American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

BibiMed, Inc (Applicant)	AAA Case No.	17-23-1285-9424
	Applicant's File No.	RB-57-325864
- and -	Insurer's Claim File No.	04682724601
	NAIC No.	36447
Liberty Mutual Insurance Company (Respondent)		

ARBITRATION AWARD

I, Victor Moritz, 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: IP

1. Hearing(s) held on 07/25/2024
   Declared closed by the arbitrator on 07/25/2024

   Elyse Ulino, Esq. from Baker & Narkolayeva Law P.C. participated virtually for the Applicant

   Justine Vandenberghe from Liberty Mutual Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$1,751.54**, 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 applicant seeks reimbursement for the rental cost of a low-frequency ultrasonic diathermy device (ultrasound) with patches provided to the IP (L.W. 47-year-old female) from November 15 through December 12, 2021, relative to the September 3, 2021, motor vehicle accident. For the period November 15 through November 30, 2021, the denial was based on a defense of lack of medical necessity per the results of a peer review by Dr. Suart Springer dated January 6, 2022. In response, I acknowledge the rebuttal by Dr. Erica David-Park dated June 11, 2024. For services from December 1 through December 12, 2021, the denial was based on the defense that the IP made a material misrepresentation when the policy was purchased. There were no fee schedule issues raised at this hearing. This matter is determined after reviewing the submissions

and presentations of both sides. I have reviewed the documents contained in the electronic case folder as of the closing of the file. The hearing was held on Zoom.

4. Findings, Conclusions, and Basis Therefor

I find for the applicant and award $1000.88 for the use of the ultrasound device from November 15-29, 2021. The claim for the use of this item from December 1-12, 2021, is denied based on the respondent's establishing that the policy was fraudulently procured.

Prior Arbitration

Notwithstanding, for services provided from December 1-12, 2021, the respondent did issue a timely denial based on the defense the insured made material misrepresentations when the policy was procured.

Further, the parties acknowledge that ***Arbitrator Theresa Girolamo, Esq***., in the matters ***BMB Solutions LLC v. LM General Insurance Company, AAA17-22-1255-5368, (March 31, 2023)*** and ***Advanced Recovery Equipment and Supplies LLC v. LM General Insurance Company, AAA17-22-1246-4045, (May 19, 2023***), determined that the IP made a material misrepresentation when obtaining the policy and the defense of fraudulent procurement had been established.

In pertinent part,

In this case, the evidence shows that Respondent's insured L.W. was the operator of a vehicle that she owned on the date of loss of 9/03/2021.

For the license, the address is 207 East 93 Street, Brooklyn. The vehicle however is listed as being registered at 9 Hillside Dr., Wynantskill, NY 12198.

The vehicle is insured under NYS Insurance Code 618 which is for Respondent. Respondent issued a policy of insurance to L.W. effective from 6/28/2021 - 6/28/2022 based upon the representation that her address was in Wynantskill, N.Y. According to L.W's No Fault Application L.W. lists the upstate address as her place of residence.

Upon receipt of Applicant's health claim form, Respondent timely denied same on the following basis: Based on our review of this claim, currently known facts and the terms of the Automobile Policy we have determined that the allegations of the claim do not create a potential of first-party coverage under this policy.

As a result, we will not investigate, settle or otherwise handle this matter on behalf of L.W. Our information indicates that you misrepresented the location of your residence of 9 Hillside Dr. Wyantskill, NY and the location where the insured vehicle would be garaged at 207 E. 93rd St. Apt. 1F, Brooklyn, NY.

Accordingly, Liberty is disclaiming any claims for first party coverage due to material misrepresentation on your policy application. While we have attempted to address all coverage considerations related to this matter, Liberty reserves all rights under applicable law and the policy. This letter should in no way be construed as a waiver or estoppels of any possible coverage defenses afforded by the policy or applicable law.

At the time of the Arbitration Respondent argues that the misrepresentation of the valid residence was material, and that had they known it Respondent would not have issued the policy for the premium charged. In this case Respondent offers an Affidavit of Kyle Ryan, employed by Respondent with the SIU department. In this case Mr. Ryan states that, in pertaint part:

All of the medical billing submitted on behalf of L.W. documented her address as 207 E. 93rd Street, Brooklyn, New York. L.W.'s No-Fault application indicated that she was employed for USPS in Queens, NY. An Accurint (sic) report was run on (the IP) which showed her current address as 207 E. 93rd St., Apt 1F, Brooklyn NY 11212.

