American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:		
Intergrated Medical Rehab. & Diagnostic, PC / Athenise Thelisme (Applicant)	AAA Case No. AAA Assessment No. Applicant's File No.	412009008630 17 991 08491 09
- and -		
Allstate Insurance Company (Respondent)	Insurer's Claim File No.	4816725289

ARBITRATION AWARD

I, Maureen A. Callahan, 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
- ☐ 6.30.2009
- ☐ 7.28.2009
- ☐ 9.15.2009
- ☐ 11.17.2009
- ☐ 1.12.2009
- ☐ 3.2.2010, 3.9.2010,

and declared closed by the arbitrator on 4/27/10.

Seth Romanick participated in person for the Applicant.
Ed Ryan participated in person for the Respondent.

2. The amount claimed in the Arbitration Request, **$13,319.18**, 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

Applicant seeks reimbursement for physical therapy, office visits, evaluations, and chiropractic care.
Did the respondent have founded beliefs as to the improper and management and control of applicant's corporation, thereby shifting the burden to applicant to explain otherwise?

4. Findings, Conclusions, and Basis Therefor

The case in dispute centers upon an accident occurring on 08/29/07. Both sides were present at the hearing on 4/27/2010. Applicant seeks reimbursement for physical therapy, office visits, evaluations, and chiropractic care rendered from 09/17/07 through 05/28/08. Forty-one bills for medical services were submitted and discussed. This decision is rendered upon review of the evidence contained in the ECF as of 04/27/10, and upon consideration of the arguments made by the parties. Also considered are the arguments made at the five previously scheduled arbitration dates in this case, from 07/28/09 up until and through 04/27/10.

According to ll NYCRR 65-4.5(o)(1): The arbitrator shall be the judge of the relevance and materiality of the evidence offered, and strict conformity to legal rules of evidence shall not be necessary. The arbitrator my question any witness or party and independently raise any issue that the arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department regulations.

Additional time and courtesy was extended to both sides in this case to submit briefs and documentation not originally not contained in the ECF, so that a decision could be rendered upon a complete review of the pertinent documents relevant to this matter. Time was given to both sides to submit briefs and bring witnesses. In fact, after all of the adjournments granted in this case, both parties were instructed that it would be marked final and be held on 04/27/10. The applicant advised that Dr. McGee would be ready, willing, and able to testify on 04/27/10. The witness, Dr. McGee, did not appear at the hearing, and a negative inference is therefore taken.

No fault benefits are overdue if not paid within 30 calendar days after the insurer receives proof of claim, which shall include verification of all of the relevant information requested pursuant to section 65-3.5 of this part, New York Sate Insurance Law Sec 68.

All of the bills were looked at individually. The majority were timely denied based upon 'no standing', although some of the bills had a late denial, respondent still argues that the claims ought not be paid, as there is no standing and that the payments are precluded.

An insurer may raise a "Mallela" fraudulent incorporation defense (State Farm v. Mallela, 4 N.Y.3d 313, 794 N.Y.S.2d 700 (2005) despite a late denial in raising it, or not even having raised it in the denial, and the Court of Appeals decision in Fair Price Medical Supply Corp. does not alter this. Manhattan Medical Imaging, PC v. Statefarm Mut. Auto. Ins. Co., 20 Misc.3d 1144(A), 2008 WL 4200317, 2008 NY Slip Op (Civ. CT. Kings Co., Katherine Levine, J., Sept. 4 2008). Prior to Hospital for Joint Diseases and Fair Price Medical Supply, the Appellate Term held that the defense that a provider is fraudulently licensed and hence ineligible for reimbursement of no-fault benefits is a non-waivable defense and is not subject to the thirty day preclusion rule. Midwood Acupuncture PC v Statefarm Mut Auto. Ins. Co., 14 Misc. 3d 131(A), 836 N.Y.S. 2d 486, 2007 WL93176

2007 NY Slip Op. 50052(U) (App. Term 2d & 11th Dists. Jan 8 2007); see also Muti Quest PLLC v. Allstate Insurance Co., 17 Misc. 3d 37, 844NYS2d 565 (App Term 2d & 11Dists. 2007).

First examined is whether or not respondent has established a 'founded belief' of fraud in the PC of applicant, in the running of the corporation, management, and control of same. Respondent alleges that the applicant is involved in a fee splitting with non-doctors, amongst other things, and that Dr. McGee, the shareholder and owner, does not really manage or control the corporation. This is a major point in respondent's arguments. Respondent argues that if the corporation is managed and controlled by a third party, that the no-fault benefits can not be collected. This is true and a non-wavable defense according to the case law.

The applicant establishes a prima facie case. It is well settled under New York State No Fault Law that an applicant can make a prima facie showing of medical necessity by submitting a properly completed claim for, which suffices on its face to establish the particulars of the nature and extent of the injuries, and health benefits received and contemplated and the "proof of the fact that the amount of loss sustained. 11 NYCRR 65-1.1, Insurance Law Sec.5102 (A), See Amaze med. Supply Inc. a/a/o Johnny Bermudez v. Eagle Ins. Co., 784 NYS 2d 918.

