American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

| | | |
|---|---|---|
| Queens Arthroscopy & Sports Medicine PC (Applicant) | AAA Case No. | 17-19-1134-6885 |
| | Applicant's File No. | 00041744 |
| - and - | Insurer's Claim File No. | 1045989-04 |
| | NAIC No. | 16616 |
| American Transit Insurance Company (Respondent) | | |

**ARBITRATION AWARD**

I, Kihyun Kim, 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: the Assignor

1. Hearing(s) held on 03/19/2021
   Declared closed by the arbitrator on 03/19/2021

   Justin Rosenbaum, Esq. from Drachman Katz, LLP participated for the Applicant

   Dmitriy Dykman, Esq. from American Transit Insurance Company participated for the Respondent

2. The amount claimed in the Arbitration Request, **$ 10,830.58**, 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
   The issues presented are (1) whether verification remains outstanding with respect to certain claims for an office consultation, (2) whether Respondent established its policy violation defense of "IME no show," and (3) whether the left shoulder arthroscopy and derivative/associated were medically necessary and causally related to the accident of record.

   The Assignor (OB) was a 50-year-old male who was the driver of an automobile that was involved in an accident on December 3, 2018. Applicant seeks reimbursement in the aggregate amount of $10,830.58 for an office evaluation of the Assignor conducted on January 8, 2019, and for the professional services related to an arthroscopy of the left

shoulder of the Assignor conducted on March 22, 2019. Reimbursement for the arthroscopy was denied based upon, among other things, the peer review by Richard Weiss, M.D., dated November 8, 2019.

4. Findings, Conclusions, and Basis Therefor

This arbitration was conducted using the documentary submissions of the parties contained in the ADR Center, maintained by the American Arbitration Association. I have reviewed the documents contained therein as of the closing of the hearing, and such documents are hereby incorporated into the record of this hearing. The hearing was held by Zoom video conference. Both parties appeared at the hearing by counsel, who presented oral argument and relied upon their documentary submissions. There were no witnesses. Further, this matter was heard with linked cases, *EMU Surgical Center LLC d/b/a EMU Health and American Transit Insurance Company*, AAA Case No: 17-20-1158-1837, and *Queens Arthroscopy & Sports Medicine PC and American Transit Insurance Company*, AAA Case No: 17-20-1178-1118. The documents uploaded to the ADR Center for this case, as well as for the linked cases, were considered in making this award.

The Assignor was a 50-year-old male who was injured in an automobile accident on December 3, 2018. The Assignor sought treatment for his injuries from various providers, including Applicant.

On January 8, 2019, the Assignor presented to Laxmidhar Diwan, M.D. for an office evaluation. Applicant thereafter billed Respondent for its services. Respondent acknowledged receipt of the bill but asserted that Applicant's claim should be dismissed without prejudice as premature as additional verification remain outstanding.

On March 22, 2019, the Assignor underwent an arthroscopy of the left shoulder performed by Laxmidhar Diwan, M.D., at a surgical center in Glendale, New York. Applicant billed Respondent for its services and Respondent initially requested additional verification with respect to Applicant's claims. Eventually, Respondent denied Applicant's claims based upon the November 8, 2019 peer review by Richard Weiss M.D., who found the surgery and all derivative services related to, or as a result of the surgery to be medically unnecessary and not causally related to the accident of record. Respondent also denied Applicant's claims based on the Assignor's failure to appear for IMEs on August 7, 2019 and September 16, 2019.

Applicant now seeks reimbursement in the aggregate amount of $10,830.58 for an office evaluation of the Assignor conducted on January 8, 2018, and for the professional services relating to an arthroscopy of the left shoulder of the Assignor conducted on March 22, 2019.

**DATE OF SERVICE: 1/8/19**

**Legal Framework - Tolling of claims/Verification**

The general rule regarding payment of claims is set forth in 11 NYCRR §65-3.8(c), which states that "within 30 calendar days after proof of claim is received, the insurer

shall either pay or deny the claim in whole or in part." No-Fault benefits are overdue if not paid within 30 calendar days after the insurer receives proof of claim, which shall include verification of all of the relevant information requested pursuant to 11 NYCRR §65-3.5. *See* 11 NYCRR §65-3.8(a). As such, a claim need not be paid or denied until all demanded verification is provided. *See Nyack Hospital v. General Motors Acceptance Corp.,* 27 A.D.3d 96, 808 N.Y.S.2d 399 (2d Dept. 2005), *mod'd on other grounds,* 8 N.Y.3d 294, 832 N.Y.S.2d 880 (2007).

