

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Town Supply Inc
(Applicant)

- and -

Country-Wide Insurance Company
(Respondent)

AAA Case No. 17-19-1144-2689

Applicant's File No. DislaDi

Insurer's Claim File No. 000327723 001

NAIC No. 10839

ARBITRATION AWARD

I, Gregory Watford, 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: Assignor (DD)

1. Hearing(s) held on 01/05/2021
Declared closed by the arbitrator on 01/05/2021

Karen Wagner from Dash Law Firm, P.C. participated by telephone for the Applicant

Edilane D'Arce from Jaffe & Velazquez, LLP participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 1,839.78**, was NOT AMENDED at the oral hearing.
Stipulations WERE made by the parties regarding the issues to be determined.

The parties stipulated that the amount in dispute is \$1,839.78.

3. Summary of Issues in Dispute

The dispute arises from the underlying automobile accident of June 14, 2017, in which the Assignor, a 47-year old female, was a driver. As a result of the impact, she complained of pain in her neck, mid back, lower back, left shoulder pain. She subsequently received conservative care including acupuncture treatments and also underwent diagnostic tests.

On October 27, 2017, Assignor underwent left knee surgery and was prescribed post-operative durable medical equipment (DME). On October 28, 2017, Assignor received DME in the form of a knee continuous passive motion (CPM) device and the accompanying pad. In dispute in this case are the rental fees for the DME provided to Assignor from 10/28/17 through 11/24/17. Applicant timely submitted the claims to Respondent for payment. Respondent timely denied payment based upon the peer review of Dr. Andrew Bazos.

The issues to be decided in this case are:

Whether Applicant established entitlement to No-Fault compensation for DME provided to Assignor.

Whether Respondent made out a prima facie case of lack of medical necessity and, if so, whether Applicant rebutted it.

4. Findings, Conclusions, and Basis Therefor

I have reviewed the submissions contained in the American Arbitration Association's ADR Center Electronic Case File (ECF). These submissions are the record in this case.

Pursuant to Insurance Law § 5106(a) and the Insurance regulations, an insurer must either pay or deny a claim for motor vehicle no-fault benefits, in whole or in part, within 30 days after an applicant's proof of claim is received. (*see* Insurance Law § 5106[a]; 11 NYCRR 65-3.8[c]; *see also* 11 NYCRR 65-3.5). Infinity Health Products, Ltd. v. Eveready Ins. Co., 67 A.D.3d 862, 864, 890 N.Y.S.2d 545, 547 (2d Dept. 2009). A claimant's prima facie proof of claim for no-fault benefits must demonstrate that the prescribed claim forms were mailed to and received by the insurer and are overdue. Viviane Etienne Medical Care, P.C. v. Country-Wide Ins. Co., 25 N.Y.3d 498, 506, 14 N.Y.S.3d 283, 290 (2015). Applicant's proof is also in Respondent's denials, which acknowledged receipt of the bills.

After reviewing the record and evidence presented, I find that Applicant established a prima facie case of entitlement to reimbursement of its claim. Viviane Etienne Med Care, PC v. Countrywide Ins. Co., *Id.* Once an applicant establishes a prima facie case, the burden then shifts to the insurer to prove its defense. *See Citywide Social Work & Psych. Serv. P.L.L.C v. Travelers Indemnity Co.*, 3 Misc. 3d 608, 2004, NY Slip Op 24034 (Civ. Ct., Kings County 2004).

Medical Necessity

Since Respondent's denials were timely, it was within its rights to assert that further treatment was medically unnecessary. *See Liberty Queens Medical, P.C. v. Liberty*

Mutual Insurance Co., 2002 NY Slip Op 40420(U), 2002 WL 31108069 (App. Term 2d & 11th Dists. June 27, 2002); Country-Wide Insurance Co. v. Zabloski, 257 A.D.2d 506, 684 N.Y.S.2d 229 (1st Dept. 1999).

A presumption of medical necessity attaches to a timely submitted no fault claim. Elmont Open MRI & Diagnostic Radiology, P.C. v. State Farm Ins. Co., 26 Misc.3d 1211(A), 906 N.Y.S.2d 779 (Table), 2010 N.Y. Slip Op. 50053(U) at 3, 2010 WL 157564 (Dist. Ct. Nassau Co., Fred J. Hirsh, J., Jan. 6, 2010).

