

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

CitiMed Complete Medical Care PC  
(Applicant)

- and -

Liberty Mutual Insurance Company  
(Respondent)

AAA Case No. 17-24-1345-6217

Applicant's File No. RB-203-417165

Insurer's Claim File No. 0482456220001

NAIC No. 36447

### ARBITRATION AWARD

I, Neal S Dobshinsky, 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: J Doe

1. Hearing(s) held on 06/04/2025  
Declared closed by the arbitrator on 07/13/2025

Alex A. Samaroo from Baker & Narkolayeva Law P.C. participated virtually for the Applicant

Kiia Clark from Liberty Mutual Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,929.57**, 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

On 2/10/22, Applicant performed a cervical MRI on J Doe. Applicant sought payment from Insurer for the MRI.

Insurer received Applicant's claim and contends that it sought additional verification, which tolled its time to pay or deny the claim. After more than 120 days following Insurer's request for additional verification and after Insurer received no response, Insurer denied Applicant's claim for violation of the 120-day rule.

On 3/31/22, Applicant performed a brain MRI on Doe. Applicant sought payment from Insurer for the MRI.

Based on a report by its peer reviewer, Insurer denied Applicant's claim on the ground that the MRI was not medically necessary.

Did Insurer establish its 120-rule violation defense? Did Insurer establish its lack of medical necessity defense?

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

I considered the materials in the AAA ADR case file and the authorities cited by the parties that could be located and are not in the submissions or behind a paywall. I considered the arguments of counsel. I find and conclude as follows:

##### **Background**

On 12/23/21, J Doe, then 26 years old, was a pedestrian who was struck by a motor vehicle. Doe claimed he was injured. An ambulance took Doe to a hospital emergency room where he was evaluated, treated, and released.

According to the emergency room record, Doe "was closing the door to his van when he was struck on the left side by a woman [who was] parking. . . . [Doe] felt immediate, 10/10 pain in the left leg. Denies any numbness or tingling. Unable to weight bear or ambulate, difficulty with active motion of left knee. Denies any other pain or location of physical trauma at this time. Denies any lightheadedness or dizziness, chest pain or difficulty breathing, abdominal pain, or muscle weakness." A physician examined Doe and ordered x-rays of his pelvis, femur, and knee. The x-rays were negative. Doe was discharged with crutches and pain medication.

Doe then sought care and treatment from providers with applicant CitiMed Complete Medical Care.

On 1/3/22, Doe saw Marc Levinson, MD, a physician board-certified in physical medicine and rehabilitation at Applicant, for complaints of headaches with blurring of vision, and pains in his neck, lower back, and left knee. Doe did not bring the emergency room report with him; however, he reported that he lost consciousness.

Levinson examined Doe. Doe's head was normocephalic with no external sign of trauma. The diagnostic impressions were headaches, and cervical, lumbar, and left knee sprains/strains. The plan of care included a course of physical therapy, 2 to 3 times per week, for 6 weeks; oral medication; referrals to orthopedics, pain management, acupuncture, and chiropractic; a brain MRI to rule out a subdural hematoma, considering the history of concussion and persistent headaches, and lumbar and left knee MRIs. Doe was to follow up in 3 to 4 weeks.

On 2/4/22, Doe saw Barbara C Steele, MD, an orthopedic surgeon at Applicant, for an initial consultation, complaining of knee pain. According to the history, Doe sustained a brief loss of consciousness and multiple injuries, including to his neck, back, and left knee. The review of symptoms was significant for headache, among other things.

On 2/10/22, a cervical MRI was performed at Applicant on referral from Jeremy Whitfield, DC. Steven Meyreson, MD, a diagnostic radiologist, read the MRI.

On 3/4/22, Doe saw Steele for an orthopedic follow-up, complaining of left knee pain. The history and review of symptoms, including headache, were unchanged from the 2/4/22 consultation.

On 3/22/22, Doe saw Richard A. Gasalberti, MD, a physician board-certified in physical medicine and rehabilitation, at Applicant for a psychiatric follow-up, still complaining of headache, and pains in his neck, low back, and left knee. Much of the report is the same as Levinson's 1/3/22 initial report.

Gasalberti examined Doe. His diagnostic impressions included headaches, closed head injury and post-concussion syndrome; and others that incorporate the cervical, lumbar, and left knee MRI findings. Gasalberti recommended a brain MRI to rule out intracranial bleed versus intracranial mass; he referred Doe for a neurological evaluation and second opinion. Gasalberti's plan included other, further recommendations.

On 3/31/22, a brain MRI was performed at Applicant on referral from Gasalberti. Reginald J. Denis, MD, a diagnostic neuroradiologist, read the MRI.

It is undisputed that Doe is eligible for no-fault insurance benefits from Insurer.

### **Applicant's Claims and Insurer's Denials**

Applicant, as Doe's assignee, timely submitted two separate claims to Insurer for no-fault benefits for payment for MRIs.

