

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Diana Besleaga, MD PC
(Applicant)

- and -

Progressive Casualty Insurance Company
(Respondent)

AAA Case No. 17-24-1370-7891

Applicant's File No. M16006

Insurer's Claim File No. 23-8746631

NAIC No. 11851

ARBITRATION AWARD

I, Maureen Callahan, 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 08/25/2025
Declared closed by the arbitrator on 08/25/2025

Ashley Andrews from Munawar Law Firm, PLLC participated virtually for the Applicant

Liz Peabody from Progressive Casualty Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$500.00**, was AMENDED and permitted by the arbitrator at the oral hearing.

The claim is amended downward; applicant seeks \$178.26.

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

The parties stipulated and agreed that (i) Applicant has met its prima facie burden by submitting evidence that payment of no-fault benefits are overdue, and proof of its claim was mailed to and received by Respondent; (ii) Respondent's denial of the subject claim was timely issued.

3. Summary of Issues in Dispute

CASE SUMMARY

The accident occurred on 11/9/23. The eligible injured party (EIP) is a 32-year-old operator of a vehicle involved in this accident. Subsequent to the accident, assignor suffered injuries which resulted in her seeking medical treatment. A treatment plan was recommended and the assignor commenced a course of care. This claim seeks reimbursement for anesthesia utilized in connection with lumbar spine epidural injections, services performed on 9/25/24. Respondent denied the claim based upon an independent medical examination by Dr. Dorothy Scarpinata on 12/28/23. The issue is if respondent meets their burden and substantiates their denial of claim, or if this is overcome.

4. Findings, Conclusions, and Basis Therefor

The accident occurred on 11/9/23. I have reviewed all of the relevant exhibits contained in the electronic file center maintained by the American Arbitration Association. The hearing was held via ZOOM. This decision is rendered upon consideration of the oral arguments made by the parties at the hearing and upon a review of the evidence contained in the case folder as of the date of this hearing. No witness testimony is offered. This case is linked to another involving the same injured party and same accident: 17 - 24 - 1373 - 1091. The cases were heard in tandem.

The Arbitrator, in weighing the evidence, has broad powers and discretion in determining what evidence is relevant and material. The Arbitrator is in the best position to evaluate the evidence and decide on the credibility of the submitted documents." It is well-settled that a health care provider establishes its prima facie entitlement to reimbursement as a matter of law by proof that it submitted a claim, setting forth the fact and the amount of the loss sustained, and that payment of No-Fault benefits was Page 2/7 overdue. *Damadian MRI in Canarsie, P.C. a/a/o Tyrone Harley v. General Assurance Co.*, 2006 NY Slip Op 51048U, Supreme Court of NY, App. Term 2d Dept., June 2, 2006; See Insurance Law Section 5106a, *Mary Immaculate Hosp. v. Allstate Ins. Co.*, 5 AD 3d 742, 774 N.Y.S. 2d 564 (2004); *Amaze Med. Supply v. Eagle Ins. Co.*, 2 Misc. 3d 128A, 784 N.Y.S. 2d 918 [2003 NY Slip Op 51701U (App. Term 2d & 11 Jud. th Dists.)]. See also 11 NYCRR Section 65-1.1 *Vista Surgical Supplies, Inc. v. Metropolitan Property and Casualty Ins. Co.*, 2005-1328 KC, 2006 NY Slip Op 51047U, June 2, 2006.

The records submitted to the electronic case folder indicate the injured party was a 32-year-old owner/operator of a Hyundai involved in an accident on Hegeman Avenue in Kings County, N.Y. The EIP claimed injured, and commenced a course of

chiropractic care and physical therapy 4 days postaccident. On 9/25/24, approximately 11 months later, the EIP had a lumbar epidural steroid injection. This claim seeks reimbursement for the anesthesia utilized in connection with the injections on 9/25/24.

A prima facie showing of entitlement to judgment as a matter of law is made out by submitting evidentiary proof that the prescribed statutory billing forms have been mailed and received, and that payment of No-Fault benefits was overdue. *LMK Psychological Services, P.C. v. Liberty Mut. Ins. Co.*, 30 A.D.3d 727, 816 N.Y.S.2d 587 (3d Dept. 2006) (claimant submitted signed return receipt cards); Accordingly, Applicant has made out a prima facie case for reimbursement as a matter of law. (See, Insurance Law § 5106(a); *Mary Immaculate Hosp. v. Allstate Ins. Co.*, 5 AD3d 742 [2d Dept. 2004].).

