

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Complete Orthopedic Services Inc.
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No.	17-17-1058-7178
Applicant's File No.	103357
Insurer's Claim File No.	0374652560101061
NAIC No.	35882

ARBITRATION AWARD

I, Sandra Adelson, 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: the patient.

1. Hearing(s) held on 08/13/2018
Declared closed by the arbitrator on 08/13/2018

Kevin Griffiths, Esq. from The Odierno Law Firm P.C. participated in person for the Applicant

Crystal Russo, claims representative from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 1,968.99**, was AMENDED and permitted by the arbitrator at the oral hearing.

The applicant amended this claim to \$882.89. This amendment was a fee schedule correction.

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

The parties stipulated that there was no fee schedule issue to be litigated and that the denial was timely.

3. Summary of Issues in Dispute

The applicant seeks payment for a Tens unit and LSO which were provided on 11/28/16.

Respondent issued a denial based on the peer review report of Dr. Hip-Flores.

4. Findings, Conclusions, and Basis Therefor

The record consisted of claimant's submission, respondent's submission, as well as documents not enumerated within this decision but which are contained in the case file maintained by the American Arbitration Association. THE ARBITRATOR SHALL BE THE JUDGE OF THE RELEVANCE AND MATERIALITY OF THE EVIDENCE OFFERED. 11 NYCRR 65-4.5 (o) (1) (Regulation 68-D), reads as follows: The arbitrator shall be the judge of the relevance and materiality of the evidence offered and strict conformity to legal rules of evidence shall not be necessary. The arbitrator may question any witness or party and independently raise any issue that the arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department Regulations.

Based on a review of the documentary evidence submitted to the case file, the claim is decided as follows:

Applicant establishes "a prima facie showing of their entitlement to judgment as matter of law by submitting evidentiary proof that the prescribed statutory billing forms [setting forth the fact and the amount of the loss sustained] had been mailed and received and that payment of no-fault benefits were overdue." Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). Once Applicant has established a prima facie case the burden is on the insurer to prove the treatment was medically unnecessary. See, Citywide Social Work & Psychological Services, PLLC a/a/o Gloria Zhune v. Allstate Ins. Co., 8 Misc.3d 1025A, 806 N.Y.S.2d 444 (App. Term 1st Dept. 2005); A.B. Medical Services, PLLC v. GEICO Ins. Co., 2 Misc 3d 26, 773 N.Y.S.2d 773 (App Term 2nd & 11th Jud Dist 2003).

The courts have held that a respondent's peer review report or medical evidence such as an IME examination must set forth more than just a basic recitation of the expert's opinion. Lack of medical necessity is a valid defense to an action to recover No-Fault benefits, Countrywide Ins. Co. v. 563 Grand Med., P.C., 50 A.D.3d 313 (1st Dept.2008); A.B. Med. Servs., PLLC v. Liberty Mut. Ins. Co., 39 A.D.3d 779 (2d Dept. 2007), if raised in a denial that is (1) timely, Presbyterian Hosp. in the City of New York v. Maryland Casualty Ins. Co., 226 A.D.2d 613 (2nd Dept. 1996); Central Gen. Hosp. v. Chubb Group of Ins. Co., 90 N.Y.2d 195 (1997).

The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment, Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co., 2009 NY Slip Op 00351 (App Div 2d Dept., Jan. 20, 2009); Channel Chiropractic, P.C. v. Country-Wide Ins. Co., 2007 Slip Op 01973, 38 A.D.3d 294 (1st Dept. 2007); Bronx Radiology, P.C. v. New York Cent. Mut. Fire Ins. Co., 2007 NY Slip Op 27427, 17 Misc.3d 97 (App Term 1st Dept., 2007), such as by a qualified expert performing an independent medical examination, or conducting a peer review of the injured person's treatment.

