American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Taira Rx Corp d/b/a Forest Drugs , RKD Rx Corp (Applicant)	AAA Case No.	17-18-1100-2754
	Applicant's File No.	336618, 336619, 336620, 340846
- and -	Insurer's Claim File No.	0450744380101038
	NAIC No.	22055
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Lisa Abrams, 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: IP

1. Hearing(s) held on 01/10/2019
   Declared closed by the arbitrator on 01/10/2019

   David Foreman, Esq. from Leon Kucherovsky Esq. participated in person for the Applicant

   Robert Pollack from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 1,686.29**, 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

   Whether Respondent's verification requests were reasonable and whether Applicant substantially complied with these requests?

   Whether the prescribed durable medical equipment (DME) was medically necessary?

4. Findings, Conclusions, and Basis Therefor

This case was decided based upon the submissions of the parties as contained in the electronic case file maintained by the American Arbitration Association and the oral arguments of the parties' representatives. There were no witnesses. I reviewed, among other things, the documents contained in MODRIA for both parties and make my decision in reliance thereon.

This arbitration arises out of medical treatment for the IP (TG), a 44-year-old female driver, related to injuries the IP sustained in a motor vehicle accident that occurred on November 13, 2017. Following the accident, the IP went to a hospital for evaluation; thereafter, the IP sought private medical attention. Applicant seeks reimbursement for pharmaceuticals provided to the IP on December 19, 2017. According to Respondent, it sought post Examination Under Oath (EUO) verification demands and Applicant failed to provide the requested information. Applicant argues that it responded to the requests with objections. Respondent counters that Applicant only provided "minimal responsive documentation." In turn, Applicant disputes this contention and argues that it substantially complied with all of Respondent's verification requests. Separately, Applicant seeks reimbursement for the DME supplied on January 26, 2018 (*i.e.*, a back brace). Respondent timely denied payment for the DME based on a peer review report by Dr. Kevin Curley, dated March 27, 2018.

The Open Verification Requests

It is well settled that an insurer is not obligated to pay or deny a claim until it has received verification of all relevant information requested. *See, Mount Sinai Hosp. v. Chubb Grp. of Ins. Companies*, 43 A.D.3d 889, 843 N.Y.S.2d 634 (2nd Dept. 2007); *Hosp. for Joint Diseases v. New York Cent. Mut. Fire Ins. Co.,* 44 A.D.3d 903, 844 N.Y.S.2d 371 (2nd Dept. 2007); *New York & Presbyterian Hosp. v. Progressive Cas. Ins. Co*., 5 A.D.3d 568, 569, 774 N.Y.S.2d 72 (2nd Dept. 2004).

An insurer can extend or toll its time to pay or deny a claim by demanding verification within 30 days of receipt of the claim.*Victory Med. Diagnostics, P.C. v. Nationwide Prop. & Cas. Ins. Co.*, 36 Misc. 3d 568, 572, 949 N.Y.S.2d 855, 859 (Dist. Ct. 2012) *citing Nyack Hosp. v. General Motors Acceptance Corp.,*8 N.Y.3d 294, 832 N.Y.S.2d 880, 864 N.E.2d 1279 (2007). No-fault regulations do not specifically define or limit the information or documentation an insurer may request through verification. In fact, the regulations provide that an insurer can request "... all items necessary to verify the claim directly from the parties from whom such verification was requested." 11 NYCRR 65-3.5(c).

Once verification has been received, an insurer has 30 days within which to make a determination on the claim. *Liberty Queens Medical, P.C. v. Tri-State Consumer Ins.,* 188 Misc.2d 835, 839, 729 N.Y.S.2d 882, 885 (Dist. Ct. Nassau Co. 2001). As long as a medical provider's documentation is arguably responsive to an insurer's verification request, the insurer must act within 30 days of the medical provider's response, or it will

be precluded from presenting any non-coverage defenses; an insurer must affirmatively act once it receives a response to its verification request. *All Health Medical Care, P.C. v. Government Employees Ins. Co.*, 2 Misc.3d 907, 771 N.Y.S.2d 832 (Civ. Ct. Queens Co. 2004).

