

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Sedation Vacation Perioperative Medicine
PLLC
(Applicant)

- and -

AAA Case No.	17-22-1243-8637
Applicant's File No.	na
Insurer's Claim File No.	0593314354 2SJ
NAIC No.	29688

Allstate Fire & Casualty Insurance Company
(Respondent)

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 03/15/2023
Declared closed by the arbitrator on 03/23/2023

Kim Gitlin, Esq. from Dino R. DiRienzo Esq. participated virtually for the Applicant

Steven Miranda, Esq. from Law Office Of Lawrence & Lawrence participated virtually
for the Respondent

2. The amount claimed in the Arbitration Request, **\$554.23**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant reduced the total amount in dispute to \$386.23 pursuant to fee schedule.

Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

The claimant was the 34 year-old male restrained driver of a motor vehicle that was involved in an accident on 7/18/20. Following the accident the claimant suffered injuries which resulted in the claimant seeking treatment. At issue is the medical necessity of 9/29/20 anesthesia services provided by Applicant that Respondent timely denied

reimbursement for based on a 11/5/20 peer review by Ayman Hadhoud, M.D. and 11/9/20 anesthesia services provided by Applicant that Respondent timely denied reimbursement for based on the results of a 10/12/20 independent orthopedic evaluation (IME) conducted by Thomas P. Nipper, 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.

The claimant was the 34 year-old male restrained driver of a motor vehicle that was involved in an accident on 7/18/20. The claimant reportedly injured his neck, left shoulder, and right knee. There was no reported loss of consciousness. There were no reported lacerations or fractures. There was no reported emergency treatment sought or received. On 7/20/20 the claimant presented to Alexander Zilberman, D.C. of RHS Chiropractic, P.C. with complaints of cervical pain and thoracic pain rated 8/10 (where 0 is no pain and 10 is the worst pain). Positive orthopedic tests were Cervical Distraction, Cervical Depression, Jackson's Compression, Max Cervical Compression, and Kemp's (thoracic). Manual muscle strength, deep tendon reflexes, and sensation were normal. Subluxations and muscle spasms were noted. No trigger points were indicated. The claimant was prescribed durable medical equipment consisting of a massager, cervical pillow, infrared lamp, water circulating pump with heat pad and was initiated on chiropractic treatment. On 7/20/20 the claimant presented to Pascale Lawson, L.Ac. of Pascale Acupuncture, P.C. with complaints of pain in the neck, left shoulder, and right knee. Pain was rated 8/10. The claimant presented with a regular pulse of normal speed. No tongue examination was documented. The claimant was initiated on acupuncture and cupping. On 7/21/20 the claimant presented to Riaz Ahmad, M.D. of Comfort Care Medical PLLC with complaints of radiating neck pain rated 8/10, left shoulder pain rated 8/10, and right knee pain rated 8/10. Cervical examination revealed no tenderness; but muscle spasms and trigger points. Spurling's test was negative. Left shoulder examination revealed tenderness over the anterior aspect of the AC joints, with mild pain on movement and motor power reduced on abduction. Right knee examination revealed medial joint line tenderness, without swelling or crepitus. The claimant was recommended for physical therapy, physical capacity testing, ROM/MMT, OAT, MRIs (cervical spine and right knee), and orthopedic consultation. Dr. Ahmad supervised Outcome Assessment (OSWESTRY) Testing (OAT). The claimant was prescribed a right knee support, left shoulder support, and 200gm Diclofenac 3% gel. On 7/21/20 the claimant presented to Dynamism Physical Therapy, P.C. and was initiated on physical

