

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

BL Pain Management PLLC
(Applicant)

- and -

Geico Insurance Company
(Respondent)

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|--------------------------|------------------|
| AAA Case No. | 17-23-1309-1367 |
| Applicant's File No. | 164303 |
| Insurer's Claim File No. | 0671433570000007 |
| NAIC No. | 35882 |

ARBITRATION AWARD

I, Gregory Watford, 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 (IS)

1. Hearing(s) held on 11/21/2023
Declared closed by the arbitrator on 11/21/2023

Emilia Rutigliano from Law Office of Emilia I. Rutigliano, P.C. participated virtually for the **Applicant**

Danielle Axelrad from Geico Insurance Company participated virtually for the **Respondent**

2. The amount claimed in the Arbitration Request, **\$700.39**, 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

The dispute arises from the underlying automobile accident of June 22, 2021, in which the Assignor, then a 57-year-old female was a driver. As a result of the impact, she complained of multiple injuries including injuries to her back. Thereafter, Assignor sought private medical care where she was recommended to begin conservative care treatments.

On July 2, 2021, Assignor received Extracorporeal Shock Wave Treatments (ESWT). In dispute in this case are the fees for the ESWT services (\$700.39) provided to Assignor.

Applicant timely submitted the bill to Respondent for payment. Respondent denied payment for the ESWT based upon the peer review of Dr. Jason Cohen, dated 8/27/2021.

At the hearing, when asked, Respondent did not raise any fee schedule objections to the amounts billed by Applicant.

The issues that are to be decided in this case are:

Whether Applicant established entitlement to No-Fault compensation for ESWT services provided to Assignor.

Whether Respondent made out a prima facie case of lack of medical necessity and, if so, whether Applicant rebutted it.

4. Findings, Conclusions, and Basis Therefor

I have reviewed the submissions and documents contained in the American Arbitration Association's ADR Center Electronic Case File (ECF). These submissions constitute the record in this case. This case was decided on the submissions of the parties as contained in the ECF and the oral arguments of the parties' representatives. There were no witnesses.

Pursuant to Insurance Law § 5106(a) and the Insurance regulations, an insurer must either pay or deny a claim for motor vehicle no-fault benefits, in whole or in part, within 30 days after an applicant's proof of claim is received (*see* Insurance Law § 5106[a]; 11 NYCRR 65-3.8[c]; *see also* 11 NYCRR 65-3.5). Infinity Health Products, Ltd. v. Eveready Ins. Co., 67 A.D.3d 862, 864, 890 N.Y.S.2d 545, 547 (2d Dept. 2009). A claimant's prima facie proof of claim for no-fault benefits must demonstrate that the prescribed claim forms were mailed to and received by the insurer and are overdue. Viviane Etienne Medical Care, P.C. v. Country-Wide Ins. Co., 25 N.Y.3d 498, 506, 14 N.Y.S.3d 283, 290 (2015). Applicant's proof is also in Respondent's denials, which acknowledged receipt of the bills.

After reviewing the record and evidence presented, I find that Applicant established a prima facie case of entitlement to reimbursement of its claim. Viviane Etienne Med Care, PC v. Countrywide Ins. Co., *Id.* Once an applicant establishes a prima facie case, the burden then shifts to the insurer to prove its defense. *See Citywide Social Work & Psych. Serv. P.L.L.C v. Travelers Indemnity Co.*, 3 Misc. 3d 608, 2004, NY Slip Op 24034 (Civ. Ct., Kings County 2004).

Policy Exhaustion

In its submission, Respondent uploaded documents that were consistent with a policy exhaustion defense. Respondent uploaded the Declarations page indicating that the policy limit is \$50,000.00. Respondent uploaded the payment ledger which indicated that \$49,553.68 has been paid as of the date of the hearing. Accordingly, there is a balance of \$446.32 remaining on the policy.