On September 23, 2021 a visit was made to the Wynantskill, New York residence for the purpose of conducting a residency check. The residence is a two-story, single-family home with a brown roof, orange siding and yellow and white trim located in a quiet suburban neighborhood. A brown delivery box was located at the front door that was addressed to Tamekea Bevas at the provided address. A male answered the door and advised that he didn't know who L.W. was. He advised that he bought the house about a year ago and didn't know who the prior owner was. A search revealed that 9 Hillside Dr, Wynantskill, NY 12198 is currently owned by Jarret Bevas and Tamekea Bevas.

The affidavit states that L.W. appeared for an EUO and provided her address as "East 93 Street, Brooklyn." L..W. testified that her daughter is Tamekea Bevas, however, I find that this lacks credibility based upon the check on the residence wherein the owner did not know who L.W. is.

Respondent offers a Copy of the L.W's EUO transcript and I as the trier of fact find her testimony lacks credibility.

Respondent also offers an Affidavit from Darren Demmon, an employee of Global Markets Division, Product Management 0 Regulatory Compliance Department of Liberty Mutual Insurance. Mr. Demmon has been employed with Respondent for over 10 years in the underwriting department..

Mr. Demmon states,

The policy address given to us by L.W. was 9 Hillside Drive, Wynantskill, New York. Based on this address, a policy was created and issued to her with a premium of $1,422.00. Upon information and belief, L.W. is an individual residing in the County of Brooklyn, State of New York at 207 E. 93rd Street, Brooklyn, New York.

Upon discovery of L.W's correct address at 207 E. 93rd Street, Brooklyn, New York, a New York policy quoted for the operator and vehicle rated on the current policy had a premium of $3,998.00. 8. Our company would not have written the policy for the Wynantskill, New York address with a premium of only $1,422.00 had we known that the true address was in Brooklyn, New York. A New York policy quoted for the operator and vehicle rated on the current policy with the Brooklyn, New York address would have been approximately $2,576.00 more for the same vehicle at the inception of the policy.

Decision:

Based upon the evidence presented, I find that misrepresentations were made in procuring the policy of insurance. The next question is whether the misrepresentations were "material". Hereto, I find that Respondent has established the basis for the two-prong test, in that "misrepresentations" were made and that they are "material". Thus, having considered the evidence presented and the arguments of the parties, Respondent's denial is upheld, and Applicant's claim is denied.

I acknowledge it is within the arbitrator's authority to determine the preclusive effect of a prior arbitration. Matter of Falzone v. New York Central Mutual Fire Ins. Co., 15 N.Y.3d 530, 914 N.Y.S.2d 67 (2010), aff'g, 64 A.D.3d 1149, 881 N.Y.S.2d 769 (4th Dept. 2009).

When one no-fault arbitrator determines the merits or lack thereof of evidence submitted, these findings should not be disturbed to allow for uniformity in decisions regarding a set of facts for a particular motor vehicle accident.

However, this methodology in deciding cases is one of policy only and will be disregarded when compelling circumstances call for a redetermination of an evidentiary decision.

This principle should only be disregarded when substantially different evidence is raised, when a controlling authority decides on a subsequent contrary view of the law, or when a decision is clearly erroneous and would result in a manifest injustice. None of these circumstances exist here.

Finally, I note that even if this was a case of first impression, I fully agree with Arbitrator Girolamo's assessment and find the respondent has established its defense.

Therefore, the applicant's claim for the rental cost of the device from December 1-12, 2021is denied.

Fraudulent Procurement-Precludable Defense

In Compas Medical, P.C. v. Praetorian Ins. Co.,52 Misc3d 132(A), NY Slip Op 51000(U) (2016), the Court held:

[D]efendant failed to establish that it had timely mailed letters scheduling plaintiff's assignor's examination under oath (see St. Vincent's Hosp. of Richmond v. Government Empls. Ins. Co., 50 AD3d 1123 [2008]); therefore, defendant failed to demonstrate, as a matter of law, that it had tolled its time to deny those claims on the proffered ground of fraudulent procurement of the insurance policy (see Great Health Care Chiropractic, P.C. v. Hanover Ins. Co., 42 Misc.3d 147[A], 2014 N.Y. Slip Op 50359[U] [App Term, 2d Dept, 2d, 11th & 13th Jud Dists 2014]).

