American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Sanford Family Chiropractic, P.C. (Applicant)	AAA Case No.	17-23-1281-6307
	Applicant's File No.	RB-212-313080
- and -	Insurer's Claim File No.	0654515055 2DD
Allstate Insurance Company (Respondent)	NAIC No.	17230

ARBITRATION AWARD

I, Cathryn Roberts, 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 12/18/2023
   Declared closed by the arbitrator on 12/18/2023

   Alex Samaroo, Esq. from Baker & Narkolayeva Law P.C. participated virtually for the Applicant

   Dara Goodman, Esq. from Law Offices of John Trop participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$3,959.16**, was AMENDED and permitted by the arbitrator at the oral hearing.

   Applicant submitted an amended AR-1 Form on 10/18/23, to reflect the partial reimbursement made by Respondent in this case and support their claim for the remaining amount in dispute of $1,369.41.

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

3. Summary of Issues in Dispute

   The EIP, (G.R.) was a then 37 year old male, involved in a motor vehicle accident on 01/04/22. At issue in this case is $1,369.41 for reimbursement of chiropractic treatment, performed 05/05/22-10/20/22. Respondent provided partial reimbursement of dates of

service 05/05/22-09/29/22, with the remainder denied based upon a fee schedule defense. The remainder of this claim was denied based upon a lack of medical necessity, with an independent medical examination (hereafter "IME") by John Iozzio, D.C., L.Ac., performed on 09/06/22, with an effective cut-off date for treatment of 10/05/22.

Therefore, the issues presented are whether Respondent established the medical necessity and fee schedule defenses asserted.

4. Findings, Conclusions, and Basis Therefor

This case was decided based upon the submissions of the parties as contained in the electronic file maintained by the American Arbitration Association, and the oral arguments of the parties' representatives. There were no witnesses. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

A review of the competent evidence in the record reveals that Applicant established a prima facie case of entitlement to reimbursement of its claim, by submitting evidence that the prescribed statutory billing form was mailed and received, and that the Respondent failed to either pay or deny the claim within the requisite 30-day period. Mary Immaculate Hospital v. Allstate Insurance Co., 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004).

Once Applicant established its prima facie case, the burden of proof shifts to Respondent to come forward with admissible evidence demonstrating the existence of a material issue of fact. Amaze Medical Supply Inc. v. Allstate Insurance Co. 3 Misc3d at 133. Based upon a review of the parties' submissions, I find that Respondent timely denied the subject bills.

DOS 05/05/22-09/29/22

Respondent argues that the fees charged by Applicant for the services in issue were in excess of those permitted under the Workers' Compensation Fee Schedule.

Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. See, Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 2006 NY Slip 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006). See also, Power Acupuncture PC v. State Farm Mutual Automobile Ins. Co., 11 Misc.3d 1065A, 816 N.Y.S.2d 700, 2006 NY Slip Op 50393U, 2006 N.Y. Misc. LEXIS 514 (Civil Ct, Kings Co. 2006). If Respondent fails to demonstrate by competent evidentiary proof that a plaintiff's claims were in excess of the appropriate fee schedules, defendant's defense of noncompliance with the appropriate fee schedules cannot be sustained. See, Continental Medical PC v. Travelers Indemnity Co., 11 Misc.3d 145A, 819 N.Y.S.2d 847, 2006 NY Slip Op 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Term, 1st Dep't, per curiam, 2006).

The record reflects that Applicant billed for treatment performed 05/05/22 through 09/29/22, in the amount of $2,596.15. Respondent provided reimbursement of $2,589.75, based upon the reasoning that reimbursement had been provided in accordance with the fee schedule and 12 unit rule.

To support their partial reimbursement, Respondent submitted a fee coder affidavit by Carolyn Mallory, CPC, dated 06/05/23. Ms. Mallory asserted that in accordance with the New York Fee Schedule, Applicant was underpaid $6.40. Ms. Mallory outlined the calculations for the bills submitted and affirmed the allowable amount of reimbursement for the services performed. I find Ms. Mallory's affidavit sufficient to establish the fee schedule reimbursement of these bills. Applicant failed to submit any documentation in response, to rebut the calculations of Ms. Mallory or support their claim for reimbursement as billed.

