American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

All City Family Healthcare Center (Applicant)	AAA Case No.	17-24-1347-5305
	Applicant's File No.	N/A
- and -	Insurer's Claim File No.	238005631-001
	NAIC No.	Self-Insured
Avis Budget Group (Respondent)		

ARBITRATION AWARD

I, Teresa Girolamo, Esq., 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: G.R.

1. Hearing(s) held on 09/17/2024
   Declared closed by the arbitrator on 09/17/2024

   John Faris, Esq. from Jakubowitz Law Firm PC participated virtually for the Applicant

   Justin Calabrese, Esq. from Hollander Legal Group PC participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$7,898.71**, 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 Applicant's claim for date of service of 7/12/2023 billed in the amount of $7,898.71 was medically necessary as same was timely denied by Respondent based upon a peer review by Michael Tawfellos, M.D. dated 3/19/2024?

   Whether Applicant billed in excess of fee schedule?

4. Findings, Conclusions, and Basis Therefor

I have reviewed the documents contained in the Electronic Case Folder as of the date of the hearing. This decision is based on my review of that file, as well as the arguments of the parties. Each of the parties appeared via ZOOM.

Legal Analysis:

With respect to the question of medical necessity, Respondent has the burden to rebut the claim with proof that the health care services were not medically necessary or with some other viable defense (See *Amaze Med. Supply v. Eagle Ins. Co.,* 2 Misc. 3rd 128[A] 2003.

With respect to lack of medical necessity is an affirmative defense that is the Respondent's burden to prove. *See*, *Alliance Medical Office, P.C. v. Allstate*, 196 Misc.2d 268, 269, 764 N.Y.S.2d 341, 342 (Civil Ct., Kings Cty. 2003); *Choicenet Chiropractic P.C. v. Allstate*, 2003 WL 1904296, 2003 N.Y. Slip Op. 50672U (App.Term 2nd Dept. 2003). "At a minimum, [Respondent] must establish a factual basis and medical rationale for the lack of medical necessity of [Applicant's] services. *Nir v. Allstate*, 7 Misc.3d 544, 546-47, 796 N.Y.S.2d 857, 860 (Civil Court, Kings Cty. 2005).

Once the insurer makes a sufficient showing to carry its burden of coming forward with evidence of lack of medical necessity, "plaintiff must rebut it or succumb", *Bedford Park Medical Practice P.C. v. American Transit Ins. Co*. 8 Misc. 3d 1025 (A) 806 N.Y.S. 2d 443 (Table), 2005 N.Y. Slip Op. 51282 (U) at 3, 2005, WL 193646 (Civ. Ct. Kings Co. Jack M. Battaglia, J. August 12, 2005). The burden is on the insurer to show lack of medical necessity. See, *Expo Med. Supplies, Inc. v. Clarendon Ins. Co.,* 2006 N.Y. Slip Op. 50892U, 12 Misc. 3d 1154A, 2006 N.Y. Misc. LEXIS 1169 [Civ. Ct., Kings Co., 2006]. See, also, *A.R. Med. Art., P.C. v. State Farm Mut. Auto Ins. Co*., 2006 N.Y. Slip Op. 50260U, 11 Misc. 3d 1057A, 815 NYS2d 493, 2006 N.Y. Misc. LEXIS 348 [Civ. Ct., Kings Co., 2006]; *Citywide Social Work & Psy. Serv. v. Travelers Indem.* Co., 3 Misc. 3d 608, 777 NYS2d 241 [Civ. Ct, Kings Co., 2004]; *Elm Medical P.C. v. American Home Assurance Co*., 2003 N.Y. Slip Op. 51357U, 2003 N.Y. Misc. LEXIS 1337 [Civ. Ct., Kings Co., 2003];

A treatment or service is medically necessary if it is "appropriate, suitable, proper and conducive to the end sought by the professional health service in consultation with the patient. It means more than merely convenient or useful treatment or services, but treatment or services that are reasonable in light of the patient's injury, subjective and objective evidence of the patient's complaints of pain, and the goals of evaluating and treating the patient." *Fifth Avenue Pain Control Center v. Allstate*, 196 Misc. 2d 801, 807-808 (Civ. Ct. Queens Cty. 2003). Medically necessary treatment or services must be "consistent with the patient's condition, circumstances and best interest of the patient with regard to the type of treatment or services

rendered, the amount of treatment or services rendered, and the duration of the treatment or services rendered." *Id.*

Medical services are compensable where they serve a valid medical purpose. *Sunrise Medical Imaging PC v. Lumbermans Mutual* 2001 N.Y. Slip Op. 4009.