The No-Fault carrier may rebut the inference of medical necessity by providing proof that the claimed healthcare benefits were not medically necessary. A. Khodadadi Radiology, P.C. v. New York Central Mutual Fire Ins Co., 16 Misc. 3d 131(A), 841 N.Y.S.2d 824, 2007 N.Y. Slip Op 51342(U) (App Term, 2nd Dept 2007); Delta Diagnostic Radiology, P.C. v. Progressive Casualty Ins. Co., 21 Misc. 3d 142(A), 2008 NY Slip Op 52450(U) (App Term, 2nd Dept. 2008); Delta Diagnostic Radiology, P.C. v. Integon Natl. Ins. Co., 2009 NY Slip Op 51502(U) (App Term, 2nd Dept. 2009). The burden now shifts to respondent to establish a lack of medical necessity with competent medical evidence which sets forth a clear factual basis (specifics of the claim) and medical rationale for denying the claim. Citywide Social Work and Psych Services, PLLC v. Allstate, 8 Misc. 3d 1025A (2005); Healing Hands Chiropractic v. Nationwide Assurance Co., 5 Misc. 3d 975 (2004).

The courts have held that a peer review 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 medical practice as a medical rationale for his findings; and 3) the peer review report fails to provide specifics as to the claim at issue, is conclusory or vague. See, Jacob Nir, M.D. v. Allstate Insurance Co., 7 Misc.3d 544 (N.Y. City Civ. Ct. 2005).

A determination of medical necessity must be based on evidence in existence prior to the rendering of the service. Foster Diagnostic Imaging, PC v General Assur Co., 10 Misc. 3d 428 (Civ. Ct. Kings Cty. 2005).

Dr. Bazos reviewed Assignor's medical records including evaluation reports, treatment records, prescriptions and diagnostic test results. He then summarized the accident and outlined the treatment of Assignor.

After reviewing the medical records in this case, Dr. Bazos opined:

"After a careful review of submitted documentation from an orthopedic surgical standpoint, the causal relationship between the claimant's knee complaints and the motor vehicle accident has not been established. There is lack of evidence that the claimant complained of any type of knee complaints in close proximity to the date of the accident."

Respondent bears the burden to prove its defense that the injuries in question were not related to the accident in addition to proof that the accident did not exacerbate or

aggravate any pre-existing condition or injury. See, Bronx Radiology, P.C. v. New York Central Mutual Fire Ins. Co., 847 N.Y.S.2d 313, 314- 315, 17 Misc. 3d 97 (N.Y. App. Term 1st Dept. 2007).

In Bronx Radiology, P.C. v. New York Central Mutual Fire Ins. Co., the court clarified the parties' respective burdens with respect to establishing causation, or the lack of causation, in a no-fault action:

In the typical negligence action, plaintiff's burden of establishing causation is met by a showing that the accident was a proximate cause of the claimed injuries. See Derdarian v. Felix Contracting Corp., 51 N.Y.2d 308, 434 N.Y.S.2d 166, 414 N.E.2d 666 (1980). However, in an action to recover first party no fault benefits, a plaintiff bears no such burden and establishes his or her prima facie case by proof that the claim form was mailed and received, and that the insurer failed to pay within the 30-day statutory period. See Mary Immaculate Hosp. v. Allstate Ins. Co., 5 A.D.3d 742, 774 N.Y.S.2d 564 (2004). In essence, causation is presumed since 'it would not be reasonable to insist that a [medical provider] must prove as a threshold matter that its patient's condition was caused' by the automobile accident. Mount Sinai v. Triboro Coach, 263 A.D.2d 11, 20, 699 N.Y.S.2d 77 (1999). Thus, the burden is on the defendant insurer to come forward with proof establishing by 'fact or founded belief' its defense that the claimed injuries have no nexus to the accident." Central Gen. Hosp. v. Chubb Group of Ins. Cos., 90 N.Y.2d 195, 199, 659 N.Y.S.2d 246, 681 N.E.2d 413 (1999).

