

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Ambulatory Anesthesia, PC  
(Applicant)

- and -

Allstate Property and Casualty Insurance  
Company  
(Respondent)

AAA Case No. 17-19-1116-4913

Applicant's File No. NF 29551

Insurer's Claim File No. 0503717662  
2CT

NAIC No. 17230

**ARBITRATION AWARD**

I, Kevin R. Glynn, 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 12/19/2019  
Declared closed by the arbitrator on 12/19/2019

Michael Manfredi, Esq. from Law Office of Thomas Tona P.C participated in person for the Applicant

James McNamara, Esq. from Allstate Property and Casualty Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 270.10**, was NOT AMENDED at the oral hearing.  
Stipulations WERE made by the parties regarding the issues to be determined.

Respondent stipulated that Applicant established a prima facie case and Applicant stipulated that Respondent issued a timely denial. Both parties stipulated that the amount in dispute is in compliance with the appropriate fee schedule.

3. Summary of Issues in Dispute

The Assignor, AV, a 64yo male driver, was injured in a motor vehicle accident on 5/25/18. AV suffered injuries which resulted in his seeking treatment. In dispute is Applicant's claim for anesthesia (01400 P2) provided during a right knee arthroscopic

surgery performed on 11/9/18, in the total amount of \$270.10. The claim was denied as not medically necessary based on peer review report by Dr. Raghava R. Polavarapu, M.D., dated 12/21/18. Therefore, the issue to be determined is the medical necessity of the surgery.

#### 4. Findings, Conclusions, and Basis Therefor

This case was decided based upon the submissions of the Parties as contained in the electronic file maintained by the American Arbitration Association, and the oral arguments of the parties' representatives. There were no witnesses. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon. Only the arguments presented at the hearing are preserved in this decision; all other arguments not presented at the hearing are considered waived. Applicant submitted a rebuttal report in the related hearing under AAA Case No.: 17-19-1116-4910, which was heard on the same date as hearing. As Respondent had an opportunity to review and discuss that report in the related matter it is being admitted into evidence herein and will be considered in this award.

To support a lack of medical necessity defense Respondent must "set forth a factual basis and medical rationale for the peer reviewer's determination that there was a lack of medical necessity for the services rendered." See Provvedere, Inc. v. Republic Western Ins. Co., 2014 NY Slip Op 50219(U) (App. Term 2, 11 and 13 Jud. Dists. 2014). Respondent bears the burden of production in support of its lack of medical necessity defense, which if established shifts the burden of persuasion to Applicant. See generally, Bronx Expert Radiology, P.C. v. Travelers Ins. Co. 2006 NY Slip Op 52116 (App Term 1<sup>st</sup> Dept. 2006). The Appellate Courts have not clearly defined what satisfies this standard except to the extent that "bald assertions" are insufficient. Amherst Medical Supply, LLC v. A Central Ins. Co., 2013 NY Slip Op 51800(U) (App. Term 1<sup>st</sup> Dept. 2013). To meet the burden of persuasion regarding medical necessity - in the absence of factually contradictory records - the applicant must submit a rebuttal which meaningfully refers to and rebuts the assertions set forth in the peer review report. See generally, Pan Chiropractic, P.C. v Mercury Ins. Co., 24 Misc 3d 136[A], 2009 NY Slip Op 51495[U] [App Term, 2d, 11th & 13th Jud Dists 2009].

Respondent's evidence established that the bill was timely denied pursuant to a peer review report by Dr. Raghava R. Polavarapu, M.D., dated 12/21/18. After listing the medical records he reviewed and presenting a clinical history of the Assignor, Dr. Polavarapu opines:

A causally related medical necessity for the right knee arthroscopy has not been substantiated. The claimant was seen on two occasions by this evaluator at which time there was no resolution noted to the right knee injury with an impression of a resolving sprains/ strain noted. On 7/23/18, he was seen for an initial consultation with Dr. Mirza complaining of right knee pain and there was a

positive patellar grind test reported. He was provided with a cortisone injection. There was a fluoroscopically guided right knee arthrogram performed on 8/3/18 noting interstitial edema of the anterior horn lateral meniscus with degeneration, no evidence of displaced meniscal tear and patellar tendinopathy. On 7/6/18, Mr. [AV] was seen for an MRI of the right knee which

