American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Anarafena Medical PLLC , Marty Antonio Fernando RPT , WL Life Care Acupuncture, PC (Applicant)	AAA Case No.	17-20-1167-5149
	Applicant's File No.	2425243
	Insurer's Claim File No.	0565458114 2CT
- and -	NAIC No.	19232
Allstate Insurance Company (Respondent)		

ARBITRATION AWARD

I, James Hogan, 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 01/25/2022, 01/27/2022
   Declared closed by the arbitrator on 01/25/2022

   Ryan Berry from Israel, Israel & Purdy, LLP (Great Neck) participated in person for the Applicant

   Allison Lindsey from Law Offices Of Karen L. Lawrence participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 2,264.75**, was AMENDED and permitted by the arbitrator at the oral hearing.

   At the hearing, the Applicant amended the amount of the claim by WL Life Care Acupuncture to $557.06 as Respondent paid for acupuncture services from 2/1 through 3/4/2020 at $546.26. The total amount of the claim was amended to $1,718.49.

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

3. Summary of Issues in Dispute

The EIP a 29 year old man, was injured in a collision on 10/20/19. This claim is for services provided to the EIP by 3 different entities: Anarfena Medical, PLLC for DOS 2/24 - 3/12/2020 and billing in the amount of $422,23; Marty Antonio Fernando, RPT, for DOS 2/21 - 3/25/2020 and billing in the amount of $1,478.40, Respondent paid $$739.20, leaving an amount in dispute of 739.20; WL Life Care Acupuncture, PC for DOS 2/1 - 3/31/2020 and billing in the amount of $1,103.32. The Applicants billing totaled $2,264.75. The EIP had an orthopedic IME with Joseph Margulies, MD which resulted in a denial of all future orthopedic benefits including physical therapy effective 2/25/2020. Based upon that IME, Respondent denied the claim of Anarfena Medical PLLC, in total; it paid part of the claim of Marty Antonio Fernando, RPT, at the fee scheduled rate of $61.60 per DOS from 2/1 through 2/24/2020, thereafter, the claims were denied based upon the negative IME. The EIP had an acupuncture IME on 1/31/2020. WL Acupuncture's billing for DOS 2/1 - 2/24/2020 were paid, with the exception of a follow-up visit on 2/10/2020; thereafter, its claims were denied based upon the negative IME.

4. Findings, Conclusions, and Basis Therefor

This decision is based upon my review of the electronic file maintained by the American Arbitration Association, and the arguments of the parties set forth in the hearing.

Applicant's submission:

Applicant is billing for services provided to the EIP as follows:

Anarafena Medical PLLC: -

An office consultation for new patient billed under CPT code 99245 at $299.26; pulse oximetry billed under CPT code 94760 at $30.00 for billing totaling $329.26 for DOS 2/24/2020.

A follow-up orthopedic examination of the EIP, billed under CPT code 99214 at $92.97 3/12/2020.for DOS

The total amount billed by this provider was $422.23.

Fernando PT, PC:

Physical therapy services in the form of a hot pack, therapeutic exercises, electrostimulation and massage billed at a total of $61.60 for DOS 2/1, 2/3, 2/5, 2/6, 2/8, 2/10, 2/13, 2/14, 2/17, 2/19, 2/20, 2/21, 2/24, 2/26, 2/28, 3/3, 3/4, 3/6, 3/10, 3/12, 3/16, 3/18, 3/20 and 3/25/2020.

The AR-1 indicates that this provider billed a total of $1,478.40; Respondent paid $739.20 leaving an amount in dispute of $739.20.

WL Life Care Acupuncture, PC:

A re-evaluation billed under CPT code 99212 at $26.41; an initial acupuncture session with electrical stimulation billed under CPT code 97813 at $22.48 and an additional acupuncture session, with electrical stimulation, billed under CPT code 97814 at $19.54 for billing totaling $68.43 for DOS 2/10 and 3/12/2020.

