American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

LR Medical PLLC (Applicant)	AAA Case No.	17-23-1284-8428
	Applicant's File No.	00109462
- and -	Insurer's Claim File No.	0676106636 2PU
Allstate Property and Casualty Insurance Company (Respondent)	NAIC No.	17230

ARBITRATION AWARD

I, Steven Celauro, 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: NL

1. Hearing(s) held on 11/29/2023
   Declared closed by the arbitrator on 11/29/2023

   Sasha Hochman from Drachman Katz, LLP participated virtually for the Applicant

   Kevin Davis from Law Offices of John Trop participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$7,695.82**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The amount in dispute was reduced to $5,673.22 in accordance with the purported fee schedule.

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

3. Summary of Issues in Dispute

   This arbitration arises out of medical treatment for the EIP (NL), a 43-year-old male, related to injuries sustained as a bicyclist in a motor vehicle accident that occurred on 6/21/22. Applicant seeks reimbursement for medical services provided on 10/24/22. Respondent denied reimbursement based on the findings of the peer review by Dr. Cohen, dated 11/28/22. Respondent has also set forth a fee schedule.

4. Findings, Conclusions, and Basis Therefor

Applicant seeks reimbursement for the performance of a percutaneous lumbar discectomy and associated services.

Applicant has established its prima facie case with proof that it submitted a proper claim, setting forth the fact and the amount charged for the services rendered and that payment of no-fault benefits was overdue (see Insurance Law § 5106 a; Mary Immaculate Hosp. v. Allstate Ins. Co., 5 AD 3d 742, 774 N.Y.S. 2d 564 [2004]). The burden shifts to the insurer to prove that the services were not medically necessary.

If an insurer asserts that the medical test, treatment, supply or other service was medically unnecessary, the burden is on the insurer to prove that assertion with competent evidence such as an independent medical examination, a peer review or other proof that sets forth a factual basis and a medical rationale for denying the claim. (See *A.B. Medical Services, PLLC v. Geico Insurance Co.,* 2 Misc. 3d 26 [App Term, 2nd & 11th Jud Dists 2003]).

When an insurer relies upon a peer review report to demonstrate that a particular service was not medically necessary, the peer reviewer's opinion must be supported by sufficient factual evidence or proof and cannot simply be conclusory. As per the holding in Jacob Nir, M.D. v.Allstate Insurance Co., 7 Misc.3d 544 (2005), the peer reviewer must establish a factual basis and medical rationale to support a finding that the services were not medically necessary, including setting forth generally accepted standards in the medical community. The opinion of the insurer's expert, standing alone, is insufficient to carry the insurer's burden to prove that the services were not medically necessary. CityWide Social Work & Psychological Services, PLLC v. Travelers Indemnity Co., 3 Misc.3d 608, 777 N.Y.S.2d 241 (N.Y.Civ. Ct. Kings Co. 2004).

In denying the medical necessity of the surgery, Dr. Cohen refers to the exam conducted by Dr. Reyfman on the day of the surgery, 10/24/22. At that time, complaints were of subjective lower back pain that radiated to the buttocks and left leg with numbness/tingling in the feet/toes. Examination revealed tenderness, spasm, limited range of motion, facet loading as well as decreased sensation and strength. The clinical impression was other intervertebral disc displacement, lumbar region, other intervertebral disc displacement lumbosacral region. Recommendations were for lumbar discectomy, nucleoplasty and annuloplasty. The peer reviewer notes that although the operative report documents decompression of the L4-L5 nucleus for extraction, it does not specify an exact placement of decompression at that level. An inexact and generalized decompression cannot reasonably be expected to satisfactorily address the multilevel disc herniation and disc bulges with thecal sac compression and bilateral neural foraminal narrowing identified on MRI. Moreover, Dr. Cohen contends that Dr. Reyfman failed to indicate the medical necessity for his choice of decompression at the L4-L5 level despite multilevel pathology. The complicated pathology identified on MRI is best managed by a skilled spine surgeon. In the case of radiculopathy, physical

