

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Sedation Vacation Perioperative Medicine  
PLLC  
(Applicant)

- and -

LM Insurance Corporation  
(Respondent)

AAA Case No.	17-22-1238-9509
Applicant's File No.	none
Insurer's Claim File No.	0421047720004
NAIC No.	33600

**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 03/15/2023  
Declared closed by the arbitrator on 03/23/2023

Kim Gitlin, Esq. from Dino R. DiRienzo Esq. participated virtually for the Applicant

Melissa Coppola from LM Insurance Corporation participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$351.39**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant reduced the total amount in dispute to \$318.67 pursuant to fee schedule. This is the same amount set forth in the affidavit of Gina M. Ball, RN, CCM, CPC submitted by Respondent.

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

3. Summary of Issues in Dispute

The claimant was the 57 year-old male restrained driver of a motor vehicle that was involved in an accident on 2/19/20. Following the accident the claimant suffered injuries

which resulted in the claimant seeking treatment. At issue is the medical necessity of anesthesia services provided by Applicant associated with a 7/21/20 lumbar percutaneous discectomy that Respondent timely denied reimbursement for based on a 9/9/20 peer review by Ajendra Sohal, 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 male restrained driver of a motor vehicle that was involved in an accident on 2/19/20. The claimant reportedly injured his neck, left shoulder, and low back. On 3/9/20 the claimant presented to Barry Jupiter, M.D. of Island Musculoskeletal Care MD, P.C. with complaints of left shoulder pain and lower back pain radiating down the left leg. Pain was exacerbated with bending, lifting and carrying. Examination revealed: "Spine/Left Shoulder: Limits motion mildly. Tenderness. Weakness with abductors. Neurovascular status intact. Lower Back: Tenderness, guarding and restricted motion. Neurovascular status intact." The claimant was recommended for MRIs (left shoulder and cervical spine) and was initiated on physical therapy. The 3/10/20 left shoulder MRI produced an impression of paramagnetic susceptibility artifact compatible with prior surgical intervention, supraspinatus tendonitis, and subchondral cystic degenerative changes of the inferior glenoid. The 3/16/20 cervical spine MRI produced an impression of straightening of the normal cervical lordosis with bulges at C4-5, C5-6 and C6-7. On 3/23/20 Dr. Jupiter conducted a follow-up examination. The claimant presented with complaints of pain in the neck, left shoulder and lower back pain associated with weakness at the legs. Examination of the thoracolumbar spine revealed tenderness with positive Straight Leg Raising test bilaterally. The claimant was recommended for MRI of the lumbar spine. The 3/27/20 lumbar spine MRI produced an impression of L4-L5 and L5-S1 disc bulges. On 5/20/20 the claimant presented to Herschel Kotkes, M.D. with complaints of radiating low back pain rated 6/10, radiating cervical pain rated 5/10, and left shoulder pain rated 6/10. Cervical examination revealed tenderness to palpation of the cervical facets C3-C7 bilaterally. Anterior flexion 40/60° with pain, extension 55/75° with pain, left lateral rotation 45/80° with pain, right lateral rotation 30/80° with pain, left lateral flexion noted to be 35/45° with pain, and right lateral flexion 30/45° with pain. Palpable trigger points were noted in the muscles of the head and neck. Positive orthopedic tests were Cervical Compression and Spurling's. Lumbar examination revealed lumbar facet pain bilaterally at L3-S1 region. Straight leg test was positive bilaterally. Anterior

