

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Modern Remedies LLC
(Applicant)

- and -

Integon National Insurance Company
(Respondent)

AAA Case No. 17-23-1297-8529

Applicant's File No. DK23-337445

Insurer's Claim File No. 9WINY11028

NAIC No. 29742

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 08/14/2024
Declared closed by the arbitrator on 08/14/2024

Henry Guindi from Korsunskiy Legal Group P.C. participated virtually for the Applicant

John Rosillo from Rossillo & Licata LLP participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$4,282.75**, was AMENDED and permitted by the arbitrator at the oral hearing.

The applicant amends the claim downward pursuant to the coder's opinions. They seek \$1528.72 for lidocaine and \$1892.14 for diclofenac. The claim is amended to \$3420.86.

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 11/1/22. The eligible injured party (EIP) is a 33-year-old female driver involved in this accident. It was a front impact accident. There was no loss of consciousness; there was no emergent care. The EIP was seen initially 3 days postaccident on 11/4/22 with complaints of neck pain low back pain and shoulder pain. On 2/3/23 the EIP was provided diclofenac 3% and lidocaine ointment 5%. These 2 medications are the subject of this dispute. The issue is whether or not these medications were reasonable and medically necessary. The respondent denied payment based upon a peer review from Dr. Jay Weiss. Applicant offers a rebuttal from Dr. John McGee. This case is heard in tandem with another involving the same EIP, same accident: AAA#17 - 23 - 1297 - 8521.

4. Findings, Conclusions, and Basis Therefor

The accident occurred on 11/1/22.. 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.

According to 11 NYCRR 65-4.5(o)(1): The arbitrator shall be the judge of the relevance and materiality of the evidence offered, and strict conformity to legal rules of evidence shall not be necessary. The arbitrator may question any witness or party and independently raise any issue that the arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department regulations. 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 records contained in the electronic case folder indicate the injured party to be a 33-year-old female driver of a vehicle that was hit in the front. There was no loss of consciousness, and there was no emergent care. She was seen for an initial evaluation on 11/4/22 with complaints of neck pain, low back pain, and shoulder pain. Lidocaine and

diclofenac were provided on 11/10/22, and are the subject of the companion case. This claim seeks reimbursement for diclofenac 3% and lidocaine ointment 5% provided on 2/3/23.

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).

This bill was received in by respondent on 2/13/23. The claim was timely denied by respondent on 3/9/23 based upon a peer review of Dr. Jay Weiss of 3/7/23. 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). 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). 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).

The peer reviewer Dr. Weiss lists many records he had to review in conjunction with the formulation of his opinion. These include and are not limited to initial chiropractic evaluation of 11th initial report by Dr. McGee of 11/4/22, prescriptions by Dr. McGee lidocaine ointment and diclofenac gel of 11/4/22, initial acupuncture evaluation of 11/22, diagnostic ultrasounds, functional capacity evaluation, functional assessment form, DME order forms, the EMG report, MRI reports, pain management outcome assessment report, physical therapy records. Dr. Weiss notes that when the EIP was seen by Dr. McGee on 11/4/22, he was experiencing back pain radiating to the legs. There were positive findings on physical examination and lidocaine and diclofenac was ordered at that time. When the EIP was seen again by Dr. McGee on 1/13/23, she reported cervical, lumbar, and left shoulder strain. The report states that the pain continued to radiate in a radicular pattern upper and lower extremity. The physical exam reported no abnormalities of strength, sensation, or reflex. The plan called for continued physical therapy, and a cervical traction device was ordered 2 days prior to this exam. Dr. Weiss notes that based upon the records, lumbar epidural injection and trigger point injections were performed on 2/6/23. This peer review addresses DME's, and testing in addition to this medication - - lidocaine 5% and diclofenac 5%. That the EIP P had been provided this medication on 2 prior occasions. Significantly, he notes that diclofenac 3% gel is only indicated and approved for dermatological disorders specifically actinic keratosis, which was not present here nor would it be accident related. Diclofenac 3% is not approved for muscular pain. He opines that it is not necessary here. He cites to medical treatise to substantiate this. With respect to the lidocaine, he notes that there is no postherpeti neuralgia or similar disorder which might necessitate topical lidocaine. He notes that is FDA approved as an anesthetic lubricant for intubation and temporarily relief of pain associated with birds. The use of it for musculoskeletal pain is an off label use and no rationale was given for it in this case. Dr. Weiss opines that these medications were not reasonable or medically necessary.

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). . I find that the respondent has met their burden with this detailed analysis by Dr. Weiss.

