

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Queens Arthroscopy & Sports Medicine PC
(Applicant)

- and -

State Farm Mutual Automobile Insurance
Company
(Respondent)

AAA Case No. 17-20-1160-8604

Applicant's File No. 00060809

Insurer's Claim File No. 32-C120-8HO

NAIC No. 25178

ARBITRATION AWARD

I, Corinne Pascariu, 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 09/03/2021
Declared closed by the arbitrator on 09/03/2021

Rachel Drachman, Esq. from Drachman Katz, LLP participated in person for the Applicant

Ann Henriksen, Esq. from Goldberg, Miller and Rubin, P.C. participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 6,820.81**, was NOT AMENDED at the oral hearing.
Stipulations WERE NOT made by the parties regarding the issues to be determined.
3. Summary of Issues in Dispute

Background

The Assignor is a male who was 42-year-old when he was injured as the driver of a motor vehicle involved in an accident on November 6, 2019. On November 14, 2019, he presented to Dr. Madhu Babu Boppana for an evaluation. Thereafter he commenced conservative treatment, including physical therapy. On December 19, 2019, assignor presented to Laximar Diwan, M.D. for a diagnostic arthroscopy of his right knee, which was denied based upon a peer review by Jimmy Lim, M.D. dated January 26, 2020. Applicant seeks \$6820.81 for the fees associated with the arthroscopy. Respondent also

asserts that the amount billed by Applicant for the procedure exceeds the reimbursable rate under the fee schedule.

Issue

Whether Respondent can establish that the surgery was not medically necessary. If not, whether Respondent can establish that Applicant billed in excess of the permissible reimbursable rate under the New York State Worker's Compensation fee schedule.â

4. Findings, Conclusions, and Basis Therefor

The case was decided on the submissions of the parties as contained in the ADR Center maintained by the American Arbitration Association and the oral arguments of the parties' representatives. There were no witnesses. I reviewed the documents contained in the file for both parties and make my decision in reliance thereon.

To receive payment of a claim, Applicant "need only file a 'proof of claim' (11 NYCRR 65.11(k)(3)), and the insurers are obliged to honor it promptly or suffer the statutory penalties." Dermatossian v. New York City Transit Authority, 67 N.Y.2d 219, 224, 501 N.Y.S.2d 784, 787 (1986). Furthermore, the No-Fault law requires a carrier to either pay or deny a claim for No-Fault benefits within thirty (30) days from the date an applicant supplies proof of claim. See, Insurance Law §5106 (a) and 11 NYCRR 65-3.8. I find that Applicant established a prima facie case of entitlement to reimbursement of its claim, by submitting evidence that the prescribed statutory billing form was mailed and received and that the Respondent failed to either pay or deny the claim within the requisite 30-day period. Viviane Etienne Medical Care, P.C. v. Country-Wide Ins. Co., 25 N.Y.3d 498, 14 N.Y.S.3d 283 (2015); Mary Immaculate Hospital v. Allstate Insurance Co., 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004).

Respondent's denial was timely issued.

Medical Necessity:

To meet its burden, at a minimum, the No-Fault insurer must establish a factual basis and medical rationale for its asserted lack of medical necessity of the health care provider's services. A.M. Medical Services, P.C. v. Deerbrook Ins. Co., 18 Misc.3d 1139(A), 859 N.Y.S.2d 892 (Table), 2008 N.Y. Slip Op. 50368(U), 2008 WL 518022 (Civ. Ct. Kings Co., Sylvia G. Ash, J., Feb. 25, 2008).

The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment, Kingsbrook Jewish Medical Center v. Allstate Ins. Co., 61 A.D.3d 13, 871 N.Y.S.2d 680 (2d Dept. 2009), such as by a qualified expert performing an independent medical examination or conducting a peer review of the injured person's treatment. See Rockaway Boulevard Medical P.C. v. Travelers Property Casualty Corp., 2003 N.Y. Slip Op. 50842(U), 2003 WL 21049583 (App. Term 2d & 11th Dists. Apr. 1, 2003).

The appellate courts have not clearly defined what satisfies the insurer's evidentiary standard except to the extent that "bald assertions" are insufficient. Amherst Medical Supply, LLC v. A Central Ins. Co., 41 Misc.3d 133(A), 981 N.Y.S.2d 633 (Table), 2013 NY Slip Op 51800(U), 2013 WL 5861523 (App. Term 1st Dept. Oct. 30, 2013). However, there are myriad civil court decisions tackling the issue of what constitutes a "factual basis and medical rationale" sufficient to establish a lack of medical necessity.

The civil courts have held that a defendant's peer review or medical evidence must set forth more than just a basic recitation of the expert's opinion. The trial courts have held that a peer review report's medical rationale will be insufficient to meet respondent's burden of proof if: 1) the medical rationale of its expert witness is not supported by evidence of a deviation from "generally accepted medical" standards; 2) the expert fails to cite to medical authority, standard, or generally accepted medical practice as a medical rationale for his findings; and 3) the peer review report fails to provide specifics as to the claim at issue, is conclusory or vague. See generally Nir v. Allstate Ins. Co., 7 Misc.3d 544, 547, 796 N.Y.S.2d 857, 860 (Civ. Ct. Kings Co. 2005); see also All Boro Psychological Servs. P.C. v. GEICO, 34 Misc.3d 1219(A), 950 N.Y.S.2d 490 (Table), 2012 NY Slip Op 50137(U), 2012 WL 309328 (Civ. Ct. Kings Co., Reginald A. Boddie, J., Jan. 31, 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), 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). Assuming the insurer establishes a lack of medical necessity, it is ultimately the claimant who must prove, by a preponderance of the evidence, that the services or supplies were medically necessary. Dayan v. Allstate Ins. Co., 49 Misc.3d 151(A), 29 N.Y.S.3d 846 (Table), 2015 N.Y. Slip Op. 51751(U), 2015 WL 7900115 (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., 952 N.Y.S.2d 372, 374 n. (App. Term 2d, 11th & 13th Dists. 2012).