On 3/10/22, Applicant billed \$967.69 for the 2/10/22 cervical MRI.

Insurer received the claim and contends that on 4/7/22, it wrote to Applicant. In part, Insurer stated, "[r]ecently we've had to delay the processing of your bill. The reason for this delay is we require a narrative report from the referring physician that documents the patient's complaints, examination findings, and medical necessity of the services prescribed. In addition, please return a copy of this letter with your submission."

Insurer contends that the 4/7/22 letter was a request for additional verification, which tolled its time to pay or deny the claim.

Insurer contends that on 5/10/22, it sent a follow-up letter to Applicant that was essentially the same as its 4/7/22 letter.

Insurer contends that Applicant never responded to the request for additional verification. So, on 8/17/22, Insurer denied Applicant's claim for payment for the cervical MRI for Applicant's violation of the 120-day rule.

On 4/12/22, Applicant billed \$961.88 for the 3/31/22 brain MRI.

Based on a report by its peer reviewer, Insurer denied Applicant's claim on the ground that the MRI was not medically necessary.

The only issues argued and submitted for determination are: Did Insurer establish its 120-rule violation defense? Did Insurer establish its lack of medical necessity defense? All other issues were waived.

### **Claim Processing and the 120-Day Rule**

Under the regulations, "[w]ithin 30 calendar days after proof of claim is received, the insurer shall either pay or deny the claim in whole or in part." 11 NYCRR 65-3.8 (c). Insurer may extend the 30 days by making a timely demand for additional verification. 11 NYCRR 65-3.5 (b); 65-3.6 (b). Such demand must be made within 15 business days of receipt of the prescribed verification forms. 11 NYCRR 65-3.5 (b). If the demanded verification is not received within 30 days, the insurance company must issue a follow-up request within 10 days of the insured's failure to respond. 11 NYCRR 65-3.6 (b). Insurer need not pay or deny the claim until all verification is provided. 11 NYCRR 65-3.8 (b) (3). No-fault benefits are overdue unless paid within 30 calendar days after the insurer receives proof of claim, which includes verification of all relevant information requested under 11 NYCRR 65-3.5.

An insurer may toll or extend its time to pay a claim by timely demanding an EUO, a medical examination, or verification. *Hospital for Joint Diseases v New York Cent. Mut. Fire Ins. Co.*, 44 AD3d 903 [2d Dept 2007]; 11 NYCRR 65-3.5 [c]; 65-3.8 [a] [1]. However, a no-fault insurer that "fails to pay or deny a claim within the requisite 30 days . . . is subject to 'substantial consequences,' namely, preclusion 'from asserting a defense against payment of the claim.' The only exception is where an insurer raises lack of coverage as a defense" (internal citations omitted). *Viviane Etienne Med. Care v Country-Wide Ins. Co.*, 25 NY3d 498, 506 [2015].

"[A]n 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 the applicant's control or possession or written proof providing reasonable justification for the failure to comply, provided that the verification request so advised the applicant as required in section 65-3.5 (o) of this Subpart" . . . 11 NYCRR 65-3.8 (b) (3).

### **Insurer's 120-Day Rule Defense Is Ineffective**

Insurer's 120-day rule defense fails for two reasons.

First, where a defense is predicated on an applicant's failure to respond to an insurer's request, the insurer needs to submit evidence that it made the request and raise the presumption that the applicant received the request.

The mere submission of the request is not enough to raise the presumption of receipt.

"Generally, proof of proper mailing gives rise to a presumption that the item was received by the addressee. 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" (internal citations omitted). *Residential Holding Corp. v Scottsdale Ins. Co.*, 286 AD2d 679 [2d Dept 2001].

Here, Insurer failed to submit evidence to raise the presumption that Applicant received its request by mail or any other means.

Second, although Insurer characterizes its 4/7/22 letter as a request for additional verification, it is not. By its own terms, it is a mere delay letter. Insurer submitted no evidence that it requested the narrative report it mentions in the letter.

Insurer's 120-day rule defense to payment for the 2/10/22 cervical MRI has no merit.

### **Medical Necessity and the Burden of Proof**

Medical necessity for services or supplies is established by proof of an applicant's properly submitted claim form. *All County Open MRI & Diagn. Radiology P.C. v Travelers Ins. Co.*, 11 Misc3d 131[A], 2006 NY Slip Op. 50318[U] [App Term, 2d Dept 9th & 10th Jud Dists 2006]. Here, Applicants' submissions establish the presumption of medical necessity for the brain MRI.

The insurer "bears both the burden of production and persuasion" as to its lack of medical necessity defense. *Nir v Allstate Ins. Co.*, 7 Misc3d 544, 546 [Civ Ct, Kings County 2005]. The defense must be based on evidence that furnishes a sufficiently detailed factual basis and medical rationale for the denial. *Amaze Med. Supply v Eagle Ins. Co.*, 2 Misc3d 128[A], 2003 NY Slip Op 51701[U] [App Term, 2d Dept, 2d & 11th Jud Dists 2003].

