

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Orthocare Supplies Inc.  
(Applicant)

- and -

Geico Insurance Company  
(Respondent)

AAA Case No.

17-22-1255-3345

Applicant's File No.

GM22-437457,  
GM22-439677

Insurer's Claim File No.

0450540250010103

NAIC No.

35882

**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 03/08/2023  
Declared closed by the arbitrator on 03/16/2023

Koenig Pierre, Esq. from Law Offices of Gabriel & Moroff, P.C. participated virtually for the Applicant

Christine DiGregorio, Esq. from Rivkin & Radler LLP participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,367.95**, 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 22 year-old female restrained driver of a motor vehicle that was involved in an accident on 10/18/21. Following the accident the claimant suffered injuries which resulted in the claimant seeking treatment. At issue is the 3/4/22-3/14/22 use of a continuous passive motion (CPM) unit provided by Applicant. Respondent denied the claim based on Applicant's failure to provide requested verification within 120 days of the initial verification request.

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

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

An 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 22 year-old female restrained driver of a motor vehicle that was involved in an accident on 10/18/21. The claimant reportedly injured her neck, bilateral shoulders, chest wall, upper back, lower back, and right knee. There was no reported loss of consciousness. There were no reported lacerations or fractures. Following the accident the claimant was transported to Huntington Hospital where she was evaluated, treated, and released. Subsequently the claimant was initiated/continued on conservative care. On 10/19/21 Robert M. Buurma, D.C. prescribed a custom fitted lumbosacral orthosis (LSO) with sagittal control. It is noted that there is no corresponding medical report by Dr. Buurma in evidence. On 11/3/21 the claimant presented to David Shabtian, D.O. of Total Anesthesia Provider, P.C. with complaints of pain in the her neck, bilateral shoulders, upper back, lower back, and right knee. Dr. Shabtian noted that the claimant was undergoing treatment for a prior accident at the time of the subject MVA. Cervical examination revealed tenderness, muscle spasms, and restricted range of motion in all planes (quantified). Manual muscle strength was reduced 4/5. Spurling's test was positive. Lumbar examination revealed tenderness, muscle spasms, and restricted range of motion in all planes (quantified). Manual muscle strength was reduced 4/5. SLR and Femoral Stretch were positive. Thoracic spine showed restricted motion. Examination of the bilateral shoulders and right knee revealed tenderness and restricted range of motion (unquantified). The claimant was referred for an orthopedic consultation. On 12/13/21 the claimant presented to Anthony L. Finuoli, M.D. of Branch Orthopedics for an orthopedic consultation with complaints of pain in the bilateral shoulders and right knee. Bilateral shoulder examination revealed "Skin is intact. No signs of infection. Tenderness to palpation diffusely. Flexion and Abduction 110° Ext Rotation 50°. Positive Hawkins Test. Positive O'Brien's Test. Positive Neer's Test. Pain with resisted motions. Strength 4/5. Grossly, neurovascularly intact with compartments soft." Right knee examination revealed "Skin is intact. Medial and lateral Joint line tenderness. Mild patellofemoral tenderness. Positive Joint Effusion. No gross Valgus - Varus Instability. Flexion 110° Extension 10°. Negative Homan's Sign. No palpable cords. Compartments are soft. Grossly, neurovascularly intact." Bilateral shoulders and right knee MRIs were ordered. The 1/3/22 left shoulder MRI interpreted by David R. Payne, M.D. produced an impression of tendinosis of anterior fibers of supraspinatus, anteroinferior labral tear, and no appreciable interval change from 7/6/21. On 2/14/22 Dr. Finuoli conducted a follow-up examination that was substantially similar to that of 12/13/21 and the claimant was recommended for right knee arthroscopy with partial meniscectomy and left shoulder arthroscopy with possible labral repair. On 3/2/22

Anthony L. Finuoli, M.D. (surgeon) and Charles Brogan, P.A. (surgical assistant) performed left shoulder surgery consisting of arthroscopic labral tear debridement, rotator cuff tear debridement, anterior and posterior capsular synovectomy, lysis of adhesions, manipulation under anesthesia, and subacromial decompression/acromioplasty. The operative report indicated a peripheral radial tear, an associated paralabral cyst, and a partial tear within the supraspinatus tendon. Dr. Finuoli prescribed a sheepskin pad, the use of a continuous passive motion (CPM) unit and a cold water circulating pump with pad. At issue is the 3/4/22-3/14/22 use of the CPM provided by Orthocare Supplies, Inc. (Applicant).

Respondent contends that Applicant's claim was properly delayed for verification that was never fully complied with. Respondent subsequently denied the claim in reliance upon 11 NYCRR Section 65-3.8(b)(3) which provides that "an insurer may issue a denial, if, more than 120 calendar days after the initial request for verification, the applicant has not submitted all verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply."

The verification requests stem from an Examination Under Oath ("EUO") conducted on 8/6/21 of Artashes Baghdasaryn, Applicant's owner. Although the EUO did not involve claims regarding this assignor, Respondent subsequently sent verification requests regarding this assignor and the bills contested herein requesting information emanating from the EUO.

