

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

NYEEQASC, LLC d/b/a North Queens
Surgical Center
(Applicant)

- and -

Allstate Fire & Casualty Insurance Company
(Respondent)

AAA Case No.	17-21-1219-4504
Applicant's File No.	BT21-144980
Insurer's Claim File No.	0586295379-08
NAIC No.	29688

ARBITRATION AWARD

I, Charles Blattberg, 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: Eligible injured person

1. Hearing(s) held on 01/11/2023
Declared closed by the arbitrator on 01/18/2023

Krikor Ghazarian, Esq. from The Tadchiev Law Firm, P.C. participated virtually for the Applicant

Rosemary Krupp, Esq. from Law Office Of Lawrence & Lawrence participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,321.74**, 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 claimant was the 17 year-old female restrained front seat passenger of a motor vehicle that was involved in an accident on 5/10/20. Following the accident the claimant suffered injuries which resulted in the claimant seeking treatment. At issue is the medical necessity of facility services provided by Applicant associated with a supraclavicular nerve block under ultrasonic guidance performed on 9/14/20 that Respondent timely denied reimbursement for based on a 10/14/20 peer review by Julio V. Westerband, M.D.

4. Findings, Conclusions, and Basis Therefor

Based on a review of the documentary evidence, this claim is decided as follows:

An applicant establishes a prima facie case of entitlement to reimbursement of its claim by the submission of a completed NF-3 form or similar document documenting the facts and amounts of the losses sustained and by submitting evidentiary proof that the prescribed statutory billing forms [setting forth the fact and the amount of the loss sustained] had been mailed and received and that payment of no-fault benefits were overdue. See, *Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). I find that Applicant established a prima facie case for reimbursement.

Previously I would have dismissed this claim citing CPLR § 1209, which provides that a controversy involving an infant shall not be submitted to arbitration except pursuant to a court order. I now reject this argument here since the assignor is now 19 years of age. While the assignor may have signed the assignment of benefits as a minor, such defect renders the assignment voidable, not void. There is no evidence that the assignor interposed an objection regarding her signing the assignment as a minor.

The claimant was the 17 year-old female restrained front seat passenger of a motor vehicle that was involved in an accident on 5/10/20. The claimant reportedly injured her neck, right shoulder, right wrist, and middle/lower back. There was no reported loss of consciousness. There were no reported lacerations or fractures. There was no reported emergency treatment sought or received. On 5/13/20 the claimant presented to Mark Slamowitz, D.C. and was initiated on chiropractic treatment and prescribed durable medical equipment consisting of a lumbosacral support, moist heating pad, lumbar cushion, cervical collar, and cervical pillow. On 5/16/20 the claimant presented to Peijun Zeng, OMD, Ph.D., L.Ac. of Five Elements Acupuncture and was initiated on acupuncture and cupping. On 5/18/20 the claimant presented to David N. Lifschutz, M.D. of Integrated Neurological Associates, PLLC with complaints of occipital headaches rated 7-8/10 (where 0 is no pain and 10 is the worst pain), neck pain rated 7-8/10 radiating with paresthesias into the right shoulder/proximal RUE, right shoulder pain, right wrist pain with paresthesias in the right hand, and middle/lower back pain extending into the right paraspinal muscles rated 7-8/10. The claimant was initiated on physical therapy, prescribed MRIs (cervical spine, lumbar spine, right shoulder, and right wrist), Flector patches (Diclofenac epolamine topical patches), and recommended for an orthopedic consultation. The 6/1/20 right shoulder MRI produced an impression of tendinosis of the supraspinatus muscle and tendon complex, biceps tenosynovitis, and questionable partial-thickness rotator cuff tear which should be correlated clinically. The 6/5/20 lumbar spine MRI produced an impression of lateral disc bulge at L5-S1 with bilateral neural foraminal narrowing and lateral recess stenosis. The 6/5/20 right wrist MRI produced an impression of fluid signal at the level of the radial ulnar joint consistent with internal derangement and increased intercarpal fluid also consistent with internal derangement. The 6/15/20 cervical spine MRI produced an impression of unremarkable MRI examination of the cervical spine. On 7/6/20 Dr. Lifschutz

