American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Ocean Spine & Joint Medical Care, PC (Applicant)	AAA Case No.	17-19-1123-7094
	Applicant's File No.	FDNY18-33184
- and -	Insurer's Claim File No.	9SINY07066-02
	NAIC No.	29742
Integon National Insurance Company (Respondent)		

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 10/07/2020
   Declared closed by the arbitrator on 10/07/2020

   Todd Fass, Esq. from Fass & D'Agostino, P.C. participated by telephone for the Applicant

   Joseph Licata, Esq. from Rossillo & Licata LLP participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **$ 910.60**, was AMENDED and permitted by the arbitrator at the oral hearing.

   At the hearing, Applicant's counsel amended the amount in dispute down to $826.50 total, pursuant to the fee schedule and prior payments made. Accordingly, $826.50 is the amended amount in dispute herein.

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

3. Summary of Issues in Dispute

   In dispute are the Applicant's claims totaling $910.60 for a knee brace, biofeedback training, physical performance testing, strapping and physical therapy treatments performed on the patient (CB) from 7/30/18 - 8/16/18 as a result of injuries alleged to have been sustained in a motor vehicle accident on July11, 2018.

The issues are whether or not the Applicant failed to comply with verification requests and established, prima facie, its entitlement to reimbursement and whether or not the services were not medically based upon a peer review report by Dr. Michael Russ, M.D. dated 10/1/18. 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.

At the hearing, Applicant's counsel amended the amount in dispute down to $826.50 total, pursuant to the fee schedule and prior payments made. Accordingly, $826.50 is the amended amount in dispute herein.

The EIP (CB) was a 67-year old female driver who was allegedly involved in a motor vehicle accident on July 11, 2018. Thereafter from 7/30/18 - 8/6/18, she underwent biofeedback training, physical performance testing and strapping treatment performed 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, 774N.Y.S. 2d 564 [2004]; Amaze Med. Supply v. Eagle Ins. Co., 2 Misc. 3d 128A, 784 N.Y.S. 2d918, 2003 NY Slip Op 51701U [App Term, 2d & 11th Jud Dists]).
Bill for date of service 8/15/18 in the amount of $75.00.

The record herein indicated that the Respondent received the Applicant's bill on 9/17/18. Thereafter Respondent sent the Applicant a verification request dated 9/27/18, which requested medical records and a referral for the knee brace. Respondent, sent a follow up verification request dated 11/5/18 requesting the identical list of items. Respondent did not issue a denial for the bill herein.

Applicant's counsel argued that they had sufficiently complied with Respondent's verification requests by virtue of their verification response sent to the Respondent dated 1/17/19. Thereafter, Respondent sent the Applicant a follow up letter dated 2/7/19, which acknowledged receipt of the initial response and indicated that the documentation received did not satisfy the original request for a letter of medical necessity for the DME dispensed. An Affidavit from Maria Panduro, Respondent's Claims Examiner, discussed

the mailing procedures and indicated that the verification remains outstanding. Respondent's counsel argued that the verification requests remain outstanding because they were not fully complied with.

Importantly, there is no provision in the No-Fault regulations which permit a claimant or an insurance company to ignore communications from each other without risking its chance to prevail in the matter. Back to Back Chiropractor, P.C. v. State Farm Mutual Automobile Ins. Co., 35 Misc.3d 1241(A), 954 N.Y.S.2d 757 (Table), 2012 N.Y. Slip Op. 51088(U) at 5, 2012 WL 2161476 (Dist. Ct. Suffolk Co., C. Stephen Hackeling, J., June 15, 2012). A provider's obligation to respond even when the requests are vague has been recognized. Westchester County Medical Center v. NY Central Mutual Insurance Co., 692 NYS2d 665 (A.D. 2d Dept. 1999), Mary Immaculate Hospital v. NY Central Mutual Insurance Co., 2008 Slip Op. 52046(U) (App. Term 2d & 11 Depts.) [T]he No-Fault carrier may inquire into their medical necessity by requesting a letter of medical necessity from the referring physician and a claim form with a valid provider's signature. Lenox Hill Radiology v. Global Liberty Ins., 20 Misc.3d 434, 858 N.Y.S.2d 587 (Civ. Ct. Kings Co. 2008). Similarly, "when a claimant submits bills to an insurer for payment, the claimant, who stands in the shoes of his assignor, must deal in good faith and cooperate with the insurer if it wants to get paid." Dilon Medical Supply Corp. v. Travelers Ins. Co., 7 Misc.3d 927, 930, 796 N.Y.S.2d 872, 875 (Civ. Ct. Kings Co. 2005) (any verification which may be sought from an eligible injured person may be sought from his assignee-medical supply provider). Once the insurer proves that it timely mailed its request and follow-up request for verification to the health care provider, if the latter does not demonstrate that it provided the insurer with the requested verification prior to the commencement of litigation, the litigation is premature inasmuch as the 30-day period within which the insurer was required to pay or deny the claim did not commence to run. Proscan Imaging, P.C. v. Travelers Indemnity Co., 28 Misc.3d 127(A), 2010 N.Y. Slip Op. 51176(U), 2010 WL 2681691 (App. Term 2d, 11th &13th Dists. July 7, 2010).

