

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Excellent Choice Pharmacy  
(Applicant)

- and -

Allstate Fire & Casualty Insurance Company  
(Respondent)

AAA Case No. 17-18-1102-0330

Applicant's File No. RN 15-350

Insurer's Claim File No. 0480748599 2SJ

NAIC No. 29688

**ARBITRATION AWARD**

I, Anthony Kobets, 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 05/15/2019  
Declared closed by the arbitrator on 05/15/2019

Rima Nayberg, Esq. from Law Offices of Rima Nayberg P.C participated in person for the Applicant

Michael Rago, Esq. from Law Offices Of Karen L Lawrence participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 1,891.40**, was NOT AMENDED at the oral hearing.  
Stipulations WERE made by the parties regarding the issues to be determined.

At the hearing, the parties' representatives stipulated to the timely service of the bill and denial, to Applicant's prima facie burden and to the amount in dispute being in accordance with the applicable provisions of the fee schedule.

3. Summary of Issues in Dispute

In dispute is the Applicant's bill totaling \$1891.40 for Diclofenac gel provided to the patient (PM) on 3/8/18 as a result of injuries alleged to have been sustained in a motor vehicle accident on October 14, 2017.

Respondent timely denied the claim based upon a peer review report by Dr. Glenn Babus, D.O. dated 4/25/18. Was the Applicant entitled to reimbursement for the services provided to the EIP?

#### 4. Findings, Conclusions, and Basis Therefor

I have reviewed all documents as available in the ADR Center as of the date of this hearing pertaining to this case. This case was decided based on the submissions of the Parties as contained in the electronic case folder maintained by the American Arbitration Association and the oral arguments of the parties at the hearing. There was no witness testimony at the hearing. This case is linked with AAA case no. 171811032455.

At the hearing, the parties' representatives stipulated to the timely service of the bill and denial, to Applicant's *prima facie* burden and to the amount in dispute being in accordance with the applicable provisions of the fee schedule.

The EIP (PM) was a 60-year old female who was allegedly involved in a motor vehicle accident on October 14, 2017. Thereafter on 3/8/18, the patient received Diclofenac gel provided by the Applicant. Applicant seeks no-fault reimbursement for these services.

A health care provider establishes its *prima facie* entitlement to payment as a matter of law by proof that it submitted a proper claim, setting forth the fact and the amount charged for the services rendered and that payment of no-fault benefits was overdue (see Insurance Law § 5106 a; Mary Immaculate Hosp. v. Allstate Ins. Co., 5 AD 3d 742, 774 N.Y.S. 2d 564 [2004]; Amaze Med. Supply v. Eagle Ins. Co., 2 Misc. 3d 128A, 784 N.Y.S. 2d 918, 2003 NY Slip Op 51701U [App Term, 2d & 11th Jud Dists]).

A treatment or service is medically necessary if it is "appropriate, suitable, proper and conducive to the end sought by the professional health service in consultation with the patient. It means more than merely convenient or useful treatment or services, but treatment or services that are reasonable in light of the patient's injury, subjective and objective evidence of the patient's complaints of pain, and the goals of evaluating and treating the patient." Fifth Avenue Pain Control Center v. Allstate, 196 Misc. 2d 801, 807-808 (Civ. Ct. Queens Cty. 2003). Medically necessary treatment or services must be "consistent with the patient's condition, circumstances and best interest of the patient with regard to the type of treatment or services rendered, the amount of treatment or services rendered, and the duration of the treatment or services rendered." *Id.* Medical services are compensable where they serve a valid medical purpose. Sunrise Medical Imaging PC v. Lumbermans Mutual, 2001 N.Y. Slip Op. 4009.

A presumption of medical necessity attaches to a Respondent's admission of the Applicant's timely submission of proper claim forms such as in the within case, the burden then switches to the respondent to demonstrate the lack of medical necessity. A.B. Medical Services, PLLC v. Lumbermens Mutual Casualty Company, 4 Misc.3d 86, 2004 N.Y. Slip Op. 24194 (App.Term 2nd and 11th Jud. Dists. 2004); Kings Medical Supply, Inc. v. Country-Wide Insurance Company, 5 Misc.3d 767, 2004 N.Y. Slip Op.

