

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Right Choice Supply, Inc.
(Applicant)

- and -

Liberty Mutual Fire Insurance Company
(Respondent)

AAA Case No.	17-17-1065-5034
Applicant's File No.	N/A
Insurer's Claim File No.	LA000-033606090-02
NAIC No.	23035

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 06/13/2018
Declared closed by the arbitrator on 06/13/2018

Cathryn Roberts, Esq. from Gene Sigalov Esq. participated in person for the Applicant

Alan Zysberg from Liberty Mutual Fire Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 2,436.04**, 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 bills 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 are the Applicant's bills totaling \$2436.04 for (2) pads and the rental of a Continuous Passive Motion Machine (CPM) and a Cold Therapy Unit (CTU) from 7/28/16- 8/24/16 to the patient (IS) as a result of injuries alleged to have been sustained in a motor vehicle accident on 3/4/16.

Respondent timely denied the claims based upon the peer review report of Dr. Jay Eneman, M.D. dated 9/1/16. 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 testimony at the hearing.

At the hearing, the parties' representatives stipulated to the timely service of the bills 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' representatives agreed that medical necessity and causation were the sole issues in dispute herein.

The parties' representatives further agreed that the AAA arbitration commencement date will be utilized for interest purposes, if applicable.

The EIP (IS) was a 37-year old male driver who was allegedly involved in a motor vehicle accident on March 4, 2016. Thereafter from 7/28/16 - 8/24/16, he utilized a CPM and CTU with accessories provided by the Applicant. Applicant is seeking 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]).

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.

A presumption of medical necessity attaches to a Respondent's admission of the Applicant's timely submission of proper claim forms such as in the within case, the burden then switches to the respondent to demonstrate the lack of medical necessity. 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 thus bears the burden of production and persuasion with respect to medical necessity of the treatment for which payment is sought. (See Bajaj v. Progressive, 14 Misc 3d 1202(A) (N.Y.C. Civ Ct 2006).

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 11thJud 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.

In order for Respondent to meet its burden of establishing the lack of medical necessity, a peer review should (1) set forth applicable accepted medical standards relevant to the services at issue; and (2) comment on whether the Applicant had followed or deviated from those standards in providing the disputed services. This does not necessarily require that the peer review quote or cite medical literature. The Nir decision clearly contemplates that a peer may cite "medical authority, standard, or generally accepted practice as a medical rationale for his findings". Nir, 7 Misc.3d at 548.

Bill for dates of service 7/28/16 - 8/24/16 in the amount of \$929.64;

Bill for dates of service 8/11/16 - 8/24/16 in the amount of \$910.14;

B ill for dates of service 7/28/16 - 8/10/116 in the amount of \$596.26.

Respondent timely denied the above referenced bills based upon the peer review report of Dr. Jay Eneman, M.D. dated 9/1/16. Dr. Eneman's peer review was based upon his review of the available medical documents and he indicated that "[t]he active in-office physical therapy including the modalities of exercise and range of motion would be sufficient for the patient to improve range of motion and the CPM would be

excessive. There is never an indication for a CPM unit in standard arthroscopy to a knee. This equipment may be indicated in fractures and arthroscopically assisted repairs to a knee such as plateau fractures. Some use it for TKR post-op for a few days which has justification under correct guidelines. Post infection and adhesive capsulitis might be of assistance but at no time is there any medical necessity for this equipment for simple arthroscopy, meniscectomy and debridement. As an aside, there is no instruction as to time of use, quantifying use and parameters of use such as range and settings of the unit. As to the cold therapy unit, it remains a comfort and convenience only for two or three days post simple meniscectomy and remains no better than an ice pack. Also, CPM, Cold therapy and Compression devices have not been shown to be superior to ROM exercises, lee packs and elevation with mild compression by a stocking. The cold therapy unit lacks the safety and effectiveness that treatment provided by healthcare professionals would deliver. Furthermore, according to my examination on 06/23/16, I had diagnosed the claimant with 'resolved left knee sprain/contusion' and there was no need for surgery or durable medical equipment indicated at that time."

