American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Thompson Medical PC (Applicant)	AAA Case No.	17-20-1169-2056
	Applicant's File No.	44153
- and -	Insurer's Claim File No.	1058923-02
	NAIC No.	16616
American Transit Insurance Company (Respondent)		

ARBITRATION AWARD

I, John Talay, 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 10/12/2021
   Declared closed by the arbitrator on 10/12/2021

   John Faris, Esq. from Law Offices of Eitan Dagan participated for the Applicant

   Mustafa Noun, Esq. from American Transit Insurance Company participated for the Respondent

2. The amount claimed in the Arbitration Request, **$ 5,982.53**, 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

   Whether applicant is entitled to No-Fault reimbursement for medical services attendant to left shoulder arthroscopic procedure. The service herein relates to the physician fee. There are prior linked cases which weigh decisively in this decision.

   There is no consent agreement as to the amount in dispute. However, respondent interposes a fee schedule affidavit by a fee coder expert places the amount in dispute is $4155.93. Applicant remains with the original calculation, as billed, at $5982.53. Applicant presents no competing fee audit.

   The date of accident is May 17, 2019. Assignor/EIP is a 57-year-old female passenger involved in a two-car MVA. This arbitration is a result of a denial of

claim pursuant to peer opinion of Dr. Matthew Skolnick, 10/15/19. Respondent also submits a biomechanical engineer/ causality report.

Whether the medical services for which benefits are sought were reasonable and medically necessary as required by 11 NYCRR 65.1 (d) (1).

4. Findings, Conclusions, and Basis Therefor

BOTH SIDES WERE REPRESENTED BY COUNSEL. WRITTEN SUBMISSIONS FROM THE PARTIES WERE DULY FILED AND ARE CONTAINED WITHIN THE ELECTRONIC CASE FOLDER OF THIS FORUM. THEY ARE INCORPORATED, BY REFERENCE, IN THIS DECISION. DOCUMENTS WILL BE IDENTIFIED SPECIFICALLY, AS NEEDED.

The within dispute springs from an underlying motor vehicle accident of May 17, 2019. The date of service, described - above, is August 19, 2019. Previous thereto, a CT scan left shoulder provided on 6/12/19 dictated positive findings. EIP underwent left shoulder surgery on 8/19/19 and was provided with postop durable medical equipment, coal compression unit and started on a postop CPM and compression therapy treatments. At issue is a surgeon's bill, in the amount above - stated.

In support of the claim, applicant presents assignment of benefits form, verified billing and contemporaneous medical documentation. Applicant seeks no-fault reimbursement for these services.

Under Section 5102 of the New York Insurance Law, No-Fault first party benefits are reimbursable for all medically necessary expenses due to personal injuries arising out of the use or operation of a motor vehicle. Applicant establishes a prima facie entitlement to judgment as a matter of law by proof that he submitted a claim, setting forth the fact and amount of the loss sustained, and that the payment of No-Fault benefits was overdue. See Insurance Law Section 5106a; Mary Immaculate Hosp. v. Allstate Ins. Co. 5 AD 3d 742, 774 N.Y.S. 2d 564 [2004]; Damadian MRI in Canarsie, P.C. v. General Assurance Company, 2006 NY Slip Op 51048U, 2006 NYS Misc. Lexis 1363 (Decided June 2, 2006 Appellate Term, 2d Department); Amaze Medical Supply, Inc. v. Eagle Insurance Company, 2 Misc. 3rd 128, 784 N.Y.S. 2d 918 (2003).

Pursuant to 11 NYCRR 65-4.5 (O) (1), an arbitrator shall be the judge of the relevance and materiality of the evidence offered. The arbitrator may question any witness or party and independently raise any issue that the arbitrator deems relevant

to making an award that is consistent with the Insurance Law and Department Regulations.

The medical necessity of therapeutic treatment must be proven to justify payment for it. There must be some explanation as to how the treatments will alleviate the symptoms and improve the condition of the patient. There also must be evidence that the treatment took place. The evidence may consist of notes made when the treatment took place or a narrative report. Finally, there must be an explanation of how the treatment affected the patient.

Respondent resists the claim in a position paper with annexed supporting documentation. This arbitration is the result of a denial of claim pursuant to the peer opinion of Dr. Matthew Skolnick, orthopedic surgeon, 10/15/19. He concluded that the surgery of the left shoulder with associated services and postoperative supplies were not medically necessary or causally related to the accident of record. He reviewed the records of Dr. Thompson, surgeon. Surgery of the left shoulder was indicated by Dr. Thompson after the office visit on 7/24/19 and the procedure was performed one month later.

Dr. Skolnick indicated that the CT scan revealed no acute abnormalities. He also references the radiology by Dr. Cavaliere who notes no findings of trauma but rather degenerative changes were seen. In other words, there was no injuries from the accident; no traumatic tears were seen and no evidence of acute injuries noted. He also reviewed an IME report of 7/23/19 by Dr. Roth who diagnosed the claimant with "resolved left shoulder sprain" at the time. This is only three weeks before the surgery.

Although the denial of claim, NF 10, 10/18/19 references only the peer review has rationale for denial, respondent also includes a biomechanical engineering report. It is informative, but only tangentially specific to the facts and circumstances of the accident. It also is not the basis of either the peer review or the respondent's denial of claim. It is noted that this ECF file does contain a specific denial based on the biomechanical engineering report. I likewise find this report to be non- persuasive.

Fee schedule:

There is no consent to amend the claim. I am more persuaded by the respondent submission and calculate the amount in dispute is $4155.93.

Once the insurer makes a prima facie showing that the amounts charged by a provider were in excess of the fee schedule, the burden shifts to the provider to show that the charges involved a different interpretation of such schedule or an inadvertent miscalculation or error. Cornell Medical, P.C. v. Mercury Casualty Co., 24 Misc.3d 58, 884 N.Y.S.2d 558 (App. Term 2d, 11th & 13th Dists. 2009).

