

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

OrthoPro Services, Inc.
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No.	17-19-1117-3750
Applicant's File No.	2194957
Insurer's Claim File No.	0525769990101012
NAIC No.	35882

ARBITRATION AWARD

I, Charles Blattberg, 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: Eligible injured person

1. Hearing(s) held on 09/30/2020
Declared closed by the arbitrator on 10/05/2020

Helen Mann Ruzhy, Esq. from Israel, Israel & Purdy, LLP (Great Neck) participated by telephone for the Applicant

Dustin Mule from Geico Insurance Company participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 1,279.58**, 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 claimant was the 41 year-old male restrained driver of a motor vehicle that was involved in an accident on 10/22/18. Following the accident the claimant suffered injuries which resulted in the claimant seeking treatment. At issue is the medical necessity of a cervical traction unit, LSO with sagittal control, and a TENs unit with accessories (lead wires and electrodes) provided by Applicant on 11/7/18 that Respondent timely denied reimbursement for based on a 1/3/19 peer review by Edward M. Weiland, M.D.

4. Findings, Conclusions, and Basis Therefor

Based on a review of the documentary evidence, this claim is decided as follows:

Applicant establishes a prima facie case of entitlement to reimbursement of its claim by the submission of a completed NF-3 form or similar document documenting the facts and amounts of the losses sustained and by submitting evidentiary proof that the prescribed statutory billing forms [setting forth the fact and the amount of the loss sustained] had been mailed and received and that payment of no-fault benefits were overdue. See, *Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). I find that Applicant established a prima facie case for reimbursement.

The claimant was the 41 year-old male restrained driver of a motor vehicle that was involved in an accident on 10/22/18. The claimant reportedly injured his neck and low back. There was no reported loss of consciousness. There were no reported lacerations or fractures. There was no reported emergency treatment sought or received. Reportedly on 10/24/18 the claimant presented to Mt. Sinai Hospital where he was evaluated and released. On 11/6/18 the claimant presented to Nick C. Chiappetta, D.C. of Healthquest with complaints of neck pain with radiation of pain to his bilateral upper trapezius rated 4/10 (with 10 being the worst possible pain) and low back pain with radiation of pain to his bilateral gluteal muscles rated 2/10. Cervical examination revealed tenderness and spasm from the 2nd through 6th cervical vertebrae as well as over the posterior musculature bilaterally. He had a negative cervical compression test and positive cervical distraction test. Range of motion was restricted in all planes with pain (quantified). Lumbar examination revealed tenderness and spasm from the 3rd through 5th lumbar vertebrae as well as over the posterior musculature bilaterally. He had a positive straight leg raise bilaterally at 50°, positive Milgram's test and positive Kemp's test bilaterally. Range of motion was restricted in all planes with pain (quantified). Muscle strength, sensation, and deep tendon reflexes were normal. The claimant was initiated on chiropractic treatment. On 11/7/18 the claimant presented to Igor Stiler, M.D. of Healthquest with complaints of neck pain rated 6/10, low back pain rated 6-7/10, and headaches rated 8-9/10. Cervicothoracic examination revealed tenderness to palpation of suboccipital region to T5. Cervical spine range of motion was: flexion 40/50°, extension 30/50°, left lateral flexion 30/45°, right lateral flexion 30/45° with pain, left rotation 30/80° and right rotation 30/80°. Thoracolumbar spine revealed tenderness to palpation of T12 to L5. Lumbar spine range of motion was: flexion 60/90° with pain, extension 15/20°, left lateral flexion 30/30° and right lateral flexion 30/30°. Motor examination revealed 5/5 strength in both the upper and lower extremities with no signs of atrophy or spasticity. Dermatomal examination of the skin with the modalities of light touch, pinprick, proprioception, vibration, graphesthesia and two-point discrimination revealed no abnormalities. Deep tendon reflexes were 2+/4 bilaterally in the upper and lower extremities. Dr. Stiler's treatment plan included "the patient will be referred for physical therapy daily for 2-3 times a week for an additional two weeks. He will be referred for x-rays of the neck and low back. We will request his imaging. He will be referred to orthotist to receive cervical traction unit and TENs unit and back

brace. He will be referred for video ENG. He will return for re-evaluation in four weeks." At issue is the durable medical equipment (DME) equipment consisting of a cervical traction unit, LSO with sagittal control, and a TENs unit with accessories (lead wires and electrodes) prescribed by Dr. Stiler on 11/7/18 and dispensed by OrthoPro Services, Inc. (Applicant) on 11/7/18.