therapy and pharmacotherapy would have been the appropriate course of treatment. The standard of care is physical therapy for a six-week period, which the EIP had completed. In the case of failure, the EIP should have undergone a trial of three epidural steroid injections, which were not performed. Additionally, a trial of aggressive pharmacotherapy, including gabapentinoids, was not attempted. Reference was made to numerous medical publications in questioning the use and efficacy of the services performed. Based on the foregoing, Dr. Cohen opines that the services at issue were not medically necessary.

Where the Respondent presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden then shifts to the Applicant which must then present its own evidence of medical necessity. [see Prince, Richardson on Evidence §§ 3-104, 3-202 [Farrell 11th ed]), Andrew Carothers, M.D., P.C. v. GEICO Indemnity Company, 2008 NY Slip Op 50456U, 18 Misc. 3d 1147A, 2008 N.Y. Misc. LEXIS 1121.

Applicant has submitted the rebuttal from the treating physician, Dr. Reyfman, dated 10/19/23. In setting forth his disagreement with Dr. Cohen regarding his "choice of decompression", Dr. Reyfman refers to the 8/13/22 MRI findings of L4-L5 right foraminal disc herniation and annular disc bulge, which encroach and impress on and cause narrowing of the bilateral neural foramen. The L4-L5 level was the only level which had both a herniation and bulge, which is clearly more significant than the other level, indicating the medical necessity for more invasive treatment there. Moreover, the discography was performed to further confirm on which level to operate and it confirmed that concordant pain was not reproduced at L3-L4, but was reproduced at L4-L5. Based on these findings, the discectomy and associated services were deemed medically necessary and performed only at the L4-L5 level. Additionally, Dr. Cohen notes that prior to the procedures, the EIP had undergone physical therapy and used medications, including, cyclobenzaprine, Lidoderm 5% patch and Mobic, without relief. At the time of the 10/24/22 exam it was noted that the EIP was still complaining of severe lower back pain with radiculopathy and had severe functional limitations secondary to pain. Reference was made to numerous medical publications in discussing the use and efficacy of the procedures. Dr. Reyfman also referenced his qualifications to perform interventional spine procedures. Based on the foregoing, Dr. Reyfman opines that the services at issue were medically necessary.

After due consideration of the evidence submitted and the arguments of counsel, I find that Applicant has successfully refuted the peer review report of Dr. Cohen and has established the medical necessity for the services at issue by a fair preponderance of the evidence. I am persuaded by Dr. Reyfman's rebuttal which sets forth a credible, detailed and persuasive analysis of the need for the services. The EIP had presented with persistent and severe back pain despite undergoing a course of conservative treatment. The treating doctor set forth evidence of the use and efficacy of the procedures as well as the EIP's need. Accordingly, I find that the services at issue were reasonable and medically necessary under the circumstances. Since there is such a divergence of medical opinions as to the necessity of the device, I feel bound to defer to the opinion of the EIP's treating physician rather than to the opinion of Respondent's peer consultant who was not personally responsible for the claimant's care and treatment.

Therefore, I find in favor of the Applicant.

Fee Schedule

The Applicant seeks reimbursement in the amended amount of $5,672.22. The Respondent contends that the allowable reimbursement in accordance with the fee schedule is $4,673.22.

Respondent has the burden of coming forward with "competent evidentiary proof" supporting its fee schedule defenses. See, Continental Med., P.C. v. Travelers Indem. Co ., 11 Misc.3d 145a (2006).

