American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Kaleida Health (Applicant)	AAA Case No.	17-19-1149-6669
	Applicant's File No.	19-20219X
- and -	Insurer's Claim File No.	0516390977 2KK
Allstate Fire & Casualty Insurance Company (Respondent)	NAIC No.	29688

ARBITRATION AWARD

I, Fred Lutzen, 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/claimant/patient

1. Hearing(s) held on 10/27/2020
   Declared closed by the arbitrator on 10/27/2020

   Nicole Jones, Esq., from The Morris Law Firm, P.C. participated by telephone for the Applicant

   Meghan McDonough, Esq., from Law Offices of John Trop participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **$ 601.47**, was AMENDED and permitted by the arbitrator at the oral hearing.

   This award addresses two arbitration matters that were held on the same date, 10/27/2020, involving the same EIP, same provider (Buffalo General Hospital a/k/a Kaleida Health - same NPI#), and were argued together by the same counsel.

   Applicant amended the claim for case ending *6669 down to $125.12.

   Applicant amended the claim for case ending *9054 down to $2,383.45.

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

3. Summary of Issues in Dispute

This male EIP (first initial "J") was 61-years-old when he was injured as a passenger in an automobile accident on 9/9/18. He subsequently came under the care of Dr. Graham R. Huckell, M.D., who performed right knee surgery on 10/1/19.

Applicant seeks reimbursement for pre-operative lab work performed on 9/20/19 (case ending *6669) and right knee surgery performed on 10/1/19 (case ending *9054).

Respondent denied the claims asserting that no further orthopedic treatment was medically necessary beyond an examination by Dr. Edward L. Mills, M.D., performed on 3/18/19. The general denial was issued on 4/8/19, and timely specific denials were issued thereafter, cutting off orthopedic and related benefits effective 4/15/19.

The issues to be determined are (1) whether the post-IME orthopedic services for the right knee were medically necessary and, if so, (2) whether the amended amounts are correct per the fee schedule.

4. Findings, Conclusions, and Basis Therefor

These cases were decided based upon the submissions of the parties as contained in the electronic file ["MODRIA"] maintained by the American Arbitration Association and the oral arguments of the parties' representatives.

No Collateral Estoppel

I recently decided **AAA Case No. 17-20-1159-4946** (decided on 11/5/2020), which was after the hearings were held for the subject matters. Therefore, there is no collateral estoppel effect on these cases.

Medical Necessity

Respondent has the burden to first demonstrate, prima facie, that the services lacked medical necessity.

An insurer may rely on an IME that the injured person has reached the status quo, shifting the burden to the claimant to demonstrate by a preponderance of the credible evidence that the treatment at issue was medically necessary. Amato v. State Farm Ins. Co., 40 Misc.3d 129(A), 975 N.Y.S.2d 364 (Table), 2013 N.Y. Slip Op. 51113(U), 2013 WL 3497906 (App. Term 9th & 10th Dists. July 3, 2013), *rev'g*, 30 Misc.3d 238, 910 N.Y.S.2d 637 (Dist. Ct. Nassau Co. 2010). 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*, A Khodadadi Radiology, P.C. v. NY Central Mutual Fire Ins. Co., 16 Misc.3d 131(A), 841 N.Y.S.2d 824 (Table), 2007 N.Y. Slip Op. 51342(U), 2007 WL 1989432 (App. Term 2d & 11th Dists. July 3, 2007); s*ee*, Bronx Expert Radiology, P.C. v. Travelers Ins. Co., 2006 NY Slip Op 52116 (App. Term 1st Dept. 2006).

On 3/18/19, the EIP appeared for an orthopedic examination (an "IME"), arranged by the Respondent with Dr. Edward L. Mills, M.D. Dr. Mills reported that the EIP's complaints included pain in the "right knee." He reviewed medical records, including ER records, right knee x-ray report, progress notes, evaluation reports, right knee MRI report, and other records

On examination, Dr. Mills reported right knee flexion was to 50 degrees (out of 140 degrees normal), and "flexion at extension 15 degrees" (out of 0 degrees normal). The EIP was able to straight leg raise, and there was complaint of diffuse tenderness in a "grossly stable" knee. Dr. Mills diagnosed the EIP with a "Right knee sprain - resolved."