Peer Review by Jimmy Lim, M.D.â

In support of its contention that the arthroscopic surgery was not medically necessary, Respondent relies upon the peer review report of Dr. Lim dated January 26, 2020. Dr. Lim reviewed assignor's records and MRI imaging and opined that the arthroscopic surgery was neither medically necessary nor causally related to the underlying accident. He notes that assignor first presented to Dr. Boppana on November 14, 2019. His knees were not at examined at that evaluation, but he was referred for a right knee MRI and conservative treatment including physical therapy. On December 3, 2019, Dr. Boppana ordered an orthosis for assignor's right knee. Dr. Lim indicates that there was no reevaluation by Dr. Boppana prior to the arthroscopy and underscores that there was no documentation of a thorough history and orthopedic evaluation by Dr. Diwan establishing the necessity for the surgical intervention six weeks post injury. There was, however, a brief preoperative orthopedic examination at the surgical facility. Dr. Lim goes on to provide an overview of the operative report and diagnoses. He concludes that the arthroscopy was not medically necessary. He opines that the clinical findings shown on the imaging studies do not correlate with Dr. Diwan's examination findings in support of the requested procedure. The treatment was not related to the injuries or conditions diagnosed and documented in the clinical records. Based on the right knee MRI the diagnosed injuries were anterior cruciate ligament and medial collateral ligament sprain, productive changes of the right compartment, mucoid changes involving the posterior horn of the medial meniscus, degenerative tendinopathy of the quadriceps and patellar tendons and deep infrapatellar bursitis. The sprains of the anterior cruciate ligament and medial collateral ligament are inconsistent with the accident history. The productive and mucoid changes revealed on the right knee MRI were age/wear and tear related and preexisted the date of loss. Dr. Lim goes on to argue that Dr. Boppana nor Dr. Diwan performed a thorough history and examination of assignor and he did not undergo a sufficient amount of conservative treatment prior to the procedure.

I find that Dr. Lim's peer report meets the burden of proof. The reports contain a detailed and credible review of the record as well as the information maintained in the Assignor's medical records. It is based on his educated opinion of the arthroscopy conducted and explain when such a procedure is medically necessary. It clearly indicates the standard of care and cites to the medical authority upon which it is based. It also reference the patient, his history, his complaints of pain and clinical findings and contains a factual basis and medical rationale sufficient to establish a lack of medical necessity. In short, I find that Dr. Lim's analysis is persuasive and, accordingly, that the burden of proof shifted to the Applicant to establish that the arthroscopy was medically necessary.

"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).

Laxmidhar Diwan, M.D. and Medical Records

In support of its claim, Applicant submitted a rebuttal by Dr. Diwan, assignor's physician. Dr. Diwan provides an overview of evaluations of assignor. Based upon the evaluation findings which documented pain and limitations as well as a positive MRI results, he recommended the arthroscopy. Relying on several treatment guidelines, Dr. Diwan argues that the surgery was medically indicated because assignor continued to complain of unrelenting right knee pain and impaired functioning. He had already pursued extensive conservative treatment, including physical therapy and the use of NSAIDs which were insufficient and alleviating assignor's continued right knee pain. Therefore, the diagnostic arthroscopy was justified and necessary, as per the guidelines to properly diagnose and treat assignor's right knee joint problems. Finally, Dr. Diwan notes that it is not uncommon for a pre and post-operative diagnosis to be different. The preoperative diagnosis is based on a clinical evaluation and an MRI, but not actual observations. The operative diagnosis is a post-fact actual, direct observation. Here, the preoperative diagnosis was highly indicative of the need for surgery.

Findings

After careful review of the record, I find upon the evidence provided that Respondent set forth a medical rationale and factual basis for denying payment. Applicant has not successfully refuted Dr. Lim's peer review or established that the arthroscopy was within accepted medical practice. Dr. Diwan states that assignor had a sufficient amount of conservative treatment prior to the procedure. However, the records support Dr. Lim's argument that applicant did not. He did not even commence conservative therapy until three weeks before the accident. Dr. Diwan also fails to address Dr. Lim's assertion that assignor's knee pain was degenerative and unrelated to the accident. He makes a conclusory statement that the injuries were traumatic in nature and caused by the accident, but provides no reasoning for this assertion. In short, I find that Dr. Diwan's report fails to rebut Dr. Lim's peer. Accordingly, I find in favor of Respondent and deny this claim.

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 New Jersey, Bergen County

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

09/22/2021
(Dated)

Corinne Pascariu

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:
24cfd962681c8f927275081cd8176489

Electronically Signed

Your name: Corinne Pascariu
Signed on: 09/22/2021