

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

BL Pain Management PLLC
(Applicant)

- and -

Allstate Insurance Company
(Respondent)

AAA Case No. 17-21-1230-4534

Applicant's File No. 248882

Insurer's Claim File No. 0595047481 2SJ

NAIC No. 19232

ARBITRATION AWARD

I, Charles Blattberg, 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: Eligible injured person

1. Hearing(s) held on 06/29/2022
Declared closed by the arbitrator on 07/06/2022

Kurt Lundgren, Esq. from Thwaites, Lundgren & D'Arcy Esqs participated by telephone for the **Applicant**

David Kelly, Esq. from Law Offices of James F. Sullivan, PC participated by telephone for the **Respondent**

2. The amount claimed in the Arbitration Request, **\$7,760.39**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant reduced the total amount in dispute to \$4,231.34 pursuant to fee schedule.

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

Respondent stipulated that the amended claim amount is in accordance with the NY Workers' Compensation Fee Schedule.

3. Summary of Issues in Dispute

The claimant was the 57 year-old female restrained driver of a motor vehicle that was involved in an accident on 8/3/20. Following the accident the claimant suffered injuries which resulted in the claimant seeking treatment. At issue is the medical necessity of the facility fee associated with a 1/18/21 C5-6 provocative discogram, C5-6 anterior cervical percutaneous discectomy, and C5-6 Annuloplasty that Respondent timely denied reimbursement for based on a 2/11/21 peer review by Jay M. Weiss, M.D.

4. Findings, Conclusions, and Basis Therefor

Based on a review of the documentary evidence, this claim is decided as follows:

An applicant establishes a prima facie case of entitlement to reimbursement of its claim by the submission of a completed NF-3 form or similar document documenting the facts and amounts of the losses sustained and by submitting evidentiary proof that the prescribed statutory billing forms [setting forth the fact and the amount of the loss sustained] had been mailed and received and that payment of no-fault benefits were overdue. See, *Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). I find that Applicant established a prima facie case for reimbursement.

The claimant was the 57 year-old female restrained driver of a motor vehicle that was involved in an accident on 8/3/20. The claimant reportedly injured her neck, upper back, mid back, and lower back. There was no reported loss of consciousness. There were no reported lacerations or fractures. Following the accident the claimant was transported to Montefiore Hospital where she was evaluated, treated, and released. On 8/5/20 the claimant presented to Muhammad Zakaria, M.D. of QR Medical Services, P.C. with complaints of radiating neck pain rated 8/10 (where 0 is no pain and 10 is the worst pain), upper and mid back pain rated 8/10, and radiating low back pain rated 8/10. Cervical examination revealed restricted range of motion in all planes (quantified), tenderness, trigger points and muscle spasms. Thoracic examination revealed tenderness. Lumbar examination revealed restricted range of motion in all planes (quantified), tenderness, trigger points and muscle spasms. Dr. Zakaria supervised Outcome Assessment (OSWESTRY) testing. Dr. Zakaria performed left L4-L5 trigger point injections under ultrasonic guidance. The claimant was recommended for physical therapy and prescribed Lidocaine 5% ointment, Naproxen 500mg, cyclobenzaprine 10mg, and durable medical equipment (consisting of a lumbar sacral support, EMS unit with accessories, eggcrate mattress, cervical collar, and bed board). On 8/5/20 the claimant presented to Reactive Physical Therapy, P.C. and was initiated on physical therapy. On 8/5/20 the claimant presented to Journey Acupuncture, P.C. and was initiated on acupuncture and cupping. On 8/5/20 the claimant presented to Martin Miller, D.C. with complaints neck pain, mid back pain and lower back pain. Examination of the cervical spine revealed tenderness, hypertonicity, crepitus, myospasm and torticollis on palpation at C1, C2, C3, C6 and C7 level. Positive orthopedic tests were Foraminal Compressions, Jackson's Compression, Cervical Distraction, Shoulder Depression, and Spurling's Maneuver. Range of motion

