American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Metro Healthcare Partners (Applicant)	AAA Case No.	17-23-1327-8309
	Applicant's File No.	3133757
- and -	Insurer's Claim File No.	0295310090101139
	NAIC No.	35882
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Anne Malone, 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 06/18/2024
   Declared closed by the arbitrator on 06/18/2024

   Gary Pustel, 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, **$740.40**, 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

   The 52 year old EIP reported involvement in a motor vehicle accident on October 30, 2022; claimed related injury and underwent Shockwave treatment, physical therapy provided by the applicant from May 4, 2023 to October 17, 2023 and lumbar spine radiographs provided on October 5, 2023.

   The applicant submitted a claim for these medical services. Payment of the bill for services rendered on May 4, 2023 was denied by the respondent because it was not submitted within 45 days of the date of service.

Payment of the remainder of the bills were either paid in full pursuant to an agreement between the parties or timely denied by the respondent based on the independent medical examination of the EIP by Aruna Senevirante, M.D. which was performed on July 5, 2023. The IME cut off was effective on July 20, 2023.

The issues to be determined at the hearing are:

Whether the applicant established its *prima facie* entitlement to no fault benefits for services rendered on May 4, 2023.

Whether the respondent established that the remainder of the services at issue were not medically necessary.

4. Findings, Conclusions, and Basis Therefor

This hearing was held on Zoom and the decision is based upon the documents reviewed in the Modria File as well as the arguments made by counsel and/or representative at the arbitration hearing. Only the arguments presented at the hearing are preserved in this decision; all other arguments not presented at the hearing are considered waived.

Applicant's *prima facie* entitlement to no-fault benefits for date of service May 4, 2023

It is well settled that an applicant establishes its *prima facie* showing of entitlement to No-Fault benefits by submitting evidentiary proof that the prescribed statutory billing forms had been mailed, received by the respondent and that payment of no fault benefits were overdue. Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D. 3d 742, 774 N.Y.S.2d 564 (2d Dept. 2004.)

An insurer in a no-fault matter will be precluded as a matter of law from asserting a defense based upon the untimely submission of the bill/bills at issue if such defense is not raised in a timely denial. See New York and Presbyterian Hospital v. Empire Ins. Co., 286 A.D.2d 322 (2d Dept.2001.)

If respondent has preserved such defense in a timely denial, respondent will still be precluded from proffering such defense as a matter of law unless respondent advised applicant that late submission of the bill/bills will be excused where the applicant can provide a reasonable justification of the failure to timely submit the bill/bills. 11 NYCRR 65-3.3(e). See also Radiology Today, P.C. v. Citiwide Auto Leasing, Inc., 2007 NY Slip Op 27111 (App. Term 2nd and 11th Jud. Dists. 2007.)

The respondent's denial was based on late submission of the bill for Shockwave treatment provided by the applicant on May 4, 2023, which was dated May 18, 2023. According to the NF-10 the bill was received by the respondent on September 22, 2023and the denial, which contained the requisite "reasonable justification" language was dated October 2, 2023.

The applicant submitted a proof of mailing dated October 16, 2023 which did not identify the bill to which it referred. In any event, this submission establishes that the bill at issue was not timely mailed to the respondent.

Based on the foregoing, the respondent has established that the bill for services rendered on May 4, 2023 was submitted more than 45 days after the date of service and the applicant has not established its *prima facie* entitlement for no fault benefits for this claim.

Therefore, the claim for services rendered on May 4, 2023 is dismissed with prejudice.

Medical Necessity

The remainer of the bills submitted by the applicant for dates of service September 12, 2023 to October 17, 2023 were denied by the respondent for a lack of medical necessity.

To support a lack of medical necessity defense respondent must "set forth a factual basis and medical rationale for the peer reviewer's [or examining physician's] determination that there was a lack of medical necessity for the services rendered." Provvedere, Inc. v. Republic Western Ins. Co., 2014 NY Slip Op 50219(U) (App. Term2d, 11th and 13th Jud. Dists. 2014.) 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 Bronx Expert Radiology, P.C. v. Travelers Ins. Co., 2006 NY Slip Op 52116 (App. Term 1st Dept. 2006.)

