

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Progressive-Hudson Anesthesia LLC
(Applicant)

- and -

American Transit Insurance Company
(Respondent)

AAA Case No. 17-19-1141-6715

Applicant's File No. NA

Insurer's Claim File No. 679924-06

NAIC No. 16616

ARBITRATION AWARD

I, Aaron Maslow, 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 ["JS"]

1. Hearing(s) held on 03/16/2020
Declared closed by the arbitrator on 03/16/2020

Justyn Verzillo, Esq., from La Sorsa & Beneventano Esqs participated by telephone for the Applicant

Jacob Lamar, Esq., from Daniel J. Tucker, P.C. participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 4,964.00**, was NOT AMENDED at the oral hearing.
Stipulations WERE made by the parties regarding the issues to be determined.

The parties stipulated that Applicant established a prima facie case of entitlement to No-Fault compensation with respect to its bill. They also stipulated that Respondent's Form NF-10 denial of claim form was timely issued, i.e., within the 30-day deadline prescribed by Insurance Law §5106(a) and 11 NYCRR 65-3.8(a)(1). Additionally, they stipulated that should Applicant prevail, interest would accrue as of the date that the American Arbitration Association received Applicant's arbitration request.

3. Summary of Issues in Dispute

- Whether Applicant established entitlement to No-Fault insurance compensation for anesthesia services provided to Assignor when he underwent right shoulder arthroscopic surgery
- Whether fees were not in accordance with fee schedule
- Whether Respondent made out a prima facie case of lack of medical necessity for the shoulder surgery and, if so, whether Applicant rebutted it

4. Findings, Conclusions, and Basis Therefor

Appearances

For Applicant:

La Sorsa & Beneventano Esqs.
3 Barker Avenue
White Plains, NY 10601
By: Justyn Verzillo, Esq.

For Respondent:

Daniel J. Tucker, P.C.
One Metro Tech Center
7th floor
Brooklyn, NY 11201
By: Jacob Lamar, Esq.

Applicant commenced this New York No-Fault insurance arbitration, seeking as compensation \$4,964.00 which it billed for performing anesthesia services on Aug. 23, 2017, when Assignor underwent right shoulder arthroscopic surgery. Assignor was a 21-year-old male who was injured in a motor vehicle accident on May 17, 2017. Respondent denied payment on several grounds: fees not in accordance with fee schedule, lack of medical necessity for the shoulder surgery, and lack of proximate causation. At the hearing, Respondent stated that it was still asserting that the fee charged was excessive although it did not submit a fee analysis. It was not pursuing lack of proximate causation but it was asserting lack of medical necessity.

This arbitration was organized by the American Arbitration Association, which has been designated by the New York State Department of Financial Services to coordinate the mandatory arbitration provisions of Insurance Law § 5106(b), which provides:

Every insurer shall provide a claimant with the option of submitting any dispute involving the insurer's liability to pay first party ["No-Fault insurance"] benefits, or additional first party benefits, the

amount thereof or any other matter which may arise pursuant to subsection (a) of this section to arbitration pursuant to simplified procedures to be promulgated or approved by the superintendent.

Both parties appeared at the telephone hearing by counsel, who presented oral argument and relied upon documentary submissions. I have reviewed the submissions' documents contained in the American Arbitration Association's ADR Center as of the date of the hearing, said submissions constituting the record in this case.

The parties stipulated that Applicant established a prima facie case of entitlement to No-Fault compensation with respect to its bill. They also stipulated that Respondent's Form NF-10 denial of claim form was timely issued, i.e., within the 30-day deadline prescribed by Insurance Law §5106(a) and 11 NYCRR 65-3.8(a)(1).

Since Respondent's denial was timely, it was within its rights to assert lack of medical necessity as a defense. Liberty Queens Medical, P.C. v. Liberty Mutual Insurance Co., 2002 WL 31108069 (App. Term 2d & 11th Dists. June 27, 2002); cf. Country-Wide Insurance Co. v. Zablocki, 257 A.D.2d 506 (1st Dept. 1999). "The no-fault law defines 'basic economic loss,' for which accident victims are entitled to reimbursement up to \$50,000, as '[a]ll *necessary* expenses incurred for: (i) medical, hospital ... surgical, nursing, dental, ambulance, x-ray, prescription drug and prosthetic services' (Insurance Law § 5102[a][1] [emphasis added]). Like the statute, the regulations promulgated thereunder expressly state that reimbursable medical expenses consist of '*necessary* expenses' (11 NYCRR 65-1-1 [emphasis added])." Long Island Radiology v. Allstate Ins. Co., 36 A.D.3d 763, 765 (2d Dept. 2007).

