American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Danny Fuzaylov PA (Applicant)	AAA Case No.	17-24-1377-7305
	Applicant's File No.	3389456
- and -	Insurer's Claim File No.	0515409410001
	NAIC No.	36447
LM General Insurance Company (Respondent)		

ARBITRATION AWARD

I, Eileen Hennessy, 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-R.R.

1. Hearing(s) held on 05/21/2025
   Declared closed by the arbitrator on 05/21/2025

   Ryan Berry from Israel Purdy, LLP participated virtually for the Applicant

   Jonathan Humphries from LM General Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$1,209.15**, 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 record reveals that the Assignor-R.R., a 32-year-old female, claimed injuries as a passenger of a motor vehicle involved in an accident that occurred on 11/12/2022. Applicant billed for office visits, trigger point injections, and ultrasonic guidance conducted from 6/3/2024 through 7/29/2024. Respondent denied the claim based on a lack of medical necessity per the results of the orthopedic Independent Medical Evaluation (IME) performed by Howard Kiernan, M.D., effective 12/21/2023. The issue to be determined is whether the services are medically necessary?

4. Findings, Conclusions, and Basis Therefor

Applicant seeks reimbursement foroffice visits, trigger point injections, and ultrasonic guidance. This hearing was conducted using the documents contained in the Electronic Case Folder (ECF) maintained by the American Arbitration Association. All documents contained in the ECF are made part of the record of this hearing and my decision was made after a review of all relevant documents found in the ECF as well as the arguments presented by the parties during the hearing held via Zoom.

In accordance with 11 NYCRR 65-4.5(o) (1), an arbitrator shall be the judge of the relevance and materiality of the evidence and strict conformity of the legal rules of evidence shall not be necessary. Further, the arbitrator may question or examine any witnesses and independently raise any issue that Arbitrator deems relevant to making an award that is consistent with the Insurance Law and the Department Regulations.

Legal Standards for Determining Medical Necessity

Once applicant has established a prima facie case, the burden then shifts to respondent to establish a lack of medical necessity with respect to the benefits sought. *See*, Citywide Social Work & Psychological Services, PLLC v. Allstate Ins. Co., 8 Misc3d 1025A (2005). A denial premised on lack of medical necessity must be supported by competent evidence such as an IME, peer review or other proof which sets forth a factual basis and medical rational for denying the claim. *See*, Healing Hands Chiropractic, P.C. v. Nationwide Assur. Co., 5 Misc3d 975 (2004).

In evaluating the medical necessity of services with proof of each party, particularly where 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. All State 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 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). 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). For an applicant to prove that the disputed expense was medically necessary, it must meaningfully refer to, or rebut, respondent's evidence. *See*, Yklik, Inc. v. Geico Ins. Co., 28 Misc3d 133A (2010). 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., 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 medication 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). 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 showing, the claim should be denied, as the ultimate burden of proof on the issue of medical necessity lies with the claimant. *See* Insurance Law § 5102; AJS Chiropractic, P.C. v. Mercury Ins. Co., 22 Misc.3d 133(A), (App. Term 2d & 11th Dist. Feb. 9, 2002); Wagner v. Baird, 208 A.D.2d 1087 (3d Dept. 1994).

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.); A.Khodadadi Radiology, P.C. v. NY Cent. Mut. Fire Ins. Co., 16 Misc. 3d. 131 (A) (App Term 2d Dept.).

In support of its contention that further treatment was not medically necessary, Respondent relies upon the orthopedic examination report of Howard Kiernan, M.D., conducted on 12/5/2023. The examination reveals all tests were objectively negative and unremarkable with no muscle spasm, heat, or swelling. Range of motion was full. Orthopedic testing was normal. Neurological testing revealed no deficits. Dr. Kiernan diagnosed all injuries as resolved. Dr. Kiernan indicated there were no clinical objective findings to support the claimant's subjective complaints. From an orthopedic viewpoint, there was no need for any further treatment. Based upon Dr. Kiernan's examination all orthopedic No-fault benefits were denied effective 12/21/2023.

In this matter, I am faced with conflicting opinions concerning the medical necessity for the treatment. There are no legal issues to resolve. This dispute involves solely an issue of fact, that is, whether the services billed were medically necessary. Resolution of that fact is determined by which opinion is accepted by the trier of fact.

I find the report for the IME conducted by Howard Kiernan, M.D.on 12/5/2023 to be sufficient for the purpose of establishing Respondent's defense. The report adequately sets forth the factual basis and medical rationale to support the conclusion that the Assignor was not in need of any further treatment. That being so, the burden shifts to the Applicant to counter Respondent's showing.

Having carefully reviewed all the evidence I find that Applicant has failed to rebut Dr. Kiernan's assessment and has not succeeded in demonstrating that the claimed services

were necessary for the Assignor. Applicant relies on examinations by Danny Fuzaylov, PA, dated 4/1/2024 through 7/29/2024, and physical therapy records. Respondent submits the extensive medical records reviewed by the IME doctor.

These records do not serve to overcome the IME as the IME is more detailed and comprehensive. While the records memorialize the Assignor's continuing complaints of pain and provide some insight on her condition, the information is limited, not contemporaneous to the IME, and not as comprehensive as the findings noted within the IME report. There is no contemporaneous examination report from a medical doctor, which documents positive objective findings, which rebuts the findings of the IME doctor

Without reports of an examination at or about the time of the IME detailing objective findings of abnormalities requiring further treatment, Applicant failed to rebut the Respondent's IME objective examination and has failed to satisfy its burden. Accordingly, in balancing the two positions, I find that the more credible and persuasive proof on the issue of medical necessity resides with the Respondent.

CONCLUSION

Accordingly, Applicant's claim is denied in its entirety. 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 NY
SS :
County of Nassau

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

06/20/2025
(Dated)

Eileen Hennessy

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:
915888ba9aa3895065358b4e2f2666e7

Electronically Signed

Your name: Eileen Hennessy
Signed on: 06/20/2025