American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:		
Gramercy Surgery Center / **Applicant_ 1** (Applicant)	AAA Case No.	412009052263
	AAA Assessment No.	17 991 06196 10
- and -	Applicant's File No.	
Liberty Mutual Fire Insurance Company (Respondent)	Insurer's Claim File No.	LA2030111204750 4

ARBITRATION AWARD

I, Stacy A. Presser, Esq., 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
☒05/06/10
and declared closed by the arbitrator on 5/6/10.

Jeffrey S. Kimmel, by Yulia Dernovsky, Esq., participated in person for the Applicant.
Claims Department, by Herman Buchanan, participated in person for the Respondent.

2. The amount claimed in the Arbitration Request, **$3,367.41**, 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

Whether Applicant is entitled to recover for surgery, with respect to which Respondent denied reimbursement predicated upon a peer review and/or independent medical examination.

4. Findings, Conclusions, and Basis Therefor

Applicant is seeking reimbursement for arthroscopic surgery, performed on July 30, 2009, in connection with the repair of a left shoulder injury allegedly sustained by Assignor, a 34–

year-old male who, on April 25, 2009, was involved in a collision while operating the insured vehicle. Assignor was seen in consultation with an orthopedic surgeon, David T. Neuman, M.D., on July 14, 2009, for evaluation of his persistent accident-related pain, especially with regard to his left shoulder and knee. Assignor was lacking significant degrees of flexion, abduction and rotation in the left shoulder as compared to the right. Passive increases in motion elicited sharp pain. There was diminished sensation to the radial sensory nerve distribution into left hand. Hawkin's and Neer's tests were markedly positive in the left shoulder. Palpation of the left AC joint elicited sharp pain. According to Dr. Neuman, in addition to tendinosis and tendinopathy, an MRI scan of the left shoulder, performed on May 30, 2009, revealed irregularities to the acromioclavicular joint and joint swelling. Labral tear could not be excluded. Dr. Neuman, concluded, in pertinent part,

> *Due to length of time since the injury and that the patient has failed conservative management, physical therapy and time, surgical intervention is warranted for the left shoulder.*

According to the operative note, the preoperative diagnosis was anterior instability, left shoulder impingement, bursitis and AC joint sprain. Post operative diagnosis confirmed same, as well as a superior labral tear, which was arthroscopically repaired.

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 fact and the amount of the loss sustained, have been 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).* A denial premised on lack of medical necessity must be supported by competent evidence such as an independent medical examination, 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).* Restated, the evidence must at least show that the services were inconsistent with generally accepted medical/professional practice.

Respondent timely denied reimbursement predicated upon a peer review by its consulting orthopedic surgeon, J. Serge Parisien, M.D., who also conducted an independent medical examination of Assignor on July 15, 2009, based upon which future benefits were terminated. Upon reviewing the medical records, Dr. Parisien concluded that the disputed arthroscopic surgery was not medically indicated and/or performed in a manner consistent with accepted medical standards. The peer review reads, in pertinent part,

> *The only findings by Dr. Neuman are some decreased range of motion and some tenderness. Please note that tendinopathy often can be successfully treated at home. Treatment usually includes resting the painful area, applying ice, taking pain relievers (such as nonsteroidal anti-inflammatory drugs) if necessary, and doing gentle exercises and stretching to prevent stiffness. These steps typically reduce pain and tenderness and allow the tendon to heal. The claimant did not have a full course of physical therapy for the left shoulder, nor was there evidence*

if non-steroid anti-inflammatory medication was given. Therefore…there is no medical indication for the left shoulder surgery performed on 7/30/09 as related to the motor vehicle accident of 4/25/09.

Dr. Parisien examined Assignor on July 15, 2009. Examination of the left shoulder is stated to have revealed mild tenderness and minimal restrictions of motion. Dr. Parisien concluded,

Based on my examination, there is no need for orthopedic treatment including physical therapy. An end result has been achieved. There is no need for diagnostic testing. There is no need for surgery.

In order to establish an absence of medical necessity and overcome the Applicant's prima facie case, Respondent must present a sufficient factual basis and medical rationale based on generally accepted medical standards. See, *Nir v. Allstate Ins. Co., 7 Misc. 3d 544 (2005).* A mere statement of opinion is not sufficient to overcome Applicant's prima face case. See, *CityWide Social Work & Psychological Servs. v. Travelers Indem. Co., 3 Misc.3d 608 (2004)*. Having established the standard of care, the peer reviewer must indicate that the disputed treatment was not in accordance with such practice. See, *Elmont Open MRI v. Progressive Casualty, 2009 N.Y. Slip Op. 50693(u).*

Respondent failed to meet the afore-referenced burden of proof. Respondent, via its peer and IME reports, has not presented a sufficient factual basis or medical rational for its denial, and hence has not established the requisite lack of medical necessity so as to overcome Applicant's prima facie evidence. Dr. Parisien completely mischaracterizes the findings of Assignor's treating orthopedic surgeon, Dr. Neuman, which he contends were limited to tenderness and decreased range of motion. These more accurately reflect his IME findings. Furthermore, Dr. Parisien has not presented any clear standard of care. What can "often" be treated in a particular manner, or what steps "typically" work with respect to an injury or condition, clearly do not cover the full spectrum of accepted treatments. There is no evidence whatsoever to suggest that Dr. Neuman acted in contravention of any accepted medical protocol. I therefore defer to his judgment, as the treating physician.

Accordingly, I find in favor of Applicant and direct Respondent to issue reimbursement in full, plus interest and an attorney's fee as delineated below in Sections B and C.

This decision is in full disposition of all claims for No Fault benefits presently before this Arbitrator.

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.

Accordingly, the applicant is AWARDED the following:

A.

Benefits	Amount Claimed	Amount Awarded
Health Service Benefits	3,367.41	3,367.41
Totals:	$3,367.41	$3,367.41

B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 12/29/2009, which is a relevant date only to the extent set forth below.)

The awarded claim totaling $3,367.41, resulting from a motor vehicle accident that occurred after April 5, 2002, shall bear interest at the rate of two percent (2%) per month, simple (not compounded), calculated on a pro rata basis using a 30-day month, and commencing on December 29, 2009, the date arbitration was requested. See, 11 NYCRR 65-3.9 (a); (c).

C. Attorney's Fees

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

After calculating the sum total of the first-party benefits awarded in this arbitration plus the interest thereon, Respondent shall pay Applicant an attorney's fee equal to twenty percent (20%) of that sum total, subject to a minimum of $60 and a maximum of $850. See, 11 NYCRR 65-4.6 (c); (e). Since the within arbitration request was filed on or after April 5, 2002, if the sum total of the benefits and interest awarded thereon is equal to or less than Respondent's written offer during the conciliation process, then the attorney's fee shall be based upon the provisions set forth in 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 New York.

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

Stacy A Presser

5/26/10
(Dated) (Stacy A. Presser, Esq.)

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.