

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

RK Med Inc.  
(Applicant)

- and -

Electric Insurance Company  
(Respondent)

AAA Case No. 17-21-1206-9122

Applicant's File No. BT21-136143

Insurer's Claim File No. 20201005A08

NAIC No. Self-Insured

**ARBITRATION AWARD**

I, Neal S Dobshinsky, 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: J Doe

1. Hearing(s) held on 06/08/2022  
Declared closed by the arbitrator on 06/08/2022

Sabine Sciarrotto from The Tachiev Law Firm, P.C. participated in person for the Applicant

Todd Hyman from Brand Glick & Brand, Esqs. participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$2,881.00**, 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

J Doe's treating chiropractor prescribed that he use a Pain Away Laser device for home therapy on his lumbar spine for 6 weeks. Applicant furnished Doe with the device on a rental basis from 10/21 to 11/9/20 and from 11/10 to 12/2/20. Applicant sought payment of the rental fees.

Based on a report by its peer reviewer, Insurer denied payment of Applicant's first bill on the ground that the device was not necessary. As to the second bill, Insurer contends that Applicant did not submit it. Payment is not overdue and the claim is not arbitrable.

Was the laser device necessary? Is payment on the second bill overdue?

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

I have read and considered the materials in the case file and the authorities cited by the parties that could be located (and are not behind a paywall). I have heard and considered the arguments of counsel who appeared at the hearing virtually, via Zoom. I find as follows:

##### **Background**

On 9/30/20, J Doe, a male, then 33 years old, was the driver of a motor vehicle, insured by Insurer, that was in an accident. Doe claims to have been injured. He then sought care and treatment.

On 10/6/20, Doe saw Richard Ebbrecht, DC, for an initial examination. Doe complained of pains in his neck, thoracic spine, lower back, and upper hamstring on the left.

Ebbrecht examined Doe. Cervical ranges of motion were restricted with pain. Orthopedic tests were positive (foraminal compression test, bilaterally without radiation; Jackson's compression test, bilaterally with radiation; O'Donoghue maneuver, bilaterally). Thoracic ranges of motion were restricted with pain. Lumbar ranges of motion were restricted with pain. Orthopedic tests were positive (Kemp's test, bilaterally with radiation to the left hamstrings; O'Donoghue maneuver, bilaterally; straight leg raise, on the left with radiation to the left hamstrings). Ebbrecht examined Doe's shoulder, knee, and hip joints. All those findings were within normal limits. The neurological exam and tests of motor muscle strength were all within normal limits.

Ebbrecht's diagnoses included stiffness due to cervical arthropathy, cervical arthropathy, cervical muscle spasm, subluxation/dislocation or segmental dysfunction of the cervical spine, and cervical strain/ sprain; thoracic strain/ sprain, thoracic spine pain, and thoracic paravertebral myospasm; lumbar spine stiffness, contracture of muscles, lumbar region, paravertebral myospasm, myositis/ lumbosacral myofascitis, segmental subluxation/ dislocation of the lumbar vertebrae, and lumbosacral strain/ sprain.

The plan of treatment/ recommendation was for Doe to have regular chiropractic adjustments 3 to 4 times per week, a follow-up visit in 3 to 4 weeks, and consideration of an MUA consultation if Doe's condition plateaus and he does not reach maximum improvement in 6 to 8 weeks. There is no mention of the need for any durable medical equipment or supplies.

Doe started treatment. The records submitted show that Doe was treated on 10/6, 7, 13, 14, 19, 20, 27, 11/2, and 3. There is no record of any re-evaluation during that time or that Doe was using or needed any durable medical equipment or supplies.

Applicant's submission includes a Multi Radiance Medical Laser Longevity form physician's prescription dated 10/15/20 and signed by Ebbrecht. The prescription is for a product identified as a Pain Away Home Care Laser Device. The form states, "[l]aser therapy is a recognized treatment that works by increasing circulation to the affected areas through [the] process of photobiomodulation. Multiple studies have been published in peer review journals on its use in reducing pain, healing chronic wounds, and restoring protective sensation. I believe the patient's condition will benefit from use of this laser therapy at home because of musculoskeletal injury treatment and find it medically necessary to control pain, and increase local blood circulation that will assist in rehabilitation. The modality of treatment is cost-effective and appropriate since the patient's symptoms have not improved with other listed interventions. Since this device may be used at home, the patient will be better able to comply with their treatment regimen. The patient will remain in my care while using this device. The form has lumbar spine checked. The rental period is indicated as 1 treatment per day for up to 6 weeks.

