American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

All City Family Healthcare Center (Applicant)	AAA Case No.	17-20-1157-1603
	Applicant's File No.	SS-138322
- and -	Insurer's Claim File No.	1034516-01
	NAIC No.	16616
American Transit Insurance Company (Respondent)		

ARBITRATION AWARD

I, Gregory Watford, 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 (JM)

1. Hearing(s) held on 01/19/2021
   Declared closed by the arbitrator on 01/19/2021

   Gregory Itingen from Samandarov & Associates, P.C. participated by telephone for the Applicant

   Mustafa Nouri from American Transit Insurance Company participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **$ 7,443.59**, 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 dispute arises from the underlying automobile accident of July 28, 2019, in which the Assignor, a 29-year-old male, was a passenger. As a result of the accident, he suffered multiple injuries including injuries to his right knee. Thereafter, he sought private medical attention where he was recommended to begin conservative care treatments and was referred for diagnostic testing. Assignor was subsequently diagnosed with a meniscus tear and a partial ACL tear of the right knee.

On October 18, 2018, Assignor underwent right knee surgery. In dispute in this case are the facility fees for the knee surgery. Applicant timely submitted the bill in the amount of $7,443.59. Respondent denied payment based upon the peer review of Dr. Richard Weiss.

At the hearing, when asked, Respondent did not produce any evidence to support a fee schedule defense.

The issues to be decided in this case are:

Whether Applicant established entitlement to No-Fault compensation for facility fees related to right knee surgery services provided to Assignor.

Whether Respondent made out a prima facie case of lack of medical necessity and, if so, whether Applicant rebutted it.

4. Findings, Conclusions, and Basis Therefor

I have reviewed the submissions and documents contained in the American Arbitration Association's ADR Center Electronic Case File (ECF). These submissions constitute the record in this case. This case was decided on the submissions of the parties as contained in the ECF and the oral arguments of the parties' representatives. There were no witnesses.

A claimant's prima facie proof of claim for no-fault benefits must demonstrate that the prescribed claim forms were mailed to and received by the insurer. Viviane Etienne Medical Care, P.C. v. Country-Wide Ins. Co., 25 N.Y.3d 498, 506, 14 N.Y.S.3d 283, 290 (2015). Applicant's proof is also in Respondent's denials, which acknowledged receipt of the bills.

After reviewing the record and evidence presented, I find that Applicant established a prima facie case of entitlement to reimbursement of its claim. Viviane Etienne Med Care, PC v. Countrywide Ins. Co., *Id*. Once an applicant establishes a prima facie case, the burden then shifts to the insurer to prove its defense. See Citywide Social Work & Psych. Serv. P.L.L.C v. Travelers Indemnity Co., 3 Misc. 3d 608, 2004, NY Slip Op 24034 (Civ. Ct., Kings County 2004).

Untimely Denial

Applicant's counsel argued that Respondent's denial was untimely.

"Pursuant to Insurance Law § 5106(a) and the Insurance regulations, an insurer must either pay or deny a claim for motor vehicle no-fault benefits, in whole or in part, within

30 days after an applicant's proof of claim is received (*see* Insurance Law § 5106[a]; 11 NYCRR 65-3.8[c]; *see also* 11 NYCRR 65-3.5)." Infinity Health Products, Ltd. v. Eveready Ins. Co., 67 A.D.3d 862, 864, 890 N.Y.S.2d 545, 547 (2d Dept. 2009). "The 30-day period in which to either pay or deny a claim is extended where the insurer makes a request for additional verification within the requisite 15-[business] day time period (*see* Montefiore Med. Ctr. v Government Empls. Ins. Co., 34 AD3d 771; New York & Presbyt. Hosp. v. Allstate Ins. Co., 31 AD3d 512)." Kingsbrook Jewish Medical Center v. Allstate Insurance Co., 61 A.D.3d 13, 17-18, 871 N.Y.S.2d 680, 683 (2d Dept. 2009). "If the requested verification is not received within 30 days, the insurer must send a follow-up letter within 10 days thereafter (see 11 NYCRR 65.15[e][2])." New York & Presbyterian Hospital v. American Transit Insurance Co., 287 A.D.2d 699, 700, 733 N.Y.S.2d 80, 81-82 (2d Dept. 2001).

