

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Winthrop University Hospital
(Applicant)

- and -

Liberty Mutual Insurance Company
(Respondent)

AAA Case No.	17-17-1060-6049
Applicant's File No.	RFA17-197387
Insurer's Claim File No.	LA000-033453907-04
NAIC No.	36447

ARBITRATION AWARD

I, Anthony Kobets, 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 01/31/2018
Declared closed by the arbitrator on 01/31/2018

Emily Bennett, Esq. from Russell Friedman & Associates LLP participated in person for the Applicant

James Eurera, Esq. from Liberty Mutual Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 3,060.57**, was NOT AMENDED at the oral hearing.
Stipulations WERE made by the parties regarding the issues to be determined.

At the hearing, the parties' representatives stipulated to the timely service of the bill and denial, to Applicant's prima facie burden and to the amount in dispute being in accordance with the applicable provisions of the New York State Workers' Compensation Fee Schedule.

3. Summary of Issues in Dispute

In dispute is the Applicant's bill totaling \$3060.57 for facility fees associated with a left shoulder arthroscopic surgery performed on the patient (HG) on 8/30/16 as a result of injuries alleged to have been sustained in a motor vehicle accident on March 16, 2016.

Respondent denied the 8/30/16 claim based upon a peer review report by Dr. Frank Oliveto, M.D. dated 10/4/16 and based upon an Independent Medical Examination (IME) conducted by Dr. Frank Oliveto, M.D. on 6/9/16 with an effective cutoff date of 7/5/16. Was the Applicant entitled to reimbursement for the services provided to the EIP?

4. Findings, Conclusions, and Basis Therefor

I have reviewed all documents as available in the ADR Center as of the date of this hearing pertaining to this case. This case was decided based on the submissions of the Parties as contained in the electronic case folder maintained by the American Arbitration Association and the oral arguments of the parties at the hearing. There was no witness testimony at the hearing.

At the hearing, the parties' representatives stipulated to the timely service of the bill and denial, to Applicant's *prima facie* burden and to the amount in dispute being in accordance with the applicable provisions of the New York State Workers' Compensation Fee Schedule.

The parties' representative agreed that medical necessity was the sole issue in dispute herein.

The EIP (HG) was a 48-year old female driver who was allegedly involved in a motor vehicle accident on March 16, 2016. Thereafter on 8/30/16, the patient underwent a left shoulder arthroscopic surgery at the Applicant's facility. Applicant seeks no-fault reimbursement for these services.

A health care provider establishes its *prima facie* entitlement to payment as a matter of law by proof that it submitted a proper claim, setting forth the fact and the amount charged for the services rendered and that payment of no-fault benefits was overdue (see Insurance Law § 5106 a; Mary Immaculate Hosp. v. Allstate Ins. Co., 5 AD 3d 742, 774 N.Y.S. 2d 564 [2004]; Amaze Med. Supply v. Eagle Ins. Co., 2 Misc. 3d 128A, 784 N.Y.S. 2d 918, 2003 NY Slip Op 51701U [App Term, 2d & 11th Jud Dists]).

Bill for date of service 8/30/16 in the amount of \$3060.57

Respondent timely denied payment of the above referenced bill based upon the peer review report of Dr. Frank Oliveto, M.D. dated 10/4/16 and based upon an IME conducted by Dr. Frank Oliveto, M.D. on 6/9/16 with an effective cutoff date of 7/5/16.

In his peer report, Dr. Oliveto examined the patient's records and stated that "[w]hen I evaluated the claimant on 06/09/16, there was full range of motion of the left shoulder, no crepitus and no impingement sign. My diagnosis was left shoulder sprain, resolved. I found no need for further physical therapy, orthopedic treatment or surgery, and no evidence of an orthopedic disability. Additionally, the MRI of the left shoulder did in fact reveal hypertrophy of the acromioclavicular joint which is a chronic degenerative condition. As there were no objective findings at the time of my orthopedic evaluation on 06/09/16, there was no medical necessity on a causally related basis for the left shoulder arthroscopy performed 08/30/16." He further indicated and concluded that "Superior labrum anterior-posterior (SLAP) lesions of the shoulder that require surgical repair are relatively uncommon. However, recent observations suggest that there may be a rise in the incidence of SLAP lesion repair."