Dr. Mills concluded that there was "no medical necessity for continued orthopedic care including physical therapy as there is no evidence of any positive objective, correlative findings" and no need for related services.

In his IME report, Dr. Mills did not attempt to explain why there was such a diminished range of motion in right knee flexion, which was reduced by almost 65% of the normal range. Dr. Mills did review the right knee MRI, which reported "a complex tear of the posterior horn on the medial meniscus", "moderate knee joint effusion", and a "[s]ubtle bony contusion [at the] medial aspect of the medial tibial plateau." It is unclear, therefore, if the range of motion reduction might be related to the tear and/or contusion.

Assuming Respondent's IME by Dr. Mills met its burden of proof, focus would turn to Applicant's rebuttal evidence.

Rebuttal Case

Applicant relies on the submitted records, as well as a record review/rebuttal prepared by Dr. Drora Hirsch, M.D., on 9/17/2020.

Applicant also relies on the evaluation reports for visits on 1/9/19, and earlier dates, as well as the right knee arthroscopy operative report of 10/1/19.

Prior to the IME, on 1/9/19, the EIP was evaluated by Dr. Huckell, the surgeon. He diagnosed the EIP with a meniscal tear per the MRI, reported a positive McMurray's test, and recommended 6 more weeks of physical therapy and then a re-evaluation.

In the rebuttal report of 9/17/2020, Dr. Hirsch stated the following, in relevant part:

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> [] MRI of the right knee performed on 11/13/2018 revealed complex tear of the posterior horn of the medial meniscus, moderate knee joint effusion and subtle bony contusion at the medial aspect of the medial tibial plateau. Diagnoses were: Right knee pain, right knee contusion, right knee osteoarthritis and right knee medial meniscus tear. The patient was recommended to continue physical therapy, knee brace as needed, and modifying activities as needed. The patient was subsequently recommended right knee arthroscopic surgery due to failed conservative management.
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Operative report signed by Dr. Huckell dated 10/1/2019 indicated right knee arthroscopy and partial medial and lateral meniscectomy. Preoperative Diagnoses were: Osteoarthritis of the right knee, torn medial meniscus and chondromalacia patella. Postoperative Diagnoses were: Osteoarthritis of the right knee, torn medial and lateral meniscus and chondromalacia patella.

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The right knee surgery and the associated services provided to the patient were denied pursuant to an independent medical examination performed by Dr. Mills on 3/18/2019. Dr. Mills concludes in his IME report that based on physical examination there was no medical necessity for continued orthopedic care including physical therapy as there was no evidence of any positive, objective, correlative findings and also no medical necessity for household help, special transportation, DME/supplies or prescription medications as well as massage therapy or surgery as the patient's injuries were resolved. I respectfully disagree with Dr. Mills' conclusion and find that the patient needed further orthopedic treatment as his injuries were not resolved. Please note the following discussion.

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Dr. Mills states in his independent medical examination report that the patient presented to his office for an independent medical examination on 3/18/2019 with the complaints of low back pain, neck pain and right knee pain. This indicates that the patient was experiencing pain at the time of the IME. Further, physical examination performed by Dr. Mills revealed decreased and painful range of motion of the cervical spine, lumbar spine and right knee; tenderness over the midline and over the right cervical and lumbar paraspinal muscle and right knee. Based on the foregoing, it is clear that the patient was responding to the treatment, but his injuries were certainly not resolved as of the date that the insurer determined to deny all future benefits based on the aforementioned IME report.

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Assuming the IME report is accurate as to findings on the exam, one cannot get an accurate picture of a patient's overall condition without considering all subsequent exams, which apparently is the case, as the IME report did not encompass any subsequent evaluations. Moreover, a patient's condition can appear to improve one day, but exacerbate a subsequent day, particularly as the IME report acknowledges the patient's subjective complaints and revealed objective findings. The treating physician who is responsible for the care and treatment of the patient is in the best position to determine the need for continued treatment. The IME physician, on the other hand, who is retained by the insurance carrier, has no responsibility for the patient's best interests. In the light of the positive findings that were revealed during and after the subject IME, Dr. Mills incorrectly recommended against further treatment for this patient.

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The patient had a combination of subjective complaints, positive clinical findings and MRI, which were unresponsive to conservative treatment and were consistent with meniscal tear injury for which surgery is clearly the treatment of choice. The clinical necessity was thoroughly established and is backed up by considerable documentation in recent major orthopedic textbooks and current peer review orthopedic literature.