An initial acupuncture session with electrical stimulation billed under CPT code 97813 at $22.48 and an additional acupuncture session, with electrical stimulation, billed under CPT code 97814 at $19.54 for billing totaling $42.02 for DOS 2/1, 2/3, 2/5, 2/6, 2/8, 2/13, 2/14, 2/17, 2/19, 2/20, 2/21, 2/24, 2/26, 2/28, 3/3, 3/4, 3/6, 3/10, 3/16, 3/18, 3/20, 3/25 and 3/31/2020.

The total amount billed by this provider was $1,103.32. (This amount was amended at the hearing.)

In addition to its billing, Applicant has provided copies of corresponding documentation for the services rendered. These include:

On 2/24/2020, the EIP had an Initial Orthopedic Comprehensive Evaluation at Anarafena Medical, PC with Azriel Benaroya, MD, an orthopedic surgeon.

The EIP presented with complaints of pain in the neck that radiated to the bilateral shoulder; chest wall pain; left shoulder pain; low back pain with sciatica. His pain was rated at 6-7/10.

The Review of Systems was non-contributory.

The neurological examination showed that motor was 5/5 in the bilateral upper and lower extremities with the exception of the bilateral fist and grasp which were rated 4/5.

DTRs with 2+ throughout. The sensory examination was intact. The coordination examination was normal. The report indicates that the patient may perform his ADLs.

The examination of the cervical spine found pain and tenderness upon palpation percussion and with the range of motion. There is an old scar for previous surgery over

the neck at childhood. Pain radiated over the trapezium muscle and both shoulder blades, including rhomboids and levator scapulae. There were no signs of paresthesia. Spurling's sign was positive, bilaterally.

The cervical spine range of motion was quantified as reduced in all planes.

The examination of the thoracolumbar spine noted low back pain and back stiffness. The pain propagates to both buttocks, periformis fossa and bilateral SI joints on palpation percussion with exacerbation of the pain with range of motion in flexion and extension and radiating pain to the pelvis on both hips. Spinal percussion was positive. Fabere Patrick was negative, bilaterally. There was sterno costal pain that started and disturbing the patient after the accident.

The range of motion of the lumbosacral spine was quantified as reduced in all planes.

The examination of the left shoulder found severe pain with muscle weakness and restricted range of motion in flexion and abduction. There was bilateral sciatica.

The left shoulder range of motion was quantified in flexion at 110/150; extension was 40/40; abduction was 100/150; adduction was 30/30; external rotation was 90/90; internal rotation was 40/40, with pain.

The examinations of the elbows, wrists/hands, hips, knees and ankles/feet were normal with normal range of motion and no tenderness, pain or swelling noted.

The EIP had an antalgic gait.

The results of the MRIs are reported. The left shoulder MRI demonstrated diffuse tendinitis involving the supraspinatus and infraspinatus tendons. There was mild to moderate impingement of the supraspinatus outlet. This MRI was performed on 12/2/19.

The MRI of the right hip, also done on 12/2/19, did not find any evidence of internal derangement of the right hip joint.

The MRI the cervical spine was done on 11/25/19. It found a 2 mm central disc herniation impressing upon the ventral cord at C3-C4; at C4-C5, it found the 3 mm broad-based paracentral/central disc herniation impressing on the ventral cord with mild central canal stenosis and narrowing from the left neural foramen, C5-C6, 2 mm

broad-based central disc herniation impressing upon the thecal sac. As to C6-7 there was a 1-2 mm subligamentous central disc herniation impressing on the thecal sac. At C7-T1, a 2 mm central disc herniation impressing upon the thecal sac. Straightening of the cervical lordosis was also noted.

The MRI the lumbar spine, which was done on 11/25/19, found a 5 mm central disc herniation at L4-5 which impressed upon the thecal sac with narrowing of the lateral recesses, bilaterally. Additionally, there was a straightening of the lumbar lordosis.

The MRI of the right ankle done on 12/9/19 demonstrated diffuse tenosynovitis along the posterior tibialis tendon. A small tibiotalar and talonavicular joint effusion was also noted.

