American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

New York Spine Specialists (Applicant)	AAA Case No.	17-18-1094-1435
	Applicant's File No.	2103407
- and -	Insurer's Claim File No.	0450342001 UTC
Allstate Insurance Company (Respondent)	NAIC No.	19232

ARBITRATION AWARD

I, John O'Grady, 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 11/26/2019
   Declared closed by the arbitrator on 11/26/2019

   Helen Mann Ruzhy Esq. from Israel, Israel & Purdy, LLP (Great Neck) participated in person for the Applicant

   Jeff Winston Esq. from Law Offices of John Trop participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **$ 236.94**, 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

   CASE SUMMARY

   The motor vehicle accident that gives rise to this arbitration occurred on March 20, 2017.

   The applicant - assignee makes a claim for an examination on March 28, 2018.

The respondent denied the claim relying on the physical examination conducted by Dr. Regina Hillsman on February 8, 2018 after which it issued a Denial of Claim terminating benefits effective March 6, 2018

The assignor is a 27-year-old female.

ISSUE(S)

The issue in this arbitration is whether respondent makes out its initial burden to show that there was no medical necessity for any treatment after the independent medical examination and, if so, whether applicant's proof is sufficient to overcome that demonstration.

4. Findings, Conclusions, and Basis Therefor

THIS HEARING WAS CONDUCTED USING THE ADR CENTER MAINTAINED BY THE AMERICAN ARBITRATION ASSOCIATION. ALL DOCUMENTS IN THE CENTER ARE MADE PART OF THE RECORD OF THIS HEARING. I HAVE REVIEWED THE DOCUMENTS CONTAINED IN THE ADR CENTER AS OF THE DATE OF THIS AWARD AS WELL AS ANY DOCUMENTS SUBMITTED UPON CONTINUANCE OF THE CASE. THOSE DOCUMENTS SUBMITTED AFTER THE HEARING THAT HAVE NOT BEEN ENTERED IN THE CENTER AS OF THE DATE OF THIS AWARD WILL BE LISTED IMMEDIATELY BELOW THIS LANGUAGE AND FORWARDED TO THE AMERICAN ARBITRATION ASSOCIATION AT THE TIME THIS AWARD IS ISSUED FOR INCLUSION IN IT.

A review of the report of the examination by Dr. Hillsman notes that the assignor was a pedestrian involved in a motor vehicle accident. She had injuries to her neck and back and was complaining of neck pain with a sharp shooting pain radiating into her arms, mid and lower back pain with a sharp shooting pain radiating to her legs, with left shoulder pain, left wrist pain and bilateral hip pain. Dr. Hillsman examined ranges of motion in the cervical spine and quantified them as equal to normal in all planes. Orthopedic testing was negative. Reflexes were equal and symmetric and muscle strength was good with no atrophy, and sensation was intact. The examination of the thoracic spine noted symmetrical shoulder blades with no tenderness over the trapezius muscle and normal thoracic curvature. The examination of the lumbar spine was similar to the exam of the cervical spine quantifying range of motion in all four planes as equal to normal with negative straight leg raising and other orthopedic testing that was negative. Reflexes were equal and symmetrical, sensation intact and no neurotrophic changes noted. Dr. Hillsman, who had previously examined the assignor, found the lumbar spine sprain and strain to be resolved. She had

previously found the cervical, thoracic, bilateral hip and left shoulder sprains and strains to be resolved. She concluded that no further treatment was necessary.

Respondent's proof includes the report of the exam by Dr. Hillsman about five months earlier, on September 7, 2017. Her examination was similarly normal except for the lumbar spine which revealed very slight losses in ranges of motion.

On March 28, 2018 the assignor was seen and examined by Dr. Mikelis at the request of Dr. Demetrius. It was explained to Dr. Mikelis at that time that the assignor was a pedestrian struck by a motor vehicle on March 20, 2017. She was currently working but her injuries continued to interfere with activities of daily living. She had received physical therapy, epidural injections, and chiropractic care. She was complaining of low back pain and neck pain with radiation into both the arms and legs. There was some numbness and tingling as well. The pain was described as very severe.

