American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Precise Medical Solutions LLC (Applicant)	AAA Case No.	17-24-1349-6834
	Applicant's File No.	BT24-278416
- and -	Insurer's Claim File No.	1134381-01
	NAIC No.	16616
American Transit Insurance Company (Respondent)		

ARBITRATION AWARD

I, Fred Lutzen, 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: EIP or "Assignor"

1. Hearing(s) held on 03/26/2025
   Declared closed by the arbitrator on 03/26/2025

   Sabine Sciarrotto, Esq., from The Tadchiev Law Firm, P.C. participated virtually for the Applicant

   Erisa Ahmedi, Esq., from American Transit Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$1,838.39**, 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 male EIP (first initial "N") was 54-years-old when he was injured as the driver in an automobile accident on 7/21/2023. He subsequently underwent lumbar percutaneous discectomy with interoperative monitoring / EDX on 2/4/2024. Applicant seeks reimbursement of $1,838.39 for interoperative monitoring services and the technical component of the EDX services.

   Respondent denied the claim for lack of medical necessity in reliance on a peer review report prepared by Dr. Gary L. Yen, M.D., dated 3/26/2024. Applicant submitted a rebuttal report by Dr. Aristide Burducea, D.O. dated 2/19/2025.

The issues presented are (1) whether the percutaneous lumbar discectomy with interoperative monitoring was medically necessary and, if so (2) whether the charges are within fee schedule allowances.

4. Findings, Conclusions, and Basis Therefor

This case was decided based on prevailing law, the submissions of the parties as contained in the electronic file ["MODRIA"] maintained by the American Arbitration Association, and the oral arguments of the parties' representatives. There were no live witnesses.

Unless the parties' agreement provides otherwise, arbitrators need not apply the rules of evidence, are not bound by principles of substantive law, may do justice as they see it, and may apply their own sense of law and equity to the facts as they find them to be. Matter of New Century Acupuncture, P.C. v. Country Wide Ins. Co., 48 Misc.3d 1201(A), 18 N.Y.S.3d 580 (Table), 2015 N.Y. Slip Op. 50919(U) at 2, 2015 WL 3821534 (Dist. Ct. Suffolk Co., C. Stephen Hackeling, J., June 18, 2015); see also, *Rules for Arbitration of No-Fault Disputes in the State of New York*; Effective August 16, 2013, [p](1), "The arbitrator shall be the judge of the relevance and materiality of the evidence offered, and strict conformity to legal rules of evidence shall not be necessary." https://nysinsurance.adr.org.

Note: While it is noted that in rebuttal that Dr. Burducea disputes Dr. Yen's purported opinion that there was no causal-relationship to the MVA of 7/21/2023, it should be pointed out that Dr. Yen did not, in fact, dispute the causal-relationship. Dr. Yen's peer opinion is limited to the issue of medical necessity.

Medical Necessity

The burden is on the Respondent to demonstrate, prima facie, that the services lacked medical necessity. Respondent's denial for lack of medical necessity must be supported by a peer review or other competent medical evidence which sets forth a clear factual basis and medical rationale for denying the claim. Healing Hands Chiropractic, P.C. v. Nationwide Assurance Co., 5 Misc.3d 975, 787 N.Y.S.2d 645 (Civ. Ct. New York Co. 2004); CityWide Social Work & Psy. Serv., P.L.L.C. v. Travelers Indemnity Co., 3 Misc.3d 608, 609, 777 N.Y.S.2d 241, 242 (Civ. Ct. Kings Co. 2004).

To successfully support its denial, the respondent's peer review must address all of the pertinent objective findings contained in the applicant's medical submissions. The peer review must set forth how and why the disputed services were inconsistent with generally accepted medical and/or professional practices. The conclusory opinions of the peer reviewer, standing alone and without support of medical authorities, will not be considered sufficient to establish the absence of medical necessity. (See, Citywide Social Work, et. al. v. Travelers Indemnity Co., *supra*; Amaze Medical Supply Inc. v. Eagle Ins. Co., 2 Misc.3d 128(A), 784 N.Y.S.2d 918 (Table), 2003 N.Y. Slip Op. 51701(U), 2003 WL 23310886 (App. Term 2d & 11th Dists. Dec. 24, 2003).

Defense

On 3/26/2024, Dr. Yen reviewed numerous medical records, including the operative report, evaluation reports, the lumbar MRI report, treatment records, and other records. Based on a review of the records, Dr. Yen opined that the percutaneous lumbar discectomy and the interoperative monitoring deviated from the standard of care and lacked medical necessity.

Dr. Yen summarized the patient's history, which included initial complaints of low back pain following the accident. The EIP received physical therapy and low-level laser light therapy beginning 7/26/2023 and through February 2024. The EIP received chiropractic treatment from 9/15/2023 through 11/3/2023. The lumbar spine MRI revealed, "Grade I retrolisthesis of L5 on S1. L4-L5, 2 mm central disc herniation impresses on the thecal sac. L5-S1, 3 mm central disc herniation, and annular disc bulge impress on the anterior epidural space with bilateral neural foraminal narrowing."

