

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

MK Medical Care PC  
(Applicant)

- and -

Kemper/Lumbermans/Kemper A Unitrin  
Business  
(Respondent)

AAA Case No. 17-24-1367-9466

Applicant's File No. 173188

Insurer's Claim File No. 23123657787

NAIC No. 10914

**ARBITRATION AWARD**

I, Yael Aspir, 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 02/05/2025  
Declared closed by the arbitrator on 02/05/2025

John Faris from Law Offices of Eitan Dagan (Woodhaven) participated virtually for the Applicant

Arthur De Martini from De Martini & Yi, LLP participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$4,560.16**, 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 EIP, RP, a 32 year old male driver, was injured by a motor vehicle involved in an accident on 05/17/23.

In dispute are the Applicant's claims for \$4,560.16 for treatment provided to the EIP on 05/18/23 through 10/05/23. Respondent issued partial payment and denied the balance of the claims based on the fee schedule, bill non-receipt, and the 07/26/23, 08/09/23, and 08/19/23 peer reports of Dr. Ajendra Sohal.

Accordingly, the issues to be determined are whether Respondent has established payment in compliance with the applicable fee schedules, whether Applicant has

established a proper and timely bill submission, and the medical necessity of the services provided.

#### 4. Findings, Conclusions, and Basis Therefor

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

Applicant establishes a prima facie case of entitlement to reimbursement of its claim by the submission of a completed NF-3 form reflecting the amounts of the losses sustained and by submitting evidentiary proof that the prescribed statutory billing forms [setting forth the fact and the amount of the loss sustained] had been mailed and received and that payment of no-fault benefits were overdue. See, Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004).

#### **Fee Schedule**

Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. See, Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 2006 NY Slip 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006). See also, Power Acupuncture PC v. State Farm Mutual Automobile Ins. Co., 11 Misc.3d 1065A, 816 N.Y.S.2d 700, 2006 NY Slip Op 50393U, 2006 N.Y. Misc. LEXIS 514 (Civil Ct, Kings Co. 2006). If Respondent fails to demonstrate by competent evidentiary proof that a plaintiff's claims were in excess of the appropriate fee schedules, defendant's defense of noncompliance with the appropriate fee schedules cannot be sustained. See, Continental Medical PC v. Travelers Indemnity Co., 11 Misc.3d 145A, 819 N.Y.S.2d 847, 2006 NY Slip Op 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Term, 1st Dep't, per curiam, 2006).

For dates of service 05/18/23 through 05/26/23, 06/30/23 through 07/14/23, 08/16/23 through 09/06/23, 08/23 through 08/31/23 and 09/13/23 through 10/05/23, Respondent issued denials predicated on exhaustion of the daily RVU cap. Respondent's submission does not include sufficient proof of payment for all available units for each service date to this provider, or any other service provider. Accordingly, the balance of this portion of Applicant's claim is awarded to the max available RVUs for each date of service.

#### **Proof of mailing**

Respondent claims that the bill for service dates 06/14/23 through 06/29/23 was never received prior to Arbitration. Applicant's submission does not include proof of mailing.

Generally, "proof that an item was properly mailed gives rise to a rebuttable presumption that the item was received by the addressee" (*Matter of Rodriguez v Wing*, 251 AD2d 335, 336 [1998] [internal quotation marks omitted]). "The presumption may

be created by either proof of actual mailing or proof of a standard office practice or procedure designed to ensure that items are properly addressed and mailed" (Residential Holding Corp. v. Scottsdale Ins. Co., 286 AD2d 679, 680 [2001]). See New York & Presbyt. Hosp. v. Allstate Ins. Co., 29 A.D.3d 547, 2006 NY Slip Op 03558 (2d Dept. 2006); Hospital for Joint Diseases v. Nationwide Mut. Ins. Co., 284 A.D.2d 374, 375 (2d Dept. 2001).

After a careful review of the records, and in consideration of the parties' oral arguments at the hearing, I find that Applicant has not established a proper and timely bill submission of its claim. Accordingly, this portion of Applicant's claim is denied.

**ESWT (dos 06/07/23 and 06/21/23)**

Since Respondent's denial was timely, it was within its rights to assert lack of medical necessity as a defense. Liberty Queens Medical, P.C. v. Liberty Mutual Insurance Co., 2002 WL 31108069 (App. Term 2d & 11th Dists. June 27, 2002). A peer review report relied upon by an insurer in timely denying a claim is a proper vehicle to assert the defense of lack of medical necessity. S & M Supply, Inc. v. Allstate Ins. Co., 2003 N.Y. Slip Op. 51191(U), 2003 WL 21960336 (App. Term 2d & 11th Dists. July 9, 2003).

A peer reviewer must establish a factual basis and medical rationale for his asserted lack of medical necessity of the health care provider's services. See Amaze Medical Supply Inc. v. Allstate Ins. Co., 12 Misc.3d 142(A), 824 N.Y.S.2d 760 (Table), 2006 N.Y. Slip Op. 51412(U), 2006 WL 2035559 (App. Term 2d & 11th Dists. July 12, 2006). If the peer review satisfies these standards, it becomes incumbent on the claimant to rebut the peer review. See Be Well Medical Supply, Inc. v. New York Cent. Mut. Fire Ins. Co., 18 Misc3d 139(A), 2008 WL 506180 (App. Term 2d & 11th Dists. Feb. 21, 2008), because the ultimate burden of proof on the issue of medical necessity lies with the claimant. See Insurance Law § 5102; Shtarkman v. Allstate Insurance Co., 2002 WL 32001277 (App. Term 9th & 10th Jud. Dists. 2002) (burden of establishing whether a medical test performed by a medical provider was medically necessary is on the latter, not the insurance company).

