

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Bergenfield Surgical Center
(Applicant)

- and -

Liberty Mutual Fire Insurance Company
(Respondent)

AAA Case No. 17-16-1036-0932

Applicant's File No.

Insurer's Claim File No. LA00002120930304

NAIC No. 23035

ARBITRATION AWARD

I, Anthony Kobets, 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 10/04/2017
Declared closed by the arbitrator on 10/04/2017

Nurseda Kuculkarca, Esq. from Revaz Chachanashvili and Associates PC participated in person for the Applicant

Alan Zysberg from Liberty Mutual Fire Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 1,475.91**, was AMENDED and permitted by the arbitrator at the oral hearing.

At the hearing, Applicant's counsel amended the amount in dispute down to \$1244.12 total, pursuant to the New Jersey Fee Schedule. Accordingly, \$1244.12 is the amended amount in dispute herein.

Stipulations WERE made by the parties regarding the issues to be determined.

The parties' representatives stipulated to the timely service of the bill and denial, to Applicant's prima facie burden and to the amended amount in dispute being in accordance with the applicable provisions of the New Jersey Fee Schedule.

3. Summary of Issues in Dispute

In dispute is the Applicant's bill totaling \$1457.91 for facility fees associated with a lumbar epidural steroid injection and trigger point injections performed on the Patient (MA) on 3/1/16 as a result of injuries alleged to have been sustained in a motor vehicle accident on December 2, 2011.

Respondent timely denied the claim based upon a peer review report by Dr. Vijay Sidhwani, M.D. dated 4/8/16. Was the Applicant entitled to reimbursement for the services provided to the EIP?

4. Findings, Conclusions, and Basis Therefor

I have reviewed all documents as available in the ADR Center as of the date of this hearing pertaining to this case. This case was decided based on the submissions of the Parties as contained in the electronic case folder maintained by the American Arbitration Association and the oral arguments of the parties at the hearing. There was no witness testimony at the hearing.

At the hearing, Applicant's counsel amended the amount in dispute down to \$1244.12 total, pursuant to the New Jersey Fee Schedule. Accordingly, \$1244.12 is the amended amount in dispute herein.

The parties' representatives stipulated to the timely service of the bill and denial, to Applicant's *prima facie* burden and to the amended amount in dispute being in accordance with the applicable provisions of the New Jersey Fee Schedule.

The parties' representatives agreed that the sole issue remaining herein was medical necessity.

The EIP (MA) was a 43-year old female who was allegedly involved in a motor vehicle accident on December 2, 2011. Thereafter on 3/1/16, the patient underwent a lumbar epidural steroid injection and trigger point injections at the Applicant's facility. Applicant seeks no-fault reimbursement for these services.

A health care provider establishes its *prima facie* entitlement to payment as a matter of law by proof that it submitted a proper claim, setting forth the fact and the amount charged for the services rendered and that payment of no-fault benefits was overdue (see Insurance Law § 5106 a; Mary Immaculate Hosp. v. Allstate Ins. Co., 5 AD 3d 742, 774N.Y.S. 2d 564 [2004]; Amaze Med. Supply v. Eagle Ins. Co., 2 Misc. 3d 128A, 784 N.Y.S. 2d 918, 2003 NY Slip Op 51701U [App Term, 2d & 11th Jud Dists]).

A treatment or service is medically necessary if it is "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 or services, but treatment 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, 196 Misc. 2d

801, 807-808 (Civ. Ct. Queens Cty. 2003). Medically necessary treatment or services must be "consistent with the patient's condition, circumstances and best interest of the patient with regard to the type of treatment or services rendered, the amount of treatment or services rendered, and the duration of the treatment or services rendered." *Id.* Medical services are compensable where they serve a valid medical purpose. Sunrise Medical Imaging PC v. Lumbermans Mutual, 2001 N.Y. Slip Op. 4009.

If an insurer asserts that the medical test, treatment, supply or other service was medically unnecessary the burden is on the insurer to prove that assertion with competent evidence such as an independent medical examination, a peer review or other proof that sets forth a factual basis and a medical rationale for denying the claim. (See A.B. Medical Services, PLLC v. Geico Insurance Co., 2 Misc. 3d 26 [App Term, 2nd & 11th Jud Dists 2003]; Kings Medical Supply Inc. v. Country Wide Insurance Company, 783 N.Y.S. 2d at 448 & 452; Amaze Medical Supply, Inc. v. Eagle Insurance Company, 2 Misc. 3d 128 [App Term, 2nd and 11th Jud Dists 2003]).