See also Great Health Care Chiropractic PC v Hanover Ins. Co., 42 Misc. 3d. 147 (A) [App Term, 2d Dept, 2d, 11th & 13th Jud Dists 2014] where the court held, "With respect to defendant's motion for summary judgment, although defendant contends that, in connection with the issuance of the insurance policy at issue, plaintiff's assignor had misrepresented the state where the insured vehicle was garaged, defendant is precluded from asserting that defense in support of its motion and in opposition to plaintiff's motion as it failed to establish that it had timely denied plaintiff's claim on that ground (citations omitted)."

As such, the defense of material misrepresentation in procuring the insurance policy was not raised in a timely denial and cannot be raised now.

Based on the foregoing, the fraudulent procurement defense is not available for the use of the ultrasound device from November 15-30, 2021.

Medical Necessity

As noted above, a fraudulent procurement defense must be timely issued, and services from November 15-30, 2021, for $1,000.88 were denied on a lack of medical necessity defense, per the results of the peer review from Dr. Springer.

The record reflects the IP was involved in an accident on September 3, 2021 and was evaluated by Dr. Marc Parnes D.O. on September 10, 2021 with complaints of left shoulder pain. Range of motion was restricted and the impression includes left shoulder sprain and pain medication was prescribed. The IP also began conservative treatment which included acupuncture and physical therapy.

An MRI of the left shoulder from October 7, 2021 revealed a partial tear and tendinosis of the supraspinatus tendon with some fluid/synovitis of the subacromial subdeltoid bursa. The acromioclavicular joint had mild hypertrophic changes with a mild degree of subacromial impingement.

Dr. Parnes's re-evaluations on October 11 and 19, 2021, revealed similar findings. On October 11, 2021, an ultrasound of the left shoulder revealed edema.

On October 28, 2021, Dr. Jonathan Simahee evaluated the IP for left shoulder pain. The evaluation revealed tenderness over the acromioclavicular joint. Range of motion was

decreased, and multiple orthopedic tests, including Neer's and Hawkins, were positive. The impression included incomplete rotator cuff tear/rupture, and physical therapy was to continue.

A November 15, 2021 evaluation by Dr. Raz Winiarsky revealed continued left shoulder pain. Medical findings by Dr. Winiarsky were similar to those of Dr. Simahaee. A left shoulder arthroscopy was advised. Also, Dr. Winiarsky prescribed the ultrasound therapy system discussed above.

Peer Review

The item was denied based on the peer review results from Dr. Springer, who noted the medical findings and indicated that the standard of care to prescribe this item was not met. Specifically, he notes the item is prescribed to fight inflammation, which is essential to the effective repair of tissue. Dr. Springer indicates that studies have shown the anti-inflammatory effect of ultrasound has not been established and is deemed ineffective citing sources.

In this case, the IP's injuries to the left shoulder meant that prescribing this item was not appropriate as there is no indication of any treatment plan, plan of care, or clinical rationale for its use. The anti-inflammatory effect of ultrasound has failed, indicating that it is an ineffective tool. Under these circumstances, the claim should be denied.

Rebuttal to Peer Review

In response, I acknowledge the rebuttal by Dr. David-Park, noting the medical findings and disagreeing with Dr. Springer's assessment. The rebuttal discussed the continued positive findings for the left shoulder, noting the reduced range of motion, pain, and positive tests with the MRI study revealing the tears of the supraspinatus as well as the fluid buildup of the subacromial subdeltoid bursa and subacromial impingement due to hypertrophic changes of the acromioclavicular joint provided the basis for this item. Dr. David-Park also noted Dr. Winiarsky provided a letter of necessity for using this item so this item would accelerate the healing process, notwithstanding Dr. Springer's contentions. She continues that this ultrasound-type treatment is commonly prescribed for various conditions, including that sustained by the IP of a shoulder/rotator cuff tear, and provides citations to literature indicating that low-intensity therapeutic ultrasound (LITUS) has been deemed an effective treatment for tendon muscle injuries.

