American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Health East Ambulatory Surgical Center (Applicant)	AAA Case No.	17-23-1305-1534
	Applicant's File No.	1061649
- and -	Insurer's Claim File No.	0631253810101023
	NAIC No.	35882
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Felix Papadakis, 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/IP

1. Hearing(s) held on 12/27/2023
   Declared closed by the arbitrator on 12/27/2023

   Tricia Smith, Esq. from The Law Office Of Cohen & Jaffe, LLP participated virtually for the Applicant

   Brian McDonough, Esq. from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$38,352.10**, was AMENDED and permitted by the arbitrator at the oral hearing.

   There are two matters being heard today both of which were amended:

   #1534 $14,591.08-Facility

   #1541 $7,206.73-Doctor

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

3. Summary of Issues in Dispute

   Arthroscopic surgery of the shoulder (right) is in issue herein. There are two cases, one for the facility and one for the doctor.

The date of accident was 9/24/22.

The date of service was 1/24/23.

The IP was male, aged 68 and a driver. His initials are HKK.

The Respondent has presented a peer review of Dr. Howard Kiernan and the Applicant a rebuttal by Dr. Thomas Scilaris.

The hearing was conducted by Zoom.

4. Findings, Conclusions, and Basis Therefor

I have reviewed all of the evidence as maintained in the respective files of the parties and also considered the oral arguments of the parties.

This decision is final as to the issue before me.

The matter has its crux on the issue of medical necessity.

Here is the relevant case law on medical necessity:

The applicant has made a prima-facie showing of its entitlement to reimbursement, as a matter of law, by submitting evidentiary proof that the prescribed statutory billing forms, setting forth the facts and the amount of the loss sustained, were mailed and received and that payment of no-fault benefits is overdue. See, Mary Immaculate Hospital v. Allstate Ins. Co., 5 A.D.3d 742 (2004).

Once Applicant has established a prima facie case, the burden then shifts to Respondent to establish a lack of medical necessity with respect to the benefits sought. See, Citywide Social Work & Psychological Services, PLLC v. Allstate Ins. Co., 8 Misc3d 1025A (2005).

"Pursuant to the statutory and regulatory framework governing the payment of no-fault automobile benefits, insurance companies are required to either pay or deny a claim for benefits within 30 days of receipt of the claim (see Insurance Law § 5106[a]; 11 NYCRR 65-3.8[c]).

A denial premised on lack of medical necessity must be supported by competent evidence such as an independent medical examination (IME), peer review or other proof which sets forth a factual basis and medical rational for denying the claim. See, Healing Hands Chiropractic, P.C. v. Nationwide Assur. Co., 5 Misc3d 975 (2004).

If the insurer presents sufficient evidence establishing a lack of medical necessity, then the burden shifts back to the Applicant to present its own evidence of medical necessity. See: West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc3d 131A (2006).

Medical necessity is to be used to clinically advance a patient. Testing out of convenience is improper. Medically necessary treatments or services are "treatment[s] or services which are appropriate, suitable, proper and conducive to the end sought by the professional health service in consultation with the patient. It means more than merely convenient or useful treatment[s] or services, but treatment[s] or services that are reasonable in light of the patient's injury, subjective and objective evidence of the patient's complaints of pain, and the goals of evaluating and treating the patient." Fifth Avenue Pain Control Center v. Allstate Ins. Co., 196 Misc.2d 801, 807, 766 N.Y.S.2d 748, 753 (Civ Ct. Queens Co. 2003). In order for an Applicant to prove that the disputed expense was medically necessary, it must meaningfully refer to or rebut Respondent's evidence. See Yklik, Inc. v. GEICO, 29 Misc.3d 133A (2010).

I also hasten to mention that the No-Fault statutes and related regulations require that a determination of medical necessity be made prospectively from the standpoint of the insured at the time a treatment or service is rendered, not at a time when its effectiveness or lack thereof can be established retrospectively. Complete Medical Care Services of NY, P.C. v. State Farm Mutual Automobile Ins. Co., 21 Misc.3d 436, 863 N.Y.S.2d 551 (Civ. Ct. Queens Co. 2008).

ANALYSIS:

Right shoulder arthroscopy is in issue, with a peer review and rebuttal. The matters were amended each to comport with the fee schedule.

These are my findings:

After a careful review, I find for the Applicant on both matters.

The peer reviewer fails in my judgment, to persuade me that the surgery was not necessary and I am more persuaded by the rebuttal author.

I have reviewed first the peer review which is with the party with the first burden. I note that the peer reviewer does not absolutely deny that surgery was NOT necessary but rather, he states that a full conservative care regime and injections would have quelled the condition while acknowledging that surgery could be an option if conservative measures failed.

This is not the most persuasive case against payment. The peer reviewer mentioned a standard of care of 3-6 months of conservative care and this surgery was 4 months post-accident, well within the standard. The fact that he did not have injections was the decision of the treating provider who even stated that injections mask pain and do not cure a tear.

Indeed the MRI was positive. The patient had received 4 months of conservative care. Injections would have quelled the pain, but not repaired the situation-states the rebuttal author.

Therefore I find between the two pieces of evidence, peer and rebuttal, is it a question of timing and indeed, in this case the rebuttal author commented that the timing of the surgery was appropriate at that juncture after a holistic review of the patient, the treatment and the resulting symptoms.

I find in favor of the Applicant.

I am more persuaded that the rationale for proceeding to surgery on that date was the proper course of action that that continued PT and conservative care would have been futile.

The Applicant decided to proceed to surgery and I agree.

The 2 claims are awarded.

Accordingly, for the reasons delineated above, I find in favor of the Applicant, and direct the Respondent to issue reimbursement as described below, plus interest, and attorney's fee and the arbitration filing fee, as outlined in Sections A through D below.

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
	Health East Ambulatory Surgical Center	**01/24/23 - 01/24/23**	**$38,352.10**	**$14,591.08**	**Awarded: $14,591.08**
Total			**$38,352.10**		**Awarded: $14,591.08**

B. The insurer shall also compute and pay the applicant interest set forth below. 06/26/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest on the above-awarded amount shall be computed and paid at a rate of two percent per month, calculated on a pro rata basis using a 30-day month, commencing as of the date reflected above, per 11 NYCRR 65-3.9. In accordance with 11 NYCRR 65-3.9c, interest shall be paid on the claims from the above date, which is the date the arbitration was commenced.

C. Attorney's Fees

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

Respondent shall pay Applicant an attorney's fee in accordance with 11 NYCRR 65-4.6(d), i.e., 20 percent of the amount of first party benefits, plus interest thereon with no minimum fee and a maximum fee of $1360.00.

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 NJ
SS :
County of Ocean

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

12/28/2023
(Dated)

Felix Papadakis

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:
e0d3df71c664248205394d3ab9d2e91b

Electronically Signed

Your name: Felix Papadakis
Signed on: 12/28/2023