American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Quality Care RX, Inc. (Applicant)	AAA Case No.	17-23-1302-4359
	Applicant's File No.	801.385
- and -	Insurer's Claim File No.	0493466150001
	NAIC No.	19704
American States Insurance Company (Respondent)		

ARBITRATION AWARD

I, Teresa Girolamo, Esq., 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: C.G.C.

1. Hearing(s) held on 09/23/2024
   Declared closed by the arbitrator on 09/23/2024

   Applicant from Tsirelman Law Firm PLLC participated by written submission for the Applicant

   Respondent from Callinan & Smith LLP participated by written submission for the Respondent

2. The amount claimed in the Arbitration Request, **$1,620.26**, 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 Applicant's bill in the amount of $1,620.26 for medication was medically necessary as same was timely denied by Respondent based upon a peer report of Howard J. Levy, M.D. dated 7/29/2022? Applicant offers a rebuttal by Pervaiz Qureshi, M.D. dated 8/20/2024.

   Whether Respondent is able to establish a policy violation wherein it is claimed that C.C.C. failed to provide requested verification within 120 Days of the initial request?

4. Findings, Conclusions, and Basis Therefor

I have reviewed the documents contained in the Electronic Case Folder as of the date of the hearing. This decision is based on my review of that file.

Arbitration:

THE ARBITRATOR SHALL BE THE JUDGE OF THE RELEVANCE AND THE MATERIALITY OF THE EVIDENCE OFFERED.

11 NYCRR 65-4.5(0)(1) (Regulation 68-D), reads as follows:

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.

Pursuant to Regulation 68 11 NYCRR 65-4.5 (a) entitled, "*Notice*", same reads as follows:

If a dispute has been transmitted for arbitration by the Department of Financial Services or the conciliation center, the parties will be notified by the designation organization, in writing, that the dispute will be resolved by arbitration. At the arbitrator's discretion, if the dispute involved an amount less than $2,000, the parties may be notified that the dispute shall be resolved on the basis of written submissions of the parties. All such submissions shall be received by the designated organization within 30 calendar days of the date of the mailing of the notice. No oral arguments will be permitted, unless the arbitrator determines that additional evidence or testimony is necessary. In order to facilitate receipt of evidence by the designated organization, the partis may forward their submissions prior to receipt of the above notification.

Legal Analysis: Medical Necessity:

I find that the provider made a *prima facie* case, therefore Respondent has the burden to rebut the claim with proof that the health care services were not medically necessary or with some other viable defense (See *Amaze Med. Supply v. Eagle Ins. Co*. 2 Misc. 3rd 128[A] 2003.

I find in this case that Applicant has made out its *prima facie* case Respondent has the burden to rebut the claim with proof that the health care services were not medically necessary or with some other viable defense (See *Amaze Med. Supply v. Eagle Ins*. Co. 2 Misc. 3rd 128[A] 2003.

Once the insurer makes a *prima facie* showing that the amounts charged by a provider were in excess of the fee schedule, the burden shifts to the provider to show that the charges involved a different interpretation of such schedule or an inadvertent miscalculation or error. Cornell Medical, P.C. v. Mercury Casualty Co., 24 Misc.3d 58, 884 N.Y.S.2d 558 (App. Term 2d, 11th & 13th Dists. 2009).

With respect to lack of medical necessity is an affirmative defense that is the Respondent's burden to prove. See, Alliance Medical Office, P.C. v. Allstate, 196 Misc.2d 268, 269, 764 N.Y.S.2d 341, 342 (Civil Ct., Kings Cty. 2003); Choicenet Chiropractic P.C. v. Allstate, 2003 WL 1904296, 2003 N.Y. Slip Op. 50672U (App.Term 2nd Dept. 2003). "At a minimum, [Respondent] must establish a factual basis and medical rationale for the lack of medical necessity of [Applicant's] services. Nir v. Allstate, 7 Misc.3d 544, 546-47, 796 N.Y.S.2d 857, 860 (Civil Court, Kings Cty. 2005). Once the insurer makes a sufficient showing to carry its burden of coming forward with evidence of lack of medical necessity, "plaintiff must rebut it or succumb", Bedford Park Medical Practice P.C. v. American Transit Ins. Co. 8 Misc. 3d 1025 (A) 806 N.Y.S. 2d 443 (Table),

