American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Dove Supply Inc. (Applicant)	AAA Case No.	17-23-1321-8768
	Applicant's File No.	166265
- and -	Insurer's Claim File No.	0580341090101015
	NAIC No.	35882
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Anne Malone, 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 09/03/2024
   Declared closed by the arbitrator on 09/03/2024

   Dimitry Joffe, Esq. from The Law Offices of John Gallagher, PLLC participated virtually for the Applicant

   Brittany DePrimo, Esq. from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$1,332.65**, 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 51 year old EIP reported involvement in a motor vehicle accident on July 12, 2023; claimed related injury and received an EMS belt and unit, infrared heat lamp, and whirlpool provided by the applicant on August 24, 2023.

   The applicant submitted a claim for this durable medical equipment (DME), payment of which was timely denied by the respondent based upon a peer review by Gary Yen, M.D. dated October 5, 2023. In response, the applicant submitted a rebuttal dated July 30, 2024 by Kyungsook Bu, F.N.P., the treating and prescribing medical provider.

The respondent also asserted a fee schedule defense.

The issues to be determined at the hearing are:

Whether the respondent established that the DME provided by the applicant was not medically necessary.

Whether the respondent established its fee schedule defense.

4. Findings, Conclusions, and Basis Therefor

This hearing was held on Zoom and the decision is based upon the documents reviewed from the Modria File as well as the arguments made by counsel and/or representative at the arbitration hearing. Only the arguments presented at the hearing are preserved in this decision; all other arguments not presented at the hearing are considered waived.

Medical Necessity

To support a lack of medical necessity defense respondent must "set forth a factual basis and medical rationale for the peer reviewer's [or examining physician's] determination that there was a lack of medical necessity for the services rendered." Provvedere, Inc. v. Republic Western Ins. Co., 2014 NY Slip Op 50219(U) (App. Term2d, 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 Bronx Expert Radiology, P.C. v. Travelers Ins. Co., 2006 NY Slip Op 52116 (App. Term 1st Dept. 2006.)

The Civil Courts have held that a defendant's peer review or report of medical examination must set forth more than just a basic recitation of the expert's opinion. The trial courts have held that a peer review or medical examination 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 specifics as to the claim at issue, is conclusory or vague. See Nir v. Allstate, 7 Misc.3d 544 (N.Y. City Civ. Ct. 2005.)

To support its contention that the durable medical equipment provided by the applicant was not medically necessary, respondent relies upon the peer review by Dr. Yen who reviewed the medical records of the EIP, noted the injuries claimed and the treatment rendered to him. Dr. Yen considered possible arguments and justification for the need for the durable medical equipment at issue and determined that it was not warranted under these circumstances.

Dr. Yen submitted a report in which he discussed each item of equipment provided and his reasons for determining that each one was not medically necessary for this EIP. It was Dr. Yen's opinion that at-home use is not the medical standard of care for the DME provided.

He discussed the general uses and benefits of each item of DME and argued that studies did not support the use of this durable medical equipment at home. However, he did not sufficiently discuss the medical necessity, or lack thereof for each specific item for this particular EIP.

In the section entitled "regarding DME Modalities (Infrared Lamp, Whirlpool)" Dr. Yen states that the medical standard of care allows for clinicians to use passive modalities within the clinical setting at his or her discretion but concludes that the "massager" is not medically necessary. He does not refer to the whirlpool at all.

In the section regarding the EMS Unit, Dr. Yen describes the way that this device works and cites medical citations which states that pilot studies were inconclusive in determining whether this device is effective in increasing muscle strength. He concluded that this device does not meet the medical standard of care for musculoskeletal pain.

I find that the peer review is conclusory and factually insufficient to meet the burden of rebutting the applicant's presumption of medical necessity. The respondent did not provide an adequate response to the recommendations made by the EIP's treating medical providers to establish that the DME at issue was not medically necessary. Under these circumstances, pursuant to Provvedere, Inc., *supra* the burden did not shift to the applicant since respondent did not meet its burden to establish lack of medical necessity.

Although it was not necessary under these circumstances, the applicant submitted a rebuttal by Kyungsook Bu, F.N.P.

Based on the foregoing, the respondent has failed to establish that the durable medical equipment at issue was not medically necessary.

Therefore, an award will be issued in favor of the applicant pursuant to the appropriate fee schedule.

Fee Schedule

In order to prevail in its fee schedule defense, the respondent must demonstrate by competent evidentiary proof that the applicant's claims are in excess of the appropriate fee schedule. If the respondent fails to do so, its defense of noncompliance with the New York Workers' Compensation Medical Fee Schedule cannot be sustained. See Continental Medical, P.C. v Travelers Indemnity Co., 11 Misc. 3d 145A (App. Term 1st Dept. 2006.)

A fee schedule defense does not always require expert proof. There are two fee schedule scenarios. The first involves the basic application of the fee codes and simple arithmetic. The second scenario involves interpretation of the codes and often requires testimony and evidence beyond that of a lay individual. I find that the claim at issue is analogous to the second scenario and requires expert testimony.

The respondent asserted a fee schedule defense for the DME at issue under CPT code E1399 which is not in the DME fee schedule. However, the respondent did not provide any support for a fee schedule defense by submitting an affidavit from a certified professional fee coder, medical professional or other expert.

The respondent argued that Dr. Yen stated that EMS unit is commonly referred to as TENS unit and that the device should have been billed as such. However, I do not consider this sufficient to establish that the EIP was not provided with an EMS unit. The device was generally described in the peer review as NMES.

There was no other issue regarding fee schedule and the respondent did not submit any evidence that the DME at issue was not billed properly.

Under these circumstances, the respondent has not established its fee schedule defense.

Accordingly, the applicant is awarded $1,332.65 in disposition of this claim.

Any further issues submitted in the record are held to be moot and/or waived insofar as they were not raised at the time of this hearing. This decision is in full disposition of all claims for no-fault benefits presently before this Arbitrator.

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**
	Dove Supply Inc.	**08/24/23 - 08/24/23**	**$1,332.65**	**Awarded: $1,332.65**
Total			**$1,332.65**	**Awarded: $1,332.65**

B. The insurer shall also compute and pay the applicant interest set forth below. 10/20/2023 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." See 11 NYCRR §64-3.9(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. Where a claim is untimely denied, or not denied or paid, interest shall accrue as of the 30th day following the date the claim is presented by the claimant to the insurer for payment. Where a claim is timely denied, interest shall accrue as of the date an action is commenced or an arbitration requested, unless an action is commenced or an arbitration requested within 30 days after receipt of the denial, in which event interest shall begin to accrue as of the date the denial is received by the claimant. 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 was timely. LMK Psychological Servs. P.C. v. State Farm Mut. Auto. Ins. Co., 12 NY3d 217 (2009.)

C. Attorney's Fees

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

Applicant is awarded statutory attorney's fees pursuant to the no fault regulations. For cases filed after February 4, 2015 the attorney's fee shall be calculated as follows: 20% of the amount of first-party benefits awarded, plus interest thereon subject to no minimum fee and a maximum of $1,360.00. See 11 NYCRR §65-4.6(d.)

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 CT
SS :
County of Fairfield

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

09/09/2024
(Dated)

Anne Malone

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:
47edb2f0f300a7aa511654c1f2f6b6e6

Electronically Signed

Your name: Anne Malone
Signed on: 09/09/2024