American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Ocean Blue Chiropractic, PC (Applicant)	AAA Case No.	17-24-1348-2375
	Applicant's File No.	172664
- and -	Insurer's Claim File No.	0433734970101046
	NAIC No.	22063
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Glen Wiener, 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: Assignor

1. Hearing(s) held on 04/30/2025
   Declared closed by the arbitrator on 04/30/2025

   Aleksey Selipanov, Esq. from The Law Offices of John Gallagher, PLLC participated virtually for the Applicant

   Chelsea Waller, C.R. from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$1,317.90**, 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

   Assignor A.B. a 28-year-old male was the driver of a vehicle involved in an automobile accident on April 19, 2021. He was initially evaluated and treated at Northwell Hospital.

   On April 21, 2021, Assignor presented to Applicant and commenced treatment. From April 27, 2021, through April 29, 2021, Applicant provided treatments to Assignor. Respondent denied Applicant's request for reimbursement averring the proof of claim was received more than 45-days after the services were provided.

On July 7, 2021, Assignor was examined by Ronald A. Csillag, D.C., a chiropractor selected by Respondent [the "IME"]. The chiropractic examination did not reveal any abnormalities. Based on the IME report, Respondent terminated Assignor's chiropractic benefits effective July 23, 2021.

From July 26, 2021, through November 2, 2021, Applicant provided additional chiropractic services to Assignor. Respondent denied Applicant's requests for reimbursement based on the IME.

For the services provided from August 24, 2021, through September 16, 2021, Respondent denied Applicant's request for reimbursement averring the proof of claim was received more than 45-days after the services were provided.

The two questions presented are:

Whether Applicant's two proofs of claim were submitted within 45 days after the services were provided to Assignor; and

Whether the remaining post-IME chiropractic treatments were medically necessary.

4. Findings, Conclusions, and Basis Therefor

The decision below is based on the documents on file in the Electronic Case Folder maintained by the American Arbitration Association as of the date of this hearing and on oral arguments of the parties. No witness testimony was produced at the hearing.

Applicant Ocean Blue Chiropractic, P.C. as assignee of A.B. seeks $1,317.90 reimbursement, with interest and counsel fees, under the No-Fault Regulations, for chiropractic services provided to Assignor.

Respondent Geico Insurance Company insured the motor vehicle involved in the automobile accident. Under New York's Comprehensive Motor Vehicle Insurance Reparation Act (the "No-Fault Law"), New York Ins. Law §§ 5101 et seq., Respondent was obligated to reimburse the injured party (or their assignee) for all "reasonable and necessary" medical expenses arising from the use or operation of the insured vehicle.

Assignor A.B. a 28-year-old male was the driver of a vehicle involved in an automobile accident on April 19, 2021. He was initially evaluated and treated at Northwell Hospital.

On April 21, 2021, complaining of radiating neck, intermittent radiating back, and intermittent right knee pains, Assignor presented to Applicant and commenced treatment.

From April 27, 2021, through April 29, 2021, Applicant provided treatments to Assignor. Respondent denied Applicant's request for reimbursement averring the proof of claim was received more than 45-days after the services were provided.

On July 7, 2021, Assignor was examined by Ronald A. Csillag, D.C., a chiropractor selected by Respondent [the "IME"]. The chiropractic examination did not reveal any abnormalities. Specifically, the examination of Assignor's cervical and lumbar spines revealed no spasms and full ranges of motion. Strength, sensation, and reflexes were not pathological. Provocative testing was normal. It was determined that Assignor's injuries had fully resolved and there was no need for any additional chiropractic treatment. Based on the IME report, Respondent terminated Assignor's chiropractic benefits effective July 23, 2021.

From July 26, 2021, through November 2, 2021, Applicant provided additional chiropractic services to Assignor. Respondent denied Applicant's requests for reimbursement based on the IME.

For the services provided from August 24, 2021, through September 16, 2021, Respondent denied Applicant's request for reimbursement averring the proof of claim was received more than 45-days after the services were provided.

The two questions presented are:

Whether Applicant's two proofs of claim were submitted within 45 days after the services were provided to Assignor; and

Whether the remaining post-IME chiropractic treatments were medically necessary.

First, Applicant seeks $744.90 reimbursement for the services provided to Assignor from April 27, 2021, through April 29, 2021, and from August 24, 2021, through September 16, 2021.

Respondent timely denied the claims for the services provided, alleging Applicant failed to submit its written proofs of claim within 45 days after the services were rendered.

11 N.Y.C.R.R. 65.1.1 (c) requires:

> *In the case of a claim for health service expenses, the eligible injured person or that person's assignee or representative shall*

> *submit written proof of claim to the Company, including full particulars of the nature and extent of the injuries and treatment received and contemplated, as soon as reasonably practicable but, in no event later than 45 days after the date services are rendered. The eligible injured person or that person's representative shall submit written proof of claim for work loss benefits and for other necessary expenses to the Company as soon as reasonably practicable but, in no event, later than 90 days after the work loss is incurred or the other necessary services are rendered. The foregoing time limitations for the submission of proof of claim shall apply unless the eligible injured person or that person's representative submits written proof providing clear and reasonable justification for the failure to comply with such time limitation.*

Respondent avers both proofs of claim were received on May 22, 2024, years after the services were provided.

Applicant did not submit any evidence disputing Respondent's assertions and establishing the claims were timely submitted.

