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.	17-24-1334-3245
	Applicant's File No.	00128525
- and -	Insurer's Claim File No.	96609-03
	NAIC No.	24309
Hereford Insurance Company (Respondent)		

ARBITRATION AWARD

I, Eileen Casey, 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: EIP

1. Hearing(s) held on 09/05/2024
   Declared closed by the arbitrator on 09/05/2024

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

   Rosemary Repetto, Esq. from Law Offices of Ruth Nazarian participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$13,241.61**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The original amount claimed was $13,241.61 forthe facility fees associated with a lumbar percutaneous discectomy and related procedures performed on November 15, 2023. Applicant's counsel amended the amount claimed to $7,898.71 pursuant to the fee schedule.

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

   It was stipulated that Applicant established a prima facie case and Respondent issued a timely denial.

3. Summary of Issues in Dispute

The EIP (KW), a 22-year-old female, was a passenger in a motor vehicle involved in an accident on November 14, 2021. The amount claimed, as amended, is $7,898.71 for the facility fees associated with a lumbar percutaneous discectomy and laboratory services performed on November 15, 2023. Respondent denied Applicant's claim based on a December 22, 2023 peer review by Dr. Vijay Sidhwani, D.O. Respondent also raised a fee schedule defense. The issues are whether Respondent established a defense of lack of medical necessity based on the peer review or a fee schedule defense.

4. Findings, Conclusions, and Basis Therefor

This case was decided based upon oral arguments and a review of the documents contained in the ADR Center maintained by the American Arbitration Association. The original amount claimed was $13,241.61 forthe facility fees associated with a lumbar percutaneous discectomy and related procedures performed on November 15, 2023. Applicant's counsel amended the amount claimed to $7,898.71 pursuant to the fee schedule.

The evidence demonstrates that the EIP (KW), a 22-year-old female, was a passenger in a motor vehicle involved in an accident on November 14, 2021.

The Peer Review (Lack of Medical Necessity) Defense

Lack of medical necessity is a defense to an action to recover no-fault benefits, which an insurer may assert upon a timely denial, based either on a medical examination or a peer review report. *Rockaway Boulevard Medical P.C. v. Travelers Property Casualty Corp*, 2003 N.Y. Slip Op. 50842(U), 2003 WL 21049583 (App. Term 2d & 11th Dists. Apr. 1, 2003).

Respondent denied Applicant's claim based on a December 22, 2023 peer review by Dr. Vijay Sidhwani, D.O.

In his report, Dr. Sidhwani listed the records he reviewed and detailed the EIP's pertinent medical history. He noted that the records reviewed included a May 25, 2023 orthopedic IME report by Anna Seneviratne, M.D, a May 25, 2023 acupuncture/chiropractic IME report by John lozzio, DC, L.Ac. and a July 12, 2023 pain management IME by Getahun Kifle, M.D. He wrote that while records indicate that the EIP reported undergoing a lumbar MRI, there is no documentation of any lumbar MRI performed or a report provided for review. He also noted that the only documentation of imaging was a musculoskeletal ultrasound, conducted on November 17, 2021, revealing no evidence of posttraumatic changes, and demonstrating a mild degree of sprain and strain. He added that a report by Omar Ahmed, MD, clearly indicates that an unremarkable lumbar MRI had been obtained. Dr. Sidhwani said that he was unable to establish a need for the lumbar percutaneous discectomy and annuloplasty with platelet

rich plasma injection and all accompanying services and procedures. He explained that there is no clinical evidence of radiculopathy nor is there any evidence of disc pathology reportedly being treated as there is no documentation of any MRI or CT scan obtained revealing any specific disc pathology warranting this procedure related to the accident or otherwise.

Dr. Sidhwani asserted that the standard of care for a lumbar sprain/strain with disc bulge or herniation due to spondylosis typically involves a course of conservative care in the range of 6 to 12 weeks. He also said that if a 12-week course of physical therapy is not adequate a case can be made to increase the amount of exercise based physical therapy to a longer period of time based upon the degree of involvement as well as the intensity of symptoms from a clinical perspective. Dr. Sidhwani also stated that NSAIDs are recommended to be tried during the acute and subacute phases of treatment. If, throughout the course of conservative care, an injured person reaches a plateau or if neurological symptoms are present such as motor weakness, numbness, tingling or even decreased deep tendon reflexes, interventional treatment, such as an epidural steroid injection, can be considered. Dr. Sidhwani said that the treatment for lumbar spondylosis does not involve a routine lumbar percutaneous discectomy and secondary to a sprain/strain injury.

