

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Tri-Borough NY Medical Practice PC
(Applicant)

- and -

LM General Insurance Company
(Respondent)

AAA Case No. 17-23-1292-8980

Applicant's File No. none

Insurer's Claim File No. 0515690300002

NAIC No. 36447

ARBITRATION AWARD

I, Kenneth Rybacki, 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 10/24/2023
Declared closed by the arbitrator on 10/24/2023

Rajesh Barua, Esq. from Law Offices of Hillary Blumenthal LLC (Hoboken)
participated virtually for the Applicant

Sheena Faublas from LM General Insurance Company participated virtually for the
Respondent

2. The amount claimed in the Arbitration Request, **\$13,199.13**, was NOT AMENDED at the oral hearing.
Stipulations WERE made by the parties regarding the issues to be determined.

The representatives for the parties stipulated that Respondent's denial was issued within thirty-day claim-determination periods prescribed by Ins. Law Sec. 5106 and/or 11 NYCRR 65-3.8.

3. Summary of Issues in Dispute

The medical necessity of surgical intervention for the management of injuries sustained in an 11/14/22 accident by thirty-one-year-old male T.D. Applicant's claim for the services of a surgeon in connection with right shoulder arthroscopy including major

synovectomy, bursectomy, extensive debridement, Bankart repair, subacromial decompression, lysis of adhesions, and Coblation arthroplasty of the glenoid performed on 1/14/23 was denied by the Respondent on the recommendation of peer reviewer, Dr. Daniel Schlatterer.

4. Findings, Conclusions, and Basis Therefor

This matter was decided on the submissions of the parties as maintained by the American Arbitration Association ("AAA") in its ADR Center and oral argument. No submissions following the close of the record on 6/7/23, extended by the AAA at Respondent's request from 5/8/23 were admitted, 11 NYCRR 65-4.2 (b); Matter of Mercury Casualty Co. v. Healthmakers Medical Group, P.C., 67 A.D.3d 1017, 888 N.Y.S.2d 762 (2d Dept. 2009). Arbitration procedure contained in the No-Fault regulations, specifically, 11 N.Y.C.R.R. 65-4.2 (b)(3)(iii), provides

(iii) The written record shall be closed upon receipt of the respondent's submission or the expiration of the period for receipt of the respondent's submission. Documents submitted by either party after the record is closed shall be marked "Late."

This action for the payment of a health services claim for the services of a surgeon in connection with right shoulder arthroscopy including major synovectomy, bursectomy, extensive debridement, Bankart repair, subacromial decompression, lysis of adhesions, and Coblation arthroplasty of the glenoid performed on 1/14/23 arises from a motor vehicle accident that took place on 11/14/22. Respondent denied the claim on the recommendations of its peer reviewer, Dr. Schlatterer thus presenting a question of fact as to the need for the surgery.

It is well-settled that submission of a provider's claim form to the carrier is prima facie evidence of the necessity of the services contained therein, Viviane Etienne Med. Care, P.C. v. Country-Wide Ins. Co., 25 N.Y.3d 498; Amaze Medical Supply Inc. v. Eagle Ins. Co., 2 Misc.3d 128(A), 784 N.Y.S.2d 918. Respondent can rebut that presumption through competent, contrary opinion that would shift the burden back to the applicant to put forth evidence in support of its claims, see, e.g., Bedford Park Medical Practice P.C. v. American Transit Ins. Co., 8 Misc.3d 1025(A), 806 N.Y.S.2d 443; B.Y., M.D., P.C. v. Progressive Casualty Ins. Co., 26 Misc.3d 125(A), 907 N.Y.S.2d.

Respondent's peer reviewer, utilized by the Respondent to assess the necessity of the surgical intervention, must provide a factual basis and medical rationale to support the expert's opinion that the same was not necessary, Delta Diagnostic Radiology, P.C. v. Progressive Cas. Ins. Co., 21 Misc.3d 142(A). That factual basis is lacking if the expert's report fails to provide specifics of the claim, is conclusory, or otherwise lacks a basis in the facts of the claim, Nir v. Allstate Ins. Co., 7 Misc.3d 544, 796 N.Y.S.2d 857. Respondent's peer reviewer is also required to establish the generally accepted professional practices regarding surgical intervention for conditions sustained by the

Assignor and how it is that the provider being reviewed departed from those practices and standards, Elmont Open MRI & Diagnostic Radiology, P.C. v. State Farm Ins. Co., 26 Misc.3d 1211(A), 906 N.Y.S.2d 779.