Requests for verification, however, are not without restraint. The regulations provide that an insurer should not "... demand verification of facts unless there are good reasons to do so." 11 NYCRR 65-3.2(c). Indeed, no-fault decisions require that good cause or a reasonable basis be shown to obtain further verification. *See, State Farm Mutual Insurance Co. v. Mallela*, 4 N.Y. 3d 313, 794 N.Y.S.2d 700 (2005) (in order for a request for verification to be valid concerning a request for applicant's bank records, tax returns, and licensing status, a respondent must "show good cause" by putting forth proof that demonstrates "behavior tantamount to fraud."); *Dynamic Medical Imaging P.C. a/a/o v. State Farm Mut. Auto. Ins. Co.*, 29 Misc. 2d. 278, 2010 NY Slip Op. 20285 (Dist. Ct., Nassau Co. July 15, 2010); *A.B. Medical Services PLLC v. Highlands Insurance Co.*, N.Y.L.J., May 27, 2003 (Civ. Ct. New York Co. 2003) (the burden is on Respondent to prove that the verification requests are valid). *See also*, *Concourse Chiropractic, PLLC v. State Farm Mutual Ins. Co.*, 35 Misc.3d 1213(A), 2012 N.Y. Slip Op. 50676(U), (Dist. Ct. Nassau Co., Apr. 16, 2012); *Midborough Acupuncture P.C. v. State Farm Ins. Co*., 21 Misc. 3d. 10, 12 (App. Term, 2nd Dept. 2008).

Thus, the issue before me requires a balancing between Respondent's right to request verification and Applicant's right to challenge Respondent's verification requests as improper, unduly burdensome and substantially complied with.

At the outset, I note that there is an extensive history of exchanges between the parties.

Respondent states that Applicant provided some documentation, but at the hearing it became apparent that Respondent is particularly looking for the pharmaceutical purchase invoices and wholesale receipts. In response, Applicant argued that it substantially complied with the verification requests and that it has provided a majority of the documentation requested and has posed objections where necessary.

Specifically, Respondent states that Applicant has provided:

> (1) Some documentation regarding the transfer of the pharmacy license filed with New York State ("NYS");
> (2) A two-page bill of sale for MSB Rx in the amount of $10.00;
> (3) W2s for MSB Rx; and
> (4) A spreadsheet listing incidents of Ushyarov prescriptions, without identifying what was actually prescribed.

Respondent alleges that Applicant failed to provide:

(1) Asset purchase agreement between MSB Rx and Taira Rx;
(2) Other contracts between MSB Rx and Taira Rx;
(3) W2 for Taira Rx;
(4) Federal, NYS, and New York City payroll tax returns;
(5) Purchase invoices and wholesale receipts;
(6) Number of prescriptions dispensed by Taira per month for the following: diclofenac gel, diclofenac/lidocaine compound, lidocaine patches, and flector patches; and
(7) Number of prescriptions dispensed by Taira per month for the following: Dr. Mani Ushyarov, Dr. Solomon Halioua, Dr. Oleg Fuzaylov, Dr. Terry-Jan Blackett-Bonnett, and Danny Fuzaylov

Applicant states that it has provided numerous responses to Respondent and that its specific objections provide reasonable justification for Applicant's refusal to comply with what it claims are improper demands. Applicant asserts that because it has substantially complied with the verification requests, there is no basis to deny its claim on grounds that it has not provided verification within 120 days.

In support of its claim that Respondent's verification requests were unreasonable, Applicant has submitted a number of decisions by other Arbitrators who have found that Applicant has substantially complied with similar verification requests. After I have independently considered the merits of the parties' arguments and reviewed the record and the submitted decisions of my fellow arbitrators, I conclude that Respondent's repeated demands for the same materials are unreasonable and its subsequent declination of Applicant's claim due to Applicant's refusal to provide such materials without merit. Moreover, I find that Respondent's demands are, in many instances, patently unreasonable and, if allowed, would defeat the oft stated purpose of No-Fault law to insure prompt payment for medical services rendered to persons injured in motor vehicle accidents. *See, Dynamic Medical Imaging P.C. a/a/o v. State Farm Mut. Auto. Ins. Co.*, 29 Misc. 2d. 278, 284, 2010 NY Slip Op. 20285 (Dist. Ct., Nassau Co. July 15, 2010). Lastly, while not applying collateral estoppel, I find significant that in nine other arbitration proceedings, similar (if not exactly the same) verification requests made by Respondent to Applicant were determined to be unreasonable. I also agree that Respondent's verification requests are unreasonable for the reasons set forth in such decisions.

