American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Bay Ridge Orthopedic Assoc. PC
(Applicant)

- and -

American Transit Insurance Company
(Respondent)

AAA Case No.	17-23-1301-2732
Applicant's File No.	n/a
Insurer's Claim File No.	1048772-02
NAIC No.	16616

ARBITRATION AWARD

I, Alison Berdnik, 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: Claimant

1. Hearing(s) held on 12/07/2023
   Declared closed by the arbitrator on 12/07/2023

   April Mittleman, Esq. from April Mittleman Esq. participated virtually for the Applicant

   Adam Kass, Esq., of counsel from American Transit Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$826.42**, was AMENDED and permitted by the arbitrator at the oral hearing.

   At the commencement of the hearing, Applicant amended the amount in dispute to $638.21 to bring the charges into compliance with what Applicant deems is the appropriate fee schedule.

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

3. Summary of Issues in Dispute

   The Claimant, EV, a 53-year-old male, was a pedestrian struck by a motor vehicle on December 29, 2018. At issue in this proceeding is $638.21, as amended, for the

physician assistant's fee associated with left knee surgery performed April 12, 2019. Respondent denied the claim based upon a peer review report by Mathew Skolnick, MD dated July 12, 2019.

The issues presented for determination are:

1) Whether the injury and, consequently, the treatment rendered was causally related to the underlying accident;

2) Whether the disputed services were medically necessary; and,

3) Whether the disputed charges exceed those permitted under the governing fee schedule.

4. Findings, Conclusions, and Basis Therefor

This case was decided based upon the submissions of the parties as contained in the electronic file maintained by the American Arbitration Association, and the oral arguments of the parties' representatives. There were no witnesses present to testify at the hearing. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

An Applicant establishes its *prima facie* showing of an entitlement to judgment as a matter of law by submitting evidentiary proof that the prescribed statutory billing forms had been mailed, received by the Respondent and that payment of no-fault benefits is overdue. *Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.2d 742, 774 N.Y.S.2d 564 (2nd Dept. 2005). A facially valid claim has been defined as one that sets forth the name of the patient, date of accident, date of service, description of services rendered and the charges for those services. *See, Vinings Spinal Diagnostic P.C. v. Liberty Mutual Insurance Company*, 186 Misc.2d 128(A), 784 N.Y.S.2d 918 (2003).

At issue in this proceeding is $638.21, as amended, for the physician assistant's fee associated with left knee surgery performed April 12, 2019. Respondent denied the claim based upon a peer review report by Mathew Skolnick, MD dated July 12, 2019.

The submission of Respondent's Denial of Claim Form ("NF-10") establishes that Respondent received Applicant's claim and that Respondent has not paid the claim. *Lopes v. Liberty Mutual Ins. Co.*, 24 Misc.3d 127(A), 2009 N.Y. Slip Op. 51279(U), 2009 WL 1799812 (App. Term 2nd, 11th & 13th Dists. Jan. 26, 2009). Thus, the submission of Respondent's NF-10 in this proceeding is sufficient to satisfy Applicant's burden in this instance.

As such, the burden now shifts to the Respondent to prove that the services were not medically necessary. *Amaze Medical Supply v. Eagle Insurance*, 2 Misc.3d 128(A)

(2003). Once the Respondent makes a sufficient showing to carry its burden of coming forth with evidence of lack of medical necessity, the Applicant must rebut it. *A. Khodadadi Radiology, P.C. v. NY Central Mutual Fire Insurance*, 16 Misc.3d 131(A), 841 N.Y.S.2d 824 (2007).

It is well-settled that 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, Bronx Expert Radiology, P.C. v. Travelers Ins. Co.*, 2006 NY Slip Op. 52116 (App. Term 1st Dept. 2006). 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 & 11th Jud. Dists. 2003].)

The trial courts have held that a peer review report's medical rationale will be insufficient to meet respondent's burden of proof if: 1) the medical rationale of its expert witness is not supported by evidence of a deviation from "generally accepted medical" standards; 2) the expert fails to cite to medical authority, standard, or generally accepted medical practice as a medical rationale for his findings; and 3) the peer review report fails to provide specifics as to the claim at issue, is conclusory or vague. *See, Nir v. Allstate Ins. Co.*, 7 Misc.3d 544, 547, 796 N.Y.S.2d 857, 860 (Civ. Ct. Kings Co. 2005); *see also, All Boro Psychological Servs. P.C. v. GEICO*, 2012 N.Y. Slip Op. 50137(U) (Civ. Ct. Kings Co. 2012).

