American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

North American Partners In Anesthesia LLP (Applicant)	AAA Case No.	17-22-1235-3225
	Applicant's File No.	154498
- and -	Insurer's Claim File No.	U7H6564
	NAIC No.	27998
St. Paul Travelers Insurance Co. (Respondent)		

ARBITRATION AWARD

I, Phyllis Saxe, 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(JC)

1. Hearing(s) held on 11/10/2022
   Declared closed by the arbitrator on 11/10/2022

   Kevin Griffiths, Esq. from The Odierno Law Firm P.C. participated for the Applicant

   Helen Mann Ruzhy, Esq. from Law Offices of Tina Newsome-Lee participated for the Respondent

2. The amount claimed in the Arbitration Request, **$950.72**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The parties amended the amount in dispute to $861.59.

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

   The parties stipulated that the applicant established its prima facie entitlement to no-fault compensation benefits and that respondent issued timely denials.

3. Summary of Issues in Dispute

This no-fault arbitration dispute arises from an accident that occurred on 3/15/19. The injured party (JC), a 76-year-old female, was taken by ambulance to Huntington Hospital after the accident, where she was evaluated and released the same day. Following the accident, JC engaged in a multi-modality treatment plan. Over the next two years, JC underwent extensive conservative treatment for her back and multiple procedures, including spinal surgery, on 9/20/20. After that, on 5/11/21, JC had a revision spinal surgery laminectomy performed at the same disc level as the surgery on 9/20/20. The Anesthesiologist submitted this claim for the 5/11/21 surgery. The Insurer denied payment based on a Peer Review report from Dr. Howard Levy dated 7/16/21. The issue is whether the insurer met its burden of proof with its lack of medical necessity defense.

4. Findings, Conclusions, and Basis Therefor

Both parties appeared at the hearing via Zoom by counsel, who presented oral arguments and relied upon documentary submissions. I have reviewed the submissions' documents contained in the American Arbitration Association's ADR Center as of the hearing, and said submissions constitute the record in this case. In accordance with 11 NYCRR 65-4.5(o) (1), an arbitrator shall judge the evidence's relevance and materiality, and strict conformity to the legal rules of evidence shall not be necessary. Further, the arbitrator may question or examine any witnesses and independently raise any issue that the Arbitrator deems relevant to making an award consistent with the Insurance Law and the Department of Insurance Regulations.

Legal Standards for Determining Medical Necessity

To support a lack of medical necessity defense, the 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 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 1st Dept. 2006).

The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment, Kingsbrook Jewish Medical Center v. Allstate Ins. Co., 61 A.D.3d 13, 871 N.Y.S.2d 680 (2d Dept. 2009), such as by a qualified expert performing an independent medical examination or conducting a peer review of the injured person's treatment. See Rockaway Boulevard Medical P.C. v. Travelers Property Casualty Corp., 2003 N.Y. Slip Op. 50842(U), 2003 WL 21049583 (App. Term 2d & 11th Dists. Apr. 1, 2003).

The appellate courts have not clearly defined what satisfies the insurer's evidentiary standard except to the extent that "bald assertions" are insufficient. Amherst Medical Supply, LLC v. A Central Ins. Co., 41 Misc.3d 133(A), 981 N.Y.S.2d 633 (Table), 2013

NY Slip Op 51800(U), 2013 WL 5861523 (App. Term 1st Dept. Oct. 30, 2013). However, there are myriad civil court decisions tackling the issue of what constitutes a "factual basis and medical rationale" sufficient to establish a lack of medical necessity. The trial courts have held that 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 generally Nir v. Allstate Ins. Co., 7 Misc.3d 544, 547, 796 N.Y.S.2d 857, 860 (Civ. Ct. Kings Co. 2005); See All Boro Psychological Servs. P.C. v. GEICO, 2012 NY Slip Op 50137(U) (N.Y. City Civ. Ct. 2012).

