

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

White Plains Hospital Medical Center
(Applicant)

- and -

Allstate Fire & Casualty Insurance Company
(Respondent)

AAA Case No. 17-23-1299-3978

Applicant's File No. EliasC

Insurer's Claim File No. 0665697552-01

NAIC No. 29688

ARBITRATION AWARD

I, Victor Moritz, 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: IP

1. Hearing(s) held on 12/06/2023
Declared closed by the arbitrator on 12/06/2023

Michael Tomforde, Esq. from Dash Law Firm, P.C. participated virtually for the
Applicant

Marissa Allis, Esq. from Law Offices of John Trop participated virtually for the
Respondent

2. The amount claimed in the Arbitration Request, **\$6,436.36**, 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 applicant seeks reimbursement for the hospital costs related to a cervical discectomy and spinal fusion provided to the IP (C.E. 56 year old male driver) on February 16, 2023, relative to an April 7, 2022 motor vehicle accident. The respondent denied this claim based on the defense of lack of medical necessity per the results of the peer review by Dr. Peter Zahos on March 20, 2023. The applicant has submitted a rebuttal to this peer review by Dr. Didier Demesmin, dated June 29, 2023. There were no fee schedule issues outstanding. This matter is determined after reviewing the submissions and presentations of both sides. I have reviewed the documents contained in the electronic case folder as of the closing of the file. The hearing was held on Zoom.

4. Findings, Conclusions, and Basis Therefor

I find the applicant and award the sum of \$6,436.36 for the costs of the services at issue.

Submissions

The record reflects the IP was involved in a motor vehicle accident on April 7, 2022, sustaining multiple injuries, including to the neck and spinal region. After being treated in the emergency department at Suffern Hospital, he began conservative treatment as an outpatient.

An April 25, 2022 an MRI of the cervical spine revealed C5-C6 central herniation with central canal narrowing as well as C7-T1 lateral herniation with right foraminal encroachment. An EMG/NCV study of the upper extremity from June 1, 2022 revealed bilateral C5-C6 radiculopathies.

The IP received a period of conservative treatment but continued to experience pain and, on September 26, 2022 was evaluated by Dr. Kaushik Das with neck pain radiating to the upper extremities worsened with movement. The evaluation of the cervical spine revealed tenderness and spasms with limited range of motion. Given these findings, recommendations included an anterior cervical discectomy and fusion at C5-C6 levels. At this juncture, the IP continued with other conservative ventures, including an August 16, 2022 cervical epidural steroid injection (CESI) at C7-T1 and on October 11, 2022 received cervical facet injections at C3-C4, C4-C5 and C5-C6 levels.

On February 16, 2023 the IP was admitted to White Plains Hospital due to the aforementioned condition. On that date Dr. Das assisted by Dr. Virany Hillard performed an anterior cervical discectomy and fusion at C5-C6 with the placement of cage biomechanical device at C5-C6 and the use of local autograft and of morselized allograft. The pre and post-operative diagnosis was C5-C6 herniated disc.

Peer Review

The procedure was denied based on the results of the peer review from Dr. Zahos, stating the medical necessity for this procedure had not been established in case there were limited objective findings to support neurological deficits to warrant surgical intervention.

He further opined it was not clear as to why the IP underwent CESI and what the response was to these injections. In the absence of objective findings, surgical intervention cannot be deemed medically necessary, and all pre and post-operative services should also be denied.

Dr. Zahos then cites various studies discussing the standard of care for the use of cervical discectomies, including medical findings of cervical radiculopathy and cervical spondylotic myelopathy, which could lead to spinal instability and dysfunction. He does mention these types of conditions could warrant various medical procedures, including decompression surgery.

Rebuttal to Peer Review

In response to this peer review, I note the rebuttal from Dr. Demesmin who noted the medical findings and disagreed with Dr. Zahos' statements.

The rebuttal mentions Dr. Zahos does not discuss the MRI and EMG/NCV studies, which revealed disc herniations confirming radiculopathy. Dr. Demesmin then discusses the procedures undertaken, noting that spinal fusion may be done to stabilize the neck and prevent a bone fracture from instability, which could damage the spinal cord, resulting in paralysis.

