American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Express Supply & Services Inc. (Applicant)	AAA Case No.	17-20-1188-7909
	Applicant's File No.	2480702
- and -	Insurer's Claim File No.	9104204
	NAIC No.	24309
Hereford Insurance Company (Respondent)		

ARBITRATION AWARD

I, Debbie Kotin Insdorf, 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: Assignor

1. Hearing(s) held on 05/24/2022, 06/28/2022
   Declared closed by the arbitrator on 06/28/2022

   Neda Melamed, Esq. from Israel, Israel & Purdy, LLP (Great Neck) participated for the Applicant

   Andrew Schiavone, Esq. from Law Offices of Rubin & Nazarian participated for the Respondent

2. The amount claimed in the Arbitration Request, **$620.62**, 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 Applicant is seeking reimbursement for non-segmental pneumatic compressor and pneumatic appliance supplied to Assignor JG post-operatively on 10/01/20, following a motor vehicle accident on 8/01/20. The Respondent issued a timely denial based on a peer review by Dr. Douglas Pertroski.

4. Findings, Conclusions, and Basis Therefor

   The Applicant's claim is for $620.62 for non-segmental pneumatic compressor and pneumatic appliance supplied on 10-01-20.

The Applicant issued a timely denial based on a peer review.

On 8/01/20 the forty seven year old Assignor was the backseat passenger in a motor vehicle when an accident occurred. She was taken to Montefiore Hospital by ambulance.

On 9/16/20, Dr. David Capiola examined the Assignor. He noted that the MRI of the left shoulder was performed 8/20/20. It demonstrated a partial thickness bursal sided tear of the supraspinatus rotator cuff tendon, increased signal in the subscapularis rotator cuff and synovitis.

Dr. Capiola indicated that due to the Assignor's persistence of symptoms, physical examination findings, MRI findings and failure of conservative treatments (physical therapy/medications), surgical intervention was recommended.

On 10/01/20, left shoulder arthroscopic surgery was performed.

On 10/01/20, Dr. Capiola prescribed the non-segmental pneumatic compressor and appliance to prevent deep vein thrombosis. Applicant supplied it to the Assignor on 10/01/20.

On 12/04/20, Dr. Douglas Petroski reviewed documents made available to him to determine the medical necessity for the pneumatic compressor with appliance. He did not find it medically necessary.

In an action to recover assigned first-party no-fault benefits, an Applicant establishes a "prima facie showing of their entitlement to judgment as a matter of law 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." Mary Immaculate Hospital v. Allstate Insurance Company, 5 AD3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004).

Once Applicant has established a prima facie case the burden is on the insurer to prove that the medical treatment was medically unnecessary. See, Citywide Social Work & Psychological Services, PLLC a/a/o Gloria Zhune v. Allstate Ins. Co., 8 Misc.3d 1025A, 806 N.Y.S.2d 444 (App Term 1st Dept 2005); A.B. Medical Services, PLLC v. Geico Ins. Co., 2 Misc 3d 26, 773 N.Y.S.2d 773 (App Term, 2nd & 11th Jud Dist 2003); Fifth Ave. Pain Control Center a/a/o Gladys Quintero v. Allstate Ins. Co.,196 Misc.2d 801, 766 N.Y.S. 2d 748 (Civ. Ct. Queens Co. 2003). "A denial premised on lack of medical necessity must be supported by competent evidence such as an independent medical examination, peer review or other proof which sets forth a factual basis and medical rational for denying the claim." Healing Hands Chiropractic, P.C. a/a/o Cleeford Franklin v. Nationwide Assurance Company, 5 Misc.3d 975, 787 N.Y.S. 645, (Civ. Ct NY Co. 2004). Restated, the evidence must at least show that the services were inconsistent with generally accepted medical/professional practice. Once the generally accepted medical practice (the medical rationale) is articulated, the expert must apply the facts of the case and only then may she properly conclude the services in issue were not medically necessary due to the provider's violation of the generally accepted medical standards.

Dr Petroski wrote, "…in order to certify the medical necessity for prescribing medical supplies, it is necessary to assess the claimant's medical status in relation to such items, as well as incorporate items into the individual plan of care, and instruct the claimant in the safe and effective use of these

items addressing such issues as sights of application, duration and frequency." He indicated this was not done by Dr. Capiola.

Dr. Petroski noted the compression device has not been shown to be superior to range of motion exercise, ice pack and elevation with mild compression by a stocking. He also remarked that the Assignor didn't have a medical history which would necessitate the compression device.

