

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Island Ambulatory Surgery Center LLC
(Applicant)

- and -

Allstate Insurance Company
(Respondent)

AAA Case No. 17-21-1214-7973

Applicant's File No. 00087955

Insurer's Claim File No. 0581932829
2NW

NAIC No. 19232

ARBITRATION AWARD

I, Heidi Obiajulu, 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: Injured Party

1. Hearing(s) held on 12/23/2022
Declared closed by the arbitrator on 12/23/2022

Anna Goldman, Esq., of counsel from Drachman Katz, LLP participated in person for the Applicant

Michael Zeleznock, Esq. from Peter C. Merani Esq. participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,548.90**, 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 applicant seeks reimbursement of charges for the ambulatory surgical services for an interlaminar lumbosacral steroid injection with epidurography performed on 05/07/21, following a motor vehicle accident occurring on 03/19/20. Respondent denied the claim based upon the peer review by Dr. Michael E. Tawfelllos, MD, dated 06/28/21. The respondent also asserted the defense that the Injured Party violated a condition precedent of the PIP policy based on his alleged failure to attend independent medical examinations on 06/28/22, 07/15/22, and 08/19/22.

4. Findings, Conclusions, and Basis Therefor

The below decision is based on the documents contained in the Modria ADR Electronic Case folder maintained by the American Arbitration Association (hereinafter referred to as AAA) as of the date of this hearing.

The applicant, as assignee of the Injured Party, seeks reimbursement, with interest and counsel fees, under the No-Fault Regulations, for the ambulatory surgical services for an interlaminar lumbosacral steroid injection with epidurography performed on 05/07/21, in the amount of \$1548.90.

The respondent insured the motor vehicle involved in the automobile accident. Under New York's Comprehensive Motor Vehicle Insurance Reparation Act (the "No-Fault Law"), New York Ins. Law §§ 5101 et seq., the respondent was obligated to reimburse the Injured Party (or his assignee) for all reasonable and necessary medical expenses arising from the use and operation of the insured vehicle.

This case arises out of a motor vehicle accident occurring on March 19, 2020, in which the Injured Party (MM), a then 67-year-old male sustained multiple injuries including to his neck, lower back, left hip, and left knee while driving the insured vehicle when it collided with the adverse vehicle. After the accident, he did not seek emergency care.

Subsequently, the Injured Party was commenced on conservative care.

On 11/30/20, Dr. Leonid Reyfman, MD initially evaluated the Injured Party and reported that he presented with lower back pain radiating to the buttocks and associated with numbness/tingling. Physical examination revealed tenderness on palpation of the paravertebral over lumbar facet joints L3-4, L4-5, and L5-S1 and spinous processes at the L3-S1 levels with muscle spasms over lumbar paravertebral, multifidus, sacrospinalis, gluteus, and piriformis muscles bilaterally, tender trigger points at the lumbar spinalis, longissimus, and gluteal muscles, restricted lumbar ranges of motion, positive lumbar facet loading and a positive SLR test. Based on his exam, Dr. Reyfman diagnosed lumbar radiculopathy and recommended a lumbar epidural steroid injection.

On 03/01/21, Dr. Reyfman re-evaluated the Injured Party and reported that the radiating lumbar spine pain persisted and was associated with numbness/tingling. Physical examination was essentially the same as the above exam. A lumbar epidural steroid injection was recommended.

On 05/07/21, Dr. Leonid Chernyak, DO evaluated the Injured Party and reported that he presented with complaints of neck pain radiating to the bilateral shoulders [rated 9/10 on the pain scale], and lower back pain radiating to the buttocks and left with numbness/tingling in the feet/toes. Physical examination of the lumbar spine revealed tenderness on palpation of the paravertebral over lumbar facet joints L3-4, L4-5, and L5-S1 and spinous processes at the L3-S1 levels with muscle spasms along lumbar paravertebral, multifidus, sacrospinalis, gluteus, and piriformis muscle bilaterally, tender trigger points at the lumbar spinalis, longissimus, and gluteal muscles, restricted lumbar ranges of motion, lumbar facet loading, a positive SLR test, and positive axial

compression test on extension and lateral rotation. The neurological exam of the lower extremities revealed motor deficits in knee extension and hip flexion [graded 4/5]. Based on his exam findings, Dr. Chernyak diagnosed intervertebral disc displacement and lumbar radiculopathy. He performed the interlaminar lumbosacral steroid injection with epidurography.