Based upon a review of the evidence herein and the arguments of counsel, I find that the Respondent has presented sufficient evidence to demonstrate that the requests for verification were reasonable, timely and properly mailed to the Applicant. **Accordingly, as the verification request remains outstanding and no denial was issued in this matter, the $75.00 claim for date of service 8/15/18 is dismissed without prejudice.**

Bills for dates of service 7/30/18 - 8/16/18 in the amended amount of $751.50

Respondent timely denied payment of the bills herein based upon the peer review report of Dr. Michael Russ, M.D. dated 10/1/18. Dr. Russ's peer review was based upon his review of the available medical documents and he indicated that "[t]here was no medical necessity for the taping/strapping. Continued management of these services has not been established as medically necessary…The procedure for taping/strapping is not the standard of care for treatment status post the motor vehicle accident as described and is not consistent with AMA Guidelines."

Dr. Russ also indicated that "Biofeedback is used to treat many types of conditions including chronic pain, migraine headache, spinal cord injury, and movement disorders. It is a type of relaxation training and behavior modification. Biofeedback works to control physiological reactions such as muscle tension, body temperature, heart rate, brain wave activity, and other life responses. The therapy requires the patient's intense participation to learn how to control these functions. Biofeedback does not work for all patients. Electrical sensors, attached to monitoring equipment, are applied to special points on the patient's body. The monitoring equipment feeds back the patient's progress. The biofeedback therapist teaches the patient mental and physical exercises, visualization, and deep breathing to treat their specific disorder (e.g. low back muscle spasms). (http:llwww.spineuniverse.com/treatments/pain-managementlpain-management-technique conquer-back-neck-pain). In this case, there was no substantiation for the need for biofeedback training at this point following the motor vehicle accident as there was no need to add this modality as there was no evidence of chronicity at this time post the motor vehicle accident. Lastly, the computerized muscle testing (billed as physical performance testing) was not medically necessary. Information with respect to this type of testing is usually determined by the standard physical examination; they are considered to be an integral part of that procedure…Therefore, the aforementioned computerized muscle testing was not medically necessary, and payment should be denied." Respondent's representative argued that the peer review met its burden in proving the lack of medical necessity for the services rendered.

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.

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 11thJud 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.

"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 11th 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 peer review failed to meet its burden regarding the lack of medical necessity based on the lack of a sufficient factual basis and the generic nature of the peer doctor's arguments.

The records herein indicated that the patient attended an initial examination on 7/16/18 performed by Dr. Hadiyane and presented with complaints of pain in the neck, lower back and bilateral hip pain. Right hip pain radiates into the groin area and neck pain radiates to the upper extremities. She also reported right knee, right ankle and left shoulder pain. Physical examination revealed somewhat limited range of motion of the cervical spine, lumbar spine, right hip, left hip, left shoulder, right knee and right ankle with tenderness. Reflexes were +1 in the brachioradialis and Achilles on the right. Sensation was decreased the L5 on the right. The patient was recommended conservative treatment and was prescribed medical supplies.

The records indicate the claimant received physical therapy treatment and strapping from 7/30/2018 through 8/16/2018, taping on 8/10/18, biofeedback on 7/30/18 and physical performance testing on 8/16/2018. She also underwent right knee x-ray on 8/16/2018.

