

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Mogul Supplies Inc  
(Applicant)

- and -

Geico Insurance Company  
(Respondent)

AAA Case No.	17-20-1163-2433
Applicant's File No.	none
Insurer's Claim File No.	0574093030101028
NAIC No.	22063

**ARBITRATION AWARD**

I, Heidi Obiajulu, 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: Injured Party

1. Hearing(s) held on 12/18/2020  
Declared closed by the arbitrator on 12/18/2020

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

David Muller, Esq. from Geico Insurance Company participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 1,041.07**, was AMENDED and permitted by the arbitrator at the oral hearing.

The applicant amended its claim to \$844.13 to conform to the maximum allowance under the NYS Medicaid DME fee schedule for the billed CPT code.

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

3. Summary of Issues in Dispute

Applicant seeks reimbursement of charges for the LSO with APL control custom-fitted lumbar support dispensed on 01/30/20, following a motor vehicle accident occurring on 11/26/19. Respondent timely denied claim(s) based upon the peer review report by Dr. Harry E. Jackson, MD.

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

The below decision is based on the documents contained in the Modria ADR Electronic Case folder maintained by the American Arbitration Association (hereinafter referred to as AAA) as of the date of this hearing.

The applicant, as assignee of the Injured Party, seeks the reimbursement, with interest and counsel fees, under the No-Fault Regulations, for the LSO with APL control custom-fitted lumbar support dispensed on 01/30/20, in the amended amount of \$844.13.

This case arises out of a motor vehicle accident occurring on November 26, 2019, in which the Injured Party (AA), a then 29-year-old male sustained multiple injuries including to his back while occupying the insured vehicle when it was hit the front right corner by the adverse vehicle that ran a stop sign. According to the note by Darby M. Winson, PA for emergency treatment rendered at Montefiore Hospital, the impact of the collision caused the airbags to deploy and the windshield to crack. However, it was noted that the Injured Party did not hit his head or require extrication. Also, he refused treatment by EMS but later presented to Montefiore Hospital for pain that developed later. At the emergency room of Montefiore Hospital, the Injured Party was evaluated, X-rayed (the knee), treated, and released.

On 12/02/19, the treating chiropractor of NAM Chiropractic PC evaluated the Injured Party and reported that he presented with complaints of pain in his neck, mid-back, and left knee. His physical exam revealed positive findings affecting the cervical and thoracic spine. He did not diagnose any conditions affecting the lumbar spine, he diagnosed conditions affecting the cervical and thoracic spine. He commenced the Injured Party on chiropractic care and prescribed durable medical equipment (hereafter referred to as DME) including an LSO.

On 12/09/19, Dr. Viviane Etienne, MD ( or her PA) initially evaluated the Injured Party and reported that he presented with complaints of headaches, and pain in the neck, mid-back, low back, right shoulder, and left knee. Physical examination of the lumbar spine revealed no scoliosis, pain on palpation of the lumbar facet at L3-S1 region, spasms/trigger points, pain noted over the lumbar intervertebral spaces (discs), decreased ranges of motion (see the report for ranges) and a positive SLR test at 60 degrees on the left. There were normal muscle strength and tone. Based on the exam findings, the Injured Party was commenced on physical therapy, trigger point injections in the bilateral paralumbar spine and bilateral spinal musculature, prescribed Lidocaine 5% ointment, Ibuprofen, Tizanidine, Omeprazole, and Esgic.

On 12/27/19, a lumbar spine MRI was performed and revealed right paracentral disc herniation with compression of the ventral sac at L5-S1 posteriorly.

On 01/14/20, Mario Leon RPA-C prescribed the disputed LSO.

On 01/23/20, the treating chiropractor of NAM Chiropractic re-evaluated the Injured Party and reported decreased muscle strength in the lower extremities (graded 4/5), muscle spasms and trigger points in the latissimus dorsi, diminished left Patella and Achilles DTRs (+1), restricted lumbar spine pain with discomfort (see the report for ranges), and a positive SLR test on the left and Kemp's test. Based on his exam findings, he diagnosed lower back pain, displacement of the lumbar region, and lumbar radiculopathy. **This exam appears to show a worsening of the Injured Party's condition.**

On 01/30/20, the applicant dispensed the disputed LSO with APL control custom-fitted lumbar support.

Thereafter, the applicant submitted its claim form to the respondent seeking the reimbursement of no-fault benefits.

