

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Northeast Anesthesia & Pain Management
(Applicant)

- and -

American Transit Insurance Company
(Respondent)

AAA Case No. 17-17-1081-9225

Applicant's File No. N/A

Insurer's Claim File No. 785156-02

NAIC No. 16616

ARBITRATION AWARD

I, Valerie D. Greaves, 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: Patient

1. Hearing(s) held on 02/13/2019, 05/15/2019, 12/04/2019,
03/31/2020
Declared closed by the arbitrator on 03/31/2020

Lucerigia Messiah, Esq. from Judd Shaw Injury Law P.A. participated by telephone for the Applicant

Patrice Soberano, Esq. from Short & Billy PC participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 1,762.68**, was AMENDED and permitted by the arbitrator at the oral hearing.

At the 3/21/2020 hearing, both attorneys accepted the fee schedule report of the assigned IHC fee schedule specialist who determined that the correct New Jersey fee schedule amount was \$1048.56.

The amount in dispute is now \$1048.56.

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

3. Summary of Issues in Dispute

Whether Applicant is entitled to reimbursement in the sum of \$1048.56 for anesthesia fees associated left shoulder arthroscopic surgery and left interscalene brachial nerve block injection(s) performed on January 5, 2017, allegedly in connection with the treatment of injuries sustained by Patient in a motor vehicle accident on October 14, 2015.

Respondent timely denied reimbursement based on orthopedic insurer medical examination findings.

4. Findings, Conclusions, and Basis Therefor

The decision below is based on the documents contained in the ADR Center as of the date of the hearing and the oral arguments of the parties. No witnesses testified at the hearing.

The Arbitrator shall be the judge of the relevance and materiality of the evidence offered, and strict conformity to legal rules of evidence shall not be necessary. The Arbitrator may question any witness or party and independently raise any issue that the Arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department regulations [11 NYCRR 65-4.5 (o) (1) (Regulation 68-D)].

The Appellate Division, Second Department held that applicant "made a prima facie showing of their entitlement to judgment as a matter of law by submitting evidentiary proof that the prescribed statutory billing forms had been mailed and received and that payment of no-fault benefits were overdue." (Mary Immaculate Hospital v. Allstate Insurance Co., 5 A.D.3d 742, 774 N.Y.S.2d 564 (2d Dept. 2004)). A "facially valid claim" is presented when it sets forth the name of the facility and/or health provider, date of the accident, the name of the patient, description of the services rendered, date of service(s) and the fees charged for those services. (Vinings Spinal Diagnostic P.C. v. Liberty Mutual Insurance Company, 186 Misc.2d 287; 717 NYS2d 466 (1st Dist. Ct. Nass. Co.)). Applicant herein has established a prima facie case of entitlement to reimbursement by submission of completed proof of claim, documenting the fact of the loss and the amount due.

Applicant is seeking reimbursement for anesthesia fees associated left shoulder arthroscopic surgery and left interscalene brachial nerve block injection(s) performed on January 5, 2017, allegedly in connection with the treatment of injuries sustained by Patient in a motor vehicle accident on October 14, 2015. As reported in the Lincoln Hospital emergency room report dated October 14, 2015, Patient, then 62 years old was riding a bicycle when he was struck with the car door of a motor vehicle; the emergency room record also reported no loss of consciousness, no fractures and no lacerations, the sole complaint noted was left side facial pain and redness for which Patient was given medication, he was released without admission with instructions to follow up with his primary care physician.

The initial consultation report dated October 14, 2015 from Gerard Avenue Medical reflects a different date of accident, October 9, 2015; most notably, the report does not mention the Lincoln Hospital emergency room visit, instead it reports (contrary to the record) that Patient went home to rest immediately post accident and it contains no complaint of shoulder pain and tenderness. The conservative treatment plan involved physical therapy applied to the face contusion, neck and low back at a frequency of 4 times a week, as well as, massage therapy and myofascial release.

Further review of the Lincoln Hospital emergency room record revealed:

On 11/6/2015, Patient presented with a complaint of swelling to genital area (no complaint of shoulder pain was noted).

On 1/11/2016, Patient's sole complaint was left foot pain, which was diagnosed as gout.

On 3/11/2016, a ER note titled *"Unscheduled Non Urgent Visit Note"* indicates that Patient presented with *"neck pain, for one year had MRI done showed herniate disc according to Patient, follow up in physical therapy...primary diagnosis was cervicalgia...[The neurologic exam revealed] no neurological deficit"*; Patient was evaluated and released with medication. No complaint of shoulder pain was noted on that date.

On 2/27/2017, Patient presented with complaints of hemorrhoids (instructed to eat more vegetables), left foot pain (diagnosed as gout) and neck pain for which he was given medication; no complaint of shoulder pain was noted.

The first medical examination containing a complaint of left shoulder pain is the initial orthopedic consultation report by Dr. Scilaris performed more than one year post accident on October 31, 2016. Dr. Scilaris reports (contrary to the Lincoln Hospital record) that Patient presented to the emergency room on the date of accident with injuries to his neck, back and bilateral shoulders. Patient purportedly presented with bilateral shoulder pain. Examination of the left shoulder revealed 165 degrees forward flexion (normal degree of motion not provided), 140 degrees abduction (normal degree of motion not provided), internal and external rotations at 175 degrees with impingement. Dr. Scilaris noted that Patient had undergone a MRI study of the right shoulder, but not the left shoulder; he recommended a left shoulder MRI. Left shoulder MRI study was conducted on November 3, 2016. On November 14, 2016, Patient presented for a orthopedic follow up examination which contends that Patient injured both shoulders on the date of accident and that physical therapy had not improved his shoulder symptoms, for which left shoulder arthroscopic surgery and left interscalene brachial nerve block injection(s) were recommended.