The MRI of the left ankle which was done on 12/9/19 demonstrated diffuse tenosynovitis. Small tibiotalar joint effusion was also noted.

The Diagnosis/Impression was: 1) cervical disc herniation; 2) chest wall contusion; 3) low back pain with bilateral sciatica;4) SI joint pain; 5) left shoulder contusion with impingement.

The Plan called for physical therapy as well as acupuncture and chiropractic care. An LSO was also prescribed and the patient was scheduled for follow-up evaluation in 4-6 weeks.

Physical therapy progress notes dated from 1/30/2020 through 3/25/2020.

Acupuncture progress notes dated from 1/28/2020 through 3/20/2020

An Acupuncture Re-Evaluation of the EIP dated 2/10/2020. As per this report, the date of the first treatment was 10/22/19. The Original Diagnosis was pain in the right shoulder, left shoulder, lumbar spine, cervicalgia, pain in the right foot, muscle spasm, headaches and dizziness.

The Updated Diagnosis was pain in the bilateral shoulders, cervicalgia, lumbar pain and pain in the right foot.

The Complaints and Findings indicate present subjective complaints of neck pain, low back pain, bilateral shoulder pain and right foot pain.

The patient stated restricted movement of the neck with paresthesia into the left and right upper extremities; low back pain with paresthesia into the left and right lower extremity.

The neck had bilateral pain which was aggravated by movement.

There was bilateral shoulder pain aggravated by movement.

There was lower back pain aggravated by movement.

There was right foot pain aggravated by movement.

The patient also had anxiety and pain insomnia.

No additional complications were noted.

Treatment Goals were to decrease pain, improve range of motion, strength and flexibility and will continue to be the main objective of the treatment.

The Treatment Plan says that the patient was responding positively to acupuncture treatment. In order to maintain this progress the patient will have to continue to undergo intensive therapy on a minimum of 3 times per week schedule for a period of 4-6 weeks. At the end of that period, the patient's condition will be re-evaluated and the therapeutic program modified accordingly.

The patient's prognosis was guarded for complete recovery.

An Acupuncture Re-Evaluation of the EIP dated 3/12/2020. As per this report, the date of the first treatment was 10/22/19. The Original Diagnosis was pain in the right shoulder, left shoulder, lumbar spine, cervicalgia, pain in the right foot, muscle spasm, headaches and dizziness.

The Updated Diagnosis was pain in the bilateral shoulders, cervicalgia, lumbar pain and pain in the right foot.

The Complaints and Findings indicate present subjective complaints of neck pain, low back pain, bilateral shoulder pain and right foot pain.

The patient stated restricted movement of the neck with paresthesia into the left and right upper extremities; low back pain with paresthesia into the left and right lower extremity.

The neck had bilateral pain which was aggravated by movement.

There was bilateral shoulder pain aggravated by movement.

There was lower back pain aggravated by movement.

There was right foot pain aggravated by movement.

The patient also had anxiety and pain insomnia.

No additional complications were noted.

Treatment Goals were to decrease pain, improve range of motion, strength and flexibility and will continue to be the main objective of the treatment.

The Treatment Plan says that the patient was responding positively to acupuncture treatment. In order to maintain this progress the patient will have to continue to undergo intensive therapy on a minimum of 3 times per week schedule for a period of 4-6 weeks. At the end of that period, the patient's condition will be re-evaluated and the therapeutic program modified accordingly.

The patient's prognosis was guarded for complete recovery.

On 3/12/2020, the EIP had a follow-up orthopedic consultation at Anarafena Medical, PC.

The patient presented with residual headache, low back pain with right sciatic radiculopathy and left shoulder pain.

The physical examination shows that as to the cervical spine, there was pain and tenderness which was exacerbated with range of motion and at night. Muscle spasms were noted over the cervical paravertebral muscles. The range of motion for the cervical spine was quantified as reduced in all planes.

