American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Third Avenue Medical Care , Third Avenue Chiropractic Care (Applicant)	AAA Case No.	17-16-1043-7342
	Applicant's File No.	59723
- and -	Insurer's Claim File No.	03890860832PU
	NAIC No.	19232
Allstate Insurance Company (Respondent)		

ARBITRATION AWARD

I, Aaron Maslow, 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 ["GG"]

1. Hearing(s) held on 03/20/2017
   Declared closed by the arbitrator on 03/20/2017

   Mark Fenelon, Esq., from Gitelis Law Firm, PC participated in person for the Applicant

   William Wilson, Esq., from Allstate Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 509.14**, was NOT AMENDED at the oral hearing.
   Stipulations WERE made by the parties regarding the issues to be determined.

   The parties stipulated that Applicant established a prima facie case of entitlement to No-Fault compensation with respect to its bills. They also stipulated that Respondent's Form NF-10 denial of claim forms were timely issued, i.e., within the 30-day deadline prescribed by Insurance Law §5106(a) and 11 NYCRR 65-3.8(a)(1). Additionally, they stipulated that should Applicant prevail, interest would accrue as of the filing date set forth by the American Arbitration Association in Part B of the conclusion of the award template.

3. Summary of Issues in Dispute

- Whether Applicants established entitlement to No-Fault insurance compensation for chiropractic services and a follow-up examination performed to treat Assignor

- Whether Respondents' denials were legally sufficient to assert a defense of lack of medical necessity for further medical services

4. Findings, Conclusions, and Basis Therefor

Appearances

For Applicant:

Gitelis Law Firm, P.C.
2004 Coney Island Avenue
Brooklyn, NY 11223
Of counsel: Mark Fenelon, Esq.

For Respondent:

Law Office of Karen Lawrence
1 Metrotech Plaza
10th floor
Brooklyn, NY 11201
By: William Wilson, Esq.

Applicants commenced this New York No-Fault insurance arbitration, seeking as compensation a total of $509.14 for performing medical services to treat Assignor, a 41-year-old male who was injured in a motor vehicle accident on Oct. 7, 2015. Applicant Third Avenue Chiropractic Care seeks $92.48 remaining unpaid on a bill for dates of service Mar. 29-Apr. 12, 2016, and $323.68 billed for dates of service Apr. 18-May 4, 2016. Respondent's defense to payment -- set forth in two denials of claim -- was as follows: "New York No-Fault benefits have been denied based upon an independent medical examination," and "As per the findings of the physical examination conducted by Dr. John Iozzio on 3/22/16, all chiropractic, acupuncture and related claims benefits were denied effective 4/8/16." Applicant Third Avenue Medical Care seeks $92.98 for a follow-up office visit on May 10, 2016. Respondent's defense to payment stated, "New York No-Fault benefits have been denied based upon an independent medical examination," and "As per the findings of the physical examination conducted by Dr. Jay Eneman on 4/19/16, all Orthopaedic, Physical Therapy, Massage Therapy, Physical Medicine and Rehabilitation (PMR), Pain Management, and Prescription Medication benefits were denied effective 5/5/16."

The three denial forms of Respondent also asserted that fees were excessive. However, at the hearing Respondent stated that it was not pursuing such defense.

This arbitration was conducted under the auspices of the American Arbitration Association, which has been designated by the New York State Department of Financial Services to administer the mandatory arbitration provisions of Insurance Law § 5106(b), which provides:

> Every insurer shall provide a claimant with the option of submitting any dispute involving the insurer's liability to pay first party ["No-Fault insurance"] benefits, or additional first party benefits, the amount thereof or any other matter which may arise pursuant to subsection (a) of this section to arbitration pursuant to simplified procedures to be promulgated or approved by the superintendent.

All parties appeared at the hearing by counsel, who presented oral argument and relied upon documentary submissions. I have reviewed the submissions' documents contained in the American Arbitration Association's ADR Center as of the date of the hearing, said submissions constituting the record in this case.