The applicant performed the disputed ambulatory surgical services for the interlaminar lumbosacral steroid injection with epidurography.

Thereafter, the applicant submitted its claim form to the respondent seeking the reimbursement of no-fault benefits.

On 07/01/21, within 30-days of its receipt of the applicant's claim form, the respondent denied reimbursement on the grounds that the interlaminar lumbosacral steroid injection with epidurography was medically unnecessary, and therefore the disputed associated ambulatory surgical services as well.

Subsequently, on 09/26/22, the respondent issued a global denial asserting the defense that the Injured Party allegedly violated a condition precedent to coverage based on his failure to attend independent medical examinations [hereafter referred to as IMEs] on 06/28/22, 07/15/22, and 08/19/22.

After it received the respondent's claim-specific denial, the applicant commenced this arbitration seeking reimbursement of its claim.

At the outset, I find that the applicant established its prima facie case with the submission of its claim form and the copy of the respondent's claim-specific denial of claim form, which demonstrates that the respondent received the applicant's claim form, that more than 30-days elapsed since its receipt of same, and that the respondent denied reimbursement of the applicant's claim, which shows that the applicant's claim is now due and owing. See Insurance Law section 5106 [a]; Viviane Etienne Medical Care, PC v. County-Wide Ins. Co 25 N.Y.3d. 498, (NY, June 10, 2015), Westchester Medical Center v. Nationwide Mut. Ins. Co., 78 A.D.3d. 1168, (N.Y.A.D. 2nd Dept., November 30, 2010).

Once an applicant establishes a prima facie case, the burden then shifts to the insurer to prove its defense.

However, even before determining whether the respondent met its burden of proof, it must first be determined whether the respondent's defenses survive preclusion.

I find that the respondent's lack of medical necessity defense is preserved based on the uncontested timely and legally sufficient denial asserting that defense. I find that the defense that the Injured Party violated a condition precedent to coverage based on missed IMEs on 06/28/22, 07/15/22, and 08/19/22 is preserved based on the case of Unitrin Advantage Ins. Co. v. Bayshore Physical Therapy, PLLC 82 AD.3d 559,(N.Y.A.D 1st Dept., March 17, 2012).

Therefore, the issue is whether the respondent met its burden of proof in establishing its defenses.

Violation of Condition Precedent- Missed IMEs on 06/28/22, 07/15/22, and 08/19/22

The applicant's attorney argued that the respondent failed to meet its burden of proof in establishing its defense that the Injured Party violated a condition precedent to coverage of the PIP policy based on missed IMEs on 06/28/22, 07/15/22, and 08/19/22 because it failed to show that the time requirements set forth in 11 NYCRR section 65-3.5(d) was complied with.

The respondent's attorney relied on the evidence in the record regarding whether the IMEs complied with the verification protocols of the No-fault regulations.

The No-Fault regulations, at 11 NYCRR § 65-1.1, set forth an insurer's right to conduct IMEs, it states that "The eligible injured person shall submit to a medical examination by physicians selected by, or acceptable to, the Company, when, and as often as, the Company may reasonably require." (Emphasis added).

Moreover, in the "Conditions" provision of the No-Fault prescribed endorsements in Section 65-1.1, under the section entitled "Action Against Company" it states that "No action shall lie against the company unless, as a condition precedent thereto, there shall have been full compliance with the terms of this coverage."

However, 11 NYCRR sec. 65-3.5 (d) mandates that the medical examination be scheduled to be held within 30 calendar days from the insured's receipt of the verification forms. See American Tr. Ins. Co. v Vance, 131 AD3d 849 [2015]; American Tr. Ins. Co. v Longevity, 131 AD3d 841 [2015]; Acupuncture, Approach, P.C. v Allstate Ins. Co., 46 Misc. 3d 151[A], [App Term, 1st Dept. 2015]). Although it has been held that the parties may agree to a later IME date. See Allstate Ins. Co. v. Health E. Ambulatory Surgical Ctr. 55 Misc. 3d 1213(A), (N.Y. Sup. March 20, 2017). Also, the defense is not determined based on a bill-by-bill basis, and therefore if timely asserted against one bill, it is timely against the applicant's entire claim. See Unitrin Advantage Ins. Co. v. Dowd 194 A.D. 3d 507, (N.Y.A.D., 1st. Dept., May 11, 2021) and Unitrin Direct Ins. Co. v. Beckles, 188 A.D.3d 620 (N.Y. A.D., 1st Dept., November 24, 2020)

