

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Heidi Fyrberg P.A. P.C.
(Applicant)

- and -

Allstate Fire & Casualty Insurance Company
(Respondent)

AAA Case No.	17-20-1183-2001
Applicant's File No.	314744
Insurer's Claim File No.	0572655884 2NJ
NAIC No.	29688

ARBITRATION AWARD

I, James Hogan, 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: EIP

1. Hearing(s) held on 11/04/2021
Declared closed by the arbitrator on 11/04/2021

Neil Menashe from Neil Menashe Attorney at Law P.C. participated in person for the Applicant

Allison Lindsey from Law Offices Of Karen L. Lawrence participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 987.44**, was AMENDED and permitted by the arbitrator at the oral hearing.

At the hearing, Applicant amended the amount in controversy to \$423.63 to be in accordance with the fee schedule.

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

3. Summary of Issues in Dispute

The EIP, a 54 year old man, was injured in a collision on 12/22/19. This claim is for the services of the Applicant in assisting David Weissberg, MD in performing knee surgery to the EIP on 4/16/2020 and billed at a total of \$987.44. Respondent denied the Applicant's claim based upon a peer review.

4. Findings, Conclusions, and Basis Therefor

This decision is based upon my review of the electronic file maintained by the American Arbitration Association, and the arguments of the parties set forth in the hearing.

Applicant's submission:

Applicant is billing for services provided to the EIP on 4/16/2020:

Arthroscopy, knee, surgical with meniscectomy, including debridement, billed under CPT code 29880 at \$290.87.

Arthroscopy, knee, surgical; for infection, lavage and drainage billed under CPT code 29871 at \$100.00;

Arthroscopy, knee, surgical for removal of loose body or foreign body, billed under CPT code 29874 at \$202.45;

Arthroscopy, knee, surgical; synovectomy, limited billed under CPT code 29875 at \$202.45;

Arthroscopy, knee, surgical, debridement/shaving of articular cartilage, billed under CPT code 29877 at \$191.67.

The total amount of the Applicant billing was \$987.44.

As per the AR-1, Applicant billed \$987.44; Respondent paid \$0.00, leaving an amount in dispute of \$987.44. This amount was amended at the hearing.

Applicant has provided a copy of the Operative Report for left knee surgery performed by Dr. Weissberg, assisted by the Applicant on 4/16/2020.

Respondent's submission:

Respondent's position is that the Applicant's claim was properly denied based upon a peer review performed on 5/15/2020 by Regina O. Hillsman, MD, who determined that the surgery was not medically necessary.

On 5/19/2020, Respondent issued an NF-10 denying the Applicant's claim based upon the peer review by Dr. Hillsman.

Peer Review:

Regina O. Hillsman, MD, an orthopedic surgeon, performed a peer review on 5/15/2020.

The purpose of the peer review was to determine the medical necessity for services provided to the EIP as a result of the 12/22/19 accident. These services included those provided by David J Weissberg, MD, PC, for the left knee surgery performed on 4/16/2020 and billed at \$9,293.88.

In addition, those of Heidi Fryberg, PA, who assisted with the EIP's left knee surgery. Her billing totaled \$987.44.

There is a list of medical records that were reviewed. These include the initial orthopedic evaluation of the EIP by Dr. Weissberg on 2/27/2020.

Orthopedic follow-ups by Dr. Weissberg dated 4/9 and 4/24/2020.

The operative report dated 4/16/2020.

In addition, Dr. Hillsman reviewed copies of MRI reports for the EIP's left knee, left shoulder, right knee and cervical spine.

Dr. Hillsman summarizes the EIP's accident history noting that he sustained injuries to the neck, left shoulder and bilateral knees. The day after the accident he went to an urgent care.

On 1/9/2020, he was evaluated by Natalie Givargidze, NP, with complaints of left knee pain rated at 7/10. The pain was throbbing in nature. A Medrol pack was prescribed.

On 1/14/2020, the EIP was seen by Barry Kleeman, MD, for complaint of left knee pain. After the examination which included an x-ray, the diagnosis was left knee osteoarthritis with a dashboard injury. An MRI of the left he was ordered. Physical therapy was recommended.

The EIP had an MRI of the left knee on 1/25/2020. The findings are recorded. They included a tear of the medial meniscal anterior horn.

The EIP had an initial evaluation with Dr. Weissberg on 2/27/2020 as result of his left knee pain. After the examination, left knee arthroscopy was recommended.

Dr. Hillsman has reviewed the 4/9/2020 progress note from Dr. Weissberg.

The EIP had left knee surgery on 4/16/2020 by Dr. Weissberg. He was assisted by Heidi Fyrberg, PA.

