American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Pain Management Jersey, LLC (Applicant)	AAA Case No.	17-23-1288-9399
	Applicant's File No.	STLG22-61787
- and -	Insurer's Claim File No.	IAN8191002
	NAIC No.	38130
St. Paul Travelers Insurance Co. (Respondent)		

ARBITRATION AWARD

I, Debbie Kotin Insdorf, 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 11/13/2023
   Declared closed by the arbitrator on 11/13/2023

   Colleen Terry, Esq. from Strauss Terry Law Group, PLLC participated virtually for the Applicant

   Ann Moran, Esq. from Law Offices of Tina Newsome-Lee participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$32,450.00**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The Applicant's Attorney amended the amount in dispute to $5,701.18 to be in accordance with the fee schedule.

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

3. Summary of Issues in Dispute

   The Applicant is seeking reimbursement for Transection and Avalusion of Extraspinal Nerves performed 4/23/21, following a motor vehicle accident on 7/30/19 involving

Assignor WK. The Respondent issued a timely denial based on a peer review by Dr. Steven J. Litman on 6/04/21 and the fees not being in accordance with the fee schedules.

4. Findings, Conclusions, and Basis Therefor

The Applicant's claim is for $5,701.18 for Right Transection and Avalusion of Extraspinal Nerves performed 4/23/21.

The Respondent issued a timely denial based on a peer review. Box 18 (Fees not in accordance with the fee schedules) is checked off.

On 7/30/19, the forty four year old Assignor was driving when involved in a motor vehicle accident.

An MRI of the lumbar spine performed 3/19/20 revealed bulge at L4-L5 level, facet hypertrophy L4-S1 and lateral recessed stenosis.

On 4/07/21, the Assignor was evaluated by Dr.Baher Yanni. She complained of lower back pain radiating to the right thigh. The examination of lumbar spine revealed tenderness over the sacroiliac joint, muscle spasm with decrease and painful range of motion and positive testing (Fabere Patrick and Gaenslens).

The doctor recommended Transection and Avulsion of Extraspinal nerves right L3-L4, L4-LS and LS-S1. The diagnosis was facet syndrome.

On 4/23/21, the procedure was performed.

On 6/04/21, Dr. Steven J. Litman reviewed documents made available to him to determine the medical necessity for the procedure. He did not find it medically necessary.

In an action to recover assigned first-party no-fault benefits, an Applicant establishes a "prima facie showing of their entitlement to judgment as a matter of law 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." Mary Immaculate Hospital v. Allstate Insurance Company, 5 AD3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004).

Once Applicant has established a prima facie case the burden is on the insurer to prove that the medical treatment was medically unnecessary. See, Citywide Social Work & Psychological Services, PLLC a/a/o Gloria Zhune v. Allstate Ins. Co., 8 Misc.3d 1025A, 806 N.Y.S.2d 444 (App Term 1st Dept 2005); A.B. Medical Services, PLLC v. Geico Ins. Co., 2 Misc 3d 26, 773 N.Y.S.2d 773 (App Term, 2nd & 11th Jud Dist 2003); Fifth Ave. Pain Control Center a/a/o Gladys Quintero v. Allstate Ins. Co.,196 Misc.2d 801, 766 N.Y.S. 2d 748 (Civ. Ct. Queens Co. 2003). "A denial premised on lack of medical

necessity must be supported by competent evidence such as an independent medical examination, peer review or other proof which sets forth a factual basis and medical rational for denying the claim." Healing Hands Chiropractic, P.C. a/a/o Cleeford Franklin v. Nationwide Assurance Company, 5 Misc.3d 975, 787 N.Y.S. 645, (Civ. Ct NY Co. 2004). Restated, the evidence must at least show that the services were inconsistent with generally accepted medical/professional practice. Once the generally accepted medical practice (the medical rationale) is articulated, the expert must apply the facts of the case and only then may she properly conclude the services in issue were not medically necessary due to the provider's violation of the generally accepted medical standards.

Dr. Litman noted that the interventional procedure was not required as the Assignor improved with conservative care and lumbar facet radio frequency. Since the Assignor showed improvement with the radio frequency and there was no documentation of significant relief with a diagnostic facet medial branch block done after the radio frequency to assess for residual pain and before the Transection and Avulsion of Extraspinal nerves, the procedure was not a necessary course of action.

In the instant case, the conclusion of the peer reviewer upon which the denial was based was supported by a sufficient factual foundation and medical rationale to warrant rejection of Applicant's claim and accordingly, was sufficient to support the defense of medical necessity.