therapy. On 7/21/20 BV Physical Therapy, P.C. conducted physical capacity (NIOSH) testing/Activity Limitations Measurement and Training Report. On 7/30/20 Richard Sternberg, D.C. of RHS Chiropractic, P.C. conducted pf-NCS testing. On 8/3/20 the claimant presented to Georgette T. Dixon, FNP-BC with complaints of neck pain rated 7/10, left shoulder pain rated 6/10, and right knee pain rated 8/10. The claimant was recommended for physical therapy, chiropractic care, acupuncture care, and consultations (orthopaedic and pain management). FNP Dixon performed left shoulder dry needling. The 8/11/20 left shoulder MRI produced an impression of bicipital strain and glenohumeral joint fluid. The 8/11/20 right knee MRI produced an impression of oblique tear posterior medial meniscus and joint fluid. On 8/19/20 BV Physical Therapy conducted physical capacity (NIOSH) testing/Activity Limitations Measurement and Training Report. On 8/19/20 the claimant presented to Sara Malagold, Ph.D. of Complete Neuropsychology, P.C. for psychological evaluation and testing (mental status exam, BDI-II, BHS, BAI, SBT, PTSD, pain disability index, health status questionnaire, psychological inflexibility scale and BSI). The claimant was recommended for psychotherapy and cognitive remediation. On 8/20/20 the claimant presented to Richard E. Pearl, M.D. with complaints of pain in his right knee is an 8/10 and left shoulder is a 3/10. Left shoulder examination revealed "skin is intact without evidence of bruises, abrasions, or ecchymosis. There is no swelling. There is positive tenderness to palpation to the AC joint and bicipital groove. Range of motion: Flexion 0 to 120, abduction 0 to 120, internal and external rotation 0 to 60. Positive Neer, positive Hawkins, and positive O'Brien signs. Sensation is intact. Pulses are+2. Cuff strength is 4/5." Right knee examination revealed "skin is intact without evidence of bruises, abrasions, or ecchymosis. There is no swelling. There is positive tenderness to palpation to the medial and lateral joint lines and tenderness to palpation to the patellar facets. Range of motion 0 to 110, with pain. Positive McMurray, positive patellar compression test, negative Lachman. Knee is stable to AP, valgus, and varus stress. Sensation is intact. Pulses are+2. Calf strength is 4/5." Dr. Pearl notes "I discussed the physical examination findings and diagnostic imaging results with the patient. The patient is to continue physical therapy three days a week. Conservative versus surgical management options were discussed with the patient. The patient was worried that it would affect his basketball. The patient will think about right knee arthroscopy at this time and follow up in two to four weeks for further treatment." On 8/21/20 Kyungsook Bu, N.P. performed dry needling of the neck, upper back, left shoulder, and right knee. On 8/25/20 Dean Mauro, D.C. conducted upper extremities EMG/NCV that suggested evidence consistent with right C6-C7 radiculopathy. On 9/1/20 Faisal Masood, D.C. conducted medial and ulnar NCS testing. On 9/3/20 BV Physical Therapy conducted computerized range of motion and manual muscle testing (ROM/MMT). On 9/10/20 the claimant underwent an unattributed "initial examination report" with an illegible signature. The claimant presented with complaints of neck pain rated 5-8/10 radiating to the left shoulder associated with numbness and tingling, shoulder plain rated 5-8/10, mid-back pain rated 5-8/10 and right knee pain rated 7-9/10. Cervical spine examination revealed decreased range of motion in all planes (quantified). Positive orthopedic tests were Foramina Compression, Jackson's Compression, Hyperflexion Compression, Hyperextension Compression, Rotary Compression, O'Donahue, Shoulder Depression and Cervical Distraction. Thoracic examination revealed decreased range of motion in all planes (quantified). No positive orthopedic tests were documented. Left shoulder examination decreased range of motion in all planes (quantified). Supraspinatus test was positive.