Between 8/25/21 and 3/2/22, counsel for Applicant provided eleven correspondences to Respondent in which it complied with the post-EUO verification requests, submitting some of the documentation requested and raising objections to others. At the hearing Respondent's counsel conceded that the majority of the documents requested were provided by Applicant prior to the issuance of the denials here. Following correspondence going back and forth between the parties, Respondent indicated that the only items that remain outstanding are *"copies of bank statements from February 1, 2019 to the present relating to Orthocare's bank account(s), including the opening/signatory authorization documents for the account and copies of all cancelled checks, front and back"; "copies of documents relating to the income and expenses of Orthocare, including but not limited to corporate tax returns (including quarterly tax returns) since February 1, 2019" and "documentation reviewed to determine the usual and customary price charged to the general public for those items, i.e., any research conducted, any AAA awards relied upon, and any documentation relating to Mr. Baghdasaryn's prior experience that helped Orthocare determine the prices to charge for the equipment provided to GEICO insureds."* Regarding this last item Respondent notes in their verification requests Applicant's previous objections and advises Applicant *"in light of your objection that the AAA awards relied upon by the witness to determine pricing of various DME equipment is public record, please provide AAA numbers of the awards so GEICO can obtain them through the public record."* In addition, both sides agree that while Applicant continued to object to the requests for financial documents, Applicant did subsequently offer Respondent and an opportunity to do an "in-camera" review of Applicant's financial documents at Applicant's counsel's office which Respondent asserts is insufficient *"to properly review the documents and verify the claims at issue."*

Respondent contends that Applicant did not substantially comply with the verification requests and denied the claim in reliance upon 11 NYCRR Section 65-3.8(b)(3). Applicant argues that they substantially complied with all reasonable verification requested and the denial of this claim was improper.

It is well-established that an insurer is not obligated to pay a claim until it has received verification of all relevant information requested. Moreover, the verification provisions promulgated by the no-fault regulations confer upon the Respondent the right to obtain verification of a claim. "If the provider objects to the request for verification, then the issue of whether the requested verification material and the objection were proper are preserved and become questions of fact for the trier of fact. If the insurer can establish it had a reasonable, good faith, factual basis for requesting the verification, then the failure of the claimant provider to furnish the material will result in the dismissal of the action. If the insurer cannot establish a reasonable, good faith, factual basis for requesting the verification, then the insurer will be required to pay the claim." *Victory Medical Diagnostics, P.C. v. Nationwide Property and Casualty Ins. Co.*, 36 Misc.3d 568, 576, 949 N.Y.S.2d 855, 862 (Dist. Ct. Nassau Co. 2012).

Respondent submitted an affidavit by Daniel Curto, an employee in Respondent's Special Investigations Unit (SIU), summarizing Respondent's investigation of Applicant and the need for the EUO and post-EUO verification. Mr. Curto generally states that Applicant is providing products that are not medically necessary, pursuant to a protocol designed to maximize profits; is improperly billing; and Applicant's charges are the byproducts of unlawful, collusive, or otherwise suspect referral agreements. Mr. Curto then references portions of Mr. Baghdasaryan's EUO testimony and based therein asserts Respondent found it necessary for Applicant to produce the requested post-EUO information. Mr. Curto further acknowledged that although Applicant provided some of the information requested, Applicant refuses to provide the names of the arbitration decisions relied upon to determine what to bill GEICO for various DME equipment, the financial records, and tax returns.

Based upon a review of the affidavit and the EUO transcript, I find in favor of Applicant. With respect to the financial documents requested, Applicant's principal appeared for a five hour EUO on 8/6/21 and answered a litany of questions regarding Applicant's formation, operations, employee/independent contractors, storage facilities, inventory, product descriptions, marketing, and management. Mr. Baghdasaryan's answers were straightforward and forthcoming. There is no evidence submitted by Respondent to doubt the veracity of his answers, or to suspect that Applicant is engaged in fraudulent conduct to support the request for the financial documents from 2019 to the present. In addition, irrespective of the reasonableness for the request of the financial documents, Respondent was afforded an opportunity for an "in-camera" review of Applicant's financial documents that potentially could have bolstered Respondent claims of wrongdoing by Applicant, but instead Respondent declined to take the opportunity to do the "in-camera" review. In addition, Respondent failed to articulate how the request for the AAA awards Applicant utilizes in determining its prices would assist in verifying the claim. Mr. Baghdasaryan testified that he not only consults AAA awards but utilizes other sources such as attorneys, the Optum360 fee analyzer, and billing companies to

determine its prices for unlisted DME products. Therefore, Applicant does not base its determination of pricing solely on AAA awards and it is unreasonable to request all the AAA awards that Applicant may reference in determining pricing. Applicant identified what sources it used to determine its billing and I find Respondent has been provided with sufficient information to pay or deny the claim based upon any fee schedule defense and/or in the alternative to request bill-specific information so that it may perform its own fee schedule review without the additional need for the specific AAA awards utilized by Applicant.

Based on the totality of the evidence in the record, I find that Applicant's responses substantially complied with all of Respondent's reasonable requests for verification in this case, and that there is no outstanding verification necessary to verify the claims. Respondent's 120 day defense cannot be sustained.

Accordingly, Applicant is awarded \$1,367.95.

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
	Orthocare Supplies Inc.	03/04/22 - 03/10/22	\$891.95	Awarded: \$891.95
	Orthocare Supplies Inc.	03/11/22 - 03/14/22	\$476.00	Awarded: \$476.00
Total			\$1,367.95	Awarded: \$1,367.95

- B. The insurer shall also compute and pay the applicant interest set forth below. 06/22/2022 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest runs from 6/22/22 (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 NY  
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.

04/07/2023  
(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:**  
b92428fd479f035f744ffab1d127f203

### Electronically Signed

Your name: Charles Blattberg  
Signed on: 04/07/2023