The examination of the lumbosacral spine found low back pain upon palpation percussion with radiation of the pain to the right periformis fossa and right sciatica. The range of motion of the lumbar spine was quantified as reduced in all planes.

The examination of the left shoulder found pain with exacerbation with range of motion. The range of motion was not quantified.

Muscle strength testing indicated that no deficits were noted in the upper and lower extremities. There were no sensory deficits noted in the upper or lower extremities. Leg length was equal.

The patient walked on toes and heels without difficulty and ambulated without a limp. He stood straight, without a list.

The results of the MRIs of the left shoulder, right hip, lumbar spine, cervical spine, right ankle and left hip are recorded.

The Diagnosis/Impression was: 1) whiplash syndrome; 2) low back pain with sciatica; 3) left shoulder pain.

The Treatment Plan called for continued physical therapy and acupuncture. A re-evaluation in 6 weeks was indicated.

Applicant has also provided Supporting Documentation including:

An evaluation dated 10/22/19 at Bay Ridge Orthopedic Associates, PC.

An initial acupuncture evaluation dated 10/22/19.

Physical therapy progress notes dated from 10/22/19 - 3/20/2020.

Acupuncture progress notes from 10/22/19 - 3/20/2020.

Range of motion testing dated 11/8, 12/6, 12/13 and 12/27/19, which included computerized muscle testing.

Follow-up examinations of the EIP at Caring Touch Medical, PC dated 11/22 and 12/18/19.

An Acupuncture Re-Evaluation dated 12/11/19.

An Initial Physiatric Evaluation of the EIP on 12/16/19 at Caring Touch Medical, PC, followed by a copy of EMG/NCV testing of the upper and lower extremities.

Follow-up orthopedic consultations dated 3/12 and 4/16/2020 at Anarafena Medical, PLLC.

Respondent's submission:

Respondent's position is that the Applicant, Anarfena Medical, PLLC, claims were properly denied based upon a negative orthopedic IME.

The physical therapy claims were paid in part pursuant to the fee schedule and thereafter denied based upon an orthopedic IME administered to the EIP on 1/31/2020 by Joseph Margulies, MD.

The acupuncture claims were paid in part at the fee schedule rate and then denied based upon an IME administered to the EIP on 1/31/2020 by Martin P. LoCascio, L.Ac.

IMEs;

Joseph Margulies, MD, administered an orthopedic IME to the EIP on 1/31/2020.

He summarizes the EIP's accident history noting that the claimant injured his neck, back, left shoulder and hips. He was taken to the hospital by ambulance where he was evaluated and discharged the same day. Softly, he was getting physical therapy 3 times per week which he continues to date. He received a neck collar and the back brace.

There is a list of medical records that were reviewed.

The EIP had a past medical history of a back injury due to heavy lifting in December, 2016.

As his employment situation, he was working at a salesperson at the time of the accident. He missed 41 days from work. He is not returned to work yet.

Current Complaints: "The patients feel that in situations between same and worse. He complains of pain in the neck, back, chest, shoulders (right shoulder started a couple of days after the accident) and hips. He also complains of dizziness and difficulty in walking, bending, sitting and sleeping."

The physical examination indicates that the EIP was oriented, cooperative, responsive and in no distress.

Motor strength, sensation to light touch and DTRs were within normal limits throughout the upper and lower limbs.

Gait, coordination and higher cortical functions appear intact.

Ranges of motion were says visually and with the use of a handheld goniometer.

Examination of the cervical spine notes that the EIP stood erect with no loss of cervical lordosis.

The range of motion was quantified as full in all planes. No paravertebral spasm or tenderness to palpation was noted. There were no objective findings on examination of the head and neck.

Foraminal compression and Soto Hall tests were negative. A scar was noted on the right side of the neck from removal of a birthmark (not related).

The evaluation of the shoulders found that the patient had full range of motion which was quantified as normal in all planes. There was no evidence of rotator cuff disease as the Speed's test and Drop Arm tests were negative.

There was no instability to the fulcrum or jerk test noted. Impingement signs in both Hawkins and Neer were negative.