A treatment or service is medically necessary if it is "appropriate, suitable, proper and conducive to the end sought by the professional health service in consultation with the patient. It means more than merely convenient or useful treatment or services, but treatment or services that are reasonable in light of the patient's injury, subjective and objective evidence of the patient's complaints of pain, and the goals of evaluating and treating the patient." Fifth Avenue Pain Control Center v. Allstate, 196 Misc. 2d 801, 807-808 (Civ. Ct. Queens Cty. 2003). Medically necessary treatment or services must be "consistent with the patient's condition, circumstances and best interest of the patient with regard to the type of treatment or services rendered, the amount of treatment or services rendered, and the duration of the treatment or services rendered." Id.

Medical services are compensable where they serve a valid medical purpose. *Sunrise Medical Imaging PC v. Lumbermans Mutual* 2001 N.Y. Slip Op. 4009.

"A peer review report's medical rationale is insufficient if it is unsupported by or controverted by evidence of medical standards." *Id*. Similarly, "[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." *Id.*, *citing, Amaze Medical Supply v. Allstate*, 3 Misc.3d 43, 779 N.Y.S.2d 715 (App Term 2d and 11th Jud Dists 2004).

In order for Respondent to meet its burden of establishing the lack of medical necessity, a peer review should (1) set forth applicable accepted medical standards relevant to the services at issue; and (2) comment on whether the Applicant had followed or deviated from those standards in providing the disputed services. This does not necessarily require that the peer review quote or cite medical literature. The *Nir* decision clearly contemplates that a peer may cite "medical authority, standard, or generally accepted practice as a medical rationale for his findings". *Nir*, 7 Misc.3d at 548.

Only if Respondent can establish a *prima facie* defense does the burden of proof shift to Applicant to rebut the defense. See, *A. Khodadadi Radiology PC v. NY Central Mutual Fire Ins. Co.*, 2007 NY Slip Op 51342(U). In general, Applicant's "rebuttal" need not be in the form of an affidavit or other statement specifically created in response to the peer review; Applicant may rely on the existing medical records and reports already in evidence to counter the peer's arguments.

Legal Analysis: Verification & 120 Day Rule

As a complete proof of claim is a prerequisite to receiving no fault benefits, a claim need not be paid or denied until all demanded verification is provided (see, 11 NYCRR 65- 3.5[c]; *Montefiore Med. Ctr . NY Central Mutual Fire Ins. Co.*, 9 A.D.3d 354, 780 N.Y.S.2d 161 (2nd Dep't 2004); *NY & Presbyterian Hosp. v. American Transit Ins. Co.*, 287 A.D.2d 699, 733 N.Y.S.2d 80 2nd Dep't 2001); *Hosp. for Joint Diseases v. Elrac, Inc.* , 11 A.D.3d 432, 783 N.YS.2d 612 2nd Dep't 2004).

When verification has properly been requested on a claim, a follow up request has been issued and verification has not been received, any action or arbitration to collect that claim is premature. *Metroscan Medical Diagnostics PC v. Progressive C as. Ins. Co.*, 15 Misc.3d 126A, 836 N.Y.S.2d 500, 2007 NY Slip Op 50500U, 2007 N.Y. Misc. LEXIS 903 (App. Tm, 2nd Dep't 2007); *Doshi Diagnostic Imaging Servs. v. State Farm Ins. Co.*, 16 Misc.3d 42, 842 N.Y.S.2d 153, 2007 NY Slip Op 27193, 2007 Misc. LEXIS 3524 (App. Tm, 2nd Dep't 2007); *Elmont Open MRI & Diagnostic Radiology P.C. d/b/a/ All County Open MRI & Diagnostic Radiology v. State Farm Ins. Co.*, 15 Misc.3d 139A, 841 N.Y.S.2d 819, 2007 NY Slip Op 50988U, 2007 N.Y. Misc. LEXIS 3526 (App. Term, 2d Dept 2007).

If a provider, who has failed to respond to verification requests, brings an action, the action should be dismissed as premature. *Elite Chiropractic Services PC v. Travelers Ins. Co.*, 9 Misc.3d 137(A) (App Tm, 1st Dep't 2005).

