American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Mogul Supplies Inc (Applicant)	AAA Case No.	17-19-1152-0120
	Applicant's File No.	n/a
- and -	Insurer's Claim File No.	0585543980101028
	NAIC No.	22055
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Valerie D. Greaves, 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: Patient/Claimant

1. Hearing(s) held on 07/21/2020, 09/30/2020
   Declared closed by the arbitrator on 09/30/2020

   Vladimir Tamayeff, Esq. from Law Office of Tamayeff, P.C. participated by telephone for the Applicant

   Crystal Russo, Claims Representative from Geico Insurance Company participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **$ 844.13**, 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 Applicant is entitled to reimbursement in the sum of $844.13 for the lumbosacral orthosis with anterior/posterior/lateral control (LSO with APL control) provided on 10/16/2019, allegedly in connection with the treatment of injuries sustained by Patient in a motor vehicle accident on 8/8/2019.

Respondent timely denied reimbursement based on its interpretation of the applicable fee schedule and the peer review analysis of Eric M. Littman, DC, dated 12/13/2019.

4. Findings, Conclusions, and Basis Therefor

The decision below is based on the documents contained in the ADR Center as of the date of the hearing and the oral arguments of the parties. No witnesses testified at the hearing.

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 [11 NYCRR 65-4.5 (o) (1) (Regulation 68-D].

The Appellate Division, Second Department held that applicant "made a prima facie showing of their entitlement to judgment as a matter of law by submitting evidentiary proof that the prescribed statutory billing forms had been mailed and received and that payment of no-fault benefits were overdue." (Mary Immaculate Hospital v. Allstate Insurance Co., 5 A.D.3d 742, 774 N.Y.S.2d 564 (2d Dept. 2004). A facially valid claim is presented when it sets forth the name of the facility and/or health provider, date of the accident, the name of the patient, description of the services rendered, date of service(s) and the fees charged for those services. 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). Applicant has established a prima facie case of entitlement to reimbursement by submission of completed proof of claim, documenting the fact of the loss and the amount due.

Applicant is seeking reimbursement for the lumbosacral orthosis with anterior/posterior/lateral control (LSO with APL control) provided on 10/16/2019, allegedly in connection with the treatment of injuries sustained by Patient in a motor vehicle accident on 8/8/2019. Reportedly, Patient a male then 33years old, was operating a motor vehicle when the instant

accident occurred; he sustained no loss of consciousness and received no immediate post-accident medical treatment. A review of the report of the initial chiropractic examination conducted on 8/13/2019 reveals that Patient presented with occasional neck stiffness, intermittent mid and lower back pain radiating bilaterally to the knees; the cervical compression was positive, Jackson compression was positive and straight leg raise was reported as positive bilaterally without indicating the deviation from normal in degrees; Kemp's, Braggard's, Yeoman's and Fabere tests were bilaterally positive. There was no neurological assessment despite the section of the examination report for its notation. The diagnostic impression was cervical spine sprain, thoracic spine sprain and lumbar spine sprain. Chiropractic care was immediately initiated; notably, physical therapy and acupuncture treatment were also initiated on 8/13/2019**.**The 8/13/2019 initial chiropractic examination is the sole chiropractic examination in the record. The disputed LSO with APL control (L0637) was prescribed by Lenny Simakovsky, DC on 10/16/2019 without a contemporaneously performed chiropractic follow-up examination; additionally, just one-month earlier Patient had received on 9/17/2019, a lumbar orthosis with sagittal control (L0627) prescribed by Radha K. Gara, MD.

Lumbar spine MRI was performed on 9/19/2019; the diagnostic impression was:

1. Lumbar multilevel discopathy.
2. L4-L5 herniation with annular tear.
3. L3-L4 and L5-S1 annular bulges.
4. Spinal canal and nerve root impingement produced.
5. Conus preserved.
6. Minimal malalignment levels.
7. Discogenic endplate reaction.
8. Hypolordosis.
9. No discernible lesion.

Respondent timely denied reimbursement based on its interpretation of the applicable fee schedule and the peer review analysis of Eric M. Littman, DC, dated 12/13/2019. A persuasive peer review must contain a cogent basis for its opinion that Applicant deviated from medical/chiropractic community standards for the service under review or establish that the service was not necessary under the circumstances or demonstrate that the service was not causally related to the accident.

When the issue in contention involves the fee schedule, Respondent must first demonstrate that it has credibly established the basis of its denial(s) before the burden of proof shifts to Applicant to establish that Respondent's interpretation was contrary to No-Fault regulations and/or the applicable fee schedule. After Respondent meets this burden, Applicant must establish a prima facie case of entitlement to reimbursement by demonstrating credible evidence that Respondent's fee schedule contention(s) are incorrect. (See, Continental Medical PC v. Travelers Indemnity Company, 11 Misc. 3d 145(A), 2006 N.Y. Slip Op. 50841 (U) (App. Term 1st Dept. 2006); Westchester Medical Center v. Nationwide Mut. Ins. Co., 78 A.D.3d 1168, 911 N.Y.S.2d 907 (2d Dept. 2010).

