American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Bowen MD PLLC (Applicant)	AAA Case No.	17-25-1410-0379
	Applicant's File No.	197913
- and -	Insurer's Claim File No.	HLV25005843-01
	NAIC No.	24309
Hereford 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 06/26/2026
   Declared closed by the arbitrator on 06/26/2026

   Edilaine D'Arce, Esq. from Law Offices of Eitan Dagan P.C. participated virtually for the Applicant

   Rosemary Repetto, Esq. from Law Offices of Ruth Nazarian participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$8,364.41**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The amount claimed was amended by the applicant to $6,448.40 to conform to the appropriate fee schedule.

   Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

   The 81 year old EIP reported involvement in a motor vehicle accident on January 30, 2025; claimed related injury and underwent lumbar percutaneous discectomy provided by the applicant on May 18, 2025.

The applicant submitted a claim for the surgeon services, payment of which was timely denied by the respondent based upon a peer review by Don Nicholson, M.D. dated July 2, 2025. In response, the applicant submitted a rebuttal dated October 12, 2025 by Alexander Bowen, M.D. the EIP's treating surgeon.

The issue to be determined at the hearing is whether the respondent established that the lumbar percutaneous discectomy and related surgeon services at issue were 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.)

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 lumbar percutaneous discectomy and related medical services provided by the applicant were not medically necessary, respondent relies upon the peer review by Dr. Nicholson who reviewed the medical records of the EIP, noted the injuries claimed and the treatment rendered to him. Dr. Nicholson considered possible arguments and justification for the need for the lumbar percutaneous discectomy and related surgeon services at issue and determined that they were not warranted under the circumstances presented.

Dr. Nicholson submitted a comprehensive report in which he discussed the lumbar percutaneous discectomy and related services provided and his reasons for determining that they were not medically necessary for this EIP. The submissions include more than 60 medical records reviewed by Dr. Nicholson

which consisted of evaluations by providers of various medical specialties including pain management, lumbar trigger point injections, prescription medication, positive MRI studies, EMG/NCV testing, conservative treatment, chiropractic, physical therapy, beginning on February 2, 2025 and durable medical equipment.

Dr. Nicholson specifically noted that the office visit note provided by Dr. Kohler dated May 18, 2025 documented pain in the lower back, and at L3-S1, decreased range of motion and positive SLR. The recommendation was for lumbar discectomy, annuloplasty. In addition he stated that some patients' clinical symptoms could be released with conservative treatment for about 4 weeks but that once they could not be released with conservative treatment surgery is required. He noted that the popularity of minimally invasive spine operation for treatment of lumbar disc herniation is growing and that standard open discectomy is being replaced by microdiscectomy.

It was Dr. Nicholson's opinion that prior to surgical intervention, conservative treatment and epidurals should be tried. He cited medical literature which recommended at least 12 weeks of conservative treatment before a patient was considered for surgery absent severe symptoms such as severe pain and disability. He also cited literature that supported surgical intervention for severe lumbar disc herniation patients within 6 months to one year since it is related to faster recovery and better long-term outcomes.

Dr. Nicolson concluded that the clinical examination of this EIP failed to note symptoms which were sufficient to establish medical necessity for the lumbar percutaneous discectomy and that any associated or derivative services, including anesthesia, x-ray of the lumbar spine and lumbar discography.

He specifically concluded that the medical records presented for the peer review failed to support the medical necessity of anesthesia for this EIP of extreme age.

I find that the peer review is conclusory and factually insufficient to meet the burden of rebutting the applicant's presumption of medical necessity. The respondent did not provide an adequate response to the recommendations made by the EIP's treating medical providers to establish that the medical services at issue were not medically necessary. Based on the foregoing, pursuant to Provvedere, Inc., *supra* the burden did not shift to the applicant since respondent did not meet its burden to establish lack of medical necessity.

Although it was not necessary under these circumstances, the applicant submitted a rebuttal by Dr. Bowen, the EIP's treating surgeon.

Based on the foregoing, I find that the respondent has failed to establish that the lumbar percutaneous discectomy and related surgeon services at issue were not medically necessary.

Accordingly, the applicant is awarded $6,448.40 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**	**Amount Amended**	**Status**
	Bowen MD PLLC	**05/18/25 - 05/18/25**	**$8,364.41**	**$6,448.40**	**Awarded: $6,448.40**
Total			**$8,364.41**		**Awarded: $6,448.40**

B. The insurer shall also compute and pay the applicant interest set forth below. 07/22/2025 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.

07/25/2026
(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:
078b0ede7fe2b58ea70ffdba182d0b4f

Electronically Signed

Your name: Anne Malone
Signed on: 07/25/2026