American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

BL Pain Management PLLC (Applicant)	AAA Case No.	17-23-1281-1421
	Applicant's File No.	00103149
- and -	Insurer's Claim File No.	1079949-02
	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 (JW)

1. Hearing(s) held on 11/01/2023
   Declared closed by the arbitrator on 11/01/2023

   Justin Rosenbaum from Drachman Katz, LLP participated virtually for the Applicant

   Janna El Jamal from American Transit Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$351.20**, 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 January 26, 2020, in which the Assignor, a 46-year-old male, was injured. As a result of the accident, he complained of multiple injuries including injuries to his back. Thereafter, Assignor sought private medical attention where he was recommended to begin conservative care treatments and was referred for diagnostic testing.

   On June 9, 2020, Assignor underwent a Physical Medicine and Rehabilitation (PM& R)/Acupuncture independent medical examination (IME) conducted by Dr. Eric Roth who concluded that Assignor's injuries had fully resolved. As a result of the IME, Respondent cut-off no-fault benefits effective 6/26/20.

On June 9, 2022, July 7, 2022, August 4, 2022, and September 19, 2022, Assignor underwent follow-up evaluations at Applicant's office. In dispute in this case are the fees for the evaluation services provided to Assignor. Applicant timely submitted the bills to Respondent for payment in an amount totaling $351.20. Respondent timely denied payment of all bills based upon the IME of Dr. Roth.

At the hearing, Respondent did not raise any fee schedule objections to the amounts billed by Applicant.

The issues to be decided in this case are:

Whether Applicant established entitlement to No-Fault compensation for follow-up office evaluation 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.

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). 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 and are overdue. 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).

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]).

IME Cut-Off

It should be noted that the sufficiency of Respondent's defense based upon the IME of Dr. Roth has previously been addressed in linked awards under AAA case ## 17-21-1221-3084, 17-21-1221-6914, 17-21-1201-5543. In those linked awards, this arbitrator found in favor of Applicant.

Addressing Respondent's defenses in AAA case # 17-21-1221-6914, this arbitrator opined:

"It should be noted that there are three linked cases that were heard before this arbitrator on the same date under AAA case # 17-21-1221-3084, 17-21-1221-6914, 17-21-1201-5543. All cases involved the same Assignor and same Respondent. Counsel for Applicant and Respondent's representative were the same for all cases which all involved the same issue of lack of medical necessity based upon the IME report of Dr. Roth.

11 NYCRR § 65-4.5(o)(1) provides that an arbitrator shall be the judge of the relevance and materiality of the evidence offered, and strict conformity to the legal rules of evidence shall not be necessary. The arbitrator may question or examine any witness or party and independently raise any issue that the arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department regulations.

Therefore, I will consider the submissions from the ECF for all cases when rendering my decisions on each of the cases.

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).

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IME-Cut off

The purpose of an IME is to permit the insurer to verify the person's injuries, to determine the injured party's condition and to determine if the injured party needs any additional treatment or testing for those conditions and injuries. (See, Mangione v Jacobs, 37 Misc. 3d 711 [Sup Ct, Queens County 2012].)

A denial premised on a lack of medical necessity must be supported by competent evidence such as an independent medical examination (IME), a peer review or other proof which sets forth a factual basis and a medical rationale for denying the claim. See, Amaze Med. Supply Inc. v Eagle Ins. Co., 2 Misc. 3d 128[A], 2003 NY Slip Op 51701[U] [N.Y. App Term, 2nd& 11th Jud Dists 2003]; King's Med. Supply Inc. v Country-Wide Ins. Co., 5 Misc. 3d 767, 771 (Civ. Ct Kings Cty 2004).

An IME doctor must establish a factual basis and medical rationale for his asserted lack of medical necessity of further health care services. E.g., Ying Eastern Acupuncture, P.C. v. Global Liberty Insurance, 20 Misc.3d 144(A), 2008 NY Slip Op 51863(U), 2008 WL 4222084 (App. Term 2d & 11th Dists. Sept. 3, 2008). If he does so, it becomes incumbent on the claimant to rebut the IME review, see AJS Chiropractic, P.C. v. Mercury Ins. Co., 22 Misc.3d 133(A), 2009 NY Slip Op 50208(U), 2009 WL 323421 (N.Y. App. Term 2nd& 11th Dist. Feb. 9, 2002), because the ultimate burden of proof on the issue of medical necessity lies with the claimant. See Insurance Law § 5102; Shtarkman v. Allstate Insurance Co., 2002 NY Slip Op 50568(U), 2002 WL 32001277 (N.Y. 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).