conducted upper extremities EMG/NCV testing that produced a negative study. On 7/31/20 Dr. Lifschutz prescribed Lidocaine 5% ointment 100gm and Celecoxib 200mg x60. On 8/26/20 the claimant presented to Hank Ross, M.D. for an orthopedic consultation of the right shoulder with complaints of "persistent popping, clicking, and loss of function in her right shoulder." Right shoulder examination revealed positive Impingement sign, reproducible clicking and clunking; negative O'Brien sign; positive Sulcus sign, positive Apprehension test, and positive Speed's test. Right shoulder range of motion was abduction 120/150°, forward flexion 160/180°, external rotation 80/90°, and internal rotation 80/90°. The claimant was recommended for arthroscopic surgery. On 9/14/20 Tal Levy, M.D. (anesthesiologist) performed a supraclavicular nerve block under ultrasonic guidance and Dr. Ross performed right shoulder surgery consisting of manipulation and evaluation under anesthesia, shoulder arthroscopy, debridement partial rotator cuff tear, subacromial decompression with release of coracoacromial ligament, and anterior thermal capsulorrhaphy. The preoperative diagnosis was partial thickness rotator cuff tear and biceps tenosynovitis right shoulder. The postoperative diagnosis was anteroinferior instability, partial tear supraspinatus, and subacromial bursitis. The operative report details hyperemia in the subscapularis tendon, but no frank tear... no frank Bankart lesion...biceps tendon tenosynovitis with no tear or subluxation of the tendon...supraspinatus partial-thickness tearing...small Hill-Sachs lesion...erythema and inflammation around the coracoacromial ligament with thickening of the ligament. On 9/14/20 Dr. Ross prescribed a PT9 cold compression unit and non-segmental pneumatic appliance; as well as the use of a right shoulder continuous passive motion (CPM) unit and a right shoulder cryo-compression device (cold pad with fluid pump). On 10/9/20 the claimant presented to Adnan Qureshi, M.D. of Pulse Medical Care with complaints that included pain in the right shoulder radiating down the right arm with clicking and weakness (4/5). Right shoulder pain was rated 9/10. Right shoulder range of motion was flexion 100/180°, extension 30/50°, abduction 80/180°, internal rotation 45/90°, external rotation 45/90°. Positive orthopedic tests were Empty Can, Neer's, Speed's, and O'Brien's. The claimant underwent right shoulder and right wrist ultrasound evaluation. Dr. Qureshi prescribed Lidocaine 5% patches x60 and Diclofenac 3% gel 100gm. At issue are the facility services provided by Applicant associated with the 9/14/20 supraclavicular nerve block under ultrasonic guidance.

The burden has shifted to the Respondent as they have raised a medical necessity defense. In order to support a lack of medical necessity defense Respondent must "set forth a factual basis and medical rationale for the peer reviewer's determination that there was a lack of medical necessity for the services rendered." See, *Provvedere, Inc. v. Republic Western Ins. Co.*, 2014 NY Slip Op. 50219(U) (App. Term 2nd, 11th and 13th Jud. Dists. 2014). 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 generally, *Bronx Expert Radiology, P.C. v. Travelers Ins. Co.*, 2006 NY Slip Op. 52116 (App. Term 1st Dept. 2006). As a general rule, reliance on rebuttal documentation will be weighed in light of the documentary proofs and the arguments presented at the arbitration. Moreover, the case law is clear that a provider must rebut the conclusions and determinations of the IME/peer doctor with his own facts. *Park Slope Medical and Surgical Supply, Inc. v. Travelers*, 37 Misc.3d 19 (2012).

