

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Portal Medical PC  
(Applicant)

- and -

Palisades Insurance Company  
(Respondent)

AAA Case No.	17-24-1357-7616
Applicant's File No.	168166
Insurer's Claim File No.	601602280816-002
NAIC No.	10791

**ARBITRATION AWARD**

I, Cathryn Ann Cohen, 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 02/12/2025  
Declared closed by the arbitrator on 02/12/2025

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

Kevin Savage, Esq. from Law Office of William J. Fitzula participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$11,072.24**, was AMENDED and permitted by the arbitrator at the oral hearing.

The amount in dispute was amended to \$7,538.61 per Applicant's counsel's stipulation at the hearing.

Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

Applicant seeks \$7,538.61 reimbursement of charges for the physician's fee (\$6,809.95) and the physician's assistant (PA's) fee (\$728.66) in connection with cervical percutaneous discectomy reported using code 63075, annuloplasty reported using code

22526-59 and associated services provided on September 10, 2023, to Assignor a 53-year-old female passenger involved in a motor vehicle accident on June 9, 2023.

Respondent timely denied reimbursement based on a peer review by Jason Cohen, M.D. dated October 4, 2023, opining that the surgical services were not medically necessary.

In addition, Respondent raises the defense that the fees are not in accordance with the fee schedule.

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

Applicant seeks \$7,538.61 reimbursement of charges for the physician's fee (\$6,809.95) and the physician's assistant (PA's) fee (\$728.66) in connection with cervical percutaneous discectomy reported using code 63075, annuloplasty reported using code 22526-59 and associated services provided on September 10, 2023, to Assignor a 53-year-old female passenger involved in a motor vehicle accident on June 9, 2023. Respondent timely denied reimbursement based on a peer review by Jason Cohen, M.D. dated October 4, 2023, opining that the surgical services were not medically necessary. In addition, Respondent raises the defense that the fees are not in accordance with the fee schedule. I have reviewed the documents contained in the ADR Center record of the case maintained by the AAA as of the date of the hearing.

It is well settled that a health care provider establishes a prima facie case of entitlement to recover first-party no-fault benefits by submitting 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 was overdue. (*see Insurance Law Sec. 5106[a]*; *Mary Immaculate Hosp v. Allstate Ins. Co.*, 5 AD3d 742 [2004]). Respondent's denial(s) indicating receipt of the proof of claim shows that Applicant mailed the proof of claim form(s) to the Respondent (*see Ultra Diagnostic Imaging v. Liberty Mutual Insurance Co.*, 9 Misc3d 97). The evidence is sufficient to make out a prima facie case of entitlement to recovery of Applicant's bill.

Once Applicant has established a prima facie case the burden shifts to the insurer to prove that the medical treatment was not medically necessary (*see Citywide Social Work & Psychological Services v Allstate Ins. Co.*, 8 Misc3d 1025A; *A.B. Medical Services, v Geico Ins. Co.*, 2 Misc3d 26). Neither the Insurance Law nor the Regulations define "medical necessity." A review of case law reveals that most courts have evaluated medical necessity based on whether or not services provided were in accord with the generally accepted medical practices. Therefore, to prove that the services were not medically necessary, at a minimum, lack of necessity must be supported by competent evidence such as an IME or peer review or other proof which sets forth a factual basis and medical rationale for denying the claim. A peer review report's medical rationale is insufficient if it is unsupported by or

controverted by evidence of medical standards (*see Nir v. Allstate Insurance Company* 7 Misc3d 544).

Upon a showing of lack of medical necessity through a peer review, an Applicant is required

to rebut same (*see A Khodadadi Radiology, P.C. v. NY Central Mutual Fire Ins. Co.*, 16

Misc.3d 131(A).

The peer notes that on June 9, 2023, Assignor was a front seat passenger in a vehicle that was rear-ended. Report of examination by Matthew Jordan, PA on June 27, 2023, reported complaints of pain in the neck, low back, right shoulder, bilateral hip, left knee, left ankle and bilateral ribcage, with examination findings of tenderness and limited range of motion in the cervical spine as well as moderate spasm and moderate range of motion in the lumbar spine. There was decreased range of motion in the right shoulder, bilateral hip and left knee. Neurological examination revealed no motor, sensory or reflex deficits. Assignor was recommended physical therapy, chiropractic, orthopedic and pain management evaluation, MRI of the cervical spine, lumbar spine and right shoulder, EMG/NCS testing and prescribed Naproxen 220 mg. The peer discusses the positive findings documented in the cervical spine MRI report dated July 20, 2023. Report of examination by Benjamin Portal, M.D. on August 8, 2023 reported complaints of neck pain radiating to the bilateral shoulder. Physical examination of the cervical spine revealed tenderness, facet pain at C3-C7 and decreased range of motion. Neurological examination revealed motor strength 5/5 except 4/5 in the flexors/extensors upper extremities. Sensation was normal. Assignor was recommended trigger point injection, medial branch block injections, cervical discectomy, ESI, and follow-up. On August 8, 2023, Assignor underwent cervical ESI at C7-T1 by Dr. Portal. Report of examination by Benjamin Portal, M.D. on September 10, 2023, reported complaints of pain in the cervical spine which radiated to the bilateral shoulders. Use of pain medications was documented. Physical examination of the cervical spine revealed positive compression test, cervical facet revealed pain and tenderness at C3-C7 region on both sides. Motor strength was 4/5 on the left upper extremity. On September 10, 2023, Assignor underwent cervical percutaneous discectomy anterior approach, annuloplasty and disc injection and radiographic interpretation at C5-C6 levels by Benjamin Portal, M.D.