Moreover, a defense based upon lack of causation must be supported by a report from an expert with medical training. Kingsbrook Jewish Medical Center v. Allstate Ins. Co., 61 A.D.3d 13, 22, 871 N.Y.S.2d 680, 687 (2d Dept. 2009). When Respondent's expert report to support its defense is in the form of a peer review, the peer review must make "recourse to medical facts," providing the factual basis and medical rationale for the expert's opinion and demonstrating the basis for his or her "fact or founded belief" that the specific treatment in dispute was not a result of (either caused or exacerbated by) the accident in question. See, Kingsbrook v. Allstate Ins. Co., supra at 22, citing Mt. Sinai Hosp. v. Triboro Coach, supra.

At the hearing, Applicant argued that Respondent should not be permitted to argue lack of causation in this case because the issue raised by Dr. Bazos has already been addressed by Arbitrator Marina O'Leary and litigated in a linked related case under AAA case # 17-18-1096-2128, dated 12/18/19. Applicant argued that although there was a different Applicant in the linked case, the 10/27/17 surgery in the linked case was the same surgery in the instant matter, the Respondent was the same and the peer review of Dr. Bazos is the same peer review in both cases. Moreover, the parties (Assignor (DD) and Respondent had a full and fair opportunity to litigate the issue which was decided in Applicant's favor.

In the linked case, Arbitrator O'Leary opined:

Further, Dr. Bazos could not recommend the evaluation by Dr. Dowd on October 24, 2017 due to a lack of documented evidence of any pathology of the left knee as a direct result of the motor vehicle accident.

Applicant's counsel argues that, even if everything Dr. Bazos says is true, this accident exacerbated the pre-existing injury. He argues that these injuries are also covered by no-fault. Further, he states that it is not the applicant's burden to establish causation as it is presumed.

I agree.

Based on all the materials before me, and having carefully considered the reports and records submitted by both parties, I find that Respondent's peer review has failed to establish a prima facie case as to lack of medical necessity. I note that the entirety of Dr. Bazo's report is addressed to a purported lack of causation. In this regard, it is significant to note that causation is presumed since "it would not be reasonable to insist that (an applicant) must prove as a threshold matter that (a) patient's condition was 'caused' by the automobile accident." Mount Sinai Hospital v. Triboro Coach, 263 A.D.2d 11, 20, 699 N.Y.S.2d 77 (2nd Dept. 1999). Thus, the burden is on the insurer to come forward with proof establishing by "fact or founded belief" its defense that the claimed injuries have no nexus to the accident. Mount Sinai Hospital v. Triboro Coach, 263 A.D.2d 11, 19 (2nd Dept. 1999). It also remains the case that the Appellate Courts have consistently held that the no-fault insurer must demonstrate not only a lack of causation but that the accident did not exacerbate or aggravate any preexisting condition or injury. This issue was addressed in Kingsbrook v. Allstate, 61 A.D.3d 13, in which the Appellate Division specifically stated that "[e]xacerbations of preexisting conditions are covered by the No Fault Law." Sec. Kingsbrook v. Allstate, supra, at 23.

Accordingly, in light of the foregoing, based on the arguments of counsel and after a thorough review and consideration of all submissions, I find in favor of the Applicant.

I find the award of Arbitrator O'Leary a well-reasoned award which properly applied the no-fault regulations and relevant laws to the facts. I find it persuasive on this issue.

Under the doctrine of collateral estoppel, a party is precluded from relitigating an issue which has been previously decided against it in a prior proceeding where it had a full and fair opportunity to litigate the issue (see D'Arata v. New York Cent. Mut. Fire Ins. Co., 76 N.Y.2d 659 [1990]). 'The two elements that must be satisfied to invoke the doctrine of estoppel are that (1) the identical issue was decided in the prior action and is decisive in the present action, and (2) the party to be precluded from relitigating the issue had a full and fair opportunity to contest the prior issue (see Kaufman v. Lilly Co. [65 N.Y.2d 449, 455 (1985)])' (Luscher v. Arrua, 21 AD3d 1005, 1007 [2005]). 'The burden is on the party attempting to defeat the application of collateral estoppel to establish the absence of a full and fair opportunity to litigate' (D'Arata, 76 N.Y.2d at 664; see also Kaufman, 65 N.Y.2d at 456)." Uptodate Medical Service, P.C. v. State Farm Mutual Automobile Ins. Co., 22 Misc.3d 128(A), 880 N.Y.S.2d 227 (Table), 2009 N.Y. Slip Op. 50046(U) at 2, 2009 WL 78376 (App. Term 2d & 11th Dists. Jan. 9, 2009).

