American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Esco Medical Supply Corp. (Applicant)	AAA Case No.	17-23-1294-0641
	Applicant's File No.	OS-70525
- and -	Insurer's Claim File No.	0251071120101025
	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 11/14/2024
   Declared closed by the arbitrator on 11/14/2024

   Olga Sklyut, Esq. from Law Office of Olga Sklyut P.C. participated virtually for the Applicant

   Chelsea Waller from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$4,073.97**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The amount claimed was amended by the applicant to $4,061.00 to conform to the appropriate fee schedule.

   Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

   The 30 year old EIP reported involvement in a motor vehicle accident on September 27, 2022; claimed related injury and received numerous items of durable medical equipment provided by the applicant from October 28, 2022 to December 16, 2022.

The applicant submitted a claim for durable medical equipment (DME.) Payment of the bill for DME provided on October 28, 2022 ($1,401.33) was timely denied by the respondent based on peer review by Shruti Patel, M.D. dated December 16, 2022. The applicant submitted a rebuttal dated July 4, 2023 by Lubov Klimova, M.D. who was not one of the EIP's treating medical providers.

The bills for three other dates of service, October 28, 2022 ($1,007.04), December 12, 2022 and December 16, 2022 were denied based on the applicant's failure to appear for an examination under oath.

The issues to be determined at the hearing are:

Whether the respondent established that the medical services provided by the applicant on December 28, 2022 were not medically necessary.

Whether the applicant violated a condition precedent to coverage.

Whether respondent's denial based on the applicant's failure to appear for an EUO can be sustained.

4. Findings, Conclusions, and Basis Therefor

This hearing was held on Zoom and the decision is based upon the documents reviewed in 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 medical evidence must set forth more than just a basic recitation of the expert's opinion. The trial courts have held that a peer review 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 medical practice as a medical rationale for his/her findings; and 3) the peer review report fails to provide 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. Patel, who reviewed the medical records of the EIP; noted the injuries claimed and the treatment rendered to him. Dr. Patel considered the 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. Patel submitted a report in which he identified each item of DME at issue, which included LSO, electric heating pad, cervical pillow and collar, bed board, mattress, back cushion and orthopedic car seat. He discussed the standard of care, general uses and benefits of each one. He cited medical literature to support his opinion that the benefits of many of the items are questionable.

Respondent has factually demonstrated that the durable medical equipment at issue was not medically necessary. Accordingly, the burden now shifts to the applicant, who bears the ultimate burden of persuasion, pursuant to Bronx Expert Radiology, P.C., *supra.*

In opposition to the peer review, the applicant presented a rebuttal byDr. Klimova,who disagreed with the conclusions reached by Dr. Patel and described in detail the injuries sustained by the EIP and the treatment rendered to him. He explained the rationale for his determination that each item of durable medical equipment was necessary for this particular EIP based on the medical records submitted.

A review of the applicant's submissions reveals that it has met the burden of persuasion in rebuttal. The medical records and rebuttal submitted in opposition to the findings of Dr. Patel are sufficient to overcome the burden of production established by respondent.

Based on the foregoing, I find that the respondent has failed to establish that the DME at issue was not medically necessary.

Therefore, the applicant is awarded $1,401.33 for the DME provided on October 28, 2022.

No show EUO of applicant

It is the respondent's burden to prove that the bills in question were properly denied. Under 11 NYCRR 65-1.1, which prescribes the No-Fault Mandatory Personal Injury Protection Endorsement which must be included in all owners polices of motor vehicle liability insurance issued in New York, the "Conditions"

section of the endorsement contains a "Proof of Claim" provision which states in pertinent part that "Upon request by the Company, the eligible injured person or that person's assignee or representative shall:(b) as may reasonably be required submit to examinations under oath by any person named by the Company and subscribe the same…"

If the respondent requires an EUO of the applicant it has 15 business days after receipt of proof of claim in which to send correspondence requesting the examination under oath. If the party fails to attend, within 10 calendar days of the no-show the insurer must contact the party from whom the EUO is requested to give the party a second opportunity to attend.

If the party fails to appear at the rescheduled EUO, an insurer may issue a denial of pending claims based upon the failure to meet the condition for coverage in not submitting to the requested EUO, as required under the prescribed endorsement. There is no requirement in the regulation that the denial must state the specific reason(s) why the insurer required the EUO.

The respondent alleges to have attempted to schedule the EUO of the applicant, who failed to appear.

The only submission related to this issue is an affidavit from the attorney who was scheduled to conduct the EUO to establish that no one on behalf of the applicant appeared for any EUO.

Based upon the proof presented, I find that the respondent failed to establish that the applicant violated a condition precedent to coverage.

Therefore, the applicant is awarded $2,659.676 for dates of service October 28, 2022, December 12, 2022 and December 16, 2022.

Accordingly, the applicant is awarded a total of $4,061.00 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	Amount Amended	Status
	Esco Medical Supply Corp.	**10/28/22 - 10/28/22**	**$1,401.33**	**$1,401.33**	**Awarded: $1,401.33**
	Esco Medical Supply Corp.	**10/28/22 - 10/28/22**	**$12.97**		**Withdrawn with prejudice**
	Esco Medical Supply Corp.	**10/28/22 - 10/28/22**	**$1,007.04**	**$1,007.04**	**Awarded: $1,007.04**
	Esco Medical Supply Corp.	**12/12/22 - 12/12/22**	**$502.63**	**$502.63**	**Awarded: $502.63**
	Esco Medical Supply Corp.	**12/16/22 - 12/16/22**	**$1,150.00**	**$1,150.00**	**Awarded: $1,150.00**
Total			**$4,073.97**		**Awarded: $4,061.00**

B. The insurer shall also compute and pay the applicant interest set forth below. 04/05/2023 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.

11/19/2024
(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:
7a0aa903fa61c854d7c98e2c291e8a73

Electronically Signed

Your name: Anne Malone
Signed on: 11/19/2024