American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Buffalo General Hospital (Applicant)	AAA Case No.	17-17-1055-6635
	Applicant's File No.	17-8179
- and -	Insurer's Claim File No.	52-8306-056
	NAIC No.	25178
State Farm Mutual Automobile Insurance Company (Respondent)		

ARBITRATION AWARD

I, Fred Lutzen, 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: EIP/claimant/patient

1. Hearing(s) held on 09/25/2018
   Declared closed by the arbitrator on 09/25/2018

   Nicole Jones, Esq., from The Morris Law Firm, P.C. participated in person for the Applicant

   AnneMarie Lanni, Esq., from Bruno Gerbino & Soriano LLP participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **$ 46,403.48**, was AMENDED and permitted by the arbitrator at the oral hearing.

   Applicant amended its claim down to $27,348.18, which now coincides with Respondent's fee coder review/opinion.

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

3. Summary of Issues in Dispute

   Applicant seeks reimbursement for lumbar surgery services provided to the EIP on 9/20/16-9/21/16. The female EIP (initials "JB") was 44-years-old when she injured in an automobile accident on 3/3/09. She subsequently came under the care of various

providers, including Dr. Simmons who initially evaluated her on 3/12/10. On 9/20/16, the EIP underwent the disputed lumbar spine surgery. Respondent denied reimbursement asserting lack of medical necessity and causality defenses in reliance on a peer review report prepared by Dr. Joseph C. Elfenbein, M.D., on 11/4/16.

The evidence clearly demonstrates that Applicant submitted its claim to Respondent and that Respondent issued a timely denial on 11/14/16.

The issues to be determined is whether the denied services were medically necessary and/or causally related to the accident of 3/3/09.

4. Findings, Conclusions, and Basis Therefor

This case was decided based upon the submissions of the parties as contained in the electronic file maintained by the American Arbitration Association, and the oral arguments of the parties' representatives. There were no witnesses. I reviewed the documents contained in MODRIA and make my decision in reliance thereon.

Respondent's denial states that "[t]he above L4-5 laminectomy, foraminectomy and discectomy, as well as all related services related services pre and post operatively to the lumbar surgery including but not limited to physical therapy, occupational therapy, follow-up office visits, post-operative radiology, and prescription medication are denied based upon an independent consultant's medical record review performed by Joseph C. Elfenbein, M.D., on November 4, 2016 advising it is not medically necessary or causally related to the accident."

For the denial to be upheld, Respondent must "set forth a factual basis and medical rationale for the peer reviewer's determination that there was a lack of medical necessity for the services rendered." *See,* Provvedere, Inc. v. Republic Western Ins. Co., 2014 NY Slip Op 50219(U) (App. Term 2nd, 11th and 13th Jud. Dists. 2014). Respondent bears the burden of production in support of it lack of medical necessity defense, which if established shifts the burden of persuasion to Applicant. *See,* Bronx Expert Radiology, P.C. v. Travelers Ins. Co., 2006 NY Slip Op 52116 (App. Term 1st Dept. 2006).

A peer review report's medical rationale will be insufficient to meet Respondent's burden of proof if: 1) the medical rationale of its expert witness is not supported by evidence of a deviation from "generally accepted medical" standards; 2) the expert fails to cite to medical authority, standard, or generally accepted medical practice as a medical rationale for his findings; and 3) the peer review report fails to provide specifics as to the claim at issue, is conclusory or vague. *See,* Nir v. Allstate Ins. Co., 7 Misc.3d 544 (N.Y. City Civ. Ct. 2005); *See also,* All Boro Psychological Servs. P.C. v. GEICO Gen. Ins. Co., 2012 NY Slip Op 50137(U) (N.Y. City Civ. Ct. 2012). "Generally accepted 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." Nir, *supra, citing,* CityWide Social Work & Psychological Servs. v Travelers Indem. Co., 3 Misc 3d 608 [Civ Ct, Kings County 2004].

