American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Steven Struhl MD (Applicant)	AAA Case No.	17-16-1048-6726
	Applicant's File No.	TM-16-3247
- and -	Insurer's Claim File No.	B02NY1526121
	NAIC No.	Self-Insured
Maidstone Insurance Company fka Auto One (Respondent)		

ARBITRATION AWARD

I, Eylan Schulman, 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 11/10/2017
   Declared closed by the arbitrator on 11/10/2017

   Naomi Jean-Philippe, Esq., from Abrams, Fensterman, Fensterman, Eisman, Formato, Ferrara, Wolf LLP participated in person for the Applicant

   Nancy Orlowski, Representative, from Law Office of Jason Tenenbaum, PC participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 4,603.50**, 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

   A. Whether left knee surgery was medically necessary.
   B.Whether Respondent met its burden in support of its Fee Schedule defense.

   This is a claim for reimbursement for the surgical fee in connection with left knee surgery performed on February 25, 2016, following an automobile accident which occurred on September 4, 2015.

   Respondent denied the claim based on lack of medical necessity. Specifically, Respondent denied the claim based on the peer review of orthopedic surgeon Jeffrey Passick, M.D., dated June 3, 2016.

4. Findings, Conclusions, and Basis Therefor

The findings herein are based on documentary evidence set forth in the ADR Center submitted by the parties prior to the date of hearing and oral argument at the hearing.

An Applicant establishes a *prima facie* showing of entitlement to No-Fault benefits under Article 51 of the Insurance Law by submitting proof that it submitted a claim setting forth the fact and the amount of the loss sustained and payment of No-Fault benefits was overdue. A.B. Med. Servs., PLLC v. Liberty Mutual Ins. Co., 39 A.D.3d 779 (2d Dep't 2007); Nyack Hosp. v. Metro. Prop. & Cas. Ins. Co., 16 A.D.3d 564 (2d Dep't 2005); Mary Immaculate Hospital v. Allstate Insurance Co., 5 AD3d 742 (2d Dep't 2004).

Once Applicant makes a *prima facie* showing, the burden shifts to Respondent. Respondent's denial for lack of medical necessity must be supported by competent medical evidence setting forth a clear factual basis and medical rationale for denying the claim. Citywide Social Work, & Psy. Serv. P.L.L.C. v. Travelers Indemnity Co., 3 Misc.3d 608 (Civ. Ct. Kings Co. 2004).

To successfully support its denial, Respondent's peer review must address all pertinent objective findings contained in Applicant's medical submission and set forth how and why the disputed services were inconsistent with generally accepted medical practices. The conclusory opinions of the peer reviewer, standing alone and without support of medical authorities, will not be considered sufficient to establish the absence of medical necessity. *See* Citywide Social Work, & Psy. Serv. P.L.L.C. v. Travelers Indemnity Co., supra; Amaze Medical Supply, Inc. v. Eagle Insurance Co., 2 Misc. 3d 128A, 784 NYS2d 918 (App Term 2d & 11th Jud Dists.).

Where a Respondent meets its burden, it becomes incumbent on the claimant to rebut the peer review. Be Well Medical Supply, Inc. v. New York Cent. Mut. Fire Ins. Co., 18 Misc.3d 139(A), 2008 WL 506180 (App. Term 2d & 11th Dists. Feb. 21, 2008); A Khodadadi Radiology, P.C. v. NY Central Mutual Fire Ins. Co., 16 Misc.3d 131(A), 2007 WL 1989432 (App. Term 2d & 11th Dists July 3, 2007.

"[T]he insured/provider bears the burden of persuasion on the question of medical necessity. Specifically, once the insurer makes a sufficient showing to carry its burden of coming forward with evidence of lack of medical necessity, 'plaintiff must rebut it or succumb." Bedford Park Medical Practice, P.C. v. American Transit Ins. Co., 8 Misc.3d 1025(A), 2005 WL 1936346 at 3 (Civ. Ct. Kings Co., Jack M. Battaglia, J., Aug. 12, 2005). "Where the defendant insurer presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden shifts to the plaintiff which must then present its own evidence of medical necessity (see Prince, Richardson on Evidence §§

3-104, 3-202 [Farrell 11th ed])." West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc.3d 131(A), 2006 N.Y. Slip. Op. 5187(U) at 2, 2006 WL 2829826 (App. Term 2d & 11th Dists. Sept. 29, 2006).

The EIP was an 85-year-old male involved in a motor vehicle accident on September 4, 2015. The EIP sustained a knee injury in the accident. The EIP presented to Applicant on October 28, 2015, where left knee examination revealed restricted ranges of motion and the EIP reported additional difficulties. The EIP initiated a course of conservative treatment and underwent a left knee MRI on January 12, 2016, revealing a medial meniscus tear and joint effusion. On February 25, 2016, the EIP underwent left knee surgery, the necessity of which is now at issue.

It is undisputed that Applicant established its *prima facie* case of entitlement to first-party no-fault benefits by demonstrating it submitted a timely claim setting forth the fact and amount of loss sustained and payment for the claim has not been made.

The burden shifts to Respondent to set forth a clear factual basis and medical rationale for denying the claim. Respondent attempts to meet its burden through the peer review of orthopedic surgeon Jeffrey Passick, M.D., dated June 3, 2016. Dr. Passick claims the surgery was unnecessary because there is not adequate medical indication justifying performance of the procedure. Dr. Passick takes issue with his failure to review an MRI or pre and post-operative evaluation reports evidencing deterioration in the EIP's knee condition despite an adequate course of conservative treatment. Respondent also submitted an Addendum by Dr. Passick, dated December 12, 2016, addressing a rebuttal from Applicant. After reviewing the rebuttal, Dr. Passick maintained his position that the procedure at issue was unnecessary.

