American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Triborough ASC (Applicant)	AAA Case No.	17-24-1334-7041
	Applicant's File No.	00128668
- and -	Insurer's Claim File No.	0539068580005
	NAIC No.	36447
LM General Insurance Company (Respondent)		

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 08/14/2024
   Declared closed by the arbitrator on 08/14/2024

   Mikhail Guseynov, Esq. from Drachman Katz, LLP participated virtually for the Applicant

   Lisa Tuzzi from LM General Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$11,393.29**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The applicant amended their claim to $10,504.50 to comply with the fee schedule.

   Stipulations WERE made by the parties regarding the issues to be determined.

   The parties stipulated to the amount at issue.

3. Summary of Issues in Dispute

The applicant seeks reimbursement for the ambulatory surgical center (ASC) costs related to a lumbar percutaneous discectomy with intradiscal electrothermal annuloplasty (IDET) and other associated procedures, provided the IP (J.S.M. 37 year old male) on October 10, 2023, relative to a June 15, 2023 motor vehicle accident. The respondent denied this claim based on the defense of lack of medical necessity per the results of a peer review by Dr. Matthew Kalter on November 30, 2023. The applicant has submitted a rebuttal to this peer review by Dr. Mark Gladstein, dated July 1, 2024. The applicant has amended the amount of the claim to comply with the fee schedule and the parties have stipulated to the amount at issue. 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 for the applicant and award $10,504.50 for the costs associated with the operative procedure.

I note that an arbitrator need not adhere with strict conformity to the evidentiary rules set forth in CPLR 2016 see Auto One Ins. Co., v Hillside Chiropractic P.C. 126 A.D. 3d. 423 (1st Dept., 2015) citing 11 NYCRR 65-4.5 (o) the arbitrator shall be the judge of the relevance and materiality of the evidence offered. The arbitrator may question any witness or party and independently raise any issue that the arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department regulations. Arbitrators sit in equity and have the powers to enforce the spirit and intent of the No-fault law and regulations Bd. of Education, et. al. v. Bellmore-Merrick39 N.Y. 2d. 167 (1976).

Submissions

On June 28, 2023, the IP was seen by Dr. Adman Qureshi with multiple complaints, including shooting lower back pain. The evaluation of the lumbar spine revealed decreased range of motion with multiple positive orthopedic test findings. The sensation was decreased through the lower extremity. The impression included lumbar radiculopathy. The IP was referred for conservative care, given prescription medications, and an MRI of the lumbar spine was ordered.

The results of the August 8, 2023 MRI revealed posterior bulges at L4, L5 and L5, S1 impinging the thecal sac.

On September 28, 2023, the IP undertook a lumbar pain fiber nerve conduction study, revealing positive findings.

The IP was evaluated on October 10, 2023 by Dr. Daniel Feldman, with complaints of lower back pain, tingling and numbness to the feet and toes. The evaluation of the lumbar spine had revealed tenderness on touch with trigger points and painful range of motion. The Straight Leg Raise and Facet Loading tests were positive bilaterally. The IP was administered a lumbar epidural the lumbar percutaneous discectomy and annuloplasty procedures were also performed.

Peer Review

The basis of the respondent's denial was the peer report by Dr. Kalter dated November 30, 2023, which concerned a number of services, including the percutaneous discectomy procedure at issue. Dr. Kalter comments on the accident and multiple medical records (enclosed by the respondent) showing that the IP sustained multiple injuries, including to the lower back.

Dr. Kalter recommended against reimbursement for the procedure and related to services, noting the findings and MRI and the clinical findings by Dr. Feldman, "did not demonstrate a dermatomal distribution pattern of pain or paresthesia, which would be reflective of a lumbar radiculopathy requiring surgical intervention."

Further, the IP should have received additional conservative treatment, including lumbar interventional injections, prior to undergoing the lumbar percutaneous discectomy.

Additionally, the IP underwent a lumbar epidural steroid injection on the same date as this procedure. "The purpose of the lumbar epidural steroid injection was to provide a period of pain relief where the patient can tolerate more vigorous physical therapy and speed their recovery process in hopes of avoiding the need for more invasive procedures, such as percutaneous discectomy. Generally, a patient can expect the pain relief to last anywhere from one to three months. Pain relief may last twelve months or even longer in some patients.

"Considering that the claimant received the lumbar epidural steroid injection on the same day before undergoing the lumbar percutaneous discectomy on 10/10/2023, the claimant had not undergone an adequate amount of time and physical therapy after the lumbar epidural steroid injection to properly assess whether or not a lumbar percutaneous discectomy was medically necessary."

Finally, the procedure is still considered investigational and, at a minimum, should have been performed by a neurosurgeon or orthopedic surgeon rather than an interventional pain specialist.

Rebuttal to Peer Review

In response, I acknowledge the rebuttal from Dr. Gladstein. Initially, he disagrees with the crux of Dr. Kalter's argument, noting that "in most cases nerve root pain should not

be expected to follow along a specific dermatome, at least as described by commonly used dermatomal maps, and a dermatomal distribution of pain is not a useful historical factor in the diagnosis of radiculopathy."