**Verification**

11 NYCRR §65-3.5 (c) mandates that the insurer is entitled to receive all items necessary to verify the claim directly from the parties from whom such verification was requested. The insurer has 15 business days from the date it receives the prescribed verification forms to seek additional verification from an Applicant. *See* 11 NYCRR §65-3.5 (b). Thereafter, "at a minimum, if any requested verification has not been supplied to the insurer 30 calendar days after the original request, the insurer shall, within 10 calendar days, follow up with the party from whom the verification was requested, either by telephone call, properly documented in the file, or by mail. At the same time the insurer shall inform the applicant and such person's attorney of the reason(s) why the claim is delayed by identifying in writing the missing verification and the party from whom it was requested." *See* 11 NYCRR §65-3.6 (b). If the additional verification required by the insurer is a medical examination, the insurer shall schedule the examination to be held within 30 calendar days from the date of receipt of the prescribed verification forms. 11 NYCRR §65-3.5 (d)

Upon receipt of a verification request, it is incumbent upon the Applicant to respond. ( *Dilon Medical Supply Corp v. Travelers Insurance Company* , 7 Misc. 3d 927, 796 N.Y.S.2d 872 (N.Y.
Civ Ct. Kings County 2005); *Westchester County Medical Center v. N.Y. Central Mutual Fire Ins. Co.*, 262 A.D.2d 553, 692 N.Y.S.2d 665 (2nd Dep't1999); *Canarsie Chiropractic, P.C. v. State Farm Mutual Automobile Ins. Co.*, 27 Misc. 3d 1228(A), 2010 NY Slip Op 50950(U) (N.Y. Civ Ct. Kings County 2010)). On the other hand, it has been held that a response to a verification request that is "arguably responsive" places the burden to take further action upon the respondent. *See All Health Medical Care, P.C. v. Gov't Empls. Ins, Co.*, 2 Misc.3d 907 (N.Y. City Civ. Ct. 2004); *see also, Media Neurology, P.C. v. Countrywide Ins. Co.*, 21 Misc.3d 1101 (N.Y. City Civ. Ct. 2005). The Court, in *Canarsie Chiropractic, P.C. v. State Farm Mut. Auto. Ins. Co.*, 911 N.Y.S.2d 691 (Table), 27 Misc. 3d 1228(A)(Civ. Ct. Kings Cty. 2010), expressed, "[N]either party may ignore communications from the other without risking its chance to prevail in the matter." *Id.*

If an insurer asserts that the claim(s) are premature due to outstanding verification, the insurer must demonstrate that the verification request and follow-up verification request were timely issued, and that no response was received. *Compas Med., P.C. v. Praetorian* , 49 Misc 3d 129(A), 2015 NY Slip Op 51403(U)(App Term, 2nd , 11th and 13th Jud. Dists. 2015). If demonstrated, the matter will be deemed premature and not ripe for adjudication. *Mount Sinai Hosp. v. Chubb Group of Ins. Cos*., 43 AD3d 889, 2007 NY Slip Op 06650 (App. Div., 2nd Dept., 2007).

**EUO as Verification**

The Mandatory Personal Injury Endorsement, outlined in 11 NYCRR §65-1.1 confers upon the insurer the right to request the eligible injured person or that person's assignee or representative to submit to examinations under oath as may reasonably be required. Section 65-3.5(e) specifically includes an examination under oath as a verification request (in addition to being a condition of coverage) which an insurer may require in order to establish proof of claim. *See* Ops Gen Counsel NY DFS No. 06-12-16 (December 2006). 11 NYCRR §65-3.5(e) states:

> All examinations under oath and medical examinations requested by the insurer shall be held at a place and time reasonably convenient to the applicant and medical examinations shall be conducted in a facility properly equipped for the performance of the medical examination. The insurer shall inform the applicant at the time the examination is scheduled that the applicant will be reimbursed for any loss of earnings and reasonable transportation expenses incurred in complying with the request. When an insurer requires an examination under oath of an applicant to establish proof of claim, such requirement must be based upon the application of objective standards so that there is specific objective justification supporting the use of such examination. Insurer standards shall be available for review by Department examiners.

As the request for an EUO constitutes a request for verification, it is subject to the follow-up provisions of 11 NYCRR Section 65-3.6(b). *See* Ops Gen Counsel NY DFS No. 06-12-16 (December 2006). In the case of an examination under oath or a medical examination, the verification is deemed to have been received by the insurer on the day the examination was performed. 11 NYCRR §65-3.8(a).

**Analysis - Tolling/Verification - Office - DOS 1/8/19**

In the present case, Applicant billed Respondent in the amount of $299.26 under CPT code 99245 for an office consultation performed on January 8, 2019. Upon receipt, Respondent sent a "First Request" for additional verification with respect to Applicant's claim on February 20, 2019. The letter to Applicant stated, in pertinent part, that:

> Please be advised the entire claim is delayed pending an examination under oath of the claimant, scheduled to verify the claim.

On March 27, 2019, Respondent sent Applicant a follow-up "Second Request" for additional verification with respect to Applicant's claim. The letter again advised that the entire claim was delayed pending an examination under oath of the Assignor.

By letter, dated April 1, 2019, Applicant responded to Respondent's letters advising that it was disputing the decision to delay payment of the claim pending examination under oath of the Assignor. By letter, dated April 16, 2019, Respondent acknowledged receipt of Applicant's correspondence on April 5, 2019 (a date-stamped copy is included in the record) but maintained its position, informing Applicant that the entire claim was delayed pending an examination under oath of the Assignor.

Respondent did not upload any EUO scheduling letters to the record. However, Respondent did upload a copy of the EUO transcript that establishes that the EUO of the Assignor was held on June 12, 2019.