examination of cervical spine was restricted: flexion 30/60°, extension 40/75°, bilateral lateral flexion of 25/45°, right rotation 60/80° and left rotation 50/80°. Examination of the thoracic spine revealed tenderness and hypertonicity on palpation at T1-T12 level. Examination of the lumbar spine revealed tenderness and hypertonicity on palpation at L1, L2, L3, L4, L5, sacral and left sacroiliac joint level with decreased and painful range of motion (unquantified). Positive orthopedic tests were Kemp's Maneuver, Lasegue's test/Straight Leg Raising test and Braggard's Maneuver. Decreased muscles strength was noted on upper extremities at bilateral biceps and brachioradialis 4/5 and left triceps 4/5. Decreased muscles strength was noted on lower extremities at bilateral patellar and Achilles 4/5 and left hamstring 4/5. Asymmetrical reflexes were noted on upper extremities at C5 and C6 at 1+. Asymmetrical reflexes were noted on lower extremities at L4, L5 and S1 at 1+. The claimant was initiated on chiropractic treatment. The 8/14/20 brain MRI ordered by Dr. Miller produced a normal study. The 8/14/20 cervical spine MRI ordered by Dr. Miller produced an impression of disc bulges and endplate hypertrophy impinging upon the ventral thecal sac at C3-4, C4-5, and C5-6; and no fractures, spinal stenosis, or cervical cord lesion. The 8/14/20 thoracic spine MRI ordered by Dr. Miller produced an impression of endplate hypertrophy and disc bulges impinging the ventral thecal sac at T5-6, T6-7, T7-8, and T8-9; and no fractures, cord compression, or intradural lesion. The 8/14/20 lumbar spine MRI ordered by Dr. Miller produced an impression of levoscoliosis and straightening of the lumbar lordosis consistent with muscular strain or spasm and disc desiccation, bulging, and facet joint hypertrophy impinging upon the thecal sac and the left and right lateral neural foramina at the L5-S1 interspace. On 8/20/20 Dr. Miller prescribed a lumbosacral orthosis and the 6 weeks use of a SAM (sustained acoustic medicine) device with coupling patches. On 8/24/20 the claimant presented to Boleslav Kosharsky, M.D. of Pain Physicians NY, LLC with complaints of lower back pain radiating to the buttocks and lower left and cervical pain radiating to the bilateral shoulders and left arm. Cervical examination revealed "Palpation: Tenderness at the upper trapezius muscle and periscapular region and also paravertebral over the Right and Left C2-3, C3-4, C4-5, C5-6, C6-7 cervical facet Joints. Muscle spasms and trigger point felt along the cervical paravertebral, occipital, trapezius, levator scapulae b/l. ROM: Restricted flexion, extension and lateral rotation on the right and left with end range discomfort noted." Lumbar examination revealed "Palpation: Tenderness on palpation paravertebral over lumbar facet joints L3-4, L4-5 and L5-S1, as well as spinous processes L3-S1. There is moderate to severe tenderness over the Left and Right Sacroiliac Joints, Muscle spasm along lumbar paravertebral, multifidus, sacrospinalis, gluteus and piriformis b/l. Tender trigger points felt at the lumbar spinalis, longissimus and gluteal muscles. ROM: Restricted flexion, extension and lateral rotation on the right and left with end range discomfort noted." General examination revealed "The patient's ability to get on/off the examination table was moderately impaired. Mobility on the examination table was moderately impaired. Lumbar Facet loading + b/l. SLR positive for lower back pain. Cervical distraction test: Positive Extension and lateral rotation with axial compression: positive on the Right and Left. Sensory (right): diminished pin prick and light touch sensation C4, C5, C6 dermatome. Reflexes (right): brachioradialis and bicep +1. Motor (right): 4/5 deltoid, biceps, wrist extensors. Sensory (right): pin prick and light touch decreased L4, L5 and S1. Motor (right): hip extensors, ankle extensors, knee flexors 4/5. DTR (right): +1 Patella, Achilles." The claimant was recommended for lumbar discectomy. On 8/25/20 the claimant underwent physical capacity (NIOSH) testing. On 8/26/20 Dr. Kosharsky

conducted DXD lumbar radiographic spinal analysis. On 9/14/20 V. Zhivotenko, D.O. of Pain Physicians NY, LLC conducted lower extremities EMG/NCV that suggested evidence consistent with right L5 radiculopathy and right sensory nerve neuropathy. On 9/14/20 Dr. Kosharskyy conducted a follow-up examination that was substantially similar to that of 8/24/20 and performed lumbar surgery consisting of "Discectomy. Mechanical Decompression. Level: L5-S1; Nucleoplasty: Radiofrequency Ablation. Level: L5-S1; Annuloplasty L5-S1 [and] Contrast Injection and Evaluation of Nucleograms. Level: L5-S1." On 9/24/20 Dr. Kosharskyy conducted a follow-up examination noting that the surgery of 9/14/20 produced "mild relief in pain continues to have pain radiating to right leg." The claimant also complained of "cervical pain with pain radiating to left upper extremity." Cervical examination revealed "Tenderness at the upper trapezius muscle and periscapular region and also paravertebral over the Right and Left C2-3, C3-4, C4-5, C5-6, C6-7 cervical facet joints. Muscle spasms and trigger point felt along the cervical paravertebral, occipitaltrapezius, levator scapulae b/l. ROM: Restricted flexion, extension and lateral rotation on the right and left with end range discomfort noted... Sensory (right): diminished pin prick and light touch sensation C4, C5, C6 dermatome. Reflexes (right): brachioradialis and bicep +1. Motor (right): 4/5 deltoid, biceps, wrist extensors." Dr. Kosharskyy performed a C7/T1 Interlaminar Epidural Steroid Injection, epidurogram, and trigger point injections. On 1/18/21 Dr. Kosharskyy conducted a follow-up examination that was substantially similar to that of 9/24/20. Dr. Kosharskyy recommended and performed surgery consisting of C5-6 provocative discogram, C5-6 anterior cervical percutaneous discectomy, and C5-6 Annuloplasty. At issue is the 1/18/21 associated facility fee.

