

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Greenpoint Chiropractic P.C
(Applicant)

- and -

American Transit Insurance Company
(Respondent)

AAA Case No. 17-22-1271-0820

Applicant's File No. 3116118

Insurer's Claim File No. 680117-02

NAIC No. 16616

ARBITRATION AWARD

I, Gregory Watford, 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 (AS)

1. Hearing(s) held on 10/24/2023
Declared closed by the arbitrator on 10/24/2023

Melissa Scotti from Law Offices of Andrew J. Costella Jr., Esq. participated virtually for the Applicant

Anthony Troise from American Transit Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$3,668.86**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant amended the amount in dispute to \$2,431.25 based upon Respondent's coder affidavit calculations.

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

3. Summary of Issues in Dispute

The dispute arises from the underlying automobile accident of June 1, 2017, in which the Assignor, then a 51-year-old female, was a bicyclist. As a result of the impact, she complained of multiple injuries, including injuries to her neck, mid back, lower back, left shoulder, left wrist/hand, left hip, left knee, left foot and headaches. Thereafter, she was transported to a local hospital where she was treated and released. She then

sought private medical attention and was recommended for conservative care treatments including chiropractic treatments.

On April 18, 2018, Assignor underwent a chiropractic/acupuncture independent medical examination (IME) conducted by Dr. John Iozzio who concluded that Assignor's injuries had fully resolved. As a result of the IME, Respondent cut off no fault chiropractic benefits effective 5/8/18.

In dispute in this claim are the fees for chiropractic treatment services, pain management injection services and various items of durable medical equipment (DME) provided to Assignor from 7/8/17 - 6/4/18. Applicant submitted the bills for payment. Respondent denied payment of the bills for DOS 5/14/18 - 6/14/28 (\$775.00), based upon IME of Dr. Iozzio.

For the bills dated 7/8/17 (\$574.40), 7/17/17 (\$1,103.75), 7/20/17 (\$440.71) & 5/16/18 - 5/17/18 (\$387.50), Respondent did not pay or deny these bills on the grounds that it did not receive the bills until they were included in Applicant's submission. Respondent asserts that these bills were included in the instant arbitration prematurely and should be dismissed without prejudice.

Respondent also did not pay or deny the bill for DOS 4/26/18 - 5/3/18 (\$1,162.50) on the ground that Applicant did not adequately respond to outstanding verification requests. Respondent also asserts that this bill is not ripe for arbitration and should be dismissed as premature.

At the hearing, when asked, Respondent did not raise any fee schedule objections to the amounts billed by Applicant.

The issues to be decided in this case are:

Whether Applicant established entitlement to No-Fault compensation for the post IME for chiropractic treatment services, DME and pain management injection services and various items of durable medical equipment (DME) provided to Assignor.

Whether Respondent made out a prima facie case of lack of medical necessity and, if so, whether Applicant rebutted it.

Whether Respondent established that there are still outstanding requests for further verification of these claims.

4. Findings, Conclusions, and Basis Therefor

I have reviewed the submissions and documents contained in the American Arbitration Association's ADR Center Electronic Case File (ECF). These submissions constitute the record in this case. This case was decided on the submissions of the parties as contained

in the ECF and the oral arguments of the parties' representatives. There were no witnesses.

Bills Not Received - Lack of Prima Facie Case

DOS 7/8/17 (\$574.40), 7/17/17 (\$1,103.75), 7/20/17 (\$440.71) & 5/16/18 - 5/17/18 (\$387.50)

Pursuant to Insurance Law § 5106(a) and the Insurance regulations, an insurer must either pay or deny a claim for motor vehicle no-fault benefits, in whole or in part, within 30 days after an applicant's proof of claim is received (*see* Insurance Law § 5106[a]; 11 NYCRR 65-3.8[c]; *see also* 11 NYCRR 65-3.5). Infinity Health Products, Ltd. v. Eveready Ins. Co., 67 A.D.3d 862, 864, 890 N.Y.S.2d 545, 547 (2d Dept. 2009). A claimant's prima facie proof of claim for no-fault benefits must demonstrate that the prescribed claim forms were mailed to and received by the insurer and are overdue. Viviane Etienne Medical Care, P.C. v. Country-Wide Ins. Co., 25 N.Y.3d 498, 506, 14 N.Y.S.3d 283, 290 (2015). Applicant's proof is also in Respondent's denials, which acknowledged receipt of the bills.