Right knee examination revealed decreased range of motion with swelling and crepitus. McMurray's test was positive. Deep tendon reflexes were normal (+2); except +1 right Achilles, left biceps, and left radial. Sensation revealed hypoesthesia at the dermatome level of left C5, C6, right L5 and S1. Muscle strength was normal (5/5); except 4/5 left shoulder abduction, left wrist flexion, right heel walk and right toe walk. No complaints or abnormalities of the lumbar spine were documented. No complaints or abnormalities of the bilateral hips were documented. The claimant was recommended for manipulation under anesthesia (MUA). The 9/10/20 cervical spine MRI produced an impression of straightening of the physiologic lordosis consistent with pain and/or spasm, C4-C5 posterior central disc herniation effacing the CSF column, C5-C6 posterior ridge disc complex impressing the CSF column with narrowing of the neural foramina, and C6-C7 left paracentral disc herniation impressing the left side of the cervical cord with narrowing of the neural foramina. On 9/21/20 the claimant presented to Ketan D. Vora, D.O. of KV Medical, P.C. with complaints of neck pain that radiated to the left shoulder and arm rated 7/10, left shoulder pain rated 7/10, and right knee pain rated 8/10. The claimant denied having double vision, hearing loss, or lightheadedness. Neurologic examination was negative with cranial nerves II-XII grossly intact. Deep tendon reflexes, manual muscle strength, and sensation were normal. The claimant was recommended for trigger point injections, continued physical therapy, chiropractic treatment, and acupuncture. On 9/23/20 Dr. Sternberg prescribed a Transcranial Doppler study and a bilateral Duplex Carotid ultrasound study performed the same day by Alan R. Zakheim, M.D. of Complete Express Medical, P.C. that produced normal studies. On 9/29/20 Dominic Onyema, M.D. (primary physician) and Nachmy Bronstein, D.C. (assistant physician) performed MUA to the cervical spine, thoracic spine, lumbar spine, bilateral sacroiliac, bilateral hips, and right knee. On 9/30/20 the claimant presented to L. Sean Thompson, M.D. complaining of intermittent right knee pain rated 8/10 without giving way or swelling. Examination revealed motor strength and sensation are grossly intact. Right knee examination revealed "No swelling, no color changes. Tenderness to the anterior and medial joint lines. Positive McMurray and Aple/s compression test. Positive varus and valgus stress test. No instability to AP and rotational stress. Negative Lachman sign. Negative anterior drawer, negative posterior drawer sign. Negative Inhibition sign. 4 out of 5 quad strength. Range of motion is from 0-110°. Normal range of motion is from 0-140° in flexion/extension." Right knee arthroscopy was discussed. On 10/8/20 BV Physical Therapy conducted physical capacity (NIOSH) testing/Activity Limitations Measurement and Training Report. On 10/12/20 the claimant was required to present to Thomas P. Nipper, M.D. for an independent orthopedic evaluation (IME) that was purportedly negative and Respondent determined "As per the findings of the physical examination conducted by Dr. THOMAS NIPPER on 10/12/2020, all Orthopaedic, Physical Therapy, Massage Therapy, Physical Medicine and Rehabilitation (PMR), Pain Management, and Prescription Medication benefits were determined to be not medically necessary and were denied effective 11/9/2020." Purportedly on 11/9/20 the claimant underwent right knee arthroscopy performed by Dr. Thompson, based the anesthesia report submitted by Sedation Vacation Perioperative Medicine, PLLC (Applicant). No 11/9/20 operative report is in evidence here. At issue are the associated anesthesia services of 9/29/20 and 11/9/20 provided by Applicant.

