

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Surgicore Of Jersey City, LLC
(Applicant)

- and -

LM Personal Insurance Company
(Respondent)

AAA Case No. 17-24-1359-0507

Applicant's File No. SS-275596

Insurer's Claim File No. 0454498860002

NAIC No. 12484

ARBITRATION AWARD

I, Frank Marotta, 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-JV

1. Hearing(s) held on 01/14/2025
Declared closed by the arbitrator on 01/14/2025

Greg Itingen, Esq. from Samandarov & Associates, P.C. participated virtually for the Applicant

Meliane Diedro from LM Personal Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$19,043.40**, was NOT AMENDED at the oral hearing.
Stipulations WERE made by the parties regarding the issues to be determined.

The parties stipulate and agree that the Applicant established its prima facie burden, and the Respondent timely denied the claim in issue.

3. Summary of Issues in Dispute

The record reveals that the Assignor-JV, a 53-year-old-female, sustained injuries in a motor vehicle accident on 4/23/21.

The Applicant seeks reimbursement for an ambulatory facility fee in connection with a cervical spine surgery performed by Dr. Shiveindra Jeyamonhan and assisted by Dr. Abishek Kumar

The Respondent denied reimbursement based on a peer review by Dr. Peter Zahos dated 6/3/24. The Respondent further asserts that the proper reimbursement for the Applicant's service is \$15,883.05.

The issue is whether the ambulatory facility fee is medically necessary and if so, what fee is the Applicant entitled to receive.

4. Findings, Conclusions, and Basis Therefor

The Applicant filed this arbitration in the amount of \$19,043.40 for a disputed ambulatory facility fee in connection with a cervical spine surgery performed by Dr. Shiveindra Jeyamonhan and assisted by Abishek Kumar on 3/25/24.

This hearing was conducted using the documents contained in the Electronic Case Folder (ECF) maintained by the American Arbitration Association. All documents contained in the ECF are made part of the record of this hearing and my decision was made after a review of all relevant documents found in the ECF as well as the arguments presented by the parties during the hearing. In accordance with 11 NYCRR 65-4.5(o) (1), an arbitrator shall be the judge of the relevance and materiality of the evidence and strict conformity of the legal rules of evidence shall not be necessary. Further, the arbitrator may question or examine any witnesses and independently raise any issue that Arbitrator deems relevant to making an award that is consistent with the Insurance Law and the Department Regulations. The parties appeared and the hearing was conducted virtually via zoom.

The Respondent denied reimbursement asserting the ambulatory facility fee was not medically necessary. To deny a claim based on a lack of medical necessity the insurer must present medical evidence which sets forth with sufficient particularity the factual basis and medical rationale underlying that determination. Elmont Open MRI & Diagnostic Radiology, P.C. v. Geico Ins. Co., 12 Misc. 3d 133(A), 2006 NY Slip Op 51185(U) (App Term 2d Dept. 9th and 10th Jud Dist. June 8, 2006). See also A. B. Med. Servs. PLLC v Liberty Mut. Ins. Co., 10 Misc 3d 128(A), 2005 NY Slip Op 51902 (U) (App Term, 2d & 11th Jud Dists); Amaze Med. Supply v Allstate Ins. Co., 2004 NY Slip Op 24119, 3 Misc3d 43, 44 [App Term, 2d & 11th Jud Dists 2004]. Such evidence can take the form of a "*peer review or any other proof, such as an independent medical examination, setting forth a sufficiently detailed factual basis and medical rationale for the claim's rejection, e.g. Choicenet Chiropractic P.C. v Allstate Ins. Co., NYLJ, Mar. 7, 2003 (App Term, 2d & 11th Jud Dists)*" Amaze Med. Supply, Inc. v. Eagle Ins. Co., 2003 NY Slip Op 51701(U) (NY App. Term 2003); see also 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).

