

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

LI Ortho Solutions
(Applicant)

- and -

Allstate Insurance Company
(Respondent)

AAA Case No. 17-19-1143-2264

Applicant's File No. 291517

Insurer's Claim File No. 0513962613
2CK

NAIC No. 19232

ARBITRATION AWARD

I, Ritesh Mallick, 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: JH

1. Hearing(s) held on 03/31/2021
Declared closed by the arbitrator on 03/31/2021

Neil Menashe, Esq. from Neil Menashe Attorney At Law P.C. participated in person for the Applicant

John Palatianos, Esq. from Law Offices Of Karen L. Lawrence participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 1,209.72**, 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 Assignor JH was injured in a motor vehicle accident that occurred on 8/30/18. JH was the 76-year-old male driver at the time of accident. JH's injuries served as the impetus for treatment. In dispute is the billing for an injection and ancillary services rendered on 6/20/19. Reimbursement for the services was timely denied by Respondent for lack of medical necessity based upon the 4/17/19 IME of Dr. Rafael Lopez Steuart, M.D. The issue to be decided is the validity of Respondent's denial based upon lack of medical necessity.

4. Findings, Conclusions, and Basis Therefor

This case was decided based upon the submissions of the parties as contained in the electronic file maintained by the American Arbitration Association and the oral arguments of the parties' representatives. There were no witnesses. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

IME DENIAL

In order 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., 2014 NY Slip Op 50219(U) (App. Term, 2d Dep't, 2nd, 11th, & 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., 2006 NY Slip Op 52116 (App. Term, 1st Dep't 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. New York Cent. Mut. Fire Ins. Co., 2013 NY Slip Op 50586(U) (App. Term, 1st Dep't 2013). However, there are a myriad of 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, 7 Misc. 3d 544 (Civ. Ct., Kings County 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." Nir, citing CityWide Social Work & Psychological Servs. v. Travelers Indem. Co., 3 Misc. 3d 608, 612 (Civ. Ct., Kings County 2004).

An insurance carrier must, at a minimum, establish a detailed factual basis and a sufficient medical rationale for its asserted lack of medical necessity. Vladimir Zlatnick, M.D., P.C. v. Travelers Indem. Co., 2006 NY Slip Op 50963(U) (App. Term, 1st Dep't 2006); accord Delta Diagnostic Radiology, P.C. v. Progressive Cas. Ins. Co., 21 Misc. 3d 142(A), 2008 NY Slip Op 52450(U) (App. Term, 2d Dep't, 2nd & 11th Jud. Dists. 2008).

Applicant's claim is for an injection and ancillary services performed on 6/20/19. Respondent timely denied the claim for lack of medical necessity. In support of its

contention that further treatment was not medically necessary Respondent relies upon the examination of Dr. Rafael Lopez Steuart, M.D. performed on 4/17/19. A review of Dr. Steuart's report reveals that the claimant had diminished range of motion in every observed plane for the cervical spine region, diminished lumbar flexion, diminished lumbar extension, diminished range of motion in every observed plane for the right shoulder, diminished range of motion in every observed plane for the left shoulder, diminished right wrist dorsiflexion, diminished right wrist palmar flexion, diminished left wrist dorsiflexion, and diminished left wrist palmar flexion per the IME's contents. Dr. Steuart indicates that the range of motion limitations did not correlate with any objective findings consistent with pathology. This rationale is insufficient as it pertains to reconciling the recorded limitations with Dr. Steuart's conclusion that further orthopedic care was not medically necessary for this claimant. The claimant's symptomatology as memorialized in the IME report of Dr. Steuart is inapposite to his conclusion that orthopedic treatment was no longer medically necessary for this claimant. Based upon the foregoing, Respondent has not set forth a cogent medical rationale in support of its defense.

Assuming, *arguendo*, that the IME report of Dr. Steuart did serve to meet Respondent's burden on the issue of medical necessity, the burden would shift to the Applicant, who bears the ultimate burden of persuasion. Bronx Expert, 2006 NY Slip Op 52116.

Even in this instance, the outcome would be the same. In opposition to the examination report of Dr. Steuart, Applicant has submitted follow-up evaluation reports contemporaneous with Dr. Steuart's report. The 3/27/19 detailed progress note of Dr. David Welesberg, M.D. reflects the claimant had unresolved symptomatology including restricted range of motion in the cervical region, restricted range of motion in the lumbar region, a positive O'Brien's test on the right, and a positive impingement test on the right amongst the findings. The 5/16/19 detailed progress note of Dr. Welesberg reflects the claimant had unresolved symptomatology including restricted range of motion in the cervical region, restricted range of motion in the lumbar region, a positive O'Brien's test on the right, and a positive impingement test on the right amongst the findings. The referenced findings directly refute Dr. Steuart's contention that the claimant did not exhibit objective indicators of pathology.

I note that as the court held in Amato v. State Farm Ins. Co. (30 Misc. 3d 238, 910 N.Y.S.2d 637 [Nassau Dist. Ct. 2010]), an IME is a snapshot of the injured party's medical condition as of the date of the IME, and the opinion of the doctor conducting an IME and issuing a report indicating that a claimant requires no further treatment is nothing more than an expert's opinion rendered at the time the examination was conducted. Applicant's submitted medical records are factually sufficient to meet the burden of persuasion that the services were medically necessary.

As such, having reviewed all of the submissions and taking into account the oral arguments of the parties, I find in favor of Applicant.

Any further issues raised in the hearing record are held to be moot and/or waived insofar as not 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 |
|---------|--------------------|---------------------|--------------|---------------------|
| | LI Ortho Solutions | 06/20/19 - 06/20/19 | \$1,209.72 | Awarded: \$1,209.72 |
| Total | | | \$1,209.72 | Awarded: \$1,209.72 |

- B. The insurer shall also compute and pay the applicant interest set forth below. 09/27/2019 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." 11 NYCRR § 65-3.9 (c). 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 (Ct. App. 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 at 11 NYCRR § 65-4.5 (s) (2). The award of attorney fees shall be paid by the insurer. 11 NYCRR § 65-4.5 (e). For matters filed before February 4, 2015, "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 \$850." Id. The minimum attorney fee that shall be awarded is \$60. 11 NYCRR § 65-4.5 (c). 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 (i).

Alternatively, if this matter 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 newly promulgated 11 NYCRR § 65-4.6 (d). For claims that fall under the Sixth Amendment to the regulation, the following shall apply: "If the claim is resolved by the designated organization at any time prior to transmittal to an arbitrator and it was initially denied by the insurer or overdue, the payment of the applicant's attorney's fee by the insurer shall be limited to 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon, for each applicant with whom the respective parties have agreed and resolved dispute, 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 Putnam

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

04/26/2021
(Dated)

Ritesh Mallick

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:
b21205aa28168a8559110736de609d12

Electronically Signed

Your name: Ritesh Mallick
Signed on: 04/26/2021