

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Infinite Supply Group Inc.
(Applicant)

- and -

Allstate Insurance Company
(Respondent)

AAA Case No. 17-23-1299-9015

Applicant's File No. 138646

Insurer's Claim File No. 0697734598
VCB

NAIC No. 29688

ARBITRATION AWARD

I, Nicholas Tafuri, 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: EIP (YBD)

1. Hearing(s) held on 10/13/2023
Declared closed by the arbitrator on 10/13/2023

Robert Cippitelli, Esq. from Law Offices of Eitan Dagan (Woodhaven) participated virtually for the Applicant

David Kelly, Esq. from Law Offices of James F. Sullivan, PC participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,275.00**, was NOT AMENDED at the oral hearing.
Stipulations WERE made by the parties regarding the issues to be determined.

The parties stipulated that there are no fee schedule disputes.

3. Summary of Issues in Dispute

EIP (YBD), is a 33-year-old female, who was the driver of a motor vehicle when an accident occurred on December 29, 2022. Following the accident, EIP sought medical treatment. DME is dispensed by Applicant for use on 3/15/23-3/29/23.

Applicant's reimbursement claim is denied by Respondent based upon a peer review by Dr. Alexander Merson, dated April 13, 2023.

The issue to be determined at the hearing: Whether Applicant is entitled to no-fault reimbursement for health services provided that are denied by Respondent based on peer reviews?

4. Findings, Conclusions, and Basis Therefor

I have reviewed the documents contained in the ADR Center Record as of the date of the hearing. This Award is based upon my review of the Record and the arguments made by the representatives of the parties at the Hearing. Pursuant to 11 NYCRR 65-4 (Regulation 68-D), §65-4.5 (o) (1), an Arbitrator shall be the judge of the relevance and materiality of the evidence offered, and strict conformity to legal rules of evidence shall not be necessary. The case was decided on the submissions of the Parties as contained in the ADR Center Record maintained by the American Arbitration Association. Applicant's request to rely on submissions was granted. No oral arguments were presented at the hearing.

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It is well settled that an applicant establishes its *prima facie* showing of entitlement to No-Fault benefits by submitting evidentiary proof that the prescribed statutory billing forms had been mailed, received by the respondent and that payment of no-fault benefits were overdue. Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2d Dept. 2004). I find Applicant establishes its *prima facie* case of entitlement to No-Fault compensation for its claim. The burden then shifts to the respondent to prove that the bill in question was properly denied. I find Respondent's denials are timely.

Applicant's reimbursement claim is denied by Respondent based upon a peer review by Dr. Alexander Merson, dated April 13, 2023.

Medical Necessity

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 [or examining physician'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 2d, 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 Bronx Expert Radiology, P.C. v. Travelers Ins. Co., 2006 NY Slip Op 52116 (App. Term 1st Dept. 2006).

The Civil Courts have held that a defendant's peer review or report of medical examination must set forth more than just a basic recitation of the expert's opinion. The trial courts have held that a peer review or medical examination report's medical rationale will be insufficient to meet respondent's burden of proof if: 1) the medical rationale of its expert witness is not supported by evidence of a deviation from "generally accepted medical" standards; 2) the expert fails to cite to medical authority, standard, or generally accepted specifics as to the claim at issue, is conclusory or vague. See Nir v. Allstate, 7 Misc.3d 544 (N.Y. City Civ. Ct. 2005); See also, All Boro Psychological Servs. P.C. v. GEICO, 2012 Slip Op 50137(U) (N.Y. City Civ. Ct. 2012.) "Generally accepted practice is that range of practice that the profession will follow in the diagnosis and treatment of patients in light of the standards and values that define its calling." Nir, supra.

In the peer review of 4/13/23, Dr. Alexander Merson discusses EIP's examination findings of 1/17/23, and the commencement of conservative treatment and injection therapy. On 3/15/23, EIP was provided a Low Frequency Ultrasonic Diathermy Treatment Device for home use. Dr. Merson avers that this device was not necessary in this clinical setting when ultrasound therapy was available during physical therapy sessions in the office. There was no need to use the same modalities at home. Dr. Merson reasons that if EIP was not offered the ultrasound therapy in the office, there was no requirement to apply them at home. Dr. Merson cites to medical authority that acknowledges that ultrasound therapy is widely used for the treatment of many musculoskeletal pain syndromes, however few studies have demonstrated ultrasound therapy to be effective for the treatment of low back pain. In this case, Dr. Merson opines that the system was provided when the course of physical therapy was in progress, and manifested to be effective. Therefore, the medical standard was not met in

this regard. Dr. Merson is critical of the letter of medical necessity by Dr. Igor Zilberman, and concludes that there was no medical necessity to prescribe a Low Frequency Ultrasonic Diathermy Treatment Device.

