

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Prolog Supply Inc
(Applicant)

- and -

St. Paul Travelers Insurance Co.
(Respondent)

AAA Case No. 17-24-1339-9156

Applicant's File No. 128334

Insurer's Claim File No. IWN5309

NAIC No. 38130

ARBITRATION AWARD

I, Maureen Callahan, 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 07/23/2024
Declared closed by the arbitrator on 07/23/2024

Naomi Cohen from Ursulova Law Offices P.C. participated virtually for the Applicant

Liz Souza from Law Offices of Tina Newsome-Lee participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$2,076.71**, was AMENDED and permitted by the arbitrator at the oral hearing.

This claim is amended downward. Applicant seeks \$1270.07.

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

The parties stipulated and agreed that (i) Applicant has met its prima facie burden by submitting evidence that payment of no-fault benefits are overdue, and proof of its claim was mailed to and received by Respondent; (ii) Respondent's denial of the subject claim was timely issued

3. Summary of Issues in Dispute

CASE SUMMARY

The accident occurred on 10/16/23. The eligible injured party (EIP) is a 63-year-old male driver, whose vehicle was struck in the rear while stopped at a red light. The day following the accident he was evaluated at the emergency room of South Brooklyn Medical Center with complaints of pain to his head, neck, teeth, left hand, left leg, wrist, and cervical spine. Following the accident, assignor suffered injuries which resulted in her seeking medical treatment. This claim seeks reimbursement for a variety of durable medical equipment provided on 12/18/23 through 1/8/23. The respondent denied the claim based upon a peer review from Dr. Bonnie Cory. The issue is whether or not this equipment was reasonable medically necessary as required by 11 NYCRR 65.1 (d) (1).

4. Findings, Conclusions, and Basis Therefor

The accident occurred on 10/16/23. I have reviewed all of the relevant exhibits contained in the electronic file center maintained by the American Arbitration Association. The hearing was held via ZOOM. This decision is rendered upon consideration of the oral arguments made by the parties at the hearing and upon a review of the evidence contained in the case folder as of the date of this hearing. The Arbitrator, in weighing the evidence, has broad powers and discretion in determining what evidence is relevant and material. The Arbitrator is in the best position to evaluate the evidence and decide on the credibility of the submitted documents." It is well-settled that a health care provider establishes its prima facie entitlement to reimbursement as a matter of law by proof that it submitted a claim, setting forth the fact and the amount of the loss sustained, and that payment of No-Fault benefits was overdue. *Damadian MRI in Canarsie, P.C. a/a/o Tyrone Harley v. General Assurance Co.*, 2006 NY Slip Op 51048U, Supreme Court of NY, App. Term 2d Dept., June 2, 2006; See Insurance Law Section 5106a, *Mary Immaculate Hosp. v. Allstate Ins. Co.*, 5 AD 3d 742, 774 N.Y.S. 2d 564 (2004); *Amaze Med. Supply v. Eagle Ins. Co.*, 2 Misc. 3d 128A, 784 N.Y.S. 2d 918 [2003 NY Slip Op 51701U (App. Term 2d & 11 Jud. th Dists.)]. See also 11 NYCRR Section 65-1.1 *Vista Surgical Supplies, Inc. v. Metropolitan Property and Casualty Ins. Co.*, 2005-1328 KC, 2006 NY Slip Op 51047U, June 2, 2006.

The police report contained in the electronic case folder. It indicates the EIP is a 63-year-old male owner/operator of the 2021 GMC/SUV involved in the accident on Avenue Y in Kings County. The EIP was seen at the emergency room of South Brooklyn Medical Center the day after the accident, and thereafter commenced a course of conservative care. This claim seeks reimbursement for durable medical equipment: pillow, massager, LSO, cushion, water therapy system.

