

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Wert Specialty Orthopedic PC
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No. 17-17-1056-2193

Applicant's File No.

Insurer's Claim File No. 0558957560101013

NAIC No. 22063

ARBITRATION AWARD

I, Rhonda Barry, 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: EIP

1. Hearing(s) held on 10/17/2017
Declared closed by the arbitrator on 10/17/2017

Peter Diconza,, Jr, Esq. from Peter J. Diconza Jr. P.C. participated in person for the Applicant

Augustine Ardizzzone, Esq. from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 4,414.73**, was NOT AMENDED at the oral hearing.
Stipulations WERE made by the parties regarding the issues to be determined.

The parties stipulated that the denial was timely.

3. Summary of Issues in Dispute

Was the claim for a right shoulder arthroscopy properly and timely denied for lack of medical necessity pursuant to peer review?

4. Findings, Conclusions, and Basis Therefor

The EIP is a 45 year old male injured as a restrained driver in a motor vehicle accident on 8/20/16. There was no loss of consciousness or immediate medical attention. Applicant seeks \$4,414.73 for a right shoulder arthroscopy on DOS 11/11/16. Respondent denied applicant's claim based upon lack of medical necessity according to the peer review and addendum of Julio Westerband, MD, orthopedic surgeon. Applicant submits a rebuttal from the treating orthopedic surgeon, Sanford Wert, MD.

I have completely reviewed all timely submitted documents contained in the ADR Center record maintained by the American Arbitration Association and considered all oral arguments. No additional documents were submitted by either party at hearing. No witnesses testified at hearing.

ANALYSIS

Applicant has established its prima facie entitlement to reimbursement for no fault benefits based upon the submission of a properly completed claim form setting forth the amount of the loss sustained and that payment is overdue. Mary Immaculate Hospital v. Allstate Insurance Company, 5 AD 3d 742, (2nd Dept. 2004). Westchester Medical Center v. Lincoln General Ins Co, 60 AD 3d 1045 (2nd Dept. 2009).

The burden now shifts to respondent to establish a lack of medical necessity with competent medical evidence which sets forth a clear factual basis (specifics of the claim) and medical rationale for denying the claim. Citywide Social Work and Psych Services, PLLC v. Allstate, 8 Misc. 3d 1025A (2005); Healing Hands Chiropractic v. Nationwide Assurance Co., 5 Misc. 3d 975 (2004). Respondent must offer sufficient and credible medical evidence that addresses the standards in the applicable medical community for the services and treatment in issue; explains when such services and treatment would be medically appropriate, preferably with understandable objective criteria; and why it was not medically necessary in the instance at issue.

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, 2 Misc. 3d 128(A), Citywide Social Work, et al. v. Travelers Indemnity Company, 3 Misc. 3d 608. 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 NY Slip op. 51467 (U) 2010 WL 3258144 (App Term 2nd, 11th and 13th Dists. 2010).

Dr. Westerband reviewed extensive medical records and determined that it was not clear what led to the decision to perform the surgery. Additional nonsurgical modalities were not offered, specifically a judicious use of steroid injections. As there was no shoulder instability or neurological impairment and the EIP was only two months post-accident,

there was a rush to surgical intervention. If the EIP failed to respond to conservative therapy and steroid injections for what he determined was a right shoulder sprain, a further evaluation should have been performed. Citing to the New York State Shoulder Injury Treatment Guidelines, Dr. Westerband explains that all operative interventions must be based upon positive correlation of clinical findings, clinical course and imaging and other diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis and identification of a pathological condition. When surgery is used to treat pain there must be a clear correlation between the pain symptoms and the objective evidence of its cause. As all surgery could result in complications that should be sufficient attempts to treat non-surgically.

At hearing, respondent's counsel opined that the EIP sustained a partial tear for which conservative care was sufficient to allow the EIP to return to his activities of daily living without pain and with proper function. Applicant's counsel disagreed opining that conservative care does not repair a tear (partial or otherwise); a tear could be aggravated by activities of daily living, resulting in an even more significant injury. Rehabilitative treatment is palliative only. Counsel further argued that Dr. Westerband's reliance on the Workers Compensation Guidelines is at best misplaced. The goal of the Guidelines (and its recommendation for conservative care) is to increase range of motion so as to return the EIP to the workforce as soon as possible while the goal of the no fault law is to return the patient to his pre-accident status. Therefore, Dr. Westerband's reliance upon the Workers Compensation Guidelines is insufficient to sustain respondent's burden of proof.