Respondent carries the initial burden of proof to timely raise and establish lack of medical necessity before the burden of proof shifts to the Applicant to establish that the disputed service(s) were medically necessary. If the insurer medical examination or peer review is not rebutted, the insurer is entitled to denial of the claim. Khodadadi Radiology v. New York Central, 16 Misc.3d 131(A), 841 N.Y.S.2d 824, (App. Term 2d & 11th Dists. (2007); Dayan v. Allstate Ins. Co., 49 Misc. 3d 151 (A), 29 N.Y.S. 3d 846, 2015 NY Slip Op 51751 (U) (App. Term 2d, 11th & 13th Dists. 2015). "…Once the insurer makes a sufficient showing to carry its burden of coming forward with evidence of lack of medical necessity, 'plaintiff must rebut it or succumb'." Bedford Park Medical Practice P.C. v. American Transit Ins. Co., 8 Misc.3d 1025(A), 806 N.Y.S.2d 443 (Table), 2005 N.Y. Slip Op. 51282(U), 2005 WL 1936346 (Civ. Ct. Kings Co., (2005). Where a peer review or insurer medical examination findings provide a factual basis and medical rationale for the opinion that a particular service is not medically necessary and Applicant fails to present any evidence to refute that showing, the claim should be denied. Delta Diagnostic Radiology, P.C. v. Progressive Cas. Ins. Co., 21 Misc.3d 142(A), 880 N.Y.S.2d 223 (Table), 2008 N.Y. Slip Op. 52450(U), 2008 WL 5146967 (App. Term 2d & 11th Dists. (2008).

Respondent's peer reviewer, Dr. Littman, advised that the disputed LSO with APL control was not medically/chiropractically necessary in pertinent part based on the following:

> *"An MRI of the lumbar spine was done on 9/19/19. There was no evidence of fracture or instability of this claimant's lumbar spine. There was no reason to limit this claimant's movement in this type of*

device more than one month after the initial injury. Doing so would have been inconsistent with routine chiropractic practice. The clinical utility of utilizing a lumbosacral orthosis in the treatment or prevention of acute or chronic low back pain would not have been established."

Applicant's rebuttal from Lenny Simakovsky, DC summarizes in detail Patient's record, extensively covering Patient's cervical spine which is immaterial to the durable medical equipment in dispute. Regarding the lumbar spine, Dr. Simakovsky offers no explanation for prescribing the additional and more restrictive lumbar support (in addition to the one prescribed by R. Gara, MD) more than four weeks after chiropractic treatment was initiated, issuing the prescription without a contemporaneously performed chiropractic examination and fails to credibly establish that the equipment was chiropractically necessary.

Dr. Eric Littman's peer addendum dated 7/28/2020, written in response to Dr. Simakovsky's undated peer rebuttal maintains that Dr. Simakovsky has confused his report with the report from a different doctor, Robert Littman, DC, and then incorrectly attributed the content of the other Dr. Littman's peer review report to him [Dr. Eric Littman]. Dr. Eric Littman maintains the New York State Mid and Low Back Injury Medical Treatment Guidelines *"specifically indicate that lumbar supports may be useful for treatment of spondylolisthesis, documented instability or post-operative treatment."* Although Dr. Simakovsky indicates that the claimant had spondylolisthesis and contends that that diagnosis was confirmed by MRI, Dr. Littman noted that the report of the 9/19/2019 lumbar spine MRI *"makes no mention of spondylolisthesis" and that there was nothing to indicate spondylolisthesis in the [lumbar] MRI report that [he] reviewed.*

Additionally, Applicant's counsel submitted an undated Attorney "Affirmation re: Defective Peer Review" in which he maintains that Respondent surreptitiously directs, and perhaps writes the content of its peer review reports, which are then submitted by various medical professionals as their independent opinion. A review of Applicant's Attorney Affirmation reveals that it implies wrongdoing without reference to any specific evidence of wrongdoing by either Dr. Littman or Respondent in this instant matter.

Respondent's submission includes an undated rebuttal Attorney "Affirmation re: Defective Peer Review" from Anthony A. Flecker, Esq., to counter the content of Applicant's Attorney Affirmation. Mr. Flecker

maintains that the contentions in Applicant's attorney affirmation are untrue, and replete with unsupported suppositions and conjectures based on presumptions made by Applicant counsel without evidence pertaining to either Respondent or the peer review doctor.

When Applicant's counsel was asked how he knew the content of his affirmation to be true, he stated that there was a court case in which the presiding judge had held that an insurer's peer review report(s) were pre-determined and directed by the insurer. Applicant's counsel was asked *"was the insurer or peer review doctor in that Court matter, the same insurer or medical doctor in this matter"*, and he answered *"no"*. When asked how he could affirm that the insurer in this matter had conspired with the medical doctor by directing and pre-determining the outcome of the peer review report, he offered no evidence whatsoever and had no answer.

Applicant's Attorney Affirmation implies wrongdoing based solely on his imaginings extracted from the aforementioned Court matter, even though, that Court matter did not involve any of the parties in this matter.

I find Applicant's Attorney Affirmation to be without merit and incredulous, on its face, lacking any reference to any actual facts or evidence pertaining to the parties before me.

I further find that Respondent has established lack of medical necessity by a preponderance of the credible evidence; Applicant's documentation is insufficient to credibly rebut lack of medical/chiropractic necessity.

Under the circumstances, there is no reason to consider the correct fee schedule rate for the disputed service.

Based on the foregoing, Applicant is not entitled to No-Fault benefits.

This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator.

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 New York

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

10/19/2020
(Dated)

Valerie D. Greaves

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:
52604fefd7b449f27b7aedfe6fb02d3d

Electronically Signed

Your name: Valerie D. Greaves
Signed on: 10/19/2020