American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Metro Pain Specialists PC (Applicant)	AAA Case No.	17-16-1047-5851
	Applicant's File No.	GS-479266
- and -	Insurer's Claim File No.	0395174147
	NAIC No.	19232
Allstate Insurance Company (Respondent)		

ARBITRATION AWARD

I, Charles Blattberg, 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: Eligible injured person

1. Hearing(s) held on 01/17/2018
   Declared closed by the arbitrator on 04/23/2018

   Steven Palumbo, Esq. from Law Offices Of Gabriel & Shapiro, LLC. participated in person for the Applicant

   Karen Stulgaitis, Esq. from Law Offices of Karen L. Lawrence participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 64.07**, 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 claimant was the 48 year-old male passenger of a motor vehicle that was involved in an accident on 12/13/15. Following the accident the claimant suffered injuries which resulted in the claimant seeking treatment. At issue is a 6/28/16 office visit performed by Applicant. The issue to be decided is whether this claim is premature in light of outstanding verification.

4. Findings, Conclusions, and Basis Therefor

THIS HEARING WAS CONDUCTED USING THE ELECTRONIC CASE FOLDER MAINTAINED BY THE AMERICAN ARBITRATION ASSOCIATION. ALL DOCUMENTS CONTAINED IN THAT FOLDER ARE MADE PART OF THE RECORD OF THIS HEARING.

THE ARBITRATOR SHALL BE THE JUDGE OF THE RELEVANCE AND MATERIALITY OF THE EVIDENCE OFFERED.

Based on a review of the documentary evidence, this claim is decided as follows:

Applicant establishes a prima facie case of entitlement to reimbursement of its claim by the submission of a completed NF-3 form or similar document documenting the facts and amounts of the losses sustained and by submitting evidentiary proof that the prescribed statutory billing forms [setting forth the fact and the amount of the loss sustained] had been mailed and received and that payment of no-fault benefits were overdue. See, *Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). I find that Applicant established a prima facie case for reimbursement.

This hearing was held open for Applicant "to submit a short brief setting forth their position (this could include dates of general/specific responses, what was provided and what (if any) requests were objected to)." This hearing was also held open for Respondent "to submit a short brief setting forth their position (this could include dates of follow-up requests and what verification remains outstanding). In addition Respondent could submit arbitration awards in their favor involving these issues."

Both sides made post hearing submissions after follow-up by the American Arbitration Association (AAA). A hearing closed disposition was entered on 4/23/18. On 5/21/18 Respondent uploaded an additional 219 page submission which appears to correct Respondent's 1/24/18 submission. This post hearing submission was not requested and was made twenty eight days after a hearing closed disposition had been entered. Per the notification by the AAA documents received after 12/1/16 would be marked late. Such documents would then be received only at the sole discretion of the arbitrator. 11 N.Y.C.R.R. 65-4.2(b)(3)(4). There was no explanation proffered as to why this submission was late. To accept Respondent's 5/21/18 submission twenty eight days after a hearing closed disposition had been entered would highly prejudice Applicant and entirely negate the "Rocket Docket" system. As such, Respondent's 5/21/18 submission will not be considered.

The claimant was the 48 year-old male passenger of a motor vehicle that was involved in an accident on 12/13/15. The claimant reportedly injured his neck, left shoulder, and upper back. There was no reported loss of consciousness. There were no reported lacerations or fractures. There was no reported emergency treatment sought or received. On 12/29/15 the claimant presented to Mani Ushyarov, D.O., M.D. of Health Balance Medical, P.C. with complaints of neck pain rated 6/10 radiating to left shoulder, mid back pain rated 6/10 and left shoulder pain rated 5-6/10. The pain was exacerbated with movements. Examination revealed moderate distress due to pain and discomfort.

