American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Rutman Medical PLLC (Applicant)	AAA Case No.	17-23-1294-3995
	Applicant's File No.	166279
- and -	Insurer's Claim File No.	272PPIGT6693003
	NAIC No.	38130
St. Paul Travelers Insurance Co. (Respondent)		

ARBITRATION AWARD

I, Ann Lorraine Russo, 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: patient

1. Hearing(s) held on 12/21/2023
   Declared closed by the arbitrator on 12/21/2023

   Michael Spector, Esq. from The Odierno Law Firm P.C. participated virtually for the Applicant

   Sheridan Chu, Esq. from Law Offices of Tina Newsome-Lee participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$336.17**, 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 issue in dispute in this case is the nonpayment by the respondent for medical and injection services for the forty-five-year-old female patient provided by the applicant on 11/1/2022 as a result of motor vehicle accident on 6/18/2019. The respondent issued timely denials of the claims based an independent medical examination.

4. Findings, Conclusions, and Basis Therefor

I have reviewed the documents contained in the electronic case folder as of the date of the hearing and oral arguments of counsel for the respective parties. No witness testimony was presented at the hearing.

This case is a companion case with another case for the same applicant, patient and date of accident on 6/18/2019 for different dates of services bearing American Arbitration Association case number 17 23 1297 9026.

The issue in dispute in this case is the nonpayment by the respondent for medical and injection services for the forty-five-year-old female patient provided by the applicant on 11/1/2022 as a result of motor vehicle accident on 6/18/2019. The respondent issued timely denials of the claims based an independent medical examination. The applicant provided that the denial is defective in this case. The amount in dispute is $336.17 for the services in this case.

A no-fault provider establishes its prima facie entitlement to summary judgment by proof of the submission to the defendant of a claim form, proof of the fact and the amount of the loss sustained, and proof either that the defendant had failed to pay or deny the claim within the requisite 30-day period, or that the defendant had issued a timely denial of claim that was conclusory, vague or without merit as a matter of law. See Insurance Law Section 5106(a); Ave T MPC Corp. v. Auto One Ins. Co., 32 Misc.3d 128(A), 934 N.Y.S.2d 32 (Table), 2011 N.Y. Slip Op. 51292(U), 2011 WL 2712964 (App. Term 2d, 11th & 13th Dists. July 5, 2011); Westchester Medical Center v. Nationwide Mut. Ins. Co., 78 AD3d 1168, 911 N.Y.S.2d 907 (2nd Dept. 2010) and New York & Presbyt. Hosp. v. Allstate Ins. Co., 31 AD3d 512 (2006). In the case at hand, the respondent issued timely denials based upon an independent medical examination report for the services in dispute.

The applicant provided that the denial is defective in this case. The applicant provided that the denial does not promptly apprise(s) the claimant with a high degree of specificity of the ground or grounds on which the disclaimers are predicated in this case. The applicant noted that the respondent's denial in this case is vague and conclusory which is prejudicial to applicant pursuant to case law. In 2020, the Appellate Division held that an insurer's vague and conclusory denial based on an IME not supporting reimbursement, without providing any of the examination's findings, or checking boxes on the NF-10 form to indicate that the denial was based on a lack of medical necessity, lacks the degree of specificity required by statute and case law, which provide that insurers must clearly inform applicants of their position regarding disputed matters by apprising the claimant with a high degree of specificity of the ground or grounds on which the disclaimer is predicated. Matter of Global Liberty Ins. Co. of N.Y. v. Avanguard Supply, Inc., 188 A.D.3d 568 (1st Dept. 2020), sustaining AAA Case No. 17-18-1112-3655 (Corinne Pascariu, Arb., Apr. 24, 2019, and Richard B. Ancowitz, Master Arb., June 7, 2019). In the case at hand, the denial provides that "ORTHOPEDIC SURGERY TREATMENT DENIED AS OF 10/14/2022 BASED ON INDEPENDENT MEDICAL EXAM FINDINGS BY DR. DR. RONALD H. ISRAELSKI." The denial does not provide the date of the independent medical examination by Dr. Israelski.

It was noted that Dr. Israelski performed more than one independent medical examination, on 3/4/2020 and 9/8/2022 but not on 10/14/2022. The applicant provided that pursuant to General Acc. Ins. Group v. Cirucci, supra, a denial of claim must "promptly apprise the claimant with a high degree of specificity of the ground or grounds on which the disclaimer is predicated." The Court of Appeals considered a claimant's "difficulty assessing whether the insurer will be able to disclaim successfully" and stated "[t]his uncertainty could prejudice the claimant's ability to ultimately obtain recovery." The denial does not provide the pertinent information including the date of the examination which is significant information necessary to determine whether contemporaneous medical records exist, thus effecting Applicant's ability to ultimately obtain recovery. The denial of claim lacks a "high degree of specificity" regarding Respondent's lack of medical necessity defense. The applicant provided that the denial is defective in this case. The applicant noted that the denial does not provide the necessary information pursuant to the caselaw of Cirucci and Avanguard. The applicant provided that the denial itself is defective and not in compliance with the no fault statutes and case law.

