

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Zwanger-Pesiri Radiology Group LLP
(Applicant)

- and -

Allstate Indemnity Company
(Respondent)

AAA Case No. 17-24-1347-1517

Applicant's File No. CF13028115

Insurer's Claim File No. 0747017747
2M2

NAIC No. 19240

ARBITRATION AWARD

I, Corinne Pascariu, 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

1. Hearing(s) held on 09/06/2024
Declared closed by the arbitrator on 09/06/2024

Tinamarie Franzoni, Esq. from Choudhry & Franzoni, PLLC participated virtually for the Applicant

Sharon Basirtmand, Esq. from Law Offices of John Trop participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$2,058.77**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant amended the amount in dispute to \$1557.17 to comply with the fee schedule.

Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

The Assignor is a male who was 28-years-old when he was injured as the driver of a motor vehicle involved in an accident on February 20, 2024. Following the accident, assignor presented to Cathia Saint Jean, P.A., with complaints of neck, back and left shoulder pain. Based on her findings, Ms. Saint Jean referred assignor for an MRI of his lumbar and thoracic spine which he underwent on March 12, 2024. Respondent denied

reimbursement of the MRIs based on a peer review report by Richard Coven, M.D. dated April 16, 2024, wherein he opined that the MRIs were not medically necessary. In dispute is the Applicant's claim for reimbursement totaling \$1557.17.

Issue

The issue is whether Respondent's denial of reimbursement of the MRIs on the ground of lack of medical necessity was proper.

4. Findings, Conclusions, and Basis Therefor

The case was decided on the submissions of the parties as contained in the ADR Center maintained by the American Arbitration Association and the oral arguments of the parties' representatives. There were no witnesses. I reviewed the documents contained in the file for both parties and make my decision in reliance thereon.

Upon reviewing the evidence submitted by the Applicant, I find the Applicant submitted sufficient credible evidence to establish a prima facie case with the respect to the services that are the subject of this arbitration. See, Viviane Etienne Medical Care, P.C. v. Country-Wide Ins. Co., 25 N.Y.3d 498, 14 N.Y.S.3d 283 (2015); Amaze Medical Supply Inc. v. Eagle Ins. Co., 2 Misc 3d 128[A], 2003 NY Slip Op 51701 (U) (App Term, 2d and 11th Jud Dists 2003).

Once Applicant has made out a prima facie case, the burden shifts to Respondent to timely request additional verification, deny, or pay the claim. Hospital for Joint Diseases v. Travelers Prop. Cas. Ins. Co., 9 NY3d 312 (2007).

Medical Necessity:

Following the accident, assignor presented to Cathia Saint Jean, P.A., with complaints of neck, back and left shoulder pain. Based on her findings, Ms. Saint Jean referred assignor for an MRI of his lumbar and thoracic spine which he underwent on March 12, 2024. Respondent denied reimbursement of the MRIs based on a peer review report by Richard Coven, M.D. dated April 16, 2024, wherein he opined that the MRIs were not medically necessary. In dispute is the Applicant's claim for reimbursement totaling \$1557.17.

To meet its burden, at a minimum, the No-Fault insurer must establish a factual basis and medical rationale for its asserted lack of medical necessity of the health care provider's services. A.M. Medical Services, P.C. v. Deerbrook Ins. Co., 18 Misc.3d

1139(A), 859 N.Y.S.2d 892 (Table), 2008 N.Y. Slip Op. 50368(U), 2008 WL 518022 (Civ. Ct. Kings Co., Sylvia G. Ash, J., Feb. 25, 2008).

The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment, Kingsbrook Jewish Medical Center v. Allstate Ins. Co., 61 A.D.3d 13, 871 N.Y.S.2d 680 (2d Dept. 2009), such as by a qualified expert performing an independent medical examination or conducting a peer review of the injured person's treatment. See Rockaway Boulevard Medical P.C. v. Travelers Property Casualty Corp., 2003 N.Y. Slip Op. 50842(U), 2003 WL 21049583 (App. Term 2d & 11th Dists. Apr. 1, 2003).

The appellate courts have not clearly defined what satisfies the insurer's evidentiary standard except to the extent that "bald assertions" are insufficient. Amherst Medical Supply, LLC v. A Central Ins. Co., 41 Misc.3d 133(A), 981 N.Y.S.2d 633 (Table), 2013 NY Slip Op 51800(U), 2013 WL 5861523 (App. Term 1st Dept. Oct. 30, 2013). However, there are myriad civil court decisions tackling the issue of what constitutes a "factual basis and medical rationale" sufficient to establish a lack of medical necessity.