Where a Respondent meets its burden, it becomes incumbent on the claimant to rebut the peer review. Be Well Medical Supply, Inc. v. New York Cent. Mut. Fire Ins. Co., 18 Misc.3d 139(A), 2008 WL 506180 (App. Term 2d & 11 Dists. Feb. 21, 2008); A Khodadadi Radiology, P.C. v. NY Central Mutual Fire Ins. Co., 16 Misc.3d 131(A), 2007 WL 1989432 (App. Term 2d & 11 Dists July 3, 2007. "

[T]he insured/provider bears the burden of persuasion on the question of medical necessity. Specifically, once the insurer makes a sufficient showing to carry its burden of coming forward with evidence of lack of medical necessity, 'plaintiff must rebut it or succumb." Bedford Park Medical Practice, P.C. v. American Transit Ins. Co., 8 Misc.3d 1025(A), 2005 WL 1936346 at 3 (Civ. Ct. Kings Co., Jack M. Battaglia, J., Aug. 12, 2005).

Stipulations were entered into at the hearing, amongst which were that Applicant established a prima facie case of entitlement of No-Fault compensation for the amount it sought and that Respondent timely denied Applicant's bills. No evidence was presented at the hearing to support a fee schedule defense.

Dr. Levy's Peer review addressed seventeen different Providers. The services discussed in the Peer Review report were supplied on dates ranging from 4/20/21 through 6/3/21. Dr. Levy spent nearly all of the substantive part of the Peer review discussing the second laminectomy and his reasons for deciding that the surgery lacked medical necessity. Dr. Levy's basic premise was that since the surgery was not medically necessary, neither was the anesthesia.

The medical records showed that the patient complained of lower back pain soon after the accident and as early as in the emergency room on the date of the accident. On 5/6/19, a lumbar MR indicated: Stable levoscoliotic curvature of the lumbar spine in the coronal plane with trace anterolisthesis at L5-S1. L1-L2 stable, broad, posterior disc herniation flattening the ventral thecal sac with encroachment on the lateral recesses and neural foramina. L2-L3 stable, broad, posterior disc bulge flattening the ventral thecal sac with abutment of both traversing L3 nerve roots within the lateral recesses. There is bilateral facet hypertrophy. L3-L4 stable, broad, right paracentral/foraminal disc herniation superimposed on diffuse disc bulging with asymmetric impression on the right side of the ventral thecal sac. There is stable encroachment on the right lateral

recess with impingement of the traversing right L4 nerve root and stable impingement of the exiting right L3 nerve root within the right neural foramen. There is bilateral facet hypertrophy. L4-L5 stable, broad, posterior disc herniation impressing on the ventral thecal sac with central canal stenosis, and there is stable encroachment on both lateral recesses with impingement of both traversing L5 nerve roots. The left neural foramen is narrowing with impingement of the exiting left L4 nerve root. There is bilateral facet hypertrophy. L5-S1 stable, broad, central disc herniation impressing on the ventral thecal sac with encroachment on the lateral recesses and impingement of the traversing S1 nerve roots. There is a stable, broad left foraminal disc herniation compressing the exiting left L5 nerve root. There is also a stable narrowing of the right neural foramen with abutment of the exiting right L5 nerve root. There is bilateral facet hypertrophy.

The patient engaged in a conservative treatment plan spanning months, including chiropractic treatment, psychical therapy, and acupuncture. JC then had multiple lumbar steroid injections on 10/31/19 and 9/19/20. JC then presented to Dr. Laurence Mermelstein on 11/21/19 for unrelenting low back pain. The medical records stated that the pain was radiating to the left buttock. Examination of the lumbar spine revealed tenderness. The range of motion was painful. The diagnoses were lumbar facet joint syndrome, lumbar disc displacement, left lumbar radiculopathy, and spinal stenosis at multiple levels. A left L4-L5, L5-51 laminectomy, facetectomy, transforaminal interbody fusion with prosthetic spacers, and posterior instrumentation LS-51 were recommended.

