

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Richmond Pain Management ASC LLC  
(Applicant)

- and -

American Transit Insurance Company  
(Respondent)

AAA Case No. 17-21-1229-7875

Applicant's File No. A31846

Insurer's Claim File No. 1032638-02

NAIC No. 16616

**ARBITRATION AWARD**

I, Susan Mandiberg, 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 EIP

1. Hearing(s) held on 09/28/2022  
Declared closed by the arbitrator on 09/28/2022

Amisha Dukarm, Esq. from Munawar & Hashmat LLP participated in person for the Applicant

Adam Kass, Esq. from American Transit Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$11,766.65**, was AMENDED and permitted by the arbitrator at the oral hearing.

At the time of the hearing, Applicant amended the total amount in dispute to the sum of \$1,871.39, which comports with Respondent's Fee Schedule calculations.

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

Counsel stipulated that the remaining balance left on the PIP policy was \$14,867.15, as of the date of the hearing. Counsel further stipulated that the total amount in dispute for the four linked cases heard together on this same Hearing date, as amended by Applicant's counsel, totaled the sum of \$11,005.62, respectfully. As a result, no policy exhaustion issues were raised with regard to the instant billing.

### 3. Summary of Issues in Dispute

The 23-year-old female EIP was a passenger in a vehicle involved in the instant motor vehicle accident on 7/10/18. Presently in dispute is billing for facility fees billed in conjunction with thoracic spine radiofrequency ablation performed on date of service 9/2/20. Respondent timely denied reimbursement for this billing pursuant to an IME examination performed by Jay Eneman, M.D. on 4/22/19, after which Respondent terminated No-Fault benefits effective 5/20/19. Respondent also relies upon a peer review issued by Peter Chiu, M.D. dated 9/1/21 in support of its denial. The issue presented is whether the billing in dispute was medically necessary vis-à-vis the findings of the IME exam upon and peer review upon which Respondent's denials are premised. As amended, no Fee Schedule issues have been raised with regard to this billing.

### 4. Findings, Conclusions, and Basis Therefor

This case involves billing for facility fees billed in conjunction with thoracic spine radiofrequency ablation performed on 9/2/20. The services were rendered following a motor vehicle accident that took place on 7/10/18. Respondent timely denied reimbursement for this billing pursuant to an IME examination performed by Jay Eneman, M.D. on 4/22/19, after which Respondent terminated No-Fault benefits effective 5/20/19. Respondent also relies upon a peer review issued by Peter Chiu, M.D. dated 9/1/21. This case was decided after careful consideration of the arguments of the parties via Zoom and after review of the documents contained in the electronic case folder maintained by the American Arbitration Association, which are incorporated by reference herein.

Pursuant to 11 NYCRR 65-4 (Regulation 68-D), §65-4.5, 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. In addition, Master Arbitrator Peter J. Merani, in the case of Sports Medicine & Orthopedic Rehabilitation a/a/o "I.B." v. Country-Wide Insurance Co., AAA Case No. 17-R-991-14272- 3, stated, in relevant part, that "the Arbitrator below is the trier of facts and must evaluate and weigh the evidence presented at the hearing in arrive at his decision. The Arbitrator, in weighing the evidence, has broad powers and discretion in determining what evidence is relevant and material. The Arbitrator is in the best position to evaluate the evidence and decide on the credibility of the submitted documents".