If respondent fails to demonstrate by competent evidentiary proof that a plaintiff's claims were in excess of the appropriate fee schedules, defendants defense of noncompliance with the appropriate fee schedules cannot be sustained. See

Continental Medical, PC V. Travelers indemnity Co., 11 Misc. 3d 145A, 819 N.Y.S. 2d 847, 2006 NY Slip Op 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Term 1st Dept, per curiam 2006).

Determination:

Respondent resists the claim on two different lines of logic. The first relates to a supposed minor injury and no medical justification for the surgical procedure. The second line of logic deals of causality, essentially stating that the accident could not have been a cause of any sustained injury.

On both counts, I am not persuaded by the peer opinion and/or engineering report; I award reimbursement. The positive findings within CT scan are sufficient to establish injury. In addition, the preoperative diagnosis was confirmed in a postoperative finding. I do not find the logic of the peer review to be persuasive. I find that the peer and/or engineering report has not sustained its burden of demonstrating the lack of medical necessity for the shoulder procedure at issue herein. I award in favor of applicant and allow reimbursement.

The Appellate Court has held that once the affirmative defense is raised that the injury is not related to the motor vehicle accident, the respondent/carrier is bound by the following guidelines. The Appellate Court in *Mount Sinai v. Triboro Coach*, stated the carrier has the burden of coming forward with proof in an admissible form to establish the fact or evidentiary foundation for its belief that the patient's condition for which he was treated was unrelated to the motor vehicle accident.

Further, carrier must show the injury was not related to the accident at all. They must show how, when and where the injury happened and was not aggravated or exacerbated. Finally, the carrier proof may not be vague, conclusive, inconsistent, or unsupported by records.

The patient does not have to prove the condition was related after the defense is raised. The Court specifically stated, "It would be unreasonable to insist that a plaintiff prove as a threshold matter that his patient's condition was caused by the motor vehicle accident." The burden is totally on the carrier to prove the condition was not caused by the motor vehicle accident. In this case the respondent does not present any evidence to support its position. In this case the radiologist for respondent does not indicate whether the shoulder injury was aggravated or exacerbated by the motor vehicle accident. I find the medical opinion, therefore, to be not qualified. *Mount Sinai v. Triboro Coach*, 699 N.Y.S.2d 77 (2nd Dept. 11/29/99).

Further, it is noted that two linked cases previously decided on different aspects of the shoulder surgery. On both cases, I awarded in favor of applicant. I was not persuaded by the engineer's causality argument nor the medical necessity argument as presented by the peer physician and the engineering consultant. In that sense, the law of the case is established that reimbursement is warranted. See AAA Case # 17 20 1159 5727 and # 17 20 1157 2478.

In the matter before me, I find the respondent had the opportunity to litigate the issue concerning the sufficiency and persuasiveness of the IME review and the respondent's proof was found to be insufficient. While I am not certain collateral estoppel should apply in New York No-Fault arbitration, I do believe "the doctrine of the law of the case" applies under these circumstances.

I note the decision by Arbitrator Sandra Adelson Sound Chiropractic PC v. GEICO Insurance Company AAA 412013073449 (September 11, 2014):

"The doctrine of the law of the case seeks to prevent relitigation of issues of law that have already been determined at an earlier stage of the proceeding (see Bellavia v Allied Elec. Motor Serv., 46 AD2d 807 [1974]). The doctrine applies only to legal determinations that were necessarily resolved on the merits in a prior decision (see Gay v Farella, 5 AD3d 540 [2004]). The doctrine may be ignored in extraordinary circumstances such as a change in law or a showing of new evidence (see Foley v Roche, 86 AD2d 887 [1982])" Brownrigg v. New York City Hous.Auth., 29 AD 3d, 721, 722[2006].

Furthermore, the doctrine of the law of the case "is a rule of practice, an articulation of sound policy that, when an issue is once judicially determined, that should be the end of the matter as far as Judges . . . are concerned;" stated differently, "[t]he doctrine " applies only to legal determinations that were necessarily resolved on the merits in the prior decision.'" Oyster Bay Assocs. Ltd. Partnership v. Town Bd. of Town of Oyster Bay, 21 AD3d 964, 966, 801 NYS2d 612 (2d Dept. 2005) (citations omitted) (emphasis added). See also Shatzkin v. Village of Croton-on- Hudson, 51 AD3d 903, 858 NYS2d 362 (2d Dept. 2008).

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, aff'd, 64 A.D.3d 1149 (4th Dept. 2009).

Decision: Award in favor of applicant in the total amount of $4155.93, together with statutory costs, interests and fees.

This award is in full disposition of all No-Fault benefit claims submitted to this arbitrator.

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**
	Thompson Medical PC	**08/23/19 - 08/23/19**	**$5,982.53**	**Awarded: $4,155.93**
Total			**$5,982.53**	**Awarded: $4,155.93**

B. The insurer shall also compute and pay the applicant interest set forth below. 06/22/2020 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

The denial in this matter is timely issued. Principal amount awarded is $4155.93. Interest shall be computed from the filing of the AR-1 or commencement of action, **SEE DATE ABOVE**, at a a rate 2% per month, simple, and ending with 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

Attorney fee is payable on a per claimant basis in which benefits are paid pursuant to the case of LMK Psychological Services, PC vs. State Farm Mutual Automobile Ins. Co (2009 NY Slip Op 02481), Decided April 2, 2009.

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

10/15/2021
(Dated)

John Talay

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:
20d81000582fa6d53628ca9f10d482f8

Electronically Signed

Your name: John Talay
Signed on: 10/15/2021