The burden has shifted to the Respondent as they have raised a medical necessity defense. In order to support a lack of medical necessity defense 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 2, 11th and 13th Jud. Dists. 20140). Respondent bears the burden of production in support of its lack of medical necessity defense, which if established shifts the burden of persuasion to Applicant. See generally, *Bronx Expert Radiology, P.C. v. Travelers Ins. Co.*, 2006 NY Slip Op. 52116 (App. Term 1 Dept. 2006). As a general rule, reliance on rebuttal documentation will be weighed in light of the documentary proofs and the arguments presented at the arbitration. Moreover, the case law is clear that a provider must rebut the conclusions and determinations of the IME/peer doctor with his own facts. *Park Slope Medical and Surgical Supply, Inc. v. Travelers*, 37 Misc.3d 19 (2012).

Respondent timely denied the 1/18/21 surgery and associated services based on the 2/11/21 peer review by Jay M. Weiss, M.D. After reviewing the claimant's history, treatment, and medical records, Dr. Weiss opines "as a matter of fact, the standard of care in the medical community as well as New York State for performing any type of discectomy is that the indications for discectomy is "Radiculopathy from ruptured disc or spondylosis, spinal instability, or patients with nonradicular neck pain meeting fusion criteria." They further note that "Discectomy alone is generally considered in patients with pure radicular symptoms from their herniated disc and have sufficiently large foramina that disc space collapse is unlikely to further compromise the nerve root", New York Neck Injury Medical Treatment Guidelines, NYS Worker's Compensation Board,

Third Edition, September 15, 2014, E.2.b.i.). Furthermore, it should be noted that in addition to the indications for discectomy of any type not being present, percutaneous discectomy is not accepted by New York State and they specifically state "Percutaneous discectomy is indicated only in cases of suspected septic discitis in order to obtain diagnostic tissue. The procedure is not recommended for contained disc herniations or bulges with associated radiculopathy due to lack of evidence to support long term improvement", (E.2.b.v.)." Dr. Weiss continues "even those who support the use of cervical percutaneous discectomy note that the criteria for discectomy in general need to be met. According to Quillo-Olvera et.al. they note "The success of this procedure depends on the proper selection of patients and adequate decompression of the neural elements. Clinical outcomes have been shown to be better in patients with lateral soft disc herniations and unilateral radicular pain irradiated to the arm." *Annals of Translational Medicine, Percutaneous Discectomy: A Technical Review, Anterior PECD, I, 2018 March; 6(6): 100, Quillo-Olvera, Lin, Kim, PMC5900065.* It should be noted that discectomy should only be performed in very specific circumstances. The standard of care in the medical community and that outlined by New York State in the New York Mid and Low Back Injury Medical Treatment Guidelines is that before discectomy be performed all of the following should be present: "(1) Radicular pain syndrome with current dermatomal pain and/or numbness, or myotomal muscle weakness - consistent with a herniated disc at the corresponding level; (2) Imaging findings by MRI or CT with/out myelography that confirmed persistent nerve root compression at the level on the side predicted by the history and clinical examination; (3) Continued significant pain and functional limitation after 6-12 weeks who had already been provided appropriate conservative therapy during which time they experienced no progressive neurological deficits", New York Mid and Low Back Injury Medical Treatment Guidelines, (NYS Worker's Compensation Board, Third Edition, Sept 15, 2014, E.1.a.ii). Furthermore, according to the Official Disability Guidelines published by the Worker's Comp Research Institute, the indications for any type of discectomy or laminectomy is that symptoms and findings confirming the presence of radiculopathy need to be present. In order for discectomy or laminectomy to be performed, they require specific unilateral weakness in one muscle group corresponding with one specific nerve root or radiating pain in one limb corresponding with that nerve root. Additionally, there must be imaging findings that show concordance between radicular findings on radiologic evaluation and physical examination findings including nerve root compression on a specific side or a lateral disc rupture or lateral recessed stenosis on a side and level that corresponds with the clinical picture." Dr. Weiss concludes "with regards to percutaneous discectomy (diskectomy) the Official Disability Guidelines state it is not recommended. "Percutaneous diskectomy (PCD) is not recommended, proof of its effectiveness has not been demonstrated. PCD is a "blind" procedure done under the direction of fluoroscopy. It involves placing an instrument into the center of the disc, and either mechanically removing disc material or vaporizing it by use of a laser, to create a void so that extruded material can return to the center of the disc. Percutaneous lumbar diskectomy procedures are rarely performed in the US, and no studies have demonstrated the procedure to be as effective as diskectomy or microsurgical diskectomy." It should be stressed that while cervical discectomy can be indicated, percutaneous discectomy is not medically accepted. If one would argue, however, that percutaneous discectomy has some limited place, it should still be pointed out that the criteria for performing any type of discectomy were not met. As the

