

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Excel Surgery Center, LLC
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No.	17-16-1037-9404
Applicant's File No.	119626
Insurer's Claim File No.	0128261601010171
NAIC No.	35882

ARBITRATION AWARD

I, Paul Weidenbaum, 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: IP

1. Hearing(s) held on 03/28/2017
Declared closed by the arbitrator on 03/28/2017

Roman Kulik from Kulik Law Firm, PC participated in person for the Applicant

Morgan McKay from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 3,936.34**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant amended the claimed amount from \$3,936.34 to \$3,105.16 at the arbitration hearing.

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

3. Summary of Issues in Dispute

Whether the sacroiliac joint blocks administered on 1/29/16, and the lumbar facet joint injections administered on 2/6/16 were medically necessary in light of the Respondent's peer reviews dated 3/14/16 and 3/25/16, respectively.

4. Findings, Conclusions, and Basis Therefor

This arbitration arises out of medical treatment for the IP, a 72 year old female, related to injuries sustained in a motor vehicle accident which occurred on 11/25/15. Applicant seeks reimbursement for bilateral sacroiliac joint blocks administered on 1/29/16, and for bilateral lumbar facet joint injections on 2/6/16. Respondent timely denied payment of the 1/29/16 and the 2/6/16 dates of service based upon peer reviews of Dr. Weiss dated 3/14/16 and 3/25/16, respectively. Applicant has submitted a rebuttal by Dr. Popa dated 6/16/16.

It is the Applicant's prima facie obligation to establish its entitlement to payment for each service for which reimbursement is sought. It is well-settled that a health care provider establishes its prima facie entitlement to payment as a matter of law by proof that it submitted a proper claim, setting forth the fact and the amount charged for the services rendered and that payment of no-fault benefits was overdue (see Insurance Law Section 5106(a); *Mary Immaculate Hosp. v. Allstate Ins. Co.*, 5 AD 3d 742, 774 N.Y.S. 2d 564 [2004]; *Amaze Med. Supply v. Eagle Ins. Co.*, 2 Misc. 3d 128(A), 784 N.Y.S. 2d 918, 2003 N.Y. Slip Op 51701U [App. Term, 2nd and 11th Jud. Dists.]). Applicant has met its prima facie burden in the instant matter.

Upon proof of a prima facie case by the Applicant, the burden shifts to the insurer to prove that the services were not medically necessary. *A.B. Medical Services, PLLC v. Lumbermen's Mutual Casualty Company*, 4 Misc. 3d 86, 2004 NY Slip Op 24194 [App. Term 2nd & 11th Jud. Dists. 2004]; *Kings Medical Supply, Inc. v. Country-Wide Insurance Company*, 5 Misc. 3d 767, N.Y. Slip Op 24394 [Civ. Ct. Kings Co. 2004]; *Amaze Medical Supply, Inc. v. Eagle Insurance Company*, 2 Misc. 3d 128(A), 2003 N.Y. Slip Op 51701U (App. Term 2nd & 11th Jud. Dists. 2003).

It is Respondent's obligation to object to any deficiencies in Applicant's submissions by either formally objecting to any error or omission, or by seeking additional information. Since Respondent failed to object to the completeness of the forms submitted by Applicant or to seek verification of same as required pursuant to 11 NYCRR 65-3.5, Respondent waived any defense based thereon (see *Hospital For Joint Diseases v. Allstate Ins. Co.*, 21 AD 3d 348, 800 N.Y.S. 2d 190 [2005]; *Nyack Hosp. v. Metropolitan Prop. & Cas. Ins. Co.*, 16 AD 3d 564, 791 N.Y.S. 2d 658 [2005]; *New York Hosp. Med. Ctr. Of Queens v. New York Cent. Mut. Fire Ins. Co.*, 8 AD 3d 640, 779 N.Y.S. 2d 548 [2004]).

If an insurer asserts that the medical test, treatment, supply or other service was medically unnecessary, the burden is on the insurer to prove that assertion with competent evidence such as an independent medical examination, a peer review, or other proof that sets forth a factual basis and a medical rationale for denying the claim. (see *A.B. Medical Services, PLLC v. Geico Insurance Co.*, 2 Misc. 3d 26 [App. Term, 2nd & 11th Jud. Dists. 2003]; *Kings Medical Supply, Inc. v. Country-Wide Insurance Company*, 2 Misc. 3d 128 [App. Term, 2nd & 11th Jud. Dists. 2003]).

