

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Armengol Medical PC
(Applicant)

- and -

Country-Wide Insurance Company
(Respondent)

AAA Case No. 17-17-1079-3750

Applicant's File No. 67849

Insurer's Claim File No. 000302933 002

NAIC No. 10839

ARBITRATION AWARD

I, Amanda R. Kronin, 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: OP

1. Hearing(s) held on 10/17/2018
Declared closed by the arbitrator on 10/17/2018

Janene Cangrow, Esq from Fazio, Rynsky & Associates, LLP participated in person for the Applicant

Jacob Marks, Esq from Jaffe & Koumourdas, LLP participated in person for the Respondent

2. The amount claimed in the Arbitration Request, \$ 3,044.88, 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 Assignor, OP is a 37 year old male who was a restrained passenger he driver of a vehicle involved in a motor vehicle on 02/02/15. Following the accident, Assignor suffered injuries which resulted in the Assignor seeking treatment. Thereafter, the Assignor was referred for EMG/NCV testing of the upper and lower extremities which was performed on 4/15/15 and denied based upon based on the peer review report of Allan Rubenstein, MD, dated 8/06/15. The issue presented herein is whether the testing was medically necessary.

4. Findings, Conclusions, and Basis Therefor

This hearing was conducted using documents contained in the ADR CENTER. Any documents contained in the folder are hereby incorporated into this hearing. I have reviewed all relevant exhibits contained in the ADR CENTER maintained by the American Arbitration Association.

As a result of the accident, the Assignor sustained injuries to his neck and back. He sought treatment. Applicant seeks no-fault reimbursement for the upper/lower EMG/NCV performed on 4/15/15 was denied by the Respondent pursuant to a peer review report by Allan Rubenstein, MD dated 8/06/15.

A health care provider Applicant establishes its prima facie entitlement to No-Fault benefits by submitting proof that its claim, on the statutory billing form, was mailed and received by the insurance company and that payment is overdue. Viviane Etienne Med. Care, P.C. v. Country-Wide Ins. Co., 25 N.Y. 3d 498, 14 N.Y.S. 3d 283 (2015).

In support of its position, Applicant submitted a claim in the amount of \$3044.88 for the testing at issue, an assignment of benefits form and contemporaneous medical documentation.

Herein, the record reflects that the bill in dispute, dated April 22, 2015 was received on by the Respondent on May 13, 2015. Respondent made a timely request for additional verification on 6/02/15. A follow up request was issued on 7/03/15. Respondent received proof of claim on 8/06/15. A denial based on the peer review report of Allan Rubenstein, MD, was issued on 8/06/15. Applicant has established a prima facie case, and in order to rebut the presumption of medical necessity, the burden then shifts to insurer-Respondent to present sufficient evidence to establish a lack of medical necessity for the services rendered. The insurer bears the burden of production. Bronx Expert Radiology, P.C. v. Travelers Ins. Co., 13 Misc. 3d 136(A), 831 N.Y.S.2d 351(Table)(App. Term 1st Dept. 2006).

Respondent issued a denial based on the peer review report of Allan Rubenstein, MD dated 8/06/15, which opined that there was no diagnostic dilemma. Dr. Rubenstein opined that there was nothing to indicate that this Applicant had anything other than traumatic radiculopathy due to the motor vehicle accident on 02/02/15. There were no findings to suggest that the Applicant required EMG/NCV testing in order to properly diagnose or treat this Applicant. There was nothing to suggest any other diagnosis such as neuropathy. For these reasons, Dr. Rubenstein opined that medical necessity has not been established and he recommended against reimbursement of the EMG/NCV testing.

When an insurer relies upon a peer review report to demonstrate that a particular service was not medically necessary, the peer reviewer's opinion must be supported by sufficient factual evidence or proof and cannot simply be conclusory. As per the holding in Jacob Nir, M.D. v. Allstate Insurance Co., 7 Misc.3d 544 (2005), the peer reviewer must establish a factual basis and medical rationale to support a finding that the services were not medically necessary, including setting forth generally accepted standards in the medical community. The opinion of the insurer's expert, standing alone, is insufficient to carry the insurer's burden to prove that the services were not medically necessary. CityWide Social Work & Psychological Services, PLLC v. Travelers Indemnity Co., 3 Misc.3d 608, 777 N.Y.S.2d 241 (N.Y.Civ. Ct. Kings Co. 2004).