Following the EUO, on June 18, 2018, Respondent sent an initial request for post-EUO additional verification to the Assignor c/o of the Assignor's counsel, seeking "[p]hotos captured at the scene of the accident," which the Assignor had discussed in his EUO testimony. The letter was cc:d to the Assignor and various providers, including Applicant. A follow-up request for post-EUO additional verification was sent to the Assignor c/o of the Assignor's counsel on July 23, 2019, seeking the same information. The follow-up letter was cc:d to the Assignor and various providers, including Applicant. The record also includes a verification response letter stating that the information was not in its possession but the response was apparently from a different provider and relates to a different claimant.

At the hearing, Respondent asserted that Applicant's claim was premature as the photos at the scene were still outstanding. Respondent pointed to an award by Arbitrator Kenneth Rybacki in linked case, *Value Care Pharmacy, Inc and American Transit Insurance Company*, AAA Case No: 17-19-1136-0499 (June 4, 2020), where the claims therein were dismissed as premature as additional verification, namely the scene photographs, remained outstanding.

After reviewing all of the submissions and taking into account the oral arguments of the parties, I find that Respondent's lack of verification defense cannot be sustained. Notwithstanding Arbitrator Rybacki's award in AAA Case No: 17-19-1136-0499, Respondent's lack of verification defense herein initially depends upon whether the specific claim at issue was properly tolled by Respondent extending the 30 day time period to pay or deny the claim. Respondent has failed to upload sufficient proof that Applicant's claim was properly tolled for any additional verification. The February 19, 2019 and March 26, 2019 letters that were uploaded to the record should be considered "delay letters" as to Applicant's claim as no specific verification was requested from Applicant in these letters. The law is clear that such "delay letters" do not toll the statutory time period within which a claim must be paid or denied. *See Points of Health Acupuncture, P.C. v. Lancer Ins. Co.*, 28 Misc.3d 133(A), 2010 N.Y. Slip Op. 51338(U), 2010 WL 2990138 (App. Term 2d , 11th & 13th Dists. July 22, 2010). Respondent did not upload to the record any EUO scheduling letters that were apparently sent to the Assignor; thus, it is impossible to determine whether the EUO of the Assignor was scheduled consistently with the regulations as to allow for an extension of the time to pay or deny the claims herein. *See* 11 NYCRR §65-3.5 (b), 11 NYCRR §65-3.6 (b). I also found no EUO scheduling letters in the case files in the linked cases that were heard with this case. While the EUO was, in fact, held on June 12, 2019, I also find nothing in the record that allows me to infer that EUO scheduling letters were send to the Assignor in accordance with 11 NYCRR §65-3.5 (b) and 11 NYCRR §65-3.6 (b) with respect to the bill at issue herein, particularly as the bill was received approximately four months prior to the EUO. The EUO could have been requested at any time during that four month period before or after the normal 30 day

time period to pay or deny the claim. Respondent has simply failed to upload sufficient proof that Applicant's claim for the office consultation was properly tolled for additional verification in the first instance.

Even if such failure could be overlooked, I also question whether the June 18, 2019 and July 23, 2019 post-EUO verification requests sent to the Assignor would have been sufficient to continue any purported tolling of the claim herein. While such letters were cc:d to the various providers, no specific claims were identified. Under the regulations, with respect to an examination under oath, verification is deemed to have been received by the insurer on the day the examination was performed. 11 NYCRR §65-3.8(a). Thus, arguably any new post-EUO verification requests, even if permitted, would arguably have had to have been sent to Applicant consistent with requirements of 11 NYCRR §65-3.5 (b) and 11 NYCRR §65-3.6 (b) to toll the claim at issue. I do not believe that simply cc:ing Applicant on a post-EUO verification request letter sent to the Assignor is consistent with the requirements in the regulations, especially as no specific claims to be tolled/delayed were identified.

In any event, Respondent has failed to upload sufficient proof that Applicant's claim was properly tolled for additional verification in the first instance. Thus, on this record, Respondent was required to pay or deny Applicant's claim within 30 days. As such, Applicant is entitled to reimbursement in the amount of $299.26 for an office consultation performed on January 8, 2019.

**DATE OF SERVICE: 3/22/19**

**Legal Framework - IME no show**

The appearance at scheduled IMEs is a condition precedent to No-Fault coverage, and the failure to attend entitles the insurer to deny the claim. *American Transit Ins. Co. v. Marte-Rosario*, 111 A.D.3d 442, 974 N.Y.S.2d 411 (1st Dept. 2013). Regulation 11 NYCRR 65-1.1 provides that the eligible injured person shall submit to an independent medical examination (IME) by physicians selected by the insurance company as the company may reasonably require. The request for an IME constitutes a request for verification whether it is made before a claim is submitted, or after the submission of a claim as additional verification, and as such, is subject to the follow-up provisions of 11 NYCRR Section 65-3.6(b). *See* Ops Gen Counsel NY DFS No.: 05-02-21 (2005). 11 NYCRR § 65-3.5(d) states that, "If the additional verification required by the insurer is a medical examination, the insurer shall schedule the examination to be held within 30 calendar days from the date of receipt of the prescribed verification forms."

