

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Allure Recovery Inc. (Applicant)	AAA Case No.	17-21-1221-5458
- and -	Applicant's File No.	ZJ161674946
	Insurer's Claim File No.	2021603191-0 210019414
New York Central Mutual Fire Insurance Company (Respondent)	NAIC No.	14834

ARBITRATION AWARD

I, Charles Blattberg, 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: Eligible injured person

1. Hearing(s) held on 05/27/2022
Declared closed by the arbitrator on 06/03/2022

Melnia Cordis, Esq. from Law Offices of Zara Javakov, Esq. P.C. participated by telephone for the Applicant

Kristina O'Shea, Esq. from Gullo & Associates, LLP participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **\$3,903.90**, 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

The claimant was the 64 year-old male restrained driver of a motor vehicle that was involved in an accident on 2/11/21. Following the accident the claimant suffered injuries which resulted in the claimant seeking treatment. At issue is the medical necessity of the 6/15/21-7/5/21 rental of the intermittent limb cold compression DVT prevention device dispensed by Applicant that Respondent timely denied reimbursement for based on a 7/20/21 peer review by Howard Levy, M.D.

4. Findings, Conclusions, and Basis Therefor

Based on a review of the documentary evidence, this claim is decided as follows:

Applicant establishes a prima facie case of entitlement to reimbursement of its claim by the submission of a completed NF-3 form or similar document documenting the facts and amounts of the losses sustained and by submitting evidentiary proof that the prescribed statutory billing forms [setting forth the fact and the amount of the loss sustained] had been mailed and received and that payment of no-fault benefits were overdue. See, *Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). I find that Applicant established a prima facie case for reimbursement.

The claimant was the 64 year-old male restrained driver of a motor vehicle that was involved in an accident on 2/11/21. The claimant reportedly injured his neck, left shoulder, upper back, mid back, lower back, and left knee. There was no reported loss of consciousness. There were no reported lacerations or fractures. There was no reported emergency treatment sought or received. On 2/17/21 the claimant presented to Christine Antoldi, D.C. of Forest Hill Chiropractic and Wellness with complaints of radiating neck pain, left shoulder pain, upper back pain, mid back pain, and low back pain. Pain was rated 9/10 (where 0 is no pain and 10 is the worst pain). The claimant was initiated on chiropractic treatment. On 2/24/21 the claimant underwent a cervical spine MRI and a lumbar spine MRI ordered by Dr. Antoldi. The 2/26/21 left shoulder MRI ordered by Dr. Antoldi produced an impression of subacromial-subdeltoid bursitis, acromioclavicular capsular hypertrophy with osteophytosis impressing upon the supraspinatus myotendinous junction; and supraspinatus, infraspinatus and subscapularis tendinopathy with superimposed focal partial bursal surface tear. On 3/8/21 the claimant underwent a thoracic spine MRI. On 3/22/21 the claimant presented to Farhana Ahmed, M.D. of Multi-Specialty Pain Management with complaints of intermittent neck pain, left shoulder pain, mid back pain, and low back pain. Left shoulder examination revealed diminished range of motion with abduction and flexion 120/180°, adduction 15/30°, posterior extension 30/60°, and internal and external rotation 50/90°. There was tenderness over the acromioclavicular joint and anterolateral shoulder. The treatment plan included continued therapy and cervical and lumbar trigger point injections. On 3/26/21 the claimant presented to Jeffrey Cohen, M.D. of Cohen & Kramer, M.D., P.C. with complaints of left shoulder pain rated 7/10. Examination of the left shoulder revealed swelling, crepitus, pain, forward flexion and abduction to 60°, decreased muscle strength (4/5), and positive Impingement, Hawkins and Neer tests. The claimant was recommended to continue conservative care. On 4/2/21 Dr. Antoldi conducted upper extremities EMG/NCV that suggested evidence consistent with right C6 radiculopathy and bilateral median sensory demyelinating entrapment neuropathies with compression at the level of the transcarpal ligaments consistent with the clinical diagnosis of bilateral sensory carpal tunnel syndrome. On 4/26/21 Dr. Ahmed conducted a follow-up examination and the left shoulder findings were unchanged. On 4/30/21 the claimant presented to Mikhail Kogan, M.D. where left shoulder examination revealed decreased range of motion (unquantified) in the left shoulder with pain with the left arm abduction