Respondent argued that it did not become aware of the above-referenced bills until after Applicant's AR-1 was filed and said bill was listed in Applicant's arbitration submission. In support of its defense, Respondent relied upon the affidavit of non-receipt from Cheryl Glaze, dated 12/2/22. I find the affidavit credible.

Accordingly, the burden shifts to Applicant to demonstrate that it submitted/mailed/transmitted the bills in dispute to Respondent's claims offices.

Generally, proof that an item was properly mailed gives rise to a rebuttable presumption that the item was received by the addressee. New York and Presbyterian Hospital v. Allstate Insurance Company, 29 A.D. 3d 547 (N.Y. App. Div. 2nd Dept. 2006) *quoting*, Matter of Rodriguez v Wing, 251 A.D.2d 335 (App. Div. 2nd Dept. 1998). "The presumption may be created by either proof of actual mailing or proof of the standard office practice or procedure designed to ensure that items are properly addressed and mailed." New York and Presbyterian Hospital v. Allstate Insurance Company, 29 AD 3d 547 *quoting* Residential Holding Corp. Scottsdale Insurance Company, 286 A.D. 2d 679 (App. Div. 2nd Dept. 2001).

At the hearing, when asked, Applicant did not produce any proof of mailing for these bills in dispute. A review of the ECF also failed to produce any proof of mailing for these bills. Consequently, I find that Applicant has not sufficiently established a prima facie case of entitlement for no-fault benefits for these bills. Accordingly, these bills are dismissed as premature without prejudice.

After reviewing the record and evidence presented for the remaining bills in dispute, I find that Applicant established a prima facie case of entitlement for reimbursement. Viviane Etienne Med Care, PC v. Countrywide Ins. Co., *Id.*

Once an applicant establishes a prima facie case, the burden then shifts to the insurer to prove its defense. See Citywide Social Work & Psych. Serv. P.L.L.C v. Travelers Indemnity Co., 3 Misc. 3d 608, 2004, NY Slip Op 24034 (Civ. Ct., Kings County 2004).

Outstanding verification 4/26/18 - 5/3/18 (\$1,162.50)

"The 30-day period in which to either pay or deny a claim is extended where the insurer makes a request for additional verification within the requisite 15-[business] day time period (see Montefiore Med. Ctr. v Government Empls. Ins. Co., 34 AD3d 771; New York & Presbyt. Hosp. v. Allstate Ins. Co., 31 AD3d 512)." Kingsbrook Jewish Medical Center v. Allstate Insurance Co., 61 A.D.3d 13, 17-18, 871 N.Y.S.2d 680, 683 (2d Dept. 2009). "If the requested verification is not received within 30 days, the insurer must send a follow-up letter within 10 days thereafter (see 11 NYCRR 65.15[e][2])." New York & Presbyterian Hospital v. American Transit Insurance Co., 287 A.D.2d 699, 700, 733 N.Y.S.2d 80, 81-82 (2d Dept. 2001).

A claim need not be paid or denied until all demanded verification is provided (see 11 NYCRR 65-3.8(b) (3); Westchester County Med. Ctr. v. New York Cent. Mut. Fire Ins. Co., 262 A.D.2d 553, 554, 692 N.Y.S.2d 665 (N.Y. App. Div. 2nd Dept. 1999). When a hospital fails to respond to a verification request, the 30-day period in which to pay or deny the claim does not begin to run, and any claim for payment by the hospital is premature. See St. Vincent's Hosp. of Richmond v. American Tr. Ins. Co., 299 A.D.2d 338, 340, 750 N.Y.S.2d 98 (N.Y. App. Div. 2nd Dept. 2002); Nyack Hosp. v. Progressive Cas. Ins. Co., 296 A.D.2d 482, 483, 747 N.Y.S.2d 516 (N.Y. App. Div. 2nd Dept. 2002); New York Hosp. Med. Ctr. Of Queens v. State Farm Mut. Auto Ins. Co., 293 A.D.2d 588, 590, 741 N.Y.S.2d 86 (N.Y. App. Div. 2nd Dept. 2002). No-fault benefits are overdue, however, if not paid within 30 calendar days after the insurer receives verification of all of the relevant information requested pursuant to 11 NYCRR 65.15(d)(see 11 NYCRR 65-3.8(a)(1); New York Hosp. Med. Ctr. Of Queens v. Country-Wide Ins. Co., 295 A.D.2d 583, 584, 744 N.Y.S.2d 201(N.Y. App. Div. 2nd Dept. 2002).

