American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Flotus Inc. (Applicant)	AAA Case No.	17-25-1400-6039
	Applicant's File No.	RB-494-589086
- and -	Insurer's Claim File No.	0779774016
	NAIC No.	29688
Allstate Insurance Company (Respondent)		

ARBITRATION AWARD

I, Anne Malone, 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 04/13/2026
   Declared closed by the arbitrator on 04/13/2026

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

   Iffat Astha, Esq. from Law Offices Of Richard Schoenberg participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$3,184.06**, 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

   The 69 year old EIP reported involvement a motor vehicle accident on December 30, 2025; claimed related injury and received various items of durable medical equipment provided by the applicant on January 6, 2025, January 9, 2025 and January 30, 2025.

   The applicant submitted a claim for this durable medical equipment (DME), payment of which was denied by the respondent based upon a peer review by Stuart Springer, M.D. dated March 14, 2025. In response, the applicant submitted a rebuttal dated February 18, 2026 by Vladimir Gressel, M.D.

The issue to be determined at the hearing is whether the respondent established that the durable medical equipment at issue was not medically necessary.

4. Findings, Conclusions, and Basis Therefor

This hearing was held on Zoom and the decision is based upon the documents reviewed from the Modria File as well as the arguments made by counsel and/or representative at the arbitration hearing. Only the arguments presented at the hearing are preserved in this decision; all other arguments not presented at the hearing are considered waived.

To support a lack of medical necessity defense respondent must "set forth a factual basis and medical rationale for the peer reviewer's [or examining physician'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. Term2d, 11th and 13th Jud. Dists. 2014.)

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 Bronx Expert Radiology, P.C. v. Travelers Ins. Co., 2006 NY Slip Op 52116 (App. Term 1st Dept. 2006.)

The Civil Courts have held that a defendant's peer review or report of medical examination must set forth more than just a basic recitation of the expert's opinion. The trial courts have held that a peer review or medical examination report's medical rationale will be insufficient to meet respondent's 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 specifics as to the claim at issue, is conclusory or vague. See Nir v. Allstate, 7 Misc.3d 544 (N.Y. City Civ. Ct. 2005.)

To support its contention that the DME provided by the applicant was not medically necessary, respondent relies upon the report of the peer review by Dr. Springer, who reviewed 48 medical records of the EIP, noted the injuries claimed and the treatment rendered to him. Dr. Springer considered possible arguments and justification for the need for the DME at issue and determined that it was not warranted under the circumstances presented.

Dr. Springer specifically discussed each of the items of DME at issue and his reasons for determining why each was not medically necessary for this particular EIP at the time it was provided. He discussed the standard of care for the injuries sustained by the EIP and determined that he did not meet these criteria.

He supported, with relevant medical literature, his opinion that the DME at issue was not medically necessary for this particular EIP at the time it was provided.

Respondent has factually demonstrated that the services at issue were not medically necessary. Accordingly, the burden now shifts to the applicant, who bears the ultimate burden of persuasion, pursuant to Bronx Expert Radiology, P.C., *supra.*

In opposition to the peer review, the applicant presented a rebuttal by Dr. Gressel who reviewed the EIP's medical records, disagreed with the conclusions reached by Dr. Springer and discussed in detail the injuries sustained by the EIP and the treatment rendered to him.

He also discussed each item of DME and his specific reasons for determining that each was medically necessary for this particular EIP at the time it was provided and supported his findings with relevant medical literature.

After a review of all of the evidence submitted an issue of fact remains as to whether the services rendered are medically necessary. Conflicting opinions have been presented in the peer review by Dr. Springer and the rebuttal by Dr. Gressel submitted on behalf of the applicant.

In this instance, the rebuttal by Dr. Gressel meaningfully refers to and rebuts the findings of Dr. Springer. In addition, the medical reports submitted are sufficient to establish the medical necessity for the services at issue.

Therefore, I find that the submission of Dr. Gressel was more persuasive in this instance.

Based on the foregoing, I find that the respondent has failed to establish that the DME at issue was not medically necessary.

Accordingly, the applicant is awarded $3,184.06 in disposition of this claim.

Any further issues submitted in the record are held to be moot and/or waived insofar as they were not raised at the time of this hearing. This decision is in full disposition of all claims for no-fault benefits presently before this Arbitrator.

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**
	Flotus Inc.	**01/06/25 - 01/06/25**	**$1,430.98**	**Awarded: $1,430.98**
	Flotus Inc.	**01/09/25 - 01/09/25**	**$150.96**	**Awarded: $150.96**
	Flotus Inc.	**01/30/25 - 01/30/25**	**$1,602.12**	**Awarded: $1,602.12**
Total			**$3,184.06**	**Awarded: $3,184.06**

B. The insurer shall also compute and pay the applicant interest set forth below. 05/16/2025 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant is awarded interest pursuant to the no-fault regulations. See generally, 11 NYCRR §65-3.9. Interest shall be calculated "at a rate of two percent per month, calculated on a *pro rata* basis using a 30 day month." See 11 NYCRR §64-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. However, the regulations toll the accrual of interest when an applicant "does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits" calculated pursuant to Insurance Department regulations. Where a claim is untimely denied, or not denied or paid, interest shall accrue as of the 30th day following the date the claim is presented by the claimant to the insurer for payment. Where a claim is timely denied, interest shall accrue as of the date an action is commenced or an arbitration requested, unless an action is commenced or an arbitration requested within 30 days after receipt of the

denial, in which event interest shall begin to accrue as of the date the denial is received by the claimant. See, 11 NYCRR §65-3.9(c.) The Superintendent and the New York Court of Appeals has interpreted this provision to apply regardless of whether the particular denial was timely. LMK Psychological Servs. P.C. v. State Farm Mut. Auto. Ins. Co., 12 NY3d 217 (2009.)

C. Attorney's Fees

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

Applicant is awarded statutory attorney's fees pursuant to the no fault regulations. For cases filed after February 4, 2015 the attorney's fee shall be calculated as follows: 20% of the amount of first-party benefits awarded, plus interest thereon subject to no minimum fee and a maximum of $1,360.00. See 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 CT
SS :
County of Fairfield

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

04/25/2026
(Dated)

Anne Malone

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:
2d6c998b4d747d8075f6c0e943e1691b

Electronically Signed

Your name: Anne Malone
Signed on: 04/25/2026