

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Jama 4343 Inc.  
(Applicant)

- and -

Accident Fund Insurance Company of  
America  
(Respondent)

AAA Case No. 17-25-1420-3578  
Applicant's File No. BT25-318609  
Insurer's Claim File No. VGM-BG-25-0296501  
NAIC No. 10166

### **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 05/27/2026  
Declared closed by the arbitrator on 06/14/2026

James DiCarlo, Esq. from The Tadchiev Law Firm, P.C. participated virtually for the Applicant

Kimberly Glock, Esq. from Law Office of Jason Tenenbaum, PC participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,145.75**, 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 40 year old EIP reported involvement a motor vehicle accident on May 9, 2025; claimed related injury and received a transcutaneous electrical joint stimulation device and other miscellaneous durable medical equipment provided by the applicant on June 26, 2025.

The applicant submitted a claim for this durable medical equipment (DME), payment of which was denied by the respondent based upon a peer review by

Howard Kiernan, M.D. dated August 7, 2025. In response, the applicant submitted a rebuttal dated May 29, 2026 by Joseph Gorum, M.D. one of the EIP's treating medical provider.

The applicant objected to the late submission of the peer review by the respondent. I accepted the late submission and allowed the applicant time to submit a rebuttal.

The respondent also asserted a fee schedule defense.

**The issues to be determined at the hearing are:**

**Whether the respondent established that the 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.

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, 11<sup>th</sup> and 13<sup>th</sup> 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 1<sup>st</sup> Dept. 2006.)

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 DME provided by the applicant was not medically necessary, respondent relies upon the report of the peer review by Dr. Kiernan, who reviewed the medical records of the EIP and noted the injuries claimed and the treatment rendered to him. Dr. Kiernan considered possible arguments and justification for the need for the DME at issue and determined that it was not warranted under the circumstances presented.

Dr. Kiernan discussed in detail the trans electric stimulator, massager, infrared heating lamp and whirlpool and the reasons that he determined that each was not medically necessary for this EIP. He specifically noted that the EIP's medical records did not provide evidence that the EIP had failed to respond to conservative treatment and medications. In addition, in his opinion the trans electric stimulator was prescribed prematurely just four weeks post-accident before the EIP completed a full course of conservative therapy.

Dr. Kiernan supported, with relevant medical literature, his opinion that the DME at issue was not medically necessary for this particular EIP at the time it was provided.

Respondent has factually demonstrated that the services at issue were 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 by Dr. Gorum, M.D., who disagreed with the conclusions reached by Dr. Kiernan and discussed in detail the injuries sustained by the EIP and the treatment rendered to him.

Dr. Gorum referred to the specific arguments raised by Dr. Kiernan and provided arguments supported by relevant medical citations to refute his conclusions.

Dr. Gorum supported, with relevant medical literature, his opinion that the DME at issue was medically necessary for this EIP at the time it was provided.

After a review of all of the evidence submitted an issue of fact remains as to whether the services rendered are medically necessary. Conflicting opinions have been presented in the peer review by Dr. Kiernan and the rebuttal by Dr. Gorum submitted on behalf of the applicant.

The rebuttal by Dr. Gorum meaningfully refers to and rebuts the findings of Dr. Kienan. In addition, the medical reports submitted **are sufficient to establish the medical necessity for the services at issue.**

Therefore, I find that the submission of Dr. Gorum was more persuasive in this instance.

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

**Therefore, an award will be submitted in favor of the applicant pursuant to the appropriate fee schedule.**

#### Fee Schedule

The applicant billed a total of \$1,145.75 for the DME payment for which was denied by the respondent based on the peer review by Dr. Kiernan. I have already determined that the respondent did not establish this defense. The only remaining issue is the appropriate fee schedule for the DME at issue.

In order to prevail in a fee schedule defense, the respondent must demonstrate by competent evidentiary proof that applicant's claims were in excess of the appropriate fee schedules, or otherwise respondent's defense of noncompliance with the appropriate fee schedule cannot be sustained. Continental Medical, P.C. v. Travelers Indemnity Co., 11 Misc.3d 145(A) (App. Term 1<sup>st</sup> 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.)

A fee schedule defense does not always require expert proof. There are two fee schedule scenarios. The first involves the basic application of the fee codes and simple arithmetic. The second scenario involves interpretation of the codes and often requires testimony and evidence beyond that of a lay individual. I find that the fee schedule issue presented in this case is analogous to the latter scenario and requires an expert's opinion.

The respondent supported its fee schedule defense, with the affidavit of Dardan Bunjaku, a fee coder and certified compliance and regulatory expert who submitted a comprehensive analysis and determined that the correct total reimbursable amount for the DME at issue is \$1,032.93.

The applicant did not submit the affidavit of a certified professional fee coder, medical professional or other expert to refute the determination of the respondent's expert.

Based on the foregoing, the respondent established its fee schedule defense.

**Accordingly, the applicant is awarded \$1,032.93 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
	Jama 4343 Inc.	06/26/25 - 06/26/25	\$1,145.75	Awarded: \$1,032.93
<b>Total</b>			<b>\$1,145.75</b>	<b>Awarded: \$1,032.93</b>

- B. The insurer shall also compute and pay the applicant interest set forth below. 09/25/2025 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 30<sup>th</sup> 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.

06/26/2026  
(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:**  
cd438e00b32ba21eea4fc4c68362ccf9

**Electronically Signed**

Your name: Anne Malone  
Signed on: 06/26/2026