A claim need not be paid or denied until all demanded verification is provided (see 11 NYCRR 65-3.8(b) (3); Westchester County Med. Ctr. v. New York Cent. Mut. Fire Ins. Co., 262 A.D.2d 553, 554, 692 N.Y.S.2d 665 (N.Y. App. Div. 2nd Dept. 1999). When a provider fails to respond to a verification request, the 30-day period in which to pay or deny the claim does not begin to run, and any claim for payment by the provider is premature. See St. Vincent's Hosp. of Richmond v. American Tr. Ins. Co., 299 A.D.2d 338, 340, 750 N.Y.S.2d 98 (N.Y. App. Div. 2nd Dept. 2002); Nyack Hosp. v. Progressive Cas. Ins. Co., 296 A.D.2d 482, 483, 747 N.Y.S.2d 516 (N.Y. App. Div. 2nd Dept. 2002); New York Hosp. Med. Ctr. Of Queens v. State Farm Mut. Auto Ins. Co., 293 A.D.2d 588, 590, 741 N.Y.S.2d 86 (N.Y. App. Div. 2nd Dept. 2002). No-fault benefits are overdue, however, if not paid within 30 calendar days after the insurer receives verification of all of the relevant information requested pursuant to 11 NYCRR 65.15(d)(see 11 NYCRR 65-3.8(a)(1); New York Hosp. Med. Ctr. Of Queens v. Country-Wide Ins. Co., 295 A.D.2d 583, 584, 744 N.Y.S.2d 201(N.Y. App. Div. 2nd Dept. 2002).

Based upon the NF-10, Respondent received the bill on 11/28/18. Respondent provided additional verification letters dated 12/11/18 and 1/15/19. Applicant did not argue that these initial verification requests were untimely. I find that both verification requests were timely under the regulations.

Respondent's NF-10 also indicated that the final verification request for the bill was not received until 11/8/19 and the bill was denied on 12/2/19.

There are additional verification request letters dated 5/20/19, 5/31/19, 7/5/19, 10/2/19, 11/5/19. It should be noted that the 5/20/19 letter acknowledged receipt of a verification response on 5/10/19 and referenced the attached additional verification titled "1st Notice of Examination Under Oath" and dated 5/16/19 which related to the 10/18/18 bill in dispute. The EUO of Assignor was initially scheduled for 7/18/19. There is also an EUO "rescheduling" letter dated 9/6/19 which rescheduled the EUO for Assignor on 11/8/19. The letter is not titled "Second Request" and there is no indication that Assignor failed to appear for any prior scheduled EUO. Although there is no copy of the EUO transcript in the ECF, it appears that it was conducted on 11/8/19 which corresponds with Box # 29 on the NF-10.

Applicant's counsel argued that the 5/31/19 verification letter to Applicant acknowledged "verification response received" and therefore the bill should have been paid or denied 30 days after 5/31/19. Applicant's counsel further argued that based upon the documents in the ECF, Respondent's denial was untimely under Neptune Med. Care, P.C. v. Ameriprise Auto & Home Ins., 48 Misc. 3d 139(A)(App. Term, 2nd Dept 2015). Pursuant to Neptune Medical Care, upon receipt of an applicant's proof of claim, an insurer has fifteen business days within which to request "any additional verification required by the insurer to establish proof of claim." 11 NYCRR 65-3.5(b). The 15-business day period for requesting an EUO shall commence on the date the claim is received. Id. Pursuant to 11 NYCRR 65-3.8 (l) deviations from the verification time frames reduce the 30 days to pay or deny the claim by the same number of days that the request was late. Examinations under oath and independent medical examinations are deemed verification. "(T)he Regulations do not provide that such a toll grants an insurer additional opportunities to make requests for verification that would otherwise be untimely." Neptune Med. Care, *supra.*

