

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Robert A. Marini MD
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No.	17-23-1296-6626
Applicant's File No.	JR-1159
Insurer's Claim File No.	8726063310000003
NAIC No.	22063

ARBITRATION AWARD

I, Kathleen Sweeney, 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: IP

1. Hearing(s) held on 10/27/2023
Declared closed by the arbitrator on 10/27/2023

Maria Dudley from Rosado, Apat & Dudley, LLP participated virtually for the Applicant

Tara Hardinger from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$752.58**, 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

Whether the IP's lumbar injection was medically necessary considering Respondent's peer review?

This arbitration arises out of medical treatment for the IP, a 36 year old female, related to injuries sustained in a motor vehicle accident that occurred on 7/8/22. Applicant seeks reimbursement for fees related to lumbar injection which took place on 1/26/23. Respondent timely denied payment based upon a peer review by Dr. Tawfelllos dated 3/1/23.

4. Findings, Conclusions, and Basis Therefor

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]).

If an insurer asserts that the medical test, treatment, supply or other service was medically unnecessary, 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 Insurance Co.*, 2 Misc. 3d 26 [App Term, 2nd & 11th Jud Dists 2003]; *Kings Medical Supply Inc. v. Country Wide Insurance Company*, 783 N.Y.S. 2d at 448 & 452; *Amaze Medical Supply, Inc. v. Eagle Insurance Company*, 2 Misc. 3d 128 [App Term, 2nd and 11 Jud Dists 2003]).

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), the peer reviewer must establish a factual basis and medical rationale to support a finding that the services were not medically necessary, including setting forth generally accepted standards in the medical community. The opinion of the insurer's expert, standing alone, is insufficient to carry the insurer's burden to prove that the services were not medically necessary. *CityWide Social Work & Psychological Services, PLLC v. Travelers Indemnity Co.*, 3 Misc.3d 608, 777 N.Y.S.2d 241 (N.Y. Civ. Ct. Kings Co. 2004).

The peer Dr. asserts that the injection performed was not medically necessary. The Dr. reviewed the records which revealed complaints of radiating pain and restriction of motion. However, the Dr. states that there was only 3 chiropractic sessions prior to the injection and as such he finds the treatment was medically unnecessary. He specifically states that the records are incomplete to establish medical necessity. This is interesting because there does not seem to be any verification requests for additional medical records nor are the records he reviewed attached. He relies on numerous scholarly articles to support his opinion. Where the Respondent presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden then shifts to the Applicant which must then present its own evidence of medical necessity. [see *Prince, Richardson on Evidence* §§ 3-104, 3-202 [Farrell 11th ed]), *Andrew Carothers, M.D., P.C. v. GEICO Indemnity Company*, 2008 NY Slip Op 50456U, 18 Misc. 3d 1147A, 2008 N.Y. Misc. LEXIS 1121, *West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co.* 13 Misc.3d 131, 824 N.Y.S.2d 759, 2006 NY Slip Op51871(U) (Sup. Ct. App. T. 2d Dep't 2006)].

In support of the claim, Applicant relies on the IP's medical records and rebuttal by the treating provider. The Dr.'s records indicate that the IP's lumbar condition was unresponsive to conservative care and further show exactly the symptoms the peer Dr. says should be present to qualify the injection as medically necessary. The treating Dr. has a responsibility to take an accurate history and his rebuttal is very specific. I find it responsive to the peer Dr's concerns and as such sufficient to meet the Applicant's burden on the issue of medical necessity.

A Respondent defending a denial of first party benefits on the grounds that the subject medical services or testing were not medically necessary must show that the services were inconsistent with generally accepted medical practice, and here the Respondent has not. The opinion of the insurer's expert standing alone is insufficient to meet the burden of proving that the services were not medically necessary (see *Citywide Social Work v. Travelers Indem. Co.*, 3 Misc 3d 608 (Civ Ct Kings County 2004)).

Applicant was apparently confronted with certain subjective complaints as well as objective clinical findings and opined that further evaluation and treatment was medically necessary. A treating physician cannot merely discount and disregard his/her patient's subjective complaints as unfounded and irrational. Since there is such a divergence of medical opinions as to the necessity of the disputed therapy, I feel bound to defer to the opinions of Assignor's treating physicians.

Accordingly, after a careful review of the records and consideration of the parties' oral arguments, I find as a matter of fact that Applicant met its burden of establishing a prima facie case and Respondent failed to rebut it with evidence that the services were not medically necessary. I therefore find for the Applicant. This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator.

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
	Robert A. Marini MD	01/26/23 - 01/26/23	\$752.58	Awarded: \$752.58
Total			\$752.58	Awarded: \$752.58

B. The insurer shall also compute and pay the applicant interest set forth below. 04/24/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest runs from the filing date for this case until the date that payment is made at two percent per month, simple interest, on a pro rata basis using a thirty day month.

C. Attorney's Fees

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

After calculating the sum total of the first-party benefits awarded in this arbitration plus the interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20% of that sum total, subject to a maximum fee of \$1,360. See, 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 Nassau

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

11/27/2023

(Dated)

Kathleen Sweeney

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:
a933cc2171c6ee1a9ac84e7027636046

Electronically Signed

Your name: Kathleen Sweeney
Signed on: 11/27/2023