

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Montvale Surgical Center
(Applicant)

- and -

Safeco Insurance Company Of Indiana
(Respondent)

AAA Case No. 17-17-1058-5078
Applicant's File No. TM-17-3093
Insurer's Claim File No. 297671126039-00006
NAIC No. 11215

ARBITRATION AWARD

I, John O'Grady, 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 05/01/2018
Declared closed by the arbitrator on 05/01/2018

Naomi Jean Philippe Esq. from Abrams, Fensterman, Fensterman, Eisman, Formato, Ferrara, Wolf LLP participated in person for the Applicant

Cristina Galang Esq. from Safeco Insurance Company Of Indiana participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 4,208.32**, 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

CASE SUMMARY

Naomi Jean Philippe and Cristina Galang

The motor vehicle accident that gives rise to this arbitration took place on March 27, 2016.

The applicant - assignee makes a claim for lumbar epidural steroid injections performed on October 7, 2016.

The respondent denied the claim lying on the peer review of Dr. Syed Hosain.

The assignor is a 31-year-old female.

ISSUE(S)

The issue in this arbitration is whether respondent makes out its initial burden to show that the medical treatment was not medically necessary and, if so, whether applicant's proof is sufficient to overcome that demonstration. A corollary issue is the proper amount payable for the service provided, pursuant to the Workers Compensation Fee Schedule.

4. Findings, Conclusions, and Basis Therefor

THIS HEARING WAS CONDUCTED USING THE ADR CENTER MAINTAINED BY THE AMERICAN ARBITRATION ASSOCIATION. ALL DOCUMENTS IN THE CENTER ARE MADE PART OF THE RECORD OF THIS HEARING. I HAVE REVIEWED THE DOCUMENTS CONTAINED IN THE ADR CENTER AS OF THE DATE OF THIS AWARD AS WELL AS ANY DOCUMENTS SUBMITTED UPON CONTINUANCE OF THE CASE. THOSE DOCUMENTS SUBMITTED AFTER THE HEARING THAT HAVE NOT BEEN ENTERED IN THE CENTER AS OF THE DATE OF THIS AWARD WILL BE LISTED IMMEDIATELY BELOW THIS LANGUAGE AND FORWARDED TO THE AMERICAN ARBITRATION ASSOCIATION AT THE TIME THIS AWARD IS ISSUED FOR INCLUSION IN IT.

Dr. Dumesh reviews the medical treatment received by the assignor after her motor vehicle accident. That treatment included chiropractic care and acupuncture treatment for persistent pain in the lower back and both shoulders. MRI exams were performed of multiple parts of the body including the cervical spine, lumbar spine and shoulders. Dr. Dumesh notes persistent low back pain and lower extremity pain. The assignor was diagnosed as suffering from lumbar radiculopathy and the MRI exam of the low back showed minor degenerative changes without significant disc herniation. Electrodiagnostic study of the legs demonstrated L5-S1 radiculopathy. He says that the basis of the radiculopathy is unclear because the patient did not have any significant lumbar disc herniation. Lumbar epidural steroid injections may be indicated for patients with radicular symptoms confirmed by positive physical examination findings of radiculopathy such as decreased sensation, decreased reflexes, decreased

strength and positive straight leg raising maneuver with radicular pain in the dermatomal distribution and with imaging studies demonstrating significant disc herniation. Here, the findings of the physical exam were not definite for demonstrating radiculopathy and the findings of the lumbar MRI exam did not demonstrate any significant disc herniation. He therefore says that the electrodiagnostic studies demonstrating L5-S1 radiculopathy was inconsistent with the findings on the MRI exam. The performance of a lumbar epidural steroid injection on July 14, 2016 was medically unnecessary. Subsequent medical records contain no information regarding any benefit from the injection and therefore the injection in issue, on October 7, 2016 was medically unnecessary. He cites to materials relied upon in his profession to support his opinion.