In support of its defense Respondent relies on a peer review by Dr. Peter Zahos dated 6/3/24. Dr. Zahos provides a history of the Assignor a 46-year-old female who as involved in an MVA on 4/23/21 as a restrained front seat passenger in a vehicle struck on the passenger's side by school bus. Dr. Zahos notes that the airbags did not deploy, there was a positive loss of consciousness, and the claimant required extrication from the vehicle by the fire department. She was transported from the scene via ambulance to the hospital with complaints of pain in the bilateral knee, bilateral shoulder, head, and lower back. The claimant was treated and released the same day and referred to outside evaluation.

Dr. Zahos reviewed medical records beginning with the report by Stephanie Tureck-Hochman, D.C dated 4/28/21 stating that the claimant reports, among other complaints, neck pain 8/10 travels down the right arm from the neck and right shoulder. Physical examination of the cervical spine revealed tenderness and spasm of the cervical paraspinal musculature, trapezius muscle, levator scapulae muscles and sternocleidomastoid muscles. There was pain and tenderness over C1-C2-C3-C4-C5-C6-C7 spinous vertebral levels. ROM decreased. Valsalva test was Positive. Shoulder depressor was positive bilaterally. Sensation was normal. Reflexes were 2+ bilaterally. MMT was 5/5 bilaterally.

Dr. Zahos report a vascular surgery consultation with Yale Vascular Surgery which took place on 6/14/22 for a large pulsatile lump in the middle of the claimant's forehead that had increased in size, was pulsatile and painful. It was noted that the claimant struck her forehead at the time of the MVA of record. Also of note was that when the claimant was a young teenager she had fallen from a bicycle and bumped her head causing a raised area on her forehead that eventually subsided. Dr. Zahos discusses an office visit on 6/28/22 with Cornell Scott Hill Health Center that notes the claimant had a complaint of forehead mass, generalized back pain and pain all over her body. She was noted to be taking gabapentin, Motrin and Voltaren gel. Physical examination documented cervical ROM normal. The dosage of gabapentin was increased, she was told to stop taking Motrin and start taking acetaminophen. Office visit on 12/16/22 with Charles Christian Matouk, MD for evaluation and management of a posttraumatic arteriovenous malformation (AVM). Assessment was that claimant likely suffered a post-traumatic facial AVM however it is associated with an apparent bony deformation of her skull and recommendation was for a CTA. Follow up office visit on 3/15/23 with Charles Christian Matouk, MD notes that the CTA was performed on 2/16/23 that demonstrated small superficial arteriovenous malformation in the forehead with arterial feeders from bilateral facial and superficial temporal arteries, as well as the left anterior ethmoid artery. Assessment and plan was that of a superficial AVM and next step would be diagnostic cerebral angiogram. Follow up office visit on 5/25/23 with Charles Christian Matouk, MD notes visit taking place via telehealth. On 5/8/23, claimant underwent a cerebral angiogram that demonstrated a complex scalp AVM with associated cranial dAVF (Borden Type 1). Plan was to follow up in 6 months as the AVM involves the cranial dural arteriovenous fistula which places her at "above-average risk".

Dr. Zahos refers to an initial surgical consultation office visit on 11/10/23 with Total Orthopedics and Sports Medicine for complaints of cervical and lumbar spine pain.

Cervical pain is rated 9/10 and lower back pain 10/10. Neck pain is described as sharp and aching. Claimant notes prior to MVA having occasional neck pain related to a previous WC accident in 2009 resulting in an ACDF C5-6. The claimant has been attending physical therapy 3x/week and completed a total of 4 months. The claimant has had no imaging and no injections to date. Examination of cervical spine documented tenderness in midline, none at C6 or C7. Muscle tenderness bilaterally in a symmetrical distribution. Muscle spasm bilaterally. Active ROM flexion restricted to 30 degrees, extension restricted to 40 degrees, right lateral flexion restricted to 30 degrees, left lateral flexion restricted to 30 degrees, right lateral rotation restricted to 60 degrees, left lateral rotation restricted to 60 degrees. Strength 5/5 except for right and left flexor carpi radialis 4+/5, right pronator teres 4/5, left pronator teres 4-/5, right and left wrist extension 4+/5, right wrist flexion 4+/5, left wrist flexion 5-/5. Biceps reflex normal at +2, brachioradialis reflex on the right and left 1+. Light touch perception C6-7 grade 2 (decreased superficial cutaneous pain and tactile sensibility with abnormal sensations or moderate pain). Spurling's positive. Assessment was that of cervical and lumbar region radiculopathy. Recommendation was for MRI of cervical and lumbar spine and to continue with PT and home exercise program. Claimant to follow up in two weeks.

