

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Portal Medical PC  
(Applicant)

- and -

Geico Insurance Company  
(Respondent)

AAA Case No.	17-24-1358-0310
Applicant's File No.	167886
Insurer's Claim File No.	0431976020000001
NAIC No.	35882

**ARBITRATION AWARD**

I, Charles Blattberg, 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: Eligible injured person

1. Hearing(s) held on 01/15/2025  
Declared closed by the arbitrator on 01/23/2025

Edilaine D'Arce, Esq. from Law Offices of Eitan Dagan (Woodhaven) participated virtually for the Applicant

Joseph Costa-Cappucci from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$7,393.42**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant reduced the total amount in dispute to \$4,610.58 pursuant to fee schedule.

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

Respondent stipulated that the amended amount was correctly fee scheduled.

3. Summary of Issues in Dispute

The claimant [BS] was a 17-year-old female rear seat passenger of a motor vehicle that was involved in an accident on 2/24/23. Following the accident, the claimant suffered injuries which resulted in the claimant seeking treatment. At issue is the medical necessity of the surgeon's and surgical assistant's services provided by Applicant that were associated with a 9/10/23 lumbar spine surgery that Respondent timely denied reimbursement for based on a 10/2/23 peer review by Dilip Subhedar, M.D.

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

Based on a review of the documentary evidence, this claim is decided as follows:

An applicant establishes a prima facie case of entitlement to reimbursement of its claim by the submission of a completed NF-3 form or similar document documenting the facts and amounts of the losses sustained and by submitting evidentiary proof that the prescribed statutory billing forms [setting forth the fact and the amount of the loss sustained] had been mailed and received and that payment of no-fault benefits were overdue. See, *Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). I find that Applicant established a prima facie case for reimbursement.

The claimant [BS] was a 17-year-old female rear seat passenger of a motor vehicle that was involved in an accident on 2/24/23. The claimant reportedly injured her neck, mid back, and low back. There was no reported loss of consciousness. There were no reported lacerations or fractures. There was no reported emergency treatment sought or received. Subsequently the claimant was initiated on physical therapy, chiropractic treatment and acupuncture. The 4/6/23 lumbar MSK ultrasonography produced an impression of the lumbar vertebrae revealed evidence of articular and/or soft tissue inflammatory changes consistent with nerve irritation. Bilateral mild swelling of the lumbar paraspinal muscle consistent with a significant muscle spasm. Findings are consistent with bulging or herniation of the intervertebral discs. An abnormal acoustic pattern is visualized in the bilateral paraspinal musculature, which in conjunction with the appropriate clinical findings is compatible with paraspinal muscle with spasms. Moderate inflammatory response consistent with trauma noted around the L3/L4/L5 facet joints with PSM swelling/strains and left LSM. On 5/2/23 the claimant presented to Benjamin Portal, M.D. of Portal Medical, PC (Applicant). Examination revealed no evidence of atrophy or asymmetry noted in the thoracic spine. There was tenderness noted at paraspinal muscles. Range of motion of the thoracic spine was restricted with flexion and extension. Palpation of the thoracic spine was evident for crepitation, laxity or instability. Hyperextension of thoracic spine did not cause increased pain. Inspection of the lumbar spine revealed no signs of inflammation. Palpation of the lumbar facet revealed pain on both the sides at L3-S1 region. Palpation of the bilateral sacroiliac joint area revealed right and left sided pain. Straight leg raise positive bilaterally. Anterior flexion of lumbar spine was noted to be 50°. Anterior lumbar flexion caused pain. Extension of lumbar spine was noted to be 20°. There was pain noted with lumbar extension. Left lateral flexion of the lumbar spine was noted to be 10°. Left lateral flexion caused no pain. Right lateral flexion of the lumbar spine was noted to be 10°.