flexion 50/90° with pain, extension 20/30° with pain, left lateral flexion 15/25° with pain, and right lateral flexion 15/25° with pain. Left shoulder examination revealed positive Labral test and O'Brien's test. Muscle strength in the upper and lower extremities were normal (5/5); except 4/5 in the left flexors and left extensors. There was normal sensation and deep tendon reflexes. The treatment plan included lumbar percutaneous discectomy and annuloplasty, cervical percutaneous discectomy and annuloplasty, epidural injections, and trigger point injections. Dr. Kotkes performed a suprascapular nerve block injection (Lidocaine and Dexamethasone) with ultrasonic guidance for needle placement and paralumbar trigger point injections with ultrasonic guidance for needle placement. On 5/29/20 the claimant presented to Kenneth McCulloch, M.D. with complaints of left shoulder pain rated 7/10 VAS. Left shoulder examination revealed tenderness to palpation to the biceps tendon anteriorly and anterior aspect of the humeral head. Range of motion was forward elevation 120°, external rotation 60°, and internal rotation L4-L5 with a normal being 180°, 80°, and T8. Positive supraspinatus stress test with pain and weakness, positive O'Brien's test with pain and weakness, and Positive Hawkins and Neer's. The claimant was prescribed Voltaren gel. On 7/2/20 Dr. Kotkes conducted a follow-up examination that was substantially similar to that of 5/20/20. Dr. Kotkes performed lumbar epidural steroid injections (LESI) under fluoroscopic guidance and an epidurogram. On 7/10/20 Dr. McCulloch conducted a follow-up examination and the claimant was recommended for left shoulder arthroscopy. On 7/21/20 Dr. Kotkes conducted a follow-up examination. The claimant presented with complaints of lumbar pain rated 7/10. On examination "palpation of the lumbar facet reveals pain on both the sides at L3-S1 region. Straight leg test is positive bilaterally. Anterior lumbar flexion causes pain. There is pain noted with lumbar extension. Left lateral flexion causes pain. There is pain noted with right lateral flexion." Lower extremities muscle strength, sensation, and deep tendon reflexes were normal. Herschel Kotkes, M.D. (surgeon) and Robert Robenov, PA-C (surgical assistant) performed lumbar percutaneous discectomy, nucleus pulposus ablation, percutaneous intradiscal electrothermal annuloplasty with fluoroscopic guidance, and percutaneous aspiration or decompression nucleus pulposus. Dr. Kotkes noted "indications- Immediately prior to procedure, I performed a brief focused H&P and review of pertinent radiologic studies. The patient has severe back pain and extremity pain. Conservative treatment has failed to provide adequate relief. On physical exam, the skin overlying the injection site was examined and there were no signs of infection." The 7/21/20 associated anesthesia is at issue here.

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 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). 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 (in light of verification that was requested and received) denied the 7/21/20 surgical procedures and associated services based on the 9/9/20 peer review by Ajendra S. Sohal, M.D. After reviewing the claimant's history, treatment, and medical records, Dr. Sohal opines "the above-captioned claimant was injured on 02/19/2020 and on 07/21/2020 percutaneous discectomy was performed with IDET. It should be noted that this is a percutaneous discectomy and not a classical discectomy or similar procedure. It is an intradiscal procedure, it is controversial procedure. Intradiscal procedures are not accepted as norm by Workers' Comp Board and/or CMS and/or ACOEM, although claimed to be safer, they carry their own risks such as recurrent disc herniation or herniation from the portals, premature DJD, need for lumbar fusion, etc. The MRI revealed disc bulges with some degenerative changes. Pain is reported to be at times 10/10 without appropriate pharmacotherapy. If the claimant was not responding and needed surgery, appropriate referral to the spine orthopedic surgeon or neurosurgeon with surgery as a standard of care should be considered, not just procedure." Dr. Sohal continues "the lower extremity motor power, sensations, and DTRs were non-focal. It should be noted that a note on 05/20/2020, plan for suprascapular nerve blocks, trigger point injections, lumbar discectomy and annuloplasty, percutaneous and percutaneous cervical discectomy and annuloplasty with epidural injections and trigger point injections with MRI findings of disc bulges only and without evidence of radiculopathy. Berry J A, Elia C, Saini H S, et al. (October 17, 2019) A Review of Lumbar Radiculopathy, Diagnosis, and Treatment. *Cureus* 11(10): e5934. "Surgical options include open laminectomy with discectomy, the so-called "mini-open" hemilaminectomy with a microdiscectomy, minimally invasive hemilaminectomy with microdiscectomy via tubular retractors, and MED. Studies have shown MED to be superior to open surgical techniques in producing less irritation of the nerve by intraoperative EMG studies, less requirement of postoperative analgesia during the hospital stay, less mean operative blood loss, and a lower mean number of rest days. Less invasive methods may also produce less joint destabilization due to less destructive techniques as well as decreased surgical and hospital costs. Minimally invasive techniques are not without limitations such as a restricted cone field of vision for the surgeon and inability to approach pathology from other angles. Minimally invasive techniques may be appropriate under the correct conditions and should be evaluated on a case-by-case basis." Dr. Sohal asserts "please see article titled "Radicular Pain Syndromes: Cervical, Lumbar, and Spinal Stenosis" by Patel and Perloff published in *Seminars in Neurology* 2018;38:634-639. "If the aforementioned medications and physical therapy achieve minimal to no improvement of radicular symptoms over a period of 6 to 12 weeks, especially with nonstenosis etiologies, a trial of epidural steroid injections (ESIs) is considerable. With acute and subacute radicular symptoms, ESIs have been shown to provide improvement of radicular pain symptoms compared with baseline, especially with symptoms secondary to herniated disks. Pain improvement is typically noted to be significant up to 6 weeks from the injection, but not after 3 months. Additionally, though there may be subacute radicular pain improvement, the need for surgery is not decreased. With spinal stenosis as an exception, lumbar or cervical radicular symptoms seem to respond similarly to medications and ESI as described

