

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Sedation Vacation Perioperative Medicine
PLLC
(Applicant)

- and -

MVAIC
(Respondent)

AAA Case No.	17-23-1307-7548
Applicant's File No.	NF 3737165
Insurer's Claim File No.	681352
NAIC No.	Self-Insured

ARBITRATION AWARD

I, Victoria Thomas, 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 11/30/2023
Declared closed by the arbitrator on 11/30/2023

Andrew Cicaroni from The Law Office of Thomas Tona, PC participated virtually for the Applicant

Frank D'Esposito from Marshall & Marshall, Esqs. participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$297.10**, 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

Was the anesthesia for the lumbar percutaneous discectomy conducted on the Assignor a reasonable and necessary expense?

The Assignor, 'RP' was a 38-year-old female pedestrian who was involved in a motor vehicle accident on 7/21/22. She presented to Coney Island Hospital Center where she was evaluated and released. Post-accident, the Assignor complained of injuries to her neck, back, left leg, left elbow, left wrist, and left arm. Applicant billed for anesthesia related to a lumbar percutaneous discectomy conducted on 2/22/23. Respondent denied the claim based on the peer review of Dr. Miranda Smith dated 3/20/23.

4. Findings, Conclusions, and Basis Therefor

I have reviewed the file regarding this matter maintained by the AAA in the eCenter. This decision is based on my review of that file, as well as the arguments of the parties at the hearing.

After reviewing the record and evidence presented, I find that Applicant established a prima facie case of entitlement to reimbursement of its claim, by the submission of a completed NF-3 form documenting the facts and amounts of the losses sustained and 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. See, *Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004).

Medical Necessity

It was determined at the hearing that the Respondent also timely denied Applicant's claim based on a peer review conducted by Dr. Miranda Smith on 3/20/23. To support a lack of medical necessity defense respondent must "set forth a factual basis and medical rationale for the peer reviewer's determination that there was a lack of medical necessity for the services rendered." See, *Provvedere, Inc. v. Republic Western Ins. Co.*, 2014 NY Slip Op 50219(U) (App. Term 2nd, 11th, and 13th Jud. Dists. 2014). Respondent bears the burden of production in support of its lack of medical necessity defense, which if established shifts the burden of persuasion to applicant. See generally, *Bronx Expert Radiology, P.C. v. Travelers Ins. Co.*, 2006 NY Slip Op 52116 (App. Term 1st Dept. 2006). The Appellate Courts have not clearly defined what satisfies this standard except to the extent that "bald assertions" are insufficient. *Amherst Medical Supply, LLC v. A Central Ins. Co.*, 2013 NY Slip Op 51800(U) (App. Term 1st Dept. 2013). However, there are myriad civil court decisions tackling the issue of what constitutes a "factual basis and medical rationale" sufficient to establish a lack of medical necessity.

The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment. *Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co.*, 2009 NY Slip Op 00351 (App Div. 2d Dept., Jan. 20, 2009); *Channel Chiropractic, P.C. v. Country Wide Ins. Co.*, 2007 Slip Op 01973, 38 A.D.3d 294 (1st Dept. 2007); *Bronx Radiology, P.C. v. New York Cent. Mut. Fire Ins. Co.*, 2007 NY Slip Op 27427, 17 Misc.3d 97 (App Term 1st Dept., 2007), such as by a qualified expert performing an independent medical examination, conducting a peer review of the injured person's treatment, or reconstructing the accident. *Id.*

Based on a review of all the evidence including the peer review, clinical records, and the arguments of the parties at the hearing, Respondent established the lack of medical necessity for the disputed treatment by a fair preponderance of the credible evidence.

Dr. Smith indicated that the standard of care in the treatment of lumbar radiculopathy due to lumbar disc herniation includes an initial trial of 4-6 weeks of conservative management including physical therapy, activity modifications, and oral analgesic medications. Dr. Smith further discussed that if symptoms persist, spinal injections such as epidural injections can be trialed and possibly a surgical discectomy/decompression, or endoscopic discectomy. The clinical records do not indicate that 4-6 weeks of conservative care was conducted prior to the claims. Furthermore, the progress notes provided did not indicate that the Assignor received treatment for her lower back. In addition, the 8/25/22 and 9/29/22 reports reveal normal ROM in the lumbar spine even though the Assignor complained of lower back pain. Applicant did not submit a rebuttal to the peer review.

Therefore, Applicant's claim is denied.

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 claim is DENIED in its entirety

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of NY

SS :

County of Nassau

I, Victoria Thomas, 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)

Victoria Thomas

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:
5134377a19ac8d05adce0837f499ca20

Electronically Signed

Your name: Victoria Thomas
Signed on: 12/29/2023