The peer asserts that the operative report documents placement of discectomy probe through the cannula into the C5-C6 nucleus for extraction. It does not specify an exact placement of decompression at that level. The peer states such inexact and generalized decompression cannot reasonably be expected to satisfactorily address the multilevel disc herniation identified on MRI of the cervical spine. More concerning, the peer states, is that Dr. Portal fails to indicate the medical necessity

for his choice of decompression at the C5-C6 level despite multilevel pathology and casts doubt on Dr. Portal's competence stating that the complicated pathology identified on MRI is best managed by a skilled spine surgeon.

The peer cites an article which he states suggests that percutaneous discectomy is not the recommended choice of treatment for radiculopathy and an article indicating there is non-convincing evidence as to the efficacy of percutaneous cervical discectomy compared to microdiscectomy. The peer also states that intradiscal annuloplasty is considered experimental with no proven benefit over placebo and that there is inconsistent evidence of efficacy of annuloplasty.

The peer stated the standard of care for radiculopathy is physical therapy and pharmacotherapy including NSAIDs and gabapentinoids for six weeks. If that fails, then then Assignor should have undergone a trial of ESI x 3. The peer asserts that this standard of care has not been met. And even if surgery was considered, Assignor should have been referred to a surgical consultant and/or a neurological consultant for further treatment adding that the treating physician had not ruled out other mechanisms of pain like spasm.

Respondent's evidence fails to set forth sufficient factual basis and medical rationale to establish lack of medical necessity for the disputed cervical percutaneous discectomy and annuloplasty and related services provided to Assignor which it is Respondent's burden to proffer. It is not, as the peer suggests, Applicant's burden to establish the medical necessity of the billed-for services which is presumed. The peer wrongly shifts the burden of proof. Also, lack of proven efficacy for the disputed services provided to Assignor does not establish lack of medical necessity as the judgment of experts often differs on the appropriate treatment approach. Here, the peer review is the peer's opinion standing alone, unsupported by or controverted by evidence of medical standards demonstrating that performance of these services based on the examination findings corroborated by MRI was a departure from generally accepted standard of care.

Moreover, Applicant submits a rebuttal from Benjamin Portal, M.D., Assignor's treating pain management physician which meaningfully addresses the peer review. As regards the placement of decompression at C5-C6 level, his examination Assignor had neck pain radiating to the bilateral upper extremities which are innervated by C5-C6 nerves. Also, the MRI study of the cervical spine revealed disc herniation at C5-C6 level. Hence, the surgery satisfactorily addresses the C5-C6 level. As for the peer's questioning his credentials, Dr. Portal pointed out that he is an anesthesiology specialist with over 7 years of experience and his qualifications are in compliance with standard of care regarding this surgery. The peer completely ignored his September 10, 2023 evaluation documenting a positive cervical compression test/Spurling's test supporting the diagnosis of cervical radiculopathy which warranted cervical discectomy. Contrary to the peer's opinion, percutaneous

cervical discectomy is safe and effective for pain relief and annuloplasty is not experimental. The rebuttal cites an article noting that the approach of coblation annuloplasty combined with nucleoplasty significantly improved pain intensity and functional status in patients with cervical discogenic and radicular pain and is an effective, safe, minimally invasive and less uncomfortable procedure.

The rebuttal from the treating physician is more informed than the opinion of the peer and thus, is sufficient to refute the peer review. Applicant is entitled to reimbursement.

As regards the appropriate fees for the disputed services provided to Assignor, Respondent submits an affidavit from its coder, Carolyn Mallory, CPC to support a reduction of the bill.

Here, Applicant reported code 63075 for the physician and 63075-83 for the PA. Code 63075 is defined as "Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace". This code is not supported. This is an "open" procedure. The operative report does not indicate this was performed. Rather, the operative report indicates services were performed percutaneously using fluoroscopic guidance.

The coder notes that had the provider not performed 22526 (percutaneous intradiscal electrothermal annuloplasty; single level) the correct code to report would have been 62287/0274T and not 63075. However, 62287 (percutaneous decompression of disc) cannot be reported with 22526. The coder references the "AMA CPT Knowledge Base" noting that percutaneous discectomy is an integral and included component of the procedure described by code 22526. Also, per AMA CPT Knowledge Base, the coder notes that codes 62291 & 62291-83 (injection for discography) & 72285 & 72285-83 (discography) are included in 22526 and cannot be separately reported.

The coder allows reimbursement per fee schedule for code 22526-59 reported by the physician in the amount of \$2,738.59; and reimbursement per fee schedule for code 22526-83 reported by the PA in the amount of \$293.03. Total reimbursement allowed at \$3,031.62.

Respondent's coder's reimbursement amounts are supported by substantial evidence. Applicant submits no coder affidavit or any evidence from a competent medical professional to challenge Respondent's evidence on the appropriate fees for the reported codes billed.

Accordingly, Applicant's request for reimbursement is granted in the amount of \$3,031.61.

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
	Portal Medical PC	09/10/23 - 09/10/23	\$11,072.24	\$7,538.61	Awarded: \$3,031.62
Total			\$11,072.24		Awarded: \$3,031.62

- B. The insurer shall also compute and pay the applicant interest set forth below. 07/24/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

In accordance with 11 NYCRR 65-3.9(c) interest shall be paid on the claim awarded in the amount of \$3,031.62 from July 24, 2024 the date the arbitration request was received by the AAA.

C. Attorney's Fees

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

In accordance with 11 NYCRR 65-4.6(d) the insurer shall pay Applicant an attorney's fee on the claim awarded in the amount of \$3,031.62.

- 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 New York

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

02/27/2025

(Dated)

Cathryn Ann Cohen

**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:**  
47f396649342ff1c43832760cd10fe81

### **Electronically Signed**

Your name: Cathryn Ann Cohen  
Signed on: 02/27/2025