An insurer makes its prima facie showing of the defense by demonstrating that two separate requests for IMEs were mailed to the assignor and that the assignor failed to appear for the examination on either scheduled date pursuant to the requests. *Apollo Chiropractic Care, P.C. v. Praetorian Insurance Company*, 27 Misc.3d 139(A), 2010 N.Y. Slip Op. 50911(U) (1st Dept. 2010). It is incumbent upon the insurer to establish that the scheduling letters were properly and timely addressed and mailed, *see SK Prime Medical Supply, Inc. v. Hertz Claim Management Corp.*, 37 Misc.3d 138(A), 2012 N.Y. Slip Op. 52192(U) (App. Term 1st Dept. 2012); *Ortech Express Corp. v. MVAIC*, 37 Misc.3d 128(A), 2012 N.Y. Slip Op. 51913(U) (App. Term 1st Dept. 2012); *Perfect*

*Point Acupuncture, P.C. v. Auto One Insurance Company*, 36 Misc.3d 140(A), 2012 N,Y. Slip Op. 51486(U) (App. Term 2nd, 11th and 13th Jud. Dists. 2012), and contained the required notice regarding reimbursement of travel expenses and lost wages. *See Matter of Venditti (General Acc. Ins.)*, 236 A.D.2d 759 (3rd Dept. 1997) (IME requests were "null and void" in that they failed to advise petitioner that he would be reimbursed for loss earnings and transportation expenses in complying therewith). Moreover, in order to sustain its "no show" defense, the Respondent must demonstrate that the disputed bill or bills were timely denied based on the IP's non-appearance. *Westchester Medical Center v. Lincoln General*, 60 AD3d 1045 (2nd Dept. 2009).

**Analysis - IME no show - Left Shoulder Arthroscopy - DOS 3/22/19**

In the present case, Applicant billed Respondent in the amount of $10,531.32 for the professional services relating to an arthroscopy of the left shoulder of the Assignor conducted on March 22, 2019. The record establishes that Respondent received such bill on April 30, 2019. Upon receipt, Respondent initially made requests for additional verification for the bill. Ultimately, Respondent denied the bill based on, among other things, the Assignor's failure to appear for IMEs on August 7, 2019 and September 16, 2019.

In support of its defense of IME no show, Respondent uploaded to the ADR Center a copy of the denial; the requests for additional verification; a letter of representation from the Assignor's counsel; a transcript, dated June 12, 2019, of the EUO of the Assignor; the general denial, dated October 2, 2019; the IME scheduling letters addressed to the Assignor and cc'd to the Assignor's counsel of record; an affidavit, dated February 11, 2020, by Stuart Hershon, M.D., regarding the Assignor's failure to appear for the scheduled IME on August 7, 2019; an affidavit, dated March 10, 2020, by Carlos Montero, M.D., regarding the Assignor's failure to appear for the scheduled IME on September 16, 2019; a mailing affidavits from employees of Respondent's third-party IME vendor regarding the mailing of the IME scheduling letters to the Assignor and Assignor's counsel; the Assignor's NF-2 and the police report for the accident of record.

At the hearing, Applicant's counsel asserted that the Respondent failed to comply with the regulations with respect to the IME verification requests, that the claims were not properly tolled for the IME, and that the denial was untimely. Among other things, Applicant asserted that Respondent did not timely request any IMEs in relation to the claims at issue herein; and that the first scheduled IME was scheduled more than thirty days after the receipt of Applicant's bill. Relying on *Unitrin Advantage Ins. Co. v Bayshore Physical Therapy, PLLC*, 82 AD3d 559 (1st Dept. 2011), Respondent asserted that its IME no show defense was proper as the Assignor's failure to appear for the IMEs was a breach of a policy condition voiding the policy *ab initio*.

After reviewing all of the submissions and taking into account the oral arguments of the parties, I find that Respondent's defense based upon the Assignor's failure to appear at IMEs on August 7, 2019 and September 16, 2019 cannot be sustained. The parties do not dispute that the bill at issue was received on April 30, 2019. The record further establishes that the first IME scheduling letter was sent to the Assignor on July 5, 2019, scheduling an IME for July 24, 2019. While this IME was subsequently rescheduled and the Assignor subsequently failed to appear for IMEs on August 7, 2019 and September

16, 2019, it cannot be disputed that the first scheduling letter was sent more than 30 days after receipt of the Applicant's bill herein. More importantly, the first scheduled IME was not scheduled to be held within 30 calendar days from the date of receipt of the bill in violation of the requirements of 11 NYCRR § 65-3.5(d). *See American Tr. Ins. Co. v Longevity Med. Supply, Inc.*, 131 AD3d 841 (1st Dept. 2015).

