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)	AAA Case No.	17-24-1336-0306
	Applicant's File No.	TLD23-1049575
- and -	Insurer's Claim File No.	0697705200-01
	NAIC No.	29688
Allstate Fire & Casualty Insurance Company (Respondent)		

ARBITRATION AWARD

I, Diane Flood Taylor, 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 09/19/2024
   Declared closed by the arbitrator on 09/19/2024

   Kurt Lundgren from Thwaites, Lundgren & D'Arcy Esqs participated virtually for the Applicant

   Allison Lindsey from Law Offices of John Trop participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$11,145.01**, 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

   Whether the Applicant is entitled to recover for facility fees, which the Respondent has denied as medically unnecessary predicated upon a peer review.

   Applicant is seeking reimbursement in the amended amount of $8,539.22 for facility fees in connection with the management of injuries sustained by the Assignor, JTS, a then 40-year-old eligible injured person who, on 12/25/22, was involved in a collision with the insured motor vehicle.

Respondent denied reimbursement for the percutaneous discectomy procedure on 6/15/23 premised on a peer review conducted by Ajendra S. Sohal, MD, dated 8/4/23.

Respondent denied reimbursement for the right-hand carpel tunnel release procedure on 6/19/23 premised on a peer review conducted by Julio V. Westerband, MD, dated 8/4/23.

The decision below is based upon a review of the documents that have been submitted electronically, as well as the arguments of counsel and/or representatives appearing via video conference on behalf of the parties.

4. Findings, Conclusions, and Basis Therefor

In dispute in this Arbitration are bills for a facility fee for a lumbar discectomy procedure performed on 6/15/23 and a right-hand carpal tunnel release surgery performed on 6/19/23.

Respondent raises no issue or argument concerning Applicant's submission of proof of claim.

Applicant establishes its prima facie entitlement to reimbursement 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); Viviane Etienne Med. Care v. Country-Wide Ins. Co., 25 N.Y.3d 498, 501 (2015); Mary Immaculate Hosp. v. Allstate Ins. Co., 5 A.D. 3d 742, 774 N.Y.S. 2d 564 (2nd Dept., 2004).

The burden shifts to the Respondent to demonstrate a lack of medical necessity for the disputed services. See, Citywide Social Work & Psychological Services, PLLC v. Allstate Ins. Co., 8 Misc 3d 1025 A (2005). A denial premised on a lack of medical necessity must be supported by competent evidence such as an independent medical examination, a peer review or other proof which sets forth a factual basis and a medical rationale for denying the claim. See, Healing Hands Chiropractic, P.C., v. Nationwide Assur. Co., 5 Misc., 3d 975, 787 N.Y.S. 2d 645 (Civ. Ct., New York County, 2004); King's Med. Supply Inc. v. Country Wide Ins. Co., 5 Misc 3d 767, 783 N.Y.S. 2d 448. The medical rationale should be supported by evidence of the generally accepted medical professional practice. See, Nir v. Allstate Ins. Co., 7 Misc. 3d 544 (2005).

Peer Review

Respondent timely denies reimbursement for the services at issue premised upon a peer review conducted on its behalf by Ajendra S. Sohal, MD, who writes in a report dated 8/4/23 in support of the recommendation against

reimbursement, "There was no medical necessity for the lumbar percutaneous and all associated pre-operative and post-operative services performed on 06/15/2023. This particular intervention is an intradiscal procedure which is a questionable procedure and CMS and Medical Treatment Guidelines and other medical literature do not recommend it. It is different from a classical discectomy performed. It leads to recurrent disc herniation at the portals of the needle penetration and also leads to premature arthritis with incidental lumbar fusion performed, discitis can also take place. Therefore, it is not a totally safe procedure. If there was tissue removed, histopathological report should be provided."

Dr. Sohal emphasizes, "A note dated 03/28/2023 by Rafael Sezan, MD, indicates the claimant presented with complaints of pain in the neck, lower back, left shoulder, right wrist, and left hand. Medication use was not documented. Straight leg raise test was negative. A note dated 04/26/2023 by Yadid Nisimov, NP, indicates the claimant presented with complaints of neck pain and lower back pain. The pain was rated as 9/10. Medication use was not documented. Motor strength was 4/5. Sensation was normal. DTR was 2. There was no reason for the claimant not to be sent to neurosurgical or spine consultation, if indeed there were neurological issues. Not providing pharmacotherapy or repeat ESI is also reflective of inadequate conservative care and rush to the questionable interventions."

Dr. Sohal indicates that this procedure is not the standard of care which was articulated by the peer.

Respondent timely denies reimbursement for the services at issue premised upon a peer review conducted on its behalf by Julio V. Westerband, MD, who writes in a report dated 9/25/23 in support of the recommendation against reimbursement, "In this case, Dr. Ross failed to provide other non-surgical treatment modalities like cortisone injections. Also, the claimant received only four physical therapy sessions to the right wrist prior to the recommendation of the surgery. No documentation that the claimant tried using a brace."

Dr. Westerband indicates, "The MRI did not demonstrate any abnormality of the median nerve such as swelling or degeneration. The treating physician should have treated the claimant's right wrist symptoms with a cortisone shot which is considered one of the most efficacious methods. Hence, It is evident that the treating physician gave an inappropriate treatment recommendation for the right wrist surgery, as the right wrist symptoms could have easily been resolved with additional non-surgical treatment modalities."