The patient was a 38-year old male driver who was injured in a motor vehicle accident on 11/16/16. The 11/28/16 report of treating doctor, Dr. Gabriel Dassa, an orthopedist documented that the patient had complaints of pain in the cervical spine and lumbar spine following the motor vehicle accident which took place on 11/16/16. The patient stated that his car was involved in a collision with a tractor trailer. He was treated at St. Joseph Hospital Emergency Department. Dr. Dassa's report of 11/28/16 documented the patient as having persistent burning, numbness and tingling radiating down to his extremities. After his examination, Dr. Dassa prescribed a Tens unit and LSO.

Respondent issued a denial based on the peer review report of Dr. Jules Hip-Flores, orthopedist. Dr. Hip-Flores discussed the medical history of this patient and documented the positive findings noted by Dr. Dassa, the treating orthopedist. Dr. Hip Flores relied on only the ODG treatment guidelines and New York Workers Compensation Guidelines for Mid and Low Back Injuries.

Because Dr. Hip Flores relied on the Workers Compensation Guidelines for Mid and Low Back Injury Medical Treatment with regard to the testing in issue, reference must be made to Arbitrator Michael Parsons discussion of the New York State Workers Compensation Guidelines as set forth in the arbitration award- AAA Case No. 17-17-1081-1689, *Phoenix Medical Services, P.C. and Geico Insurance Company* dated 6/8/18. I agree with Arbitrator Parson's decision and rationale as it applied to the New York State Workers Compensation Guidelines.

Arbitrator Parsons in his well- reasoned decision held that "Regardless, I find the Workers Compensation Guidelines to be irrelevant to the question of medical necessity. Since the Guidelines are the only source cited in support of the peer's proffered standard of care, that alone renders the opinion insufficient. The reason that authoritative sources to establish a standard of care supporting a peer reviewer's opinion are required is because testimony is not required in this forum and a written peer review is not subject to cross examination. The Workers' Compensation Guidelines are not binding on this forum. These guidelines were promulgated by a payor to set forth when and under what circumstances it will reimburse for various treatment, tests and procedures for the purpose of assuring a return to work. The Guidelines, although possibly based on standards of care, do not constitute recitations of any standards of care. Although not necessary to my determination insofar as I find the peer review facially insufficient to meet Respondent's *prima facie* burden, I note that the rebuttal is replete with citations to actual medical authority as to standards of

care. I find the peer review to be conclusory, global and non-specific in nature and that it fails to comport with the standards set forth in *Nir v. Allstate Ins. Co.*, 7 Misc.3d 544, 796 N.Y.S.2d 857 (Civ. Ct. Kings Co. 2005)."

I concur with this analysis that the Workers' Compensation Guidelines are not binding on the No-Fault forum as these guidelines were actually set up by the payor for treatment in order to return to work. Accordingly, I find that the peer review report of Dr. Hip-Flores submitted to this particular claim to be conclusory, non-specific and general. This report failed to comport with the standards set forth in *Nir v. Allstate Ins. Co.*, 7 Misc.3d 544, 796 N.Y.S.2d 857 (Civ. Ct. Kings Co. 2005).

Dr. Hip-Flores also relied on the on the Official Disability Guidelines from the Work Loss Data Institute to support his brief opinion that the supplies in issue should be denied.

However, the "ODG" or Official Disability Guidelines cited by the peer review report of Dr. Hip-Flores is not a peer-reviewed medical publication or authority on electrodiagnostic testing. According to their own statement, the Work Loss Data Institute (WLDI) is an independent database development company focused on workplace health and productivity. A database company only assesses general statistics for insurance companies. The mere fact that a private company which caters to insurance companies calls their guidelines "official" does not make them so.