The Second Department Appellate Division held that "[t]he appearance of the insured at IMEs at any time is a condition precedent to the insurer's liability on the policy. Stephen Fogel Psychological PC v. Progressive Insurance Company, 35 A.D.3d 720; 827 N.Y.S.2d 217 (App. Div. 2nd .Dept. 2006). Significantly, the Court stated: "Consequently, an insurer may deny a claim retroactively to the date of loss for a claimant's failure to attend IMEs when and as often as the [insurer] may reasonably require." The Court gave two criteria that must be met for an insurer to prove a violation of a condition precedent of coverage: (1) that it provided sufficient notice of the IME to the applicant, and (2) that it submitted sufficient evidence to show that the applicant failed to attend the IME.

Based on recent case law, I find that the current criteria that an insurer must meet to establish its prima facie case that an applicant violated a condition precedent to coverage are:

(1) it properly mailed the scheduling letter for the IMEs/EUOs to the applicant, (2) that the IME/EUO was timely scheduled [11 NYCRR section 65-3.5(d) and Kemper Independence Ins. Co. v. Adelaida Physical Therapy, P.C. 147 A.D.3d 437, (N.Y.A.D. 1st Dept., February 07, 2017), the IME/EUO notices were timely sent [11 NYCRR 65-3.5(b) and 11 NYCRR 65-3.6 (b), See Kemper Independence Ins. Co. v. Adelaida Physical Therapy, P.C. 147 A.D.3d 437, (N.Y.A.D. 1st Dept., February 07, 2017) and Unitrin Advantage Ins. Co. v. All of NY, Inc. 158 A.D. 3d. 449, (February 06, 2018), unless the EUO was scheduled before the claim form was received See Hereford Ins. Co. v. Lida's Med. Supply Inc. 161 A.D. 3d 442, (N.Y.A.D. 1st Dept., May 03, 2018) and Mapfre Ins. Co. of N.Y. v. Manoo 140 A.D.3d 468, (N.Y.A. D. 1st Dept., June 09, 2016) appeal withdrawn 29 NY3d 995 [2017]; and (3) the applicant failed to appear at the initial and subsequently scheduled IMEs with evidence by someone with the requisite personal knowledge. See Matter of Global Liberty Ins. Co. v. Cambridge Med. PC 193 A.D.3d 573, (N.Y.A.D., 1st Dept, 04/22/21), Village Medical Supply Inc. v. Travelers Property Cas. Co. of America, 51 Misc. 3d 126(A), (N.Y. Sup. App. Term, 03/21/16), and MSB Physical Therapy, P.C. v. Nationwide Ins. 72 Misc. 3d 1215(A), (N.Y. City Civ. Ct., 07/13/21).

Applying the above case law and regulations to the evidence in the record, I find that the respondent failed to establish its defense that the Injured Party violated a condition precedent to coverage under the PIP policy based on missed IMEs on 06/28/22, 07/15/22, and 08/19/22 because it failed to show that the IMEs were scheduled within 30-days of its receipt of the applicant's claim form or any other claim form. The respondent submitted a copy of a date-stamped claim form showing receipt on 06/09/21. The first IME notice was sent almost a year later on 06/07/22. Additionally, I find that the respondent's proof of mailing is insufficient because the affiant does not indicate that the IME notices were sent to the Injured Party's proper address. She mentions the address of the IMEs. Finally, I find that the respondent's proof of no-show is legally insufficient because the IME vendor's letters dated 07/19/22 and 08/21/22 fail to show that Dr. Sidhwani, D.O, and Dr. Tanju P. Palvia, MD had the requisite personal knowledge to attest/affirm that the Injured Party failed to appear for the IMEs **and** Joleen Veneziano also lacked personal knowledge of the alleged non-appearances.

Thus, the issue becomes whether the respondent established its lack of medical necessity defense.

Lack of Medical Necessity Defense

To establish its lack of medical necessity defense, the respondent relies on the peer review by Dr. Michael E. Tawfellos, MD dated 06/28/21 and the addendum dated 09/28/22. To rebut that defense, the applicant relies on the rebuttal by Dr. Leonid Chernyak, MD and the medical evidence in the record.