The insured or the provider bears the burden of persuasion on the question of medical necessity. Bedford Park Medical Practice P.C. v. American Transit Ins. Co., 8 Misc.3d 1025(A), 806 N.Y.S.2d 443 (Table), 2005 NY Slip Op. 51282(U), 2005 WL 1936346 (Civ. Ct. Kings Co., Jack M. Battaglia, J., Aug. 12, 2005). This burden of proof is properly placed on a claimant health care provider because presumably it is in possession of the injured party's medical records.

On 6/9/20, Dr. Roth conducted a PM&R/Acupuncture IME on Assignor. The IME report was relied upon by the Respondent and said report set forth those documents that were reviewed, detailed the examination that was performed, the findings of the examination, and concluded that Assignor was no longer in need of any further treatment and was

recommended for further physical therapy treatments. Based on this report, the Respondent terminated future benefits effective 6/26/20.

I find that the IME of Dr. Roth has set forth sufficient factual basis and medical rationale for her opinion that at the time of his examination, the disputed services were no longer medically necessary and therefore has established, prima facie, a lack of medical necessity for those services rendered by Applicant.

If the carrier has satisfied its burden of demonstrating the lack of medical necessity, the applicant ultimately carries the burden of persuasion on the issue of medical necessity and must rebut the carrier's evidence or succumb. A.B Med Servs., P.L.L.C. v. State Farm Mutual Auto Ins. Co., 7 Misc. 3d 822, 795 N.Y.S 2d 843 (N.Y. App. Term, 2nd Dept. - 2005) citing Baumann v. Long Is. R.R., 110 A.D.2d 739, 741 487 N.Y.S.2d 833 (N.Y. App. Div., 2nd Dept. - 1985); See also, Canarsie Family Med Practice, PLLC v. American Tr. Ins. Co., 26 Misc. 3d 132(A), 2010 NY Slip Op 50070(U) (N.Y. App. Term, 2nd Dept - 2010); Crotona Hgts. Med., P.C. v. Geico Ins. Co., 25 Misc. 3d 142(A), 2009 NY Slip Op 524664/4/17 (U) (N.Y. App. Term, 2nd Dept - 2009).

Applicant's counsel did not submit a rebuttal and relied upon submissions contained in the ECF. Specifically, he directed this arbitrator to a follow-up evaluation report dated 7/2/20 with positive findings in the lumbar spine along with positive orthopedic tests which indicate that at the time of the IME, Assignor's injuries had not fully resolved. Counsel also identified additional follow-up evaluation reports prior to the IME and after the IME along with treatment notes to support his arguments.

Comparing the relevant evidence presented by both parties against each other, I am persuaded by the Applicant's arguments and evidence. I find the documents relied upon by Applicant are credible and cotemporaneous documents which credibly demonstrated that at the time of the IME, Assignor was in need of further treatment.

Consequently, I am persuaded that Applicant has rebutted the IME of Dr. Roth and sufficiently established that the post IME services were medically necessary by a preponderance of the credible evidence.

In the instant matter, Respondent did not present any additional arguments or evidence to persuade this arbitrator to reconsider my prior award. Accordingly, I uphold my prior award along with the findings of fact and conclusions of law and adopt them in the instant matter. Applicant is entitled to be reimbursed in an amount consistent under the fee schedule and available on the on-fault policy.

As noted earlier, Respondent did not raise any fee schedule objections to the amounts billed by Applicant.

Policy Exhaustion and the availability of APIP Coverage

It should be noted that in a linked award under AAA case # 17-20-1185-8011, dated 2/24/23, this arbitrator addressed the issue of APIP coverage in the amount of

$150,000.00 which is available. However, the NF-11 has not been executed in order to activate the APIP coverage. At the original hearing date on 4/4/23, this issue was raised, and Applicant was provided time to obtain the proper signature to activate the APIP coverage. At the continued hearing, when asked, Applicant still had not obtained the proper signature form Assignor or Assignor's attorney.

