

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.	17-23-1293-2368
Applicant's File No.	2965715
Insurer's Claim File No.	0545742980101019
NAIC No.	35882

ARBITRATION AWARD

I, Nicole J. Simmons, 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 11/17/2023
Declared closed by the arbitrator on 11/17/2023

Ryan Berry, Esq. from Israel Purdy, LLP participated virtually for the Applicant

Chad Meyers from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$4,082.04**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant has amended the amount in dispute to **\$3,517.29**, thereby acknowledging receipt of prior partial payments and resolving all issues regarding compliance with the applicable provisions of the Workers' Compensation Fee Schedule.

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

3. Summary of Issues in Dispute

Whether Respondent's denial of Applicant's claims for MRIs, based upon a peer review report, can be sustained.

Whether Respondent's denial, based upon an independent medical examination (IME), can be sustained.

Whether Respondent's verification defense is sustainable.

The IP (AG), a 22-year-old female driver, was involved in a motor vehicle accident on 5/21/20. Thereafter, she sought treatment for various complaints of pain. The instant claim is for a 6/20/20 lumbar spine MRI (\$912.00) denied based upon a peer review report by Jason Cohen, M.D., a cervical spine MRI (\$879.73) denied based upon a peer review report by Terence McAlarney, M.D., and 1/18/21 EMG/NCV testing (\$1,330.82) denied based upon a verification defense. The remainder of the claim for physical therapy was denied based upon the 6/26/21 IME conducted by Michael Tawfelllos, M.D. with an effective cutoff date of 7/10/21.

4. Findings, Conclusions, and Basis Therefor

I have reviewed and considered all pertinent documents contained in the American Arbitration Association's ADR Center. The case was decided based upon the submissions of the parties and the oral arguments of the parties' representatives made at the arbitration hearing. There were no witnesses.

The Arbitrator shall be the judge of the relevance and materiality of the evidence offered, and strict conformity to legal rules of evidence shall not be necessary. The Arbitrator may question any witness or party and independently raise any issue that the Arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department Regulations. 11 NYCRR 65-4.5(o)(1). (Regulation 68-D.)

I find that Applicant has established its prima facie case as Applicant has met the requirements enunciated in Ave T MPC Corp. v Auto One Ins. Co., 32 Misc 3d 128[A], 2011 NY Slip Op 51292[U] [App Term, 2d, 11th & 13th Jud Dists 2011]). The Court held that "A no-fault provider establishes its prima facie entitlement to summary judgment by proof of the submission to the defendant of a claim form, proof of the fact and the amount of the loss sustained, and proof that the defendant either failed to pay or deny the claim within the requisite 30-day period, or issued a timely denial of claim that was conclusory, vague or without merit as a matter of law," (see Insurance Law § 5106 [a]; Westchester Med. Ctr. v Nationwide Mut. Ins. Co., 78 AD AD3d 1168 [2010]; see also New York & Presbyterian Hosp v. Allstate 31 AD3d 512 [2006]).

Medical Necessity

When an insurer relies upon a peer review report to demonstrate that a 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).

MRI/Peer Review Reports

The claim for the 6/20/20 lumbar spine MRI was denied based upon the 8/8/20 peer review report by Dr. Cohen. He notes that the IP was initially evaluated by Stanley Ikezi, M.D. on 5/29/20 for complaints of neck and lower back pain. The lumbar spine evaluation revealed decreased range of motion, tenderness on palpation, muscle spasms, muscle weakness, hypoesthesia, and positive straight leg raise test. The clinical impression was lumbar radiculopathy and lumbar myofascitis. PT, x-ray, lumbar spine MRI, and follow up visit were recommended. The subject MRI was performed on 6/20/20. Dr. Cohen states that the accepted standard practice for acute lower back pain does not include imaging studies within the initial 4-8 weeks in the absence of risk factors for serious spine abnormalities. Here, no risk factors were noted in the IP's medical records, therefore the subject MRI was not medically necessary.