When an insurer relies upon a peer review report to demonstrate that a particular service was not medically necessary, the peer reviewer's opinion must be supported by sufficient factual evidence or proof and cannot simply be conclusory. As per the holding in *Jacob Nir, M.D. v. Allstate Insurance Company*, 7 Misc. 3d 544 [2005], the peer reviewer must establish a factual basis and a medical rationale to support a finding that the services were not medically necessary, including setting forth generally accepted standards in the medical community. The opinion of the insurer's expert, standing alone, is insufficient to carry the insurer's burden of proving that the services were not medically necessary. *Citywide Social Work & Psychological Services, PLLC v. Travelers Indemnity Co.*, 3 Misc. 3d 608, 777 N.Y.S. 2d 241 [Civ. Ct. Kings Co. 2004].

In his 3/14/16 and 3/25/16 peer reviews, Dr. Weiss concluded the sacroiliac joint blocks administered to the IP on 1/29/16 and the lumbar facet joint injections administered on 2/6/16, respectively, were not medically necessary. Specifically, Dr. Weiss, in his peer reviews of 3/14/16 and 3/25/16, opined that there was no "consistent evidence" of either sacroiliac-mediated or lumbar facet joint-mediated pain. Rather, in Dr. Weiss' view, the symptomatology described was of diffuse pain throughout the lumbosacral spine, and was consistent with either myofascial pain or musculoskeletal pain. Dr. Weiss further noted that trigger point injections should be considered prior to the administration of a sacroiliac joint block. Dr. Weiss referred to the 1/19/16 initial visit to Dr. Popa's office, at which time the IP presented with complaints consisting of lower back pain radiating into the buttocks, hips, and upper thighs. There was reportedly restricted motion on extension and rotation, as well as tenderness bilaterally in the lumbar spine from L3 to L5 in what is described by Dr. Popa as facet joint levels, and tenderness over the right and left sacroiliac joints. There was a positive sacroiliac distraction test bilaterally. Dr. Weiss states that sacroiliac joint blocks were not medically necessary for this IP, and that sacroiliac joint blocks are recommended for patients with a specific cause of 'sacroiliitis', citing the New York State Workers Compensation Board Mid and Low Back Injury Medical Treatment Guidelines 2d Edition, effective March 1, 2013. With respect to lumbar facet joint injections, Dr. Weiss cites the Workers Compensation Board Guidelines to the effect that such injections may be recommended for patients with chronic back pain which is significantly exacerbated by extension and rotation, and not alleviated with conservative treatment, in order to determine whether specific interventions targeting the facet joint are recommended.

Where the Respondent presents sufficient evidence to establish a defense based upon the lack of medical necessity, the burden then shifts to the Applicant which must then present its own evidence of medical necessity. [see *Prince, Richardson On Evidence Sections 3-104, 3-202 (Farrell 11th ed.)*], *Andrew Carothers, M.D., P.C. v. Geico Indemnity Company*, 2008 N.Y. Slip Op 50456U, 18 Misc. 3d 1147A, 2008 N.Y. Misc. LEXIS 1121, *West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co.*, 13 Misc. 3d 131, 824 N.Y.S. 2d 759, 2006 N.Y. Slip Op 51871U (Sup. Ct. App. Term 2d Dept. 2006).

In support of the claim, Applicant relies upon the IP's medical records and a rebuttal by Dr. Popa. Dr. Popa notes that the MRI study of the lumbar spine dated 12/3/15 revealed disc bulges at L2-L3, L3-L4, L4-L5 and L5-S1, and that the patient complained of

severe low back pain radiating into her buttocks, thighs and hips. Despite a course of physical therapy and medications, the IP still had extreme lumbar spine pain with radicular symptoms as of the date of her initial visit to Dr. Popa for an evaluation on 1/19/16. During the clinical examination on 1/19/16, severe tenderness on palpation over the bilateral paravertebral lumbar facet joints at L3-L4, L4-L5 and L5-S1 was observed, in addition to severe tenderness on palpation of the bilateral sacroiliac joints. Dr. Popa diagnosed bilateral lumbar facet arthropathy at the L3-L4, L4-L5 and L5-S1 levels in addition to bilateral sacroiliac joint arthropathy. Because she had failed to obtain any benefit in terms of relief from her symptoms of pain from conservative therapy, Dr. Popa determined that bilateral sacroiliac joint blocks and bilateral lumbar facet joint injections were warranted.