In the instant case, the conclusion of the peer reviewer upon which the denial was based was supported by a sufficient factual foundation and medical rationale to warrant rejection of Applicant's claim and accordingly, was sufficient to support the defense of medical necessity.

The burden now shifts to applicant to refute Respondent's evidence. See, Bath Med. Supply, Inc. v. New York Cent. Mut. Fire Ins. Co., 2008 NY Slip Op 50347 (U) (App Term 2d Dept., Feb. 21, 2008); A. Khodadadi Radiology, P.C. v. New York Cent. Mut. Fire Ins. Co., 16 Misc.3d 131,(A), 841 N.Y.S.2d 824 (Table), 2007 NY Slip Op 51342 (U), 2007 WL 1989432 (App. Term 2d & 11th Dists. July 3, 2007).

A rebuttal was written by Dr. Capiola. He explained that the left shoulder arthroscopic surgery placed the Assignor at a greater risk of developing deep vein thrombosis.

Dr. Capiola wrote, "It is well known in the orthopedic community that there is a substantial increase in risk of developing DVT post-operatively…Clots are system-wide risks due to the potential of pulmonary embolism. The pneumatic compression device at issue is a preferred method over the use of anticoagulants because anticoagulants significantly delay the healing process of wounds. Delayed healing can lead to many complications, including bleeding, deep infections, and failed wound closure…Pneumatic compression devices are, therefore, a reasonable alternative and patients at high risk for bleeding. A patient who just underwent an invasive arthroscopic procedure would be expected to be at risk of bleeding. Deep vein thrombosis and pulmonary embolism are recognized as major causes of morbidity and mortality in orthopedic trauma patients."

Dr Petroski wrote an addendum to his peer review after reviewing Dr. Capiola's rebuttal. He reiterated that the left shoulder arthroscopic surgery was not medically necessary. He also found the Assignor was not a high-risk candidate for postoperative DVD/embolism.

The medical necessity for the left shoulder arthroscopic surgery was already decided by this Arbitrator (See 17-21-1206-9371).

After reviewing all of the documents on file in the ADR Center maintained by the American Arbitration Association and considering the arguments set forth by both sides, I find there was sufficient evidence to refute the conclusion reached by Respondent's peer reviewer. The Respondent's denial cannot be upheld.

It is Respondent's burden to come forward with "competent evidentiary proof" supporting its fee schedule defenses (see, Continental Med., P.C. v. Travelers Indem. Co ., 11 Misc 3d 145 (a) [App Term, 1st Dept 2006]; see also, Jami M. Abraham, MD., P.C. v. Country-Wide Ins. Co., 3 Misc 3d 130(a), [App Term, 2nd & 11th Dists 2004]; Power Acupuncture, P.C. v. State Farm Mut. Auto Ins. Co., 11 Misc 3d 1065 (a), [Civ Ct, Kings County 2006]. This Respondent has not done.

Accordingly, the Applicant is awarded $620.62.

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**
	Express Supply & Services Inc.	**10/01/20 - 10/01/20**	**$620.62**	**Awarded: $620.62**
Total			**$620.62**	**Awarded: $620.62**

B. The insurer shall also compute and pay the applicant interest set forth below. 12/21/2020 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Since the motor vehicle accident occurred after Apr.5, 2002, interest shall be calculated at the rate of two percent per month, simple, calculated on a pro rata basis using a 30-day month. 11 NYCRR 65-3.9(a). If an applicant does not request arbitration or institute a lawsuit within 30 days after receipt of a denial of claim form or from the payment of benefits, interest shall not accumulate on the disputed claim or element until such action is taken. 11 NYCRR 65-3.9(c). In accordance with 11 NYCRR 65-3.9 (c), interest shall be paid on the claim (s), totaling $620.62 from 12-21-20, the date the arbitration was commenced.

C. Attorney's Fees

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

As this matter was filed after February 4, 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). The insurer shall pay the applicant an attorney's fee, in accordance with 65-4.6(d). This amendment takes into account that there is an attorney fee of 20% of benefits plus interest with no minimum fee and a maximum attorney fee of $1360.00.

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 New York

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

07/10/2022
(Dated)

Debbie Kotin Insdorf

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:
00fe8eed3045f31ed7ef8393955af851

Electronically Signed

Your name: Debbie Kotin Insdorf
Signed on: 07/10/2022