

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

North Shore LIJ Medical Hospital (NSUH)
(Applicant)

- and -

County of Suffolk
(Respondent)

AAA Case No. 17-21-1217-5647

Applicant's File No. RFA21-300183

Insurer's Claim File No. ALP17220

NAIC No. Self-Insured

ARBITRATION AWARD

I, Paul Weidenbaum, 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: IP

1. Hearing(s) held on 06/20/2023
Declared closed by the arbitrator on 06/20/2023

John Sherman from Russell Friedman & Associates LLP participated virtually for the Applicant

Craig Cusano from County of Suffolk participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$259.21**, 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

This arbitration arises out of a pre-surgical cardiovascular evaluation undergone by the injured person, a 54 year old male, who was involved in a motor vehicle accident which occurred on 12/18/17.

Whether the pre-surgical cardiovascular evaluation undergone by the claimant on 11/12/18 were medically necessary in light of the Independent Medical Examination [IME] performed by Dr. Maindiratta on 9/10/18?

4. Findings, Conclusions, and Basis Therefor

This arbitration arises out of a pre-surgical cardiovascular evaluation undergone by the injured person, a 54 year old male, who was involved in a motor vehicle accident which occurred on 12/18/17. Applicant seeks reimbursement in the sum of \$259.21.

Respondent timely denied reimbursement of the disputed balance based on the Independent Medical Examination [IME] performed by Dr. Maindiratta on 9/10/18.

Applicant has established its prima facie case with proof that it submitted a proper claim, setting forth the fact and the amount charged for the services rendered and that payment of no-fault benefits was overdue (see Insurance Law § 5106 a; *Mary Immaculate Hosp. v. Allstate Ins. Co.*, 5 AD 3d 742, 774 N.Y.S. 2d 564 [2004]; *Amaze Med. Supply v. Eagle Ins. Co.*, 2 Misc. 3d 128A, 784 N.Y.S. 2d 918, 2003 NY Slip Op 51701U [App Term, 2d & 11th Jud Dists]).

The burden shifts to the insurer to prove that the services were not medically necessary. If an insurer asserts that the medical test, treatment, supply or other service was medically unnecessary, the burden is on the insurer to prove that assertion with competent evidence such as an independent medical examination, a peer review or other proof that sets forth a factual basis and a medical rationale for denying the claim. (See *A.B. Medical Services, PLLC v. Geico Insurance Co.*, 2 Misc. 3d 26 [App Term, 2nd & 11th Jud Dists 2003]; *Kings Medical Supply Inc. v. Country Wide Insurance Company*, 783 N.Y.S. 2d at 448 & 452; *Amaze Medical Supply, Inc. v. Eagle Insurance Company*, 2 Misc. 3d 128 [App Term, 2nd and 11th Jud Dists 2003]).

An IME report asserting that no further treatment is medically necessary must be supported by a sufficiently detailed factual basis and medical rationale, which includes mention of the applicable generally accepted medical/professional standards. *Carle Place Chiropractic v. New York Central Mut. Fire Ins Co.*, 19 Misc.3d 1139(A), 866 N.Y.S.2d 90 (Table), 2008 N.Y. Slip Op. 51065(U), 2008 WL 2228633 (Dist. Ct., Nassau Co., May 29, 2008, Andrew M. Engle, J.). An IME report must set forth a factual basis and medical rationale for the conclusion that further services are not medically necessary. E.g., *Ying Eastern Acupuncture, P.C. v. Global Liberty Insurance*, 20 Misc.3d 144(A), 873 N.Y.S.2d 238 (Table), 2008 N.Y. Slip Op. 51863(U), 2008 WL 4222084 (App. Term 2d & 11th Dists. Sept. 3, 2008).

Dr. Maindiratta reported his findings based upon the 9/10/18 physical examination of the injured person as follows:

The claimant ambulated with a normal gait. There were no muscle spasms in either the cervical or lumbar spine upon palpation. Range of motion was within normal limits in the cervical and lumbar spine. In the bilateral shoulders, range of motion was within normal limits with the sole exception of forward flexion which demonstrated 120 degrees of flexion [150 degrees normal], 70 degrees of abduction [90 degrees normal], and 30 degrees of extension [50 degrees normal]. Dr. Maindiratta noted that left shoulder range of motion was still reduced but had improved somewhat since the last evaluation on 7/9/18.