The respondent insured the motor vehicle involved in the automobile accident. Under New York's Comprehensive Motor Vehicle Insurance Reparation Act (the "No-Fault Law"), New York Ins. Law §§ 5101 et seq., the respondent was obligated to reimburse the Injured Party (or his assignee) for all reasonable and necessary medical expenses arising from the use and operation of the insured vehicle.

Within 30-days of its receipt of the applicant's claim form, the respondent denied reimbursement on the grounds that the disputed LSO with APL control custom-fitted lumbar support was medically unnecessary with the peer review report by Dr. Harry E. Jackson, MD.

After it received the respondent's denial, the applicant commenced this arbitration seeking reimbursement of its claim.

At the outset, I find that the applicant established its prima facie case with the submission of its claim form and the copy of the respondent's denial of claim form, which demonstrates that the respondent received the applicant's claim form, that more than 30-days elapsed since its receipt of same, and that the respondent denied reimbursement of the applicant's claim, which shows that the applicant's claim is now due and owing. See Insurance Law section 5106 [a]; Viviane Etienne Medical Care, PC v. County-Wide Ins. Co 25 N.Y.3d. 498, ( NY, June 10, 2015), Westchester Medical Center v. Nationwide Mut. Ins. Co., 78 A.D.3d. 1168, (N.Y.A.D. 2<sup>nd</sup> Dept., November 30, 2010).

Once an applicant establishes a prima facie case, the burden then shifts to the insurer to prove its defense.

However, even before determining whether the respondent met its burden of proof, it must first be determined whether the respondent's lack of medical necessity defense survives preclusion.

In a no-fault action, a defense (other than one based upon a lack of coverage) survives preclusion only if raised in a denial that is (1) timely, Presbyterian Hosp. in the City of

New York v. Maryland Casualty Ins. Co., 90 NY.2d 274, ( N.Y., June 10, 1997), Central Gen. Hosp. v. Chubb Group of Ins. Co., 90 N.Y.2d 195 (1997), (2) includes the information called for in the prescribed denial of claim form, 11 NYCRR § 65-3.4 (c) (11); Nyack Hosp. v. Metropolitan Prop. & Cas. Ins. Co., 16 A.D.3d 564 (2d Dept. 2005); Nyack Hosp. v. State Farm Mut. Auto. Ins. Co., 11 A.D.3d 664, ( App. Div. 2<sup>nd</sup> Dept. Oct. 25, 2004), or is not fatally defective, and (3) "promptly apprise(s) the claimant with a high degree of specificity of the ground or grounds on which the disclaimer is predicated", General Accident Ins. Group v. Cirucci, 46 N.Y.2d 862, 864, (1979); New York University Hosp. Rusk Ins. v. Hartford Acc. & Indem. Co., 32 A.D.3d 458, (2d Dept. 2006).

Applying the above case law and criteria to the respondent's denial, I find that its lack of medical necessity defense is preserved because the denial was issued in a timely manner, included the information called for in the prescribed denial of claim form, and promptly apprised the applicant with a high degree of specificity of the basis of the denial.

Therefore, the issue is whether the respondent met its burden of proof in establishing its defense.

Regarding its lack of medical necessity defense, the respondent relies on the peer review report by Dr. Harry E. Jackson, MD. To rebut that defense, the applicant relies on the legal arguments of its attorney and the medical records in evidence.

The applicant's attorney argued that the peer review report was legally insufficient to refute the presumption [created by the applicant's submitted claim form] that the disputed LSO was medically necessary because the peer reviewer failed to establish that the orthosis was prescribed inconsistent with the generally accepted medical practices followed by the medical community in prescribing an LSO with APL control custom-fitted lumbar support. The attorney argued that instead the peer reviewer cited a medical authority that discussed the efficacy of LSOs, which is not the standard of care. Finally, he argued that the submitted lumbar spine MRI report and hospital records refute the peer reviewer's arguments that the Injured Party solely sustained soft tissue injuries requiring a limited conservative care regimen. Hence, he argued that the applicant should be reimbursed its claim.

The respondent's attorney argued that the peer reviewer demonstrated that the disputed LSO was prescribed inconsistently with the applicable standard of care because he opined that the Injured Party sustained soft tissue injuries that are treated with physical therapy and analgesic agents. Also, he noted that the peer reviewer argued that the LSO in dispute contradicts the goal of chiropractic treatment [which is mobilization]. To support the peer reviewer's argument that the injury to the lumbar spine was minor, he referenced the hospital emergency room records and noted that they indicated a normal exam of the lumbar spine. He also argued that the treating acupuncturist's pain chart did not show injury to the lumbar spine. Finally, he argued that the lumbar spine MRI findings were not recent because there was no indicated edema. For those reasons, he argued that the peer review report is legally sufficient to sustain the respondent's defense and denial.

