

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Ortho-Med Equipment, Inc
(Applicant)

- and -

American Transit Insurance Company
(Respondent)

AAA Case No. 17-20-1172-6247

Applicant's File No. BT19-107100

Insurer's Claim File No. 1063649-02

NAIC No. 16616

ARBITRATION AWARD

I, Gary Peters, 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

1. Hearing(s) held on 09/10/2021
Declared closed by the arbitrator on 09/10/2021

J. Buckley from The Tadchiev Law Firm, P.C. participated in person for the Applicant

D. Kelly from American Transit Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 1,636.50**, 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 was a 47 year old female who was a restrained passenger involved in a motor vehicle accident on 7/12/19. She was initially evaluated at a local hospital emergency room and thereafter came under the care of various medical providers and was initiated on a course of conservative treatment.

M.R.I. studies of the right wrist were performed on 8/2/19 and the Assignor underwent right wrist surgery on 11/14/19.

Applicant is seeking payment for various medical supplies wherein the claim was denied by the Respondent for lack of medical necessity based upon its Independent Peer Review Report.

4. Findings, Conclusions, and Basis Therefor

This hearing was conducted using the Electronic Case Folder maintained by the American Arbitration Association. All documents contained in that folder are made part of the record of the hearing and I have reviewed the documents contained therein. Any documents submitted after the hearing or at the hearing that have not been entered in the Electronic Case Folder as of the date of this award, will be listed immediately below this language and forwarded to the American Arbitration Association at the time this award is issued for inclusion.

Once an Applicant establishes a prima facie showing, the burden shifts to the Respondent. Respondent's denial for lack of medical necessity must be supported by competent medical evidence setting forth a clear and factual basis and medical rationale for denying the claim. Citywide Social Work v. Travelers Indemnity Company, 3 Misc.3d 608 (Civil Court, Kings County, 2004).

To successfully support its denial, the Respondent's Peer Review or I.M.E. Report must address all pertinent objective findings contained in the Applicant's medical submissions and set forth how and why the disputed services were inconsistent with generally accepted medical practices. The conclusory opinions of a peer reviewer, standing alone and without support of medical authorities, will not be considered sufficient to establish the absence of medical necessity (Citywide Social Work v. Travelers Indemnity Company,) Supra; Amaze Medical Supply Inc. v. Eagle Insurance Company, 2 Misc.3d 128A, 784 N.Y.S.2d 918 (App. Term 2d 11th Judicial District).

Where Respondent meets its burden, it is incumbent upon the claimant to rebut the findings and recommendations of the Respondent's reports. The insured/provider bears the burden of persuasion on the question of medical necessity. Specifically, once the insurer makes a sufficient showing to carry its burden of coming forward with evidence of lack of medical necessity, plaintiff must rebut it or succumb (Bedford Park Medical Practice, P.C. v. American Transit Insurance Company, 8 Misc.3d 1025A).

It is undisputed that the Applicant has established a prima facie case of entitlement to first party benefits by demonstrating it submitted a timely claim setting forth the fact, amount of loss sustained and that payment of the claim has not been made. As stated above, the burden shifts to the Respondent to set forth a clear and factual basis in medical rationale to deny the claim.

Based upon the aforementioned evidence and case law, the Applicant has established a prima facie case and the only issues to be determined if the Respondent timely and properly denied reimbursement of the claim based upon the Worker's Compensation Fee Schedule.

On behalf of the Respondent, Dr. Matthew Skolnick reviewed multiple medical records and submitted an Independent Peer Review Report. He noted that the Assignor presented to Dr. Avshalumov and was treating from 5/14/19 through 11/6/19 for complaints of right wrist pain. On 11/6/19, physical examination of the wrist revealed no swelling or tenderness and range of motion was decreased with slightly decreased motor strength. Finkelstein, Tinel, Phalen and carpal compression tests was negative with no effusion, crepitus or instability reported.

M.R.I. of the right wrist was performed on 8/2/19 and indicated a TFCC tear. As stated above, the surgery of the right wrist was indicated by Dr. Avshalumov after the office visit on 11/6/19 and the surgery performed 8 days later.

Dr. Skolnick noted that after a review of the M.R.I. studies by Dr. Fitzpatrick, no tear was seen and no evidence of traumatic injury noted. Additionally, his review of the intra operative photos, indicated no significant acute injury.

For the reasons as stated above, Dr. Skolnick recommended against payment. He referenced The American Medical Association's definition of medical necessity to support his position.

Dr. Stanislau Avshalumov submitted a Peer Review Rebuttal Report. He reiterated the M.R.I. indicated a tear involving the triangular fibro cartilage with distal radicular joint effusion and a ganglion cyst. The treating physician stated that the Assignor was re-evaluated on 11/4/19 and continued to experience wrist pain which he described as constant and sharp. She rated the pain as an 8/10 on a 10 point scale. Activity was made worse with increased activity, lifting, and movement.

As the Assignor had been engaged in conservative treatment, physical therapy, home exercise, heat, and ice; however, there was not much improvement. Based upon his

examination, including positive objective testing surgery was indicated. The pre-operative diagnosis was triangular fiber cartilage tear - partial, bursitis and synovitis.

As stated above, Applicant is seeking payment for a surgical facility fee in connection with arthroscopic surgery of the right wrist.

The treating physician stated that he relied upon the M.R.I. report by the patient's treating radiologist, Dr. Dauita. He also reviewed the M.R.I. and his interpretation and agreed with the radiologist's finding. Additionally, he stated that he was uncertain as to what the quality of the photos were that were provided for review and that this is no substitute for actual moving image arthroscopic observation which he observed. Furthermore, he performed the arthroscopic surgery which was medically indicated. Reference was made to Current Surgical Treatment Options for Triangular Fibroid Cartilage Complex Tears - Dr. Pirolo and Yao.

On 1/8/21, I presided over A.A.A. Case No. 17-20-1178-9315 and awarded lost wages to the Assignor on the same claim. I also presided over A.A.A. Case No. 17-20-1175-4918 and found the Respondent's Peer Review Report/Causality Report to be insufficient and gave deference to the treating physician.

Dr. Avshalumov exhibited a sound basis and credible rationale to justify the operative procedure based on his physical examination findings, review of M.R.I. studies. Additionally, he referenced medical authority to support his position.

Although the above cases do not lend themselves to Collateral Estoppel, I find for the Applicant for the same reason as stated in the Peer Review Rebuttal Report.

Accordingly, Applicant is awarded the sum of \$1,636.50.

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
	Ortho-Med Equipment, Inc	11/20/19 - 12/10/19	\$1,636.50	Awarded: \$1,636.50
Total			\$1,636.50	Awarded: \$1,636.50

- B. The insurer shall also compute and pay the applicant interest set forth below. 07/21/2020 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest to be 2% per month simple, not compounded on a pro rata basis using a 30 day month. Respondent shall compute and pay Applicant interest from the day of filing of arbitration to the date of payment of the award.

C. Attorney's Fees

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

The insurer shall pay th Applicant an attorney fee in accordance with 11 NYCRR 65-4.6(d) or "As this matter was filed on or after February 4, 2015, this case is subject to the provisions promulgated bt the Departmenet of Financial Services in

the Sixth Amendment to 11NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the the Applicant an attorney fee in accordance with the newly promulgated 11 NYCRR 65-4.6(d). This amendment takes into account that the the maximim attorney fee has been raised from \$850.00 to \$1360.00

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

10/06/2021
(Dated)

Gary Peters

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:
4e8a2715d224fc9a4cdec655f57ba83c

Electronically Signed

Your name: Gary Peters
Signed on: 10/06/2021