Regarding the procedure performed, he notes the anterior cervical discectomy and fusion is a common procedure and allows for direct decompression of the spinal cord and neural foramen, citing sources. He continues noting the surgery is considered a proper option for symptomatic cervical disc herniations with or without concomitant spondylosis and/or foraminal stenosis.

Legal Standards for Determining Medical Necessity

It is well settled that an applicant established its prima facie entitlement to payment by proving it submitted a claim set forth the facts and the amount of the loss sustained and that payment of no-fault benefits were overdue (see Insurance Law § 5106[a]; Viviane Etienne Med. Care v Country-Wide Ins. Co., 25 NY3d 498, 501 (2015); Countrywide Ins. Co. v. 563 Grand Medical PC 50 A.D. 3d. 313 (1st Dep't, 2008); Sunshine Imaging Assoc./WNY MRI v. Geico. Ins. Co., 66 A.D. 3d. 1419 (4th Dep't, 2009). A facially valid claim is presented when it sets forth the name of the patient; date of accident; date of the services; description of services rendered and the charges for those services. See Vinings Spinal Diagnostic PC v. Liberty Mutual Insurance Company, 186 Misc. 2d 287 (1st Dist. Ct. Nass. Co.1996). The applicant has met this burden.

When evaluating the medical necessity of services with 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. A peer review report must set forth a factual basis to establish, prima facie the absence of medical necessity.

The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment Kingsborough Jewish Med. Ctr. v. Allstate Ins. Co. 2009 NY Slip Op. 00351 (2d. Dep't, January 20, 2009), See also Channel Chiropractic PC v. Country Wide Ins. Co. 38 AD 3d. 294 (1st Dep't, 2007). An

insurance carrier must at a minimum establish a detailed factual basis and a sufficient medical rationale for asserting lack of medical necessity. See Vladimir Zlatnick, M.D. v. Travelers Indem. Co., 2006 NY Slip Op. (50963U) (App. Term 1st Dep't, 2006). See also Delta Diagnostic Radiology PC v. Progressive Casualty Ins. Co., 21 Misc. 3d. (142A) (App. Term 2d. Dep't, 2008). In evaluating the medical necessity of services with 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. A peer review report must set forth a factual basis to establish, prima facie the absence of medical necessity.

Conclusions outlined in peer reviews may be insufficient if it fails to provide specifics of the claim, is conclusory or otherwise lacks a basis in the facts of the claim (Amaze Medical Supply v. Allstate Ins., Co., 3 Misc. 3d. 43 (App. Term, 2d Dep't, 2004). A peer review report must set forth a factual basis to establish, prima facie the absence of medical necessity. See Nir v Allstate Ins. Co., 7 Misc. 3d. 544, 547 (Civ. Ct., Kings Co., 2005) which indicates a respondent's peer review defending a denial of first-party benefits on the ground that the billed-for services were not "medically necessary" must at least show that the services were inconsistent with generally accepted medical/professional practice. The opinion of the insurer's expert, standing alone, is insufficient to carry the insurer's burden of proving that the services were not "medically necessary", citing Citywide Social work & Psy. Serv. P.L.L.C. v Travelers Indemnity Co., 3 Misc. 3d. 608, 616 (Civ. Ct., Kings Co. 2004). A peer report must demonstrate that the services rendered were not in agreement with generally accepted medical or professional standards. Generally accepted practice is the range of practice that the profession will follow in diagnosing and treating the patient in light of the standards and values that define it.

Therefore, an opinion offered by a respondent is more likely to establish a lack of medical necessity when it provides some reference to the standards in the applicable medical community for the services and treatment at issue with an explanation as to when such services and treatment would be medically appropriate with objective criteria and an explanation why it was not medically necessary herein.