The Assignor was initially evaluated by Sonia Sikand, PA with complaints of right shoulder pain, as well as other complaints referable to the subject accident. Physical examination demonstrated a positive impingement sign. Right shoulder derangement was diagnosed, and the Assignor was placed on a therapeutic program consisting of physical therapy and analgesics. Similar findings were noted on a follow-up examination on 12/14/22 with similar recommendations. Surgical intervention for a labrum tear, Grade 2 chondral lesion, SLAP tear, partial rotator cuff tear, subscapularis tendon tear, biceps tendon tear, synovitis, subacromial adhesions, adhesive capsulitis and impingement syndrome and bursitis was recommended by treating surgeon Dr. Robert Drazic due to continuing sequelae despite compliance with conservative therapy over a two month period.

Respondent's expert opined that surgical intervention for partial rotator cuff tears is indicated where there is continuing pain after a three-to-six-month trial of conservative therapy. The expert concluded that "the surgery is not medically necessary due to lack of conservative care." Firstly, the blanket statement that three to six months of therapy is a prerequisite to surgery for simple rotator cuff tears does not address whether that period applies where, as here, there is a constellation of conditions for which surgical intervention was recommended. Secondly, nothing cited by the expert indicates that a three-to-six-month period of therapy must be attempted prior to surgical intervention. In fact, even in cases of simple rotator cuff tears, the expert cites Conservative versus surgical management for patients with rotator cuff tears: a systematic review and META-analysis, BMC Musculoskelet Disord. 2021; 22: 50 in which the authors state

"what is the optimal treatment for partial...[rotator cuff] tears is still unclear since both conservative and surgical treatment have strengths and weaknesses [and] conservative treatment may predispose patients to continued irreversible tissue degeneration over time [and] [t]herefore, [rotator cuff] tears which initially could be managed as repairable may become irreparable, leading to the need for further treatments and worse results."

According to the cited publication, continuing conservative care may lead to worsening outcomes. Consequently, I will not displace the decision of the treating surgeon by opinion evidence that simply determines the need for surgery based on a function of time rather than based on an assessment of the particular presenting conditions of the particular patient under review.

The surgery was performed in New Jersey. The controlling regulation, 11 NYCRR 68.6, as amended, effective 1/23/18, provides with certain exceptions not applicable in the instant matter, that

(b)...if a professional health service reimbursable under Insurance Law section 5102(a)(1) is performed outside this State with respect to an eligible injured person that is a resident of this State, the amount that the insurer shall reimburse for the service shall be the lowest of:

(1) the amount of the fee set forth in the region of this State that has the highest applicable amount in the fee schedule for that service;

(2) the amount charged by the provider; and

(3) the prevailing fee in the geographic location of the provider.

In New Jersey, N.J.S.A. 39:6A-4.6 requires the New Jersey Commissioner of the Department of Banking and Insurance (the Department) to set a physicians' fee schedule, pursuant to which providers of medical care to accident victims are paid. The fee schedule "shall incorporate the reasonable and prevailing fees of 75% of the practitioners within the region." N.J.S.A. 39:6A-4.6.

The admitted record is devoid of expert opinion from either side discussing, comparing and contrasting the allowable fees in New York and New Jersey for the services performed. As such, I addressed with the parties each CPT code billed by the applicant and the allowable fees for the same in New York and New Jersey which are as follows: 29821, \$1,942.46 New York, \$3,233.10 New Jersey; 29999 "by report" fee in New York, \$0 in New Jersey; 29823 \$2065.91 New York, \$3430.85 New Jersey; 29806, \$2,698.28 New York, \$5,808.16 New Jersey; 29826 \$496.32 New York, \$3,650.34 New Jersey; 29825, \$2,060.87 New York, \$3202.11 New Jersey. It is clear that the services in New York are lesser than those in New Jersey except for CPT code 29999 that offers no reimbursement in New Jersey and is therefore not payable in New York. The remaining New York Codes are also subject to the multiple procedure reduction rules contained in Ground Rule No. 5 of the Surgery portion of the New York Workers Compensation fee schedule which allows payment at 100% for the procedure with the highest allowance and 50% of the lesser procedures. An exception to this rule is add-on procedures such as 29826 which is allowable at 100%. Applying the rule in the instant matter, the allowable procedures total \$6,229.22, the amount that Applicant 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	Status
	Tri-Borough NY Medical Practice PC	01/14/23 - 01/14/23	\$13,199.1 3	Awarded: \$6,229.22
Total			\$13,199.1 3	Awarded: \$6,229.22

- B. The insurer shall also compute and pay the applicant interest set forth below. 03/29/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Statutory interest shall run from the date of filing, 3/29/23 to the date of payment by the Respondent.

C. Attorney's Fees

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

Attorney fees are awarded at 20% of the amount of first-party benefits awarded in the aggregate, plus interest, in accordance with the limitations set forth in 11 NYCRR 65-4.6.

- 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 NY

SS :

County of Suffolk

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

10/27/2023

(Dated)

Kenneth Rybacki

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:
e60d1133aefb582a8970c323b39e7c60

Electronically Signed

Your name: Kenneth Rybacki
Signed on: 10/27/2023