

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Richard Grosso DC PC
(Applicant)

- and -

Stillwater Property and Casualty Insurance
Company f/k/a Tri-State Consumer Insurance
Company
(Respondent)

AAA Case No.	17-23-1293-8038
Applicant's File No.	STLG22-59297
Insurer's Claim File No.	AP17900704
NAIC No.	25180

ARBITRATION AWARD

I, Tracy Morgan, 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: injured person-assignor

1. Hearing(s) held on 10/04/2023
Declared closed by the arbitrator on 11/07/2023

Colleen Terry, Esq. from Strauss Terry Law Group, PLLC participated virtually for the Applicant

Tara Gutman, Esq. from Stillwater Property and Casualty Insurance Company f/k/a Tri-State Consumer Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,886.41**, was NOT AMENDED at the oral hearing.
Stipulations WERE made by the parties regarding the issues to be determined.
The parties agree and the Respondent concedes that the bill for date of service May 29, 2021 was received by Respondent and was not processed. Respondent contends that the billed amount, however, exceeds the fee schedule and maintains that the correct amount of reimbursement is \$114.60.

3. Summary of Issues in Dispute

The Applicant is the assignee of no-fault benefits from injured person-assignor (DB), a 58 year old female driver involved in a motor vehicle accident on November 1, 2019. Following the accident, the injured person-assignor sought medical treatment and

underwent chiropractic office visits and treatment May 1, 2021-October 2, 2021 performed by Applicant. Respondent contends that Applicant's bills for dates of service July 3, 2021-July 29, 2022 were never received prior to arbitration. For the remaining dates of service, Respondent denied reimbursement contending a lack of medical necessity based upon the Independent Medical Examination performed by Glenn Berman, D.C. on July 7, 2020. Respondent further contends that Applicant's billed charges exceed the maximum amount allowed under the fee schedule.

The issues presented on this arbitration are whether Applicant demonstrated prima facie submission of the claims to Respondent, whether the services in dispute were medically necessary and whether Applicant's charges are in accord with the fee schedule?

4. Findings, Conclusions, and Basis Therefor

This hearing was conducted using documents contained in ADR Center. Any documents contained in the folder are hereby incorporated into this hearing. I have reviewed the relevant exhibits contained in the electronic file maintained by the American Arbitration Association and have considered all of the stipulations and arguments presented by both parties at the hearing of this matter. No witnesses appeared or testified.

The parties were permitted to submit supporting evidence post-hearing until November 2, 2023. Submissions from both sides were uploaded and considered.

Dates of Service July 3, 2021-July 29, 2022

Applicant billed for reimbursement of chiropractic office visits and treatment rendered July 3, 2021-July 29, 2022. Respondent did not pay or deny the claims and there is no evidence indicating that Respondent tolled them.

Respondent submitted the Affidavit of Jennifer Piccolo, No-Fault examiner employed by Respondent who attested that upon review of the Respondent's file, there is no record of receiving Applicant's bills prior to arbitration.

In *Viviane Etienne Med Care, PC v Countrywide Ins. Co.*, 25 NY3d 498 (2015) the Court of Appeals determined that "a plaintiff demonstrates prima facie entitlement to summary judgment by submitting evidence that payment of no-fault benefits is overdue, and proof of its claim, using the statutory billing form, was mailed to and received by

the defendant insurer. Proof evincing the mailing must be presented in admissible form, including where it is applicable, meeting the business records exception to the hearsay rule." *See also, Westchester Medical Center v Lincoln General Insurance Company*, 60 AD3d 1045, 877 NYS2d 340 (2d Dept 2009); *Westchester Medical Center v Clarendon National Insurance Company*, 57 AD3d 659, 816 NYS2d 759 (2d Dept 2008).

Generally, "proof that an item was properly mailed gives rise to a rebuttable presumption that the item was received by the addressee" *Matter of Government Empls. Ins. Co. v Morris*, 95 AD3d 887, 2012 NY Slip Op 03448 (2d Dept, 2012). "The presumption may be created by either proof of actual mailing or proof of a 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 AD3d 547 (2d Dept, 2006), *citing Residential Holding Corp. v Scottsdale Ins. Co.*, 286 AD2d 679, 680 (2d Dept, 2001).

