

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

ASM Diagnostic Inc.
(Applicant)

- and -

American Transit Insurance Company
(Respondent)

AAA Case No. 17-23-1299-8985

Applicant's File No. DK22-310396

Insurer's Claim File No. 1119219-04

NAIC No. 16616

ARBITRATION AWARD

I, Allison Schimel, 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/Assignor/Claimant

1. Hearing(s) held on 07/31/2024
Declared closed by the arbitrator on 07/31/2024

Henry Guindi from Korsunskiy Legal Group P.C. participated virtually for the Applicant

Helen Cohen from American Transit Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$263.78**, 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 claim in the amount of \$263.78, for VNG testing (nystagmus, oscillating tracking, posturography, caloric vestibular, and rotational testing) performed on date of service 10/31/22, arises out of a motor vehicle accident that occurred on 9/9/22. The Assignor, OAN, was a 51 year old male driver of a motor vehicle involved in the subject accident. The issues in dispute are whether Respondent established its defenses based upon eligibility for workers' compensation coverage, and a peer review by Peter Chiu, M.D. dated 3/28/23.

4. Findings, Conclusions, and Basis Therefor

The case was decided on 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 at the hearing.

Herein, Applicant established a prima facie case of entitlement to reimbursement of its claim, by submitting evidence that the prescribed statutory billing forms were mailed and received by the insurer and payment of No-Fault benefits was overdue. See, *Viviane Etienne Med. Care v. Country-Wide Ins. Co.*, 25 N.Y.3d 498, NY Slip Op 04787 (2015). A No-Fault claim must be paid or denied within thirty (30) calendar days from the date an Applicant supplies proof of claim. See, New York Insurance Law Sec. 5106(a); 11 NYCRR 65. 3.8 (a) (1). Since the parties stipulated that the claim was timely denied, Respondent's defenses to claim are admissible.

Where an insurer asserts that the medical services at issue were 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. *A.B. Medical Services, PLLC v. Geico Insurance Co.*, 2 Misc. 3d 26, NY Slip Op 23949 (N.Y. App. Term 2003). Where the denial is predicated upon a peer review report, the peer reviewer must establish a factual basis and medical rationale to support a finding that the services were not medically necessary, including setting forth generally accepted standards in the medical community. *Jacob Nir, M.D. v. Allstate Insurance Co.*, 7 Misc.3d 544, NY Slip Op 25090 (2005).

Workers' Compensation Issue

Respondent denied Applicant's claim in part based upon eligibility for workers' compensation coverage. However, Applicant submitted an NCEC-101 form which states that the Workers' Compensation Board does not have jurisdiction as the claimed injury does not meet the qualifying criteria for the Independent Livery Driver Benefit Fund. The WC Board decision further states, "This notice (NCEC101) constitutes a decision by the Workers' Compensation Board that the claimant is ineligible for any Workers' Compensation benefits.

Master Arbitrator Victor Hershendorfer has held that it is not arbitrary or capricious for an arbitrator to rely upon a determination of the WC Board. See, *AAA Case Number 99-15-1018-2414*. In the instant case, I find that based upon the WC Board NCEC-101 determination that the accident is not covered by Workers' Compensation, Respondent's defense of eligibility for WC coverage fails.

Medical Necessity Issue

Respondent also denied Applicant's claim based upon a peer review by Peter Chiu, M.D. dated 3/28/23. Dr. Chiu states that the VNG testing (nystagmus, oscillating tracking, posturography, caloric vestibular, and rotational testing) was not medically necessary. He cites the standard of care for such testing, and states that there were no indication that a differential diagnosis was rendered or that this claimant required all these vestibular / nystagmus testing. In addition, there was no causal relationship of the

non-specific headache or dizziness to this incident; therefore, these tests were not medically indicated. The standard of care for non-specific headache or dizziness would include a detailed and thorough history, a comprehensive examination by the treating provider to include cranial nerve and memory tests, possible referral to neurologist, course of conservative care (eg. physical therapy, chiropractor care, acupuncture, etc) for a period of 4 to 8 weeks, rest, cold modality, and prescribing of oral anti-inflammatory medication (eg. Ibuprofen, Motrin, etc.) for a short period of time as needed. The standard of care does not involve routine prescribing of vestibular/nystagmus testing for non-specific headache or dizziness as it plays no role in treatment plan and a comprehensive history and physical exam would suffice. There was no indication this claimant had any causally related autonomic dysfunction(s) and/or small nerve fiber neuropathy which would require from this type of testing; the related injuries were sprain/strain and contusion/strain. Hence, there was no causal relationship and/or medical necessity for this type of testing.

Comparing the relevant evidence presented by both parties against each other including the peer review, Applicant's rebuttal by David Carmili, M.D., and the medical records, I am more persuaded by the peer review that the subject testing was not medically necessary. Although the 9/30/22 evaluation states that the patient presented with a headache, it also specifically does not have dizziness circled and the 10/27/22 does not state complaint of headache or dizziness. There is insufficient evidence of any head/cranial injury, dizziness, vertigo, or vestibular disturbance. Although the rebuttal states that the testing was performed to address persistent complaints of dizziness, the records are insufficient to support this. I am not persuaded by the rebuttal that the testing was medically necessary, and find that the peer review establishes that it was ordered in a routine manner without sufficient findings warranting the testing, and that it was not within the standard of care set forth in the peer review. Accordingly, the claim is denied. This decision is in full disposition of all claims for no-fault benefits presently before this Arbitrator.

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 claim is DENIED in its entirety

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of NY

SS :

County of Suffolk

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

08/03/2024

(Dated)

Allison Schimel

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:
67afa2a23295a73b21078c0281a22c13

Electronically Signed

Your name: Allison Schimel
Signed on: 08/03/2024