In order to prevail, respondent's peer review must address all of the pertinent objective findings contained in applicant's medical evidence. It must then clearly explain why, notwithstanding those findings, the disputed service was inconsistent with generally accepted medical or professional practices. *Amaze Medical Supply Inc. v. Eagle Insurance Co*., *supra*, 2 Misc.3d 128(A); *Citywide Social Work, et al, v. Travelers Indemnity Company*, 3 Misc.3d 608, 777 N.Y.S.2d 241 (Civ. Ct. Kings Co. 2004). Where other reports in the insurer's papers contradict the conclusion of its peer review, or that the service was not medically necessary, it has failed to make out a *prima facie* case in support of the defense of lack of medical necessity. *Hillcrest Radiology Associates v. State Farm Mutual Automobile Insurance Company*, 28 Misc.3d 138(A), 200 N.Y. Slip Op. 51467(U) 2010 WL 3258144 (App Term 2nd, 11th, and 13th Dists. 2010).

To the extent Respondent contends that the underlying injury giving rise to the claim at issue is not causally related to the accident, unlike negligence actions where plaintiffs must prove causation, claimants seeking to recover first-party no-fault payments bear no such initial burden, as causation is presumed. *Kingsbrook Jewish Medical Center v. Allstate Ins. Co.*, 61 A.D.3d 13, 22 -23, 871 N.Y.S.2d 680, 687 (2nd Dept. 2009). To prevail, an expert's affirmation is needed to provide a factual foundation for an insurance

carrier's good faith belief that an alleged injury did not arise out of an insured accident. *Mt. Sinai Hospital v. Triboro Coach Inc*., 263 A.D.2d 11, 699 N.Y.S.2d 77 (2nd Dept. 1999). The question of whether a condition is unrelated to a motor vehicle accident cannot be resolved without opinion evidence by a medical expert qualified to render an opinion on causality. *Kingsbrook Jewish Medical Center, supra*, 61 A.D.3d at 21.

Respondent offers a peer review report by Mathew Skolnick, MD dated July 12, 2019 in support of its denial predicated upon a lack of medical necessity and lack of a causal relationship between the injury to the Claimant's left knee and the underlying accident. In *Bay Ridge Orthopedic Assoc., PC and American Transit Ins. Co.*, AAA case no. 17-20-1179-3250, Arbitrator John O'Grady was presented with the primary surgeon's claim associated with the same left knee surgery at issue in this proceeding and asked to consider the merits of Respondent's defense supported by the same peer review by Dr. Skolnick offered in this proceeding. In finding in favor of Applicant, Arbitrator O'Grady reasoned, in pertinent part, as follows:

> Applicant relies largely on a rebuttal by Dr. Ashraf Salem who was a treating physician. He comments that the assignor had continuing complaints of pain in the left shoulder and left knee pain along with limited and decreased range of motion. The MRI of the left knee revealed patellofemoral chondrosis and effusion and MRI of the left shoulder revealed partial tear of the supraspinatus tendon at the critical zone with tendinosis, biceps tenosynovitis, and tear of the anterior/ inferior labrum at the 4 o'clock position. All these complaints and findings persisted despite receiving the conservative line of treatment. Therefore, the left knee and left shoulder arthroscopy were medically necessary. Hence the post-operative DVT Compression provided to the patient was also medically necessary.
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> He comments that the assignor continued to make complaints of left knee pain with associated symptoms and that surgery was therefore necessary.
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> He argues, essentially, that the surgery for the knee was necessary despite negative findings on MRI. Surgery, he says, was necessary because the assignor was suffering knee pain and had never suffered an injury prior to the accident. He continues by arguing that the surgery was not solely based on the MRI study but was also based on the patient's signs and symptoms upon examination.
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> * * *
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> He disputes Dr. Skolnick's conclusion upon his review of the intra-operative photos as there were indeed meniscal tear, noting the intraoperative findings noted during the left knee arthroscopy.
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> Addressing Dr. Skolnick's argument that there was no evidence that that the was deteriorating he refers to the conservative treatment that

was provided and contends that the assignor received adequate physical therapy, treatment for more than 2 ½ months prior to proceeding with the left knee surgery. When he presented to Dr. Baum, he was complaining of persistent left knee pain along with diminished range of motion. As an appropriate treatment plan, he completed formal supervised physical therapy with strengthening exercises. Despite all these, he found to have no complete relief in his left knee symptoms. Therefore, the left knee arthroscopy was indicated to properly diagnose the patient's condition and to objectively verify presence and severity of tears in quantitative and qualitative terms and achieve better prognosis. Since the patient failed all conservative modalities of treatment for the left knee, Dr. Baum determined that the patient's injuries would certainly not resolve by further physical therapy and would require surgical intervention.