Respondent timely denied the services at issue based on the 10/14/20 peer review by Julio V. Westerband, M.D. After reviewing the claimant's history, treatment, and medical records, Dr. Westerband opines "the shoulder surgery was not medically necessary, it was premature for the claimant to be sent for a surgical intervention of the right shoulder. The claimant should've been sent for adequate conservative treatment which included steroid injections. The claimant tried physical therapy but was not tried with steroid injection in this case. Dr. Ross could have been more patient and also tried other non surgical modalities available. The ultimate point that has to be noted here is that Dr. Ross rushed to perform a surgery for symptoms that do not warrant any urgent intervention. There is also no explanation provided as to why did Dr. Ross choose surgery over steroid injection for such benign symptoms, in the very first evaluation itself, Dr. Ross prescribed the claimant to undergo right shoulder surgery." Dr. Westerband asserts "as per the MRI report of the right shoulder dated 06/20/2020, the following impressions were revealed "Tendinosis of the supraspinatus muscle and tendon complex, biceps tenosynovitis, questionable partial-thickness rotator cuff tear which should be correlated clinically." These findings documented on the MRI do not warrant an urgent surgical intervention as they can be easily treatment with progressively challenging plan of conservative treatment and non surgical modalities. There is some damage to the rotator cuff however; those findings can be treated with non-surgical modalities as well. There were other non surgical modalities available for the same problems which would have been far more cost effective. It is my opinion that the surgery was not medically necessary. No explanation is provided by Dr. Ross regarding steroid injections as to why he did not try the claimant with steroid injections first when there were no indications to warrant urgent surgical intervention. "Your doctor may recommend shoulder arthroscopy if you have a painful condition that does not respond to nonsurgical treatment. Nonsurgical treatment includes rest, physical therapy, and medications or injections that can reduce inflammation and allow injured tissues to heal." (Orthoinfo; AAOS; October 2019) "Cortisone shots are injections that may help relieve pain and inflammation in a specific area of your body. They're most commonly injected into joints - such as your ankle, elbow, hip, knee, shoulder, spine and wrist. Even the small joints in your hands and feet might benefit from cortisone shots." (MayoClinic; Cortisone Shots; Sept. 10, 2019)." Dr. Westerband continues "The initial phase of conservative management consists of cessation of throwing activities, followed by a short course of anti-inflammatory medication to reduce pain and inflammation. Once the pain has subsided, we initiate physical therapy focused on restoring normal shoulder motion. Strengthening of the shoulder girdle musculature is also crucial to restore normal scapula-thoracic motion." (SLAP Lesions: An Update on Recognition and Treatment; journal of orthopaedic & sports physical therapy | volume 39 | number 2 | February 2009) Treatment of shoulder pain with steroid injection and physiotherapy significantly improved pain in a sustained manner through 6 weeks, according to study results." Our results support that corticosteroid injection is an effective and safe tool in the management of shoulder pain," Hassan M. T. Fawi, MBBS, MRCS Eng, of University Hospital of Wales, told Orthopedics Today. (Orthopedics Today, February 2018; Joshua D. Harris, MD) Please note that 3-6 months of conservative care should be provided before making a surgical decision. If the care has been nonstop then 3 months may suffice but 6 months are required if treatment has not been constant. The objective of treatment is attempting to gain full ROM with stretching and strengthening. Passive

modalities by themselves are not sufficient to be considered adequate non-surgical treatment. Table 2: Criteria for Shoulder Surgery - Impingement Syndrome If the patient has AND the diagnosis is supported by AND this has been done (if recommended) The following surgery may be appropriate

DIAGNOSIS	CLINICAL FINDING	SUBJECTIVE	OBJECTIVE	IMAGING	CONSERVATIVE CARE	SURGICAL PROCEDURE
Acromial Impingement Syndrome (80% of these patients will get better without surgery)	Pain with active arc motion 90 - 130° AND Pain at night; Tenderness over the greater tuberosity is common in acute cases. Weak or absent abduction. May also demonstrate atrophy AND Tenderness over rotator cuff or anterior acromial area AND Positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). Conventional xrays, AP, and true lateral or axillary view AND MRI, Ultrasound or Arthrogram shows positive evidence of deficit in rotator cuff. Recommend 3-6 months: three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full range of motion, which requires both stretching and strengthening to balance the musculature. Anterior Acromioplasty. According to the research article "Internal impingement of the shoulder in the overhead athlete.", Internal impingement of the shoulder refers to a constellation of pathologic conditions, including, but not limited to, articular-sided rotator cuff tears, labral tears, biceps tendinitis, anterior instability, internal rotation deficit, and scapular dysfunction. Physiologic adaptations to throwing include increased external rotation, increased humeral and glenoid retroversion, and anterior laxity, all of which may predispose an individual to internal impingement. Nonoperative treatment should always be attempted first, with a focus on increasing the range of motion and improving scapular function. When an operative intervention is chosen, it is important to address microinstability in order to have a good outcome and prevent failure." Dr. Westerland concludes "in this case, the standard of care was to try the claimant was non-surgical modalities including steroid injection first and based on how the claimant responds to it, determine the further treatment modalities."					

