

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

SMG Mediquip, LLC
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No.	17-17-1061-1828
Applicant's File No.	FDNY17-17033
Insurer's Claim File No.	0274828940101051
NAIC No.	35882

ARBITRATION AWARD

I, Bryan Hiller, 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: Assignor

1. Hearing(s) held on 03/13/2018
Declared closed by the arbitrator on 03/13/2018

Joe D'Agostino, Esq. from Fass & D'Agostino, P.C. participated in person for the Applicant

Jasleen Kaur, Esq. from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 980.97**, 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

Whether Applicant is entitled to reimbursement for the fees associated with Durable Medical Equipment Assignor was prescribed in connection with injuries sustained in a motor vehicle accident on August 13, 2016 in light of the Respondent's Peer Review done by Dr. Christopher Ferrante on October 18, 2016?

4. Findings, Conclusions, and Basis Therefor

Applicant seeks reimbursement, along with interest and counsel fees, under the No-Fault Regulations, for the costs associated with durable medical equipment, specifically an LSO and a TENS unit, prescribed to the Assignor. The medical supplies were denied following the completion of a Peer Review done by Dr. Christopher Ferrante on behalf of the Respondent. All denials were timely. This decision is based upon the written submissions of counsel for the respective parties as well as oral argument at the hearing conducted March 13, 2017. I have reviewed the documents contained in the Record as of the date of the hearing. At the hearing, Respondent's representative stated that it was not pursuing a fee schedule issue, so I deem that defense abandoned.

Assignor, a then 39 year old male, was involved in an automobile as a restrained driver on August 13, 2016. Following the accident, Assignor was taken by a relative to the emergency room at Mather Hospital later in the day where he was evaluated, given x-rays and discharged. Due to continued symptomology, Assignor came under the care of multiple conservative care providers. At the initial chiropractic evaluation on August 15, 2016, Assignor's complaints referable to the accident included pain in the neck, upper back, middle back, lower back, intrascapular region and bilateral arm and leg numbness. On examination, Assignor had active trigger points throughout the cervical spine, motor weakness in the left wrist flexor and quadriceps, decreased ranges of motion on all planes of the cervical and lumbar spines, diminished reflex function in the Achilles, hypoesthesia at the left L5 level and positive provocative orthopedic testing including cervical compression test, shoulder depression test, Soto-Hall test on the right side, maximum cervical compression test, Spurlings test, Jackson compression test, Tinel's on the right, Milgrams on the right, Kemp's test, Hibb's test, Yeoman's test, Patrick's test, straight leg raise test, Bragrad's test, Valsalva maneuver and Bechterew's test. Following the evaluation, Assignor was diagnosed with cervical sprain/strain, disc displacement and radiculopathy, thoracic disc displacement, lumbar sprain/strain, disc displacement, myofascitis and radiculopathy and cervicogenic headaches and Assignor was started on a course of care including spinal adjustments at a rate of four times per week and MRIs of the spine. When pain persisted despite treatment, Assignor was prescribed the durable medical equipment at issue. The subject LSO and TENS unit were delivered to the Assignor by Applicant SMG Mediquip, LLC between September 21, 2016 and October 28, 2016 and the prescription and notes related to those devices are attached to the Record.

Applicant has established its prima facie case with proof that it submitted a proper claim, setting forth the fact and the amount charges for the services rendered and that payment of no-fault benefits was overdue (see Insurance Law Section 5106a; *Mary Immaculate Hosp. v. Allstate Ins. Co.*, 5 AD 3d 742, 774 N.Y.S. 2d 564[2004]). The burden shifts to the insurer to prove that the services were not medically necessary.

If an insurer asserts that the medical test, treatment, supply or other service was medically unnecessary, the burden is on the insurer to prove that assertion with competent evidence such as an independent medical examination, a peer review or other proof that sets forth a factual basis and a medical rationale for denying the claim (see *A.B. Medical Services, PLLC v. Geico Insurance Co.*, 2 Misc. 3d 26 [App Term 2nd & 11th Jud Dists 2003]).

When an insurer relies upon a peer review report to demonstrate that a particular service was not medically necessary, the peer reviewer's opinion must be supported by sufficient factual evidence or proof and cannot simply be conclusory. As per the holding in Jacob Nir, M.D. v. Allstate Insurance Co., 7 Misc.3d 544 (2005), the peer reviewer must establish a factual basis and medical rationale to support a finding that the services were not medically necessary, including setting forth generally accepted standards in the medical community. The opinion of the insurer's expert, standing alone, is insufficient to carry the insurer's burden to prove that the services were not medically necessary (see CityWide Social Work & Psychological Services, PLLC v Travelers Indemnity Co., 3 Misc.3d 608, 777 N.Y.S.2d 241 (N.Y. Civ Ct. Kings Co. 2004)).