He argues further that meniscal tears should be surgically treated. If a tear is not treated it may get worse with potentially severe complications due to increased contact pressures and stresses on the remaining meniscal tissue. There are no standard requirements for a patient to undergo any particular amount of physical therapy. In fact, there is no clear consensus regarding whether physical therapy should be performed for any particular time period. Surgical repair was medically necessary, supporting his contention with a citation to Orthopedic knowledge Update. 8 ed. Chapter 37, Knee and Leg Soft-Trauma. (Eric C McCarty. MD. Kurt P. Spindler. MD and Reed Bartz. MD.) American Academy of Orthopaedic Surgeons and Biomechanical Consequences of a Tear of the Posterior Root of the Medial Meniscus. (Robert Allaire. MD Muturi Muriuki. PhD. Lars Gilbertson. MD. and Christopher D. Hamer. MD.)

* * *

Dr. Skolnick makes out respondent's initial burden to show that there was no medical necessity for the knee or shoulder surgery. With respect to the both [sic] surgeries he says that findings on examination and MRI are not sufficient to necessitate the surgery although he does not establish a standard for when the surgery is necessary. Where he says that MRI findings do not show any injury in the knee he does note a labral tear in the shoulder. He relied on the opinions of Dr. Setton and Dr. Levin, who performed review of the MRIs and intraoperative photos on behalf of the respondent insurer, in making his conclusion, including that the labral tear was not "causally related". He contends that there was no evidence that the shoulder was "deteriorating". He also contends that the intraoperative photos reviewed by him show no evidence of "acute traumatic injury". He comments that there is no indication that the patient's condition was deteriorating despite conservative treatment. Finally he

> says that the use of compression devices such as that provided here have not been shown to be useful in terms of long term functional outcome. Again, he does not establish when a compression device would be appropriate and for what purpose.
>
> His opinion is open to discrediting in the following ways. Where he does not establish a standard for the surgery or for when compression devices should be provided, he does not establish that a standard recognized in his profession was not met. Where he says that the shoulder was not shown to be "deteriorating" he does not establish that deterioration, as opposed to persistent pain, objective findings and abnormality is the standard for performing the surgery. Where he relies on his own review of intraoperative photos and the review by Dr. Setton, those opinions are subject to the actual review of the injury by the treating surgeon during surgery. Finally, where he refers to lack of evidence of "acute traumatic injury" he appears to contend that the accident did not cause the injury for which the surgery was performed. That conclusion does not account for exacerbation of a pre-existing condition conclusion which would depend on the assignor's perception of his condition before the accident. In the absence of questioning of the assignor, a necessary predicate to drawing that conclusion, relying on that contention is especially precarious.
>
> To whatever extent he demonstrates that there was no medical necessity for the surgery or for the compression devices following the surgeries, that demonstration is overcome by the proof of the applicant with significant assistance from Dr. Salem in his rebuttal. He explains, first, that the surgery was appropriate because conservative treatment did not satisfactorily resolve the injuries, and that the MRI exams revealed abnormalities and injury and that those findings are supported by the operative record. He explains that the surgeries were performed to repair the injuries rather than just manage them. Regarding the compression devices that are specifically in issue in this claim, applicant's proof is sufficient to establish that there is no standard dictating that provision of the compression devices is outside of the standard of care. Further, Dr. Salem explains the specific benefits of the compression devices to avoid certain postoperative complications and satisfactorily argues that the compression devices were provided as an adjunct to other therapeutic treatment and not as a substitute for them. In all, applicant establishes the medical necessity of the knee surgery, the shoulder surgery and compression devices in issue here that were provided after them. The claim is granted.