above the shoulder line. There was tenderness to palpation over the anterior aspect of the left shoulder, but no swelling or redness. Dr. Kogan performed a left shoulder subacromial bursa steroid injection that as of 5/18/21 had produced a 30% pain reduction. On 5/21/21 Dr. Cohen conducted a follow-up left shoulder examination that revealed swelling, crepitus, pain, forward flexion and abduction to 80°, decreased muscle strength (4/5), and positive Impingement, Hawkins and Neer tests. The claimant was recommended for left shoulder arthroscopy. On 6/7/21 Mark Kramer, M.D. performed left shoulder surgery consisting of left shoulder arthroscopy, partial labrectomy, partial synovectomy, complete bursectomy, debridement of the subscapularis tendon, acromioplasty, partial claviclectomy and tenotomy. The preoperative diagnosis was rule out rotator cuff tear. The postoperative diagnosis was impingement, bursitis, adhesive capsulitis, synovitis, subscapularis tear, bursal sided rotator cuff tear, and labral tear. The intraoperative report indicated anterior and superior labral tear, fraying of the subscapularis tendon, multiple adhesions between the rotator cuff and capsule, impingement and fraying of the bursal side of the rotator cuff. On 6/9/21 Dr. Kramer prescribed the use of a continuous passive motion (CPM) unit and an intermittent limb cold compression DVT prevention device. The rental of the intermittent limb cold compression DVT prevention device from 6/15/21-7/5/21 by Allure Recovery, Inc. (Applicant) is at issue here.

The burden has shifted to the Respondent as they have raised a medical necessity defense. In order to support a lack of medical necessity defense Respondent must "set forth a factual basis and medical rationale for the peer reviewer's determination that there was a lack of medical necessity for the services rendered." See, *Provvedere, Inc. v. Republic Western Ins. Co.*, 2014 NY Slip Op. 50219(U) (App. Term 2nd, 11th and 13th Jud. Dists. 2014). Respondent bears the burden of production in support of its lack of medical necessity defense, which if established shifts the burden of persuasion to Applicant. See generally, *Bronx Expert Radiology, P.C. v. Travelers Ins. Co.*, 2006 NY Slip Op. 52116 (App. Term 1st Dept. 2006). As a general rule, reliance on rebuttal documentation will be weighed in light of the documentary proofs and the arguments presented at the arbitration. Moreover, the case law is clear that a provider must rebut the conclusions and determinations of the IME/peer doctor with his own facts. *Park Slope Medical and Surgical Supply, Inc. v. Travelers*, 37 Misc.3d 19 (2012).

Respondent timely denied the surgery at issue and associated services based on the 7/20/21 peer review by Howard Levy, M.D. After reviewing the claimant's history, treatment, and medical records, Dr. Levy lists: as per, ODG Treatment Integrated Treatment/Disability Duration Guidelines Shoulder Acute & Chronic), 2016, Surgery for SLAP lesions, Criteria for Surgery for SLAP lesions: "After 3 months of conservative treatment (NSAIDs, injection and PT) with symptoms and/or activity limitations significant enough to justify surgery." As per, ODG Treatment Integrated Treatment/Disability Duration Guidelines Shoulder (Acute & Chronic), 2017, Surgery for SLAP lesions, Criteria for Surgery for SLAP lesions: After 3 months of conservative treatment (NSAIDs, injection and PT) with symptoms and/or activity limitations significant enough to justify surgery. History, physical examination and imaging (which can only accurately rule out) indicate high likelihood of SLAP tear (beware confusion with anterior sublabral recess or Buford complex in up to 25% of the population); review by musculoskeletal radiologist can increase accuracy of diagnosis. Definitive