It should be noted that the First Department recently confirmed that once the no-fault policy has been exhausted, it is beyond the arbitrator's authority to issue an award that exceeds the policy limits. Matter Of DTR Country-Wide Ins. Co. V. Refill Rx Pharmacy, Inc., 2023 NY Slip Op 179 (NY: Appellate Div., 1st Dept. 2023)(Court held lower arbitrator exceeded his power by issuing an award exceeding the contractual limit for the subject no-fault coverage policy of \$50,000, and the Master Arbitrator erred in affirming.)

Therefore, any award in favor of Applicant will be limited to \$446.32.

Medical Necessity - Peer Review

A presumption of medical necessity attaches to a timely submitted no fault claim. Elmont Open MRI & Diagnostic Radiology, P.C. v. State Farm Ins. Co., 26 Misc.3d 1211(A), 906 N.Y.S.2d 779 (Table), 2010 N.Y. Slip Op. 50053(U) at 3, 2010 WL 157564 (Dist. Ct. Nassau Co., Fred J. Hirsh, J., Jan. 6, 2010). If an insurer asserts that the medical test, treatment, supply or other service was medically unnecessary, 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 [N.Y. 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 [N.Y. App. Term, 2nd and 11th Jud Dists 2003]).

The purpose of a peer review is to determine whether the service/test provided was medically necessary. The peer reviewer discusses the standard of care in the medical community and offers his/her opinion as to why the service/test at issue falls outside of that standard of care. The peer reviewer buttresses his/her opinion with authoritative texts, treatises, and articles, generally from peer-reviewed publications.

The 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, Jacob Nir, M.D. v. Allstate Insurance Co., 7 Misc. 3d 544 (N.Y. City Civ. Ct. 2005).

A determination of medical necessity must be based on evidence in existence prior to the rendering of the service. Foster Diagnostic Imaging, PC v General Assur Co., 10 Misc. 3d 428 (Civ. Ct. Kings Cty 2005).

Dr. Cohen drafted a peer review regarding the medical necessity for the EWST. He reviewed Assignor's medical records including evaluation reports, progress notes and diagnostic test results. He then summarized the accident and outlined the treatment of Assignor. He noted that after Assignor's records indicated the clinical impression was other cervical disc displacement, unspecified cervical region; cervicalgia; other intervertebral disc displacement, lumbar region; other intervertebral disc displacement, lumbosacral region; radiculopathy, lumbar region; muscle spasm.

Addressing the ESWT, he cited to literature which stated ESWT is indicated in chronic tendinopathies in which conventional conservative treatment is considered unsatisfactory after a prolonged and comprehensive management or as an alternative to surgery in patients with nonunion. ESWT is a noninvasive alternative in select cases when the indication for surgical treatment arises.

Dr. Cohen opined:

"Based on the medical records presented for review, I believe the extracorporeal shockwave therapy performed on July 2, 2021, may deviate from the standard protocol utilized in that there is no documentation of failure of conservative care by Boleslav Kosharsky, M.D. There is no evidence of chronic tendinopathies as a result of the motor vehicle accident of June 22, 2021. ESWT has not been indicated as an efficacious modality for pain management. ESWT is not recognized as an accepted treatment modality for other cervical disc displacement, unspecified cervical region; cervicalgia; other intervertebral disc displacement, lumbar region; other intervertebral disc displacement, lumbosacral region; radiculopathy, lumbar region; muscle spasm in the Pain Management and greater medical community. Therefore, based upon the medical records presented for review, the extracorporeal shockwave therapy performed on July 2, 2021, CPT code 0101T was not medically necessary."

He cited to medical literature to support his arguments.

I find that the peer review of Dr. Cohen has set forth a sufficient factual basis and medical rationale for her opinion that the disputed services were not medically necessary and therefore has established, prima facie, a lack of medical necessity for those services rendered by applicant.