I acknowledge the letter of necessity from Dr. Winiarsky does indicate that ultrasound has been clinically shown to elevate recovery and reduction of pain.

Legal Standards for Determining Medical Necessity

It is well settled that an applicant established its prima facie entitlement to payment by proving it submitted a claim set forth the facts and the amount of the loss sustained and that payment of no-fault benefits were overdue (see Insurance Law § 5106[a]; Viviane Etienne Med. Care v Country-Wide Ins. Co., 25 NY3d 498, 501 (2015); Countrywide Ins. Co. v. 563 Grand Medical PC 50 A.D. 3d. 313 (1st Dep't, 2008); Sunshine Imaging

Assoc./WNY MRI v. Geico. Ins. Co., 66 A.D. 3d. 1419 (4th Dep't, 2009). A facially valid claim is presented when it sets forth the name of the patient; date of accident; date of the services; description of services rendered and the charges for those services. See Vinings Spinal Diagnostic PC v. Liberty Mutual Insurance Company, 186 Misc. 2d 287 (1st Dist. Ct. Nass. Co.1996). The applicant has met this burden.

When evaluating the medical necessity of services with proof of each party, particularly the conclusion is contradictory; consideration must be given to the evidentiary burdens. Respondent must prove first that the services were not medically necessary. A peer review report must set forth a factual basis to establish, prima facie the absence of medical necessity.

The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment Kingsborough Jewish Med. Ctr. v. Allstate Ins. Co. 2009 NY Slip Op. 00351 (2d. Dep't, January 20, 2009), See also Channel Chiropractic PC v. Country Wide Ins. Co. 38 AD 3d. 294 (1st Dep't, 2007). An insurance carrier must at a minimum establish a detailed factual basis and a sufficient medical rationale for asserting lack of medical necessity. See Vladmir Zlatnick, M.D. v. Travelers Indem. Co. 2006 NY Slip Op. (50963U) (App. Term 1st Dep't, 2006). See also Delta Diagnostic Radiology PC v. Progressive Casualty Ins. Co. 21 Misc. 3d. (142A) (App. Term 2d. Dep't, 2008). In evaluating the medical necessity of services with proof of each party, particularly the conclusion is contradictory; consideration must be given to the evidentiary burdens. Respondent must prove first that the services were not medically necessary. A peer review report must set forth a factual basis to establish, prima facie the absence of medical necessity.

Conclusions outlined in peer reviews may be insufficient if it fails to provide specifics of the claim, is conclusory or otherwise lacks a basis in the facts of the claim (Amaze Medical Supply v. Allstate Ins). Co. 3 Misc. 3d. 43 (App. Term, 2d Dep't, 2004). A peer review report must set forth a factual basis to establish, prima facie the absence of medical necessity. See Nir v Allstate Ins. Co., 7 Misc. 3d. 544, 547 (Civ. Ct., Kings Co., 2005) which indicates a respondent's peer review defending a denial of first-party benefits on the ground that the billed-for services were not "medically necessary" must at least show that the services were inconsistent with generally accepted medical/professional practice. The opinion of the insurer's expert, standing alone, is insufficient to carry the insurer's burden of proving that the services were not "medically necessary", citing Citywide Social work & Psy. Serv. P.L.L.C. v Travelers Indemnity Co., 3 Misc. 3d. 608, 616 (Civ. Ct., Kings Co. 2004). A peer report must demonstrate that the services rendered were not in agreement with generally accepted medical or professional standards. Generally accepted practice is the range of practice that the profession will follow in diagnosing and treating the patient in light of the standards and values that define it.

Therefore, an opinion offered by a respondent is more likely to establish a lack of medical necessity when it provides some reference to the standards in the applicable

medical community for the services and treatment at issue with an explanation as to when such services and treatment would be medically appropriate with objective criteria and an explanation why it was not medically necessary herein.