Applicant has submitted the requisite documentation to make a prima facie case of entitlement to payment. It is well settled that an applicant for no fault benefits establishes a prima facie entitlement to payment by proving that it submitted a claim, set forth the fact and the amount of the loss sustained, and that payment of no fault benefits was overdue. (Insurance Law Sec. 5106 (A); *Mary Immaculate Hosp. v. Allstate Ins.*

Co., 5Ad 3d 742; 774 NYS 2d 564; 2004 NY App. Div. Lexus 3597 (2nd Dept.) 2004; Amaze Med. Supply v. Eagle Ins. Co., 2 Misc. 3d 128 A (2003) NY Slip Op. 51701 (App. Term 2d and 11th Jud. Dist.). A facially valid claim is presented where it sets forth the name of the patient, date of the accident, date of service, description of service, and charges for those services. (Vinings Diagnostic P.C. v. Liberty Mutual Ins. Co., 186 Misc. 2d 287; 717 NYS 2d 466 (1st Dis. Ct. Nass. Co.)

No fault benefits are overdue if not paid within 30 calendar days after the insurer receives proof of claim, which shall include verification of all of the relevant information requested pursuant to section 65-3.5. It is well settled that an insurer must pay or deny a claim within thirty days of receiving proof of claim. Insurance Law § 5106 [a]; 11 NYCRR 65-3.8(a). Presbyterian Hosp. in City of N.Y. v Maryland Cas. Co., 90 NY2d 274 (1997). An insurer may extend the thirty-day period through the verification procedures set forth in 11 NYCRR 65-3.5. Failure to comply with or extend the thirty-day period results in the preclusion of most defenses, including medical necessity. Presbyterian Hosp. in City of N.Y. v Maryland Cas. Co.; Vista Surgical Supplies v. State Farm Mut. Ins. Co., 14 Misc. 3d 135(A) (App Term, 2 and 11 Jud. Dists. 2007). The narrow exceptions to the preclusion rule apply and the to lack of coverage and fraud defenses. See Central Gen. Hosp. v Chubb Group of Ins. Cos., 90 NY2d 195(1997); Matter of Metro Med. Diagnostics v Eagle Ins. Co., 293 AD2d 751 (2002).

The claim was concededly timely denied. The basis of the denial was a peer review from Dr. Bonnie Cory of 2/19/24. A peer review report relied upon by an insurer in timely denying a claim is a proper vehicle to assert the defense of lack of medical necessity. S & M Supply, Inc. v. Allstate Ins. Co., 2003 N.Y. Slip Op. 51191(U) (App. Term 2d & 11th Dists. July 9, 2003); Rockaway Boulevard Medical P.C. v. Travelers Property Casualty Corp., 2003 N.Y. Slip Op. 50842(U) (App. Term 2d & 11th Dists. Apr. 1, 2003). A peer reviewer must establish a factual basis and medical rationale for his asserted lack of medical necessity of the health care provider's services. See Amaze Medical Supply Inc. v. Allstate Ins. Co., 12 Misc.3d 142(A), 2006 N.Y. Slip Op. 51412(U) (App. Term 2d & 11th Dists. July 12, 2006); Prime Psychological Services, P.C. v. Progressive Casualty Ins. Co., 24 Misc.3d 1244(A), 2009 N.Y. Slip Op. 51868(U) at 3 (Civ. Ct. Richmond Co., Katherine A. Levine, J., Aug. 5, 2009); A.M. Medical Services, P.C. v. Deerbrook Ins. Co., 18 Misc.3d 1139(A), 2008 N.Y. Slip Op. 50368(U) (Civ. Ct. Kings Co., Sylvia G. Ash, J., Feb. 25, 2008). The insurer bears the burden of proof of proving lack of medical necessity as a defense; the claimant does not have to prove the existence of medical necessity. Fifth Avenue Pain Control Center v Allstate Ins. Co., 196 Misc.2d 801, 803 (Civ Ct. Queens Co. 2013).