In this case, the IP had severe radiating lower back pain with intermittent tingling and numbness in bilateral feet and toes and objective findings, including a positive Straight Leg Raise test, which correlated with MRI findings of L4/5 and L5/S1 disc bulging impinging on the thecal sac. Further, the IP underwent extensive physical therapy, chiropractic care and pain medication which failed to address his radicular lower back pain, indicating the medical necessity of the procedure.

The rebuttal specifies the positive Straight Leg Raise test was indicative of nerve root impingement and that contrary to the peer, the IP received extensive multi-modality conservative care for three months prior to surgical intervention.

Concerning the peer's contention that the lumbar epidural steroid injection (LESI) that was performed in conjunction with the discectomy in discussion was merely performed for immediate pain relief. According to the literature cited above, epidural steroid injections are clearly not as effective as a percutaneous discectomy procedure. As noted above, at the time of the October 10, 2023 procedure in discussion, the patient had undergone extensive conservative care, including physical therapy, chiropractic care, and the use of pain medications, yet nevertheless still presented with both subjective and objective findings of significant radicular low back pain. Therefore, as the treating physicians, we determined that at this juncture, it was entirely justified and medically necessary to address the patient's unrelenting radicular lower back pain more permanently with a lumbar percutaneous discectomy procedure, albeit simultaneously providing an LESI for short-term pain relief, until the true benefit of the percutaneous discectomy procedure would be felt.

The rebuttal continues refuting the peer's contention that the procedure is considered investigational, citing sources in support of its efficacy and cites additional studies in support of the annuloplasty, "typically an adjunct procedure to discectomy was performed to seal the annular tear noted on MRI and discography, aid in decreasing back and leg pain, and prevent re-injury of the damaged disc. IDET provides favorable clinical outcomes in patients with discogenic lower back pain refractory to conservative treatment."

Further, "intradiscal electrothermal annuloplasty provides a new alternative to other surgical procedures for patients who suffer from back pain caused by certain types of disc problems. It is a fairly advanced procedure made possible by the development of electrothermal catheters that allow for careful and accurate temperature control. The procedure works by cauterizing the nerve endings within the disc wall to help block the pain signals. IDET is a minimally invasive outpatient surgical procedure developed over the last few years to treat patients with chronic back pain that is caused by tears or small herniation of their lumbar discs," again citing studies in support.

Legal Standards for Determining Medical Necessity

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 Vladmir 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 vNew 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 surgical costs related to this procedure.

Dr. Gladstein provides a specific basis as to why this procedure was necessary. In contrast to the peer review, he indicates the IP received a significant amount of conservative care, noting physical therapy and chiropractic treatment notes were provided extensively for three months, and conservative treatment failed and that the peer is incorrect in alleging the necessity of findings of a specific dermatomal pattern.

In terms of the argument that it was inappropriate to perform an epidural on the same day as this procedure, this too is refuted by Dr. Gladstein, stating that the epidural was provided for immediate relief. Still, long-term relief would only be provided by the lumbar percutaneous discectomy. Dr. Gladstein also cites multiple studies that support

the efficacy of this procedure and the IDET as being beyond investigational, with multiple studies discussing their effectiveness.

Finally, I acknowledge that in a related matter for anesthesia services, ***Sedation Vacation Perioperative Medicine PLLC v LM General Ins. Co., AAA-17-24-1332-8775,*** I found Dr. Kalter's peer review sufficient to deny the anesthesia-related to this procedure and the epidural.

There is no collateral estoppel as different providers are at issue and further, it is within the arbitrator's authority to determine the preclusive effect of a prior arbitration. Matter of Falzone v. New York Central Mutual Fire Ins. Co., 15 N.Y.3d 530, 914 N.Y.S.2d 67 (2010), aff'g, 64 A.D.3d 1149, 881 N.Y.S.2d 769 (4th Dept. 2009).

Further, in the claim brought by the anesthesiologist, I stated as follows: "The applicant provider is an entity that provides anesthesia services, and no additional medical records were provided. It is possible that if a claim is brought by the surgeon or medical facility, a rebuttal may provide sufficient evidence to refute the peer's determinations."

Under these circumstances, the applicant has established the services were medically appropriate and has refuted the respondent's contention that the services were provided contrary to accepted medical standards.

Therefore, the claim is awarded for $10,504.50.

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
	Triborough ASC	**10/10/23 - 10/10/23**	**$11,393.29**	**$10,504.50**	**Awarded: $10,504.50**
Total			**$11,393.29**		**Awarded: $10,504.50**

B. The insurer shall also compute and pay the applicant interest set forth below. 01/31/2024 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 January 31, 2024, 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 $10,504.50.

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.

09/03/2024
(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:
e47f656e3141cde7a0cc6bd2ecebdda0

Electronically Signed

Your name: Victor Moritz
Signed on: 09/03/2024