24394 (N.Y. Civ. Ct. Kings Co. 2004); Amaze Medical Supply, Inc. v. Eagle Insurance Company, 2 Misc.3d 128(A), 2003 N.Y. Slip Op. 51701(U) (App Term 2nd and 11th Jud. Dists. 2003). Respondent thus bears the burden of production and persuasion with respect to medical necessity of the treatment for which payment is sought. (See Bajaj v. Progressive, 14 Misc 3d 1202(A) (N.Y.C. Civ Ct 2006).

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]; Kings Medical Supply Inc. v. Country Wide Insurance Company, 783 N.Y.S. 2d at 448 & 452; Amaze Medical Supply, Inc. v. Eagle Insurance Company, 2 Misc. 3d 128 [App Term, 2nd and 11th Jud Dists 2003]).

In the event an insurer relies on a peer review report to demonstrate that a particular service was medically unnecessary the peer reviewer's opinion must be supported by sufficient factual evidence or proof and cannot simply be conclusory or may be supported by evidence of generally accepted medical/professional practice or standards. See Nir v. Allstate Insurance Company, 2005 NY Slip Op 25090; 7 Misc.3d 544; 796 N.Y.S.2d 857; 2005 N.Y.Misc. LEXIS 419 and Citywide Social Work & Psy. Serv. P.L.L.C. v. Travelers IndemnityCo., 3 Misc. 3d 608; 777 N.Y.S.2d 241; 2004 NY Slip Op 24034.

In order for Respondent to meet its burden of establishing the lack of medical necessity, a peer review should (1) set forth applicable accepted medical standards relevant to the services at issue; and (2) comment on whether the Applicant had followed or deviated from those standards in providing the disputed services. This does not necessarily require that the peer review quote or cite medical literature. The Nir decision clearly contemplates that a peer may cite "medical authority, standard, or generally accepted practice as a medical rationale for his findings". Nir, 7 Misc.3d at 548.

Respondent timely denied the bill in dispute herein based on the peer review report from Dr. Glenn Babus, D.O. dated 4/25/18, wherein Dr. Babus reviewed the patient's medical records and indicated that "[t]he standards of care for the musculoskeletal injury after a motor vehicle accident would begin with a reasonable trial of conservative treatment which consists of evaluation by a physician, prescribing activity modification if necessary, encouraging return to activity as much as possible, prescription of medications such as anti-inflammatory medications, and conservative physiotherapy for a period of 4-6 weeks, followed by another modified course of therapy and exercises program if the patient is not responding to the initial course of treatment... As per the DICLOFENAC SODIUM- Diclofenac sodium gel, Impax Generics, Diclofenac Sodium Gel, 3%, INDICATIONS AND USAGE: 'Diclofenac Sodium Gel, 3% is indicated for the topical treatment of actinic keratoses (AK). Sun avoidance is indicated during therapy.' In this clinical case, as per the available medical records there was no documentation which substantiates the condition of actinic keratoses or any contraindication to sun light. Hence as per the cited guideline, the topical Diclofenac Sodium Gel 3% was not

medically necessary at that time." Respondent's counsel argued that Dr. Babus set forth a sufficient factual basis and medical rationale to prove the lack of medical necessity for the disputed services herein.

"Where the defendant insurer presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden shifts to the plaintiff which must then present its own evidence of medical necessity (see Prince, Richardson on Evidence §§ 3-104, 3-202 [Farrell 11<sup>th</sup> ed])." West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc.3d 131(A), 824 N.Y.S.2d 759 (Table), 2006 N.Y. Slip Op. 51871(U) at 2, 2006 WL 2829826 (App. Term 2d & 11th Dists. Sept. 29, 2006); A. Khodadadi Radiology PC v. NY Central Mutual Fire Ins. Co., 2007 NY Slip Op 51342(U). Applicant's counsel argued that the Respondent's proofs failed to meet their burden regarding the lack of medical necessity based upon the positive objective findings in the medical records and the patient's documented symptomology.

