American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

New York Spine Specialists (Applicant)	AAA Case No.	17-18-1101-5843
	Applicant's File No.	2145739
- and -	Insurer's Claim File No.	576085
	NAIC No.	Self-Insured
MVAIC (Respondent)		

ARBITRATION AWARD

I, Neal S. Dobshinsky, 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: J Doe

1. Hearing(s) held on 10/24/2019
   Declared closed by the arbitrator on 10/24/2019

   Scott Fisher from Israel, Israel & Purdy, LLP (Great Neck) participated in person for the Applicant

   Jeffrey Kadushin from Marshall & Marshall, Esqs. participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 20,193.51**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The amount claimed was amended to $16,129.74 to conform to the fee schedule.

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

3. Summary of Issues in Dispute

   Dr. Andrew Cordiale, a physician with Applicant, performed a spinal posterolateral lumbar fusion and related services on Doe. Respondent denied payment for Applicant's entire claim for lack of medical necessity as determined by Respondent's peer reviewer.

Were these surgical procedures medically necessary? Is Applicant entitled to payment on its claims? If so, how much?

4. Findings, Conclusions, and Basis Therefor

I have read and considered the materials in the American Arbitration Association's ADR Center case file and heard and considered the parties' oral arguments. I find as follows:

Background

On 10/8/17, J Doe, a male, then 39 years old, was a pedestrian who claims to have been struck by a motor vehicle. Doe claims he was injured. He sought medical care and treatment from a number or medical providers.

On 11/7/17, Doe aw Andrew J. Cordiale, DO, a spine specialist with Applicant, for complaints of lower back pain and neck pain.

Doe reported that he was a pedestrian who was struck by a van, thrown into the air, and landed on the vehicle. He was taken to the hospital by ambulance and seen in the emergency room where he was treated and released. Doe had a significant history of a prior neck and back injury. At some time in the past, he had a course of 3 cervical epidural steroid injections and 3 lumbar epidural steroid injections. He was unemployed. Doe has been treated with physical therapy, exercise and massage.

At the initial visit with Dr. Cordiale, Doe's back pain was rated as 8 out of 10 and the neck pain was 6 out of 10. The pain was constant and sharp, shooting. Pain was worsened by lifting, carrying, and other activities.

Dr. Cordiale examined Doe. Cervical and lumbar ranges of motion were restricted. Cervical and lumbar neurological exams were not within normal limits. The doctor diagnosed Doe with cervical spine pain; cervical radiculopathy; and lumbar spine strain. The initial treatment plan was for Doe to continue with physical therapy; for MRIs of Doe's cervical and lumbar spines; and for a pain management consult.

Doe saw Dr. Cordiale for a follow-up on 12/14/17. The history now notes that Doe "has had significant history of previous neck or back injury of an MVA in 2012." The rest of this report is similar to the 11/7/17 report. The findings are similar. The diagnosis and plan were as before.

Doe saw Dr. Cordiale for another follow-up on 3/29/18. Doe was examined. It is noted that Doe had a left knee brace and that he walked with a cane. Doe was diagnosed with cervical spine pain; cervical radiculopathy; and lumbar spine strain; herniated lumbar and cervical discs. The plan was as before.

Doe saw Dr. Cordiale yet again on 4/5/18. Doe was examined. The doctor notes the MRI findings which include herniated nucleus pulposi at C3/4 and C5/6 and herniated nucleus pulposus at L4/5.

The plan was for Doe to proceed with a PSFL L4/5. The doctor noted indications for surgery: (i) failed conservative treatments, 6 months of physical therapy; (ii) failed epidural injections; (iii) MRIs positive for HNP L4/5, S1, (iv) neurological deficits at L4-L5, S1; (v) severe low back and leg pain 7-10 out of 10; lumbar x-ray positive foraminal stenosis at L4-L5, requiring more than 50% of the pars and facts to be removed for adequate decompression of the nerves; (vii) nonsmoker; (viii) no history of depression or drug abuse.

On 5/11/18, Dr. Cordiale performed the surgery. He was assisted by a physician's assistant. Dr. Cordiale performed a posterolateral fusion L4/5; segmental pedical fixation L4/5; lumbar laminectomy L4; Hemi-laminectomy L5; dural repair of arachnoid bleed without CSF loss' facetectomy, foraminotomy; morselized bone graft; BMP implant bilateral; neurolysis L4/5; fluoroscopy; and closure.

Applicant's Claim and Respondent's Denial

Applicant, as Doe's assignee, timely submitted a claim for no-fault benefits for payment for the surgery. Respondent denied payment for lack of medical necessity based on a peer review. At the hearing Respondent questioned the amount of the fee sought.

The only issues argued and submitted by the parties were whether the surgery was medically necessary and whether the fee was proper. All other issues are deemed waived.

Medical Necessity and the Burden of Proof Under No-Fault

Medical necessity for services or supplies is established by applicant's claim form itself. *All County Open MRI & Diagn. Radiology P.C. v Travelers Ins. Co.*, 11 Misc3d 131(A), 2006 N.Y. Slip Op. 50318[U] [App Term, 2d Dept 9th & 10th Jud Dists 2006].

