

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Richard Grosso DC PC
(Applicant)

- and -

Liberty Mutual Insurance Company
(Respondent)

AAA Case No. 17-24-1361-6583

Applicant's File No. STLG24-

Insurer's Claim File No. 052644695

NAIC No. 19704

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 02/18/2025, 03/03/2025
Declared closed by the arbitrator on 04/23/2025

John Faris, Esq. from Law Office Of Stephen A. Strauss, PC participated virtually for the Applicant

Sherona Solomon from Liberty Mutual Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$8,229.36**, 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 56 year old EIP reported involvement in a motor vehicle accident on January 31, 2023; claimed related injury and underwent office visits and chiropractic treatment provided by the applicant from May 15, 2023 to February 16, 2024.

The respondent submitted a claim for the medical services provided from May 15, 2023 to February 16, 2024 for a total of \$8,229.36.

The respondent contends that bills for dates of service 6/5/23 to 6/30/23, 9/13/23 to 9/25/23, 10/2/23 to 10/31/23 and 11/1/23 to 11/8/23 were never received. These bills total \$3,019.02.

There is no proof of payment for pre-IME dates of service May 15, 2023 to July 7, 2023.

The bills for dates of service July 17, 2023 to February 16, 2024 (excluding bills which the respondent contends were not received) were denied based on the IME of the EIP by Philip Cilio, D.C., which was performed on June 27, 2023. The IME cut-off was effective of July 7, 2023.

The respondent asserted a fee schedule defense for all bills for services rendered from May 15, 2023 to July 24, 2023 and July 31, 2023 to February 16, 2024, (with the exception of the bills which it contends were not received) based on its calculation of the correct reimbursable amount pursuant to the New York Workers' Compensation Chiropractic Fee Schedule.

The issues to be determined at the hearing are:

Whether the applicant established its *prima facie* entitlement to no fault benefits for services rendered from June 5, 2023 to November 8, 2023.

Whether the respondent established that the services provided from July 17, 2023 to February 16, 2023 were not medically necessary.

Whether the respondent established its fee schedule defense.

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 dates of service June 5, 2023 to November 8, 2023

The respondent contends that it did not receive the bills for dates of service 6/5/23 to 6/30/23, 9/13/23 to 9/25/23, 10/2/2/23 to 10/31/23 and 11/1/23 to 11/8/23. According to the submissions, these bills total \$3,019.02.

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.)

In this matter, the applicant failed to submit proof of timely mailing of the bills at issue.

In addition, the respondent submitted the affidavit of Shertona Solomon, Senior Claims Specialist in the respondent's no-fault department who attested to the fact that the bills for dates of service 6/5/23 to 6/30/23, 9/13/23 to 9/25/23, 10/2/23 to 10/31/23 and 11/1/23 to 11/8/23 were not received by the respondent.

An insurer in a no-fault matter will be precluded as a matter of law from asserting a defense based upon the ground that plaintiff untimely submitted its claim if such defense is not raised in a timely denial of claim. 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 of claim, it will still be precluded from proffering such defense as a matter of law unless respondent advised applicant that "late notice will be excused where the applicant can provide a reasonable justification of the failure to give timely notice." 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.)

In the instant matter, the respondent's denial for the bills at issue was timely and it contained the requisite language regarding "reasonable justification."

Under these circumstances, the applicant failed to establish its *prima facie* entitlement to no-fault benefits and the respondent has established its late notice defense for the bills for dates of service 6/5/23 to 6/30/23, 9/13/23 to 9/25/23, 10/31/23 to 10/31/23 and 11/1/23 to 11/8/23.

Therefore, the claim for dates of service 6/5/23 to 6/30/23, 9/13/23 to 9/25/23, 10/2/23 to 10/31/23 and 11/1/23 to 11/8/23 is dismissed with prejudice.

Medical Necessity

To support a lack of medical necessity respondent must "set forth a factual basis and medical rationale for the IME doctor'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. Term 2^d, 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.)

