

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

RES Physical Medicine & Rehab Services  
(Applicant)

- and -

Travelers Personal Insurance Company  
(Respondent)

AAA Case No. 17-23-1302-7237

Applicant's File No. 23-46359

Insurer's Claim File No. 263 PP ITF9931  
002

NAIC No. 38130

### ARBITRATION AWARD

I, Hersh Jakubowitz, 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 12/20/2023  
Declared closed by the arbitrator on 12/20/2023

Dan Morris from The Morris Law Firm, P.C. participated virtually for the Applicant

Omar Mosqueda from Law Offices of Tina Newsome-Lee participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,949.33**, was AMENDED and permitted by the arbitrator at the oral hearing.

Claim amount amended to \$1,559.47 to conform to fee schedule.

Stipulations WERE made by the parties regarding the issues to be determined.

The Parties stipulated that Applicant had met its prima facie burden of proof, that Respondent's denials were interposed in a timely fashion and the amended claim amount adheres to the fee schedule.

### 3. Summary of Issues in Dispute

Applicant seeks reimbursement, along with interest and counsel fees, under the No-Fault Regulations, for the costs associated with EIP undergoing extracorporeal shockwave therapy on February 10, 2023, February 17, 2023 and March 1, 2023 in connection with injuries allegedly sustained by EIP in a motor vehicle accident on September 1, 2022. The payment, for the extracorporeal shockwave therapy was denied, following a review of the medical records and Peer Review by Dr. Christopher Burrei, D.O., at Respondent's behest, as not medically necessary. The denials were timely. This decision is based upon the written submissions of counsel for the respective parties contained within the electronic case file maintained by the American Arbitration Association as well as oral argument at the hearing conducted on December 20, 2023.

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

#### **History**

The dispute arises from a motor vehicle accident on September 1, 2022, in which the EIP, a then 84-year-old female was a restrained driver wherein she sustained numerous injuries. The Record reflects that the EIP received emergency services at Binghampton General Hospital emergency room and was released for outpatient care.

The EIP consulted the Applicant with complaints of radiating pain in her neck and back. Examination revealed limited range of motion, tenderness and spasm. EIP underwent extracorporeal shockwave therapy on February 10, 2023, February 17, 2023 and March 1, 2023 and the reimbursement of said medical services is the issue in this matter.

#### **Prima Facie**

The Applicant established its prima facie case by proof that the prescribed statutory billing forms had been received and that payment of no-fault benefits was not forthcoming. (See, New York & Presbyt. Hosp. v. Countrywide Ins. Co., 44 A.D.3d 729 [N.Y. App. Div. 2d Dep't 2007]). Proof of the receipt of the Applicant's billing is implicit, in the timely denials issued by the Respondent.

## **Denials**

The Respondent's denial raised the asserted absence of medical necessity based on the analysis of its designated peer, Dr. Christopher Burrei, DO. The corresponding report dated March 24, 2023, has been submitted in support of the Respondent's position.

In considering the issue presented, I note that as part of its prima facie showing, the Applicant is not required to show that the contents of the statutory no-fault forms themselves are accurate or that the medical services documented therein were actually rendered or necessary. Stated another way, the Applicant is not required to establish the merits of the claim to meet its prima facie burden. (*Viviane Etienne Med. Care, P.C. v Country-Wide Ins. Co.*, 114 A.D.3d 33, 46, *aff'd* 25 NY3d 498)

On the contrary, "[m]edical necessity is presumed upon the timely submission of a no-fault claim (see [All County Open MRI & Diagn. Radiology P.C. v. Travelers Ins. Co.](#), 11 Misc. 3d 131[A], 815 N.Y.S.2d 493, 2006 NY Slip Op 50318[U] [App Term, 9th & 10th Jud Dists 2006]). Thus, ordinarily it falls to the defense to establish that the billed-for services were not medically necessary." (*Park Slope Med. & Surgical Supply, Inc. v. Progressive Ins. Co.*, 34 Misc. 3d 154[A] [N.Y. App. Term 2012] [concurring opinion, Golia, J.]; see, also, *Kings Med. Supply Inc. v. Country-Wide Ins. Co.*, 5 Misc. 3d 767, 771 [N.Y. Civ. Ct. 2004] ["It is by now firmly established that the burden is on the insurer to prove that the medical services or supplies in question were medically unnecessary {citation omitted}."])

