American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Phoenix Medical Services P.C. DBA Rockville Centre Pain Management & Rehabilitation (Applicant)	AAA Case No.	17-20-1160-2074
	Applicant's File No.	2395551
	Insurer's Claim File No.	0563017898 2CT
- and -	NAIC No.	19232
Allstate Insurance Company (Respondent)		

ARBITRATION AWARD

I, Perry Criscitelli, 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: EIP

1. Hearing(s) held on 10/04/2021
   Declared closed by the arbitrator on 10/04/2021

   Justin Skaferowsky, Esq. from Israel, Israel & Purdy, LLP (Great Neck) participated by telephone for the Applicant

   Steven Miranda, Esq. from Law Offices Of Karen L. Lawrence participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **$ 1,193.08**, was AMENDED and permitted by the arbitrator at the oral hearing.

   Applicant amened the amount in dispute to $993.60 to resolve fee schedule issues.

   Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

   Were the health services provided by Applicant set forth below medically necessary?

The EIP, a female age 24, was involved in a motor vehicle accident on July 12, 2019. The EIP thereafter sought medical treatment and was prescribed a variety of neurological and diagnostic testing administered by Applicant on November 27, 2019 through December 10, 2019. Respondent conducted an independent medical examination of the EIP on October 22, 2019, and Dr. Jimmy Lim determined based upon negative findings that no further medical treatment was required. Respondent terminated no fault benefits effective November 7, 2019, and denied payment to Applicant.

4. Findings, Conclusions, and Basis Therefor

I have reviewed all of the documents in the Electronic Case Folder which is maintained by the American Arbitration Association. This decision is based upon the documents reviewed as well as the arguments made by the parties' representatives at the arbitration hearing. The parties agree that there are no timeliness or fee schedule issues, and the sole issue to be determined in this arbitration is one of medical necessity.

Medical Necessity Standard

A treatment or service is medically necessary if it is "appropriate, suitable, proper and conducive to the end sought by the professional health service in consultation with the patient. It means more than merely convenient or useful treatment or services, but treatment or services that are reasonable in light of the patient's injury, subjective and objective evidence of the patient's complaints of pain, and the goals of evaluating and treating the patient." Fifth Avenue Pain Control Center v. Allstate, 196 Misc.2d 801, 807-808 (Civ. Ct. Queens Cty. 2003). See also, Bernhard J. Sengstock, DC, PC v. Travelers Home & Mar. Ins. Co., 2017 N.Y. Misc. LEXIS 3957, 2017 NY Slip Op 32204(U) (Civ.Ct. Bronx Cty 2017). Medically necessary treatment or services must be "consistent with the patient's condition, circumstances and best interest of the patient with regard to the type of treatment or services rendered, the amount of treatment or services rendered, and the duration of the treatment or services rendered." Id.

An independent medical examination ("IME") report asserting that no further treatment is medically necessary must be supported by a sufficiently detailed factual basis and medical rationale, which includes mention of the applicable generally accepted medical/professional standards. Carle Place Chiropractic v. New York Central Mutual Fire Co., 19 Misc.3d 1139(A), 866 N.Y.S.2d 90, 2008 N.Y. Slip Op. 51065(U) (Dist. Ct. Nassau Cty, 2008).

"Where the defendant insurer presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden shifts to the plaintiff, which must then present its own evidence of medical necessity" West Tremont Medical Diagnostic, P.C. v. GEICO Insurance Co., 13 Misc. 3d 131(A), 824 N.Y.S.2d 759, 2006 N.Y. Slip Op. 51871(U), 2006 WL 2829826 (App. Term 2nd &11th Dists. 2006). The Respondent

no-fault insurer defending a denial based on lack of medical necessity must at least show that the services were inconsistent with generally accepted medical/professional practice, which is defined as 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; unless there is reference to generally accepted medical/professional practice, conflicting expert testimony will only show a difference in professional medical judgment between two doctors. Accelerated Chiropractic Care, P.C. v. Progressive Ins., 58 Misc.3d 1212(A), 2017 N.Y. Slip Op. 51967(U) (Civ. Ct. Kings Co., 2017).

