

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Rockaways ASC Development LLC d/b/a  
ASC of Rockaway Beach  
(Applicant)

- and -

MVAIC  
(Respondent)

AAA Case No.	17-23-1290-3718
Applicant's File No.	TLD23-1023048
Insurer's Claim File No.	674515
NAIC No.	Self-Insured

### **ARBITRATION AWARD**

I, Anthony Kobets, 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 10/04/2023  
Declared closed by the arbitrator on 10/04/2023

Jodi Ann Chambers, Esq. from Thwaites, Lundgren & D'Arcy Esqs participated virtually for the Applicant

Craig Marshall, Esq. from Marshall & Marshall, Esqs. participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$10,504.49**, was AMENDED and permitted by the arbitrator at the oral hearing.

At the hearing, Applicant's counsel amended the amount in dispute down to \$5292.93 total pursuant to the fee schedule. Accordingly, \$5292.93 is the amended amount in dispute herein.

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

3. Summary of Issues in Dispute

In dispute is the Applicant's bill totaling \$10,504.49 for facility fees associated with a lumbar spine percutaneous discectomy procedure and associated services performed on

the Patient (AP) on 10/27/22 as a result of injuries sustained in a motor vehicle accident on February 24, 2022.

Respondent denied the claims based upon a peer review report by Dr. Miranda Smith dated 12/5/22. Was the Applicant entitled to reimbursement for the services provided to the EIP?

#### 4. Findings, Conclusions, and Basis Therefor

At the hearing, Applicant's counsel amended the amount in dispute down to \$5292.93 total pursuant to the fee schedule. Accordingly, \$5292.93 is the amended amount in dispute herein.

The EIP (AP) was an 18-year old female passenger who was involved in a motor vehicle accident on February 24, 2022. Thereafter on 10/27/22, she underwent a lumbar percutaneous discectomy procedure and associated services performed at the Applicant's facility. Applicant seeks no-fault reimbursement for these services.

Respondent timely denied the bill in dispute herein based upon the peer review report of Dr. Miranda Smith dated 12/5/22 and an Addendum report dated 8/23/23, wherein she indicated, inter alia, that "[w]hile the North American Spine Society guidelines do allow for a percutaneous discectomy performed with the use of an endoscope (which was not utilized in this case), it should be noted that this procedure is not routinely performed in the United States other than for patients who are involved in no-fault or Workmen's Compensation claims. While not binding in these insurance cases, it should be noted that commercial insurers and Medicare do not cover this procedure due to its lack of evidence. Percutaneous discectomy (PCD) is not recommended because proof of its effectiveness has not been demonstrated... There is no role for provocation discography in establishing a diagnosis of radiculopathy. Such as a diagnosis can be confirmed through radiographic, historical, and clinical findings alone." Respondent's counsel argued that the Respondent's proofs sufficiently demonstrated that the disputed services were not medically necessary.

If the insurer presents sufficient evidence establishing a lack of medical necessity, then the burden shifts back to the Applicant to present its own evidence of medical necessity. See: *West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co.*, 13 Misc3d 131A (2006). Once the insurer [Respondent] makes a sufficient showing to carry its burden of coming forward with evidence of lack of medical necessity, "[Applicant] must rebut it or succumb." See, *Bedford Park Med. Practice P.C. v. American Transit Tr. Ins. Co.*, 8 Misc. 3d 1025 (A), 2005, 2005 NY Slip Op 51282 citing *Bauman v Long Island Railroad*, 110AD2d 739, 741, [2d Dept 1985]). Applicant's counsel argued that Dr. Smith's conclusion was contradicted by the patient's complaints and objective findings contained in the medical records.

Applicant also relied on a rebuttal report from Joseph Jimenez, M.D. dated 8/11/23, wherein he reviewed the medical records, including the peer report and stated,

inter alia, that "[t]o address her radicular low back pain and symptoms that persisted for more than 8 months, it was imperative to perform the minimally invasive discectomy and annuloplasty. Clinical studies further recommend percutaneous lumbar discectomy for patients with lumbar radiculopathy compatible with the imaging findings and those who failed non-operative treatments for ~6 weeks. The annuloplasty was also medically indicated to destroy the pain-generating nerve fibers and toughen the affected discs, thereby providing pain relief and preventing re-herniation of the discs. Performing percutaneous discectomy and annuloplasty has been shown to result in pain relief and improved function in patients with back and leg pain associated with disc herniation, such as [Assignor]."

The records herein indicated that a lumbar spine MRI performed on 6/28/2022 revealed a broad-based posterior disc bulge at L4-L5 abutting the thecal sac and broad-based posterior disc bulge at L5-S1 abutting the epidural space.

On 10/27/2022, the patient underwent a percutaneous lumbar discectomy at the L4/5 and L5/S1 levels. A discectomy probe was advanced, disc material was removed and a discography was performed.

Based upon a review of the evidence herein and the arguments of counsel, I find that the Respondent has not met its burden in this case with regard to the services provided to the patient on 10/27/22. Dr. Smith did not adequately discuss the significance of the patient's complaints and objective findings noted in the medical records, including radiating pain, a positive SLR test and disc bulges.

