

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Total Anesthesia Provider, P.C. f/k/a
Advanced Anesthesiology of NY, PC
(Applicant)

- and -

State Farm Mutual Automobile Insurance
Company
(Respondent)

| | |
|--------------------------|-----------------|
| AAA Case No. | 17-22-1257-5799 |
| Applicant's File No. | GM22-485425 |
| Insurer's Claim File No. | 32-12J7-70H |
| NAIC No. | 25178 |

ARBITRATION AWARD

I, John O'Grady, 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 05/10/2023
Declared closed by the arbitrator on 05/10/2023

John Fagan Esq. from Law Offices of Gabriel & Moroff, P.C. participated virtually for the Applicant

Angeliki Kokkosis Esq. from De Martini & Yi, LLP participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$3,617.86**, was AMENDED and permitted by the arbitrator at the oral hearing.

At the hearing the applicant reduced the amount in dispute from \$3617.86 to \$2862.04, consistent with respondent's contention that the lower amount is the proper amount payable for the service provided, pursuant to the Workers Compensation Fee Schedule.

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

3. Summary of Issues in Dispute

CASE SUMMARY

Applicant, as assignee of an eligible injured person, a 26-year-old male, seeks reimbursement of the following charge(s) following a motor vehicle accident on October 10, 2020: a percutaneous cervical discectomy on January 9, 2022.

Respondent timely denied the claim(s) relying on the January 31, 2022 peer review by Dr. Gary Florio.

ISSUE(S)

Whether respondent makes out its initial burden to show that the percutaneous discectomy was not medically necessary and, if so, whether applicant's proof is sufficient to overcome that demonstration.

4. Findings, Conclusions, and Basis Therefor

Dr. Florio reviewed the medical records of treatment of the assignor noting that he had chief complaints of low back pain, left knee, right knee, right ankle and left ankle pain. In the emergency room following the accident, the patient had no cervical spine pain and was not rendered a diagnosis for that body part. A year later, on October 15, 2021, Dr. Florio examined the assignor, performing an independent medical examination (IME) on behalf of the respondent, and the patient did not report ongoing neck pain. There was normal spinal range of motion at the time of that exam. Muscle strength was normal and sensation and reflexes were without abnormality. Orthopedic testing was negative.

Dr. Florio acknowledges that percutaneous endoscopic cervical discectomy has demonstrated the ability to decompress the exiting nerve root and dural sac and encourages clinical outcomes that reduce pain. The purpose of the procedure is to treat radicular pain caused by cervical disc herniation.

He refers to the September 27, 2021 examination at the office of the applicant, Total Anesthesia, three weeks prior to his IME, when the patient denied subjective complaints of neck pain and was noted to have no tenderness over the cervical spine with normal muscle strength, sensation and reflexes. With the two exams three weeks apart and no demonstration of subjective complaints of cervical or radicular pain and no objective evidence of abnormalities consistent with those complaints, Dr. Florio concludes that the cervical discectomy was not medically necessary.

The applicant relies on a rebuttal by Dr. Arun Agrawal who is not the treating provider. He refers to the January 9, 2022 operative report which indicates that the patient "returns today with cervical radicular pain, positive Spurling sign and nonprogressive numbness and tingling down the upper extremities." He refers to no other specific exam report demonstrating any subjective complaints or objective abnormalities in the cervical spine and the proof submitted by both the applicant and respondent includes no reports making that demonstration, prior to the operative report. Dr. Agrawal argues that the evidence of cervical spine pain and abnormalities contained in the operative report

demonstrate persistence unresolved by other treatment for which the percutaneous discectomy was medically necessary. He supports the contention that percutaneous discectomy is an appropriate treatment for that condition with references to materials relied upon in his profession.

It is well settled that an applicant for no-fault benefits establishes its prima facie entitlement to payment by submitting evidence that payment of no-fault benefits are overdue, and proof of its claim, using the statutory billing form, was mailed to and received by the defendant insurer." *Viviane Etienne Medical Care, P.C. v. Country-Wide Ins. Co.*, 25 N.Y.3d 498, 501, 14 N.Y.S.3d 283, 286 (2015). A "facially valid claim," is presented where it sets forth the name of the patient; date of accident; date of services; description of services rendered and the charges for those services. See, *Vinings Spinal Diagnostic P.C. v. Liberty Mutual Insurance Company*, 186 Misc.2d 287; 717 NYS2d 466 (1st Dist. Ct. Nass. Co.)

In evaluating the medical necessity of services where the proof of each party, particularly the conclusion, is contradictory, consideration must be given to the evidentiary burdens. Respondent must prove first that the services were not medically necessary. That proof must come from someone qualified by education, training and experience to give such opinion. A peer review report must set forth a factual basis to establish, prima facie, the absence of medical necessity and a conclusory assertion that certain procedures were medically unnecessary fail to create a triable issue of fact, *Choicenet Chiropractic PC v Allstate*, 2003 NY Slip Op 50672U, 2003 N.Y. Misc. LEXIS 314 (App. Term, 2nd and 11th Jud Dists 2003; *Amaze Medical Supply v Allstate Ins. Co.*, 3 Misc. 3d 43, 779 N.Y.S.2d 715, 2004 NY Slip Op 24119 (App Term 2d and 11th Jud Dists 2004).

An opinion offered by respondent is more likely to withstand the opinion of a treating medical provider when it includes:

1. some reference to the standards in the applicable medical community for the services and treatment in issue;
2. an explanation as to when such services and treatment would be medically appropriate, preferably with an understandable objective criteria; and
3. an explanation of why it was not medically necessary in the instance at issue.

If the proof of the respondent is found to meet its burden, the proof of the applicant must be considered in opposition to it, mindful that it is likely offered by the provider who actually performed examinations, established treatment and diagnostic plans, made diagnoses and performed medical services.

Respondent establishes its initial burden to show that there was no medical necessity for the percutaneous discectomy. Dr. Florio acknowledges that percutaneous discectomy is an appropriate treatment to relieve pressure on an exiting nerve and therefore relieve pain in a person suffering from radicular symptoms in the cervical spine. He further explains that the records of treatment of this assignor did not demonstrate the necessity

for that surgery because there is no evidence of cervical spine pain, in particular at the time of an examination by the treating provider, Total Anesthesia, in late September, 2021 and at the time of his IME, three weeks later and three months prior to the service in issue. Applicant's proof fails to overcome that demonstration. Dr. Agrawal relies on the contention in the operative report that there was persistent cervical spine pain for which treatment was provided but, in the absence of other proof demonstrating cervical spine pain and abnormalities, the operative report is self-serving and insufficient to demonstrate an abnormality for which the surgery was appropriate. Dr. Agrawal is unable to offer a more substantial argument in favor of the surgery because he was not the treating provider and does not know the details of the treatment and examination findings, and because the reports of prior examinations do not demonstrate cervical spine abnormality, especially from September, 2021 to the date of surgery in January, 2022. Applicant therefore fails to overcome respondent's initial demonstration, fails to establish the medical necessity of the percutaneous discectomy, and the 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 NY

SS :

County of Nassau

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

05/15/2023
(Dated)

John O'Grady

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:
79820575e9cd2d4cbd036effdc4e64d6

Electronically Signed

Your name: John O'Grady
Signed on: 05/15/2023