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 9/29/20 MUA and associated anesthesia based on two 11/5/20 peer reviews by Ayman Hadhoud, M.D. One argues against the medical necessity of the subject MUA and the other argues against the medical necessity of the subject anesthesia at issue here. They will be discussed together. After reviewing the claimant's history, treatment, and medical records, Dr. Hadhoud opines "The manipulation under anesthesia (MUA) session performed on 09/29/20 is deemed not medically necessary. The patient underwent manipulations under anesthesia of the spine, shoulder, hip and knee on 09/29/20. According to [citation omitted] "The patient has undergone an adequate trial of appropriate care, usually including spinal manipulation by a chiropractor, and often with medical co-management, and continues to experience intractable pain, interference to activities of daily living, and/or biomechanical dysfunction" and according to [citation omitted] "The patient has responded sub-optimally to conservative physical medicine treatment, usually including spinal adjustments by a chiropractor, and often with medical co-management, and continues to experience intractable pain, interference to activities of daily living, and/or biomechanical dysfunction." In this case, I do not see that this patient had responded sub-optimally to conservative chiropractic treatment or medical co-management such as physical therapy. As a matter of fact, the submitted physical therapy progress notes showed that the claimant tolerated the treatment well. Furthermore, trigger point injection, shoulder injection and SI/hip injection are among several common procedures that are considered "co-management." I do not see that the MUA provider documented that the patient failed to respond to any of these procedures when the MUAs were planned. Also, there was no disability caused by the accident of 07/18/20. Reviewing the submitted physical therapy, acupuncture and chiropractic notes from 07/20/20 till the MUA did not show any functional deficits caused by this accident that should be corrected / treated by manipulation under anesthesia. The treatment notes reveal no restrictions in the daily living activities or inability to work because of the injuries the patient sustained as a result of the motor vehicle accident of 07/18/20. Also, reviewing the evaluation report dated 09/10/20 reveals that the MUA provider did not even mention what the patient's job entails, what activities the patient is required to do at work and what obstacle the patient is encountering because of adhesions that should only be treated by manipulations under anesthesia. This was not documented in this patient's case. Therefore, the very first criterion to perform the manipulation under anesthesia was not met in this case as the injuries did not cause disability." Dr. Hadhoud continues "according to [citation omitted] and [citation omitted] "Sufficient care has been rendered prior to recommending MUA. A sufficient time period is usually

considered a minimum of 4-8 weeks, but exceptions may apply depending on the patient's individual needs. Most patients selected for MUA procedures have had longer courses of care, but those with more severe symptoms and little or no response to conservative management are best considered sooner than later to avoid unnecessary additional costs and increased suffering." In this case, the submitted records showed that the claimant had received physical therapy, acupuncture and chiropractic treatment sessions from 07/20/20 till the MUA. The fact that the patient had received all these sessions, shows that the patient was tolerating the treatments and responding satisfactorily to the manipulations and chiropractic treatments, otherwise there would be no medical reason to perform all of these sessions over that period of time unless the patient was responding well to treatment. In fact, reviewing, the physical therapy progress notes showed that the claimant tolerated the treatment well. Overall, the records do not show that there were severe symptoms or that the patient had little or no response to conservative management. Thus, the patient was not a candidate for MUA procedures. According to [citation omitted] "The patient's level of reproduced pain interferes with activities of daily living or causes disability (that is, the inability to fully participate in work and other activities)" I do not see in the report of 09/10/20 any specific functional deficits, or any obstacle that the patient encounters because of level of pain or restriction in the range of motion that would require a manipulation under anesthesia procedure to correct such restriction. The provider in the evaluation of 09/10/20 documented that the claimant had "difficulty" with most of daily living activities such as (lifting, sitting, walking, house chores and standing for too long). Nevertheless, generalized limitation in the function of this patient that includes all movements and activities would not be indicative of adhesions. It is indicative of weakness which would be either neurologic or muscular. It has nothing to do with the range of motion or pain. The same holds true with regard to walking and standing, as all of these activities are not dependent on range of motion but mainly on patient's strength specially that the deficits are generalized and not specific to a certain specific movement. In other words, there was no specific limitation in the range of motion that resulted in a specific functional deficit in order to suspect the presence of localized adhesions that needs MUA. Scientifically and logically, a person cannot develop adhesions throughout their body. Also, the provider stated that there was "difficulty" associated with these activities but did not even bother to document where the pain is. It seems that the MUA provider was going to perform the MUA regardless of the site of the pain. Needless to say, that the MUA provider did not even bother to comment on what their job entails which shows that there was no specific goal to perform these manipulations under anesthesia." Dr. Hadhoud asserts "according to the [citation omitted] and [citation omitted] diagnosed conditions must fall within the recognized categories of conditions responsive to MUA. The following disorders are classified as acceptable conditions for utilization of MUA: "Patients for whom manipulation of the spine or other articulations is the treatment of choice; however, the patient's pain threshold inhibits the effectiveness of conservative manipulation." In this case, as mentioned above, there was no documentation that there was severe pain that caused any obstruction or was an obstacle to perform chiropractic manipulations or participate in a physical therapy program. The conservative management records do not reveal any lack of effectiveness of conservative treatment due to the patient's low pain threshold. The claimant had received physical therapy treatment, acupuncture and chiropractic manipulations from 07/20/20 till the date of the MUA and there was no documentation