Applicant's submission includes an affidavit executed by Maryann Gaudino, the office and billing manager for the Applicant. Ms. Gaudino attested that she ensures compliance with the billing and mailing procedures by the staff. Treatment notes are created electronically and are utilized to create billing forms in their Mineola office. Applicant mails bills using a Stamps.com account with a mail weight meter machine. The office maintains a "mailing ledger" and she can access receipts showing outgoing mail. Ms. Gaudino stated she personally prints the bills, copies and scans them into the patient file, puts them into envelopes, weighs the envelopes and enters the information into the stamps.com account. The address and postage is then printed on the envelope. She prints a "mailing page" and notes by hand the dates of service for each envelope. She then scans the page into the patient's computer file. She places the envelope in the outgoing mail bin kept at the reception desk of Applicant's office. A US Postal mailman picks up the mail every day. She concluded by stating that all bills were properly addressed and mailed to the Respondent at their Jericho address.

Applicant also included the Stamps.com mailing pages/receipts with handwritten treatment dates and patient name on each page. The mailing pages/receipts indicate that mail pertaining to this injured person-assignor for the dates of service at issue here were mailed to the Respondent at their Jericho address. The mailing pages/receipts contain shipping dates, tracking numbers and costs as well.

Respondent in their brief argued that Applicant's proof of mailing was not accurate since the evidence indicates that the May 29, 2021 bill was shipped on June 14, 2021 yet it was only received by Respondent in an envelope postmarked July 8, 2021. Further that the alleged tracking numbers are not traceable on the USPS website and the mailing pages fail to indicate a delivery date. Finally, the Stamps.com mailing pages/receipts have handwritten notations that are not addressed by Ms. Gaudino in her mailing Affidavit.

Respondent submitted the health insurance claim form for date of service May 29, 2021, which is dated July 6, 2021, and corresponding envelope demonstrating that the postage date was stamped as July 8, 2021 with 51 cents as the cost of postage. The envelope and bill include stamped received dates of July 12, 2021. As Respondent pointed out, the Stamps.com mailing page/receipt for the May 29, 2021 bill indicates that it was shipped on June 14, 2021 and the cost of shipping was noted to be 53 cents which does not coincide with the bill or envelope submitted by Respondent. I note that Applicant did not submit copies of the actual claim forms that were received by the Respondent. As and for Applicant's bills, Applicant did not submit NF-3 forms or Health Insurance Claim forms. Instead the documents purporting to be Applicant's claims appear to be computer print-outs that are dated either April 25, 2022 or December 8, 2022.

After a review of the Record and consideration of the parties' arguments, the weight of the credible evidence demonstrates that Respondent never received the bills at issue prior to arbitration. I find Applicant's evidence insufficient and less than reliable. In the first instance, there is no description in the Gaudino Affidavit as to when the billing is created only that at some point after the treatment notes are electronically created, the billing is generated. Additionally, Ms. Gaudino attested to a "mail ledger" kept by the office but the mail ledger was not submitted on this Record. Ms. Gaudino similarly attested to scanning information into the patient's file but evidence of that was not submitted either. As to the Stamps.com mailing pages/receipts, the only notation as to which patient they pertain to is a handwritten name and as Respondent pointed out, Ms. Gaudino never attested to handwriting the patient's name on the receipt as part of Applicant's regular business practice. Further, the discrepancy highlighted by Respondent for the May 29, 2021 bill is left unexplained. Finally, Applicant failed to submit copies of the billing they purportedly mailed to the Respondent and only submitted computer print-outs bearing generation/signature dates that do not correspond with any of the evidence on this Record.

Consequently, I find that Applicant failed to prove that it submitted its claims to the Respondent. Applicant's claim for these dates of service is denied.

Remaining Dates of Service

As to the remaining dates of service, I find that Applicant established its prima facie entitlement to No-fault benefits as proofs of claim were mailed to and received by the insurer and payment of No-Fault benefits is overdue See Insurance Law § 5106 [a]; 11 NYCRR 65.15 [g]; *Viviane Etienne Medical Care, P.C. v Country-Wide Ins. Co.*, 25 NY3d 498 (2015).

