

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Saddle Brook Endoscopic & Orthopedic
Surgical Center
(Applicant)

- and -

Esurance Insurance Co.
(Respondent)

AAA Case No.	17-19-1141-4378
Applicant's File No.	291885
Insurer's Claim File No.	NYA-0153109
NAIC No.	30210

ARBITRATION AWARD

I, Stacey Charkey, 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 11/10/2020
Declared closed by the arbitrator on 11/10/2020

Neil Menashe, Esq. from Neil Menashe Attorney At Law P.C. participated by telephone for the **Applicant**

Omid Khani, Esq. from Law Offices Of Karen L. Lawrence participated in person for the **Respondent**

2. The amount claimed in the Arbitration Request, **\$ 12,660.00**, was **AMENDED** and permitted by the arbitrator at the oral hearing.

AR1 was reduced to \$1871.42 to reflect fee schedule.

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

3. Summary of Issues in Dispute

Whether Applicant is entitled to reimbursement for the fees associated with a thoracic medial branch block at the bilateral T6-T7, T7-T8, T8-T9 and T9-T10 levels performed 5/30/19 on assignor, a 27 year old male, in connection with injuries sustained in a motor vehicle accident occurring on 6/13/18. The claims were denied based upon a peer review performed by Dr. Stuart Springer dated 7/3/19.

4. Findings, Conclusions, and Basis Therefor

I have reviewed the documents contained in the Electronic Case Folder as of the date of the Hearing and this Award is based upon my review of the Record and the arguments made by the representatives of the parties at the Hearing.

This arbitration arises out of medical treatment of a 27 year old male, related to injuries sustained in a motor vehicle accident that occurred on 6/13/18. Applicant seeks reimbursement for the fees associated with a thoracic medial branch block at the bilateral T6-T7, T7-T8, T8-T9 and T9-T10 levels performed 5/30/19 .

This assignor is a 27-year old male who was involved in a motor vehicle accident on 06/13/2018. He was hit by a vehicle while walking across the crosswalk. The assignor was hit on the left arm, left sided neck/shoulder and left leg. There was no loss of consciousness. Following the accident he went to Health Alliance Westchester Medical Center, where he was treated and released with pain medications. According to the Health Alliance Westchester Medical Center records, dated 06/13/2018, the assignor had neck pain. He was prescribed with the pain medications. As per the new patient evaluation report, dated 07/09/2018, by Aditya Patel, M.D., the assignor had neck and lower back pain. MRI of the thoracic spine was ordered. Physical therapy and chiropractic treatment were advised. As per the initial evaluation report, dated 07/09/2018, by Eugene R. Koloski, M.D., the assignor was evaluated for a hernia.

MRI report of the thoracic spine, dated 07/31/2018, demonstrated: Thoracic cord is unremarkable in caliber, contour and signal without evidence of focal lesion. There is a small right paracentral disc bulge at T2-T3 without significant spinal canal stenosis or neuroforaminal narrowing.

The assignor received physical therapy from 08/06/2018 to 05/13/2019, for the spine. As per the follow-up patient evaluation report, dated 09/10/2018, by Aditya Patel, M.D., the assignor had mid back pain. On examination, muscle spasm was noted over the T1 to T12 levels. The impression was thoracic disc herniation. Thoracic epidural steroid injection was recommended.

According to the follow-up patient evaluation reports, dated 10/15/2018, 11/26/2018, and 02/11/2019, by Sukdeb Datta, M.D., the assignor had mid back pain with tenderness over the thoracic spine and decreased range of motion. He was recommended to continue with physical therapy.

On 12/14/2018, the assignor underwent thoracic epidural steroid injection at the T6-T7 level and epidurography by Aditya Patil, M.D., under monitored anesthesia care. The pre-operative and postoperative diagnosis was intervertebral disc disorder with radiculopathy, thoracic region. On

12/28/2018, the assignor underwent thoracic epidural steroid injection with fluoroscopic guidance at the T4-T5 level and epidurography by Aditya Patil, M.D., under monitored anesthesia care. The pre-operative and post-operative diagnosis were intervertebral disc disorder with radiculopathy, thoracic region.

