

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Physician Medical Rehabilitation
Associates Of PB
(Applicant)

- and -

American Transit Insurance Company
(Respondent)

AAA Case No.	17-23-1292-5720
Applicant's File No.	GTLXPB030623.002
Insurer's Claim File No.	1099124-03
NAIC No.	16616

ARBITRATION AWARD

I, Jacques M. Leandre, 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 (NR)

1. Hearing(s) held on 11/13/2023
Declared closed by the arbitrator on 11/13/2023

George T. Lewis from Law Offices of George T. Lewis, Jr., PC participated virtually for the Applicant

Jeffrey Siegel from American Transit Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$3,211.91**, 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 Assignor (NR), an 81 year-old male, was involved in a motor vehicle accident on 6/20/21. At issue in this case is \$3,211.91 for a variety of medical services. Respondent timely denied the claim based upon the independent medical examination (IME) of Dr. David Manevitz performed on 1/19/22 with an effective termination of benefits date of 2/14/22. The issue to be determined is:
 - a) Whether the Respondent can sustain its Medical Necessity defense.

4. Findings, Conclusions, and Basis Therefor

This hearing was decided based upon the submissions of the parties as contained in the electronic file maintained by the American Arbitration Association, and the oral arguments of the parties' representatives. No witnesses testified at this hearing. Any documents contained in the electronic file are hereby incorporated into this hearing. I have reviewed all relevant exhibits for both parties and make my decision in reliance thereon.

This matter contains 25 Bills. The numbering of the bills in this Award will be pursuant to the AR-1 as submitted by the Applicant.

BILL #	DATE OF SERVICE	AMOUNT IN DISPUTE	DEFENSE
1	08/12/2021 - 08/12/2021	\$31.44	Fee Schedule
2	09/10/2021 - 09/10/2021	\$26.20	Fee Schedule
3	10/01/2021 - 10/01/2021	\$92.13	Pending Verification
4	10/04/2021 - 10/04/2021	\$184.26	Non-Receipt
5	10/06/2021 - 10/06/2021	\$127.41	Non-Receipt
6	10/29/2021 - 10/29/2021	\$202.25	Fee Schedule
7	02/14/2022 - 02/14/2022	\$184.26	Lack of Med. Necessity
8	02/18/2022 - 02/18/2022	\$92.13	Non-Receipt

9	02/22/2022 - 02/22/2022	\$133.74	Lack of Med. Necessity
10	02/28/2022 - 02/28/2022	\$133.73	Lack of Med. Necessity 45 Day Rule
11	10/03/2022 - 10/03/2022	\$178.06	Lack of Med. Necessity
12	10/04/2022 - 10/04/2022	\$87.80	Lack of Med. Necessity
13	10/06/2022 - 10/06/2022	\$133.73	Lack of Med. Necessity
14	10/11/2022 - 10/11/2022	\$133.74	Lack of Med. Necessity
15	10/13/2022 - 10/13/2022	\$133.73	Lack of Med. Necessity
16	10/27/2022 - 10/27/2022	\$133.73	Lack of Med. Necessity
17	10/28/2022 - 10/28/2022	\$133.73	Lack of Med. Necessity
18	11/01/2022 - 11/01/2022	\$133.73	Lack of Med. Necessity
19	11/03/2022 - 11/03/2022	\$133.73	Lack of Med. Necessity

20	11/07/2022 - 11/07/2022	\$133.73	Lack of Med. Necessity
21	11/09/2022 - 11/09/2022	\$133.73	Non-Receipt
22	11/14/2022 - 11/14/2022	\$133.73	Non-Receipt
23	11/15/2022 - 11/15/2022	\$133.73	Non-Receipt
24	11/21/2022 - 11/21/2022	\$133.73	Non-Receipt
25	11/23/2022 - 11/23/2022	\$133.73	Non-Receipt