Reviewing the relevant evidence in the record and considering the oral arguments made by the parties, I find as follows:

In determining whether an insurer met its burden of proof in establishing its lack of medical necessity defense, the courts have found that an insurer must submit an IME report/peer review with a detailed basis and medical rationale for the denial of benefits in order to prevail. See Vladimir Zlatnick, M.D., P.C. v. Travelers Ins. Indemnity Co., 12 Misc. 3d 128A (App. Term 1<sup>st</sup> Dept. 2006) and Nir v. Allstate, 7 Misc.3d 544, 546-47 (Civ. Ct., Kings Cty. 2005). ("At a minimum, (the respondent) must establish a factual basis and medical rationale for the lack of medical necessity of (applicant's) services"). Once the respondent submits an IME report or peer review that has a sufficient factual basis and medical rationale, then the courts have routinely found that the respondent has established its prima facie defense that the disputed medical service is medically unnecessary. A Khodadadi Radiology, P.C. v. NY Cent. Mut. Fire Ins. Co., 16 Misc.3d 131(A), (N.Y. Sup. App. Term Jul 03, 2007). Then, the burden of persuasion regarding the medical necessity of the medical services shift to the applicant to submit competent medical evidence to refute the respondent's prima facie defense that the disputed medical service/test was medically unnecessary. See Pan Chiropractic PC v. Mercury Ins. Co., 24 Misc.3d. 136 (A)(July 9, 2009).

Applying the above case law and criteria to the medical evidence in the record, I find that the respondent failed to rebut the presumption [created by the applicant's submitted prescribed claim form] that the disputed LSO with APL control custom-fitted lumbar support was medically necessary with the peer review report by Dr. Harry E. Jackson, MD because I find that the peer reviewer failed to set forth a sufficient medical rationale to support his opinion that the disputed LSO was medically unnecessary. In his peer review report, Dr. Jackson argued that the disputed LSO was medically unnecessary because the Injured Party sustained soft tissue injuries and the appropriate treatment for soft tissue injuries is physical therapy and analgesic. He also cited a medical authority that described lumbar segmental instability and a medical authority that questioned the efficacy of LSOs. My problem with this peer review report is that Dr. Jackson did not indicate why he determined that the injuries sustained were minor soft tissue acute traumatic strains that only required limited conservative care, which would make his one cited standard of care applicable. He reviewed the MRI but completely ignored the findings. The respondent's attorney referenced medical records and even discussed the MRI findings. However, as a layperson, he lacks the requisite expertise to show that the lumbar MRI findings were not recent and did not evidence either a more severe lower back injury or exacerbation that would require the disputed custom-fitted LSO. At the very least, I want a discussion of the lumbar MRI findings. **Additionally, the reported clinical findings by the treating chiropractor for a re-evaluation on 01/23/30 that consider the positive lumbar MRI findings diagnosed the Injured Party with more severe injuries than a lumbar sprain/strain or lumbar pain.** The peer reviewer does not discuss those findings. So, I am not persuaded that the Injured Party only sustained minor soft tissue injuries. Additionally, the peer reviewer did not cite a standard of care for prescribing an LSO with APL control custom-fitted lumbar support. So, the bottom line is that I find that the peer reviewer failed to show that an applicable standard of care for prescribing the custom-fitted LSO in dispute was not followed in this case.

Consequently, I find that the respondent failed to establish its prima facie case that the disputed LSO with APL control custom-fitted support was medically unnecessary. **Accordingly, for the above reasons, I find in favor of the applicant in the amount of \$844.13, as reimbursement of the disputed LSO with APL control custom-fitted lumbar support dispensed on 01/30/20.**

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
	Mogul Supplies Inc	01/30/20 - 01/30/20	\$1,041.07	\$844.13	Awarded: \$844.13
Total			\$1,041.07		Awarded: \$844.13

- B. The insurer shall also compute and pay the applicant interest set forth below. 04/23/2020 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant's award in the amount of \$844.13 shall bear interest at a rate of two percent per month, calculated on a pro-rata basis using a 30-day month from 04/23/20, the date that the applicant initiated this arbitration, to the date of the payment of the award.

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 New York

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

12/18/2020  
(Dated)

Heidi Obiajulu

**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:**  
cb8cb62dbd80c096434bfe4d4dcd5655

### **Electronically Signed**

Your name: Heidi Obiajulu  
Signed on: 12/18/2020