The burden has shifted to the Respondent as they have raised a medical necessity defense. In order to support a lack of medical necessity defense Respondent must "set forth a factual basis and medical rationale for the peer reviewer's determination that there was a lack of medical necessity for the services rendered." See, *Provvedere, Inc. v. Republic Western Ins. Co.*, 2014 NY Slip Op. 50219(U) (App. Term 2nd, 11th and 13th Jud. Dists. 20140. Respondent bears the burden of production in support of its lack of medical necessity defense, which if established shifts the burden of persuasion to Applicant. See generally, *Bronx Expert Radiology, P.C. v. Travelers Ins. Co.*, 2006 NY Slip Op. 52116 (App. Term 1st Dept. 2006). As a general rule, reliance on rebuttal documentation will be weighed in light of the documentary proofs and the arguments presented at the arbitration. Moreover, the case law is clear that a provider must rebut the conclusions and determinations of the IME/peer doctor with his own facts. *Park Slope Medical and Surgical Supply, Inc. v. Travelers*, 37 Misc.3d 19 (2012).

Respondent timely denied the DME at issue based on the 1/3/19 peer review by Edward M. Weiland, M.D. After reviewing the claimant's history, treatment, and medical records, Dr. Weiland recites the AMA definition of medical necessity without specifically indicating how it was contravened here. Dr. Weiland asserts "as identified in an article submitted by Dr. Borman, et al entitled, "Efficacy of Intermittent Cervical Traction in patients with Chronic Neck Pain" taken from the *Clinical Rheumatology* 2008, 27:1249-1253. The authors indicate, "In conclusion, no specific affect of traction over standard physiotherapeutic interventions was observed in adults with chronic neck pain. We suggest the clinicians to consider this condition and to focus on exercise therapy in the management of patients suffering from this condition." Dr. Weiland continues "regarding the use of the LSO (lumbosacral orthotic), the medical documentation made available for review did not indicate that the claimant sustained a significant traumatic injury to the spine to require immobilization. One of the expected goals of physical therapy would have been to increase range of motion, as well as promote muscle strength. The prolonged used of an LSO during the acute phase of rehabilitation may have been contraindicated. I refer to an article written by B A Casazza entitled, "Diagnosis and Treatment of Acute Low Back Pain," in the *Journal of The American Academy of Family Physicians*. This article indicates, "no substantiate benefit has been shown with oral steroids, acupuncture, massage, traction, lumbar supports or regular exercise programs." Dr. Weiland opines "as reported by KE Nnosham and J. Kumbang in The Cochrane Collaboration Review of Transcutaneous electrical nerve stimulation (TENS) for Chronic Pain 2008 they state, "despite the widespread use of TENS machines, the analgesic effectiveness of TENS still remains uncertain. This has mainly been due to inadequate methodology and reporting in earlier studies but more recent studies of TENS for chronic pain fail to offer necessary improvements in methodological rigor to define the place of TENS in chronic pain management with any certitude. The search process identified 124 studies; 25 met the inclusion criteria for evaluation in this review but there was insufficient extractable data

