

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Quality Med Equipment Inc
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No.	17-20-1167-0401
Applicant's File No.	N/A
Insurer's Claim File No.	0449777370101026
NAIC No.	35882

ARBITRATION AWARD

I, Vincent Gerardi, 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 06/25/2021
Declared closed by the arbitrator on 06/25/2021

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

Katherine Shepardson, Esq. from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 844.13**, 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 case arises from a motor vehicle accident that occurred on 8/14/19. The eligible injured party was the driver in a motor vehicle. The issue in dispute is the denial of claim, for an LSO, based upon the Peer Review report, of Dr. Neil Ganz, D.C., concluding the lack of medical necessity. The applicant has offered the Letter of Medical Necessity of Dr. Anthony Siano, Jr., D.C. The respondent's denial was timely denied.

4. Findings, Conclusions, and Basis Therefor

I have reviewed the documents contained in the ADR Center as of the date of the Hearing and entered in to the ADR Center, and have considered the oral arguments of the parties. Initially, according to the First Amendment to Regulation 68-D 11NYCRR 65-4.5, the Arbitrator shall be the judge of the relevance and materiality of the evidence offered that the Arbitrator deems relevant to making an Award that is consistent with Insurance Law and Insurance Department Regulations.

This case arises from a motor vehicle accident that occurred on 8/14/19. The eligible injured party was a sixty-five-year-old male. The injured party went to Metropolitan Hospital three weeks after the accident, was evaluated, treated, and released. The injured party's initial chief complaints were of injuries to the neck, bilateral-shoulders, upper-back, midback, bilateral-elbows, lower-back, bilateral-knees, and feet. There were decreased ranges-of-motion in the cervical, and lumbar, spines. The Cervical-Compression, Foraminal-Compression, Maximal-Foraminal-Compression, Shoulder-Yergarsons (on the left), Shoulder-Dugas (on the left), Shoulder-Depression (on the left), Kemps, Straight-Leg-Raise, McMurrays (on the left), Posterior-Drawer (on the left), Medial-Stability (on the left), Hibbs (on the left), Nachlas (on the left), and Yeomans, Tests were positive. The injured party started a treatment plan. The injured party was prescribed an LSO. A review of the medical records reflects that the injured party to date has received chiropractic care, examinations, evaluations, consultations; orthopedic/ neurological/ physiatrist/ pain management; procedures; lumbar epidurogram (11/26/19), EMG-NCV studies, PF-NCS studies, Ct-scans; chest/ cervical/ lumbar/ right-shoulder/ left-shoulder/ right-knee/ left-knee, drug screening, functional capacity testing, outcome assessment testing, activity limitation measurement, range-of-motion and muscle-strength testing, pharmaceuticals, and durable medical equipment. The issue before me is the medical necessity, and reimbursement, of an LSO received on 2/7/20.

Under Sec. 5102 of the New York Insurance Law (McKinney 1985), No-Fault first party benefits are reimbursement for all medically necessary expenses on account of personal injuries arising out of the use or operation of a motor vehicle.

It is well settled that an applicant for no-fault benefits establishes its prima facie entitlement to payment by proving that it submitted a claim, set forth the fact and the amount of the loss sustained, and that payment of no-fault benefits were overdue (see Insurance Law 5106(a), *Mary Immaculate Hosp. v. Allstate Ins. Co.*, 5 A.D. 3d 742, 774 N.Y.S. 2d 564, 2004 N.Y. App. Div. LEXIS 3597 (2nd Dept. 2004), *Amaze Med. Supply v. Eagle Ins. Co.*, 2 Misc. 3d 128(A), 2003 N.Y. Slip Op. 51701(U) (App Term 2nd & 11th Jud Dists). A "facially valid claim" is presented where it sets forth the name of the patient, date of accident, date of services, description of services rendered and the charges for those services (see *Vinings Spinal Diagnostic P.C. v. Liberty Mutual Insurance Company*, 186 Misc. 2d 287, 717 N.Y.S. 2d 466 (1st Dist. Ct. Nass. Co.)). The applicant has established a prima facie case.

Proof that the benefits were "medically necessary" is not an element of the prima facie case. The defense that the benefits were not "medically necessary" is an affirmative defense borne by the insurer. The weight of judicial authority is now well established that the burden of proof is upon the insurer to prove that the medical treatment was not

medically necessary (see *AB 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 Co.*, 783 N.Y.S. 2d 448 (N.Y. City Civ Ct., 2004). A denial premised on a lack of medical necessity must be supported by other proof which sets forth a factual basis and a medical rationale for denying the claim (see *Amaze Medical Supply Inc. v. Eagle Insurance Co.*, 2 Misc. 3d 1284, 784 N.Y.S. 2d 918 (Sup Ct App Term 2003). Respondent submitted its Peer Review report as evidence that the within medical services were not medically necessary.