Where the Defendant insurer presents sufficient evidence to establish a defense based on lack of medical necessity, the burden shifts to the Plaintiff which must then present its own evidence of medical necessity (see Prince on Evidence section 3-104, 3-202). *West Tremont Medical Diagnostic PC v. Geico*, 13 Misc.3d 131, 824 N.Y.S. 2d 759.

Applicant submitted an 11/7/22 peer rebuttal by Hank Ross, M.D. This rebuttal contains significant citations which for space and readability considerations are omitted and the position noted by "[CO]." After reviewing the claimant's history, treatment, and medical records, Dr. Ross opines "Regarding the difference between the peer reviewer's suggested standard of care for the aforementioned pathologies and the treatment course that was enacted for this patient, I would like to make it clear that there are conflicting standards of care for rotator cuff injuries, and it is recommended that clinicians use their best judgement for surgical intervention. It has been established that there is "significant variation in surgical decision-making and a lack of clinical agreement among orthopaedic surgeons about rotator cuff surgery" [CO]. Regarding an alternative standard of care, the peer reviewer states that "3-6 months of conservative care should be provided before making a surgical decision." Please note that the peer reviewer fails to appropriately cite any medical literature to support this claim, thus it solely represents their personal opinion. Additionally, the patient initiated physical therapy prior to

07/06/2020, and the surgical intervention did not occur until 4 months after the initial injury. There was ample time allowed for conservative care to occur, and the surgical intervention was not "premature" or "rushed." As indicated below, early repair of the patient's suffered injuries yields better outcomes following a failure of conservative management - particularly due to this patient's young age. As stated in the peer reviewer's cited AAOS quote, "Your doctor may recommend shoulder arthroscopy if you have a painful condition that does not respond to nonsurgical treatment. Nonsurgical treatment includes rest, physical therapy, and medications or injections." The patient failed to respond to nonsurgical treatment, thus the shoulder surgery was medically necessary. The peer reviewer additionally claims that, the patient "should've been sent for adequate conservative treatment which included steroid injections." Please note that it has been established that there is "no benefit of subacromial steroid injection over NSAID," which had already failed to provide adequate pain relief to the patient [CO]. Additionally, "for patients with partial rotator cuff tear, corticosteroid plays a role in the short term but not in long-term pain reduction" [CO]. Similarly, per the National Institute for Health and Care Research, "injections provide no pain relief at three months after the injection. The authors report a small and short lived reduction in pain between one and two months after treatment and that multiple injections are no more beneficial than single injection. The widespread use of corticosteroid injections for shoulder pain is not supported by evidence" [CO]. Furthermore, "[s]everal authors agree with the concept that repeated corticosteroids injections at short intervals are dangerous with regard to tendon atrophy and reduction of connective tissue quality" [CO]. Thus, the peer reviewer's denial of the medical necessity of the arthroscopy based on the lack of corticosteroid injections is not in line with the current body of peer-reviewed research. Steroid injections solely provide short-term pain relief and would not have healed the traumatic pathologies present in this patient." Dr. Ross continues "regarding shoulder injuries, the NYS Workers' Compensation Board Medical Treatment Guidelines state: "All operative interventions must be based upon positive correlation of clinical findings, clinical course and imaging and other diagnostic tests... For surgery to be performed to treat pain, there must be clear correlation between the pain symptoms and objective evidence of its cause." As explained below, there was careful consideration of the patient's subjective findings, clinical course, clinical findings, and imaging prior to moving from conservative treatment to surgical intervention. The aforementioned clinical course included persistent shoulder pain and impairment despite a sufficient trial of conservative management. Thus, in accordance with the *NYS Workers' Compensation Treatment Guidelines*, it was determined that the patient was an ideal candidate for surgical intervention. Analysis of the patient's subjective history is the first step in the diagnosis of an acute shoulder injury that would necessitate surgical intervention. In this case, the patient had a history of presenting illness that was highly indicative of the diagnosed pathologies: "Acute rotator cuff tears can be caused by a fairly minor injury to the shoulder in an older person or by a significant trauma, such as a shoulder dislocation or motor vehicle crash. Pain with overhead activities and pain that awakens the patient from sleep are typically reported" [CO]. "The cause of shoulder impingement syndrome usually is considered to be compression of the rotator cuff and subacromial bursa against the anterolateral aspect of the acromion. The typical symptom is anterolateral shoulder pain that worsens at night and with overhead activity" [CO]. Per the AAFP, "[p]ain and weakness are the main symptoms of shoulder instability" [CO]. Additional symptoms may include "[f]eeling or hearing a 'pop' in the shoulder,"

