American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

MiiSupply, LLC (Applicant)	AAA Case No.	17-18-1098-6926
	Applicant's File No.	None
- and -	Insurer's Claim File No.	796529-02
	NAIC No.	16616
American Transit Insurance Company (Respondent)		

ARBITRATION AWARD

I, Marcelo Vera, 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 06/19/2019
   Declared closed by the arbitrator on 06/19/2019

   Elke Mirabella, Esq from Dino R. DiRienzo Esq. participated in person for the Applicant

   Christopher O'Donnel, Esq. from American Transit Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 2,865.53**, 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 arbitration arises out of treatment to the EIP, RCP, a 40-year-old female, involved in a motor vehicle accident on May 30, 2017. Applicant seeks reimbursement in the amount of $2865.53 for a Venaflow Elite System post right shoulder arthroscopic surgery. The Respondent has issued timely denials based on the peer review prepared by Gary Kelman, M.D. dated January 17, 2018 The issue presented is whether the DME prescribed post-surgical intervention was medically necessary.

4. Findings, Conclusions, and Basis Therefor

My decision is based on the arguments of representatives for each party as well as those documents contained in the electronic file maintained by the American Arbitration Association. I have reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

It is Applicant's *prima facie*obligation to establish its entitlement to payment for each service for which reimbursement is sought. It is well settled that 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]).* Herein, applicant established its prima facie entitlement to first party no-fault benefits by proof that it submitted a claim setting forth the fact and amount of the loss sustained and that payment of no-fault benefits was overdue.

Medical Necessity

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 11 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) Further, a denial based on lack of medical necessity must be supported by competent medical evidence setting forth a clear factual basis and medical rationale for denying the claim. *Citywide Social Work, & Psy. Serv. P.L.L.C. v Travelers Indemnity Co.*, 3 Misc. 3d 608 (Civ. Ct. Kings Co. 2004)

Respondent timely denied the bill at issue based upon the peer review report prepared by Gary Kelman, M.D., dated January 17, 2018 . Dr.Kelman opines in relevant part:

> "In order to certify the medical necessity for prescribing DME it is necessary to assess the claimant's medical status in relation to such items, as well as incorporate itmes into the individual plan of care and instruct the claimant in the safe and effective use of these items, sites of application, duration and frequency…without documentation of this which was absent from the file the medical necessity cannot be established…further cold therapy devices have not

> been shown to be superior to ice packs…also the SAM unit and cold therapy unit lack the safety and effectiveness that treatment provided by a healthcare professional would deliver."

Dr. Kelman, incorporates by reference his original surgical peer where he found the underlying procedure was not medically necessary. It should be noted Dr. Kelman does not rely on any medical authority to support his conclusion of lack of medical necessity, his only citations are to "Durable Medical equipment (DME) published by Apollo Managed Care Consultants, 4th edition…for the definition of medical necessity of the durable medical equipment

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 Indemnity Company*, 2008 NY Slip Op 50456U, 18 Misc. 3d 1147A, 2008 N.Y. Misc. LEXIS 1121, *West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co*. 13 Misc.3d 131, 824 N.Y.S.2d 759, 2006 NY Slip Op51871(U) (Sup. Ct. App. T. 2d Dep't 2006)].

Applicant argues that the Peer review is conclusory and not supported by generally accepted medical standards. Applicant indicates Dr. Kelman's only citations are to the definition of medical necessity of the DME and are not specific to the issues at hand, thereby failing to support the conclusions reached by the peer reviewer. Applicant argues the Respondent's peer review fails to adhere to the standars set forth in *Jacob Nir, M.D. v. Allstate Ins. Co.*, 7 Misc. 3d 544, 796 N.Y.S.2d 857 (Civ. Ct. Kings Co. 2005) and *CityWide Social Work & Psychological Services, P.L.L.C.* v. Travelers Indemnity Company, 3 Misc. 3d 608, 777 N.Y.S.2d 241 (Civ. Ct. Kings Co. 2004).

Further, I find Respondent fails to meet its prima facie burden establishing that the Venaflow Elite System prescribed post-surgery lacked medical necessity. Dr. Kelman does not explain why the DME was not medically necessary, instead he maintains that the surgery performed on August 28, 2017 was not medically necessary and therefore any associated services were also not medically necessary, by incorporating his original peer review. Applicant argues that Dr. Kelman's opinion regarding the use of the DME post-operatively is unsupported by a proper factual basis and medical rationale. After consideration, I agree. Dr. Kelman's peer review provides no discussion as to the use of the DME prescribed post-operatively or why prescribing them following surgery deviated from generally accepted medical standards. In order to establish a defense that services provided lack medical necessity through a peer review report, the peer reviewer's opinion must set forth a factual basis and medical rationale in support of a lack of medical necessity defense, including evidence of medical standards. Provvedere, Inc. v. Republic Western Ins. Co., 2014 NY Slip Op 50219(U) (App. Term 2 , 11 and 13 Jud. Dists. 2014); nd th th Jacob Nir, M.D. v. Allstate Ins. Co., 7 Misc.3d 544, 546-47 (Civ. Ct. Kings Co. 2005).

"Once the surgery is performed, the necessity of any DME needed for post-surgical rehabilitation must be evaluated separately and on its own individual merits." See award

of Master Arbitrator, Victor D'Ammora, AAA No.: 412013011622; as well as the award of Master Arbitrator, Norman Dachs, AAA No.: 412013038824 and Master Arbitrator, Robyn Weisman, AAA No,:412013101200. I find that in the absence of a specific discussion as to the use of the medications prescribed post-surgery, the peer reviewer has failed to set forth a sufficient rationale to justify the Respondent's denial.

I agree with the Applicant and find the peer reviewer fails to support his conclusion.

Accordingly, in light of the foregoing, based on the arguments of counsel and after a thorough review and consideration of all submissions, I find in favor of the Applicant and award Applicant's claim in the amount of $2865.53

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
	MiiSupply, LLC	**10/02/17 - 10/29/17**	**$1,897.56**	**Awarded: $1,897.56**
	MiiSupply, LLC	**08/28/17 - 08/28/17**	**$967.97**	**Awarded: $967.97**
Total			**$2,865.53**	**Awarded: $2,865.53**

B. The insurer shall also compute and pay the applicant interest set forth below. 06/20/2018 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. However, the regulations toll the accrual of interest when an applicant "does not request arbitration or institute a lawsuit within 30 days aft er the receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations." See, 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

The insurer shall pay the applicant an attorney's fee in accordance with 11 NYCRR 65-4.6(d) This matter was filed **after** February 4, 2015, this case is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant an attorney's fee, in accordance with newly promulgated 11 NYCRR 65-4.6(d). This amendment takes into account that the maximum attorney fee has been raised from $850.00 to $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, Marcelo Vera, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

07/09/2019
(Dated)

Marcelo Vera

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:
dc57183a58ed31524a40e8661ff1d739

Electronically Signed

Your name: Marcelo Vera
Signed on: 07/09/2019