American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

C. Edward Robins Psychologist PC, MD (Applicant)	AAA Case No.	17-20-1171-7828
	Applicant's File No.	2440232
- and -	Insurer's Claim File No.	76413-01
	NAIC No.	24309
Hereford Insurance Company (Respondent)		

ARBITRATION AWARD

I, Jennifer Jacques-Miller, 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 11/12/2021
   Declared closed by the arbitrator on 11/12/2021

   Neda Melamed, Esq. from Israel, Israel & Purdy, LLP (Great Neck) participated in person for the Applicant

   Nathan Bruce, Esq. from Hereford Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 720.60**, 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
   Whether or not Respondent properly denied Applicant's claim for medical services based upon a lack of medical necessity pursuant to an Independent Medical Examination ("IME")?

   The EIP (FM) is a 31-year-old female, injured as a pedestrian by a motor vehicle accident on 06/29/18. Applicant seeks an amount of $720.60 for medical services performed from 04/20/20-06/08/20. Respondent denied Applicant's claim based upon a lack of medical necessity according to the IME of Dr. Richard DeBenedetto, PhD. dated 12/13/19.

4. Findings, Conclusions, and Basis Therefor
   I have completely reviewed all timely submitted documents contained in the ADR Center record maintained by the American Arbitration Association and considered all oral arguments. No additional documents were submitted by either party at the hearing. No witnesses testified at the hearing.

   It should be noted that this case is linked to AAA case 17-20-1165-6911, 17-20-1171-7828 and 17-20-1178-2142. All matters were arbitrated before the undersigned with the same parties for both sides.

   Analysis

   Applicant has established its prima facie entitlement to reimbursement for no fault benefits as a matter of law based upon the submission of a properly completed claim form setting forth the amount of the loss sustained and that payment is overdue. Mary Immaculate Hospital v. AllState Insurance Company, 5 AD 3d 742, (2nd Dept. 2004).

   The burden now shifts to Respondent to establish lack of medical necessity with competent medical evidence, which sets forth a clear factual basis (specifics of the claim) and medical rationale for denying the claim. Citywide Social Work and Psych Services, PLLC v. Allstate, 8 Misc. 3d 1025A (2005); Healing Hands Chiropractic v. Nationwide Assurance Co., 5 Misc. 3d 975 (2004). Respondent must offer sufficient and credible medical evidence that addresses the standards in the applicable medical community for the services and treatment in issue; explains when such services and treatment would be medically appropriate, preferably with understandable objective criteria; and why it was not medically necessary in the instance at issue.

   Respondent must offer sufficient and credible medical evidence that addresses the standards in the applicable medical community for the services and treatment in issue; explains when such services and treatment would be medically appropriate, preferably with understandable objective criteria; and why it was not medically necessary in the instance at issue. An 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 Insurance Company, 19 Misc. 3d 1139 (A) (Dis. Ct. Nassau 2008). Furthermore, an IME report must set forth a factual basis and medical rationale for the collusion that further services are not medically necessary. Ying Eastern acupuncture PC v. Global Liberty Insurance, 20 Misc. 3d 144 (A), 873 NYS 2d 238 (App. Term 2d and 11th Dists. 2008).

   Respondent timely denied the instant claim based upon an IME by Dr. Richard P. DeBenedetto, Ph.D dated 12/13/19. Dr. DeBenededetto noted that the EIP's psychological evaluation included poor sleep secondary to pain and ruminative ideation, and anxiety and hyper vigilance, especially when crossing the street. The EIP was diagnosed with an anxious-depressive order.

Dr. DeBenedetto's examination revealed that the EIP's thinking was logical, coherent, and appropriately goal directed. Dr. DeBenedetto's examination was completely normal and he found that there was no evidence to suggest the need for continued weekly psychotherapy. Accordingly, I find Dr. DeBenedetto's IME report sufficient to set forth a factual basis and medical rationale for the conclusion that further services were not medically necessary. E.g., Ying Eastern Acupuncture, P.C. v. Global Liberty Insurance, 20 Misc.3d 144(A), 873 N.Y.S.2d 238 (Table), 2008 N.Y. Slip Op. 51863(U), 2008 WL 4222084 (App. Term 2d & 11th Dists. Sept. 3, 2008).

It is the Applicant's burden, ultimately, to establish the medical necessity of the services at issue. See Insurance Law § 5102; Shtarkman v. Allstate Insurance Co., 2002 NY Slip Op 50568(U), 2002 WL 32001277 (App. Term 9th & 10th Jud. Dists. 2002) (burden of establishing whether a medical test performed by a medical provider was medically necessary is on the latter, not the insurance company).

In support of its position, Applicant submitted contemporaneous medical records. I find that the Applicant's medical records are sufficient to refute Respondent's burden of proof. In particular, the treatment notes from Dr. Jacqueline Bilikiewicz, MHC and Charles E. Robins, PhD dated 03/16/20, which establish that the EIP experienced trauma and her response involved intense fear, helplessness and horror. The EIP was diagnosed with excessive anxiety, worry, restlessness and fatigue, loss of energy. I find that the contemporaneous medical records establish persistent and consistent complaints of pain and positive objective findings sufficient to demonstrate the medical necessity for ongoing medical treatment. Applicant's medical records credibly demonstrate a need for continued treatment to achieve that goal

"Putting weight on the treating physician's prescription serves the reasonable expectations of the insured. An insured expects coverage for treatment recommended by a physician because he trusts that the physician has recommended a reasonable treatment consistent with good medical practice; the insured expectations can best be fulfilled by construing policy liberally so that uncertainties about the reasonableness of treatment will be resolved in favor of coverage." Oceanside Medical Healthcare v. Progressive, 2002 NY Slip op 50188 [U] (2002). Proscan Radiology of Buffalo v. Progressive Casualty Insurance Company, 12 Misc. 3d 1176 (A) (2006).

Decision
Based upon the reasons set forth above, Applicant is awarded the total sum of $720.60 in full disposition of this claim.

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
	C. Edward Robins Psychologist PC, MD	**04/20/20 - 04/27/20**	**$240.20**	**Awarded: $240.20**
	C. Edward Robins Psychologist PC, MD	**05/11/20 - 05/18/20**	**$240.20**	**Awarded: $240.20**
	C. Edward Robins Psychologist PC, MD	**06/01/20 - 06/08/20**	**$240.20**	**Awarded: $240.20**
Total			**$720.60**	**Awarded: $720.60**

B. The insurer shall also compute and pay the applicant interest set forth below. 07/15/2020 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Based on the submission of a timely denial, interest shall be paid from 07/15/20, the date of the initiation letter on the amount awarded of $720.60 at a rate of 2% per month, simple, and ending with the date of payment of the award subject to the provisions of 11NYCRR 65- 3.9 (e).

C. Attorney's Fees

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

Respondent shall pay Applicant an attorney's fee equal to 20% of the total amount of first-party benefits awarded, plus interest thereon, subject to a maximum fee of $1,360. 11 NYCRR 65-4.6.

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

11/14/2021
(Dated)

Jennifer Jacques-Miller

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:
f31253f097283592636b4e6a2fc92eac

Electronically Signed

Your name: Jennifer Jacques-Miller
Signed on: 11/14/2021