"A peer review report's medical rationale is insufficient if it is unsupported by or controverted by evidence of medical standards." *Id*. Similarly, "[a] peer review report's factual basis 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." *Id.*, *citing*, *Amaze Medical Supply v. Allstate*, 3 Misc.3d 43, 779 N.Y.S.2d 715 (App Term 2d and 11th Jud Dists 2004).

In order for Respondent to meet its burden of establishing the lack of medical necessity, a peer review should (1) set forth applicable accepted medical standards relevant to the services at issue; and (2) comment on whether the Applicant had followed or deviated from those standards in providing the disputed services. This does not necessarily require that the peer review quote or cite medical literature. The *Nir* decision clearly contemplates that a peer may cite "medical authority, standard, or generally accepted practice as a medical rationale for his findings". *Nir*, 7 Misc.3d at 548.

Only if Respondent can establish a *prima facie* defense does the burden of proof shift to Applicant to rebut the defense. See, *A. Khodadadi Radiology PC v. NY Central Mutual Fire Ins. Co.*, 2007 NY Slip Op 51342(U). In general, Applicant's "rebuttal" need not be in the form of an affidavit or other statement specifically created in response to the peer review; Applicant may rely on the existing medical records and reports already in evidence to counter the peer's arguments.

Prior Linked Matters:

On 8/28/2024 the matter of AAA 17-23-1328-3724 *Care Touch PT/ G.R. v. Avis Budget Group* came before me on 7/15/2024. In that matter Applicant was seeking recovery of $1,059.26 for dates of service of 2/16/2023 - 6/26/2023. The issue in that case was one of fee schedule only. However what this matter confirms is that there was a course of physical therapy.

There is also the linked matter of AAA 17-24-1332-1588 *Sedation Vacation Perioperative Medicine / G.R. v. Avis Budget Group* that came before Arbitrator Laura Yantsos. In that matter the services were anesthesia relating to a cervical discectomy performed on 6/15/2023. The services were denied by Respondent based upon a peer report of Michael Tawfellos, M.D. however the Arbitrator did not specify the date of the peer report. Irrespective of same the date of service herein is not 6/12/2023 but 7/12/2023.

Current Arbitration:

Respondent received Applicant's bill dated 10/26/2023 on 2/21/2024 The bill was not denied based upon the 45 Day Rule. The bill was denied on 3/21/2024 based upon a peer report of Michael Tawfellos, M.D. dated 3/19/2024. According to the Explanation of Review, the peer reviewer determined that the "lumbar percutaneous discectomy, percutaneous augmentation and annuloplasty procedures performed by All City Family Healthcare on 07/12/2023 was not medically necessary."

Facts:

According to an NF-2 which appears to be dated 5/9/2023, on 2/14/2023 G.R. was involved in an accident. The NF-2 does not provide a description of the accident nor much of any information such as if he was the driver or a passenger; whether he received medical treatment at an ER etc.

According to Applicants submissions uploaded on 5/13/2024 the Report from Total Anesthesia Provider, PC, by Hanif Kunti, PA. with date of service of 3/14/2023 states that G.R.. was involved in a motor vehicle accident on 2/14/2023 while a passenger in a vehicle. Due to said accident he reportedly sustained injuries to his neck, upper back, lower back, right shoulder and right arm. On 3/14/2023 G.A. presented complaining of lower back pain at an 8/10; frequent, sharp, shooting, radiating to the right lower extremity. Pain was exacerbated by mechanical type activities. G.A. also presented with complaint of neck pain at a 9/10, with the pain a sharp deep pain and pressure around the neck and radiating to the right shoulder and right arm.

The report states, "*patient has had interim treatment which consisted of medications such as Ibuprofen, Lidocaine cream, Tylenol, Cyclobenzaprine, going to physical therapy and acupuncture services 4 times a week, however, remains symptomatic*.."

Following this initial evaluation the plan of care included cervical epidural steroid injection as it is contended that G.R. failed conservative management of physical therapy and PO pain medications." This report is electronically signed by David Shabtian, D.O. on 3/16/2023. On 3/26/2023 the CESI was performed.

