

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Uptown Healthcare Management Inc d/b/a  
ETM- ASC Ambulatory Surgery Center of  
East Tremont  
(Applicant)

- and -

Geico Insurance Company  
(Respondent)

AAA Case No.	17-24-1334-1201
Applicant's File No.	TLD23-1040233
Insurer's Claim File No.	0483149470101044
NAIC No.	35882

**ARBITRATION AWARD**

I, Mary Anne Theiss, 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: Claimant

1. Hearing(s) held on 10/16/2024  
Declared closed by the arbitrator on 10/16/2024

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

Kevin Smith, Esq. from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$14,724.86**, 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

The Claimant, a sixty-year-old male was involved in a motor vehicle accident on June 21, 2022, as a restrained driver whose vehicle was T-boned on the right side. The Claimant went to South Nassau Hospital. The Claimant had complaints of cervical, bilateral shoulders, thoracic, and lumbar pain. The pain was 9/10.

The Applicant Uptown Healthcare Management Inc d/b/a ETM-ASC Ambulatory Service Center of East Tremont is seeking \$14,724.86. The amount left on the policy is \$2,388.47 for dates of service July 13, 2023.

The denial is based upon a peer review of Jeffry Beer, M.D. dated August 17, 2023.

#### 4. Findings, Conclusions, and Basis Therefor

The Claimant, a sixty-year-old male was involved in a motor vehicle accident on June 21, 2022, as a restrained driver whose vehicle was T-boned on the right side. The Claimant went to South Nassau Hospital. The Claimant had complaints of cervical, bilateral shoulders, thoracic, and lumbar pain. The pain was 9/10.

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The Applicant has established a prima facie case of entitlement to benefits. Once an applicant has established a prima facie case of entitlement to No-Fault benefits, the burden then shifts to the insurer to prove that the disputed services were not medically necessary. To meet this burden, the insurer's denial(s) of the applicant's claim(s) must be based on a peer review, IME report, or other competent medical evidence that sets forth a clear factual basis and a medical rationale for the denial(s). *Amaze Medical Supply, Inc. v. Eagle Ins. Co.*, 2 Misc. 3d 128A (App. Term, 2nd Dept., 2003); *Tahir v. Progressive Cas. Ins. Co.*, 12 Misc. 3d 657 (N.Y.C. Civ. Ct., N.Y. Co., 2006); *Healing Hands Chiropractic, P.C. v. Nationwide Assurance Co.*, 5 Misc. 3d 975 (N.Y.C. Civ. Ct., N.Y. Co., 2004); *Millennium Radiology, P.C. v. New York Cent. Mut.*, 23 Misc. 3d 1121(A) (N.Y.C. Civ. Ct., Richmond Co., 2009); *Beal-Medea Prods., Inc. v GEICO Gen. Ins. Co.*, 27 Misc. 3d 1218(A) (N.Y.C. Civ. Ct., Kings Co., 2010); *All Boro Psychological Servs., P.C. v GEICO Gen. Ins. Co.*, 34 Misc. 3d 1219(A) (N.Y.C. Civ. Ct., Kings Co., 2012).

Dr. Beer stated the following:

Based upon a review of the available documentation and consideration of the pertinent medical literature, I have determined that medical necessity has not been established for the facility fees associated with a percutaneous discectomy, annuloplasty, discography and cervical transforaminal injection (63075, 22526-59, 22527-59, 62290-59, 77003-59, 64479-59 and 64480-59), for procedure supplies (99070 x 2), for Covid 19 testing (87635) and for sedation provided during the procedure (00600 x14) performed on July 13, 2023.

The standard of care in the treatment of acute musculoskeletal injuries after a motor vehicle accident based upon current evidence-based literature supports the use of plain radiographs and/or conservative modalities of treatment such as relative rest, activity modification, therapeutic exercise, and appropriate analgesic medications.

The treatment rendered in this case represents a deviation from the standard of care.

Percutaneous discectomy (PCD) is a "blind" procedure performed under the direction of fluoroscopy. It involves placing an instrument into the center of the disc space, and either mechanically removing disc material or vaporizing it by use of a laser, to create a void so that extruded material can return to the center of the disc. Percutaneous lumbar discectomy procedures are rarely performed in the U.S., and no studies have demonstrated the procedure to be as effective as discectomy or microsurgical discectomy (Boult M, Fraser RD, Jones N, Osti O, Dohrmann P, Donnelly P, Liddell J, Maddern GJ, Percutaneous endoscopic laser discectomy, Aust N Z J Surg 2000 Jul;70(7):475-9) (Mochida J, Toh E, Nomura T, Nishimura K. The risks and benefits of percutaneous nucleotomy for lumbar disc herniation. A 10-year longitudinal study. J Bone Joint Surg Br. 2001 May;83(4):501-5.) (Singh V, Manchikanti L, Benyamin RM, Helm S, & Hirsch JA. Percutaneous lumbar laser disc decompression: a systematic review of current evidence. Pain Physician. 2009;12(3):573-88.) This systematic review found no benefit from minimally invasive percutaneous techniques, and a tendency for more safety in open procedures in lumbar disc surgery. (Payer M. "Minimally invasive" lumbar spine surgery: a critical review. Acta Neurochir (Wien). 2011 Jul;153(7):1455-9.)