The Respondent, to establish the validity of its denial on a prima facie level and put the Applicant to its proof, must, as a minimum, demonstrate both a factual predicate and medical rationale for the asserted absence of medical justification for the specific service provided to the patient, and must premise its contention upon uncontroverted evidence of generally accepted medical standards of care. (See, *Nir v. Allstate Ins. Co.*, 7 Misc. 3d 544, 547 [N.Y. Civ. Ct. 2005])

## **Peer**

Thus, the focus falls squarely on the Burrei report.

Critical of the challenged extracorporeal shockwave therapy, Dr. Burrei citing NO supportive medical literature, and, based on his analysis of the EIP's medical records, opined that the clinical findings and reported symptoms did not rise to a level sufficient to justify the extracorporeal shockwave therapy requested.

As to the extracorporeal shockwave therapy and office visits, Dr. Burrei states "*the extracorporeal shockwave therapy is experimental and investigational and not indicated for myofascial pain. I would note that in addition, the physician has stated that the EIP had only three days of relief of symptoms and returned to baseline. As such, it is clear the EIP had no long-term improvement from this treatment that was being rendered for an extended period of time in addition to routine treatment. As I have noted previously, on review of the literature in rare instances, a trial of extracorporeal shockwave therapy may be provided for refractory patients with severe osteoarthritis of the knee, who cannot undergo surgery as well as some anecdotal evidence in regard to chronic refractory tendinopathies. I would note that neither of these diagnoses was an issue as related to the accident. In addition, the CMS National Coverage Policy does not recommend extracorporeal shockwave therapy for the spine or the extremities. As I have noted, there is no documented response suggesting any functional improvement or long-term pain control with the performance of this service. As such, it is unclear why the practitioner has continued to repeat this type of treatment. The records also failed to document any difficulty tolerating the recommended chiropractic care and conservative regimen that was being rendered to the EIP.*

### **Analysis**

Upon a review of the credible evidence the peer review has failed to meet the burden of production. The peer review does not set forth that Applicant deviated from an established standard of care and does not adhere to the Nir paradigm.

The peer review report has a factual basis but is insufficient because it is conclusory. See Devonshire Surgical Facility, Carnegie Hill Orthopedic Servs., P.C. v. American Tr. Ins. Co., 2011 NY Slip Op 50513(U) (App Term 1st Dept. April 5, 2011). Christopher Burrei DO peer review fails to illustrate a medical rationale for his conclusion that the said medical services were medically unnecessary and he was only conveying his own

opinion. There is not one medical cite that supports his numerous reasonings for the conclusion that the extracorporeal shockwave therapy was not medically necessary. See, James M. Ligouri Physician, P.C. v. State Farm Mut. Auto. Ins. Co., 2007 NY Slip Op 50465(U) (N.Y. Dis. Ct. 2007).

His only cite, CMS National Coverage Policy, has been found not to be applicable to No-Fault, **Tahir v ProgressiveCas.Ins.Co.** 2006 NY Slip Op 26149 [12 Misc 3d 657] "*the court must reject the insurer's contention that the programmatic noncompensability under Medicare bars submission of a claim under the no-fault program. To adopt that argument would require judicial rewriting of New York's no-fault statute to insert a reference to Medicare standards... A health services provider's eligibility for compensation under Medicare is not, standing on its own, a cognizable reason to deny payment of a no-fault claim and this argument is rejected.*"

In addition, the contemporaneous medical records of the EIP indicates that the EIP received pain relief , albeit temporary, from the shockwave treatments.

Based on the foregoing, Respondent has not set forth a cogent medical rationale in support of its lack of medical necessity defense. As such, the burden does not shift to Applicant.

As such, upon a preponderance of the evidence submitted and arguments at the hearing in this matter, I find that Respondent has not sustained its denial.

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>RES Physical Medicine &amp; Rehab Services</b>	<b>02/10/23 - 03/01/23</b>	<b>\$1,949.33</b>	<b>\$1,559.47</b>	<b>Awarded: \$1,559.47</b>
<b>Total</b>			<b>\$1,949.33</b>		<b>Awarded: \$1,559.47</b>

B. The insurer shall also compute and pay the applicant interest set forth below. 06/07/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Based on the submission of a timely denial, interest shall be paid from the above date, until the date that payment is made at a rate of 2% per month.

C. Attorney's Fees

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

As this matter was filed after February 4, 2015, this case is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant an attorney fee, in accordance with newly promulgated 11 NYCRR 65-4(d). 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% of the sum total, subject to no minimum and a maximum 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, Hersh Jakubowitz, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

12/23/2023  
(Dated)

Hersh Jakubowitz

#### **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:**  
1663e3ea0294a388984c509437376ebb

**Electronically Signed**

Your name: Hersh Jakubowitz  
Signed on: 12/23/2023