However, the Court, in Neptune, takes a narrow reading of 3.5(b). I find the Court reads the word "any" to mean "all." I also find that this narrow reading is contrary to the intent of the no-fault regulation which states that "the insurer is entitled to receive all items necessary to verify the claim directly from the parties from whom such verification was requested." See 11 NYCRR 3.5(c); see also 11 NYCRR 65-3.8(a)(1). "A claim need not be paid or denied until all demanded verification is provided." Nyack Hosp. v. General Motors Acceptance Corp., *supra*. The Court, in misinterpreting the word "any", fails to give the word its plain meaning. See Orens v. Novello, 99 N.Y.2d 180 (2002). Any does not mean all.

Moreover, the Appellate Term, First Department, has held while an insurer may request further verification in the form of an EUO after receipt of additional verification, the insurance carrier has an "initial burden of establishing, prima facie, that it requested (examinations) in accordance with the procedures and time frames set forth in 11 NYCRR 3.5 of the no-fault regulations. See Quality Psychological Servs. P.C. v. Utica Mut. Ins. Co., 38 Misc. 3d 136(a), 2013 NY Slip Op 50148(U) (App Term 1st Dept., Feb. 1, 2013.

Utilizing the 5/20/19, letter as the basis for calculating the receipt of the additional verification on 5/10/19, the 5/16/19 initial EUO scheduling letter would be timely under the regulations. Moreover, the denial of the claim on 12/2/19 after the 11/8/19 rescheduled EUO, would make the Respondent's denial timely under the regulations. Consequently, Applicant's untimely denial argument is not supported by the documents in the ECF.

Medical Necessity

A presumption of medical necessity attaches to a timely submitted no fault claim. Elmont Open MRI & Diagnostic Radiology, P.C. v. State Farm Ins. Co., 26 Misc.3d 1211(A), 906 N.Y.S.2d 779 (Table), 2010 N.Y. Slip Op. 50053(U) at 3, 2010 WL

157564 (Dist. Ct. Nassau Co., Fred J. Hirsh, J., Jan. 6, 2010). 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 [N.Y. 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 [N.Y. App. Term, 2nd and 11th Jud Dists 2003]).

The purpose of a peer review is to determine whether the service/test provided was medically necessary. The peer reviewer discusses the standard of care in the medical community and offers his/her opinion as to why the service/test at issue falls outside of that standard of care. The peer reviewer buttresses his/her opinion with authoritative texts, treatises, and articles, generally from peer-reviewed publications.

The 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, Jacob Nir, M.D. v. Allstate Insurance Co., 7 Misc. 3d 544 (N.Y. City Civ. Ct. 2005).

A determination of medical necessity must be based on evidence in existence prior to the rendering of the service. Foster Diagnostic Imaging, PC v General Assur Co., 10 Misc. 3d 428 (Civ. Ct. Kings Cty 2005).

Dr. Weiss reviewed documents including the hospital records, initial evaluation reports, operative report, follow-up evaluation reports, and diagnostic test results. He then outlined the treatment of the Assignor. Dr. Weiss noted Assignor underwent right knee arthroscopy, partial medial meniscectomy, partial lateral meniscectomy, synovectomy, chondroplasty lateral femoral condyle and debridement of ACL. *"According to the operative report, there was evidence of a meniscal tear. I have come to the conclusion that there was no causally related medical necessity for the right knee arthroscopic and associated services , including the anesthesia services. Based on the film review from Dr. Setton dated 3/22/19 the right knee MRI study dated 7/31/18 revealed no evidence of any traumatic findings. Findings consistent with advanced osteoarthritis. Based on the clinical findings, there was no medical necessity for the arthroscopy. The surgery was not necessary with consideration of the response to conservative treatment."*

Dr. Weiss also noted that Assignor sustained injury to the right knee in 2009 which required surgery for meniscal, ACL and MCL repair.

