

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Brooklyn Medical Practice, PC
(Applicant)

- and -

American Transit Insurance Company
(Respondent)

AAA Case No. 17-24-1364-0580

Applicant's File No. AR24-25681

Insurer's Claim File No. 1127906

NAIC No. 16616

ARBITRATION AWARD

I, Darren Sheehan, 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 03/25/2025
Declared closed by the arbitrator on 03/25/2025

Alek Beynenson from The Beynenson Law Firm, PC participated virtually for the
Applicant

Jeffrey Siegel from American Transit Insurance Company participated virtually for the
Respondent

2. The amount claimed in the Arbitration Request, **\$3,244.52**, 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

Applicant submitted bills totaling \$3,244.52 for dates of service 3/24/2023-7/31/2024. The bills relate to a comprehensive examination and physical therapy provided to the claimant, a 34-year-old female, involved in a motor vehicle accident on 3/22/2023. All claims were denied on the basis that following an examination under oath ("EUO") of the claimant, respondent determined that there was a "fact and founded" belief that the

claimant's treated condition was unrelated to the motor vehicle accident. Other secondary reasons for denial pertain to specific date(s) or service and/or bills, which are outlined below.

4. Findings, Conclusions, and Basis Therefor

Addressing the "fact or founded belief" basis, I have several times rejected this defense, see below:

I should say off the bat that respondent's denial lacks any specificity to the general assertion that the claimant's "treated condition" was unrelated to the accident.

General Accident Ins. Group v. Cirucci, 46 N.Y.2d 862, 864, 414 N.Y.S.2d 512, 514 (App. Div. 2nd Dept. 1978) wherein that Court set the standard that the Respondent must apprise Applicant with a "high degree of specificity of the ground or grounds on which the disclaimer is predicated." The Court there recognized that "this uncertainty could prejudice the claimant's ability to ultimately obtain recovery."

I doubt any case can be made that respondent's denial here apprised applicant with a *high degree of specificity* of the ground for which it denied its claim. Let's start with the fact that there is no evidence the transcript was provided to the applicant. Even putting that aside, at the very least, respondent should be required to specifically detail in its denial the actual testimony it relied upon to form its basis. Merely stating in the vagueness terms that the "treated condition" (was it the neck, back, shoulder, knee etc.,?) was unrelated to the accident falls far short.

What body part are we referring to?

How was it unrelated?

It should not be up to this arbitrator at the time of the hearing to make respondent's arguments or for that matter try to even find them.

Are we to comb through the transcript to piece together what we believe might have formed respondent's basis for denial?

And also, is it fair to leave the applicant wondering what particular testimony respondent hung to when receiving a denial of its claim?

Is it too difficult to ask that respondent submit the transcript and refer to the page and line numbers, so we have a specific understanding at the time of the denial as to then also allow applicant ample opportunity to refute the denial of their claim?

Thus, for the reasons set forth above, respondent did not establish its basis for denial.

Secondarily, several bills, as listed below, were also denied on the basis of an independent medical examination ("IME") conducted by Magda Fahmy, M.D., dated 11/14/2023. These bills include: 12/6/2023-12/13/2023 (\$67.28), 2/1/2024-2/28/2024 (\$329.13), 3/6/2024-3/20/2024 (\$168.20), 5/1/2024-5/31/2024 (\$430.05), and 6/4/2024-6/25/2024 (\$168.20).

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 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 a myriad of civil court decisions tackling the issue of what constitutes a "factual basis and medical rationale" sufficient to establish a lack of medical necessity. An insurance carrier must, at a minimum, establish a detailed factual basis and a sufficient medical rationale for its asserted lack of medical necessity. Vladimir Zlatnick, M.D., P.C. v. Travelers Indem. Co., 2006 NY Slip Op 50963(U) (App Term 1st Dept., 2006); Delta Diagnostic Radiology, P.C. v. Progressive Casualty Ins. Co., 2008 Slip Op 52450(U), 21 Misc.3d 142(A) (App Term 2d Dept., 2008).

Dr. Fahmy reported that the claimant was a rear-seat passenger in a motor vehicle involved in an accident on 3/22/2023. No further details were included.

