American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Axion Med Inc. (Applicant)	AAA Case No.	17-24-1350-5656
	Applicant's File No.	BT23-270269
- and -	Insurer's Claim File No.	104490-02
	NAIC No.	24309
Hereford 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 06/02/2025
   Declared closed by the arbitrator on 06/02/2025

   Sabine Sciarotto, Esq. from The Tadchiev Law Firm, P.C. participated virtually for the Applicant

   Cliff Ryan, Esq. from Law Offices of Ruth Nazarian participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$2,325.00**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The amount claimed was amended by the applicant to $2,250.00 to conform to the appropriate fee schedule. Respondent did not agree to this amended amount.

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

3. Summary of Issues in Dispute

   The 45 year old EIP reported involvement in a motor vehicle accident on July 28, 2023; claimed related injury and underwent left shoulder arthroscopic surgery on November 7, 2023 and received a cold compression unit provided by the applicant on November 10, 2023.

The applicant submitted a claim for this durable medical equipment (DME), payment of which was timely denied by the respondent based upon a peer review by Howard Kiernan, M.D. dated May 2, 2024. In response, the applicant submitted a rebuttal dated April 1, 2025 by Ronald Daly, M.D. who was the surgeon who performed the left shoulder arthroscopy.

The respondent also asserted a fee schedule defense.

The issues to be determined at the hearing are:

Whether the respondent established that the left shoulder arthroscopic surgery and related durable medical equipment at issue was not medically necessary.

Whether the respondent established its fee schedule defense.

4. Findings, Conclusions, and Basis Therefor

This hearing was held on Zoom and the decision is based upon the documents reviewed from 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.)

The Civil Courts have held that a defendant's peer review or report of medical examination must set forth more than just a basic recitation of the expert's opinion. The trial courts have held that a peer review or medical examination 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 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 left shoulder surgery and related durable medical equipment provided by the applicant were not medically necessary, respondent relies upon the peer review by Dr. Kiernan, who reviewed the

medical records of the EIP, noted the injuries claimed and the treatment rendered to her. Dr. Kiernan considered possible arguments and justification for the need for the medical services at issue and determined that they were not warranted under the circumstances presented.

Dr. Kiernan submitted a comprehensive report in which he discussed the left shoulder surgery which was performed on November 7, 2023. He noted that the EIP underwent 21 physical therapy treatments prior to the surgery. He determined that this was insufficient conservative care and therefore the surgery was not medically necessary at the time it was provided.

Based on the medical records, and relevant medical citations, it was Dr. Kiernan's opinion that the left shoulder arthroscopy and related DME were not medically necessary for this EIP at the time they were provided.

Respondent has met its evidentiary burden. The peer review adequately sets forth the factual basis and medical rationale to support the conclusion that the medical services at issue were not indicated for this EIP. Therefore, pursuant to Bronx Expert Radiology, *supra* the burden shifts to the applicant, which bears the ultimate burden of persuasion to establish that the services at issue were medically necessary.

In opposition to the peer review, the applicant presented a rebuttal by Dr. Daly, the treating surgeon, who reviewed the EIP's medical records, disagreed with the conclusions reached by Dr. Kiernan and discussed in detail the injuries sustained by the EIP and the treatment rendered to her.

Dr. Daly determined that the EIP had undergone sufficient conservative treatment and that delaying needed surgery could potentially worsen the tear and/or lead to further complications.

He also specifically addressed the need for the cold compression unit and determined that Dr. Kiernan's opinion that "simple ice therapy would suffice" was incorrect.

Dr. Daly supported, with numerous relevant medical citations, his opinion that the medical services at issue were medically necessary.

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

Based on the foregoing, I find that the respondent has failed to establish that the left shoulder arthroscopy and related cold compression unit were not medically necessary.

Therefore, an award will be issued in favor of the applicant pursuant to the applicable fee schedule.

Fee Schedule

The applicant billed a total of $2,325.00 under CPT code E1399 which included $2,250.00 for a cold compression unit and $75.00 for set up. At the hearing, the applicant amended the amount claimed to $2,250.00. The respondent denied payment of this claim based on a lack of medical necessity. I have already determined that the respondent did not establish this defense.

To prevail in its fee schedule defense, the respondent must demonstrate by competent evidentiary proof that the applicant's claims are in excess of the appropriate fee schedule. If the respondent fails to do so, its defense of noncompliance with the New York Workers' Compensation Medical Fee Schedule cannot be sustained. See Continental Medical, P.C. v Travelers Indemnity Co., 11 Misc. 3d 145A (App. Term 1st Dept. 2006.)

An insurer fails to raise a triable issue of fact with respect to a defense that the fees charged were not in conformity with the Workers' Compensation fee schedule when it does not specify the actual reimbursement rates which formed the basis for its determination that the claimant billed in excess of the maximum amount permitted. See St. Vincent Medical Services, P.C. v. GEICO Ins. Co., 29 Misc.3d 141(A), 907 N.Y.S.2d 441 (App. Term 2d, Dec. 8, 2010.)

The respondent asserted a fee schedule defense but did not provide any documentation regarding the correct reimbursement for the DME at issue.

The applicant submitted an invoice which determined that the unit price for the cold compression therapy system at issue is $1,500.00.

The general rule is that in order to prevail in its fee schedule defense, the respondent must demonstrate by competent evidentiary proof that the applicant's claims are in excess of the appropriate fee schedule. If the respondent fails to do so, its defense of noncompliance with the New York Workers' Compensation Medical Fee Schedule cannot be sustained. See Continental Medical, P.C. v Travelers Indemnity Co., 11 Misc. 3d 145A (App. Term 1st Dept. 2006.)

Regarding items of durable medical equipment that are not rentals, 12 NYCRR 442.2(a) provides that if there is no price indicated in the fee schedule, then reimbursement is limited to the lower of:

1. The acquisition cost (by invoice to the provider) plus 50%; or

2. The usual and customary charge to the general public

Based upon the proofs presented, the billing by the applicant of $2,250.00 is the correct reimbursable amount for the cold compression unit at issue.

Under these circumstances, the respondent has failed to establish its fee schedule defense.

Accordingly, the applicant is awarded a total of $2,250.00 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**
	Axion Med Inc.	**11/10/23 - 11/10/23**	**$2,325.00**	**$2,250.00**	**Awarded: $2,250.00**

Total	**$2,325.00**		**Awarded: $2,250.00**

B. The insurer shall also compute and pay the applicant interest set forth below. 06/04/2024 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.

06/27/2025
(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:
a7bd7a77a01fe6ce8ac7f5c8a0c373bc

Electronically Signed

Your name: Anne Malone
Signed on: 06/27/2025