The MRI of the cervical spine dated 11/10/23 as per the report impression revealed C4-5 new kyphosis and new right posterior disc herniation impressing on the right ventral cord and extending into the right anterior recess where the right C5 ventral nerve root is impressed upon as it emanates from the cord. C3-4 new right lateral disc herniation extending into and narrowing the right neural foramen causing stenosis and right C4 nerve root impingement which is now evident. C6-7 right eccentric posterior subligamentous disc herniation which causes increasing ventral thecal sac impression and encroaches toward the right anterior recess. Status post ACDF at C5-6 with left posterior bony ridge formation abutting but not deforming the left ventral margin of the cord with patent foramina.

Dr. Zahos notes that on 1/15/24 the claimant presented to Pain Physicians NY Center for Musculoskeletal and Neurological Care for complaints of bilateral knee pain, bilateral shoulder pain, low back pain and head trauma. Diagnoses were those of lumbar intervertebral disc displacement, lumbar radiculopathy, muscle spasm of back, internal derangement of right knee, internal derangement of left knee, bursitis of left shoulder and bursitis of right shoulder. Recommendation was for lumbar epidural steroid injection.

Dr. Zahos refers to the neurosurgical office notes by Shiveindra Jeyamohan, MD on 2/17/24 state the claimant reports severe neck pain 8-9/10 that radiates down her left shoulder, down her left-arm, with numbness and tingling into her left hand and severe low back pain 8-9/10 that radiates into her buttocks and legs. Physical examination of the cervical spine revealed moderate straightening of normal lordosis. There was midline tenderness. Muscle tenderness bilaterally in a symmetrical distribution. ROM restricted. MMT was biceps 5/5 bilaterally, triceps 5/5 bilaterally, extensor carpi radialis 5/5 bilaterally, right flexor carpi radialis 4+/5, left flexor carpi radialis 4+/5, flexor digitorum profundus 5/5 bilaterally, pronates quadratus 5/5 bilaterally, right pronator teres 4/5, left pronator teres 4-/5, right wrist extension 4+/5, left wrist extension 4+/5, right wrist flexion 4+/5 and left wrist flexion 5-/5. Reflexes were biceps 2+/4 and

brachioradialis reflex 1+ bilaterally. There was grade 2 (decreased superficial cutaneous pain and tactile sensibility with abnormal sensations or moderate pain). Spurling's sign was positive bilaterally. Head compression test was positive bilaterally. Physical examination of the lumbar spine revealed moderate straightening of normal lordosis. There was tenderness in midline at L4-L5. There was muscle spasm and tenderness bilaterally. ROM restricted. MMT was 5/5 bilaterally except for right anterior tibialis 4-/5 and right extensor hallucis longus 4/5. Patellar reflexes were 2+ bilaterally and Achilles reflex was 1+ bilaterally. There was hypoesthesia on the right L4 distribution and L5 distribution. SLR was positive on the right. Recommended C4-5 ACDF.

The claimant underwent ACDF at C4-5, Placement of interbody C4-5, Anterior Instrumentation C4-C5, Use of Allograft, Use of Autograft, Use of Microscope, by Shiveindra Jeyamohan MD/Abishek Kumar MD on 3/25/24.

