American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

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| Health Plus Surgery Center, LLC , Citimed Services, PA<br>(Applicant) | AAA Case No. | 17-17-1064-4531 |
| | Applicant's File No. | None |
| | Insurer's Claim File No. | 2683569 |
| - and - | NAIC No. | 12130 |
| National General Insurance Company f/k/a GMAC<br>(Respondent) | | |

**ARBITRATION AWARD**

I, Stacey Charkey, 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 10/30/2018
   Declared closed by the arbitrator on 10/30/2018

   Elke Mirabella, Esq. from Dino R. DiRienzo Esq. participated in person for the Applicant

   Peter L. Pagones, esq. from Roe & Associates participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 27,122.88**, was AMENDED and permitted by the arbitrator at the oral hearing.

   AR1 was reduced to $15,986.42Whether Applicant is entitled to reimbursement for the fees associated with an right shoulder arthroscopic procedure performed 3/20/17 in connection with injures purportedly sustained by assignor, a then 49 year old man, in a motor vehicle accident occurring 1/25/17. The claim was denied based upon a peer review by Dr. Richard Weiss.

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

3. Summary of Issues in Dispute

Whether Applicant is entitled to reimbursement for the fees associated with an right shoulder arthroscopic procedure performed 3/20/17 in connection with injures purportedly sustained by assignor, a then 39 year old man, in a motor vehicle accident occurring 1/25/17. The claim was denied based upon a peer review by Dr. Richard Weiss.

4. Findings, Conclusions, and Basis Therefor
    1.

The decision below is based on the documents on file in the Electronic Case Folder maintained by the American Arbitration Association as of the date of this hearing and on oral arguments of the parties. No witness testimony was produced at the hearing. Applicant seeks reimbursement, together with interest and counsel fees, under the No-Fault Regulations, for the fees associated with an arthroscopic procedure to the right shoulder.

Assignor, a then 39 year old male, was involved in a motor vehicle accident on 1/25/17. As a result of the accident, Assignor purportedly sustained an injury to his right shoulder. I have not been provided with assignor's complete medical records, however, it appears that assignor presented to his "local medical practitioner" with complaints of right knee and right shoulder pain. Assignor was purportedly referred to Cohen and Kramer, MD PC and was examined by Dr. Jeffrey Cohen on with respect to right knee and right shoulder pain. Dr. Jeffrey Cohen examined assignor on 3/16/17 at which time he offered assignor lidocaine injections to the right shoulder and right knee. That day both injections were performed. The injections were said to have been tolerated well and helpful. That day assignor was scheduled for right shoulder arthroscopy on 3/20/17, 4 days thereafter. According to Dr. Cohen, Assignor had undergone a right shoulder MRI on 3/11/17 that revealed impingement, bursitis and tendinitis. Assignor returned on 3/20/17 for the surgery which was performed by Dr. Mark Kramer at applicant's facility. According to Dr. Kramer's operative report, the surgery was performed to rule out a rotator cuff tear of labral tear. This diagnosis appears nowhere in the 3/16/17 report of Dr. Cohen. There is no evidence that Dr. Kramer had seen the assignor prior to the surgery as assignor appears to have been examined and treated initially by Dr. Kramer's partner, Dr. Cohen. No therapy records have been provided for my review. No examination/evaluation records from the "local medical practitioner" have been provided. The only record pre-dating the 3/6/17 evaluation by Dr. Cohen is a 2/23/17 referral for physical therapy from "Smart Choice Medical."

Respondent insured the motor vehicle involved in the automobile accident. Under New York's Comprehensive Motor Vehicle Insurance Reparation Act (the "No-Fault Law"), New York Ins. Law §§ 5101 et seq., Respondent was obligated to reimburse the injured party (or its assignee) for all "reasonable and necessary expenses" and "medical expenses" arising from the use and operation of the insured vehicle. However, Respondent denied Applicant's claims based upon a peer review performed by Richard Weiss, M.D. opining that the resulting surgery and all related surgicial fees and post operative care was not medically necessary.

All denials were timely issued.

Applicant establishes "a prima facie showing of their entitlement to judgment as matter of law by submitting evidentiary proof that the prescribed statutory billing forms [setting forth the fact and the amount of the loss sustained] had been mailed and received and that payment of no-fault benefits were overdue." Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2d Dept. 2004).