reportedly demonstrated patellofemoral cartilage defects with joint effusion and synovitis, posterior cruciate ligament tendinopathy with partial tear and anterior cruciate ligament mucoid change with partial tear. There was no medical necessity substantiated following the standard of care noting the mechanism of injury, subjective and objective findings, and imaging. In the adult population, treatment is primarily nonsurgical. "Treatment options for meniscal tears fall into three broad categories; non-operative, meniscectomy or meniscal repair. Selecting the most appropriate treatment for a given patient involves both patient factors (e.g., age, co-morbidities and compliance) and tear characteristics (e.g., location of tear/ age/ reducibility of tear). There is evidence suggesting that degenerative tears in older patients without mechanical symptoms can be effectively treated non-operatively with a structured physical therapy program as a first line. Even if these patients later require meniscectomy, they will still achieve similar functional outcomes than if they had initially been treated surgically. Partial meniscectomy is suitable for symptomatic tears not amenable to repair and can still preserve meniscal function especially when the peripheral meniscal rim is intact. Meniscal repair shows 80% success at 2 years and is more suitable in younger patients with reducible tears that are peripheral (e.g., nearer the capsular attachment) and horizontal or longitudinal in nature. However, careful patient selection and repair technique is required with good compliance to post-operative rehabilitation, which often consists of bracing and non-weight bearing for 4-6 wk.

Owing to the long term complications associated with meniscectomy, as well as the recognition of the functional importance of the meniscus, there has been increasing interest in avoidance of meniscectomy where possible and meniscal repair has gained popularity." (World J Orthop. 2014 Jul 18; 5(3): 233-241) "Researchers from Finland found no significant difference in outcomes for patients with knee osteoarthritis following arthroscopic partial meniscectomy or sham surgery, according to a recently

published study. "In this trial involving patients without knee osteoarthritis but with symptoms of a degenerative medial meniscus tear, the outcomes after arthroscopic partial meniscectomy were no better than those after a sham surgical procedure," Raine Sihvonen, MD, and colleagues wrote in the abstract." (Sihvonen R. New Eng/J Med. 2013.) According to the AMA, "Medical Necessity" is defined as follows: "Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the convenience of the patient, physician, or other health care provider." (American Medical Association, 2011). The surgery performed was not medically necessary therefore, any derivative services, are also not medically necessary.

RECOMMENDATION: Based on the documentation submitted for review, a causally related medical necessity has not been established for the following:

11/9/18, North Shore Surgi-Center, ambul surg, 29880RT, 2987659RT, 2061059RT

11/9/18, Brian Slepian / Ambulatory Anesthesia, P.C., 01400 P2 x 10 units anesthesia time.

Respondent has presented a medical rationale and factual basis to support its defense of lack of medical necessity. Accordingly, the burden now shifts to Applicant, who bears the ultimate burden of persuasion. See, Bronx Expert, supra.

Applicant relies upon the rebuttal affirmation by Dr. Justin Mirza, D.O., dated 2/27/19. Dr. Mirza opines:

... In response to this, it should be noted that, my patient was asymptomatic prior to the subject MVA. The patient injured his right knee due to the subject motor vehicle accident. As documented in my medical report, the patient had complaint of persistent right knee pain medially and laterally. The pain was aggravated by extended walking and weather changes such as cold, rain and humidity. Examination of the right knee revealed tenderness over lateral joint with decreased range of motion as well as positive Patella Grind Test and McMurray's test. The patient was diagnosed with tear of medial meniscus current injury, right knee, initial encounter. Also, MRI

revealed patellofemoral cartilage defects with joint effusion and synovitis, posterior cruciate ligament tendinopathy with partial tear and anterior cruciate ligament mucoid change with partial tear. My patient was asymptomatic prior to the subject MVA. Here, my patient suffered a tear due to the subject motor vehicle accident. The injuries sustained were not at all pre-existing and in fact the surgery corrected the tear that was as a result of the motor vehicle accident and not due to pre-existing deficits. However, it had been six months since the accident and my patient continued to have pain in the right knee with tenderness, decreased range of motion as well as positive orthopedic test. The peer doctor's statement is incorrect and completely speculative. It should be noted that any exacerbation of injury is covered by No-Fault and still, the peer doctor failed to refer to a prior MRI to show that these injuries were not related to motor vehicle accident.

Further, as per Knee arthroscopic surgery: Knee arthroscopic surgery is a procedure performed through small incisions in the skin to repair injuries to tissues such as ligaments, cartilage, or bone within the knee joint area. The surgery is conducted with the aid of an arthroscope, which is a very small instrument guided by a lighted scope attached to a television monitor. Other instruments are inserted through three incisions around the knee. Arthroscopic surgeries range from minor procedures such as flushing or smoothing out bone surfaces or tissue fragments (lavage and debridement) associated with osteoarthritis, to the realignment of a dislocated knee and ligament grafting surgeries. The range of surgeries represents very different procedures, risks, and aftercare requirements.

While the clear advantages of arthroscopic surgery lie in surgery with less anesthetic, less cutting, and less recovery time, this surgery nonetheless requires a very thorough examination of the causes of knee injury or pain prior to a decision for surgery.