She sustained injuries to her neck, back, and right shoulder, however nothing was said as to whether the claimant sought immediate emergency care at a hospital or elsewhere.

Sometime following the accident, we are told that the claimant began a regimen of physical therapy, chiropractic care, acupuncture, and massage therapy at a frequency of 2-3 times per week.

On the day of the IME, she presented with continued pain in the neck, back, and right shoulder.

In examining the cervical spine, there was no evidence of tenderness or muscle spasms. Range of motion was full and unrestricted in all planes (e.g., flexion, extension, rotation, lateral bending). Muscle strength was normal, as were the sensory and reflex examinations. The thoracic spine examination indicated no deficiencies and the lumbar spine likewise demonstrated full range of motion, no muscle spasms, and normal strength, sensory and reflexes. There too, the doctor conducted orthopedic tests, all of which were normal (e.g., Hawkins, Neer, Drop Arm, O'Brien, etc.). Likewise, the right shoulder was shown to have full range of motion, without tenderness or evidence of crepitus.

On the basis of this evaluation, together with the doctor's review of the treatment records provided to him, it was determined that the claimant's injuries had resolved and no further treatment was medically necessary.

It was clear to me that Dr. Fahmy conducted a thorough examination and overall observed only normal findings from his evaluation. In my view, this IME sufficiently established the lack of medical necessity for continued treatment.

In contrast, I reviewed the medical records submitted by applicant to determine if any contemporaneous records refute the IME.

There was a 9/9/2024, re-evaluation by Brooklyn Medical P.C., however it being two-plus months prior to the IME, I did not consider it. Similarly, another re-evaluation occurred on 1/8/2024, however this one was two months post-IME. The 10/9/2023, re-evaluation was only one month before our IME, and while I recognize that the doctor found restrictions of motion, nothing much else was seemingly evaluated. There was not even an indication as to how range of motion was measured and the entirety of the report can easily be summed up as rushed and illegible at times.

Although there were physical therapy notes contemporaneous to our IME, these offered nothing of value.

Therefore, as it pertains to those claims that were also denied on the basis of this IME, I uphold respondent's basis of denial and award in applicant's favor only on the other claims (see below for breakdown).

Respondent maintains that pursuant to the New York State Workers Compensation Fee Schedule ("fee schedule"), however, applicant did not charge in accordance with this fee schedule.

Since respondent raised the issue of a fee schedule defense, it is incumbent upon respondent to establish that the fees charged were excessive and not in accordance with the fee schedule. Vincent Med. Servs. P.C. v. GEICO Ins. Co., 29 Misc.3d 141(A), 920 N.Y.S.2d 45 (App. Term 2nd Dept. 2010); Raz Acupuncture, P.C. v. Praetorian Ins. Co., 34 Misc.3d 152(A), 951 N.Y.S.2d 83, (App. Term 2nd Dept. 2012); Rogy Medical, P.C. v. Mercury Cas. Co., 23 Misc.3d 132(A) (App. Term 2nd 2009).

Therefore, respondent has the burden to come forward with "competent evidentiary proof supporting its fee schedule defense." Robert Physical Therapy, P.C. v. State Farm Mutual Automobile Ins. Co., 13 Misc.3d 172, 176, 822 N.Y.S.2d 378, 381 (Civ. Ct. Kings Co. 2006). Continuing, this Court held that defendant was not competent to opine on a particular fee schedule issue involving medical testing. "In the absence of any testimony by a competent medical profession, this court cannot determine whether plaintiff's charges were medically appropriate. Since it was defendant's burden to make out its defense, the court finds that defendant has failed to carry its burden". See also, Continental Med. P.C. v. Travelers Indem. Co., 11 Misc.3d 145(A), 819 N.Y.S.2d 847 (App. Term, 1st Dept. 2006); Jamil M. Abraham, M.D. v. Country-Wide Ins. Co., 3 Misc.3d 130(A), 787 N.Y.S.2d 678 (App. Term, 2nd & 11th Jud. Dists., 2004).

