American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Metropolitan Medical and Surgical, P.C. (Applicant)	AAA Case No.	17-23-1287-7112
	Applicant's File No.	23-001044
- and -	Insurer's Claim File No.	0496739080001
	NAIC No.	36447
LM General Insurance Company (Respondent)		

ARBITRATION AWARD

I, Karen Fisher-Isaacs, 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 10/31/2023
   Declared closed by the arbitrator on 10/31/2023

   Jared Mallimo from The Licatesi Law Group, LLP participated virtually for the Applicant

   Meliane Diedro from LM General Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$9,505.70**, was NOT AMENDED at the oral hearing.
   Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

   Applicant seeks reimbursement of charges for a lumbar percutaneous discectomy performed on October 17, 2022 for Assignor, a 62-year old female, in connection with treating injuries following a May 26, 2022 motor vehicle accident. Respondent timely denied Applicant's claim based on Dr. Jason Cohen's peer review report dated October 31, 2022. Applicant submitted Dr. Arden Kaisman's rebuttal dated June 5, 2023. Respondent also raised a fee schedule defense.

4. Findings, Conclusions, and Basis Therefor

I have reviewed the documents contained in the American Arbitration Association's ADR Center as of the date of the hearing in this matter and have considered all pertinent documents contained therein for the purpose of rendering this award.

Applicant seeks reimbursement in the amount of $9,500.24 for a lumbar discectomy performed on November 4, 2022 for Assignor, a 24-year old female, in connection with treating injuries sustained in a motor vehicle accident on May 21, 2022. Respondent timely denied Applicant's claim based on a peer review report.

As a threshold matter, I find that Applicant has established its prima facie case as Applicant has met the requirements enunciated in Ave T MPC Corp. v Auto One Ins. Co., 32 Misc 3d 128[A], 2011 NY Slip Op 51292[U] [App Term, 2d, 11th & 13th Jud Dists 2011]). To meet its burden and establish a lack of medical necessity, Respondent must present competent medical evidence setting forth a clear factual basis (specifics of the claim) and medical rationale for denying the claim. Citywide Social Work and Psych Services, PLLC v. Allstate, 8 Misc. 3d 1025A (2005); Healing Hands Chiropractic v. Nationwide Assurance Co., 5 Misc. 3d 975 (2004).

Assignor was a front seated passenger in a motor vehicle that was involved in an accident on May 26, 2022. She was evaluated at St. Barnabas Hospital's ER and discharged for outpatient treatment. Assignor's lumbar MRI performed on August 1, 2022 revealed levoscoliosis, L3/4 and L4/5 herniated discs resulting in central and bilateral neuroforaminal encroachment with neuroforaminal narrowing and L5/S1 herniated disc resulting in central and bilateral neural foraminal encroachment.

She presented to PA Augustus Igbokwe on September 7, 2022 complaining of inter alia, constant radiating low back pain (8/10). The physical exam of Assignor's lumbar spine revealed restricted range of motion testing with pain, tenderness and spasms, a positive SLR test and positive facet loading. After performing his exam and reviewing Assignor's lumbar spine MRI, PA Igbokwe's diagnoses included lumbar radiculopathy, myalgia, fibro myositis and lumbar facet syndrome. On September 21, 2022 Assignor underwent a LESI at L5/S1, epidurogram and trigger point injections at the left L4 and L5 bilateral paravertebral muscles.

On October 17, 2022, Assignor underwent a lumbar discectomy at L3-4, L4-5 with fluoroscopy, annuloplasty at L3-4 and L4-5, lumbar discogram and LESI at L3-4 and L4-5 by Dr. Arden Kaisman.

Respondent's evidence established that it timely denied Applicant's billing based on Dr. Cohen's peer review report. He advised that the lumbar surgery was not necessary because Assignor's "imaging studies and electrodiagnostic testing [failed] to identify lumbar radiculopathy" and that PA Igbokwe's physical exam did not reveal findings consistent with lumbar radiculopathy. Additionally, he stated that there is limited evidence to the efficacy of automated percutaneous lumbar discectomy. Regarding the LESI, he advised that there is no proven efficacy and no long term benefit to epidural steroid injections. As regards the annuloplasty, he wrote that "intradiscal annuloplasty is considered experimental with no proven benefit over placebo."

