

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Zynex Medical  
(Applicant)

- and -

Geico Insurance Company  
(Respondent)

AAA Case No.	17-19-1137-4831
Applicant's File No.	19-18935X
Insurer's Claim File No.	0260639660101080
NAIC No.	22063

**ARBITRATION AWARD**

I, Brian Bogner, 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 04/24/2020  
Declared closed by the arbitrator on 04/24/2020

Nicole Jones, Esq. from The Morris Law Firm, P.C. participated by telephone for the Applicant

Jason Ciani, Esq. from Law Office of Daniel R. Archilla participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 4,900.75**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant's counsel amended the amount in dispute to \$4,515.88 after acknowledging payments made in connection with dates of service April 20, 2018, May 20, 2018, June 20, 2018 and July 20, 2018.

Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

The eligible injured person (EIP) is a nineteen (19) year old who was involved in a motor vehicle accident on February 7, 2018. At issue is reimbursement for an electrical stimulation unit supplied on March 20, 2018, supplies for the electrical stimulation unit supplied from March 20, 2018 through December 20, 2018 and lumbar support orthoses

(LSOs) supplied on March 26, 2018 and June 1, 2018. The electrical stimulation unit was denied based on the peer review of Dominick Garofalo, D.C. dated May 14, 2018. The LSOs were denied based on the peer reviews of Ronald Csillag, D.C. dated April 12, 2018 and Dominick Garofalo, D.C. dated June 26, 2018. With respect to the supplies, some of the bills were partially paid, some were denied based on Dr. Garofalo's May 14, 2018 peer review, some were denied based on the failure to appear for independent medical examinations (IMEs) and some were denied because they were duplicate bills and were not timely submitted.

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

I have reviewed the documents uploaded to the ADR Center maintained by the American Arbitration Association. This case was decided based upon the documents uploaded to the ADR Center and the oral arguments of the parties' representatives at the hearing.

This matter arises from a motor vehicle accident that occurred on February 7, 2018. The EIP was a passenger in a vehicle that struck another vehicle on the side. It was noted that she struck her head on the dashboard. She was evaluated in the Emergency Department at Women and Children's Hospital with complaints of a headache, neck pain and low back pain. She was diagnosed with muscular pain and prescribed Ibuprofen. She subsequently presented to the Emergency Department at Sister's Hospital and was diagnosed with low back pain and prescribed Naprosyn.

On February 19, 2018, the EIP consulted with a chiropractor, Dr. John Bialecki, with complaints of headaches, neck pain, back pain, dizziness, moodiness, difficulty concentrating, poor sleep, fatigue and sensitivity to light. She was examined and diagnosed with concussion without loss of consciousness, acute post-traumatic headache, upper extremity muscle weakness, myalgia, cervicalgia, cervical non-allopathic lesion, dorsalgia, thoracic non-allopathic lesion, lumbago and lumbar non-allopathic lesion. It was recommended imaging be performed before any chiropractic treatment was rendered. She was referred for cervical and lumbar x-rays, as well as an MRI of the brain. She was also referred to a neurologist.

On March 7, 2018, the EIP consulted with a different chiropractor, Dr. Nicole Curtin. She complained of severe low back pain. Her head and neck pain had subsided. Physical examination revealed restricted joint function, muscle spasms, stiffness, swelling, limited range of motion and a positive iliac compression test. She was diagnosed with low back pain, segmental and somatic dysfunction of the lumbar spine and sacral region, lumbar sprain and contracture of muscle. She was started on a course of treatment two (2) times per week.

On March 19, 2018, the EIP was prescribed an electrical stimulation unit and an LSO. The electrical stimulation unit was prescribed to "relieve pain, reduce muscle spasms, increase blood circulation, increase range of motion and re-educate muscles." The LSO was prescribed "reduce pain by restricting mobility of the trunk."

The EIP was provided the electrical stimulation unit on March 20, 2018 and supplies for use with the electrical stimulation unit on a monthly basis through December 20, 2018.

The EIP was provided with an LSO on March 26, 2018.

The EIP was provided a second LSO on June 1, 2018.

The electrical stimulation unit was denied based on the peer review of Dominick Garofalo, D.C. dated May 14, 2018. The LSOs were denied based on the peer reviews of Ronald Csillag, D.C. dated April 12, 2018 and Dominick Garofalo, D.C. dated June 26, 2018. With respect to the supplies, some of the bills were partially paid, some were denied based on Dr. Garofalo's May 14, 2018 peer review, some were denied based on the failure to appear for IMEs and some were denied because they were duplicate bills and were not submitted within forty-five (45) days of the date of service.

### Medical Necessity

The burden is on the insurer to prove that treatment was not medically necessary. Behavioral Diagnostics v. Allstate Ins. Co., 3 Misc. 3d 246, 248 (Civ. Ct., Kings Co. 2004); Fifth Ave. Pain Control Ctr. v. Allstate Ins. Co., 196 Misc.2d 801, 803 (Civ. Ct., Queens Co. 2003).

