American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

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| Nara PT, Chiro & Acupuncture PLLC (Applicant) | AAA Case No. | 17-23-1330-5253 |
| | Applicant's File No. | 3127623 |
| - and - | Insurer's Claim File No. | 0677683520000001 |
| | NAIC No. | 22063 |
| Geico Insurance Company (Respondent) | | |

**ARBITRATION AWARD**

I, Victor Moritz, 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 10/03/2024
   Declared closed by the arbitrator on 10/03/2024

   Melissa Scotti, Esq. from Law Offices of Andrew J. Costella Jr., Esq. participated virtually for the Applicant

   Jerry Marino from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$2,060.00**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The claim was amended to $554.62, reflecting services provided from May 5 through June 16, 2022, reduced per fee schedule and denied based on the defense of lack of medical necessity. All other bills were withdrawn with prejudice based on the failure of the applicant to establish the bills were properly submitted to the respondent.

   Stipulations WERE made by the parties regarding the issues to be determined.

   The parties stipulated to the amount at issue.

3. Summary of Issues in Dispute

The applicant seeks reimbursement for the cost of physical therapy services provided to the IP (D.H.L., 53âyear-old female) from May 5 through June 16, 2022, relative to an October 17, 2021, motor vehicle accident. The respondent denied this claim based on the defense of lack of medical necessity, per the results of an Independent Medical Evaluation (IME) performed by Dr. William Walsh on February 22, 2022. The applicant has further amended their claim, withdrawing all bills for services from June 20 through August 4, 2022, based on failure to establish whether they were properly submitted to the respondent. The parties have stipulated to the amount at issue, as well as the dates of service and that the claim complies with the fee schedule. This matter is determined after reviewing the submissions and presentations of both sides. I have reviewed the documents contained in the electronic case folder, as of the closing of the file. The hearing was held on Zoom.

4. Findings, Conclusions, and Basis Therefor

**I find for the respondent and deny the claim in its entirety.**

**Prior Arbitrations**

The parties acknowledge that ***Arbitrator Ben Feder*** determined in ***Colin Clarke, M.D., P.C. v Geico Ins.Co., AAA 17-23-1289-8856,*** concerning a June 16, 2022 evaluation determined Dr. Walsh's IME was sufficient to deny future medical services.

In pertinent part, Arbitrator Feder noted:

*Dr. Walsh examined the IP on 2/22/22. Dr. Walsh diagnosed the IP with resolved sprains/strains of the cervical spine, thoracic spine, lumbar spine, bilateral shoulders, right elbow & left hip. Dr. Walsh determined that the IP did not present with deficits in range of motion in all body parts examined. In addition, orthopedic and neurological testing yielded negative findings. Dr. Walsh declared that the IP was no longer in need of further orthopedic treatment, including prescription medication.*

*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 support of the claim, Applicant relies upon the IP's medical records and a rebuttal by Dr. Clarke. Specifically, Applicant relies on the evaluation examinations and reports of 2/3/22 & 3/24/22. These evaluation reports note spasm and decreased range of motion in the IP's cervical and lumbar spine. However, no specific range of motion findings are presented. No orthopedic testing was performed or provided. No neurological testing was conducted. These contemporaneous medical records do not refute the findings of the IME report.*

*Comparing the relevant evidence presented by both parties against each other I find I am persuaded by the Respondent. I find that Applicant did not prove medical necessity by a preponderance of the credible evidence. Rather, Respondent proved lack of medical necessity. Applicant has not submitted any evidence to refute the findings of the IME report.*

I acknowledge it is within the arbitrator's authority to determine the effect of a prior arbitration. Matter of Falzone v. New York Central Mutual Fire Ins. Co., 15 N.Y.3d 530, 914 N.Y.S.2d 67 (2010), aff'g, 64 A.D.3d 1149, 881 N.Y.S.2d 769 (4th Dept. 2009) and noting the applicant was not the party in interest, it does not have a collateral estoppel effect on this claim.

Notwithstanding, for the reasons noted below, I find the IME sufficient to cut off future physical therapy services.

**IME**

Dr. Walsh noted the history of the IP's motor vehicle accident, wherein he sustained injuries to his neck and right hip. He began conservative treatment, which included physical therapy and massage therapy. Dr. Walsh noted the IP received trigger point injections from Dr. Clarke on October 28, 2021. In this instance, the evaluation of the cervical spine revealed a full range of motion without tenderness or spasms. Multiple orthopedic test findings were negative. The neurological evaluation was intact. The evaluation of the thoracic spine revealed no deficits. The evaluation of the lumbar spine revealed no tenderness or spasms with full range of motion in all planes. Various orthopedic test findings were negative. The evaluation of the shoulders, elbows, and hips also were within normal limits, without deficits. The impression includes cervical, thoracic, and lumbar spine sprain/strains resolved; bilateral shoulder, right elbow, and left hip sprain/strain resolved, and the IP required no further care.

**Applicant's Submissions**

To refute these findings, the applicant has provided physical therapy treatment notes, which were preprinted forms indicating areas of pain and modalities provided.

