American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Excell Clinical Lab (Applicant)	AAA Case No.	17-19-1120-3393
	Applicant's File No.	DK19-67536
- and -	Insurer's Claim File No.	1028584-02
	NAIC No.	16616
American Transit Insurance Company (Respondent)		

ARBITRATION AWARD

I, Alison Berdnik, 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: Claimant

1. Hearing(s) held on 11/12/2020
   Declared closed by the arbitrator on 11/12/2020

   Evan Polansky, Esq. from Korsunskiy Legal Group P.C. participated by telephone for the Applicant

   Helen Cohen, Esq., of counsel from American Transit Insurance Company participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **$ 1,203.50**, 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 Claimant, RS, a 66-year-old female, was a passenger in a motor vehicle involved in an accident on May 21, 2018. At issue in this case is $1,203.50 for a urine drug screening performed August 7, 2018. Respondent timely denied the claim based upon a peer review report by Peter Chiu, M.D. dated October 5, 2018.

   The issue presented for determination is whether the disputed service was medically necessary.

4. Findings, Conclusions, and Basis Therefor

This case was decided based upon the submissions of the parties as contained in the electronic file maintained by the American Arbitration Association, and the oral arguments of the parties' representatives. There were no witnesses present to testify at the hearing. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

An Applicant establishes its *prima facie* showing of an entitlement to judgment as a matter of law by submitting evidentiary proof that the prescribed statutory billing forms had been mailed, received by the Respondent and that payment of no-fault benefits is overdue. *Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.2d 742, 774 N.Y.S.2d 564 (2nd Dept. 2005). A facially valid claim has been defined as one that sets forth the name of the patient, date of accident, date of service, description of services rendered and the charges for those services. *See, Vinings Spinal Diagnostic P.C. v. Liberty Mutual Insurance Company*, 186 Misc.2d 128(A), 784 N.Y.S.2d 918 (2003).

The submission of Respondent's Denial of Claim Form ("NF-10") establishes that Respondent received Applicant's claim and that Respondent has not paid the claim. *Lopes v. Liberty Mutual Ins. Co.*, 24 Misc.3d 127(A), 2009 N.Y. Slip Op. 51279(U), 2009 WL 1799812 (App. Term 2nd, 11th & 13th Dists. Jan. 26, 2009). Thus, the submission of Respondent's NF-10 in this proceeding is sufficient to satisfy Applicant's burden in this instance.

As such, the burden now shifts to the Respondent to prove that the services were not medically necessary. *Amaze Medical Supply v. Eagle Insurance*, 2 Misc.3d 128(A) (2003). Once the Respondent makes a sufficient showing to carry its burden of coming forth with evidence of lack of medical necessity, the Applicant must rebut it. *A. Khodadadi Radiology, P.C. v. NY Central Mutual Fire Insurance*, 16 Misc.3d 131(A), 841 N.Y.S.2d 824 (2007).

It is well-settled that 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, Bronx Expert Radiology, P.C. v. Travelers Ins. Co.*, 2006 NY Slip Op. 52116 (App. Term 1st Dept. 2006). If an insurer asserts that the medical test, treatment, supply or other service was medically unnecessary, the burden is on the insurer to prove that assertion with competent evidence such as an independent medical examination, a peer review or other proof that sets forth a factual basis and a medical rationale for denying the claim. (*See A.B. Medical Services, PLLC v. Geico Insurance Co.*, 2 Misc.3d 26 [App. Term 2nd & 11th Jud. Dists. 2003]; *Kings Medical Supply Inc. v. Country Wide Insurance Company*, 783 N.Y.S.2d at 448 & 452; *Amaze Medical Supply, Inc. v. Eagle Insurance Company*, 2 Misc.3d 128 [App. Term 2nd & 11th Jud. Dists. 2003].)

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, Nir v. Allstate Ins. Co.*, 7 Misc.3d 544, 547, 796 N.Y.S.2d 857, 860 (Civ. Ct. Kings Co. 2005); *see also, All Boro Psychological Servs. P.C. v. GEICO*, 2012 N.Y. Slip Op. 50137(U) (Civ. Ct. Kings Co. 2012).

In order to prevail, respondent's peer review must address all of the pertinent objective findings contained in applicant's medical evidence. It must then clearly explain why, notwithstanding those findings, the disputed service was inconsistent with generally accepted medical or professional practices. *Amaze Medical Supply Inc. v. Eagle Insurance Co., supra*, 2 Misc.3d 128(A); *Citywide Social Work, et al, v. Travelers Indemnity Company*, 3 Misc.3d 608, 777 N.Y.S.2d 241 (Civ. Ct. Kings Co. 2004). Where other reports in the insurer's papers contradict the conclusion of its peer review, or that the service was not medically necessary, it has failed to make out a prima facie case in support of the defense of lack of medical necessity. *Hillcrest Radiology Associates v. State Farm Mutual Automobile Insurance Company*, 28 Misc.3d 138(A), 200 N.Y. Slip Op. 51467(U) 2010 WL 3258144 (App Term 2nd, 11th, and 13th Dists. 2010).

Respondent relies upon a peer review report by Peter Chiu, M.D. dated October 5, 2018 in support of its denial predicated upon a lack of medical necessity.