I find that the standard for Collateral Estoppel is met in this case. There is an identity of issues between the cases, namely, whether Respondent's peer review report sufficiently

established a lack of proximate causation between Assignor's injuries and the surgery in dispute. The parties had a full and fair opportunity to contest the prior decision, prosecuted the claims on the merits, and a decision was made on the merits. I find that Respondent's counsel has not sufficiently satisfied its burden to show the absence of a full and fair opportunity to litigate the issue of lack of causality. Moreover, there are no documents to establish that the prior related and linked award has been vacated.

Moreover, the lack of medical necessity for DME prescribed for use post operatively must be evaluated separately and on its own merits. Notably, Master Arbitrator D'Ammora held that *"a determination that the surgery was not medically necessary is not dispositive on the issue of the medical necessity of the DME. Once the surgery is performed the necessity of any DME needed for post-surgical rehabilitation must be evaluated separately and on its own individual merits"* (AAA# 991490519105, 2/27/15). Other arbitrators have similarly ruled notwithstanding a conclusion that the surgical procedure was unnecessary; See Isurply LLC and State Farm Mutual Automobile Insurance Company, AAA 17-16-1039-7572 (Arbitrator Victor Moritz, July 24, 2017); AAMG Leasing Corp. v. Geico Ins. Co., AAA 412012118410 (Arbitrator Stacey Charkey, July 13, 2013).

Here, Dr. Bazos failed to discuss the medical necessity of the DME in his peer review.

Based upon the foregoing, I find that Respondent's denials based upon lack of causation cannot be sustained.

Accordingly, Applicant's claim is granted. Applicant is awarded \$1,839.78

This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator. Any further issues raised in the hearing record are held to be moot, without merit, and/or waived insofar as not raised at the time of the 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
	Town Supply Inc	10/28/17 - 11/24/17	\$1,839.78	Awarded: \$1,839.78
Total			\$1,839.78	Awarded: \$1,839.78

B. The insurer shall also compute and pay the applicant interest set forth below. 10/11/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant's award shall bear interest at a rate of two percent per month, calculated on a pro rata basis using a 30-day month from the date payment became overdue to the date of the payment of the award pursuant to 11 NYCRR 65-3.9. The end date for the calculation of the period of interest shall be the date of payment of the claim. General Construction Law § 20 ("The day from which any specified period of time is reckoned shall be excluded in making the reckoning.")

Where a claim is timely denied, interest shall begin to accrue as of the date arbitration is requested by the claimant unless arbitration is commenced within 30 days after receipt of the denial, in which event interest shall begin to accrue as of the 30th day after proof of claim was received by the insurer. 11 NYCRR 65-4.5(s)(3), 65-3.9(c); Canarsie Medical Health, P.C. v. National Grange Mut. Ins. Co., 21 Misc.3d 791, 797 (Sup. Ct. New York Co. 2008) ("The regulation provides that where the insurer timely denies, then the applicant is to seek redress within 30 days, after which interest will accrue.")

C. Attorney's Fees

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

Respondent shall pay Applicant a separate attorney's fee, in accordance with 11 NYCRR 65-4.6(d). Since the within arbitration request was filed on or after February 4, 2015, this case is subject to the provisions promulgated by the Department of Financial

Services in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant an attorney's fee, in accordance with 11 NYCRR 65-4.6(d) subject to a maximum fee of \$1,360.

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

01/07/2021

(Dated)

Gregory Watford

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:
bc497150cd2b1bffc3d482185a972f2

Electronically Signed

Your name: Gregory Watford
Signed on: 01/07/2021