I am however not so inclined to preclude the medical opinion offered by an insurer that fails to address the accepted medical/ professional practices. "While an expert affidavit cannot be speculative, there is no threshold requirement in an ordinary case, not involving a novel scientific theory, that a medical opinion regarding deviation be based upon medical literature, studies, or professional group rules in order for it to be considered. It can be based upon personal knowledge acquired through professional experience." Mitroyic y Silverman, 2013 NY Slip Op 01465 (1st Dep't 2013), citing Diaz v New York Downtown Hosp., 99 NY2d 542, 545 (2002) and Limmer v Rosenfeld, 92 AD3d 609, 609 (1st Dept 2012). The burden returns to Applicant to rebut Respondent's showing. Notwithstanding, I am inclined to view proof that does cite to respected medical authorities with much greater weight than one that does not.

Further, a negative inference will be taken if the items, including medical reports, test results and other sources that are relied upon by the peer are not part of the respondent's submission. Notwithstanding, these facts impact upon the weight given the report but do not provide a basis to preclude the document.

In any event, 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.

Application to This Claim

When an insurer interposes a timely denial of claim that sets forth a sufficiently detailed factual basis and adequate medical rationale for the claim's rejection, the presumption of medical necessity and causality attached to the applicant's properly completed claim is rebutted and the burden shifts back to the claimant to refute the peer review and prove the necessity of the disputed services and the causal relationship between the injuries and the accident. See, CPT Med. Servs., P.C. v. New York Cent. Mut. Fire Ins. Co., 18 Misc.3d 87 (App. Term 1st Dept.); Eden Med., P.C. v. Progressive Cas. Ins. Co., 19 Misc.3d 143(A) (App Term 2d & 11th Jud. Dists., 2008). When the provider failed to rebut peer review's showing of a lack of medical necessity, defendant is entitled to dismissal of complaint. Be Well Med. Supply, Inc. v. New York Cent. Mut. Fire Ins. Co., 18 Misc. 3d. 139 (A) (App. Term 2d Dept., Feb. 21, 2008; A. Khodadadi Radiology, P.C. v. NY Cent. Mut. Fire Ins. Co., 16 Misc. 3d. 131 (A) (App Term 2d. Dept.); West Tremont Med. Diagnostic, P.C. v. Geico Ins. Co., 13 Misc. 3d. 131 (A) (App Term 2d Dept., 2006).

In the instant matter, however, I find for the applicant and award reimbursement for the hospital costs related to the procedure at issue.

I accept the statements from the rebuttal in which Dr. Demesmin notes the underlying medical findings herein were consistent for disc herniation and radiculopathy. It does appear the IP received a sufficient amount of conservative treatment; an epidural was administered in August 2022, which was not commented on by the peer. Dr. Demesmin cites multiple studies discussing the efficacy of this procedure, allowing for a direct decompression of the spinal cord and neural foramen, found to be a safe option for symptomatic cervical disc herniations with or without spondylosis and/or foraminal stenosis. The IP appeared symptomatic from disc herniations despite conservative treatment and the surgical intervention was done almost one year after the motor vehicle accident.

As such I find the rebuttal is sufficient to establish the procedure was performed within accepted medical guidelines.

Accordingly, the applicant is awarded the sum of \$6,436.36.

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
	White Plains Hospital	02/16/23 - 02/16/23	\$6,436.36	Awarded: \$6,436.36
Total			\$6,436.36	Awarded: \$6,436.36

- B. The insurer shall also compute and pay the applicant interest set forth below. 05/12/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

The respondent shall pay interest at a rate of two percent per month, simple on a pro rata basis using a thirty day month. With respect to the claim herein, interest will run from May 12, 2023, the date of the filing of this claim, through payment of the claim.

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). Accordingly, the insurer shall pay the applicant an attorney's fee, in accordance with promulgated 11 NYCRR 65-4.6(d).

With respect to this claim, the applicant is entitled to attorney's fees for the medical services provided to the IP for which the applicant is awarded the sum of \$6436.36.

- 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 Westchester

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

12/26/2023
(Dated)

Victor Moritz

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:
29cfbc7d9b7e9090773b8db166a76271

Electronically Signed

Your name: Victor Moritz
Signed on: 12/26/2023