American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Kuman Medical Supply Inc. (Applicant)	AAA Case No.	17-25-1400-6067
	Applicant's File No.	RB-201-590990
- and -	Insurer's Claim File No.	13G7463
	NAIC No.	Self-Insured
The Travelers Indemnity 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 07/07/2026
   Declared closed by the arbitrator on 07/07/2026

   Alex Samaroo, Esq. from Baker & Narkolayeva Law P.C. participated virtually for the Applicant

   Michael Philippou, Esq. from Marshall Dennehey participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$3,946.34**, 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 55 year old EIP reported involvement a motor vehicle accident on January 17, 2025; claimed related injury and received bead board, cervical collar and pillow, lumbar cushion, LSO, mattress and water circulation heat pad with pump on February 7, 2025, cervical traction unit with pump on February 27, 2025, TENS unit and percussive massager on March 14, 2025 and infrared heat lamp on March 17, 2025.

   The applicant submitted a claim for this durable medical equipment (DME), payment of the DME provided on February 7, 2025 was denied by the respondent based upon a peer review by Isandr Dumesh, M.D. dated March 31,

2025; payment of DME provided on February 27, 2025 and March 14, 2025 was denied based on the peer review dated April 10, 2025 by port by Tal Mednick, M.D. In response to the peer reports, the applicant submitted a rebuttal dated May 19, 2026 by Erica David-Park, M.D. who was not one of the EIP's treating medical providers.

Payment of the DME provided on March 17, 2025 was delayed pending outstanding verification requests. The request was for a manufacturer's invoice for the DME provided on March 17, 2025.

The issues to be determined at the hearing are:

Whether the respondent established that the durable medical equipment provided on February 7, 2025, February 27, 2025 and March 14, 2025 were not medically necessary.

Whether the respondent established that the bill for date of service March 17, 2025 was premature.

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.)

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 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 from February 7, 2025 to March 14, 2025 was not medically necessary, respondent relies upon the reports of the peer reviews by Dr. Dumesh and Dr. Mednick, who reviewed the medical records of the EIP, noted the injuries claimed and the treatment rendered to her. Both Drs. Dumesh and Mednick 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. Dumesh - date of service February 7, 2025

Dr. Dumesh discussed each item of DME provided to the EIP on February 7, 2025 and his reasons for determining that each was not medically necessary for this EIP at the time it was provided.

He 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.

Dr. Mednick - dates of service February 27 2025 and March 14, 2025

Dr. Mednick also discussed the DME provided on February 27, 2025 and March 14, 2025 which included cervical traction unit with pump (2/27) and EMS/TENS unit and percussive massager (3/14/25) and his specific reasons why each of these items were not medically necessary for this EIP at the time they were provided.

He also 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 DME 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 reviews, the applicant presented a rebuttal by Dr. David-Parkwho reviewed the EIP's medical records, disagreed with the conclusions reached by Dr. Dumesh and Dr. Mednick and discussed in detail the injuries sustained by the EIP and the treatment rendered to her. She specifically noted the positive objective tests results documented on January 17, 2025, the date of the subject accident.

Dr. David-Park discussed the general uses and benefits of each item of DME at issue and concluded that there was a medical utility to the use of these devices and that there is no single accepted treatment protocol for treatment of soft tissue

injuries, supported by relevant medical literature and therefore deference should be given to the treating provider.

After a review of all of the evidence submitted an issue of fact remains as to whether the DME provided was medically necessary. Conflicting opinions have been presented in the peer reviews by Dr. Dumesh and Dr. Mednick and the rebuttal by Dr. David-Park who submitted a rebuttal on behalf of the applicant.

In this instance, Dr. David-Park did not submit a rebuttal which meaningfully refers to and rebuts the findings of Drs. Dumesh and Mednick. In addition, the medical reports submitted do not contradict their assertions.

Therefore, I find that the submissions of Dr. Dumesh and Dr. Mednick were more persuasive.

Based on the foregoing, I find that the respondent established that the DME at issue was not medically necessary.

Therefore, the claim for dates of service February 7, 2025, February 27, 2025 and March 14, 2025 are dismissed with prejudice.

Verification requests for services rendered on March 17, 2025

If an insurer requires any additional information to evaluate the proof of claim, such request for verification must be made within 15 business days of the receipt of the bill in order to toll the 30 day period to pay or deny the claim. See 11 NYCRR 65-3.5(b); See also New York Hosp. Med. Ctr. of Queens v. Allstate Ins. Co., 2014 NY Slip Op 00640 (2d Dept. 2014.)

Where there is a timely original request for verification, but no response to the original request for verification is received within 30 days, or the response to the verification request is incomplete, then the insurer, within 10 calendar days after the expiration of that 30 day period, must follow up with a second request for verification. Id.

If there is no response to the second or follow up request for verification, the time in which the insurer must decide whether to pay or deny the claim is indefinitely tolled. Id.

Therefore, when a no-fault medical service provider fails to respond to the requests for verification the claim is premature and should be denied without prejudice.

In the instant matter, the respondent sent timely verification requests to which the applicant did not submit a response.

The verification requested was for the manufacturer's invoice for the DME provided on March 17, 2025, which was billed under CPT code EO205 which is

a valid code that does not have an established fee in the New York Workers' Compensation DME Fee Schedule.

In Island Life Chiropractic, PC v Travelers Ins.Co, 64 Misc. 3d 143(A), 117 N.Y.S.3d 428 (App Term 2d Dept. 2019) the court held that "Where a no-fault insurer is relying on the defense that an action is premature because verification is outstanding, it is the defendant insurer's prima facie burden at trial to demonstrate (1) that verification requests were timely mailed and that the defendant did not receive the requested verification. (See 11 NYCRR 65-3.8[a]; Right Aid Medical Supply Corp. v State Farm Mut. Auto Ins. Co., 58 Misc. 3d 140(A), 94 N.Y.S.3d 540 NY Slip OP 51875[U] (App Term 2d Dept, 2d, 11th & 13th Jud Dists (2017.)

In the instant matter, the respondent did not submit proof of mailing of the verification requests and did not submit evidence from someone with personal knowledge that a response was not received from the applicant.

Under these circumstances, the respondent failed to establish that the claim is premature and therefore, the time to pay or deny this bill at issue is not tolled.

Therefore, the applicant is awarded $264.79 for the DME provided on March 17, 2025.

Accordingly, the applicant is awarded $264.79 and the remainder of the claim is dismissed with prejudice.

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**
	Kuman Medical Supply Inc.	**02/07/25 - 02/07/25**	**$2,015.11**	**Denied**
	Kuman Medical Supply Inc.	**02/27/25 - 02/27/25**	**$502.63**	**Denied**
	Kuman Medical Supply Inc.	**03/14/25 - 03/14/25**	**$1,163.81**	**Denied**
	Kuman Medical Supply Inc.	**03/17/25 - 03/17/25**	**$264.79**	**Awarded: $264.79**
Total			**$3,946.34**	**Awarded: $264.79**

B. The insurer shall also compute and pay the applicant interest set forth below. 05/16/2025 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 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.

08/04/2026
(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:
0acdd547e1581595a666496d466d0f87

Electronically Signed

Your name: Anne Malone
Signed on: 08/04/2026