

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

BW Orthopedics LLC
(Applicant)

- and -

Allstate Fire & Casualty Insurance Company
(Respondent)

AAA Case No. 17-24-1333-2383

Applicant's File No. 00128158

Insurer's Claim File No. 0612978908
2FM

NAIC No. 29688

ARBITRATION AWARD

I, Antonietta 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: Assignor

1. Hearing(s) held on 08/23/2024
Declared closed by the arbitrator on 08/23/2024

Sasha Hochman from Drachman Katz, LLP participated virtually for the Applicant

Adam Kass from Merani Kamara Law Group participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$290,490.86**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant amended the claim amount to \$7738.03 to reflect the appropriate charges and resolve any fee schedule issues.

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

3. Summary of Issues in Dispute

The Assignor, a 25-year-old male driver, was reportedly involved in a motor vehicle accident on January 14, 2021. Following the accident, Assignor suffered injuries that resulted in him seeking medical treatment. Thereafter, a treatment plan was recommended and the Assignor underwent right shoulder arthroscopic surgery performed on November 6, 2023. Applicant is seeking reimbursement for the surgeon and physician assistant's fees associated with

these services; however, Respondent denied the claim on a lack of medical necessity defense predicated on a peer review by Dr. Levy. Thus, the only issue presented at the hearing was:

- 1.) Whether Respondent's lack of medical necessity defense predicated on the peer review can be sustained?

4. Findings, Conclusions, and Basis Therefor

The Applicant and the Respondent submitted documentary evidence in support of their respective positions. All such evidence is contained within MODRIA maintained by the American Arbitration Association, as of the date of the hearing. The below noted decision is based upon my review of the submitted evidence, along with the oral argument of the representatives present at the hearing.

I find that Applicant has demonstrated its prima facie case for the claim in dispute. A medical provider establishes prima facie showing of their entitlement to judgment as a matter of law by submitting evidentiary proof that the prescribed statutory billing forms had been mailed and received and that payment of no-fault benefits was overdue. See, Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept.2004); See also: Viviane Etienne Med. Care v Country-Wide Ins. Co. 2015 NY Slip Op 04787 (proof of mailing is satisfied by an insurer's admission of receipt of bills.) Similarly, I find that the Respondent has proffered a timely denial which preserves the defense of lack of medical necessity and fee schedule. As the defense of fee schedule may be raised at any time under the revised regulations, it is not material to the defense whether the denial is timely. See, 11 NYCRR §65-3.8(g)(1)(ii); see also, Precious Acupuncture Care, P.C. v Hereford Ins. Co., 2018 NY Slip Op 50042(U), 58 Misc. 3d 147(A) (Appellate Term, Second Dept. 2018).

Once Applicant has established a prima facie case, the burden is on the insurer to prove that the medical treatment was not medically necessary. See, Citywide Social Work & Psychological Services, PLLC a/a/o Gloria Zhune v. Allstate Ins. Co., 8 Misc.3d 1025A, 806 N.Y.S.2d 444 (App. Term 1st Dep't. 2005); A.B. Medical Services, PLLC v. Geico Ins. Co., 2 Misc 3d 26, 773 N.Y.S.2d 773 (App Term 2nd & 11th Jud Dist 2003).

MEDICAL NECESSITY

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. 20140. 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).

The civil courts have held that a defendant's peer review or medical evidence must set forth more than just a basic recitation of the expert's opinion. 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 generally, Nir v. Allstate, 7 Misc.3d 544 (N.Y. City Civ. Ct. 2005); See also, All Boro Psychological Servs. P.C. v. GEICO, 2012 NY Slip Op 50137(U) (N.Y. City Civ. Ct. 2012). "Generally accepted practice is that range of practice that the profession will follow in the diagnosis and treatment of patients in light of the standards and values that define its calling." *Nir, supra*.