Dr. Chiu considered various records in conjunction with his peer review. He notes the Claimant's involvement in the underlying accident on May 21, 2018, and that she was evaluated at St. Barnabas Hospital, had x-rays taken, and was later released. Dr. Chiu notes that the Claimant subsequently came under the care of Teddy Calixte, PA at Phoenix Medical Services, P.C. on August 7, 2018 for complaints including pain in the neck and back. Medications included Eliquis, Amiodarone, Metoprolol, Pantoprazole, and Nifedipine. According to Dr. Chiu, history, subjective complaints, and physical exam findings were consistent with a sprain/strain injury. Following examination, the Claimant was recommended for drug screening. Upon completion of his review of the records, Dr. Chiu concluded that performance of the urine drug screening was medically unnecessary. According to Dr. Chiu, there was no history of drug abuse, narcotic use, or controlled substance being prescribed to warrant toxicology testing. Citing to medical literature, Dr. Chiu states that the standard of care for a toxicology screen is used to determine the type and approximate amount of legal and illegal drugs a person has taken. If the test is used as a drug screen, it must be done during a certain time period after the drug has been taken or while forms of the drug can still be detected. If a person has not been prescribed and/or will not be prescribed controlled substances, there is very little indication to order a toxicology screen in the context of pain management compliance. Dr. Chiu then discussed the use of narcotics for severe neck and back pain and asserted that there was no medical justification for Assignor to use narcotics.

At the outset, Applicant's counsel argued that Dr. Chiu's report fails to meet Respondent's burden of establishing that the toxicology screening was performed

outside the generally accepted standard of care. Counsel argued that Dr. Chiu did not review sufficient medical records to arrive at a conclusion regarding the medical necessity of the toxicology screening.

I respectfully disagree. The report of Dr. Chiu is sufficient to support Respondent's denial based upon a lack of medical necessity as it maintains a factual basis and medically cogent rationale to support his opinion that the service at issue was not medically necessary. Where the Respondent presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden then shifts to the Applicant which must then present its own evidence of medical necessity. *Andrew Carothers, M.D., P.C. v. GEICO Indemnity Company*, 2008 NY Slip Op. 50456U, 18 Misc.3d 1147A, 2008; *West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co.*, 13 Misc.3d 131, 824 N.Y.S.2d 759 (App. Term 2nd Dept. 2006).

In support of its claim, Applicant relies upon the medical records contained in evidence in the record below. Applicant also seeks to offer a rebuttal by Drora Hirsch, M.D., which was not uploaded to the electronic case file until November 6, 2020, one week prior to the hearing in this proceeding.

Pursuant to 11 NYCRR 65-4.2 (b)(3)(ii), within five business days after receipt of the request for arbitration, the American Arbitration Association shall notify the Respondent of the filing. Within thirty calendar days, the Respondent is to submit "all documents supporting its position on the disputed matter. Such documents shall be submitted to the applicant at the same time." Within that initial thirty-day period, the Respondent may request an additional thirty calendar days to respond, "based upon reasonable circumstances that prevent it from complying". It does not appear that any request for an extension of time was made by Respondent. 11 NYCRR 65-4.2 (b)(3)(iii) states "The written record shall be closed upon receipt of the respondent's submission or the expiration of the period for receipt of the respondent's submission." Additional submissions will be allowed "only at the request or with the approval of the arbitrator". 11 NYCRR 65-4.2 (b)(3)(iv).

Although I follow "Rocket Docket', I do not do so strictly. A review of the particular circumstances of the late filing is taken under consideration as it is always more judicial to decide a case on the merits rather than procedure. Some of the factors considered include, but are not limited to, how late the evidence was submitted, the reason for the late submission, and the prejudice to the other party.

The sections of the Regulations expedite the arbitration process and eliminate the element of surprise in the proceedings. Both sides should be able to rely on the timely submissions interposed by the other and not have to constantly check to ascertain if additional untimely documents have been submitted. To find to the contrary would fly in the face of the Regulations, backlog the arbitration system and prejudice the respective parties. Here, Applicant uploaded a rebuttal to the peer review one week prior to this proceeding. While, as an Arbitrator, I can use my discretion to allow a late submission,

see 11 NYCRR 65-4.2 (b)(3)(iv), I will not do so without good cause shown, and none has been shown here. Therefore, Applicant's late submission is precluded. To determine otherwise would be an abuse of my discretion.

Comparing the relevant evidence presented by both parties as against each other, and hearing the arguments of the parties, I find that the Applicant has not rebutted the peer review report, and has not established the medical necessity for the disputed service. As set forth above, the peer review report was credible, persuasive and facially sound, and, therefore, sufficient to sustain the Respondent's burden of proof with regard to the lack of medical necessity for the disputed medication. I am not persuaded by Applicant that the information contained in the August 7, 2018 report review by Dr. Chiu is insufficient to arrive at a conclusion regarding the medical necessity of the toxicology screening. The report documents the Claimant's currently prescribed medications, a complete history of the Claimant's injuries and therapy and treatment received thus far by the Claimant following the underlying accident, and a thorough examination.

After due consideration of the evidence, I find that Applicant has not successfully refuted the peer review report and has failed to establish the medical necessity of the disputed service by a fair preponderance of the evidence. Applicant's medical records, standing alone, do not adequately establish that the peer reviewer's standards of care were either incorrect, inapplicable, or had been sufficiently fulfilled in this case. Overall, the weight, credibility, and persuasiveness of the evidence favors Respondent. As noted by Respondent's counsel, following examination, the plan was to "continue analgesics as needed" together with physical therapy and a home exercise program. Thus, I am not persuaded by Mr. Calixte's report that the collection of urine for drug screening was necessary in this instance. Based on the evidence submitted, it appears that the urine toxicology was performed as a routine screening device without any specific need demonstrated, and I sustain the defense asserted in the denial.

Accordingly, Applicant's claim is denied in its entirety.

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 claim is DENIED in its entirety

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of New York
SS :
County of Suffolk

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

11/13/2020
(Dated)

Alison Berdnik

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:
d4aaba3930fcf58d2162fe80dbd8f7dc

Electronically Signed

Your name: Alison Berdnik
Signed on: 11/13/2020