If the peer review satisfies these standards, it becomes incumbent on the claimant to rebut the peer review. See *Be Well Medical Supply, Inc. v. New York Cent. Mut. Fire Ins. Co.*, 18 Misc3d 139(A), 2008 N.Y. Slip Op. 50346(U) (App. Term 2d & 11th Dists. Feb. 21, 2008); *A Khodadadi Radiology, P.C. v. NY Central Mutual Fire Ins. Co.*, 16 Misc.3d 131(A), 2007 N.Y. Slip Op. 51342(U) (App. Term 2d & 11th Dists. July 3, 2007), because the ultimate burden of proof on the issue of medical necessity lies with the claimant. *Dayan v. Allstate Ins. Co.*, 49 Misc.3d 151(A), 2015 N.Y. Slip Op. 51751(U) (App. Term 2d, 11th & 13th Dists. Nov. 30, 2015); *Park Slope Medical and Surgical Supply, Inc. v. Travelers Ins. Co.*, 37 Misc.3d 19, 22 n. (App. Term 2d, 11th & 13th Dists. 2012).

Once applicant has established a prima facie case, the burden then shifts to respondent to establish a lack of medical necessity with respect to the benefits sought. See, *Citywide Social Work & Psychological Services, PLLC v. Allstate Ins. Co.*, 8 Misc3d 1025A (2005). A denial premised on lack of medical necessity must be supported by competent evidence such as an IME, peer review or other proof which sets forth a factual basis and medical rationale for denying the claim. See, *Healing Hands Chiropractic, P.C. v. Nationwide Assur. Co.*, 5 Misc3d 975 (2004).

To meet their burden, applicant presents a rebuttal from Dr. John McGee of 7/3/24. Rebuttal that was provided for the linked case, heard in tandem with the instant matter. Dr. McGee summarizes the EIP's medical history. He opines that these 2 medications improve the quality of life and are helpful in the pain management of the EIP. Respondent argues against Dr. McGee's rebuttal, arguing that it is generic and does not correlate any specific findings to this particular injured party.

In evaluating the medical necessity of services with proof of each party, particularly where the conclusion is contradictory; consideration must be given to the evidentiary burdens. Respondent must prove first that the services were not medically necessary. The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment. *Kingsborough Jewish Med. Ctr. v. All State Ins. Co.*, 61 A.D. 3d. 13 (2d. Dep't, 2009), See also *Channel Chiropractic PC v. Country Wide Ins. Co.*, 38 AD 3d. 294 (1st Dep't, 2007). An IME doctor must establish a factual basis and medical rationale for his asserted lack of medical necessity for future health care services. E.g., *Ying Eastern Acupuncture, P.C. v. Global Liberty Insurance*, 20 Misc.3d 144(A), (App. Term 2d & 11th Dists. Sept. 3, 2008). Where the defendant insurer presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden shifts to the plaintiff which must then present its own evidence of medical necessity. *West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co.*, 13 Misc.3d 4(App. Term 2d & 11th Dists. Sept. 29, 2006). For an applicant to prove that

the disputed expense was medically necessary, it must meaningfully refer to, or rebut, respondent's evidence. See, *Yklik, Inc. v. Geico Ins. Co.*, 28 Misc3d 133A (2010). The case law is clear that a provider must rebut the conclusions and determinations of the IME doctor with his own facts. Moreover, the Appellate Term, 2d, 11th & 13th Dists., stated: "Assuming the insurer is successful in satisfying its burden, it is ultimately plaintiff who must prove, by a preponderance of the evidence, that the services or supplies were medically necessary." *Park Slope Medical and Surgical Supply, Inc. v. Travelers Ins. Co.*, 37 Misc.3d 19, 22 (App. Term 2d, 11th & 13th Dists. 2012).

I have listened to the arguments and evaluated the evidence. The applicant makes a prima facie showing of entitlement to payment by submission of the requisite documentation. The burden then becomes respondent's to show otherwise. Respondent meets this burden via the detailed peer review from Dr. Weiss, which addresses each medication and offers opinions as to why they are not necessary. The burden then becomes applicant's to show otherwise. I have not been persuaded by Dr. McGee's rebuttal that the lidocaine and diclofenac were reasonable and medically necessary. Respondent's arguments that the rebuttal does not correlate specifics as to why these medications were necessary for this eip in this scenario are persuasive. I do not find his rebuttal to overcome the opinions of Dr. Weiss. 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.

08/21/2024
(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:

445322e2bbd9cdd6fb8d2689ed118778

Electronically Signed

Your name: Maureen Callahan
Signed on: 08/21/2024