earlier. Overall, ESI is not a standalone therapy but best used with other modalities as part of an interdisciplinary approach. It is important to keep in mind that ESI, especially in the cervical region, has significant risks including additional neurologic symptoms, abscess, and epidural hematoma." Alternatively, in the case of lumbar and cervical radicular pain, surgery is an option, but only when symptoms are intractable or intolerable to the patient, as conservative treatment often has similar long-term benefit compared with surgical decompression." Dr. Sohal expounds "review article titled "Effectiveness of Thermal Annular Procedures in Treating Discogenic Low Back Pain" by S Helm et. al, published in Pain Physician 2017; 20:447-470 • ISSN 1533-3159. Conclusion of the article states "Discogenic pain, or 1DD, is a distinct clinical entity in which the attempts to heal a damaged annulus lead to sensitized nerves and pain. Treatment of discogenic pain can be frustrating. Heat applied to the annulus has been used to treat discogenic pain. 1DET has quality evidence supporting its use, but a countervailing study has been interpreted to show lack of efficacy of the procedure. There is no high quality evidence supporting the use of discrode. Biacuplasty has 2 high quality studies, one with a placebo-control and another with an active comparator, showing efficacy. Given the lack of treatment options with evidence showing efficacy and given the documented superiority of biacuplasty over conventional medical treatment, biacuplasty should be considered as a treatment option in patients with refractory discogenic pain", [also] "please see ACOEM Low Back Disorders, February 24, 2016. Page 518 and 519: DISCECTOMY, MICRODISCECTOMY, SEQUESTRECTOMY, ENDOSCOPIC DECOMPRESSION: There are multiple surgical techniques that have been used to surgically relieve pressure on lumbosacral nerve roots causing radicular pain syndromes. (1845-1849). These include open discectomy (with or without microscope),(1850-1855) automated percutaneous discectomy,(1856-1858) epidural percutaneous discectomy,(1859) sequestrectomy, and endoscopic procedures. (1860-1864) More recent techniques include percutaneous laser disc decompression, (1865) automated percutaneous discectomies (also known as nucleoplasty), (1866, 1867) disc coblation, and endoscopic approaches (1868) The same surgical approaches are also sometimes used to address less common spinal pathology (e.g., facet joint arthropathy with consequent nerve root impingement). This section reviews the indications for discectomy for a herniated lumbar disc. Recommendation: Lumbar Discectomy for Radiculopathy Lumbar discectomy is moderately recommended to speed recovery in patients with radiculopathy due to ongoing nerve root compression who continue to have significant pain and functional limitation after 4 to 6 weeks of time and appropriate conservative therapy. For patients who are candidates for discectomy (other than for cauda equina syndrome and the rare progressive major neurologic deficit), there is evidence that there is no need to rush surgical decisions as there is no difference in long-term functional recovery whether the surgery is performed early or delayed. Open discectomy, microdiscectomy, and endoscopic discectomy are all potentially appropriate ways to perform discectomy. The decision as to which of these procedures to choose should be left to the surgeon and the patient until quality evidence becomes available to provide evidence-based guidance. Other procedures such as laser discectomy and/or PERC involve indirect procedures with limited access to the disc contents. Indications - All of the following should be present: 1) radicular pain syndrome with current dermatomal pain and/or numbness, or myotomal muscle weakness all consistent with a herniated disc; 2) imaging findings by MRI, or CT with or without myelography that confirm persisting nerve root compression at the level and

