American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Jordan Fersel, M.D. (Applicant)	AAA Case No.	17-24-1358-3205
	Applicant's File No.	N/A
- and -	Insurer's Claim File No.	0540008250002
	NAIC No.	36447
LM General Insurance Company (Respondent)		

ARBITRATION AWARD

I, Anne Malone, 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 02/18/2025
   Declared closed by the arbitrator on 02/18/2025

   Roman Kulik, Esq. from Kulik Law Firm, PC participated virtually for the Applicant

   Lisa Castle from LM General Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$1,052.68**, 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 40 year old EIP reported involvement in a motor vehicle accident on June 26, 2023; claimed related injury and underwent and office visit and Outcome Assessment Testing (OAT) on October 17, 2023 and an office visit ,and injection on November 21, 2023 and OAT on November 23, 2023.

   The applicant submitted a claim for these medical services, payment of the bill for services rendered on October 17, 2023 was timely denied by the respondent based on the IME of the EIP by Dorothy Scarpinato, M.D. which was performed on September 28, 2023. The IME cut-off was effective on October 10, 2023.

The bill for dates of service November 21, 2023 to November 23, 2023 was delayed pending verification requests and then denied after 120 days from the initial date of the request for verification.

The respondent also asserted a fee schedule defense.

The issues to be determined at the hearing are:

Whether the respondent established that the medical services provided by the applicant on November 17, 2023 were not medically necessary.

Whether the respondent established its 120 day defense for services rendered on November 21, 2023 and November 23, 2023.

Whether the respondent established its fee schedule defense.

4. Findings, Conclusions, and Basis Therefor

This hearing was held on Zoom and the decision is based upon the documents reviewed in the Modria File as well as the arguments made by counsel and/or representative at the arbitration hearing. Only the arguments presented at the hearing are preserved in this decision; all other arguments not presented at the hearing are considered waived.

Medical Necessity

To support a lack of medical necessity defense respondent must "set forth a factual basis and medical rationale for the peer reviewer's [or examining physician's] determination that there was a lack of medical necessity for the services rendered." Provvedere, Inc. v. Republic Western Ins. Co., 2014 NY Slip Op 50219(U) (App. Term2d, 11th and 13th Jud. Dists. 2014.) Respondent bears the burden of production in support of its lack of medical necessity defense, which if established shifts the burden of persuasion to applicant. See Bronx Expert Radiology, P.C. v. Travelers Ins. Co., 2006 NY Slip Op 52116 (App. Term 1st Dept. 2006.)

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/her findings;

and 3) the peer review report fails to provide specifics as to the claim at issue; is conclusory or vague. See Nir v. Allstate, 7 Misc.3d 544 (N.Y. City Civ. Ct. 2005.)

To support its contention that the services provided to the EIP were not medically necessary, the respondent relied upon the report of the independent medical examination of the EIP by Dr. Scarpinato, which was objectively negative and unremarkable. Range of motion was determined with the assistance of a goniometer. The report presents a factually sufficient, cogent medical rationale in support of respondent's lack of medical necessity defense. Dr. Scarpinato performed a complete and comprehensive examination of the EIP which did not identify any objective positive findings and determined that his injuries were resolved. She specifically examined the EIP's bilateral shoulders and documented specific negative findings.

Based upon the physical examination and medical records reviewed, Dr. Scarpinato determined that despite his subjective complaints, the EIP was not disabled and that he could perform his activities of daily living and working full time without restrictions or limitations. It was Dr. Scarpinato's opinion that there was no medical necessity for further orthopedic treatment, physical therapy, massage therapy, injections, shockwave therapy, surgery, prescription medication, diagnostic testing, durable medical equipment, household help or special transportation.

Respondent has factually demonstrated that the services provided by the applicant were not medically necessary. Accordingly, the burden now shifts to the applicant, who bears the ultimate burden of persuasion. See Bronx Expert Radiology, P.C. v. Travelers Ins. Co., 2006 NY Slip Op 52116 (App. Term 1st Dept. 2006.)

In response to the report of the physical examination of the EIP by Dr. Scarpinato the applicant relied upon the submissions, including a follow up examination of the EIP on August 21, 2023 which documented normal range of motion in the bilateral shoulders, an October 17, 2023 examination which documented subjective complaints of bilateral shoulder pain and no positive objective findings and physical therapy progress notes for treatment from July 18, 2023 to August 31, 2023.

Also submitted were copies of the office visits on October 17, 2023 and November 21, 2023.

Based on the foregoing, the applicant failed to document sufficient contemporaneous objective findings that would warrant continued treatment after the IME cut-off date and has not met the burden of persuasion in rebuttal. The medical records submitted do not meaningfully address the arguments that are raised in the IME report and are insufficient to overcome the burden of production established by respondent.