In the event an insurer relies on a peer review report to demonstrate that a particular service was medically unnecessary the peer reviewer's opinion must be supported by sufficient factual evidence or proof and cannot simply be conclusory or may be supported by evidence of generally accepted medical/professional practice or standards. See Nir v. Allstate Insurance Company, 2005 NY Slip Op 25090; 7 Misc.3d 544; 796 N.Y.S.2d 857; 2005 N.Y.Misc. LEXIS 419 and Citywide Social Work & Psy. Serv. P.L.L.C. v. Travelers Indemnity Co., 3 Misc. 3d 608; 777 N.Y.S.2d 241; 2004 NY Slip Op 24034.

In order for Respondent to meet its burden of establishing the lack of medical necessity, a peer review should (1) set forth applicable accepted medical standards relevant to the services at issue; and (2) comment on whether the Applicant had followed or deviated from those standards in providing the disputed services. This does not necessarily require that the peer review quote or cite medical literature. The Nir decision clearly contemplates that a peer may cite "medical authority, standard, or generally accepted practice as a medical rationale for his findings". Nir, 7 Misc.3d at 548.

Respondent timely denied payment of the bill in dispute herein based upon the peer review report of Dr. Vijay Sidhwani, M.D. dated 4/8/16. Dr. Sidhwani's peer review was based upon his review of the available medical documents and he indicated that "in this particular case, the date of the accident was in December 2011 and the injections were administered more than four and half years later. Also, as noted above, a report in 2011 notes that the claimant has a past medical history of lumbar disc herniation and none of the records even indicate any back pain as a result of this motor vehicle accident, only knee pain. Furthermore, the claimant has not received, as far as the records show, any physical therapy to her lower back, only to her left knee. There are also no medical records submitted subsequent to 2013 indicating the claimant's current complaints, which could indicate some medical rationale for ordering these injections. Therefore, from a pain management viewpoint, it is concluded that this procedure was not medically necessary."

Respondent also provided a peer review addendum by Dr. Vijay Sidhwani, M.D. dated 8/31/17, wherein Dr. Sidhwani reviewed additional records, including the rebuttal

by Dr. Jonathan Simhaee M.D. and concluded that "some lumbar examination findings were noted intermittently, yet, the claimant failed to obtain any physical therapy for her lumbar spine. While the claimant may have had a positive EMG/NCV study in 2015, some four years following a soft tissue injury, that's quite a stretch in relating these injections or the EMG/NCV findings to the motor vehicle accident of 12/02/11 in an individual with prior low back pain and RSD. Therefore, since Dr. Simhaee completed avoided addressing the causality of these injections and provided no evidence that the claimant's ongoing complaints were related to the accident, rather than clearly documented prior history of back pain and RSD, I stand by my opinion and find that these injections were not medically necessary as related to the soft tissue injury sustained on 12/02/11." Respondent's counsel argued that based on the patient's medical records, the peer and addendum sufficiently met their burden in demonstrating that the services herein were not medically necessary.

"Where the defendant insurer presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden shifts to the plaintiff which must then present its own evidence of medical necessity (see Prince, Richardson on Evidence §§ 3-104, 3-202 [Farrell 11th ed])." West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc.3d 131(A), 824 N.Y.S.2d 759 (Table), 2006 N.Y. Slip Op. 51871(U) at 2, 2006 WL 2829826 (App. Term 2d & 11th Dists. Sept. 29, 2006); A. Khodadadi Radiology PC v. NY Central Mutual Fire Ins. Co., 2007 NY Slip Op 51342(U). Applicant's counsel argued that the peer review and addendum failed to meet their burden regarding the lack of medical necessity based on the subjective complaints and objective findings in the patient's contemporaneous medical records.

Applicant also relied upon a rebuttal report by Dr. Jonathan Simhaee, M.D. dated 7/30/17, wherein he reviewed the patient's medical records, including the peer report by Dr. Sidhwani, M.D., and stated that "the medical literature Dr. Sidhwani quoted does not support his denial of the aforementioned procedure, but rather supports the medical necessity of the performed injection. Please refer to the medical notes from myself, and from my associate, Dr. Steven Horowitz, which Dr. Sidhwani failed to review, in which we consistently examined the patient from 6/8/15 until 2/16/16 and noted consistent complaints of constant, sharp and burning pain radiating down her left lower extremity collaborated with objective findings of tenderness, spasms, diminished motor strength and positive Slump and Straight Leg Raise test findings, consistent with radiculopathy. Based on the patient's complaints, symptomology and physical exam findings and correlated with positive MRI and EMG test findings detailed below, it was clear that [EIP] did indeed have a component of acute radiculopathy to her pain, in contrary to Dr. Sidhwani's assessment, and therefore, she was an excellent candidate to undergo ESI treatment."

The evidence herein demonstrated that on 11/12/12, the patient underwent an orthopedic examination and presented with complaints, inter alia, of "ongoing back pain." Upon examination, lumbar flexion was noted as 60 degrees with pain.