Purpose: There are many procedures that currently fall under the general surgical category of knee arthroscopy. They fall into roughly two groups-acute injuries that destabilize the knee, and pain management for floating or displaced cartilage and rough bone. Acute injuries are usually the result of traumatic injury to the knee tissues such as ligaments and cartilage through accidents, sports movements, and some overuse causes. Acute injuries

involve damage to the mechanical features, including ligaments and patella of the knee. These injuries can result in knee instability, severe knee dislocations, and complete lack of knee mobility. Ligament, tendon, and patella placements are key elements of the surgery. The type of treatment for acute injuries depends in large part on a strict grading system that rates the injury. For instance, grades I and II call for rest, support by crutches or leg brace, pain management, and rehabilitation. Grades III and IV indicate the need for surgery. Acute injuries to the four stabilizing ligaments of the knee joint-the anterior cruciate ligament (ACL), the posterior cruciate ligament (PCL), the medial collateral ligament (MCL), and the lateral collateral ligament (LCL)-as well as to the "tracking," or seating of the patella, can be highly debilitating.

Treatment of these acute injuries include such common surgeries as:

Repairs of a torn ligament or reconstruction of the ligament.

Release of a maligned kneecap. This involves tendon surgery to release and fit the patella better into its groove.

Grafts to ligaments to support smoother tracking of the knee with the femur. (Please see: <http://www.surgeryencyclopedia.com/Fi-LaJKnee-ArthroscopicSurgery-ht>

Furthermore, as per the Arthroscopic Meniscus Repair, Surgical Options for Torn Meniscus: Meniscus tears can be treated by meniscus removal (meniscectomy), meniscus repair, or in unusual circumstances, meniscus replacement. Since the goal of surgery is to preserve healthy meniscus, meniscus repair is attempted when the tear is repairable. Meniscectomy, removal of the damaged meniscus tissue, has good short-term results but leads to the development of arthritis ten to twenty years later. Meniscus repair also has good results but has a longer recovery time than meniscectomy and is limited to tears which are amenable to repair. Meniscus replacement is considered for young, active patients who have previously had most of their meniscus removed and develop pain in the area without having advanced degenerative changes to the articular (gliding surface) cartilage. Possible benefits of arthroscopic meniscus repair: The meniscus is an important structure for load transmission and shock absorption in the knee. The knee is subjected to up to 5 times body weight during activity, and half this force is transmitted through the meniscus with the knee straight,

and 85% of the force goes through the meniscus with the knee bent ninety degrees. Loss of the meniscus increases the pressure on the articular (gliding) cartilage, which leads to degenerative changes. A successful meniscus repair preserves meniscus tissue and mitigates these changes. (Please see: <http://www.orthop.washington.edu/?q=patient-care/articles/sports/arthroscopic-m>

The surgery was appropriate as per Workers Compensation Guideline and medically necessary as he clearly fits within these guidelines.

According to the AMA definition of "Medically Necessary" or "Medical Necessity" shall mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury disease or its symptoms, and that are a) in accordance with generally accepted standards of medical practice; b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and c) not primarily for the convenience of the patient, physician or other health care provider.

I find the rebuttal report more persuasive than the peer report; I find that it meaningfully rebutted the opinion by Dr. Polavarapu, and by a preponderance of the evidence has established the medical necessity of the claim.

As such, Applicant is awarded reimbursement of its claim in the amount of \$270.10.

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
	Ambulatory Anesthesia, PC	11/09/18 - 11/09/18	\$270.10	Awarded: \$270.10
Total			\$270.10	Awarded: \$270.10

- B. The insurer shall also compute and pay the applicant interest set forth below. 01/02/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

In the instant matter Applicant is awarded interest pursuant to the no-fault regulations. 11 NYCRR 65-3.9 (a) provides that Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30 day month." Pursuant to 11 NYCRR 65-3.9 (c) provides that "if 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 Department of Financial Services regulations, interest shall not accumulate on the disputed claim or element of claim until such action is taken." Based upon the record, Applicant's claims were received by Respondent on 12/3/18 and was denied on 12/27/18. Applicant electronically submitted its claim to arbitration on 1/9/19, within 30 days of the denial. As applicant requested arbitration within 30 days of receipt of the denial, interest does not toll. Interest shall run effective 1/2/19, which is 30 days after proof of claim was received by the insurer.

C. Attorney's Fees

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

An attorney's fee of 20% shall be paid on the sum of the awarded claim plus interest, subject to a maximum of \$1,360.00.



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

01/21/2020

(Dated)

Kevin R. Glynn

#### **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:**  
5e560126349dc3e5a471e71d52681623

### **Electronically Signed**

Your name: Kevin R. Glynn  
Signed on: 01/21/2020