

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Global Surgery Center LLC
(Applicant)

- and -

LM General Insurance Company
(Respondent)

AAA Case No. 17-24-1365-5079

Applicant's File No. M14960

Insurer's Claim File No. 0567463490002

NAIC No. 36447

ARBITRATION AWARD

I, Theresa A. Kelly, 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, KT

1. Hearing(s) held on 01/07/2025
Declared closed by the arbitrator on 01/07/2025

Ashley Andrews-Santillo, Esq. from Munawar Law Firm, PLLC participated virtually for the Applicant

Lowell Handschu from LM General Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$14,521.36**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant amended its claim to \$7,214.17 in accordance with the applicable provisions of the workers' compensation fee schedule.

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

3. Summary of Issues in Dispute

The Assignor, KT, was injured as a passenger of an automobile involved in a motor vehicle accident on 5/3/2024. Following the accident, the Assignor underwent a right

shoulder surgery; the facility fee associated with the surgery is the service at question herein. The claim was timely denied based on the peer review of Dr. Douglas Unis dated 8/29/2024. The issue is whether the surgery was medically necessary.

4. Findings, Conclusions, and Basis Therefor

The case was decided on 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. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

To receive payment of a claim, Applicant "need only file a 'proof of claim' (11 NYCRR 65.11(k)(3)), and the insurers are obliged to honor it promptly or suffer the statutory penalties." Dermatossian v. New York City Transit Authority, 67 N.Y.2d 219, 224, 501 N.Y.S.2d 784, 787 (1986). Furthermore, the No-Fault law requires a carrier to either pay or deny a claim for No-Fault benefits within thirty (30) days from the date an applicant supplies proof of claim. See, Insurance Law §5106 (a) and 11 NYCRR 65-3.8.

Once Applicant established its prima facie case, the burden of proof shifts to Respondent to come forward with admissible evidence demonstrating the existence of a material issue of fact. Amaze Medical Supply Inc. v. Allstate Insurance Co. 3 Misc3d at 133.

In support of its position, Applicant submitted a bill for \$7,214.17 (after amendment) for the facility fee, and an assignment of benefits form. Thus, a review of the competent evidence in the record reveals that Applicant established a prima facie case of entitlement to reimbursement of its claim, by submitting evidence that the prescribed statutory billing form was mailed and received, and that the Respondent failed to either pay or deny the claim within the requisite 30-day period. Mary Immaculate Hospital v. Allstate Insurance Co., 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004).

Upon proof of a prima facie case by the applicant, the burden shifts to the insurer to prove that the services were not medically necessary. A.B. Medical Services, PLLC v. Lumbermens Mutual Casualty Company, 4 Misc.3d 86, 2004 N.Y. Slip Op. 24194 (App.Term 2nd and 11th Jud. Dists. 2004); Kings Medical Supply, Inc. v. Country-Wide Insurance Company, 5 Misc.3d 767, 2004 N.Y. Slip Op. 24394 (N.Y. Civ. Ct. Kings Co. 2004); Amaze Medical Supply, Inc. v. Eagle Insurance Company, 2 Misc.3d 128(A), 2003 N.Y. Slip Op. 51701(U) (App Term 2nd and 11th Jud. Dists. 2003).

Respondent's evidence established that the right shoulder surgery was timely denied based upon the peer review of Dr. Ronald Unis dated 8/29/2024. In the peer review, Dr.

Unis detailed the results of his IME that occurred two days prior to the surgery at question herein. According to Dr. Unis, the patient did not discuss any pain to his right shoulder and did not state that he was scheduled for surgery in two days' time.

Dr. Unis stated that at an initial orthopedic consultation on 6/10/24 the treating doctor reviewed the right shoulder MRI which reportedly stated that on 5/28/24, there was an impression of a distal subscapularis tendon which was thickened with heterogeneously increased signal consistent with a partial tear in combination with tendinosis / tendinopathy. The assessment was noted of right shoulder pain, right shoulder internals arrangement, right shoulder rotator cuff tear, and a discussion regarding a continuation of conservative management or right shoulder arthroscopy was provided.

He went on to state that the claimant should have completed a conservative treatment plan which was orthopedically supervised including physical therapy and possible injections as the standard of care. To recommend interventional services at the initial orthopedic consultation post the date of accident is inappropriate.

Ultimately, the treating physician needs to a) tailor the treatment to the severity of the symptoms as described by the patient and appreciated through the history and b) use their expertise, knowledge, and experience to treat the patient with the optimal management (considering patient's expectations) for that particular patient after discussing the options with the patient." (AAOS Evidence-Based Medicine Unit, September 2013). The surgery (and all derivative services) is not established as medically necessary.

In reviewing the peer review, I find hereto, that Dr. Unis failed to establish a factual basis and medical rationale for the lack of medical necessity of the shoulder surgery. He cites to the AAOS standard of care for shoulder treatment. However, he fails to apply the standard to the claimant herein. He fails to analyze the standard of care and demonstrate how the surgeon failed to adhere to that standard. The patient had undergone physical therapy treatment to the shoulder. Dr. Unis failed to discuss how the treatment was not accomplished in accordance with the AAOS standard of care as outlined above, which is to use the doctor's "expertise, knowledge and experience to treat the patient." He did not state how this standard was not accomplished.

Dr. Unis discusses the fact that the IME revealed no complaints of pain to the shoulder, though there was no discussion of any examination of the shoulder, nor was the surgery denied based on the results of the IME.

Where the Respondent presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden then shifts to the Applicant which must then present its own evidence of medical necessity. [see Prince, Richardson on Evidence §§

3-104, 3-202 [Farrell 11th ed]), Andrew Carothers, M.D., P.C. v. GEICO Indemnity Company, 2008 NY Slip Op 50456U, 18 Misc. 3d 1147A, 2008 N.Y. Misc. LEXIS 1121, West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co. 13 Misc.3d 131, 824 N.Y.S.2d 759, 2006 NY Slip Op51871(U) (Sup. Ct. App. T. 2d Dep't 2006)].

Applicant submitted the rebuttal affidavit of the treating physician. However, the burden never shifts to Applicant to prove medical necessity. In light of the above, I find in favor of the Applicant in the amended amount.

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
	Global Surgery Center LLC	07/25/24 - 07/25/24	\$14,521.36	\$7,214.17	Awarded: \$7,214.17
Total			\$14,521.36		Awarded: \$7,214.17

- B. The insurer shall also compute and pay the applicant interest set forth below. 09/16/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant is awarded interest pursuant to the no-fault regulations. See generally, 11 NYCRR §65-3.9. Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30 day month." 11 NYCRR §65-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. However, the regulations toll the accrual of interest when an applicant "does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations." See, 11 NYCRR 65-3.9(c). The Superintendent and the New York Court of Appeals has interpreted this provision to apply regardless of whether the particular denial at issue was timely. LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co. 12.N.Y.3d 217 (2009).

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 maximum fee of \$1,360. See, 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, Theresa A. Kelly, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

02/05/2025
(Dated)

Theresa A. Kelly

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:
fb5b6ac117143128b1a7e3b108bf62fa

Electronically Signed

Your name: Theresa A. Kelly
Signed on: 02/05/2025