At the hearing, Respondent argued that there was a lack of medical necessity for the services of the two Applicants covered by the three bills. He adverted to IMEs conducted by Dr. John Iozzio, D.C., and Dr. Jay Eneman, M.D. I raised an issue as to whether the language employed in Respondent's Form NF-10 denials of claim sufficed to assert a defense of lack of medical necessity or that further services were not needed.*

The Insurance Department regulations governing No-Fault claims processing, in 11 NYCRR 65-3.2(e), provide that an insurer must "[c]learly inform the applicant of the insurer's position regarding any disputed matter." The Court of Appeals has held:

> Although an insurer may disclaim coverage for a valid reason (Insurance Law, s 167, subd. 8) the notice of disclaimer must promptly apprise the claimant with a high degree of specificity of the ground or grounds on which the disclaimer is predicated. Absent such specific notice, a claimant might have difficulty assessing whether the insurer will be able to disclaim successfully. This uncertainty could prejudice the claimant's ability to ultimately obtain recovery. In addition, the insurer's responsibility to furnish notice of the specific ground on which the disclaimer is based is not unduly burdensome, the insurer being highly experienced and sophisticated in such matters.

General Accident Insurance Group v. Cirucci, 46 N.Y.2d 862, 864, 414 N.Y.S.2d 512, 514 (1979).

While a denial need not set forth a medical rationale, New York University Hospital-Tisch Institute v. Government Employees Ins. Co., 117 A.D.3d 1012, 986 N.Y.S.2d 617 (2d Dept. 2014); A.B. Medical Services, PLLC v. Liberty Mut. Ins.

Co., 39 A.D.3d 779, 835 N.Y.S.2d 614 (2d Dept. 2007), it must not be factually insufficient, conclusory, or vague. Nyack Hospital v. Metropolitan Property & Casualty Ins. Co., 16 A.D.3d 564, 791 N.Y.S.2d 658 (2d Dept. 2005).

"This claim is denied based on an examination under oath" is invalid as lacking a sufficiently detailed factual basis; such a basis for denial is too vague and ambiguous to alert the claimant as to the actual grounds. Mega Supply & Billing, Inc. v. American Transit Ins. Co., 9 Misc.3d 1116(A), 808 N.Y.S.2d 918 (Table), 2005 N.Y. Slip Op. 51569(U), 2005 WL 2432384 (Civ. Ct. Kings Co., Eileen Nadelson, J., Oct. 3, 2005). The language used in Respondent's denials is similar: "New York No-Fault benefits have been denied based upon an independent medical examination."

Where a defense of lack of medical necessity is not raised in a denial, it is waived. Palladium Car & Limo Service Corp. v. Liberty Mutual Ins. Co., 4 Misc.3d 1021(A), 798 N.Y.S.2d 346 (Table), 2004 N.Y. Slip Op. 50987(U), 2004 WL 2032516 (Civ. Ct. Kings Co., Donald Scott Kurtz, J., July 22, 2004). A defense of excess medical treatments is subject to preclusion when not asserted in a timely denial of claim. Central General Hospital v. Chubb Group of Ins. Cos., 90 N.Y.2d 195, 659 N.Y.S.2d 246 (1997). The denials here *do not allege* that the IME doctor found further services to be medically unnecessary. Neither are Boxes 19 ("Excessive treatment, service or hospitalization") or 21 ("Unnecessary treatment, service or hospitalization") checked. Merely stating, "New York No-Fault benefits have been denied based upon an independent medical examination," and "As per the findings of the physical examination conducted by Dr. John Iozzio on 3/22/16, all chiropractic, acupuncture and related claims benefits were denied effective 4/8/16," or "As per the findings of the physical examination conducted by Dr. Jay Eneman on 4/19/16, all Orthopaedic, Physical Therapy, Massage Therapy, Physical Medicine and Rehabilitation (PMR), Pain Management, and Prescription Medication benefits were denied effective 5/5/16," does not convey the specific grounds or a legally sufficient defense. **They clearly do not convey that the examination was negative and no further treatment was necessary.** Further, there is nothing to indicate that the IME reports were included with the denials. Had they been, the asserted grounds for denying would have been adequately asserted; the contents of the reports would have been incorporated by reference. One cannot assume that all IME reports find services to be unnecessary. I have seen IME reports where the examining physicians concluded that further medical services were necessary or that some services were necessary but others were not. Inasmuch as the defenses regarding the IME in the denials at issue are too vague and legally insufficient, I hold as a matter of law that the respective denials were deficient in setting forth a cognizable defense to payment of No-Fault claims insofar as lack of medical necessity for further treatment is concerned.

