American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Zynex Medical (Applicant)	AAA Case No.	17-19-1137-8873
	Applicant's File No.	19-18940X
- and -	Insurer's Claim File No.	0491387452 2EZ
	NAIC No.	29688
Allstate Fire & Casualty Insurance Company (Respondent)		

ARBITRATION AWARD

I, Fred Lutzen, 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/claimant/patient

1. Hearing(s) held on 09/29/2020
   Declared closed by the arbitrator on 11/28/2020

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

   Meghan McDonough, Esq., from Law Offices of John Trop participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **$ 3,759.05**, was AMENDED and permitted by the arbitrator at the oral hearing.

   At the time of the hearing on 9/29/2020, Applicant amended its claim down to $3,724.05. This total considers withdrawal without prejudice of the claim for DOS 2/1/19 in the amount of $35.00. The relevant date range was amended to 3/13/18 - 12/1/18.

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

3. Summary of Issues in Dispute

This female EIP (first initial "B") was 58-years-old when she was injured in an automobile accident on 2/8/18. She subsequently came under the care of William J. Owens, Jr., D.C., and other providers. Dr. Owens prescribed DME for the EIP, which were provided by Applicant initially on 3/13/18 and 3/14/18.

Applicant seeks reimbursement for DME and supplies provided to the EIP from 3/13/18 through 12/1/18.

Respondent denied reimbursement for a lumbar support (LSO) and an electrical stimulation device (NexWave) with supplies, and rental of a second NexWave device on 7/1/18-9/1/18, for lack of medical necessity based on a peer review report prepared by Kevin Portnoy, D.C., dated 4/16/18. Respondent reduced and partially reimbursed/partially denied the claims for DOS 5/1/18 (incorrectly referred to as 5/17/18 in the denial) and 6/1/18 based on fee defenses with respect to a PPO contract. Respondent denied reimbursement for the rental of the e-stimulation unit (the second NexWave) re: DOS 10/1/18-12/1/18 for lack of medical necessity based on a chiropractic examination [IME] conducted by Craig Horner, D.C., on 8/16/18.

The issues to be determined are (1) whether the DME items were medically necessary, (2) billed within fee schedule allowances, and (3) whether Respondent's 'PPO' defenses are supported by the credible evidence.

4. Findings, Conclusions, and Basis Therefor

My decision is based on the arguments of representatives for both parties, prevailing case law, and those documents submitted to the American Arbitration Association as contained in the MODRIA electronic case folder as of the date of this hearing. No witnesses testified in this case.

The amended claims are broken down as follows:

.

DOS	Amended	Service	Reason(s)
3/13/18	2081.18	MMS w/supplies	Portnoy Peer 4/16/18
3/14/18	741.59	LSO	Portnoy Peer 4/16/18
4/13/18	66.64	MMS Supplies	Portnoy Peer 4/16/18
7/1/18-	378.57	MMS Rental	Portnoy Peer

9/1/18		(x3)	4/16/18
Subtotal: $3,267.98			
5/1/18 (aka 5/17/18)	27.38	MMS Rental	Reduced PPO Contract
6/1/18	50.12	MMS Rental	Reduced PPO Contract
Subtotal: $77.50			
10/1/18- 12/1/18	378.57	MMS Rental (x3)	Horner IME 8/16/18
Subtotal: $378.57			
2/1/19	[35.00]		Withdrawn Without Prejudice
TOTAL	**$3,724.05**		

PPO Defense

Respondent partially paid for DOS 5/1/18 (aka 5/17/18) and 6/1/18, leaving unpaid balances of $27.38 and $50.12, respectively. Respondent's denial/EOBs explain that these charges were reduced and paid according to a PPO/Coventry contract between the parties.

Respondent's counsel conceded that no evidence was submitted to support these reductions.

As such, I find that Respondent has failed to meet its burden of proof with respect to these fee defenses.

Applicant is awarded $77.50.

Medical Necessity - Peer Review

Defense

The Respondent's denial for lack of medical necessity must be supported by a peer-review or other competent medical evidence which sets forth a clear factual basis and medical rationale for denying the claim. Healing Hands Chiropractic, P.C. v. Nationwide Assurance Co., 5 Misc.3d 975, 787 N.Y.S.2d 645 (Civ. Ct. New York Co. 2004); CityWide Social Work & Psy. Serv., P.L.L.C. v. Travelers Indemnity Co., 3 Misc.3d 608, 609, 777 N.Y.S.2d 241, 242 (Civ. Ct. Kings Co. 2004). Respondent's peer review must also address all of the pertinent objective findings contained in the applicant's medical submissions. The peer review must set forth how and why the disputed services were inconsistent with generally accepted medical and/or professional practices.