In the linked award, this arbitrator opined:

"A defense that the coverage limits of the policy have been exhausted may be asserted by an insurer despite its failure to issue a denial of the claim within the 30-day period, and an arbitrator's award directing payment in excess of the $50,000 limit of a No-Fault insurance policy exceeds the arbitrator's power and constitutes grounds for vacatur of the award. Ameriprise Ins. Co. v. Kensington Radiology Group, P.C., 58 Misc.3d 144(A), 2017 N.Y. Slip Op. 51911(U) (App. Term 1st Dept. Dec. 22, 2017).

It should be noted that in a linked award under AAA case # 17-21-1224-5404, dated 1/19/23, this arbitrator addressed the issue of policy exhaustion and whether the additional PIP (APIP) coverage has been activated. In the linked award, the policy was approaching exhaustion but had not yet been exhausted.

In the linked award, this arbitrator opined:

At the initial hearing on this matter scheduled for 12/6/22, Respondent provided a copy of the payment ledger related to the underlying policy. The ledger is dated 12/5/22, the day before the hearing. It listed the various providers, the dates of service, the amount of the payments made by Respondent and the date of the check/payment.

The last payment listed on the ledger was in the amount of $448.78 and the check was issued on 11/16/22. The total amount paid on the ledger, as of 12./5/22 is $49,697.45.

Respondent also provided a copy of the declaration page which indicated that the policy has $50,000.00 of PIP benefits, and $150,000.00 of Additional PIP (APIP).

Respondent also provided a copy of the letter of Representation, dated 2/18/20, from Assignor's attorney Alexander Bespechny.

On the date of the hearing, Respondent also uploaded a copy of the NF-11 APIP Subrogation Agreement addressed to Assignor in care of his attorney Mr. Bespechny. The NF-11 is dated 11/22/22 and is fully completed, except for the signature of applicant.

Under Section 65-3.5. Claim procedure subsection (h) provides:

(h) When benefits are claimed under an additional personal injury protection endorsement, the insurer may require that the applicant execute a prescribed subrogation agreement (NYS form NF-11) prior to the payment of any benefits. If the

insurer shall impose the above requirement, it shall deliver the prescribed agreement to the applicant as soon as it is known that the claim is payable under an additional personal injury protection endorsement.

At the hearing, Respondent argued that the APIP coverage has not been activated due to the NF-11 not being signed. Applicant counsel asserted that it did not receive the NF-11.

The hearing was continued to 12/20/22 with directives to the parties as follows:

Directive for the parties: The parties are ordered to investigate the policy exhaustion vs. APIP coverage issue and provide documents supporting their position on the issue.

Respondent to upload the Declaration Page and proof of mailing of the request for NF-11 from Assignor/Applicant.

Applicant to provide proof of signed NF-11, if necessary, to demonstrate that APIP coverage has been activated.

The parties requested that the matter be rescheduled to 12/20/22 at 2:30 pm.

The hearing continued on 12/20/22 however, neither party produced a signed NF-11 to activate APIP coverage.

Additionally, Respondent failed to produce proof of mailing as requested. Respondent's representative asserted that since he was not the representative at the initial hearing, he was not informed or award of this arbitrator's directive to provide proof of mailing. I denied Respondent's request for additional time to obtain proof of mailing.

Applicant's counsel argued that due to Respondent's failure to provide proof of mailing for the 11/22/22 NF-11, Respondent waived its right to demand the NF-11 be signed before APIP can be activated. Applicant's counsel uploaded an award by Arbitrator Sandra Adelson under AAA case # 17-19-1126-8056, dated 2/20/21.

In the award, addressing the Respondent's policy exhaustion denial, Arbitrator Adelson provided a detailed and thorough analysis of the regulations, Respondent's obligations under the regulations, and how Respondent failed to follow the regulations timely notice requirements, follow up verification requirements or claim practice principles under the regulations. She concluded that Respondent treated the Applicant like an adversary regarding the APIP coverage by not properly demonstrating that Applicant was informed of the APIP coverage along with the signature requirement and then seeking to deny or delay payments under APIP for failure to sign the NF-11.