The applicant provided that Cirucci and its progeny demand insurers apprise with specificity and the insurer may not rest upon the general informative ability of its denial where its specific details are incorrect or unarticulated. A party is reasonably prejudiced where it is supplied incorrect facts, believes it can successfully litigate/arbitrate against said incorrect facts, only to learn during the course of litigation/arbitration that said facts were false. See Westchester Med. Ctr. v. Nationwide, 78 A.D.3d 1168 (App. Div., 2d Dept. 2010) and St. Barnabas Hosp. v. Penrac, Inc., 79 A.D.3d 733 (App. Div., 2d Dept. 2010) (jointly standing for proposition that denial invalid where discrepancy creates confusion or prejudice to applicant under facts of case).

Respondent argued that the denial and explanation of benefits provides the specific and proper events and basis of the denial. Respondent argued that any alleged defect complained of by the applicant is de-minimus in this case and all the documentation was properly processed by the respondent. Respondent noted in 11 CRR-NY 65-3.8 (h): With respect to a denial of claim (NYS form NF-10), an insurer's non-substantive technical or immaterial defect or omission shall not affect the validity of a denial of claim. Respondent provided that the failure to provide the information pertaining to the independent medical examination in the denial is a de minimis non-prejudicial error that does not affect the validity of the denial, or the defense asserted therein. The Courts have consistently held that a minor factual discrepancy in a denial of claim form does not invalidate a denial. See, Westchester Medical Center v. Nationwide Mutual Ins., Co., 78 A.D.3d 1168, 911 N.Y.S.2d 907, 2010 NY Slip Op 08933 (App. Div., 2nd Dept., Nov. 30, 2010).

The court has reasoned that what amounts to a consequential error is one that poses the possibility of confusion or prejudice under the circumstances of the case. See, St. Barnabas Hospital v. Penrac, Inc., 79 A.D.3d 733, 911 N.Y.S.2d 920, 2010 NY Slip Op 09122 (App. Div., 2nd Dept., Dec. 7, 2010). A mistake or omission which does not cause prejudice will not render the denial a nullity. See, NYU-Hospital for Joint Diseases v. Esurance Ins. Co., 84 A.D.3d 1190, 923 N.Y.S.2d 686, 2011 NY Slip Op

04436 (App. Div., 2 Dept, May 24, 2011); NYU-Hospital for Joint Diseases v. Allstate Ins. Co., 123 A.D.3d 781, 1 N.Y.S.3d 114, 2014 NY Slip Op 08613 (App. Div., 2 Dept, Dec. 10, 2014). However, it remains unknown the date of the independent medical examination in the denial in this case. In addition, it is noted that the denial provides that the claim is denied on the independent medical exam findings by Dr. Israelski but does not provide the date of the independent medical examination and does not even specifically provide that the denial is based upon the lack of medical necessity of the services in this case. The denial does not provide the date of the independent medical examination by Dr. Israelski and provides a broad and vague statement, and such pertinent information such as the date of the independent medical examination remains unknown in this case. The respondent has not established that the denial to the applicant is effective in this case. Consequently, the respondent's argument is not persuasive, and the missing information pertaining to the independent medical examination based upon medical necessity is not deemed deminimus pursuant to 11 NYCRR Section 65-3.8(h) in this case. Consequently, the denial is defective in this case.

The Respondent's NF-10s and annexed explanations of benefits to this applicant do not identify the date of the examination. In fact, the denials do not even state that lack of medical necessity is the reason for denial. Instead, the denial's explanation of benefits generically states that the billed services are denied based on "INDEPENDENT MEDICAL EXAM FINDINGS BY DR. DR. RONALD H. ISRAELSKI " of an Independent Medical Examination." Dr. Israelski performed two independent medical examinations on 3/4/2020 and 9/8/2022. The denial does not provide the date of the independent medical examination upon which the denial is based for the services in this case. From these statements, the NF-10s for this applicant and their annexed explanations of benefits create an entirely vague denial basis which create defective and invalid disclaimers despite their timeliness. See Matter of Global Liberty Ins. Co. of NY v. Avangard Supply, Inc., 2020 NY Slip Op 06855 (App. Div., 1st Dept. 2020) (affirming arbitrator's determination that denial of claim vague and conclusory under Cirucci where it said, "Review of the IME results and/or other documentation does not support reimbursement for these Services."); see also Nyack Hosp. v. Metropolitan Prop. & Casualty Ins. Co., 16 A.D.3d 564 (App. Div., 2d Dept. 2005) (holding that timely denial alone does not avoid preclusion where said denial is factually insufficient, conclusory, vague or otherwise involves a defense which has no merit as matter of law). Moreover, the Respondent's generic language substantially impairs, if not entirely frustrates, the trier-of-fact's ability to identify whether the medical examination report submitted in evidence is in fact the report upon which the insurer's denials are predicated.