procedure was not medically necessary, related services such as intradiscal electrothermal annuloplasty. According to the New York State Mid and Low Back Medical Treatment Guidelines, Intradiscal Electrothermal Therapy (IDET) is not recommended treatment of acute or non-acute back pain, or any other back related disorder, New York State Workers' Compensation Board, New York Mid and Low Back Injury Medical Treatment Guidelines, Third Edition, 9/15/14 D.12.C. "No significant change exists in outcome measures in either group at six months. This study demonstrates no significant benefit from IDET over placebo." Freeman, Brian J.C., November 2005. Randomized, Double-Blind, Controlled Trial Intradiscal Electrothermal Therapy Versus Placebo for the Treatment of Chronic Discogenic Low Back Pain". Nov. 2005, 30(21). P.2369. Intradiscal annuloplasty is considered experimental with no proven benefit over placebo. Obviously if the procedure is not necessary, related imaging, medication, supply, anesthesia or facility services would not be necessary. The standard of care for any type of discectomy is that there be persistent clinical evidence of nerve involvement along with imaging findings that would confirm a lesion at the level and side predicted by the clinical picture. The standard of care was not met. The standard of care for IDET is this has not been shown to be beneficial. The standard of care for IDET was also not met."

Where the Defendant insurer presents sufficient evidence to establish a defense based on lack of medical necessity, the burden shifts to the Plaintiff which must then present its own evidence of medical necessity (see Prince on Evidence section 3-104, 3-202). *West Tremont Medical Diagnostic PC v. Geico*, 13 Misc.3d 131, 824 N.Y.S. 2d 759.

Applicant submitted a 4/6/22 peer rebuttal by Boleslav Kosharsky, M.D. It is noted that this peer rebuttal employs foot notes that are incompatible with the narrative format of this award and were thoroughly reviewed and considered but are omitted here. After reviewing the claimant's history, treatment, and medical records, Dr. Kosharsky opines "Note that [*the claimant's*] case satisfied the indications for cervical discectomy noted in current guidelines, such as the ACOEM Cervical and Thoracic Spine Disorders Guideline effective date: October 17, 2018: "Cervical discectomy is recommended to speed recovery in patients with subacute or chronic radiculopathy due to ongoing nerve root compression who continue to have significant pain and functional limitation after at least 6 weeks of time and appropriate non-operative therapy." Dr. Kosharsky continues "percutaneous endoscopic cervical discectomy has demonstrated the ability to decompress the exiting nerve root and dural sac correctly and encouraging clinical outcomes have been reported in the literature. The adjunct procedure Annuloplasty was performed to assist in relieving pain and strengthening the outer wall of the disc after it has been decompressed. Discography was also performed prior to these procedures to elucidate the pain generator and inform decision to avoid or proceed with therapeutic intradiscal procedures (such as discectomy and annuloplasty)...on September 24, 2020, she reported persisting neck pain radiating to the shoulders. As recommended, that same day, I performed cervical interlaminar epidural steroid injection under fluoroscopic guidance with epidurography at C7- T1 level and trigger point injection at bilateral trapezius, rhomboid, and levator scapulae muscles. She tolerated the procedures well and reported 75% pain relief post-injection...The patient then returned for another examination on January 18, 2021. She continued to report neck pain radiating to both shoulders and difficulty performing activities of daily living. Further examination