Dr. Sidhwani noted that a lumbar microdiscectomy is an effective and safe treatment for lumbar disc herniation, lumbar spinal stenosis, recurrent lumbar disc herniation, and other lumbar diseases. He explained that while this procedure may be useful under the appropriate circumstances, there is no indication for this procedure to treat a lumbar sprain/strain as sustained in this case. He added that PEDs are effective and minimally invasive methods for the surgical treatment of LDH, causing fewer complications due to the very minimal operational trauma for the muscle-ligament complex and stability of the spine. Nevertheless, a variety of problems may occur. Dr. Sidhwani added that, with regard to the intradiscal PRP injections (platelet rich plasma), there is no clear medical based evidence as to the efficacy of these injections in patients with chronic disc pain and there is no clear evidence that this injection, combined with a percutaneous discectomy would change the outcome of this procedure secondary to the underlying degenerative disc disease being treated. He also said that intradiscal electrothermal therapy (IDET) is commonly performed in conjunction with the percutaneous discectomy. However, there are inherent risks such as direct trauma to the spinal nerve, bleeding, and infection. Dr. Sidhwani found that the lumbar percutaneous discectomy and annuloplasty and accompanying procedures were not medically necessary.

When Respondent has timely raised and established lack medical necessity, the burden of proof then shifts to the Applicant to establish that the disputed services were reasonable and medically necessary. If the insurer medical examination or peer review is not rebutted, the insurer is entitled to denial of the claim. *A Khodadadi Radiology v. New York Central,* 16 Misc.3d 131(A), 841 N.Y.S.2d 824, 2007 N.Y. 51342(U), 2007 WL 1989432 (App. Term 2d & 11th Dists. 2007).

The 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, *Nir v. Allstate Ins. Co.* 7 Misc.3d 544 (N.Y. City Civ. Ct. 2005).

Rebuttal

Applicant submitted an August 1, 2024 rebuttal from Mark Cohen, the EIP's treating orthopedic surgeon. Dr. Cohen detailed the EIP's pertinent medical history. He requested that the IME reports not be considered valid bases upon which to deny further treatment He explained that the IME reports failed to establish a resolved lumbar sprain/strain. Dr. Cohen noted that the EIP saw Dr. Leonid Reyfman on June 7, 2022 with complaints that included severe (8/10) lower back pain radiating to the buttocks. Examination revealed tenderness, restricted and painful range of motion in the cervical and lumbar regions as well as the right knee, decreased motor strength in the upper and lower extremities and positive Spurling's, McMurray, Lumbar Facet Loading and Straight Leg Raise tests.

Dr. Cohen also referenced his November 9, 2023 and November 15, 2023 examinations, which he said documented the EIP's ongoing post traumatic severe (8/10), dull, aching, sharp, shooting lower back pain radiating to the bilateral buttocks and lower extremities and physical examination findings including decreased motor strength in the lower extremities and a positive Straight Leg Raise test. Dr. Cohen said that these significant examination findings correlated with the EIP's February 4, 2022 MRI of the lumbar spine which revealed symptomatic L3-4 posterior bulge with encroachment into the inferior aspect of the foramina bilaterally and L4-5 broad-based posterior disc bulge with encroachment into the foramina bilaterally. He stated that a positive Straight Leg Raising Test as part of the neurological exam indicated the presence of a lumbar disc protrusion, sprain, or nerve root impingement in the lumbar spine. He asserted that there was evidence of radiculopathy and functional limitation. Dr. Cohen opined that, due to the EIP's unrelenting radiating lower back pain and symptomology, despite extensive (failed) conservative care treatments including physical therapy and medication, a lumbar percutaneous discectomy procedure was deemed to be medically necessary, to provide sustained relief and aid in recovery. Dr. Cohen contended that Dr. Sidhwani's failure to review the available MRI calls into question the validity of his clinical assessment of the EIP's condition.

Dr. Cohen stated that the EIP underwent extensive conservative care treatment in the form of physical therapy, chiropractic care, acupuncture treatment and medication. He added that his November 15, 2023 report noted that the EIP presented with low back pain associated with lower extremity pain with exacerbation with walking, lumbar flexion, which failed to respond to various modalities of treatments including physical therapy and analgesics. Dr. Cohen also stated that an epidural steroid injection was not as effective as discectomy with regard to reducing symptoms and disability. Dr. Cohen also noted that PEDs are effective and minimally invasive methods for the surgical treatment of LDH, causing fewer complications due to the very minimal operational trauma for the muscle-ligament complex and stability of the spine. Dr. Cohen asserted

