

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Alpine Rx Inc. DBA Crown Pharmacy
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No.	17-24-1337-0668
Applicant's File No.	FDNY24-73267
Insurer's Claim File No.	0356954100101054
NAIC No.	22063

ARBITRATION AWARD

I, Susan Mandiberg, 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: The EIP

1. Hearing(s) held on 09/04/2024
Declared closed by the arbitrator on 09/04/2024

Melissa Pirillo, Esq. from Fass & D'Agostino, P.C. participated virtually for the Applicant

Mark Graziano, Claim Representative from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,832.72**, 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 67-year-old male EIP was a passenger in a vehicle involved in the instant motor vehicle accident on 8/20/23. Presently in dispute is billing for lidocaine ointment which was dispensed to the EIP on 11/7/22. Respondent timely denied reimbursement for this billing pursuant to a peer review generated by Nilesh Vyas 12/11/23, M.D. on 1/4/24. Therefore, the issue to be determined is whether the billing for the lidocaine ointment was medically necessary vis-à-vis the peer review upon which Respondent's denial relies. No Fee Schedule or policy exhaustion issues were raised regarding the instant billing.

4. Findings, Conclusions, and Basis Therefor

This case involves billing for lidocaine ointment dispensed to the EIP on 11/7/22, following motor vehicle accident that took place on 8/20/23. Respondent timely denied reimbursement for this billing pursuant to a peer review generated by Niles Vyas 12/11/23, M.D. on 1/4/24. The case was decided after consideration of the arguments of the parties via Zoom and after a thorough review of the submissions and the documents contained in the electronic case folder maintained by the American Arbitration Association, which are incorporated by reference herein.

11 N.Y.C.R.R. § 65-4.5 (o) (1) provides, in part: "(o) Evidence. (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." Additionally, Master Arbitrator Peter J. Merani, in the case of Sports Medicine & Ortho. Rehab. a/a/o "I.B." v. Country-Wide Ins. Co., AAA Case No. 17-R-991-14272-3, held, in relevant part, that "the Arbitrator below is the trier of facts and must evaluate and weigh the evidence presented at the hearing in arrive at [his/her] decision. 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." Furthermore, it is within the province of an arbitrator to determine what evidence to accept or reject and what inferences should be drawn based on the evidence. See: Mott v. State Farm, 55 NY2d 224 (1982).

It is well-settled that a health care provider establishes its prima facie entitlement to judgment 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, PC a/a/o Tyrone Harley v General Assurance Co., 1006 NY Slip Op. 51048U; Supreme Court of NY, App. Term., 2nd Dept., June 2, 2006; See: Insurance Law §5106 a, Mary Immaculate Hosp. v. Allstate Ins. Co., 5 AD3d 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, 2nd & 11th Jud Dists.)]. See also: 11 NYCRR §65-1.1, Vista Surgical Supplies, Inc. v. Metropolitan Prop. and Cas. Ins. Co., 2005-1328 K C., 2006 NY Slip Op. 51047U, June 2, 2006. Based upon the evidence submitted, I find that Applicant has established its prima facie case.

Lack of Medical Necessity Defense:

The evidence in this case demonstrates that the 67-year-old male EIP was a passenger in a vehicle involved in the instant motor vehicle accident on 8/20/23. Following the accident, the EIP was evaluated emergently at Northwell Hospital, and was discharged later that day. On 9/8/23, the EIP was evaluated by Matthew Jordan, PA. At that time, the EIP complained of pain in the lower back, right wrist, finger, and right shoulder. The examination revealed decreased ranges of motion of the lumbar spine and of the right

shoulder, among other things. The treatment plan consisted of a course of physical therapy and chiropractic care, as well as MRI of the lumbar spine, MIR of the right shoulder, naproxen 220 mg, hot/cold pack, electrical stimulation, and therapeutic massage, respectively. The EIP ultimately underwent MRI testing of the right hand on 10/16/23; of the lumbar spine on 10/18/23, and of the cervical spine on 10/18/23, which revealed multiple objective findings. A right wrist MRI was performed on 10/20/23 and a right shoulder MRI was conducted on 10/23/23. All of the relevant medical reports, treatment notes, test results and documents were carefully reviewed and considered, including a peer review rebuttal generated by Clifton Burt, M.D.

