

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Surgicore Of Jersey City, LLC  
(Applicant)

- and -

American Transit Insurance Company  
(Respondent)

AAA Case No. 17-19-1140-2327

Applicant's File No. SS-123231

Insurer's Claim File No. 104570802

NAIC No. 16616

**ARBITRATION AWARD**

I, Matthew Brew, 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: Injured Party or IP

1. Hearing(s) held on 06/22/2020  
Declared closed by the arbitrator on 06/22/2020

Greg Itingen, Esq. from Samandarov & Associates, P.C. participated by telephone for the Applicant

Marc Attias, Claims Specialist from American Transit Insurance Company participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 5,820.43**, was NOT AMENDED at the oral hearing.  
Stipulations WERE made by the parties regarding the issues to be determined.

**The Parties stipulated to Applicant's prima facie case and further stipulated to the timeliness of Respondent's denial.**

**The Parties also stipulated that should Applicant prevail interest would accrue from the filing date of September 2, 2019.**

3. Summary of Issues in Dispute

**Whether Respondent established and sustained its lack of medical necessity defense in regard to the facility fees and anesthesia associated with the underlying left**

**shoulder surgery and perioperative blocks provided on April 23, 2019 as based upon the results of a peer review by Dr. Matthew Skolnick, MD dated June 17, 2019?**

**Whether Respondent established and sustained its defense based on its "fact or founded belief" that "alleged injuries did not arise out of an insured event and/or are the result of an intentionally staged occurrence"?**

#### 4. Findings, Conclusions, and Basis Therefor

Upon comparing all the relevant evidence submitted by the parties as contained in the electronic file maintained by the American Arbitration Association, and in consideration of the oral arguments presented by each party, **I find in favor of Applicant and its claim for reimbursement in the amount of \$5820.43 is granted in its entirety.**

Applicant's assignor, hereinafter referred to as the Injured Party or "IP", is described as a then then 24-yr-old male passenger of a motor vehicle involved in an accident on November 24, 2018. He presented to Maimonides Hospital where he was evaluated, treated and released the same day.

Following his initial visit to the hospital, the IP sought additional treatment in regard to injuries claimed to have resulted from the underlying loss. Such treatment included physical therapy, X-rays, DME, MRIs, and left shoulder surgery.

In this case, Applicant is seeking reimbursement in the amount of \$5820.43 in regard to the facility fees (\$4498.69) and anesthesia (\$1321.74) associated with the left shoulder surgery performed on April 23, 2019. Reimbursement in regard to both claims was denied upon Respondent's determination that the surgery was not medically necessary nor related to an injury suffered in the accident. Reimbursement was also denied based on Respondent's "founded belief the alleged injuries did not arise out of an insured event and/or are the result of an intentionally staged occurrence". The parties stipulated to Applicant's prima facie case and to the timeliness of Respondent's denials. Respondent did not raise any substantive fee schedule argument. Nor did it submit any persuasive evidence suggesting the amounts billed by Applicant were excessive.

Upon stipulating to the Applicant's prima facie case, the burden shifted to the Respondent to come forward with enough evidence to rebut the presumption of medical necessity that attached to the Applicant's bills. West Tremont Med. Diagnostic, PC v. Geico Ins. Co., 13 Misc.3d 131(A) (N.Y. App. Term 2006). When a Respondent carrier establishes a defense based on a lack of medical necessity the burden shifts back to the provider who then must then come forward with its own evidence of medical necessity. West Tremont Med. Diagnostic, PC v. Geico Ins. Co., Id. However, an insurance carrier must, at a minimum, establish a detailed factual basis and a sufficient medical rationale for asserting the lack of medical necessity defense. Vladimir Zlatnick, M.D. v. Travelers Indem. Co. 2006 NY Slip Op. (50963U) (App. Term 1st Dept., 2006). See also Delta

Diagnostic Radiology PC v. Progressive Casualty Ins. Co. 21 Misc. 3d. (142A) (App. Term 2<sup>nd</sup> Dept., 2008). Conclusions set forth in peer reviews may be insufficient if the peer review fails to provide specifics of the claim, is conclusory or otherwise lacks a basis in the facts of the claim. Amaze Medical Supply v. All State Ins. Co. 3 Misc. 3d. 43 (App. Term 2<sup>nd</sup> Dept., 2004).