Peer Review and IMEs

Dr. Elfenbein reviewed the various records provided to him, which included the initial urgent care visit on 3/4/09, massage therapy notes, chiropractic records, notes from Buffalo Neurosurgery Group, x-rays reports of the cervical/lumbar spine and right shoulder from 5/6/09, MRI reports of the cervical/lumbar spine on 5/6/09, physical therapy records, right shoulder MRI reports and right shoulder surgery records, follow-up lumbar spine x-ray reports of 10/30/13, follow-up lumbar spine MRI report of 10/30/13, lumbar epidural injection records of 11/14/13, lumbar MRI report of 3/15/16, various IME reports of the EIP, the lumbar surgery records of 9/20/16, and numerous additional records. Dr. Elfenbein provided a detailed summary of all of the records reviewed, and stated the following, in relevant part:

> I have carefully reviewed the medical records attached and I came to the conclusion that the L4-5 laminectomy, foraminectomy and discectomy is not medically necessary and ***not causally related*** to the injuries sustained in the MVA of 03/03/2009.
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> The claimant underwent X-Rays and MRI of the lumbar spine immediately following the accident which revealed degenerative changes to the lumbar spine and there was mild disc disease and no evidence of any neurological compromise of the bilateral lower extremities.
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> Claimant underwent a series of diagnostic testing of the lumbar spine each showing the progression of the degenerative joint disease.
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> MRI of the lumbar spine was done on 03/15/2016 from South Towns Radiology Associates, LLC revealed the impression of moderate-sized central to left paracentral disc protrusion at L4-LS contributing to moderate to severe central canal stenosis. Moderate bilateral foraminal narrowing at this level as well mostly secondary to facet arthropathy.
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> .
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> The findings in the latest MRI show the progression of age related degenerative joint disease and narrowing of the foramina caused by the facet joint hypertrophy. These findings are not related to the trauma sustained in the MVA. There was no evidence of spondylolisthesis.
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> .
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> Moreover, Despite of the claimant's prolonged complaints of radiculopathy, there was no evidence of objective clinical evidence of muscle atrophy of the lower extremities or ***deep tendon reflex changes*** that would support the claimant's persistent complaints.
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> "Lumbar fusion is recommended as a treatment for spinal stenosis when concomitant instability has been proven. Lumbar fusion is not recommended for spinal stenosis ***without instability***. Indications: All of

the following should be present: 1) neurogenic claudication (leg pain and/or numbness with standing or walking); 2) imaging findings, by MRI, or CT/myelogram that confirm the nerve roots compressed are ***consistent with the neurological symptoms***; 3) lack of responsiveness or unsatisfactory response(s) to adequate conservative treatment over a minimum 6 to 8 week period that may or may not include an epidural steroid injection." (New York State Workers' Compensation Board Mid and Low Back Injury Medical Treatment Guidelines of September 2014).

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It is clear that the surgery is ***not indicated***. Regardless of the findings in the MRI**,** the treating physician should not be treating the pathology in the MRI ***without assessing the general condition of the claimant, which shows a normal neurological examination of the bilateral lower extremities.***

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Therefore, based on the above mentioned the lumbar spine surgery appear to be ***not medically necessary*** and not causally related to the accident of records, Also, all related services rendered pre and post operatively related to the lumbar spine surgery including and not limited to physical therapy, occupational therapy, follow- up office visits, post-operative radiology, and prescription medication, are considered not medically necessary and not causally related. (emphasis added)

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On 7/18/16, the EIP was examined by Romanth Waghmarae, M.D., at the request of Respondent (IME). Dr. Waghmarae reported that the EIP told him "that the new issues of low back pain are not related to that MVA. In fact, the low back pain is related to a different MVA dated 2004." (sic) However, it appears that Dr. Waghmarae may have confused or reversed the accident dates, because he states that the 2009 accident occurred in Colorado. All of the evidence submitted herein demonstrates that the 2009 accident occurred in New York, not in Colorado. Respondent submitted photos of the damaged automobile showing New York license places and the EIP was seen at the urgent care facility in Buffalo, New York, following this 3/3/09 accident. In any event, I find the history provided by Dr. Waghmarae to be unreliable. If the EIP told him that the low back pain was not caused by the accident in Colorado, perhaps this was the 2004 accident.

Nevertheless, on 7/18/16, Dr. Waghmarae examined the EIP's lumbar spine and reported that "palpation of the lumbosacral spine revealed abnormalities", "lumbosacral spine exhibited tenderness on palpation left side", and "lumbosacral spine motion was abnormal." Dr. Waghmarae reported that straight-leg raise was positive at 90 degrees on the right leg and ***positive at 50 degrees on the left leg causing left sided back pain. In sum, not equal bilaterally and not normal***. Dr. Waghmarae also noted there was " ***weakness against resistance noted left leg***" and "***Neurological***: ***motor muscle bulk was abnormal weakness left leg***." Dr. Waghmarae noted that the ODI (Oswestry Disability Index) was 82% for the low back.