The insurer "bears both the burden of production and persuasion" as to its defense of lack of medical necessity. *Nir v Allstate Ins. Co*., 7 Misc3d 544, 546 [Civ Ct, Kings County 2005]. The defense must be supported by a peer review report or other evidence, such as an independent medical examination report. The report must set forth a sufficiently detailed factual basis and medical rationale for the denial. *Amaze Med. Supply v Eagle Ins. Co*., 2 Misc3d 128(A), 2003 NY Slip Op 51701[U] [App Term, 2d Dept, 2d & 11th Jud Dists 2003].

"[H]owever, it is the [applicant] who has the ultimate burden of proving, by a preponderance of the evidence, that the services at issue were medically necessary (citations omitted)." *Radiology Today, P.C. v Geico Ins. Co*., 58 Misc 3d 132(A) n, 2017 NY Slip Op 51768[U] [App Term, 2d Dept, 2d, 11th & 13th Jud Dists 2017].

Nevertheless, in an action or arbitration to recover no-fault benefits, "an [insurer] has the burden to come forward with proof in admissible form to establish "the fact" or the evidentiary "found[ation for its] belief" that the patient's treated condition was unrelated to his or her automobile accident. *Mount Sinai Hosp. v Triboro Coach Inc.*, 263 AD2d 11, 19-20 [2d Dept 1999] [internal citations omitted]. "Unlike negligence actions where plaintiffs must prove causation, plaintiffs seeking to recover first party no-fault payments bear no such initial burden, as causation is presumed. . . ." *Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co.*, 61 AD3d 13, 21 [2d Dept 2009] [internal citations omitted].

The Peer Review and Insurer's Lack of Medical Necessity Defense

Insurer based its denial of claim on the affirmed "orthopedic surgical causality" review report of Andrew N. Bazos, MD, a physician board certified in orthopedic surgery. The doctor states his reasons, opinion, and recommendation why the surgery was not medically necessary or causally related to the underlying accident in his 10/8/17 report.

The doctor lists the records and reports he reviewed. These included: the operative report for the L4-L5 posterior lumbar fusion; MRI reports of Doe's lumbar and cervical spines; hospital emergency room records, 10/15/17; police report 10/8/17; physical therapy evaluation and evaluation records; chiropractic evaluation and treatment records; Applicant's reports 11/7/17, 12/14/17, and 4/5/18; reports of multiple visits with and operative reports by Prompt Medical Spine Care, and a few others.

Dr. Bazos states that "the causal relationship between the motor vehicle accident and need for spinal surgery has not been established. It is clearly obvious that this claimant has extensive significant pre-existing conditions of the lumbar spine unrelated to the motor vehicle accident." "Due to lack of adequate supporting documentation by the treating surgeon, lack of adequate documentation of the claimant's preexisting conditions, and lack of clinical correlation between the claimant's preexisting clinical correlations and any supposed positive findings both on physical exam and diagnostic imaging which may have resulted from the accident of 10/08/2017, the medical necessity for any operative procedures has not been established."

Dr. Bazos' peer review is conclusory. It is not persuasive.

Perhaps, Dr. Bazos is unaware that an Applicant is aided by the presumption of medical necessity and that causation is presumed. Yet the entirety of Dr. Bazos' report is based on his opinion that Applicant has not established medical necessity. On that basis alone, Dr. Bazos' report has no weight.

In addition, while Dr. Bazos is very critical of Dr. Cordaile's records, there are significant issues with Dr. Basos' peer review. He states reviewed the police report dated 10/8/17. That report plainly states that Doe was "removed to Metropolitan Hospital by EMS." While neither party has submitted the EMS record or the hospital record, the police report shows that Doe did get immediate treatment. Yet, Dr. Bazos states, '[a]n additional unexplained situation is the lack of evidence of any care rendered in close proximity to date of the motor vehicle accident. This claimant did not seek medical treatment until five days post trauma. One would expect an individual who supposedly sustained significant trauma as a result of the motor vehicle accident to seek immediate emergency medical care, which is not the case to this individual. At no point in time did the claimant or any physician document why there was such a delay in this claimant seeking emergent medical services." Perhaps, Dr. Bazos' opinion would be different had he obtained and reviewed the EMS and Metropolitan Hospital records of the immediate care.

He states that Dr. Cordiale does not note in his 11/7/17 record that Doe had had back surgery. But, there is such a note in Dr. Cordiale's 12/14 record, and the surgery at issue was not yet being considered.

Dr. Bazos does not state that he himself reviewed the MRI films, just the report from the radiologist. Yet he states, "MRI findings are most consistent with that of pre-existing degenerative changes strictly at L4-L5 level which clearly indicated evidence of dehydration present in the disc indicating chronic degenerative attrition as opposed to acute trauma. In fact, the MRI itself failed to indicate any evidence of acute traumatic injuries for this individual with regard to lumbar spine complaints." The MRI report, which is in the submissions, does not state "chronic degenerative attrition as opposed to acute trauma." Neither the word "chronic" nor the word "acute," is in the report.