The records herein indicated that on 11/18/2017, the patient attended an examination at Flatlands Chiropractic Wellness, PC and presented with complaints of neck pain, upper back pain, lower back pain and bilateral shoulder pain. Examination of cervical and thoracic spine revealed moderate to severe tenderness and muscle spasm on palpation of the paraspinal muscles and decreased range of motion with pain on extremes of movement. Cervical compression test and Soto Halls test were positive. The patient was diagnosed with segmental and somatic dysfunction of cervical, thoracic and lumbar region, sprain of ligaments of cervical and lumbar spine, cervical disc disorder with radiculopathy, pain in thoracic spine and lower back pain. The patient was prescribed a Sam Sport Unit and Patches to use at home.

An MRI of the lumbar spine performed on 12/26/2017, revealed T12/L1 posterior central disc herniation deforms the ventral thecal sac. L1/2 posterior annular disc bulge deforms the ventral thecal sac. L2/3 broad posterior disc herniation deforms the ventral thecal sac and focal peripheral right sided component approaching the right neural foramen. L3/4 posterior central disc herniation deforms the ventral thecal sac. L4/5 grade I anterolisthesis and broad shallow disc herniation favoring the left deforms the ventral thecal sac and extends peripherally with proximal left foraminal extension below the level of the exiting nerve root. L5/S1 1-2 mm anterolisthesis and posterior subligamentous disc bulge deforms the ventral epidural space and extends peripherally with proximal bilateral foraminal extension approaching the exiting L5 nerve roots. Facet hypertrophic changes at L4/5 and L5/S1. Scoliotic curvature of the lumbar spine, convex to the right. Ventral left renal cyst measuring 3.4 cm in maximum transverse diameter.

An MRI of the cervical spine performed on 12/26/2017 revealed C2/3 posterior annular disc bulge deforms the ventral thecal sac. C3/4 posterior central disc herniation abuts the ventral surface of the cord and there is narrowing of the right neural foramen. C4/5 posterior subligamentous disc herniation with paracentral components bilaterally deforming the ventral thecal sac and extending peripherally approaching the neural foramina. C5/6 posterior subligamentous disc herniation with central component

deforms the ventral thecal sac. C6/7 posterior annular disc bulge and adjacent bony ridge abuts the ventral surface of the cord. Mild facet hypertrophic changes posteriorly at C3/4 through C6/7. Accentuation of the normal cervical lordosis.

On 1/3/18, the patient was examined by Maria Del Carmen Rivera Iturbe, M.D. and recommended continuing physical therapy treatments 3-4 times per week as well as pain medications.

On 1/8/18, the patient was examined by Dr. Alexander Zhuravkov, M.D. and presented with the complaint of radiating neck and lower back pain. Examination of the cervical spine revealed decreased range of motion. Spurling's test and Axial Compression test were positive. Sensations were decreased over C5, C6 and C7 dermatome. Reflexes were diminished. Examination of the lumbar spine revealed decreased range of motion. Straight Leg Raise test was positive. Sensations were decreased at L4, L5 and S1 dermatome. The diagnoses were cervical and lumbar disc herniation as well as radiculopathy. The treatment plan recommended a lumbar epidural steroid injection in order to "reduce painful symptoms".

The patient was prescribed Diclofenac gel 3% by Dr. Alexander Zhuravkov on 1/8/18. The patient was also prescribed 60 tablets of Ibuprofen.

On 1/17/18, the patient was prescribed a cervical traction unit with pump and an LSO.

Chiropractic treatment notes from January 2018 documented the treatments rendered and indicated that the patient was slightly better.

Physical therapy treatment notes from January 2018 documented the treatments rendered and indicated that the patient tolerated the treatment well.