On August 24, 2013, the patient underwent an MRI of the lumbar spine, which revealed mildly narrowed AP diameter of the neural foramina at L4-L5 secondary to facet joint hypertrophy.

On 2/19/15, the patient underwent EMG/NCV testing, which revealed, inter alia, evidence of bilateral L4/5 and L5/S1 radiculopathies.

On 6/22/15, the patient underwent another MRI of the lumbar spine which revealed an L4-L5 disc bulge, lateral recess stenosis bilaterally, and facet arthropathy.

An initial lumbar epidural steroid injection performed on 7/8/15, indicated that the patient exhibited a positive response of over 80% relief of pain. The preoperative diagnosis and postoperative diagnoses were lumbar radiculopathy.

On 2/16/16, the patient was reexamined by Dr Jonathan Simhaee, M.D. and presented with complaints of radiating lower back pain with numbness and tingling at night. The patient indicated that P.T. is not helping long term and that the epidural steroid injections "help tremendously." Examination of the lumbar spine revealed decreased range of motion with weakness in the lower extremities, spasms, tenderness and decreased sensation. She had a positive slump test, positive straight leg raise test on the left side, a positive facet loading test bilaterally and a positive Faber's test on the left. The patient's gait was antalgic and the doctor's assessment included lumbar radiculopathy. The treatment plan recommended home exercise, medications and a repeat lumbar epidural steroid injection.

On March 1, 2016, the patient was administered lumbar epidural and trigger point injections. The preoperative and postoperative diagnoses were lumbar radiculopathy.

Based upon a review of the evidence herein and the arguments of counsel, I find that the Respondent has not met its burden in this case with regard to the facility fee for the lumbar epidural and trigger point injections. Dr. Sidhwani did not adequately discuss the significance of the patient's complaints and objective findings nor did he provide a sufficiently persuasive factual basis and medical rationale for his conclusion regarding the lack of medical necessity for the services rendered. Specifically, the symptomology and objective findings including decreased range of motion, L4/5 and L5/S1 radiculopathies, an L4-L5 disc bulge, lateral recess stenosis bilaterally, and facet arthropathy, tenderness, decreased sensation, a positive straight leg raise test on the left side, a positive facet loading test bilaterally and a positive Faber's test on the left.

Furthermore, I find that the patient's medical records showed persistent complaints of pain with positive objective findings thereby warranting the additional treatment and disputing the peer review doctor's conclusion that the services were not medically necessary or causally related. A peer review which concludes there was no medical necessity due to the lack of sufficient information upon which the reviewer could make such a determination does not set forth a factual basis and medical rationale sufficient to establish the absence of medical necessity. Park Neurological Services P.C. v. GEICO Ins., 4 Misc.3d 95, 782 N.Y.S.2d 506 (App. Term 9th & 10th Dists. 2004). In addition, I find that Dr. Sidhwani's peer review was unpersuasive and overly conclusory without the necessary detailed analysis or factual basis to support its conclusion. I find that the patient's medical records, including the rebuttal by Dr. Simhaee, were more

persuasive that the services herein were reasonable and medically necessary to resolve an ongoing condition that had not been resolved. I was persuaded by Dr. Simhaee's explanation that "[b]ased on the patient's complaints, symptomology and physical exam findings and correlated with positive MRI and EMG test findings detailed below, it was clear that [EIP] did indeed have a component of acute radiculopathy to her pain, in contrary to Dr. Sidhwani's assessment, and therefore, she was an excellent candidate to undergo ESI treatment." A letter of medical necessity which raises a question of fact as to the medical necessity of services may serve to rebut the peer review report. E.g., American Chiropractic Care, P.C. v. Praetorian Ins. Co., 42 Misc.3d 145(A), 988 N.Y.S.2d 521 (Table), 2014 N.Y. Slip Op. 50346(U), 2014 WL 996509 (App. Term 9th & 10th Dists. Feb. 28, 2014). A respondent defending a denial of first party benefits on the grounds that the subject medical services or testing were not medically necessary must show that the services were inconsistent with generally accepted medical practice, and here the Respondent has not. The opinion of the insurer's expert standing alone is insufficient to meet the *burden of proving that the services were not medically necessary* (see Citywide Social Work v. Travelers Indem. Co., 3 Misc.3d 608 (Civ Ct Kings County 2004)). Where a peer review opinion rests upon conclusory assumptions and disputed or incorrect facts, the review is insufficient to prove the insurer's entitlement to judgment as a matter of law on its lack of medical necessity defense; in these circumstances, the absence of opposing expert proof from the claimant is immaterial. E.g., Novacare Medical P.C. v. Travelers Property Casualty Ins. Co., 31 Misc.3d 1205(A), 927 N.Y.S.2d 817 (Table), 2011 N.Y. Slip Op. 50500(U) at 5, 2011 WL 1226956 (Dist. Ct. Nassau Co., Michael A. Ciaffa, J., Apr. 1, 2011). Where other reports in the insurer's papers contradict the conclusion of its peer reviewer that a service was not medically necessary, it has failed to make out a prima facie case in support of the defense of lack of medical necessity. Hillcrest Radiology Associates v. State Farm Mutual Automobile Ins. Co., 28 Misc.3d 138(A), 2010 N.Y. Slip Op. 51467(U), 2010 WL 3258144 (App. Term 2d, 11th & 13th Dists. Aug. 13, 2010).