Once Applicant has established a prima facie case the burden is on the insurer to prove the treatment was medically unnecessary. See, Citywide Social Work & Psychological Services, PLLC a/a/o Gloria Zhune v. Allstate Ins. Co., 8 Misc. 3d 1025A, 806 N.Y.S.2d 444 (App. Term 1st Dept. 2005); .A.B. Medical Services, PLLC v. Geico Ins. Co., 2 Misc. 3d 26, 773 N.Y.S.2d 773 (App Term 2nd & 11th Jud Dist 2003).

Neither the Insurance Law nor the Regulations provide a definition of "medical necessity." Over the years, various trial courts have struggled with the definition of "medical necessity." In 2001 the District Court in Nassau County defined "medical necessity" as serving a valid medical purpose.Sunrise Medical Imaging, P.C. a/a/o Patricia Downie v. Liberty Mutual Ins. Co. 2001 NY Slip op. 40091U, 2001 N.Y. Misc. Lexis 725 (Dist. Ct. Nassau Co. 2001).

"To find treatment or services are not medically necessary, it must first be reasonably shown by medical evidence, inconsideration of the patient's condition, circumstances, and best interest of the patient, that the treatment or services would be ineffective or that the insurer's preferred health care treatment or lack of treatment would lead to an equally good result." Fifth Ave. Pain Control Center a/a/o Gladys Quintero v. Allstate Ins. Co., 196 Misc. 2d 801, 766 N.Y.S.2d 748 (Civ. Ct. Queens Co. 2003). "A necessary medical expense under the No-Fault Act is one incurred for treatment, procedure, or service ordered by a qualified physician based on the physician's objectively reasonable belief that it will further the patient's diagnosis and treatment. The use of the treatment, procedure, or service must be warranted by the circumstances and its medical value be verified by credible and reliable evidence." Medical Expertise, P.C. a/a/o Irina oukha v. Trumbull Insurance Company, 196 Misc. 2d 389, 765 N.Y.S2d 171 (Civ. Ct. Queens Co. 2003). A similar approach was followed in Behavioral Diagnostics a/a/o Maria Arevalo v. Allstate Ins., 3 Mic3d 246, 246 N.Y.S.2d 178 (Civ. Ct. Kings Co. 2004)(Within the standard of care for accepted medical practice or the treating physician made a reasonable judgment the services would assist in formulating an accurate diagnosis and treatment plan.) Lastly, courts have used a standard for medical necessity based on "generally accepted medical/professional practice." Citywide Social Work & Psychological Services, PLLC a/a/o Tremayne Brow v. Travelers Indemnity Co., 3 Misc.3d 608, 777 N.Y.S.2d 241 (Civ. Ct. NY Co. 2004); See also, Expo Medical Supplies Inc. v. Clarendon Ins. Co., 12 Misc. 3d 1154A (Civ. Ct.Kings Co. 2006).

Respondent denied this service based upon the peer review of Dr. Richard Weiss. Dr. Weiss reviewed various records and determined it failed to meet the criteria for medical necessity as defined by the No-Fault Law and the medical community standards. Dr. Weiss, set forth a generally accepted medical practice and opined that the type of service billed for was inappropriate for reimbursement under the circumstances. Dr. Weiss

noted that there was insufficient documentation of conservative care prior to the surgery. He pointed out that injections were performed just 4 days prior, as of the initial consultation. The peer reviewer then integrated the facts of this case. Inasmuch as Dr. Weiss articulated what he believed to be the customary medical standard and illustrated using facts from the record how the disputed treatment deviated from said standard; I find that Respondent established, prima facie, a lack of medical necessity for the procedures now at issue.

Hence the burden shifted back to the claimant to refute the peer review and prove the necessity of the disputed testing. See, e.g., CPT Med. Servs., P.C. v. New York Cent. Mut. Fire Ins. Co., 2007 NY Slip Op 27526, 18 Misc.3d 87 (App. Term 1st Dept.); Eden Med., P.C. v. Progressive Cas. Ins. Co., 2008 NY Slip Op 51098(U), 19 Misc.3d 143(A) (App Term 2d & 11th Jud Dists., 2008); Bath Med. Supply, Inc. v. New York Cent. Mut. Fire Ins. Co., 2008 NY Slip Op 50347(U) (App. Term 2d Dept., Feb. 26, 2008) (since the provider failed to rebut peer review's showing of a lack of medical necessity, defendant was entitled to dismissal of complaint); Be Well Med. Supply, Inc. v. New York Cent. Mut. Fire Ins. Co., 2008 NY Slip Op 50346(U)(App. Term 2d Dept., Feb. 21, 2008) (inasmuch as the provider offered no medical evidence to rebut the insurer's peer review, insurer should have been granted summary judgment); A. Khodadadi Radiology, P .C. v. NY Cent. Mut. Fire Ins. Co., 2007 NY Slip Op 51342(U) (App Term 2d Dept.); West Tremont Med. Diagnostic, P.C. v. Geico Ins.

