April 21, 2022, for Applicant's claim seeking the same documentation. The letter was also cc:d to the Assignor and the Assignor's counsel.

Respondent issued a denial, dated August 2, 2022, based on the 120-day rule, asserting that Applicant did not provide the requested verification, or any reasonable justification for failing to comply, within 120 days of Respondent's first request. The denial/EOB, stated in pertinent part, that:

Invoice for J1040 requested x2 to not receive post 120 days from initial delay claim denied.

Per New York State Regulation 68- C, section 65-3.5, an applicant from whom verification is requested shall, within 120 calendar days from the date of the initial request for verification, submit all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply. The medical bill is denied as you have failed to provide within 120 days from the date of the initial request, either all such verification under the applicants control or possession or written proof providing reasonable justification for the failure to comply.

To support its denial, Respondent uploaded an affidavit, sworn to on June 1, 2023, by Jason Zhu, a PIP Litigation Specialist, regarding the preparation and mailing of the verification requests and the denial and Respondent's non-receipt of the requested additional verification.

There is no verification response from Applicant in the record, and Applicant has not asserted that any responses were ever provided to Respondent. At the hearing, Applicant's counsel asserted that pursuant to *State Farm Ins. Co. v. Domotor*, 266 A.D.2d 219, 220, 697 N.Y.S.2d 348, 349 (2d Dept. 1999), Respondent repudiated coverage on August 23, 2022 (the date of the IME general denial); thus, excusing Applicant from further compliance with the obligations under the policy.

After reviewing all of the submissions and taking into account the oral arguments of the parties, I find that Respondent has sufficiently established its 120 day/lack of verification defense. The record includes sufficient credible evidence that Respondent timely and properly requested additional verification from Applicant with respect to the claims at issue; that Applicant failed to provide all the requested verification within its possession or control, or reasonable justification for its failure to comply, within 120 days from the first request, and Respondent timely and properly denied Applicant's claims pursuant to 11 NYCRR §65-3.8(b)(3) based on the 120 day defense. *See* 11 NYCRR §65-3.8(b)(3); 11 NYCRR §65-3.5(o). There is nothing in the record that establishes that Applicant ever responded to the verification requests; ever advised that the requested additional verification was not in its possession and control; or ever objected to the additional verification requested. Though Applicant's counsel asserted that Applicant was excused from its obligations under the policy based on Respondent's repudiated coverage on August 23, 2022 (the date of the IME general denial), the record establishes that Respondent had already denied the claims at issue on August 2, 2022

prior to the purported repudiation of coverage. Thus, Applicant has not provided any excuse or reasonable justification for failing to provide all the requested verification within its possession or control within 120 days from the first request. Accordingly, based on the totality of the evidence in the record, I find that Respondent has established its 120 day/lack of verification defense. As Applicant has failed to adequately rebut such defense, Applicant's claims for reimbursement for the office evaluation of the Assignor and corticosteroid injection provided to the Assignor on February 17, 2022 are denied.

DATE OF SERVICE: 8/30/22

Legal Framework - Medical Necessity - IME

The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment (*Kingsbrook Jewish Medical Center v. Allstate Ins. Co.*, 61 A.D.3d 13 [2d Dept. 2009]), such as by a qualified expert performing an independent medical examination or conducting a peer review of the injured person's treatment. *See Rockaway Boulevard Medical P.C. v. Travelers Property Casualty Corp.*, 2003 N.Y. Slip Op. 50842(U), 2003 WL 21049583 (App. Term 2d & 11th Dists. Apr. 1, 2003). An insurance carrier may utilize an independent medical examination (IME) to determine whether an eligible injured person is entitled to further care and treatment or other first-party benefits. *See Rowe v. Wahnaw*, 26 Misc.3d 8, 11-12 (App Term, 1st Dept 2009, McKeon, P.J., dissenting). "An IME is a snapshot of the injured party's medical condition as of the date" it is conducted. *Amato v. State Farm Ins. Co.*, 2010 NY Slip Op. 20431 (Dist. Ct. Nassau Co., Fred J. Hirsh, J., Oct. 13, 2010).