Furthermore, in Mount Sinai v. Triboro Coach, 263 A.D. 2d 11 (Second Dep't, 1999), the Court stated that the insurer has the burden of coming forward with proof in an admissible form to establish the fact or evidentiary foundation for its belief that the patient's condition was unrelated to the motor vehicle accident. Moreover, the insurer must show that the injury was not related to the accident at all. It must show how, when and where the injury happened and that it was not aggravated or exacerbated by the accident (emphasis added). The insurer's proof may not be vague, conclusory, inconsistent or unsupported by records. In Kingsbrook Jewish Medical Center v. Allstate Ins. Co., 61 A.D.3d 13, (A.D. 2d. Dep't, 2009) the Appellate Division, ruled that exacerbations of pre-existing conditions are covered by No-Fault, and that causation is presumed under the New York No-Fault law. An expert's affirmation is needed to provide a factual foundation for an insurance carrier's good faith belief that an alleged injury did not arise out of an insured accident; speculation or wishful thinking does not suffice. Mt. Sinai Hospital v. Triboro Coach Inc., 263 A.D.2d 11, 699 N.Y.S.2d 77 (2d Dept. 1999). Dr. Sidhwani's report in this matter is deficient, among other reasons, because it lacks sufficient factual support and medical rationale to justify the position that the services herein were not causally related. I find that the patient's medical records demonstrated that the services herein were causally related and reasonable to resolve an

ongoing condition. I am also persuaded that the patient's injuries visualized and treated at the time of the 3/1/16 treatment were consistent with the patient's mechanism of injury as a direct result of the motor vehicle accident. An insurer fails to come forward with proof in admissible form to demonstrate the fact or the evidentiary foundation for its belief that the patient's treated condition was unrelated to his or her automobile accident where the affidavit of its medical expert is conclusory, speculative, and unsupported by the evidence. E.g., New York & Presbyterian Hospital v. Selective Ins. Co. of America, 43 A.D.3d 1019, 842 N.Y.S.2d 63 (2d Dept. 2007). Based upon the aforementioned, I find that the Respondent has failed to sufficiently establish that the services herein were not medically necessary or causally related and grant Applicant's claim in the amended amount of \$1244.12. This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator. Any further issues raised in the hearing record are held to be moot and/or waived insofar as not raised at the time of the hearing.

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
	Bergenfield Surgical Center	03/01/16 - 03/01/16	\$1,475.91	\$1,244.12	Awarded: \$1,244.12
Total			\$1,475.91		Awarded: \$1,244.12

- B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 06/02/2016, 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 arbitration is commenced by the claimant, i.e., the date the claim is received by the American Arbitration Association, unless arbitration is commenced within 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. See generally, 11 NYCRR 65-3.9. Where a motor vehicle accident occurs after Apr. 5, 2002, interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30 day month." 11 NYCRR §65-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. However, the regulations toll the accrual of interest when an applicant "does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations." See, 11 NYCRR 65-3.9(c). The Superintendent and the New York Court of Appeals has interpreted this provision to apply regardless of whether the particular denial at issue was timely. LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 217 (2009). Where no denial has been issued and no payment has been made, it is clear from the statute that the claim is overdue and interest runs from the thirty first day after the claim was presented to the carrier for payment. New York Presbyterian Hospital v. Allstate Insurance Company, 30 A.D.3d 492, 819 N.Y.S.2d 268, 2006 N.Y. Slip Op. 04815 (2nd Dep't 2006). Hempstead General Hospital v. Insurance Company of North America, 208 A.D.2d 501, 617 N.Y.S.2d 478 (2nd Dep't 1994).

C. Attorney's Fees

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

As this matter was filed **after** February 4, 2015, this case is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11

NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant an attorney's fee, in accordance with newly promulgated 11 NYCRR 65-4.6(d).

- 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 Nassau

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

10/10/2017

(Dated)

Anthony Kobets

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:
aae77f6327a21eb546ed0d27ec8aa255

Electronically Signed

Your name: Anthony Kobets
Signed on: 10/10/2017