The patient presented to the 6/9/16 IME conducted by Dr. Frank Oliveto, M.D. with complaints of neck pain, mid back pain, radiating low back pain left shoulder pain, left knee pain and pain in the left side of her jaw. The claimant denied being in any prior automobile accidents and any prior serious illness. Examinations of the cervical spine, thoracic spine and lumbar spine revealed tenderness with decreased ranges of motion. Examination of the left shoulder revealed tenderness on palpation with full range of motion with no effusion, crepitus or impingement sign noted. The diagnosis included resolved sprain/strain, cervical, thoracic and lumbar spine, left shoulder and left knee and Dr. Oliveto's concluded that no further treatment was necessary. Dr. Oliveto also indicated that "[b]ased upon the history provided, findings on examination and submitted records, there is a causal relationship between the accident of record and the claimant's reported symptomatology." Respondent's counsel argued that the conclusions contained in the IME report and peer report established that there was no medical justification for the 8/30/16 services.

A treatment or service is medically necessary if it is "appropriate, suitable, proper and conducive to the end sought by the professional health service in consultation with the patient. It means more than merely convenient or useful treatment or services, but treatment or services that are reasonable in light of the patient's injury, subjective and objective evidence of the patient's complaints of pain, and the goals of evaluating and treating the patient." Fifth Avenue Pain Control Center v. Allstate, 196 Misc. 2d 801, 807-808 (Civ. Ct. Queens Cty. 2003). Medically necessary treatment or services must be "consistent with the patient's condition, circumstances and best interest of the patient with regard to the type of treatment or services rendered, the amount of treatment or services rendered, and the duration of the treatment or services rendered." *Id.* Medical services are compensable where they serve a valid medical purpose. Sunrise Medical Imaging PC v. Lumbermans Mutual, 2001 N.Y. Slip Op. 4009.

If an insurer asserts that the medical test, treatment, supply or other service was medically unnecessary the burden is on the insurer to prove that assertion with competent evidence such as an independent medical examination, a peer review or other proof that sets forth a factual basis and a medical rationale for denying the claim. (See A.B. Medical Services, PLLC v. Geico Insurance Co., 2 Misc. 3d 26 [App Term, 2nd & 11th Jud Dists 2003]; Kings Medical Supply Inc. v. Country Wide Insurance Company, 783 N.Y.S. 2d at 448 & 452; Amaze Medical Supply, Inc. v. Eagle Insurance Company, 2 Misc. 3d 128 [App Term, 2nd and 11th Jud Dists 2003]).

In the event an insurer relies on a peer review report to demonstrate that a particular service was medically unnecessary the peer reviewer's opinion must be supported by sufficient factual evidence or proof and cannot simply be conclusory or may be supported by evidence of generally accepted medical/professional practice or standards. See Nir v. Allstate Insurance Company, 2005 NY Slip Op 25090; 7 Misc.3d 544; 796 N.Y.S.2d 857; 2005 N.Y.Misc. LEXIS 419 and Citywide Social Work & Psy. Serv. P.L.L.C. v. Travelers Indemnity Co., 3 Misc. 3d 608; 777 N.Y.S.2d 241; 2004 NY Slip Op 24034.

An IME report asserting that no further treatment is medically necessary must be supported by a sufficiently detailed factual basis and medical rationale, which includes mention of the applicable generally accepted medical/professional standards. Carle Place Chiropractic v. New York Central Mut. Fire Ins Co., 19 Misc.3d 1139(A), 866 N.Y.S.2d 90 (Table), 2008 N.Y. Slip Op. 51065(U), 2008 WL 2228633 (Dist. Ct., Nassau Co., May 29, 2008, Andrew M. Engle, J.). An IME doctor must establish a factual basis and medical rationale for his asserted lack of medical necessity for future health care services. E.g., Ying Eastern Acupuncture, P.C. v. Global Liberty Insurance, 20 Misc.3d 144(A), (App. Term 2d & 11th Dists. Sept. 3, 2008).

"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), 824 N.Y.S.2d 759 (Table), 2006 N.Y. Slip Op. 51871(U) at 2, 2006 WL 2829826 (App. Term 2d & 11th Dists. Sept. 29, 2006); A. Khodadadi Radiology PC v. NY Central Mutual Fire Ins. Co., 2007 NY Slip Op 51342(U). Applicant's counsel argued that the IME and peer review failed to meet their burden regarding the lack of medical necessity for the surgical procedure by not having sufficient records, ignoring the patient's subjective complaints and by disregarding the objective positive findings contained in the various medical records, including the left shoulder MRI report.

The evidence herein demonstrated that following the accident, the patient was evaluated initially at the ER of St. Joseph Hospital. The triage report noted that she was a 47 year old woman who presented complaining of neck pain, headache, and facial pain. At the ER, the examination of the extremities documented tenderness to the anterior aspect of the left shoulder. X rays were taken of the neck, low back and left shoulder but no fractures were found. The patient was given pain medication and discharged.