The applicant's counsel provided that the commonsense rule articulated in Cirucci, Nyack, and their progeny allows parties to be collectively and unambiguously on notice of their rights, duties, and obligations while imposing minimal burden on the insurer. The rule also enables third parties (to a conflict) to better understand a dispute's subject-matter and what resolution can hinge on. The Respondent-insurer failed to undertake the simple act of listing the date of examination in its disclaimers to this applicant, especially where more than one examination was performed by the examiner on different dates. Including these identifying characteristics in the NF-10s would have swiftly cured this deficiency. As a result, the respondent is precluded from presenting its

lack of medical necessity defense. Considering its defective denials' preclusive effect on its defense, the issue of medical necessity is moot. Accordingly, the Applicant's claims are awarded. After a review of the records, I find that Respondent did not sufficiently apprise Applicant as to the reason for its denial due to its failure to set forth the date of the examination in the denial of claim form. I therefore conclude as a matter of law that the defense asserted in Respondent's denial of claim form was legally insufficient to assert a defense of lack of medical necessity for the testing at issue in this case. Applicants' prima facie case of entitlement to No-Fault compensation remains. Accordingly, the amended arbitration claim is granted in its entirety.

The respondent submitted two global denials dated 8/19/2022 and 10/14/2022 that provided significant positive clinical findings and events. The global denial dated 8/19/2022 provided that the patient required additional treatment. The global denial dated 10/14/2022 provides that "In accordance with the NYS No-Fault Law, please see attached report of an Orthopedic Surgery IME performed on 9/8/2022 by Dr. Ronald H. Israelski, M.D. After completion of exam and review of medical reports submitted by Dr. indicated: Further treatment involves the following: The claimant has been through exhaustive amounts of physical therapy, chiropractic treatments, trigger point and epidural injections to the neck and low back. The claimant needs no further treatment for her arms, her shoulders, her right wrist, or her left clavicle, but treatment for the low back should be a home exercise program, abdominal conditioning, paraspinal conditioning, postural training. I do not think the claimant needs further treatment for the low back other than a home exercise program. For her cervical spine, she has been through everything. The claimant needs a cervical consultation. The claimant did have a documented C5-C6 radiculopathy. The claimant has some components of complaints of radiculopathy despite having a relatively good physical exam. The claimant needs surgical consultation. If the surgical consultation does not indicate need for surgery, then at that point I think the claimant will then have reached permanency, and a permanency statement can be made, but not until surgical consultation for her neck, as she does warrant further treatment and evaluation for that condition. There is no need for physical therapy." The global denial does provide that a surgical consultation would benefit the patient as well as recognize the injuries to the patient's spinal column and extremities sustained as a result of the accident on 6/18/2019. The denials and the independent medical examination reports by Dr. Israelski contain positive clinical events and findings in support of additional treatment for the patient in this case.

The independent medical examination reports by Dr. Ronald Israelski on 3/4/2020 and 9/8/2022 are not persuasive for the denials in this case. The independent medical examination reports provided significant positive clinical findings and events that warrant additional medical services for the patient in this case. The independent medical examination performed on 3/4/2020 provided positive testing including cervical spine distraction test and limited ranges of motion in the spinal column and cervical spine, thoracic spine and lumbar spine strain with radiculopathy. In the medical examination performed on 9/8/2022 the examiner provided tenderness in the right more than the left paracervical spine, diminished C5-C6 reflexes tingling in the hands, restriction of motion in the lumbar spine and diagnosis of cervical strain with radiculapathy by patient report and lumbosacral strain. The examiner did not provide the lumbosacral strain was resolved and noted that the patient possessed radiculopathy. The independent medical

examinations provide significant clinical events and findings in support of the additional treatment for the patient including the injection services in this case. The global denials dated 8/19/2022 and 10/14/2022 provided positive results from the independent medical examinations and the denial dated 10/14/2022 further provided that "The claimant needs a cervical consultation. The claimant did have a documented C5-C6 radiculopathy. The claimant has some components of complaints of radiculopathy despite having a relatively good physical exam. The claimant needs a surgical consultation." The independent medical examination reports by Dr. Israelski and the medical records and reports provide significant clinical findings and events in support of additional medical treatment, including the injection services for this forty-five-year-old female patient as a result of the motor vehicle accident on 6/18/2019 in this case. The independent medical examinations and the medical records provide pertinent persistent clinical findings and events for the patient together with positive objective tests to warrant the performance of the continuation of the medical treatment, including the medical injection services in this case.

Based upon the evidence presented in this case, it is the opinion of this Arbitrator that the applicant has established that the respondent's denial was legally insufficient, and the services were warranted in this case.

Accordingly, the applicant's claim is granted.

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.

		Claim	

Medical		From/To	Amount	Status
	Rutman Medical PLLC	**11/01/22 - 11/01/22**	**$336.17**	**Awarded: $336.17**
Total			**$336.17**	**Awarded: $336.17**

B. The insurer shall also compute and pay the applicant interest set forth below. 04/10/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

The respondent shall pay the applicant interest from the date of the arbitration filing on 4/10/2023.

C. Attorney's Fees

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

The respondent shall pay the applicant attorney fees pursuant to 11 NYCRR Section 65-4.6.

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

12/28/2023
(Dated)

Ann Lorraine Russo

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:
8e9b3f85f405a53b566a796697683222

Electronically Signed

Your name: Ann Lorraine Russo
Signed on: 12/28/2023