Based upon the foregoing, Arbitrator Adelson concluded that Respondent waived its policy exhaustion defense based upon the fact that APIP coverage was available, and Respondent issued a policy exhaustion denial prior to NF-11 being sent to Applicant. She opined that since the basis for the denial was erroneous, the Respondent waived its right to require a signed NF-11 from the patient. She further held that the Respondent

cannot deny the patient's entitlement to receiving additional APIP in the amount of $150,000.00.

Respondent's representative noted that the NF-11 was not issued until 11/22/22 and at the time of the hearing, 30 days had not elapsed which would trigger Respondent's obligation to send a second verification request for the NF-11 as required by the regulations. Respondent uploaded several awards to support its argument that the NF-11 request remains outstanding and therefore, its obligation to provide APIP coverage has not been activated without the signed subrogation form (NF-11).

I note that an arbitrator need not adhere with strict conformity to the evidentiary rules set forth in CPLR 2016 see Auto One Ins. Co., v Hillside Chiropractic P.C., 126 A.D. 3d. 423 (1st Dept. 2015) citing 11 NYCRR 65-4.5 (o) the arbitrator shall be the judge of the relevance and materiality of the evidence offered. The arbitrator may question any witness or party and independently raise any issue that the arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department regulations. Arbitrators sit in equity and have the powers to enforce the spirit and intent of the No-fault law and regulations. Bd. of Education, et. al. v. Bellmore-Merrick, 39 N.Y. 2d. 167 (1976).

Based upon the evidence before this arbitrator at the time of the hearing, neither party has taken significant steps to genuinely assist in moving the process forward. Specifically, neither party followed my directives. Respondent did not provide proof of mailing of the initial request for the NF-11. Similarly, Applicant's counsel, who is seeking to get paid for its client's services, did not investigate or attempt to get the NF-11 signed knowing that it exists and is attached to an additional $150,000.00 of coverage related to this case.

However, it should be noted that Arbitrator Adelson's case is distinguished from the instant matter. Here Respondent did not issue an erroneous policy exhaustion denial. At the time of the hearing, the policy was not believed to be exhausted. A review of the ledger revealed that the last payment listed was 11/16/22. The NF-11 is dated shortly thereafter (11/22/22). At the first hearing (12/6/22), Respondent made the parties aware that there was APIP and was seeking to activate it.

Moreover, at the time of the second hearing (12/20/22), more than 30 days had not passed since Respondent's initial request. Furthermore, at the time of the hearing, Respondent's' time to follow-up had not been triggered. I am aware that at the time of the hearing, Respondent did not have proof of mailing for the initial request. However, I find that lack of proof, by itself, is insufficient to find that, at this time, Respondent waived its right to make the second request for the NF-11.

Consequently, although Applicant is entitled to be awarded a total of $473.88 under the APIP policy, it has not been activated with a fully executed NF-11 which remains outstanding.

Applicant's claim is dismissed without prejudice.

When and if the APIP Policy is properly activated, or there is a subsequent determination that Respondent waived its to demand a signed NF-11, Applicant is entitled to be awarded $473.88."

In the instant case, Applicant provided a copy of the executed NF-11, dated 8/18/23 along with proof that the document was mailed to Respondent. Accordingly, I find that there is sufficient proof that the APIP Policy on has been activated. Respondent did not provide any evidence that the APIP policy limits have been exhausted.

Applicant's claim is awarded as billed in the amount of $351.20.

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**
	BL Pain Management PLLC	**06/09/22 - 06/09/22**	**$87.80**	**Awarded: $87.80**
	BL Pain Management	**07/07/22 -**	**$87.80**	**Awarded:**

	PLLC	**07/07/22**		**$87.80**
	BL Pain Management PLLC	**08/04/22 - 08/04/22**	**$87.80**	**Awarded: $87.80**
	BL Pain Management PLLC	**09/19/22 - 09/19/22**	**$87.80**	**Awarded: $87.80**
Total			**$351.20**	**Awarded: $351.20**

B. The insurer shall also compute and pay the applicant interest set forth below. 01/04/2023 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 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 $1,360.00.

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 NY
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.

11/30/2023
(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:
48acc79235bb19ca6d520c24823c8dc6

Electronically Signed

Your name: Gregory Watford
Signed on: 11/30/2023