A letter of medical necessity for biofeedback from Dr. Procesco Villarica, M.D. indicated that the patient acquired relaxation techniques during the treatment session today, which has been continued verbally after the session ended. "Patient hasn't fully adapted to the objective interaction between him/her and the SEMG signal, further sessions are necessary to achieve reduced muscular tension." The reason for the session was cervical myofascitis.

A letter of medical necessity from Dr. Proceso Villarica, M.D. for the strapping performed indicated that the patient's treatment diagnosis was sprain of left aromioclavicular joint; and sprain of right knee and that it was used in this particular case "because of a neuromuscular and orthopedic injury. As an added benefit to intramuscular selling its application here added in regional edema reduction."

Applicant also provided letters of medical necessity for range of motion and muscle testing.

Based upon a review of the evidence herein and the arguments of the parties' representatives, I find that the Respondent has not met its burden in this case with regard to the physical performance testing provided to the patient on 8/16/18. Dr. Russ indicated that the tests were an integral part of a physical examination however; the record herein does not reflect that there was a separate evaluation performed on that date. His statement that "[t]herefore, the aforementioned computerized muscle testing was not medically necessary, and payment should be denied" is unsupported by a factual basis considering the only consultation report he reviewed was dated 7/16/18. Furthermore, Dr. Russ's conclusions were presumptive, conclusory and unsupported by the various medical records, which contained examples of the patient's continued complaints of pain and objective positive findings. Where other reports in the insurer's papers contradict the conclusion of its peer reviewer that a service was not medically necessary, it has failed to make out a prima facie case in support of the defense of lack of medical necessity. Hillcrest Radiology Associates v. State Farm Mutual Automobile Ins. Co., 28 Misc.3d 138(A), 2010 N.Y. Slip Op. 51467(U), 2010 WL 3258144 (App. Term 2d, 11th & 13th Dists. Aug. 13, 2010). A letter of medical necessity which raises a question of fact as to the medical necessity of services may serve to rebut the peer review report. E.g., American Chiropractic Care, P.C. v. Praetorian Ins. Co., 42 Misc.3d 145(A), 988 N.Y.S.2d 521 (Table), 2014 N.Y. Slip Op. 50346(U), 2014 WL 996509 (App. Term 9th & 10th Dists. Feb. 28, 2014). **Accordingly, Applicant is awarded $91.42 for the physical performance testing.**

With regard to the biofeedback training and strapping, I find that the peer review set forth a sufficient medical rationale supported by a factual basis in persuasively demonstrating that the services were not medically necessary and contrary to established standards. I agree with Dr. Russ that "[t]he procedure for taping/strapping is not the standard of care for treatment status post the motor vehicle accident as described and is not consistent with AMA Guidelines…In this case, there was no substantiation for the need for biofeedback training at this point following the motor vehicle accident as there was no need to add this modality as there was no evidence of chronicity at this time post the motor vehicle accident." Dr. Russ reviewed the medical records, including the letters of medical necessity and discussed the patient's history including the medical necessity for continued testing and treatments. In addition, I find that the Applicant's proofs failed to effectively rebut the arguments made in the peer review. 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). 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). **Accordingly, the Applicant's claims totaling $660.08 for the biofeedback training and strapping are denied. Applicant is awarded $91.42.** 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 applicant is AWARDED the following:

A.

Medical		**From/To**	**Claim Amount**	**Amount Amended**	**Status**
	Ocean Spine & Joi	**07/30/18 -**			**Awarded:**

	nt Medical Care, PC	**08/16/18**	**$910.60**	**$826.50**	**$91.42**
Total			**$910.60**		**Awarded: $91.42**

B. The insurer shall also compute and pay the applicant interest set forth below. 03/21/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Where a claim is timely denied, interest shall begin to accrue as of the date arbitration is commenced by the claimant, i.e., the date the claim is received by the American Arbitration Association, unless arbitration is commenced within 30 days after receipt of the denial, in which event interest shall begin to accrue as of the date the denial is received by the claimant. See generally, 11 NYCRR 65-3.9. Where a motor vehicle accident occurs after Apr. 5, 2002, 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).

C. Attorney's Fees

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

As 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).

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, 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.

11/03/2020
(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:
f535f65b03a03172a99feec125a134ea

Electronically Signed

Your name: Anthony Kobets
Signed on: 11/03/2020