diagnosis of SLAP lesions is only by diagnostic arthroscopy. Direct Repair: Isolated Type II lesions (detachment of superior labrum). Isolated Type IV lesions (more than 50% of the tendon is involved, vertical tear, bucket-handle tear of the superior labrum, which extends into biceps, intrasubstance tear). Age under 40 (otherwise consider Biceps tenodesis). Avoid direct repair for revision SLAP surgery and with associated large rotator cuff repair (biceps tenotomy preferred). Worse outcomes can be anticipated with overhead throwers and injured workers. SLAP repair with simultaneous anterior/anterior-inferior, or posterior/posterior-inferior labral repair; with documentation of prior dislocation(s) or clear instability on exam and correlating imaging. Biceps Tenodesis: Age 40 and over. Option for revision SLAP surgery or in combination with large rotator cuff repair in younger individuals and those avoiding mild cosmetic deformity. Biceps Tenotomy: Preferred for revision SLAP surgery and with associated large rotator cuff repair in older patients. Debridement: Generally, type I and type III lesions do not need any treatment or can be lightly debrided if other arthroscopic shoulder procedures are indicated. In addition as per, ODG Treatment Integrated Treatment/Disability Duration Guidelines Shoulder (Acute & Chronic), 2017, Surgery for impingement syndrome: "Surgery for impingement syndrome is usually arthroscopic decompression (acromioplasty). Conservative care, including cortisone injections, should be carried out for at least three to six months prior to considering surgery. ODG Indications for Surgery™ -- Acromioplasty: Criteria for anterior acromioplasty with diagnosis of acromial impingement syndrome (80% of these patients will get better without surgery). Conservative Care: Recommend 3 to 6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent." In addition, Link/Source: <http://odg-twc.com/> As per ODG Treatment Integrated Treatment/Disability Duration Guidelines Shoulder (Acute & Chronic), 2016, Partial claviclectomy (Mumford procedure): "Criteria for partial claviclectomy (includes Mumford procedure) with diagnosis of post-traumatic arthritis of AC joint: Conservative Care: At least 6 weeks of care directed toward symptom relief prior to surgery. (Surgery is not indicated before 6 weeks.) PLUS Subjective Clinical Findings: Pain at AC joint; aggravation of pain with shoulder motion or carrying weight. OR Previous Grade I or II AC separation. PLUS Objective Clinical Findings: Tenderness over the AC joint (most symptomatic patients with partial AC joint separation have a positive bone scan). AND/OR Pain relief obtained with an injection of anesthetic for diagnostic therapeutic trial. PLUS Imaging Clinical Findings: Conventional films show either: Post-traumatic changes of AC joint. OR Severe DJD of AC joint. OR Complete or incomplete separation of AC joint. AND Bone scan is positive for AC joint separation." After listing these citations, Dr. Levy finally opines "in this clinical setting, the claimant had left shoulder pain after the MVA dated 02/11/2021. The left shoulder arthroscopy was performed on 06/07/2021. As per the above cited guidelines, SLAP repair is indicated after 3 months of conservative treatment including NSAIDs, injection, and physical therapy. However, as per the provided medical records, the claimant's left shoulder was not treated with conservative care in any form. The guideline criteria did not meet. In this case, the left shoulder pain should have been addressed and treated with invasive and non-invasive conservative care at least for 3 months before proceeding to the surgery. Conservative care in the form of physical therapy, acupuncture treatment, NSAID's, and steroid injections should have been attempted. The surgical intervention is feasible only after the failure of adequate conservative care. Therefore, due to lack of conservative care, the left shoulder surgery comprising debridement, subacromial

decompression, and Mumford procedure was not medically necessary."

Where the Defendant insurer presents sufficient evidence to establish a defense based on lack of medical necessity, the burden shifts to the Plaintiff which must then present its own evidence of medical necessity (see Prince on Evidence section 3-104, 3-202). *West Tremont Medical Diagnostic PC v. Geico*, 13 Misc.3d 131, 824 N.Y.S. 2d 759.

