American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Dove Supply Inc. (Applicant)	AAA Case No.	17-23-1324-8173
	Applicant's File No.	166436
- and -	Insurer's Claim File No.	0266308530101180
	NAIC No.	22063
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Jennifer Jacques-Miller, 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 08/22/2024
   Declared closed by the arbitrator on 08/22/2024

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

   Joseph Costa Cappucci, Esq. from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$1,296.96**, 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 or not Respondent properly denied Applicant's claim for medical services based upon a lack of medical necessity pursuant to a peer review?

   The EIP (JF) is a 58-year-old male, injured as a driver by a motor vehicle accident on 08/02/23. Applicant seeks an amount of $1,296.96 for medical services performed from 08/31/23-09/06/23. Respondent denied Applicant's claim based upon a lack of medical necessity according to the Peer Review of Dr. Michael Tadros, M.D., dated 10/09/23.

4. Findings, Conclusions, and Basis Therefor

I have completely reviewed all timely submitted documents contained in the ADR Center record maintained by the American Arbitration Association and considered all oral arguments. No additional documents were submitted by either party at the hearing. No witnesses testified at the hearing.

Analysis

Applicant has established its prima facie entitlement to reimbursement for no fault benefits as a matter of law based upon the submission of a properly completed claim form setting forth the amount of the loss sustained and that payment is overdue. *Mary Immaculate Hospital v. AllState Insurance Company*, 5 AD 3d 742, (2nd Dept. 2004).

The burden now shifts to Respondent to establish lack of medical necessity with competent medical evidence, which sets forth a clear factual basis (specifics of the claim) and medical rationale for denying the claim. *Citywide Social Work and Psych Services, PLLC v. Allstate*, 8 Misc. 3d 1025A (2005); *Healing Hands Chiropractic v. Nationwide Assurance Co.*, 5 Misc. 3d 975 (2004). Respondent must offer sufficient and credible medical evidence that addresses the standards in the applicable medical community for the services and treatment in issue; explains when such services and treatment would be medically appropriate, preferably with understandable objective criteria; and why it was not medically necessary in the instance at issue.

The insurer must establish a factual basis and medical rational for the services at issue. AJS Chiropractic, PC v. Mercury Ins. Co. 22 Misc. 3d 133 (A), 880 NYS 2d 871 (App. Term 2d & 11th Jud Dist. 2009).

The claim was denied based upon a Peer Review by Dr. Michael Tadros, M.D. Dr. Tadros reviewed sufficient medical records and he noted that the EIP complained of pain in the left shoulder, lower back, and right hip.

Dr. Tadros concluded that the medical records presented for the peer review failed to support the medical necessity of shoulder support custom (left), EMS unit, Whirlpool, EMS belt, and Infrared heat lamp.

With respect to the shoulder orthosis, Dr. Tadros opined that results of this study show that even in young, healthy volunteers immobilization of the shoulder in an orthosis for two (2) days leads to significantly reduced activity levels. Dr. Tadros further opined that a negative influence on general health, especially in older patients who are immobilized for up to six (6) weeks, can potentially occur. Dr. Tadros further opined that medical necessity for orthosis or shoulder immobilization as indicated above is not supported, given the EIP does not have a dislocation or fracture and as such a shoulder orthosis is excessive and not medically necessary and not according to the medical standard of care.

With respect to the EMS Unit, Dr. Tadros opined that electrical muscle stimulation employs electric pulses with different waveforms, repetition rates, and amplitudes that affect muscles of the human musculoskeletal system. Dr. Tadros further opined that the main feature of the electrical muscle stimulation lies in the fact that the number of activated muscle fibers is greater than that in normal muscle contraction. Dr. Tadros

further opined that according to the medical standard of care, this is not recommended for treatment of chronic pain. NMES can be beneficial during hospital rehabilitation for patients who are critically ill, have advanced disease, or post-stroke.

Dr. Tafros concluded that in the absence of red flag findings, four (4) to six (6) weeks of conservative care is safe and appropriate, and imaging is not indicated. Dr. Tadros further opined that studies of physical therapy for acute low back pain are heterogeneous because the intervention method differs: it can include education, exercises, traction, manipulation, or massage, as well as modalities such as heat, ice, and ultrasonography. Dr. Tadros further concluded that in this case, the EIP exceeded guidelines in terms of optimal duration as well as time frame to complete massage therapies, and as such further conservative treatment (in the form of infrared, whirlpool) is not medically necessary, is considered palliative modality, and has not met the medical standards of care.

Respondent established a reasonable factual basis and medical rationale with its expert opinion as to the medical necessity for the disputed treatment. Applicant must now meaningfully refer to or rebut the conclusions set forth in the peer review. *Ykik, Inc. v. Geico Ins Co.*, 2010 NY Slip Op 51336(u) (App Term 2nd, 11th and 13th Jud Dist. 07/22/10). In the absence of such a rebuttal, the claim may be denied.

It is the Applicant's burden, ultimately, to establish the medical necessity of the services at issue. See Insurance Law § 5102; *Shtarkman v. Allstate Insurance Co.*, 2002 NY Slip Op 50568(U), 2002 WL 32001277 (App. Term 9th & 10th Jud. Dists. 2002) (burden of establishing whether a medical test performed by a medical provider was medically necessary is on the latter, not the insurance company).

In support of its position, Applicant submitted contemporaneous medical records consisting of daily prognosis notes from HJ Physical Therapy, P.C., dated 08/09/23 among other treatment notes, which lacked a comprehensive and detailed report regarding the EIP's level of treatment and progressive recovery or lack thereof. The submitted medical records consisted of check marks, circled words, and raw data, which failed to specifically identify this EIP's subjective complaints corroborated by a comprehensive and objective analysis.

Decision
After a review of all of the evidence and careful consideration of oral arguments I find that Applicant was unable to present sufficient evidence to diminish or rebut the contentions of Dr. Tadros. After a review of Dr. Tadros' Peer Review, I find his opinion more persuasive and sufficient to establish that the medical services were not medically necessary. I have reviewed the contemporaneous medical records of the EIP and I find that they do not provide sufficient objective or subjective information regarding the EIP's condition, which would refute Dr. Tadros' conclusion.

Accordingly, the claim is denied in its entirety.

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 Nassau

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

09/17/2024
(Dated)

Jennifer Jacques-Miller

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:
a609160b78970f96246dfdc0dcaee8c8

Electronically Signed

Your name: Jennifer Jacques-Miller
Signed on: 09/17/2024