In A.B Med Servs., P.L.L.C. v. State Farm Mutual Auto Ins. Co., 7 Misc. 3d 822, 795 N.Y.S 2d 843 (N.Y. App Term, 2nd Dept - 2005) citing Baumann v. Long Is. R.R., 110 A.D.2d 739, 741 487 N.Y.S.2d 833 (N.Y. App Div., 2nd Dept - 1985) the Court held that a plaintiff continues to bear the "burden of persuasion" and, if the carrier has satisfied the burden of coming forward, a "plaintiff must rebut it or succumb". Also see Canarsie Family Med Practice, PLLC v. American Tr. Ins. Co., 26 Misc. 3d 132(A),

2010 NY Slip Op 50070(U) (N.Y. App Term, 2nd Dept - 2010); Crotona Hgts. Med., P.C. v. Geico Ins. Co., 25 Misc. 3d 142(A), 2009 NY Slip Op 52466(U) (N.Y. App Term, 2nd Dept - 2009).

In order for an applicant to prove that the disputed expenses were medically necessary, it must meaningfully refer to, or rebut, the conclusions set forth in the peer review. Ortho-Med Surgical Supply, Inc. v. Progressive Cas. Ins. Co., 2012 NY Slip Op 50149(U) (App Term 2d, 11th & 13th Jud Dists Jan. 24, 2012. High Quality Medical, P.C. v. Mercury Ins. Co., 2010 N.Y. Slip Op. 50447(U) (App Term 2d, 11th & 13th Dists. Mar. 10, 2010).

Preclusion of late documents

Applicant's counsel sought to have the rebuttal of Dr. Boleslav Kosharskyy, dated 10/16/23, considered by this arbitrator which was uploaded into the ECF on 10/27/23.

11 NYCRR-65-4 (b) (3) as adopted in the first Amendment to Regulation 68D, governs all matters filed after March 1, 2002. Accordingly, the written record shall be closed during the case conciliation process, upon the respondent's submission or the expiration of the period for receipt of respondent's submission. Documents submitted by either party after the record is closed shall be marked "LATE." Any additional written submissions may be made only at the request or with the approval of the arbitrator.

11 NYCRR § 65-4.5(o)(1) provides that an arbitrator shall be the judge of the relevance and materiality of the evidence offered, and strict conformity to the legal rules of evidence shall not be necessary. An arbitrator acts within his discretion in refusing to entertain late submissions. (*see* 11 NYCRR 65-4.2 [b] [3]); Matter of Mercury Casualty Co. v. Healthmakers Medical Group, P.C., 67 A.D.3d 1017, 888 N.Y.S. 762 (N.Y. App. Div. 2nd Dept. 2009).

I do not strictly adhere to the "rocket docket" rule and require that the parties perfect their arguments and submissions at least thirty (30) days prior to the hearing date. In this case, the late document was uploaded on 10/27/23 for the hearing scheduled for 11/21/23. Applicant's counsel did not present any extraordinary circumstances to explain the late submission in response to the peer review which uploaded on 8/25/23. There must be finality to the submission of documents. As such, this late submission is precluded.

Comparing the evidence and arguments submitted by the parties, I am persuaded by the evidence and arguments of Respondent that the ESWT in dispute was not medically necessary. Based upon the peer review, I was not persuaded that Assignor presented with injuries that justified the services in dispute.

I find that the assertions of a peer reviewer setting forth a factual basis and medical rationale for his determination that there was a lack of medical necessity for the ESWT were not rebutted by the Applicant. AJS Chiropractor, P.C. v. Travelers Ins. Co., 25 Misc.3d 140(A), 906 N.Y.S.2d 770 (Table), 2009 N.Y. Slip Op. 52446(U), 2009 WL

4639680 (App. Term 2d, 11th & 13th Dists. Dec. 1, 2009). Applicant's counsel made several arguments regarding the sufficiency of peer review. Counsel's arguments may have been more persuasive if supported by a timely submitted rebuttal or other expert evidence.

Based upon the forgoing, I find that Applicant has not sufficiently rebutted Respondent's proof by a preponderance of the credible evidence.

Consequently, Applicant's claim is denied.

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, without merit, 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 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 Westchester

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

12/21/2023
(Dated)

Gregory Watford

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:
1d550539b7d3ce8f9a1434bfdb3288fb

Electronically Signed

Your name: Gregory Watford
Signed on: 12/21/2023