revealed tenderness of the upper trapezius muscle, periscapular region, and paravertebral muscles over the C2-C3 to C6-C7 facet joints; muscle spasms and trigger point along the cervical paravertebral, occipital, trapezius, and levator scapulae bilaterally; restricted range of motion with end range discomfort; positive cervical distraction test and axial compression test bilaterally; diminished sensation to pin prick and light touch along the right C4 to C6 dermatomes; decreased motor strength at 4/5 in the right deltoid, biceps, and wrist extensors; and decreased reflex at +1 in the right brachioradialis and bicep tendons. As the patient continued to have neck pain associated with upper extremity pain and symptoms despite various modalities of conservative treatment as well as epidural steroid injection which provided only temporary pain relief, she was deemed an appropriate candidate for anterior cervical discectomy." Dr. Kosharskyy asserts "discography is a far more sophisticated technique than an imaging study as it can reveal disc defects that may otherwise be missed by imaging studies such as MRI. Discography uses imaging guidance to direct an injection of contrast material into the center of one or more spinal discs to help identify the source of neck pain. It also is used to help guide the treatment of abnormal intervertebral discs-sponge-like cushions located between the vertebrae of the spine. Cervical discectomy by the anterior approach is a technique that combines the intradiscal thermal effect with mechanical nucleus resection (decompression), aiming to achieve ablation and decompression of the pain-generating nerve structures. The goal of this procedure is to decompress the spinal nerve root through percutaneously removing the herniated mass and shrinking the nucleus pulposus while the patient is under local anesthesia. Disc material is removed with the guidance of live X-ray imaging, and as a result, painful nerve pressure is relieved. Annuloplasty was performed as an adjunct procedure to seal ruptures in the discs, burn nerve endings in the outer annulus fibrosus that are pain generators, and create less sensitivity to pain to treat intervertebral disc disease. It is a minimally invasive outpatient procedure developed over the last few years to treat patients with pain that is caused by tears or small herniation of their cervical discs." Dr. Kosharskyy explains "let me clarify that radiculopathy occurs secondary to irritation of a particular nerve, which can occur at any point along the nerve itself and is most often a result of a compressive force. Compression of the thecal sac causes pressure on the nerve bundle at the end of the spinal cord or the individual nerves within the thecal sac. According to the 2020 article by Robinson, J. and Kothari, M., Clinical features and diagnosis of cervical radiculopathy, cervical radiculopathy is a clinical condition that may involve neck, shoulder, or arm pain; muscle weakness; sensory symptoms; or diminished deep tendon reflexes, either alone or in combination. Moreover, a positive cervical distraction test may indicate cervical radiculopathy. These signs and symptoms were evident in the patient's examinations." Dr. Kosharskyy continues "according to a study published by de Rooij, J.D., et al. in 2017, "Cervical radiculopathy is characterized by compression of the roots of the nerve. When conservative treatment fails and symptoms persist or increase in severity, surgical treatment is considered." Discectomy relieves pressure on the irritated nerve by decompressing the herniated/bulging disc, resulting in relief of painful symptoms. A percutaneous approach to discectomy was utilized to achieve disc decompression while still maintaining the stability of the disc and the spine...according to the more recent guideline, Cervical and Thoracic Spine Disorders Guideline published by the American College of Occupational and Environmental Medicine (ACOEM), effective date: October 17, 2018, "Cervical discectomy is recommended to speed recovery in patients with subacute or chronic radiculopathy due to ongoing nerve

root compression who continue to have significant pain and functional limitation after at least 6 weeks of time and appropriate non-operative therapy." As demonstrated in the previous paragraphs, these indications were met in [*the claimant's*] case." Dr. Kosharsky expounds "percutaneous discectomy has been listed as a Category I CPT code in the American Medical Association (AMA) Codebook of Reimbursable Procedures. The introduction of that book notes that in order to qualify as a Category I code, "the clinical efficacy of the service/procedure is well established and documented in the United States per review literature." This was later reaffirmed by the AMA, where they noted that simply by having a Category I code, a procedure, by definition is not experimental and has a well- established clinical efficacy. Furthermore, evidence attesting to the effectiveness of percutaneous discectomy has been published in recent studies. Results of the 2017 study, Anterior Percutaneous Cervical Discectomy. Two-Year Follow-up of a Blunt Technique Procedure, by Ramirez Leon, J.F., et al. Coluna/Columna, 16(4), 261-264, revealed that treated patients had excellent improvement in MacNab scores at 3, 12, and 24 months; and statistically significant decrease in pain VAS from 7.4 to 2.3 two years after the procedure. No major complications or re-interventions related to the technique were noted." Dr. Kosharsky concludes "because the cervical percutaneous discectomy was medically necessary, the related services were also medically necessary. Annuloplasty was performed in this case as an adjunct procedure to the discectomy. Annuloplasty strengthens the outer wall of the disc and can help prevent re-herniation or recurrent injury of the disc after it has been decompressed using a percutaneous discectomy approach. The procedure additionally provides relief of pain by destroying nociceptors or pain-generating nerve fibers around the disc. Combining these minimally invasive procedures thereby enhances the results of each treatment...When patients have chronic neck and radicular pain that fail to respond to conservative treatment and minimal procedures such as injection, and evidence of disc protrusion-such as [*the claimant*], annuloplasty should be considered. Annular defects are the focal points of chronic exposure between neural sensory receptors in the defect and the nucleus pulposus. Radiofrequency annuloplasty aims to interrupt the annular defect pain sensitization process. In their study entitled, Percutaneous Pulsed Radiofrequency in the Treatment of Cervical and Lumbar Radicular Pain, Chao, S.C., et al. stated that, "The results of this retrospective analysis showed that the application of pulsed radiofrequency is a safe and useful intervention for cervical and lumbar radicular pain. The satisfactory pain relief obtained by most of our patients justifies the start of this study for at least 6 months." Results of another study, Radiofrequency Heating of Painful Annular Disruptions: One-Year Outcomes, by Finch, P., et al., indicated that the VAS decreased significantly after the radiofrequency treatment, and this decrease persisted at 12 months of follow-up. The decrease in VAS was significantly greater in the treated patients than the control subjects. The Oswestry Disability Index (ODI) also decreased in treated patients but not in controlled subjects. Additionally, Discography was also necessary to better elucidate the pain generator and disc pathology since cervical percutaneous discectomy was being contemplated for this patient. Specific indications for discography include assessment of candidates for minimally invasive surgery who have a confirmed disk herniation, such as [*the claimant*]. The information obtained from the discogram will be used to rule-out or plan subsequent treatment decisions such as therapeutic intradiscal procedures such as minimally invasive surgery or annuloplasty. Of note, the discography identified the C5-C6 disc level as positive for concordant neck pain, thus prompting the necessary

