American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

South Ozone Park Medical PC (Applicant)	AAA Case No.	17-19-1116-7138
	Applicant's File No.	none
- and -	Insurer's Claim File No.	0424233420101045
	NAIC No.	35882
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Nada Saxon, 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 09/08/2020
   Declared closed by the arbitrator on 09/08/2020

   Hillary Blumenthal from The Law Offices of Hillary Blumenthal P.C. participated by telephone for the Applicant

   Rachel Stein from Geico Insurance Company participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **$ 1,573.24**, 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 (LL) was a 36-year-old female involved in a motor vehicle accident on 11/24/14.

   Applicant seeks payment for EMG testing performed on 2/26/15.

   Respondent denied the based upon a peer review report by Dr. Feuer, M.D. dated 3/31/15.

   Applicant asserts Respondent's denial is defective.

The issues are whether Respondent has established its defenses based upon lack of medical necessity.

4. Findings, Conclusions, and Basis Therefor

This case was conducted using the documents submitted by the parties in the ADR Center, maintained by the American Arbitration Association, and the oral arguments of the parties. Any documents in the ADR Center are hereby incorporated into this hearing. I have reviewed all the relevant documents. No witnesses testified at this hearing.

11 NYCRR 65-4.5 (o) (1) (Regulation 68-D), reads as follows: The arbitrator shall be the judge of the relevance and materiality of the evidence offered and strict conformity to legal rules of evidence shall not be necessary. The arbitrator may question any witness or party and independently raise any issue that the arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department Regulations.

Any further issues raised in the hearing record are held to be moot and/or waived insofar as not specifically raised at the time of the hearing.

Prima Facie/Sufficiency of Denial

Applicant argues that Respondent's denial is defective because box 24 (date of bill) is incorrect. Box 24 indicates the date of bill is 11/24/14; the date of Applicant's bill is 2/27/15.

However, the remainder of the pertinent information, such as date of treatment, amount, date of receipt and date of denial are accurate. Furthermore, the basis of the denial is clear, i.e. lack of medical necessity based upon a peer review report by Dr. Feuer dated 3/31/15.

I am aware of the holding in General Accident Insurance Company v. Cirucci, 46 N.Y.2d 862, 414 N.Y.S.2d 512 (1979); a denial must "promptly apprise the claimant with a high degree of specificity of the ground or grounds on which the disclaimer is predicated.".

In Actual Chiropractic, P.C., v. Mercury Casualty Company, 2016 NY Slip Op, 51435 (U), 2016 WL (App. Term 2d, 11 and 13 Dists. Sept. 27, 2016), the Court held that:

> *The failure to set forth the dates of the scheduled examinations in the denial of claim form[s] did not render the denial[s] conclusory, vague, or without merit as a matter of law." (citing to Quality Psychological Servs., P.C. v Avis Rent-A-Car Sys., LLC, 47 Misc 3d 129[A], 2015 NY Slip Op 50378[U], *1 [App Term, 2d Dept, 2d, 11th & 13th Jud Dists 2015]).*

Additionally, the Court has consistently held that a minor factual discrepancy in a denial of claim form does not invalidate a denial. *See*, Westchester Medical Center v. Nationwide Mutual Ins., Co., 78 A.D.3d 1168, 911 N.Y.S.2d 907, 2010 NY Slip Op 08933 (App. Div., 2nd Dept., Nov. 30, 2010). The Court has reasoned that what amounts to a consequential error is one that poses the possibility of confusion or prejudice under the circumstances of the case. *See*, St. Barnabas Hospital v. Penrac, Inc., 79 A.D.3d 733, 911 N.Y.S.2d 920, 2010 NY Slip Op 09122 (App. Div., 2nd Dept., Dec. 7, 2010).

A mistake or omission which does not cause prejudice that will not render the denial a nullity. See, NYU-Hospital for Joint Diseases v. Esurance Ins. Co., 84 A.D.3d 1190, 923 N.Y.S.2d 686, 2011 NY Slip Op 04436 (App. Div., 2 Dept, May 24, 2011); NYU-Hospital for Joint Diseases v. Allstate Ins. Co., 123 A.D.3d 781, 1 N.Y.S.3d 114, 2014 NY Slip Op 08613 (App. Div., 2 Dept, Dec. 10, 2014).