Dr. Portnoy reviewed the EIP's medical records and provided his opinion, which was, in relevant part:

> .
>
> It is my professional opinion that the claimant is not in need of the LSO and an interferential stimulator ("Durable Medical Equipment"). In order to substantiate the chiropractic necessity of the Durable Medical Equipment it is necessary to have contemporaneous chiropractic documentation that relates to the specific need for the Durable Medical Equipment. This would include, at least, documentation of evaluation for the Durable Medical Equipment, instruction in the safe and effective use of the [DME] and follow up in relation to response to treatment with the Durable Medical Equipment, including any complications as well as compliance with instructions. Dr. Owens fails to provide any chiropractic necessity for the Durable Medical Equipment. Specifically, an LSO and an interferential stimulator could be ineffective without appropriate evaluation prior to prescription, along with detailed instruction in self-application. Dr. Owens does not provide any chiropractic documentation that relates to the specific need for the Durable Medical Equipment. Dr. Owens does not indicate how the [DME] will aide in devising, altering, reducing the number of visits to his office or enhancing the clinical prognosis of the claimant.
>
> .
>
> Based upon a review of Dr. Owens records the claimant sustained soft tissue injury. The standard of care for these types of injuries would be an evaluation by a physician, ordering of plain radiographs (only if there is suspicion of fracture or a severe mechanism of injury), prescribing of medications such as anti-inflammatory medications, rest and/or conservative care. If there is deterioration in the condition or progressive, worsening neurological deficits, MRI may be indicated at that point in time. At that point, interventional pain management or surgery may be indicated depending upon the results of the advanced imaging or the progression of the condition. However, the standard of care in chiropractic does not involve the routine prescribing of durable medical equipment in soil tissue injuries.
>
> .

With respect to the lumbar support brace (LSO) specifically, Dr. Portnoy continued:

> .
>
> Furthermore, the main risk in wearing an LSO is that deep abdominal muscles and back muscles that support the spine will become weaker. These muscles are less active while the spine is being artificially supported by the LSO. Additionally, an LSO

can increase blood pressure and heart rate and claimant s may be inclined to lift heavier objects while wearing an LSO. The purpose of chiropractic care is to mobilize individual vertebral segments, increase flexibility and facilitate circulation by decreasing paraspinal muscular spasm. There is no rationale to manipulate the spinal vertebral segments in the office while attempting to immobilize the spine outside the office using an LSO. Dr. Owens fails to indicate any lumbar spinal instability to warrant the referral for the LSO. The primary goal or chiropractic is the restoration of aberrant joint mobility through chiropractic manipulation. Therefore. this particular type of LSO would not be complementary towards the treatment goals of chiropractic.

.

Furthermore, there is no indication in the examination report of any significant spinal instability, a high-grade spondylolisthesis or ligament laxity as it relates to the injuries sustained to the area of the lumbar spine that would require this particular type of LSO.

.

Furthermore, according to the New York State Workers Compensation Board Mid and Low Back Injury Medical Treatment Guidelines Section D.2.c Lumbar Support: sections: D.2.c.i and D.2.cii: states that lumbar supports may be useful for specific treatment of spondylolisthesis, documented instability or post-operative treatment and lumbar supports are not recommended for the prevention or treatment of other back pain conditions. Since Dr. Owens fails to document any spondylolisthesis, documented instability or postoperative treatment the LSO was not necessary.

.

According to the Official Disability Guideline Work Loss Data Institute, 2012 lumbar supports are not recommended for the prevention of low back pain. They are recommended for the treatment of compression fractures, spondylolisthesis. documented instability. postoperative treatment and nonspecific low back pain. None of these conditions apply to this claimant.

.

According to the American Academy of Orthopedic Surgeons August 2006; Volume 14 (8), pp4 77-87. Shen. et.al. It is concluded that evidence does not support the effectiveness of lumbar orthoses. This article goes on the mention "The role of corsets, lumbosacral orthosis. braces, back supports and abdominal binders in the treatment of low back pain is controversial at best. The use of a corset for a short period (a few weeks) may be indicated in claimant s with osteoporotic compression fractures.

.

With respect to the electrical stimulation device specifically, Dr. Portnoy noted that the "New York State Mid and Low Back Injury Medical Treatment Guidelines 2010 which states that "interferential therapy is not recommended for treatment of acute, subacute, chronic back pain, chronic radicular pain syndromes, or other back-related conditions." (emphasis added). He noted that the standard of care concerning interferential stimulator is that they are customarily dispensed to claimants with chronic neuropathic pain syndromes. By definition, chronic neuropathic pain syndrome is symptomatology that has persisted for more than six (6) months secondary to nerve injury or damage." Dr. Portnoy cited to additional sources that contend these electrical stimulation devices are

not recommended for acute and chronic back pain conditions, and that studies were inconclusive as to the efficacy of these devices.

