American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Big Apple Med Equipment Inc. (Applicant)	AAA Case No.	17-19-1134-4239
	Applicant's File No.	N/A
- and -	Insurer's Claim File No.	0565920740101023
	NAIC No.	35882
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Stacey Erdheim, 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: Claimant

1. Hearing(s) held on 03/22/2021
   Declared closed by the arbitrator on 03/22/2021

   Ian Besso from The Sigalov Firm PLLC participated in person for the Applicant

   Joe Costa-Cappucci from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 502.63**, 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

   This arbitration arises out of treatment of a male Claimant (MV) for injuries sustained in a motor vehicle accident occurring on 1/17/19. Applicant seeks reimbursement for Durable medical equipment provided on 2/19/19 in the amount of $502.63. Respondent timely denied the bill based upon a Peer Review by Kevin Portnoy DC dated 3/22/19.

4. Findings, Conclusions, and Basis Therefor

I have reviewed the documents contained in the ADR Center file as of the date of the Hearing and this Award is based upon my review of the Record and the arguments made by the representatives of the parties 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.)

This arbitration arises out of treatment of a male Claimant (MV) for injuries sustained in a motor vehicle accident occurring on 1/17/19. Applicant seeks reimbursement for Durable medical equipment provided on 2/19/19 in the amount of $502.63. Respondent timely denied the bill based upon a Peer Review by Kevin Portnoy DC dated 3/22/19.

It is Applicant's *prima facie*obligation to establish entitlement to payment for each service for which reimbursement is sought. It is well settled that 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, 774 N.Y.S. 2d 564 [2004]; Amaze Med. Supply v. Eagle Ins. Co., 2 Misc. 3d 128A, 784 N.Y.S. 2d 918, 2003 NY Slip Op 51701U [App Term, 2d & 11th Jud Dists]).*Applicant has met its Prima Facie burden in the case at hand.

The record reveals that Claimant was injured in a motor vehicle accident on 11/3/18.

Claimant was seen by Anthony Siano, Jr., on 1/18/19. Examination of the cervical spine revealed decreased Range of motion, tenderness and spasm. Positive tests·included Cervical Compression, Foraminal Compression test, Maximal Foraminal Com, 1 ression, Shoulder Depression test, Shoulder Dugas test, Shoulder Yergarson's and Codman's test, and Cervical Distraction test. Claimant was recommended to start on a course of chiropractic treatment. She was also recommended for various diagnostic tests. . MRI study of the cervical spine on 2/10/19 revealed left posterolateral disc herniation at the L5-S1 level, left posterolateral disc herniation at the *U-5* level superimposed upon a posterior disc bulge, and posterior bulges at the Ll-2 through L3- 4 levels. Claimant was prescribed CTU to use at home on 2/ 11/ 19.

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 11th Jud 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 and should be supported by evidence of

generally accepted medical/professional practice or standards. *James M. Ligouri Physician, PC v. State Farm Mut. Auto Ins. Co., 2007 N.Y. Slip Op 50465 (U) (N.Y. Dist. Ct. 2007); Jacob 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 Indemnity Co.*,3 Misc. 3d 608; 777 N.Y.S.2d 241; 2004 NY Slip Op 24034.

In the event that an insurer's evidence rebuts the inference of medical necessity, by proof in admissible form, establishing that the services are not medically necessary and if such proof is not refuted by applicant such proof may entitle the insurer to a judgment in its favor. *Alfa Medical Supplies v. Geico General Ins. Co., 36 Misc.3d 156(A), 2012 N.Y. Slip Op. 51765(U) (App. Term 2nd, 11th and 13th Jud. Dists. 2012); Delta Diagnostic Radiology, PC v. American Transit Insurance Co., 18 Misc.3d 128(A), 2007 N.Y. Slip Op. 52455(U) (App. Term 2nd, 11th and 13th Jud. Dists. 2007); A. Khodadi Radiology, P.C. v. NY Central Mutual Fire Ins. Co., 16 Misc.3d 131(A), 2007 N.Y. Slip Op. 51342(U) (App. Term 2nd, 11th and 13th Jud. Dists. 2007*).

With respect to the traction Unit, Respondent timely denied the bill in dispute based upon a peer review by Kevin Portnoy DC dated 3/22/19. Dr Portnoy reviewed numerous medical examination ad reports and concluded that the durable medical equipment was not medically necessary. He noted that there was no examination at or around the time the equipment was provided to explain Claimant's condition or why the items were needed. Dr. Portnoy states that Dr. Anthony Siano, Jr. failed to show that there was a positive cervical distraction test at the time the traction was prescribed to warrant the device.

Once the peer review sets forth a reasonable factual basis and medical rationale for the opinion regarding the medical necessity for the treatment in dispute, the trier-of-fact will look to the Applicant to rebut the evidence and conclusion reached by the peer reviewer. In the absence of such a rebuttal, the denial of the claim can be sustained. A. Khodadadi Radiology, P.C. v. N.Y. Centr. Mut. Fire Ins. Co., 16 Misc.3d 131[A], 2007 NYS Slip Op 51342[U] [App. Term 2d & 11th Jud Dsts 2007].

Applicant argues that Respondent's Peer Reviews fail to meet Respondent's burden in proving the devices were not medically necessary and that providing them was a deviation from generally accepted medical practice. To meet its burden of proving disputed services were not medically necessary, Respondent's expert must demonstrate the disputed treatment was inconsistent with generally accepted professional practice. Generally accepted practice is the range of practice that the profession will follow in the diagnosis and treatment of the patient in light of the standards and values that define it. CityWide Social Work &. A. Psychological Services, P.L.L.C. v. Travelers Indemnity Co., 3 Misc. 3d 608 (Civ Ct Kings Co 2004).

I find that Respondent's Peer Review meets the above burden and I will look to Applicant to refute the conclusion reached by Dr. Portnoy . Applicant has submitted a rebuttal to the Peer Review by Dr. Anthony Siano, Jr. D.C., Dr. Siano, reiterates the findings of his examination on 1/18/19 as well as the MRI results. Dr. Siano argued that based on the Claimant's response to conservative treatment, the subjective complaints and objective findings upon evaluation and the results of the MRI study, he prescribed Cervical Traction unit on 2/11/19 for use at home in conjunction with office-based treatment.

After reading all the submissions including the medical records, The Peer Review, the rebuttal and the addendum, I find that Applicant has not set forth sufficient evidence to refute the conclusion by the Peer Review. There is no evidence in the record to substantiate the need for the durable medical equipment at issue. There is no examination performed around the time of the prescription to explain Claimant's condition or reasons for the items. I do not find the rebuttal persuasive as Dr. Siano, relies on his initial evaluation to support the need. The referral for the DME is dated 1/18/19. Dr Siano fails to mention any examination done by him on this date. I am persuaded by the Peer Reviewer and find that the durable medical equipment was not medically necessary.

Accordingly, in light of the foregoing, based on the arguments of counsel and after a thorough review and consideration of all submissions, I find in favor of the Respondent and deny Applicant's Claim.

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 Nassau

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

03/24/2021
(Dated)

Stacey Erdheim

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:
78da7489b8cd1d22fac9712f10a61ed4

Electronically Signed

Your name: Stacey Erdheim
Signed on: 03/24/2021