Reference is made to my decisions in linked matters 17-19-1137-5971, 17-18-1137-5920 and 17-19-1137-5971. Those cases involved the underlying shoulder surgery, the CPM and cold compression and orthosis provided the IP. In all three cases, I found in favor of the Applicants. Notably, Respondent's defenses were identical to the defenses presented in the current matter. A strong argument can be made for the applicability of the doctrine of collateral estoppel, and I incorporate by reference my prior decisions, especially in regard to the shoulder surgery itself.

### **Medical Necessity**

In support of its lack of medical necessity defense, Respondent relied on a peer review by Dr. Matthew Skolnick, MD dated June 17, 2019. After reviewing certain medical records and providing a history of the IP's injury and treatment, Dr. Skolnick concluded that neither the underlying shoulder surgery or any of the related services were medically necessary or causally related to the underlying MVA.

In regard to the actual left shoulder surgery itself, Dr. Skolnick provided:

*The surgery of the left shoulder was performed by Dr. Avshalumov on April 23, 2019. According to the provided medical records, the claimant was evaluated by Dr. Avshalumov on March 4 through April 8, 2019 for complaints of left shoulder pain. On April 8, 2019, physical examination of the left shoulder revealed pain and limited range of motion with slightly decreased motor strength. Cross arm adduction, empty can and drop arm tests, impingement signs, apprehension, O'Brien's, Yergason's and Speed's were positive and no effusion, crepitus or instability was reported. Surgery of the left shoulder was indicated by Dr. Avshalumov after the office visit on April 8, 2019 and the procedure was performed on April 23, 2019.*

*Furthermore, the MRI of the left shoulder performed on November 27, 2018 indicated a rotator cuff tear; however, according to the radiology review of this study by Dr. Feit, no rotator cuff tear was seen and no evidence of post-traumatic injury was noted.*

*Based on the above, there is not adequate medical indication to justify the surgery of the left shoulder. In addition, there is no evidence that this claimant's left shoulder was deteriorating despite conservative treatment.*

During argument, counsel for Applicant aggressively attacked Dr. Skolnick's peer report and the conclusions presented therein. Counsel argued that the doctor not only failed to

set forth the standard for when the surgery or the disputed treatment would be medically warranted, but that he also failed to state how the disputed services at issue in this case deviated from the standard.

Counsel further argued that Dr. Skolnick did not really provide his own opinion in regard to the underlying surgery but relied upon Dr. Feit's report. Counsel took objection to Dr. Skolnick's reliance on another doctor's findings and claimed that he did not report on what he actually found but instead commented on what the other doctor had provided. Ultimately, counsel argued that Dr. Skolnick's peer review failed to satisfy the Nir standard because it was not grounded upon a "factual basis" and because there was no citation to a standard of care or mention as to how the disputed treatment deviated from that standard in this case.

In support of these arguments Applicant upload several prior arbitration decisions. These cases involved circumstances where peer doctors arguably failed to address actual findings documented in MRI reports and other medical records, cases where a clear standard of care was not set forth in the applicable peer review, and a case where the peer doctor had not received the actual MRI report or intraoperative photographs and ultimately based his opinion on findings from other physicians. Of the cases cited by Applicant, I found the decision from Arbitrator Allison Berdnik to be quite compelling ( see *In the Matter of the Arbitration between Laxmidhar Diwan MD and American Transit Insurance Company*, 17-18-1100-6339). In pertinent part, Arbitrator Berdnik noted the following:

*According to Dr. Kelman, the MRI of the right knee indicated meniscal tears. However, he notes that the that the radiology review by Dr. Springer, commissioned by Respondent, concluded that no meniscal or ligament tears were observed, and, as such, there was no evidence of a causally related injury. He also notes that his own review of the intra-operative photos did not reveal any tears or evidence of post-traumatic findings that would justify causally related surgery. As a consequence, Dr. Kelman concluded that there was not adequate medical indication to justify surgery to the right knee....*

*Dr. Kelman also fails to provide any explanation why he elected to rely upon Dr. Springer's radiological review of the MRI film, and completely disregard the positive findings documented in the evaluation reports from the Claimant's treating surgeon, the original MRI report, and the post-operative findings noted in the operative report, all of which identify partial tears to the medial and lateral menisci, thus calling into question the veracity of Dr. Kelman's opinion that the surgery was not medically indicated. While Dr. Kelman opines that his own review of the intra-operative photographs did not reveal evidence of any tears, he also describes the photographs as being "of poor quality, out of focus, with glare and poor white balance." Thus, Dr. Kelman's opinion that the photographs failed to identify any tears is contrary to the medical evidence and, based upon his own characterization of the photographs, of no probative value.*