Respondent's evidence established that the claims for shockwave therapy on 06/07/23 and 06/21/23 were timely denied on the 07/26/23 and 08/09/23 peer reports of Dr. Ajendra Sohal. The peer reports are based upon review of the available medical documents and reliance upon the generally accepted standard of care in the medical community. Dr. Sohal states that although ESWT may play a part in rehabilitation of musculoskeletal injuries in certain clinical scenarios, the EIP was already started on a rehabilitation regimen consisting of several modalities of physical therapy. There was no evidence that the EIP was failing to improve on the conventional rehabilitation regimen and required any additional treatment modalities to help aid in treatment. Additionally, ESWT may be indicated in chronic non-calcific tendinopathies or degenerative neuro-spinal pathologies, but there is no indication for use in treating acute neck and back injuries.

In opposition, Applicant relies on the medical records in evidence and the Rebuttal of Dr. Kovalevskiy which does not address the ESWT treatment specifically.

Comparing the relevant evidence presented by both parties against each other and the above referenced medical necessity standard, I find in favor of Respondent. The medical literature cited by the peer doctor indicates the possible benefits of ESWT for treating chronic tendinopathies. According to the records, the EIP presented for an initial evaluation on 05/18/23 and received ESWT on 06/07/23 and 06/21/23. At the time of treatment, the EIP remained in the acute phase of treatment and was actively participating in a conservative care regimen. I am persuaded by the peer doctor that ESWT at this phase of treatment was not provided in accordance with the standard of care. Accordingly, this portion of Applicant's claim is denied.

**EMG/NCV - upper and lower (dos 06/22/23 and 07/06/23)**

Respondent's evidence established that the claim for EMG/NCV upper and lower on service dates 06/22/23 and 07/06/23, was timely denied on the 08/09/23 and 08/19/23 peer reports of Dr. Ajendra Sohal. Dr. Sohal's reports are based upon his review of the available medical documents and his reliance upon the generally accepted standard of care in the medical community. Dr. Sohal found no medical necessity for the EMG/NCV. He reviews the records and treatment notes including the initial evaluation on 05/18/23 and cervical and lumbar spine MRI reports. He opines that the neurologic findings were non-specific and that the EIP's history, subjective complaints and physical examination findings were consistent with sprain/strain injury of the spine and would not warrant nerve testing. There were no focal findings reflecting radiculopathy and no correlation to imaging studies. Dr. Sohal additionally states that it was unclear how the nerve testing would alter the treatment plan as there was no indication the EIP was a surgical or injection candidate, and that there was no plausible differential diagnosis.

In opposition, Applicant submits the medical records in evidence including the 12/05/24 Rebuttal of Dr. Mark Kovalevskiy. Dr. Kovalevskiy reviews the peer report of Dr. Sohal and notes his disagreement, relying on records and citations to current medical literature. He notes the EIP had continued radicular symptoms, including numbness and diminished sensation. Dr. Kovalevskiy discusses the EIP's neurological findings of either neuropathy or radiculopathy, and how treatment protocols could differ between the two, necessitating the testing to differentiate the diagnosis, and to guide treatment accordingly.

Comparing the relevant evidence presented by both parties against each other and the above referenced medical necessity standard, I find that Dr. Sohal's peer report contains a sufficient medical rationale to justify a denial for lack of medical necessity. However, Applicant's medical records in evidence are sufficient to rebut the denial. The EIP exhibited signs of persistent back and neck pain with radicular symptoms and paresthesia, and multiple positive orthopedic and neurologic findings and deficits upon examination. I am persuaded by the records that the testing was necessary to differentiate radiculopathy from neuropathy in order to provide the most efficient continued treatment plan for the EIP.

Accordingly, this portion of Applicant's claim is awarded in accordance with the fee schedule.

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
	MK Medical Care PC	05/18/23 - 10/05/23	\$4,560.16	Awarded: \$2,785.22
Total			\$4,560.16	Awarded: \$2,785.22

- B. The insurer shall also compute and pay the applicant interest set forth below. 10/02/2024 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." 11 NYCRR §65-3.9(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." 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 at issue was timely. LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 217 (2009).

C. Attorney's Fees

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

As this matter was filed on or 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 (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) For claims that fall under the Sixth Amendment to the regulation, the following shall apply: "If the claim is resolved by the designated organization at any time prior to transmittal to an arbitrator and it was initially denied by the insurer or overdue, the payment of the applicant's attorney's fee by the insurer shall be limited to 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon, for each applicant with whom the respective parties have agreed and resolved dispute, subject to a maximum fee of \$1,360.

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

02/23/2025  
(Dated)

Yael Aspir

**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:**  
dadac8a26786b42ac7acf68ffe36015b

### Electronically Signed

Your name: Yael Aspir  
Signed on: 02/23/2025