American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Lenox Hill Radiology & Medical Imaging Associates PC (Applicant)	AAA Case No.	17-25-1385-1516
	Applicant's File No.	CF13031951
- and -	Insurer's Claim File No.	0584069660001
	NAIC No.	36447
LM General Insurance Company (Respondent)		

ARBITRATION AWARD

I, Josh Youngman, 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: IP

1. Hearing(s) held on 06/02/2025
   Declared closed by the arbitrator on 06/02/2025

   Tinamarie Franzoni, Esq. from Choudhry & Franzoni, PLLC participated virtually for the Applicant

   Virginia Scala from LM General Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$1,970.90**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The applicant amended the amount in dispute to $1,728.98 based on their interpretation of the proper amount per the fee schedule.

   Stipulations WERE made by the parties regarding the issues to be determined.

   At the hearing, the parties stipulated to the following facts and/or legal issues:

   1. The applicant submitted the disputed claim(s) for $1,970.90 to the respondent and did not receive payment. As a result, it establishes its prima facie entitlement to an Award for said claim(s) and the service(s) is/are presumed to be medically

necessary. See Viviane Etienne Med. Care, P.C. v. Country-Wide Ins. Co., 25 N.Y.3d 498 (2015); and

2. The respondent timely denied the claim(s) pertaining to date(s) of service 12/11/24 and properly preserved the defense of lack of medical necessity.

3. Summary of Issues in Dispute

This dispute involves a claim for PIP benefits brought by the applicant as an assignee of a 40-year old male (A.M.H.) who was injured on December 3, 2024 when the motor vehicle he was driving was involved in an accident. The evidence shows following the accident the injured party (IP) sought treatment and received MRI's of his cervical and lumbar spine on December 11, 2024.

The evidence further shows the applicant's bill seeking reimbursement for the MRI's was denied by the respondent based on a peer review performed by Matthew H. Kalter, M.D. dated January 16, 2025.

The applicant now seeks an award in the amount of $1,728.98.

Per the parties' stipulations, the issue to be decided is whether the respondent submitted sufficient evidence to sustain their lack of medical necessity defense.

4. Findings, Conclusions, and Basis Therefor

This Award is rendered after diligent review and consideration of the parties' evidence submitted to and maintained by the American Arbitration Association's electronic case filing system, "MODRIA," as well as the parties' oral arguments and any testimony presented at this matter's hearing. Evidence that was submitted after this matter's "closing" and without this Arbitrator's authorization was not considered.

In order to support a lack of medical necessity defense, the 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." Provvedere, Inc. v. Republic Western Ins. Co., 2014 NY Slip Op 50219(U) (App. Term 2d Dept. 2014). The respondent bears the burden of production in support of their lack of medical necessity defense and must overcome the presumption of necessity that attaches to applicant's billing forms. West Tremont Med. Diagnostic, PC v. Geico Ins. Co., 13 Misc.3d 131(A) (App. Term 2d Dept. 2006). Where the respondent presents sufficient evidence to meet this burden, the burden shifts to the applicant to present its own evidence of medical necessity. See West Tremont Med. Diagnostic, PC v. Geico Ins. Co., supra.

There are a myriad of court decisions addressing 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. Those courts have held that a peer

review report's medical rationale will be insufficient to meet the 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. Civ. Ct. 2005); See also, All Boro Psychological Servs. P.C. v. Geico Ins. Co., 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." See Nir v. Allstate, supra.

In the instant matter, Matthew H. Kalter, M.D., per a peer review dated January 16, 2025, lists the medical records that he reviewed and provides a summary of the findings noted in those records before commenting on the necessity of the MRI's.

Dr. Kalter states the American College of Radiology (ACR) does not recommend MRI's for acute low back pain of "less than six weeks in duration" unless there are "red flags". Dr. Kalter further states the "established medical standard of care" is to use "pharmacological interventions and/or therapeutic procedures, for a minimum duration of six weeks."

Dr. Kalter further states "Simple acute lower back pain (LBP) and/or radiculopathy are generally benign, self-resolving conditions which usually do not necessitate any imaging studies."

Dr. Kalter notes the MRI was performed prior to the performed of 4-6 weeks of treatment and asserts the IP did not have any of the red flags which would have necessitated an earlier MRI.

Dr. Kalter makes similar assertions for the cervical spine MRI.

I find that Dr. Kalter has stated a medical rationale and factual basis for his determination that the subject MRI's were not medically necessary. Dr. Kalter states his interpretation of the applicable standard of care, supports that standard with citations to medical journals and applies that standard to this particular IP. Thus, the burden has shifted to the applicant, who bears the ultimate burden of persuasion. Bronx Expert Radiology, P.C. v. Travelers Ins. Co., 2006 NY Slip Op 52116 (App. Term 1st Dept. 2006); West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc.3d 131 (App. Term 2d Dept. 2006).

The applicant does not submit a formal rebuttal. Further, the applicant relied on the report of Felix Almentero, M.D. dated December 10, 2024.

Dr. Almentero, however, does not meaningfully explain why he ordered MRI's of the IP's cervical and lumbar spine after his December 10, 2024 examination. Further, the applicant failed to submit sufficient evidence to show the standard of care stated by Dr. Kalter was either incorrect or misapplied herein.

Thus, I find the applicant has failed to submit sufficient evidence to rebut Dr. Kalter's assertions and the claim is denied.

Further, as stated by the Supreme Court of the State of New York, County of New York in the matter of Country-Wide Ins. Co. v. Sayed Physical Therapy, P.C., 2022 NY Slip Op 31874(U) (Sup. Ct. NY County 2022):

> It is not the duty of the arbiter, be it an arbitrator or Court, to parse [through] hundreds of pages of exhibits to make a out a claim or defense for a party (*see e.g. Barsella v. City of New York*, 82 A.D.2d 747, 748 [1st Dept 1981]); such duty belongs to counsel, as advocate. Failing to elucidate evidence in support of a party's claim is not error of the arbitrator but is rather error of counsel, and such failure does not render an arbitrator's award arbitrary and capricious (*see Stephen Fogel Psychological, P.C. v. Progressive Cas. Ins. Co.*, 35 A.D.3d 720, 721 [2d 2006]).

Thus, any issues not referenced above are held to be moot and/or waived insofar as they were not sufficiently raised at the time of the hearing.

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 claim is DENIED in its entirety

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of CA
SS :
County of San Diego

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

06/10/2025
(Dated)

Josh Youngman

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:
d8cf40ebb069b76ec0b4fa29711fff02

Electronically Signed

Your name: Josh Youngman
Signed on: 06/10/2025