Ranges of motion were quantified on that date as reduced in both the cervical spine and lumbar spine. Sensation was altered at the left C5, C6 and C7 dermatomes. Sensation was also altered at the left L4 L5 and S1 dermatomes.

Dr. Mikelis saw the assignor again on May 16, 2018. Ranges of motion continued to be reduced but improvement is noted by the quantified ranges found. Sensation remained altered in the same dermatomes. Further therapy was recommended. Surgical options were considered at that time. Dr. Mikelis saw the assignor two weeks later, on June 1, 2018, with similar complaints relative to the neck and low back. Range of motion findings in the cervical spine and in the low back are identical to the findings made two weeks earlier. Dermatomal sensation remained altered in the same dermatomes. Dr. Mikelis was requesting a posterior spinal fusion and laminectomy and to continue with physical therapy until surgery was performed.

It is well settled that an applicant for no-fault benefits establishes its prima facie entitlement to payment by proof of the submission to the defendant of a claim form, proof of the fact and the amount of the loss sustained, and proof either that the defendant had failed to pay or deny the claim within the requisite 30-day period, or that the defendant had issued a timely denial of claim that was conclusory, vague or without merit as a matter of law. **Ave T MPC Corp. v. Auto One Ins. Co., 32 Misc.3d 128(A), 934 N.Y.S.2d 32 (Table), 2011 N.Y. Slip Op. 51292(U), 2011 WL 2712964 (App. Term 2d, 11th & 13th Dists. July 5, 2011)**. **(*see also* Insurance Law §5106).**

In evaluating the medical necessity of services where the proof of each party, particularly the conclusion, is contradictory, consideration must be given to the evidentiary burdens. Respondent must prove first that the services were not medically necessary. That proof must come from someone qualified by education, training and experience to give such opinion. A peer review report must set forth a factual basis to establish, prima facie, the absence of medical necessity and a conclusory assertion that certain procedures were medically unnecessary fail to create a triable issue of fact, **Choicenet Chiropractic PC v Allstate, 2003 NY Slip Op 50672U, 2003 N.Y. Misc. LEXIS 314 (App. Term, 2nd and 11th Jud Dists 2003; Amaze Medical Supply v Allstate Ins. Co., 3 Misc. 3d 43, 779 N.Y.S.2d 715, 2004 NY Slip Op 24119 (App Term 2d and 11th Jud Dists 2004**

An opinion offered by respondent is more likely to withstand the opinion of a treating medical provider when it includes:

1. some reference to the standards in the applicable medical community for the services and treatment in issue;
2. an explanation as to when such services and treatment would be medically appropriate, preferably with an understandable objective criteria; and
3. an explanation of why it was not medically necessary in the instance at issue.

If the proof of the respondent is found to meet its burden, the proof of the applicant must be considered in opposition to it, mindful that it is likely offered by the provider who actually performed examinations, established treatment and diagnostic plans, made diagnoses and performed medical services.

Respondent makes out its initial burden to demonstrate that the assignor was in no further need of treatment as of the date of her February, 2018 exam by Dr. Hillsman's exam, report and conclusion. She establishes that on that date the assignor suffered from no residual abnormalities from the motor vehicle accident, was resolved of all injuries and in no further need of treatment. Dr. Hillsman's conclusion is supported, in part, by her exam in September, 2017 which found all injuries resolved except for some slight residual abnormalities in the lumbar spine.

Applicant's proof is sufficient to overcome that demonstration because applicant was examined not one but three times between March 28 and June 1, 2018 and at the time of the second examination on May 16, 2018 surgery was considered and then discussed further after the third examination. Those three exams are

consistent and demonstrate that the assignor was continuing to suffer with pain in the neck and low back. Those subjective complaints are supported by objective findings of quantified ranges of motion that are less than normal in multiple planes. There was some slight improvement over the course of those three exams but because the injuries persisted despite several months of physical of therapeutic treatment, surgery was being considered. In all, applicant's proof is sufficient to overcome respondent's initial demonstration and establish the medical necessity of the exams in issue. For these reasons, the claim is granted.