that lumbar percutaneous discectomy is a procedure indicated for patients with lumbar radiculopathy who have not responded to more conservative methods of treatment. He referenced an article that concludes that nucleoplasty is a promising treatment option for patients with symptomatic disc protrusion and herniation who present with lumbalgic and/or sciatalgic pain, have failed conservative therapies and are not considered candidates for open surgery. He added that discectomy is recommended in patients with unremitting symptoms of lumbar radiculopathy despite a reasonable period of nonsurgical treatment (more than 6 weeks), which was the case here. Dr. Cohen notes that Dr. Sidhwani himself quotes a recent study that notes, "Intradiscal PRP has shown promising results in the CLDP literature." Dr. Cohen also said that Platelet-rich plasma (PRP) injection is used alongside lumbar percutaneous discectomy to enhance the overall outcome of the procedure. He said that PRP promotes healing, reduces inflammation, decreases pain, enhances regeneration, and minimizes scar tissue formation. Dr. Cohen opined that the surgery and related procedures were medically necessary.

Applicant also submitted various medical records including the November 9, 2023 and November 15, 2023 examination reports and the February 4, 2022 lumbar MRI report.

Addendum

Respondent submitted an August 9, 2024 addendum by Dr. Sidhwani. Dr. Sidhwani said that, based upon his review of Dr. Cohen's rebuttal as well as the medical records, he stood by his opinion and said that he was unable to establish any clinical or MRI evidence that would warrant the elective lumbar percutaneous discectomy and accompanying PRP injection performed on November 15, 2023. Dr. Sidhwani asserts that the symptoms suggested by the EIP's physicians, as well as the general and nonspecific examinations of the EIP, are not consistent with the remainder of the file including a treating provider, Dr. Omar Ahmed who clearly noted that the lumbar MRI was "unremarkable." Dr. Sidhwani stated that he had not been provided with any MRI in order to make any determination and therefore, his opinion has not changed. He added that it is unclear as to why this report had not been made available for his review. He contended that the clinical history provided is inconsistent with the subjective findings and complaints suggested by Dr. Cohen in this rebuttal and therefore, he has not provided any additional clinical evidence or accurate assessment of the clinical history from 2021 through 2023, other than arguing findings submitted by other examiners.

Fee Schedule Defense

Respondent also raised a fee schedule defense.

11 NYCRR 65-3.8(g)(1), in effect as of April 1, 2013, provides that proof of the fact and amount of loss sustained pursuant to Insurance Law section 5106 (a) shall not be deemed supplied by an applicant to an insurer and no payment shall be due for such claimed medical services under any circumstances for those claimed medical service

fees that exceed the charges permissible pursuant to Insurance Law sections 5108(a) and (b) and the regulations promulgated thereunder for services rendered by medical providers.

Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. See, *Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co*., 2006 NY Slip 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct. Kings Co. 2006).

Applicant billed $7,898.71, as amended, ($5,292.93 under CPT code 62287 and $2,605.78 under CPT code 22526-59) for the facility fee associated with the lumbar percutaneous discectomy.

Respondent contends that the proper reimbursement for the facility fee is $5,292.93 under CPT code 62287.

In support of its fee schedule defense, Respondent submitted a July 25, 2024 affidavit by Carolyn Mallory, CPC, and supporting documentation. Ms. Mallory states that reimbursement for CPT code 62287 is $5,292.93. She added that NY EAPG Significant Procedure Consolidation refers to the collapsing of multiple related significant procedure APGs into a single EAPG for the purpose of determining payment based on the New York Enhanced Ambulatory Patient Grouping (EAPG) Methodology. She notes that CPT codes 62287 and 22526 group to APG 28. She asserts that modifier 59 is an important NCCI PTP-associated modifier that is often used incorrectly. She adds that all services in dispute were performed on the same anatomic site at the same encounter. She asserts that Applicant did not meet the criteria required per the EAPG Manual and the NCCI Manual to use modifier 59. She explains that NCCI criteria to use modifier 59:provides that the procedures remain bundled unless the procedures/surgeries are performed at different anatomic sites or separate patient encounters. She adds that all services in dispute were performed on the same anatomic site at the same encounter. She found that the CPT code 22526 charge was bundled with CPT code 62287 and was not separately reimbursable. She references Arbitrator Papadakis's decision in AAA# 17-22-1235-8730. She opines that, if it is found that the charges are to be reimbursed, the New York EAPG Fee Schedule allowed amount is $5,292.93.