"[H]owever, it is the [applicant] who has the ultimate burden of proving, by a preponderance of the evidence, that the services at issue were medically necessary" (citations omitted). *Radiology Today, P.C. v Geico Ins. Co.*, 58 Misc3d 132[A], 2017 NY Slip Op 51768[U] [App Term, 2d Dept, 2d, 11th & 13th Jud Dists 2017].

### **The Peer Review and Insurer's Lack of Medical Necessity Defense**

Insurer denied Applicant's claim for the brain MRI on an affirmed peer review by Amit Khaneja, MD, a board-certified neurologist. In his 4/27/22 report, Khaneja states his reasons and opinion why the MRI was not medically necessary.

Khaneja lists the records and reports he reviewed, more than 25 bullet-point items. These included the 12/23/21 hospital emergency department notes; 12/23/21 x-ray reports (knee, pelvis, left femur); initial psychiatric evaluation by Levinson on 1/3/22; 1/26/22 MRI reports (lumbar spine, left knee); initial orthopedic evaluation by Steele on 2/4/22; 3/22/22 note by Gasalberti; 3/31/22 brain MRI; acupuncture notes; physical therapy notes; and other records and reports.

Khaneja notes the accident and that Doe was a pedestrian. There was an emergency room visit, and no reported loss of consciousness. Doe reported lower back and knee pains. Doe was treated with physical therapy and acupuncture.

Khaneja states that according to the standard of care, diagnostic neuroimaging such as a brain MRI is typically recommended in the context of neurological deficits that initial CT scans have not explained or to evaluate prolonged intervals of disturbed consciousness, corroborated by neurological deficits.

Khaneja notes that Doe saw Levinson on 1/3/22, complaining of posttraumatic headache. The neurological exam revealed his speech was coherent, judgment was intact, CN II-XII grossly intact. Deep tendon reflexes, both lower extremity quadriceps and Achilles were 1+, sensory light touch and pain were grossly intact. Levinson's diagnoses included headaches. Levinson recommended the brain MRI.

Khaneja concludes that there was no head injury or loss of consciousness noted. There was no cognitive or neurological deficit. Therefore, the brain MRI was not medically necessary and not according to the medical standard of care.

Khaneja assumes that the brain MRI was performed on a referral by Levinson as a result of the 1/3/22 initial evaluation. However, it was not. The evidence shows that the MRI was performed on 3/31/22 based on referral by Gasalberti at the 3/22/22 follow-up evaluation and because of Doe's continuing complaints of headache.

While Khaneja's peer review is appealing, his failure to discuss Doe's months' long complaints of headaches, the 3/22 evaluation by Gasalberti, and Doe's clinical condition at that time undermines the value of his opinion.

In this circumstance, there is an inadequate factual basis for Khaneja's opinion. Insurer failed to meet its initial evidentiary burden. Insurer failed to establish its lack of medical necessity defense.

(Note, Insurer submitted the peer review shortly before the hearing date. At the hearing, Applicant requested and was then given an opportunity to submit a rebuttal to

the peer review following the hearing. Applicant did submit a rebuttal by Ashraf Salem, MD, dated 6/10/25. I did not consider the Salem rebuttal because Insurer failed to meet its initial evidentiary burden).

**Conclusion**

Insurer failed to establish its 120-day rule defense regarding the cervical MRI, and it failed to establish its lack of medical necessity defense regarding the brain MRI.

Based on the parties' submissions, their arguments, the law, the regulations, and the weight of the credible evidence, Applicant is entitled to payment.

- 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
	<b>CitiMed Complete Medical Care PC</b>	<b>02/10/22 - 02/10/22</b>	<b>\$967.69</b>	<b>Awarded: \$967.69</b>
	<b>CitiMed Complete Medical Care PC</b>	<b>03/31/22 - 03/31/22</b>	<b>\$961.88</b>	<b>Awarded: \$961.88</b>

<b>Total</b>	<b>\$1,929.57</b>	<b>Awarded: \$1,929.57</b>
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B. The insurer shall also compute and pay the applicant interest set forth below. 04/26/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Insurer shall compute and pay interest from the accrual date noted above-the date on which Applicant requested arbitration by filing with the AAA-at a rate of 2% per month, simple interest, calculated on a pro-rata basis using a 30-day month and ending with the date of payment subject to the provisions of 11 NYCRR 65-3.9.

C. Attorney's Fees

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

Insurer shall pay Applicant's attorney a fee in an amount equal to 20% of the total amount of the benefits plus interest awarded in this arbitration, subject to the provisions of 11 NYCRR 65-4.6.

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 NJ  
 SS :  
 County of Monmouth

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

08/04/2025  
 (Dated)

Neal S Dobshinsky

**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:**  
e1c7db22002fe2fed3fec8f5098d1c75

**Electronically Signed**

Your name: Neal S Dobshinsky  
Signed on: 08/04/2025