In this instance, the respondent did not submit a copy of the report of the IME of the EIP which it contends was performed on June 27, 2023.

Based on the foregoing, the respondent failed to establish that the services rendered to the EIP from July 17, 2023 to February 16, 2024 were not medically necessary.

Therefore, an award will be issued in favor of the applicant for dates of service July 17, 2023 to February 16, 2024 (excluding the bills which were not received) pursuant to the appropriate fee schedule.

Fee Schedule

The applicant billed a total of \$5,210.34 for the services provided from May 15, 2023 to February 16, 2024 (excluding the bills which were not received) for which no payment was received from the respondent. The respondent contends that the charges for these dates of service were billed in excess of the chiropractic fee schedule.

To prevail in its fee schedule defense, the respondent must demonstrate by competent evidentiary proof that the applicant's claims are in excess of the appropriate fee schedule. If the respondent fails to do so, its defense of noncompliance with the New York Workers' Compensation Medical Fee Schedule cannot be sustained. See Continental Medical, P.C. v Travelers Indemnity Co., 11 Misc. 3d 145A (App. Term 1st Dept. 2006.)

An insurer fails to raise a triable issue of fact with respect to a defense that the fees charged were not in conformity with the Workers' Compensation fee schedule when it does not specify the actual reimbursement rates which formed the basis for its determination that the claimant billed in excess of the maximum amount permitted. See St. Vincent Medical Services, P.C. v. GEICO Ins. Co., 29 Misc.3d 141(A), 907 N.Y.S.2d 441 (App. Term 2d, Dec. 8, 2010.)

A fee schedule defense does not always require expert proof. There are two fee schedule scenarios. The first involves the basic application of the fee codes and simple arithmetic. The second scenario involves interpretation of the codes and often requires testimony and evidence beyond that of a lay individual. I find that the fee schedule issue presented in this case is analogous to the former scenario and does not require an expert opinion.

Neither party submitted an affidavit from a certified professional fee coder, medical professional or other expert to support the correct reimbursable amount

pursuant to the New York Workers' Compensation Chiropractic Fee Schedule in effect at the time that the charges at issue were billed.

In the absence of any submissions regarding this issue I have taken judicial notice of the applicable fee schedule and determined that the correct reimbursable amount for the pre and post IME services for which the respondent received bills is \$4,541.63.

Based on the foregoing, the respondent established its fee schedule defense.

Accordingly, the applicant is awarded \$4,541.63 in disposition of the claim for bills received by the respondent and the remainder of the 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 applicant is AWARDED the following:

A.

Medical		From/To	Claim Amount	Status
	Richard Grosso DC PC	05/15/23 - 02/16/24	\$8,229.36	Awarded: \$4,541.63
Total			\$8,229.36	Awarded: \$4,541.63

- B. The insurer shall also compute and pay the applicant interest set forth below. 08/20/2024 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." See 11 NYCRR §64-3.9(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. Where a claim is untimely denied, or not denied or paid, interest shall accrue as of the 30th day following the date the claim is presented by the claimant to the insurer for payment. Where a claim is timely denied, interest shall accrue as of the date an action is commenced or an arbitration requested, unless an action is commenced or an arbitration requested within 30 days after receipt of the denial, in which event interest shall begin to accrue as of the date the denial is received by the claimant. 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 was timely. LMK Psychological Servs. P.C. v. State Farm Mut. Auto. Ins. Co., 12 NY3d 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's fees pursuant to the no fault regulations. For cases filed after February 4, 2015 the attorney's fee shall be calculated as follows: 20% of the amount of first-party benefits awarded, plus interest thereon subject to no minimum fee and a maximum of \$1,360.00. 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 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.

04/23/2025

(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:
ecbb31aa2b9eac9cdd104d6757d9bc96

Electronically Signed

Your name: Anne Malone
Signed on: 04/23/2025