American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

BibiMed, Inc (Applicant)	AAA Case No.	17-22-1272-1905
	Applicant's File No.	n/a
- and -	Insurer's Claim File No.	38-09Q4-16G
	NAIC No.	25178
State Farm Mutual Automobile Insurance Company (Respondent)		

ARBITRATION AWARD

I, Karen Fisher-Isaacs, 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 11/14/2023
   Declared closed by the arbitrator on 11/14/2023

   Kim Gitlin from Dino R. DiRienzo Esq. participated virtually for the Applicant

   Mitchell Feder from James F. Butler & Associates participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$8,904.56**, 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
   Applicant seeks reimbursement of charges for providing Assignor, a 31-year old male, with a cold compression unit with wrap from November 20, 2020 through December 17, 2020 ($1,890.00 in dispute) and with a sustained acoustic medicine unit ("SAM") with patches from November 20, 2020 through January 14, 2021 ($7,014.56 in dispute) in connection with treating injuries following an August 4, 2021 motor vehicle accident. Respondent timely denied Applicant's billing based on Dr. Jeffrey Passick's peer review report dated January 14, 2021 and addenda dated February 1, 2021 and February 12, 2021 intended as peer review reports and treated as such. While Applicant submitted Dr. Ashraf Salem's rebuttal it was not submitted

within 30 days of the hearing without good cause shown and therefore it was precluded.

4. Findings, Conclusions, and Basis Therefor

I have reviewed the documents contained in the American Arbitration Association's ADR Center as of the date of the hearing in this matter and have considered all pertinent documents contained therein for the purpose of rendering this award.

Applicant seeks reimbursement in the amount of $8,904.56 for providing Assignor, a 31 year old male, with a SAM unit and patches from November 20, 2020 through January 14, 2021 and with an cold compression unit with wrap from November 20, 2020 through December 17, 2020 in connection with treating injuries sustained in a motor vehicle accident on August 4, 2020. Respondent timely denied Applicant's claim based on a peer review report and two addenda intended as peer review reports and considered as such with full weight given.

As a threshold matter, I find that Applicant has established its prima facie case as Applicant has met the requirements enunciated in Ave T MPC Corp. v Auto One Ins. Co., 32 Misc 3d 128[A], 2011 NY Slip Op 51292[U] [App Term, 2d, 11th & 13th Jud Dists 2011]). To meet its burden and establish a lack of medical necessity, Respondent must present competent medical evidence setting forth a clear factual basis (specifics of the claim) and medical rationale for denying the claim. Citywide Social Work and Psych Services, PLLC v. Allstate, 8 Misc. 3d 1025A (2005); Healing Hands Chiropractic v. Nationwide Assurance Co., 5 Misc. 3d 975 (2004).

Assignor was the driver of a motor vehicle that was involved in an accident on August 4, 2020. He was evaluated at Nassau University Medical Center's ER and discharged with medication. Shortly after the accident he began conservative treatment for his neck, back and right shoulder soft tissue injuries.

Respondent's evidence established that it timely denied Applicant's billing for providing Assignor with the cold compression unit with wrap and SAM unit with patches based on Dr. Jeffrey Passick's peer review reports. Dr. Passick first noted that there was no prescription for the SAM Unit and no explanation for why it was provided. While there was a prescription with generic letter of medical necessary (referencing surgery which Assignor did not have) attached for the cold compression unit, there was no explanation as to why it was medically necessary for this Assignor. Dr. Passick advised that Assignor was

started on conservative treatment- physical therapy, chiropractic and acupuncture which was "sufficient to treat the claimant's soft tissue injuries and [did] not require the additional items for home use." Prescribing these supplies while Assignor was receiving a comprehensive course of conservative treatment by licensed professionals was "excessive." Additionally, these items lack the clinical value and effectiveness that Assignor's treating providers were providing.

The law is well settled that the burden is on the insurer to prove that medical treatment performed was not medically necessary. (See A.B. Medical Services PLLC v. Geico Insurance, 2 Misc.3d 26, 773 N.Y.S.2d 773 [App. Term, 2nd & 11th Jud. Dists. 2003]; King's Medical Supply Inc. v. Country-Wide Insurance Company, 783 N.Y.S.2d at 448). I find Dr. Passick's peer review report sufficient to meet this burden. Dr. Passick sufficiently explained why the items were not medically necessary to treat Assignor's soft tissue neck, back and shoulder injuries. It set forth a factual basis and a medical rationale, per the above-cited case law, to establish a prima facie case in support of Respondent's medical necessity defense.

Once Respondent, through Dr. Passick's report, established the merits of its challenge to the medical necessity of the supplies, the burden shifted. Now, Applicant was bound to present competent medical proof establishing the medical necessity for the cold compression and SAM units, and to do so 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 & 11 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 & 11 Dists. 7/3/08). Ultimately, the burden of proof rests with the Applicant (See, Insurance Law Section 5102).

Applicant argued that its rebuttal by Dr. Ashraf Salem, a non-treating doctor, which was first uploaded to the ADR on October 19, 2022 served to prove medical necessity. While, as an Arbitrator, I can use my discretion to allow a late submission, see 11 NYCRR 65-4.2 (b)(3)(iv), I will not allow a late submission when it is submitted less than thirty days before the first scheduled hearing without good cause shown. None was shown here. Since Applicant failed to show good cause for failing to submit its proof in a timely matter, the rebuttal was precluded and is not considered.

Accordingly, as Respondent's peer review reports are unrefuted by medical evidence or an admissible rebuttal, Respondent's denials are sustained. I am persuaded that there was no basis for Applicant having dispensed these items

when Assignor was undergoing a comprehensive rehabilitation program to treat his mild soft tissue injuries. Dr. Passick reviewed Assignor's medical records and unequivocally explained why the DME prescribed was a clear deviation from the standard of care for this Assignor's soft tissue injuries. Accordingly, Applicant's claim is denied.

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 NJ
SS :
County of Bergen

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

11/17/2023
(Dated)

Karen Fisher-Isaacs

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:
60b04f85bde003e01e4e8680e3c5ef71

Electronically Signed

Your name: Karen Fisher-Isaacs
Signed on: 11/17/2023