It is well-settled that a health care provider establishes its prima facie entitlement to judgment as a matter of law by proof that it submitted a claim, setting forth the fact and the amount of the loss sustained, and that payment of No-Fault benefits was overdue. *Damadian MRI in Canarsie, PC a/a/o Tyrone Harley v General Assurance Co.*, 1006 NY

Slip Op. 51048U; Supreme Court of NY, App. Term., 2nd Dept., June 2, 2006; See: Insurance Law §5106 a, Mary Immaculate Hosp. v. Allstate Ins. Co., 5 AD3d 742, 774 N.Y.S.2d 564 (2004); Amaze Med. Supply v. Eagle Ins. Co., 2 Misc. 3d 128A, 784 N.Y.S.2d 918 [2003 NY Slip Op 51701U (App. Term, 2nd & 11th Jud Dists.)]. See also: 11 NYCRR §65-1.1, Vista Surgical Supplies, Inc. v. Metropolitan Property and Casualty Ins. Co., 2005-1328 K C., 2006 NY Slip Op. 51047U, June 2, 2006. Based upon the records submitted herein, I find that Applicant has established its prima facie case.

#### IME Defense:

As noted above, Respondent timely denied reimbursement for the billing in dispute based, in part, upon an IME exam performed by Jay Eneman, M.D. on 4/22/19, after which Respondent terminated No-Fault benefits effective 5/20/19. This very same IME was discussed (and discounted) in linked Awards rendered by Arbitrator Lisa Capruso in AAA Case #17-20-1182-0962 and Arbitrator Jeffrey Held in AAA Case #17-21-1196-4929, respectfully.

More specifically, in AAA Case # 17-20-1182-0962, Arbitrator Lisa Capruso held, in relevant part as follows:

"Applicants submitted claims to the Respondent for pain management injections and the associated anesthesia provided to the Assignor after an automobile accident that occurred on 7/10/18. Assignor, a passenger in the vehicle, alleged injuries to the neck and back. In dispute in this arbitration are dates of service 1/30/20, 2/5/20 and 5/11/20 for which the Applicants have submitted bills for an office visit, thoracic medial branch block injections and the associated anesthesia services. A no-fault provider establishes its prima facie entitlement to judgment by submitting proper evidentiary proof that it generated and mailed the prescribed statutory billing forms to the insurer, that the insurer received it, and that the no-fault benefits were overdue. Mary Immaculate Hosp. v. Allstate Ins. Co. 5 A.D. 3d 742-43 (2d Dept. 2004).

Respondent denied the claims based on Dr. Jay Eneman's independent medical examination conducted on 4/22/19. The burden shifts to the Respondent to demonstrate a lack of medical necessity for the items at issue. Citywide Social Work & Psychological Services, PLLC v. Allstate Ins. Co., 8 Misc 3d 1025 A (2005). A denial premised on a lack of medical necessity must be supported by competent evidence such as an independent medical examination, a peer review or other proof which sets forth a factual basis and a medical rationale for denying the claim. Healing Hands Chiropractic, P.C., v. Nationwide Assur. Co., 5 Misc., 3d 975, 787 N.Y.S. 2d 645 (Civ. Ct., New York County, 2004); King's Med. Supply Inc. v. Country Wide Ins. Co., 5 Misc 3d 767, 783 N.Y.S. 2d 448. Dr. Eneman reported that the Assignor initially sustained injuries to her neck, back and right shoulder and was started on a course of physical therapy, acupuncture, and massage treatments. Assignor underwent surgery to her right shoulder on 9/13/18. At the time of the IME, Assignor reported headaches and pain in her neck, back and right shoulder. The examination of the thoracic spine showed slightly reduced ranges of motion, but no tenderness or spasms were noted. The examination of the right shoulder showed the surgical scars, reduced ranges of motion, and negative orthopedic testing. The diagnosis was resolved cervical and thoracic sprain/strain and post right

shoulder arthroscopic surgery, recovered with residuals. Dr. Eneman found that further orthopedic treatment was not necessary as there were no objective finding to confirm the subjective complaints.