On 10/21, applicant RK Med delivered a Pain Away Laser device (L/ spine) to Doe.

### **Applicant's Claims and Insurer's Denial**

Applicant, as Doe's assignee, contends that it timely submitted claims to Insurer for no-fault benefits for payment for the rental of the laser device.

The first bill covers the period from 10/21 to 11/9/20, 20 days. Applicant billed rental fees of \$1,340.00 for use of the device, coded as E1399, during that period.

The second bill covers the period from 11/10 to 12/2/20, 23 days. Applicant billed rental fees of \$1,541.00 for use of the device during that period.

Based on a report by its peer reviewer, Insurer timely denied payment of the first bill on the ground that the device was not necessary.

Insurer neither paid nor denied the second bill. Insurer contends that Applicant did not submit it for payment. Payment is not overdue. The dispute is not arbitrable.

The only issues argued and submitted for determination were: Was the laser device necessary? Is payment on the second bill overdue? Is the dispute arbitrable? If so, how much is Applicant entitled to? All other issues were waived.

### **Medical Necessity and the Burden of Proof**

Medical necessity for services or supplies is established by proof of an applicant's properly submitted claim form. *All County Open MRI & Diagn. Radiology P.C. v Travelers Ins. Co.*, 11 Misc3d 131(A), 2006 NY Slip Op. 50318[U] [App Term, 2d Dept 9th & 10th Jud Dists 2006]. The same presumption applies where the services are performed or the supplies are prescribed by a chiropractor.

The insurer "bears both the burden of production and persuasion" as to its lack of medical necessity defense. *Nir v Allstate Ins. Co.*, 7 Misc3d 544, 546 [Civ Ct, Kings County 2005]. The defense must be supported by a peer review report or other evidence, such as an independent medical examination report. The report must set forth a sufficiently detailed factual basis and medical rationale for the denial. *Amaze Med. Supply v Eagle Ins. Co.*, 2 Misc3d 128(A), 2003 NY Slip Op 51701[U] [App Term, 2d Dept, 2d & 11th Jud Dists 2003].

"[H]owever, it is the [applicant] who has the ultimate burden of proving, by a preponderance of the evidence, that the services at issue were necessary" (internal citations omitted). *Radiology Today, P.C. v Geico Ins. Co.*, 58 Misc3d 132(A), 2017 NY Slip Op 51768[U] [App Term, 2d Dept, 2d, 11th & 13th Jud Dists 2017].

### **The Chiropractic Peer Review and Insurer's Lack of Necessity Defense**

Insurer denied Applicant's claim based on a peer review by Chester L. Bogdan, DC, a New York licensed chiropractor. In his 12/3/20 report, Bogdan, states his reasons and opinion why the laser device was not necessary.

Bogdan lists the few records and reports he reviewed. These include the initial exam by Ebbrecht, 10/6, chiropractic treatment notes, 10/6 to 11/3/20; prescription for the device, 10/15; bill, and delivery receipt.

Bogdan mentions the accident and that Doe injured his neck and back. Doe did not go to any emergency room. Doe came under the care of Ebbrecht and received chiropractic treatment and a laser device.

Bogdan states, "there is no medical necessity for the pain away home care laser device provided from 10/21/20 to 11/9/20. Dr. Ebbrecht . . . does not provide any objective clinical findings or medical rationale sustaining the need for this item. He provides an initial exam form dated 10/6/20, which contains the history, complaints, physical examination findings including orthopedic and neurological test results and ranges of motion diagnosis, plan of treatment and recommendations. The clinical findings in this initial exam . . . and the additional records reviewed . . . are typical of those seen in individuals who have sustained soft tissue injuries which are clearly resulting from such traumatic etiology. Symptoms of this nature often resolve with a conservative treatment program, and such supplies would not aid or alter the management of such a soft tissue injury and not affect the clinical outcome. The treatment plan indicated for such findings of this nature would be sufficient without the need for such a device. In the course of chiropractic practice it is not reasonable or customary or an acceptable standard of care to prescribe this device for such findings, especially as Dr. Ebbrecht recommended in his initial exam [ ] regular chiropractic adjustment 3 - 4 times per week. There are no other specific findings to sufficiently support the need for this device, and no factual basis or medical rationale provided by . . . for this device."

