American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:		
V & B Magic Recovery Supply / **Applicant_ 1** (Applicant)	AAA Case No. AAA Assessment No. Applicant's File No.	412010020587 17 991 14726 10
- and -		
Geico Insurance Company (Respondent)	Insurer's Claim File No.	0314918960101024

ARBITRATION AWARD

I, Maria G. Schuchmann, Esq., 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:Claimant

1. Hearing(s) held on
☒08/11/10
and declared closed by the arbitrator on 8/11/10.

Hyman Ashkenazy, Esq participated by telephone for the Applicant.
Bob Pollack participated in person for the Respondent.

2. The amount claimed in the Arbitration Request, **$1,938.99**, 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

Whether medical supplies dispensed to Claimant as a result of injuries allegedly sustained in a motor vehicle accident were medically necessary.

4. Findings, Conclusions, and Basis Therefor

Claimant was involved in a motor vehicle acc9ident on September 27, 2009. On October 5, 2009 she saw Dr. McGee complaining of cervical, thoracic, lumbar and left shoulder pain with weakness. After an examination that was positive for decreased ranges of motion with tenderness in her cervical spine, lumbar spine and left shoulder with positive Spurlings and Straight Leg Raise tests, Claimant was referred for therapy. She was also given a prescription

for medical supplies including a cervical pillow, a bed board, an egg crate mattress, an LSO, a hot/cold pack and a thermophore.

Those items were dispensed by Applicant's facility on October 12, 2009.

Claimant was re-evaluated by Dr. McGee on November 9, 2009 when she was still complaining of cervical, thoracic, lumbar and left shoulder pain. At that point her exam was virtually unchanged. She was given another referral and a prescription for additional supplies, including a massager, a TENs/EMS unit and a whirlpool.

These items were dispensed by Applicant's facility on November 16, 2009.

Respondent has denied payment for both sets of supplies based upon two separate peer reviews by Dr. Lim that found that the supplies were not medically necessary.

With respect to the first set, he found that there is nothing in the medical literature to show that cervical pillows help to reduce pain. Therefore, this item was unnecessary.

The recent medical literature shows that the use of an LSO is counterproductive in that it may weaken muscles. The better course is exercise and increasing range of motion.

Ordering a bed board and egg crate mattress is contradictory. The board is used to firm up the bed while the mattress is for softening in order to prevent bed sores. There was no evidence that Claimant's bed was contributing to her condition and there was no reason to act to prevent against bed sores so these items were not necessary.

Finally, ordering the hot/cold pack and thermophore was duplicative. In addition, Claimant was receiving hot/cold packs in the formal therapy setting and there is no evidence in the medical literature to show that continuing with this process at home would be beneficial. Therefore, these items were unnecessary.

Dr. Lim also found that the second set of supplies was unnecessary based upon the medcial literature. However, in reviewing that referral he did not have the opportunity to review Dr. McGee's November 9th re-evaluation report.

It is settled law that to recover assigned first-party no-fault benefits, a provider establishes a prima facie entitlement to an award by proof of submission of statutory claim forms setting forth the fact and amounts of the losses sustained, and that payment of No-Fault benefits was overdue.(*See Insurance Law 5106(a); Mary Immaculate Hospital v Allstate Ins. Co., 5 AD3d 742,774 NYS2d 564 [2004]).* In addition, Respondent's acknowledgement of receipt of the bill in its denial of claims forms is proof of submission of the claim. (*see Careplus Med. Supply Inc. v State-wide Ins. Co., 11 Misc 3d 29, 812 NYS2d 736 [App Term, 2nd & 11th Jud Dists 2005]).*

The burden then shifts to Respondent for proof of any defenses, including causality and medical necessity.

With respect to the issue of medical necessity, it has been held that "[a]t a minimum, defendant must establish a factual basis and medical rationale for the lack of medical

necessity of plaintiff's services". (*See Citywide Social Work & Psy. Serv v Travelers Indemnity Co., 3 Misc.3d 608, 777 NYS2d 241[Civ Ct Kings County 2004]*.

After a review of all of the evidence submitted, I find that Respondent has met its burden only with respect to the first bill. In that first peer review he sets out the recent medical literature and gives reasonable medical basis for finding that those supplies were unnecessary. In addition, the Letter of Medical Necessity that was submitted by Dr. McGee is merely a generic recitation of the item and its general usefulness. There is nothing submitted to indicate why these items were necessary for the care of this patient.

On the other hand, I find that Dr. Lim's opinion with respect to the second set of supplies could have been very different had he had the opportunity to review Dr. McGee's November 9th re-evaluation report. Before a peer review doctor takes a step to deny a claim, he or she should have The opportunity to fairly review and evaluate all of the relevant medical documents. In the absence of that, their opinion is meaningless.

Therefore, while I find that the first set of supplies was not medically necessary, I also find that the second set was necessary and that Respondent has failed to prove otherwise.

Accordingly, Applicant is awarded $1,404.00 plus applicable interest calculated from May 3, 2010. Applicant is also awarded statutory attorneys fees on the amount awarded herein plus interest, as well as return of the filing fee.

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.

Accordingly, the applicant is AWARDED the following:

A.

Benefits	Amount Claimed	Amount Awarded
Health Service Benefits	1,938.99	1,404.00
Totals:	$1,938.99	$1,404.00

B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 05/03/2010, which is a relevant date only to the extent set forth below.)

Applicant is awarded $1,404.00 plus applicable interest calculated from May 3, 2010.

C. Attorney's Fees

The insurer shall also pay the applicant for attorney's fees as set forth below.

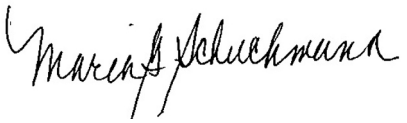
Applicant is also awarded statutory attorneys fees on the amount awarded herein plus interest.

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 New York
SS :
County of Suffolk.

I, Maria G. Schuchmann, Esq., do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.



9/3/10
(Dated) (Maria G. Schuchmann, Esq.)

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.