As per the follow-up orthopedic evaluation report, dated 01/22/2019, by Gabriel L. Dassa, D.O., the assignor was diagnosed with thoracic spine disc bulging. He was recommended to continue with physical therapy and pain medications. On 02/15/2019, the assignor underwent thoracic epidural steroid injection at the T6-T7 level and epidurography by Aditya Patil, M.D., under monitored anesthesia care. The pre-operative and postoperative diagnosis were intervertebral disc disorder with radiculopathy, thoracic region. X-ray report of the thoracic spine, dated 04/05/2019, revealed no acute abnormality of the thoracic spine. According to the follow-up patient evaluation report, dated 04/22/2019, by Sukdeb Datta, M.D., the assignor had mid back pain with tenderness over the thoracic spine and decreased range of motion. He was recommended to continue with the physical therapy. Medial branch block was advised.

On 05/30/2019, the assignor underwent thoracic medial branch block at the bilateral T6-T7, T7-T8, T8-T9 and T9-T10 levels and multiplanar fluoroscopy by Aditya Patil, M.D., under monitored anesthesia care. The pre-operative and post-operative diagnoses were thoracic pain, spondylosis thoracic region, intervertebral disc disorder with radiculopathy, and chronic pain syndrome.

Applicant submitted its bill for the procedure to respondent who timely denied payment of the services based upon a peer review by Dr. Stuart Springer. No rebuttal was submitted.

According to Dr. Springer, "the service of the thoracic spine medial branch block and associated services performed on 05/30/2019 were not medically necessary. Dr. Springer fleetingly and conclusorily noted that *"In regards to thoracic medial branch block, the following should be noted [Link/Source intentionally omitted] "Facet joints are clinically important spinal pain generators in patients with chronic spinal pain. Pain mediated by the facet joints may be caused by repetitive stress and/or cumulative low-level trauma resulting in osteoarthritis and inflammation. Imaging findings are of little value in determining the source and location of 'facet joint syndrome', a term originally used by Ghormley and referring to back pain caused by pathology at the facet joints. Imaging studies may detect changes in facet joint architecture, but correlation between radiologic findings and symptoms is unreliable. Facet joints are known to be a source of pain with definitive innervations. Interventions used in the treatment of patients with a confirmed diagnosis of facet joint pain include: medial branch nerve blocks in the lumbar, cervical and thoracic spine."*

Dr. Springer noted further that *" In this clinical scenario, the assignor had mid back pain following the accident. According to the medical records, the documentation does not substantiate that the assignor had a facet joint syndrome on the imaging study or in the clinical findings. Hence based on the guideline, the thoracic medial branch block was not medically necessary. Since the thoracic medial branch block was not medically necessary hence the associated services of drug(s) or substance(s), fluoroscopic guidance, supplies, and transportation were also not medically necessary."*

It is well settled that an applicant established its prima facie entitlement to payment by proving it submitted a claim set forth the facts and the amount of the loss sustained and that payment of no fault benefits were overdue (see Insurance Law § 5106[a]; , Mary Immaculate Hospital v Allstate Ins. Co. 5 A.D.3d. 742 Second Dep't 2004), A.B. Medical Services PLLC v Lumbermans Mutual Cas. Co., 4 Misc. 3d. 86 (App. Term 2d. & 11th Jud. Dists. 2004). A facially valid claim is presented when it sets forth the name of the patient; date of accident; date of the services; description of services rendered and the charges

for those services. See *Vinings Spinal Diagnostic PC v. Liberty Mutual Insurance Company*, 186 Misc. 2d 287 (1st Dist. Ct. Nass. Co.1996). In evaluating the medical necessity of services with proof of each party particularly where the conclusions are contradictory; consideration must be given to the evidentiary burdens.

Respondent must prove first that the services were not medically necessary. A peer review report must set forth a factual basis to establish, prima facie the absence of medical necessity. The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment *Kingsborough Jewish Med. Ctr. v. All State Ins. Co.* 2009 NY Slip Op. 00351 (2d. Dep't, January 20, 2009), See also *Channel Chiropractic PC v. Country Wide Ins. Co.* 38 AD 3d. 294 (1st Dep't, 2007). An insurance carrier must at a minimum establish a detailed factual basis and a sufficient medical rationale for asserting lack of medical necessity. See *Vladimir Zlatnick, M.D. v. Travelers Indem. Co.* 2006 NY Slip Op. (50963U) (App. Term 1st Dep't, 2006). See also *Delta Diagnostic Radiology PC v. Progressive Casualty Ins. Co.* 21 Misc. 3d. (142A) (App. Term 2d. Dep't, 2008).