Based upon a review of the evidence herein and the arguments of counsel, I find that Respondent has adequately met its burden of establishing the lack of medical necessity for the topical medication in dispute herein. Dr. Babus's peer review provided a sufficient medical rationale and factual basis to justify a lack of medical necessity for the Dyclofenac gel provided to the patient based on the patient's symptomology and clinical findings documented in the medical records. After careful consideration of the parties' evidence, I find that the peer review is more persuasive, regarding how there was no medical necessity for services considering the claimant was being treated with conservative care including chiropractic treatment, physical therapy treatments, acupuncture treatment, durable medical equipment and oral medications.

Additionally, I find that the Applicant's proofs failed to meaningfully rebut the arguments made in the peer review report or provide a sufficient reasonable medical rationale for the topical medication considering the patient's reported improvement following the conservative treatment. I do not find the Applicant's proofs to be persuasive based on his failure to sufficiently delineate why this particular patient qualified for the gel at that particular point in time considering improvement was

documented and there was no indication that continuing with conservative treatment would not yield beneficial results. The evidence submitted does not demonstrate objective findings that would warrant the necessity for the medication.

I find Dr. Babus's Peer Review Report more persuasive and case specific in outlining why the services were not medically necessary for this particular patient based on his symptomology and conclude that the peer review credibly established the lack of medical necessity. Where the assertions of a peer reviewer setting forth a factual basis and medical rationale for his determination that there was a lack of medical necessity for services rendered are unrebutted by the provider, judgment should be granted to the insurer. AJS Chiropractor, P.C. v. Travelers Ins. Co., 25 Misc.3d 140(A), 906 N.Y.S.2d 770 (Table), 2009 N.Y. Slip Op. 52446(U), 2009 WL 4639680 (App. Term 2d, 11th & 13th Dists. Dec. 1, 2009). The affidavit submitted by the claimant in opposition to a peer review is insufficient if it merely consists of the affiant's conclusory statement that he disagrees with the opinion of the peer review doctor that there was no medical necessity for the services rendered, and the affiant does not meaningfully refer to, or discuss, the determination of the peer review doctor. Pan Chiropractic, P.C. v. Mercury Ins. Co., 24 Misc.3d 136(A), 897 N.Y.S.2d 671 (Table), 2009 N.Y. Slip Op. 51495(U), 2009 WL 2032906 (App. Term 2d, 11th & 13th Dists. July 9, 2009). An affidavit which fails to justify the services with specificity does not rebut the conclusions set forth in the peer review. E.g., Neomy Medical, P.C. v. American Transit Ins. Co., 35 Misc.3d 135(A), 950 N.Y.S.2d 724 (Table), 2012 N.Y. Slip Op. 50769(U), 2012 WL 1556573 (App. Term 2d, 11th & 13th Dists. Apr. 25, 2012). Since the Applicant failed to adequately rebut the insurer's prima facie showing of lack of medical necessity, Respondent's denial is upheld and the Applicant's claim is denied in its entirety. Hong Tao Acupuncture, P.C. v. Praetorian Insurance Company, 35 Misc.3d 131(A), 2012 N.Y. Slip Op. 50678(U) (App. Term 2nd, 11th and 13th Jud. Dists. 2012). **Based upon the aforementioned, I find that the Respondent has sufficiently established that the medication gel was not medically necessary and deny Applicant's \$1891.40 claim.** 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 and/or waived insofar as not raised at the time of the hearing.

This arbitrator has not made a determination that benefits provided for under Article 51 (the No-Fault statute) of the Insurance Law are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of Assignor. As such and in accordance with the provisions of the prescribed NYS Form NF-AOB (the assignment of benefits), Applicant health provider shall not pursue payment directly from Assignor for services which were the subject of this arbitration, notwithstanding any other agreement to the contrary.

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 New York

SS :

County of Nassau

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

06/02/2019

(Dated)

Anthony Kobets

**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:**  
a1ef8e6ab783b7f4c567fb5a1ea0bbb2

### **Electronically Signed**

Your name: Anthony Kobets  
Signed on: 06/02/2019