

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 -

Enterprise Rent A Car
(Respondent)

AAA Case No.	17-23-1291-5300
Applicant's File No.	N/A
Insurer's Claim File No.	18827913
NAIC No.	Self-Insured

ARBITRATION AWARD

I, Stephen Czuchman, 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: the patient, EB.

1. Hearing(s) held on 11/17/2023
Declared closed by the arbitrator on 11/17/2023

John Faris, Esq. from Jakubowitz Law Firm PC participated virtually for the Applicant

Erin M. O'Neil, Esq. from McCormack, Mattei & Holler participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$10,504.49**, 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

The patient (EB), a then 55-year-old male, was injured in a motor vehicle accident on 8/26/22 as the driver of an automobile involved in a multi-vehicle collision. Applicant seeks to recover assigned first-party no-fault benefits consisting of a facility fee for a lumbar discectomy performed on 12/18/22. Respondent timely denied the claim, alleging a lack of medical necessity based on a 2/3/23 peer review report by Dr. Michael Tawfellos and that the billed fees were not in accordance with the applicable fee schedule.

The issues in dispute are whether the services were medically necessary and, if so, whether respondent has substantiated the fee schedule defense.

4. Findings, Conclusions, and Basis Therefor

I determine that applicant has made out a prima facie case for reimbursement of the claim. See *Viviane Etienne Med. Care v. Country-Wide Ins. Co.*, 25 NY3d 498 (2015) ("a plaintiff demonstrates prima facie entitlement to summary judgment by submitting evidence that payment of no-fault benefits [is] overdue, and proof of its claim, using the statutory billing form, was mailed to and received by the defendant insurer.")

Once an applicant health services provider makes out a prima facie case, the burden shifts to the respondent insurer to timely request additional verification, deny or pay the claim. *Hospital for Joint Diseases v. Travelers Prop. Cas. Ins. Co.*, 9 NY3d 312 (2007). 11 NYCRR § 65-3.8 provides that a no-fault insurer has thirty days from the date of receipt of a health services provider's proof of claim to pay or deny that claim in whole or in part.

Applicant billed respondent for \$10,504.49 for a facility fee for a lumbar discectomy performed by Rajivan Maniam, M.D., assisted by Robert Robenov, P.A., at ASC of Rockway Beach on 12/18/22. Respondent timely denied the bill, alleging a lack of medical necessity based on a 2/3/23 peer review report by Michael Tawfelllos, M.D., and that the billed fees were excessive. Lack of medical necessity is a valid defense to an action to recover no-fault benefits. *A.B. Med. Servs., PLLC v. Liberty Mut. Ins. Co.*, 39 A.D.3d 779 (2d Dept 2007). Under Insurance Law § 5102, New York's Comprehensive Motor Vehicle Insurance Reparation Act, first-party no-fault benefits are reimbursable to an injured party or his or her assignee for all medically necessary expenses on account of personal injuries arising out of the use or operation of a motor vehicle. The Mandatory Personal Injury Protection Endorsement set forth at 11 NYCRR § 65-1.1 provides that the insurer shall pay first-party benefits to reimburse for basic economic loss, including (a) medical expense, defined as necessary expenses for "medical, hospital (including services rendered in compliance with Article 41 of the Public Health Law, whether or not such services are rendered directly by a hospital), surgical, nursing, dental, ambulance, X-ray, prescription drug and prosthetic services; (b) psychiatric, physical and occupational therapy and rehabilitation; (c) any nonmedical remedial care and treatment rendered in accordance with a religious method of healing recognized by the laws of New York; and (d) any other professional health services." Treatment for an exacerbation of a preexisting injury is a covered expense under no-fault. 11 NYCRR § 65-3.14 (a). See *Kingsbrook Jewish Medical Center v. Allstate Insurance Co.*, 61 AD3d 13 (2d Dept 2009). The question of whether disputed health services were medically unnecessary cannot be resolved without resorting to meaningful medical assessment, such as by a qualified medical expert conducting a peer review of an injured party's medical records. *Id.*

A peer review must set forth a factual basis and a medical rationale for denying a claim for a lack of medical necessity. *Amaze Medical Supply Inc., v. Allstate Ins. Co.*, 12