There is also nothing in the record that shows that Respondent ever delayed or properly tolled Applicant's claims in any way based on the IMEs. While Respondent uploaded all of the IME scheduling letters that were sent to the Assignor, there are no delay letters, timely or even untimely, informing Applicant that its claims were being delayed pending the IME of the Assignor; in fact, there is nothing in the record that shows that Applicant was ever informed of the IME of the Assignor in any way during the processing of its claim until the denial was issued on November 13, 2019. Further, the denial issued on November 13, 2019 was mailed more than 30 days after the second alleged non-appearance on September 16, 2019. Respondent's failure to timely notify of any verification delay/toll pending the IME impermissibly violated 11 NYCRR 65-3.5(b) and 65-3.6(b) with respect to Applicant's bill, and the IME scheduling letters should be considered nullities as to Applicant's claims (and even more so, as they were mailed well after 30 days from receipt of Applicant's bill). While I do note that Respondent did make some timely and proper requests for other additional verification, it has been held that, "the Regulations do not provide that such a toll grants an insurer additional opportunities to make requests for verification that would otherwise be untimely." *Neptune Medical Care, P.C. v Ameriprise Auto & Home Ins.*, 2015 NY Slip Op 51220(U), (App. Term 2nd, 11th and 13th Dists. 2015).

To the extent that Respondent's relies upon *Unitrin Advantage Ins. Co. v. Bayshore Physical Therapy, PLLC*, 82 AD3d 559 (1st Dept. 2011) *lv denied* 17 NY3d 705 (2011), in which the court held that breach of a policy condition voids the policy *ab initio* and is not precludable even when not raised in a timely denial. I first note that, in *Unitrin*, the court found that the insurer had "requested IME's in accordance with the procedures and time frames set forth in the no-fault implementing regulations…" Thus, the facts in *Unitrin* are distinguishable from the facts herein, where Respondent impermissibly violated the requirements of 11 NYCRR § 65-3.5(b) and § 65-3.6(b) with respect to Applicant's bills. In fact, the First Department has enumerated through the line of cases following *Unitrin* that even if the failure of a person eligible for no-fault benefits to appear for a properly noticed IME constitutes a breach of a condition precedent vitiating coverage, the insurer must still demonstrate that it has satisfied the foundational timeliness requirements of 11 NYCRR 65-3.5 (b) and 11 NYCRR 65-3.6 (b). *See Unitrin Advantage Ins. Co. v All of NY, Inc.*, 2018 Slip Op 00810, 158 AD3d 449 (App Div. 1st Dept. 2018); *see also American Tr. Ins. Co. v Longevity Med. Supply, Inc.*, *supra*. Respondent failed to upload any case law, briefs or authority to excuse its failure to follow the clear requirements for verification and tolling set forth in the regulations. Moreover, excusing such Respondent's failures under the circumstances set forth herein would seem inconsistent with the goals of No-Fault regulatory scheme that requires prompt processing and payment of claims.

Based on all of the foregoing, Respondent's defense based upon IME no show cannot be sustained.

**Legal Framework - Causation**

With regard to causation of injuries in no fault matters, the courts have held 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 Hosp. v. Triboro Coach*, 263 A.D.2d 11, 20 (2d Dept. 1999). Thus, the initial 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, *id.* at 19 (quoting *Central Gen. Hosp. v. Chubb Group of Ins. Cos.*, 90 N.Y.2d 195, 199), that is, that the conditions were not caused or exacerbated by the accident. S*ee Mount Sinai*, 263 A.D.2d 11, 18 - 19; *Kingsbrook Jewish Medical Center v. Allstate Ins. Co.*, 61 A.D. 3d 13, 871 N.Y.S.2d. 680 (2d Dept. 2009). Since No-Fault covers exacerbations of pre-existing conditions, *see Wolf v. Holyoke Mut. Ins. Co.*, 3 A.D.3d 660 (3d Dept. 2004), and if the insurer's own medical expert does not eliminate the possibility that the injured person sustained an exacerbation of a degenerative process, Respondent will be liable for coverage. *See Sanclemente v. MTA Bus Co.*, 2014 NY Slip Op 02280 (2d Dept., April 2, 2014); *Rodgers v. Duffy*, 95 A.D.3d 864 (2d Dept. 2012); *Pfeiffer v. New York Cent. Mut. Fire Ins. Co.*, 71 A.D.3d 971 (2nd Dept. 2010).

**Legal Framework - Medical Necessity**

The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment (*Kingsbrook Jewish Medical Center v. Allstate Ins. Co.*, 61 A.D.3d 13 [2d Dept. 2009]), such as by a qualified expert performing an independent medical examination or conducting a peer review of the injured person's treatment. *See Rockaway Boulevard Medical P.C. v. Travelers Property Casualty Corp.*, 2003 N.Y. Slip Op. 50842(U), 2003 WL 21049583 (App. Term 2d & 11th Dists. Apr. 1, 2003).

To support a lack of medical necessity defense Respondent must "set forth a factual basis and medical rationale for the peer reviewer's determination that there was a lack of medical necessity for the services rendered." *See Provvedere, Inc. v. Republic W. Ins. Co.*, 42 Misc 3d 141(A), 2014 NY Slip Op 50219(U) (App. Term 2d, 11th and 13th Jud. Dists. 2014). 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 generally, Bronx Expert Radiology, P.C. v. Travelers Ins. Co.*, 13 Misc 3d 136(A), 2006 NY Slip Op 52116 (App Term 1st Dept. 2006). The Appellate Courts have not clearly defined what satisfies this standard except to the extent that "bald assertions" are insufficient. *Amherst Med. Supply, LLC v. A. Cent. Ins. Co.*, 41 Misc 3d 133(A), 2013 NY Slip Op 51800(U) (App. Term 1st Dept. 2013). However, there are myriad civil court decisions tackling the issue of what constitutes a "factual basis and medical rationale" sufficient to establish a lack of medical necessity.

