

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

PARS Medical PC
(Applicant)

- and -

Accident Fund Insurance Company of
America
(Respondent)

AAA Case No. 17-25-1425-0385
Applicant's File No. 65930
Insurer's Claim File No. VGM-BG-25-0296501
NAIC No. 10166

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 07/27/2026
Declared closed by the arbitrator on 07/27/2026

Jeff Henle, Esq. from Mullaev Law Group participated virtually for the Applicant

Kimberly Glock, Esq. from Law Office of Jason Tenenbaum, PC participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$5,847.29**, 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 40 year old EIP reported involvement in a motor vehicle accident on May 9, 2025; claimed related injury and underwent an office visit and lumbar percutaneous discectomy provided by the applicant on July 14, 2025.

The applicant submitted a claim for these medical services, payment of which was timely denied by the respondent based upon a peer review by Jeffry Beer, M.D. dated August 17, 2025.

The issue to be determined at the hearing is whether the respondent established that the medical 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.

In order 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.)

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

He discussed the standard of care for treatment of the injuries sustained by the EIP and determined that he did not meet these criteria. He discussed the medical literature which generally lack of effectiveness of percutaneous discectomy and specifically noted that the MRI for this EIP revealed only disc bulging without evidence of herniation and the lack of symptoms documented for him that would warrant this procedure at the time it was provided.

Respondent has met its evidentiary burden. The peer review adequately sets forth the factual basis and medical rationale to support the conclusion that the medical services at issue were not indicated for this EIP at the time they were provided.

Therefore, pursuant to Bronx Expert Radiology, *supra* the burden shifts to the applicant, which bears the ultimate burden of persuasion to establish that the medical services at issue were medically necessary.

The applicant did not submit a formal rebuttal. However, the applicant relies upon the submissions, including The MRI studies and the initial evaluation of the EIP on June 18, 2025 which documented subjective complaints of pain and tenderness and reduced muscle strength with unspecified decreased range of motion.

The initial recommendation was for physical therapy 2 to 3 times a week, medications an LSO and cervical traction with a follow up in 2 to 4 weeks. A LESI was performed on June 30, 2025. The lumbar percutaneous discectomy was performed on July 14, 2025.

An office visit performed on that date stated that the EIP had experienced only temporary relief from the LESI and recommended other options including physical therapy, chiropractic adjustments and acupuncture, epidural procedures, nerve blocks , percutaneous discectomy and endoscopic discectomy surgery. The percutaneous discectomy was performed on that day.

Since the applicant did not provide a rebuttal to the peer review it did not respond to the respondent's argument that the medical services provided to the EIP were a deviation from a reasonable medical standard of care. The medical records alone are not sufficient to rebut the conclusions of Dr. Beer. In addition, the respondent did not provide any citations to refute the medical literature relied upon by him.

Based on the foregoing, I find that the respondent established that the medical services at issue were not medically necessary.

Under these circumstances, the fee schedule issue is moot.

Accordingly, the claim is dismissed with prejudice.

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 claim is DENIED in its entirety

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.

08/15/2026

(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:
553196238acdf043fa3f8427befefead

Electronically Signed

Your name: Anne Malone
Signed on: 08/15/2026