

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Exon Medical Equipment, Inc.  
(Applicant)

- and -

LM General Insurance Company  
(Respondent)

AAA Case No. 17-23-1281-6557

Applicant's File No. 156069

Insurer's Claim File No. 0498023800002

NAIC No. 36447

**ARBITRATION AWARD**

I, Nicole J. Simmons, 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: IP

1. Hearing(s) held on 10/20/2023  
Declared closed by the arbitrator on 10/20/2023

Nison Mirakov, Esq. from The Law Offices of John Gallagher, PLLC participated virtually for the Applicant

Michelle Crismali from LM General Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,063.95**, 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

Whether Respondent's denial of Applicant's claim for durable medical equipment (DME), based upon a peer review report, can be sustained.

The IP (SN), a 51-year-old female passenger, was involved in a motor vehicle accident on 6/11/22. Thereafter, she sought treatment for various injuries including neck and back pain. The instant claim is for a lumbar support orthosis (LSO), cervical support, cervical pillow, wheelchair seat cushion, and heat pad dispensed to the IP on 7/6/22. Respondent timely denied the claim based upon the 8/11/22 peer review report by Amit Kaneja, M.D.

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

I have reviewed and considered all pertinent documents contained in the American Arbitration Association's ADR Center. The case was decided based upon the submissions of the parties and the oral arguments of the parties' representatives made at the arbitration hearing. There were no witnesses.

The 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 Arbitrator may question any witness or party and independently raise any issue that the Arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department Regulations. 11 NYCRR 65-4.5(o)(1). (Regulation 68-D.)

I find that Applicant has established its prima facie case by meeting 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]. The Court held that "A no-fault provider establishes its prima facie entitlement to summary judgment by proof of the submission to the defendant of a claim form, proof of the fact and the amount of the loss sustained, and proof that the defendant either failed to pay or deny the claim within the requisite 30-day period, or issued a timely denial of claim that was conclusory, vague or without merit as a matter of law," (see Insurance Law § 5106 [a]; Westchester Med. Ctr. v Nationwide Mut. Ins. Co., 78 AD AD3d 1168 [2010]; see also New York & Presbyterian Hosp v. Allstate 31 AD3d 512 [2006]).

##### Medical Necessity

When an insurer relies upon a peer review report to demonstrate that a service was not medically necessary, the peer reviewer's opinion must be supported by sufficient factual evidence or proof and cannot simply be conclusory. As per the holding in Jacob Nir, M.D. v. Allstate Insurance Co., 7 Misc.3d 544 (2005), the peer reviewer must establish a factual basis and medical rationale to support a finding that the services were not medically necessary, including setting forth generally accepted standards in the medical community. The opinion of the insurer's expert, standing alone, is insufficient to carry the insurer's burden to prove that the services were not medically necessary. CityWide Social Work & Psychological Services, PLLC v. Travelers Indemnity Co., 3 Misc.3d 608, 777 N.Y.S.2d 241 (N.Y. Civ. Ct. Kings Co. 2004).

Respondent relies on the 8/11/22 peer review report of Dr. Kaneja in support of its denial. He notes that the IP initially reported neck, lower back, and right knee pain. The IP was examined by Igor Zilberman, FNP on 6/22/22. The examination revealed cervical and lumbar decreased range of motion, tenderness on palpation, spasms, facet loading, and positive Maximum Cervical Compression, Jackson's Compression, Straight Leg Raise, Piriformis, and Gaenslen's tests. The diagnoses included "*cervicalgia, cervical radiculopathy and spondylosis without myelopathy or radiculopathy of cervical spine, lumbar radiculopathy, spondylosis without myelopathy or radiculopathy of lumbar spine.*" Dr. Kaneja asserts that based on his review of the medical records, there

