

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Midwood Surgical Supplies Inc
(Applicant)

- and -

Enterprise Rent A Car
(Respondent)

AAA Case No. 17-24-1340-4364

Applicant's File No. n/a

Insurer's Claim File No. 20226500

NAIC No. Self-Insured

ARBITRATION AWARD

I, Bryan Hiller, 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

1. Hearing(s) held on 08/06/2024
Declared closed by the arbitrator on 08/06/2024

Usman Nawaz, Esq. from Law Offices of Hillary Blumenthal LLC (Hoboken)
participated virtually for the Applicant

Charles Fishbaum, Esq. from McCormack, Mattei & Holler participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$697.13**, 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 Applicant is entitled to reimbursement for the fees associated with durable medical equipment, specifically a right shoulder orthosis, delivered to Assignor on January 19, 2024 in connection with injuries sustained in a motor vehicle accident on October 5, 2023 in light of the Respondent's Peer Review done by Dr. Regina Hillsman dated February 14, 2024?

4. Findings, Conclusions, and Basis Therefor

Applicant seeks reimbursement, along with interest and counsel fees, under the No-Fault Regulations, for the costs associated with durable medical equipment, specifically a right shoulder orthosis, delivered to the Assignor on January 19, 2024 following his October 5, 2023 accident. This decision is based upon the written submissions of counsel for the respective parties as well as oral argument at the hearing conducted on August 6, 2024. I have reviewed the documents contained in the Record as of the date of the hearing. At the time of the hearing, Respondent's representative stated that it was no longer pursuing a fee schedule issue, so I deem that defense abandoned.

Assignor, a then 42 year old male restrained driver, was involved in a motor vehicle on October 5, 2023. There were no records related to the Assignor's immediate post-accident care. Due to continued symptomology, Assignor came under the care of multiple conservative treatment providers. When symptoms persisted despite treatment, Assignor was referred to Dr. Robert Drazic for an orthopedic surgery evaluation. As part of the treatment program, Dr. Drazic prescribed the subject durable medical device. The right shoulder orthosis at issue was provided by Applicant Midwood Surgical Supplies Inc on January 19, 2024 and the notes related to the testing are attached to the Record.

Applicant has established its prima facie case with proof that it submitted a proper claim, setting forth the fact and the amount charges for the services rendered and that payment of no-fault benefits was overdue (see Insurance Law Section 5106a; *Mary Immaculate Hosp. v. Allstate Ins. Co.*, 5 AD 3d 742, 774 N.Y.S. 2d 564[2004]). The burden shifts to the insurer to prove that the services were not medically necessary.

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 [App Term 2nd & 11th Jud Dists 2003]).

When an insurer relies upon a peer review report to demonstrate that a particular 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 (see *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)).

In support of their position, Respondent submitted a Peer Review report done by Dr. Regina Hillsman dated February 14, 2024. Dr. Hillsman outlined the course of care as well as the initial evaluation of prescribing physician Dr. Robert Drazic. With respect to the shoulder brace, Dr. Hillsman argued that the Assignor only had soft tissue injuries and the treatment should be focused on physical therapy and mobility of the joint rather than immobilization. Dr. Hillsman argued that the standard of care called for a shoulder orthosis if there is a fracture or for post-operative rehabilitation but that was not the case with the Assignor. As such, Dr. Hillsman concluded that the shoulder orthosis was not medically necessary.

Applicant submitted the rebuttal of Dr. Leonid Shapiro dated July 8, 2024. Dr. Shapiro outlined Dr. Drazic's initial examination findings including neck and lower back pain, decreased ranges of motion and tenderness and spasm in the spine and decreased ranges of motion and tenderness of the AC joint in the right shoulder. Dr.

Shapiro's rebuttal with respect to the right shoulder orthosis indicated that based on the examination findings and MRI results, the Assignor needed to protect from dangerous movement during out of office periods so Assignor gets the most benefit from the in office treatment. Dr. Shapiro cited to medical authority for the efficacy of each device and concluded that they had beneficial effects to this Assignor's pain management and recovery time based on the findings of the initial examination.

Comparing the relevant evidence presented by both parties against each other and the above referenced medical necessity standard, I find the Applicant is entitled to reimbursement for the right shoulder orthosis provided to the Assignor. I find the medical records sufficient to meet the Applicant's burden on the issue of medical necessity. The records rebut the conclusions set forth in the peer review report (see High Quality Medical, P.C. v. Mercury Ins. Co., 26 Misc.3d 145(A), 2010 N.Y. Slip.Op. 50447(U)(Sup. Ct. App. Term 2nd Dept 2010)). Specifically, in this matter, the MRI and records showed significant pathology in the right shoulder indicating instability that would require a brace to prevent dangerous movement that could exacerbate the injury as the Assignor made decision on surgical intervention. As such, Applicant's claim is granted for the right shoulder orthosis in the full claim amount of \$697.13.

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
	Midwood Surgical Supplies Inc	01/19/24 - 01/19/24	\$697.13	Awarded: \$697.13

Total	\$697.13	Awarded: \$697.13
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- B. The insurer shall also compute and pay the applicant interest set forth below. 03/15/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant is awarded interest pursuant to the no-fault regulations. See generally, 11 NYCRR §65-3.9. Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30 day month." 11 NYCRR §65-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. However, the regulations toll the accrual of interest when an applicant "does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations." See, 11 NYCRR 65-3.9(c). The Superintendent and the New York Court of Appeals has interpreted this provision to apply regardless of whether the particular denial at issue was timely. LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 217 (2009).

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 no minimum and a maximum of \$1360.00. However, if the benefits and interest awarded thereon is equal to or less than the Respondent's written offer during the conciliation process, the attorney's fee shall be based upon the provisions of 11 NYCRR 65-4.6 (b).

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

08/07/2024

(Dated)

Bryan Hiller

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:
6420aaf3209f7e1f07fa3d59c62c9f23

Electronically Signed

Your name: Bryan Hiller
Signed on: 08/07/2024