American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Orthocare Supplies Inc. (Applicant)	AAA Case No.	17-24-1350-7403
	Applicant's File No.	179801
- and -	Insurer's Claim File No.	9WINV12023-01
	NAIC No.	29742
Integon National 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 01/06/2025
   Declared closed by the arbitrator on 01/06/2025

   Michael Spector , Esq. from The Odierno Law Firm P.C. participated virtually for the Applicant

   Lauren Hirshfeld, Esq. from Law Offices of Eric Fendt participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$1,464.68**, 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 46 year old EIP reported involvement in a motor vehicle accident on December 21, 2022; claimed related injury and received a positioning seat and LSO provided by the applicant on December 14, 2023.

   The applicant submitted a claim for this durable medical equipment (DME), payment of which was timely denied by the respondent based on the IME of the EIP by John Johnson, D.C., L.Ac. which was performed on April 13, 2023. The IME cut-off was effective on May 8, 2023.

The issue to be determined at the hearing is whether the respondent established that the DME provided by the applicant was medically necessary.

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.

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 [IME] 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 [IME] 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 services provided to the EIP were not medically necessary, the respondent relied upon the report of the independent medical examination of the EIP by Dr. Johnson which was objectively negative and unremarkable. Range of motion was determined with the assistance of a goniometer. The report presents a medical rationale in support of respondent's lack of medical necessity defense. Dr. Johnson performed a complete and comprehensive examination of the EIP which did not identify any objective positive findings and determined that his injuries were resolved.

Based upon the physical examination and medical records reviewed, Dr. Johnson determined that despite his subjective complaints, the EIP was not disabled and

that he could perform his activities of daily living without limitations. It was Dr. Johnson 's opinion that there was no medical necessity for further chiropractic treatment, acupuncture, massage therapy, diagnostic testing, durable medical equipment, household help or special transportation.

Respondent has factually demonstrated that the services provided by the applicant were not medically necessary. Accordingly, the burden now shifts to the applicant, who bears the ultimate burden of persuasion. See Bronx Expert Radiology, P.C. v. Travelers Ins. Co., 2006 NY Slip Op 52116 (App. Term 1st Dept. 2006.)

In response to the report of the physical examination of the EIP by Dr. Johnson, the applicant argued that it was insufficient to meet the respondent's burden to establish a lack of medical necessity based on Mount Sinai v Triboro Coach, 263 A.D.2d 11 (2d Dept 1999) in which the court found that an insurer has the burden to establish that the EIP's condition is unrelated to the subject accident and that it was not aggravated or exacerbated by this occurrence.

In this instance, the applicant, who only provided durable medical equipment and did not have access to the EIP's medical records, specifically demanded "that respondent provided all records reviewed by the peer/IME doctor."

Although Dr. Johnson enumerated all records he reviewed, none of the medical records were provided.

Based on the foregoing, the respondent failed to establish its defense of a lack of medical necessity.

Therefore, the applicant is awarded $1,464.68 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**
	Orthocare Supplies Inc.	**12/14/23 - 12/14/23**	**$1,464.68**	**Awarded: $1,464.68**
Total			**$1,464.68**	**Awarded: $1,464.68**

B. The insurer shall also compute and pay the applicant interest set forth below. 06/05/2024 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.

01/11/2025
(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:
fe823c12181aba46ff7e45d51f1fcbf6

Electronically Signed

Your name: Anne Malone
Signed on: 01/11/2025