Based on his review of the records and considering the standards of care he discussed, with authoritative support, Dr. Portnoy opined stated that both DME items were "excessive and unnecessary, and not consistent with the definition of medical necessity as described by the AMA."

I find that the peer reviewer based his opinion on the pertinent facts of this case, provided support for his opinion, and provided a sound medical rationale sufficient to meet Respondent's burden of proof. The burden has shifted back to the Applicant to persuade otherwise. *See*, A Khodadadi Radiology, P.C. v. NY Central Mutual Fire Ins. Co., 16 Misc.3d 131(A), 841 N.Y.S.2d 824 (Table), 2007 N.Y. Slip Op. 51342(U), 2007 WL 1989432 (App. Term 2d & 11th Dists. July 3, 2007.

Rebuttal Case

Applicant submitted a record review by Dr. Drora Hirsch, M.D., dated 8/12/2020. Applicant also relies on the submitted records to rebut the peer reviewer's opinion.

Dr. Hirsch stated that Dr. Portnoy "essentially ignored all contemporaneous chiropractic documentation which lists all the subjective as well as objective physical examination findings that led to the prescription of durable medical equipment. There was clearly contemporaneous chiropractic documentation dated 2/13/2018 that warranted the specific need for the durable medical supplies that were prescribed." However, it should be noted that the DME items were prescribed on 3/7/18. The initial evaluation report on 2/13/18 was not a "contemporaneous" record that supported use of the disputed DME. The DME items were not prescribed on that date or mentioned as necessary on that date. Dr. Hirsch did not identify any other contemporaneous record that recommended DME. Dr. Portnoy stated that "Dr. Owens does not provide any chiropractic documentation that relates to the specific need for the Durable Medical Equipment." I have reviewed all of the records and find this to be an accurate statement by Dr. Portnoy. There are letters by Dr. Owens, dated 3/7/18 and 3/9/18, entitled "DME Referral." Dr. Owens stated that the DME items have "been successful in the past with similar patients", but does not discuss the specifics pertaining to the EIP's specific need for the DME, and no examination of the EIP was reported.

The remainder of Dr. Hirsch's review goes on to explain that LSOs are used generally for all sorts of patients with low back pain and other conditions, and he cites several articles that support the use of LSOs under a wide variety of circumstances, including pain. However, only general reasons are provided. My reading of Dr. Hirsch's rebuttal opinion is that Dr. Hirsch's position is that every patient with back pain should be prescribed a lumbar support brace. However, in this case, Dr. Portnoy sufficiently explained why the LSO was not necessary based on the medical records for this patient and noted, to the contrary, that the "standard of care in chiropractic does not involve the routine prescribing of durable medical equipment in soil tissue injuries." Compared to Dr. Owen's general statements "being prescribed due to pain associated with traumatic event", "successful in the past with similar patients", and "to relieve pain, reduce muscle

spasm, increase blood circulation, increase range of motion and re-educate muscles", I find Dr. Portnoy's opinion more probative and persuasive.

The only additional detailed examination by a treating provider is dated 3/9/18, by General Physician PC. This provider performed a detailed examination of the EIP and recommended that she continue conservative treatments as she has had "good results" with chiropractic by Dr. Owens, and that it would be reasonable to continue with this treatment modality indefinitely. There was no mention of any need for DME by this provider.

Regarding the electric stimulation device, Dr. Hirsch stated that he disagreed with Dr. Portnoy's conclusion "since the literature widely supports TENS and other electro stimulating units for pain in various stages of treatment and injury and for a variety of different intensity pain syndromes. TENS unit is effective as a supplement to the patient's outpatient electrical stimulation therapy." However, there is no evidence of any outpatient electrical stimulation therapy being performed, as suggested by Dr. Hirsch. It is not mentioned on 2/13/18 by Dr. Owens, or on 3/9/18 by General Physician PC, who stated specifically that treatment to date "consist[s] of regular chiropractic manipulations." There was no mention of any other electrical stimulation therapy being performed.

The ultimate burden of proof on issues of medical necessity lies with the plaintiff. Dayan v. Allstate Ins. Co., 2015 N.Y. Slip Op. 51751(U), 2015 WL 7900115 (App. Term 2d, 11th & 13th Dists. Nov. 30, 2015). I find that Applicant has failed to meet its shifted burden. When weighing the competing expert opinions, I find that Dr. Portnoy's opinion is more probative and convincing.

The denial is sustained.

The denials sustained are for the NexWave with supplies ($2,081.18), the LSO ($741.59), the NexWave supplies on 4/13/18 ($66.64), and rental of a second NexWave device on 7/1/18-9/1/18.

Second NexWave Device

Applicant's 'Statement of Medical Services", dated 11/28/18, summarizes the charges for all of the DME and services in dispute.

