American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:	
	AAA Case No. AAA Assessment No.
(Applicant)	Applicant's File No.
- and -	
Fiduciary Insurance Company of America	Insurer's Claim File No.
(Respondent)	

ARBITRATION AWARD

I, Marilyn Felenstein, 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
☒11/13/12
and declared closed by the arbitrator on 11/13/12.

Naomi Cohn Esq. for Gene Sigalov Esq. participated in person for the Applicant.
Rory Sheridan Esq. for Skendaris & Cornacchia participated in person for the Respondent.

2. The amount claimed in the Arbitration Request, **$3,589.50**, 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

Was the CPM unit provided to Assignor medically necessary?

4. Findings, Conclusions, and Basis Therefor

The Arbitrator has considered all of the documentation submitted by the parties to the American Arbitration Association electronic case folder (ECF) as of the date of the hearing as well as the oral arguments of the parties.

Applicant submitted a claim for a CPM machine provided to Assignor following the surgical repair of Assignor's knee as the result of injuries sustained when Assignor was truck by a motor vehicle on September 23, 2011. The CPM unit was provided from November 30, 2011 through January 10, 2012.

A provider establishes a prima facie case of entitlement to reimbursement by submitting evidentiary proof that the prescribed statutory billing forms had been mailed and received and that payment of no-fault benefits was overdue. *See Insurance law sec. 5106; Mary Immaculate Hosp. v. Allstate Insurance Co,* 5 AD3d 742, 77 N.Y.S.2d 56 (2004). A properly completed claim form, which suffices on its face to establish the particulars of the nature and extent of the injuries and health benefits received and contemplated and proof and fact of the loss sustained is all that is needed at the claim stage to establish the health benefits medical necessity. *Amaze Medical Supply v. Eagle Insurance.* 2 Misc. 3d 128 (A). Applicant herein has met that burden.

Once Applicant has established a prima facie case, Respondent must prove that the treating doctor's services were not medically necessary. As an element of its proof, the insurer may use a peer review report which is a medical professional's written evaluation of the medical necessity of the services provided. The peer reviewer report should however, set forth a sufficiently detailed factual basis and medical rationale for the rejection of the claim. *Contempo Med. Care PV v. Travelers*, 2006 Slip Op 51338U, 2006 NY Misc. LEXIS 1815; *Amaze Med. Supply v Eagle Ins Co.,* 2 Misc3d 128[A], 2003 NY Slip Op 51701[U] [App. Term 2d and 11th Jud Dists 2003]; *S & M Supply v Kemper Auto Home Ins. Co.,* 2 Misc3d 14[A], 2004 NY Slip Op 50209[U] [App Term, 2d & 11th Jud Dsts 2004]

A no-fault insurer defending a denial of first party benefits on the ground that the billed for services were not medically necessary must show that the services rendered were inconsistent with generally accepted medical/professional practices. The opinion of the insurer's expert, standing alone, is insufficient to meet the insurer's burden of proving that the services were not "medically necessary". *CityWide Social Work & Psychological Servs. V. Travelers Indem. Co.* , 3 Misc3d 608 [Civ Ct. Kings County]; *Ultimate Med. Supplies v. Lancer Ins Co.,*7 Misc3d 1002[] [Civ.Ct. Kings Co. 2004. At a minimum, the insurer should establish a factual basis and medical rationale for the lack of medical necessity determination. Generally accepted medical practice is that range of practice that the profession will follow in the diagnosis and treatment of patients in light of the standards and values that define its calling.

Once the peer review sets forth a reasonable factual basis and medical rationale for the opinion regarding the medical necessity for the treatment in dispute, the trier-of-fact will look to the Applicant to rebut the evidence and conclusion reached by the peer reviewer. In the absence of such a rebuttal, the denial of the claim can be sustained. A. Khodadadi Radiology, P.C. v. N.Y. Centr. Mut. Fire Ins. Co., 16 Misc.3d 131[A], 2007 NYS Slip Op 51342[U] [App. Term 2d & 11th Jud Dsts 2007] In order for an applicant to prove that the disputed expense was medically necessary, it must meaningfully refer to, or rebut, the conclusions set forth in the peer reviews, Yklik, Inc. v. Geico Ins. Co., 2010 NY Slip Op. 51336(U) (App Term 2d, 11th & 13th Dists. July 22, 2010); High Quality Medical, P.C. v. Mercury Ins. Co., 2010 N.Y. Slip Op. 50447(U) (App Term 2d, 11th & 13th Dists. Mar. 10, 2010); Pan Chiropractic, P.C. v. Mercury Ins. Co., 24 Misc.3d 136(A), 2009 N.Y. Slip Op. 51495(U) (App Term 2d, 11th & 13th Dists. July 9, 2009), or the IME reports, Eastern Star

Acupuncture, P.C. v. Mercury Ins. Co., 2010 NY Slip Op. 50380(U) (App. Term 2d, 11th & 13th Dists. Mar. 8, 2010).