Moreover, I note that Applicant has not ignored Respondent's verification requests. Rather, Applicant has supplied numerous responses and objections which are at issue in this arbitration. I find that Applicant's responses were sufficient to satisfy Respondent's verification requests. Accordingly, Applicant is entitled to reimbursement in the amount of $1,083.89.

The Medical Necessity of the DME

If an insurer asserts that the medical test, treatment, supply or other service was medically unnecessary, as it does here, the burden shifts to 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. *A.B. Med. Servs. PLLC v. Geico Ins.,* 2 Misc. 3d 26, 27, 773 N.Y.S.2d 773 (App. Term 2003); *King's Med. Supply Inc. v. Country-Wide Ins. Co.,* 5 Misc. 3d 767, 770, 783 N.Y.S.2d 448, 451 (Civ. Ct. Kings Cty. 2004); *Amaze Med. Supply, supra. See also, All Boro Psychological Servs., P.C. v. GEICO Gen. Ins. Co.,* 34 Misc. 3d 1219(A), 950 N.Y.S.2d 490 (Civ. Ct. Kings Cty. 2012) ("[Respondent] 'bears both the burden of production and persuasion' as to its defense of lack of medical necessity'" (citations omitted)).

When an insurer relies upon a peer review report to demonstrate that a particular service was not medically necessary, 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. *Nir v. Allstate Ins. Co.,* 7 Misc. 3d 544, 546, 796 N.Y.S.2d 857 (Civ. Ct. Kings Cty. 2005); *All Boro Psychological Servs., P.C. supra. at *2 citing Nir, supra.* at 547 (the defense cannot be conclusory). *See also, Amaze Med. Supply v. Allstate Ins. Co.,* 3 Misc.3d 43, 2004 N.Y. Slip Op 24119 (App Term, 2d Dept. 2004). 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. *CityWide Soc. Work & Psy. Serv., P.L.L.C. v. Travelers Indem. Co.,* 3 Misc. 3d 608, 777 N.Y.S.2d 241 (Civ. Ct. Kings Cty. 2004).

Furthermore, the medical rationale referenced in a peer review report must be within the generally accepted medical or professional practice. "Generally accepted practice is that range of practice that the profession will follow in the diagnosis and treatment of patients in light of the standards and values that define its calling." *Citywide Social Work & Psychological Serv. PLLC, supra*. at 616. A peer review report may be found insufficient when unsupported or controverted by evidence of "generally accepted medical/professional practice." *Id*. However, where the health care provider rebuts the insurer's evidence with its own demonstrating that the medical services were consistent with generally accepted medical practice, the insurer's peer report may be accorded less weight, and the court or other trier of fact may find that the insurer failed to meet its burden. *All Boro Psychological Servs., P.C. supra.* at *2 *citing Nir, supra.* at 547.

Where Respondent presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden then shifts to Applicant which must then present its own evidence of medical necessity. *See,* Prince, Richardson on Evidence §§ 3-104, 3-202 ((Farrell 11th ed.); *Andrew Carothers, M.D., P.C. v. Geico Indem. Co.,* 18 Misc. 3d 1147(A), 859 N.Y.S.2d 892 (Civ. Ct. Kings Cty. 2008); *W. Tremont Med. Diagnostic, P.C. v. Geico Ins. Co.,* 13 Misc. 3d 131(A), 824 N.Y.S.2d 759 (App. Term 2006).

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Respondent relies on the peer review report of Dr. Curley, dated March 27, 2018. Dr. Curley opines that there is no medical necessity for the DME. In this case, a back brace. Dr. Curley asserts that only a radiculopathy was noted in the lower extremities and there was no other specific evaluation of the lumbar spine. He further states that "A back brace may be indicated in limited circumstances such as cases of gross instability of the lumbar spine or in the post-surgical setting, neither which was present here. A back brace is a restrictive device which would be contradictory to the intended goals of a physical therapy program in which the claimant was participating in. The goals of such a program are to increase mobility and flexibility."

