

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

| | | |
|---|--------------------------|-------------------|
| Advanced Recovery Equipment & Supplies, LLC (Applicant) | AAA Case No. | 17-24-1337-9143 |
| | Applicant's File No. | 00129636 |
| - and - | Insurer's Claim File No. | 0708329735 2FM |
| Allstate Fire & Casualty Insurance Company (Respondent) | NAIC No. | 29688 |

ARBITRATION AWARD

I, James Skelton, 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 party

1. Hearing(s) held on 09/30/2024
Declared closed by the arbitrator on 09/30/2024

Sasha Hochman, Esq. from Drachman Katz, LLP participated virtually for the Applicant

Donna Strudwick, Esq. from Law Offices of John Trop participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$325.08**, 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 injured party, EG, is a 53-year-old female who suffered injuries in a motor vehicle accident that occurred on 03/30/23. At the time of the accident, the injured party was a driver in a vehicle. Following the accident, the injured party suffered injuries which resulted in the injured party seeking treatment. The claim in this case is for durable medical equipment. The claim was denied based upon an IME performed by Dr. David Essig on 08/28/23.

Respondent did not argue any fee schedule defenses at the hearing. The question presented is whether the treatment was medically necessary.

In dispute is Applicant's claim as assignee for reimbursement in the sum of the amount of \$325.08 for treatment rendered to the injured party on 01/10/23.

4. Findings, Conclusions, and Basis Therefor

This hearing was conducted using documents contained in the ADR Center. I have reviewed all of the submissions contained in the ADR CENTER which is maintained by the American Arbitration Association. I have considered the documents contained in the ADR Center as well as the arguments of the parties at the hearing in rendering this decision.

Applicant establishes a prima facie entitlement to payment by proving that it submitted a claim, set forth the facts and the amount of the loss sustained, and that payment of no-fault benefits is overdue (see Insurance Law § 5106[a]; *Viviane Etienne Med. Care v Country-Wide Ins. Co.*, 25 NY3d 498, 501 (2015); *Countrywide Ins. Co. v. 563 Grand Medical PC* 50 A.D. 3d. 313 (1 Dep't, 2008); *Sunshine Imaging Assoc./WNY MRI v. Geico. Ins. Co.*, 66 A.D. 3d. 1419 (4 Dep't, 2009). A facially valid claim is presented when it sets forth the name of the patient, date of accident, the date of the services, a description of the services rendered and the charges for those services. See *Vinings Spinal Diagnostic PC v. Liberty Mutual Insurance Company*, 186 Misc. 2d 287 (1 Dist. Ct. Nass. Co.1996).

The claim was denied based upon an IME report of Dr. David Essig on 08/28/23. The IME doctor reviewed several medical records and examined the patient. The IME doctor found that there was no tenderness to palpation and no spasm noted in the paraspinal musculature. Examination of the cervical spine was normal with normal ranges of motion. All testing was negative. Examination of the thoracic spine revealed no spasm or tenderness. Range of motion was normal. Examination of the lumbar spine revealed no spasm or tenderness. Range of motion was normal. Neurological exam was normal. Muscle strength was 5/5 bilaterally. Upper and lower extremity examinations were also normal. Based upon the examination, the doctor found that the patient's cervical spine and left knee sprain/strain injuries had resolved and that there was a normal evaluation of the lumbar spine thoracic spine, left shoulder, left wrist and left hip.

The claimant has submitted a copy of an examination report dated 12/29/23 in which the injured party had tenderness and muscle spasm in the cervical spine and lumbar spine. The claimant has also submitted a report dated 9/1/23 which is a few days after the IME. AT that time, neck pain was radiating to bilateral shoulders and left lower back and was described as intermittent, dull, aching, sharp, shooting, burning. Pain radiating to the buttocks and left/right leg with numbness/tingling in feet/toes. Pain is exacerbated by mechanical type activities including standing, sitting, bending forward, lifting and twisting, whereas standing and walking worsens leg pain. In the cervical spine there was tenderness in the paraspinal muscles, spinous processes, interspinous ligaments and the medial border of the scapula. There was moderate muscle spasm along the cervical paravertebral, occipital, trapezius and levator scapulae. There was limited range of motion involving rotation, lateral bending and extension with pain at extremes of

motion. There was tenderness in lower back and sacroiliac region, as well as spinous processes from L2-S1. There was muscle spasm along lumbar paravertebral, multifidus, sacrospinalis, gluteus and piriformis. There was limited range of motion of lumbar spine and pelvis, especially with extension (pain). Based on the history, examination, and imaging, the patient was diagnosed with cervical disc displacement.