The patient was initially examined on 3/31/16 by Dr. Philip Rafiy and presented with injuries to the neck, lower back, left shoulder and left knee. She was started on a treatment program consisting of physical therapy and acupuncture. MRI of the left shoulder was considered.

An MRI of the left shoulder performed on 5/9/16 revealed hypertrophy of the acromioclavicular joint, shoulder joint effusion with fluid pooling in the subscapularis bursa, and tearing of the glenoid labral.

Electrodiagnostic testing performed on 5/20/16 revealed mild bilateral carpal tunnel syndrome, mild acute C6 radiculopathy, left and moderate S1 radiculopathy, right.

The patient was reexamined by Dr. Philip Rafiy on 06/06/16 and presented with complaints of injuries to her cervical spine, lumbar spine left knee and left shoulder. She indicated she had been going for physical therapy and taking pain medication. Examination of the left shoulder revealed tenderness with a positive impingement and a positive apprehension. The impression included left shoulder labral tear and the claimant was recommended continuing with physical therapy. Dr. Rafiy also performed a left shoulder injection on that date.

The patient was examined by Dr. Barry Katzman, M.D. on 06/22/16 for complaints of left shoulder pain. Examination of the left shoulder revealed decreased range of motion with tenderness, a positive Neer's Sign and a positive Hawkins impingement sign. The diagnosis listed left shoulder glenoid labral tear and the treatment plan indicated that it would be reasonable to do the left shoulder arthroscopic surgery.

On 06/29/16, Dr. Philip Rafiy, M.D. reevaluated the patient for complaints including left shoulder pain, which causes difficulty reaching overhead, lifting heavy objects, pushing and pulling. Examination of the left shoulder revealed AC joint line tenderness with limited range of motion and positive impingement and apprehension tests. The impression was left shoulder labral tear and left shoulder arthroscopic surgery was recommended as a treatment option.

On 7/13/16, the patient was examined by Dr. Sunil Butani, M.D. for complaints including left shoulder pain. Examination of the left shoulder revealed tenderness, pain and a positive impingement sign. The recommendations included possible injections to the left shoulder if the pain does not improve with conservative care.

The patient underwent lumbar epidural steroid injections on 07/23/16, 08/06/16 and 08/27/16.

On 8/30/16, the patient underwent a left shoulder arthroscopy performed by Dr. Philip Rafiy, M.D. The preoperative and postoperative diagnoses were left shoulder synovitis with glenoid labral tear with subacromial impingement. The impression was left shoulder arthroscopy with glenoid labral extensive debridement and partial glenohumeral synovectomy with subacromial decompression of the subacromial joint.

Physical therapy treatment notes from March 2016 - May 2016 documented the patient's persistent left shoulder pain and the treatments rendered.

Based upon a review of the evidence herein and the arguments of counsel, I find that Respondent has not met its burden in this case. Neither Dr. Oliveto's IME report nor his peer review report provided a sufficient medical rationale or factual basis to justify a lack of medical necessity for the left shoulder surgery based on the patient's ongoing symptomology and objective positive test results documented in the medical records.

Specifically, Dr. Oliveto did not adequately discuss the significance of the patient's persistent complaints of pain, as well as the glenoid labral tear documented in the patient's left shoulder MRI reports or the other objective positive findings including hypertrophy of the acromioclavicular joint, shoulder joint effusion with fluid pooling in the subscapularis bursa, decreased range of motion, tenderness, positive impingement, positive apprehension, positive Neer's Sign, and a positive Hawkins impingement sign,