When the insurer presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden shifts to the plaintiff which must then present its own evidence of medical necessity. *West Tremont Medical Diagnostic P.C., v. GEICO*, 13 Misc.3d 131 (A), 824 NYS 2d 759 (App. Term 2d & 11th Dists, 2006). Applicant submitted a letter from Dr. Chapman, the treating provider, as rebuttal to the IME. Dr. Chapman pointed out the positive findings relative to the Assignor's thoracic spine and right shoulder indicated on the IME. Dr. Chapman initially examined the Assignor on 11/6/19, when the Assignor noted that she was not getting pain relief. She was still experiencing pain in her mid-back and neck. Due to positive findings, Dr. Chapman

recommended and performed the thoracic epidural. Applicant also submitted narrative reports from examinations conducted from 11/6/19 through 8/17/20. I find that the Applicants have submitted evidence that rebutted the findings of the Respondent IME and have established the medical necessity of the services in dispute.

Accordingly, the Applicants are entitled to reimbursement in the amount of \$702.04 for the claims in dispute."

Similarly, Arbitrator Jeffrey Held, in AAA Case # 17-21-1196-4929 held, in relevant part:

"Turning first to the IME, it is noted that at the time of the examination, the EIP reported complaints of pain to the neck, mid back and right shoulder. The examination proved remarkable, inter alia, for cervical tenderness, reduced range of motion of the thoracic spine and right shoulder, with an arthroscopic surgical scar noted in the right shoulder. The doctor's diagnosis/impression included cervical and thoracic spine sprain/strain resolved and status post right shoulder arthroscopic surgery, recovered with residuals.

Applicant relies, in part, on narrative reports and a rebuttal from K. Chapman. Applicant further relies on linked arbitration awards, including AAA case number 17-20-1182-0962. Therein, Arbitrator Capruso overruled the IME cutoff and sustained claims for pain management procedures and associated anesthesia for dates of service ranging from January 30, 2020 through May 11, 2020. After due consideration, I find that the IME cutoff is not supported by a preponderance of the credible evidence. To that end, I rely, in part, on the complaints, positive findings and diagnosis noted in the IME report, coupled with the credibility that I ascribe to the Applicant's submission. Further, I find that Applicant's reliance on the aforesaid linked arbitration award is, at minimum, persuasive authority in support of its hearing position.

In such posture, Applicant is awarded \$162.09 for the bill/claim for December 18, 2019."

The above-cited Awards, discounted the same IME report upon which the instant denial, in part, relies. As such, the prior Awards were rendered after consideration of the same

IME report and involved the identical issue of medical necessity as in the instant matter. I therefore find that the doctrine of collateral estoppel, vis a vis the IME of Dr. Eneman, is applicable to the billing presently in dispute. According to Black's Law Dictionary, Sixth ed., 1990, the doctrine of collateral estoppel is defined as follows: "Prior judgment between the same parties on different cause of action is an estoppel as to those matters in issue or points controverted, on determination of which finding or verdict was rendered" (Citation omitted). Furthermore, the doctrine of collateral estoppel precludes a party from re-litigating in a subsequent action or proceeding, an issue that was raised in a prior action or proceeding and decided against that party, whether or not the tribunals or causes of action are the same. See: *Ryan v. New York Telephone*, 62 N.Y.2d 494, 478 N.Y.2d 823. In addition, the Court of Appeals has held that the doctrine of collateral estoppel "is applicable to issues resolved by earlier arbitration. See: *Rembrandt Industries v. Hodges International*, 38 N.Y.2d 592, 381 N.Y.S.2d 383. Furthermore, it is within the Arbitrator's authority to determine the preclusive effect of a prior arbitration. See: *Matter of Falzone v. New York Central Mutual Fire Ins. Co.*, 64 A.D.3d 1149, 881 N.Y.S.2d 769 (4th Dept. 2009).