I note that the New York State Department of Financial Services, issues a 4th Amendment to the 11 N.Y.C.R.R . §65-3. Specifically the following section, 65-3.5 (o) which is effective for all dates of service on or after 4/1/13. Same clearly pertains to the case now before me.

11 N.Y.C.R.R . §65-3 (o) reads as follows:

(o) An applicant from whom verification is requested shall, within 120 calendar days from the date of the initial request for verification, submit all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply. The insurer shall advise the applicant in the verification request that the insurer may deny the claim if the applicant does not provide within 120 calendar days from the date of the initial request either all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply. This subdivision shall not apply to a prescribed form (NF-Form) as set forth in Appendix 13 of this Title, medical examination request, or examination under oath request. This subdivision shall apply, with respect to claims for medical services, to any treatment or service rendered on or after April 1, 2013 and with respect to claims for lost earnings and reasonable and necessary expenses, to any accident occurring on or after April 1, 2013.

Facts:

In this case on **5/3/2022** C.G.C. was involved in a motor vehicle accident. According to the police report C.G.C. was a then 24-year-old male who was the operator of a vehicle that was involved in an accident. According to the NF-2 dated 5/17/2022 C.G.C. lists pain to his left shoulder, neck and back. ER and medical treatment is not listed.

The medical records document that C.G.C. was reported to have been transported by ambulance to Brooklyn Hospital where he was treated and released.

On **5/11/2022** C.G.C. presented for a Physical Therapy Initial evaluation at which time C.G.C. presented with neck, mid back, low back and left shoulder pain. With respect to the left shoulder pain, same was a 6-7/10. Ranges of motion were reduced. There was spasm noted on the left shoulder. The treatment plan was physical therapy 4 times a week for 2-3 weeks.

The PT notes for the left shoulder are dated **5/12/2022, 5/13/2022, 5/16/2022, 5/31/2022 6/2/2022, 6/10/2022, and 6/14/2022** (see page 301-303 /361 of Respondent's supplemental submissions.) This would be 7 PT treatments including the initial evaluation date with William L. King, M.D. dated 6/14/2022. The PT records all document slight improvement.

On **6/14/2022** C.G.C. presented to William L. King, M.D., for an initial evaluation due to pain in his left shoulder. This would be 3 weeks post date of loss. According to the initial report, C.G.C. started treatment 4 days post accident and was treating with physical therapists, for acupuncture and for massage therapy.

At the time of this initial examination, the left shoulder examination documented a positive O'Brien test, there was complaint of tenderness over the acromioclavicular joint and supraspinatus, ranges of motion were reduced.

William King reviewed the MRI of the left shoulder performed on 5/12/2022.

William King, M.D., states that "*based on the severity of the patient's complaints and the nature of the patient's increasing left shoulder pain, and limitations, the lack of improvement with conservative management, the clinical findings of the patient's left shoulder, diagnostic (MRI) findings, and orthopedic evaluation, I feel that surgical procedure of the left shoulder is indicated*."

In the meantime, C.G.C. was to continue with physical therapy 3 times a week for 4 weeks.

There is one more PT note for 6/16/2022 at page 303/371.

On 6/24/2022 C.G.C. underwent a left shoulder arthroscopic procedure.

According to the AR-1 and supporting documentation filed on 6/6/2023, Applicant billed Respondent $1,620.26 for date of service of 6/24/2022. According to the AR-1 and supporting documentation filed on 6/6/2023 the AOB is "blank" as to the date of loss, and in particular according to the NF-3 Applicant billed for the following:

Oxycodone $41.10

Ondansetron $604.50

Stool Softener $0.70

Lidocaine 4% ointment $762.00

Celecoxib $211.96

The bill was received on 7/20/2022 and timely denied on 8/1/2022 based upon a peer review by Howard J. Levy, M.D. dated 7/29/2022.

Peer: Howard J. Levy, M.D. dated 7/29/2022

In looking at the peer report there was a significant number of medical records provided for consideration. However Respondent entire submission is only 18 pages which includes a Global Denial of Benefit dated 11/3/2022. The medical documentation are separated out as a supplemental submission.