In line with the above, Courts have discouraged taking judicial notice of the NYS Workers' Compensation Fee Schedule since the fee schedule, in and of itself, does not establish that the insurer properly utilized the codes set forth within it to calculate the amount which a health service provider was entitled to recover for each service rendered. Acupuncture Healthcare Plaza I, P.C. v. MetLife Auto & Home, 54 Misc.3d 142(A), 2017 N.Y. Slip Op. 50207(U) (App. Term 2d, 11th & 13th Dists. Feb. 8, 2017).

As to the question of what level of proof is required to demonstrate a fee schedule defense the courts have offered some guidance. For example, in the matter of Gentle Acupuncture, P.C. v. tri-State Consumer Ins. Co. 55 Misc. 3d 147(A), 2017 N.Y. Slip Op. 50706(U) (App. Term 9th & 10th Jud. Dists. May 23, 2017) it required "an expert's affidavit to explain its interpretation of the fee schedule at issue". While it is not required that this "expert" be certified (*see, Acupuncture Approach P.C. v. USAA General Indemnity Co.* 59 Misc. 3d 1231(A), 2018 N.Y. Slip Op. 50807(U) (Civ. Ct. New York Co., Mary V. Rosado, J., Apr. 24, 2018), this affidavit must articulately explain the affiant's analysis in a coherent manner and must provide not only the appropriate relative value units but also the conversion factor to support its position. Tyorkin v. Garrison Property & Casualty Ins. Co., 51 Misc. 3d 1227(A), 2016 N.Y. Slip Op. 50846(U) (Civ. Ct. Kings Co., Richard J. Montelione, J., May 20, 2016), Renelique v. American Transit Ins. Co. 57 Misc. 3d 145(A), 2017 N.Y. Slip Op. 51450(U).

To that end, respondent failed to submit "competent evidentiary proof supporting its fee schedule defense."

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.

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Medical		From/To	Claim Amount	Status
	Brooklyn Medical Practice, PC	03/24/23 - 03/24/23	\$149.78	Awarded: \$149.78
	Brooklyn Medical Practice, PC	03/27/23 - 03/31/23	\$128.38	Awarded: \$128.38
	Brooklyn Medical Practice, PC	04/03/23 - 04/25/23	\$362.77	Awarded: \$362.77
	Brooklyn Medical Practice, PC	05/01/23 - 05/30/23	\$362.77	Awarded: \$362.77
	Brooklyn Medical Practice, PC	06/01/23 - 06/28/23	\$201.84	Awarded: \$201.84
	Brooklyn Medical Practice, PC	07/06/23 - 07/25/23	\$134.56	Awarded: \$134.56
	Brooklyn Medical Practice, PC	10/09/23 - 10/18/23	\$160.93	Awarded: \$160.93
	Brooklyn Medical Practice, PC	11/03/23 - 11/20/23	\$251.50	Awarded: \$251.50
	Brooklyn Medical Practice, PC	12/06/23 - 12/13/23	\$67.28	Denied
	Brooklyn Medical Practice, PC	01/03/24 - 01/26/24	\$228.21	Awarded: \$228.21
	Brooklyn Medical Practice, PC	02/01/24 - 02/28/24	\$329.13	Denied
	Brooklyn Medical	03/06/24 -	\$168.20	Denied

	Practice, PC	03/20/24		
	Brooklyn Medical Practice, PC	05/01/24 - 05/31/24	\$430.05	Denied
	Brooklyn Medical Practice, PC	06/04/24 - 06/25/24	\$168.20	Denied
	Brooklyn Medical Practice, PC	07/09/24 - 07/31/24	\$100.92	Awarded: \$100.92
Total			\$3,244.52	Awarded: \$2,081.66

- B. The insurer shall also compute and pay the applicant interest set forth below. 09/05/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Since the claim(s) in question arose from an accident that occurred on or after April 5, 2002, the insurer shall compute and pay the applicant the amount of interest computed from the filing date of this case, 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) (stay of interest).

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 (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 Suffolk

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

03/28/2025

(Dated)

Darren Sheehan

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:
e34a580a02d80ec898677fd0dcfba5ce

Electronically Signed

Your name: Darren Sheehan
Signed on: 03/28/2025