

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Michael R. Jurkowich Medical  
(Applicant)

- and -

Enterprise Rent A Car  
(Respondent)

AAA Case No. 17-24-1332-7853

Applicant's File No. N/A

Insurer's Claim File No. 18435362

NAIC No. Self-Insured

**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 (MHY)

1. Hearing(s) held on 06/25/2024  
Declared closed by the arbitrator on 06/25/2024

Alex Roytblat from Roytblat Law Group, PLLC participated virtually for the Applicant

Iris Ganjian from McCormack, Mattei & Holler participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,275.00**, 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 May 19, 2022, in which the Assignor, then a 36-year-old male, was injured. As a result of the impact, he complained of multiple injuries, including injury to his lower back. Thereafter, he sought private medical attention where he was recommended to begin conservative care treatments, including pain management treatments.

On December 29, 2022, Assignor underwent a pain medicine/PM&R independent medical examination (IME) conducted by Dr. Gary Florio who determined that Assignor's injuries had fully resolved. As a result of the IME, Respondent cut of no-fault benefits effective January 13, 2023.

On January 19, 2023, Assignor underwent a follow-up evaluation at Applicant's office. On January 27, Assignor received pain management treatment in the form of a lumbar

epidural steroid injection with an Epidurogram. In dispute in this case are fees for the aforementioned services provided to Assignor. Applicant timely submitted bills to Respondent for payment in an amount totaling \$1,275.00 (\$275.00 & \$1,000.00). Respondent denied payment of the office evaluation based upon the IME of Dr. Florio. Respondent denied payment of the LESI and related services based upon the peer review of Dr. Mitchell Ehrlich, dated 2/27/23. Respondent also denied payment on the grounds that Applicant billed in excess of the amounts allowed under the fee schedule.

The issues to be decided in this case are:

Whether Applicant established entitlement to No-Fault compensation for an office evaluation, pain management injections and related services provided to Assignor.

Whether Respondent made out a prima facie case of lack of medical necessity and, if so, whether Applicant rebutted it.

Whether Respondent established that Applicant billed in excess of the Fee schedule.

#### 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). This matter was decided based upon the submissions of the parties as contained in the ECF, as well as upon the oral arguments of the parties at the time of the hearing. All documents contained in the ADR folder that were submitted at least 30 days prior to the hearing date are hereby incorporated into this hearing and were considered in reaching my findings. These submissions constitute the record in this case. Evidence relating to the issues of fraud, staged accidents, fee disputes, proof of paid claims, and policy exhaustion need not be submitted at least 30 days prior to the hearing date. 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).

## **IME Cut-Off**

### **DOS 1/19/23 (\$275.00)**

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, 2<sup>nd</sup> & 11<sup>th</sup> 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, 2<sup>nd</sup> and 11<sup>th</sup> Jud Dists 2003]).

An IME is a snapshot of the injured party's medical condition as of the date of the IME. In no-fault cases, 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].)

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 2<sup>nd</sup> & 11<sup>th</sup> Dist. Feb. 9, 2002), because the ultimate burden of proof on the issue of medical necessity lies with the claimant. See Insurance Law § 5102.

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 the claimant health care provider because presumably it is in possession of the injured party's medical records.

The IME report of Dr. Florio 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 found to be within

normal limits and without need for further treatment. Based on this report, the Respondent terminated future no-fault treatment benefits as of 1/13/23.

A review of the IME report revealed reduced range of motion in the cervical, thoracic and lumbar spines.

I am not persuaded by Dr. Florio's report, question its credibility and find that it is insufficient to establish lack of medical necessity of post IME services. Applicant's counsel argued that there were documented reduced ranges of motion of on all planes of the cervical, thoracic and lumbar spines. Dr. Florio noted that Assignor complained of tenderness in the cervical and lumbar spines, however, there was no objective evidence of pathology to correlate these complaints. According to the IME, Assignor had no prior or pre-existing conditions that had an impact on his current injury.

Although there was documented decreased range of motion (by goniometer) to these areas of Assignor's spines on all planes, Dr. Florio's diagnosis was resolved sprain and strain. I find that this objective finding from an independent source (goniometer) persuasively refutes Dr. Florio's conclusion that Assignor's injuries to his back had fully resolved.