I note that I have consistently held that the language used (quoted herein) or very similar language is legally insufficient. See, e.g., Matter of Arbitration of Scott Leist DC a/a/o "LD" v. USAA Casualty Ins. Co., AAA Case No. 17-15-1023-6215 (May 12, 2016); Matter of Arbitration of C21 Acupuncture PC a/a/o "BS" v. Garrison Property & Casualty Ins. Co., AAA Case No. 17-14-9051-4699 (Nov. 17,

2015); Matter of Arbitration of NR Motion PT PC a/a/o "BPL" v. MAPFRE Ins. Co. of New York, AAA Case No. 17-14-9045-4685 (Feb. 9, 2015); Matter of Arbitration of Advantage Health Medical P.C. a/a/o "MRM" v. MAPFRE Ins. Co. of New York, AAA Case No. 412013095664 (Oct. 2, 2014); Matter of Arbitration of Caring Mind Medical P.C. a/a/o "VS" v. Allstate Property and Casualty Ins. Co., AAA Case No. 412013117154 (Feb. 11, 2014); Matter of Arbitration of Targee Medical Services P.C. a/a/o "JV" v. St. Paul Travelers Ins., AAA Case No. 412013078571 (Dec. 2, 2013); Matter of Arbitration of Jaga Medical Services PC a/a/o "OV" v. 21st Century Centennial Ins. Co., AAA Case No. 412013047908 (Oct. 14, 2013); Matter of Arbitration of Perfect Point Acupuncture, P.C. a/a/o "CP" v. Allstate Property and Casualty Ins. Co., AAA Case No. 412012097912 (Jan. 25, 2013). I adhere to my prior determinations.

My award in Matter of Arbitration of Caring Mind Medical P.C. a/a/o "VS" v. Allstate Property and Casualty Ins. Co., supra, was affirmed by Master Arbitrator Victor J. D'Ammora (AAA Appeal No. 17-991-R-17122-14, Apr. 25, 2014), who stated:

> The lower arbitrator reviewed all of the evidence and conducted a hearing. The lower arbitrator determined that the Respondent's denial of the claim was vague and insufficient to set forth a defense to payment of the claims. The lower arbitrator found that the denial failed to set forth that the services were either excessive or medically unnecessary. Moreover, there was nothing to indicate the report of Dr Bleifer was included with the denial. Having found the denial to be deficient, Arbitrator Maslow allowed the claim.
>
> I agree with Arbitrator Maslow's analysis and conclusions.
>
> Moreover, there is nothing in the record before me to indicate that Arbitrator Maslow's decision was arbitrary, capricious or incorrect as a matter of law. Thus, I find that the arbitrator's award should not be disturbed in accordance within the standards set forth above. Therefore, I must affirm the award.

My award in Matter of Arbitration of Pacific Chiropractic P.C. a/a/o "DGL" v. Allstate Property and Casualty Ins. Co., supra, was affirmed by Master Arbitrator Victor J. Hershdorfer (AAA Appeal No. 17-991-R-43118-14, July 16, 2014), who stated:

> The no-fault arbitrator found the wording of the defense in the denial of claim form to be ". . . legally deficient." The denial did not allege that the IME doctor found further services to be medically unnecessary. There was no conveyance to the applicant that the examination was negative. There was no indication that the IME report was attached to the denial.

The basic rule is found at 11 N.Y.C.R.R. 65-3.2(e) which provides, ". . . that an insurer must '(c)learly' inform the applicant of the insurer's position regarding any disputed matters."

The language necessary to be included in the denial is not set forth specifically, however it is generally a matter of fact to be determined by the arbitrator and/or the judge looking at the denial to see whether it meets that standard. Two master arbitration decisions have been cited on this appeal, dealing with the same or similar language used in the denial in this case. Master Arbitrator Victor J. D'Ammora in AAA Assessment No. 17-991-R-17122-14 (4/25/2014) upheld a no-fault arbitrator's determination that the language that was used in that case, and which was similar to the language used in the instant case, was insufficient.

On the other hand, Master Arbitrator Harris Levy in AAA Assessment No. 17-991-R-04001-10 (5/20/2010) found that language similar to the language used in the instant case to be sufficient because the applicant would have been entitled to request a copy of the IME and/or peer review, pursuant to 11 N.Y.C.R.R. 65-3.8(b)(4).

Both sides have also cited no-fault arbitration decisions to support their respective positions.