The civil courts have held that a defendant's peer review or medical evidence must set forth more than just a basic recitation of the expert's opinion. The trial 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 generally Nir v. Allstate Ins. Co.*, 7 Misc.3d 544, 547 (Civ. Ct. Kings Co. 2005). "Generally accepted practice is that range of practice that the profession will follow in the diagnosis and treatment of patients in light of the standards and values that define its calling." *Id.*, at 547 (*citing City Wide Social Work & Psychological Servs. v. Travelers Indem. Co.*, 3 Misc. 3d 608, 612 [Civ. Ct., Kings County 2004]).

To meet the burden of persuasion regarding medical necessity - in the absence of factually contradictory records - the applicant must submit a rebuttal which meaningfully refers to and rebuts the assertions set forth in the peer review report. *See generally, Pan Chiropractic, P.C. v Mercury Ins. Co.*, 24 Misc 3d 136[A], 2009 NY Slip Op 51495[U] (App Term, 2d, 11th & 13th Jud Dists 2009).

**Peer Review - Richard Weiss, M.D., dated November 8, 2019**

Respondent relies principally upon the peer review report of Richard Weiss, M.D., dated November 8, 2019, in asserting lack of causation and lack of medical necessity for the professional services relating to an arthroscopy of the left shoulder of the Assignor conducted on March 22, 2019. At the outset, the peer report lists the various medical records that Dr. Weiss reviewed, and provides a brief medical history of the accident and the treatment that the Assignor received. Dr. Weiss opined that, "Based on review of the medical records medical necessity has not been established for left shoulder shaving and debridement of the rotator cuff and the labral tear, complete synovectomy, lysis of adhesions, CA ligament release and intraarticular injection performed on 3/22/19 or any associated services."

Dr. Weiss noted that:

> According to the medical records, the claimant was involved in a motor vehicle accident on 12/3/18 and came under the care of Dr. Diwan. He was diagnosed with left shoulder tendinosis of the anterior and central fibers of the supraspinatus of the left shoulder, anterior and inferior labrum tear compatible with a Bankart tear of the left shoulder.
>
> According to the film review from Dr. Fitzpatrick dated 11/6/19 the left shoulder MRI study revealed no traumatic findings and findings were chronic which included tendinosis.
>
> Based on my review of the available records there is no clinical indication for causally related left shoulder arthroscopy surgery. Additionally the claimant should have received a complete conservative treatment plan prior to undergoing any surgical intervention. Conservative treatment (rest, ice packs, nonsteroidal anti-inflammatory drugs and physical therapy) is usually sufficient. Some patients benefit from steroid injection, and a few require surgery. ("Management of Shoulder Impingement Syndrome and Rotator Cuff Tears", Allen E. Fongemie, M.D., Daniel D. Buss, M.D., and Sharon J. Rolnick, Ph.D.) Based upon the above findings, the claimant did not meet the criteria for surgical intervention. In addition, based on my opinion that the surgery was not medically necessary, any

> derivative services related to, or as a result of the surgery should also be denied, including all as noted below ancillary and associated with the procedure as discussed.

He then quoted the AMA definition of medical necessity.

**Analysis - Medical Necessity/Causation - Arthroscopy - DOS 3/22/19**

At the hearing, Applicant asserted that collateral estoppel is applicable herein as the undersigned previously ruled against Respondent in linked case, *Protechmed Inc. and American Transit Insurance Company,* AAA Case No: 17-19-1149-3816 (December 6, 2020), relating to the same peer review and surgery at issue herein. In AAA Case No: 17-19-1149-3816, I found:

> After reviewing all of the submissions and taking into account the oral arguments of the parties, I find that Dr. Weiss' peer review fails to set forth a factual basis and medical rationale for his determination that post-operative DME was medically unnecessary. With respect to the alleged lack of causation, Respondent also failed to meet its burden to support its defense. I find the peer report to be conclusory and unpersuasive.
>
> I first note that Dr. Weiss failed to make any direct argument regarding the utility and medical necessity of the pneumatic compression device, non-segmental pneumatic appliance and shoulder orthosis, or their specific relationship to the accident record. Respondent's and Dr. Weiss's determinations that such items were medically unnecessary and not causally related to the accident of record were based solely on Dr. Weiss's determination regarding the surgery itself and that such items were derivative of the surgery.
>
> I also note that Dr. Weiss's opinion was largely based upon Dr. Fitzpatrick's "independent radiology evaluation," dated November 6, 2019, two days prior to the peer review. While my analysis might be somewhat different if Dr. Weiss's opinion was based on his own review of the MRI films, there is no indication that Dr. Weiss made his own independent review and assessment of the MRI study. Rather, it appears that Dr. Weiss simply accepted and relied on the radiology review by Dr. Fitzpatrick to reach his conclusion while apparently ignoring, without adequate explanation or any meaningful discussion, other credible evidence of the Assignor's post-accident left shoulder injury, including Dr. Payne's original impression of the MRI of the left shoulder of "Tendinosis of anterior and central fibers of supraspinatus, reactive subacromial/sub deltoid bursitis, and anteroinferior labral tear, the appearance compatible with Bankart tear." Dr. Weiss's lack of explanation for his selective reliance on the "after the fact" radiology review is particularly concerning in this case as Dr. Payne's original impression, including the labral tear was largely confirmed by the surgery, while Dr. Fitzpatrick's review impression noted only supraspinatus tendinosis and small glenohumeral joint effusion. Further, Dr. Fitzpatrick even noted that the joint effusion could be the result of recent trauma. The lack of explanation in the peer review demonstrates the conclusory nature of Dr. Weiss's opinion. The Assignor's post-accident subjective complaints of left shoulder pain and numerous positive

