

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Flatlands Medical Care PC  
(Applicant)

- and -

Allstate Fire & Casualty Insurance Company  
(Respondent)

AAA Case No. 17-17-1064-7904

Applicant's File No. GS-479707

Insurer's Claim File No. 0416209625  
2MG

NAIC No. 29688

**ARBITRATION AWARD**

I, Victoria Thomas, 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

1. Hearing(s) held on 05/08/2019  
Declared closed by the arbitrator on 05/08/2019

Leonard Brumfield from Law Offices Of Gabriel & Shapiro, LLC. participated in person for the Applicant

Michael Rago from Law Offices Of Karen L Lawrence participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 3,119.44**, was AMENDED and permitted by the arbitrator at the oral hearing.

The claim was amended to \$3045.08.

Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

Was the nerve testing of the upper and lower extremities conducted on the Assignor a reasonable and necessary expense?

The Assignor, "OT" was a 24-year-old male who was involved in a motor vehicle accident on 6/2/16. Post-accident, the Assignor complained of pain in his neck, knees,

left shoulder and lower back. Applicant billed for EMG/NCV testing of the upper and lower extremities conducted on 9/2/15. Respondent denied the claim because of lack of medical necessity based on the peer review of Dr. Alexander Merson.

#### 4. Findings, Conclusions, and Basis Therefor

I have reviewed the file with regard to this matter maintained by the AAA in the eCenter. This decision is based on my review of that file, as well as the arguments of the parties at the hearing.

After reviewing the record and evidence presented, I find that Applicant established a prima facie case of entitlement to reimbursement of its claim, by the submission of a completed NF-3 form 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).

It was determined at the hearing that the Respondent timely denied Applicant's claim based on a peer review conducted by Dr. Alexander Merson on 8/13/16. In order to support a lack of medical necessity defense Respondent must "set forth a factual basis and medical rationale for the peer reviewer's determination that there was a lack of medical necessity for the services rendered." See, *Provvedere, Inc. v. Republic Western Ins. Co.*, 2014 NY Slip Op 50219(U) (App. Term 2nd, 11th and 13th Jud. Dists. 2014). Respondent bears the burden of production in support of its lack of medical necessity defense, which if established shifts the burden of persuasion to applicant. See generally, *Bronx Expert Radiology, P.C. v. Travelers Ins. Co.*, 2006 NY Slip Op 52116 (App. Term 1st Dept. 2006). The Appellate Courts have not clearly defined what satisfies this standard except to the extent that "bald assertions" are insufficient. *Amherst Medical Supply, LLC v. A Central Ins. Co.*, 2013 NY Slip Op 51800(U) (App. Term 1st Dept. 2013). However, there are myriad civil court decisions tackling the issue of what constitutes a "factual basis and medical rationale" sufficient to establish a lack of medical necessity.

The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment. *Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co.*, 2009 NY Slip Op 00351 (App Div. 2d Dept., Jan. 20, 2009); *Channel Chiropractic, P.C. v. Country Wide Ins. Co.*, 2007 Slip Op 01973, 38 A.D.3d 294 (1st Dept. 2007); *Bronx Radiology, P.C. v. New York Cent. Mut. Fire Ins. Co.*, 2007 NY Slip Op 27427, 17 Misc.3d 97 (App Term 1<sup>st</sup> Dept., 2007), such as by a qualified expert performing an independent medical examination, conducting a peer review of the injured person's treatment, or reconstructing the accident. *Id.*

Dr. Merson reviewed the medical documents and concluded that the nerve testing was not medically necessary because: 1) there was a clear diagnosis as well as its etiology; 2) there were no undiagnosed pathologies; 3) no clinical signs of traumatic nerve disorder; and 4) the EMG is a suboptimal test.

Based on a review of all the evidence, including the peer review, rebuttal and the arguments of the parties at the hearing, Respondent has not established the lack of medical necessity for the disputed treatment by a fair preponderance of the credible evidence. I find Applicant sufficiently rebutted the peer review.

Therefore, Applicant's claim is granted.

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	Amount Amended	Status
	Flatlands Medical Care PC	07/05/16 - 07/05/16	\$3,119.44	\$3,045.08	Awarded: \$3,045.08
Total			\$3,119.44		Awarded: \$3,045.08

- B. The insurer shall also compute and pay the applicant interest set forth below. 06/06/2017 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

This case is subject to the provisions as to attorney fee promulgated in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D).

Applicant is awarded statutory attorney fees pursuant to the no-fault regulations. See, 11 NYCRR §65-4.6. The award of attorney fees shall be paid by the insurer. 11 NYCRR §65-4.5(d). Accordingly, "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 per arbitration or court proceeding, subject to a maximum fee of \$1,360." Id.

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

06/09/2019  
(Dated)

Victoria Thomas

### **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:**  
09ae5568bfe98abe6af6b042cbe70c66

### **Electronically Signed**

Your name: Victoria Thomas  
Signed on: 06/09/2019