The applicant has also provided chiropractic reports, including contemporaneous reevaluations, and has postdated the IME. The narratives indicated the IP continued complaining of neck and lower back pain, stiffness, spasms, and tenderness, with trigger points noted. Restricted range of motion was indicated, and chiropractic manipulations were provided. It is noted that these reevaluations were preprinted forms, with check marks indicating the positive findings.

I also note the reports from Dr. Clarke mentioned above that are contemporaneous to the IME, including February 3, 2022, and March 24, 2022, with indications of spinal pain and positive findings noted. The IP was provided various prescriptions and received trigger points in the cervical spine region.

**Legal Standards for Determining Medical Necessity**

It is well settled that an applicant established its prima facie entitlement to payment by proving it submitted a claim set forth the facts and the amount of the loss sustained and that payment of no-fault benefits were 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 (1st Dep't, 2008); Sunshine Imaging Assoc./WNY MRI v. Geico. Ins. Co., 66 A.D. 3d. 1419 (4th Dep't, 2009). A facially valid claim is presented when it sets forth the name of the patient; date of accident; date of the services; description of services rendered and the charges for those services. See Vinings Spinal Diagnostic PC v. Liberty Mutual Insurance Company, 186 Misc. 2d 287 (1st Dist. Ct. Nass. Co.1996). The applicant has met this burden.

When evaluating the medical necessity of services with proof of each party, particularly the conclusion is contradictory; consideration must be given to the evidentiary burdens. Respondent must prove first that the services were not medically necessary.

The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment Kingsborough Jewish Med. Ctr. v. Allstate Ins. Co. 61 A.D. 3d. 13 (2d. Dep't, 2009), See also Channel Chiropractic PC v. Country Wide Ins. Co. 38 AD 3d. 294 (1st Dep't, 2007). An insurance carrier must at a minimum establish a detailed factual basis and a sufficient medical rationale for asserting lack of medical necessity. See Delta Diagnostic Radiology PC v. Progressive Casualty Ins. Co. 21 Misc. 3d. (142A) (App. Term 2d. Dep't, 2008). In evaluating the medical necessity of services with proof of each party, particularly the conclusion is contradictory; consideration must be given to the evidentiary burdens. Respondent must prove first that the services were not medically necessary.

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).

**Application of Legal Standards**

I note the validity of denials based upon negative IME findings have been recognized by several Courts. See, e.g., Innovative Chiropractics P.C. v. Mercury Ins. Co., 25 Misc3d 137 (App. Term 2d & 11th Dists. 2009); B.Y. M.D., P.C. v. Progressive Casualty Ins. Co., 26 Misc3d 125 (App. Term 9th & 10th Dists. 2010). An IME report can be the basis of a termination of benefits if ultimately found to be persuasive. Whether an IME report is persuasive, and meets the carrier's burden is a factual decision, which must be rendered on a case-by-case basis.

Therefore, when as here an insurer interposes a timely denial of claim that sets forth a sufficiently detailed factual basis and adequate medical rationale for the claim's rejection, the presumption of medical necessity and causality attached to the applicant's properly completed claim is rebutted and the burden shifts back to the claimant to refute the IME findings and prove the necessity of the disputed services and the causal relationship between the injuries and the accident. See, CPT Med. Servs., P.C. v. New York Cent. Mut. Fire Ins. Co., 18 Misc.3d 87 (App. Term 1st Dept.); Eden Med., P.C. v. Progressive Cas. Ins. Co., 19 Misc.3d 143(A) (App Term 2d & 11th Jud.Dists., 2008). Be Well Med. Supply, Inc. v. NewYork Cent. Mut. Fire Ins. Co., 18 Misc. 3d. 139 (A) (App. Term 2d Dept., Feb. 21, 2008; A.Khodadadi Radiology, P.C. v. NY Cent. Mut. Fire Ins. Co., 16 Misc. 3d. 131 (A) (App Term 2d Dept.); West Tremont Med. Diagnostic, P.C. v. Geico Ins. Co., 13 Misc. 3d. 131 (A) (App Term 2d Dept., 2006).

In the instant matter, I find for the respondent and deny this claim.

The contemporaneous and post-IME physical therapy notes and chiropractic reevaluations are less comprehensive than Dr. Walsh's IME. They are insufficient to refute his determination that the IP required no further care, including physical therapy.

Regarding Dr. Clarke's records, which were also submitted, Arbitrator Feder had already determined that Dr. Clarke's narratives were insufficient to refute Dr. Walsh's IME findings. Even if this was a case of first impression concerning Dr. Clarke's reports, I agree with Arbitrator Feder's determination that Dr. Walsh performed the most comprehensive examination, determining that no further care was necessary.

**Therefore, the claim is denied in its entirety.**

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 NY
SS :
County of Westchester

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

10/15/2024
(Dated)

Victor Moritz

**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:**
24dee97ea905b1836bb7a9854518d6b8

**Electronically Signed**

Your name: Victor Moritz
Signed on: 10/15/2024