In the instant matter, the identical issue regarding the medical necessity of treatment rendered following the IME cutoff date - premised upon the same 4/22/19 IME - was decided in the aforementioned Arbitration Awards. In addition, it has been held that the doctrines of res judicata and collateral estoppel apply to Arbitration Awards, "including those rendered in disputes over no-fault benefits, and will bar re-litigation of the same claim or issue". Furthermore, the court held that "a judgment in one action is conclusive in a later one...when the two causes of action have such measure of identity that a different judgment in the second would destroy or impair rights or interests established by the first..." See: *Matter of Ranni*, 58 N.Y.2d 715, 458 N.Y.S.2d 910 (1982); *Monroe v. Providence Washington Ins. Co.*, 126 A.D.2d 929, 511, N.Y.S.2d 449 (3rd Dept. 1987).

Irrespective of the foregoing, this Arbitrator reviewed the substantive evidence proffered in the instant matter. All of the relevant reports, treatment notes and test results were carefully reviewed and considered. After such review, I find that there is sufficient credible evidence to rebut the findings as denoted at the time of Dr. Eneman's IME exam.

Accordingly, this portion of the denial is found to be unpersuasive.

Peer review Defense:

As noted above, Respondent also relies upon the 9/1/21 peer review issued by Peter Chiu M.D. in support of its denial for the instant billing. This peer review discussed multiple dates of service and services reviewed. With regard to the 9/2/20 thoracic spine radiofrequency ablation billing presently in dispute, Dr. Chiu opined that "there was no indication of a progressive neurological deficit, "red flags" (e.g. paralysis, bowel / bladder dysfunction, caudal equina syndrome, etc.), treatment response to conservative care and/or alternations in conservative care (e.g. HEP, physical therapy, medication, etc.). The history and exam findings were indicative of a whiplash (sprain/strain) injury which would not require this type of injection(s); hence, there was no medical necessity

for this invasive procedure. There was no medical necessity for the facility fee or anesthesia and associated services because the injections were not medically necessary." In support of this opinion, Dr. Chiu cited to authoritative sources indicating the definition of radiofrequency ablation, as delineated in the web M.D. website. There was no discussion of any particular deviation of standard of care vis-à-vis this EIP for the thoracic spine radiofrequency ablation procedure performed on 9/2/20. As an additional matter, Applicant has submitted a peer review rebuttal generated by the EIP's treating physician, Dr. Chapman, regarding this very procedure. The rebuttal delineates the rationale behind the treating physician's decision to perform this procedure and notes that "Dr. Chiu argues that there was no neurological deficit and therefore there would be no need for this invasive procedure. However, an RFA procedure is done when there is a presence of facet injury and not when there is a neurological deficit. This patient was a candidate due to the facet injury." After citing to authoritative sources, Dr. Chapman posits that the EIP's course of treatment was in line with the recommendation for ablative therapies, thereby justifying the instant procedure (and, by extension, the associated fees billed). Dr. Chapman notes the EIP had "treated conservatively and that the procedure was being used as a part of a conference of management regimen plan, as the pain had been refractory to conservative care." Dr. Chapman further states "Here, the patient had thoracic medial branch blocks performed on 2/5/20 and 5/11/20 which were not only diagnostic in nature confirming the injury site but also therapeutic in nature as they did give the patient pain relief. An RFA procedure was medically necessary."