of any severe pain or pain threshold that interfered with those treatments. "Patients for whom manipulation of the spine or other articulations is the treatment of choice; however, due to the extent of the injury mechanism, conservative manipulation has been minimally effective during a minimum of 4-8 weeks of care (minimum 6 weeks as per 2009 guidelines) and a greater degree of movement of the affected joint(s) is needed to obtain patient progress." In this case, the fact that the patient had received all these chiropractic manipulations sessions, acupuncture and physical therapy sessions, shows that the patient was tolerating the treatments and responding satisfactorily to the manipulations and chiropractic treatment, otherwise there would be no medical reason to perform all of these sessions of conservative manipulations over that long period of time unless they were effective and the patient was responding to all of these conservative lines of treatments. "Patients for whom manipulation of the spine or other articulations is the treatment of choice by the doctor; however, due to the chronicity of the problem and/or the fibrous tissue adhesions present, in-office manipulation has been incomplete and the plateau in the patient's improvement is unsatisfactory." In this case, the submitted chiropractic progress notes did not show any specific chiropractic manipulations that were directed towards breaking down adhesions in the spine or hip. None of the records show that the in--office manipulation has been incomplete. If the patient had plateaued, the treating chiropractor and therapist would have stopped their therapy and documented such "plateau" in their notes. Nonetheless, this was not mentioned in any of the notes. "When the patient is considered for surgical intervention (spinal disc surgery as per 2009 & 2012 guidelines), MUA is an alternative and/or an interim treatment and may be used as a therapeutic and/or diagnostic tool in the overall consideration of the patient's condition." In this case, I do not see that spinal disc surgery was considered in the first place. Therefore, the notion that MUA would be an alternative treatment is not even applicable in this case. In this case, as mentioned above, there were many better treatment options available such as shoulder injection and SI/hip injection. "When there are no better treatment options available for the patient in the opinions of the treating doctor and patient and in consideration of the cause of the patient's related pain, impairment, and/or disability." In this case, as mentioned above, there were many better treatment options available such as SI/hip injection." Dr. Hadhoud concludes [*Citation omitted*] "MUA not recommended for back conditions in the absence of vertebral fracture or dislocation (which is not the case here). Manipulation under anesthesia (MUA) cannot be recommended at the present time. Existing studies are not high quality and the outcomes were not great, plus the procedure is expensive and has risks." Also, the same reference states "Patients who have had a failed back surgery or who have nerve entrapment or muscle contracture may be good candidates for this treatment; However, these indications for MUA have yet to be verified via controlled trials." In this case, there was no vertebral fracture or dislocation. The claimant did not even meet the criteria to be candidate for the manipulations under anesthesia in the first place. According to the [*citation omitted*] "The clinical value of the distinct application of MUA to the shoulder and/or hip articulations, as a natural extension of MUA treatment of approximating vertebral/pelvic joints, has yet to be determined through scientific investigation. It is recognized that some of the commonly applied spine-related MUA maneuvers/techniques rely on the upper or lower extremity as a long lever. This serves to stretch the musculature from origin to insertion as it traverses both the targeted vertebral/pelvic motion units under care and the conjoining extremity. However, technique application does not signify that any incidental or