Furthermore, I find that the patient's medical records showed persistent complaints of pain with positive objective findings thereby warranting the additional treatment and disputing the peer review doctor's general conclusion that the services were not medically necessary. I was also persuaded by Dr. Jimenez's explanation that "[t]his was evident in the case of [Assignor] who initially underwent physical therapy after the motor vehicle accident, and she also received epidural steroid injection which only provided temporary relief for 1-2 weeks. Despite these modalities, [Assignor] noted persistent low back pain with radiating dysesthesias to the right leg and right-sided numbness and tingling, neurological deficits innervating the L4-S1 nerve roots, positive SLR test, and pain on lumbar paraspinals. After careful consideration of the patient's symptoms that persisted for more than 8 months which still interfered with her mobility and daily activities and corroborative MRI findings showing disc bulges at L4-L5 and L5-S1 levels, lumbar discectomy with nucleoplasty and annuloplasty were recommended for definitive management of her condition secondary to radiculopathy and intervertebral disc disorder. In fact, clinical practice guidelines recommend lumbar percutaneous discectomy as a medically necessary procedure for the treatment of lumbar radiculopathy that failed to improve with nonsurgical management (which may include manual spinal manipulation, physical therapy, nonsteroidal anti-inflammatory drugs, analgesics, and steroid injection) for more than 6 weeks, such as here." A peer review which concludes there was no medical necessity due to the lack of sufficient information upon which the reviewer could make such a determination does not set forth a factual

basis and medical rationale sufficient to establish the absence of medical necessity. Park Neurological Services P.C. v. GEICO Ins., 4 Misc.3d 95, 782 N.Y.S.2d 506 (App. Term 9th & 10th Dists. 2004).

I find that the patient's medical records were more persuasive that the services herein were reasonable and medically necessary based on the patient's continued symptomology. A letter of medical necessity which raises a question of fact as to the medical necessity of services may serve to rebut the peer review report. E.g., American Chiropractic Care, P.C. v. Praetorian Ins. Co., 42 Misc.3d 145(A), 988 N.Y.S.2d 521 (Table), 2014 N.Y. Slip Op. 50346(U), 2014 WL 996509 (App. Term 9th & 10th Dists. Feb. 28, 2014). A respondent defending a denial of first party benefits on the grounds that the subject medical services or testing were not medically necessary must show that the services were inconsistent with generally accepted medical practice, and here the Respondent has not.

The opinion of the insurer's expert standing alone is insufficient to meet the *burden of proving that the services were not medically necessary* (see Citywide Social Work v. Travelers Indem. Co., 3 Misc 3d 608 (Civ Ct Kings County 2004)). Where a peer review opinion rests upon conclusory assumptions and disputed or incorrect facts, the review is insufficient to prove the insurer's entitlement to judgment as a matter of law on its lack of medical necessity defense; in these circumstances, the absence of opposing expert proof from the claimant is immaterial. E.g., Novacare Medical P.C. v. Travelers Property Casualty Ins. Co., 31 Misc.3d 1205(A), 927 N.Y.S.2d 817 (Table), 2011 N.Y. Slip Op. 50500(U) at 5, 2011 WL 1226956 (Dist. Ct. Nassau Co., Michael A. Ciaffa, J., Apr. 1, 2011). Where other reports in the insurer's papers contradict the conclusion of its peer reviewer that a service was not medically necessary, it has failed to make out a prima facie case in support of the defense of lack of medical necessity. Hillcrest Radiology Associates v. State Farm Mutual Automobile Ins. Co., 28 Misc.3d 138(A), 2010 N.Y. Slip Op. 51467(U), 2010 WL 3258144 (App. Term 2d, 11th & 13th Dists. Aug. 13, 2010). **Based upon the aforementioned, I find that the Respondent has failed to sufficiently prove that the 10/27/22 services were not medically necessary and grant Applicants' \$5292.93 amended claim.** This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator. Any further issues raised in the hearing record are held to be moot and/or waived insofar as not raised at the time of the hearing.

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
	<b>Rockaways ASC Development LLC d/b/a ASC of Rockaway Beach</b>	<b>10/27/22 - 10/27/22</b>	<b>\$10,504.49</b>	<b>\$5,292.93</b>	<b>Awarded: \$5,292.93</b>
<b>Total</b>			<b>\$10,504.49</b>		<b>Awarded: \$5,292.93</b>

B. The insurer shall also compute and pay the applicant interest set forth below. 03/13/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Where a claim is timely denied, interest shall begin to accrue as of the date arbitration is commenced by the claimant, i.e., the date the claim is received by the American Arbitration Association, unless arbitration is commenced within 30 days after receipt of the denial, in which event interest shall begin to accrue as of the date the denial is received by the claimant. See generally, 11 NYCRR 65-3.9. Where a motor vehicle accident occurs after Apr. 5, 2002, 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 has 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). Where no denial has been issued and no

payment has been made, it is clear from the statute that the claim is overdue and interest runs from the thirty first day after the claim was presented to the carrier for payment. New York Presbyterian Hospital v. Allstate Insurance Company, 30 A.D.3d 492, 819 N.Y.S.2d 268, 2006 N.Y. Slip Op. 04815 (2nd Dep't 2006). Hempstead General Hospital v. Insurance Company of North America, 208 A.D.2d 501, 617 N.Y.S.2d 478 (2nd Dep't 1994).

C. Attorney's Fees

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

As this matter was filed **after** 4, 2015, this case is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant an attorney's fee, in accordance with newly promulgated 11 NYCRR 65-4.6(d).

- 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 NY  
SS :  
County of Nassau

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

10/26/2023  
(Dated)

Anthony Kobets

**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:**  
f789f1c36855b17bcda69882b2569661

**Electronically Signed**

Your name: Anthony Kobets  
Signed on: 10/26/2023