performance of the discectomy and annuloplasty. Performing discography prior to percutaneous disc decompression has been linked to improved clinical results. The fluoroscopy utilized during the minimally invasive procedures was necessary as well as it provides an x-ray image of the spine during surgery, which is used to confirm the correct level of the affected disc/s. Fluoroscopy allows real-time visualization of the spinal discs and is essential in the safe performance of interventional spine procedures. Finally, disc decompression was achieved using a medically necessary single-use mechanical decompressor probe. The device extracts variable amounts of nuclear disc material, reducing pressure in the disc and surrounding area. The use of the probe allows efficient removal of disc material, thus decreasing procedure time. Indeed, it is very clear that the standard of care for the medical necessity of the Cervical Discography, Anterior Cervical Percutaneous Discectomy, and Annuloplasty under Fluoroscopic Guidance was met. I can therefore say within a reasonable degree of certainty that the treatment and its associated services were medically necessary and causally related to the accident."

Dr. Weiss argues "percutaneous discectomy is not accepted by New York State;" but fails to establish that the procedure(s) at issue are either prohibited or non-reimbursable in New York State. Dr. Weiss alternatively asserts "if one would argue, however, that percutaneous discectomy has some limited place, it should still be pointed out that the criteria for performing any type of discectomy were not met." Dr. Kosharsky's rebuttal is sufficient to that point and acknowledging the Treating Physician Rule this Arbitrator is compelled to find for Applicant and Respondent's denial cannot be upheld. Applicant would be entitled to \$4,231.34.

At the hearing it was noted that the policy was close to exhaustion. On 7/12/22 (13 days after the hearing) Respondent uploaded a 7/7/22 denial that states "*The eligible injured party has exhausted the maximum No-Fault coverage available on this policy. Therefore, your claim is denied.*" Respondent submitted copies of the Policy Declarations Pages (confirming a \$125,000.00 a total aggregate policy limit with respect to PIP benefits) and a Payment Log that demonstrated \$125,000.00 in medical payments were made. After carefully reviewing all of Respondent's submissions I am persuaded that the policy limits were exhausted.

Applicant argued that if I determined that the total amount of the claim was to be paid, then Respondent should pay the claim since it was received prior in time to claims of other providers which were paid. In other words, Applicant argued that the insurer would be obligated to set aside money for all denied claims pending the possibility of ensuing litigation/arbitration which may be filed within six years. This would also mean not paying subsequently received claims and would hold up the payment of claims for services which the carrier found medically necessary.

The Court of Appeals addressed a similar issue in *Nyack Hospital v. General Motors Acceptance Corp.*, 8 NY3d 294, 832 N.Y.S.2d 880 (2007). The *Nyack* Court found that an insurer which is waiting for information to verify a pending claim that causes aggregate claims to exceed \$50,000 is not prohibited by the priority-of-payment regulation - 11 NYCRR 65-3.15. The Court noted that to hold up payment of other medical providers bills to wait for additional verification of a previously received bill

would contravene the requirement that the other bills be paid or denied within 30 days. Similarly, where services were paid pursuant to fee schedule, having the insurer set aside funds in the anticipation of litigation would contravene the requirement that other bills be paid within 30 days. Once the policy limits are exhausted, the insurer is not obligated to make any further payments to an assignee or an assignor, notwithstanding a priority of claim or an overturned denial. The New York State Insurance Department Office of General Counsel issued an opinion on 7/30/08 stating that once the policy limits are exhausted, the assignment of benefits becomes ineffective. (OGC Op. No. 08-07-28).