As the Denial of Claim dated April 13, in 2018 indicates that the Bill dated April 2, 2018 for date of service March 28, 2018 was received by the respondent on April 10, 2018, interest runs from 30 days after the bill was received, May 11, 2018.

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**
	New York Spine Specialists LLP	**03/28/18 - 03/28/18**	**$236.94**	**Awarded: $236.94**
Total			**$236.94**	**Awarded: $236.94**

B. The insurer shall also compute and pay the applicant interest set forth below. 05/11/2018 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

INTEREST: Pursuant to Insurance Law § 5106 (a), interest accrues on overdue no-fault insurance claims at a rate of 2% per month. A claim is overdue when it is not paid within 30 days after a proper demand is made for its payment (Insurance Law § 5106 [a]; 11 NYCRR 65.15 [g]). The Superintendent's regulation tolls the accumulation of interest if the claimant "does not request arbitration or institute a lawsuit within 30 days after receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations" (11 NYCRR 65-3.9 [c]). The Superintendent has interpreted this provision to mandate that the accrual of interest is tolled, regardless of whether the particular denial at issue was timely. That interpretation was upheld by the Court of Appeals in LMK Psychological Servs, P.C. v. State Farm Mut. Auto. Ins. Co., 2009 NY Slip Op 02481 (April 2, 2009). Where no denial of claim is issued in response to a proper demand for payment, the insurer does not benefit from the tolling provision and interest will accrue from the date 30 days after the proper demand for payment is made. Interest that accrues when a denial of claim is not issued within 30 days after the proper demand for payment is made will be tolled upon the issuance of a denial of claim, although such denial is untimely, and the failure to request arbitration or institute a lawsuit within 30 days after receipt of that denial of claim form.

C. Attorney's Fees

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

ATTORNEY'S FEES: 11 NYCRR 65-4.6 establishes a minimum attorneys' fee and further provides that:

For cases filed on or before February 4, 2015, the "attorney's fee shall be limited as follows: 20 percent of the amount of first-party benefits, plus interest thereon, awarded by the . . . court, subject to a maximum of $850" (11 NYCRR 65-4.6 [e]). The October 8, 2003, opinion letter of the Superintendent interpreted that regulation and stated that the minimum amount of attorneys' fees awarded to an assignee health care provider pursuant to Insurance Law § 5106 is "based upon the aggregate amount of payment required to be reimbursed based upon the amount awarded for each bill which had been submitted and denied. The minimum attorney fee . . . is not due and owing for each bill submitted as part of the total amount of the disputed claim sought in the court action" (Ops Gen Counsel NY Ins Dept No. 03-10-04 [Oct. 2003]). For purposes of calculating attorneys' fees, the Superintendent has interpreted a claim to be the total medical expenses claimed in a cause of action pertaining to a single insured, and not each separate medical bill submitted by the provider. The Insurance Department's interpretation of its own regulation was upheld by the Court of Appeals in LMK Psychological Servs, P.C. v. State Farm Mut. Auto. Ins. Co., 2009 NY Slip Op 02481

(April 2, 2009). Attorneys' fees are therefore to be calculated based on the aggregate of all bills for each insured; and

For cases filed after February 4, 2015, the attorney's fee is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-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 per arbitration or court proceeding, subject to a maximum fee of $1,360. If the nature of the dispute results in an attorney's fee that could be computed in accordance with the limitations prescribed in both subdivision (c) and this subdivision, the higher attorney's fee shall be payable.

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

11/27/2019
(Dated)

John O'Grady

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:
31dd562ba8da8890332299c6dedf706c

Electronically Signed

Your name: John O'Grady
Signed on: 11/27/2019