American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Island Ambulatory Surgery Center LLC (Applicant)	AAA Case No.	17-24-1341-1887
	Applicant's File No.	00130216
- and -	Insurer's Claim File No.	0708329735 2FM
Allstate Fire & Casualty Insurance Company (Respondent)	NAIC No.	29688

ARBITRATION AWARD

I, James Skelton, 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: injured party

1. Hearing(s) held on 09/30/2024
   Declared closed by the arbitrator on 09/30/2024

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

   Donna Strudwick, Esq. from Law Offices of John Trop participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$18,252.52**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The amount in dispute was amended to $7898.75 at the hearing.

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

3. Summary of Issues in Dispute

   The injured party, EG, is a 53-year-old female who suffered injuries during a motor vehicle accident on 03/30/23. At the time of the accident, the injured party was a driver in a vehicle. Following the accident, the injured party suffered injuries which resulted in the injured party seeking treatment. The claim in this case is for facility fee. The claim was denied based upon a peer review submitted by Dr. Julio Westerband dated 01/16/24.

Applicant has submitted a peer review rebuttal by Dr. Roman Shulkin dated 08/22/24.

Respondent did not argue any fee schedule defenses at the hearing. The question presented is whether the treatment was medically necessary.

In dispute is Applicant's claim as assignee for reimbursement in the sum of the claimed amount of $7898.75 for treatment rendered to the injured party on 12/29/23.

4. Findings, Conclusions, and Basis Therefor

This hearing was conducted using documents contained in the ADR Center. I have reviewed all of the submissions contained in the ADR CENTER which is maintained by the American Arbitration Association. I have considered the documents contained in the ADR Center as well as the arguments of the parties at the hearing in rendering this decision.

Applicant establishes a prima facie entitlement to payment by proving that it submitted a claim, set forth the facts and the amount of the loss sustained, and that payment of no-fault benefits is 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 (1 Dep't, 2008); Sunshine Imaging Assoc./WNY MRI v. Geico. Ins. Co., 66 A.D. 3d. 1419 (4 Dep't, 2009). A facially valid claim is presented when it sets forth the name of the patient, date of accident, the date of the services, a description of the services rendered and the charges for those services. See Vinings Spinal Diagnostic PC v. Liberty Mutual Insurance Company, 186 Misc. 2d 287 (1 Dist. Ct. Nass. Co.1996).

Following the accident, the injured party started on a course of conservative treatment which included facility fee. The claim was denied based upon a peer review by Dr. Julio Westerband dated 01/16/24. The peer reviewer reviewed several medical records prior to rendering the opinion. Based upon the medical records review the peer reviewer opined that the treatment was not medically necessary. The peer reviewer opined that the nerve test dated 5/25/23 revealed no evidence of cervical or lumbar radiculopathy. There was no evidence of a traumatic herniation displacing, compressing, or impinging on a nerve root. There was no evidence of cervical radiculopathy that would require nerve decompression and discectomy. The peer review states that the injured party claimant is a 53-year-old female who was involved in a motor vehicle accident on 03/30/2023. On 11/29/2023, the claimant presented to Roman Shulkin, M.D., with the chief complaint of neck pain. The claimant was evaluated and was recommended to proceed with cervical discectomy. On 12/29/2023,the claimant underwent cervical spine surgery by Roman Shulkin, M.D., at Island AmbulatorySurgery Center, LLC.

The peer reviewer opines that the cervical spine surgery was not medically necessary in this case. He states that it is unclear why cervical spine surgery was conducted. The nerve test dated 05/25/2023 revealed no evidence of cervical or lumbar radiculopathy. The IME exam by Dr. Essig dated 08/28/2023 describes a resolved neck sprain and

normal back and left shoulder, hip, and wrist exams. The MRI of the cervical spine dated 11/17/2023 revealed C7-T1 right neural foraminal disc herniation abutting the exiting right C8 nerve root. C3-4, C4-5, and C5-6 disc bulges with C3-4 and C4-5 left neural foraminal narrowing and C5-6 bilateral neural foraminal narrowing in conjunctionwith facet and uncinate hypertrophic changes, with increased conspicuity on extension view at C3-4. Cervical spine straightening. Moderate bilateral maxillary sinus mucosal thickening with mild sphenoid sinus mucosal thickening also noted. The l1/17/2023 MRI reveals HNP at C7-T1 abutting the right C8 nerve root. C5-C6 has a disc bulge with hypertrophic nerve changes.

On 12/29/2023 neck surgery was done. C5-C6 percutaneous discectomy and facet fusion were done. The surgery that was performed was not supported by the records. There is no evidence of a traumatic herniation displacing, compressing, or impinging on a root. There is no evidence of cervical radiculopathy that would require nerve decompression and discectomy. The OR report indicates that "facet fusion was done". The level/levels of said fusion are not indicated and there is no explanation as to why a facet fusion would be required after a neck sprain that was only nine months old. There is no evidence that aggressive non-surgical treatment for facet syndrome was provided and failed. Based on the above, the peer reviewer opined that the treatment in question was not medically necessary.

The applicant has submitted a peer review rebuttal by Dr. Roman Shulkin dated 08/22/24. The peer review rebuttal states that the nerve test dated 5/25/23 revealed no evidence of cervical or lumbar radiculopathy. However, while it is true that EMG testing has the potential to confirm the presence of a radicular component, a negative EMG does not unequivocally prove there is no radiculopathy present. The American Agency for Orthopaedic Surgeons agrees that in such cases, where EMG testing is negative, it is acceptable and necessary for the treating physician to rely on other clinical findings to properly determine treatment for the patient.