There was no pain noted with right lateral flexion. Treatment options included trigger point injections, epidural injections and/or medial branch block injection. The 5/9/23 lumbar spine MRI produced an impression of at L4-L5 level, disc bulge with compression of anterior thecal sac with encroachment of neural foramina. The 5/15/23 lower extremities EMG/NCV testing suggested no evidence of lumbar radiculopathy. On 8/8/23 Dr. Portal conducted a follow-up examination that was substantially similar to that of 5/2/23. Treatment options included trigger point injections, epidural injections, medial branch block injection and/or percutaneous lumbar discectomy and annuloplasty. Dr. Portal performed a lumbar epidural steroid injection under fluoroscopic guidance, epidurogram and lumbar trigger point injections under ultrasonic guidance. On 9/10/23 Benjamin Portal, M.D. (surgeon) and Rafael Robenov, PA-C (surgical assistant) performed lumbar percutaneous discectomy, nucleus pulposus ablation, annuloplasty, and disc injection and radiographic interpretation. The preoperative examination performed the same day documents the claimant presented with complaints of low back pain rated 8/10. Lumbar spine examination revealed no signs of inflammation. Palpation of the lumbar facet revealed pain on both the sides at L3-S1 region. Palpation of the bilateral sacroiliac joint area revealed right and left sided pain. Straight leg raise positive bilaterally. Anterior lumbar flexion caused pain. There was pain noted with lumbar extension. Left lateral flexion caused no pain. There was no pain noted with right lateral flexion. At issue are the 9/10/23 surgeon's and surgical assistant's services.

The burden has shifted to the Respondent as they have raised a medical necessity defense. In order to support a lack of medical necessity defense respondent must "set forth a factual basis and medical rationale for the peer reviewer's determination that there was a lack of medical necessity for the services rendered." See, *Provvedere, Inc. v. Republic Western Ins. Co.*, 2014 NY Slip Op. 50219(U) (App. Term 2nd, 11th and 13th Jud. Dists. 20140. Respondent bears the burden of production in support of its lack of medical necessity defense, which if established shifts the burden of persuasion to Applicant. See generally, *Bronx Expert Radiology, P.C. v. Travelers Ins. Co.*, 2006 NY Slip Op. 52116 (App. Term 1 Dept. 2006). As a general rule, reliance on rebuttal documentation will be weighed in light of the documentary proofs and the arguments presented at the arbitration. Moreover, the case law is clear that a provider must rebut the conclusions and determinations of the IME/peer doctor with his own facts. *Park Slope Medical and Surgical Supply, Inc. v. Travelers*, 37 Misc.3d 19 (2012).

Respondent timely denied the 9/10/23 surgical procedure and all associated services based on the 10/2/23 peer review by Dilip Subhedar, M.D. After reviewing the claimant's history, treatment, and medical records, Dr. Subhedar opines "decompression may be a surgical procedure that is performed to alleviate pain caused by pinched nerves (neural impingement). There are two common types of spine surgery decompression procedures: Microdiscectomy or Open decompression (Discectomy/Laminectomy). Percutaneous discectomies are considered experimental and not the medical standard of care. According to the medical standard of care, the claimant should undergo conservative treatment via chiropractic and physical therapy. Should this fail and there is radiculopathy present, injections should be trialed. The claimant may then be a surgical candidate. However, microdiscectomies are not the medical standard of care." Dr. Subhedar continues "this is cited and supported in [*Citation omitted*]. The patient underwent surgery twice for PELD at L4-L5 in 1 month. Symptoms were not improved

effectively until the conventional posterior discectomy with fusion was performed. No signs of recurrence have been detected in 6 months of follow-up, except for mild lower back pain meeting the temperature change. Rapid decompression and instant therapeutic effect do not mean extending the indications of PELD. It is unreasonable to revise the recurrent LDH or treat the primary LDH with PELD under inadequate preoperative assessment" [*Citation omitted*]. Dr. Subhedar asserts "there is still conflicting information regarding percutaneous discectomies. They have not been proven to be more effective than traditional procedures. MRI was suggestive of a possible nerve root compression. As per the standard of care, 4-6 weeks of conservative care should be attempted. For persistent radiculopathy secondary to a disc pathology epidural should be attempted. And lastly, should this fail this claimant should be referred to a spine surgeon to discuss other treatment options. Recurrent disc herniations and low success rates do not make the risks outweigh the benefits for this procedure" [*Citations omitted*].

When an insurer, through a peer review, 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).

