

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Precise Medical Solutions LLC
(Applicant)

- and -

Allstate Insurance Company
(Respondent)

AAA Case No. 17-24-1362-5104

Applicant's File No. BT24-278278

Insurer's Claim File No. 0673745196

NAIC No. 29688

ARBITRATION AWARD

I, Hersh Jakubowitz, 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 03/27/2025
Declared closed by the arbitrator on 03/27/2025

Heather Landeros from The Tadchiev Law Firm, P.C. participated virtually for the Applicant

Adva White from Law Offices of John Trop participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,838.39**, was NOT AMENDED at the oral hearing.
Stipulations WERE made by the parties regarding the issues to be determined.

The Parties stipulated that Applicant had met its prima facie burden of proof and that Respondent's denials were interposed in a timely fashion.

3. Summary of Issues in Dispute

Applicant seeks reimbursement, along with interest and counsel fees, under the No-Fault Regulations, for the costs associated with the cervical discectomy, intraoperative neuromonitoring, and associated services undergone by EIP on January 28, 2024 in connection with injuries allegedly

sustained by EIP in a motor vehicle accident on June 13, 2022. The payment, for the cervical discectomy, intraoperative neuromonitoring, and associated services, was denied, following a review of the medical records and Peer Review by Dr. Ajendra Sohal, M.D., at Respondent's behest, as not medically necessary. The denial was timely. This decision, awarding Applicant's claim, is based upon the written submissions of counsel contained within the electronic case file maintained by the American Arbitration Association for the respective parties as well as oral argument at the hearing conducted on March 27, 2025.

4. Findings, Conclusions, and Basis Therefor

History

EIP, a then 27-year-old male was involved in a motor vehicle accident on June 13, 2022 as a restrained front seat passenger wherein he sustained multiple injuries. After the accident, the EIP was seen in the emergency room of St. John's Hospital for an evaluation and treatment.

The EIP consulted Applicant, on November 21, 2022, complaining of pain in his neck, mid back, low back and right shoulder. Examination revealed tenderness, decreased range of motion, sensation and motor strength, positive Spurling sign and positive straight leg raising test bilaterally. The EIP was recommended physical therapy, chiropractic care; cervical and lumbar discectomy. On January 28, 2024, the EIP underwent a cervical discectomy, intraoperative neuromonitoring, and associated services performed by Applicant who seeks no-fault benefits.

Prima Facie

The Applicant established its prima facie case by proof that the prescribed statutory billing forms had been received and that payment of no-fault benefits was not forthcoming. (See, New York & Presbyt. Hosp. v. Countrywide Ins. Co., 44 A.D.3d 729 [N.Y. App. Div. 2d Dep't 2007]). Proof of the receipt of the Applicant's billing is implicit, in the timely denial issued by the Respondent. The Respondent's obligation is to now demonstrate the validity of its denial.

Denial

The Respondent's denial raised the asserted absence of medical necessity based on the analysis of its designated peer, Dr. Ajendra Sohal, M.D. The corresponding report dated April 1, 2024 has been submitted in support of the Respondent's position.

In considering the issue presented, I note that as part of its prima facie showing, the Applicant is not required to show that the contents of the statutory no-fault forms themselves are accurate or that the medical services documented therein were actually rendered or necessary. Stated another way, the Applicant is not required to establish the merits of the claim to meet its prima facie burden. (*Viviane Etienne Med. Care, P.C. v Country-Wide Ins. Co.*, 114 A.D.3d 33, 46, *aff'd* 25 NY3d 498)

On the contrary, "[m]edical necessity is presumed upon the timely submission of a no-fault claim (see [All County Open MRI & Diagn. Radiology P.C. v. Travelers Ins. Co.](#), 11 Misc. 3d 131[A], 815 N.Y.S.2d 493, 2006 NY Slip Op 50318[U] [App Term, 9th & 10th Jud Dists 2006]). Thus, ordinarily it falls to the defense to establish that the billed-for services were not medically necessary." (*Park Slope Med. & Surgical Supply, Inc. v. Progressive Ins. Co.*, 34 Misc. 3d 154[A] [N.Y. App. Term 2012] [concurring opinion, Golia, J.]; see, also, *Kings Med. Supply Inc. v. Country-Wide Ins. Co.*, 5 Misc. 3d 767, 771 [N.Y. Civ. Ct. 2004] ["It is by now firmly established that the burden is on the insurer to prove that the medical services or supplies in question were medically unnecessary {citation omitted}."])

The Respondent, to establish the validity of its defense on a prima facie level and put the Applicant to its proof, must, as a minimum, demonstrate both a factual predicate and medical rationale for the asserted absence of medical justification for the specific service provided to the patient, and must premise its contention upon uncontroverted evidence of generally accepted medical standards of care. (See, *Nir v. Allstate Ins. Co.*, 7 Misc. 3d 544, 547 [N.Y. Civ. Ct. 2005])

Thus, the focus falls squarely on the Sohal report.