Examination of the cervical spine revealed tenderness upon palpation over the paraspinal muscles with spasms in paraspinal structures bilaterally, increased muscle tone in the left paravertebral, trapezius and rhomboid muscles, decreased range of motion with pain: flexion 45/60, extension 40/50, right rotation 60/80, left rotation 40/80, right lateral flexion 30/40, and left lateral flexion 20/40. There was a positive Foramina Compression test. Examination of the thoracic spine revealed tenderness upon palpation over the paraspinal muscles with the spasm of the left paraspinal structures. Examination of the left shoulder revealed decreased range of motion with pain flexion/elevation 130/150, extension 130/150, abduction 140/150, adduction 25/30, internal rotation 30/40, and external rotation 80/90. There were a positive Apprehension sign and Impingement sign. Dr. Ushyarov's diagnosis was cervical radiculitis, cervical and thoracic spine sprains/strains, contusion of the left shoulder, left shoulder pain and left shoulder sprain/strain. Dr. Ushyarov recommended physical therapy, neurological consultation, left shoulder MRI, Outcome Assessment Testing (OAT), ROM/MMT testing, and prescribed a compounded cream containing Ketoprofen, Cyclobenzaprine, Baclofen, Lidocaine and Versapro Cream Base. Reportedly the claimant was also initiated on chiropractic treatment and acupuncture. The 1/12/16 left shoulder MRI interpreted by Alan B. Greenfield, M.D. produced an impression of tendinosis of the supraspinatus and subscapularis tendons but without focal tear, subcortical cyst of the anterior humeral head, and no evidence of fracture. The 1/19/16 cervical spine MRI interpreted by Alan B. Greenfield, M.D. produced an impression of straightening of cervical lordosis, central broad-based disc herniation at C4-C5 indenting the dural sac with slight extension to the right of midline, bulging disc at C5-C6 with flattening of the dural sac and left greater than right foraminal encroachment, and coexistent spondylosis from C4 through C6. On 2/16/16 and 3/8/16 the claimant presented to Inna Levtsenko, A-GNP-C of Metro Pain Specialists, P.C. (Applicant) and was recommended for cervical facet steroid injections, 1 to 3 cervical interlaminar epidural steroid injections, and trigger point injection at tender trigger points. On 3/20/16 David Abbatematteo, M.D. of Applicant's office performed bilateral cervical medial branch block to address the cervical facet syndrome. On 4/17/16 Dr. Abbatematteo performed bilateral cervical medial branch block to address the cervical facet syndrome. On 6/28/16 the claimant presented to Inna Levtsenko, A-GNP-C who recommended cervical facet steroid injections, 1 to 3 cervical interlaminar epidural steroid injections, and trigger point injection at tender trigger points. At issue is the 6/28/16 office visit.

Pursuant to Insurance Law § 5106(a) and the Insurance regulations, an insurer must either pay or deny a claim for motor vehicle no-fault benefits, in whole or in part, within 30 days after an applicant's proof of claim is received (*see*Insurance Law § 5106[a]; 11 NYCRR 65-3.8[c]; *see also*11 NYCRR 65-3.5). *Infinity Health Products, Ltd. v. Eveready Ins. Co.*, 67 A.D.3d 862, 864, 890 N.Y.S.2d 545, 547 (2d Dept. 2009). The 30-day period in which to either pay or deny a claim is extended where the insurer makes a request for additional verification within the requisite 15-[business] day time period (*see Montefiore Med. Ctr. v Government Empls. Ins. Co.*, 34 AD3d 771; *New York & Presbyt. Hosp. v. Allstate Ins. Co.*,31 AD3d 512). *Kingsbrook Jewish Medical Center v. Allstate Insurance Co.*, 61 A.D.3d 13, 17-18, 871 N.Y.S.2d 680, 683 (2d Dept. 2009). If the requested verification is not received within 30 days, the insurer must send a follow-up letter within 10 days thereafter (see 11 NYCRR 65.15[e][2]). *New York & Presbyterian Hospital v. American Transit Insurance Co.*, 287 A.D.2d 699, 700, 733

N.Y.S.2d 80, 81-82 (2d Dept. 2001). Thus, a timely additional verification request tolls the insurer's time within which to pay or deny a claim (*see Fair Price Med. Supply Corp. v. Travelers Indem. Co.*, 10 NY3d at 563; *New York & Presbyt. Hosp. v. Countrywide Ins. Co.*,44 AD3d 729, 730)." *Kingsbrook Jewish Medical Center v. Allstate Insurance Co.*, supra at 18, 871 N.Y.S.2d at 683 (2d Dept. 2009).

Respondent asserts the defense of outstanding verification based on verification requests, dated 8/17/16 and 9/22/16. Respondent received the bill at issue on 7/28/16 and timely requested verification on 8/17/16 in the form of: "1. Identify the person or healthcare provider that referred this patient to you, provide a copy of the referral and/or letter of medical necessity for the services that were referred, and disclose any arrangement, financial or otherwise, that exists between you and the referring doctor; 2. Certificate of Incorporation of Metro Pain Specialists RC.; 3. Provide unredacted W-2 for each and every employee at Metro Pain Specialists, P.C.; 4. W-2 or other employment information for Clifton Burt and Luydmily Porestsky; 5. Lease agreements between Metro Pain Specialists, P.C., and Noel Blackman M.D. and Washington Heights RE, LLC; 6. A schedule for when an employee/healthcare professional from Metro Pain Specialists, P.C. is treating patients at each of the facilities/locations at which Metro Pain Specialists, P.C. treats patients; 7. Employment agreement between Dr. Shapiro and Excel Surgery Center LLC; 8. If the service was performed at a surgical center or ambulatory care facility, please provide any documentation verifying your authority to perform the services at that facility. and disclose any arrangement, financial or otherwise, that exists between you and the facility where the services were performed and/or any other healthcare provider involved in the procedure or the medical clearance of the patient; 9. A copy of any correspondence between Excel Surgery Center, LLC and Metro Pain Specialists, P.C.; 10. A copy of any written agreements between Excel Surgery Center, LLC and Metro Pain Specialists, P.C.; 11. If the subject services were performed at a surgical center or ambulatory care facilities, please provide a copy of the surgical report and any documents relating to the clearance of that patient for any surgical procedure; 12. Any and all billing and/or collection agreements between Metro Pain Specialists, P.C. and any and all billing companies now used or in the past by Metro Pain Specialist. P.C.; and 13. An Examination Under Oath of the Eligible Injured Person/assignor." On 9/22/16 Respondent timely sent a follow-up request.