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In the operative report for the surgery performed on 10/1/19, Dr. Huckell stated that the "[EIP] has a history of [MVA] that has led to the development of a right knee injury. This problem unfortunately, is no longer amendable to conservative treatment. To a reasonable degree of medical certainty, this problem is directly related to the [MVA], and had the [MVA] not occurred, the surgery would not be necessary. It is therefore on the basis of medical necessity and failure to improve without surgery, the nature of the injury, and the relationship of the development of this injury secondary and casually related to [the MVA] has made this surgical intervention medically necessary."

I reviewed the operative report and note that the complex tear found on MRI was, in fact, confirmed by visual inspection.

Analysis

While not always determinative, the treating physician's opinion is entitled to some deference. Oceanside Medical Healthcare, P.C. v. Progressive Ins., 2002 N.Y. Slip Op. 50188(U) at 5, 2002 WL 1013008 (Civ. Ct. Kings Co., Jack M. Battaglia, J., May 9, 2002). In this case, I defer to the treating providers and determine that Applicant has proven the post-IME services for the right knee were medically necessary by a preponderance of the credible evidence. Dr. Mills' opinion was less detailed and less persuasive than the rebuttal evidence. In addition, the fact that Dr. Mills did not rule out the meniscal tear as a cause for the reduced range of motion noted on IME made it easier for Applicant to rebut Dr. Mill's opinion.

According to the Second Department, an IME doctor who describes restrictions in range of motion as "self-restricted" must explain or substantiate, with objective medical evidence, the basis for such a conclusion. E.g., Cuevas v. Compote Cab Corp., 61 A.D.3d 812, 878 N.Y.S.2d 124 (2d Dept. 2009); Torres v. Garcia, 59 A.D.3d 705, 874 N.Y.S.2d 527 (2d Dept. 2009).

In this case, Dr. Mills recorded reduced ranges of motion (almost 65% in flexion), but he did not attribute these reductions to self-restrictions or suboptimal effort. Without any explanation by Dr. Mills, these findings appear to be objective or positive findings, particularly in light of the positive findings on MRI that were discussed in detail by Dr. Huckell.

Fee Schedule

While fee schedule defenses were raised in the denial forms, no evidence was submitted to rebut the amended amounts proposed by Applicant. The fee schedule defenses are not sustained.

Conclusion

Arguments by counsel on both sides were very persuasive, and I did find the IME report to be somewhat credible. However, after carefully considering the submissions of the parties, the relevant case law and the arguments of respective counsel, I conclude that

the preponderance of the credible evidence supports a finding in favor of the Applicant on the issue of medical necessity for the post-IME right knee treatment and surgery.

Applicant is awarded $125.12 on case ending *6669.

Applicant is awarded $2,383.45 on case ending *9054.

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**	**Amount Amended**	**Status**
	Kaleida Health	**09/20/19 - 09/20/19**	**$601.47**	**$125.12**	**Awarded: $125.12**
Total			**$601.47**		**Awarded: $125.12**

B. The insurer shall also compute and pay the applicant interest set forth below. 11/27/2019 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." 11 NYCRR §65-3.9(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." See, 11 NYCRR 65-3.9(c); and OGC Op. No. 10-09-05 (interest accrues from date Applicant "*actually requests arbitration*" or commences a lawsuit). The Superintendent and the New York Court of Appeals have interpreted this provision to apply regardless of whether the particular denial at issue was timely. LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 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 fees pursuant to the no-fault regulations. See, 11 NYCRR §65-4.5(s)(2). The award of attorney fees shall be paid by the insurer. 11 NYCRR §65-4.5(e). Accordingly, "the attorney's fee shall be limited as follows: 20 percent of the amount of first-party benefits, plus interest thereon, awarded by the arbitrator or the court, subject to a maximum fee of $1360." Id. However, if the benefits and interest awarded thereon is equal to or less than the respondent's written offer during the conciliation process, then the attorney's fee shall be based upon the provisions of 11 NYCRR 65-4.6(b).

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 Erie

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

11/21/2020
(Dated)

Fred Lutzen

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:
27577b434a6c9a091ad6864f238e7f37

Electronically Signed

Your name: Fred Lutzen
Signed on: 11/21/2020