I am however not so inclined to preclude the medical opinion offered by an insurer that fails to address the accepted medical/ professional practices. "While an expert affidavit cannot be speculative, there is no threshold requirement in an ordinary case, not involving a novel scientific theory, that a medical opinion regarding deviation be based upon medical literature, studies, or professional group rules in order for it to be considered. It can be based upon personal knowledge acquired through professional experience." Mitroyic y Silverman,2013 NY Slip Op 01465 (1st Dep't 2013), *citing*Diaz vNew York Downtown Hosp.,99 NY2d 542,545 (2002) *and*Limmer v Rosenfeld,92 AD3d 609,609 (1st Dept 2012). The burden returns to Applicant to rebut Respondent's showing. Notwithstanding, I am inclined to view proof that does cite to respected medical authorities with much greater weight than one that does not.

Further, a negative inference will be taken if the items, including medical reports, test results and other sources that are relied upon by the peer are not part of the respondent's submission. Notwithstanding, these facts impact upon the weight given the report but do not provide a basis to preclude the document.

In any event, if the proof of the respondent is found to meet its burden, the proof of the applicant must be considered in opposition to it, mindful that it is likely offered by the provider who actually performed examinations, established treatment and diagnostic plans, made diagnoses and performed medical services.

Application to This Claim

When an insurer interposes a timely denial of claim that sets forth a sufficiently detailed factual basis and adequate medical rationale for the claim's rejection, the presumption of medical necessity and causality attached to the applicant's properly completed claim is rebutted and the burden shifts back to the claimant to refute the peer review and prove the necessity of the disputed services and the causal relationship between the injuries and the accident. See, CPT Med. Servs., P.C. v. New York Cent. Mut. Fire Ins. Co., 18 Misc.3d 87 (App. Term 1st Dept.); Eden Med., P.C. v. Progressive Cas. Ins. Co., 19 Misc.3d 143(A) (App Term 2d & 11th Jud. Dists., 2008). When the provider failed to rebut peer review's showing of a lack of medical necessity, defendant is entitled to dismissal of complaint. Be Well Med. Supply, Inc. v. New York Cent. Mut. Fire Ins. Co ., 18 Misc. 3d. 139 (A) (App. Term 2d Dept., Feb. 21, 2008; A. Khodadadi Radiology, P.C. v. NY Cent. Mut. Fire Ins. Co., 16 Misc. 3d. 131 (A) (App Term 2d. Dept.); West Tremont Med. Diagnostic, P.C. v. Geico Ins. Co., 13 Misc. 3d. 131 (A) (App Term 2d Dept., 2006).

In the instant matter, however, I find for the applicant and award reimbursement for the ultrasound device at issue.

Again, while I acknowledge I find the defense a fraudulent procurement viable, it is uncontested that this must be timely instituted and that the basis of the denial for the use of this item from November 15 through November 30, 2021 were solely on the grounds of medical necessity and that defense must fail.

Dr. Springer questions the efficacy and effectiveness of ultrasound; however, Dr. David-Park's rebuttal and the letter of necessity indicate that at least some studies support its use for accelerating the recovery of patients with various ailments, including injuries to the shoulder. Under these circumstances, the applicant has successfully refuted the respondent's claim that the item was prescribed contrary to accepted medical standards.

Accordingly, the applicant is awarded $1,000.88 for the use of this item from November 15 through November 30, 2021.

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**
	BibiMed, Inc	**11/15/21 - 11/30/21**	**$1,000.88**	**Awarded: $1,000.88**
	BibiMed, Inc	**12/01/21 - 12/12/21**	**$750.66**	**Denied**

Total	**$1,751.54**	**Awarded: $1,000.88**

B. The insurer shall also compute and pay the applicant interest set forth below. 02/08/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

The respondent shall pay interest at a rate of two percent per month, simple on a pro rata basis using a thirty day month. With respect to the claim herein, interest will run from February 8, 2023, the date of the filing of this claim, through payment of the claim.

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's fee, in accordance with promulgated 11 NYCRR 65-4.6(d).

With respect to this claim, the applicant is entitled to attorney's fees for the medical services provided to the IP for which the applicant is awarded the sum of $1000.88.

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 Westchester

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

08/08/2024
(Dated)

Victor Moritz

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:
080d72a8d5b083ef2ee0264ea061f722

Electronically Signed

Your name: Victor Moritz
Signed on: 08/08/2024