A denial claiming lack of medical necessity must be supported by a peer review, IME report or other competent medical evidence which sets forth a clear factual basis and medical rationale for denying the claim. Amaze Med. Supply, Inc. v. Eagle Ins. Co., 2 Misc. 3d 128A (App. Term, 2<sup>nd</sup> & 11<sup>th</sup> Dists. 2003); Healing Hands Chiropractic, P.C. v. Nationwide Assurance Co., 5 Misc. 3d 975, 976 (Civ. Ct., NY Co. 2004).

Once the respondent presents sufficient evidence establishing lack of medical necessity, the burden shifts back to the applicant to present its own evidence of medical necessity. West Tremont Med. Diagnostic, P.C. v. Geico Ins. Co., 13 Misc. 3d 131(A) (App. Term, 2<sup>nd</sup> & 11<sup>th</sup> Jud. Dists. 2006).

With respect to the electrical stimulation unit, the Respondent relies on the peer review of Dr. Dominick Garofalo dated May 14, 2018. Dr. Garofalo opined that there was no in-office trial period documenting the efficacy of the device prior to prescribing it for home use, contrary to the usual and customary medical protocol. He noted that the major components of the device are interferential current, TENS and neuromuscular electrical stimulation. He cited to treatment guidelines that do not recommended interferential therapy or neuromuscular electrical stimulation. He also cited to treatment guidelines that require consistent measurable functionally improvement to be documented and a determination made of the likelihood of chronicity prior to prescribing a home-based TENS unit. He noted that there is no indication that TENS was trialed in the office and the device was prescribed five (5) weeks after the motor vehicle accident when a determination regarding the likelihood of chronicity would have been difficult at best.

I find that Dr. Garofalo's May 14, 2018 peer review sets forth a clear factual basis and medical rationale and is sufficient to establish that the electrical stimulation unit and related supplies were not medically necessary.

The Applicant has not submitted a rebuttal and I am not persuaded by the treatment records and referral that the electrical stimulation unit was medically necessary. There was no in-office trial of this device, nor were any of its treatment modalities trialed in the office, and it is unclear why this device was needed so early in the treatment course.

With respect to the LSOs, the Respondent relies on the peer reviews of Ronald Csillag, D.C. dated April 12, 2018 and Dominick Garofalo, D.C. dated June 26, 2018. Dr. Csillag opined that lumbar supports have not been proven beneficial for treatment of acute low back pain, citing various medical authorities that do not support the use of lumbar supports for treatment of low back pain. He also cited to treatment guidelines that support the use of lumbar supports in cases of compression fractures, spondylolisthesis, documented instability or post-operatively and opined that none of those conditions were present in this case. He noted that the lumbar x-rays performed on February 14, 2018 and February 21, 2018 did not show any fracture, spondylolisthesis or instability. He also noted that lumbar supports restrict motion and are contradictory to the goal of chiropractic care. Dr. Csillag addressed the referral from Dr. Curtin and noted that the study she referenced deals with chronic low back pain but the LSO was prescribed during the acute phase of care.

Dr. Garofalo took issue with the fact that there was no re-examination around the time the LSO was provided on June 1, 2018. Dr. Garofalo also opined that LSOs are reserved for patients who have spinal instability or recently underwent spinal surgery, neither of which were present in this case. He cited to the same treatment guidelines as Dr. Csillag. He also cited to medical authority that does not support lumbar supports for treatment of low back pain. Dr. Garofalo also opined that LSOs are counterproductive to the goals of chiropractic treatment.

I find that Dr. Csillig's April 12, 2018 peer review and Dr. Garofalo's June 26, 2018 peer review set forth a clear factual basis and medical rationale and are sufficient to establish that the LSOs were not medically necessary.

The Applicant has not submitted a rebuttal and I am not persuaded by the treatment records and referral that the LSOs were medically necessary. In addition, there is no explanation as to why the EIP was provided two (2) LSOs.

The Respondent's denials based on Dr. Garofalo's May 14, 2018 peer review, Dr. Csillig's April 12, 2018 peer review and Dr. Garofalo's June 26, 2018 peer review are upheld.

#### IME No-Show

The supplies provided on October 20, 2018 were not denied based on Dr. Garofalo's May 14, 2018 peer review but were denied because the EIP allegedly failed to appear for IMEs scheduled for August 6, 2018 and September 25, 2018.