Reviewing the relevant evidence in the record and considering the oral arguments made by the parties, I find as follows:

In determining whether an insurer met its burden of proof in establishing its lack of medical necessity defense, the courts have found that an insurer must submit an IME report/peer review with a detailed basis and medical rationale for the denial of benefits in order to prevail. See Vladimir Zlatnick, M.D., P.C. v. Travelers Ins. Indemnity Co., 12 Misc. 3d 128A (App. Term 1st Dept. 2006) and Nir v. Allstate, 7 Misc.3d 544, 546-47 (Civ. Ct., Kings County. 2005). ("At a minimum, (the respondent) must establish a factual basis and medical rationale for the lack of medical necessity of (applicant's) services"). Once the respondent submits an IME report or peer review that has a sufficient factual basis and medical rationale, then the courts have routinely found that the respondent has established its prima facie defense that the disputed medical service is medically unnecessary. A Khodadadi Radiology, P.C. v. NY Cent. Mut. Fire Ins. Co., 16 Misc.3d 131(A), (N.Y. Sup. App. Term Jul 03, 2007). Then, the burden of persuasion regarding the medical necessity of the medical services shifts to the applicant to submit competent medical evidence to refute the respondent's prima facie defense that the disputed medical service/test was medically unnecessary. See Pan Chiropractic PC v. Mercury Ins. Co., 24 Misc.3d. 136 (A)(July 9, 2009).

Applying the above case law and criteria to the medical evidence in the record, I find in favor of the applicant because: (1) I find that the peer reviewer's cited standard of care was met. The peer reviewer cited medical authority that epidural injections/nerve blocks are medically warranted if there is acute radicular pain after 2 weeks or more of acute radicular pain that failed to respond or poorly responded to active conservative (including medication) management and average pain levels of 6 on a scale of 0 to 10 or Intermittent or continuous pain causing functional disability," or, failed surgery or, spinal stenosis. The peer reviewer argued that there was no evidence that the Injured Party received conservative care in the form of physical therapy, acupuncture treatment, and chiropractic treatment of the lumbar spine. The medical evidence in the record shows that the Injured Party was treated conservatively with medications, E/M exams, exercises, diagnostic testing [a lumbar MRI study], and lumbar epidural injections; and (2) I am persuaded by the treating physician Dr. Chernyak, D.O. that his cited standard of care was met. The Injured Party received adequate conservative care before the injections and related services on 05/07/21. He took Tramadol for several months, which is noted in the submitted medical records. He underwent lumbar epidural steroid injections. Also, the treating providers recommended physical therapy; he stated "*the [Injured Party] underwent extensive conservative care treatments including physical therapy, therapeutic exercise, home exercise program and medications, all of which failed to alleviate his pain and symptoms.*" Dr. Chernyak also noted positive lumbar MRI findings evidencing disc bulges and herniation with spinal canal stenosis and nerve root abutment that correlated to the reported complaints and positive findings; he argued that based on his cited medical authority, the epidural injections/nerve blocks were indicated. Finally, Dr. Chernyak indicated that the Injured Party contracted the COVID virus and was not in therapy after the COVID-19 virus but still used Tramadol. Notably, Dr. Tawfellos reiterated his opinions that the respondent failed to demonstrate that sufficient conservative care was not first attempted and/or failed before the injections were performed on 05/07/21. Considering the totality of the medical evidence in the

record and affording deference to the treating provider's superior knowledge of the Injured Party's condition and conservative care, I find that the underlying injections associated with the disputed ambulatory surgical services were medically necessary and performed consistent with the applicable standard of care. **Accordingly, for the above reasons, I find in favor of the applicant in the amount of \$1548.90, as reimbursement of its entire claim.**

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
	Island Ambulatory Surgery Center LLC	05/07/21 - 05/07/21	\$1,548.90	Awarded: \$1,548.90
Total			\$1,548.90	Awarded: \$1,548.90

- B. The insurer shall also compute and pay the applicant interest set forth below. 08/10/2021 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant's award in the amount of \$1548.90 shall bear interest at a rate of two percent per month, calculated on a pro-rata basis using a 30-day month from 08/10/21, the date the applicant initiated this arbitration, to the date of the payment of the award, pursuant to 11 NYCRR 65-3.9 (a) and LMK Psychological Servs. P.C. v. State Farm Mut. Auto Ins. Co., 12 N.Y.3d 217, (N.Y., April 02, 2009) since Applicant did not commence this Arbitration proceeding within 30 days after receiving the subject denial(s).

C. Attorney's Fees

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

As this matter was filed **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 11 NYCRR 65-4.6(d).

- 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 New York

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

12/23/2022
(Dated)

Heidi Obiajulu

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:
af3bde87f82ec0c4fd6a59169b0d176c

Electronically Signed

Your name: Heidi Obiajulu
Signed on: 12/23/2022