FEE SCHEDULE DEFENSE

Bill #1, #2, #6

An insurance carrier's timely asserted defense that the bills submitted were not properly No-Fault rated or that the fees charged were in excess of the Workers' Compensation fee schedule is sufficient, if proven, to justify a reduction in payment or denial of a claim. See New York Hosp. Med. Ctr. of Queens v. Country-Wide Ins. Co., 295 A.D.2d 583, 586 (2002); East Coast Acupuncture, P.C. v. New York Cent. Mut. Ins., 2008 NY Slip Op 50344(U) (App. Term 2d Dep't., Feb. 21, 2008); A.B. Med. Servs., PLLC v. American Tr. Ins. Co., 15 Misc.3d 132(A), 2007 NY Slip Op 50680(U) (App. Term, 2nd & 11th Jud Dists. 2007); Rigid Medical of Flatbush, P.C. v. New York Cent. Mut. Fire Ins. Co., 11 Misc.3d 139(A), 816 N.Y.S.2d 700, 2006 NY Op 50582 (U) (App. Term 2nd & 11th Jud Dists. 2006); Ultra Diagnostics Imaging v. Liberty Mut. Ins. Co., 9 Misc.3d 97, 98, 804 N.Y.S.2d 532, 2005 N.Y. Slip Op. 25402 (App Term, 2d Dep't.); Capio Med., P.C. v Progressive Cas. Ins. Co., 7 Misc 3d 129[A], 2005 NY Slip Op 50526 (U) (2005); Triboro Chiropractic & Acupuncture, PLLC v New York Cent. Mut. Fire Ins. Co., 6 Misc.3d 132 (A), 2005 NY Slip Op 50110 (U) (App Term, 2nd & 11th Jud Dists 2005).

Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. See, Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 2006 NY Slip 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006). See also, Power Acupuncture PC v. State Farm Mutual Automobile Ins. Co., 11 Misc.3d 1065A, 816 N.Y.S.2d 700, 2006 NY Slip Op 50393U, 2006 N.Y. Misc. LEXIS 514 (Civil Ct, Kings Co. 2006). If Respondent fails to demonstrate by competent evidentiary proof that a plaintiff's claims were in excess of the appropriate fee schedules, defendant's defense of noncompliance with the appropriate fee schedules cannot be sustained. See, Continental Medical PC v. Travelers Indemnity Co., 11 Misc.3d 145A, 819 N.Y.S.2d 847, 2006 NY Slip Op 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Term, 1st Dep't., per curiam, 2006).

Regarding Bill #1, #2, and #6, Respondent fails to support documentation justifying its reduction. Respondent cannot unilaterally alter a claim without the benefit of a medical expert or fee coder. See Compas Medical P.C. v. American Transit Ins. Co., 56 Misc. 3d 133(A) (App Term 2nd Dept., 2017).

As such, I find that Applicant is entitled to payment for Bill #1, #2, and #6.

NON-RECEIPT OF CLAIM

Bill #3, #4, #5, #8

It is Applicant's *prima facie* obligation to establish its entitlement to payment for each service for which reimbursement is sought. It is well settled that a health care provider establishes its *prima facie* entitlement to payment as a matter of law by proof that it submitted a proper claim, setting forth the fact and the amount charged for the services rendered and that payment of no-fault benefits was overdue (see *Insurance Law* § 5106 a; *Mary Immaculate Hosp. v. Allstate Ins. Co.*, 5 AD 3d 742, 774 N.Y.S. 2d 564 [2004]; *Amaze Med. Supply v. Eagle Ins. Co.*, 2 Misc. 3d 128A, 784 N.Y.S. 2d 918, 2003 NY Slip Op 51701U [App Term, 2d & 11th Jud Dists]). Herein, Applicant established its *prima facie* entitlement to first party no-fault benefits by proof that it timely submitted a claim setting forth the fact and amount of the loss sustained and that payment of no-fault benefits was overdue. Applicant submitted mail logs with USPS barrel stamps indicating that Bill #3, #4, #5, and #8 were timely submitted.

Applicant notes that a denial of claim was never received for this portion of the case. "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).

As Respondent has failed to demonstrate that a timely denial was issued for the abovementioned bills.

Bill #21, #22, #23, #24, #25

Respondent claims that it never received the bill at issue in this case. It is well settled that an applicant establishes its prima facie showing of entitlement to no-fault benefits by submitting evidentiary proof that the prescribed statutory billing forms had been mailed, received by the respondent and that payment of no-fault benefits were overdue. Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D. 3d 742, 774 N.Y.S.2d 564 (2d Dept. 2004).

After reviewing the evidence submitted and in consideration of the oral argument, I find that Applicant has failed to create a rebuttable presumption that it properly mailed the claim to Respondent. Therefore, as Applicant has failed to submit evidence that the bills were properly and timely mailed to Respondent, Applicant has failed to satisfy its prima facie burden, and this portion of Applicant's claim is denied.