As noted above, there is an exception to the 45-day limit. The delay may be excused if the applicant provides "clear and reasonable justification for the failure to comply with such time limitation." Further amplification of this exception is provided in 11 N.Y.C.R.R. §65-3.5 (l):

> *The insurer shall establish standards for review of its determinations that applicants have provided late notice of claim or late proof of claim. In the case of notice of claim, such standards shall include, but not limited to, appropriate consideration for pedestrians and non-related occupants of motor vehicles who may have difficulty ascertaining the identity of the insurer.* ***In the case of proof of claim,*** *such standards shall include, but not be limited to, appropriate consideration for emergency care providers, demonstrated difficulty in ascertaining the identity of the insurer and inadvertent submission to the incorrect insurer. The insurer shall establish procedures, based upon objective criteria, to ensure due consideration of denial of claims based upon late notice or late submission of claims based upon late notice or late submission of proof of claim, including supervisory review of all such determination.*

Applicant did not submit any written proof establishing a "clear and reasonable justification" for its failure to comply with the regulations time limitation.

Hence, Applicant's request for $744.90 reimbursement is denied and Respondent denials are sustained.

[2] Applicant also seeks $573.00 reimbursement for the remaining chiropractic services provided to Assignor. Respondent denied Applicant's requests for reimbursement based on the IME.

Applicant established a prima facie case by submitting evidence that payment of no-fault benefits is overdue, and proof of its claims, using the statutory billing forms, were mailed to, and received by Respondent. *Viviane Etienne Med. Care, P.C. v Country-Wide Ins. Co.*, 25 N.Y.3d 498, 501 (2015).The proof that Applicant mailed the claims form to Respondent is embodied in the latter's denials, which reference receipt of the proofs of claim. *See, Ultra Diagnostic Imaging v. Liberty Mutual Insurance Co*., 9 Misc.3d 97, 804 N.Y.S.2d 532 (App. Term 9th and 10th Jud. Dist. 2005).

Once Applicant established a prima facie case the burden shifted to Respondent to prove the chiropractic services provided were not medically necessary. *See Citywide Social Work & Psychological Services, PLLC v. Allstate Ins. Co.,* 8 Misc.3d 1025A, 806 N.Y.S.2d 444 (App. Term 1st Dept. 2005); *A.B. Medical Services, PLLC v. Geico Ins. Co.,* 2 Misc.3d 26, 773 N.Y.S.2d 773 (App. Term 2d & 11th Jud. Dist. 2003); *Fifth Ave. Pain Control Center v. Allstate Ins. Co*, 196 Misc.2d 801, 766 N.Y.S.2d 748 (Civ. Ct. Queens Co. 2003).

"A denial premised on lack of medical necessity must be supported by competent evidence such as an independent medical examination, peer review or other proof which sets forth a factual basis and medical rationale for denying the claim." *Healing Hands Chiropractic, P.C. v. Nationwide Assurance Company,* 5 Misc.3d 975, 787 N.Y.S. 645, (Civ. Ct. N.Y. Co. 2004).

Dr. Csillag performed the independent chiropractic examination on Assignor on July 7, 2021. He identifies the records reviewed prior to rendering the IME report. Range of motion testing performed with a goniometer, established normal ranges of motion in Assignor's cervical, and lumbar spines in accord with AMA Guide to Permanent Impairment. All other objective tests were normal. After this comprehensive examination, Dr. Csillag reasonably opined there was no objective evidence of a disability, and no additional treatment or diagnostic testing was necessary.

The IME report submitted provides a sufficient factual basis and rationale for the opinion the chiropractic services billed for were not medically necessary and therefore established prima facie the services billed for were not medically necessary. *See Delta Diagnostic Radiology, PC v. Progressive Casualty Ins. Co.,*21 Misc.3d 142A (App. Term 2d & 11th Jud. Dist. 2008); *Crossbridge Diagnostic Radiology, PC v. Progressive Casualty Ins. Co.,*20 Misc.3d 143A (App. Term 2d & 11th Jud. Dist. 2008).

Once Respondent established a factual basis and chiropractic rationale for the determination there was lack of medical necessity for any further chiropractic treatment and testing, the burden shifted to Applicant to present evidence as to why additional chiropractic services were needed either because Assignor's condition had changed after the IME or because the IME doctor's opinion was erroneous. *New Horizon Surgical Center, LLC v. Allstate Ins. Co.*, 52 Misc.3d 139(A) (App. Term 2d, 11th & 13th Jud. Dist. 2016).

Applicant only submitted chiropractic checklist progress notes. Applicant did not submit any contemporaneous chiropractic reports describing any chiropractic examinations conducted about the time of the IME disputing the findings of Dr. Csillag. Applicant also did not submit any chiropractic reports describing any chiropractic examinations when the services were provided.

Without any chiropractic reports describing Assignor's condition in detail, at or about the time the chiropractic IME was conducted, and showing the services provided were medically necessary, it would be unreasonable to conclude the IME doctor was erroneous and that additional treatments were necessary.

It is ultimately Applicant who must prove, by a preponderance of the evidence, the chiropractic services in question were medically necessary. *Dayan v. Allstate Ins. Co,*39 Misc.3d 151(A) (App. Term 2d, 11th & 13th Dists. 2015); *Park Slope Medical and Surgical Supply, Inc. v. Travelers Ins. Co*., 37 Misc.3d 19, 952 N.Y.S.2d 372. (App. Term 2d, 11th & 13th Dists. 2012) This was not done herein.

Accordingly, Applicant's request for reimbursement is denied and Respondent's denials are sustained. This award is in full disposition of all No-Fault benefit claims submitted to 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 NY
SS :
County of New York

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

05/01/2025
(Dated)

Glen Wiener

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:
e82b0c797a7cb7e65bf1da25af56a5ce

Electronically Signed

Your name: Glen Wiener
Signed on: 05/01/2025