Dr. Yen noted that the EIP was evaluated by Dr. Joseph Jiminez, M.D., on 1/30/2024, and the EIP "continued to complain of pain in the neck, mid-back, and lower back. … The lumbar spine examination revealed pain and decreased ROM with a positive SLR test bilaterally. He was advised to continue physical therapy & chiropractic care. He was recommended caudal epidural steroid injection, lumbar trigger point injection with lumbar and cervical discectomy."

Dr. Yen opined that the standard of care was not met and that the percutaneous lumbar discectomy performed on 2/4/2024 was not medically necessary. Dr. Yen stated, in part:

> According to the medical standard of care, discectomies are recommended after conservative treatment and injection therapy have been trialed and exhausted. However, there is conflicting data around the use of percutaneous discectomies.
>
> These types of surgical procedures have not been established as the medical standard of care. According to Lühmann D, et al, "The literature search retrieves no controlled trials to assess efficacy and/or effectiveness of laser-discectomy, percutaneous manual discectomy or endoscopic procedures using a posterior approach in comparison to the standard procedures. Results from recent case series permit no assessment of efficacy, especially not in comparison to standard procedures. Due to highly selected patients, modification of operative procedures, highly specialized surgical units and poorly standard[ized] outcome assessment results of case series are highly variable, their general [advisability] is low."
>
> Also cited in Kim, et al, "While percutaneous endoscopic lumbar discectomy showed better results than open lumbar microdiscectomy in some items, open lumbar microdiscectomy still showed good clinical results, and it is therefore reckoned that a randomized controlled trial with a large sample size would be required in the future to compare these two surgical methods."
>
> Percutaneous discectomy (nucleoplasty), laser discectomy, and disc coblation therapy are not recommended as treatment for any back or radicular pain syndrome.

> There is conflicting data regarding this type of procedure. The medical standard of care, given the claimant has radiating pain evidenced by nerve root compression on MRI, is to undergo conservative treatment of 4-6 weeks, modify if this fails, trial injection therapy, and then undergo a spine surgeon consult. A percutaneous discectomy is not the medical standard of care. In addition, any services including supplies or any associated/derivative services would not meet the standard of care and are therefore also not medically necessary.

In sum, Dr. Yen's opinions are (1) that discectomies **are recommended** after conservative treatment and injection therapy failed, (2) that percutaneous discectomies **have conflicting data** and are not the standard of care, (3) that the **literature does not assess** the efficacy and/or effectiveness of percutaneous discectomy, and (4) that these procedures are **highly variable** and **general advisability** is low.

Dr. Yen cited a reference that suggests 4-6 weeks of treatment, MRI, and if treatment and injection fails, then see the surgeon.

Rebuttal Case

In rebuttal, Applicant relies on the submitted records and a rebuttal report by Dr. Burducea, who disagrees with Dr. Yen.

Dr. Burducea cited and quoted from the International Society for the Advancement of Spine Surgery guidelines, which state, "A large body of evidence shows that, in patients with unremitting symptoms despite a reasonable period of nonsurgical treatment, discectomy surgery is safe and efficacious. In patients with symptoms lasting greater than 6 weeks, various forms of discectomy (open, microtubular, and endoscopic) are superior to continued nonsurgical treatment." (emphasis/underline from original).

Dr. Burducea noted this article's "requirements for discectomy intervention are as follows: [] 1) **Radiculopathy confirmed on history and physical examination**. AND 2) EITHER **Disabling leg or back pain refractory to 6 weeks of conservative care** including any one of the following: **time**, physician structured exercise regimen, lumbar epidural therapy, **or physical/chiropractic therapy**….. [OR] …." (emphasis from original).

Dr. Burducea added, "**Thus, in accordance with the aforementioned guidelines and the standard of care that they represent, the patient was an ideal candidate for discectomy intervention**. The procedure was medically necessary, as the patient met the aforementioned criteria after failing to reasonably improve following an appropriate conservative course of treatment." (emphasis from original).

Dr. Burducea opined, "Given the patient's subjective reports of lower back pain radiating to the bilateral lower extremities with associated difficulty performing activities of daily living, it was entirely likely that the patient suffered from lumbosacral radiculopathy secondary to a disc pathology based on their history and presentation alone."

Analysis

I am now tasked with weighing these competing reports to determine which is more persuasive on the issue of medical necessity.

I find Dr. Burducea's opinion more persuasive. Dr. Burducea provided a contrary rationale to support medical necessity for the percutaneous lumbar discectomy and contrary medical authority to support this opinion that the procedure was medically necessary. While not always determinative, the treating physician's opinion is entitled to some deference. Oceanside Medical Healthcare, P.C. v. Progressive Ins., 2002 N.Y. Slip Op. 50188(U) at 5, 2002 WL 1013008 (Civ. Ct. Kings Co., Jack M. Battaglia, J., May 9, 2002).