on the side predicted by the history and clinical examination; and 3) continued significant pain and functional limitation after 4 to 6 weeks of time and appropriate non-operative therapy that usually includes NSAID(s). Progressive neurological deficits are considered a separate indication. Benefits- Earlier pain relief Harms - Operative complications that very rarely include severe adverse effects or fatality comparable with other moderate surgical procedures. Strength of Evidence - Moderately Recommended, Evidence (B) Level of Confidence - High Recommendation: Discectomy for Treatment of Acute, Subacute, or Chronic Low Back Pain without Radiculopathy Discectomy is moderately not recommended for treatment of acute, subacute, or chronic low back pain without radiculopathy. Strength of Evidence - Moderately Not Recommended, Evidence (B) Level of Confidence - High Recommendation: Discectomy for Back or Radicular Pain Syndrome Percutaneous discectomy (nucleoplasty), laser discectomy, and disc coblation therapy are not recommended for treatment for any back or radicular pain syndrome. Strength of Evidence - Not Recommended, Insufficient Evidence (I) Level of Confidence - Low. Dr. Sohal citations in conclusion: "Clinical Guidelines CMM-308 -Thermal Intradiscal Procedures Version 19.0 Effective August 11, 2017. CMM-308.2 General Guidelines indicates "The use of thermal intradiscal procedures are considered not medically necessary. This decision is based on the lack of conclusive scientific evidence demonstrating the clinical efficacy of thermal intradiscal procedures such as intradiscal electrothermal therapy (IDET), intradiscal thermal annuloplasty (IDTA), percutaneous intradiscal radiofrequency thermocoagulation (PIRET), radiofrequency annuloplasty (RA), and percutaneous disc decompression (PDD) (aka Coblation nucleoplasty), combined with the potential to expose patients to serious adverse side effects or complications." Please see "An Update of Comprehensive Evidence-Based Guidelines for Interventional Techniques in Chronic Spinal Pain. Part II: Guidance and Recommendations" in Pain Physician 2013; 16:S49-S283 \* ISSN1533-3159 by Manchikanti and others. "The current evidence indicates lack of evidence for transforaminal epidural injections and high risk with good evidence for cervical interlaminar epidural injections in disc herniation, and fair evidence in discogenic pain without radiculitis or disc herniation, spinal stenosis, and post surgery syndrome."

Here the submitted medical records do not meaningfully address the arguments that are raised by Dr. Sohal and do not establish that that the services at issue were medically necessary. Furthermore, Applicant did not provide a rebuttal to Dr. Sohal's peer review. Under these circumstances Applicant did not respond to Dr. Sohal's contention that the services performed were a deviation from a reasonable medical standard of care. The medical records alone are not sufficient to rebut the conclusions of Dr. Sohal which I find persuasive in this instance. Accordingly, the claim is denied in the entirety.

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 NY

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.

04/14/2023  
(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:**  
68f160dbb130b11dbcc75c838ffedf27

### Electronically Signed

Your name: Charles Blattberg  
Signed on: 04/14/2023