After reviewing voluminous medical records, Dr. Waghmarae opined that the "current treatments are partially related to the accident in question and as diagnosed in the records." He diagnosed the EIP with "post MVA related cervical fusion, cervicalgia, shoulder pain, and lumbar discogenic back and leg pain***post new MVA***, myofascial pain and spasms (***related to both MVAs***)." (emphasis added). This statement is inconsistent with his prior statements that the low back pain was related to the 2004 accident, and not this accident. In any event, regardless of what Dr. Waghmarae recalled the EIP saying to him, it was Dr. Waghmarae's professional medical opinion that the lumbar discogenic back pain and spasms were related to both MVAs.

Dr. Waghmarae opined that "[o]nce her lumbar region is addressed I do expect her to improve", "[s]he requires ongoing treatment due to the injuries from the 3/3/09 accident and the accident of 2004", "[s]he still has issues in the lumbar spine that need to be addressed further." There were additional statements in the IME report wherein Dr. Waghmarae related the low back issues to the 2004 accident, and additional statements wherein he related the low back issues to both accidents. Again, I do not find this aspect of the history to be reliable because the EIP told him it was not related to the *Colorado* accident. The other accident (this 3/3/09 accident) occurred in New York. In either case, as noted above, Dr. Waghmarae states that the lumbar discogenic back and leg pain are "post new MVA" and spasm "related to both MVAs."

The EIP was examined twice in 2010 by Dr. John H. Ring, Jr., M.D., at Respondent's request (IMEs). Dr. Ring opined that the EIP "does have permanent problems resulting from the injuries sustained in the March 3, 2009 accident. The nature and extent of her problems are residual pain in the cervical, dorsal, and lumbar spines…restriction of motion [in] lumbar spine" and "a disagreeable sensation when one tests sensation in her right foot." Dr. Ring, at that time, opined that injections for back pain were ***necessary relative to the 3/3/09 accident***.

Pre-Operative Examination

On 9/14/16, the week prior to the surgery, the EIP was examined by Jennifer Ann Yerke-McNamara, M.D., her primary care physician for pre-operative clearance. Dr. Yerke-McNamara noted that the EIP had lumbar radiculopathy, low back pain, and she was cleared for the surgery that was scheduled with Dr. Simmons for 9/20/16.

Operative Report

Dr. Edward D. Simmons, M.D., performed the disputed lumbar surgery on 9/20/16. He stated, in relevant part, the following as to the indication for surgery:

> CLINICAL NOTE: This 51-year-old woman had a history of ongoing problems with her lumbar spine dating back to an injury sustained in a motor vehicle accident on 03/03/2009. Her symptoms did not respond to ongoing nonoperative management. Radiographs showed some instability and listhesis at L4-L5 and MRI scan showed a disk herniation with associated lateral recess and foraminal stenosis at L4-L5

> correlating with her ongoing symptoms. Due to the severity of the symptoms and the effect on her quality of life and level of function, it was elected to undertake decompression and discectomy at L4-L5 along with stabilization with instrumentation and posterolateral fusion. The procedure was carried out under spinal cord monitoring.
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After reviewing all of the submitted evidence, including the peer review report by Dr. Elfenbein, the IME reports of Dr. Waghmarae and Dr. Ring, the remaining evaluation reports over the course of time, the pre-operative report, and the operative report of 9/20/16, I find that Dr. Elfenbein failed to provide the specifics as to the claim at issue in the peer review report upon which Respondent relies.

Dr. Elfenbein relied on a lack of clinical findings to support the need for surgery. However, even Respondent's IME providers confirm significant neurological deficits, such as motor strength weaknesses asymmetrically, positive straight leg raising asymmetrically, lumbar radiculopathy, and ongoing lumbar discogenic back pain. Moreover, Drs. Waghmarae, Ring, Simmons, and Yerke-McNamara all causally relate the injuries, at least in part, to the 3/3/09 accident.

I find that the peer report fails to meet Respondent's burden of proof.

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). A party cannot challenge the reliability of its own medical records. Urban Radiology, P.C. v. Tri-State Consumer Ins. Co., 27 Misc.3d 140(A), 911 N.Y.S.2d 697 (Table), 2010 N.Y. Slip Op. 50987(U), 2010 WL 2293000 (App. Term 2d, 11th & 13th Dists. June 8, 2010).