In fact, upon further review of Dr. Yen's opinion and cited references, it is difficult to understand where the provider purportedly went wrong or deviated from the standards of care discussed by Dr. Yen. Dr. Yen noted the months of therapy and MRI findings. The medical records document lumbar injections performed prior to the discectomy on 2/4/2024 with 80% relief but only temporary. The medical records document ongoing radiating pain through 1/30/2024.

After considering the medical records and opinions by Dr. Yen and Dr. Burducea, I find that the preponderance of credible evidence supports that the percutaneous lumbar discectomy performed on 2/4/2024 was medically necessary.

Interoperative Monitoring / EDX

Regarding the interoperative monitoring services, Dr. Yen opined it was not necessary and cited/quoted the following:

> Cited in Laratta, Joseph L., et al: "There are many conflicting reports on the validity and necessity of IONM in the literature, which calls for a prospective randomized trial to rigorously evaluate the long-term outcome and cost effectiveness of IONM from a national healthcare perspective.
>
> Cited in Zhang, Lingling, et al: "In addition, the real impact of IONM on the neurological outcomes after surgery remains debated although some control studies have been conducted".

Dr. Yen opined, in part, "The conclusion from recent studies suggest that there are not sufficient evidence that the use of intraoperative neurophysiologic monitoring (IOM) has reduced rates of postoperative neurological complications. As such, routine IOM for **this type of procedure is questionable**." (emphasis added).

Dr. Yen's opinion is insufficient to meet Respondent's burden of proof. Just because there is a difference of opinion in the medical community, it does not mean that a

procedure is medically unnecessary under all circumstances. Dr. Yen cited references that suggest it is questionable and that "it remains debated although some control studies have been conducted."

In any event, Dr. Burducea cited contrary authority and offered a more persuasive contrary opinion that supports the medical necessity of the IONM or interoperative monitoring services.

Fee Schedule

Pursuant to *11 NYCRR, Section 65-3.16*, Measurement of no-fault benefits, (a) Medical expenses, (1), "Payment for medical expenses shall be in accordance with fee schedules promulgated under section 5108 of the Insurance Law and contained in Part 68 of this Title (Regulation 83).

The Workers' Compensation fee schedule, which is required by law and incorporated by reference into the Insurance Department Regulations, is of such sufficient authenticity and reliability that it may be given judicial notice, and need not be submitted to the court. Z.A. Acupuncture, P.C. v. Geico Ins. Co., 33 Misc.3d 127(A), 939 N.Y.S.2d 745 (Table), 2011 N.Y. Slip Op. 51842(U), 2011 WL 4949646 (App. Term 2d, 11th & 13th Dists. Oct. 11, 2011); Lvov Acupuncture, P.C. v. Geico Ins. Co., 32 Misc.3d 144(A), 939 N.Y.S.2d 741 (Table), 2011 N.Y. Slip Op. 51721(U), 2011 WL 4424472 (App. Term 2d, 11th & 13th Dists. Sept. 16, 2011).

As such, I take appropriate evidentiary notice of the NY WC Fee Schedule and its ground rules. If the fees can be determined from a straightforward reading of the fee schedule, no coder affidavit or fee audit is required. Absent a straight-forward reading confirming the correct rate, Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. *See*, Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 2006 NY Slip 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006).

The CPT Codes, billed amounts, and calculations from a **straightforward reading** of the fee schedule are as follows:

CPT	Billed	RVU	R4 CF	PC/TC	Allowed
95940x2	147.45	6.66x2	11.07	n/a	147.45
95955-TC	336.97	30.44	11.07	5%	16.85
95938-TC	683.79	61.77	11.07	85%	581.22
95937-TC	295.79	13.36	11.07	20%	29.58
95870-TCx2	374.39	16.91x2	11.07	20%	74.88

Totals	**$1,838.39**				**$849.98**

** **Note: where applicable, the table lists only the technical component split**

Modifier TC indicates these charges are for the technical components, only. It is noted that the professional component was billed by another provider in **AAA Case No. 17-24-1349-6813**, which was heard on the same day and is contemporaneously decided.

Conclusion

Having carefully considered the submissions of the parties, the relevant case law, and the arguments of respective counsel, I conclude that the preponderance of the credible evidence supports a finding in favor of Applicant.

Applicant is awarded $849.98.

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
	Precise Medical Solutions LLC	**02/04/24 - 02/04/24**	**$1,838.39**	**Awarded: $849.98**
Total			**$1,838.39**	**Awarded: $849.98**

B. The insurer shall also compute and pay the applicant interest set forth below. 05/28/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant is awarded interest pursuant to the no-fault regulations. *See generally*, 11 NYCRR §65-3.9. 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); and OGC Op. No. 10-09-05 (interest accrues from date Applicant "*actually requests arbitration*" or commences a lawsuit). The Superintendent and the New York Court of Appeals have 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

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 $1360." *Id*.

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 Onondaga

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

04/07/2025
(Dated)

Fred Lutzen

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:
ed7da926c059af2cbd8654107d9d41d4

Electronically Signed

Your name: Fred Lutzen
Signed on: 04/07/2025