"[f]eeling that the shoulder is stuck in a certain position," and "difficulty lifting the arm overhead" [CO]. Dr. Ross asserts "given the patient's history of a traumatic accident in addition to the subjective reports of shoulder pain and weakness with popping and difficulty with overhead motion, it was entirely likely that the patient suffered from a rotator cuff tear, shoulder impingement syndrome, and shoulder instability based on their history and presentation alone. The physical exam findings following a traumatic injury to the shoulder are an essential part of the diagnostic process. The American Academy of Orthopaedic Surgeons states that: "Strong evidence supports that clinical examination can be useful to diagnose or stratify patients with rotator cuff tears; however, combination of tests will increase diagnostic accuracy." Additionally, [CO] indicate that the following tests are useful to diagnosis full thickness rotator cuff tear: bear hug test, belly press test, empty can test, external rotator lag sign, external rotation resistance test, full can test, Hawkins test, Hug up test, internal rotation lag sign (IRLS) test, internal rotation resistance test (IRRT) test, Internal rotation resistance test at maximal 90 degrees of abduction and maximal external rotation (IRRTM) test, Jobe Test, Lateral Jobe Test, Lift off test, NEER test, Patte Test, and Yocum test. Generally, these tests are better to diagnose (rule in), than screening (rule out) full thickness rotator cuff tears" [CO]. Additionally, it has been established that "patients who demonstrate full passive ROM but a limitation in active ROM may have impingement syndrome or a rotator cuff tear. Weakness in external rotation (infraspinatus/teres minor), forward elevation (supraspinatus), and internal rotation or liftoff (subscapularis) could indicate a tear of the rotator cuff" [CO]. As mentioned previously, the patient's clinical exam was positive for Hawkins/Kennedy impingement sign and decreased range of motion, indicating that there was a rotator cuff tear that would benefit from surgical repair. Regarding physical exam tests used to diagnose subacromial impingement syndrome (SIS), "the best combination of tests for making the diagnosis of impingement disease of any degree are a positive Hawkins-Kennedy impingement sign, a positive painful arc sign, and weakness in external rotation" [CO] "The clinical tests that best determined the presence of SIS (the most sensitive ones) were the Hawkins test (92.1%), Neer test (88.7%) and horizontal [cross arm] adduction test (82.0%) [...] Tests with the highest positive predictive values were found to be drop arm test (87.5%), Yergason's test (86.8%) and painful arc test (80.5%)" [CO]. As mentioned previously, the patient's clinical exam was positive for Hawkins-Kennedy impingement sign, indicating that the patient was suffering from subacromial impingement syndrome that would benefit from surgical repair. Regarding physical exam tests used to diagnose shoulder instability, "[s]pecific tests for anterior laxity and apprehension are essential. The sulcus sign (Neer & Foster, 1980), Jobe relocation test (Jobe et al., 1989), Gagey hyperabduction sign (Gagey & Gagey, 2001), apprehension sign (Rowe & Zarins, 1981), and anterior translation of the humeral head over the glenoid rim (Gerber & Ganz, 1984) can all be used to assess instability" [CO]. Similarly, "providers utilize a wide variety of physical exam maneuvers for diagnosing anterior shoulder instability. However, the apprehension, relocation, load and shift, and anterior drawer tests are each utilized by over 50% of responding surgeons. In fact, 100% of surgeons specifically reported using the apprehension test for diagnosing anterior shoulder instability" [CO]. As mentioned previously, the patient's clinical exam was positive for sulcus sign and apprehension sign, indicating that there was a shoulder instability that would benefit from surgical repair." Dr. Ross expounds "imaging results are another useful tool that can be used in conjunction with subjective complaints and physical exam results in order to diagnose