The plaintiff's prime facie case establishes a presumption of coverage. When the defense is based on lack of coverage, the defendant need only come forward with evidence that rebuts the presumption of coverage. That is, that once the plaintiff has made out a prime facie case, the burden of production (burden of going forward) on the issue of coverage falls upon the defendant, and the defendant must demonstrate that it has a founded basis for believing that in this case, that the corporation was improperly managed and controlled. The burden of persuasion, however, remains on the plaintiff who must prove its' case by a fair preponderance of the credible evidence (Kalra v. Kalra, 149AD2D, 409, 411, 539NYS2D761) (2nd Dept. 1989), Prince, Richardson on evidence, 343, 3-206, "If the insurer carries its' burden of coming forward, plaintiff must rebut or succumb". AB Med Service 7 Misc. 3D at 825, 795 NYS2D843.

In this case, when the first bill was examined, it is a bill for an initial evaluation by Dr. McGee performed 09/17/07. When respondent received the bill, two verification requests were dispatched, on 11/06/07, 12/11/07, and 12/31/07. Respondent requested that the Integrated, Dr. John McGee appear for EUO's. He never appeared. All of the other bills were examined. Some have timely denials; some have late denials. Regardless, the respondent alleges that the applicant has no standing. Indeed, there is an exception to the thirty day rule, and case law does not require the denial even be issued if there is an illegally formed, or managed, or operated corporation; they are not entitled to no-fault benefits. The EUO request was valid. As part of the submission, respondent includes an affidavit from Barbara Palazzolo. She reviewed the investigation file of this case. Respondent's SIU commenced extensive investigation into plaintiff and Dr. McGee, as to the ownership, suspected billing fraud, as well as legal formation, operation, and ownership, and illegal fee splitting. Respondent asserts that applicant has failed to prove that it is a properly controlled and operated medical professional corporation in accordance with 11NYCRR65-3.16(A)(12) which states:

A provider of health care services is not eligible for reimbursement under insurance law 5102

(A)(1) if the provider fails to meet any applicable New York State or local licensing requirement necessary to perform to such service in New York, or meet any applicable licensing requirement necessary to perform such service in any other state in which service is performed.

Respondent gathered and submitted information with respect to other PC's that Dr. McGee was and/or is listed as the owner of, financial records of 8 PC's listing Dr. McGee as the owner, establishing that 70%-80% of all monies recovered by the PC's were paid to management/billing companies, and Dr. McGee received less than 10% of the revenue, all PC's listing John McGee DO as the owner, which were closely related to management companies, financial records of two of the management companies used by McGee owned PC's, and that these management companies did not pay for legitimate management expenses. Investigative material indicates that Dr. McGee was listed as the owner of twelve professional medical corporations. That in and of itself does not prove the existence of an illegally operated PC. However, examination of the records from the management companies used by three McGee PC's note millions of dollars being received by these medical PC's, and a very small percent of payments going to Dr. McGee. The management expenses, when examined, for the expenses from HJR Management Inc. a management company of applicant, appear improper (mortgage payments, Bloomingdale's payments, designer clothes payments, Saks Fifth Avenue payments, etc.)

Respondent provides documentation illustrating that they had document requests regarding formation, ownership, and operation of Dr. McGee's professional medical corporations, including applicant corporation. Dr. McGee continues to avoid discovery. In fact, at this arbitration, he was directed to appear, and did not, without any reasonable excuse. Respondent has illustrated a reasonable basis as to why they wanted to hear from Dr. McGee.

Respondent has put forth enough evidence to shift the burden to applicant to show that the corporation was owned, managed, and controlled in accordance with New York State law. In his attempt to do so, applicant submits in their paper of 01/15/10, an affidavit of Dr. John J. McGee dated 01/14/10. He asserts, "I have never been, nor has any corporation I own now, or have ever owned in the past, black-listed by the payment of no-fault claims". He asserts that he performed or over-thought each and every medical service performed in connection with Integrated Medical Rehabilitation and Diagnostics, from its' inception in 2005. I find this assertion to be incredulous. The doctor owns many facilities, where many procedures and therapeutic services are rendered on any given day, yet he asserts that he has performed or oversaw each and every medical service performed. He asserts that Allstate Insurance Company has improperly withheld 2.5 million dollars in legitimate no-fault claims, yet he provides no documentation to substantiate the assertion. He asserts that he has incurred significant management or collections expense due to this, as well as attorney and collection fees, yet he provides no documentation. He asserts that "any checks written to any management company by me from applicant corporation was for documented management expense". The record is clear that all checks written by the management company clearly are not for documented management expenses. I have examined Dr. McGee's affidavit and I do not find it persuasive; I find his assertions improbable and unsubstantiated.

Applicant claims that respondent did not show good-faith basis for the verification request. I find this not to be the case; the respondent clearly showed a good-faith basis for requesting the verification of the ownership, management, and control of applicant corporation. The applicant clearly has not shown otherwise. Although at the hearing each the bills were examined, I am not delving into the forty-one bills that were individually examined for hours at a prior arbitration hearing to make a determination as to each therapy. Respondent had founded both a good-faith basis to assert lack of standing and improper management, ownership, and control of applicant corporation. Applicant has not met his burden by showing otherwise.

Hence, this claim is denied entirely.

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.

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 New York
SS :
County of Nassau.

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

Maureen A Callahan

5/5/10
(Dated)

(Maureen A. Callahan)

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.