Applicant submitted an undated peer rebuttal by Drora Hirsch, M.D. in affidavit form. After reviewing the claimant's history, treatment, and medical records, Dr. Hirsch opines "as a post-operative management plan; the patient was prescribed a continuous passive motion device and intermittent limb compression device for home use...Moreover, in this case there were sufficient findings that warranted the performance of the left shoulder surgery...The patient underwent a left shoulder arthroscopic surgery after which the surgeon thought that it was in the patient's best interest to utilize the CPM device post-surgical period. There has been documented evidence that the use of CPM, along with physical therapy, results in significantly quicker and better recovery post-surgery than from manual passive ROM exercises. The CPM significantly reduces postoperative pain as passive motion therapy is achieved without patient effort and without causing undue rotator cuff strain during elevation and rotation as with manual passive exercise that could be significant enough to result in a failure of surgery. CPM has become the gold standard for passive motion therapy during the initial 6-week period. In contrast, manual passive ROM exercises, can have muscle contractions over 25% secondary to postoperative pain and apprehension. The CPM moves the joint through a precise tension-free zone unlike the rotator cuff strain applied during scapular elevation and rotation during manual passive exercise that is significant enough to result in a failure of the repair. Active assistive exercise is more appropriate for phase two of the rehabilitation program. CPM functional results are statistically equivalent or superior to physical therapy, manual passive motion by a third party, patient self-directed exercise or immobilization. There is also lesser probability of the patient doing the exercises improperly or wrong, leading to further damage or aggravation of his condition. The primary goal of post-surgical rehabilitation following rotator cuff repair is to control pain, protect repaired tissue during the healing process, restore function, improve range-of-motion, restore strength and prevent a recurrence of symptoms. Studies have shown that patients using CPM devices require less pain medication than patients who have had the same type of surgery and are not using this device. The principles on which the concept of CPM is based are twofold. First, joint motion is necessary for the maintenance of articular cartilage. Second, joint homeostasis requires maintenance of normal periarticular soft tissue compliance. For CPM to accomplish this requires that the motion be full, and that the soft tissues be subjected to tension immediately following surgery in order to prevent swelling. It is this early maintenance of motion that is the key determinant of the joint long-term mobility [*Citation omitted*]. CPM usage is also indicated to prevent stiffness in the joint following surgery. It is the issue of stiffness that can lead to future joint manipulation under anesthesia and/or future surgical intervention to treat this stiffness [*Citation omitted*]. In the article "Efficiency of a postoperative treatment after rotator cuff repair with a continuous passive motion device (CPM)" [*citation omitted*], the authors conclude, "The postoperative treatment of a total tear of the rotator cuff with a combined continuous passive motion and physiotherapy protocol provided a significantly earlier range of motion in the shoulder

joint than physiotherapy alone. There was no report of CPM-related adverse effects." CPM has been evaluated by many medical reviewers and experts and the clear consensus is that it is very helpful and beneficial to the patient's recovery especially in post-operative situations. CPM is firmly established as substantially more effective than manual physical therapy. Study after study has shown that patients who undergo a regimen of CPM after joint surgery experience faster recovery to pre-operative range of motion as well as decreased pain. CPM is excellent for maintaining range of motion throughout the post-operative period thus avoiding a typical loss of motion associated with surgery and then an arduous process of trying to restore the lost range. Please note there are many medical sources that support the use of the CPM post-operatively to provide functional outcome superior to in-office physical therapy and other exercise modalities. The following studies have all been in agreement that CPM over and above range of motion exercises such as manual physical therapy is beneficial to a patient's post-operative recovery in reducing pain, improving range of motion and reducing swelling among other benefits [*Citations omitted*]. There are also some significant additional benefits of CPM. Research has revealed that the use of CPM results in an overall shorter duration of physical therapy as well as reduced costs of post-operative care [*Citations omitted*]. Clinical studies have shown that patients using CPM devices improved range of motion, required less pain medication, and recovered faster. Raab et al found CPM to be superior to manual passive range of motion for regaining ROM following a shoulder surgical procedure [*Citation omitted*]. Additionally, Plessis et al has published a systematic review which addresses the effect of CPM for patients following rotator cuff repair. They found that CPM helps to relieve pain, to increase range of motion, and to improve strength [*Citation omitted*]. The use of the CPM is medically necessary as its consistent use would enable the patient to achieve proper functional capacity in performing activities of daily living. The use of the motorized device is to gradually move the joint and is necessary to decrease soft tissue stiffness, increase range of motion, and prevent the development of scar tissue, enabling proper recovery from surgery and a return to normal functionality. This is accomplished passively as the machine moves a joint through a defined range of motion for an extended period of time. Furthermore, according to the American Academy of Orthopedic Surgeons (Alternative Methods to Help Manage Pain After Orthopedic Surgery), "CPM is believed to enhance the nutrition of your joint, discourage the formation of scar tissue, and prevent the abnormal shortening of the muscles surrounding your joints." Also, the principles on which the concept of CPM is based are twofold. First, joint motion is necessary for the maintenance of articular cartilage. Second, joint homeostasis requires maintenance of normal periarticular soft tissue compliance. For CPM to accomplish this, it requires that the motion be full, and that the soft tissues be subjected to tension immediately following surgery in order to prevent swelling. It is this early maintenance of motion that is the key determinant of the joint's long-term mobility [*Citation omitted*]. CPM is indicated to prevent stiffness and to maintain motion obtained at the time of surgery, particularly following synovectomy and contracture release. This is particularly true for joints that were stiff preoperatively. By following these guidelines and adhering strictly to the principles of CPM use, one will increase the chances of obtaining maximum range of joint motion following trauma or surgery. It would be anticipated that proper application of CPM would, indeed, be cost-effective, because it would decrease the need for physical therapy and joint manipulation under anesthesia, and later rehabilitation or surgical intervention to treat