Respondent timely denied reimbursement based on orthopedic insurer medical examination findings. A persuasive insurer medical examination must demonstrate clinical findings which convincingly support the contention that a particular good or service was not medically necessary.

Lack of medical necessity is a defense to an action for recovery of no-fault benefits, and n be asserted by the insurer provided that there has been a timely denial of the claim. Libe Queens Medical, P.C. v. Liberty Mutual Insurance Co., 2002 N.Y. Slip Op. 40420(U), 20 WL 31108069 (App. Term 2d & 11th Dists. June 27, 2002); AJS Chiropractic, P.C. Travelers Ins. Co., 25 Misc.3d 140(A), 906 N.Y.S.2d 770 (Table), (App. Term 2d, 11th 13th Dists. Dec. 1, 2009).

Respondent carries the initial burden of proof to timely raise and establish lack of medical necessity before the burden of proof shifts to the Applicant to establish that the disputed service(s) were medically necessary. If the insurer medical examination or peer review is not rebutted, the insurer is entitled to denial of the claim. Khodadadi Radiology v. New York Central, 16 Misc.3d 131(A), 841 N.Y.S.2d 824, (App. Term 2d & 11th Dists. (2007); Dayan v. Allstate Ins. Co., 49 Misc. 3d 151 (A), 29 N.Y.S. 3d 846, 2015 NY Slip Op 51751 (U) (App. Term 2d, 11th & 13th Dists. 2015). "...Once the insurer makes a sufficient showing to carry its burden of coming forward with evidence of lack of medical necessity, 'plaintiff must rebut it or succumb'." Bedford Park Medical Practice P.C. v. American Transit Ins. Co., 8 Misc.3d 1025(A), 806 N.Y.S.2d 443 (Table), 2005 N.Y. Slip Op. 51282(U), 2005 WL 1936346 (Civ. Ct. Kings Co., (2005). Where a peer review or insurer medical examination findings provide a factual basis and medical rationale for the opinion that a particular service is not medically necessary and Applicant fails to present any evidence to refute that showing, the claim should be denied. Delta Diagnostic Radiology, P.C. v. Progressive Cas. Ins. Co., 21 Misc.3d 142(A), 880 N.Y.S.2d 223 (Table), 2008 N.Y. Slip Op. 52450(U), 2008 WL 5146967 (App. Term 2d & 11th Dists. (2008).

"For an expense to be considered medically necessary, the treatment, procedure, or service ordered by a qualified physician must be based on an objectively reasonable belief that it will assist in the patient's diagnosis and treatment and cannot be reasonably dispensed with. Such treatment, procedure, or service must be warranted by the circumstances as verified by a preponderance of credible and reliable evidence, and must be reasonable in light of the subjective and objective evidence of the patient's complaints." (Nir v. Progressive Insurance Co., 7 Misc. 3d 1006(A), 801 N.Y.S. 2d 237 (Table), (Civ. Ct. Kings Co., Apr 7, 2005)

Respondent timely denied reimbursement for all future benefits based on findings revealed during an orthopedic insurer medical examination performed on January 11, 2016. Patient presented with complaints of headaches, neck, back and bilateral shoulder pain. The orthopedic IME consultant advised that he observed Patient with the ability to freely move his head, neck and body, get on the examination table without assistance, move side to side or front to back freely and not using any assistive devices. Examination of the cervical spine and lumbar spine revealed full range of motion with the exception of slightly decreased forward flexion and abduction, no tenderness and no muscle spasms; there were no neurological deficits and all orthopedic tests performed were negative. Examination of the right shoulder and left shoulder revealed full range of motion in all planes; the impingement sign test was negative bilaterally. The diagnostic impression was: Resolved - cervical spine sprain/strain. Resolved - lumbar spine sprain/strain. Resolved - bilateral shoulder sprain/strain.

The IME orthopedic consultant advised that the noted slightly restricted forward flexion and abduction were due to actions under control of Patient; the restricted range of motion was not correlated by any findings of muscle spasm, decreased sensation, muscle atrophy, or positive orthopedic tests to substantiate subjective loss of motion and his objective complaints of pain are not correlated by objective findings. Respondent's orthopedic IME consultant further advised that the IME findings revealed no objective evidence of an orthopedic disabilities or inability of Patient to perform his daily activities without limitations; therefore, no further need for orthopedic care, physical therapy, diagnostic tests, home care service, durable medical equipment or special transportation.

The IME rebuttal references no examination of Patient performed contemporaneously with the orthopedic IME. Additionally, the IME rebuttal maintains incorrectly that Patient had complained of bilateral shoulder pain in the emergency room on the date of accident (10/14/2015), when the record indicates that he made no such complaint on that date. The IME rebuttal also references a Lincoln Hospital emergency room "Non Urgent" examination conducted on March 11, 2016, that maintains contrary to the record that Patient had complained of shoulder pain on that date. Patient's first reported complaint of left shoulder pain was made during the initial orthopedic examination performed on October 31, 2016, more than one year post accident.

There is no credible and convincing medical documentation indicating that the disputed services were either medically necessary or caused by the October 14, 2015 motor vehicle accident.

I find that Respondent has established lack of medical necessity by a preponderance of the credible evidence. I further find that Applicant's documentation is insufficient to credibly refute lack of medical necessity.

Based on the foregoing, Applicant is not entitled to No-Fault benefits.

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 claim is DENIED in its entirety

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of New York

SS :

County of New York

I, Valerie D. Greaves, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

05/04/2020
(Dated)

Valerie D. Greaves

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:
5dd82384c412365cbee585106cbbc624

Electronically Signed

Your name: Valerie D. Greaves
Signed on: 05/04/2020