In support of their defense, Respondent submitted a peer review by Chiropractor Christopher Ferrante dated October 18, 2016. Peer reviewer Chiropractor Ferrante determined that the durable medical equipment supplied was not medically necessary. Chiropractor Ferrante supported his positions by citing to medical authority. Specific to the TENS unit, Chiropractor Ferrante argued that TENS are typically prescribed for patients who have progressive to the chronic stage of their condition and are no longer under active care. Here, Chiropractor Ferrante noted that the Assignor was undergoing a course of treatment that included in office electric stimulation, which would make the TENS unit redundant. As the Assignor was not in the chronic phase, Chiropractor Ferrante determined that the TENS was not medically necessary. With respect to the LSO, Chiropractor Ferrante argued that it is typically prescribed for spinal instability, fracture, dislocation or post-surgical care, none of which was the case here. In fact, Chiropractor Ferrante argued that there was absolutely no indication of instability, fracture or unstable spondylolisthesis in the lumbar spine. Lastly, Chiropractor Ferrante argued that there was no explanation regarding how the use of the LSO would decrease the frequency of treatment the Assignor was currently receiving. As such, Chiropractor Ferrante concluded that the LSO was similarly medically unnecessary.

Applicant submitted a rebuttal by non-treating Chiropractor Nestor Nicolaides dated February 2, 2017 in response to the peer review. Dr. Nicolaides outlined the findings on initial examination and defined the goal of prescribing the LSO and TENS unit in order to reduce the symptoms of pain, swelling and inflammation. Chiropractor Nicolaides argued that the peer reviewer did not consider the Assignor's significant radicular symptoms indicating nerve root pathology. Chiropractor Nicolaides opined that the use of an LSO and TENS unit would prevent secondary aggravation of the injured areas, increase the promotion of healing and expedite the improvement of the Assignor's symptoms and function. With respect to the LSO, Chiropractor Nicolaides argued that the Assignor had indications of spinal instability including lower back pain radiating into both legs with numbness, positive orthopedic and neurological testing, and muscle spasm. Chiropractor Nicolaides noted that the Assignor was still experiencing these symptoms four weeks post-accident and the LSO was specifically prescribed to relieve pressure from the lumbar disc reducing the pain and providing stability when not getting in office treatment. With respect to the TENS unit, Chiropractor Nicolaides pointed to the radicular complaints and spasm and noted that it can accelerate the healing process

for speedier recovery by stimulating the paraspinal nerve to promote active healing. As such, Chiropractor Nicolaides concluded that the prescription of the durable medical equipment was clearly warranted.

Respondent submitted a peer review rebuttal of Chiropractor Ferrante dated May 23, 2017 in response to the rebuttal. Chiropractor Ferrante noted that his opinion remained unchanged despite review of the rebuttal. Again, Chiropractor Ferrante argued that the proper treatment had already been implemented and the use of the LSO or TENS was not supported.

Comparing the relevant evidence presented by both parties against each other and the above referenced medical necessity standard, I find the Applicant is entitled to reimbursement for the LSO and TENS unit provided to the Assignor. I find the rebuttal of Dr. Ferrante sufficient to meet the Applicant's burden on the issue of medical necessity. The rebuttal documentation meaningfully referred to and rebutted the conclusions set forth in the peer review report (see High Quality Medical, P.C. v. Mercury Ins. Co., 26 Misc.3d 145(A), 2010 N.Y. Slip.Op. 50447(U)(Sup. Ct. App. Term 2nd Dept 2010)). Specifically, in this matter, Chiropractor Ferrante established the conditions after a month of treatment which led to ordering the medical equipment and how the equipment would assist in the recovery process. Chiropractor Ferrante's addendum did not refute any of the rebuttal's positions. As such, Applicant's claim is granted in the full claim amount of \$980.97.

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.

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Medical		From/To	Claim Amount	Status
	SMG Mediquip, LLC	09/21/16 - 10/28/16	\$980.97	Awarded: \$980.97
Total			\$980.97	Awarded: \$980.97

- B. The insurer shall also compute and pay the applicant interest set forth below. 04/18/2017 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." 11 NYCRR §65-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. "If an applicant 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 Department of Financial Services regulations, interest shall not accumulate on the disputed claim or element of claim until such action is taken." 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 at issue was timely. LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 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 fees pursuant to the no-fault regulations. See, 11 NYCRR §65-4.5(s)(2). The award of attorney fees shall be paid by the insurer. 11 NYCRR §65-4.5(e). Accordingly, "the attorney's fee shall be limited as follows: 20 percent of the amount of first-party benefits, plus interest thereon, awarded by the arbitrator or the court, subject to a maximum fee of \$850." Id. The minimum attorney fee that shall be awarded is \$60. 11 NYCRR §65-4.5(c). However, if the benefits and interest awarded thereon is equal to or less than the respondent's written offer during the conciliation process, then the attorney's fee shall be based upon the provisions of 11 NYCRR §65-4.6(i). For claims that fall under the Sixth Amendment to Subpart 65-4 of Title 11 NYCRR the following shall apply " If the claim is resolved by the designated organization at any time prior to transmittal to an arbitrator and it was initially denied by the insurer or overdue, the payment of the applicant's attorney's fee by the insurer shall be limited to 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon, for each applicant with whom the respective

parties have agreed and resolved disputes, subject to a maximum fee of \$1,360."
(Emphasis added)

- 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 New York
SS :
County of Nassau

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

04/17/2018
(Dated)

Bryan Hiller

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:
c09842d73654085f358d6f858ddc94e7

Electronically Signed

Your name: Bryan Hiller
Signed on: 04/17/2018