An EMG/NCV was performed, which revealed L5-S1 radiculopathy on the left. On 1/21/20, 5/29/21, and 6/11/20, JC returned to Dr. Mermelstein for low back pain. On 9/2/20, Dr. Mermelstein performed left side L4, L5, and partial S1 laminectomy, left-sided, excision of herniated nucleus pulposus, left side L4- L5, L5-S1, intra-operative use of a microscope for illumination and magnification, and external microneurolysis, left side L5 under general endotracheal anesthesia by Laurence Mermelstein, M.D. The pre-operative and postoperative diagnoses were herniated nucleus pulposus, left side L4-L5, L5-S1, and foraminal stenosis.

The claimant was examined again by Laurence Mermelstein, M.D., on 12/11/2020, for continued complaints of lower back pain. Examination of the lumbar spine revealed tenderness. The range of motion was painful. The diagnoses were lumbar facet joint syndrome, lumbar disc displacement, left lumbar radiculopathy, and spinal stenosis at multiple levels. A left L4-L5, L5-51 laminectomy, facetectomy, transforaminal interbody fusion with prosthetic spacers, posterior instrumentation LS-51 was recommended.

As per the report dated 01/07/2021 by Laurence Mermelstein, M.D., the claimant had lower back pain rated as 3/10 on the pain scale. Dr. Mermelstein referred JC for a second lumbar MRI (04/20/2021) that revealed: Laminectomies at L4-L5 and L5-S1. Findings are most notable for a 3 mm enhancing nodule in the left subarticular zone at L4-L5 with mass effect on the left L5 nerve roots. See details below. L1-L2: There is slight retrolisthesis of L1 on L2 and a disc bulge without significant stenosis. L2-L3: Disc height loss and a disc bulge with osseous ridging flattening the thecal sac with mild central and mild foraminal stenosis. L3-L4: Disc height loss and a disc bulge with

osseous ridging flattening the thecal sac. A superimposed right subarticular disc herniation compresses the right L4 nerve roots in the right lateral recess. There is mild central and mild foraminal stenosis. L4-L5: Status post laminectomy. There is disc height loss and disc bulge with osseous ridging asymmetric to the left. A 3 mm enhancing nodular focus in the left subarticular zone on series 6 image 24 reflect a combination of granulation tissue and residual disc material. This location has a mass effect on the left L5 nerve roots. There is mild right and moderate to severe left foraminal stenosis. There is severe left-sided facet arthropathy. L5-S1: Status post laminectomy. Disc height loss and a disc bulge with osseous ridging and enhancing granulation tissue in the left subarticular zone. There is severe left-sided facet arthropathy. No central stenosis. There is mild right and moderate to severe left foraminal stenosis.

On 4/15/21 and 5/4/21, JC returned to Dr. Mermelstein complaining of low back pain. The decision was made to perform a right-sided L5 laminectomy, microneurolysis right side at the L5 nerve root, right side L5-51 facetectomy and excision of herniated nucleus pulposus, right side at LS-51 in the intra-foraminal location, posterior lumbar interbody fusion, at L5-S1, placement of prosthetic disc spacer for anterior interbody fusion (NuVasive 7 mm expandable interbody titanium cage), posterior segmental instrumentation L5-S1 with pedicle screws, intraoperative use of fluoroscopy and placement of spinal instrumentation, use of locally harvested autogenous bone plus allograft for interbody fusion, posterolateral spinal fusion right-sided L5-51 and excision of herniated nucleus pulposus left side L5-S1 with left L5 microneurolysis on 05/11/2021 under general endotracheal anesthesia by Laurence Mermelstein, M.D. Christopher Frendo, D.O, assisted with the surgery. The pre-operative diagnoses were residual/recurrent herniated nucleus pulposus and right side L5-S1 with radiculopathy. The post-operative diagnoses were residual/recurrent herniated nucleus pulposus and right side L5-S1 with radiculopathy with postlaminectomy fibrosis.