Dr. Cory's peer review notes that the EIP was seen at the emergency room the day after the accident. Chiropractic treatment was initiated on 12/7/23, approximately 2 months later. The EIP presented with subjective complaints of neck pain radiating to the left shoulder, left wrist pain, low back pain, and left hip pain. There was reduced ranges of motion in the cervical and lumbar spine, with pain and muscle spasm. On the same day of this initial chiropractic exam, these medical supplies were prescribed. Dr. Cory opined they were prescribed without any medical necessity regarding chiropractic treatment. She opined that the usual standard of practice for posttraumatic soft tissue

injury is conservative Creek treatment, that was prescribed. Prescribing DME for home use when claimant was receiving in office treatment consisting of chiropractic care, is excessive. She addresses each item, and opines that they were not medically necessary. She cites to medical treatise to substantiate her opinions.

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 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 1st 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.* An insurance carrier must, at a minimum, establish a detailed factual basis and a sufficient medical rationale for its asserted lack of medical necessity. *Vladimir Zlatnick, M.D., P.C. v. Travelers Indem. Co.*, 2006 NY Slip Op 50963(U) (App Term 1st Dept., 2006); *Delta Diagnostic Radiology, P.C. v. Progressive Casualty Ins. Co.*, 2008 Slip Op 52450(U), 21 Misc.3d 142(A) (App Term 2d Dept., 2008).

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, *Provedere, 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 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 Ins. Co.*, 7 Misc.3d 544, 547, 796 N.Y.S.2d 857, 860 (Civ. Ct. Kings Co. 2005); See also, *All Boro Psychological Servs. P.C. v. GEICO*, 2012 NY Slip Op 50137(U) (N.Y. City Civ. Ct. 2012). A peer review

report relied upon by an insurer in timely denying a claim is a proper vehicle to assert the defense of lack of medical necessity. *S & M Supply, Inc. v. Allstate Ins. Co.*, 2003 N.Y. Slip Op. 51191(U) (App. Term 2d & 11th Dists. July 9, 2003); *Rockaway Boulevard Medical P.C. v. Travelers Property Casualty Corp.*, 2003 N.Y. Slip Op. 50842(U) (App. Term 2d & 11th Dists. Apr. 1, 2003). A peer reviewer must establish a factual basis and medical rationale for his asserted lack of medical necessity of the health care provider's services. See *Amaze Medical Supply Inc. v. Allstate Ins. Co.*, 12 Misc.3d 142(A), 2006 N.Y. Slip Op. 51412(U) (App. Term 2d & 11th Dists. July 12, 2006); *Prime Psychological Services, P.C. v. Progressive Casualty Ins. Co.*, 24 Misc.3d 1244(A), 2009 N.Y. Slip Op. 51868(U) at 3 (Civ. Ct. Richmond Co., Katherine A. Levine, J., Aug. 5, 2009); *A.M. Medical Services, P.C. v. Deerbrook Ins. Co.*, 18 Misc.3d 1139(A), 2008 N.Y. Slip Op. 50368(U) (Civ. Ct. Kings Co., Sylvia G. Ash, J., Feb. 25, 2008). The insurer bears the burden of proof of proving lack of medical necessity as a defense; the claimant does not have to prove the existence of medical necessity. *Fifth Avenue Pain Control Center v Allstate Ins. Co.*, 196 Misc.2d 801, 803 (Civ Ct. Queens Co. 2013). The respondent meets their burden via the opinions of Dr. Cory, and with her arguments.

Once respondent meets his burden, "plaintiff must rebut it or succumb." *Bedford Park Medical Practice PC v American Transit Ins. Co*, 8 Misc.3d 1025(A), 2005 N.Y. Slip Op. 51282(U) (Civ.Ct. Kings Co. Aug. 12, 2005). The applicant offers no formal rebuttal. She argues against the denial of Dr. Cory, arguing that her opinions are generalized and without any factual basis for relevance. However, I do not find that the applicant's arguments meet their burden in overcoming the opinions of Dr. Cory. Hence, this 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 NY

SS :

County of NY

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

07/25/2024

(Dated)

Maureen Callahan

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:
7194ed7cedd53b00e70741f49a796eb0

Electronically Signed

Your name: Maureen Callahan
Signed on: 07/25/2024