Conclusions set forth in peer reviews may be insufficient if it fails to provide specifics of the claim, is conclusory or otherwise lacks a basis in the facts of the claim see *Amaze Medical Supply v. All State Ins. Co.* 3 Misc. 3d. 43 (App. Term, 2d Dep't, 2004). A peer review report must set forth a factual basis to establish, prima facie the absence of medical necessity. See *Nir v Allstate Ins. Co.*, 7 Misc. 3d. 544, 547 (Civ. Ct., Kings Co., 2005) which indicates a respondent's peer review defending a denial of first-party benefits on the ground that the billed-for services were not "medically necessary" must at least show that the services were inconsistent with generally accepted medical/professional practice. The opinion of the insurer's expert, standing alone, is insufficient to carry the insurer's burden of proving that the services were not "medically necessary." citing *Citywide Social work & Psy. Serv. P.L.L.C. v Travelers Indemnity Co.*, 3 Misc. 3d. 608, 616 (Civ. Ct., Kings Co. 2004). A peer report must demonstrate that the services rendered were not in agreement with generally accepted medical or professional standards. Generally accepted practice is the range of practice that the profession will follow in the diagnosis and treatment of the patient in light of the standards and values that define it. Therefore an opinion offered by a respondent is more likely to establish a lack of medical necessity when it provides some reference to the standards in the applicable medical community for the services and treatment at issue with an explanation as to when such services and treatment would be medically appropriate with objective criteria and an explanation why it was not medically necessary herein.

Herein, I have reviewed Dr. Springer's Peer Review; I am not persuaded that the surgery was not medically necessary. Dr. Springer outlines various findings, but states, in a fleeting fashion, that there was no medical indication for the injection. It is my determination that as a whole, the Peer Review is conclusory. Dr. Springer does not articulate the standard of care for the performance of the injection, the circumstances in which it is prudently recommended or the conditions it effectively treats or remedies; in turn, there is no indication that the injection was performed in deviation from any such standard. Moreover, Dr. Springer fails to provide any objective medical literature or guidelines in support of his contentions; a reference and link to a document does not serve to support what I deem a subjective opinion. Although it is true that a Peer Review does not necessarily need to contain reference to any medical literature or guidelines, still, the Peer Review must not be cursory or conclusory.

I find that the Peer Review of Dr. Springer is conclusory and that it does not serve to rebut the presumption of medical necessity attached to Applicant's claim. In turn, the onus is not on Applicant to justify necessity. Within the record are medical records which evidence that the Assignor engaged in conservative treatment; still, the Assignor's symptomology and complaints of pain persisted, as

documented in re-evaluations. MRIs revealed significant injuries. Conservative treatment was attempted, failed to favorably benefit the Assignor and Assignor's condition did deteriorate. On the totality of the evidence, I find that Respondent fails to meet its burden and that the procedure was medically necessary.

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
	Saddle Brook Endoscopic & Orthopedic Surgical Center	05/30/19 - 05/30/19	\$12,660.00	\$1,871.42	Awarded: \$1,871.42
Total			\$12,660.00		Awarded: \$1,871.42

- B. The insurer shall also compute and pay the applicant interest set forth below. 09/12/2019 is the date that interest shall accrue from. This 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 the adjudication is commenced by the claimant, to wit: the date the application document was received by the American Arbitration Association, unless arbitration is commenced within 30 days as of the date the denial is received by the claimant. 11 NYCRR 65-3.9c. LMK Psychological Services P.C. v. State Farm Mut. Auto Ins. Co., 12 NY3d 217, 879 NYS2d 14 (2009). The end date for the calculation of the period of interest shall be the date of payment of the claim. In calculation the interest, the date of accrual shall be excluded from the calculation. Accordingly, at bar, unless specifically noted in the body of this award, the date the application document was received by AAA, shall be utilized as the date of accrual for the purpose of calculating interest. Where applicable, if noted within the body of this award, said date of accrual of interest shall be controlling.

C. Attorney's Fees

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

After calculating the sum total of the first-party benefits awarded in this arbitration plus interest thereon, Respondent shall pay Applicants an attorney's fee equal to 20 percent of that sum total, as provided for in 11 NYCRR 65-4.6 (as existing on the filing date of this arbitration), subject to a maximum fee of \$1,360.00.

- 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 Queens

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

12/03/2020
(Dated)

Stacey Charkey

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:
20b3d1bc0ebb40dcdee5d299f0609b9a

Electronically Signed

Your name: Stacey Charkey
Signed on: 12/03/2020