An IME report can be the basis of a termination of benefits if ultimately found to be persuasive. An IME report must set forth a factual basis and medical rationale for the conclusion that further services are not medically necessary. *Ying Eastern Acupuncture, P.C. v. Global Liberty Ins.*, 20 Misc.3d 144(A), 873 N.Y.S.2d 238 (Table), 2008 N.Y. Slip Op. 51863(U), 2008 WL 4222084 (App. Term 2d & 11th Dists. Sept. 3, 2008). The determination that an eligible injured person no longer needs treatment is generally based upon an examiner's findings that result in the conclusion that: (1) the patient has fully recovered from the injuries; (2) the patient has made as full a recovery as is possible taking into account the nature and extent of the injuries, the patient's age, pre-existing conditions or other factors; and/or (3) additional treatment or testing will not provide any medical benefit to the patient. *Amato v. State Farm Ins. Co.*, 2010 NY Slip Op. 20431 (Dist. Ct. Nassau Co., Fred J. Hirsh, J., Oct. 13, 2010). Whether an IME report is persuasive and meets the carrier's burden is a factual decision, which must be rendered on a case by case basis.

If the IME report provides a factual basis and medical rationale for an opinion that services were not medically necessary, the burden shifts back to the Applicant to refute the IME findings and prove the necessity of the disputed services. *See, CPT Med. Servs., P.C. v. New York Cent. Mut. Fire Ins. Co.*, 18 Misc.3d 87 (App. Term 1st Dept.); *Eden Med., P.C. v. Progressive Cas. Ins. Co.*, 19 Misc.3d 143(A) (App Term 2d & 11th Jud. Dists., 2008); *Be Well Med. Supply, Inc. v. New York Cent. Mut. Fire Ins. Co.*, 18 Misc. 3d. 139 (A) (App. Term 2d Dept., Feb. 21, 2008; *A. Khodadadi Radiology, P.C. v. NY Cent. Mut. Fire Ins. Co.*, 16 Misc. 3d. 131 (A) (App Term 2d Dept.); *West Tremont Med. Diagnostic, P.C. v. Geico Ins. Co.*, 13 Misc. 3d. 131 (A) (App Term 2d Dept.,

2006). If the Applicant fails to present any evidence to refute Respondent's showing, the claim should be denied, as the ultimate burden of proof on the issue of medical necessity lies with the Applicant. *See Insurance Law § 5102; Wagner v. Baird*, 208 A.D.2d 1087 (3d Dept. 1994); *AJS Chiropractic, P.C. v. Mercury Ins. Co.*, 22 Misc.3d 133(A), (App. Term 2d & 11th Dist. Feb. 9, 2002). The case law is clear that a provider must rebut the conclusions and determinations of the IME doctor with his own facts. As the Appellate Term, 2d, 11th & 13th Dists., recently stated: "it is ultimately plaintiff who must prove, by a preponderance of the evidence, that the services or supplies were medically necessary." *Park Slope Medical and Surgical Supply, Inc. v. Travelers Ins. Co.*, 37 Misc.3d 19, 22 (App. Term 2d, 11th & 13th Dists. 2012).

An opinion letter issued by the Office of General Counsel on February 14, 2005, sets forth that pursuant to 11 NYCRR 65-3.8(a)(1), "[t]he earliest date that benefits may be cut off prospectively based on the findings of [an] IME is the date the denial is sent to the applicant for benefits." *See Ops Gen Counsel NY DFS No. 05-05-21* (February 14, 2005). Thus, the earliest date the denial and determination contained therein can take effect is the date the insurer sent the timely denial to the eligible injured person with a copy to the affected providers.

IME - Pierce J. Ferriter, M.D., dated August 11, 2022

Respondent relies principally upon the IME report of Pierce J. Ferriter, M.D., dated August 11, 2022, in asserting a lack of medical necessity for the office evaluation of the Assignor conducted, subsequent to the IME cutoff, on August 30, 2022. At the August 11, 2022 orthopedic examination, Dr. Ferriter obtained the Assignor's history, reviewed medical records and conducted a physical examination of the Assignor. The examiner using a hand-held goniometer where applicable performed measurements of the ranges of motion.

At the time of the examination, the Assignor complained of pain in the neck, low back, right shoulder and left shoulder. The Assignor walked into the examination room with a normal gait and posture. No limp or foot drop was present and no brace or assistive device was used.

Examination of the cervical spine revealed no swelling, discoloration, or deformity. There was no muscle spasm upon palpation of the paracervical muscles, and no complaint of tenderness on palpation. Active ranges of motion were within normal limits (flexion: 50°/50°; extension: 60°/60°; right and left lateral flexion: 45°/45°; right and left rotation: 80°/80°). Spurling's, Shoulder Shrug, Hoffman's, Atrophy of the Scapula, Compression, Jackson's, and Soto-Hall's tests were all negative. Neurological examination of the upper extremities revealed no atrophy, muscle strength at 5/5, deep tendon reflexes at 2+, and sensation to light touch within normal limits.