intentionally induced joint cavitation from the glenohumeral or femoroacetabular articulations is an integral component of care such that it provides additional therapeutic benefit to the patient's treating spinal condition (whether or not there is an associated component of pain referral/radiation to the extremities). In fact, published MUA studies on the shoulder and hip joints are concerned solely with primary conditions of these articulations, such as adhesive capsulitis. Consequently, any supportive medical evidence for the utilization of MUA to treat frozen shoulder or hip articulations does not serve as a clinical basis for the routine application of MUA to these extremity joints when rendered as an adjunctive form of care during the MUA management of a spine pain condition. This type of treatment approach has been criticized in the chiropractic literature. In this case, the manipulation of the hip, shoulder and knee was clearly done as an extension of the manipulation of the spine. This is stated because there was no specific functional deficit that was documented as a result of a hip, shoulder or knee lesion and therefore there was no need to perform the manipulation of these joints. [*citation omitted*] "There is a general paucity of high quality clinical papers in the area of MUA management of intervertebral disc related conditions with a suspected neurological component of radiating pain into an extremity. In the presence of EMG confirmed lumbar nerve root compression, the study by [*citation omitted*] does not favor the use of MUA under that particular clinical circumstance. The authors of that paper opined that the trend of outcome deemed the procedure ineffective over the long term in the presence of positive EMG findings, with surgery likely required at some point. For lumbar disc herniation without EMG evidence of nerve root compression it was opined that MUA would probably offer lasting benefit." In this case, the records showed that there was evidence of nerve root compression as evident by the electrodiagnostic findings. Therefore, such procedure should have not been performed or considered because of its ineffectiveness over the long term. The herniated disc in this context was caused by the force applied on the spine because of the trauma of the motor vehicle accident. Obviously, applying more trauma and extreme range of motion on the spine by MUA would worsen the herniated disc and would not make it any better. Therefore, the logic is to apply MUA to break adhesions that is causing specific limited range of motion with associated functional deficits and not to treat a herniated disc. Overall, the information documented in the evaluation report dated 09/10/20 is not consistent or matching the claimant's records from other providers as explained above. For the reasons mentioned above, it was a deviation from the standards of care as explained above to perform the above mentioned manipulations under anesthesia on 09/29/20. Based on my opinion that above-mentioned procedures were not medically necessary, any associated services (anesthesia, assistants or surgical center services) would subsequently be not medically necessary."

Here this Arbitrator is persuaded by Dr. Hadhoud's unrebutted peer review and the medical reports from ALL providers that fail to document any complaints, abnormalities, or injury to the lumbar spine, pelvis, or sacroiliac. Dr. Onyema's treatment of apparently uninjured body parts undermines credibility, medical necessity, and causation.

Respondent timely denied the 11/9/20 right knee surgery and associated anesthesia based on the 10/12/20 independent orthopedic evaluation (IME) conducted by Thomas P. Nipper, M.D. After reviewing the claimant's history, treatment, and medical records,

