

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

NY Complete Medical Care PC  
(Applicant)

- and -

Geico Insurance Company  
(Respondent)

AAA Case No.	17-23-1286-1506
Applicant's File No.	2931992
Insurer's Claim File No.	0143968690101130
NAIC No.	35882

**ARBITRATION AWARD**

I, Marcelo Vera, 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: EIP

1. Hearing(s) held on 10/25/2023  
Declared closed by the arbitrator on 10/25/2023

Neda Melamed, Esq from Israel Purdy, LLP participated virtually for the Applicant

Christa Varone from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,735.14**, 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 arbitration arises out of treatment to the EIP, BV, a female, involved in a motor vehicle accident on February 3, 2018. Applicant seeks reimbursement in the amount of \$1735.14 for services performed on February 10, 2018 to September 06, 2018. Respondent has issued denials as follows: For date of service February 10, 2018 Respondent notes this bill for an office visit was a duplicate as only one office visit or consultation per patient per day is reimbursable. Date of service August 18, 2018 was denied based upon the peer review of Terence McAlarney, M.D. dated October 04, 2018. Date of service September 06, 2018 was denied based upon the IME performed by Dr. Shemelyak and Dr. Mannor on July 19, 2018.

#### 4. Findings, Conclusions, and Basis Therefor

My decision is based on the arguments of representatives for each party as well as those documents contained in the electronic file maintained by the American Arbitration Association. I have reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

It is Applicant's *prima facie* obligation to establish its entitlement to payment for each service for which reimbursement is sought. It is well settled that a health care provider establishes its *prima facie* entitlement to payment as a matter of law by proof that it submitted a proper claim, setting forth the fact and the amount charged for the services rendered and that payment of no-fault benefits was overdue (see *Insurance Law § 5106 a*; *Mary Immaculate Hosp. v. Allstate Ins. Co.*, 5 AD 3d 742, 774 N.Y.S. 2d 564 [2004]; *Amaze Med. Supply v. Eagle Ins. Co.*, 2 Misc. 3d 128A, 784 N.Y.S. 2d 918, 2003 NY Slip Op 51701U [App Term, 2d & 11th Jud Dists]). Herein, applicant established its *prima facie* entitlement to first party no-fault benefits by proof that it submitted a claim setting forth the fact and amount of the loss sustained and that payment of no-fault benefits was overdue.

Addressing Date of service February 10, 2018

Respondent's counsel argues, this bill for an office visit was a duplicate as only one office visit or consultation per patient per day is reimbursable. The Record contains the initial consultation bill from the Applicant it is noted on February 10, 2018 an Initial evaluation was conducted by the same provider and billed in the amount of \$72.92. As such I find that I am in agreement with Respondent's counsel and deny the bill in the amount of \$114.33 on February 10, 2018 as a duplicate service.

Addressing Date of service August 18, 2018

When an insurer relies upon a peer review report to demonstrate that a particular service was not medically necessary, the peer reviewer's opinion must be supported by sufficient factual evidence or proof and cannot simply be conclusory. As per the holding in *Jacob Nir, M.D. v. Allstate Insurance Co.*, 7 Misc.3d 544 (2005) Further, a denial based on lack of medical necessity must be supported by competent medical evidence setting forth a clear factual basis and medical rationale for denying the claim. *Citywide Social Work, & Psy. Serv. P.L.L.C. v Travelers Indemnity Co.*, 3 Misc. 3d 608 (Civ. Ct. Kings Co. 2004)

In support of its contention the study was not medically necessary, respondent relies upon the peer review by Terence McAlarney, M.D. dated October 08, 2018. Dr. McAlarney's report concluded the performance of the EMG/NCV study was not medically necessary, he opines in relevant part

"MRI of the cervical spine reported multi-level discs. The EMG/NCS testing is reported to be "indicated." This is a conclusory statement. There is no elaboration as to why an EMG/NCS test is "indicated." The EMG/NCS testing is

not medically necessary. The claimant does not have a condition other than or in addition to radiculopathy to investigate with EMG/NCS testing..."