shoulder pathologies. The American Academy of Orthopaedic Surgeons states that: "Strong evidence supports that MRI, MRA, and ultrasound are useful adjuncts to a clinical exam for identifying rotator cuff tears." This was based on "Thirteen high quality studies [that] evaluated MRI [use] for the diagnosis of rotator cuff tears [CO] regarding impingement syndrome, it has been shown that "MRI is a valuable method capable of demonstrating partial tears and tendinitis in stage 1 and 2 SIS" [CO]. Regarding shoulder instability, "MRI is the modality of choice in the evaluation of shoulder instability with MR arthrography being regarded as the gold-standard imaging technique for assessment of shoulder instability. The role of the radiologist in shoulder instability is localization of the lesions, revealing which one of the stabilizing elements is compromised, and to determine the acuity of lesions" [CO]. This is all to say that the MRI can be a useful component in diagnosing a rotator cuff tear or shoulder pathology. However, the results must be used in conjunction with the patient's subjective presentation and physical exam findings. In this case, the presence of "tendinosis of the supraspinatus muscle and tendon complex" and "questionable partial-thickness rotator cuff tear which should be correlated clinically" on MRI results of the shoulder confirmed the suspicion that the patient was suffering from an acute shoulder injury that necessitated surgical intervention." Dr. Ross argues "due to the more-than-sufficient evidence suggesting the presence of the aforementioned pathologies, the shoulder arthroscopy was medically necessary in order to both assess the extent of the damage to the shoulder, as well as repair said damage. Arthroscopy is a minimally invasive procedure that allows the direct visualization of the extent of the damage to the shoulder, resulting in an accurate, definitive diagnosis of the pathologies that the patient is suffering from. The ability to immediately repair the injuries after diagnosis without a separate surgical intervention is an additional boon to the procedure. There is a vast body of research indicating that the surgical repair of rotator cuff tears (partial or full) at the soonest appropriate opportunity is the optimal intervention for patient recovery: "A concern with rotator cuff tears is the risk of progression, which can lead to atrophy of the rotator cuff and a tear that could have been repaired becoming irreversible. Patients with a suspected tear should be referred to an orthopedist for a discussion about the benefits of conservative vs. operative management. It is especially important to refer young, active, healthy patients with full-thickness tears to an orthopedist as soon as possible because early operative treatment may result in better outcomes" [CO] "[S]urgical repair of traumatic tears is significantly affected by delay to diagnosis and treatment (and hence requires urgent referral)" [CO]"[P]rompt surgical repair often leads to significant improvement in pain and function and return to normal occupation" [CO]. Regarding the option of prolonging conservative care, please note that "physical therapy treatment does not result in the healing of the RC [(rotator cuff)] tear, and natural history studies have raised concerns about tear progression and irreversible fatty infiltration worsening over time. Patients surgically treated return to work earlier and incur less cost burden when compared with patients treated nonoperatively currently arthroscopic repair has replaced open surgery and is now used to treat greater than 95% of all RC tears" [CO]. Dr. Ross continues "The majority of imaging studies have demonstrated that healing of PTRCTs is, in fact, rare. This is further supported by histologic studies by Fukuda et al. who demonstrated that PTRCTs did not have the ability to heal themselves over time. Furthermore, it appears that nonanatomic procedures that do not specifically address the PTRCT do not prevent tear progression the success of nonoperative treatment of PTRCTs has rarely been reported" [CO]