The respondent has offered the Peer Review report of Dr. Neil Ganz, D.C., dated 3/9/20, in support of their denial of claim. The doctor reviewed the injured-party's medical records and history, and stated that there was limited evidence that lumbar supports are not more effective than no intervention. The LSO was deemed medically unnecessary.

Upon a showing of a lack-of-medical-necessity through a Peer Review, an applicant is required to rebut same (see, *Khodadadi Radiology P.C. v. N.Y. 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).

The applicant has offered the Letter of Medical Necessity of the treating chiropractor, Dr. Anthony Siano, Jr., D.C. The Letter concluded that the LSO was to prevent spinal compression muscle spasms, stiffness, and helped the patient perform everyday activities. The LSO was deemed medically necessary.

A Letter of Medical Necessity by a provider whom had examined the assignor, together with other medical documentation, may be sufficient to rebut the Peer Review and establish the medical necessity of the services rendered (see, *Quality Psychological Servs., P.C. v. Mercury Ins. Group*, 2010 N.Y. Slip Op. 50601(U) (App. Term 2d Dept., April 2, 2010), *Neomy Med., P.C. v. Geico Ins. Co.*, 2012 N.Y. Slip Op. 50145(U) (App. Term 2d, 11th & 13th Jud. Dists., Jan. 24, 2012), *Vinings Spinal Diagnostic, P.C. v. Geico Gen. Ins. Co.*, 2010 N.Y. Slip Op. 51897(U) (App. Term 2d Dept., Nov. 8, 2010). (An affidavit from a chiropractor 'meaningfully referred to' the Peer and 'sufficiently rebutted the conclusion set forth therein' see, *Park Slope Med. & Surgical Supply, Inc. v. New York Cent. Mut. Fire Ins. Co.*, 22 Misc. 3d 141(A), 2009 N.Y. Slip Op. 50441(U) (App. term 2d, 11th & 13th Jud. Dists., 2009).

I am persuaded by the applicant's Letter of Medical Necessity that the LSO was medically necessary. Treatment, procedures, or services may be warranted by the circumstances as verified by a preponderance of credible and reliable evidence and may be reasonable in light of the subjective, and objective, evidence of the patient's complaints (see, *Nir v. Travelers Ins. Co.*, 2005 N.Y. Slip Op. 50466(U). In *'Complete Med. Care Servs. Of N.Y. v. State Farm Mut. Auto. Ins. Co.'*, 2008 N.Y. Slip Op. 28324(U), the Court held that under the No-Fault Laws and/or Regulations, it is not whether or not the diagnostic test will produce results but rather, if the provider believes it would be helpful. It is not for a judge/arbitrator to second guess a doctor who decides that durable medical equipment, that is not inconsistent with generally accepted practices, is necessary for his diagnosis and treatment, and the only opposition is a Peer doctor who never examined the patient (see, *Alliance Medical Office, P.C. v. Allstate*

Ins. Co., 196 Misc. 2d 268, 2003 N.Y. Slip Op. 23633 (Civ. Ct. Kings County, 2003), City Wide Social Work & Psychological Services v. Travelers Ind. Co., 3 Misc. 3d 608, 777 N.Y.S. 2d 241 (Civ. Ct. Kings, 2004), A.R. Medical Art, P.C. v. State Farm Mutual Auto Ins. Co., NYLJ, 3/17/06, p.19, col. 3. At the Hearing, the respondent-representative did not cite to fee schedule issues regarding this claim.

Accordingly, the applicant's claim is granted in its entirety.

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
	Quality Med Equipment Inc	02/07/20 - 02/07/20	\$844.13	Awarded: \$844.13
Total			\$844.13	Awarded: \$844.13

- B. The insurer shall also compute and pay the applicant interest set forth below. 06/01/2020 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

For the award claim of \$844.13 for services rendered, interest is to accrue from the date of filing.

C. Attorney's Fees

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

The insurer shall pay the applicant an attorney's fee in accordance with 11 NYCRR 65-4.6(d) or as this matter was filed after February 4th, 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). This amendment takes in to account that the maximum attorney fee has been raised from \$850.00 to \$1,360.00.

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

07/25/2021
(Dated)

Vincent Gerardi

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:
daf1d000f42e24e0271c7fe258548f19

Electronically Signed

Your name: Vincent Gerardi
Signed on: 07/25/2021