Respondent has provided the letters requesting additional verification for the bill in dispute requesting a letter of medical necessity from the treating chiropractor. Respondent provided a copy of the affidavit of mailing from Luis Campbell who attested that he mailed the verification requests on 6/7/18 and 7/12/18.

At the hearing Applicant did not contest the timeliness of the verification requests or that the verification requests were not received.

After reviewing submissions in the ECF and the arguments presented at the hearing and based on the citations above, I find Respondent's verification requests to be timely made within the timeframe as stated in Section 65-3.6 (b).

A review of Applicant's submissions revealed that Applicant failed to respond at all to Respondent's verification requests. Furthermore, there are no documents evidencing that

Applicant objected to Respondent's verification requests as inappropriate or lacking merit. Moreover, there are no documents evidencing that Applicant was confused as to why the verification requests were made.

An applicant has a duty to respond to a proper and timely verification request from an insurer, even where the applicant anticipated it will be unable to fully satisfy the insurer's request or the request is unintelligible. Pro-Align Chiropractic, P.C. v. Travelers Property Casualty Ins. Co., 58 Misc3d 857, 860, (Dist. Ct. Suffolk Co. 2017).

Comparing the evidence and arguments presented by the parties at the hearing, I am persuaded by the arguments and evidence of Respondent. "Indeed, in light of the particular factual circumstances herein, it would be incongruous to conclude that the Insurance regulation regarding follow-up verification, or any other statute or rule, warrants a result which would, in effect, penalize an insurer who diligently attempts to obtain the information necessary to make a determination of a claim, and concomitantly, rewards a plaintiff who makes no attempt to even comply with the insurer's requests. Such a result is not contemplated by the "no-fault law" or its regulations, which should be interpreted to promote the expeditious handling of verification requests and prompt claim resolution." Infinity Health Products, Ltd. v. Eveready Ins. Co., 67 A.D.3d 862, 865, 890 N.Y.S.2d 545, 547-548 (2d Dept. 2009).

Based upon the foregoing, Applicant's claims for reimbursement for the chiropractic services for the dates in question are dismissed without prejudice as premature.

IME Cut-off

DOS 5/14/18 - 6/4/18

A presumption of medical necessity attaches to a timely submitted no fault claim. Elmont Open MRI & Diagnostic Radiology, P.C. v. State Farm Ins. Co., 26 Misc.3d 1211(A), 906 N.Y.S.2d 779 (Table), 2010 N.Y. Slip Op. 50053(U) at 3, 2010 WL 157564 (Dist. Ct. Nassau Co., Fred J. Hirsh, J., Jan. 6, 2010).

In no-fault cases, an IME is a snapshot of the injured party's medical condition as of the date of the IME. 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].)

An IME doctor must establish a factual basis and medical rationale for his asserted lack of medical necessity of further health care services. E.g., Ying Eastern Acupuncture, P.C. v. Global Liberty Insurance, 20 Misc.3d 144(A), 2008 NY Slip Op 51863(U), 2008 WL 4222084 (App. Term 2d & 11th Dists. Sept. 3, 2008).