objective findings documented throughout the Assignor's medical record provide additional credible evidence of the Assignor's post-accident left shoulder injury.

To establish a lack of causation, the insurance carrier must show that the condition or injuries are not related to the subject accident at all. *See, Mount Sinai v. Triboro Coach*, 263 A.D.2d 11, 699 N.Y.S.2d 77 (2d Dep't 1999). The insurer must show how, when, and where the injuries were sustained and that there was no aggravation or exacerbation due to the covered accident. *Id.* Under the No-Fault Law causation is presumed and exacerbations of pre-existing injuries are covered. *Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co.*, 61 A.D.3d 13, 871 N.Y.S.2d 680 (2d Dep't 2009). The Assignor's subjective complaints and numerous positive objective findings documented in the record clearly support that the Assignor had some injury to his left shoulder following the accident on December 3, 2018; both Dr. Weiss and Dr. Fitzpatrick appear to concede as much. However, Dr. Weiss and Dr. Fitzpatrick never address the issue of possible exacerbation or aggravation. There was no evidence in the record to demonstrate that the Assignor was symptomatic before the subject accident and causation is presumed. Further, Dr. Fitzpatrick's own conclusion of "no traumatic injury" was contradicted by his own statement that the joint effusion may be the result of recent trauma. I find that Respondent failed to put forth sufficient credible proof to support its lack of causation defense and has failed to meet its burden of production.

With respect to the alleged lack of medical necessity, Dr. Weiss generally appeared to equate lack of medical necessity with lack of causation. I note that he found "there was no causally related medical necessity" herein, which in and of itself is arguably vague and ambiguous. While lack of causation and lack of medical necessity may each relieve Respondent of any obligation to provide no fault benefits, lack of causation does not equate to lack of medical necessity. The peer report says little about the medical standards implicated in this case or whether or not such standards were met herein. Dr. Weiss's statement that there was "no clinical indication for causally related left shoulder arthroscopy surgery" is ambiguous and conclusory. As noted above, his opinion ignores, without adequate explanation or any meaningful discussion, substantial credible evidence of the Assignor's post-accident left shoulder injury, including the evidence of possible tears in the shoulder, which would arguably support the clinical necessity of the surgery. While Dr. Weiss asserted that, "conservative treatment (rest, ice packs, nonsteroidal anti-inflammatory drugs and physical therapy) is usually sufficient" in the treatment of shoulder injuries, he failed to provide any standards regarding how much conservative care is required before considering surgery and failed to adequately indicate, with reference to the clinical findings, how such standards were not met in this case as specifically applied to the Assignor. Also, as noted above, Dr. Weiss failed to make any direct argument regarding the utility and medical necessity of the pneumatic compression device, non-segmental pneumatic appliance and shoulder orthosis prescribed and provided in this case. The opinions offered by Dr. Weiss were simply conclusory, without any meaningful discussion of, or adequate support from, the Assignor's medical record. Dr. Weiss failed to adequately explain how the surgery or the post-operative DME in this case was a deviation from the standard of care.

> As Respondent has failed to meet its burden of production, I need not review the evidence submitted by Applicant to rebut Respondent's position. I find that presumption of medical necessity and causation attached to Applicant's prima facie case stands.
>
> Even assuming, *arguendo*, the peer review was sufficient to meet the burden of production, the defense would still fail as Applicant has submitted a more persuasive rebuttal by Dr. Diwan that meaningfully and adequately addresses and rebuts the assertions by Dr. Weiss with respect to the medical necessity and causation of surgery and post-operative DME at issue. Among other things, Dr. Diwan asserted, with support from medical authority, that "one cannot definitively diagnose a degenerative/nontraumatic injury purely based on MRI results," and that, "MRI is not 100% accurate and is only one part of a patient's complete clinical picture." Dr. Diwan highlighted the Assignor's complaints and positive objective findings from the Assignor's medical record demonstrating the Assignor's left shoulder injuries, including the labral tear, which was actually confirmed by the surgery, and explained that the Assignor failed to respond to the conservative modalities of treatment. In this case, based on the evidence presented, I find that deference should be accorded to the treating provider, who actually performed examinations, established treatment and diagnostic plans, made diagnoses and performed medical services for the Assignor. Ultimately, I find the rebuttal and Applicant's supporting medical records and arguments are more credible and persuasive than the peer review.

