American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

OrthoPro Services, Inc. (Applicant)	AAA Case No.	17-19-1137-4391
	Applicant's File No.	2273736
- and -	Insurer's Claim File No.	039318407
	NAIC No.	36447
LM General Insurance Company (Respondent)		

ARBITRATION AWARD

I, Frank Marotta, 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-NH

1. Hearing(s) held on 05/25/2021
   Declared closed by the arbitrator on 05/25/2021

   Jennifer Howard, Esq. from Israel, Israel & Purdy, LLP (Great Neck) participated in person for the Applicant

   Greg DeNezzo, Esq. from LM General Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 1,611.05**, was NOT AMENDED at the oral hearing.
   Stipulations WERE made by the parties regarding the issues to be determined.

   The parties stipulate and agree that the Applicant established its prima facie burden, the Respondent timely denied the claim in question and the amount in dispute does not exceed the permissible fees allowable for items of medical supplies under the New York State Medicaid Durable Medical Equipment fee schedule adopted for no-fault claims.

3. Summary of Issues in Dispute

   The record reveals that the EIP-NH, a 25-year-old-male, sustained injuries in a motor vehicle accident on 2/25/19.

The Applicant filed arbitration seeking reimbursed for medical supplies (collectively "DME") provided to the EIP on 5/24/19 and prescribed by Ilyce Maranga, RN, DC on 5/24/19.

The Respondent denied reimbursement based on a peer review by Thomas McLaughlin, DC, L. Ac. dated 7/15/19.

The issue for determination is whether the DME is medically necessary.

4. Findings, Conclusions, and Basis Therefor

The Applicant filed this arbitration in the amount of $1,611.05 for disputed fees in connection DME provided to the EIP on 5/24/19 and prescribed by Dr. Maranga on 5/24/19 following a motor vehicle accident that occurred on 2/25/19.

This hearing was conducted using the documents contained in the Electronic Case Folder (ECF) maintained by the American Arbitration Association. All documents contained in the ECF are made part of the record of this hearing and my decision was made after a review of all relevant documents found in the ECF as well as the arguments presented by the parties during the hearing. In accordance with 11 NYCRR 65-4.5(o) (1), an arbitrator shall be the judge of the relevance and materiality of the evidence and strict conformity of the legal rules of evidence shall not be necessary. Further, the arbitrator may question or examine any witnesses and independently raise any issue that Arbitrator deems relevant to making an award that is consistent with the Insurance Law and the Department Regulations.

Once an applicant establishes the submission and receipt of the bill, the burden shifts to Respondent to presented evidence that the claim was either timely and properly paid or if not precluded denied based on sufficient evidence establishing that the service was medically unnecessary. Insurance Law §5106(a); 11NYCRR §65- 3.8(a) (1); 11NYCRR §65- 3.8(c), Presbyterian Hosp. v Maryland Cas. Co., 90 NY 2d 274, 660 NYS 2d 536 (1997); or that the services were provided for an injury unrelated to the motor vehicle accident. Central General Hospital v. Chubb Group of Ins. Cos., 90 N.Y.2d 195 at 199, 659 N.Y.S.2d 246 (1997).

To deny a claim based on a lack of medical necessity the insurer must present medical evidence which sets forth with sufficient particularity the factual basis and medical rationale underlying that determination. Elmont Open MRI & Diagnostic Radiology, P.C. v. Geico Ins. Co., 12 Misc. 3d 133(A), 2006 NY Slip Op 51185(U) (App Term 2d Dept. 9th and 10th Jud Dist. June 8, 2006). Such evidence can take the form of a "*peer review or any other proof, such as an independent medical examination, setting forth a sufficiently detailed factual basis and medical rationale for the claim's rejection, e.g. Choicenet Chiropractic P.C. v Allstate Ins. Co., NYLJ, Mar. 7, 2003 (App Term, 2d & 11th Jud Dists)*" Amaze Med. Supply, Inc. v. Eagle Ins. Co., 2003 NY Slip Op

51701(U) (NY App. Term 2003); see also Rockaway Boulevard Medical P.C. v. Travelers Property Casualty Corp., 2003 N.Y. Slip Op. 50842(U), 2003 WL 21049583 (App. Term 2d & 11th Dists. Apr. 1, 2003).