An insurer fails to establish the existence of an issue of fact with respect to a defense that fees charged were excessive and not in accordance with the Workers' Compensation fee schedule in the absence of proof establishing the defense. St. Vincent Medical Care, P.C. v. Country Wide Ins. Co., 26 Misc.3d 146(A), 907 N.Y.S.2d 441 (Table), 2010 N.Y. Slip Op.50488(U), 2010 WL 1063914 (App. Term 2d, 11th & 13th Dists. Mar. 19, 2010). If respondent fails to demonstrate by competent evidentiary proof that an applicant's claims were in excess of the appropriate fee schedules, respondent's defense of noncompliance with the appropriate fee schedules cannot be sustained. See, Continental Medical PC v. Travelers Indemnity Co., 11 Misc.3d 145A, 819 N.Y.S.2d 847, 2006 NY Slip Op 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Term, 1st Dep't, per curiam, 2006).

At issue is the Applicant's request for $1,000.00 pursuant to CPT 99070 for a percutaneous lumbar discectomy probe used in the performance of the procedure.

The Respondent has submitted an affidavit from Carolyn Mallory, CPC, asserting that the Applicant is not entitled to reimbursement for CPT 99070. She states that the services were performed at an ASC/facility, which is required to have all items needed and required to perform a procedure that it has been credentialed to perform. The facility would submit the appropriate HCPC code on the UB04 for reimbursement of the probe. The EAPG fee schedule would apply for the facility bill.

The Applicant has submitted the affidavit of Esther Tetro, CPC. She avers that there is nothing in the fee schedule that distinguishes between charges performed inside or outside a facility. Ms. Tetro contends that the Applicant billed CPT 99070 for the probe as it does not fit under the description of items considered customarily included in surgical packages (62287). In addition, although Ms. Mallory argues that the charge for the probe would be included in the facility fee and that the facility would bill for it, there has been no support provided for this position. Notably, the Respondent has not shown that a payment was made to anyone else for the probe in question.

The Respondent has submitted Ms. Mallory's reply in which she refers to C2614, which is an HCPCS code for a percutaneous lumbar discectomy probe. C2614 has been assigned EAPG 2006, which are services or supplies that are incidental to the surgery performed and are "never paid."

After consideration of the documents submitted in evidence, the arguments made by the parties and taking judicial notice of the fee schedule, I find that the Respondent has established its fee schedule defense. The Respondent's fee coder, Ms. Mallory, has set forth a credible, detailed and persuasive analysis of the fee schedule and its applicability in this case. I am persuaded more by Ms. Mallory than by Ms. Tetro's analysis, which was less detailed and supported. I find that the Respondent has established its fee schedule defense in accordance with the opinion set forth by its coder.

Therefore, I find in favor of the Applicant in the amount of $4,673.22.

This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator.

The Applicant and the Respondent submitted documentary evidence in support of their respective positions. All such evidence is contained within MODRIA maintained by the American Arbitration Association, as of the date of the hearing. The above noted decision is based upon my review of the submitted evidence, along with the oral argument of the representatives present at the hearing; only the arguments offered at the hearing are preserved in this decision. Any arguments not presented at the hearing are considered waived.

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
	LR Medical PLLC	**10/24/22 - 10/24/22**	**$7,695.82**	**$5,673.22**	**Awarded: $4,673.22**
Total			**$7,695.82**		**Awarded: $4,673.22**

B. The insurer shall also compute and pay the applicant interest set forth below. 02/01/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest runs from the filing date for this case until the date that payment is made at two percent per month, simple interest, on a pro rata basis using a thirty-day month.

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 equal to 20% of that sum total, subject to a minimum of $60 and a maximum of $850. See, 11 NYCRR 65-4.6 (c) and (e). However, if the benefits and interest awarded thereon is equal to or less than the Respondent's written offer during the conciliation process, the attorney's fee shall be based upon the provisions of 11 NYCRR 65-4.6 (b). For cases filed after February 4, 2015, there is no minimum fee and a maximum 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 Nassau

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

12/29/2023
(Dated)

Steven Celauro

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:
f4eafa3131157042efc0724259948db1

Electronically Signed

Your name: Steven Celauro
Signed on: 12/29/2023