The Civil Courts have held that a defendant's peer review or medical evidence must set forth more than just a basic recitation of the expert's opinion. The trial courts have held that a peer review report's medical rationale will be insufficient to meet respondent's burden of proof if: 1) the medical rationale of its expert witness is not supported by evidence of a deviation from "generally accepted medical" standards; 2) the expert fails to cite to medical authority, standard, or generally accepted medical practice as a medical rationale for his/her findings; and 3) the peer review report fails to provide specifics as to the claim at issue; is conclusory or vague. See Nir v. Allstate, 7 Misc.3d 544 (N.Y. City Civ. Ct. 2005.)

To support its contention that the services provided to the EIP were not medically necessary, the respondent relied upon the report of the independent

medical examination of the EIP by Dr. Seneviratne which was essentially objectively negative and unremarkable. Range of motion was determined with the assistance of a goniometer. The report presents a factually sufficient, cogent medical rationale in support of respondent's lack of medical necessity defense. Dr. Seneviratne performed a complete and comprehensive examination of the EIP which identified some findings of tenderness and decreased range of motion in the neck and low back and decreased range of motion in the left knee. However, Dr. Seneviratne determined that there were no objective findings such as atrophy or any positive orthopedic testing to correlate with these subjective complaints.

Dr. Seneviratne documented that the EIP stated that she was working in NYPD/SSD and that she did not lose any time from work.

Based upon the physical examination and medical records reviewed, Dr. Seneviratne determined that despite her subjective complaints, there was no evidence of orthopedic disability and that the EIP could perform her activities of daily living and working without restrictions. It was Dr. Seneviratne's opinion that there was no medical necessity for further orthopedic treatment, physical therapy, massage therapy, surgery, injections, diagnostic testing, durable medical equipment, household help or special transportation.

Respondent has factually demonstrated that the services provided by the applicant were not medically necessary. Accordingly, the burden now shifts to the applicant, who bears the ultimate burden of persuasion. See Bronx Expert Radiology, P.C. v. Travelers Ins. Co., 2006 NY Slip Op 52116 (App. Term 1st Dept. 2006.)

In response to the report of the physical examination of the EIP by Dr. Seneviratne, the applicant relied upon the submissions, including physical therapy progress notes from July 7, 2023 to October 17, by Harshit Bhatwala, PT which documented unspecified moderate decreased range of motion in thbe cervical spine and limited range of motion secondary to pain in the lumbar spine and right knee.

From April 27, 2023 to October 17, 2023 at approximately 2 week intervals, the EIP also underwent Shockwave therapy provided by Dale Harder, PA based on continued complaints of low back pain and a diagnosis of lumbar sprain/strain.

After a review of all the evidence submitted an issue of fact remains as to whether the services rendered are medically necessary. Conflicting opinions have been presented by Dr. Seneviratne based on the independent medical examination of the EIP and the reports of Dale Harder, PA, who provided shockwave therapy and Harshit Bhatwala, PT who provided physical therapy treatment to the EIP.

Based on the reports and submitted medical records, I find that the IME report by Dr. Seneviratne was more persuasive in this matter.

Under these circumstances, the respondent has established that the post-IME treatment was not medically necessary.

Therefore, the claim for post IME physical therapy and shockwave treatment is dismissed with prejudice.

Accordingly, the entire claim is dismissed with prejudice.

Any further issues submitted in the record are held to be moot and/or waived insofar as they were not raised at the time of this hearing. 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 claim is DENIED in its entirety

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of CT
SS :
County of Fairfield

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

07/15/2024
(Dated)

Anne Malone

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:
48881f9083ec97011845285e412831b4

Electronically Signed

Your name: Anne Malone
Signed on: 07/15/2024