Dr. Oliveto relied heavily on his own medical examination of the patient and did not adequately review nor discuss the preoperative examination and diagnosis of left shoulder synovitis with glenoid labral tear with subacromial impingement. In addition, I find that Dr. Oliveto's IME report and peer review were unpersuasive and overly conclusory without the necessary detailed medical examination or factual basis to support them. A peer review which concludes there was no medical necessity due to the lack of sufficient information upon which the reviewer could make such a determination does not set forth a factual basis and medical rationale sufficient to establish the absence of medical necessity. Park Neurological Services P.C. v. GEICO Ins., 4 Misc.3d 95, 782 N.Y.S.2d 506 (App. Term 9th & 10th Dists. 2004). I find that the patient's medical records, were more persuasive that the services herein were reasonable and medically necessary to resolve an ongoing condition that was not adequately responding to conservative care. A letter of medical necessity which raises a question of fact as to the medical necessity of services may serve to rebut the peer review report. E.g., American Chiropractic Care, P.C. v. Praetorian Ins. Co., 42 Misc.3d 145(A), 988 N.Y.S.2d 521 (Table), 2014 N.Y. Slip Op. 50346(U), 2014 WL 996509 (App. Term 9th & 10th Dists. Feb. 28, 2014). A respondent defending a denial of first party benefits on the grounds that the subject medical services or testing were not medically necessary must show that the services were inconsistent with generally accepted medical practice, and here the Respondent has not. The opinion of the insurer's expert standing alone is insufficient to meet the *burden of proving that the services were not medically necessary* (see Citywide Social Work v. Travelers Indem. Co., 3 Misc 3d 608 (Civ Ct Kings County 2004)). Where a peer review opinion rests upon conclusory assumptions and disputed or incorrect facts, the review is insufficient to prove the insurer's entitlement to judgment as a matter of law on its lack of medical necessity defense; in these circumstances, the absence of opposing expert proof from the claimant is immaterial. E.g., Novacare Medical P.C. v. Travelers Property Casualty Ins. Co., 31 Misc.3d 1205(A), 927 N.Y.S.2d 817 (Table), 2011 N.Y. Slip Op. 50500(U) at 5, 2011 WL 1226956 (Dist. Ct. Nassau Co., Michael A. Ciaffa, J., Apr. 1, 2011). Where other reports in the insurer's papers contradict the conclusion of its peer reviewer that a 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 Ins. Co., 28 Misc.3d 138(A), 2010 N.Y. Slip Op. 51467(U), 2010 WL 3258144 (App. Term 2d, 11th & 13th Dists. Aug. 13, 2010).

Furthermore, in Mount Sinai v. Triboro Coach, 263 A.D. 2d. 11 (Second Dep't, 1999), the Court stated that the insurer has the burden of coming forward with proof in an admissible form to establish the fact or evidentiary foundation for its belief that the patient's condition was unrelated to the motor vehicle accident. Moreover, the insurer must show that the injury was not related to the accident at all. It must show how, when and where the injury happened and that it was not aggravated or exacerbated by the

accident (emphasis added). The insurer's proof may not be vague, conclusory, inconsistent or unsupported by records. In Kingsbrook Jewish Medical Center v. Allstate Ins. Co., 61 A.D.3d 13, (A.D. 2d. Dep't, 2009) the Appellate Division, ruled that exacerbations of pre-existing conditions are covered by No-Fault, and that causation is presumed under the New York No-Fault law. An expert's affirmation is needed to provide a factual foundation for an insurance carrier's good faith belief that an alleged injury did not arise out of an insured accident; speculation or wishful thinking does not suffice. Mt. Sinai Hospital v. Triboro Coach Inc., 263 A.D.2d 11, 699 N.Y.S.2d 77 (2d Dept. 1999). Dr. Oliveto's report in this matter is deficient, among other reasons, because it lacks sufficient factual support and medical rationale to justify the position that the services herein were not causally related. Moreover, at the IME he conducted, Dr. Oliveto concluded that the injuries were causally related to the accident. I find that the patient's medical records demonstrated that the services herein were causally related and reasonable to resolve an ongoing condition. I am also persuaded that the patient's injuries visualized and treated at the time of the 8/30/16 arthroscopy were consistent with the patient's mechanism of injury as a direct result of the motor vehicle accident. An insurer fails to come forward with proof in admissible form to demonstrate the fact or the evidentiary foundation for its belief that the patient's treated condition was unrelated to his or her automobile accident where the affidavit of its medical expert is conclusory, speculative, and unsupported by the evidence. E.g., New York & Presbyterian Hospital v. Selective Ins. Co. of America, 43 A.D.3d 1019, 842 N.Y.S.2d 63 (2d Dept. 2007). Based upon the aforementioned, I find that the Respondent has failed to sufficiently establish that the services were not medically necessary or causally related and grant Applicant's \$ 3060.57 claim. This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator. Any further issues raised in the hearing record are held to be moot and/or waived insofar as not raised at the time of the hearing.

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
	Winthrop University Hospital	08/30/16 - 08/30/16	\$3,060.57	Awarded: \$3,060.57
Total			\$3,060.57	Awarded: \$3,060.57

B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 05/02/2017, which is a relevant date only to the extent set forth below.)

Where a claim is timely denied, interest shall begin to accrue as of the date arbitration is commenced by the claimant, i.e., the date the claim is received by the American Arbitration Association, unless arbitration is commenced 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. See generally, 11 NYCRR 65-3.9. Where a motor vehicle accident occurs after Apr. 5, 2002, 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

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

02/13/2018

(Dated)

Anthony Kobets

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:
94da140e5c6cff094953f2e46867da7b

Electronically Signed

Your name: Anthony Kobets
Signed on: 02/13/2018