The doctrines of *res judicata* and collateral estoppel are fully applicable to arbitration proceedings. *American Ins. Co., v. Messinger*, 43 N.Y.2d 184, 401 N.Y.S.2d 36 (1977);

Clemens v. Apple; 65 N.Y.2d 746, 492 N.Y.S.2d 20 (1985); *County of Rockland v. Aetna Casualty & Surety Co.*, 129 A.D.2d 606, 514 N.Y.S.2d 102 (2nd Dept. 1987); *Protocom Devices, Inc. v. Figueora*, 173 A.D.2d 177, 569 N.Y.S.2d 80 (1st Dept. 1991); *Hilowitz v. Hilowitz*, 85 A.D.2d 621, 445 N.Y.S.2d 22 (2nd Dept. 1981). Collateral estoppel is a rule of justice and fairness which mandates that issues once tried should not be re-litigated by a party in a subsequent proceeding who had been afforded a full and fair opportunity to contest the issues raised in a prior proceeding. *Commissioners of State Ins. Fund v. Low*, 3 N.Y.2d 590, 595, 170 N.Y.S.2d 795, 800 (1958). The doctrine of collateral estoppel precludes a party from re-litigating in a subsequent action or proceeding, an issue that was raised in a prior action or proceeding and decided against that party, whether or not the tribunals or causes of action are the same. *See, Ryan v. New York Telephone*, 62 N.Y.2d 494, 478 N.Y.2d 823.

Irrespective of any "additional" evidence, the doctrine of collateral estoppel precludes a party from re-litigating the same issue over and over again whether by the production of new evidence or other means. *See, D'Arata v. New York Cent. Mut. Fire Ins. Co.*, 76 N.Y.2d 659 [1990]). "The two elements that must be satisfied to invoke the doctrine of estoppel are that (1) the identical issue was decided in the prior action and is decisive in the present action, and (2) the party to be precluded from relitigating the issue had a full and fair opportunity to contest the prior issue, *see Kaufman v. Lilly Co.*, 65 N.Y.2d 449, 455 (1985)"; *Luscher v. Arrua*, 21 A.D.3d 1005, 1007 (2005). "The burden is on the party attempting to defeat the application of collateral estoppel to establish the absence of a full and fair opportunity to litigate [*citing D'Arata, supra*.]; *see also Kaufman*, 65 N.Y.2d at 456." *Up-To-Date Medical Service, P.C. v. State Farm Mutual Automobile Ins. Co.*, 22 Misc.3d 128(A), 880 N.Y.S.2d 227 (Table), 2009 N.Y. Slip Op. 50046(U) at 2, 2009 WL 78376 (App. Term 2nd & 11th Dists. Jan. 9, 2009). I find that the Applicant here has failed to meet that burden.

The prior related matter previously decided by Arbitrator O'Grady involves the same parties and the identical issue. Both sides were aptly represented at the prior hearing and had a full and fair opportunity to be heard. No appeal was taken from the prior award. I therefore find that the doctrine of collateral estoppel mandates that the issue may not again be litigated. That being said, I adopt the well-reasoned analysis of Arbitrator O'Grady and, for the same reasons cited by my colleague, find the peer review insufficient to sustain Respondent's burden of establishing a lack of causal relationship between the injury and the underlying motor vehicle accident, and, similarly, find the peer insufficient to sustain Respondent's burden of establishing that the shoulder surgery at issue in this proceeding was not medically necessary.

Respondent has not offered any evidence demonstrating that Applicant's charges exceed those permitted under the governing fee schedule. The Explanation of Review offered by Respondent identifying the amount "Allowed" as $521.58 [1] is unattributed and fails to provide any analysis whatsoever in support of its suggested reduced rate of reimbursement. No issue has been raised regarding any potential exhaustion of no-fault benefits in the event an award is entered in Applicant's favor. Accordingly, Applicant is awarded $638.21 in full satisfaction of its amended claim.

[1] The "Explanation" section of the EOB includes the following notation: "Award". However, Applicant's counsel maintains that no reimbursement was ever received by her client, and, in fact, Respondent's counsel confirms that the evidence in the record below fails to include any evidence remotely suggesting any payment made by Respondent.

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**	**Amount Amended**	**Status**
	Bay Ridge Orthopedic Assoc. PC	**04/12/19 - 04/12/19**	**$826.42**	**$638.21**	**Awarded: $638.21**
Total			**$826.42**		**Awarded: $638.21**

B. The insurer shall also compute and pay the applicant interest set forth below. 05/26/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant is awarded $638.21, together with applicable interest computed from the date of the filing of the AR-1 until the date of payment.

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 NY
SS :
County of Suffolk

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

12/07/2023
(Dated)

Alison Berdnik

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:
a98ed93127295df96fdeca422adf59da

Electronically Signed

Your name: Alison Berdnik
Signed on: 12/07/2023