I find that Respondent has set forth a cogent medical rationale in support of its defense that the multiple DME items provided were not medically necessary.

Where a Respondent meets its burden, it becomes incumbent on the claimant to rebut the peer review. Be Well Medical Supply, Inc. v. New York Cent. Mut. Fire Ins. Co., 18 Misc.3d 139(A), 2008 WL 506180 (App. Term 2d & 11th Dists. Feb. 21, 2008); A Khodadadi Radiology, P.C. v. NY Central Mutual Fire Ins. Co., 16 Misc.3d 131(A), 2007 WL 1989432 (App. Term 2d & 11th Dists July 3, 2007).

In response to the peer review by Dr. Merson, Applicant submits a rebuttal by Igor Zilberman, FNP, dated 6/28/23. The rebuttal details EIP's positive examination findings of 1/17/23 and 2/21/23, and the lumbar spine MRI findings of 2/13/23, that revealed herniated discs and bulging discs. The Low Frequency Ultrasonic Diathermy Treatment Device was prescribed for home use as a supplement to in-office treatment. It is quite useful for patients who benefit from their use on those days and at those times when the patient is not receiving in-office treatment. EIP's continuing complaints of pain and positive examination findings on 2/21/23, as well as the lumbar spine MRI findings of 2/13/23, establish that EIP would benefit from this treatment device. Citing medical authority, the rebuttal notes that ultrasound modalities are well established, not only as a diagnostic imaging modality, but as a therapeutic modality in which energy is deposited in tissue to induce various biological effects. Based on the foregoing, the Low Frequency Ultrasonic Diathermy Treatment Device was medically necessary to facilitate the healing process and allow other therapeutic modalities to work.

After a thorough review of all submissions, I find that Applicant has successfully refuted the opinion of the Respondent's peer review expert, and has established the medical necessity for the prescribed ultrasonic treatment device, by a preponderance of the evidence. I am persuaded by Applicant's proof that the DME items prescribed by EIP's treating physician was medically necessary. I find the rebuttal to the peer review sufficient to meet the Applicant's burden on the issue of medical necessity. I am persuaded by EIP's medical records and test findings that EIP was having persistent

physical difficulties, necessitating the subject DME item. The peer reviewer's statement that the DME item was prescribed when physical therapy was in progress and manifested to be effective, is not supported by the records reviewed. Dr. Merson fails to acknowledge and discuss EIP's persistent subjective complaints and positive examination findings upon a re-examination on 2/21/23, as well as the lumbar spine MRI findings of 2/13/23. Since the recommendation for the ultrasonic therapy device is supported by objective medical findings and rationale, I defer to the treating doctor's determination that the equipment dispensed was medically necessary.

Based on the foregoing, Applicant's reimbursement claim, for dates of service 3/15/23-3/29/23, is granted. Applicant is awarded the sum of \$ 1,275.00.

This decision is in full disposition of all claims for no-fault benefits presently before this arbitrator.

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
	Infinite Supply	03/15/23 -		Awarded:

	Group Inc.	03/29/23	\$1,275.00	\$1,275.00
Total			\$1,275.00	Awarded: \$1,275.00

- B. The insurer shall also compute and pay the applicant interest set forth below. 05/17/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Respondent shall compute and pay to Applicant the amount of interest from the filing date of the Request for Arbitration, at a rate of 2% per month, simple interest (i.e. not compounded) using a 30-day month and ending with the date of payment of the award, subject to the provisions of 11 NYCRR 65-3.9(c).

C. Attorney's Fees

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

For cases filed on or after February 4, 2015, the attorney's fee shall be calculated as follows: 20% of the amount of first-party benefits awarded, plus interest thereon, subject to no minimum fee, and a maximum fee of \$1,360.00. 11 NYCRR 65-4.6(d).

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

10/17/2023
(Dated)

Nicholas Tafuri

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:

af8c328e97e45dfd5dec20f07c35070c

Electronically Signed

Your name: Nicholas Tafuri
Signed on: 10/17/2023