Examination of the thoracic spine revealed no swelling, discoloration, or deformity. There was no parathoracic spasm upon palpation, and no complaint of tenderness on palpation. Active ranges of motion were within normal limits (flexion: 45°/45°; extension: 0°/0°; right and left lateral flexion: 45°/45°; right and left rotation: 25°/25°). Orthopedic testing (Suprascapular Winging, Kyphosis Present) were negative.

Examination of the lumbar spine revealed no swelling, discoloration, or deformity. There was no muscle spasm upon palpation of the paralumbar muscles and no complaint of tenderness on palpation. Active ranges of motion were within normal limits (flexion: 60°/60°; extension: 25°/25°; right and left lateral flexion: 25°/25°). Straight leg raise was negative with no radiculopathy. Fabere Test, Soto-Hall, Kemp's Test, Minor's sign, and Lasegue Test were all negative. Neurological examination of the lower extremities revealed no atrophy, muscle strength at 5/5, deep tendon reflexes at 2+ and sensation to light touch within normal limits.

Examination of the right and left shoulders revealed no heat, swelling, erythema or crepitus appreciated. Hawkins/Kennedy Impingement, Neer's Impingement, Cross Arm Adduction, Empty Can (Jobe's), Scapular Winging, Drop Arm, O'Brien, Painful Arc, and Atrophy of Deltoid were all negative. Rotator Cuff Strength was 5/5. There was no complaint of tenderness upon palpation in the acromioclavicular or supraspinatus. Active ranges of motion were within normal limits (forward flexion: 180°/180°; extension: 40°/40°; abduction: 180°/180°; adduction: 30°/30°; internal rotation: 80°/80°; external rotation: 90°/90°).

Examination of the right and left elbows revealed no heat, swelling, erythema or crepitus appreciated. There was no complaint of tenderness upon palpation in the olecranon or epicondyle. Tinel's and Birsitis were negative. Biceps and triceps strength were 5/5. Active ranges of motion were within normal limits (flexion: 150°/150°; extension: 0°/0°). No varus or valgus instability noted.

Examination of the right and left wrists revealed no heat, swelling, erythema or crepitus appreciated. Sensation testing was normal. Tinel's and Phalen's were negative. There was no atrophy of the thenar muscles and grip strength and intrinsic muscle strength were 5/5. Active ranges of motion were within normal limits (palmar flexion: 60°/60°; dorsiflexion: 60°/60°; radial deviation: 20°/20°; ulnar deviation: 30°/30°). Extension and flexion strength testing reveals 5/5 strength. There was no complaint of tenderness upon palpation.

Examination of the left and right hands revealed ranges of motion of the digits were within normal limits.

Examination of the right and left hips revealed no heat, swelling, or redness appreciated. There was no complaint of tenderness upon palpation Ober and bursitis were negative. Flexion, Abduction, and Adduction Strength were 5/5. Active ranges of motion were within normal limits (forward flexion: 100°/100°; extension: 30°/30°; abduction: 40°/40°; adduction: 20°/20°; external rotation: 50°/50°; internal rotation: 40°/40°).

Examination of the right and left knee revealed no heat, swelling, effusion, erythema or crepitus appreciated. There was no complaint of tenderness noted on palpation. Lachman's, Patella Tracking, Anterior Drawer, Posterior Drawer, Patella Grind, McMurray's, Varus/Valgus Deformity, Bounce and Pivot Shift were all negative. The knee was stable on Varus/Valgus Stress and there was no patella bursitis. Active ranges of motion were within normal limits (flexion: 150°/150°; extension: 0°/0°). Quadriceps and hamstring strength testing was 5/5 strength. No atrophy was noted in the quadriceps and hamstring muscles, and no chondromalacia was present on palpation of the patella.

Examination of the right and left ankles revealed no heat, swelling, erythema or crepitus appreciated. There was no evidence of atrophy. Drawer was negative. There was no instability noted, and Dorsi flexion and Plantar flexion strength were 5/5. Active ranges of motion were within normal limits (dorsiflexion: 20°/20°; plantar flexion: 40°/40°; inversion: 30°/30°; eversion: 20°/20°). There was no complaint of tenderness upon palpation.

Examination of the left and right feet revealed ranges of motion of the digits were within normal limits. There was no complaint of tenderness upon palpation.

Dr. Ferriter's diagnoses were cervical spine sprain/strain - resolved, lumbar spine sprain/strain - resolved, right shoulder sprain/strain - resolved, left shoulder sprain/strain - resolved, and objectively normal examination of the other examined body parts. Dr. Ferriter found no objective evidence of an orthopedic disability.