Bogdan also points out that the prescription form fails to provide specific objective clinical findings to establish any necessity for such a device.

Bogdan supports his argument and opinion with citations to reliable authorities including the NYS Workers' Compensation Board New York Neck Injury Medical Treatment Guidelines, the Mid and Low Back Medical Treatment Guidelines. He also states that there is no evidence-based medicine support for the use of such a device "for traumatic injuries to the neck or back or that it is of any benefit, which includes the ability to have any impact on the therapeutic outcome of such injuries.

Bogdan's discussion is consistent with the records in the submissions and the authorities he cites.

The peer review sets forth an adequate factual basis and chiropractic rationale why this laser device was not necessary. The report provides a sufficient basis to support Insurer's denial of Applicant's claim. Insurer met its initial burden of production and persuasion. Insurer established its lack of necessity defense.

### **Applicant's Rebuttal**

Applicant submits an affirmed rebuttal from David Gamburg, MD. In his 4/4/22 rebuttal, Gamburg states his reasons and opinions why the Pain Away laser device was medically necessary.

Other than stating that he is a NYS licensed physician and that he is familiar with medical standards of care, Gamburg does not give any details regarding his education, training, experience, or length of licensure/practice. He does not demonstrate that he is familiar with chiropractic standards of care, or how those standards compare with medical standards of care. He does not state his relationship, if any, to Ebbrecht, or Applicant; or his interest, if any, in the outcome of the matter. He did not examine or treat Doe or order the laser device.

Gamburg states that he reviewed the records and the peer review and "that based upon the symptoms presented by the patient, the Pain Away laser device was medically necessary."

Gamburg's discussion is general and conclusory. He references several works and argues that the device was "clinically proven to serve as effective treatment for this patient's back pain." The works that Gamburg cites do not support that assertion or are not authoritative.

For example, Gamburg cites a website of a niche practice that provides in-office laser therapy as an alternative pain management for acute and chronic orthopedic conditions without opiates and without surgery. <https://www.nylasertherapy.com/laser-therapy-for-pain-relief/laser-therapy-for-sciatica-an> (last visited 7/8/22). Gamburg cites an expert commentary by Bruce Coren, DVM, MS, a self-described "expert trainer in veterinary and human laser therapy" and developer of a laser therapy device, as recounted by Chalk, Christopher (2018). *Pain Relief and*

*Healing with Laser Therapy.*

<https://www.spineuniverse.com/treatments/physical-therapy/pain-relief-healing-laser-ther> (last visited 7/8/22) for the many beneficial properties of laser therapy.

But these and the other references miss the point. None is authoritative as to the standard of care and none establishes a standard of care for the Pain away or similar laser device for Doe's condition. Gamburg has not effectively shown that the standard of care presented by the peer reviewer was incorrect or did not apply.

Lastly, Gamburg states, "[i]t should also be noted that the FDA has approved at-home patient use under the prescribing doctor's direction." But if he is referring to the Pain Away device, that too is not quite accurate, and it is not a claim that Multi Radiance Medical makes itself. Rather, on 1/26/18 Multi Radiance stated that "[a]After extensive review and evaluation, the U.S. Food and Drug Administration (FDA) recently *cleared* Multi Radiance Medical's MR4 Laser technology for neck and shoulder pain relief under the Product Classification NHN, making Multi Radiance one of the few therapeutic laser manufacturers in the world to secure the NHN product class FDA 510(k) clearance" (emphasis added). <https://www.multiradiance.com/about/our-company/press-releases/multi-radiance-laser-therapy-cleared-neck-shoulder-pai> (last visited 7/8/22).

Gamburg should be aware that FDA *clearance* does not mean *approval*. Indeed, the FDA states, "[a]ny representation that creates an impression of official approval of a device because of complying with the premarket notification regulations is misleading and constitutes misbranding." 21 CFR 807.97.

### **Did Applicant Submit its Claim for 11/10 to 12/2/20?**

An applicant for no-fault benefits establishes its prime facie case when it proves that it submitted a completed claim to the insurer, and that payment of all or a portion of the benefits is overdue. Insurance Law §5106[a]; *Mary Immaculate Hosp. v Allstate Ins. Co.*, 5 AD3d 742, 743 [2d Dept 2004]; *Viviane Etienne Med. Care v Country-Wide Ins. Co.*, 25 NY3d 498, 507 [2015].