He then concluded *"The diagnosed findings cannot be directly attributed to any injury sustained as a result of the 7/28/18 accident, given the overall clinical picture. Based on*

the medical records the surgery was not medically necessary therefore, any associated services were also not medically necessary."

Applicant's counsel argued that the peer review was insufficient because Dr. Weiss failed to sufficiently establish that Assignor's pre-existing injury to his right knee was not exacerbated by the accident. He further argued the peer review conclusion regarding causality was also deficient because Dr. Weiss relied on the MRI study of doctor Dr. Setton to reach his conclusion.

Proximate Causation

Every peer review requires individual scrutiny to determine whether the burden should be shifted back to the claimant to submit contrary expert proof. The conclusory opinions of the peer reviewer, standing alone and without support of medical authorities, will not be considered sufficient to establish the absence of medical necessity. (See, Amaze Medical Supply Inc. v. Eagle Ins. Co., 2 Misc.3d 128(A), 784 N.Y.S.2d 918 (Table), 2003 N.Y. Slip Op. 51701(U), 2003 WL 23310886 (N.Y. App. Term 2nd & 11th Dists. Dec. 24, 2003).

Respondent bears the burden to prove its defense that the injuries in question were not related to the accident in addition to proof that the accident did not exacerbate or aggravate any pre-existing condition or injury. See, Bronx Radiology, P.C. v. New York Central Mutual Fire Ins. Co., 847 N.Y.S.2d 313, 314- 315, 17 Misc. 3d 97 (N.Y. App. Term 1st Dept. 2007).

In Bronx Radiology, P.C. v. New York Central Mutual Fire Ins. Co., the court clarified the parties' respective burdens with respect to establishing causation, or the lack of causation, in a no-fault action:

In the typical negligence action, plaintiff's burden of establishing causation is met by a showing that the accident was a proximate cause of the claimed injuries. See Derdiarian v. Felix Contracting Corp., 51 N.Y.2d 308, 434 N.Y.S.2d 166, 414 N.E.2d 666 (1980). However, in an action to recover first party no fault benefits, a plaintiff bears no such burden and establishes his or her prima facie case by proof that the claim form was mailed and received, and that the insurer failed to pay within the 30-day statutory period. See Mary Immaculate Hosp. v. Allstate Ins. Co., 5 A.D.3d 742, 774 N.Y.S.2d 564 (2004). In essence, causation is presumed since 'it would not be reasonable to insist that a [medical provider] must prove as a threshold matter that its patient's condition was caused' by the automobile accident. Mount Sinai v. Triboro Coach, 263 A.D.2d 11, 20, 699 N.Y.S.2d 77 (1999). Thus, the burden is on the defendant insurer to come forward with proof establishing by 'fact or founded belief' its defense that the claimed injuries have no nexus to the accident." Central Gen. Hosp. v. Chubb Group of Ins. Cos., 90 N.Y.2d 195, 199, 659 N.Y.S.2d 246, 681 N.E.2d 413 (1999).

Moreover, a defense based upon lack of causation must be supported by a report from an expert with medical training. Kingsbrook v. Allstate, *supra.* When Respondent's expert

report to support its defense is in the form of a peer review, the peer review must make "recourse to medical facts," providing the factual basis and medical rationale for the expert's opinion and demonstrating the basis for his or her "fact or founded belief" that the specific treatment in dispute was not a result of (either caused or exacerbated by) the accident in question. See, Kingsbrook v. Allstate Ins. Co., supra at 22, citing Mt. Sinai Hosp. v. Triboro Coach, *supra.*

Comparing the evidence and arguments presented by the parties at the hearing, I am persuaded by the arguments and evidence of Applicant. Dr. Weiss acknowledged that Assignor had a prior similar injury to the right knee which required surgery. I was not persuaded that he sufficiently addressed the lack of exacerbation of Assignor's prior injury to the same knee. Moreover, Dr. Weiss primarily relied upon the MRI review of Dr. Setton which was not sufficiently referenced in the body of the peer to support the initial burden to establish lack of medical necessity. Neither Dr. Weiss nor Dr. Setton's opinions as to lack of causation and medical necessity are supported by citation to any appropriate literature, standards, generally accepted practices, or recognized medical authorities of any kind. Moreover, Dr. Weiss does not offer a credible opinion as to lack of aggravation or exacerbation of an existing condition.