Therefore, the respondent has established that the services provided on October 17, 2023 were not medically necessary.

Therefore, the claim for date of service October 17, 2023 is dismissed with prejudice.

120 day defense

The bill for date of service November 21, 2023 was denied based on the applicants failure to respond to requested verification after 120 days from the initial date of the request for verification.

If an insurer requires any additional information to evaluate the proof of claim, such request for verification must be made within 15 business days of the receipt of the bill in order to toll the 30 day period to pay or deny the claim. See 11 NYCRR 65-3.5(b); See also New York Hosp. Med. Ctr. of Queens v. Allstate Ins. Co., 2014 NY Slip Op 00640 (2d Dept. 2014.)

Where there is a timely original request for verification, but no response to the original request for verification is received within 30 days, or the response to the verification request is incomplete, then the insurer, within 10 calendar days after the expiration of that 30 day period, must follow up with a second request for verification. Id.

If there is no response to the second or follow up request for verification, the time in which the insurer must decide whether to pay or deny the claim is indefinitely tolled. Id.

Therefore, when a no-fault medical service provider fails to respond to the requests for verification the claim is premature and should be denied without prejudice.

However, pursuant to 11 NYCRR §65-3.5(o) an insurer may issue a denial if, more than 120 calendar days after the initial request for verification, the applicant has not submitted all such verification under applicant's control or possession or written proof providing reasonable justification for the failure to comply.

In the instant matter, there is no evidence that the respondent served any requests for verification and the denial based on this issue is improper.

Therefore, the applicant is awarded $629.94 for services rendered on November 21, 2023 and November 23, 2023.

Fee Schedule

To prevail in its fee schedule defense, the respondent must demonstrate by competent evidentiary proof that the applicant's claims are in excess of the

appropriate fee schedule. If the respondent fails to do so, its defense of noncompliance with the New York Workers' Compensation Medical Fee Schedule cannot be sustained. See Continental Medical, P.C. v Travelers Indemnity Co., 11 Misc. 3d 145A (App. Term 1st Dept. 2006.)

An insurer fails to raise a triable issue of fact with respect to a defense that the fees charged were not in conformity with the Workers' Compensation fee schedule when it does not specify the actual reimbursement rates which formed the basis for its determination that the claimant billed in excess of the maximum amount permitted. See St. Vincent Medical Services, P.C. v. GEICO Ins. Co., 29 Misc.3d 141(A), 907 N.Y.S.2d 441 (App. Term 2d, Dec. 8, 2010.)

In this matter, the respondent did not submit any support to establish fee schedule defense.

Accordingly, the applicant is awarded $629.24 and the remainder of the claim is dismissed with prejudice.

Any further issues submitted in the record are held to be moot and/or waived insofar as they were not raised at the time of this hearing. 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 applicant is AWARDED the following:

A.

Medical		From/To	Claim Amount	Status
	Jordan Fersel, M.D.	**10/17/23 - 10/17/23**	**$422.74**	**Denied**
	Jordan Fersel, M.D.	**11/21/23 - 11/23/23**	**$629.94**	**Awarded: $629.94**
Total			**$1,052.68**	**Awarded: $629.94**

B. The insurer shall also compute and pay the applicant interest set forth below. 07/26/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant is awarded interest pursuant to the no-fault regulations. See generally, 11 NYCRR §65-3.9. Interest shall be calculated "at a rate of two percent per month, calculated on a *pro rata* basis using a 30 day month." See 11 NYCRR §64-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. However, the regulations toll the accrual of interest when 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 Insurance Department regulations. Where a claim is untimely denied, or not denied or paid, interest shall accrue as of the 30th day following the date the claim is presented by the claimant to the insurer for payment. Where a claim is timely denied, interest shall accrue as of the date an action is commenced or an arbitration requested, unless an action is commenced or an arbitration requested within 30 days after receipt of the denial, in which event interest shall begin to accrue as of the date the denial is received by the claimant. See, 11 NYCRR §65-3.9(c.) The Superintendent and the New York Court of Appeals has interpreted this provision to apply regardless of whether the particular denial was timely. LMK Psychological Servs. P.C. v. State Farm Mut. Auto. Ins. Co., 12 NY3d 217 (2009.)

C. Attorney's Fees

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

Applicant is awarded statutory attorney's fees pursuant to the no fault regulations. For cases filed after February 4, 2015 the attorney's fee shall be calculated as follows: 20% of the amount of first-party benefits awarded, plus interest thereon subject to no minimum fee and a maximum of $1,360.00. See 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 CT
SS :
County of Fairfield

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

02/20/2025
(Dated)

Anne Malone

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:
2a830073c64050bd8a7247edfa816170

Electronically Signed

Your name: Anne Malone
Signed on: 02/20/2025