Respondent also relied on an Addendum report by Dr. Jay Eneman, M.D. dated 9/19/17, wherein he reviewed the rebuttal by Dr. Thompson and stated that "[a] rebuttal letter was provided by Dr. Thompson in response to my conclusion regarding the above referenced supplies. However, Dr. Thompson presented no new clinical or diagnostic evidence to cause me to change or alter my opinion as previously provided. In addition, the letter contained some general statements for the CPM and cold therapy unit as well as surgery of the knee which were not applicable to this particular claimant." Respondent's counsel argued that the peer review set forth a sufficient factual basis and medical rationale to prove the lack of medical necessity for the left knee post-operative rehabilitative treatment in dispute herein.

"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 peer review failed to meet its burden regarding the lack of medical necessity based upon the positive objective findings in the medical records and the patient's documented symptomology. Applicant also submitted a Rebuttal from Dr. L. Sean Thompson, M.D. dated 7/27/17, wherein he reviewed the patient's records including the peer report by Dr. Eneman and indicated that "[d]espite receiving continued course of physical therapy; the left knee complaints of the patient did not improve, he was therefore referred for orthopedic consultation... As a post operative management plan; I then prescribed the patient cold therapy unit, CPM kit synthetic sheepskin pad and CPM knee device passive motion to use at home. These devices were provided to the patient 7/28/2016 through 8/24/2016... they are quite useful for patients, such as this one, who benefit from their use on those days and at those times when the patient is not receiving in-office treatment. Any treatment for the

same problem that uses a different mechanism to alleviate the problem is usually considered complementary, not excessive. The use of these devices is very helpful during certain activities which otherwise the patient could not participate due to pain and stiffness."

The records herein indicated that an MRI of the left knee performed on 6/10/2016 revealed a tear of the posterior horn of the medial meniscus, medial retinacular sprain, joint effusion and deep infrapatellar bursitis.

On 6/23/16, the patient attended an independent medical examination (IME) conducted by Dr. Jay Eneman, M.D, who noted that the patient's past medical history was negative. Examination of the left knee revealed decreased range of motion with anterior and patellofemoral tenderness. The diagnosis included a resolved left knee sprain/contusion and Dr. Eneman concluded that the "above-diagnosed injuries are causally related to the motor vehicle accident on 3/4/16"

The patient was initially evaluated by Dr. L. Sean Thompson, M.D. on 07/14/16 and presented with complaints of 7/10 left knee pain. Examination of the left knee revealed tenderness, pain and decreased range of motion. Patellofemoral grind test and McMurray's test were positive. The patient was diagnosed with posttraumatic left knee medial meniscal tear and the treatment plan recommended left knee arthroscopic surgery.

On 7/27/2016, the patient underwent a left knee arthroscopic surgery with medial meniscectomy; debridement; diagnostic arthroscopy left knee; left knee chondroplasty; patellofemoral articulation; left knee synovectomy, major, three compartments and Arthrocentesis left knee. The preoperative diagnoses were left knee medial meniscal tear, lateral meniscus tear, left knee chondral damage and patellofemoral articulation. The postoperative diagnoses were: left knee l damage, patellofemoral articulation.

On 7/28/16, the patient commenced CPM and cold therapy treatment (CTU) to the left knee. The delivery receipt indicated that the patient was instructed on the use of the equipment and a prescription and letter of medical necessity signed by Dr. Sean Thompson, M.D. discussed the benefits of the CPM and CTU including reducing pain, inflammation and swelling; and increasing range of motion.

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. Dr. Eneman's peer review report did not provide a sufficient medical rationale or factual basis to deny the CPM and CTU treatment based on the patient's complaints of left knee pain and the objective findings including decreased range of motion with pain and tenderness, a positive Patellofemoral Grind test, a positive McMurray's test, MRI results which revealed a tear of the posterior horn of the medial meniscus, medial retinacular sprain, joint effusion and deep infrapatellar bursitis; and a post-operative diagnosis of left knee medial meniscus tear; left knee lateral meniscus tear and left knee chondral damage, patellofemoral articulation.