Peer

Critical of the challenged discectomy, Dr. Sohal, citing supportive medical literature, outlined the criteria which govern the medical necessity calculus in this context, and based on his analysis of the EIP's medical records,

opined that the clinical findings and reported symptoms did not rise to a level sufficient to warrant the performance of a cervical discectomy and associated medical services.

In pertinent part, Dr. Sohal, notes: There was no evidence of cervical radiculopathy. There was no evidence of cervical discogenic pain. EMG studies revealed no cervical radiculopathy.

Rebuttal

The rebuttal by Dr. David Gamburg, M.D., states "a negative EMG does not unequivocally prove there is no radiculopathy present... Please note EMG's are often inaccurate in finding radiculopathy and therefore should not be solely relied upon to render a diagnosis... According to the literature it is inappropriate to rely solely on a negative EMG. Rather, in accordance with the literature, it is acceptable and necessary for the treating physician to rely on a combination of clinical findings to render an accurate diagnosis and determine proper treatment... Please note discectomy is superior to epidural steroid injections in treating patients with radiculopathy... Thus, in accordance with the aforementioned guidelines and the standard of care that they represent, the EIP was an ideal candidate for discectomy intervention. The procedure was medically necessary, as the EIP met the aforementioned criteria after failing to reasonably improve following an appropriate conservative course of treatment. As discussed below, the EIP's subjective and objective findings as well as the current body of literature indicated that surgical intervention was the appropriate course of action.

Analysis

Where, as here, there are dueling reports from physicians each raising a factual basis and medical rationale for respective opinions there becomes a question of fact for me to resolve regarding causation and/or medical necessity. See *State Farm Mut. Auto. Ins. Co. v. Stack*, 55 A.D.3d 594, 869 N.Y.S.2d 536 (2nd Dept. 2008); *Radiology Today PC v. Travelers Ins.*, 39 Misc.3d 146(A) (App. Term 2nd Dept. May 14, 2013); *Westcan Chiropractic PC v. Elco Admin. Services*, 2018 NY Slip Op. 51045(U) (App. Term 2nd Dept. June 28, 2018). As the trier of fact, I am free to accept or reject opinions on credibility grounds. See *Webster Ave. Pavilion*

PC v. Allstate Ins. Co., 42 Misc.3d 148(A) (App. Term 1st Dept. March 19, 2014); AP Orthopedic v. Allstate Ins. Co., 49 Misc.3d 144(A) (App. Term 2nd Dept. Nov. 12, 2015.).

The argument that the EIP should have received epidural injections of steroids prior to undergoing a discectomy is contradicted by the medical cite which pronounces discectomy more effective than said injection. As to the argument that EMG studies revealed no cervical radiculopathy, Dr. Gamburg explains why the negative test is not the sole indication to perform a cervical discectomy.

Lastly, "[i]n the face of a course of treatment that has not been shown to have no medical purpose or performed towards no medical objective, this [forum] is not prepared to second guess a treating doctor who decides that a medical [service] is necessary for his/her diagnosis and treatment (see also [A.B. Med. Serv. v. New York Central Mut. Fire Ins. Co., supra](#); [Alliance Med. Office, P.C. v. Allstate Ins. Co., 196 Misc. 2d 268, 764 N.Y.S.2d 341 \[Civ Ct. Kings Co. 2003\]](#); see also [Citywide Social Work & Psy. Serv. P.L.L.C v. Travelers Indemnity Co., supra](#)))." (A.R. Med. Art, P.C. v. State Farm Mut. Auto. Ins. Co., 11 Misc. 3d 1057[A] [N.Y. Civ. Ct. 2006]; see also, Matter of Integrated Neurological Assoc., PC v 21st Century North America Insurance Company, AAA No. 412013086392 [Arbitrator Moritz])

The Respondent's denial is not sustained.

Fee Schedule

The Respondent also raises the issue of the Applicant's asserted violation of the governing fee schedule as justification for its denial.

The Respondent's fee schedule defense has not been meaningfully developed and is not supported by the executed affidavit or signed report of a coder or other expert. Accordingly, this aspect of the Respondent's defense is summarily rejected (see, All Boro Psychological Servs., P.C. v GEICO Gen. Ins. Co., 34 Misc. 3d 1219[A] [N.Y. Civ. Ct. 2012]).

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
	Precise Medical Solutions LLC	01/28/24 - 01/28/24	\$1,838.39	Awarded: \$1,838.39
Total			\$1,838.39	Awarded: \$1,838.39

- B. The insurer shall also compute and pay the applicant interest set forth below. 08/26/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Based on the submission of a timely denial, interest shall be paid from the above date, until the date that payment is made at a rate of 2% per month.

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 fee, in accordance with newly promulgated 11 NYCRR 65-4(d). After calculating the sum total of the first party benefits awarded in this arbitration plus interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20% of the sum total, subject to no minimum and a maximum of \$1,360.00.

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

04/03/2025
(Dated)

Hersh Jakubowitz

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:
cb4ec9de28d4398b205dfab1c8d8803b

Electronically Signed

Your name: Hersh Jakubowitz
Signed on: 04/03/2025