After review of the medical records included on the ADR Center and consideration of the arguments advanced by counsel for both parties, I have doubts regarding whether Dr. Passick's peer review set forth a clear factual basis and medical rationale to recommend against reimbursement for the surgery at issue. Dr. Passick failed to review the MRI report from January 12, 2016, demonstrating a medial meniscus tear and joint effusion. As outlined above, to successfully support a denial, Respondent's peer review must address all pertinent objective findings contained in Applicant's medical submissions. A peer review is insufficient when it is based on inadequate medical documentation. Park Neurological Services v. Geico, 4 Misc.3d 95 (App. Term, 2d Dep't, 2004); Amaze Medical Supply v. Allstate Ins. Co., 3 Misc.3d 43 (App. Term 2d and 11th Dists., 2004). The MRI report is among of the more important documents Dr. Passick should have reviewed in considering whether the surgery was necessary. Dr. Passick's failure to review the report prevented him from understanding the full spectrum of information the treating doctor had at his disposal when the determination to recommend surgery was made. Essentially, Dr. Passick failed to review, let alone analyze, significant objective findings in the EIP's treatment records.

Assuming *arguendo* that Respondent established the surgery was unnecessary, I find that Applicant met its burden in rebuttal. The surgery was performed after the EIP failed an extensive course of conservative treatment, had continued clinical findings of a left

knee injury, and the injuries were substantiated by positive MRI findings. Given the recommendation of the EIP's treating provider for the EIP to undergo the procedure, which is supported by objective medical findings and rationale, I defer to the EIP's treating provider's decision that the surgery was necessary for the EIP's rehabilitation following the accident. *See* James M. Liguori, Physician, vs. State Farm Mut.Auto Ins., 15 Misc.3d 1103A, 836 N.Y.S.2d 499, (District Ct. Nassau Co., 2007).

Accordingly, I find that Applicant is entitled to reimbursement for the services at issue. In addition to the issue of medical necessity, there is a question about the proper rate of reimbursement for the procedure. Respondent has the burden to come forward with competent evidentiary proof to support its Fee Schedule defenses. Robert Physical Therapy, P.C. v. State Farm Mut. Auto. Ins. Co., 13 Misc.3d 172 (Civ. Ct. Kings. Co. 2006). When Respondent fails to demonstrate by competent evidentiary proof that an Applicant's claim was in excess of the appropriate Fee Schedule, Respondent's defense of noncompliance with the Fee Schedule cannot be sustained. Continental Medical, P.C. v. Travelers Indemnity Co., 11 Misc.3d 145A (App. Term 1st Dep't 2006).

In support of its Fee Schedule burden, Respondent provided a notarized Affidavit from Jeffrey Futoran, a Certified Professional Coder ("CPC"). Applying the Fee Schedule, Mr. Futoran indicates the proper amount for the procedure totals $2692.37. Mr. Futoran analyzed the codes billed by Applicant and explained why only CPT codes 29876 and 29877 were properly billable, but Codes 29850, 29870, and 20610 were not properly reported.

By producing Mr. Futoran's Fee Schedule analysis, I find that Respondent met its burden to come forward with competent evidentiary proof in support of its Fee Schedule defenses. Once Respondent makes a *prima facie* showing that the amounts charged by Applicant were in excess of the Fee Schedule, the burden shifts back to Applicant to show the charges involved a different interpretation of such schedule or an inadvertent miscalculation or error. Cornell Medical P.C. v. Mercury Causalty Co., 24 Misc.3d 58 (App. Term 2d, 11th & 13th Dists. 2009).

Applicant submitted no evidence refuting Respondent's showing or supporting Applicant's suggested amount for the procedure. There is simply nothing before me supporting Applicant's billing. Respondent submitted credible evidence from a Certified Professional Coder and Applicant submitted no expert evidence rebutting Respondent's showing. In the absence of evidence from Applicant, I find that $2692.37 was the appropriate amount of reimbursement for the procedure at issue.

Based on the foregoing, Applicant is awarded $2692.37, in full resolution of the claim.

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**
	Steven Struhl MD	**02/25/16 - 02/25/16**	**$4,603.50**	**Awarded: $2,692.37**
Total			**$4,603.50**	**Awarded: $2,692.37**

B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 11/21/2016, which is a relevant date only to the extent set forth below.)

Where a claim is untimely denied, or not denied or paid, interest shall accrue as of the 30th day following the date the claim is presented by the claimant to the insurer for payment. Where a claim is timely denied, interest shall accrue as of the date an action is commenced or an arbitration requested, unless an action is commenced or an arbitration requested within 30 days after receipt of the denial, in which event interest shall begin to accrue as of the date the denial is received by the claimant. (11 NYCRR 65-3.9(c)). The end date for the calculation of interest shall be the date of payment of the claim. In calculating interest, the date of accrual shall be excluded from the calculation. Where a motor vehicle accident occurs after April 5, 2002, interest shall be calculated at the rate of two percent per month, simple, calculated on a pro rata basis using a 30-day month. (11 NYCRR 65-3.9(a)).

C. Attorney's Fees

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

For cases filed prior to February 4, 2015, 20 percent of the amount of first party benefits awarded herein, plus interest thereon, subject to a minimum of $60 and a maximum of $850. For cases filed on or after February 4, 2015, 20 percent of the amount of first party benefits awarded herein, plus interest thereon, subject to no minimum and a maximum of $1360. (11 NYCRR 65-4).

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

11/13/2017
(Dated)

Eylan Schulman

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:
42d2f7c32890cdf1dcf2b8c8419cea68

Electronically Signed

Your name: Eylan Schulman
Signed on: 11/13/2017