The next medial report in Applicant's submission is dated 6/13/2023 almost 3 months later. The report states that G.R. presented for a follow up visit status post cervical epidural steroid injection on 03/26/2023; that G.R. is "compliant with conservative management of Physical therapy and acupuncture 4 times weekly, and

takes pain medication as needed but the neck pain persists.. neck pain VAS 9/10. The Plan of Care following this evaluation states, "patient has elected to proceed with percutaneous cervical discectomy. Will schedule ASAP." This was performed just 2 days later on 6/15/2023.

On 6/25/2023 G.R. presented again to David Shabtian, D.O. and received an LESI. The report of **7/10/2023 is a "Tele Medicine**" evaluation which is a "telephone note". A copy of the telephone note is at page 18/ 26 of Applicant's submissions. The report states that the office called G.R. for a follow-up after the LESI at which time G.R. stated that there was minimal improvement of about 20% for 2-3 fays after the injection. The lower back pain was an 8/10 and it was based upon this telephone call that G.A. "wishes to proceed with Percutaneous Lumbar Discectomy" and that it would be scheduled ASAP.

The percutaneous lumbar discectomy and annuloplasty with fluoroscopy at L5-S1 was performed on 7/12/2023.

Applicant submitted the appropriate health claim form to Respondent for reimbursement. Respondent submitted same along with the available medical records to Michael Tawfellos, M.D. for an opinion as to whether or not the percutaneous lumbar discectomy and annuloplasty with fluoroscopy at L5-S1 was performed on 7/12/2023 was medically necessary.

Peer Report: Michael Tawfellos, M.D. dated 3/19/2024

In this case Michael Tawfellos, M.D. was asked to provide an opinion as to whether or not the lumbar percutaneous discectomy and percutaneous augmentation and annuloplasty procedures performed on 7/12/2023 were medically necessary.

In reviewing the peer report, a considerable number of records were provided to Michael Tawfellos, M.D. for consideration; 41 separate listed items..

In the "History" section of the report, Michael Tawfellos, M.D. discusses the date of loss of 2/10/2022 which is clearly a typographical error as the correct date of loss is 2/10/2023.

The next paragraph is a discussion of the 3/14/2023 evaluation by David Shabtian, D.O., which is the initial evaluation for this provider. Following a discussion of the medical records, starting at the middle of page 4/6 of the peer report, Michael Tawfellos, M.D. states, that "*After a review of the medical records, the standard of*

care was not met to indicate the medical necessity of the Lumbar percutaneous discectomy and Percutaneous Augmentation and Annuloplasty Procedures performed on the date of 07/12/2023 by All City Family Healthcare. Therefore, any pre and post-operative services are also not medically necessary."

Referencing medical literature, Michael Tawfellos, M.D., states that a lumbar disc herniation (LDH) "is the most common clinical indication for lumbar percutaneous discectomy due to the compression from a protruded disc material to the spinal nerve root." Michael Tawfellos, M.D., states "*The treatment options for LDH include conservative therapy or operative treatment. The only patients in which surgical intervention is the only option are those with cauda equina syndrome, characterized by saddle anesthesia and/or bowel and bladder incontinence. All other cases of LDH with radicular pain should first undergo* ***a 4 to 6 week trial of conservative treatment with physical therapy***. *A number of patients will experience relief of their clinical symptoms with systematic conservative treatment with physical therapy. However,* ***in patients who have attempted a copious amount of physical therapy and have experienced little-to-no improvement of their clinical symptoms, surgical intervention should be discussed***." (emphasis added).

> *The standard of care for musculoskeletal injury after a motor vehicle accident should begin with a reasonable trial of conservative treatment which consist of clinical evaluation advising activity modification if necessary, with a focus on returning to full activity as soon as possible. Simple analgesics such as anti-inflammatory agents and local anesthetics as well as physiotherapy for a period of 4-6 weeks are recommended, followed by another modified course of physical therapy/exercise program if the claimant is not responding to the initial course of treatment. If this fails, a claimant may then be referred for imaging or to a pain management or orthopedic specialist to determine further course of treatment.*

Therefore, based upon the above there should be a 4-6 week period of conservative care and if there is no or little improvement then the surgery could be considered. Wan, Zhong Y., et al. "*Emerging issues questioning the current treatment strategies for lumbar disc herniation*." Frontiers in Surgery 9 (2022): 814531

Michael Tawfellos, M.D. also references an article that actually states that there should be 12 weeks of conservative treatment.