"Partial tears of the articular surface of the rotator cuff are common lesions and when not repaired can lead to persistent pain and disability" [CO]. "In general, absolute indications for surgical repair are the onset of acute, posttraumatic weakness in physiologically younger, active individuals without pre-existing rotator cuff dysfunction. Relative indications for surgery are pain or weakness that has been refractory to an appropriate course of nonoperative management; traditionally, rotator cuff tears were repaired with open surgery, most tears can now be repaired arthroscopically, which decreases morbidity for the patients. Some larger or more complex tears still require open procedures. Between 77% and 98% of patients are satisfied with their outcome after rotator cuff repair, with excellent pain relief and functional improvement in more than 80% of patients" [CO]. Dr. Ross concludes "the body of aforementioned research is directly in contrast with the peer-reviewer's unsourced claim that the patient's clinical picture did "not warrant an urgent intervention." An extended trial of nonoperative management would have been medically inappropriate and likely lead to further tear propagation, deterioration, and disability. Research also supports the treatment of impingement syndrome (compression of the rotator cuff muscles/tendons) via surgical intervention: "Impingement-type symptoms of pain brought on by overhead activities can be treated by arthroscopic or min-open subacromial decompression that involves removal of the thickened bursa, thus alleviating the compression that is the cause of chronic irritation and inflammation. In more advanced cases with associated partial- or full-thickness rotator cuff tears, a tendon debridement or repair is performed during the same procedure. This provides substantial pain relief and functional improvement in 75-86% of patients" [CO] "Impingement on the tendinous portion of the rotator cuff [...] is responsible for a characteristic syndrome of disability of the shoulder [...] Anterior acromioplasty may offer better relief of chronic pain in carefully selected patients with mechanical impingement, while it provides better exposure for repairing tears of the supraspinatus, and may prevent further impingement and wear at the critical area without loss of deltoid power" [CO]. "The rotator cuff impingement is the most important single source of chronic shoulder complaints in orthopaedic patients. The anterior acromioplasty described by Neer is accepted as efficient method if conservative treatment fails. Besides their good results the arthroscopic technique of subacromial decompression is increasingly gaining popularity due to less surgical morbidity, decreased hospital stay and quicker rehabilitation" [CO]. Finally, published literature also supports the treatment of shoulder instability via surgical intervention: "The risk of recurrence of dislocation of the PS [shoulder joint] against the background of conservative treatment is unacceptably high (reaches 43%, according to L. Hovelius et al.), and therefore, early surgical treatment of primary dislocation of the PS [shoulder joint] is becoming more common. A. De Carli et al. compared the long-term results of treatment in patients with primary dislocation in the right joint (follow-up period 3.3 ± 1.9 years). The recurrence rate in the conservative treatment group was 70%, while in the surgical treatment group it was 13.3%. Thus, surgical treatment reduces the risk of recurrence of instability, increases the chance of a full return to sports and the subjective satisfaction of the patient with the function of the shoulder joint. According to a number of authors, surgical treatment is the preferred method of treatment for young patients" [CO]. "The current "gold standard" in the management of instability is the arthroscopic Bankart repair. With the improvements in surgical technique and instrumentation, a shift from open to arthroscopic surgery has occurred in the management of simple instability (i.e., no significant glenoid, or humeral

bone loss). [...] The authors reported an overall satisfaction of 92.3% and concluded that their results were comparable to the results of open repair. Wheeler et al. performed a comparison of nonoperative management with early arthroscopic intervention. The authors found an alarmingly high rate of recurrence in non-operatively managed cadets of 92% (35 of 38), compared with 22% in those managed arthroscopically with now outdated techniques" [CO]. "A number of studies have compared nonoperative treatment vs arthroscopic stabilization (Arciero et al., 1994; DeBerardino et al., 2001; Kirkley et al., 2005; Robinson et al., 2008). Overall, these studies report a sevenfold reduction in the risk of recurrent instability after arthroscopic stabilization, when compared with nonoperative treatment for the first-time dislocator. The reduced costs of treatment during the first 2 years following arthroscopic stabilization offsets the initial higher expenditure. Furthermore, the overall cost of treatment is significantly lower than nonoperative treatment when surgery for recurrence and occupational absence is considered" [CO]. Additionally, according to the National Institutes of Health (NIH) U.S. National Library of Medicine, Arthroscopy may be recommended for the following shoulder problems: A torn or damaged cartilage ring (labrum) or ligaments; Shoulder instability, where the shoulder joint is loose and slides around too much or becomes dislocated (slips out of the ball and socket joint); A torn or damaged biceps tendon; A torn rotator cuff; A bone spur or inflammation around the rotator cuff; Inflammation or damaged lining of the joint. Often this is caused by an illness, such as rheumatoid arthritis; Arthritis of the end of the clavicle (collarbone); Loose tissue needs to be removed; Shoulder impingement syndrome, to make more room for the shoulder to move around [CO] As evidenced by the clinical history and physical exam findings, the patient's condition was consistent with multiple of the above indications and therefore required the arthroscopic surgery. As such, in accordance with the current orthopedic literature referenced above, the services rendered were in agreement with generally accepted medical and orthopedic standards. The decision for a surgical intervention was made in the best interest of the patient after an appropriate trial of nonsurgical treatment failed to resolve their shoulder injury. It is well settled that it is up to the clinician to decide, based on the circumstances of the injury, clinical course, and exam findings, whether surgical intervention is appropriate for a given patient. After extensive review of these factors, it was deemed that the surgery was medically necessary. Because the arthroscopic shoulder surgery was medically necessary, the associated services were medically necessary as well."