The peer emphasizes, "The standard of care in this case was to provide conservative treatment in the form of physical therapy sessions for three-to-six months along with the use of corticosteroid injections to resolve the right wrist pain."

The above referenced peer review sets forth a factual basis and medical rationale in support of Respondent's denial based on a lack of medical necessity for the disputed procedure. If the insurer presents sufficient evidence establishing a lack of medical necessity, then the burden shifts back to the Applicant to present its own evidence of medical necessity. See, West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc. 3d 131A (2006). In order for the Applicant to prove that the disputed expense was medically necessary, it must meaningfully refer to, or rebut, the Respondent's evidence. See, Yklik, Inc. v. Geico Ins. Co., 28 Misc. 3d 133A (2010).

Rebuttal

Ashraf Salem, MD, authored a rebuttal dated 7/8/24 in which he argues, in relevant part, "The proper standard of care in this case was surgery. The decision was guided by a history of trauma, severity of symptoms, and significant physical features which matched the diagnostic findings. There was severe pain. The condition remained severe and did not trend toward improvement despite, conservative care of almost 6months.It is confirmed by the history of the patient describing the history of the injury, MRI, physical examinations, and intra-operative findings. The standard of care was surgery to prevent the wrist symptoms, and to facilitate symptoms of relief and function improvement."

Dr. Salem emphasizes, "Peer review must be aware that if left untreated, a carpal tunnel syndrome would worsen over time and have a measurable impact on the life of the person."

Dr. Salem argues further, "It should also be noted that "The cortisone injections do not cure the condition but provide a window of symptom relief via inflammation reduction."

With regard to the percutaneous lumbar discectomy, Dr. Salem argues, "the Peer reviewer has overlooked that percutaneous disc discectomy is a minimally invasive procedure that effectively relieves pain for appropriate patients."

Dr. Salem relies on the operative note to support the surgery. He quotes the report, in relevant part, "The patient has severe back pain and extremity pain. Conservative treatment has failed to provide adequate relief."

Dr. Salem indicates, "The MRI of the lumbar spine dated 01/30/2023 revealed L4-5: Contains a broad disc herniation measuring 5 mm in the AP dimension 5 mm in transverse dimension compressing the ventral thecal sac. (sagittal T2 sequence image 8, axial T2 sequence image 19) spinal canal measures 18 mm. The neural foramen are normal bilateral."

Dr. Salem emphasizes, "a standard protocol was followed before proceeding to the lumbar surgery as well as medical examination revealed persistent pain in the lumbar spine with positive subjective complaints, objective findings, and diagnostic studies, which warranted the performance of the lumbar spine surgery."

Pursuant to 11 NYCRR 65-4.5 (o) (Regulation 68-D) 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. See Bd. of Education, et. al. v. Bellmore-Merrick, 39 N.Y. 2d. 167 (1976).

"Although an arbitration panel may not overtly disregard the law, arbitrators are not strictly tethered to substantive and procedural laws and may do justice as they see it, provided that they do not violate a strong public policy, do not exceed a specifically enumerated limitation on their power and their decisions are not totally irrational [citations omitted]." Matter of Solow Building Co., LLC v. Morgan Guarantee Trust Co. of New York, 6 A.D.3d 356, 356, 776 N.Y.S.2d 547, 548 (1st Dept. 2004).

Findings

In careful consideration of the credible evidence submitted, and in weighing the opinions of the doctors as expressed in the peer review of Dr. Sohal and the rebuttal of Dr. Salem with regard to the 6/15/23 percutaneous lumbar discectomy procedure, I find Dr. Salem's arguments more persuasive as to the medical necessity of the discectomy procedure.

I find Applicant's evidence rebuts the peer and establishes the medical necessity for the discectomy surgery at issue.

In careful consideration of the credible evidence submitted, and in weighing the opinions of the doctors as expressed in the peer review of Dr. Westerband and the rebuttal of Dr. Salem with regard to the 6/19/23 right wrist carpal tunnel release procedure, I find Dr. Westerband's arguments more persuasive as to the lack of medical necessity.

Accordingly, after reviewing the entire record and after careful consideration of the parties' oral arguments, I find in favor of Applicant in the amended amount of $5,292.93. Any further issues raised in the record are held to be moot and/or waived insofar as not raised at the time of the hearing. This decision is in full disposition of all claims for No- Fault benefits presently before this Arbitrator.

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	**06/15/23 - 06/15/23**	**$7,898.71**	**Awarded: $5,292.93**
	Rockaways ASC Development LLC d/b/a ASC of Rockaway Beach	**06/19/23 - 06/19/23**	**$3,246.30**	**Denied**
Total			**$11,145.01**	**Awarded: $5,292.93**

B. The insurer shall also compute and pay the applicant interest set forth below. 02/12/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest is awarded from the initiation date for this case until the date that payment is made at two percent (2%) 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 twenty percent (20%) of the total amount of first-party benefits awarded, plus interest thereon, as provided for in 11 NYCRR 65-4.6(d), subject to a maximum fee of $1,360.00.

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 Westchester

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

09/24/2024
(Dated)

Diane Flood Taylor

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:
414a3042f1464eedfcddd8c32bae87cc

Electronically Signed

Your name: Diane Flood Taylor
Signed on: 09/24/2024