In reviewing the medical documentation Howard J. Levy, M.D., noted the date of loss, the ER record of 5/3/2022, the initial chiropractic evaluation and the medical records up to and including the 6/24/2022 report which documents that on said date C.G.C. underwent a left shoulder arthroscopy, "*extensive debridement of the anterior labral tear, rotator cuff tears and chondral lesion of the glenoid, extensive synovectomy, lysis of multiple adhesions, and extensive bursectomy under the left scalene block and general anesthesia by William L. King, M.D. The surgery was*

assisted by David Davydov, RPA-C. As per the operative report, the presence of a physician assistant was needed for the successful completion of all the procedures performed. The pre-operative diagnosis was left shoulder internal derangement. The post-operative diagnoses were left shoulder anterior labral tear, rotator cuff tears, extensive hypertrophic synovitis, multiple adhesions, chondral lesion of the glenoid, and excessive hyperemic bursitis."

Howard J. Levy, M.D., discusses the standard of care for symptomatic shoulder after a motor vehicle accident, which would include a course of conservative treatment up to 3 months. If the claimant was non responsive to different types of therapy, then pain killers and intensive physical therapy could be considered, with surgery possibly under consideration several months later.

In this case Howard J. Levy, M.D. states that the accident was on 5/3/2022, and the surgery was on 6/24/2022 wherein C.G.C. only received 6 sessions of physical therapy for the left shoulder. As such, there was an inadequate course of conservative treatment. As such, with the left shoulder surgery not medically necessity therefore the related and associated services would also not be medically necessary.

With respect to the medications, now at issue, Howard J. Levy, M.D. states:

"*in this case, the claimant was involved in the MVA dated 5/3/2022 and sustained an injury to the left shoulder. On 6/24/2022, the claimant underwent left shoulder arthroscopy which was not medically necessary. Therefore, the post-operative medications of Oxycodone/APAP tablets x 30, Ondansetron 8 mg tablets x 15, Stool Softener tablets x 14, Lidocaine 5% ointment and Celecoxib tablets x 28 were also not medically necessary."*

Global Denial of Benefits:- Non Cooperation

The Global Denial of Benefits dated 11/3/2022 states the duties under the policy and states .."you have failed to provide requested documentation for your proof of claim. You have not cooperated with numerous communication attempts by mail to you and your attorney Pavlounis Sfouggatakis, LLP, in accordance with the policy from which you seek coverage, your claim is denied for non-cooperation.

Respondent offers an EUO transcript of C.G.C. dated 6/28/2022. There was post EUO verification requests dated 7/1/2022 and 8/28/2022. Respondent requested from Pavlounis & Sfouggatakis, LLP, counsel for C.G.C., the following information: I note that copies of the requests were sent to C.G.C. at his PA address as well as his Brooklyn Address:

1. A copy of the lease for the residence at 925 West Center Street, Mahanoy City, Pennsylvania;

2. A copy of all proofs of payment for the past year for the rent to the landlord at 925 West Center Street, Mahanoy City, Pennsylvania;

3. A copy of your client's EZ Pass records for the past 24 months starting in May of 2021;

4. A copy of your client's service records for the 2005 Honda Odyssey Van that was involved in the motor vehicle accident of May 3, 2022;

5. A copy of your client's cellular telephone records from May 1, 2022, through May 31, 2022;

6. That your client execute the attached authorization to allow our office to obtain his Pennsylvania pay by mail toll bills, as well the pay by mail toll bills for New Jersey and New York; and

7. A copy of the photographs and/or videos taken by your client at the scene of the accident regarding his vehicle and the other vehicle involved in the May 3, 2022, accident.

Respondent offers an Affirmation of Michael A. Callinan, counsel for Respondent regarding the EUO and post EUO verification requests.

Decision:

Having carefully considered the arguments herein, I find that Respondent has established a policy violation wherein necessary and requested verification was not provided within 120 days of the original requests.

I also find that Respondent established its affirmative defense of lack of medical necessity. With respect to the rebuttal offered by Applicant I find it unpersuasive.

Applicant's claims herein are 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 CT
SS :
County of Fairfield

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

09/23/2024
(Dated)

Teresa Girolamo, Esq.

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:
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Electronically Signed

Your name: Teresa Girolamo, Esq.
Signed on: 09/23/2024