Therefore, I find that Respondent satisfied their fee schedule defense. This portion of Applicant's claim is granted, in the amount of $6.40, to reflect the underpayment.

DOS 10/06/22-10/20/22

When an insurer asserts that the medical service was medically unnecessary, the burden is on the insurer to establish that the subject service was medical unnecessary by competent evidence such as an independent medical examination or a peer review or other proof that sets forth a factual basis and a medical rationale for denying the claim. See generally, Kings Medical Supply Inc. v. Country Wide Ins. Co., 5 Misc. 3d 767 (N.Y.C. Civ. Ct., 2004); Amaze Medical Supply, Inc. v. Eagle Insurance Company, 2 Misc. 3d 128 (App. Term, 2nd Dept., 2003].

An IME report asserting that 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).

Dr. Iozzio reviewed numerous forms of medical documentation and examined the EIP on 09/06/22. At the time of the examination, the EIP reported a complaint of pain in the right shoulder. Dr. Iozzio provided an impression of resolved post sprain/contusion of the right shoulder, post cervical spine percutaneous discectomy, with resolved Qi and blood stagnation. Based upon this examination, Dr. Iozzio stated that there was no need for further chiropractic/acupuncture treatment, diagnostic testing, household help, special transportation, ambulatory service or durable medical equipment.

The case law states that if the insurer presents sufficient evidence establishing a lack of medical necessity, then the burden shifts back to the Applicant to present its own evidence of medical necessity. See: West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc3d 131A (2006).

In response, Applicant relied on the documentation contained within their submission, which included contemporaneous treatment notes and evaluation reports to the IME of Dr. Iozzio. Applicant counsel highlighted an examination, performed on 08/25/22, which revealed numerous positive orthopedic testing, reduced motor strength, tenderness with reduced ranges of motion. Dr. Nguyen, the EIP's treating chiropractor, diagnosed the EIP at this time with disc displacement, sprain and muscle spasm, with the indication to continue treatment and undergo trigger points therapy.

Based on the arguments of counsel and after a thorough review and consideration of all submissions, I am not persuaded by Dr. Iozzio's IME. I find that the evaluations and treatment notes submitted, some of which were contemporaneous to the IME, showed consistent complaints of pain with positive findings thereby warranting additional treatment.

Last, Respondent counsel argued that if allowed for reimbursement, per Ms. Mallory's affidavit, Applicant would be entitled to reimbursement in the amount of $458.40 for this portion of their claim. I concur.

Accordingly, Applicant's claim is granted, in the amount of $464.80 only. Reimbursement is due and owing. 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	Amount Amended	Status
	Sanford Family Chiropractic, P.C.	**05/05/22 - 06/07/22**	**$1,486.00**	**$346.40**	**Denied**
	Sanford Family Chiropractic, P.C.	**07/14/22 - 08/04/22**	**$613.60**	**$202.00**	**Denied**
	Sanford Family Chiropractic, P.C.	**08/23/22 - 09/15/22**	**$1,017.95**	**$323.20**	**Awarded: $6.40**
	Sanford Family Chiropractic, P.C.	**09/22/22 - 10/20/22**	**$841.61**	**$497.81**	**Awarded: $458.40**
Total			**$3,959.16**		**Awarded: $464.80**

B. The insurer shall also compute and pay the applicant interest set forth below. 01/06/2023 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

Effective to filings on or after February 6, 2015, this case is subject to the provisions as to attorney fee promulgated in the Sixth Amendment to 11 NYCRR 65-4(Insurance Regulation 68-D). As amended, 11 N.Y.C.R.R. §65-4.6(d) reads: "For all other disputes subject to arbitration or court proceedings, subject to the provisions of subdivision (a) of this section, the attorney's fee shall be limited as follows: 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon, for each applicant per arbitration or court proceeding, subject to a maximum fee of $ 1360. If the nature of the dispute results in an attorney's fee that could be computed in accordance with the limitations prescribed in both subdivision (c) and this subdivision, the higher attorney's fee shall be payable."

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 Suffolk

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

12/29/2023
(Dated)

Cathryn Roberts

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:
f21a6215ddd5bbc9488049fe6ac40a07

Electronically Signed

Your name: Cathryn Roberts
Signed on: 12/29/2023