Dr. Nipper conducts what appears to be a thorough examination. Cervical examination revealed a normal cervical lordosis. Palpation of the paraspinal muscles and trapezius was negative for tenderness or spasm. Cervical compression testing was negative. Neurological evaluation in the upper extremities showed reflexes in the biceps, triceps and brachioradialis to be 2+ bilaterally and symmetrically. Sensation was intact to light touch. Motor strength was 5/5 bilaterally in all major muscles groups. Range of motion testing was within normal limits (quantified). Thoracic examination revealed on palpation the parathoracic muscles was negative for tenderness or spasm. Direct palpation over the thoracic vertebrae was negative for tenderness. Lumbar examination revealed a normal lumbar lordosis. Palpation of the paralumbar muscles was negative for spasm and/or tenderness. Direct palpation over the vertebrae was negative for tenderness. Range of motion testing was within normal limits (quantified). Straight leg raise testing was performed and was negative to 90° bilaterally. Heel/toe walking as well as tandem walking was performed without difficulty. Motor strength was 5/5 in the lower extremities. Sensation was normal. Reflexes were 2+. Bilateral shoulders examination revealed Impingement sign, apprehension testing and Speed's test were negative. There was no instability. Range of motion testing was within normal limits (quantified). Examination of the shoulders, elbows, wrists, and hips were all within normal limits. Examination of the bilateral knees revealed no tenderness to palpation over the medial or lateral joint lines. No swelling or effusion was present. McMurray's testing, Lachman's testing, pivot shift and posterior drawer signs were all negative. Both varus and valgus testing were negative. Range of motion was within normal limits (quantified). Examination of the bilateral ankles/feet was within normal limits. Dr. Nipper's diagnosis was resolved cervical sprain, resolved left shoulder sprain, and resolved right knee sprain. Dr. Nipper concluded "Treatment: No Orthopedic treatment, including physical therapy or massage is indicated. No surgery is indicated. There are no indications for household help, ambulatory services or prescription medications."

In AAA Case No.: 17-21-1190-8857 this Arbitrator was presented with the same claimant, the same Respondent, the same 10/12/20 IME by Dr. Nipper; but a different applicant (there Lima Supply Inc. for DME prescribed by Dr. Thompson on 11/9/20 and dispensed the same day). Also there, as here, no 11/9/20 operative report was in evidence. There this Arbitrator held: *"Here there are no medical or operative reports attributable to Sean Thompson, M.D. in evidence beyond the prescriptions for the subject durable medical equipment that may impliedly be associated with a right knee arthroscopy. These prescriptions are evidentially insufficient to definitively establish that any surgery was performed on or before 11/9/20 by Dr. Thompson that would, in turn, give rise to the medical necessity of the durable medical equipment being prescribed. Accordingly, the claim is denied in the entirety."*

I reached the same conclusion in AAA Case No.: 17-21-1194-9819 which involved the same claimant, the same Respondent, the same 10/12/20 IME by Dr. Nipper; but a different applicant (there Express Supply & Services Inc. for DME prescribed by Dr. Thompson on 11/9/20 and dispensed the same day). I also reached a similar conclusion in AAA Case No.: 17-21-1225-0049 which involved the same claimant, the same Respondent, the same 10/12/20 IME by Dr. Nipper; but a different applicant (there Dynamism Physical Therapy, PC for physical therapy services provided 10/1/20-1/16/21). Here the submitted anesthesia record is not dispositive as to the

medical necessity of the implied 11/9/20 right knee arthroscopy and is completely ineffective in rebutting the conclusions of the 10/12/20 IME by Dr. Nipper. It is noted that Applicant's counsel argued that I should follow my award in AAA Case No.: 17-21-1214-6498 where different evidence was submitted (including a 10/27/20 orthopedic consultation and the 11/9/20 operative report) and a denial based on the 10/12/20 IME by Dr. Nipper was not upheld while Respondent's counsel argued I should follow the three awards referenced above. 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.*, 64 A.D.3d 1149, 881 N.Y.S.2d 769 (4th Dept. 2009). In addition the Court of Appeals has held: "[C]ollateral estoppel, a flexible doctrine, should not be mechanically applied just because some of its formal prerequisites, like identity of parties, identity of issues, a final and valid prior judgment and a full and fair opportunity to litigate the prior determination, may be present" *Jeffreys v. Griffin*, 1 NY3d 34, 41 (2003), quoting *People v. Roselle*, 84 NY2d 350, 357 (1994). Here, I reach the same conclusion as I did in AAA Case Nos.: 17-21-1194-9819, 17-21-1225-0049 and 17-21-1190-8857. Accordingly, the claim is denied 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 claim is DENIED in its entirety

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.

04/14/2023
(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:
1d254fd9ec37f470cb3d758200912abc

Electronically Signed

Your name: Charles Blattberg
Signed on: 04/14/2023