In this case, the claimant described cervical pain following an automobile accident. An MRI of the cervical spine dated reveal herniations at C3/4, C4/5 and C6/7. The degree of nerve compression was not clearly described in the radiology report. However, despite the above, percutaneous discectomy (PCD) is not recommended because proof of its effectiveness has not been demonstrated.

It should be noted that although not binding in these no-fault insurance cases, the 2014 New York State Worker's Compensation Medical Treatment Guidelines do not allow the use of percutaneous discectomy for any reason given the lack of scientific validation.

Given the above considerations, the procedures under review in this case are considered a deviation of the standard of care, as other more validated treatments should have been employed in this case. These treatments include physical therapy, anti-inflammatory medication or other analgesic medications, steroid injections, and in the proper setting spinal surgery such as open discectomy.

...Given that discography has not proven to be an effective tool in the pre-operative evaluation of patients undergoing surgery, its use in this case is not considered medically necessary. In addition, there is a high likelihood of adverse effects on the target disc or on adjacent nonpathological disc levels. Finally, if transforaminal injections were thought to be of significant benefit, this should have been performed prior to the discectomy procedure and not concurrent with it.

The injection procedure offered in this case typically does not require the use of sedation and can be safely performed with local anesthetic alone. Exceptions are made only for patients presenting with unique circumstances, which are not suggested by the available medical records.

When an insurer, through a peer review or medical exam, presents sufficient evidence establishing a lack of medical necessity, the burden then shifts back to the applicant to present its own evidence of medical necessity. *West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co.*, 13 Misc. 3d 131(A) (App. Term, 2nd Dept., 2006); *Alfa Medical Supplies v. Geico General Ins. Co.*, 38 Misc. 3d 134(A) (App. Term, 2nd Dept., 2013).

Adnan Qureshi, M.D., a pain management specialist, offered a rebuttal which is undated. Dr. Qureshi noted that Dr. Beer stated the discectomy is a blind procedure, however the utilization of fluoroscopic guidance allows real time visualization of the spinal disc. He cited articles from the lumbar literature indicating that it is an effective procedure. He noted that an annuloplasty was performed as an adjunct to the cervical discectomy to treat the annular tears that were noted at C4-C5 and C5-C6 and that the transforaminal epidural injection was not performed as a stand-alone procedure.

I find that Dr. Beer's peer review does not sets forth a clear factual basis and a medical rationale for Respondent's denial of Applicant's claim for the cervical discography, the percutaneous discectomy, annuloplasty, and a transforaminal epidural steroid injection with fluoroscopic guidance in dispute. I find that Respondent has not established a lack of medical necessity for cervical discography, a percutaneous discectomy, annuloplasty, and a transforaminal epidural steroid injection with fluoroscopic guidance.

It has been held that "For an expense to be considered medically necessary, the treatment, procedure, or service ordered by a qualified physician must be based on an objectively reasonable belief that it will assist in the patient's diagnosis and treatment and cannot be reasonably dispensed with. Such treatment, procedure, or service must be warranted by the circumstances as verified by a preponderance of credible and reliable evidence and must be reasonable in light of the subjective and objective evidence of the patient's complaints." *Nir v. Progressive Ins. Co.*, 7 Misc.3d 1006(A), 2005 N.Y. Slip Op. 50466(U) (Civ. Ct. Kings Co., Nadelson, J., Apr. 7, 2005).

I find Dr. Qureshi's rebuttal more credible and probative than Dr. Beer's peer review. I find that cervical discography, a percutaneous discectomy, annuloplasty, and a transforaminal epidural steroid injection with fluoroscopic guidance were medically necessary, and I sustain the Applicant's claim to that effect. Said claim supports Applicant's prima facie case of entitlement to No-Fault compensation.

There is only \$2,388.47 left on the policy and that amount is awarded.

I want to thank the parties for taking the time to prepare their cases and participating in the arbitration process.

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
	<b>Uptown Healthcare Management Inc d/b/a ETM-ASC Ambulatory Surgery Center of East Tremont</b>	<b>07/13/23 - 07/13/23</b>	<b>\$14,724.86</b>	<b>Awarded: \$2,388.47</b>
<b>Total</b>			<b>\$14,724.86</b>	<b>Awarded: \$2,388.47</b>

- B. The insurer shall also compute and pay the applicant interest set forth below. 01/28/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

The insurer shall compute and pay the applicant the amount of interest from the filing date of the request for arbitration, at a rate of two percent (2%) per month, simple interest (i.e., not compounded), using a 30-day month and ending with the date of

payment of the award, subject to the provisions of 11 NYCRR §65-3.9(c). The filing date, pursuant to the American Arbitration Association records, is as noted above interest is paid from the date of filing.

C. Attorney's Fees

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

The insurer shall pay the applicant an attorney's fee in accordance with 11 NYCRR 65-4.6(d). 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 11NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant an attorney's fee in accordance with 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 NY

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

10/23/2024  
(Dated)

Mary Anne Theiss

**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:**  
1b049303592def0e749da4da95afb818

### **Electronically Signed**

Your name: Mary Anne Theiss  
Signed on: 10/23/2024