A peer review report relied upon by an insurer in timely denying a claim is a proper vehicle to assert the defense of lack of medical necessity. S & M Supply, Inc. v. Allstate Ins. Co., 2003 N.Y. Slip Op. 51191(U) (App. Term 2d & 11th Dists. July 9, 2003); Rockaway Boulevard Medical P.C. v. Travelers Property Casualty Corp., 2003 N.Y. Slip Op. 50842(U) (App. Term 2d & 11th Dists. Apr. 1, 2003). In fact, without a peer review, a defense of lack of medical necessity at the litigation stage cannot survive. See A.B. Medical Services PLLC v. Lumbermens Mutual Casualty Co., 4 Misc.3d 86 (App. Term 2d Dept. 2004).

A peer reviewer must establish a factual basis and medical rationale for his asserted lack of medical necessity of the health care provider's services. See Amaze Medical Supply Inc. v. Allstate Ins. Co., 12 Misc.3d 142(A), 2006 N.Y. Slip Op. 51412(U) (App. Term 2d & 11th Dists. July 12, 2006); Prime Psychological Services, P.C. v. Progressive Casualty Ins. Co., 24 Misc.3d 1244(A), 2009 N.Y. Slip Op. 51868(U) at 3 (Civ. Ct. Richmond Co., Katherine A. Levine, J., Aug. 5, 2009); A.M. Medical Services, P.C. v. Deerbrook Ins. Co., 18 Misc.3d 1139(A), 2008 N.Y. Slip Op. 50368(U) (Civ. Ct. Kings Co., Sylvia G. Ash, J., Feb. 25, 2008).

"A no-fault insurer defending a denial of first-party benefits on the ground that the billed-for services were not 'medically necessary' must at least show that the services were inconsistent with generally accepted medical / professional practice. The opinion of the insurer's expert, standing alone, is insufficient to carry the insurer's burden of proving that the services were not 'medically necessary'." CityWide Social Work & Psy. Serv., P.L.L.C. v. Travelers Indemnity Co., 3 Misc.3d 608, 609 (Civ. Ct. Kings Co. 2004). "Generally accepted practice is that range of practice that the profession will follow in the diagnosis and treatment of patients in light of the standards and values that define its calling." Id. at 616; accord, Prime Psychological Services, P.C. v. Progressive Casualty Ins. Co., supra; Millennium Radiology, P.C. v. New York Central Mutual Fire Ins. Co., 23 Misc.3d 1121(A), 2009 N.Y. Slip Op. 50877(U) (Civ. Ct. Richmond Co., Katherine A. Levine, J., Apr. 30, 2009). Without a recitation to generally accepted medical practice, a peer reviewer's opinion is simply a different professional judgment which, in and of itself, does not establish that the disputed services were medically unnecessary to treat the injured person's condition.

If the peer review satisfies these standards, it becomes incumbent on the claimant to rebut the peer review. See Be Well Medical Supply, Inc. v. New York Cent. Mut. Fire Ins. Co., 18 Misc.3d 139(A), 2008 N.Y. Slip Op. 50346(U) (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 N.Y. Slip Op. 51342(U) (App. Term 2d & 11th Dists. July 3, 2007), because the ultimate burden of proof on the issue of medical necessity lies with the claimant. Dayan v. Allstate Ins. Co., 49 Misc.3d 151(A), 2015 N.Y. Slip Op. 51751(U) (App. Term 2d, 11th & 13th Dists. Nov. 30, 2015); Park Slope Medical and Surgical Supply, Inc. v. Travelers Ins. Co., 37 Misc.3d 19, 22 n. (App. Term 2d, 11th & 13th Dists. 2012).

