

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Catholic Health Systems-Kenmore Mercy
Hospital
(Applicant)

- and -

Allstate Property and Casualty Insurance
Company
(Respondent)

AAA Case No. 17-20-1176-0198

Applicant's File No. 20-23676

Insurer's Claim File No. 0504301219
3WB

NAIC No. 17230

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 or "Assignor"

1. Hearing(s) held on 06/15/2021
Declared closed by the arbitrator on 07/13/2021

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

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

2. The amount claimed in the Arbitration Request, **\$ 50,320.48**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant amended its claim down to \$23,139.45.

Stipulations WERE made by the parties regarding the issues to be determined.

The parties stipulated that the amended amount is correct per the fee schedule.

3. Summary of Issues in Dispute

This male EIP (first initial "J") was 40-years-old when he was injured as the driver in an automobile accident on 6/1/18. He subsequently came under the care of Drs. Ross Sherban and Timothy R. Rasmussen, who performed lumbar surgery on 3/18/2020.

Applicant seeks reimbursement for its facility services provided in connection with the surgery performed on 3/18/2020 and preoperative services provided on 3/2/2020.

Respondent denied the claims for lack of medical necessity based on an examination [IME] performed by Dr. Louis Nunez, M.D., on 3/5/19.

The issue is whether the denied post-IME surgery and services were medically necessary.

4. Findings, Conclusions, and Basis Therefor

This case was 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.

Counsel appeared via Zoom video conference and no witnesses testified at the hearing.

Collateral Estoppel

Applicant's counsel pointed out that in a linked case involving the Respondent, the issue of medical necessity based on the same 'IME' report was already resolved.

In **AAA Case No. 17-19-1150-1597** (decided on 2/3/2021), the undersigned Arbitrator determined that Respondent failed to meet its initial burden of proof with the 'IME' report by Dr. Nunez because Dr. Nunez relied too heavily on prior peer reports to conclude that the cervical spine surgery was unrelated to the accident.

This case involves a lumbar surgery, and so collateral estoppel does not apply. The sufficiency of the 'IME' by Dr. Nunez was not determined with respect to ongoing lumbar spine treatments.

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).

At the time of the 'IME', the EIP's complaints included lumbar spine pain. Dr. Nunez' examination revealed mostly normal lumbar findings and ranges of motion, except that left and right-side bending were reduced by about 22% of normal (35 degrees out of 45 degrees normal).

Dr. Nunez diagnosed the EIP with resolved exacerbation of lumbar spinal pathology and opined there was no need for further orthopedic care. He stated that the pre-existing conditions had an effect on the EIP's recovery.

Dr. Nunez did not explain the reduced lumbar ranges of motion or whether he believed the reductions were related to the MVA or something else.

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). Dr. Nunez did not classify these reductions as subjective findings or suggest there was suboptimal effort at the time of the IME. As such, these reductions appear to be objective findings. In addition, the MRI of the lumbar spine revealed "L4-5 shows a small shallow far left lateral disc herniation that comes close to contacting the left L4 nerve root as it exits the neural foramen. The right neural foramen is patent." Dr. Nunez should have explained whether he believed the lumbar range of motion reductions were consistent with the lumbar spine MRI findings. In fact, the surgery at issue here was performed at the L4-5 level.

I find that the IME fails to provide a sufficient medical rationale to deny treatment for the lumbar spine beyond the date of the IME. Respondent would have been better served by submitting these records for a peer review. While there appear to be questions as to the causal-relationship of the lumbar surgery to the MVA, this must be addressed by expert opinion.

There is no need to consider Applicant's rebuttal evidence since the claims arrived to this arbitration with a presumption of medical necessity, which has not been rebutted by Respondent.

Policy Limits

In a post-hearing submission approved by the undersigned, Respondent has provided a copy of the payment ledger sheet, which establishes payments totaling \$114,305.48. This includes \$82,307.81 in medical payments, \$31,279.90 in lost wage payments, and \$717.77 in mileage reimbursement. Per a prior linked consent award, \$480.00 of the lost wage amount was for interest (linked case *8823). Therefore, the total payments are \$113,825.48.

Respondent did not submit any lost wage offset calculations or indicate whether any such offsets were taken or applied to the amount paid for lost wages.

Respondent has provided a copy of the policy evidence that concerns this matter, which reveals an aggregate total available in PIP or first party benefits to be \$125,000.00. As such, Respondent has established by a preponderance of credible evidence that \$11,174.52 remains available on the applicable policy.

The principal amount of the award should be reduced to \$11,174.52.

Conclusion

Having carefully considered 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.

The claim is awarded in full (as amended) payable only up to the available limit.

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
	Catholic Health Systems-Kennmore Mercy Hospital	03/02/20 - 03/18/20	\$50,320.48	\$23,139.45	Awarded: \$11,174.52
Total			\$50,320.48		Awarded: \$11,174.52

- B. The insurer shall also compute and pay the applicant interest set forth below. 06/25/2020 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 Onondaga

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.

07/13/2021
(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:
09fd326a7a58433b835c00423bc8ebfd

Electronically Signed

Your name: Fred Lutzen
Signed on: 07/13/2021