Dr. David Gamburg submits a letter in response to the peer review in which he reviews the medical treatment of the assignor. He notes increased mild spasm in the bilateral paraspinal muscles from L1 through L5 and L5 - S1 with tenderness and straight leg raising positive on the right side at 45° causing pain and numbness in the right leg. In refuting Dr. Hosain's evaluation of articles that he relied upon, he notes that the articles did not establish a "standard of care" and do not constitute inflexible treatment recommendations. He cites to a study by **Natalie Shur** which addresses facet joint fluid present and the degree of lumbar instability found a positive linear correlation. The MRI exam is less sensitive for evaluating cortical anatomy and one study found that MRI exams tend to underestimate the severity of facet joint osteoarthritis compared with a CAT scan. He then explains how epidural injections work by delivering steroids directly into the epidural space in the spine. He cites indications for lumbar epidural steroid injections which include a lumbar disc herniation with a nucleus pulposus of the disc that pushes to the other outer ring; degenerative disc disease where collapse of the disc may impinge on nerves in the lower back; lumbar spinal stenosis, narrowing of the spinal canal; and compression fractures, cyst and an annular tear, none of which existed here. Epidural injections are used to treat pain that starts in the spine and radiates to an arm or leg.

It is well settled that an applicant for no-fault benefits establishes its prima facie entitlement to payment by proof of the submission to the defendant of a claim form, proof of the fact and the amount of the loss sustained, and proof either that the defendant had failed to pay or deny the claim within the requisite 30-day period, or that the defendant had issued a timely denial of claim that was conclusory, vague or without merit as a matter of law. **Ave T MPC Corp. v. Auto One Ins. Co.**, 32 Misc.3d 128(A), 934 N.Y.S.2d 32 (Table), 2011 N.Y. Slip Op. 51292(U), 2011 WL 2712964 (App. Term 2d, 11th & 13th Dists. July 5, 2011). (see *also* Insurance Law §5106[a]; **Mary Immaculate Hosp. v. Allstate Ins. Co.**, 5 A.D.3d 742; 774 N.Y.S.2d 564; 2004 N.Y. App. Div. LEXIS 3597 (2nd Dept. 2004); **Amaze Med. Supply v. Eagle Ins. Co.**, 2 Misc.3d 128[A], 2003 N.Y. Slip Op 51701 [U] (App Term 2d & 11th Jud Dists). A

"facially valid claim," is presented where it sets forth the name of the patient; date of accident; date of services; description of services rendered and the charges for those services. **See, Vinings Spinal Diagnostic P.C. v. Liberty Mutual Insurance Company, 186 Misc.2d 287; 717 NYS2d 466 (1st Dist. Ct. Nass. Co.)**

In evaluating the medical necessity of services where the proof of each party, particularly the conclusion, is contradictory, consideration must be given to the evidentiary burdens. Respondent must prove first that the services were not medically necessary. That proof must come from someone qualified by education, training and experience to give such opinion. A peer review report must set forth a factual basis to establish, prima facie, the absence of medical necessity and a conclusory assertion that certain procedures were medically unnecessary fail to create a triable issue of fact, **Choicenet Chiropractic PC v Allstate, 2003 NY Slip Op 50672U, 2003 N.Y. Misc. LEXIS 314 (App. Term, 2nd and 11th Jud Dists 2003; Amaze Medical Supply v Allstate Ins. Co., 3 Misc. 3d 43, 779 N.Y.S.2d 715, 2004 NY Slip Op 24119 (App Term 2d and 11th Jud Dists 2004**

An opinion offered by respondent is more likely to withstand the opinion of a treating medical provider when it includes:

1. some reference to the standards in the applicable medical community for the services and treatment in issue;
2. an explanation as to when such services and treatment would be medically appropriate, preferably with an understandable objective criteria; and
3. an explanation of why it was not medically necessary in the instance at issue.

If the proof of the respondent is found to meet its burden, the proof of the applicant must be considered in opposition to it, mindful that it is likely offered by the provider who actually performed examinations, established treatment and diagnostic plans, made diagnoses and performed medical services.

Dr. Hosain makes out respondent's initial burden to show that there was no medical necessity for the injection by establishing some standard and demonstrating that the applicant failed to meet that standard, namely that there was demonstrated abnormality related to the discs and that here, in the absence of physical examination findings and a definitive MRI exam, applicant fails to meet the criteria. The comments by Dr. Gamburg are sufficient to overcome that demonstration. Dr. Gamburg demonstrates that the standard of care as stated by Dr. Hosain is not actually a standard of care or guideline for the provision of

the epidural injections and that the injections are appropriate where an MRI exam demonstrates some abnormality of the disc; where electrodiagnostic testing is consistent with that finding; and where the physical examination findings including positive straight leg raising radiating to the legs is consistent with the findings upon MRI exam and upon electrodiagnostic studies. He also demonstrates that the epidural steroid injections are appropriate for treating pain in the instance such as this. The claim is therefore granted as if made on one bill and timely denied, subject to the following discussion.