The orthopedic examination of the chest wall was within normal limits. The claimant had good chest expansion and normal sensation to light touch with no specific areas of tenderness.

The examination of the lumbosacral spine finds that the range of motion was quantified as normal in all planes. The patient had normal lordotic posture. He did not show any evidence of tenderness of muscle spasm upon palpation of the paraspinal musculature.

The claimant was able to walk well on toes and heels. SLR was normal.

The evaluation of the bilateral hips found that the range of motion was quantified as normal in all planes for each ship. Flexion, abduction, internal rotation testing did not find any areas of tenderness, heat, swelling, erythema or effusion.

The Impression was that the EIP was involved in an MVA on 10/21/19. There were no residual objective orthopedic findings noted upon today's examination.

The Diagnosis was: cervical sprain, resolved; contusion of both shoulders, resolved; lumbar sprain, resolved; contusion of both hips, resolved.

Dr. Margulies goes on to say that from an orthopedic perspective, there was no need for further treatment including physical therapy, prescription medication, diagnostic testing, special transportation, household help or DME.

He also says that based upon the history as related by the claimant as being accurate, and truthful, and the symptoms and injuries sustained by the claimant outlined above, there was a causal relationship to the motor vehicle accident of 10/21/19.

He also says that the EIP does not have an orthopedic disability.

On 2/18/2020, Respondent issued a global NF-10 denying all future orthopedic, physical therapy, massage therapy, PM & R, pain management or prescription medication based upon the IME by Dr. Margulies. The effective date of the denial was 2/25/2020.

Martin LoCascio, L.Ac., administered and acupuncture IME to the EIP on 1/31/2020.

He summarizes the EIP's accident history noting that he suffered injuries to the neck, left shoulder/arm and back. He was transported by EMS to the hospital where x-rays/CT scans were taken. Those scans were negative for fracture. He was treated and released the same day with medication and a lumbar support.

Thereafter, he initiated rehabilitation therapies which consisted of medical consultations, chiropractic manipulations, physical therapy and acupuncture at the rate of 4 times per week. He was currently receiving acupuncture. He described the nature of treatment that he was receiving.

The IME report indicates that the EIP denied any therapeutic benefits with the acupuncture treatments.

There is a list of records that were reviewed.

The EIP had no past medical history of consequence.

He described his occupation as a salesman and has not worked since the accident.

Current Complaints were pain in the neck, left shoulder/arm pain and low back pain.

The physical examination indicates that the EIP was a well-groomed individual with apparent good hygiene who looks appropriate for his age. He was not in any apparent distress. He was alert, awake, oriented to time, place and person. His speech was fluent. His judgment was fair. His insight was normal. Abstraction, vocabulary, perception and emotional responses were normal.

The EIP's gait was unremarkable.

His pulse was 80 bpm.

The report indicates that Mr. LoCascio gave the EIP instructions and he demonstrated an understanding of same.

Ranges of motion were ascertained visually and with the assistance of a goniometer/inclinometer.

Examination of the cervical spine was performed in a seated position. It was normal in all planes. Palpation of the posterior cervical muscles and upper trapezius musculature did not find any muscle spasms or tenderness. Muscle testing against resistance of the cervical spine was intact and strong in all planes.

The shoulder depression test was negative.

The range of motion for the shoulders was intact, bilaterally and quantified as normal in all planes.

Muscle testing against resistance of the shoulders, elbows, wrists and opposition muscles of the fingers were 5/5, bilaterally. There was no evidence of comparative atrophy. Digital palpation did not find any tenderness or spasms at the bilateral acromioclavicular and glenohumeral joint regions.

Apley's Scratch test was negative, bilaterally.

The range of motion for the lumbar spine was performed in the standing position. The range of motion was quantified as normal in all planes. He'll/toe walk and deep knee bends were performed, without difficulty.

Palpation of the thoracic/lumbosacral paraspinal musculature did not find any spasm or tenderness. The claimant was able to go from sit to stand and stand to sit, independently. He was able to maintain a seated position at 90° of lumbar flexion.