was no medical necessity for the prescribed DME. He states that according to the standard of care medical support collars and support orthoses are not recommended for neck sprains. Non-immobilization protocols show an overall better trend of pain relief and neck mobility recovery. Immobilization is not recommended and increases recovery time therefore the cervical collar and pillow were not distributed according to the medical standard of care. LSO may be indicated in cases of fracture or dislocation. Evidence shows that lumbar supports are not effective in the primary prevention of low back pain. As the IP did not have a lumbar instability the use of lumbar support orthosis and cushion is not recommended, these were not administered according to the medical standard of care. He states, "[t]he standard of care for musculoskeletal injury after a motor vehicle accident should begin with a reasonable trial of conservative treatment which consist of clinical evaluation advising activity modification if necessary, with a focus on returning to full activity as soon as possible. Simple analgesics such as anti-inflammatory agents and local anesthetics as well as physiotherapy for a period of 4-6 weeks are recommended, followed by another modified course of physical therapy/exercise program if the claimant is not responding to the initial course of treatment. The distribution of DMEs and palliative devices is not the standard of care." Here, the IP was additionally prescribed a heat pad. Dr. Kaneja notes that the standard of care includes modalities such as exercises, traction, manipulation, or massage, as well as modalities such as heat, and ice, but mentions that a water circulating pad is not the standard of care. Dr. Kaneja cite medical literature in support of his opinion that the prescribed devices were not medically necessary.

Where the Respondent presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden then shifts to the Applicant which must then present its own evidence of medical necessity. [see Prince, Richardson on Evidence §§ 3-104, 3-202 [Farrell 11th ed]], Andrew Carothers, M.D., P.C. v. GEICO Indemnity Company, 2008 NY Slip Op 50456U, 18 Misc. 3d 1147A, 2008 N.Y. Misc. LEXIS 1121, West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co. 13 Misc.3d 131, 824 N.Y.S.2d 759, 2006 NY Slip Op51871(U) (Sup. Ct. App. T. 2d Dept 2006)]. I find the peer review of Dr. Kaneja sufficient to shift the burden to the Applicant.

Applicant has not submitted a formal rebuttal and relies on the IP's medical records to refute the peer review report. The records include the IP's 6/22/22 initial evaluation report. I note this report was reviewed and considered by the peer reviewer. The report makes a vague reference to a referral sheet for medical supplies, but there is no documentation as to why these specific prescribed devices were necessary for the IP herein.

Upon a showing of lack of medical necessity through a peer review, an applicant is required to rebut same. See A Khodadadi Radiology P.C. v. N.Y. Central Mutual Ins. Co., 16 Misc 3d 131(A), 841 N.Y.S.2d 824 (table), 2007 N.Y. Slip Op 51342(U), 2007 WL 1989432 (App.Term 2d & 11 Dist. July 3, 2007).

Based on the forgoing, I find that Dr. Kaneja's report was sufficient to establish that the subject DME was not medically necessary for the IP's injuries and to shift the burden to Applicant to present competent medical proof to establish medical necessity for the devices. I was more persuaded by the peer review report than the IP's records which did

not provide sufficient basis or explanation regarding why the DME was necessary as the IP was undergoing physical therapy to increase range of motion and was tolerating the treatment well and without difficulty. The one exception was the moist heat pad. Dr. Kaneja did not refute the medical records regarding this device as he conceded that heat was an appropriate modality and within the standard of care for the injuries documented in the IP's records.

Comparing the relevant evidence presented by both parties against each other and the above referenced medical necessity standard, in this instance, I find that Respondent's denial is sustained for all items except the moist heat pad.

Accordingly, Applicant is awarded **\$20.93** in full satisfaction of this claim.

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
	<b>Exon Medical Equipment, Inc.</b>	<b>07/06/22 - 07/06/22</b>	<b>\$1,063.95</b>	<b>Awarded: \$20.93</b>
<b>Total</b>			<b>\$1,063.95</b>	<b>Awarded: \$20.93</b>

- B. The insurer shall also compute and pay the applicant interest set forth below. 01/09/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

The insurer shall compute interest and pay the Applicant the amount of interest computed from the filing date as indicated above at the rate of 2% per month, simple, not compounded, calculated on a pro rata basis using a thirty-day month, and ending with the date of payment of the award.

C. Attorney's Fees

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

After calculating the sum total of the first-party benefits awarded in this arbitration plus the interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20% of that sum total, subject to a maximum fee of \$1,360. See, 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, Nicole J. Simmons, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

11/20/2023  
(Dated)

Nicole J. Simmons

**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:**  
edc39170a24ca50e41538c902e057ea6

### Electronically Signed

Your name: Nicole J. Simmons  
Signed on: 11/20/2023