In AAA Case No.: 17-20-1186-8736 where the 9/14/20 right shoulder surgery was at issue this Arbitrator found: *"Here the weight of evidence favors Applicant. Dr. Westerband argues "no explanation is provided by Dr. Ross regarding steroid injections as to why he did not try the claimant with steroid injections first when there were no indications to warrant urgent surgical intervention." Dr. Ross provides numerous diagnostic and therapeutic reasons why arthroscopy might be necessary for the claimant here. Here Applicant prevails as even if Dr. Westerband had established that the use of steroid injections prior to arthroscopy was preferential he failed to establish that not doing so was a violation of the standard of care."*

Here Respondent hasn't submitted sufficient new evidence that would permit this Arbitrator to arrive at a different conclusion. It is noted that Respondent failed to submit anything that would support a fee schedule reduction of the bill at issue.

Respondent also uploaded a 12/23/20 general denial based on the assignor's failure to appear for EUOs along with evidence to support that defense (scheduling letters, affidavit of service, and statements on the record). I note that I am aware that in *Unitrin Advantage Ins. Co. v. Bayshore Physical Therapy, PLLC*, 82 AD3d 559 (App Div 1st Dept. 2011) lv denied 17 NY3d 705 (2011), the Appellate Division, First Department held that a defense predicated upon an assignor's failure to appear for EUOs was a lack of coverage defense not precluded by an untimely denial and did sustain the insurer's defense where it only issued a general denial, I find that the holding in *Unitrin* is inconsistent and contrary to the decision of the Appellate Division, Second Department in *Westchester Med Center v. Lincoln General*, 60 AD3d 1045 (App Div 2d Dept 2009). In *Westchester Med Center*, the Second Department noted the failure of a plaintiff's assignor to appear at an EUO did not serve to toll the thirty day period to pay or deny a claim citing *Mt. Sinai Hosp. v. Triboro Coach*, 263 AD 2d 11, 17 (2d. Dep't, 1999) and noting that such an alleged breach of a policy condition does not serve to vitiate the medical provider's right to recover no-fault benefits or to toll the thirty day statutory period. Further, the court noted that such a denial was subject to the preclusion remedy citing to *Central Gen. Hospital v. Chubb Group of Insurance Co.*, as well as *Zappone v. Home Insurance Co.*, 55 NY 2d 131, 136- 137 (1982). In this matter I am inclined to follow *Westchester Med Center*.

In *Matter of Pomona Pain Mgt., P.C. v. Praetorian Ins. Co.*, 2012 NY Slip Op. 30525(U) (Sup Ct Nassau Cty 2012), the insurer sought the court's review, pursuant to CPLR Article 75, of a master arbitrator's award affirming a lower arbitration award issued by Arbitrator Bianchino wherein he precluded Respondent's untimely IME no-show defense. Judge Winslow noted the First Department's decision in *Unitrin* and the Second Department's decision in *Westchester Med Center* appeared in conflict, and sustained Master Arbitrator Merani's award, noting there was sufficient conflicting authority to preclude the finding of an error of law warranting vacatur.

Accordingly, Applicant is awarded \$1,321.74.

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
	NYEEQASC, LLC d/b/a North Queens Surgical Center	09/14/20 - 09/14/20	\$1,321.74	Awarded: \$1,321.74
Total			\$1,321.74	Awarded: \$1,321.74

- B. The insurer shall also compute and pay the applicant interest set forth below. 09/19/2021 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest runs from 9/19/21 (the date that arbitration was requested) until the date that payment is made at two percent per month, simple interest, on a pro rata basis using a thirty day month.

C. Attorney's Fees

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

Pursuant to 11 NYCRR §65-4.6 (d), ". . . the attorney's fee shall be limited as follows: 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon for each applicant for arbitration or court proceeding, subject to a maximum fee of \$1,360."

- 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 NY

SS :

County of Nassau

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

02/10/2023

(Dated)

Charles Blattberg

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:
1eaaf876c77bae3186e03b4e64d93bc1

Electronically Signed

Your name: Charles Blattberg
Signed on: 02/10/2023