Respondent's timely denial regarding instant medication relied upon the 12/11/23 peer review report of Niles Vyas, M.D., which concluded that the Lidocaine ointment in dispute was not medically necessary. Dr. Vyas stated: "Topical lidocaine can be indicated as a first-line treatment for neuropathic pain due to postherpetic neuralgia or diabetic peripheral neuropathy. For other causes of neuropathic pain, it indicated as a second- or third-line treatment when a diagnosis of neuropathic pain is documented and other first-line tricyclic antidepressant medications have failed." Authority was cited in support of the contention that "There is insufficient evidence to recommend topical lidocaine as a first-line agent in the treatment of PHN (post-herpetic neuralgia) with allodynia. Further research should be undertaken on the efficacy of topical lidocaine for other chronic neuropathic pain disorders, and also to compare different classes of drugs (e.g., topical anesthetics versus anti-epileptics)." Dr. Vyas concluded: "In this case, records indicate the claimant has no complaints of neuropathic symptoms, there is no documented failure or intolerance to first-line oral medications such as prescription strength nonsteroidal anti-inflammatory drugs, tricyclic or SNRI antidepressants, or anticonvulsants. There is insufficient evidence to support the use of topical lidocaine ointment for acute pain since it should generally have failed NSAID, therapeutic exercise, tricyclic antidepressants, and anti-convulsant prior to trying topical lidocaine."

Once an Applicant makes a prima facie case of medical necessity, as I find Applicant has herein, the burden shifts to Respondent who may refute Applicant's prima facie showing with medial evidence that the services provided were not medically necessary. A denial claiming lack of medical necessity must be supported by a peer review, IME report or other competent medical evidence which sets forth a clear factual basis and medical rationale for denying the claim. See: *Healing Hands Chiropractic, P.C. v. National Assurance Co.*, 5 Misc3d 975; *Citywide Social Work, et al. v. Travelers Indem. Co.*, 3 Misc3d 608; *Amaze Medical Supply, Inc. v. Eagle Ins. Co.*, 2 Misc3d 128(A); *Rockaway Boulevard Medical P.C. v. Travelers Prop. Cas. Corp.*, 2003 N.Y. Slip Op. 50842(U), 2003 WL 21049583 (App. Term 2nd & 11th Dists. Apr. 1, 2003). 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.*, 12 Misc3d 128(A), 2006 N.Y. Slip Op. 50963(U) (App. Term 1st Dept. 2006); *Delta Diagnostic Radiology, P.C. v. Progressive Cas. Ins. Co.*, 21 Misc.3d 142(A), 2008 N.Y. Slip Op. 52450(U) (App. Term 2nd, 11th, and 13th Jud. Dists. 2008). A peer review report's factual basis 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. *Devonshire Surgical Facility, Carnegie Hill Orthopedic Services, P.C. v. American Transit Ins. Co.*, 31 Misc.3d 129(A), 2011 N.Y. Slip Op. 50513(U) (App. Term 1st

Dept. 2011); East Coast Acupuncture Services, P.C. v. American Transit Ins. Co., 14 Misc.3d 135(A), 2007 N.Y. Slip Op. 50213(U) (App. Term 1st Dept. 2007).

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. It must be accompanied by evidence of generally accepted medical/professional practice. 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. *Nir v. Allstate*, 7 Misc. 3d 544 (2005). Moreover, 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: *Cambridge Medical, P.C. v. Geico*, 18 Misc.3d 1144(A), 2008 N.Y. Slip Op. 50435(U) (N.Y. Civ. Ct. Richmond Co. 2008); *Williamsbridge Radiology & Open Imaging v. Travelers Indem. Co.*, 14 Misc. 3d 1231 (A), 836 NYS 2d 496. Without evidence of accepted medical practice, a peer reviewer's opinion is simply a different professional judgment which, in and of itself, does not establish that the disputed services were not medically necessary. Even if a peer review is sufficiently factually based, its medical rationale may be inadequate if it fails to demonstrate that the disputed service was inconsistent with generally accepted medical or professional practice. *James M. Ligouri Physician, P.C. v. State Farm Mut. Auto Ins. Co.*, supra; *Nir v. Allstate*, 7 Misc. 3d 544 (2005). "Generally accepted practice is that range of practice that the profession will follow in the diagnosis and treatment of the patient in light of the standards and values that define its calling." *A.B. Medical Services, PLLC v. New York Cent. Mut. Fire Ins. Co.*, 7 Misc.3d 1018(A), 2005 N.Y. Slip Op. 50662(U) (N.Y. Civ. Ct. Kings Co. 2005). Moreover, 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. *Citywide Social Work & Psychological Services, PLLC v. Travelers Indem.*, supra. When there is conflicting medical testimony, an arbitrator should be free to choose which experts it will credit and reject other opinions. *Currie v. Town of Davenport*, 37 NY2d 472, 335 NE2d 323 (NY Court of Appeals, 1975). Moreover, an arbitrator can choose between experts' testimony and reject one opinion. See: *Bilotta v. Chevrolet-Tonawanda Division GMC*, 439 NYS 2d 465, 81 A.D.2d 718 (3rd Dept. 1981).