There is no evidence that Respondent acted in bad faith. There is no evidence in this case that Respondent acted improperly or wrongfully in issuing this denial. Furthermore, I do not believe, in light of the clear language of the Statute and Regulation, that I have the authority to increase the amount of statutory, regulatory and contractually limited coverage, even were I to find some evidence of bad faith.

Respondent's defense that the policy limits have been exhausted would be dispositive of this claim without requiring a determination of the issue of medical necessity. For the reasons set forth below Respondent would only have to pay this award up to the limits of the policy.

11 NYCRR Section 65-3.15 provides as follows: "When claims aggregate to more than \$50,000, payments for basic economic loss shall be made to the applicant and/or an assignee in the order in which each service was rendered or each expense was incurred, provided claims therefore were made to the insurer prior to the exhaustion of the \$50,000. If the insurer pays the \$50,000 before receiving claims for services rendered prior in time to those which were paid, the insurer will not be liable to pay such late claims. If the insurer receives claims of a number of providers of services, all at the same time, the payments shall be made in the order of rendition of the services."

Case law dictates that an insurer is not required to pay a claim where the policy limits have been exhausted. *Mount Sinai Hospital v. Zurich American Ins. Co.*, 15 A.D.3d 550, 790 N.Y.S.2d 216 (2d Dept. 2005). An insurer's failure to issue a denial of the claim within 30 days does not preclude a defense that the coverage limits of the subject policy have been exhausted. *Crossbridge Diagnostic Radiology v. Encompass Insurance*, 24 Misc.3d 134(A), 890 N.Y.S.2d 368 (Table), 2009 N.Y. Slip Op. 51415(U), 2009 WL 1911909 (App. Term 2d, 11th & 13th Dists. June 23, 2009). See also, *New York & Presbyterian Hospital v. Allstate Ins. Co.*, 12 A.D.3d 579, 786 N.Y.S.2d 68 (2d Dept. 2004); *Flushing Traditional Acupuncture, P.C. v. Infinity Group*, 2012 NY Slip Op. 22345 (App Term 2d, 11th & 13th Jud Dists Nov. 26, 2012). Where an insurer "has paid the full monetary limits set forth in the policy, its duties under the contract of insurance cease" *Presbyterian Hosp. in the City of New York v. Liberty Mut. Ins. Co.*, 216 A.D.2d 448, 628 N.Y.S.2d 396; see also, *Hospital for Joint Diseases v. State Farm Mutual Automobile Ins. Co.*, 8 A.D.3d 533, *Champagne v. State Farm Mut. Auto. Ins. Co.*, 185 A.D.2d 835, 837, 586 N.Y.S.2d 813, *Hospital for Joint Diseases v. Hertz Corp.*, 22 AD3d 724, 2005 NY Slip Op. 07932. In addition, policy exhaustion may be proven by

submitting a payment log or payment register establishing when and to whom payments made totaling the policy limits. See *St. Vincent's Hospital & Medical Center, etc. v. Allstate Insurance Company*, 294 AD2d 425, 742 N.Y.S.2d 350 (2002).

In *Allstate Ins. Co. v. DeMoura*, the court states, "When an insurer "has paid the full monetary limits set forth in the policy, its duties under the contract of insurance cease" (*Countrywide Ins. Co. v. Sawh*, 272 AD2d 245 [2000]). A defense that the coverage limits of the policy have been exhausted may be asserted by an insurer despite its failure to issue a denial of the claim within the 30-day period (*New York & Presby. Hosp. v. Allstate Ins. Co.*, 12 AD3d 579 [2004]), **and an arbitrator's award directing payment in excess of the \$50,000 limit of a no-fault insurance policy exceeds the arbitrator's power and constitutes grounds for vacatur of the award**(see *Matter of Brijmohan v. State Farm Ins. Co.*, 92 NY2d 821, 822 [1998]; *Countrywide Ins. Co. v. Sawh*, 272 AD2d at 245; 11 NYCRR 65-1.1)." *Allstate Ins. Co. v. Moira*, 30 Misc.3d 145 (A), [App Term, 1st Dept. 2011]{Emphasis added}. In *Allstate Insurance Company v. Countrywide Insurance Company*, 2013 NY Slip Op. 33179 (December 12, 2013 Sup. Ct., NY Co.), the Court, in addressing a motion to vacate an arbitration award pursuant to CPLR 7511, noted that "with respect to arbitration proceedings concerning no-fault insurance benefits, **an arbitration award made in excess of the contractual limits of an insurance policy has been deemed an action in excess of authority** (*State Farm Ins. Co. v. Credle*, 228 A.D.2d 191, 643 N.Y.S.2d 97, 98 [1st Dept 1996]){Emphasis added}." The Court further noted that "**Such excess of authority constitutes grounds for vacatur of the award** (*See Matter of Brijmohan v. State Farm Ins. Co.*, 92 N.Y.2d 821, 822 [1998]){Emphasis added}."