The claim for the 6/27/20 cervical spine MRI was denied based upon the 8/11/20 peer review report by Dr. McAlarney. He notes that the 5/29/20 initial examination of the IP's cervical spine revealed diminished range of motion, tenderness, decreased strength, and hypoesthesia. The IP was diagnosed with cervical radiculopathy. Physical therapy, x-ray, and cervical spine MRI were recommended. The MRI was performed on 6/27/20. Dr. McAlarney states that the MRI was not necessary as the IP had not yet treated with an adequate trial of therapy. Standard practice supports the performance of an MRI of the spine when radicular symptoms exist, when there is evidence of nerve root irritation on examination, **and** when the patient has failed a course of therapy modalities of 4 to 6 weeks duration. Here, there was no evidence that the IP failed a course of conservative care and, as such, the MRI was not necessary.

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 Dept 2006)]. I find the peer review reports of Dr. Cohen and Dr. McAlarney sufficient to shift the burden to the Applicant.

Applicant relies on the IP's medical records and the 8/23/23 rebuttal by Dr. Ikezi. Dr. Ikezi contends that his findings on examination of the IP warranted the recommendation for and performance of the subject cervical and lumbar spine MRIs. He notes the IP's positive findings and maintains that they were sufficient to necessitate the MRI studies. He further notes that an early diagnosis is essential to providing safe and effective

treatment, speeding up recovery time, and reducing the need for surgery and/or injections. MRIs can show if there were multiple levels of disc pathology and are widely accepted to confirm and localize clinical suspicion of pathology.

Comparing the relevant evidence presented by both parties against each other, I am persuaded by the peer review reports of Dr. Cohen and Dr. McAlarney and the overall review of the IP's medical records that the subject MRIs were in fact not medically necessary in this case. The IP was evaluated and a course of conservative care including physical therapy was commenced. There is no evidence that the IP was not tolerating treatment, and no records indicating a lack of improvement or deterioration in her condition were noted that would warrant these further tests. Dr. Ikezi did not adequately explain why these studies were medically necessary at the time they were prescribed at the initial evaluations prior to the commencement of treatment, or when they performed.

After a thorough review of the evidence, I am unpersuaded by Applicant's evidence and arguments regarding the necessity of the MRIs prescribed prior to the commencement of a course of conservative treatment. Comparing the evidence submitted by both parties, I find that the Applicant has failed to successfully rebut the peer review reports. There has been insufficient evidence presented to demonstrate that the prescribed MRIs were medically necessary so early in the IP's treatment plan.

Accordingly, the denials of the claims for the lumbar and cervical MRIs are sustained.

EMG/NCV/Verification

Respondent denied the claim for the 1/18/21 EMG/NCV testing based upon a verification defense.

It is accepted that once presented, a claim for health care benefits must be paid or denied within (30) thirty days of an insurer's receipt thereof. This period may be tolled by requesting additional verification, as provided by 11 NYCRR Section 65-3.8 (a) (1). The insurer must make the verification request within fifteen (15) business days from its receipt of the claim, pursuant to 11 NYCRR Section 65-3.5. If a response to the initial request for additional verification is not received by the carrier within thirty (30) days, then, within ten (10) calendar days after the thirty-day period, the carrier must make a second request. See, 11 NYCRR Section 65 3.6. An insurer is not obligated to pay or deny a claim until it has received all relevant information.

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. In addition, 11 NYCRR 65-3.5 (o) states in pertinent part:

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 § 65-3.8 (b)(3) then provides that:

An 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) of this Subpart.

The submissions demonstrate that upon receipt of Applicant's claim on 2/18/21, Respondent issued verification requests dated 3/5/21, 3/8/21, and 4/23/21 stating, "*Need proper No-Fault codes for CPT codes- 95903, 95904, 95934. Your claim cannot be considered for payment until the requested documentation is received.*"

Respondent issued an NF-10 denial on 3/15/21 noting that "[v]erification was sent under separate cover."

Applicant asserts that Respondent has not provided proof of timely mailing of the requests or non-receipt of the requested verification such as an affidavit from an attorney or claims representative familiar with the case. On this issue, I concur. Where a No-Fault insurer is relying on the defense that verification is outstanding, it is the insurer's prima facie burden at trial to demonstrate (1) that verification requests were timely mailed and (2) that it did not receive the requested verification; if the insurer establishes that it did not receive the requested verification, then the burden shifts to the claimant to prove that it had provided responses. Island Life Chiropractic, P.C. v. Travelers Ins. Co., 64 Misc.3d 143(A), 2019 N.Y. Slip Op. 51273(U) (App. Term 2d, 11th & 13th Dists. Aug. 2, 2019).