Specifically, the Court has held that an incorrect amount of the claim and the amount in dispute is a minor error which does not render a denial fatally defective. See, Wyckoff Heights Medical Center v. Government Employees Ins. Co., 114 A.D.3d 855, 980 N.Y.S.2d 575 (App. Div., 2 Dept., Feb. 19, 2014).

These principles are also codified in the regulations. *See* 11NYCRR §65-3.8(h) which states:

> *With respect to a denial of claim (NYS Form N-F 10), an insurer's non-substantive technical or immaterial defect or omission shall not affect the validity of a denial of claim.*

As well as 11 NYCRR 65-3.5(p) which states*:*

> *With respect to a verification request and notice, an insurer's non-substantive technical or immaterial defect or omission, as well as an insurer's failure to comply with a prescribed time frame, shall not negate an applicant's obligation to comply with the request or notice. This subdivision shall apply to medical services rendered, and to lost earnings and other reasonable and necessary expenses incurred, on or after April 1, 2013.*

Furthermore, 11 NYCRR §65-3.8(b)(4) provides that:

> If the specific reason for a denial of a no-fault claim, or any element thereof, is a medical examination or peer review report requested by the insurer, the insurer shall release a copy of that report to the applicant for benefits, the applicant's attorney, or the applicant's treating physician, upon the written request of any of these parties.

The Court in A.B. Medical Services, PLLC v. Liberty Mut. Ins. Co., 39 A.D.3d 779, 835 N.Y.S.2d 614 (2d Dept. 2007) held as follows:

To the extent the Appellate Term's order may be understood to require an insurer denying a claim for first-party no-fault benefits on the ground of lack of medical justification to include a medical rationale in its denial of claim form, we agree with the defendant that the court erred. The applicable regulations provide that if a no-fault claim is denied in whole or in part based on a medical examination or peer review report requested by the insurer, then the insurer shall release a copy of that report to, among others, the applicant or its attorney, upon written request (see 11 NYCRR 65-3.8[b] [4]). Had it been the intent of the Department of Insurance to require the carrier to set forth a medical rationale in the prescribed denial of claim form (see NYS Form N-F 10;11 NYCRR 65-3.4 [c] [11]), it would have so provided (see A.B. Med. Servs. v GEICO Cas. Ins. Co.,39 AD3d 778[decided herewith]; New York Univ. Hosp. Rusk Inst, v Government Empls. Ins. Co.,39 AD3d 832[decided herewith]).

Respondent's denial as a whole clearly articulates the correct claim information and that it is denied based upon a peer review and lack of medical necessity. The error as to the date of the bill does not render the denial vague or conclusory.

Based on the case law and regulations, I find Respondent's denial of claim sufficient to preserve its defense.

***Medical*Necessity**

Dr. Feuer asserts the EMG/NCV study was not medically necessary. However, he repeatedly indicates that Dr. Boppana's 3/26/15 neurological exam is a pre-printed check-off sheet, asserting it is not standard practice to utilize a printed check-off sheet. However, this does not render the underlying testing medically unnecessary.

Dr. Boppana's 3/26/15 neurological exam reported weakness, diminished reflexes and decreased sensation in the lower extremities. However, Dr. Feuer fails to meaningfully discuss the specifics and asserts the pre-printed check-off sheet was poorly intelligible and did not give an accurate picture of the clinical syndrome.

I find Dr. Feuer's factual basis and rationale lacking.

Applicant does not submit a formal rebuttal report, however, Respondent's peer review report is insufficient to establish a lack of medical necessity and does not shift the burden to Applicant.

No evidence was presented establishing Applicant's claim was billed in excess of the applicable fee schedule.

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**	**Status**
	South Ozone Park Medical PC	**02/26/15 - 02/26/15**	**$1,573.24**	**Awarded: $1,573.24**
Total			**$1,573.24**	**Awarded: $1,573.24**

B. The insurer shall also compute and pay the applicant interest set forth below. 01/07/2019 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).

Based on the regulations, I find the date that interest shall accrue from is the date the Applicant requested arbitration in this matter. See, 11 NYCRR 65-3.9(c).

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

09/18/2020
(Dated)

Nada Saxon

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:
586d915ffa0ff8986bb7ef99c3d30697

Electronically Signed

Your name: Nada Saxon
Signed on: 09/18/2020