

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Hank Ross Medical PC  
(Applicant)

- and -

Allstate Insurance Company  
(Respondent)

AAA Case No. 17-23-1288-8899

Applicant's File No. 3119331

Insurer's Claim File No. 0679588227  
2PU

NAIC No. 19232

### ARBITRATION AWARD

I, Deepak Sohi, 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

1. Hearing(s) held on 11/30/2023  
Declared closed by the arbitrator on 11/30/2023

Melissa Scotti from Law Offices of Andrew J. Costella Jr., Esq. participated virtually for the Applicant

Francis Arevalo from Law Offices of John Trop participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,400.78**, was AMENDED and permitted by the arbitrator at the oral hearing.

The amount claimed was amended to \$700.39 to comport with the New York State Workers' Compensation Board Medical Fee Schedule (WCFS).

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. The parties also stipulated that Respondent's NF-10 denial of claim form was timely issued.

### 3. Summary of Issues in Dispute

This arbitration arises out of shockwave therapy provided to the EIP, a 70-year-old male who was involved in a motor vehicle accident as a driver on 7/19/2022. Applicant is seeking reimbursement for the shockwave therapy provided to the EIP on date of service 9/26/2022. Respondent denied reimbursement for the shockwave therapy based on an Independent Medical Peer Review by Dr. Regina O. Hillsman, MD, dated 11/25/2022.

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

This case was decided on the submissions of the parties as contained in the Electronic Case Folder (ECF) maintained by the American Arbitration Association and the oral arguments of the parties' representatives at the hearing. No witnesses testified at the hearing. I reviewed the documents contained in the ECF for both parties and make my decision in reliance thereon.

#### **MEDICAL NECESSITY**

#### **SHOCKWAVE THERAPY**

#### **DATE OF SERVICE 9/26/2022**

If an insurer asserts that a medical test, treatment, supply or other service was not medically necessary, the burden is on the insurer to prove that assertion with competent evidence such as an independent medical examination, a peer review or other proof that sets forth a factual basis and a medical rationale for denying the claim. (See A.B. Medical Services, PLLC v. Geico Insurance Co., 2 Misc. 3d 26 [App Term, 2nd & 11th Jud. Dists. 2003]; Kings Medical Supply Inc. v. Country Wide Insurance Company, 783 N.Y.S. 2d at 448 & 452; Amaze Medical Supply, Inc. v. Eagle Insurance Company, 2 Misc. 3d 128 [App Term, 2nd & 11th Jud. Dists. 2003]).

To establish lack of medical necessity through a peer review report, the peer reviewer's opinion must set forth a factual basis and medical rationale for the lack of medical necessity defense, including evidence of medical standards. Jacob Nir, M.D. v. Allstate Ins. Co., 7 Misc.3d 544, 546-47 (Civ. Ct. Kings Co. 2005).

A peer review report's medical rationale is insufficient if it is unsupported by or controverted by evidence of generally accepted medical practice. See CityWide Social Work & Psychological Servs. v Travelers Indem. Co., 3 Misc 3d. 608 (Civ Ct, Kings County 2004). The generally accepted practice is considered "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." Id.

When an insurer presents sufficient evidence establishing a lack of medical necessity, the burden then shifts back to the applicant to present its own evidence of medical necessity. See West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc. 3d 131(A) (App. Term 2d & 11th Jud Dists 2006).

Dr. Hillsman, in her peer review report, while noting that shockwave therapy for pain management has been widely established, concluded that that the treatment was not medically necessary because its effects are unknown and further literature is necessary. In her peer review, Dr. Hillsman stated "*As per the standard of care, shockwave therapy is a multidisciplinary device used in orthopedics, physiotherapy, sports medicine, urology, and veterinary medicine. Its main assets are fast pain relief and mobility restoration. Together with being a non-surgical therapy with no need for painkillers makes it an ideal therapy to speed up recovery and cure various indications causing acute or chronic pain. However, the exact efficacy of shockwave therapy is questionable*" and "*while the use of ESWT for pain management has widely been established, further literature should aim to identify alternative benefits, including the role of ESWT in bone healing, and to establish the long-term benefits of ESWT.*"

Dr. Hillsman also stated, "Further, as per the presented medical records, the claimant was receiving conservative treatment in the form of physical

therapy for the right shoulder and lumbar spine. However, there was no evidence that the conservative treatment aggravated the claimant's complaints or failed in pain management. It was not clear why the ESWT was performed without waiting for adequate conservative treatment to act on the pain. The claimant should have continued conservative treatment for the right shoulder and lumbar spine as it is proven to be effective in pain management." However, Dr. Hillsman never states what "adequate" conservative treatment is or for how long such treatment should have been continued before the administration of the shockwave therapy herein.

I find that the peer review of Dr. Hillsman fails to set forth a sufficient factual basis and medical rationale as to why the shockwave therapy treatment was not medically necessary. Dr. Hillsman did not identify a generally accepted standard of care in the professional medical community that was deviated from in performing the shockwave therapy treatment given the EIP's clinical symptomology and treatment history.