Applicant submitted an August 19, 2024 affidavit by Esther Tetro, CPC and supporting documents. Ms. Tetro states that CPT code 62287, the primary surgical code performed, is in EAPG group 28 and is reimbursed at $5,292.93. She asserts that CPT code 22526 was the secondary procedure and is in EAPG group 28 and billed with a modifier 59 to identify a separate procedure or distinct procedural service and, after a 50% discount, is reimbursed at $2,605.78. Ms. Tetro notes that Ms. Mallory states that Modifier 59 is not supported in this scenario. However, Ms. Tetro states that there are no conflicts between the two codes as seen by the NCCI edits. She adds that CPT 22526 is billed with modifier 59, which signifies a "Distinct procedure" and bypasses consolidation. She states that while the discectomy (CPT Code 62287) was only performed at L4-5, the annuloplasty (CPT Code 22526) was performed at an additional level of the spine, L3-4, thus allowing for separate reimbursement. She explains that the NCCI Policy Manual

defines separate anatomic sites as different spinal levels, thus warranting separate reimbursement. She references the first paragraph of page 10 of NCCI Policy Manual. She notes that, in the case at hand, the annuloplasty was clearly performed on an additional level of the spine that the discectomy was not so it would qualify for reimbursement. She asserts that the different levels of the spine are considered separate anatomic sites. She concludes that the billable fee schedule amount for the services performed is $7.898.71.

Once the insurer makes a prima facie showing that the amounts charged by a provider were in excess of the fee schedule, the burden shifts to the provider to show that the charges involved a different interpretation of such schedule or an inadvertent miscalculation or error. *Cornell Medical, P.C. v. Mercury Casualty Co*., 24 Misc.3d 58, 884 N.Y.S.2d 558 (App. Term 2d, 11th & 13th Dists. 2009).

Findings

Based on the foregoing, I find Dr. Sidhwani's peer review failed to establish that the lumbar percutaneous discectomy and associated procedures were not medically necessary. Dr. Sidhwani relied to some extent on the IME findings of Dr. Seneviratne, Dr. Iozzio, and Dr. Kifle, even though the denial was based only on Dr. Sidhwani's peer review. Additionally, Dr, Sidhwani did not review Dr. Cohen's November 9, 2023 and November 15, 2023 evaluation reports, the reports that note the recommendation for the lumbar surgery. Dr. Sidhwani also acknowledged that he did not review the lumbar MRI report. Furthermore, the surgery was performed approximately 2 years after the MVA and Dr. Sidhwani did not sufficiently address the conservative care received by the EIP prior to the surgery. I find that the peer review failed to provide an adequate factual basis and medical rationale to support Dr. Sidhwani's opinion that the lumbar surgery and associated procedures were not medically necessity. I also find Dr. Cohen's rebuttal to be persuasive. Dr. Cohen addressed the issues raised in the peer review and provided an adequate factual basis and medical rationale, supported by medical authority, to demonstrate that the lumbar discectomy and associated procedures were medically necessary. I did not find the addendum to be convincing. Dr. Sidhwani again acknowledged that he did not review the lumbar MRI report and he did not adequately address the issues raised in the rebuttal. As to Respondent's fee schedule defense, I find that Respondent met its the burden of coming forward with competent evidentiary proof to support its fee schedule defense. Respondent's fee coder affidavit demonstrated that the proper reimbursement for the facility fee is $5,292.93. I did not find Applicant's fee coder affidavit to be convincing. Ms. Tetro asserts that the first paragraph of page 10 of NCCI Policy Manual defines separate anatomic sites as different spinal levels, thus warranting separate reimbursement. However, the aforesaid paragraph relates to the PTP edit for CPT codes 22630 and 63056, not the codes at issue herein. Accordingly, Applicant is awarded $5,292.93.

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	**11/15/23 - 11/15/23**	**$13,241.61**	**$7,898.71**	**Awarded: $5,292.93**
Total			**$13,241.61**		**Awarded: $5,292.93**

B. The insurer shall also compute and pay the applicant interest set forth below. 01/29/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

   Since the claim(s) in question arose from an accident that occurred on or after April 5, 2002, the insurer shall compute and pay the applicant the amount of interest computed from the above date, which is the date that arbitration was requested, at the rate of 2% per month, simple, and ending with the date of payment of the award, subject to the provisions of 11 NYCRR 65-3.9 (c).

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, in accordance with 11 NYCRR § 65-4.6(d). Therefore, the insurer shall pay the applicant an attorney's fee of 20% of benefits plus interest, with no minimum fee and a maximum fee of $1,360. 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(b).

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 Queens

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

10/05/2024
(Dated)

Eileen Casey

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:
38736f527811fd507d97d683878090db

Electronically Signed

Your name: Eileen Casey
Signed on: 10/05/2024