stiffness [*Citation omitted*]. CPM usage is also indicated to prevent stiffness in the joint following surgery. It is the issue of stiffness that can lead to future joint manipulation under anesthesia and/or future surgical intervention to treat this stiffness [*Citation omitted*]. In an article entitled "Effects of One-Months Continuous Passive Motion After Arthroscopic Rotator Cuff Repair: Results at 1 year Follow-up of a prospective randomized study " [*citation omitted*] the authors performed a study which revealed that there was a definite "advantage in terms of ROM improvement and pain relief when compared to passive self-assisted exercise alone." CPM usage following surgery quite simply allows the patient to regain range of motion faster with less pain. The use of CPM decreases the damaging effect of bleeding and fluid buildup in the shoulder following surgery. Rehab Management: The Interdisciplinary Journal of Rehabilitation, June 2008, "A Healing Machine" by Frank Long. Passive motion machine is used to very gradually start moving the joint after surgical intervention. The use of this device makes it possible to significantly accelerate recovery time. It decreases soft tissue stiffness, increases range of motion, promotes healing of joint surfaces and soft tissue. Passive motion is extremely important in preventing the development of motion-limiting adhesions or scar tissue. Once formed, scar tissue impedes the recovery to the point most patients would require further surgery and/or manipulation under anesthesia procedures to improve. CPM works without joint pain or discomfort by moving the joint passively through a defined range of motion for an extended period of time. Studies have shown that patients using CPM devices require less pain medications, recover faster and therefore need less physical therapy. In conclusion, literature on CPM therapy use post-surgery provides better and more reliable results." Dr. Hirsch asserts "the patient was prescribed the intermittent limb compression device following the left shoulder surgery in order to prevent blood clotting. Aetna considers intermittent pneumatic compression devices of the upper and lower extremities medically necessary DME to stimulate circulation and reduce the chances of deep venous thromboses for members who are unable to walk or bedridden due to trauma, orthopedic surgery, neurosurgery or other circumstances preventing ambulation. The patient was prescribed pneumatic compressor as it alleviates pressure on the compressed nerves; helps muscles relax and reduces muscle spasms. Traction increases the space between vertebrae and reduces pressure on the intervertebral discs and nerve root. The pneumatic compressor helped the patient to achieve full restoration of musculoskeletal neurological functions. The intermittent limb compression device is a vasopneumatic compressor with cryotherapy and consists of various soft wraps and a computer-controlled control unit. The wraps are made from flexible fabric and are ergonomically designed to fit various body parts and can be secured easily with a hook and loop fastener. The wraps fit snugly to apply intermittent compression and cryotherapy at and around the injured area." Dr. Hirsch continues "the intermittent limb compression device integrates proven cold and compression therapies in a revolutionary treatment system that sets a new standard of care. It helps reduce swelling, minimize pain, and speed and enhance the natural healing abilities without pain medications. Compared to traditional RICE (Rest-Ice-Compression-Elevation) applications, the intermittent limb compression device offers more therapeutic benefits. The five documented benefits of cold compression include: reduced pain and swelling; increased healing of tissues; decreased need for oral pain medication; increased range of motion; [*and*] lowered rehabilitation time. Unlike standard cryotherapy, medical devices that employ compression cryotherapy allow for temperature adjustments based on clinician and patient preference.