Where the Respondent presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden then shifts to the Applicant which must then present its own evidence of medical necessity. See, Prince, Richardson on Evidence §§ 3-104, 3-202 (Farrell 11th ed.); *Andrew Carothers, M.D., P.C. v. Geico Indem. Co*., 18 Misc. 3d 1147(A), 859 N.Y.S.2d 892 (Civ. Ct. Kings Cty. 2008); *W. Tremont Med. Diagnostic, P.C. v. Geico Ins. Co.,* 13 Misc. 3d 131(A), 824 N.Y.S.2d 759 (App. Term 2006).

After careful review of the record, I find that Respondent set forth a medical rationale and factual basis for denying payment for the DME. Accordingly, the burden now shifts to Applicant to evidence medical necessity.

Applicant relies upon the medical records in support of its claim for the DME. The initial examination by Dr. Azu Ajudua on November 15, 2017 states that there was no lower back pain. The exam of the lumbar spine states that there was tenderness on palpation and a positive SLR test. The diagnosis was a sprain of the cervical paravertebral ligaments; a whiplash injury. Dr. Maria Del Carmen's initial evaluation on December 18, 2017 stated that the IP complained of lower back pain that was not radiating. However, radiculopathy from L-spine into right/left lower extremity was checked off and it seems that there was a decreased ROM. I note that the handwritten notes, and in particular, numbers written on Applicant's records were not clear regarding what they supposedly represented. Dr. Del Carmen diagnosed the IP with, among other things, sprain of the lumbosacral paravertebral ligaments.

While Applicant relies upon the medical records in support of its claim for the DME, such records that are part of the record do not demonstrate the underlying factual basis

for the prescription for this device. Moreover, I note that at the initial evaluation there was no lower back pain and the evaluation by Dr. Del Carmen did not meet the burden of persuasion that there was a medical necessity for the DME. Based upon the foregoing, Applicant has not successfully refuted Dr. Curley's peer review or established that the DME was medically necessary. I sustain the defense asserted in the denial for the DME. Applicant's claim for the DME is denied.

In summation, I find for Applicant on the dispute of open verification in the amount of $1,083.89 and I sustain the Respondent's denial for the DME.

This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator. Any further issues raised in the hearing record are held to be moot, without merit, and/or waived insofar as not raised at the time of the hearing.

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**
	Taira Rx Corp d/b/a Forest Drugs	**12/19/17 - 12/19/17**	**$475.75**	**Awarded: $475.75**
	Taira Rx	**12/19/17 -**		**Awarded:**

	Corp d/b/a Forest Drugs	**12/19/17**	**$511.22**	**$511.22**
	Taira Rx Corp d/b/a Forest Drugs	**12/19/17 - 12/19/17**	**$96.92**	**Awarded: $96.92**
	RKD Rx Corp	**01/26/18 - 01/26/18**	**$602.40**	**Denied**
Total			**$1,686.29**	**Awarded: $1,083.89**

B. The insurer shall also compute and pay the applicant interest set forth below. 07/10/2018 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest runs from the initiation date for this case until the date that payment is made at two percent per month, simple interest, on a*pro rata*basis using a thirty-day month.

C. Attorney's Fees

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

After calculating the sum total of the first-party benefits awarded in this arbitration plus interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20% of that sum total, subject to a minimum of $60 and a maximum of $850. *See*, 11 NYCRR 65-4.6 (c) and (e). However, if the benefits and interest awarded thereon is equal to or less than the Respondent's written offer during the conciliation process, the attorney's fee shall be based upon the provisions of 11 NYCRR 65-4.6(b). For cases filed after February 4, 2015, there is no minimum fee and a maximum fee of $1,360.00.

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

01/27/2019
(Dated)

Lisa Abrams

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:
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Electronically Signed

Your name: Lisa Abrams
Signed on: 01/27/2019