As a threshold issue, Respondent references a prior decision with the same Applicant, same Assignor, same date of accident and same peer report that had been rendered in their favor. The undersigned had rendered a decision in AAA Case No.: 17-24-1336-0407 that stated:

In support of his contentions, Respondent is relying on the peer review prepared by Howard J. Levy, dated December 8, 2023. In his peer, Dr. Levy reviews the Assignor's medical reports and asserts, there was no medical necessity for the surgery or related services performed on the Assignor. He notes that the Assignor was 25 years old at the time of the accident, but based on the current records, he is now 27 years old. He references the initial orthopedic evaluation report dated 1/21/2021 by Baruch Toledano, M.D., which revealed complaints of right thumb pain without an evaluation for the right shoulder. He also notes the claimant was evaluated by Igor Stiler, M.D., on 2/4/2021, 2/23/2021, and 6/25/2021 for complaints of neck, lower back, and right hand/thumb without any evaluation for right shoulder complaints. The peer further references the following reports:

The claimant received physical therapy from 2/26/2021 to 3/17/2022 in a total of 36 sessions for the cervical spine, lumbar spine, and right hand. None of the sessions were received for the right shoulder.

As per the initial chiropractic examination report dated 3/17/2021 by Nick Chiappetta, D.C., the claimant was advised

chiropractic treatment. As per the initial evaluation report dated 4/27/2021 by Matthew Valvo, PA-C, the claimant had a complaint of neck, lower back, and right-hand pain.

The claimant was not evaluated for the right shoulder complaints. The reports were made available for my review. The claimant received chiropractic treatment from 5/6/2021 to 3/17/2022 in a total of 30 sessions for the spine. None of the sessions were received for the right shoulder.

The claimant was evaluated by Susan Distasio, D.O., on 5/6/2021 for complaints of neck, lower back, and right hand/wrist pain. The claimant was not evaluated for the right shoulder.

As per the independent orthopedic examination report dated 7/12/2021 by John F. Waller, M.D., the claimant had complaints of neck, lower back, and right thumb pain. Examination of the right shoulder revealed normal findings.

The claimant had consultation with Amy Skinner, P.A., on 8/18/2021 and 12/3/2021 for neck, lower back, and right thumb pain. The claimant was not evaluated for the right shoulder.

The claimant was evaluated by Leonid Reyfman, M.D., from 10/18/2021 to 6/1/2022 for complaints of neck, lower back, and right hand/thumb pain.

The claimant was not evaluated for the right shoulder. The reports were made available for my review. The claimant was evaluated by Dale Harder, PA-C, from 10/27/2021 to 4/11/2022 for complaints of neck, lower back, and right thumb pain. The claimant was not evaluated for right shoulder complaints.

The claimant had a consultation with Roman Shulkin, M.D., from 7/15/2022 to 3/29/2023 for complaints of neck, lower back, and right thumb pain. The claimant was not evaluated for right shoulder complaints.

The MRI report of the right shoulder dated 1/4/2023 revealed: AC joint arthrosis. Rotator cuff tendinopathy and fraying. Fraying and tear of the superior labrum, posterior, and inferior labrum. Biceps tendinopathy with tenosynovitis. Capsular thickening which can be seen with adhesive capsulitis in the right clinical setting.

Dr. Levy further states as per the available medical records, the claimant was not evaluated for right shoulder complaints from the date of the accident 1/14/2021 to 1/4/2023 which is for almost 2 years. Further, there was no evidence that the claimant was provided with any form of conservative treatment or any diagnostic testing during this period. Thus, the causal relationship between the MVA dated 1/14/2021 and the claimant's right shoulder

complaints was not supported. Therefore, based on his articles and available medical records, the right shoulder surgery performed on 11/6/2023 was not medically necessary. Based on Dr. Levy's recommendation, Respondent denied the claim and disallowed payment.

I find that Dr. Levy' peer review set forth a clear factual basis and medical rationale to recommend against reimbursement for the services at issue. Dr. Levy's peer review advanced reasonable arguments in support of the position that the services were unnecessary. The burden returns to Applicant to rebut Respondent's showing.