Causality

Pursuant to the No-Fault Law, Respondent is obligated to cover necessary medical expenses arising out of the use or operation of a motor vehicle. A presumption of coverage is established with Applicant's prima facie case. *See*, Kingsbrook Jewish Med. Center v. Allstate Ins. Co., 61 A.D.3d 13 (2nd Dept. 2009); Bronx Radiology v. NY Central Mutual Fire Ins. Co., 17 Misc.3d 97 (App. Term 1st Dep't 2007). Respondent must also rule out the possibility of an exacerbated pre-existing condition, as those are covered by the No-Fault Law as well. Kingsbrook Jewish Medical Center v. Allstate Ins. Co., *supra*.

By not discussing whether there was any an aggravation / exacerbation of the EIP's condition (that might warrant such a surgery), as specifically mentioned by other IME providers and treating providers, the peer reviewer failed to meet Respondent's burden of proof. This sort of aggravation or exacerbation is precisely the type of exacerbated

pre-existing condition that is expressly covered by the No-Fault Law. *See*, Kingsbrook v. Allstate, *supra.*

Conclusion

On the issue of medical necessity, as noted above, Dr. Elfenbein heavily relied on a total absence of positive or abnormal clinical neurological findings in order to reach his opinion that the surgery should not have been performed or was unnecessary. However, the records clearly demonstrate otherwise, i.e., that there were positive clinical neurological deficits and findings reported by several other physicians, including Respondent's own IME providers who physically examined the EIP. As such, Respondent has failed to demonstrate, prima facie, that the surgery lacked medical necessity and did not meet its burden of proof. *See*, Nir v. Allstate Ins. Co., 7 Misc.3d 544 (N.Y. City Civ. Ct. 2005); *See also*, All Boro Psychological Servs. P.C. v. GEICO Gen. Ins. Co., 2012 NY Slip Op 50137(U) (N.Y. City Civ. Ct. 2012).

Every peer review requires individual scrutiny to determine whether the burden should be shifted back to the claimant to submit contrary expert proof. 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 3-4, 2011 WL 1226956 (Dist. Ct. Nassau Co., Michael A. Ciaffa, J., Apr. 1, 2011).

As such, there is no need to consider Applicant's rebuttal evidence, or lack thereof, since Applicant's claims arrived to this arbitration carrying a presumption of causality and medical necessity, which has not been rebutted by Respondent. *See*, Millennium Radiology, P.C. v. New York Central Mutual Fire Ins. Co., 23 Misc.3d 1121(A), 886 N.Y.S.2d 71 (Table), 2009 N.Y. Slip Op. 50877(U), 2009 WL 1261666 (Civ. Ct. Richmond Co., Katherine A. Levine, J., Apr. 30, 2009).

Having carefully considered the evidence submitted by both parties and the arguments of counsel, I find that the preponderance of credible evidence warrants a finding in favor of the Applicant on the issues of causality and medical necessity.

Applicant is awarded $27,348.18.

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**
	Buffalo General Hospital	**09/20/16 - 09/21/16**	**$46,403.48**	**$27,348.18**	**Awarded: $27,348.18**
Total			**$46,403.48**		**Awarded: $27,348.18**

B. The insurer shall also compute and pay the applicant interest set forth below. 02/07/2017 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant is awarded interest pursuant to the no-fault regulations. *See generally*, 11 NYCRR §65-3.9. 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); and OGC Op. No. 10-09-05 (interest accrues from date Applicant "*actually requests arbitration*" or commences a lawsuit). The Superintendent and the New York Court of Appeals have 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).

C. Attorney's Fees

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

Applicant is awarded statutory attorney fees pursuant to the no-fault regulations. See, 11 NYCRR §65-4.5(s)(2). The award of attorney fees shall be paid by the insurer. 11 NYCRR §65-4.5(e). Accordingly, "the attorney's fee shall be limited as follows: 20 percent of the amount of first-party benefits, plus interest thereon, awarded by the arbitrator or the court, subject to a maximum fee of $1360." Id. However, if the benefits and interest awarded thereon is equal to or less than the respondent's written offer during the conciliation process, then the attorney's fee shall be based upon the provisions of 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 Erie

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

10/02/2018
(Dated)

Fred Lutzen

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:
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Electronically Signed

Your name: Fred Lutzen
Signed on: 10/02/2018