Under these circumstances, I find that the IME report does not sufficiently set forth a credible factual basis and medical rationale for the conclusion that further post IME treatment services are medically unnecessary. See, Ying Eastern Acupuncture, PC v. Global Liberty Insurance, *supra*.

Based upon the foregoing I find that Respondent has not sufficiently established proof to sustain its burden that the post IME treatment services in this case were not medically necessary. Consequently, the burden does not shift to Applicant to rebut Respondent's proof.

Therefore, I find that Applicant's claim is granted.

I take judicial notice of the Worker's Compensation fee schedule. See LVOV Acupuncture PC v. Geico Insurance Company, 32 Misc. 3d 144 (A) (N.Y. App. Term 2<sup>nd</sup>, 11<sup>th</sup> and 13<sup>th</sup> Jud. Dists. 2011). Natural Acupuncture Health PC v. Praetorian Insurance Company, 30 Misc. 3d 132 (A), 2011 N Y slip op 50040 (U), (N.Y. App. Term 1<sup>st</sup> Dept. 2011).

Applicant billed \$275.00 under CPT code 99214. Under the fee schedule, Applicant is limited to \$127.41 (8.46 RVU x 15.06 cf).

#### **Peer Review -DOS 1/27/23 (\$1,000.00)**

The purpose of a peer review is to determine whether the service/test provided was medically necessary. The peer reviewer discusses the standard of care in the medical community and offers his/her opinion as to why the service/test at issue falls outside of

that standard of care. The peer reviewer buttresses his/her opinion with authoritative texts, treatises, and articles, generally from peer-reviewed publications.

The 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, Jacob Nir, M.D. v. Allstate Insurance Co., 7 Misc. 3d 544 (N.Y. City Civ. Ct. 2005).

A determination of medical necessity must be based on evidence in existence prior to the rendering of the service. Foster Diagnostic Imaging, PC v General Assur Co., 10 Misc. 3d 428 (Civ. Ct. Kings Cty 2005).

Dr. Ehrlich drafted a peer review regarding the medical necessity for the LESI services in dispute. He reviewed Assignor's medical records including initial evaluation reports, follow-up evaluation reports, progress notes and diagnostic test results. He then summarized the accident and outlined the treatment of Assignor.

Dr. Ehrlich noted that the standard of care for LESI would be the presence of radiculopathy with correlative findings on MRI of the lumbar spine particularly that of lateralizing disc herniation. He noted that there were no segmental neurological deficits in the lower extremities as there were no focal neurologic findings. There was no documentation of lateralizing disc herniation imaging studies. He further noted that Assignor had undergone a two-level percutaneous lumbar discectomy which is accompanied by post-procedure discomfort that is not amenable to further epidural injections.

He cited to literature to support his arguments.

I find that the IME of Dr. Ehrlich has set forth sufficient factual basis and medical rationale for her opinion that at the LESI in dispute was medically necessary.

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, 2<sup>nd</sup> 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., 2<sup>nd</sup> 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, 2<sup>nd</sup> 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, 2<sup>nd</sup> Dept - 2009).

Applicant's counsel did not submit a rebuttal and relied upon submissions contained in the ECF.

Comparing the relevant evidence presented by both parties against each other, I am persuaded by the Respondent's arguments and evidence. Applicant failed to rebut the evidence.

Accordingly, Applicant's claim is denied.

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
	Michael R. Jurkovich Medical	01/19/23 - 01/19/23	\$275.00	Awarded: \$127.41
	Michael R. Jurkovich Medical	01/27/23 - 01/27/23	\$1,000.00	Denied
Total			\$1,275.00	Awarded: \$127.41

- B. The insurer shall also compute and pay the applicant interest set forth below. 01/16/2024 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, i.e., the date the American Arbitration Association deems the arbitration claim to have been filed 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 within 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.

- 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.

07/25/2024  
(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:**  
bed6204bb2b872b9b8535d40c7014a82

### Electronically Signed

Your name: Gregory Watford  
Signed on: 07/25/2024