SLR was indicated as negative in sitting on the right and on the left. Quick test was also negative.

The examination of the lower extremities was unremarkable. There is no evidence of muscle atrophy and muscle testing was strong. Faber test was negative, bilaterally.

The Traditional Chinese Medical Discussion portion of the report said "Part of the intake and examination from the perspective of Traditional Chinese Medicine includes observation of the tongue body, coating and shape. The bilateral pulses that the radial arteries are also relevant to arrive at a diagnosis. For the above-captioned claimant, the color of the tongue is red; the color and quality of the tongue coating is white and thick; the shape of the tongue is swollen. Palpation of the cun, guan and chi (pulses which are distal, medial, and proximal to the styloid process of the radius) pulses bilaterally revealed a regular and strong quality. Combining the history, examination and

observation and tongue and pulse findings of this claimant indicates a diagnosis from a Traditional Chinese Medicine perspective of resolved qi and blood stagnation along the Tai Yang, Du and Shoa Yang channels."

The Diagnosis/Impression says "Based on the medical records, on the physical examination, and the history is provided by [the EIP] my impression is resolved cervical/thoracic/lumbar sprain-strain and resolve left shoulder/arm contusion."

As to treatment, "In my opinion, as a specialist in acupuncture, further treatment would not be necessary from an acupuncture point of view."

Mr. LoCascio also says that there was a causal relationship between the accident and the injuries sustained.

As to a disability, he found no accident related disability at this time.

This report was notarized on 2/10/2020.

At the Hearing:

Applicant was asked if it could provide copies of prescriptions for physical therapy. Counsel argued that it had established his prima facie case by submitting its billing and demonstrating that the Respondent failed to pay or deny the claim within 30 days. If the Respondent wanted prescriptions for physical therapy it should have submitted a request for additional verification requesting same. No such request was made, therefore, any defense predicated upon the lack of a prescription was waived.

Applicant uploaded its position, citing case law, as to its establishing its prima facie case.

Respondent relied upon the negative IME.

Findings:

Applicant has established this prima facie case.

This claim is for services provided to the EIP by 3 different entities:

Anarfena Medical, PLLC for DOS 2/24 - 3/12/2020 and billing in the amount of $422,23;

Marty Antonio Fernando, RPT, for DOS 2/21 - 3/25/2020 and billing in the amount of $739.20;

T**he AR-1 indicates that this provider billed a total of $1,478.40; Respondent paid $739.20 leaving an amount in dispute of $739.20.**

WL Life Care Acupuncture, PC for DOS 2/1 - 3/31/2020 and billing in the amount of $1,103.32. **Respondent has provided a check in the amount of $546.26 for DOS 2/1 through 3/4/2020. The amount in controversy was amended to $557.06.**

The EIP had an orthopedic IME with Joseph Margulies, MD which resulted in a denial of all future orthopedic benefits including physical therapy effective 2/25/2020.

Based upon that IME, Respondent denied the claim of Anarfena Medical PLLC, in total.

Respondent paid part of the claim of Marty Antonio Fernando, RPT, at the fee scheduled rate of $61.60 per DOS from 2/1 through 2/24/2020, thereafter, the claims were denied based upon the negative IME.

The EIP had an acupuncture IME on 1/31/2020 with Martin LoCascio, L.Ac.

WL Acupuncture's claims for DOS 2/1 - 2/24/2020 were paid, with the exception of a follow-up visit on 2/10/2020; thereafter, its claims were denied based upon the negative IME.

As to DOS 2/10/2020 billed by WL Acupuncture, PC, Respondent denied that portion of the claim stating that this service was included in another service provided on the same day.

Respondent position is incorrect as this provider was entitled to be reimbursed for the follow-up of his visit, billed under CPT code 99212 at $26.41. **This portion of the claim is awarded in the amount of $26.41.**

Respondent denied all claims based upon negative IMEs in the fields of orthopedics and acupuncture.