Misc.3d 142(A) (App Term 2d Dept 2006). A peer review's factual basis may be insufficient if it fails to provide specifics of the claim, is conclusory, or otherwise lacks a foundation in the facts of the claim. *Amaze Medical Supply v. Allstate Ins. Co.*, 3 Misc.3d. 43 (App Term 2d Dept 2004). A peer review's medical rationale may be insufficient if it is unsupported by evidence of the generally accepted medical practice. *Nir v. Allstate Ins. Co.*, 7 Misc.3d 544 (Civ Ct New York County 2005). Generally accepted medical practice is the range of practice that the profession will follow in the diagnosis and treatment of the patient in light of the standards and values that define it. *CityWide Social Work & Psychological Services, P.L.L.C. v. Travelers Indemnity Co.*, 3 Misc.3d 608 (Civ Ct Kings County 2004). Generally accepted medical practice may be established by reference to medical authority. *Nir v. Allstate Ins. Co.*, supra

When a respondent insurer submits a timely denial of claim based on a peer review that outlines a detailed factual basis and medical rationale for the claim's rejection, the presumption of medical necessity and causality attached to the applicant's claim is rebutted, and the burden shifts back to the applicant to refute the peer review. *CPT Med. Servs., P.C. v. New York Cent. Mut. Fire Ins. Co.*, 18 Misc.3d 87 (App Term 1st Dept 2007); *Eden Med., P.C. v. Progressive Cas. Ins. Co.*, 19 Misc.3d 143(A) (App Term 2d Dept 2008); *Lynbrook Medical of New York, P.C. v. Praetorian Ins. Co.*, 48 Misc.3d 139(A) (App Term 2d Dept 2015).

Dr. Tawfellos, a board-certified anesthesiologist and pain medicine physician, concludes that the underlying lumbar discectomy and disputed derivative ambulatory surgical facility services were medically unnecessary in his 2/3/23 peer review report. He summarizes the patient's 8/26/22 motor vehicle accident history and basic medical facts. The patient's vehicle was rear-ended. There was no loss of consciousness, and he did not seek immediate medical treatment. He was seen on 9/9/22 with complaints including low back pain. On physical examination of the lumbar spine, there was paravertebral tenderness and spasms, reduced range of motion, and positive straight leg raise test at ten degrees with reproduction of pain in a radicular pattern. The patient was referred for treatment and testing, including physical therapy, trigger point injections, and a lumbar MRI, and prescribed pain medications. A 10/20/22 MRI of the patient's lumbar spine revealed broad posterior central acute herniations at L4-S1 impinging on the regional traversing nerve roots. The patient underwent a lumbar epidural steroid injection on 11/13/22 and an L4-S1 percutaneous discectomy, nucleus pulposus ablation, annuloplasty, and radiographic interpretation on 12/18/22. Dr. Tawfellos states that percutaneous discectomy procedures are rarely performed in the United States and have not been proven to be as effective as discectomy or microdiscectomy. Dr. Tawfellos states that the lumbar percutaneous discectomy and related services were medically unnecessary because there was insufficient documentation of conservative treatments and pain management injections that were exhausted before surgery was considered. Dr. Tawfellos states that there is no documentation of the patient's response to the 11/13/22 lumbar epidural steroid injection. He cites and quotes medical literature supporting his opinion that the lumbar discectomy and related services were medically unnecessary.

Applicant submitted a 10/17/23 peer review rebuttal letter by board-certified orthopedic surgeon Laxmidhar Diwan, M.D., in opposition to the peer review. Dr. Diwan summarizes the patient's 8/26/22 motor vehicle accident history and medical facts. Dr.

Diwan states that Dr. Tawfellos' opinion that the lumbar discectomy was medically unnecessary is weak on a clinical level since he failed to review the patient's physical therapy treatment notes and medical records documenting the patient's response to the epidural steroid injection. Dr. Diwan states that Dr. Tawfellos should have asked respondent to request these records or informed them he could not offer an opinion without them. Dr. Diwan states that based on the patient's causally related lumbar disc disorder and radiculopathy that was refractory to respond to a full course of conservative treatment and an epidural steroid injection, lumbar percutaneous discectomy was medically necessary and the standard of care. Dr. Diwan states that lumbar percutaneous discectomy is widely performed in the United States and accepted by leading surgeons, medical organizations, and hospitals. Dr. Diwan cites and quotes medical authorities supporting his opinion that the surgery was medically necessary.