Even if unopposed, a "sparse and confusing opinion…offered by (an insurer's) medical expert," which "reflect(s) the expert's…lack of knowledge as to the assignor's medical condition at the time of the disputed services, "fail(s) to meet its evidentiary burden of establishing the lack of medical necessity of the (services) giving raise to (a provider's) claim for assigned first party no-fault benefits." Webster Ave Medical Pavilion, P.C. v. Allstate Insurance Company, 42 Misc.3d 148(A), 2014 N.Y. Slip Op. 50393(U) (App. Term, First Dept. 2014).

In light of the foregoing, I find that the peer reviewer's opinion is not based on a sufficient factual basis specific to this Assignor, results in a flawed medical rationale, does not provide a standard of care for the Assignor's injuries, and does not meet Respondent's burden of proof. There is no need to consider Applicant's rebuttal evidence, or lack thereof, since Applicant's claims arrived at this arbitration carrying a presumption of medical necessity, which has not been rebutted by Respondent. See, Millennium Radiology, P.C. v. New York Central Mutual Fire Ins. Co., 23 Misc.3d 1121(A), 886 N.Y.S.2d 71 (Table), 2009 N.Y. Slip Op. 50877(U), 2009 WL 1261666 (Civ. Ct. Richmond Co., Katherine A. Levine, J., Apr. 30, 2009).

Applicant us awarded as billed.

This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator. Any further issues raised in the hearing record are held to be moot, without merit, and/or waived insofar as not raised at the time of the hearing.

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**
	All City Family Healthcare Center	**10/18/18 - 10/18/18**	**$7,443.59**	**Awarded: $7,443.59**
Total			**$7,443.59**	**Awarded: $7,443.59**

B. The insurer shall also compute and pay the applicant interest set forth below. 02/19/2020 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant's award shall bear interest at a rate of two percent per month, calculated on a pro rata basis using a 30-day month from the date payment became overdue to the date of the payment of the award pursuant to 11 NYCRR 65-3.9. The end date for the calculation of the period of interest shall be the date of payment of the claim. General Construction Law § 20 ("The day from which any specified period of time is reckoned shall be excluded in making the reckoning.")

Where a claim is timely denied, interest shall begin to accrue as of the date arbitration is requested by the claimant unless arbitration is commenced within 30 days after receipt of the denial, in which event interest shall begin to accrue as of the 30th day after proof of claim was received by the insurer. 11 NYCRR 65-4.5(s)(3), 65-3.9(c); Canarsie

Medical Health, P.C. v. National Grange Mut. Ins. Co., 21 Misc.3d 791, 797 (Sup. Ct. New York Co. 2008) ("The regulation provides that where the insurer timely denies, then the applicant is to seek redress within 30 days, after which interest will accrue.")

C. Attorney's Fees

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

Respondent shall pay Applicant a separate attorney's fee, in accordance with 11 NYCRR 65-4.6(d). Since the within arbitration request was filed on or after February 4, 2015, this case 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). Accordingly, the insurer shall pay the applicant an attorney's fee, in accordance with 11 NYCRR 65-4.6(d) subject to a maximum fee of $1,360.

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 Westchester

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

02/17/2021
(Dated)

Gregory Watford

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:
b9bead1b7a52c479f3071ed37768c896

Electronically Signed

Your name: Gregory Watford
Signed on: 02/17/2021