to make meta-analysis possible. New studies of rigorous design and adequate size are needed before any evidence - base recommendations can be made for patients or health professionals." Please note that the utilization of a TENS unit is not medically necessary. A document submitted by Aetna entitled Electrical Stimulation for Pain indicates, "TENS is considered experimental and investigational for acute pain (less than three months duration) other than post-operative pain. TENS is also considered experimental and investigational for acute and chronic headaches, adhesive capsulitis, chronic lower back pain, deep abdominal pain, hip fracture pain, neuropathic pain, pain management in burn persons, pelvic pain, peripheral arterial disease, phantom pain, post-total knee arthroplasty pain, rotator cuff disease, stump pain, temporomandibular joint and other indications because there is inadequate scientific evidence to support its efficacies for these specific types of pain." Dr. Weiland concludes "based upon a review of the available medical records, I have come to the following conclusion. The delivery and application of multiple pieces of durable medical equipment, as supplied by Ortho Pro Services, Inc., to [the claimant] on 11/07/18, was not medically necessary. The medical record submitted for review indicates that [the claimant] was undergoing a course of multi-modality rehabilitation treatments to include physical therapy and chiropractic spine care under the direction of healthcare providers affiliated with Health Quest. These treatment modalities would be utilized to increase range of motion skills and muscle strength capabilities. The application of a cervical traction unit and lumbosacral orthosis would immobilize the spine and lead to disuse muscle atrophy in the paraspinal musculature, which would only impede or impair [the claimant's] neuromuscular recovery from the incident date under review, based upon the documentation submitted for analysis by Dr. Stiler and other healthcare providers rendering treatment to [the claimant]. As well, conventional physical therapy treatments being performed by providers affiliated with Health Quest would include electrical stimulation. Therefore, the utilization of a TENS unit and accessories for a TENS unit would represent a duplication of services provided by a registered physical therapist. Dr. Stiler has not identified how the utilization of these pieces of durable medical equipment would have accelerated [the claimant's] neuromuscular recovery from any injuries that he reportedly sustained from a motor vehicle accident occurring two weeks earlier, on 10/22/18. Therefore, I can recommend no reimbursement for these pieces of durable medical equipment at this time as it relates to the incident date of 10/22/18."

After due consideration of the evidence, I find Dr. Weiland's peer review failed to establish that the prescription of the DME at issue deviated from medically accepted standards. In his peer review, Dr. Weiland contends the medical documentation did not indicate that the claimant sustained significant traumatic injury to the spine to require immobilization. According to Dr. Weiland, there was no instability in the neck or lower back that would have required immobilization of these sites. However, Dr. Weiland fails to cite authority supporting the premise that instability is the sole requisite for an LSO and he doesn't describe the clinical scenarios of immobilization which may warrant an LSO. As to the CTU Dr. Weiland merely cites an article which states that no conclusions could be drawn about the efficacy of the CTU based on the quality of available data, this does not establish a lack of medical necessity. Also, Dr. Weiland's reliance on an insurance company's (Aetna) guidelines to deny reimbursement for the TENS unit is insufficient to establish evidence of the generally accepted medical professional practice of when to order a TENS unit. I find that Dr. Weiland's report is

factually insufficient to meet the burden of production. I further find the peer review is conclusory and insufficient to support a lack of medical necessity defense.

Accordingly, Applicant is awarded \$1,279.58.

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
	OrthoPro Services, Inc.	11/07/18 - 11/07/18	\$1,279.58	Awarded: \$1,279.58
Total			\$1,279.58	Awarded: \$1,279.58

B. The insurer shall also compute and pay the applicant interest set forth below. 01/14/2019 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 requested, i.e., the date the American Arbitration Association receives Applicant's arbitration request, unless the arbitration is commenced within 30 days after receipt of

the denial, in which event interest shall begin to accrue as of the 30th day after proof of claim was received by the insurer. 11 NYCRR §65-4.5(s)(3), §65-3.9(c). Here with regards to the bill at issue, Applicant requested arbitration within 30 days after receipt of Respondent's denial. The denial is dated 1/7/19 and the arbitration was requested on 1/17/19. As Applicant acted in a timely manner and in accordance with the No-Fault Regulations, interest should accrue from 30 days after receipt of the claim by the insurer or 1/14/19 (Monday) as the bill was received on 12/14/18.

C. Attorney's Fees

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

Pursuant to 11 NYCRR §65-4.6 (d), ". . . the attorney's fee shall be limited as follows: 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon for each applicant for arbitration or court proceeding, subject to a maximum fee of \$1,360."

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

11/14/2020
(Dated)

Charles Blattberg

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:

376f4f3fa32fdf73ef8c4f2f5212290b

Electronically Signed

Your name: Charles Blattberg
Signed on: 11/14/2020