The law is well settled that the burden is on the insurer to prove that medical treatment performed was not medically necessary. (See A.B. Medical Services PLLC v. Geico Insurance, 2 Misc.3d 26, 773 N.Y.S.2d 773 [App. Term, 2nd & 11th Jud. Dists. 2003]; King's Medical Supply Inc. v. Country-Wide Insurance Company, 783 N.Y.S.2d at 448). I find Dr. Cohen's peer review report sufficient to meet this burden. The report set forth a factual basis and a medical rationale, per the above-cited case law, to establish a prima facie case in support of Respondent's medical necessity defense.

Once Respondent, through Dr. Cohen's report, established the merits of its challenge to the medical necessity of the discectomy, the burden shifted. Now, Applicant was bound to present competent medical proof establishing the medical necessity for the lumbar surgery, and to do so by a preponderance of the credible evidence. West Tremont Medical Diagnostic, P.C. v. GEICO, 13 Misc.3d 131[A], 824 N.Y.S.2d 759 (Table), 2006 N.Y. Slip Op. 51871(U), 2006 WL 2829826 (App. Term 2d & 11 Jud. Dists. 9/29/06), A. Khodadadi Radiology, P.C. v. N.Y. Central Fire Mutual Insurance Company, 16 Misc. 3d 131[A], 841 N.Y.S.2d 824, 2007 WL 1989432 (App. Term 2d & 11 Dists. 7/3/08). Ultimately, the burden of proof rests with the Applicant (See, Insurance Law Section 5102).

Applicant relied on Dr. Kaisman's rebuttal. He stated that a lumbar discectomy is a surgical procedure performed to remove part of a herniated disc in a patients' lower back. It is performed when conservative treatment has not been successful in relieving a patient's pain from the herniated disc. Here Assignor's MRI revealed multiple herniated discs. He cited to authority that supports

performing lumbar discectomy to treat herniated lumbar discs. He also cited authorities that found annuloplasty effective in reducing pain and improving function in patients with lumbar discogenic pain.

I am persuaded by Dr. Kaisman's rebuttal and find it sufficient to meet Applicant's burden on the issue of medical necessity as it meaningfully refers to and rebuts the conclusions set forth in Dr. Cohen's peer review. See, High Quality Medical, P.C. v. Mercury Ins. Co., 26 Misc.3d 145(A), 2010 N.Y. Slip.Op. 50447(U) ((Sup. Ct. App .Term 2d Dep't 2010). Dr. Kaisman's rebuttal addressed the issues raised by Respondent's peer review doctor and provided a medical rationale for performing the lumbar discectomy on October 17, 2022.

Finally, Respondent's counsel argued that if the claim were to be awarded the correct amount of reimbursement is $6,448.41. Respondent submitted Registered Nurse/ Certified Professional Coder Melissa Simon's fee audit. I have reviewed the audit which I find persuasive and sufficient to meet Respondent's burden as to the proper fee. As Applicant did not submit any evidence to refute Coder Simon's audit, Applicant is now awarded $5,625.84 in total satisfaction of its 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.

		Claim	

Medical		From/To	Amount	Status
	Metropolitan Medical and Surgical, P.C.	**10/17/22 - 10/17/22**	**$9,505.70**	**Awarded: $6,448.41**
Total			**$9,505.70**	**Awarded: $6,448.41**

B. The insurer shall also compute and pay the applicant interest set forth below. 02/21/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Respondent shall pay the Applicant the amount of interest computed from the date offiling (noted above) of the AR-1, at a rate of 2% per month, simple, and ending with thedate of payment of the award subject to the provisions of 11 NYCRR 65-3.9(e).

C. Attorney's Fees

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

The insurer shall pay the applicant an attorney's fee, subject to a maximum fee of $1,360.00, in accordance with 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 Bergen

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

11/01/2023
(Dated)

Karen Fisher-Isaacs

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:
5a1f480e10ded8c38b7d070aa048ba0e

Electronically Signed

Your name: Karen Fisher-Isaacs
Signed on: 11/01/2023