At the hearing Applicant's counsel cited *Alleviation Medical Services, P.C. v. Allstate Insurance Company*, 49 N.Y.S. 3d 814, 2017 N.Y. Slip Op. 27097 in support of the position that Respondent should not be relieved of having to pay the claim.

Subsequent to denial of a claim on the ground of lack of medical necessity, a No-Fault insurer may pay uncontested claims and satisfy arbitration awards, such that if by the time the former claim is litigated, the governing policy's coverage limits have been exhausted the insurer may assert that fact as a defense. *Harmonic Physical Therapy, P.C. v. Praetorian Ins. Co.*, 47 Misc.3d 137(A), 2015 N.Y. Slip Op. 50525(U) (App. Term 1st Dept. Apr. 14, 2015). *Harmonic Physical Therapy, P.C.* is in conflict with *Alleviation Medical Services, P.C. v. Allstate Ins. Co.*, 55 Misc.3d 44, 45 (App. Term 2d, 11th & 13th Dists. 2017), wherein the Court stated, "As we read *Nyack Hosp.* to hold that fully verified claims are payable in the order they are received (*see* 11 NYCRR 65-3.8 [b] [3]; 65-3.15; *Nyack Hosp.*, 8 NY3d 294), defendant's argument-that it need not pay the claim at issue because defendant paid other claims after it had denied the instant claim, which subsequent payments exhausted the available coverage-lacks merit (*see* 11 NYCRR 65-3.15; *cf. Nyack Hosp.*, 8 NY3d 294; *but see Harmonic Physical Therapy, P.C. v. Praetorian Ins. Co.*, 47 Misc 3d 137[A], 2015 NY Slip Op. 50525[U] [App Term, 1st Dept 2015])." I find that the reasoning in *Harmonic Physical Therapy, P.C.* is more persuasive than that in *Alleviation Medical Services, P.C.* I decline to follow the holding in the latter case.

The facts here -- a timely denial -- distinguishes this case from *Nyack Hospital v. General Motors Acceptance Corp.*, 8 N.Y.3d 294 (2007), and *NYU Hospitals Center - Hospital for Joint Diseases v. State Farm Mutual Automobile Ins. Co.*, Sup. Ct. Nassau Co., Leonard Steinman, J., Oct. 26, 2016). In both cases, the insurer had to pay No-Fault benefits despite policy exhaustion since the respective denials were not timely issued.

Additionally, Applicant's counsel highlighted the fact that the holding of *Alleviation Medical Services, P.C. v. Allstate Insurance Company* was recently affirmed. [See, *Alleviation Med. Servs., P.C. v. Allstate Ins. Co.*, 2021 N.Y. Slip Op. 08159 (A.D., 2d Dept., 2/24/21)]. Although the issue of coverage exhaustion was raised therein, the Court without ruling on the issue, stated the following: "While the defendant submitted records indicating that the subject no-fault policy had been exhausted in 2013, the defendant's submissions failed to establish its prima facie entitlement to judgment as a matter of law. Although the defendant submitted an affidavit from one of its employees that set forth the defendant's ordinary business practice of receiving, recording, and denying no-fault claims from medical providers, the affidavit is bereft of any specific information regarding this claim. The defendant failed to submit the no-fault application, verification, any request for verification, or any denial associated with the plaintiff's claim for payment." As such, the Court held there were procedural and evidentiary issues remaining as to when the claim was denied, and the basis and efficacy of the denial. The Court also acknowledged that an insurer is not required to pay a claim where the policy limits have been exhausted. [Citing, *Hospital for Joint Diseases v. State Farm Mut. Auto Ins. Co.*, 9 A.D.3d 534, 534]. Therefore, based on the above, Respondent has established that the policy limits were exhausted and Applicant's No-Fault claim is 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 claim is DENIED in its entirety

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

07/29/2022

(Dated)

Charles Blattberg

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:
75d833068c51bc34ba0210187028141e

Electronically Signed

Your name: Charles Blattberg
Signed on: 07/29/2022