This function helps to avoid tissue damage and offers deeper, precise, and more consistent cooling without the pain and discomfort associated with ice packs. Active cooling devices are designed to provide a steady low temperature, which, in addition to convenience, might provide a unique benefit compared to the more variable temperature achieved with a simple application of ice or passive cooling devices [*Citation omitted*]. The intermittent limb compression device benefits in the following ways: Decreases local tissue temperature; Induces vasoconstriction of arterioles and capillaries; Decreases muscle spasm and spasticity; Reduces narcotic consumption; Decreases nerve conduction velocity; Improves functionality range of motion and gait; Decreases swelling; Decreases lymphatic and venous drainage; Decreases formation and accumulation of edema; Decreases inflammatory reaction; Decreases delivery of leukocytes, enterocytes and phagocytes; Promotes oxygen tissue saturation at deep tissue level; Reduces postoperative blood loss; Reduces risk of infection; [*and*] Promotes less wound discharge." Dr. Hirsch concludes "the pneumatic compressor was medically necessary in accordance with medical literature as the patient had an increased risk of DVT due to the recent surgery causing immobility as well as other risk factors. Some things that increase your chances of DVT include: "Risk factors include age, bed rest, congestive heart failure, estrogen, family history, hematologic cancers, immobility, indwelling catheters, long-distance travel, major trauma, noninfectious inflammatory conditions, obesity, pregnancy (and postpartum status), prior venous thromboembolism (VTE), recent surgery, smoking, solid cancers, stroke, and thrombophilias." [*Citation omitted*] factors including: You've already had a blood clot; You're over age 40; You're on a bed rest or sit for long periods of time; You have other health issues; Your vein has been injured [*Citation omitted*]. Please note the pneumatic compressor is not only effective to prevent the onset of DVT, rather it has also been shown to be an effective device to improve range of motion, muscle strength, pain intensity, and functional status. Furthermore, the pneumatic compressor has been shown to be effective for musculoskeletal injuries: "with evidence that IPC can enhance both fracture and soft-tissue healing with good functional recovery, the use of such modality in musculoskeletal trauma should be considered." Intermittent pneumatic compression in fracture and soft-tissue injuries healing [*citation omitted*]. The device was prescribed for the purpose of musculoskeletal injury treatment and for post-operative treatment. This system combines cold, compression and deep vein thrombosis (DVT) compression therapies. It is intended to treat post-surgical and acute injuries to reduce edema, swelling and pain where cold and compression are indicated as well as deep vein thrombosis (DVT). Dr. Hirsch concludes "the post-operative and rehabilitative care plan calls for the use of the device to reduce pain, swelling and DVT. Failure to control pain not only causes unnecessary suffering, but can delay any patient's recovery. Therefore, the need for compliance with the required treatment is high. The above-described product is medically indicated and necessary. Given the safety and effectiveness of this device, it was prescribed and recommended that the patient use this device daily. Without the use of this device, there is potential to cause unnecessary delay in the patient's recovery."

After a careful review of Dr. Levy's surgical peer review this Arbitrator finds it inadequate to deny post-operative durable medical equipment as the medical necessity for said equipment arises from the performance of the surgery; even if the surgery itself lacks medical necessity. As compared to anesthesia and an operative facility, which are

necessary for surgery, post-surgical services have been held to be attenuated from the surgery, so that each such service must be separately addressed and reviewed to determine the efficacy for the patient, and its choice among other available treatments. See Ortho Passive Motion, Inc. v. GEICO, AAA Case No.: 412012032501. Dr. Levy makes no direct reference to the subject post operative DME, particularly in comparison with voluminous references by Dr. Hirsch in support of their medical necessity.

Respondent submitted a 12/13/21 "addendum" by Howard Levy, M.D. to "address the rebuttal dated 08/06/2021 by Dr. Mark Kramer in regards to your peer report dated 7/20/2021. Let this serve as an addendum to the peer dated 07/20/2021 for the above mentioned claimant. The aim is to review the rebuttal letter and comment whether the decision has changed." As it in fact adds nothing in regard to the post operative DME at issue it need not be recited here. It is noted that Respondent submitted nothing to support a fee schedule reduction of the bills at issue.

Accordingly, Applicant is awarded \$3,903.90.

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
	Allure Recovery Inc.	06/15/21 - 07/05/21	\$2,223.90	Awarded: \$2,223.90

	Allure Recovery Inc.	06/15/21 - 07/05/21	\$1,680.00	Awarded: \$1,680.00
Total			\$3,903.90	Awarded: \$3,903.90

- B. The insurer shall also compute and pay the applicant interest set forth below. 10/05/2021 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest runs from 10/5/21 (the date that arbitration was requested) until the date that payment is made at two percent per month, simple interest, on a pro rata basis using a thirty day month.

C. Attorney's Fees

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

Pursuant to 11 NYCRR §65-4.6 (d), ". . . the attorney's fee shall be limited as follows: 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon for each applicant for arbitration or court proceeding, subject to a maximum fee of \$1,360.

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

06/27/2022
(Dated)

Charles Blattberg

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:
bedcb92972af9dacda3dcf3ba91f9338

Electronically Signed

Your name: Charles Blattberg
Signed on: 06/27/2022