Regarding Applicant's Nir arguments, counsel referenced the portion of Arbitrator Berdnik's decision that provided the following:

*Overall, I find Dr. Kelman's report facially insufficient to sustain Respondent's prima facie burden of establishing a lack of medical necessity for the surgery to the right knee. Fatal to Respondent's defense is Dr. Kelman's failure to proffer any standard of care for the treatment of this particular Claimant's injury, and how, in this instance, performance of the surgery deviated from any such standard. The report is conclusory, relies on medical authority only to the extent of a citation to the definition of medical necessity, and makes the unsupported claim that there is no medical evidence of an injury to the right knee warranting surgical repair. It is not enough for an expert to simply reiterate medical records, cite to medical literature for a limited premise, and then summarily conclude that a service is unnecessary. Without evidence of accepted medical practice, a peer reviewer's opinion is simply a different professional judgment which, in and of itself, does not establish that the disputed services were not medically necessary. Thus, Dr. Kelman's report in no way comports with any of the standards enumerated in Nir v. Allstate Ins. Co., 7 Misc.3d 544, 796 N.Y.S.2d 857 (Civ. Ct. Kings Co. 2005), and, as such, Respondent's defense predicated upon a lack of medical necessity cannot be sustained.*

Reference is further made to Arbitrator Nada Saxon's decision *In the Matter of the Arbitration between Advanced Orthopedics & Joint Preservation PC and American Transit Insurance Company*, 17-18-1110-6354. In that case, Arbitrator Saxon similarly reasoned that:

*Dr. Goldmark concludes the left knee surgery and associated services were not medically necessary. The crux of his rationale is based upon a radiology review by Dr. Springer, who concludes the results of the left knee MRI on 10/23/17 were degenerative and chronic in nature, and Dr. Kelman's review of intra-operative photos, who states no tears were seen in the photos and there was no justification for the surgery. I note Dr. Springer's and Dr. Kelman's reviews were commissioned by and/or on behalf of Respondent and are not considering Assignor's independent medical records. I also note that despite reviewing copies of the 12/14/17 intra-operative photos himself, Dr. Goldmark does not give his own opinion as to what they reveal. I find his lack of opinion significant considering he is also an orthopedic surgeon and the peer reviewer upon who the denial is based.*

*Dr. Goldmark does not adequately explain why he adopts the reviews and conclusions of Dr. Kelman and Dr. Springer over those set forth in Assignor's medical records. I do not find Dr. Goldmark's factual basis sufficient to support his rationale. Respondent's denial is based upon his peer review report, however the majority of his rationale is based upon reviews by other doctors commissioned by the Respondent to render conclusions, likely for the purposes*

*of litigation, without his own input as to why he finds these reviews more accurate. These other reports are not mentioned in the denial and are not the basis of Respondent's denial.*

Based on the evidence presented in this case, I found counsel's arguments to be both compelling and persuasive. In my opinion, Dr. Skolnick's peer report was insufficient in terms of establishing prima facie Respondent's defense based on lack of medical necessity or lack of causal relation. I say this not based solely on counsel's arguments, but also upon reviewing the body of the peer report. In the opinion of the undersigned, Dr. Skolnick's conclusions were not supported by a "sufficiently detailed factual basis or medical rationale". See Carle Place Chiropractic v. New York Central Mut. Fire Ins Co., 19 Misc.3d 1139(A), 866 N.Y.S.2d 90 (Table); Ying Eastern Acupuncture, P.C. v. Global Liberty Insurance, 20 Misc.3d 144(A), 873 N.Y.S.2d 238 (Table).

I further note that Dr. Slotnick provided an addendum which was far more detailed than his peer review. However, the basis for denial is not Dr. Skolnick addendum but rather the peer review itself. Respondent cannot cure any defect in Dr. Skolnick's peer review by providing a more detailed addendum.

Having failed to establish prima facie its lack of medical necessity/ lack of causation defenses, the burden never shifted to the Applicant to rebut the peer doctor's conclusions or to establish by a preponderance of the evidence the medical necessity for the disputed treatment. West Tremont Med. Diagnostic, PC v. Geico Ins. Co., 13 Misc.3d 131(A) (N.Y. App. Term 2006).