Dr. Ferriter opined based on his physical examination, that there was no medical necessity for continued care in his specialty, Orthopedics. He specifically found no medical necessity for physical therapy, household help, special transportation, DME/supplies, diagnostic testing or prescription medications, as well as no indication or medical necessity for massage therapy, injections or surgery. He found that there were no positive objective findings on examination to support the subjective complaints of pain, and that the findings noted on diagnostic testing did not correlate with his examination.

Analysis - Medical necessity - Office - DOS 8/30/22

Applicant did not submit a formal rebuttal to the August 11, 2022 IME report by Dr. Ferriter. In opposition, Applicant relies principally upon the Assignor's medical records. At the hearing, Applicant's counsel specifically pointed to the July 18, 2022 and August 30, 2022 examination reports as the most contemporaneous examination reports in the record. Counsel asserted that the Assignor's complaints at the IME, and the persistent complaints of pain and the positive findings in the contemporaneous examination reports, along with other reports in the record, established that the Assignor's injuries were not resolved at the time of the IME and that the continued treatment was medically necessary and justified. Respondent noted that there were multiple prior awards upholding Respondent's medical necessity defense based on the IME by Dr. Ferriter; however, Respondent conceded that Applicant was not a party in any of the prior proceedings. Applicant's counsel asserted that collateral estoppel did not apply as Applicant was not a party in the prior proceedings and that Applicant had the right to present its own evidence to challenge and rebut the IME report and Respondent's medical necessity defense.

After reviewing all of the submissions and taking into account the oral arguments of the parties, I find that Applicant has rebutted Respondent's defense and has established, by a preponderance of credible evidence, that the office evaluation of the Assignor conducted, subsequent to the IME cutoff, on August 30, 2022, was medically necessary. The IME was performed on August 11, 2022, approximately eleven months after the accident, and documented what appeared to be a thorough and detailed examination with no positive objective findings noted. The services at issue were provided three weeks

after the IME on August 30, 2022. The contemporaneous examination report and other reports in the record provided objective evidence of the Assignor's continuing disability and furnish sufficient justification for the continued services to the Assignor. Among other things, the medical records documented continued complaints of pain to the neck (with radiation to the upper extremities and some numbness and tingling in the hands), bilateral shoulders and low back; tenderness and muscle spasms, range of motion deficits in the bilateral shoulders, cervical spine and lumbar spine; positive orthopedic testing in the right shoulder; some diminished sensation in the right hand; and some motor weakness in the upper extremities. The ongoing symptomology and deficits revealed in the medical records are irreconcilable with the IME doctor's findings, diagnoses of resolved injuries and recommendations of no further treatment. When faced with two inconsistent, but credible opinions, deference would be accorded to the treating provider, who actually performed examinations, established treatment and diagnostic plans, made diagnoses and performed medical services for the Assignor. While I do find the prior awards to be persuasive to an extent, Applicant was not a party to the prior proceedings and is entitled to present its own evidence to rebut Respondent's medical necessity defense. Ultimately, on this record, I find Applicant's supporting medical records and arguments to be more credible and persuasive than the IME report. Based on the totality of the evidence herein, I find that Applicant has rebutted Respondent's defense and established the medical necessity of the services at issue. As Applicant has met its burden of persuasion, Applicant is entitled to reimbursement in the amount of **\$87.80** for the office evaluation of the Assignor conducted, subsequent to the IME cutoff, on August 30, 2022.

Conclusion

For the reasons set forth herein, Applicant is awarded reimbursement in the total amount of \$87.80, with attorney's fees, interest and the arbitration filing fee as set forth below. This decision is in full disposition of all claims for no-fault benefits presently before this Arbitrator. Any further issues raised in the hearing record are held to be moot and/or waived insofar as not specifically 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
	Richard S. Obedian MD PLLC	02/17/22 - 08/30/22	\$424.83	Awarded: \$87.80
Total			\$424.83	Awarded: \$87.80

B. The insurer shall also compute and pay the applicant interest set forth below. 03/22/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest shall be computed from March 22, 2023, the AR-1 filing date, at the rate of 2% per month and ending with the date of payment of the award, subject to the provisions of 11 NYCRR 65-3.9(c).

C. Attorney's Fees

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

Respondent shall pay the Applicant attorney's fees in accordance with 11 NYCRR 65-4.6(d).

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 NY
SS :
County of Suffolk

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

10/31/2023
(Dated)

Kihyun Kim

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:
82d42122bef0d1227622e0e0fd627bbd

Electronically Signed

Your name: Kihyun Kim
Signed on: 10/31/2023