Co., 2006 NY Slip Op 51871 (U) (App Term 2d Dept.); S&M Supp. Inc. v. Peerless Ins. Co., 2004 WL 2979217, 2004 NY Slip Op 51683 (U) (App Term, 2nd & 11th Jud Dists 2004); Amaze Medical Supply v. Eagle Ins. Co., 2 Misc.3d 128(A), 2003 NY Slip Op 51701(U) (App. Term 2d Dept., Dec. 24, 2003); Damadian MRI In Elmhurst v. Liberty Mut. Ins. Co., 2003 NY Slip Op 51700(U) (App. Term 2d Dept., Dec. 24, 2003) ("a provider's proof of a properly-completed claim…shift(s) the burden to the insurer who…may rebut the inference by proof…establishing that the health benefits were not medically necessary", which, "(i)f not refuted by the no-fault benefits claimant, such proof may entitle the insurer to summary judgment").

In order for an applicant to prove that the disputed expense was medically necessary, it must meaningfully refer to, or rebut, the conclusions set forth in the peer review. High Quality Medical, P.C. v. Mercury Ins. Co., 2010 N.Y. Slip Op. 50447(U) (App Term 2d, 11th & 13th Dists. Mar. 10, 2010);Pan Chiropractic, P.C. v. Mercury Ins. Co., 24 Misc.3d 136(A), 2009 N.Y. Slip Op. 51495(U) (App Term 2d, 11th & 13th Dists. July 9, 2009). A letter of medical necessity sworn to by a provider who had examined assignor, along with other medical documentation, may be sufficient to rebut the peer review and establish the medical necessity of the services rendered. See Quality Psychological Servs., P.C. v. Mercury Ins. Group, 2010 NY Slip Op 50601(U) (App Term 2d Dept., April 2, 2010).

In response to Dr. Weiss' peer review, applicant offers the rebuttal of Dr. Mark Kramer. There are a number of inconsistencies, inadvertent or otherwise, in Dr. Kramer's rebuttal which compels the arbitrator to question the credibility of the rebuttal itself. At the outset, Dr. Kramer refers to assignor throughout his records as a 49 year old male, yet he

appears to have been 39 year old. While perhaps a de minimis, it must be considered in connection with other mistakes/ misstatements made in the rebuttal. In this regard, the record is clear that Dr. Cohen saw assignor on 3/16/17 and Dr. Kramer never examined assignor prior to 3/20/17, the date of the surgery. In his rebuttal, however, Dr. Kramer states that assignor presented to him (Dr. Kramer) on 3/16/17 for a consult at which time "he" (Dr. Kramer) offered him the option of injections to which assignor consented. Dr. Kramer goes on to state that assignor returned for a follow-up examination on 3/20/17 at which time he opted to proceed with surgery. However, this oddly contradicts Dr. Cohen's report of 3/16/17 which makes it abundantly clear that surgery was scheduled as of the initial visit. Assignor did not return for a re-evaluation on 3/20/17. He was never re-examined. He returned for surgery which was scheduled the very day he was initially examined after he had been given a lidocaine injection. As aptly pointed out by Dr. Weiss, there is no evidence to establish that any conservative care was attempted. I note that lidocaine injections were given to assignor on 3/16/17 and, without seeking a determination of the efficacy thereof, that very day assignor was scheduled to undergo surgery 4 days thereafter. Quite frankly, there is an utter dearth of pre-surgical medical documentation to substantiate the need for the arthroscopy at the time it was recommended and performed. The Record is totally devoid of any proof that conservative measures were undertaken prior to surgery.

After careful review of the record, I find that Applicant has failed to sufficiently rebut Dr. Weiss's peer review with respect to the services provided.

Accordingly, Applicant's claims are denied.

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 claim is DENIED in its entirety

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of New York
SS :
County of Queens

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

11/29/2018
(Dated)

Stacey Charkey

**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:**
a4c2612102477a460c1da5d773aed64c

**Electronically Signed**

Your name: Stacey Charkey
Signed on: 11/29/2018