In this case Michael Tawfellos, M.D., stated "*the claimant's records fail to reflect the claimant underwent conservative care or epidural injections. Prior a surgical procedure, conservative treatment should be exhausted. This procedure was preemptive and not according to the medical standard of care*."

Arbitrator's Note:

Applicants' medical records discussed a reported course of conservative care of physical therapy as well as acupuncture treatment however there are no such records in Applicant's submissions. However, Respondent uploaded a PIP ledger which documents that there was acupuncture treatment ,chiropractic treatment and physical therapy. By example, in looking at the PIP ledger uploaded, same is 19 pages there are Care Touch PT note for 2/16/2023 - 3/23/2023, 3/30/2023 - 5/2/2023 Acupuncture records from 2/16/2023 - 5/15/2023 Chiropractic treatment from 3/15/2023 - 4/26/2023; etc. Therefore they exist but were never provided to the peer reviewer for consideration.

Fee Schedule:

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).

Respondent offers a fee coder Affidavit of Carolyn Mallory, CPC, who opines that the correct reimbursement for CPT Code 62287 is $5,293.93 which is what Applicant billed. The code in dispute is CPT Code 22526-59 for which Applicant billed $2,605.78 to which Ms. Mallory CPC opines that there is no reimbursement.

For this code, Applicant used the modifier 59 which according to Ms. Mallory, CPC such a modifier is used when the second code is separate and distinct with "

d) Modifier 59: Modifier 59 is an important NCCI PTP-associated modifier that is often used incorrectly. For the NCCI program, its primary purpose is to indicate that 2 or more procedures are performed at different anatomic sites or different patient encounters.

• Different anatomic sites.

• Separate patient encounters.

• Non contiguous

• The definition of modifier 59 has not met been and should not be used on this facility bill.

Applicant offers a report by Roza Vinogradov, DSPT, CPC -1, COSC in direct response to the Coder report by Carolyn Malloy, CPC.

Decision:

Pursuant to 11 N.Y.C.R.R. § 65-4.5 (o) (1) provides, in part: "(o) Evidence. (1) ***The arbitrator shall be the judge of the relevance and materiality of the evidence offered***, and strict conformity to legal rules of evidence shall not be necessary. 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***." Additionally, Master Arbitrator Peter J. Merani, in the case of *Sports Medicine & Ortho. Rehab. a/a/o "I.B." v. Country-Wide Ins. Co.*, AAA Case No. 17-R-991-14272-3, stated, in relevant part, that "***the Arbitrator below is the trier of facts and must evaluate and weigh the evidence presented at the hearing in arrive at [his/her] decision***. The ***Arbitrator, in weighing the evidence, has broad powers and discretion in determining what evidence is relevant and material. The Arbitrator is in the best position to evaluate the evidence*** and decide on the credibility of the submitted documents." Furthermore, it is within the province of an arbitrator to determine what evidence to accept or reject and what inferences should be drawn based on the evidence. See: Mott v. State Farm, 55 NY2d 224 (1982).

In this case having reviewed the evidence presented I find that Respondent has failed to establish its affirmative defense of lack of medical necessity, as the complete medical records were not provided to the peer reviewer to make a proper determination regarding the services now in dispute. Therefore the rebuttal by David Shabtian, D.O. dated 6/24/2024 is moot.

With respect to fee schedule I find Respondent's fee coder persuasive as compared to Applciant's evidence including but not limited to the Affidavit; the 3M printout and IHC reports not related to this case. Therefore Applicant is awarded $5,292.93 for its facility fee. The amount of $2,605.78 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 applicant is AWARDED the following:

A.

Medical		From/To	Claim Amount	Status
	All City Family Healthcare Center	**07/12/23 - 07/12/23**	**$7,898.71**	**Awarded: $5,292.93**
Total			**$7,898.71**	**Awarded: $5,292.93**

B. The insurer shall also compute and pay the applicant interest set forth below. 05/13/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest is payable from 5/13/2024 to date of payment.

C. Attorney's Fees

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

Respondent is directed to pay attorney fees in accordance with No Fault Regulations.

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 CT
SS :
County of Fairfield

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

10/16/2024

(Dated) Teresa Girolamo, Esq.

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
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Electronically Signed

Your name: Teresa Girolamo, Esq.
Signed on: 10/16/2024