After carefully reviewing the records on the ADR Center and considering the oral argument of counsel at the hearing, I resolve the question of fact regarding the medical necessity of the facility fee in applicant's favor. I determine that the peer review is conclusory and fails to make a prima facie showing of a lack of medical necessity for the facility fee. Dr. Diwan essentially admits that he did not review sufficient records to opine on the medical necessity of the underlying lumbar discectomy, including the physical therapy treatment notes and documentation of the patient's response to the lumbar epidural steroid injection. However, instead of asking respondent to request the records he needed from the patient's treating providers, he drew a negative inference. An expert's failure to review records is not a valid basis for denying a claim for a lack of medical necessity in the absence of a request for additional verification seeking the requisite records. See *Park Neurological Servs. P.C. v. GEICO Ins.*, 4 Misc.3d 95 (App Term 2d Dept 2004). Respondent did not issue any verification requests related to the bill. Further, if the peer review met respondent's burden, I would find Dr. Diwan's rebuttal sufficient to refute it. See *Pan Chiropractic, P.C. v. Mercury Ins. Co.*, 24 Misc.3d 136(A) (App Term 2d Dept 2009); *MIA Acupuncture, P.C. v. Geico Ins. Co.*, 29 Misc. 3d 132(A) (App Term 2d Dept 2010).

Turning to the fee schedule defense, it is the insurer's burden to prove that disputed fees exceed the applicable fee schedule. *East Coast Acupuncture, P.C. v. Hereford Ins. Co.*, 51 Misc.3d 441 (Civ Ct Kings County 2016). If an insurer fails to demonstrate by competent evidentiary proof that a provider of health services billed more than the applicable fee schedule, its fee schedule defense cannot be sustained. *Continental Medical PC v. Travelers Indemnity Co.*, 11 Misc.3d 145(A) (App Term 1st Dept 2006). However, an arbitrator may take judicial notice of the applicable fee schedules. *Kingsbrook Jewish Med. Ctr v. Allstate Ins. Co.*, supra; *Z.A. Acupuncture, P.C. v. Geico Ins. Co.*, 33 Misc.3d 127(A) (App Term 2d Dept 2011); CPLR § 4511. New York's No-Fault law adopts the existing fee schedules prepared by the chairman of the Workers' Compensation Board for industrial accidents. 11 NYCRR 68.1(a); 11 NYCRR § 65-3.16(a)(1).

In support of the fee schedule defense, respondent submitted a 4/26/23 affidavit from Jeffrey Futoran, CPC, a 3M Grouper Software Report printout, and printouts of Mr. Futoran's cited fee schedule references. Mr. Futoran attests that the proper no-fault rate for the facility fee is \$5,292.93. Mr. Futoran notes that applicant billed respondent

\$10,504.49, reporting CPT codes 62287, 22526-59, and 22527-59. Mr. Futoran attests that codes 22526 and 22527 were incorrectly reported with modifier 59 (Separate Procedures or Distinct Procedural Service) and should have been consolidated into code 62287 based on the applicable EAPG Fee Schedule and APG Guidelines and NCCI edits and CPT Book incorporated by reference therein.

I find respondent's evidence conclusively and coherently demonstrates the proper no-fault rate for the bill. See *Viviane Etienne Med. Care, P.C. v. Country-Wide Ins. Co.*, 38 Misc.3d 139(A)(App Term 2d Dept 2013). After the respondent made a prima facie showing that the amounts charged by the applicant were in excess of the applicable fee schedule, the burden shifted to the applicant to show its charges involved a different interpretation of the schedules or an inadvertent miscalculation or error. *Cornell Medical, P.C. v. Mercury Casualty Co.*, 24 Misc.3d 58 (App. Term 2d Dept 2009).

Applicant submitted the 3M Health Information Systems printout that was submitted with the bill supporting the billed fees, but it utilizes modifier 59 to prevent consolidation or unbundling and does not apply or refute any of the consolidations applied by Mr. Futoran. Therefore, I find that applicant has failed to raise a triable issue of fact regarding respondent's fee schedule interpretation or calculation of the applicable fees.

Accordingly, based on a fair preponderance of the credible evidence, applicant is awarded \$5,292.93, along with statutory interest and attorney's fees, and the return of its filing fee.

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	Status
	Rockaways ASC Development LLC d/b/a ASC of Rockaway Beach	12/18/22 - 12/18/22	\$10,504.4 9	Awarded: \$5,292.93
Total			\$10,504.4 9	Awarded: \$5,292.93

B. The insurer shall also compute and pay the applicant interest set forth below. 03/21/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Respondent shall pay applicant interest accruing from 3/21/2023, the date of filing, at the rate of 2% per month, simple, and ending with the date of payment of the award subject to the provisions of 11 NYCRR § 65-3.9.

C. Attorney's Fees

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

Respondent shall pay applicant an attorney's fee 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 Suffolk

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

12/18/2023
(Dated)

Stephen Czuchman

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:
db9c40ebdc81070d3c6d885e10a3f998

Electronically Signed

Your name: Stephen Czuchman
Signed on: 12/18/2023