Motor examination revealed no fasciculations. Motor strength was 5/5 throughout and symmetric. Sensory examination was intact to light touch and pin prick. Joint position sense was intact. Deep tendon reflexes were 2+ and symmetric with flexor plantar responses bilaterally. Gait was intact. Heel and toe walking were done without difficulty. There was a negative Romberg's sign and a negative straight leg raising test bilaterally.

A diagnosis was rendered consisting of cervical and lumbar spine sprain/strain, resolved; cervical radiculopathy, resolved; lumbosacral radiculopathy, resolved; left shoulder and left elbow derangement, resolved; vertigo, resolved.

The case law states that if the insurer presents sufficient evidence establishing a lack of medical necessity, then the burden shifts back to the Applicant to present its own evidence of medical necessity. See: West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc3d 131A (2006).

Dr. Kupersmith of Northwell Health, in his 11/12/18 pre-operative evaluation notes the following:

The patient is here for a cardiac evaluation prior to undergoing neck surgery. There were reportedly no active cardiac conditions and the claimant was able to achieve greater than 4 METS physical activity. ECG today and at PMD's office was reviewed and was unremarkable, showing sinus bradycardia only but no symptoms.

The patient is at low cardiovascular risk for low-risk surgery. Follow-up with primary medical doctor to monitor blood pressure and check lipids for risk stratification. Blood pressure borderline elevated today but coming down after re-check. Recommend aggressive dietary and lifestyle modifications. Recommend aerobic activity four (4) to five (5) days per week once recovered from surgery. Follow-up pm.

Comparing the evidence submitted by each of the parties against the other, I find that I am more persuaded by the Applicant. Sufficient evidence has been presented for the medical necessity for the pre-operative cardiovascular evaluation performed by Dr. Kupersmith on 11/12/18. I find that the Applicant was confronted with certain subjective complaints as well as objective clinical findings, and opined that a cardiovascular evaluation prior to undergoing neck surgery was medically necessary.

Accordingly, after a careful review of the records and consideration of the parties' oral arguments, I find as a matter of fact that Applicant has met its burden of establishing a prima facie case and Respondent failed to rebut it with evidence that the post-IME pre-operative cardiovascular evaluation was not medically necessary. I therefore find for the Applicant, and reimbursement in the amended sum of \$259.21 is due and owing herein. This decision is in full disposition of all claims for reimbursement of No-Fault benefits presently pending before this Arbitrator.

5. Optional imposition of administrative costs on Applicant.
Applicable for arbitration requests filed on and after March 1, 2002.

I do NOT impose the administrative costs of arbitration to the applicant, in the amount established for the current calendar year by the Designated Organization.

6. **I find as follows with regard to the policy issues before me:**

- ☐ The policy was not in force on the date of the accident
- ☐ The applicant was excluded under policy conditions or exclusions
- ☐ The applicant violated policy conditions, resulting in exclusion from coverage
- ☐ The applicant was not an "eligible injured person"
- ☐ The conditions for MVAIC eligibility were not met
- ☐ The injured person was not a "qualified person" (under the MVAIC)
- ☐ The applicant's injuries didn't arise out of the "use or operation" of a motor vehicle
- ☐ The respondent is not subject to the jurisdiction of the New York No-Fault arbitration forum

Accordingly, the applicant is AWARDED the following:

A.

| Medical | | From/To | Claim Amount | Status |
|---------|--|---------------------|--------------|-------------------|
| | | 11/12/18 - 11/12/18 | \$259.21 | Awarded: \$259.21 |
| Total | | | \$259.21 | Awarded: \$259.21 |

- B. The insurer shall also compute and pay the applicant interest set forth below. 09/03/2021 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest runs from the filing date for this case, 9/3/21, until payment has been 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

After calculating the sum total of the first party benefits awarded in this arbitration plus the interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20% of that sum total, subject to a minimum of \$60 and a maximum of \$850. See 11 NYCRR Section 65-4.6(c) and (e). However, if the benefits and interest awarded thereon are less than or equal to Respondent's written offer during the conciliation process, the attorney's fee shall be based upon the provisions of 11 NYCRR Section 65-4.6(b). For cases filed after February 4, 2015 there is no minimum fee and a maximum fee of \$1,360.00.

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

06/21/2023

(Dated)

Paul Weidenbaum

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:
391bbaf89493384ca366fc6c4179a339

Electronically Signed

Your name: Paul Weidenbaum
Signed on: 06/21/2023