Regardless, I note that in support of its claim, Applicant submitted a formal rebuttal from Dr. Stanislav Avshalumov dated July 24, 2019. Dr. Avshalumov was one of the IP's treating doctors and the physician that performed the underlying surgery. Applicant also relied upon submitted records and the arguments of counsel.

In his rebuttal, Dr. Avshalumov provided a history of the IP's treatment and condition. Notably, in his rebuttal the doctor indicated that:

*I evaluated the patient on March 4, 2019. The patient was referred to my office due to post accident related injuries. The patient complained of intermittent and shoulder pain that was described as sharp, aching, shooting, and standing. The patient stated that at its worst, the pain was seven out of 10 on a 10 point scale. The pain was made worse by increased activity, bending, and movement. The patient had been receiving physical therapy, but stated it hasn't helped much. I reviewed the patient's MRI.*

*The MRI revealed bursal surface tear seen anteriorly at the supraspinatus tendon and moderate tendinosis.*

Dr. Avshalumov further maintained that he reevaluated the patient on April 8, 2019 and that at that point the patient "continued to experience constant shoulder pain that was sharp, aching, shooting, and stabbing". The patient further intimated that his pain was

worsening. Dr. Avshalumov's examination of the shoulder "revealed pain on palpation, and reduction range of motion and muscle strength". Moreover, "the following tests were all positive: cross arm adduction, cross arm adduction resistance, empty can, drop arm, Neer's, Hawkins's, anterior load and shift, apprehension (crank), relocation, O'Brien's, Speeds, and Yergason's". Therefore, Dr. Avshalumov recommended arthroscopic surgery.

Dr. Avshalumov rebuttal continued by discussing in detail when such surgery was warranted and why it was necessary in this case based on the IP's actual condition. I found Dr. Avshalumov's report far more persuasive on the issues of medical necessity and causal relation. Therefore, even if Dr. Skolnick's report was sufficient to establish Respondent's prima facie defense, my interpretation of the evidence provides that Applicant would have sufficiently rebutted Dr. Skolnick's conclusions.

Clearly, this matter involved conflicting expert opinions as to the need for the shoulder surgery and therefore the disputed facility fees. Upon carefully reviewing the pertinent evidence submitted by both sides, and in contemplation of the arguments presented by the parties during the hearing, I found Respondent failed to establish, prima facie, its defenses based on lack of medical necessity/lack of causation. The burden therefore never shifted to Applicant to rebut Respondent's showing or to establish by a preponderance of the evidence the medical need for the disputed treatment. Regardless, even if the burden had shifted, I found Applicant's evidence in regard to medical necessity and causal relation more persuasive.

**Injuries did not arise out of an insured event and/or were the result of a staged accident**

Respondent's denial further indicates that the entire claim was denied "based upon the founded belief the alleged injuries did not arise out of an insured event and/or are the result of intentionally staged occurrence". A global denial in that regard was also issued on March 19, 2019.

In support of its defense, Respondent submitted a police report and the purported EUO transcript from the IP. Respondent also relied upon the arguments of its representative and a trial court decision from an unrelated case decided back in 2008.

Noticeably absent was any other persuasive evidence. Respondent did not submit an affidavit from any SIU investigator setting forth any actual basis that would formulate Respondent's "fact or founded belief". Respondent did not submit any evidence which would indicate any formal investigation was even ever conducted.

Rather, Respondent relied upon the unsigned, and unsworn transcript from the IP's purported examination under oath (EUO). That examination was conducted February 27, 2019; nearly three months post-accident. Nothing in the transcript was highlighted nor did Respondent submit a brief referencing any particular portions of testimony, page numbers, or line numbers. Respondent also failed to submit any proof indicating that the EUO transcript was ever forwarded to the IP for review or signature.

However, during argument Respondent's representative maintained that certain discrepancies contained within the EUO testimony established that this was a staged loss. Respondent referenced issues as to whether the IP was on his way to work when the loss occurred, whether he was running late, whether he was wearing a seatbelt, whether the airbags deployed, and whether he spoke to individuals in the other car. In conclusion, Respondent argued that "the IP didn't know much about the accident and what he did know contradicted the police report".