Once Applicant makes out a prima facie case, the burden shifts to Respondent to timely request additional verification, deny or pay the claim. (See *Hospital for Joint Diseases v. Travelers Prop. Cas. Ins. Co.* 9 NY3d 312 [2007]; 11 NYCRR § 65.15[d][1],[2]; 11 NYCRR 65.15[g][3]) ("within 30 calendar days after proof of claim is received, the insurer shall either pay or deny the claim in whole or in part.") Most defenses are precluded if not preserved in a timely denial of claim. (See *Central General Hospital v. Chubb Group of Insurance Companies*, 90 NY2d 195 [1997].)

To meet their burden, respondent called for an independent medical examination. The Appellate Division has held that "[t]he appearance of the insured at IMEs at any time is a condition precedent to the insurer's liability on the policy. *Stephen Fogel Psychological PC v. Progressive Insurance Company*, 35 A.D.3d 720; 827 N.Y.S.2d 217 (App. Div. 2 Dept. 2006). Once Applicant makes out a prima facie case, the burden shifts to Respondent to timely request additional verification, deny or pay the claim. (See *Hospital for Joint Diseases v. Travelers Prop. Cas. Ins. Co.* 9 NY3d 312 [2007]; 11 NYCRR § 65.15[d][1],[2]; 11 NYCRR 65.15[g][3]) ("within 30 calendar days after proof of claim is received, the insurer shall either pay or deny the claim in whole or in part.")

The EIP was directed to appear for an IME with Dr Dorothy Scarpinata on 12/28/23. Her thorough orthopedic exam opined that all cervical, thoracolumbar spinal sprains had resolved. The examination of the upper and lower extremities was normal. She opined that the EIP's subjective complaints did not correlate to any objective findings. I find respondent meets their burden with the IME and arguments in support thereof.

If an insurer presents evidence substantiating a lack of medical necessity defense, the burden shifts to the applicant health services provider to then present its own evidence of medical necessity. Applicant argues that the treating doctor, Dr. Akhnoukh, opined in a medical necessity letter dated 7/15/25 that the EIP had exhibited tenderness to the spine and that the pain level in August 2024 was noted to be 8/9 on a 10 point pain scale, with a positive SLR test and spasms noted at that time. She argues that this is enough to overcome this error negative IME from Dr. Scarpinata. Respondent argues to the contrary. She argues that in a linked case, 17 - 24 - 1348 - 3825, arbitrator Miller opined that the IME was sufficient to deny payment of biowave therapy performed on 2/2/24.

I have listened to the arguments and evaluated the evidence. Respondent meets their burden in denying this claim based upon the mostly negative IME from Dr. Scarpinata. However, the burden then becomes applicant's to show otherwise. I find that applicant's arguments in support of their letter of necessity from Dr. Akhnoukh a treating doctor, sufficient to overcome respondent's showing. On 7/15/25, tenderness was noted. Applicant argues that the IME was performed only 2 months after the accident. The treating doctor's note of 8/16/24 (8 months after the IME was performed) indicated a high pain level of 8/9 on a 10 point pain scale, spasms, positive SLR and Spurling test. I find these objective findings sufficient to overcome the opinions of the ime doctor. I will award for the applicant: \$178.26.

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	Amount Amended	Status
	Diana Besleaga, MD PC	09/25/24 - 09/25/24	\$500.00	\$178.26	Awarded: \$178.26
Total			\$500.00		Awarded: \$178.26

- B. The insurer shall also compute and pay the applicant interest set forth below. 10/22/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

INTEREST: Pursuant to Insurance Law § 5106 (a), interest accrues on overdue no-fault insurance claims at a rate of 2% per month. A claim is overdue when it is not paid within 30 days after a proper demand is made for its payment (Insurance Law § 5106 [a]; 11 NYCRR 65.15 [g]). The Superintendent's regulation tolls the accumulation of interest if the claimant "does not request arbitration or institute a lawsuit within 30 days after receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations" (11 NYCRR 65-3.9 [c]). The Superintendent has interpreted this provision to mandate that the accrual of interest is tolled, regardless of whether the particular denial at issue was timely. That interpretation was upheld by the Court of Appeals in LMK Psychological Servs, P.C. v. State Farm Mut. Auto. Ins. Co., 2009 NY Slip Op 02481 (April 2, 2009). Where no denial of claim is issued in response to a proper demand for payment, the insurer does not benefit from the tolling provision and interest will accrue from the date 30 days after the proper demand for payment is made. Interest that accrues when a denial of claim is not issued within 30 days after the proper demand for payment is made will be tolled upon the issuance of a denial of claim, although such denial is untimely, and the failure to request arbitration or institute a lawsuit within 30 days after receipt of that denial of claim form.

C. Attorney's Fees

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

Attorney fee to be paid in accordance with 11 NYCRR 65-4.2in

- 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 NY

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

08/26/2025
(Dated)

Maureen Callahan

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:
02e5ebeb5902bbf4ceccabb290034503

Electronically Signed

Your name: Maureen Callahan
Signed on: 08/26/2025