An EIP is required to submit to medical examinations by physicians selected by, or acceptable to, the insurer, when, and as often as, the insurer may reasonably require. 11 NYCRR §65-1.1(d). The failure by an EIP to attend two (2) separate IMEs requires dismissal of provider's claim for no-fault compensation. Apollo Chiropractic Care, P.C. v. Praetorian Ins. Co., 27 Misc.3d 139(A) (App. Term, 1st Dept. 2010); Vega Chiropractic, P.C. v. Clarendon Nat'l Ins. Co., 25 Misc.3d 144(A) (App. Term, 2nd Dept. 2009). In order to establish its defense based on an EIP's failure to appear for IMEs, the insurer must prove that the IME notices were properly mailed and that the EIP failed to appear. Stephen Fogel Psychological, P.C. v. Progressive Cas. Ins. Co., 35 A.D.3d 720, 722 (2d Dept. 2006).

The Respondent uploaded the scheduling letters but there is no proof that the scheduling letters were properly mailed to the Applicant or that the EIP failed to appear for the IMEs. As such, the Respondent failed to establish its defense based on the EIP's failure to appear for IMEs and its denial based on that ground cannot be upheld.

#### Duplicate Bills/45 Day Rule

For dates of service August 20, 2018, September 20, 2018, October 20, 2018 and November 20, 2018, the Applicant submitted bills for code A4630 in the amount of \$2.46 and A4556 in the amount of \$12.26, for a total of \$14.72. However, these codes

were already billed for these dates of service and either partially paid or denied. As such, I find that the Respondent properly denied these bills as duplicates.

In addition, the bills for dates of service August 20, 2018, September 20, 2018 and October 20, 2018 were denied because they were not received by the Respondent until December 24, 2018, more than forty-five (45) days after those dates of service.

Written proof of claim must be submitted to an insurer no later than forty-five (45) days after the date the services were rendered unless written proof is submitted providing clear and reasonable justification for the failure to comply. 11 NYCRR 65-1.1. "When an insurer denies a claim based upon the failure to provide . . . timely submission of proof of claim by the applicant, such denial must advise the applicant that late notice will be excused where the applicant can provide reasonable justification of the failure to give timely notice." 11 NYCRR 65-3.3(e). Where a claimant has failed to submit a claim within forty-five (45) days after the rendition of medical services, the claim must be denied. St. Vincent's Hosp. & Med. Ctr. v. Country Wide Ins. Co., 24 A.D.3d 748 (2d Dept. 2005).

The Applicant has not provided any justification for the failure to timely submit these bills and, therefore, the denials based on untimely submission are upheld.

#### Fee Schedule

The Respondent bears the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. Robert Physical Therapy P.C. v. State Farm Mut. Auto. Ins. Co., 13 Misc.3d 172, 175 (Civil Ct., Kings Co. 2006). Judicial notice may also be taken of the Workers' Compensation Fee Schedule. Natural Acupuncture Health, P.C. v. Praetorian Ins. Co., 30 Misc.3d 132(A) (App. Term, 1 Dept. 2011).

With respect to the supplies for the electrical stimulation unit provided on April 20, 2018, June 20, 2018 and July 20, 2018, the Applicant billed two (2) units of code A4630 in the amount of \$11.96 and four (4) units of code A4556 in the amount of \$54.68. With the exception of the April 20, 2018 date of service, the Applicant also billed code E0745 in the amount of \$98.85.

The Respondent reimbursed the Applicant \$4.92 for code A4630 and \$24.52 for code A4556. The Respondent also reimbursed the Applicant in full for code E0745.

According to the Medicaid Durable Medical Equipment Fee Schedule, which is applicable to No-Fault claims, code A4630 is reimbursable at \$2.46 and code A4556 is

reimbursable at \$6.13. The Medicaid Durable Medical Equipment Fee Schedule also provides that only two (2) electrodes (code A4556) are reimbursable per month.

The Applicant billed two (2) units of code A4630 and, therefore, was properly reimbursed at \$4.92 (\$2.46 x 2) per date of service.

The Applicant billed four (4) units of code A4556 but was only entitled to two (2) units, reimbursable at \$12.26 (\$6.13 x 2) per date of service. The Applicant was overpaid by \$12.26 per date of service, for a total of \$36.78.

With respect to date of service October 20, 2018, the Applicant is entitled to a total of \$116.03. However, that amount should be offset by the overpayment of \$36.78. As such, the amount owed is \$79.25.

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
	Zynex Medical	03/20/18 - 12/20/18	\$4,900.75	\$4,515.88	Awarded: \$79.25
					Awarded:

<b>Total</b>	<b>\$4,900.75</b>		<b>\$79.25</b>
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- B. The insurer shall also compute and pay the applicant interest set forth below. 08/06/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

The Applicant is awarded interest pursuant to the no-fault regulations. *See* 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 after 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).

Interest shall run from August 6, 2019, the date this proceeding was filed.

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. 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 Erie

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

05/07/2020



(Dated)

Brian Bogner

**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:**  
3ae03a4cf9244e989ac2237ea29754b0

### **Electronically Signed**

Your name: Brian Bogner  
Signed on: 05/07/2020