45 DAY RULE

Bill #10

"In the case of a claim for health service expenses, The [EIP] or that persons assignee... shall submit written proof of claim to the company ... as soon as reasonably practicable but in no event later then 45 days after the date of services are rendered. ... The foregoing time limitations for the submission of proof of claim shall apply unless the [EIP] ... submits written proof providing clear and reasonable justification for the failure to comply with such time limitation" 11 NYCRR 65-1.1

An insurer in a no-fault matter will be precluded as a matter of law from asserting a defense based upon the ground that plaintiff untimely submitted its claim if such defense is not raised in a timely denial of claim form. See generally, New York and Presbyterian Hospital v. Empire Ins. Co., 286 A.D.2d 322 (2nd Dept. 2001); St. Clare's Hospital v. Allcity Ins. Co., 201 A.D.2d 718 (2nd Dept. 1994). If respondent has preserved such defense in a timely denial of claim form, respondent will still be precluded from proffering such defense as a matter of law unless respondent advised the applicant that "late notice will be excused where the applicant can provide reasonable justification of the failure to give timely notice." See generally, 11 N.Y.C.R.R. 65-3.3(e); See also, Radiology Today, P.C. v. Citiwide Auto Leasing, Inc., 2007 N.Y. Slip Op. 27111 (App. Term 2nd and 11th Jud. Dists. 2007); SZ Medical, P.C. v. Country-Wide Ins. Co., 12 Misc.3d 52 (App. Term 2nd and 11th Jud. Dists. 2006).

Respondent's counsel argues that the plaintiff is unable to demonstrate that the claim was submitted within 45 Days. Respondent's denial asserted the following in part:

"THIS PROCEDURE CODE IS BEING DENIED AS IT WAS SUBMITTED TO THIS CARRIER BEYOND 45 DAYS FROM THE DATE OF SERVICE. LATE NOTICE WILL BE EXCUSED WHERE THE APPLICANT CAN PROVIDE REASONABLE JUSTIFICATION OF THE FAILURE TO GIVE TIMELY NOTICE. FORWARD ALL DOCUMENTATION THAT MAYBE HELPFUL IN REEVALUATION OF YOUR CLAIM."

Applicant failed to provide any credible evidence that supports the timely submission of the claim to Respondent.

Accordingly, I find for Respondent and deny this portion of the claim.

MEDICAL NECESSITY

Bill #7, #9, #11-#20

In order to support a lack of medical necessity defense, respondent must "set forth a factual basis and medical rationale for the peer reviewer's determination that there was a lack of medical necessity for the services rendered." See, Provvedere, Inc. v. Republic Western Ins. Co., 2014 NY Slip Op 50219(U) (App. Term 2nd , 11th and 13th Jud.

Dists. 2014). Respondent bears the burden of production in support of its lack of medical necessity defense, which if established shifts the burden of persuasion to applicant. See generally, Bronx Expert Radiology, P.C. v. Travelers Ins. Co., 2006 NY Slip Op 52116 (App. Term 1st Dept. 2006).

The trial 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 generally, Nir v. Allstate Ins. Co., 7 Misc.3d 544, 547, 796 N.Y.S.2d 857, 860 (Civ. Ct. Kings Co. 2005); See also, All Boro Psychological Servs. P.C. v. GEICO, 2012 NY Slip Op 50137(U) (N.Y. City Civ. Ct. 2012).

In support of its contention that the services were not medically necessary, Respondent relies upon the IME report of Dr. David Manevitz, dated 1/19/22. After conducting a comprehensive physical examination, Dr. Manevitz found that there were no objective findings to warrant further medical treatment, medical devices, or medical diagnoses service. Dr. Manevitz found that the Assignor had no paravertebral muscle spasm and a negative Spurling test. Additionally, the examination revealed that the Assignor had restricted range of motion in the right lateral flexion and left lateral flexion. Even in light of these findings, Dr. Manevitz asserts in pertinent part:

"Based on the lack of objective findings on my examination to support the claimant's subjective complaints of pain, there is no medical necessity for further treatment from a physical medicine and rehabilitation and acupuncture standpoint. There is no need for physical therapy. There is no need for acupuncture. There is no need for household help, testing, durable medical supplies or special transportation."

In opposition to Respondent's contentions, the Applicant relies on the medical records and evaluations which were conducted contemporaneously with Dr. Manevitz' IME. A bulk of the medical records and evaluations provide a contrary narrative to Dr. Manevitz's IME. On examination by Dr. John S. Vlattas 2/2/22, the Assignor was still suffering of neck pain to the left shoulder and left arm. Dr. Vlattas found that the Assignor had limited range of motion in the cervical and thoracic spines. Additionally, the Assignor tested positive for the Spurling maneuver and Neer and Hawkins signs.

In this matter, I am faced with conflicting opinions concerning the medical necessity for the disputed treatment herein. There are no legal issues to resolve. As such, this dispute involves solely an issue of fact, that is, whether or not further treatment was medically necessary following Respondent's IME. Resolution of that fact is determined by which opinion is accepted by the trier of fact.