If he does so, it becomes incumbent on the claimant to rebut the IME review, see AJS Chiropractic, P.C. v. Mercury Ins. Co., 22 Misc.3d 133(A), 2009 NY Slip Op 50208(U), 2009 WL 323421 (N.Y. App. Term 2nd & 11th Dist. Feb. 9, 2002), because the ultimate burden of proof on the issue of medical necessity lies with the claimant. See Insurance

Law § 5102; Shtarkman v. Allstate Insurance Co., 2002 NY Slip Op 50568(U), 2002 WL 32001277 (N.Y. App. Term 9th & 10th Jud. Dists. 2002) (burden of establishing whether a medical test performed by a medical provider was medically necessary is on the latter, not the insurance company). 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 Misc.3d 1025(A), 806 N.Y.S.2d 443 (Table), 2005 NY Slip Op. 51282(U), 2005 WL 1936346 (Civ. Ct. Kings Co., Jack M. Battaglia, J., Aug. 12, 2005). This burden of proof is properly placed on a claimant health care provider because presumably it is in possession of the injured party's medical records.

Dr. Iozzio conducted the chiropractic IME of Assignor. He reviewed the medical records of Assignor, conducted an initial interview and then conducted a physical examination of Assignor. According to Dr. Iozzio, during the IME interview, Assignor had continued complaints to her neck, mid back, low back, bilateral shoulders, left elbow, left wrist/hand, left hip and left knee.

The IME report of Dr. Iozzio was relied upon by Respondent and set forth those documents that were reviewed, detailed the examination that was performed, the findings of the examination of Assignor's cervical spine, thoracic spine and lumbar spine. Dr. Iozzio concluded that Assignor was found to be within normal limits and without need for further treatment. Based on this report, the Respondent terminated future chiropractic benefits as of 5/8/18. Dr. Iozzio rendered a diagnosis that Assignor's injuries had fully resolved.

He opined: *"Based upon my examination there is no need for any chiropractic treatments. There is no need for chiropractic treatments to the cervical, thoracic or lumbar spine as there were no objective findings to these areas which would warrant the need for further treatment. It is my opinion that there is no need for diagnostic testing, household help, medical supplies or special transportation."*

The claimant presented today for an examination with complaints of pain to the neck, mid back, low back, bilateral shoulders, left elbow, left wrist/hand and left knee. There were no objective findings at the time of today's examination to correlate with these subjective complaints. In this particular case, there were no objective findings such as spasm, atrophy or sensory loss to warrant the need for further treatment. I defer the claimant's complaints of bilateral shoulder, left elbow, left wrist/hand, left hip, left knee and left foot pain to the appropriate specialty."

I find that the IME of Dr. Iozzio has set forth sufficient factual basis and medical rationale for his opinion that at the time of his examination, medical services were no longer medically necessary and therefore has established, prima facie, a lack of medical necessity for those services rendered by Applicant.

If the carrier has satisfied its burden of demonstrating the lack of medical necessity, the applicant ultimately carries the burden of persuasion on the issue of medical necessity and must rebut the carrier's evidence or succumb. A.B. Med Servs., P.L.L.C. v. State Farm Mutual Auto Ins. Co., 7 Misc. 3d 822, 795 N.Y.S.2d 843 (N.Y. App. Term, 2nd Dept. - 2005) citing Baumann v. Long Is. R.R., 110 A.D.2d 739, 741 487 N.Y.S.2d 833

(N.Y. App. Div., 2nd Dept. - 1985); See also, Canarsie Family Med Practice, PLLC v. American Tr. Ins. Co., 26 Misc. 3d 132(A), 2010 NY Slip Op 50070(U) (N.Y. App. Term, 2nd Dept - 2010); Crotona Hgts. Med., P.C. v. Geico Ins. Co., 25 Misc. 3d 142(A), 2009 NY Slip Op 524664/4/17 (U) (N.Y. App. Term, 2nd Dept - 2009).

Applicant relied upon the rebuttal of Dr. Bartlomiej Rajowski, dated 7/31/23, and the documents in the ECF to establish medical necessity. Dr. Rajowski detailed Assignor's injuries from the car accident and relied on the re-examination report dated 4/26/18. He noted that the report documents spinal pain radiating to her shoulder, tight scapulae, a paresthesia in the upper and lower extremities. He noted that there were documents positive orthopedic findings and decreased range of motions on the cervical, thoracic and lumbar spines.

Applicant's counsel argued that the rebuttal along with the documents in the ECF, demonstrated that at the time of the IME, Assignor was in need of further chiropractic treatments.