Dr. Levy argued that it is generally difficult to determine what constitutes a revision surgery after a lumbar discectomy. For instance, degeneration of an adjacent disc space requiring another discectomy and/or arthrodesis may not necessarily be related to the primary lumbar discectomy but rather the natural course of lumbar degeneration. The effect of incorporating this revision surgery risk in the preoperative consultation will be an important avenue of investigation. These findings may be beneficial in creating realistic expectations for patients with lumbar disc herniation.

Dr.Levy then concludes that in this case, the claimant was involved in the MVA on 03/15/2019 and sustained an injury to the lower back. On 09/02/2020, the claimant underwent lumbar spine surgery. The claimant underwent revision laminectomy, microneurolysis, and facetectomy surgery on 05/11/2021. As per the available medical records, the claimant had lower back pain. However, there was no evidence of severe neurological deficits and abnormality of the gait pattern. In addition, there was no evidence of instability of the lumbar spine. Also, the imaging study did not reveal the failure of previous surgery. Thus, the claimant should have been treated with a rehabilitation program consisting of physical therapy, activity modification, a home exercise program, and oral medications instead of the revision lumbar spine surgery to resolve the complaints. Moreover, there was no evidence of contraindication of the

conservative treatment. Further, as per the above guideline, reoperation may be necessary because of persistent or recurrent symptomatic stenosis at the previously treated vertebral levels. In this case, there was no documentation of failed back surgery syndrome or recurrent symptomatic stenosis. Therefore, the revision lumbar spine surgery was not medically necessary based on the available medical records and the above-cited guidelines.

Dr. Levy argued that there should have been evidence of severe neurological deficits, abnormal gait patterns, or lumbar instability. However, Dr. Levy did not cite specific medical authority to support this statement. I note that the patient and numerous tests indicated nerve disc injury, nerve pain, nerve entrapment, and steroid injections temporarily abated the pain.

The argument that the patient failed to show that conservative treatment was not helping is belied by the nearly 500 pages of medical treatment records spanning nearly two years, indicating otherwise. Her visits to Dr. Mermelstein indicated that since the MVA, the patient has suffered continuous pain in her lower back - despite multiple serious spinal interventions.

In response to the peer review, and as noted above, a rebuttal was not submitted by Applicant. The Applicant argued that the medical records show that this patient needed the second surgery and that the second pre-operative MRI on 4/20/21 was medically necessary. Dr. Mermelstein faced a patient who, despite having had injections, therapy, tests, pain therapy, and even partial laminectomy, was still experiencing unrelenting low back pain. Counsel argued that this peer review report offered general medical statements that did not address the particular and unusual facts presented here.

After carefully reviewing the evidence submitted by both sides, including the peer review and medical records, and weighing the evidence and arguments presented by both Applicant and Respondent's counsel, I find that the Insurer's arguments in its peer review report failed to meet its burden of proof. I note that even Dr. Levy concluded that this MVA caused this 76-year-old woman to sustain low back injuries for which she sought medical treatment spanning nearly two years. Dr. Levy's arguments for denying payment for the second surgery and the anesthesia are not sufficiently supported with reliable and precise medical evidence to meet the insurer's burden of proof on its lack of medical necessity defense. Accordingly, the applicant is awarded $861.59 in full satisfaction of this claim.

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**
	North American Partners In Anesthesia LLP	**05/11/21 - 05/11/21**	**$950.72**	**$861.59**	**Awarded: $861.59**
Total			**$950.72**		**Awarded: $861.59**

B. The insurer shall also compute and pay the applicant interest set forth below. 01/14/2022 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). 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 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). 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).

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

12/07/2022
(Dated)

Phyllis Saxe

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: Phyllis Saxe
Signed on: 12/07/2022