Dr. Winnell observed that Assignor, a 50- year old female, initially was treated at Columbia Presbyterian Hospital. At that time she reported some swelling of the bilateral ankles and feet. Assignor was examined by Dr. Augustin on October 14, 2011 and made no additional complaints at that time. No ambulatory difficulties were noted, however, there was tenderness in the right knee at the suprapatellar and subpatellar areas. There was ankle edema. Sensation was intact and there was no motor weakness. There were no reflex abnormalities. The impression at that time was of cervicalgia, cervical sprain, lumbar sprain/strain, bilateral shoulder pain and right knee sprain/strain. There was no plan for any surgical or interventional management.

Based on the foregoing, Dr. Winnell concluded that there was no medical necessity for the surgical repair of the right knee and, therefore, by reference no necessity for the CPM machine. Dr. Winnell found no documentation from the treating surgeon regarding the mechanism of the injury to the right knee. He determined that Assignor had not been provided with an adequate preoperative conservative treatment trial. He further notes that the reported findings at the time of the operation were incompatible and inconsistent with any acute injury. Only chronic findings were revealed and treated. Dr. Winnell concluded that the accident could not have been the cause of the claimed injury to Assignor's knee. Additionally, Dr. Winnell states that the use of a CPM machine was unwarranted and not needed post operatively for routine arthroscopic surgery.

Respondent argues that Dr. Winnell's peer review has set forth sufficient rationale for reaching his conclusion. Counsel for Applicant counters that Dr. Winnell has not met his burden. Additionally, it is argued that documentation from the American Academy of Orthopaedic Surgeons Committee on Professionalism demonstrates that Dr. Winnell was found guilty of violating mandatory standards of condemning the performance of a provider that falls within generally accepted practice standards and/or endorsing or condoning performance falling outside those standards and/or lacking the knowledge and experience about the standard of care and available scientific evidence for the condition that led to the proceeding. She notes that the Committee on Professionalism and the Judiciary Committee conducting the appeal hearing voted to suspend his fellowship for one full year on November 2007. She further argues that Dr. Winell has demonstrated a pattern of ignoring standards or care and/or failing to accurately represent the facts of the case he performed a peer review on.

Applicant asks the Arbitrator to consider arbitration awards in which the arbitrators raised such issues. See New York Spine Specialists LLP and State Farm Mutual Automobile Ins. Co., AAA Case No. 412011067028, AAA Assessment No. 17 991 39362 11 (Arbitrator Martin Schulman, Esq. 05/25/12), Elvina Surgical Supplies, Inc. and Allstate Ins. Co, AAA Case No. 412011022139, AAA Assessment No. 17 991 21936 11 (Arbitrator Andrew Horn, Esq., 04/13/12) and Day-Op Center of Long Island Inc. and **Fiduciary Insurance Company of America**, AAA Case No. 412010021134, AAA Assessment No. 17 991 15427 10 (Arbitrator Lucille S. DiGirolomo, Esq., 08/10/10). The Arbitrator determines that the argument regarding Dr. Winnell's suspension goes to the weight to be given to his peer review.

After considering all of the documentation, the Arbitrator notes that Dr. Winnell failed to cite any medical authority to support his conclusion that the injury to the right knee was not sustained in the accident complained of, nor does he provide any medical authority for his conclusion that the disputed water circulating unit prescribed was inconsistent with the generally accepted standard of care.

The Arbitrator determines that Dr. Winnell's peer review is insufficient to support the conclusion that there was no causation or that the CPM unit was not necessary for post-arthroscopic rehabilitation.

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	3,589.50	3,589.50
Totals:	$3,589.50	$3,589.50

B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 05/11/2012, which is a relevant date only to the extent set forth below.)

Where a claim is timely denied, interest shall begin to accrue as of the date adjudication is commenced by the claimant, i.e. the date the claim is received by the American Arbitration Association, unless arbitration is commenced with 30 days after receipt of the denial, in which event interest shall begin to accrue as of the date the denial is received by the claimant. 11 NYCRR 65-3.9©. Where a motor vehicle accident occurs after April 5, 2002, interest shall be calculated at the rate of two percent per month, simple, calculated on a prorate basis useding a 30-day month. 11 NYCRR 65-3.9(a).

C. Attorney's Fees

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

The Respondent shall also pay the applicant an attorney's fee in accordance with 11 NYCRR 65-4.6(e). Attorneys' fees are to be calculated based on the aggregate of all bills for each insured. Payment shall be made of 20% of the amount of first party benefits plus interest thereon awarded by this Arbitrator subject to a maximum of $850.00 pursuant to 11 NYCRR 65-4.6(e).

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, Marilyn Felenstein, 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.

Marilyn Felenstein

12/6/12
(Dated) (Marilyn Felenstein, 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.