The rebuttal cites to an article that states "Like any diagnostic procedure or test, EMG is not perfect. A normal result does not mean a patient does not have a deficit in their nerve or muscle. Radiculopathy is a commonly missed diagnosis with EMG and also commonly associated with pain. The missed diagnosis may occur because unless the radiculopathy affects the muscle, and therefore causes areas of denervation, the needle EMG may be normal even though the nerve is compressed leading to pain."
The rebuttal states that the injured party had severe (9/10), sharp, deep pain and pressure around the neck radiating to the bilateral shoulders and left < right upper extremity, corroborated by physical examination findings including tenderness, muscle spasms, restricted and painful range of motion, decreased motor strength in the upper extremities and painful Cervical Compression test. The rebuttal argues that the 9/1/23 examination should be considered contemporaneous with Dr. Essig's IME, since the examination was conducted four days subsequent to the 8/28/23 IME. The rebuttal argues that Dr. Westerband's denial of the surgery based on Dr. Essig's 8/28/23 IME report is misplaced. The preoperative diagnoses for the procedure was cervical herniated disc C5-6. A cervical percutaneous discectomy is a procedure indicated for patients with cervical radiculopathy who have not responded to more conservative methods of treatment. This procedure enables treatment with less tissue trauma and preservation of

the spinal motion, allowing faster recovery time and earlier return to activities of daily living. The procedure is accomplished through a needle, without the need for an incision. Furthermore, it requires only conscious sedation, avoiding the need for general anesthesia. This procedure affords faster recovery with far less risk of complications than any surgery or other minimally invasive procedure, which usually requires at least a small incision. Multiple studies have shown significant pain relief, reduced need for pain medication, return to previous levels of activity, less scarring compared to surgery, quick recovery, and low complications rates. Based on the above, the rebuttal argues that the procedure was medically necessary.

In order 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. 20140. Respondent bears the burden of production in support of a 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 civil courts have held that a defendant's peer review or medical evidence must set forth more than just a basic recitation of the expert's opinion. The trial courts have held that a peer review report's medical rationale will be insufficient to meet respondent's burden of proof if: 1) the medical rationale of its expert witness is not supported by evidence of a deviation from "generally accepted medical" standards; 2) the expert fails to cite to medical authority, standard, or generally accepted medical practice as a medical rationale for his findings; and 3) the peer review report fails to provide specifics as to the claim at issue, is conclusory or vague. See generally, Nir v. Allstate, 7 Misc.3d 544 (N.Y. City Civ. Ct. 2005).

In support of its contention that the surgery was not medically necessary, Respondent relies upon the peer review report. Respondent asserts the peer review meets the burden of production in support of respondent's lack of medical necessity defense as to the treatment. Applicant argues the peer review is conclusory and fails to meet the burden and relies on the peer review rebuttal.

The peer review report fails to form a nexus between the injury of the patient and the contention that the surgery was not medically necessary. Merely setting forth conclusory statements and citing medical journals without specifically connecting this information to this patient is factually insufficient and does not reflect a cogent medical rationale.

I find that the peer reviewer failed to adequately address the actual presentation of symptoms by the injured party in forming his rationale.

Respondent has submitted a Coder affidavit from Carolyn Mallory, CPC dated 09/03/24, who performed a detailed analysis of the charges billed and opined as to the correct fee schedule for the billed services. Based upon her analysis, she opines that the correct amount for reimbursement is $5292.93. Applicant has submitted an IHC report in opposition to the Coder report.

Upon a review of the credible evidence, I find that the peer review rebuttal and supporting medicals to be more credible than the peer review report and I find for Applicant.

Also, I find the fee schedule proof submitted by the Respondent to be more credible than the proof submitted by the Applicant, and I find for Applicant in the amount detailed in Coder Mallory's report.

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**
	Island Ambulatory Surgery Center LLC	**12/29/23 - 12/29/23**	**$18,252.52**	**$7,898.75**	**Awarded: $5,292.93**
Total			**$18,252.52**		**Awarded: $5,292.93**

B. The insurer shall also compute and pay the applicant interest set forth below. 03/21/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant is awarded interest pursuant to the no-fault regulations. See generally, 11 NYCRR §65-3.9. Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30 day month." 11 NYCRR §65-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. However, the regulations toll the accrual of interest when an applicant "does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations." See, 11 NYCRR 65-3.9(c).The Superintendent and the New York Court of Appeals has interpreted this provision to apply regardless of whether the particular denial at issue was timely. LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 217 (2009).

C. Attorney's Fees

The insurer shall also pay the applicant for attorney's fees as set forth below

Applicant is awarded statutory attorney fees pursuant to the no-fault regulations. See, 11 NYCRR §65-4.5(s)(2). The award of attorney fees shall be paid by the insurer. 11 NYCRR §65-4.5(e). Accordingly, "the attorney's fee shall be limited as follows: 20 percent of the amount of first-party benefits, plus interest thereon, awarded by the arbitrator or the court, subject to a maximum fee of $850." Id. The minimum attorney fee that shall be awarded is $60. 11 NYCRR §65-4.5(c). However, if the benefits and interest awarded thereon is equal to or less than the respondent's written offer during the conciliation process, then the attorney's fee shall be based upon the provisions of 11 NYCRR §65-4.6(i). For claims that fall under the Sixth Amendment to the regulation the following shall apply: "If the claim is resolved by the designated organization at any time prior to transmittal to an arbitrator and it was initially denied by the insurer or overdue, the payment of the applicant's attorney's fee by the insurer shall be limited to 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon, for each applicant with whom the respective parties have agreed and resolved disputes, subject to a maximum fee of $1,360." 11 NYCRR 65-4.6(d).

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 Fairfield

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

10/01/2024
(Dated)

James Skelton

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:
6526f8ed963ad8cbe949f30cadea21d2

Electronically Signed

Your name: James Skelton
Signed on: 10/01/2024