American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Empire State Ambulatory Surgery Center (Applicant)	AAA Case No.	17-24-1368-1596
	Applicant's File No.	174871
- and -	Insurer's Claim File No.	0743320953
	NAIC No.	29688
Allstate Insurance Company (Respondent)		

ARBITRATION AWARD

I, Anthony Kobets, 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

1. Hearing(s) held on 01/15/2025
   Declared closed by the arbitrator on 01/15/2025

   Robin Gromet, Esq. from Law Offices of Eitan Dagan (Woodhaven) participated virtually for the Applicant

   Rachel Stein, Esq. from Law Offices of John Trop participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$3,213.98**, 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

   In dispute is the Applicant's bill totaling $3213.98 for facility fees associated with a lumbar spine medial branch block injection performed on the patient (PR), a 59 year old male driver, on 5/19/24 as a result of injuries sustained in a motor vehicle accident on January 24, 2024.

   Respondent denied the claim based upon the peer review report by Jason Cohen, M.D. dated 7/12/24. Was the Applicant entitled to reimbursement for the services provided to the EIP?

4. Findings, Conclusions, and Basis Therefor

At the hearing, the parties' representatives agreed that medical necessity was the sole issues in dispute herein.

The EIP (PR) was involved in a motor vehicle accident on January 24, 2024. Thereafter on 5/19/24, he underwent a lumbar spine medial branch block injection administered at the Applicant's facility. Applicant seeks no-fault reimbursement for these services.

Respondent timely denied the bill in dispute herein based on the peer review report by Jason Cohen, ,M.D. dated 7/12/24, wherein Dr. Cohen reviewed the patient's medical records and indicated that "[i]n the clinical scenario of radiculopathy, physical therapy, pharmacotherapy including anti-inflammatories, gabapentinoids would have been the appropriate course of treatment. The standard of care for physical therapy is two to three times per week for a six week duration which the claimant has completed. In case of failure of combined physical therapy and pharmacotherapy, the claimant should have undergone a trial of epidural steroid injection x 3 with outcome documented after each injection on follow up consultation. However, the accepted standard of practice has not been met to support the medical necessity for lumbar discectomy and all associated pre and post-operative services as the claimant has not completed epidural steroid injection x3 nor have trialed any aggressive pharmacotherapy including gabapentinoids. In the event surgery is considered, the claimant should have been referred to surgical consultant and/or neurological consultant for further course of treatment. The treating physician has not ruled out other mechanisms of pain like spasm." Respondent's counsel argued that the Respondent's denial of payment for the services in dispute herein was justified based upon the peer review report of Dr. Cohen.

"Where the defendant insurer presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden shifts to the plaintiff which must then present its own evidence of medical necessity (see Prince, Richardson on Evidence §§ 3-104, 3-202 [Farrell 11th ed])." West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc.3d 131(A), 824 N.Y.S.2d 759 (Table), 2006 N.Y. Slip Op. 51871(U) at 2, 2006 WL 2829826 (App. Term 2d & 11th Dists. Sept. 29, 2006); A. Khodadadi Radiology PC v. NY Central Mutual Fire Ins. Co., 2007 NY Slip Op 51342(U).

Applicant's counsel argued that the peer review failed to meet its burden regarding the lack of medical necessity. Applicant also submitted a rebuttal letter from Joseph Jimenez, M.D. dated 12/23/24. At the hearing, Respondent's counsel requested that the rebuttal be precluded because it was uploaded into the AAA electronic case file on 1/15/24, *the same day as the AAA hearing.* Respondent's request for preclusion of the Rebuttal was granted. A No-Fault arbitrator acts within her discretion in refusing to entertain late submissions. E.g., Matter of Mercury Casualty Co. v. Healthmakers Medical Group, P.C., 67 A.D.3d 1017, 888 N.Y.S.2d 762 (2d Dept. 2009). Accordingly, the rebuttal report will not be considered.

The evidence herein demonstrated that the patient underwent an MRI of the lumbar spine performed on 2/22/24 revealed: At L2-L3, disc bulge with compression of anterior thecal sac with encroachment of neural foramina. Mild facet and ligamentum

flavum hypertrophic changes without spinal canal stenosis. At L3-L4, diffuse disc herniation with compression of the ventral thecal sac and impingement of the lateral recesses, neural foramen and bilateral exiting nerve roots and causes mild spinal canal stenosis at this level. L4-L5 and L5-S1 levels cannot be adequately characterized due to severe magnetic susceptibility artifact due to surgical hardware. CT of the lumbar spine is recommended for further evaluation.

EMG/NCV testing of the lower extremities performed on 3/20/24 revealed evidence of peripheral neuropathy of the bilateral lower extremities and evidence of the right L5-S1 lumbar radiculopathy.

On April 12, 2024, the claimant underwent a lumbar percutaneous discectomy, nucleus pulposus ablation level L2-3, L3-4, annuloplasty, disc injection and radiographic interpretation.