Both sides agree that that Applicant's principal, Dr. Leonid Shapiro, testified at an Examination Under Oath (EUO) on 5/19/15. Thereafter, Respondent requested post EUO verification which included the documents sought here. Both parties also agree that the Applicant responded (to some extent) to those requests for identical documentation in several responses sent between 8/12/16-4/3/17. As to the claim at issue there is a specific response dated 10/14/16 which refers to the 8/12/16 response. Applicant's partial responses to the post EUO verification included providing the Certificate of Incorporation, a W-2 for Luydmily Porestsky, the lease agreement between Applicant and Washington Heights RE, LLC, an employment agreement between Dr. Shapiro and Excel Surgery Center LLC, billing and collection agreements between Applicant and other entities. Although documentation was provided, Applicant objected to certain requests (for example Applicant objected that as it is a primary care provider it does not require a referral; letters of medical necessity were already in Respondent's possession; the bills at issue and medical documentation demonstrate that

the treating healthcare professional was present performing the services; all documentation with respect to Excel Surgery Center LLC was irrelevant to the particular claim at issue; any correspondence between itself and Excel Surgery Center LLC was vague and improper; any written agreement between Excel Surgery Center LLC and itself was irrelevant; agreements between Applicant and Noel Blackman were in relation to an EUO conducted years ago and not related to any claim in 2016).

Applicant's counsel argued that the verification requests have been substantially complied with, that Respondent failed to address Applicant's objections or sufficiently explain the need for information that has been requested repeatedly over the course of approximately 2 years. 11 NYCRR § 65-3.2 (c) and (e) provide that an insurer should not demand verification of facts unless there are good reasons to do so and clearly inform the applicant of the insurer's position regarding any disputed matter. Despite Applicant's objections their responses were "arguably responsive" to Respondent's verification requests. See *All Health Medical Care v. Government Employees Insurance Company*, 2 Misc.3d 907, 771 N.Y.S.2d 832 (Civ. Ct. Queens Co. 2004). As Applicant objected to the continued demands for verification, Respondent bears the burden of proving that its verification requests were valid. *A.B. Medical Services PLLC v. Highlands Insurance Company*, NYLJ May 27, 2003 page 21 column 3 (Civil Ct. New York, Billings J.). Respondent did not submit any documentation (such as affidavit by counsel or their Special Investigation Unit) to establish a reasonable basis for continued verification of identical items that had been provided repeatedly over years. "A provider should not have to repeatedly provide documentation it has already provided unless the insurer can establish a reasonable basis and rational need for demanding serial and new." *Brownsville Advanced Medical, PC v. Countrywide Insurance Company*, 33 Misc. 3d 1236 (A), 941 NYS 2d 536 (Dist. Ct. Nassau County 2011).

With respect to the claim at issue, Applicant's documentation is arguably responsive to the verification request. Applicant has demonstrated substantial compliance with Respondent's verification requests in good faith. The remaining requests are overbroad and have little relevance to the office visit at issue. Respondent has offered no evidence that the outstanding items requested are necessary to process Applicant's bills. See, AAA Case No.: 17-16-1046- 219 (Arbitrator Cavalier), AAA Case No.: 17-16-1047-0529 (Arbitrator Shafraonov), AAA Case No.: 17-16-1044-0652 (Arbitrator Talay) and AAA Case No.: 17-16-1043-7888 (Arbitrator Russo).

Accordingly, the claim is awarded with interest from the time of filing. It was not argued and I am not persuaded that interest should be calculated from a different date.

Accordingly, Applicant is awarded $64.07.

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**
	Metro Pain Specialists PC	**06/28/16 - 06/28/16**	**$64.07**	**Awarded: $64.07**
Total			**$64.07**	**Awarded: $64.07**

B. The insurer shall also compute and pay the applicant interest set forth below. 11/01/2016 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

   Interest runs from 11/1/16 (the filing date for this case) until the date that payment is made at two percent per month, simple interest, on a pro rata basis using a thirty day month.

C. Attorney's Fees

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

   Pursuant to 11 NYCRR §65-4.6 (d), ". . . the attorney's fee shall be limited as follows: 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon for each applicant for arbitration or court proceeding, subject to a maximum fee of $1,360."

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 Nassau

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

05/30/2018
(Dated)

Charles Blattberg

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:
1e6a38556cc028f2f939437f65b93667

Electronically Signed

Your name: Charles Blattberg
Signed on: 05/30/2018