Dr. Hillsman says "Based on the history of motor vehicle accident, I find that there is an inadequate medical indication to justify the left knee surgery."

"The standard of care for symptomatic knee would begin with a course of conservative treatment (including rest, ice and medication). Most knee problems are greatly improved with physical methods alone. When exercise programs are unable to increase strength and range of motion in the knee after more than a month, surgery should be considered."

As to the arthroscopic left knee meniscectomy, Dr. Hillsman refers to the **2016 NIA Clinical Guidelines for Medical Necessity Review, Knee Arthroscopy, Knee Arthroscopy, C. Meniscectomy/Meniscal, page 389, 390**: "Repair Meniscectomy and/or meniscal repair may be medically necessary when the following criteria are met:

When At Least 3 of the Following 5 Criteria Are Met:

- 1) History of "catching" or "locking" as reported by the patient;
- 2) Knee joint line pain with forced hyperextension upon physical exam
- 3) Knee joint line pain with maximum flexion upon physical exam;
- 4) Knee pain or an audible click with McMurray's maneuver upon physical exam;
- 5) Joint line tenderness to palpation upon physical exam

AND

At least 6 weeks of non-operative care that has failed to improve symptoms

AND

One of the following radiographic findings:

Radiographic findings without moderate or severe osteoarthritic changes; OR

MRI results confirm meniscal tear in patients <30 years of age; OR

MRI results confirm displaced tear (any age)."

Additionally, she refers to another set of the NIA Clinical Guidelines for Medical Necessity Review. These are 2017-2018 - Debridement with or without Chondroplasty, page no 81 & 82.

- 1) Debridement may be medically necessary when ALL of the following criteria are met:
 - a) Knee pain with documented loss of function (deviation from normal knee function which may include painful weight-bearing, unstable articulation, and/or inadequate range of motion (>10 degrees flexion contracture or <90

degrees flexion or both) to accomplish activities of daily living (ADLs) and/or employment. (Documentation of missed days of work or modifications of work status due to injury/pain) AND

b) At least 12 weeks of non-operative care that has failed to improve symptoms;
AND

c) MRI results showing evidence of unstable chondral flap; AND

i) Recurrent (more than 2) or persistent effusion(s):"

In this case, the MVA was 12/22/19 and the EIP had left knee pain. As per the available medical records, there is no documented evidence that the claimant received conservative treatment in any form to resolve the left knee complaints. Also, there was no evidence that the claimant was treated with a single injection of corticosteroid for the left knee.

Additionally, the documentation did not substantiate that the claimant had locking from the date of accident until the date of surgery. As per the above guideline, the left the surgery would be only appropriate when the claimant receives adequate conservative treatment in the form of physical therapy, acupuncture treatment and a steroid injection for the left knee for at least 6 weeks before proceeding to the left knee surgery.

Thus, the above criterion was not met. Hence, based on the available medical records, the above cited guideline, the left knee arthroscopy with meniscectomy and chondroplasty performed on 04/16/2020 were not medically necessary.

As to the synovectomy and removal of loose bodies, Dr. Hillsman refers to the **2016 NIA Clinical Guidelines for Medical Necessity Review, Knee Arthroscopy,:F. Synovectomy (major [2+ compartments], minor [1 compartment]), page no. 393.**

She also refers to another NIA 2016 Clinical Guideline for the medical necessity regarding the removal of loose bodies.

Relying upon the aforementioned guidelines, Dr. Hillsman says that the left knee arthroscopy was performed on 4/16/2020 and it was not medically necessary due to a lack of conservative treatment. Hence, synovectomy and loose body removal performed in conjunction with the left knee surgery were also not medically necessary.

She then refers to the CMS Global Surgery Booklet, updated September, 2018 regarding the Definition of a Global Surgical Package, and refers to page number 4. "The Global surgical package, also called global surgery, includes all the necessary services normally furnished by a surgeon before, during and after the procedure. Medicare payment for a surgical procedure includes the pre-operative, intra-operative and post-operative services routinely performed by the surgeon or by members of the same group with the same specialty."

Dr. Hillsman says that in this case and the left knee surgery was performed on 4/16/2020 it was not medically necessary. Therefore, the associated services of arthroscopy, knee, surgical; for infection, lavage drainage was also not medically necessary.

She then discusses the services billed by the Physician's Assistant.

She refers to an article from the American Association of Surgical Physician Assistant, 2017, Surgical PA Roles: "While surgical PAs assist the physician in the global management of patient care in all peri-operative settings, their primary role is to assist licensed physicians in patient surgery. This end-to-end involvement enables surgical PAs to provide unparalleled continuity of patient care. Often surgical PAs handle routine problems and procedures, freeing the surgeon to concentrate on more complex patients."