The lack of medical necessity is an affirmative defense that is the Respondent's burden to prove. See, Alliance Medical Office, P.C. v. Allstate, 196 Misc.2d 268, 269, 764 N.Y.S.2d 341, 342 (Civil Ct., Kings Cty. 2003); Choicenet Chiropractic P.C. v. Allstate, 2003 WL 1904296, 2003 N.Y. Slip Op. 50672U (App.Term 2nd Dept. 2003). "At a minimum, [Respondent] must establish a factual basis and medical rationale for the lack of medical necessity of [Applicant's] services. Nir v. Allstate Ins. Co., 7 Misc.3d 544, 546-47, 796 N.Y.S.2d 857, 860 (Civil Court, Kings Cty. 2005). "A Peer Review report's medical rationale is insufficient if it is unsupported by or controverted by evidence of medical standards." Id. Similar, "[a] Peer Review report's factual basis may be insufficient if it fails to provide specifics of the claim, is conclusory, or otherwise lacks a basis in the facts of the claim." Id., citing, Amaze Medical Supply v. Allstate Ins. Co., 3 Misc.3d 43, 779 N.Y.S.2d 715 (App Term 2nd and 11th Dists 2004). See also, All Boro Psychological Servs. P.C. v. GEICO, 2012 NY Slip Op 50137(U) (N.Y. City Civ. Ct. 2012). This does not necessarily require that the Peer Review quote or cite medical literature. The *Nir* decision clearly contemplates that a peer may cite "medical authority, standard, or generally accepted practice as a medical rationale for his findings". Nir, supra. at 548.

Once Applicant has established a prima facie case the burden is on the Respondent to prove that the medical treatment was medically unnecessary. See, Citywide Social Work & Psychological Services, PLLC a/a/o Gloria Zhune v. Allstate Ins. Co., 8 Misc.3d 1025A, 806 N.Y.S.2d 444(App Term 1st Dept 2005); A.B. Medical Services, PLLC v. Geico Ins. Co., 2 Misc 3d 26, 773 N.Y.S.2d 773 (AppTerm, 2nd & 10th Jud Dist 2003); Fifth Ave. Pain Control Center a/a/o Gladys Quintero v. Allstate Ins. Co.,196 Misc.2d 801, 766 N.Y.S. 2d 748 (Civ. Ct. Queens Co. 2003).

Once Respondent satisfies its burden of demonstrating no medical necessity, the burden now shifts to Applicant to refute Respondent's evidence. See, Bath Med. Supply, Inc. v. New York Cent. Mut. Fire Ins. Co., 2008 NY Slip Op 50347 (U) (App Term 2d Dept., Feb. 21, 2008); A; Khodadadi Radiology, P.C. v. New York Cent. Mut. Fire Ins. Co., 16 Misc. 3d 131 [A], 2007 N.Y. Slip Op 51342 [U] (App Term, 2nd & 10th Dists. 2007).

Analysis and Findings

In support of its denial, the Respondent submits the independent orthopedic evaluation report of Dr. Jimmy Lim dated October 22, 2019. On that date he conducted an orthopedic evaluation of the EIP which consisted of range of motion and neurological

evaluation of the cervical spine, thoracolumbar spine, left shoulder, right shoulder, left pelvis, left knee, left leg and left ankle, and right foot and right ankle. As a result of the findings and observations made in the physical examination, a determination was made that there was no orthopedic disability and therefore no further need for orthopedic related treatment.

The Applicant relies on the medical records and treatment records that are contained in the submission. Applicant focused upon the office records of September 24, 2019, as well as the chiropractic reevaluation conducted on October 23, 2019, and the office records of December 12, 2019. A review of those records contains findings that conflict with the independent medical examination findings.

I find that the applicant has provided sufficient and credible evidence by presentation of contemporaneous medical notations which sustain its burden of refuting the IME findings.

Accordingly, I find in favor of the applicant.

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**	**Amount Amended**	**Status**
	Phoenix				

	Medical Services P.C. DBA Rockville Centre Pain Management & Rehabilitation	**11/27/19 - 12/10/19**	**$1,193.08**	**$993.60**	**Awarded: $993.60**
Total			**$1,193.08**		**Awarded: $993.60**

B. The insurer shall also compute and pay the applicant interest set forth below. 04/01/2020 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

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

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

10/06/2021
(Dated)

Perry Criscitelli

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:
6f776e8d12de545e29abc913868f7c5a

Electronically Signed

Your name: Perry Criscitelli
Signed on: 10/06/2021