Based upon the foregoing, and after careful consideration of credible evidence, I find that Applicant's evidence, which includes an unrefuted and detailed peer review rebuttal, is more credible and persuasive than Respondent's peer review regarding the instant medication. Herein, the EIP's treating physician determined that this medication was medically necessary for the EIP's proper care. In contrast, I find that Respondent's peer review has not credibly demonstrated that the prescribing physician deviated from any professional standard of care in prescribing this medication for the EIP. Moreover, although the peer review states that there are studies that are inconclusive regarding medications, this does not, in and of itself, demonstrate a deviation from a recognized standard of care. This was cogently discussed in the peer review rebuttal generated by Dr. Burt. Among other things, he stated, after referencing authoritative sources: "The patient was diagnosed with acute post-traumatic lumbar spine sprain/strain, post-traumatic lumbar/lumbosacral myofascial pain, R/O lumbosacral radiculopathy, R/O lumbar intervertebral disc displacement, pain in the right shoulder, pain in the right

wrist, pain in the right finger. (As acknowledged from the peer review report dated December 11, 2023). Due to the patient's symptoms, this topical medication was prescribed for the relief of pain in these specific areas. Such topical medication was prescribed to avoid systemic exposure, avoid sedation, avoid high serum levels of the drug, and reduce the risk of side effects and drug interactions compared to oral ingestion, the patient could not tolerate an increased dose of or addition of oral medication and the topical medication prescribed will work well with other therapies." The various findings of exam regarding the EIP herein were tied into the analysis presented. Also discussed were the various benefits of topical medications, as opposed to systemic drugs and nonpharmacological approaches. Additionally, although the peer review states that the EIP had no complaints of neuropathic symptoms, the medical records in evidence, including the exam performed at Portal Medical, P.C., undermine this contention, given that the EIP had complaints of tingling pain in the back and radiating, shooting, and tingling pain in the neck, among other things. In fact, the EIP was recommended epidural injections, medial branch block injections and both lumbar and cervical percutaneous discectomy procedures for such conditions, as noted in the 11/8/23 exam report. As a final matter, Dr. Vyas' peer review indicated that he reviewed the EIP's MRI reports, all of which denoted significant objective findings. However, the discussion regarding the use of this medication failed to reference any of these reports and multiple objective findings/conditions.

Conclusion:

Based upon the foregoing, after careful review of the totality of the credible evidence, and for the reasons set forth herein, I find, on balance, that Applicant's uncontested peer review rebuttal, on balance, credibly refutes Respondent's peer review upon which its denial its premised.

Accordingly, this claim is granted.

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
	Alpine Rx Inc. DBA Crown Pharmacy	11/07/23 - 11/07/23	\$1,832.72	Awarded: \$1,832.72
Total			\$1,832.72	Awarded: \$1,832.72

B. The insurer shall also compute and pay the applicant interest set forth below. 02/19/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Respondent shall pay the Applicant interest computed from the above-noted date, at a rate of 2% per month, simple, and ending with the date of payment of the award subject to the provisions of 11 NYCRR §65-3.9(e).

C. Attorney's Fees

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

The insurer shall also pay the Applicant an attorney's fee based upon the amount awarded herein and the interest, as calculated in section "B" above, and in accordance with the relevant Regulations.

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

09/11/2024
(Dated)

Susan Mandiberg

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:
a141ba82d9bacaecb3bd096f0759f5be

Electronically Signed

Your name: Susan Mandiberg
Signed on: 09/11/2024