Dr. Bazos does not exclude the possibility (probability) that Doe's preexisting condition(s) was (were) exacerbated or aggravated in the accident. And he does not state or compare what Doe's condition was before the accident at issue with his condition after the accident. How did he determine that the current condition was pre-existing without reviewing pre-accident records and then discussing the differences. Was there no change at all in Doe's condition as a result of the accident? The doctor needs to show by reference to evidence the basis for his belief that Doe's need for surgical intervention was not the result of any trauma sustained in the underlying accident. He does not do that.

If Dr. Bazos needed more records to offer an informed opinion he should have requested the records, and Respondent should have obtained them for him. There is no evidence of that. Furthermore, the doctor does not set forth a standard of care or treatment for Doe's constellation of symptoms and signs. He does not support his opinion with any medical authorities or literature.

For these reasons and more, Dr. Bazos' report does not provide a credible factual basis or medical rationale for MVAIC's denial of Applicant's claim. Respondent did not meet its initial evidentiary burden of production and persuasion as to its defense.

Applicant's Rebuttal; Respondent's Addendum

Because Respondent has not met its initial evidentiary burden, it was not necessary to consider either Applicant's rebuttal to the peer by Dr. Cordiale or Respondent's addendum by Dr. Bazos in reply to the rebuttal.

Respondent's Fee Schedule Defense

An insurer is only required to reimburse a claimant in accordance with the applicable fee schedule. "[A]n insurer adequately preserves its fee schedule defense 'by checking box 18 on the NF-10 denial of claim form to assert that plaintiff's fees [were] not in accordance with the fee schedule.'" *Matter of Global Liberty Ins. Co. v Therapeutic Physical Therapy, P.C.*, 148 AD3d 502 [1st Dept 2017] [internal citations omitted]. Here, Insurer checked box 18.

It is an insurer's burden to come forward with competent evidentiary proof to support the defense. *Robert Physical Therapy, P.C. v State Farm Mut. Auto Ins. Co.*, 13 Misc. 3d 172 [Civ Ct Kings Co 2006] [internal citations omitted]. The defense may be established through the parties' submissions which may include references to and excerpts from the fee schedule. See *Natural Acupuncture Health, P.C. v Praetorian Ins. Co.*, 30 Misc. 3d 132A, 2011 N.Y. Slip Op. 50040(U) [App Term 1st Dept 2011]). An arbitrator may be requested to take judicial notice of the fee schedule, CPLR 4511(b); see *Kingsbrook Jewish Med. Ctr. v Allstate Ins. Co.*, 61 AD3d 13, 21 [2d Dept 2009]), In an appropriate case, a reference to the fee schedule and the other papers submitted by the parties may be sufficient to establish the defense as a matter of law. *Jing Luo Acupuncture, P.C. v NY City Tr. Auth.*, 60 Misc 3d 136(A) [Appellate Term, 2d Dept 2018], 2018 NY Slip Op 51083(U).

Respondent has not submitted a coder's affidavit. There is no fee audit. There is no affidavit or anything else to explain the various surgical procedures, the applicable CPT codes, fees and Respondent's disagreements. Except for one line item in Applicant's bill (CPT code 13101), this is not a case where one can simply take judicial notice of the fee schedule and determine whether the fees are proper.

CPT 13101 code is for complex repair of a wound to the trunk, 2.6 to 7.5 cm. A review of the operation summary in the submissions does not show that any "wound" repair was performed. A surgical incision is not a wound. The fee schedule uses the word incision where that is what is intended. It would appear that when a surgeon makes an incision as part of a surgical procedure, closing that incision is an inherent part of the procedure. See, Surgery Ground Rule &.

Accordingly, Applicant's claim for $350.44 for wound repair is disallowed. In all other respects, Respondent has not met its burden to come forward with *competent evidentiary proof* to support its fee schedule defense.

Conclusion

Based on the parties' submissions, their arguments, the relevant law, the regulations, and the weight of the evidence, I conclude that Respondent has not met its initial evidentiary burden to establish its lack of medical necessity defense. Applicant is entitled to payment on its claim in accordance with the foregoing.

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**
	New York Spine Specialists LLP	**12/27/17 - 05/11/18**	**$20,193.51**	**$16,129.74**	**Awarded: $15,779.30**
Total			**$20,193.51**		**Awarded: $15,779.30**

B. The insurer shall also compute and pay the applicant interest set forth below. 07/26/2018 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Insurer shall compute and pay interest from the accrual date noted above-the date Applicant requested arbitration by filing with the AAA-at a rate of 2% per month, simple interest, calculated on a pro-rata basis using a 30-day month and ending with the date of payment subject to the provisions of 11 NYCRR 65-3.9.

C. Attorney's Fees

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

Insurer shall pay Applicant's attorney a fee in an amount equal to 20% of the total amount of the benefits plus interest awarded in this arbitration, subject to the provisions and limitations of 11 NYCRR §65-4.6.

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

11/22/2019
(Dated)

Neal S. Dobshinsky

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:
55f49a4bd17ec83a8026771eb0006c64

Electronically Signed

Your name: Neal S. Dobshinsky
Signed on: 11/22/2019