Applicant submitted a 10/14/24 rebuttal by Benjamin Portal, M.D. This report contains quotations from the peer review that appears verbatim above. These quotations are omitted below. After reviewing the claimant's history, treatment, and medical records, Dr. Portal opines "taking into consideration the patient's history, the history of the injury, the patient's complaints, the clinical findings, and a review of the medical history, and in accordance with the generally accepted standards of care in the relevant medical community, the lumbar discectomy and all associated services including physician assistant services provided on 9/10/2023 were medically necessary, within a reasonable degree of medical certainty." Dr. Portal continues "in view of the patient's symptoms and clinical findings upon examination, it was clear that the patient was suffering from lumbar radiculopathy which warranted lumbar discectomy. Radiculopathy is a disease involving a spinal nerve root which may result from compression related to intervertebral disc displacement; spinal cord injuries; spinal diseases; and other conditions. Please also refer to: [*Citation omitted*] "Lumbosacral radiculopathy is a term used to describe a pain syndrome caused by compression or irritation of nerve roots in the lower back. It can be caused by lumbar disc herniation, degeneration of the spinal vertebra, and narrowing of the foramen from which the nerves exit the spinal canal." Typical symptoms include radiating lower back pain, which radiates to one or both legs. Other common symptoms of radiculopathy can be numbness, tingling, reflex abnormalities, and/or weakness. Radiculopathy can be present, however, even without some of these symptoms. I would note that at the time of evaluations, the patient complained of radiating lower back pain and decreased muscle strength in the lower extremities. All these symptoms are consistent with the definition of radiculopathy. Also, a positive Straight Leg Raise test results from gluteal or leg pain by passive straight leg flexion with the knee in extension, and it may correlate with nerve root irritation and possible entrapment with decreased nerve excursion. This clinical neurological test has high sensitivity and low specificity, being an important diagnostic workup in patients with lower back pain and suspected radiculopathy [

*Citation omitted*]. This test has high sensitivity and been in common use for over a century to help diagnose lumbar disc displacement. The patient's MRI findings of disc bulge is clear indication of radiculopathy. "By definition, radiculopathy describes pain that radiates down the legs and is often described by patients as electric, burning, or sharp. The most common underlying cause of radiculopathy is irritation of a particular nerve, which can occur at any point along the nerve itself and is most often a result of a compressive force. In the case of lumbar radiculopathy, this compressive force may occur within the thecal sac, as the nerve root exits the thecal sac within the lateral recess, as the nerve root traverses the neural foramina or even after the nerve root as exited the foramina. It may be related to disc bulging or herniation, facet or ligamentous hypertrophy, spondylolisthesis, or even neoplastic and infectious processes" [*Citation omitted*]. Dr. Portal asserts "I would note that percutaneous discectomy is listed as a Category I CPT code in the AMA Codebook of Reimbursable Procedures. The introduction of the AMA Codebook notes that in order to qualify as a Category I code, the clinical efficacy of the service/procedure is well established and documented in the United States per review literature. This was later reaffirmed by the AMA, where they noted that simply by having a Category I code, a procedure, by definition is not experimental and has a well-established clinical efficacy. Thus, the fact that percutaneous discectomy is listed as a Category I CPT code in the AMA Codebook is further clear evidence that percutaneous discectomy is well-established as an effective procedure. I would submit that percutaneous endoscopic lumbar discectomy (PELD) is safe and effective for the treatment of LDH and can reduce medical costs as day surgery, and it thus warrants increased attention. [*Citation omitted*] stated that outcomes were excellent in 17 patients (80.95%), good in 3 (14.28%) and fair in 1 (4.78%), with no patients having a poor result. In our study, 19 patients (90.47%) were able to resume their previous works/jobs, and only 2 (9.52%) needed to change their jobs for lighter work. The initial and long-term results are very good for endoscopic lumbar discectomy by Destandau's technique. In properly selected patients it is a safe and minimally invasive technique, and we recommend ELD in properly selected patients. Based on the above-mentioned discussion, the lumbar discectomy was medically necessary. Hence, all associated services were also medically necessary." Dr. Portal argues "with respect to annuloplasty: Intradiscal electrothermal therapy (IDET)/annuloplasty is a procedure that was introduced as a minimally invasive treatment option for treating discogenic pain unresponsive to aggressive conservative therapy. It is a minimally invasive technique for the treatment of low back pain caused due to problems with the spinal disc. IDET involves a heat probe inserted into the spine (usually via an endoscope) at the point causing pain. The tissue is heated by the probe, which causes it to shrink and scar. IDET is thought to decrease discogenic pain by 2 different mechanisms: thermal modification of collagen fibers and the destruction of disk nociceptors. The breakage of heat-sensitive hydrogen bonds of the collagen fibers causes collagen contraction. With disk temperatures reaching 650°C, collagen may contract as much as 35% from its original size. The tightening of annular tissue may enhance the structural integrity of the degenerated disk and repair the annular fissures. The process of disk restructuring (as shown by time courses of patients' pain relief) may take several months to reach its full extent. Denervation by thermal energy is used widely for peripheral and central nervous system lesioning and might contribute to partial initial pain relief following the IDET procedure. Intradiscal electrothermal therapy is a procedure of applying heat to the annulus in cases of low back pain due to discogenic conditions that fail to respond to