An IME doctor must establish a factual basis and medical rationale for his asserted lack of medical necessity for future health care services. E.g., *Ying Eastern Acupuncture, P.C. v. Global Liberty Insurance*, 20 Misc.3d 144(A), (App. Term 2d & 11th Dists. Sept. 3, 2008); *Carle Place Chiropractic v. New York Central Mut. Fire Ins Co.*, 19 Misc.3d 1139(A), (Dist. Ct., Nassau Co., Andrew M. Engle, J., May 29, 2008). Where an IME report provides a factual basis and medical rationale for an opinion that services were not medically necessary, and the claimant fails to present any evidence to refute that the claim should be denied, *AJS Chiropractic, P.C. v. Mercury Ins. Co.*, 22 Misc.3d 133(A), (App. Term 2d & 11th Dist. Feb. 9, 2002), as the ultimate burden of proof on the issue of medical necessity lies with the claimant. See Insurance Law § 5102; *Wagner v. Baird*, 208 A.D.2d 1087 (3d Dept. 1994); Where the defendant insurer presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden shifts to the plaintiff which must then present its own evidence of medical necessity *West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co.*, 13 Misc.3d 4(App. Term 2d & 11th Dists. Sept. 29, 2006). The case law is clear that a provider must rebut the conclusions and determinations of the IME doctor with his own facts. Moreover, the Appellate Term, 2d, 11th & 13th Dists., recently stated: "Assuming the insurer is successful in satisfying its burden, it is ultimately plaintiff who must prove, by a preponderance of the evidence, that the services or supplies were medically necessary." *Park Slope Medical and Surgical Supply, Inc. v. Travelers Ins. Co.*, 37 Misc.3d 19, 22 (App. Term 2d, 11th & 13th Dists. 2012).

I find that the IME doctor has failed to establish the treatment in question was not medically necessary. The medical records submitted indicate that the injured party still had subjective and objective findings at the time of the independent medical examination as well as the time of the issuance of the durable medical equipment.

I find the proof submitted by the Applicant is more credible than the proof submitted by the Respondent and I find in favor of the Applicant.

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 |
|--------------|--|----------------------------|-----------------|--------------------------|
| | Advanced Recovery Equipment & Supplies, LLC | 01/10/24 - 01/10/24 | \$325.08 | Awarded: \$325.08 |
| Total | | | \$325.08 | Awarded: \$325.08 |

- B. The insurer shall also compute and pay the applicant interest set forth below. 02/26/2024 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

Applicant is awarded statutory attorney fees pursuant to the no-fault regulations. See, 11 NYCRR §65-4.5(s)(2). The award of attorney fees shall be paid by the insurer. 11 NYCRR §65-4.5(e). Accordingly, "the attorney's fee shall be limited as follows: 20 percent of the amount of first-party benefits, plus interest thereon, awarded by the arbitrator or the court, subject to a maximum fee of \$850." Id. The minimum attorney fee that shall be awarded is \$60. 11 NYCRR §65-4.5(c). However, if the benefits and interest awarded thereon is equal to or less than the respondent's written offer during the conciliation process, then the attorney's fee shall be based upon the provisions of 11 NYCRR §65-4.6(i). 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 disputes, subject to a maximum fee of \$1,360." 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 Fairfield

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

10/01/2024
(Dated)

James Skelton

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:
0cead3db53866f89248944681d349b3d

Electronically Signed

Your name: James Skelton
Signed on: 10/01/2024