On 5/15/2024, the patient was examined by Joseph Jimenez, M.D. and presented with complaints of sharp pain in the lower back worse with bending and sitting. Examination of the lumbar spine revealed a decreased range of motion with pain, spinal point tenderness noted on palpation, lumbar paraspinal muscle tenderness with spasms, diminished muscle strength, and a positive Straight Leg Raise test bilaterally. The patient was recommended to continue with the ongoing course of conservative treatment, as well as a lumbar medial branch block injection for diagnostic purpose.

On 5/19/24, the patient underwent an L3-4, L4-5, and L5-S1 medial branch block and L5 dorsal primary ramus block right side only under fluoroscopic needle guidance.

Based upon a review of the evidence herein and the arguments of counsel, I find that the Respondent has not met its burden of providing a sufficient medical rationale or factual basis to justify a lack of medical necessity for the lumbar medial branch blocks performed on 5/19/24 at the Applicant's facility. Dr. Cohen did not adequately explain the patient's ongoing symptomology and continued complaints of lumbar pain documented in the medical records, despite undergoing months of conservative treatment. Importantly, the medical records document the patient's continued complaints of pain as well as positive objective findings including tenderness to palpation; right L5-S1 lumbar radiculopathy; an L2-L3, disc bulge with compression of anterior thecal sac with encroachment of neural foramina; and an L3-L4, diffuse disc herniation with compression of the ventral thecal sac and impingement of the lateral recesses.

I find that Dr. Cohen's peer report was unpersuasive and overly conclusory because it lacked a sufficient factual support and medical rationale to justify the position that the diagnostic injection was not medically necessary, considering this patient's diagnosis. A peer review which concludes there was no medical necessity due to the lack of sufficient information upon which the reviewer could make such a determination does not set forth a factual basis and medical rationale sufficient to establish the absence of medical necessity. Park Neurological Services P.C. v. GEICO Ins., 4 Misc.3d 95, 782 N.Y.S.2d 506 (App. Term 9th & 10th Dists. 2004).

I find that the patient's medical records, were more persuasive that the medications were reasonable and medically necessary to treat an unresolved condition, reduce pain and expedite recovery. A respondent defending a denial of first party benefits on the grounds that the subject medical services or testing were not medically necessary must show that the services were inconsistent with generally accepted medical practice, and here the Respondent has not. The opinion of the insurer's expert standing alone is insufficient to meet the *burden of proving that the services were not medically necessary (see Citywide Social* Work v. Travelers Indem. Co., 3 Misc 3d 608 (Civ Ct Kings County 2004). Where a peer review opinion rests upon conclusory assumptions and disputed or incorrect facts, the review is insufficient to prove the insurer's entitlement to judgment as a matter of law on its lack of medical necessity defense; in these circumstances, the absence of opposing expert proof from the claimant is immaterial. E.g., Novacare Medical P.C. v. Travelers Property Casualty Ins. Co., 31 Misc.3d 1205(A), 927 N.Y.S.2d 817 (Table), 2011 N.Y. Slip Op. 50500(U) at 5, 2011 WL 1226956 (Dist. Ct. Nassau Co., Michael A. Ciaffa, J., Apr. 1, 2011).

If the insurance company's expert's main problem with a medical service is that it is not cost effective, it is insufficient to establish lack of medical necessity, despite there being a factual basis and medical rationale for his opinion. Forest Rehabilitation Medicine PC v. Allstate Ins. Co.,44 Misc.3d 476, 990 N.Y.S.2d 788 (Civ. Ct. Richmond Co. 2014). Where other reports in the insurer's papers contradict the conclusion of its peer reviewer that a service was not medically necessary, it has failed to make out a prima facie case in support of the defense of lack of medical necessity. Hillcrest Radiology Associates v. State Farm Mutual Automobile Ins. Co., 28 Misc.3d 138(A), 2010 N.Y. Slip Op. 51467(U), 2010 WL 3258144 (App. Term 2d, 11th & 13th Dists. Aug. 13, 2010). **Based upon the aforementioned, I find that the Respondent has failed to sufficiently establish that the disputed services were not medically necessary and grant Applicant's $3213.98 claim for date of service 5/19/24.** This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator. Any further issues raised in the hearing record are held to be moot and/or waived insofar as not raised at the time of the hearing.

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**
	Empire State Ambulatory Surgery Center	**05/19/24 - 05/19/24**	**$3,213.98**	**Awarded: $3,213.98**
Total			**$3,213.98**	**Awarded: $3,213.98**

B. The insurer shall also compute and pay the applicant interest set forth below. 10/03/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Where a claim is timely denied, interest shall begin to accrue as of the date arbitration is commenced by the claimant, i.e., the date the claim is received by the American Arbitration Association, unless arbitration is commenced within 30 days after receipt of the denial, in which event interest shall begin to accrue as of the date the denial is received by the claimant. See generally, 11 NYCRR 65-3.9. Where a motor vehicle accident occurs after Apr. 5, 2002, 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

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 11 NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant an attorney's fee, in accordance with newly promulgated 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 Nassau

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

02/09/2025
(Dated)

Anthony Kobets

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:
5e5ec2b2d6b2ff2c6a41ed4218c650ef

Electronically Signed

Your name: Anthony Kobets
Signed on: 02/09/2025