In support of its denial the Respondent relies on a peer review by Dr. McLaughlin dated 7/15/19. After a reviewing the documents contained in the ECF and in consideration of the arguments made by the parties at the hearing, I find that the Respondent has not met its prima facie burden of proof establishing the DME was medically unnecessary with Dr. McLaughlin's peer review. The DME was prescribed by Chiropractor, Dr. Ilyce Maranga but there is no indication that Dr. McLaughlin ever reviewed any medical report of Dr. Maranga reflecting her examination of the EIP supporting the prescription of the DME in question. Dr. McLaughlin begins his peer by listed the various medical records reviewed. He was provided with the prescription/letter of medical necessity and indicates that it provides no rationale for prescribing the supplies. There is no indication he was given any other records or reports by the prescribing healthcare provider. Dr. Mclaughlin goes on to restate sections of the examination of the EIP he performed on 5/23/19 and he moves immediately into his discussion as to why the DME should be viewed as medical unnecessity. Did not have the record of the prescribing healthcare provided but appears to have based is opinion of his own medical examination of the EIP.

To prevail, respondent's peer review must address all the pertinent objective findings contained in applicant's medical evidence. It must then clearly explain why, notwithstanding those findings, the disputed service was inconsistent with generally accepted medical or professional practices. Amaze Medical Supply Inc. v. Eagle Insurance Co., 2 Misc.3d 128(A), 2003 NY Slip Op 51701(U) (App Term, 2nd Dept, 2 and 11 Jud Dists., 2003); Citywide Social Work, et al, v. Travelers Indemnity Company, 3 Misc.3d 608, 777 N.Y.S.2d 241 (Civ. Ct. Kings Co. 2004). Moreover, in the case of a peer review, the peer reviewer must provide a factual basis and medical rationale in support of its opinion that the services in question were not medically necessary, including evidence of a of medical standards. Provvedere, Inc. v. Republic Western Ins. Co., 2014 NY Slip Op 50219 (U) (App. Term 2nd, 11th and 13th Jud. Dists. 2014); Jacob Nir, M.D. v. Allstate Ins. Co., 7 Misc.3d 544, 546-47 (Civ. Ct. Kings Co. 2005). When a peer reviewer has insufficient documentation and information, the peer reviewer opinion lacks a factual basis and medical rationale sufficient to establish the defense of lack of medical necessity. MidIsland Medical, PLLC v. Allstate Ins. Co., 20 Misc. 3d 144 (A), 873 NYS 2d 235, 2008 NY Slip Op.51861 (U) (App. Term 2d & 11th Dist. Sept. 3, 2008).

For the reasons noted I find that the Respondent failed to rebut the presumption of medical necessity that attaches to an applicant's properly submitted claim form with the peer review. Amaze Med. Supply, supra. Applicant is entitled to a reimbursement of its claim in the amount of $1,611.05.

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.	**05/24/19 - 05/24/19**	**$1,611.05**	**Awarded: $1,611.05**
Total			**$1,611.05**	**Awarded: $1,611.05**

B. The insurer shall also compute and pay the applicant interest set forth below. 08/03/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

The Respondent shall pay interest at a rate of 2% per month, calculated on a pro rata basis using 30-day month and in compliance with 11 NYCRR §65-3.9. Interest shall begin to accrue from the date of filing with the American Arbitration Association and end on the date the award is paid.

C. Attorney's Fees

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

The Respondent shall also pay the Applicant an attorney fee in accordance with 11 NYCRR §65-4.6 (e). If, however, the benefits and interest awarded thereon is equal to or less than the Respondent's written offer during the conciliation period, then the attorney 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 Suffolk

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

05/29/2021
(Dated)

Frank Marotta

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:
b3d2f437adc852de4418473f7ec8c205

Electronically Signed

Your name: Frank Marotta
Signed on: 05/29/2021