Respondent must prove not only that the verification request letters were mailed to Applicant, but also that the requested verification remains outstanding. Respondent has not fulfilled this requirement. Additionally, Respondent issued an improper and premature denial of the claim on 3/15/21, just 10 days after its first verification request, and did not allow for an adequate period of 120 days prior to its denial of the claim.

Based on the foregoing, Respondent's denial of the EMG/NVC testing cannot be sustained on this record and Applicant is awarded **\$1,330.82** for this portion of its claim.

IME

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]).

Respondent asserts that the claims for the subject dates of service were timely denied based upon the IME of Dr. Tawfellos. 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 Rad Radiology, P.C. v Travelers Ins. Co., 2006 NY Slip Op 52116 (App. Term 1st Dept. 2006).

In support of its contention that continuing treatment was not medically necessary Respondent relies upon the IME by Michael Tawfellos, M.D. performed on 6/26/21. He notes that the IP initially complained of head, neck, back, and shoulder pain. On examination by Dr. Tawfellos, all ranges of motion tested were normal. There was no spasm or tenderness. The Spurling's, Straight Leg Raise, Neer's, Cross-arm, O'Brien's, Impingement sign, Tinel's sign, Faber, Patrick's, McMurray's, Lachman's, and Anterior Drawer tests were all negative/normal. Based upon his examination of the IP, Dr. Tawfellos diagnosed her with resolved cervical, thoracic, lumbar, left hip, right leg, and left leg strains, and left and right shoulder bursitis, also resolved. As there were no objective findings such as atrophy, crepitus, spasm, effusion, swelling, tenderness, range of motion deficits, or positive tests, there was no need for further treatment including physical therapy, prescription medications, injections, massage therapy, diagnostic testing, durable medical equipment/medical supplies, special transportation, and household help from a pain management/anesthesia perspective.

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 Dept 2006)]. I find IME report of Dr. Tawfellos sufficient to shift the burden to Applicant.

Applicant relies on the IP's medical records to refute the IME findings. I have thoroughly reviewed the submissions. There are no records that could be considered contemporaneous to the 6/26/21 IME in evidence that provide any insight into the IP's condition sufficient to rebut the findings of the comprehensive IME report. I find that

the IP's medical records failed to viably negate the findings of the IME report. The records fail to document findings that adequately refute the conclusions set forth in the IME report of Dr. Tawfellos.

Comparing the Applicant's records to Dr. Tawfellos' thorough IME report, I am more persuaded that no further treatment was medically necessary. There is no narrative reporting which draws conclusions needed to substantiate the ongoing treatment. There is no indication as to how this treatment affected this patient. As such the Applicant has not sustained his burden of proof and its claims must fail. Delta Diagnostic Radiology, PC v. American Transit Ins. Co., 18 Misc. 3d 128(A) (App Term 2d and 11th Jud Dist .2007).

Applicant has not rebutted Respondent's defense and has not sustained its burden of proof by a preponderance of the credible evidence.

Accordingly, Applicant is awarded **\$1,330.82** for the 1/18/21 EMG/NCV testing. The remainder of the claim for the cervical and lumbar MRIs and the post-IME services is hereby denied.

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
	NY				

	Complete Medical Care PC	06/20/20 - 02/09/22	\$4,082.04	\$3,517.29	Awarded: \$1,330.82
Total			\$4,082.04		Awarded: \$1,330.82

- B. The insurer shall also compute and pay the applicant interest set forth below. 03/30/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

The insurer shall compute interest and pay the Applicant the amount of interest computed from the filing date as indicated above at the rate of 2% per month, simple, not compounded, calculated on a pro rata basis using a thirty-day month, and ending with the date of payment of the award.

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

12/18/2023
(Dated)

Nicole J. Simmons

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:
38d9b466aeee689c727f5b50f12c3f82

Electronically Signed

Your name: Nicole J. Simmons
Signed on: 12/18/2023