As noted Dr. Hip-Flores relied on the Official Disability Guidelines from the Work Loss Data Institute to support his peer review opinion. Reference must be made to the Master Award of Harris Levy in an unrelated master arbitration award which discounted arguments based on cost containment. The foregoing specific master arbitration award discussed a peer review report by Dr. Winell which also relied on the Work Loss Data Institute in his peer review discussion. In a Master Arbitration award, Master Arbitrator Harris Levy directed a new hearing in Damadian MRI in Canarsie PC/(patient) and Geico Insurance Company, 17 991 R 57757 13. The Master Arbitration award stated that the respondent denied the claim based on a peer review report which asserted that the services in issue were not medically necessary and that the lower arbitrator found that the review set forth a reasonable basis and medical rationale which was not refuted. The lower arbitrator denied the claim. The Master however found that the peer review conclusion was based primarily on a publication issued by an organization which assists insurers in cost containment and claims control. This Arbitrator notes that the publication cited in the peer review report of Dr. Winell [unrelated arbitration and patient] referred only to "Official Disability Guidelines" published by the Work Loss Institute, 2007 Edition. Master Arbitrator Levy then referred to Case 17 991 R 10014 12 (4/24/12), involving a similar review by the same doctor, the award denying a claim for supplies was vacated by the master arbitrator on the ground that the publication was biased and unreliable. The award was consequently vacated by Master Arbitrator Harris Levy.

Therefore, I choose to abide by the foregoing Master Award to establish that the Work Loss Data Institute was a biased publication. In light of the foregoing, The Official Disability Guidelines are not binding authority on this forum. These guidelines were therefore contained within a publication issued by an organization which assists insurers in cost containment and claims control. The Guidelines do not constitute recitations of any standards of care. I therefore find that this peer review report was facially insufficient to meet Respondent's prima facie burden. I find the peer review to be conclusory, general and non-specific in nature and that it fails to comport with the standards as set forth in *Nir v. Allstate Ins. Co.*, 7 Misc.3d 544, 796 N.Y.S.2d 857 (Civ. Ct. Kings Co. 2005).

In light of the foregoing, I am constrained to find that the more persuasive arguments and medical proof were contained in the detailed narrative report of Dr. Dassa who documented positive cervical and lumbar spine findings which included restrictions of motion (with the use of a goniometer), a positive Spurling test on the right, tenderness on palpation of L1 through L5 and L5 through S1 with bilateral paraspinal muscle spasms and multiple trigger points. The straight leg test was also positive on the left at 25 degrees. The patient was diagnosed with cervical and lumbar sprain/strains, multi ligamentous injury to the cervical and lumbar spine, cervical spine and lumbar spine multiple trigger points. Following the examination, Dr. Dassa recommended physical therapy, chiropractic care, medication, lumbar spine brace and a Tens unit as well as possible MRI scan if there was no improvement. Furthermore, the arbitration record included explanations as to how the medical supplies in issue would aid this patient. Dr. Dassa explained that the LSO stabilizes the surrounding muscles and ligaments to help relieve pain and discomfort as well as providing cushion and support and overall strength. Dr. Dassa also explained that the TENS unit was adjunctive treatment in the management of post traumatic acute pain and would provide pain relief.

After reviewing the evidence submitted by Applicant, I find that Applicant has submitted sufficient credible evidence in the form of the underlying report and the letters of medical necessity which refuted the peer review report and established a prima facie case of medical necessity for the supplies in issue. Furthermore, the peer review report failed to establish that the medical supplies were not prescribed in accordance within accepted medical guidelines.

Therefore, the claim is granted.

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
	Complete Orthopedic Services Inc.	11/28/16 - 11/28/16	\$1,968.99	\$882.89	Awarded: \$882.89
Total			\$1,968.99		Awarded: \$882.89

- B. The insurer shall also compute and pay the applicant interest set forth below. 03/24/2017 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

The Respondent shall compute and pay the Applicant the amount of interest computed from the date set forth above at the rate of 2% per month, simple, and ending with the date of payment of the award, subject to the provisions of 11 NYCRR 65-3.9(c).

C. Attorney's Fees

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

Applicable attorney fees on the amount awarded, as set forth above, in accordance with 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 New York
SS :
County of Suffolk

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

09/09/2018
(Dated)

Sandra Adelson

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:
4a081443973321a28dd01649aa3fec93

Electronically Signed

Your name: Sandra Adelson
Signed on: 09/09/2018