Comparing the relevant evidence and arguments presented by both parties against each other, I am persuaded by the Applicant's argument and evidence. I find that the 4/26/18 follow-up report is contemporaneous and credible, which established that Assignor's injuries had not fully resolved at the time of the IME.

Accordingly, Applicant is entitled to be reimbursed for the aforementioned services in an amount consistent with the fee schedule.

Fee Schedule

Effective April 1, 2013, 11 NYCRR 65-3.8(g)(1) has been amended so that the application of the New York State Workers Compensation fee schedule is no longer a precludable defense, and no payment is due on those claims in excess of the fee schedule. Respondent may present its defense without regard to a timely NF 10. USAA General Indemnity Co. v. New York Chiropractic & Physical Therapy, PLLC, 60 Misc.3d 254 (Civ. Ct. Richmond Co., Lisa Grey, J., May 1, 2018).

On December 11, 2018, a new Fee Schedule was promulgated with an original effective date of April 1, 2019. However, the 34th Amendment to Regulation 83 delayed the Fee Schedule's effective date to October 1, 2020.

I take judicial notice of the Worker's Compensation fee schedule. See LVOV Acupuncture PC v. Geico Insurance Company, 32 Misc. 3d 144 (A) (N.Y. App. Term 2nd, 11th and 13th Jud. Dists. 2011).

Accordingly, the services in dispute are not covered by the new fee schedule.

Under the old fee schedule in effect at the time of the services in dispute, the 8-unit Rule controls.

Ground Rule 3 of the Physical Medicine Section of the Chiropractic Fee Schedule, Multiple Physical Medicine Procedures and Modalities, which applies to chiropractors, and is also commonly referred to as the "8 Unit Rule", reads: "When multiple physical medicine procedures and/or modalities are performed on the same day, reimbursement is limited to 8.0 RVUs or the amount billed, whichever is less. The following codes represent the physical medicine procedures and modalities subject to this rule: 97010, 97012, 97014, 97024, 97026, 97028, 97032, 97033, 97034, 97035, 97036, 97039, 97110, 97112, 97113, 97116, 97124, 97139, 97140, 97530, 98940, 98941, and 98942."

Applicant billed under CPT codes 98941 (\$84.84), 97010 (\$43.70) and 97014 (\$63.37).

Under the fee schedule Applicant is limited to \$46.24 per day for chiropractic services. There were three dates of service on 5/14/18, 5/19/18 and 6/4/18. Accordingly, Applicant's award for these dates is limited to \$138.72.

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, without merit, 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
	Greenpoint Chiropractic P.C	07/08/17 - 06/04/18	\$3,668.86	\$2,436.25	Awarded: \$138.72
Total			\$3,668.86		Awarded: \$138.72

- B. The insurer shall also compute and pay the applicant interest set forth below. 10/19/2022 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant's award shall bear interest at a rate of two percent per month, calculated on a pro rata basis using a 30-day month from the date payment became overdue to the date of the payment of the award pursuant to 11 NYCRR 65-3.9. The end date for the calculation of the period of interest shall be the date of payment of the claim. General Construction Law § 20 ("The day from which any specified period of time is reckoned shall be excluded in making the reckoning.")

Where a claim is timely denied, interest shall begin to accrue as of the date arbitration is requested by the claimant unless arbitration is commenced within 30 days after receipt of the denial, in which event interest shall begin to accrue as of the 30th day after proof of claim was received by the insurer. 11 NYCRR 65-4.5(s)(3), 65-3.9(c); Canarsie Medical Health, P.C. v. National Grange Mut. Ins. Co., 21 Misc.3d 791, 797 (Sup. Ct. New York Co. 2008) ("The regulation provides that where the insurer timely denies, then the applicant is to seek redress within 30 days, after which interest will accrue.")

C. Attorney's Fees

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

Respondent shall pay Applicant a separate attorney's fee, in accordance with 11 NYCRR 65-4.6(d). Since the arbitration request 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 11 NYCRR 65-4.6(d) 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 NY

SS :

County of Westchester

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

11/24/2023

(Dated)

Gregory Watford

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:
7490409fdbcde1fea0c658dc0724889e

Electronically Signed

Your name: Gregory Watford
Signed on: 11/24/2023