Based upon the foregoing, Respondent has set forth a cogent medical rationale in support of its lack of medical necessity defense. Respondent has factually demonstrated the services rendered were not medically necessary. Accordingly, the burden now shifts to applicant, who bears the ultimate burden of persuasion. See, Bronx Expert, *supra*.

In opposition to the peer review report applicant offers medical records as well as a rebuttal from Sonia Armengol, MD. Dr. Armengol meaningfully refers to and rebuts each of the assertions set forth by Dr. Rubenstein. Dr. Armengol sets forth a cogent medical rationale as to why she believed the EMG/NCV testing was medically necessary under the circumstances. Dr. Armengol also cites to different authority in support of his opinion that the testing was necessary. The rebuttal specifically addresses the peer review, discusses that a diagnostic dilemma existed to rule out radiculopathy, and cites to medical authority in support of the necessity of performing the upper and lower EMG/NCV testing.

I find the rebuttal to the peer review sufficient to meet the Applicant's burden on the issue of medical necessity. The rebuttal meaningfully refers to and rebuts the conclusions set forth in the peer review report. High Quality Medical, P.C. v. Mercury Ins. Co., 26 Misc.3d 145(A), 2010 N.Y. Slip.Op. 50447(U) ((Sup. Ct.App. Term 2d Dep't 2010). Case law clearly indicates that courts will not second guess a doctor who decides that a medical testing such as the one prescribed, that is not inconsistent with generally accepted medical practices, is necessary for treatment when the only support for the denial is a peer review performed by a doctor who did not examine the patient (see Alliance Medical Office v. Allstate Ins. Co., 196 Misc2d 268, Nir v. Allstate Ins. Co., 7 Misc3d 544 (CivCt Kings County 2005). Applicant was apparently confronted with certain subjective complaints as well as objective clinical findings and opined that the subject EMG/NCV was medically necessary.

Based upon the foregoing, the rebuttal is factually sufficient to meet the burden of persuasion. After reviewing all of the submissions before me, and considering the oral arguments of the parties, I find that Applicant has met the burden of persuasion, and therefore, an award shall be issued in favor of Applicant. Any further issues raised in the hearing record are held to be moot and/or waived insofar as not raised at the time of the hearing. Accordingly, an award shall be issued in favor of applicant.

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
	Armengol Medical PC	04/15/15 - 04/15/15	\$3,044.88	Awarded: \$3,044.88
Total			\$3,044.88	Awarded: \$3,044.88

B. The insurer shall also compute and pay the applicant interest set forth below. 11/15/2017 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant is awarded interest pursuant to the no-fault regulations. See generally, 11 NYCRR §65-3.9. Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30 day month." 11 NYCRR §65-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. However, the regulations toll the accrual of interest when an applicant "does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations." See, 11 NYCRR 65-3.9(c). The Superintendent and the New York Court of Appeals has interpreted this provision to apply regardless of whether the particular denial at issue was timely. LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 217 (2009).

C. Attorney's Fees

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

Applicant is awarded statutory attorney fees pursuant to the no-fault regulations. See, 11 NYCRR §65-4.5(s)(2). The award of attorney fees shall be paid by the insurer. 11 NYCRR §65-4.5(e). Accordingly, "the attorney's fee shall be limited as follows: 20 percent of the amount of first-party benefits, plus interest thereon, awarded by the arbitrator or the court, subject to a maximum fee of \$850." Id.

The minimum attorney fee that shall be awarded is \$60. 11 NYCRR §65-4.5(c). However, if the benefits and interest awarded thereon is equal to or less than the respondent's written offer during the conciliation process, then the attorney's fee shall be based upon the provisions of 11 NYCRR §65-4.6(i). For claims that fall under the Sixth Amendment to the regulation the following shall apply: "If the claim is resolved by the designated organization at any time prior to transmittal to an arbitrator and it was initially denied by the insurer or overdue, the payment of the applicant's attorney's fee by the insurer shall be limited to 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon, for each applicant with whom the respective parties have agreed and resolved disputes, subject to a maximum fee of \$1,360." 11 NYCRR 65-4.6(d)

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

10/20/2018
(Dated)

Amanda R. Kronin

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:
d8bc668ead14df103f60d4ff6e40c39c

Electronically Signed

Your name: Amanda R. Kronin
Signed on: 10/20/2018