It is the obligation of the master arbitrator in reviewing the award to make sure that the arbitrator below reached his decision in a rational manner, that the decision was not arbitrary and capricious, incorrect as a matter of law, in excess of the no-fault policy limits or in conflict with other designated no-fault arbitration proceedings. Matter of Petrofsky v. Allstate Insurance Co., 54 N.Y.2d 207 (1981)[.]

A master arbitrator does not have the authority or statutory power to make his own factual determination, by reviewing factual and procedural errors committed during the course of the arbitration or by weighing the evidence or by resolving the issues, such as the credibility of witnesses. Richardson v. Prudential Property & Casualty Ins. Co., 230 A.D.2d 861 (2d Dept., 1996); Matter of Mott v. State Farm Insurance Co., 55 N.Y.2d 224 (1982)[.]

The lower arbitrator in this matter reviewed all of the evidence, conducted a telephone hearing and made the factual determination that the denial was insufficient and as a result went on to allow the claim.

Insurance Law 167, Subd 8 has language which is very similar to the regulation involved in this case. The Court of Appeals in General Accident Insurance Group v. Cirucci, 46 N.Y.2d 862 (1979)

> interpreted that statute and made clear that a disclaimer carrier has the obligation to apprise the claimant with a high degree of specificity as to the grounds of the disclaimer. It, in effect, equated the disclaimer to a bill of particulars and pointed out that the insurer is both highly experienced and sophisticated.
>
> It would have been a simple matter for the carrier to have attached a copy of the IME and thereby clearly informing the applicant of the carrier's position based on the IME
>
> The determination by the no-fault arbitrator was not irrational, arbitrary or capricious, nor was it incorrect as a matter of law.

Master Arbitrator Donald T. De Carlo, in Matter of Arbitration of BOB Acupuncture, PC a/a/o "RS" v. Allstate Property and Casualty Ins. Co. (AAA Appeal No. 17-991-R-26903-14, Aug. 27, 2014), did reverse me on this issue. He wrote:

> The scope of the Master Arbitrator[']s review is limited by law. See the leading case of Matter of *Petrofsky v Allstate Insurance Company*, 54 N.Y. 2d 207, 212, 445 N.Y.S. 2d 79, 80 (1981). If there is sufficient evidence a hearing de novo should not be granted. The Respondent in their brief on appeal provides sufficient case law (related to an IME) analysis to support vacating the award, and remanding to a new Arbitrator. The preclusion of Respondent[']s evidence should not be done lightly, nor based on Arbitrator preferences and not the law or regulations.

I decline to follow Master Arbitrator De Carlo's position for several reasons: (1) His analysis is conclusory and absent consideration of the case law I have cited above. (2) I have been affirmed by other Master Arbitrators -- discussed above --, who have rendered their master awards with an extensive analysis.

I note also that in Matter of Allstate Ins. Co. v. Flexicare PT Services, P.C., Index No. 70211/11 (Civ. Ct. Kings Co., Carol Feinman, J.), a short-form order was entered in which my award and that of Master Arbitrator Donald T. DeCarlo affirming me were vacated in a CPLR Article 75 proceeding. It was stated, "The Petitioner's denials were specific enough to apprise the provider of the reason the bills were being denied (based on an independent medical examination of Edward Toriello, MD). . . . Additionally, it was improper for the arbitrator to raise the issue of the alleged lack of specificity of the denials sua sponte at the hearing." I respectfully disagree with Judge Feinman. She cited to no judicial precedent to support the determination in her short-form order. She also did not take into account that "The arbitrator may . . . independently raise any issue that the arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department regulations," 11 NYCRR 65-4.5(o)(1), a regulatory provision upheld as valid by the Court of Appeals in Matter of Medical Society v. Serio, 100 N.Y.2d 854, 768 N.Y.S.2d 423 (2003).

As for the argument of Respondent's counsel in prior cases that all Applicants had to do was look at the IME reports submitted in the arbitration record or seek clarification from Respondent, I do not believe that the medical provider should be compelled to undergo this task to ascertain the insurer's complete defense to payment when such defense is supposed to be contained within the denial itself (or could accompany the denial), as per Cirucci. The denial of claim should be clear -- *when it is sent out to the provider during the claim processing period* -- that the IME was negative and further services would be medically unnecessary. The denial of claim forms utilized by Respondent contained no statement that the IME was "negative" or that further medical services were not medically necessary. There is no documentary evidence before me that a copy of the respective IME report was included with the denials. Neither Boxes 19 nor 21 were checked. Any one of these would have sufficed to properly inform Applicant of the defense asserted against payment.