"[T]he sine quo non of an expert's testimony is to opine how accepted professional standards apply to the case at hand. . . ." Prime Psychological Services, P.C. v. Progressive Casualty Ins. Co., 2009 N.Y. Slip Op. 51868(U) at 5, 2009 WL 2780152 (Civ. Ct. Richmond Co., Katherine A. Levine, J., Aug. 5, 2009). A peer reviewer does not have to use the talismanic phrase "generally accepted medical standards," *id.*, but he must analyze the medical necessity of the services by that standard, which must be articulated somehow. Unless the peer review writer conveys that generally accepted medical standards were applied, there is no way to know whether his conclusion and the relied-upon authority conform to such standards. I find that Dr. Hillsman's peer review is lacking in this respect, leaving the peer review with an insufficient medical rationale and factual basis. This deficiency denudes Respondent of a prima facie case of lack medical necessity, and Applicant did not have to bear the burden of rebutting the peer review.

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 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 2nd, 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 generally, Bronx Expert Radiology, P.C. v. Travelers Ins. Co., 2006 NY Slip Op 52116 (App. Term 1st Dept. 2006). The Appellate Courts have not clearly defined what satisfies this standard except to the extent that "bald assertions" are insufficient. Amherst Medical Supply, LLC v. A Central Ins. Co., 2013 NY Slip Op 51800(U) (App. Term 1st Dept. 2013). However, there are myriad civil court decisions tackling the issue of what constitutes a "factual basis and medical rationale" sufficient to establish a lack of medical necessity.

The civil courts have held that a defendant's peer review or medical evidence must set forth more than just a basic recitation of the expert's opinion. The trial courts have held that a peer review 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 medical practice as a medical rationale for his findings; and 3) the peer review report fails to provide specifics as to the claim at issue, is conclusory or vague. See generally, Nir v. Allstate, 7 Misc.3d 544 (N.Y. City Civ. Ct. 2005); See also, All Boro Psychological Servs. P.C. v. GEICO, 2012 NY 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.

The Applicant has met its initial burden to establish its entitlement to no fault benefits. The burden then shifts to the Respondent. The Respondent's denial for lack of medical necessity must be supported by a peer review or other competent medical evidence which sets forth a clear factual basis and medical rationale for denying the claim. Healing Hands Chiropractic, P.C. v. National Assurance Co., 5 Misc. 3d 975; Citywide Social Work, et. al v. Travelers Indemnity Co., 3 Misc. 3d 608. The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment, Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co., 2009 NY Slip Op 00351 (App Div. 2d Dept., Jan. 20, 2009); Channel Chiropractic, P.C. v. Country-Wide Ins. Co., 2007 Slip Op 01973, 38 A.D.3d 294 (1st Dept. 2007); Bronx Radiology, P.C. v. New York Cent. Mut. Fire Ins. Co., 2007 NY Slip Op 27427, 17 Misc.3d 97 (App Term 1 Dept., 2007), such as by a qualified expert performing an independent

medical examination, conducting a peer review of the injured person's treatment, or reconstructing the accident. *Id.* To successfully support its denial, the Respondent's peer review must address all of the pertinent objective findings contained in the Applicant's medical submissions. The peer review must set forth how and why the disputed services were inconsistent with generally accepted medical and/or professional practices. The conclusory opinions of the peer reviewer, standing alone and without support of medical authorities, will not be considered sufficient to establish the absence of medical necessity. See Citywide Social Work, et. al. v. Travelers Indemnity Co., supra; Amaze Medical Supply, Inc. v. Eagle Insurance Co., supra. Here, the Respondent has failed to meet its burden of proof to sustain its defense of lack of medical necessity.

Accordingly, in light of the foregoing, after reviewing the totality of the credible and admissible evidence, based on the arguments of counsel, and after thorough review and consideration of all submissions, I find in favor of the Applicant. Consequently, the Applicant's claim is granted in the amended amount of \$700.39 for the shockwave therapy provided for on dates of service 9/26/2022.

This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator. Any further issues raised in the hearing record are held to be moot and/or waived insofar as 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 applicant is AWARDED the following:

A.

Medical		From/To	Claim Amount	Amount Amended	Status
	<b>Hank Ross Medical PC</b>	<b>09/26/22 - 09/26/22</b>	<b>\$1,400.78</b>	<b>\$700.39</b>	<b>Awarded: \$700.39</b>
<b>Total</b>			<b>\$1,400.78</b>		<b>Awarded: \$700.39</b>

B. The insurer shall also compute and pay the applicant interest set forth below. 03/02/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest runs from the filing date for this case 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

After calculating the sum total of the first-party benefits awarded in this arbitration plus interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20 percent of that sum total, as provided for in 11 NYCRR 65-4.6(d), subject to a maximum fee of \$1,360.00.

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

11/30/2023  
(Dated)

Deepak Sohi

### **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:**  
b42013a76ad2fd30f6c0912254895cc8

**Electronically Signed**

Your name: Deepak Sohi  
Signed on: 11/30/2023