American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

New York Spine Specialists (Applicant)	AAA Case No.	17-18-1091-5559
	Applicant's File No.	2086986
- and -	Insurer's Claim File No.	0457364198 ATL
Allstate Fire & Casualty Insurance Company (Respondent)	NAIC No.	29688

ARBITRATION AWARD

I, Wendy Bishop, 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 09/10/2019
   Declared closed by the arbitrator on 09/10/2019

   Vijay Gupta, Esq. from Israel, Israel & Purdy, LLP (Great Neck) participated in person for the Applicant

   Marie-Ann Inguanti, Esq. from Law Offices Of Karen L Lawrence participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 92.94**, 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 is a 45-year-old female who was involved in a motor vehicle accident on May 21, 2017. Following the accident, the Assignor complained of pain to her neck and back. The Assignor underwent a course of treatment that included physical therapy. On February 16, 2018, the Assignor underwent an office visit, which Respondent denied based on an independent medical examination (IME) performed by Respondent's consultant, Jay Eneman, M.D. on October 19, 2017.

4. Findings, Conclusions, and Basis Therefor

The Applicant and the Respondent submitted documentary evidence in support of their respective positions. All such evidence is contained within MODRIA maintained by the American Arbitration Association, as of the date of the hearing. The below noted decision is based upon my review of the submitted evidence, along with the oral argument of the representatives present at the hearing; only the arguments offered at the hearing are preserved in this decision. Hence all other arguments are considered waived if not presented at such hearing.

It is now well settled that Applicant establishes "a prima facie showing of their entitlement to judgment as matter of law 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." Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2d Dep't. 2004). In the case at bar, Applicant has met this burden.

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.). Respondent bears the burden of production in support of it 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 civil courts have held that a defendant's peer review or medical evidence must set forth more than just a basic recitation of the expert's opinion. The trial courts have held that a peer review report's medical rationale will be insufficient to meet respondent's burden of proof if: 1) the medical rationale of its expert witness is not supported by evidence of a deviation from "generally accepted medical" standards; 2) the expert fails to cite to medical authority, standard, or generally accepted medical practice as a medical rationale for his findings; and 3) the peer review report fails to provide specifics as to the claim at issue, is conclusory or vague. See generally Nir v. Allstate, 7 Misc.3d 544 (N.Y. City Civ. Ct. 2005); See also All Boro Psychological Servs. P.C. v. GEICO, 2012 NY Slip Op 50137(U) (N.Y. City Civ. Ct. 2012). "Generally accepted practice is that range of practice that the profession will follow in the diagnosis and treatment of patients in light of the standards and values that define its calling." Nir, supra.

In support of its contention that further treatment was not medically necessary, Respondent relies upon the report of the IME conducted by Jay Eneman, M.D. on October 19, 2017. Deep tendon reflexes in the upper extremities were reduced. Range of motion testing of the cervical spine revealed limitations in all planes. While Dr. Eneman asserts that these limitations in range of motion were "voluntary" on the part of the Assignor, he fails to adequately reconcile the positive findings of the range of motion testing and the deep tendon reflexes examination with his conclusion that the Assignor's

injuries had resolved. Dr. Eneman's conclusion that no further treatment was necessary is not adequately supported by the findings of his IME report. Respondent has thus failed to satisfy its initial burden in support of its defense of lack of medical necessity. Accordingly, 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**	**Total**	**Status**
	New York Spine Specialists LLP	**02/16/18 - 02/16/18**	**$92.94**	**$ 92.94**	**Awarded: $92.94**
Total			**$92.94**	**Awarded: $92.94**	

B. The insurer shall also compute and pay the applicant interest set forth below. 04/01/2018 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) Those fees shall be paid by the insurer. 11 NYCRR §65-4.5(e).

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

09/11/2019
(Dated)

Wendy Bishop

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:
b0012728eba4a0363db178dcb3e484a2

Electronically Signed

Your name: Wendy Bishop
Signed on: 09/11/2019