Dr. McAlarney cites to medical authority to support his conclusion.

Applicant argues Dr. McAlarney relied on medical records in order to make a determination of medical necessity or lack thereof, and said medical records were not uploaded for review. Dr. McAlarney's peer listed several medical records reviewed, initial on February 07, 2018, MRI report of February 18, 2018, MRI on May 15, 2018 among others. The uploaded record is devoid of any of these medical reports.

Dr. McAlarney's reliance on these records in the peer review imputes an obligation on the part of Respondent to submit these records for a review by this Arbitrator to assess the accuracy of the content and interpretation of these records as detailed in the peer review. Respondent failed to provide these records and therefore, without an opportunity to review these records, I am constrained to draw a negative inference.

I find the evidence presented does not support the defense as stated on the denial. The Respondent is unable to sustain a medical necessity defense without the records reviewed by the peer reviewer. This portion of the claim in the amount of \$1556.16 is awarded.

Addressing Date of Service September 06, 2018

Respondent asserts that the treatment for dates of service post IME cut off was timely denied based upon the independent medical examination. An IME report asserting no further treatment is 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 Mut. 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., May 29, 2008, Andrew M. Engle, J.). An IME report must set forth a factual basis and medical rationale for the conclusion that further services are not medically necessary. E.g., *Ying Eastern Acupuncture, P.C. v. Global Liberty Insurance*, 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 Case law states that the 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. *Bronx Expert Radiology, P.C. v Travelers Ins. Co.*, 2006 NY Slip Op 52116 (App. Term 1<sup>st</sup> Dept. 2006).

Respondent's denial dated November 06, 2018 states as follows:

"Based on the results of a health service examination by Dr(s). SHEMELYAK 1, 2, 3 AND MANNOR on 07/19/2018 , it has been determined that no further Orthopedic Surgery, Acupuncture, Massage Therapy, Diagnostic Testing, Supplies, and Physical Therapy treatment is necessary for the injuries suffered

by EIP related to the accident. Accordingly, all Orthopedic Surgery, Acupuncture, Massage Therapy, Diagnostic Testing, Supplies, and Physical Therapy benefits will be denied effective 12:01 a.m. on 08/03/2018..."

Applicant's counsel argues Respondent's position is unsupported, and that Respondent has not met its burden of demonstrating lack of medical necessity as the denial is based on IME reports that are not in evidence. the burden is on the insurer to prove that assertion with competent evidence such as an independent medical examination, a peer review or other proof that sets forth a factual basis and a medical rationale for denying the claim. See *A.B. Medical Services, PLLC v. Geico*. I agree with Applicant's position, a thorough review of the evidence submitted shows that the record is devoid of the IME report prepared by Dr. Shemelyak or Dr. Mannor.. I find that Respondent has not met its burden and its denials are unsupported and cannot be upheld.

Accordingly, in light of the foregoing, based on the arguments of counsel and after a thorough review and consideration of all submissions, I find in favor of the Applicant and award this portion of the Applicant's claim in the amount of \$64.65

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
	NY Complete Medical Care PC	02/10/18 - 09/06/18	\$1,735.14	Awarded: \$1,620.81

<b>Total</b>	<b>\$1,735.14</b>	<b>Awarded: \$1,620.81</b>
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- B. The insurer shall also compute and pay the applicant interest set forth below. 02/09/2023 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 N.Y.3d 217 (2009).

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 in accordance with 11 NYCRR 65-4.6(d) This matter was filed **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). This amendment takes into account that the maximum attorney fee has been raised from \$850.00 to \$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 NY  
SS :  
County of Nassau

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

11/08/2023  
(Dated)

Marcelo Vera

### **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:**  
213e193a2112f68a5ca902c1aca2fe8e

### Electronically Signed

Your name: Marcelo Vera  
Signed on: 11/08/2023