I am also persuaded by the medical records and by Dr. Thompson's explanation that "[a]s evident from the pre-operative evaluation as well as intra-operative findings, the patient's condition in this case was consistent with the above indications such as tear in medial meniscus, tears in the lateral meniscus, etc and therefore required the left knee surgery." I was also persuaded by Dr. Thompson's explanation that "I would note that the CPM and CTU devices were administered as a supplement to the ROM exercises and not a replacement. Unlike standard cryotherapy, medical devices that employ compression cryotherapy allow for temperature adjustments based on clinician and patient preference. This function helps to avoid tissue damage and offers deeper, precise, and more consistent cooling without the pain and discomfort associated with ice packs. Compression helps to minimize the swelling and consequent edema associated with injuries. Standard compression aids (e.g., elastic bandages) can only provide static compression. CPM cryotherapy devices provide intermittent or cyclical compression, which is preferable to static compression as it more closely mimics the muscle contractions that the body uses to force tissue debris and excess fluid out of the affected area and into the lymphatic system for proper drainage." Dr. Thompson also explained that "[t]he physiologic effects of cold application include immediate vasoconstriction with reflexive vasodilation, decreased local metabolism and enzymatic activity, and decreased oxygen demand. Cold decreases muscle spindle fiber activity and slows nerve conduction velocity; therefore it is often used to decrease spasticity and muscle guarding. Continuous-flow cold is superior to crushed ice for outpatient ACL reconstruction pain and should not be considered an equivalent modality. Also, the sheepskin wrap is made from a high quality medical grade sheepskin belt. Commonly referred to as a decubicare pad, which is designed to reduce pressure sores by transmitting pressure evenly and smoothly allowing for maximum circulation." Dr. Thompson effectively rebutted Dr. Eneman's peer review report, exhibited a sound medical rationale and sufficiently justified the need for the services in question relying on the records submitted and credible medical authority. Park Slope Medical and Surgical Supply, Inc. v. New York Central Mutual Fire Ins. Co., 22 Misc.3d 141(A), 881 N.Y.S.2d 365 (Table), 2009 N.Y. Slip Op. 50441(U), 2009 WL 679499 (App. Term 2nd, 11th & 13th Dists. Mar. 12, 2009). 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).

In AAAMG Leasing Corp. v. Geico 17-991-R-76913 -13 the Master Arbitrator held that "once the surgery is performed the necessity of any DME needed for post-surgical rehabilitation must be evaluated separately and on its own individual merits." Every peer review requires individual scrutiny to determine whether the burden should be shifted back to the claimant to submit contrary expert proof. If the claimant can demonstrate, through references to the medical records or otherwise, that the peer review doctor's opinion lacks a sufficient basis and/or medical rationale because it is conclusory, or because it fails to address essential factual issues or is based upon disputed or apparently incorrect facts, the insurer has fallen short of its burden of proof. 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 4, 2011 WL 1226956 (Dist. Ct. Nassau Co., Michael A. Ciaffa, J., Apr. 1, 2011).

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. Eneman'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 injuries herein were not causally related. I find that the patient's medical records demonstrated that the services herein were causally related and reasonable to resolve an ongoing condition and that the services 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). I find that Dr. Eneman's report was unpersuasive and overly conclusory without a sufficient factual basis or medical rationale to support his conclusion that the services were not medically necessary or causally related. Accordingly, the Applicant is awarded \$2436.04. 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
	Right Choice Supply, Inc.	07/28/16 - 08/24/16	\$2,436.04	Awarded: \$2,436.04
Total			\$2,436.04	Awarded: \$2,436.04

- B. The insurer shall also compute and pay the applicant interest set forth below. 06/28/2017 is the date that interest shall accrue from. This 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.

07/09/2018
(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

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Electronically Signed

Your name: Anthony Kobets
Signed on: 07/09/2018