Submission of the bill is a threshold issue. Unless the insurer admits receipt of the bill, the applicant must prove that insurer received it. Where an applicant contends that it mailed the bill to insurer, the applicant must introduce sufficient competent evidence of mailing to raise the presumption of receipt.

Insurer has not admitted receipt of the bill and there is no denial for it.

To show that it mailed the bill (Form NF-3, Verification of Treatment by Attending Physician or Other Provider of Health Service) dated 12/4/20 for services rendered from 11/10 to 12/2/20 to Insurer, Applicant submits a copy of a certificate of mailing, a paper similar in appearance to a PS 3877 form, bearing a postage meter strip and postmark both dated 12/8/20. The certificate has the name and address of Applicant's attorney as the sender. One line on the form has Insurer's name and address, the date(s) of service, the bill amount, counsel's file number, and Doe's name. Applicant

also submits an affidavit, sworn to 5/6/22, by Luiza Tadchiev, a paralegal/administrative assistant with Applicant's counsel since February 2020. Tadchiev describes a standard office practice or procedure, based on her responsibility for reviewing and submitted bills, that ensures that bills were properly addressed and mailed.

"Generally, proof of proper mailing gives rise to a presumption that the item was received by the addressee. The presumption may be created by either proof of actual mailing or proof of a standard office practice or procedure designed to ensure that items are properly addressed and mailed" (internal citations omitted). *Residential Holding Corp. v Scottsdale Ins. Co.*, 286 AD2d 679 [2d Dept 2001].

Here, Applicant submitted competent, credible evidence to raise the presumption that Insurer received the second bill. Insurer did not submit any evidence to overcome the presumption of receipt.

### **When Arbitration May Be Initiated**

"In the absence of a denial of claim form, a dispute shall be considered arbitrable if the claim is overdue . . . ." 11 NYCRR 65-4.2(b)(1)(iv) (v).

No-fault benefits are overdue if not paid within 30 calendar days after the insurer receives proof of claim, which includes verification of all the relevant information requested pursuant to 11 NYCRR 65-3.5.

Applicant's evidence raised the presumption that Insurer received the second bill (claim) on 12/14/20. This considers five days for mailing. To avoid unfairness, where a bill is mailed, five days must be added to determine the date the bill was received. See, CPLR 2103[b][2]. The actual fifth day, 12/13/20, was a Sunday. The next business day was 12/14.

Insurer had until 1/19/21 to pay or deny the bill. This considers Sunday 1/17 and Monday 1/18/21, a public holiday. Public holidays are not business days. [\*Jesa Med. Supply, Inc. v American Tr. Ins. Co.\*](#), 28 Misc3d 827,829 [Civ Ct, Kings County 2010].

Applicant initiated arbitration on 6/7/21. Applicant established that payment was overdue as of 1/19/21. Because there is no denial, Applicant is entitled to interest from that date.

The dispute is arbitrable. Insurer has not raised any non-precludable defense.

### **Conclusion**

Insurer established its lack of necessity defense to the first bill. Applicant did not overcome that showing. Applicant established the presumption that Insurer received the second bill. Insurer did not overcome that showing. Payment is overdue. Insurer has no defense to the second bill.

Based on the parties' submissions, their arguments, the law, the regulations, and the weight of the credible evidence, I conclude that Applicant is entitled to payment on the second bill.

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
	RK Med Inc.	10/21/20 - 11/09/20	\$1,340.00	Denied
	RK Med Inc.	11/10/20 - 12/02/20	\$1,541.00	Awarded: \$1,541.00
Total			\$2,881.00	Awarded: \$1,541.00

- B. The insurer shall also compute and pay the applicant interest set forth below. 01/19/2021 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.



Insurer shall compute and pay interest from the accrual date noted above-the date on which payment became overdue-at a rate of 2% per month, simple interest, calculated on a pro-rata basis using a 30-day month and ending with the date of payment subject to the provisions of 11 NYCRR 65-3.9.

C. Attorney's Fees

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

Insurer shall pay Applicant's attorney a fee in an amount equal to 20% of the total amount of the benefits plus the interest awarded in this arbitration, subject to the provisions of 11 NYCRR §65-4.6.

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

07/08/2022  
(Dated)

Neal S Dobshinsky

**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:**  
7b1079040f425781f52f8560661d1f91

### **Electronically Signed**

Your name: Neal S Dobshinsky  
Signed on: 07/08/2022