A review of the Applicant's submission shows that the Applicant has provided documentation from themselves and other healthcare providers which indicate that the EIP had positive findings after the IME.

The purpose of No-fault is to restore the claimant to his/her pre-accident condition or as close thereto as possible. From an orthopedic perspective, Respondent claim that the EIP was at that point on 1/31/2020 when he had the orthopedic IME. From an acupuncture perspective, the Respondent felt that the EIP was at that point on 1/31/2020 when he had the acupuncture IME.

Looking at the totality of the circumstances, including the documentation submitted by the Applicant for services provided after the IME, I find that the Applicant billing was medically necessary.

I note that Insurance Law section 5102(a)(1) provides that necessary expenses for physical therapy are included in basic economic loss "provided that treatment is rendered pursuant to a referral."

Further, Physical Medicine Ground Rule #2 says "Physical medicine services in excess of 12 treatments were after 45 days from the first treatment, required documentation that includes physician certification of medical necessity for continued treatment, progress notes, and treatment plans. This documentation should be submitted to the insurance carrier as part of the claim."

No better case illustrates the importance of mailing a timely denial or timely demand for a verification than the Court of Appeals decision in *Presbyterian Hosp. in City of N.Y. v Maryland Cas. Co.*(90 NY2d 274[1997] [4-3 decision]). In that case, although it was later established that the plaintiff's assignor was legally drunk at the time of the motor vehicle accident, the High Court sustained a medical provider's entitlement to summary judgment. The insurer's failure to issue a timely denial or a timely demand for verification was deemed a waiver of all defenses and did not even entitle the insurer to responses to a demand for written interrogatories. During the requisite period for issuing a denial or demand for a verification, "the carrier chose to sit on its rights and do nothing in this respect" *{id.*at 280).

The Court of Appeals in *Presbyterian Hosp.*stated that "a core and essential objective" of the insurance regulations is "to provide a tightly timed process of claim, disputation and payment" *{id.*at 281). The Court of Appeals, in pertinent part, stated:

"No-fault reform was enacted to provide prompt uncontested, first-party insurance benefits . . The tradeoff of the no-fault reform still allows carriers to contest ill-founded, illegitimate and fraudulent claims, but within a strict, short-leashed contestable period and process designed to avoid prejudice and red-tape dilatory practices." *(Id.*at 285.)

Although the insurer actually later procured proof that the assignor was legally drunk while operating a motor vehicle- certainly conduct that offends our State's public policy and criminal law - the Court of Appeals refused to permit the assertion of a late defense of intoxication and even to allow discovery on the issue. Since the insurer failed to adhere to the "tightly timed process" *(id.*at 281), the Court of Appeals expressly did not let the defendant insurer "string out belated and extra bites at the apple" *(id.*at 286).

The importance of a timely denial is underscored by the Appellate Division's recent decision forbidding an insurer from relying on a prior blanket denial that simply stated that it would dishonor further claims. In A & S *Med. P.C. v Allstate Ins. Co.*(15 AD3d 170[1st Dept 2005]), an insurer's failure to deny a specific claim in timely fashion, despite a previously issued blanket denial that advised that all future claims would be rejected, warranted the grant of a medical provider's motion for summary judgment.

An insurer's denial must be made "with a high degree of specificity of the ground or grounds on which the disclaimer is predicated," and an insurer will not be permitted to assert a defense not specifically made in the NF-10, even though a denial of claim may have been previously issued in a timely manner *(General Acc. Ins. Group v Cirucci,*46 NY2d 862, 864 [1979] [per curiam]; *accord Paul M. Maintenance, Inc. v Transcontinental Ins. Co.,*300 AD2d 209, 212 [1st Dept 2002]; *see also, Universal*