I agree with applicant to the extent that the Guidelines alone are not necessarily controlling in no-fault cases. However, as Arbitrator Wiener noted, "It is logical to look at the only codified treatment guidelines in New York State, the New York State Worker's Compensation Board Treatment Guidelines. These guidelines developed by representatives of the Insurance Department, the Worker's Compensation board, the Department of Labor and most importantly highly qualified and respected medical professionals... are codified and are contained in the New York codes, rules and regulations at 12 NYCRR part 324." (Elite Medical Care New York, PC v. Allstate Property Casualty Insurance Company, AAA # 412014018767, 10/27/14). The Guidelines offer persuasive information that may, in consideration of the factual situation presented, provide a generally accepted standard of care for the medical community as a whole, particularly when coupled with the peer reviewer's experience as a physician.

That being said, the EIP's medical records and Dr. Wert's rebuttal more than satisfy the standard of care as explained by Dr. Westerband. An MRI of the right shoulder (9/30/16) revealed a partial tear of the supraspinatus tendon, tendinosis to the subscapularis tendon, type II acromion and impingement. This is an objective finding from an independent source that establishes a positive correlation between the EIP's complaints of pain and the need for arthroscopic surgery. There are multiple reports from Dr. Ng (8/24/16, 9/27/16 and 10/19/16) wherein the EIP advises of persistent and consistent complaints of worsening pain. Dr. Ng noted decreased range of motion and diminished muscle strength. As of 9/27/16 the right shoulder pain had worsened despite

conservative care. The pain was severe and interfered with the EIP's ADLs. On 9/27/16 and 10/19/16 Dr. Ng also noted positive impingement sign. Dr. Wert examined the EIP on 10/17/16. There was pain and weakness to the right shoulder. The EIP was asymptomatic prior to the 8/20/16 MVA. Upon examination Dr. Wert noted decreased range of motion, positive Hawkins, positive apprehension test, positive lift-off test and positive supraspinatus test. Diagnosis was right shoulder impingement and partial rotator cuff tear.

Dr. Wert's rebuttal is cogent. He persuasively explains that for this EIP surgery was required to return the patient to his pre-accident status. With respect to the judicious use of steroid injections, Dr. Wert explains that he does not recommend steroids as they can damage the shoulder musculature. It weakens the fibers and can precipitate rotator cuff ruptures. While conservative care reduces pain and swelling it cannot repair tears. Further, this EIP participated in 2 ½ months of continuous, failed physical therapy. His condition worsened. Citing to the National Institute of Health arthroscopic surgery may be recommended for torn or damaged cartilage ring ligaments, shoulder instability, torn biceps tendon, torn rotator cuff, bursitis for inflammation, rheumatoid arthritis, bursitis and shoulder impingement syndrome the right shoulder MRI revealed a partial tear of the supraspinatus tendon as well as impingement satisfying the criteria set forth by the National Institute of Health.

I agree with Dr. Westerband's addendum to the extent that the positive findings noted in the operative report (tear of the anterior labrum, complete rotator cuff tear, synovitis and impingement syndrome) cannot be used to justify the surgery. However, there is sufficient documentation in the EIP's medical records prior to surgery including the MRI, failed conservative care Drs. Ng's and Wert's evaluations. The remainder of Dr. Westerband's addendum is generalized and conclusory.

After careful consideration of the party submissions and arguments at hearing I find that the right shoulder arthroscopic performed by Dr. Wert on 11/11/16 was not a deviation from generally accepted medical practice. Respondent has not sustained its burden of proof.

I find for applicant and the claim is awarded.

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
	Wert Specialty Orthopedic PC	11/11/16 - 11/11/16	\$4,414.73	Awarded: \$4,414.73
Total			\$4,414.73	Awarded: \$4,414.73

- B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 02/27/2017, which is a relevant date only to the extent set forth below.)

Based on the submission of a timely denial, interest shall be paid from 2/27/17, the date of filing, on the amount awarded of \$4,414.73 at a rate of 2% per month, simple, and ending with the date of payment of the award subject to the provisions of 11NYCRR 65 - 3.9 (e).

- 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 newly promulgated 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 New York

SS :

County of Nassau

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

10/20/2017

(Dated)

Rhonda Barry

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:
4da8a3b07178488fd27cfc16e992c233

Electronically Signed

Your name: Rhonda Barry
Signed on: 10/20/2017