After reviewing the totality of the evidence and hearing the arguments presented by the parties, I find that Applicant was more persuasive and further medical services were warranted following Dr. Manevitz's IME.

Accordingly, Applicant is awarded \$3,211.91.

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
	Physician Medical Rehabilitation Associates Of PB	08/12/21 - 08/12/21	\$31.44	Awarded: \$31.44
	Physician Medical Rehabilitation Associates Of PB	09/10/21 - 09/10/21	\$26.20	Awarded: \$26.20
	Physician Medical Rehabilitation Associates Of PB	10/01/21 - 10/01/21	\$92.13	Awarded: \$92.13
	Physician Medical Rehabilitation Associates Of PB	10/04/21 - 10/04/21	\$184.26	Awarded: \$184.26
	Physician Medical Rehabilitation Associates Of PB	10/06/21 - 10/06/21	\$127.41	Awarded: \$127.41
	Physician Medical Rehabilitation Associates Of PB	10/29/21 - 10/29/21	\$202.25	Awarded: \$202.25
	Physician Medical	02/14/22 -	\$184.26	Awarded:

	Rehabilitation Associates Of PB	02/14/22		\$184.26
	Physician Medical Rehabilitation Associates Of PB	02/18/22 - 02/18/22	\$92.13	Awarded: \$92.13
	Physician Medical Rehabilitation Associates Of PB	02/22/22 - 02/22/22	\$133.74	Awarded: \$133.74
	Physician Medical Rehabilitation Associates Of PB	02/28/22 - 02/28/22	\$133.73	Denied
	Physician Medical Rehabilitation Associates Of PB	10/03/22 - 10/03/22	\$178.06	Awarded: \$178.06
	Physician Medical Rehabilitation Associates Of PB	10/04/22 - 10/04/22	\$87.80	Awarded: \$87.80
	Physician Medical Rehabilitation Associates Of PB	10/06/22 - 10/06/22	\$133.73	Awarded: \$133.73
	Physician Medical Rehabilitation Associates Of PB	10/11/22 - 10/11/22	\$133.74	Awarded: \$133.74
	Physician Medical			

	Rehabilitation Associates Of PB	10/13/22 - 10/13/22	\$133.73	Awarded: \$133.73
	Physician Medical Rehabilitation Associates Of PB	10/27/22 - 10/27/22	\$133.73	Awarded: \$133.73
	Physician Medical Rehabilitation Associates Of PB	10/28/22 - 10/28/22	\$133.73	Awarded: \$133.73
	Physician Medical Rehabilitation Associates Of PB	11/01/22 - 11/01/22	\$133.73	Awarded: \$133.73
	Physician Medical Rehabilitation Associates Of PB	11/03/22 - 11/03/22	\$133.73	Awarded: \$133.73
	Physician Medical Rehabilitation Associates Of PB	11/07/22 - 11/07/22	\$133.73	Awarded: \$133.73
	Physician Medical Rehabilitation Associates Of PB	11/09/22 - 11/09/22	\$133.73	Denied
	Physician Medical Rehabilitation Associates Of PB	11/14/22 - 11/14/22	\$133.73	Denied
	Physician Medical			

	Rehabilitation Associates Of PB	11/15/22 - 11/15/22	\$133.73	Denied
	Physician Medical Rehabilitation Associates Of PB	11/21/22 - 11/21/22	\$133.73	Denied
	Physician Medical Rehabilitation Associates Of PB	11/23/22 - 11/23/22	\$133.73	Denied
Total			\$3,211.91	Awarded: \$2,409.53

- B. The insurer shall also compute and pay the applicant interest set forth below. 03/27/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant is awarded interest pursuant to the no-fault regulations. See generally, 11 NYCRR §65-3.9. Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30-day month." 11 NYCRR §65-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. However, the regulations toll the accrual of interest when an applicant "does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations." See, 11 NYCRR 65-3.9(c). The Superintendent and the New York Court of Appeals has interpreted this provision to apply regardless of whether the particular denial at issue was timely. LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 217 (2009).

C. Attorney's Fees

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

The insurer shall also pay the applicant for attorney's fees as set forth below Applicant is awarded statutory attorney fees pursuant to the no-fault regulations. After calculating the sum total of the first-party benefits awarded in this arbitration plus interest thereon,

Respondent shall pay Applicant an attorney's fee equal to 20 percent of that sum total, as provided for in 11 NYCRR 65-4.6(d) (as existing on the filing date of this arbitration), 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 Queens

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

12/12/2023
(Dated)

Jacques M. Leandre

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:
26cb6bb1f5789ad5960ad331a6f41eeb

Electronically Signed

Your name: Jacques M. Leandre
Signed on: 12/12/2023