Dr. Zahos goes on to say that based upon review of the available medical records and his experience as a Neurosurgeon, he has concluded that there is insufficient documentation to support the surgical intervention, IOM, including anesthesia and services provided pre/post operatively was performed on 3/25/24 as it relates to the MVA of record. Dr. Zahos reports that the claimant had complaints of neck pain with radiation into the bilateral upper extremities following the MVA. The mechanism of whiplash type injury is consistent with the MVA of record. Claimant with previous history of ACDF at C5-6 for which it is documented she suffered from occasional neck pain prior to the MVA. The MVA of record was on 4/23/21, following which claimant is documented with complaints of neck pain for which she received conservative treatments consisting of chiropractic care through 09/21. Documentation provided does not support that claimant continued to receive conservative care for the cervical complaints until late in 2023, at which time she presented to Total Orthopedics and Sports Medicine on 11/10/23 for complaints of cervical and lumbar spine pain.

The MRI of the cervical spine dated 11/10/23 in comparison to 3/23/17 as per the report impression revealed C4-5 new kyphosis and new right posterior disc herniation impressing on the right ventral cord and extending into the right anterior recess where the right C5 ventral nerve root is impressed upon as it emanates from the cord. C3-4 new right lateral disc herniation extending into and narrowing the right neural foramen causing stenosis and right C4 nerve root impingement which is now evident. C6-7 right eccentric posterior subligamentous disc herniation which causes increasing ventral thecal sac impression and encroaches toward the right anterior recess. Status post ACDF at C5-6 with left posterior bony ridge formation abutting but not deforming the left ventral margin of the cord with patent foramina.

Although the surgical intervention is within acceptable medical standards given the claimant's presentation, the lack of treatments and large gaps in treatment following the MVA, the surgical intervention and associated services have not been supported in relation to the MVA of record. In the absence of additional medical documentation, the services provided Surgicore of Jersey City, LLC on 3/25/24 have not been supported in relation to the MVA of record.

Please note that actual diagnostic images were not available for my review and impressions are those of the interpreting physician's report. Should additional documentation become available, I reserve the right to review same and provide comment and/or addendum as necessary.

After a review of the documents contained in the ECF and in consideration of the arguments made by the parties at the hearing, I find the peer review and opinion of Dr. Zahos unpersuasive and insufficient for the Respondent to meet its prima facie burden establishing that the Applicant's ambulatory facility fee was medically unnecessary. I agree with the Applicant that Dr. Zahos's peer statement that the surgical intervention in issue is within acceptable medical standards given the claimant's clinical presentation is sufficient to establish the medical necessity of the facility services. Despite his assertion that the surgery is an acceptable procedure given the Assignor's condition, Dr. Zahos points to a gap in treatment raising what appears to be a causation argument noting that the intervention and associated services are not supported for the accident of record. However, Dr. Zahos' review of the records clearly establishes that the Assignor sustained an impact on her head, pointing to medical records regarding the large pulsatile lump in the middle of her forehead that existed prior to the accident but had increased in size since the accident requiring treatment. Further, Dr. Zahos does review an MRI of the cervical spine dated 11/10/23 and compare it to one on 3/23/17 noting the reports impression revealed a C4-5 new kyphosis and new right posterior disc herniation impressing on the right ventral cord and extending into the right anterior recess where the right C5 ventral nerve root is impressed upon as it emanates from the cord. C3-4 new right lateral disc herniation extending into and narrowing the right neural foramen causing stenosis and right C4 nerve root impingement which is now evident. The procedure was performed at the C4-5 level, which appears to be a new injury based upon Dr. Zahos comparison of the MRI reports. Lastly, even assuming the Assignor did have a pre-existing condition, the evidence does not foreclose the possibility that it was aggravated because of the accident on 4/23/21. There is no discussion by Dr. Zahos that the accident could not have exacerbated her condition. In the absence of competent proof showing otherwise, exacerbation of pre-existing conditions are covered under No-Fault. See Kingsbrook Jewish Medical Center, 61 A.D.3d 13, 21, 871 N.Y.S.2d 680, 686 (2d Dept. 2009).; Mount Sinai v. Triboro Coach, 263 A.D. 2d. 11, 699 N.Y.S. 2d 77 (2d Dept. 1999). See also 11 NYCRR §65-3.14(a).