The civil courts have held that a defendant's peer review or medical evidence must set forth more than just a basic recitation of the expert's opinion. 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, 34 Misc.3d 1219(A), 950 N.Y.S.2d 490 (Table), 2012 NY Slip Op 50137(U), 2012 WL 309328 (Civ. Ct. Kings Co., Reginald A. Boddie, J., Jan. 31, 2012).

"Where the defendant insurer presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden shifts to the plaintiff which must then present its own evidence of medical necessity (see Prince, Richardson on Evidence §§ 3-104, 3-202 [Farrell 11th ed])." West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc.3d 131(A), 824 N.Y.S.2d 759 (Table), 2006 N.Y. Slip Op. 51871(U) at 2, 2006 WL 2829826 (App. Term 2d & 11th Dists. Sept. 29, 2006). Assuming the insurer establishes a lack of medical necessity, it is ultimately the claimant who must prove, by a preponderance of the evidence, that the services or supplies were medically necessary. Dayan v. Allstate Ins. Co., 49 Misc.3d 151(A), 29 N.Y.S.3d 846 (Table), 2015 N.Y. Slip Op. 51751(U), 2015 WL 7900115 (App. Term 2d, 11th & 13th Dists. Nov. 30, 2015); Park Slope Medical and Surgical Supply, Inc. v. Travelers Ins. Co., 37 Misc.3d 19, 22 n., 952 N.Y.S.2d 372, 374 n. (App. Term 2d, 11th & 13th Dists. 2012).

Peer by Richard Coven, M.D.

Respondent's evidence established that the MRIs were timely denied on a peer review by Dr. Richard Coven. Dr. Coven's report was based upon his review of the available medical documents and his reliance upon cited articles stating the generally accepted standard of care in the medical community. The crux of his opinion is that it was unclear how the MRIs would alter treatment as there was no indication that assignor was a candidate for surgery or epidural injections. With regard to MRIs of the spine, Assignor did not have significant progressive neurological deficits or red flag findings that would necessitate MRI testing. In addition, the MRIs should not have been ordered so soon after the accident, without giving Assignor a chance to recover with conservative treatment. Therefore, the MRIs were not medically necessary.

I find that Dr. Coven's peer review meets the Respondent's burden of proof. It contains a detailed and credible review of the record as well as the information maintained in the Assignor's medical records. It is based on his educated opinion of the testing conducted and explains when such testing is medically necessary. It clearly indicates the standard of care and cites to the medical authority upon which it is based. It also references the patient, her history, her complaints of pain and clinical findings and contains a "factual basis and medical rationale" sufficient to establish a lack of medical necessity.

"Where the defendant insurer presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden shifts to the plaintiff which must then present its own evidence of medical necessity (see Prince, Richardson on Evidence §§ 3-104, 3-202 [Farrell 11th ed])." West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc.3d 131(A), 824 N.Y.S.2d 759 (Table), 2006 N.Y. Slip Op. 51871(U) at 2, 2006 WL 2829826 (App. Term 2d & 11th Dists. Sept. 29, 2006).

In short, I find that each doctor's analysis, which relies on assignor's medical records and generally accepted medical standards is persuasive and, accordingly, that Respondent has met its burden of proof. Therefore, the burden of proof shifts to the Applicant to establish that the MRIs were medically necessary.

Arguments

At the hearing counsel for Applicant argued that the MRIs were medically necessary and justified because assignor had a number of positive findings.

Findings

I am unpersuaded by Applicant's argument and medical records. The records did not meet the burden of persuasion rebuttal. Applicant fails to indicate how performing the testing aided in devising, altering, or enhancing the Assignor's clinical prognosis. Additionally, there is no evidence to establish a reasonable period of time was given to allow for Assignor to improve with conservative treatment. Accordingly, I deny the Applicant's claim in its entirety.

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 NJ

SS :

County of Bergen

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

09/10/2024
(Dated)

Corinne Pascariu

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:
f08137dfa1f4233a062c0088dc2218cb

Electronically Signed

Your name: Corinne Pascariu
Signed on: 09/10/2024