As the denials here were legally deficient insofar as the claim advanced at the hearing that further treatment was not medically necessary is concerned, I need not consider the IME reports.

Applicants' prima facie case of entitlement to No-Fault compensation stands. Accordingly, the within arbitration claim is granted in its entirety. Third Avenue Chiropractic Care is awarded $416.16. Third Avenue Medical Care is awarded $92.98.

Interest: The parties stipulated that should Applicant prevail, interest would accrue as of the filing date set forth by the American Arbitration Association in Part B of the conclusion of the award template. That date is Oct. 5, 2016. The end date for the calculation of the period of interest shall be the date of payment of the claim. In calculating interest, the date of accrual shall be excluded from the calculation. General Construction Law § 20 ("The day from which any specified period of time is reckoned shall be excluded in making the reckoning.") Where a motor vehicle accident occurs after Apr. 5, 2002, interest shall be calculated at the rate of two percent per month, simple, calculated on a pro rata basis using a 30-day month. 11 NYCRR 65-3.9(a); Gokey v. Blue Ridge Ins. Co., 22 Misc.3d 1129(A), 881 N.Y.S.2d 363 (Table), 2009 N.Y. Slip Op. 50361(U), 2009 WL 562755 (Sup. Ct. Ulster Co., Henry F. Zwack, J., Jan. 21, 2009).

Attorney's Fee: Respondent shall calculate the sum total of the first-party benefits awarded in this arbitration plus interest thereon for each Applicant. Then, it shall pay each Applicant an attorney's fee equal to 20 percent of that Applicant's respective said sum total, as provided for in 11 NYCRR 65-4.6(d) (as existing on the filing date of this arbitration), subject to a maximum fee of $1,360. This calculation shall be made separately with regard to each Applicant, i.e., there shall be a separate attorney's fee for work performed for each Applicant in this arbitration.

_____

* "The arbitrator may . . . independently raise any issue that the arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department regulations." 11 NYCRR 65-4.5(o)(1). This regulatory provision was validly enacted. Matter of Medical Society v. Serio, 100 N.Y.2d 854, 768 N.Y.S.2d 423 (2003). Insurance Law § 5106(b), requiring only that claimants be provided the option of arbitration, does not preclude an arbitrator from inquiring into issues deemed relevant. Id. at 872, 768 N.Y.S.2d at 434. The provision of 11 NYCRR 65-4.5(o)(1) to the effect that an arbitrator may independently raise any issue that he deems relevant to making an award does not violate the Due Process clause of the United States and New York State Constitutions. 563 Grand Medical, P.C. v. New York State Ins. Dept., 24 A.D.3d 413, 805 N.Y.S.2d 643 (2d Dept. 2005).

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**	**Amount**	**Status**
	Third Avenue Chiropractic Care	**03/29/16 - 05/04/16**	**$416.16**	**Awarded: $416.16**
	Third Avenue Medical Care	**05/10/16 - 05/10/16**	**$92.98**	**Awarded: $92.98**
Total			**$509.14**	**Awarded: $509.14**

B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 10/05/2016, which is a relevant date only to the extent set forth below.)

Respondent shall pay Applicant interest on the total first-party benefits awarded herein, computed from Oct. 5, 2016 to the date of payment of the award, but excluding Oct. 5, 2016 from being counted within the period of interest. The interest rate shall be two percent per month, simple (i.e., not compounded), on a pro rata basis using a 30-day month.

C. Attorney's Fees

The insurer shall also pay the applicant for attorney's fees as set forth below

After calculating the sum total of the first-party benefits awarded in this arbitration plus interest thereon, Respondent shall pay each Applicant an attorney's fee equal to 20 percent of that sum total, as provided for in 11 NYCRR 65-4.6(d) (as existing on the filing date of this arbitration), subject to a maximum fee of $1,360.00.

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 New York
SS :
County of Kings

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

03/24/2017
(Dated)

Aaron Maslow

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:
2ce22ebfb3e7518361651a7cb10ba791

Electronically Signed

Your name: Aaron Maslow
Signed on: 03/24/2017