non-operative techniques. This activity describes the intradiscal electrothermal therapy technique, highlighting the role of the inter-professional team in evaluating and improving care for patients who undergo this lumbar minimally invasive procedure" [*Citation omitted*]. Dr. Portal expounds "with respect to discogram: A discogram is typically performed to help diagnose the cause of back pain and to guide the treatment of abnormal discs. The procedure also may be performed prior to surgery to help identify discs that need to be treated or removed. [*Citation omitted*] concluded that this systematic review illustrates that lumbar provocation discography performed according to the International Association for the Study of Pain (IASP) criteria may be a useful tool for evaluating chronic lumbar discogenic pain. With respect to X-ray (Intra-operative imaging): [*Citation omitted*] concluded that performance of the 3 recommended x-rays may increase the identification of wrong-level exposures before the commencement of decompression and may reduce the length of surgery." Dr. Portal concludes "with respect to physician assistant services: I would note that Rafael Robenov, PA-C., assisted me throughout the lumbar discectomy. He assisted me in this patient's pre-operative and post-operative management. The assistant surgeon plays a vital role before, during, and post-surgery rehabilitation. Assistant surgeons provide a number of services before the operation begins. This work includes re-checking a patient's records and a medical chart to be sure all necessary precautions are made and conferring with the anesthesiologist and other members of the surgical team. Assistant surgeons confirm the appropriate equipment and instruments are available in the room, arranged to fit the preferences of the primary surgeon, according to the Association of Surgical Assistants. Another key duty of an assistant surgeon is creating conditions for the most advantageous positioning of the patient, based on the primary surgeon's wishes. Also, primary surgeons tap assistant surgeons to help in the closure of the surgical cut following the completion of the procedure, according to the Association of Surgical Assistants. Assistant surgeons also may be delegated the task of dressing the wound. Following the surgery, assistant surgeons may examine and assess the patient to be sure no problems arose through the surgical procedure, checking the patient's condition and then aiding the patient's removal from the operating room. As are eligible for reimbursement for first assisting in any procedure where a physician would receive such reimbursement (American Association of Physician Assistants) (CMS). The implementation of physician's assistant in a surgical ward improves continuity in daily clinical work and increases comprehensibility of nurses and physicians; [*Citation omitted*] concluded that the implementation of PA has improved the collaboration of physicians and nurses substantially. Continuity of rounds has improved and the administrative workload for residents decreased substantially. Overall, the implementation of PA was reported to be beneficial for the surgical clinic. Based on the abovementioned discussion, the patient was in need of the lumbar discectomy and annuloplasty performed on 9/10/2023 for the treatment of her lower back pain. Since the procedure was medically necessary, all associated services including physician assistant services required for the performance of the procedure were medically necessary too. Therefore, I conclude that the fees charged for performing the procedures do not violate medical protocol and deserve to be reimbursed."

After review of all of the evidence and listening to oral arguments, I find in favor of Applicant. Respondent failed to sufficiently set forth a standard of care. Dr. Subhedar cites the benefits of the percutaneous discectomy as a shorter recovery time, but states

that there are no other benefits. This is not a "lack of medical necessity" argument, but rather an efficacy argument. Saying there is conflicting information regarding percutaneous discectomies is not the same as saying the standard of care was not met here. Applicant refuted Dr. Subhedar's contentions with Dr. Portal's peer rebuttal. Accordingly, Applicant is awarded \$4,610.58.

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
	<b>Portal Medical PC</b>	<b>09/10/23 - 09/10/23</b>	<b>\$7,393.42</b>	<b>\$4,610.58</b>	<b>Awarded: \$4,610.58</b>
<b>Total</b>			<b>\$7,393.42</b>		<b>Awarded: \$4,610.58</b>

- B. The insurer shall also compute and pay the applicant interest set forth below. 07/25/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest runs from 7/25/24 (the date that arbitration was requested) until the date that payment is made at two percent per month, simple interest, on a pro rata basis using a thirty day month.

C. Attorney's Fees

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

Pursuant to 11 NYCRR §65-4.6 (d), ". . . the attorney's fee shall be limited as follows: 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon for each applicant for arbitration or court proceeding, subject to a maximum fee of \$1,360."

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

02/14/2025

(Dated)

Charles Blattberg

**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:**  
7c99fcf7db892160bd29f5afcb4cdd57

### Electronically Signed

Your name: Charles Blattberg  
Signed on: 02/14/2025