"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. 51871(U) at 2 (App. Term 2d & 11th Dists. Sept. 29, 2006). Thus, although Respondent must come forward with prima facie proof of lack of medical necessity, the burden will shift to Applicant to prove medical necessity by a preponderance of the credible evidence if Respondent meets its burden.

Respondent relied upon a peer review by Dr. Robert R. Karpman to support its defense that the underlying right shoulder surgery was not medically necessary. At the outset, Dr. Karpman listed the services he was to opine on, including the subject right shoulder surgery. He listed the various medical records pertaining to Assignor's post-accident treatment which he reviewed. He noted that Assignor was involved in a motor vehicle accident on May 17, 2017. He was examined on May 19, 2017, and then started on physical therapy treatment. An MRI of the right shoulder was performed on Aug. 1, 2017. Assignor was evaluated by Dr. Richard Pearl on Aug. 3, 2017. He complained to Dr. Pearl of right shoulder pain. "At that

time, physical examination of the right shoulder revealed no indications of swelling or joint tenderness and range of motion was decreased. Impingement signs were positive and no other special tests for the shoulder such as drop arm, apprehension and/or O'Brien's were performed. No evidence of effusion, crepitus or instability was documented. After the visit on 08/03/17, the surgery of the right shoulder was indicated by Dr. Pearl." Dr. Karpman continued by noting that the MRI did not reveal a full thickness tear or labral tear.

Dr. Karpman wrote that there was not an adequate period of conservative treatment prior to consideration of surgery. He opined that the right shoulder surgery was not medically necessary. Any derivative services related to the surgery were therefore not medically necessary.

As noted above, a peer review requires a factual basis and a medical rationale. The medical records reviewed formed the factual basis. While Dr. Karpman did not state explicitly that he applied generally accepted medical practice, he did cite to the American Medical Association's definition of medical necessity, which is that services be those that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating a condition in a manner which is (1) in accordance with generally accepted standards of medical practice, (2) clinically appropriate in terms of type, frequency, extent, site, and duration, and (3) not primarily for the convenience of the patient, physician, or other health care provider. Since the AMA definition of medical necessity incorporated the factor that the services be in accordance with generally accepted standards of medical practice, Dr. Karpman did imply that he took into account generally accepted medical practice. As such, the peer review made out a prima facie case of lack of medical necessity for the shoulder surgery.

Applicant did not submit a formal rebuttal. At the hearing, Applicant argued that the Aug. 23, 2017 operative report rebutted the peer review because the former contained a statement from Dr. Pearl that Assignor failed a course of nonoperative therapy. I have reviewed the physical therapy notes. While they reflect Assignor's complaining about right shoulder pain, they do not indicate that PT was performed on the right shoulder. I find that Applicant has not refuted Dr. Karpman's salient point that there was insufficient conservative treatment.

On balance, I find Dr. Karpman's peer review more credible and persuasive than Applicant's evidence. I find that the subject right shoulder surgery was not medically necessary. Therefore the anesthesia at issue was not medically necessary. If surgery is not medically necessary, then by extension there is a lack of medical necessity for derivative services. See Matter of Global Liberty Ins. Co. v. Medco Tech, Inc., 170 A.D.3d 558 (1st Dept. 2019) (arbitration award sustaining compensation for derivative services vacated when evidence established surgery not necessary); New Horizon Surgical Center, L.L.C. v. Allstate Ins. Co., 52 Misc.3d 139(A2016 N.Y. Slip Op. 51124(U) (App. Term 2d, 11th & 13th Dists. July 13, 2016).

I sustain Respondent's defense of lack of medical necessity. Said defense overcomes Applicant's prima facie case of entailment to No-Fault compensation. Any fee issues are academic. The within arbitration claim is denied in its entirety.

This arbitrator has not made a determination that benefits provided for under Article 51 (the No-Fault statute) of the Insurance Law are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of Assignor. As such and in accordance with the provisions of the prescribed NYS Form NF-AOB (the assignment of benefits), Applicant health provider shall not pursue payment directly from Assignor for services which were the subject of this arbitration, notwithstanding any other agreement to the contrary.

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 Kings

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

03/17/2020
(Dated)

Aaron Maslow

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:
c3f253fc188496e6df92834a55e65626

Electronically Signed

Your name: Aaron Maslow
Signed on: 03/17/2020