In response to Respondent's arguments, Applicant relied on their medical records, in addition to the rebuttal by Mark S. McMahon, MD. In Dr. McMahon's rebuttal, he disagrees with the peer reviewer and contends the surgery and related services were necessary. Dr. McMahon states the records indicate this missed diagnosis was clarified after the cervical discectomy relieved much of the cervical radicular syndrome but failed to alleviate the intermittent right shoulder symptoms radiating the arm that was worsening. The rebuttal indicates that cervical radiculopathy and internal shoulder derangement can masquerade as one another. He indicates that surgery was necessary based on the history of trauma causing persistent pain, tenderness, significant weakness and considerable loss of functional motion which failed to resolve after rest, oral medication, steroid injections and home exercises. The injury was causally related and maintains the services were medically necessary.

Dr. Levy also prepared an addendum to his peer review, in which he reviewed the medical documentation provided in conjunction to the rebuttal prepared by Dr. McMahon and contends the claimant was involved in a motor vehicle accident on 1/14/21 and as per the available medical records, the claimant was not evaluated for right shoulder complaints from the date of the accident 1/14/21 until 1/4/23, almost 2 years later. There was no evidence that the claimant was provided with any form of conservative treatment or any diagnostic testing during this period. He reiterated that the causal relationship between the MVA and the right shoulder complaints were not supported.

In this matter, I am faced with conflicting opinions concerning the medical necessity for the disputed treatment herein. There are no legal issues to resolve. This dispute involves solely an issue of fact, that is, whether or not the treatment was medically necessary. Resolution of that fact is determined by which opinion is accepted by the trier of fact.

After a thorough examination of the reports, documents, and opinions submitted by both parties, I conclude that the Applicant has not met its burden of proof nor demonstrated the medical necessity for the services in question. Upon comparing the pertinent evidence presented by both parties, I find the Respondent's evidence to be more compelling. Although Dr. McMahon's rebuttal was credible, the absence of any right shoulder complaints from the date of the accident until the surgery is not corroborated by the medical records and thus cannot be causally linked to the incident. The lack of reference to shoulder complaints over a two-year period undermines the necessity of the services and further supports Dr. Levy's peer review. Consequently, I find that the Applicant has failed to factually rebut the assertions made by the peer reviewer.

Accordingly, I find in favor of Respondent and deny the claim.

Collateral estoppel is a specific form of res judicata which bars a party from relitigating in a subsequent action an issue raised in a prior action and decided against that party, whether or not the cause of action is the same. Ryan v. New York Tel. Co., 62 NY2d 494(1984). In order to invoke the doctrine, the identical issue must have been decided in the prior action and be determinative of the present action, and the party to be precluded from relitigating the issue must have been afforded a full and fair opportunity to contest the prior determination. Comprehensive Med. Care of NY v. Hausknecht, 55AD3d 777(2008). The doctrine of collateral estoppel applies only against those who were either a party, or in privity with a party, to a prior proceeding. Alev Medical Supply, Inc. v. Allstate Property & Casualty Ins. Co., 36 Misc.3d 132(A), 957 N.Y.S.2d 263 (Table), 2012 N.Y. Slip Op. 51294(U) at 2, 2012 WL 2887931 (App. Term 2d, 11th & 13th Dists. June 28, 2012). The party invoking collateral estoppel has the burden of establishing that the issue litigated is identical to the issue on which preclusion is sought. Concord Delivery Service, Inc. v. Syosset Props, 19 Misc3d 40 (App Term, 9 & 10th Jud Dists 2008). Since the Applicant, in this case, is not the same Applicant who litigated the issue in the previous case, I find that collateral estoppel is not applicable here. However, the same evidence was presented in the matter before me.

Therefore, based on this prior decision which is referenced and incorporated in this decision, in addition to the evidence presented in the present matter, I find that Applicant has failed to sustain their burden.

Accordingly, I find in favor of Respondent and deny the claim.

Any further issues raised in the record are held to be moot and/or waived insofar as not raised at the time of the hearing. This decision is in full disposition of all claims for No-Fault benefits presently 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 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, Antonietta 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.

09/12/2024
(Dated)

Antonietta 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:
1c0b9455edecfb61703acf2af297fa8d

Electronically Signed

Your name: Antonietta Russo
Signed on: 09/12/2024