American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Brooklyn Medical Practice, PC (Applicant)	AAA Case No.	17-23-1308-8895
	Applicant's File No.	172.354
- and -	Insurer's Claim File No.	0636334476
	NAIC No.	29688
Allstate Fire & Casualty Insurance Company (Respondent)		

ARBITRATION AWARD

I, Carolynn Terrell-Nieves, 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: Claimant

1. Hearing(s) held on 10/09/2024
   Declared closed by the arbitrator on 10/09/2024

   Vincent Ku,Esq., from Tsirelman Law Firm PLLC participated virtually for the Applicant

   Donna Strudwick,Esq. from Law Offices of John Trop participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$542.67**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The initial amount was amended at the hearing to $430.27.

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

3. Summary of Issues in Dispute

   The patient was a 53 year old female who was injured in a motor vehicle accident which took place on 1/20/22. The claimant described herself as the restrained front seated passenger at the time of the accident. She states that she presented herself to a local urgent care facility following the accident. She states that she injured her head, neck,

upper back, right shoulder and right knee in the accident. The patient came under the care of medical providers. Applicant performed physical therapy treatment from 7/27/21 through 4/6/22 and now seeks payment for providing these services. The Applicant amended the initial amount claimed at the hearing to $430.27.

Respondent issued denials which asserted a fee schedule defense, denied on an agreement with the provider and that the balance of the claim was denied based on the orthopedic IME of Dr. Dorothy Scarpinato, MD which was performed on 1/20/22. (benefits denied effective 2/9/22). DOS in the amount of $75.00 no payment was made.

4. Findings, Conclusions, and Basis Therefor

The record consisted of claimant's submission, respondent's submission, as well as documents not enumerated within this decision, but which are contained in the case file maintained by the American Arbitration Association. THE ARBITRATOR SHALL BE THE JUDGE OF THE RELEVANCE AND MATERIALITY OF THE EVIDENCE OFFERED pursuant to 11 NYCRR 65-4.5 (o) (1) (Regulation 68-D). The arbitrator may question any witness or party and independently raise any issue that the arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department Regulations. Based on a review of the documentary evidence, this claim is decided as follows:

A presumption of medical necessity attaches to a timely submitted no fault claim. All County Open MRI & Diagnostic Radiology. P.C. v. Travelers Ins. Co., 11 Misc. 3d 131[A], 815 N.Y.S.2d 493 (App.Term 9th & 10th Jud. Dists. 2006). Applicant has established its prima facie case with 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]).

The burden shifts to the respondent insurer to prove that the services were not medically necessary. 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 [App Term, 2nd & 11th 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 [App Term, 2nd and 11 Jud Dists 2003]). In this claim respondent issued denials which were based 1) on the IME of Dr. Scarpinato, 2) asserted denial on agreement with the provider 3) asserted a fee schedule defense.

DOS 10/1/21 thru 10/28/21

The (2) bills denied on an alleged agreement with the provider, no agreement was uploaded. DOS 10/1/21 thru 10/28/21 in the amount of $200.19 was denied based on the 12 unit rule. Respondent submitted no support to this defense.

DOS 3/30/22 thru 4/6/22

The balance of the Applicants claim in the amount of $155.16 was denied based on the IME of Dr. Scarpinato that indicated positive findings, tenderness noted.

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. 20140. Respondent bears the burden of production in support of it 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 Appellate Courts have not clearly defined what satisfies this standard except to the extent that "bald assertions" are insufficient. Amherst Medical Supply, LLC v. A Central Ins. Co., 2013 NY Slip Op 51800(U) (App. Term 1st Dept. 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, 7 Misc.3d 544 (N.Y. City Civ. Ct. 2005); See also All Boro Psychological Servs. P.C. v. GEICO, 2012 NY Slip Op 50137(U) (N.Y. City Civ. Ct. 2012). "Generally accepted practice is that range of practice that the profession will follow in the diagnosis and treatment of patients in light of the standards and values that define its calling." Nir, supra.

In support of its contention that no further treatment was medically necessary, Respondent submits the report of the IME performed by Dorothy Scarpinato, M.D. on January 20, 2022. Range of motion testing and clinical orthopedic and neurological tests were negative and unremarkable. Dr. Scarpinato concluded that the Assignor's injuries had resolved, and that no further treatment was necessary.

In reviewing and comparing the evidence submitted to the record with regard to the IME of Dr. Scarpinato, based on the evidence submitted to this hearing, I find that the more credible documentation of the patient's orthopedic condition was documented in the claimants medical reports and not Dr. Scarpinato's IME report. Therefore I find on behalf of the Applicant as to medical necessity for continued physical therapy treatment performed subsequent to the IME.

The entire claim is granted in the amended amount if $430.27.

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
	Brooklyn Medical Practice, PC	**08/03/21 - 08/20/21**	**$112.40**	**$0.00**	**Dismissed without prejudice**
	Brooklyn Medical Practice, PC	**07/27/21 - 07/27/21**	**$75.00**	**$75.00**	**Awarded: $75.00**
	Brooklyn Medical Practice, PC	**03/30/22 - 03/30/22**	**$87.80**	**$87.80**	**Awarded: $87.80**
	Brooklyn Medical Practice, PC	**03/30/22 - 03/30/22**	**$33.64**	**$33.64**	**Awarded: $33.64**
	Brooklyn Medical Practice, PC	**10/01/21 - 10/28/21**	**$200.19**	**$200.19**	**Awarded: $200.19**
	Brooklyn Medical Practice, PC	**04/06/22 - 04/06/22**	**$33.64**	**$33.64**	**Awarded: $33.64**
Total			**$542.67**		**Awarded: $430.27**

B. The insurer shall also compute and pay the applicant interest set forth below. 07/26/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

The Respondent shall compute and pay the Applicant the amount of interest computed from the date set forth above at the 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(c).

C. Attorney's Fees

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

Applicable attorney fees on the amount awarded in accordance with 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, Carolynn Terrell-Nieves, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

11/08/2024
(Dated)

Carolynn Terrell-Nieves

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:
5aa40b7c2c9fda1d13284ce4466f7bd8

Electronically Signed

Your name: Carolynn Terrell-Nieves
Signed on: 11/08/2024