Respondent timely issued denials of claim contending that the services at issue were not medically necessary based upon the results of the Independent Medical Examination (IME) performed by Glenn Berman, D.C. on July 7, 2020.

Where a health care provider establishes its prima facie entitlement to no-fault benefits, the burden shifts to the insurer to prove that the medical services were not medically necessary *Nir v Allstate Ins. Co.*, 7 Misc. 3d 544 (2005); *Amaze Medical Supply Inc. v Eagle Insurance Co.*, 2 Misc3d 128(A), 2003 NY Slip Op. 51701(U)(App Term 2d, 11th & 13th Dists.). 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).

Respondent relies upon the IME report of Dr. Berman to support its denials of claims. Dr. Berman reviewed the relevant records, took a history and performed a physical examination. The injured person-assignor presented to the IME reporting current complaints of radiating neck pain and non-radiating pain in the upper, middle and low back. Dr. Berman's examination of the cervical, thoracic and lumbar regions revealed no swelling and no spasms but there were complaints of pain upon superficial touch to the thoracic and lumbar regions. Ranges of motion for the cervical and lumbar regions were markedly restricted and Dr. Berman noted that minimal if any effort was made by the injured person-assignor. He further noted that he observed her at other times demonstrating 90 degrees of lumbar flexion while she sat with her hips at 90 degrees. Orthopedic testing including cervical compression, cervical distraction, shoulder depression, straight leg raises and Valsalva maneuvers were negative. There was no motor weakness, reflexes were +2 and sensation was intact throughout. His impression was of resolved strains of the cervical, thoracic and lumbar regions of her spine and that no further chiropractic treatment was necessary. The restricted ranges of motion, he added, were subjective and there were no objective positive findings to warrant further treatment.

Applicant relies upon the rebuttal by Dr. Grosso which focused on SOAP notes dated December 19, 2020-October 2, 2021 and evaluations dated January 9, 2021-August 14, 2021. Applicant submitted medical records including the record dated August 17, 2020 documenting complaints of neck, mid back and low back pain. Upon examination there was hypertonicity, adhesions, tenderness and joint restrictions/subluxations in the cervical, thoracic and lumbar regions of her spine. Cervical and lumbar ranges of motion were measured and found to be restricted. Orthopedic testing including cervical compression, Jackson Compression, maximum compression, Lasegue's and Kemp's tests were positive. The injured person-assignor was recommended for further chiropractic treatment.

I find that the examination of August 17, 2020 is contemporaneous with the Glenn Berman IME and sufficiently refutes his findings and demonstrates that the injured person-assignor's condition was not resolved and required continued treatment. Accordingly, the Applicant's claim for these dates of service is awarded.

Fee Schedule

As to the amount awarded for each date of service, Respondent submitted the affidavit of No-Fault examiner Jennifer Piccolo who established that the proper rate of reimbursement for the services at issue here calculates to \$114.60 per day representing 12 units. As for dates of service where an evaluation was also conducted, she attested that \$143.25 would be appropriate representing 15 units.

There is no argument or evidence to oppose the Piccolo Affidavit. I therefore find that Respondent's calculations are proper and Applicant's claims for dates of service May 29, 2021 and May 1, 2021-June 26, 2021 are awarded accordingly. Applicant's remaining claim is denied. 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.

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Medical		From/To	Claim Amount	Status
	Richard Grosso DC PC	05/01/21 - 10/02/21	\$1,886.41	Awarded: \$744.90
Total			\$1,886.41	Awarded: \$744.90

- B. The insurer shall also compute and pay the applicant interest set forth below. 04/03/2023 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 NY3d 217 (2009).

C. Attorney's Fees

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

As this matter 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 newly promulgated 11 NYCRR 65-4.6(d) For claims that fall under the Sixth Amendment to the regulation, the following shall apply: "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 \$1,360.00."

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

11/28/2023

(Dated)

Tracy Morgan

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:
229fcd193a3fb32f00e23603e6a93812

Electronically Signed

Your name: Tracy Morgan
Signed on: 11/28/2023