Acupuncture Pain Servs. v Lumbermens Mut. Cas. Co.,195 Misc 2d 352, 354-355 [Civ Ct, Queens County 2003] [citing cases]). Thus, if an insurer's NF-10 denied a claim only on grounds of intoxication, it cannot later be permitted to assert another defense, such as the invalidity of an assignment, which was not preserved in the denial of claim form *(see, e.g., Bonetti v Integon Natl. Ins. Co.*,269 AD2d 413[2d Dept 2000] [defense of allegedly unnecessary surgeries not preserved]; *Presbyterian Hosp. in City of N.Y. v Aetna Cas. & Sur. Co.*,233 AD2d 433[2d Dept 1996] [defense of invalid assignment not preserved]; *St. Clare's Hosp. v Allcity Ins. Co.*,201 AD2d 718[2d Dept 1994] [insurer's failure to deny claim in 30 days]).

In accord with the *Presbyterian Hosp.*holding preventing an insurer from stringing out the process by prejudicial, dilatory practices and taking extra bites at the apple (90 NY2d at 285-286), the bottom line is that a defendant insurer "must 'stand or fall upon the defense upon which it based its refusal to pay' " *(King v State Farm Mut. Auto. Ins. Co.*,218 AD2d 863, 865 [3d Dept 1995], quoting *Beckley v Otsego County Farmers Coop. Fire Ins. Co.*,3 AD2d 190, 194 [3d Dept 1957], *appeal dismissed*2 NY2d 990 [1957]). The Appellate Division, Second Department, has repeatedly warned insurers against either repudiating liability or defending on one particular ground and then, shifting gears, creating new means or defenses to avoid payment (s*ee, Lee v American Tr. Ins. Co.*,304 AD2d 713, 714 [2003]; *Matter of State Farm Ins. Co. v Domotor*,266 AD2d 219, 220-221 [1999]; *accord Subia v Cosmopolitan Mut. Ins. Co.*,80 Misc 2d 1090, 1092 [Sup Ct, Queens County 1975] [striking defense from answer that was not raised in the denial of claim form]).

Applying the above to the instant case, the lack of a prescription for the physical therapy was not raised by the Respondent and therefore, it was waived.

The claim is awarded as amended.

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
	Anarafena Medical PLLC	**02/24/20 - 02/24/20**	**$329.26**	**$0.00**	**Denied**
	Anarafena Medical PLLC	**03/12/20 - 03/12/20**	**$92.97**	**$0.00**	**Denied**
	Marty Antonio Fernando RPT	**02/01/20 - 03/04/20**	**$308.00**	**$0.00**	**Denied**
	Marty Antonio Fernando RPT	**03/06/20 - 03/25/20**	**$431.20**	**$0.00**	**Denied**
	WL Life Care Acupuncture, PC	**02/01/20 - 03/04/20**	**$740.75**	**$0.00**	**Denied**
	WL Life Care Acupuncture, PC	**03/06/20 - 03/25/20**	**$320.55**	**$0.00**	**Denied**
	WL Life Care Acupuncture, PC	**03/31/20 - 03/31/20**	**$42.02**	**$0.00**	**Denied**
	WL Life Care Acupuncture, PC	**02/01/20 - 03/31/20**	**$0.00**	**$1,718.49**	**Awarded: $1,718.49**

Total	**$2,264.75**		**Awarded: $1,718.49**

B. The insurer shall also compute and pay the applicant interest set forth below. 06/04/2020 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

I find that the date for interest to accrue is the date of the filing of the arbitration, 6/4/2020 as this is the date when the Applicant's filing was processed and notice of the arbitration sent to the Respondent. As per Insurance Regulation 65-3.9, interest is due until such amount is paid, and without demand therefor.

C. Attorney's Fees

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

The insurer shall pay the Applicant's attorney as per 11 NYCRR 65-4.6 (e). However, if the award and interest is equal to, or less than, Respondent's written offer during the conciliation process, then the attorney's fee shall be based upon 11 NYCRR 65-4.6 (b).

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 Suffolk

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

01/26/2022
(Dated)

James Hogan

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:
85fdd0e7b42151a924fa75d746ef7937

Electronically Signed

Your name: James Hogan
Signed on: 01/26/2022