Respondent submits appendices from the appropriate fee schedules demonstrating the appropriate fees payable for these procedures for physicians and Ambulatory Surgical Centers. Respondent also submits a letter from Beth Paslisen, a registered nurse and Certified Professional Coder in which she explains that pursuant to those fee schedules code 62311 should be reimbursed the amount of 1012.32 and codes 72275 and 77003 should not be reimbursed in any amount. That proof is persuasive that the appropriate amount payable is \$1012.32. Applicant has no contrary proof and the claim is therefore granted in that amount as if made on one bill and timely denied.

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
	Montvale Surgical Center	10/07/16 - 10/07/16	\$4,208.32	Awarded: \$1,012.32
Total			\$4,208.32	Awarded: \$1,012.32

- B. The insurer shall also compute and pay the applicant interest set forth below. 03/29/2017 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

INTEREST: Pursuant to Insurance Law § 5106 (a), interest accrues on overdue no-fault insurance claims at a rate of 2% per month. A claim is overdue when it is not paid within 30 days after a proper demand is made for its payment (Insurance Law § 5106 [a]; 11 NYCRR 65.15 [g]). The Superintendent's regulation tolls the accumulation of interest if the claimant "does not request arbitration or institute a lawsuit within 30 days after receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations" (11 NYCRR 65-3.9 [c]). The Superintendent has interpreted this provision to mandate that the accrual of interest is tolled, regardless of whether the particular denial at issue was timely. That interpretation was upheld by the Court of Appeals in LMK Psychological Servs, P.C. v. State Farm Mut. Auto. Ins. Co., 2009 NY Slip Op 02481 (April 2, 2009). Where no denial of claim is issued in response to a proper demand for payment, the insurer does not benefit from the tolling provision and interest will accrue from the date 30 days after the proper demand for payment is made. Interest that accrues when a denial of claim is not issued within 30 days after the proper demand for payment is made will be tolled upon the issuance of a denial of claim, although such denial is untimely, and the failure to request arbitration or institute a lawsuit within 30 days after receipt of that denial of claim form.

C. Attorney's Fees

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

ATTORNEY'S FEES: 11 NYCRR 65-4.6 establishes a minimum attorneys' fee and further provides that:

For cases filed on or before February 4, 2015, the "attorney's fee shall be limited as follows: 20 percent of the amount of first-party benefits, plus interest thereon, awarded by the . . . court, subject to a maximum of \$850" (11 NYCRR 65-4.6 [e]). The October 8, 2003, opinion letter of the Superintendent interpreted that regulation and stated that the minimum amount of attorneys' fees awarded to an assignee health care provider

pursuant to Insurance Law § 5106 is "based upon the aggregate amount of payment required to be reimbursed based upon the amount awarded for each bill which had been submitted and denied. The minimum attorney fee . . . is not due and owing for each bill submitted as part of the total amount of the disputed claim sought in the court action" (Ops Gen Counsel NY Ins Dept No. 03-10-04 [Oct. 2003]). For purposes of calculating attorneys' fees, the Superintendent has interpreted a claim to be the total medical expenses claimed in a cause of action pertaining to a single insured, and not each separate medical bill submitted by the provider. The Insurance Department's interpretation of its own regulation was upheld by the Court of Appeals in LMK Psychological Servs, P.C. v. State Farm Mut. Auto. Ins. Co., 2009 NY Slip Op 02481 (April 2, 2009). Attorneys' fees are therefore to be calculated based on the aggregate of all bills for each insured; and

For cases filed after February 4, 2015, the attorney's fee 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). The attorney's fee shall be limited as follows: 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon, for each applicant per arbitration or court proceeding, subject to a maximum fee of \$1,360. If the nature of the dispute results in an attorney's fee that could be computed in accordance with the limitations prescribed in both subdivision (c) and this subdivision, the higher attorney's fee shall be payable.

- 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, John O'Grady, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

05/02/2018
(Dated)

John O'Grady

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:
d03453b45aae3bc4c511bd90fa997530

Electronically Signed

Your name: John O'Grady
Signed on: 05/02/2018