American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Igor Rubinshteyn (Applicant)	AAA Case No.	17-24-1341-3988
	Applicant's File No.	2024-551-1
- and -	Insurer's Claim File No.	0609170691 2DD
Allstate Insurance Company (Respondent)	NAIC No.	19232

ARBITRATION AWARD

I, Rhonda Barry, 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 08/19/2024
   Declared closed by the arbitrator on 08/19/2024

   Peter DiConza, Esq. from Peter J. Diconza Jr. P.C. participated virtually for the Applicant

   Robert Goldstein, Esq. from Law Offices of John Trop participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$327.03**, was AMENDED and permitted by the arbitrator at the oral hearing.

   At the hearing, the applicant's counsel amended the amount in dispute from $327.03 to $312.03 based upon the applicable fee schedule for medical services in this case.

   Stipulations WERE made by the parties regarding the issues to be determined.

   The parties stipulated that the denial is timely. If applicable, interest accrues in accordance with 11 NYCRR§65-3.9.

3. Summary of Issues in Dispute

The EIP, "AG" is a 77 year old male injured as a restrained driver in a motor vehicle accident on 12/8/20. There was no loss of consciousness, lacerations or immediate hospital attention. Applicant seeks $312.03 for an office visit and injection on DOS 7/8/21. Respondent terminated all no fault benefits effective 4/29/21 pursuant to the 4/8/21 IME findings of Eric Roth, MD, PMR, L.Ac., and denied all subsequent treatment based upon lack of medical necessity.

4. Findings, Conclusions, and Basis Therefor

I have completely reviewed all timely submitted documents contained in the ADR Center record maintained by the American Arbitration Association and considered all oral arguments. No additional documents were submitted by either party at hearing. No witnesses testified at hearing.

ANALYSIS

Applicant has established its prima facie entitlement to reimbursement for no fault benefits based upon the submission of a properly completed claim form setting forth the amount of the loss sustained, and that payment is overdue. Mary Immaculate Hospital v. Allstate Insurance Company, 5 AD 3d 742, (2nd Dept. 2004). Westchester Medical Center v. Lincoln General Ins Co, 60 AD 3d 1045 (2nd Dept. 2009). Applicant has established its prima facie entitlement to reimbursement for no fault benefits.

The burden now shifts to respondent to establish a lack of medical necessity with competent medical evidence which sets forth a clear factual basis (specifics of the claim) and medical rationale for denying the claim. Citywide Social Work and Psych Services, PLLC v. Allstate, 8 Misc. 3d 1025A (2005); Healing Hands Chiropractic v. Nationwide Assurance Co., 5 Misc. 3d 975 (2004). Respondent must offer sufficient and credible medical evidence that addresses the standards in the applicable medical community for the services and treatment in issue; explains when such services and treatment would be medically appropriate, preferably with understandable objective criteria; and why it was not medically necessary in the instance at issue.

Medically necessary treatments or services are "treatments or services which are appropriate, suitable, proper and conducive to the end sought by the professional health service in consultation with the patient. It means more than merely convenient or useful treatments or services, but treatments or services that are reasonable in light of the patient's injury, subjective and objective evidence of the patient's complaints of pain and the goals of evaluation and treating the patient." Fifth Avenue Pain Control Center v. Allstate Ins co, 196 Misc. 2d 801 (Civ. Ct Queens 2003).

The EIP advised Dr. Roth that he initially injured his left elbow and bilateral knees. He participated in a course of conservative care. Present complaints included pain to the

right elbow and bilateral knees. The EIP advised that he had prior multiple left knee replacement surgery. The EIP uses a rolling walker, has a mild limp and an antalgic gait noted to the left lower extremity. All range of motion was measured by goniometer.

Examination of the cervical, thoracic and lumbar spine revealed no tenderness or spasm. Range of motion was normal and the EIP was neurologically intact. Straight leg raise was negative examination of the bilateral shoulders, elbows, wrists and hands were normal. Examination of the hips was objectively unremarkable. There was no tenderness to the right knee but range of motion was significantly decreased. There was minimal moderate tenderness medially to the left knee with decreased range of motion. Ligaments were unstable.

Dr. Roth's diagnosis was status post bilateral elbow contusion/tendinitis - resolved and status post bilateral knee sprain/contusion resolved. Dr. Roth further indicated that there were pre-existing surgeries and the EIP's complaints of pain to the bilateral knees were unrelated to the accident of 12/8/20. The surgeries were to the left leg only.

It is unclear from Dr. Roth's report and the medical records he reviewed whether or not the accident exacerbated the EIPs condition with respect to the bilateral knees. Exacerbations of pre-existing conditions are covered by the no-fault law. Kingsbrook Jewish Medical Center v. Allstate Insurance Company, 61 AD 3d 13, 871 NYS 2d 680 (2d Dept. 2009).

Applicant's 4/26/21 report continued to note mild tenderness to the left forearm and mild crepitus and decreased range of motion to the left knee. The 7/8/21 report indicates mild effusion, crepitus and medial joint line tenderness to the right knee.

The EIP's subjective complaints cannot be disregarded in view of the significant positive findings upon examination. The contemporaneous medical records establish persistent and consistent complaints of pain and positive objective findings sufficient to demonstrate the medical necessity for ongoing pain management. The purpose of the no fault law is to restore the EIP to his pre-accident status. Applicant's medical records credibly demonstrate a need for continued treatment to achieve that goal.

"Putting weight on the treating physician's prescription serves the reasonable expectations of the insured. An insured expects coverage for treatment recommended by a physician because he trusts that the physician has recommended a reasonable treatment consistent with good medical practice; the insured expectations can best be fulfilled by construing policy liberally so that uncertainties about the reasonableness of treatment will be resolved in favor of coverage." Oceanside Medical Healthcare v. Progressive, 2002 NY Slip op 50188 [U] (2002). Proscan Radiology of Buffalo v. Progressive Casualty Insurance Company, 12 Misc. 3d 1176 (A) (2006)

I find for the applicant.

Interest: Applicant is awarded interest in accordance with 11 NYCRR§65 - 3.9 (a)-(f). Accordingly, interest is calculated at a rate of 2% per month, calculated on a pro rata

basis using the 30 day month. A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. If 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 Department of Financial Services Regulations, interest shall not accumulate on the disputed claim or element of claim until such action is taken. 11 NYCRR §65 - 3.9 (c). The Superintendent and the New York Court of Appeals have interpreted this provision to apply regardless of whether the particular denial at issue was timely. LMK Psychological Services PC v. State Farm Mutual Automobile Insurance Company, 12 NY 3d 217 (2009).

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**
	Igor Rubinshteyn	**07/08/21 - 07/08/21**	**$327.03**	**$312.03**	**Awarded: $312.03**
Total			**$327.03**		**Awarded: $312.03**

B. The insurer shall also compute and pay the applicant interest set forth below. 03/22/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

   Based on the submission of a timely denial, interest shall be paid from 3/22/24, the date of filing, on the amount awarded of $312.03 at a rate of 2% per month, simple, and ending with the date of payment of the award subject to the provisions of 11 NYCRR 65 - 3.9 (e).

C. Attorney's Fees

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

   As this matter was filed **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 65-4.6(d) (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant an attorney's fee, in accordance with newly promulgated 11 NYCRR 65-4.6(d).

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 Nassau

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

08/21/2024
(Dated)

Rhonda Barry

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:
69fd96aa84911f0012eca3b5fdace664

Electronically Signed

Your name: Rhonda Barry
Signed on: 08/21/2024