Dr. Popa notes that facet joint injections as well as sacroiliac joint blocks have both a diagnostic and a pain relief purpose. A sacroiliac joint block is used to diagnose and treat lower back pain and symptoms of sciatica, which this IP exhibited. In direct response to Dr. Weiss' contention that the administration of the injections was not medically necessary, Dr. Popa asserts that in this case there was a combination of the IP's subjective complaints and objective clinical findings which demonstrated a strong likelihood of the diagnosis necessitating the procedure. The IP's clinical exam revealed lumbar and sacroiliac arthropathies, and the appropriate standard of care was, in the first instance, to attempt conservative therapy. However, once it was apparent after more than a month of conservative care that the IP's symptoms of extreme lower back pain with radiation had not improved, more aggressive treatment in the form of sacroiliac joint blocks and lumbar facet joint injections was indicated, and such treatment was in accordance with generally accepted standards of medical practice.

Respondent submitted an addendum dated 8/2/16 to Dr. Weiss' peer review. In the addendum, Dr. Weiss states that nothing in Dr. Popa's rebuttal caused him to change the opinions expressed in his original peer reviews because the clinical picture presented by this IP's examination, in Dr. Weiss' view, was one of diffuse pain throughout the lumbar and sacral regions, which is more consistent with musculoskeletal pain. Dr. Weiss further contends that it was medically unsound not to perform a re-evaluation of the IP after the sacroiliac joint blocks had been administered [on 1/29/16] and prior to the administration of the lumbar facet joint injections [on 2/6/16]. However, this arbitrator takes note of the fact that on 2/6/16, when the IP returned to Excel Surgery Center to undergo the administration of the lumbar facet joint injections, prior to the procedure being performed, she reported that her pain in the sacral region had resolved after the bilateral sacroiliac joint blocks, although she still had pain in the lumbar region.

I find that the Applicant in the case of this IP was confronted with subjective complaints as well as objective clinical findings of persistent pain in the lumbar and sacral regions after a considerable period during which conservative therapy had been attempted. These circumstances led Dr. Popa to conclude it was probable the IP had sacroiliac-mediated [pain as well as lumbar facet joint-mediated pain, and that she would benefit from the injections administered on 1/29/16 and 2/6/16, respectively. This arbitrator further notes the fact the IP reported a significant improvement if not an elimination of the sacral pain after the administration of the first set of injections to that region.

I therefore find the rebuttal to the peer review sufficient to meet the Applicant's burden on the issue of medical necessity. The rebuttal meaningfully refers to and rebuts the conclusions set forth in the peer review reports. The addendum to the peer review essentially restates the opinions expressed in the original peer review, and does not add to an understanding of the medical necessity of the injections in any consequential way. *High Quality Medical, P.C. v. Mercury Ins. Co.*, 26 Misc. 3d 145A, 2010 N.Y. Slip Op 50447U (Sup. Ct. App. Term, 2nd Dept. 2010). 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 done so. The opinion of the insurer's expert, standing alone, is insufficient to meet the burden of proving that the administration of the injections in question was not medically necessary. (see *Citywide Social Work & Psychological Services, PLLC v. Travelers Indem. Co.*, 3 Misc. 3d 608 (Civ. Ct. Kings Co. 2004). Moreover, I find that the peer reviews did not discuss the specific conditions and complaints of this IP and correlate them to the determination that the subject treatment was not medically necessary.

Accordingly, after a careful review of the records and consideration of the parties' oral arguments, I find as a matter of fact that Applicant has met its burden of establishing a prima facie case, and Respondent failed to rebut it by a preponderance of the credible evidence that the services were not medically necessary. I therefore find for the Applicant. This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator.

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
Excel Surgery Center, LLC	01/29/16 - 02/06/16	\$3,936.34	Awarded: \$3,105.16
Total		\$3,936.34	Awarded: \$3,105.16

B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 06/28/2016, which is a relevant date only to the extent set forth below.)

Interest runs from the filing date for this case 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

After calculating the sum total of the first-party benefits awarded in this arbitration plus the interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20% of that sum total, subject to a minimum of \$60 and a maximum of \$850. See, 11 NYCRR 65-4.6(c) and (e). However, if the benefits and interest awarded thereon is equal to or less than the Respondent's written offer during the conciliation process, the attorney's fee shall be based upon the provisions of 11 NYCRR 65-4.6(b). For cases filed after February 4, 2015, there is no minimum fee and a maximum fee of \$1,360.00.

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 New York
 SS :
 County of NASSAU

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

03/31/2017
(Dated)

Paul Weidenbaum

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:
8403886270defd4d7be5d27a50fac0cd

Electronically Signed

Your name: Paul Weidenbaum
Signed on: 03/31/2017