As per Dr. Hillsman, in this case the EIP underwent knee surgery under general anesthetic. She opines that the services of Heidi Fryberg, P.A. were not medically necessary because the left knee surgery was not medically necessary.

She also discusses the causal relationship and opines that there was a causal relationship to the EIP's left knee injury and the motor vehicle accident of 12/22/19.

She concludes by saying that the services billed by Dr. Weissberg were not medically necessary and therefore the services billed by the Physician's Assistant were also not medically necessary.

At the hearing:

Applicant relied upon its submission.

Respondent relied upon the peer review.

FINDINGS:

The Applicant has established its prima facie case.

The Applicant is billing for assisting Dr. Weissberg with the knee surgery he performed on the EIP on 4/16/2020. Applicant billed \$987.44. This amount was amended at the hearing.

The Respondent denied the Applicant's claim based upon a peer review by Regina O. Hillsman, MD, who opined that the surgery was not medically necessary.

The purpose of a peer review is to determine whether the service/test provided was medically necessary. The peer reviewer discusses the standard of care in the medical community and offers his/her opinion as to why the service/test at issue falls outside of that standard of care. The peer reviewer buttresses his/her opinion with authoritative texts, treatises and articles, generally from peer-reviewed publications.

Some peer reviewers rely upon "guidelines" as a basis for denying a claim. Some "guidelines" are appropriate, while others are not. An example of a "guideline" that is not appropriate in dealing with New York No-fault, is one generated by a healthcare management entity, such as Apollo, who has promulgated a list of DME and has made a determination as to whether or not prescribing these items was medically necessary. This is simply a determination by an insurance entity, in conjunction with its advisors, in determining which devices it chooses to pay for.

The NIA is the National Imaging Associates, Inc., and they are part of Magellan Healthcare, a private healthcare insurance company, and not necessarily an authoritative source when dealing with New York No-fault. This includes the NIA Standard Clinical Guidelines. In reviewing these Clinical Guidelines, I see that they are broken up into sections where the main topic is discussed and the guidelines are set forth. At the end of the section there are a list of references which refer to articles, including when and where published. However, there is no correlation between the referenced articles and the body of the guideline to show which article is supporting which guideline.

In addition to her reliance upon the NIA guidelines, Dr. Hillsman also referred to articles published by www.ncbi.nlm.nih.gov but has not provided copies of those articles. As such, we are not in a position to determine if they were proper peer-reviewed authoritative sources.

The peer review by Dr. Hillsman has not been supported by proper authoritative sources.

Because the peer review is not properly supported, it does not shift the burden back to the Applicant to file a rebuttal.

In All Boro Psych Servs. P.C., v. GEICO, 34 Misc 3d 1219[A], Civ Ct, Kings Co, Jan 31, 2012, the Court said "Defendant 'bears both the burden of production and persuasion' as to its defenses (Nir v Allstate Ins. Co., 7 Misc 3d 544 [Civ Ct, Kings County 2005], citing King's Med. Supply Inc. v Country-Wide Ins. Co., 5 Misc 3d 767, 771 [Civ Ct, Kings County 2004]). To meet its burden of proof at trial on the defense of lack of medical necessity, at a minimum, defendant must establish a factual basis and medical rationale for the lack of medical necessity for the services for which reimbursement is sought (Nir, 7 Misc 3d at 546-547, [citations omitted])."

Based upon the totality of the circumstances contained herein, **this claim is awarded.**

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	Amount Amended	Status
	Heidi Fyrberg P.A. P.C.	04/16/20 - 04/16/20	\$987.44	\$423.63	Awarded: \$423.63
Total			\$987.44		Awarded: \$423.63

- B. The insurer shall also compute and pay the applicant interest set forth below. 10/28/2020 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

I find that the date for interest to accrue is the date of the filing of the arbitration, 10/28/2020 as this is the date when the Applicant's filing was processed and notice of the arbitration sent to the Respondent. As per Insurance Regulation 65-3.9, interest is due until such amount is paid, and without demand therefor.

C. Attorney's Fees

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

The insurer shall pay the Applicant's attorney as per 11 NYCRR 65-4.6 (e). However, if the award and interest is equal to, or less than, Respondent's written offer during the conciliation process, then the attorney's fee shall be based upon 11 NYCRR 65-4.6 (b).

- 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 Suffolk

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

11/04/2021

(Dated)

James Hogan

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:
f90dd411bef718b4a94805d2328cc317

Electronically Signed

Your name: James Hogan
Signed on: 11/04/2021