The award was also subsequently reviewed by Master Arbitrator Richard B. Ancowitz who affirmed the award in its entirety by Master Arbitration Award, dated March 9, 2021, just ten days prior to the hearing. *See Protechmed Inc. and American Transit Insurance Company,* AAA Case No: 99-19-1149-3816 (March 9, 2021). Respondent's counsel acknowledged at the hearing that Respondent was aware of the earlier arbitration and master arbitration award and that the peer review at issue in such proceeding was the same peer review at issue herein, addressing the lack of medical necessity of the same surgery, along with the associated services and post-operative supplies. Respondent's counsel failed to provide any reason, or even argument, why collateral estoppel should not apply herein.

"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).

It is within the arbitrator's authority to determine the preclusive effect of a prior arbitration. *Matter of Falzone v. New York Central Mutual Fire Ins. Co.*, 15 N.Y.3d 530, 914 N.Y.S.2d 67 (2010), aff'g, 64 A.D.3d 1149, 881 N.Y.S.2d 769 (4th Dept. 2009).

The two prongs required to invoke collateral estoppel are present herein. This case involves the identical issues, lack of causation and lack of medical necessity of the surgery with the associated services, and the party to be precluded, Respondent, had a full and fair opportunity to contest the issue. Thus, I find that Respondent is precluded from relitigating the causation and medical necessity issues as collateral estoppel applies. The prior determination is dispositive of the causation and medical necessity issues herein.

Even assuming, *arguendo*, that collateral estoppel did not apply directly, Respondent's defense would still fail as I find the rationale in my prior award to be persuasive and Applicant has submitted sufficient evidence to adequately address and rebut the peer review and establish the causation and medical necessity of the services at issue. In fact, Respondent has uploaded the same August 18, 2018 rebuttal by Dr. Diwan that I found persuasive in my prior award. Under the factual circumstances presented, I find it appropriate in this case to give some deference to the opinion of the treating physician, who actually performed examinations, established treatment and diagnostic plans, made diagnoses and performed medical services for the Assignor. Ultimately, I find Applicant's rebuttal and supporting medical records and arguments to be more credible and persuasive than the peer review.

Based on the totality of the evidence in the record, Applicant is entitled to reimbursement for the professional services relating to an arthroscopy of the left shoulder of the Assignor conducted on March 22, 2019.

Regarding the appropriate reimbursement for such services, Respondent's counsel at the hearing asserted that the fees charged by Applicant for the services provided are in excess of those permitted under the Workers' Compensation Fee Schedule. Respondent asserted that Applicant's charges should have been limited to $4,155.94. However, Respondent failed to upload any coder affidavit or any other adequate explanation of how or why Applicant's charges are in excess of the fee schedule. Although I am permitted to take judicial notice of the workers' compensation fee schedule, *see Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co.*, 61 A.D.3d 13, 20 (2d Dept. 2009); *LVOV Acupuncture, P.C. v. Geico Ins. Co.*, 32 Misc.3d 144(A) (App Term 2d, 11th & 13th Jud Dists. 2011); *Natural Acupuncture Health, P.C. v. Praetorian Ins. Co.*, 30 Misc.3d 132(A) (App Term 1st Dept. 2011), it is not abundantly clear to me exactly how Respondent determined its asserted fee reductions and that Respondent is correct when it maintains that the disputed charges were excessive. Based on the evidence presented to the record, Respondent failed to meet its burden to come forward with competent evidentiary proof to support its fee schedule defenses. *See Robert Physical Therapy, P.C. v. State Farm Mut. Auto. Ins. Co.*, 13 Misc. 3d. 172 (Civ. Ct. Kings Co. 2006). As such, Applicant is entitled to reimbursement in the amount of $10,531.32 for the

professional services relating to an arthroscopy of the left shoulder of the Assignor conducted on March 22, 2019.

**Conclusion**

For the reasons set forth herein, Applicant is awarded reimbursement in the total amount of $10,830.58, with attorney's fees, interest and the arbitration filing fee as set forth below. 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 and/or waived insofar as not specifically 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 |
|---|---|---|---|---|
| | **Queens Arthroscopy & Sports Medicine** | **01/08/19 - 01/08/19** | **$299.26** | **Awarded: $299.26** |
| | **Queens Arthroscopy & Sports Medicine** | **03/22/19 - 03/22/19** | **$10,531.32** | **Awarded: $10,531.32** |
| **Total** | | | **$10,830.58** | **Awarded: $10,830.58** |

B. The insurer shall also compute and pay the applicant interest set forth below. 07/12/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest shall be computed from July 12, 2019, the AR1 filing date, at the rate of 2% per month and ending with the date of payment of the award, subject to the provisions of 11 NYCRR 65-3.9(c).

C. Attorney's Fees

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

Respondent shall pay the Applicant attorney's fees in accordance with 11 NYCRR 65-4.6(d).

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

04/18/2021
(Dated)

Kihyun Kim

**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:**
98c9ff6fcfc32de10289845f955087a8

**Electronically Signed**

Your name: Kihyun Kim
Signed on: 04/18/2021