Applicant billed $1,995.00 for the "NexWave" as a complete purchase by the EIP. With supplies, the charges totaled $2,081.18. As noted above, the denial of this claim based on the peer review by Dr. Portnoy was sustained.

Applicant subsequently submitted claims for a rental of the same device, e.g., "NexWave - Rental" and billed $98.95 for monthly rental on 5/1/18, 6/1/18, 7/1/18, 8/1/18, 9/1/18, 10/1/18, 11/1/18, and 12/1/18, for a total of $791.60. With supplies, the charges totaled $1,033.28. It is unclear if these charges continue beyond the date range of this arbitration matter.

The first two dates of rental (DOS 5/1/18 & 6/1/18) were partially paid by Respondent, as noted above, and the unpaid balance is awarded as the fee defenses failed.

The rental charges for DOS 7/1/18, 8/1/18, and 9/1/18, were denied also based on the peer review by Dr. Portnoy.

This issue that arises is that these charges are for rental of a second NexWave device, not for charges pertaining to the same exact device denied based on Dr. Portnoy's peer review.

However, there is no evidence that the second device was ever prescribed. It is certainly odd that the EIP owns a NexWave and is also renting a second identical device for home use. In any event, where a piece of medical equipment is not listed on the prescribing doctor's prescription, there is a lack of a prima facie case of entitlement to compensation for dispensing it, even if the insurer's denial is untimely. Vista Surgical Supplies, Inc. v. State Farm Mutual Ins. Co., 12 Misc.3d 134(A), 820 N.Y.S.2d 846 (Table), 2006 N.Y. Slip Op. 51189(U), 2006 WL 1750964 (App. Term 2d & 11th Dists. June 15, 2006) (TENS accessory unit).

Initially, I considered that it might be possible that the first device was returned after the denial, and the treating provider found a subsequent need for the device and re-prescribed the device. However, there is (1) no prescription for rental of a second identical device and (2) no evidence the purchased device was returned as, after all, Applicant is seeking reimbursement for it here which demonstrates that it was not returned.

In any event, since the second identical device was not prescribed, Applicant failed to establish its prima facie case and the claims are, therefore, denied.

DOS 10/1/18-12/1/18 (Rental of NexWave and Supplies)

The remaining claims were denied based on the 'IME' by Dr. Horner.

However, all of the post-IME claims are for rental of a device that was not prescribed, i.e., a second NexWave device for home use while the EIP already owns one.

Since the second identical device was not prescribed, Applicant failed to establish its prima facie case and the claims are, therefore, denied.

Conclusion

Having carefully considered the submissions of the parties, the relevant case law and the arguments of respective counsel, I conclude that the preponderance of the credible evidence supports findings (1) in favor of the Respondent on the issues of medical necessity for the claims through 4/13/18, (2) in favor of Applicant on the fee schedule / PPO defenses, and (3) in favor of Respondent on the claims from 7/1/18 through 12/1/18 as Applicant failed to establish a prima facie case for the DME without a prescription.

The claim for DOS 2/1/19 was withdrawn without prejudice.

Applicant is awarded $77.50.

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	**03/13/18 - 02/01/19**	**$3,759.05**	**$0.00**	**Awarded (non-monetary)**
	Zynex Medical	**03/13/18 - 09/01/18**	**$0.00**	**$3,267.98**	**Denied**
	Zynex Medical	**05/01/18 - 06/01/18**	**$0.00**	**$77.50**	**Awarded: $77.50**
	Zynex Medical	**10/01/18 - 12/01/18**	**$0.00**	**$378.57**	**Denied**
	Zynex Medical	**02/01/19 - 02/01/19**	**$0.00**	**$35.00**	**Withdrawn without prejudice**

Total	**$3,759.05**		**Awarded: $77.50**

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.

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 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); and OGC Op. No. 10-09-05 (interest accrues from date Applicant "*actually requests arbitration*" or commences a lawsuit). The Superintendent and the New York Court of Appeals have 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

Applicant is awarded statutory attorney fees pursuant to the no-fault regulations. See, 11 NYCRR §65-4.5(s)(2). The award of attorney fees shall be paid by the insurer. 11 NYCRR §65-4.5(e). Accordingly, "the attorney's fee shall be limited as follows: 20 percent of the amount of first-party benefits, plus interest thereon, awarded by the arbitrator or the court, subject to a maximum fee of $1360." Id. However, if the benefits and interest awarded thereon is equal to or less than the respondent's written offer during the conciliation process, then the attorney's fee shall be based upon the provisions of 11 NYCRR 65-4.6(b).

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

12/09/2020
(Dated)

Fred Lutzen

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:
3c51a5e21b39fe7b906cebd5578ac744

Electronically Signed

Your name: Fred Lutzen
Signed on: 12/09/2020