American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Supramed Inc (Applicant)	AAA Case No.	17-21-1232-4758
	Applicant's File No.	121180
- and -	Insurer's Claim File No.	9VNLV06007
	NAIC No.	20052
National Liability & Fire Insurance Company (Respondent)		

ARBITRATION AWARD

I, Alise Schor, 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 (AB)

1. Hearing(s) held on 04/05/2023
   Declared closed by the arbitrator on 04/05/2023

   Naomi Cohn, Esq. from Ursulova Law Offices P.C. participated virtually for the Applicant

   John Calabrese, Esq. from Hollander Legal Group PC participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$1,309.27**, was NOT AMENDED at the oral hearing.
   Stipulations WERE made by the parties regarding the issues to be determined.

   The parties stipulated that Applicant established a prima facie case of entitlement to No-Fault compensation with respect to its bill. They further stipulated that Respondent's Form NF-10 denial of claim forms were timely issued, i.e., within the 30-day deadline prescribed by Insurance Law §5106(a) and 11 NYCRR 65-3.8(a)(1). Additionally, the parties agreed that the only issue to be decided by this Arbitrator is medical necessity.

3. Summary of Issues in Dispute

   Whether Respondent's denial of a CTU and an LSO provided to Assignor (AB), a 63-year-old male, on October 8, 2021, based upon a Peer Review by Dr. Jay Weiss, MD

dated November 30, 2021 should be overturned? The DME were provided to Assignor in connection with injuries he sustained as the driver of a motor vehicle involved in an accident on June 30, 2021. Applicant submits a Rebuttal by Dr. Sean Diamond, DC dated June 4, 2022 and an amended Rebuttal by Dr. Shoirakhon Bakieva, MD which is undated.

The hearing was held via Zoom.

4. Findings, Conclusions, and Basis Therefor

Respondent's Peer Review Report:

Dr. Weiss lists the numerous records he reviewed and discusses the July 6, 2021 initial examination of Assignor; the complaints; positive findings; the ensuing diagnosis, and the diagnostic plan of physical therapy and MRIs. There was an orthopedic evaluation on July 15, 2021 and the plan was for left shoulder arthroscopy. Dr. Weiss summarizes the subsequent evaluations and findings culminating with the ordering of the LSO and CTU on September 28, 2021.

Dr. Weiss opines that the LSO was not medically necessary as there was no evidence of lumbar instability that would explain why a restrictive brace would be ordered particularly more than three months after the motor vehicle accident. He cites to medical authority which finds that the evidence does not support the effectiveness of lumbar orthoses.

With regard to the CTU, Dr. Weiss states that there is no evidence that the assignor head significant improvement with a therapeutic trial of traction warranting a home unit.

Rebuttals:

Respondent submits two Rebuttals, although one is noted to be Amended, from two different providers, Dr. Sean Diamond, DC and Dr. Shoirakhon Bakieva, MD. These two Rebuttal reports are are identical, word for word, with the exception of the second paragraph of the History wherein Dr. Diamond indicates that the Assignor presented to him for an initial chiropractic evaluation.

Findings:

As it has been stipulated that Applicant has established its prima facie showing of entitlement to reimbursement, the burden now shifts to the Respondent to demonstrate lack of medical necessity. See Citywide Social Work & Psychological Services, PLLC v. Allstate Ins. Co., 8 Misc 3d 1025 A (2005). A denial premised on a lack of medical necessity must be supported by competent evidence such as an independent medical examination, a peer review or other proof which sets forth a factual basis and a medical

rationale for denying the claim. Healing Hands Chiropractic, P.C., v. Nationwide Assur. Co., 5 Misc., 3d 975, 787 N.Y.S. 2d 645 (Civ. Ct., New York County, 2004); King's Med. Supply Inc. v. Country Wide Ins. Co., 5 Misc. 3d 767, 783 N.Y.S. 2d 448.

I find that Respondent's Peer Review Report is sufficient to meet Respondent's burden of proof of lack of medical necessity. Therefore, the burden shifts back to Applicant to present competent medical proof as to the medical necessity of the LSO and CTU by a preponderance of the credible evidence. West Tremont Medical Diagnostic, P.C. v. GEICO, 13 Misc.3d 131[A], 824 N.Y.S.2d 759 (Table), 2006 N.Y. Slip Op. 51871[U], 2006 WL 2829826 (App. Term 2d & 11th Jud. Dists. 9/29/06), A. Khodadadi Radiology, P.C. v. N.Y. Central Fire Mutual Insurance Company, 16 Misc. 3d 131[A], 841 N.Y.S.2d 824, 2007 WL 1989432 (App. Term 2d & 11th Dists. 7/3/08). Ultimately, the burden of proof rests with the Applicant (See Insurance Law Section 5102).

To meet that burden, Applicant submits two Rebuttals by different providers, which are identical. This is troubling and severely diminishes their credibility. Herein, I am faced with conflicting opinions concerning the medical necessity for the DME. There are no legal issues to resolve. This dispute involves solely an issue of fact, that is, whether or not the LSO and the CTU were medically necessary. Resolution of that fact is determined by which opinion is accepted by the trier of fact. After reviewing the totality of the evidence and hearing the arguments presented by the parties, I find that Applicant is not entitled to reimbursement for the DME. A trier of fact must consider the existence of each factor which supports an insurer's fact or founded belief and determine the weight to be given to each factor. Tarnoff Chiropractic, P.C. v. Geico Ins Co., 35 Misc.3d 1213(A), 950 N.Y.S.2d 726 (Table) (Dist. Ct. Nassau Co. 2012). I cannot determine which doctor actually authored the Rebuttal and cannot discount the possibility that it was neither of them. As the Rebuttal reports lack credibility they are afforded little weight. As such, I find the Peer Review Report more persuasive.

Accordingly, in light of the foregoing, based on the arguments of the parties' representatives, and after thorough review and consideration of all submissions, Applicant's claim is denied. This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator. Any additional issues raised in the hearing record are held to be moot and/or waived insofar as they were not raised at the time of the hearing.

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 claim is DENIED in its entirety

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of NY
SS :
County of Nassau

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

04/14/2023
(Dated)

Alise Schor

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:
05dd070d3a8d506069eac9f07f258683

Electronically Signed

Your name: Alise Schor
Signed on: 04/14/2023