The burden is on the insurer to prove lack of medical necessity. See: Behavioral Diagnostics v Allstate Ins. Co., 3 Misc. 3d 246, 776 N.Y.S.2d 178, 2004 Slip Op. 24041 (Civ. Ct. Kings County 2004); A.B. Medical Services v Geico Ins., 2 Misc. 3d 26, 773 N.Y.S.2d 773, 2003 Slip Op 23949 (App Term, 2nd Dept. 2003). See also: Elm Medical P.C. v American Home Assurance Co., 2003 Slip Op. 51357U 2003 N.Y. Misc. LEXIS 1337 (Civ. Ct., Kings Co., 2003); Fifth Ave. Pain Control Ctr. v Allstate Ins. Co., 196 Misc. 2d 801, 766 NYS2d 748 (Civ. Ct., Queens Co., 2003). When a denial is premised upon lack of medical necessity, it must be supported by a peer review or other competent medical evidence which sets forth a clear factual basis and medical rationale for denying the claim. See: Healing Hands Chiropractic, P.C. v. National Assurance Co., 5 Misc. 3d 975; Citywide Social Work, et. al. v. Travelers Indemnity Co., 3 Misc. 3d 608; Elm Medical P.C. v. American Home Assurance Co., 2003 Slip Op. 51357U 2003 N.Y. Misc. LEXIS 1337 (Civ. Ct., Kings Co., 2003); Fifth Ave. Pain Control Ctr. v. Allstate Ins. Co., 196 Misc. 2d 801, 766 NYS2d 748 (Civ. Ct., Queens Co., 2003). Once Respondent meets this burden of proof then the burden shifts back to Applicant to present competent medical proof as to the medical necessity for the disputed billing by a preponderance of the credible evidence. West Tremont Medical Diagnostic, P.C. v. GEICO, 13 Misc.3d 131[A], 824 N.Y.S.2d 759 (Table), 2006 N.Y. Slip Op. 51871[U], 2006 WL 2829826 (App. Term 2nd & 11th Jud. Dists. 9/29/06). Ultimately, the burden of proof rests with the Applicant (See: Insurance Law §5102). See also: Be Well Medical Supply, Inc. v. New York Cent. Mut. Fire Ins. Co., 18 Misc3d 139(A), 2008 WL 506180 (App. Term 2nd & 11th Dists. Feb. 21, 2008); A Khodadadi Radiology, P.C. v. NY Central Mutual Fire Ins. Co., 16 Misc.3d 131(A), 841 N.Y.S.2d 824, 2007 WL 1989432 (App. Term 2nd & 11th Dists. July 3, 2007).

After careful consideration of the totality of the credible evidence, I find that the medical evidence submitted, together with the detailed and persuasive peer review rebuttal was more credible and persuasive than Respondent's peer review. The EIP's records demonstrate complaints of persisting pain with positive objective test findings despite a course of conservative treatment that ultimately led to the EIP being referred for the services performed on 9/2/20. Although the peer review asserts that the testing was not medically necessary, I find that the records in evidence undermine this position, as does the peer review rebuttal, which, in my opinion, effectively addresses the contentions interposed and discussed in the peer review. I therefore find that the unrefuted peer review rebuttal is both credible and persuasive, vis-à-vis the medical necessity of the instant billing. In sum, I find the records and opinions of the EIP's treating provider regarding the necessary care and treatment of the EIP to be more credible and persuasive than the peer review submitted herein.

**Conclusion:**

Based upon the foregoing, for the reasons set forth herein, and after careful review of the totality of the credible evidence, I find that Respondent's denials cannot reasonably be sustained.

Accordingly, this claim - as amended - is granted in its entirety.

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.

		Claim	Amount	
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Medical		From/To	Amount	Amended	Status
	<b>Richmond Pain Management ASC LLC</b>	<b>09/02/20 - 09/02/20</b>	<b>\$11,766.65</b>	<b>\$1,871.39</b>	<b>Awarded: \$1,871.39</b>
<b>Total</b>			<b>\$11,766.65</b>		<b>Awarded: \$1,871.39</b>

- B. The insurer shall also compute and pay the applicant interest set forth below. 12/06/2021 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Respondent shall pay the Applicant interest computed from the above-noted date at a rate of 2% per month, simple, and ending with the date of payment of the award subject to the provisions of 11 NYCRR §65-3.9(e).

C. Attorney's Fees

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

The insurer shall also pay the Applicant an attorney's fee based upon the amount awarded herein and the interest, as calculated in section "B" above, and in accordance with the applicable Regulations.

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



10/02/2022  
(Dated)

Susan Mandiberg

**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:**  
f556ddafe377447e76fac68fb6f40774

### **Electronically Signed**

Your name: Susan Mandiberg  
Signed on: 10/02/2022