The Respondent further asserts that the proper reimbursement for the Applicant's services is \$15,8883.05 and in support provides a fee audit by Rachel Huntwork, CPC. According to Ms. Huntwork all the codes billed by the Applicant except for CPT code 22845-59 are reimbursable as billed. Code 22845-59 is not reimbursable because Modifier 59 is not validated as the instrumentation (22845) was necessary for securing the interbody cage (22853). Therefore, code 22845-59 is denied as Modifier 59 is not validated - same operative session, same body part. Ms. Huntwork notes that CPT code with Modifier 59 does not automatically qualify for reimbursement just because it has a different CPT code number (for example, 22845 vs 22853). Further, having a different portal incision to insert the arthroscope to perform the related operative procedures (for the same shoulder/same compartments within the shoulder), also does not qualify for a Modifier 59. Again, please review the Medicare and OIG guidelines above

In support of their billing the Applicant submits a fee audit by Aaron J. Perretta, Esq., CPC.

According to Mr. Perretta surgical Codes 22845 should be reimbursed at 50% of their respective EAPG values, as they are not considered the main procedure Code. Thus, Codes 22845 would have bundled into Code 22551 if not for Modifier 59. As applied herein, Codes 22845 was properly unbundled from Code 22551 since Modifier 59 was affixed to the aforementioned codes.

Mr. Perretta Regarding Code 29845 Huntwork argues in part, "Per the Medicare NCCI edits, code 22845 flags a CCI edit with code 22853. Modifier 59 is not validated as the instrumentation (22845) was necessary for securing the interbody cage (22853). Therefore, code 22845-59 is denied as Modifier 59 is not validated - same operative session, same body part." However, the Applicant believes Huntwork overlooked some important aspects of Modifier 59 she failed to thoroughly consider when formulating her coding strategy, in complete contravention of the American Medical Association. Huntwork's audit completely fails to "conclusively establish" in a "coherent manner" why Code 22845 is not entitled to the reimbursement rate listed. Applicant's bill and operative report stand for the position that its use of Modifier 59 in this instance permits Codes 22845 to be coded with one another, per the AMA's descriptor of same. Per the operative report previously uploaded to MODRIA and annexed hereto as EXHIBIT A for this arbitrator's convenience, it is clear six different procedures were performed on various vertebrae intervals of the Applicant's cervical spine. Huntwork contends the services Code 22845 represents should be down coded as inclusive to the services Code 22853 represents. Specifically, Huntwork argues, "Modifier 59 is not validated as the instrumentation (22845) was necessary for securing the interbody cage (22853). However, an insurer's decision to remit payment at a reduced rate - or not issue any payment at all - based upon the interpretation of a medical procedure must be supported by a peer review report or other medical proof setting forth actual medical rationale for such changes. See *Amaze Med. Supply v. Eagle Ins. Co.*, 2 Misc. 3d 128A (App. Term 2d and 11th Jud. Dist., 2003). In this matter, while Huntwork contends Code 22845 represents is coded in error and is included in the services represented by Code 22853, Huntwork fails to put forth any proof that these proclamations are true.

After a review of the documents contained in the ECF and in consideration of the arguments made by the parties at the hearing, I find that Applicant has established that they are entitled to be reimbursed as billed. If the reduction is based on an interpretation of a medical procedure, it must be supported by a peer review report or other medical proof setting forth actual medical rationale for such changes.

For the reasons noted above I find for the Applicant the amount of \$19,043.40.

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
	Surgicore Of Jersey City, LLC	03/25/24 - 03/25/24	\$19,043.40	Awarded: \$19,043.40
Total			\$19,043.40	Awarded: \$19,043.40

B. The insurer shall also compute and pay the applicant interest set forth below. 07/31/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

The Respondent shall pay interest at a rate of 2% per month, calculated on a pro rata basis using 30-day month and in compliance with 11 NYCRR §65-3.9. Interest shall begin to accrue from the date of filing with the American Arbitration Association and end on the date the award is paid.

C. Attorney's Fees

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

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 Suffolk

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

01/17/2025
(Dated)

Frank Marotta

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:
e8e05fe6f85f71dfb440157413af599d

Electronically Signed

Your name: Frank Marotta
Signed on: 01/17/2025