Based on my review of the evidence, it is the opinion of the undersigned that Respondent failed to establish a "fact or founded belief" that this accident was a staged event or that the claimed injuries did not arise out of an insured event. I was not persuaded by Respondent's evidence nor by the arguments made during the hearing.

I also found Respondent's reliance upon Manhattan Med. Imaging, PC v. State Farm Mut. Auto. Ins. Co., 20 Misc.3d 1144(A) (Civ. Court, City of NY, Richmond County), somewhat misguided. First, that case dealt with the sufficiency of an insurer's evidence in terms of defeating a summary judgment motion. Second, in that case, State Farm submitted multiple statements from different assignors, as well as a signed and sworn affidavit from the relevant SIU investigator. Even upon considering that evidence, the judge suggested that "this court does not believe the defendant presents a strong case of staged accident". That evidence was however, deemed by the judge to be enough to at least defeat the summary judgment motion and allow the defendant to proceed to trial. Further I note that in Manhattan Med. Imaging, id., the court also explicitly noted that "In a number of cases, defendant insurers have been permitted to proceed to trial based upon affidavits of investigators employed by the insurance companies special investigations unit who alleged personal knowledge of the alleged fraud".

Notably, no such affidavits or any other evidence of an investigation was submitted in the case at bar.

After careful consideration of the pertinent evidence, and in contemplation of the arguments presented during the hearing, I found Respondent failed to establish its stated defense that the underlying loss was a staged event or that the "alleged injuries did not arise out of an insured event".

**Therefore, based on the foregoing, I find in favor of Applicant and its claim for reimbursement in the amount of \$5820.43 is granted in its entirety.**

This decision is in full disposition of all claims for No-Fault benefits submitted before this Arbitrator. Any further issues raised in the hearing record are held to be moot and/or waived insofar as not specifically raised at the time of hearing.

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
	<b>Surgicore Of Jersey City, LLC</b>	<b>04/23/19 - 04/23/19</b>	<b>\$4,498.69</b>	<b>Awarded: \$4,498.69</b>
	<b>Surgicore Of Jersey City, LLC</b>	<b>04/23/19 - 04/23/19</b>	<b>\$1,321.74</b>	<b>Awarded: \$1,321.74</b>
<b>Total</b>			<b>\$5,820.43</b>	<b>Awarded: \$5,820.43</b>

- B. The insurer shall also compute and pay the applicant interest set forth below. 09/02/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

September 2, 2019 is the date that the arbitration is deemed to have been commenced and the date that the parties stipulated interest would accrue from should Applicant prevail.

INTEREST: Pursuant to Insurance Law § 5106 (a), interest accrues on overdue no-fault insurance claims at a rate of 2% per month. A claim is overdue when it is not paid within 30 days after a proper demand is made for its payment (Insurance Law § 5106

[a]; 11 NYCRR 65.15 [g]). The Superintendent's regulation tolls the accumulation of interest if the claimant "does not request arbitration or institute a lawsuit within 30 days after receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations" (11 NYCRR 65-3.9 [c]). The Superintendent has interpreted this provision to mandate that the accrual of interest is tolled, regardless of whether the particular denial at issue was timely. That interpretation was upheld by the Court of Appeals in LMK Psychological Servs, P.C. v. State Farm Mut. Auto. Ins. Co., 2009 NY Slip Op 02481 (April 2, 2009). Where no denial of claim is issued in response to a proper demand for payment, the insurer does not benefit from the tolling provision and interest will accrue from the date 30 days after the proper demand for payment is made. Interest that accrues when a denial of claim is not issued within 30 days after the proper demand for payment is made will be tolled upon the issuance of a denial of claim, although such denial is untimely, and the failure to request arbitration or institute a lawsuit within 30 days after receipt of that denial of claim form.

#### C. Attorney's Fees

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

For cases filed after February 4, 2015, the attorney's fee is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4. The attorney's fee shall be limited as follows: 20% of the total amount of first-party benefits and any addition first-party benefits, plus interest thereon, for each applicant per arbitration or court proceeding, subject to a maximum fee of \$1,360. If the nature of the dispute results in an attorney's fee that could be computed in accordance with the limitations prescribed in both subdivision (c) and this subdivision, the higher attorney's fee shall be payable.

- 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 Nassau

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

07/22/2020

(Dated)

Matthew Brew

**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:**  
68720c67f087f906a3995ea1581cfcb7

### **Electronically Signed**

Your name: Matthew Brew  
Signed on: 07/22/2020