The burden now shifts to applicant to refute Respondent's evidence. See, Bath Med. Supply, Inc. v. New York Cent. Mut. Fire Ins. Co., 2008 NY Slip Op 50347 (U) (App Term 2d Dept., Feb. 21, 2008); A. Khodadadi Radiology, P.C. v. New York Cent. Mut. Fire Ins. Co., 16 Misc.3d 131,(A), 841 N.Y.S.2d 824 (Table), 2007 NY Slip Op 51342 (U), 2007 WL 1989432 (App. Term 2d & 11th Dists. July 3, 2007).

A rebuttal was written by Dr. Yanni. He noted that a median branch avulsion lasts much longer than a rhizotomy procedure and may even be permanent. Dr. Yanni wrote it may be as effective as spinal fusion in treating back pain while being less invasive and allowing for far quicker recovery.

Dr. Yanni explained that the patient had persistent pain, tenderness, decreased range of motion and MRI findings which warranted further pain management. The Assignor's failed course of conservative care as well as positive subjective and objective findings on 4/07/21 warranted the performance of the Transection and Avulsion of Extraspinal nerves of right L3-L4, L4-L5 and L5-S1.

Dr. Yanni cited to articles which endorsed the performance of the procedure as it's a minimally invasive way to relieve spine joint pain.

After reviewing all of the documents on file in the ADR Center maintained by the American Arbitration Association and considering the arguments set forth by both sides, I find Respondent's denial cannot be upheld. Dr. Yanni explained why the procedure was warranted and within the medically accepted and required standards of care. He

refuted Dr. Litman's argument that theTransection and Avulsion of Extraspinal nerves was not a necessary course of action.

It is Respondent's burden to come forward with "competent evidentiary proof" supporting its fee schedule defenses (see, Continental Med., P.C. v. Travelers Indem. Co ., 11 Misc 3d 145 (a) [App Term, 1st Dept 2006]; see also, Jami M. Abraham, MD., P.C. v. Country-Wide Ins. Co., 3 Misc 3d 130(a), [App Term, 2nd &; 11th Dists 2004]; Power Acupuncture, P.C. v. State Farm Mut. Auto Ins. Co., 11 Misc 3d 1065 (a), [Civ Ct, Kings County 2006].

The Respondent engaged Certified Professional Coder Christopher L. Ricotta to determine whether the correct CPT codes were utilized and billed correctly.

The Certified Professional Coder noted the Applicant would be reimbursed at the NY rate since it was the lowest rate between NY and NJ fee schedule.

According to the Health Insurance Claim Form, the Applicant utilized CPT codes 64772, 64772 59, 64772 59, 64727 and 76000 59 26. The total charge was $32,450.00

The Certified Professional Coder explained that CPT code 64772 is the primary procedure and is reimbursed at $687.80. CPT code 64772, the secondary procedure, is reimbursed at $687.80×50% for multiple procedure reduction ($343.90). CPT code 76000-26 is reimbursable at $57.23. CPT code 64727 was not paid. The Certified Professional Coder wrote, "Provider didn't submit a base code. Therefore, delay was appropriate."

There was no indication that Respondent ever requested the information sought. If Respondent needed the information, they could have sent a verification request. I find Respondent failed to establish its fee scheduled defense with respect to CPT code 64727.

The Applicant did not offer any evidence to refute the analysis set forth by the Respondent's Certified Professional Coder.

After reviewing all of the documents on file in the ADR Center maintained by the American Arbitration Association and considering the arguments set forth by both sides, I find Applicant is entitled to $2,138.26 ($687.80, $343.90, $343.90, $57.23 plus $705.43 for CPT code 64727).

Accordingly, the Applicant is awarded $2,138.26.

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**
	Pain Management Jersey, LLC	**04/23/21 - 04/23/21**	**$32,450.00**	**$5,701.18**	**Awarded: $2,138.26**
Total			**$32,450.00**		**Awarded: $2,138.26**

B. The insurer shall also compute and pay the applicant interest set forth below. 03/02/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

   Since the motor vehicle accident occurred after Apr.5, 2002, interest shall be calculated at the rate of two percent per month, simple, calculated on a pro rata basis using a 30-day month. 11 NYCRR 65-3.9(a). If an applicant does not request arbitration or institute a lawsuit within 30 days after receipt of a denial of claim form or from the payment of benefits, interest shall not accumulate on the disputed claim or element until such action is taken. 11 NYCRR 65-3.9(c). In accordance with 11 NYCRR 65-3.9 (c), interest shall be paid on the claim (s), totaling $2138.26 from 3/02/23, the date the arbitration was commenced.

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 February 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). The insurer shall pay the applicant an attorney's fee, in accordance with 65-4.6(d). This amendment takes into account that there is an attorney fee of 20% of benefits plus interest with no minimum fee and a maximum attorney fee of $1360.00.

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 New York

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

11/27/2023
(Dated)

Debbie Kotin Insdorf

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:
d096299f4b1db1f7343f2abb4735ed21

Electronically Signed

Your name: Debbie Kotin Insdorf
Signed on: 11/27/2023