American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Kissena Medical Imaging PC (Applicant)	AAA Case No.	17-16-1040-6448
	Applicant's File No.	
- and -	Insurer's Claim File No.	0347292340101026
	NAIC No.	35882
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Joseph Endzweig, 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: claimant

1. Hearing(s) held on 10/24/2017
   Declared closed by the arbitrator on 10/24/2017

   Chris Arzberger, Esq. from Economou & Economou PC participated in person for the Applicant

   Ann Troxler, Esq. from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 2,670.40**, 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

   This arbitration arises out of treatment of a 41 year old male for injuries sustained in a motor vehicle accident which occurred on 12/2/15. Applicant seeks reimbursement for an MRI of the right shoulder performed on 1/12/16, billed at $878.67, an MRI of the cervical spine performed on 1/19/16 billed at $879.73, and an MRI of the lumbar spine performed on 1/26/16 billed at $912.00. Respondent issued timely denials denying reimbursement based on the Peer Review reports of Dr. Alan P. Wolf and Dr. Ron Amidror.

4. Findings, Conclusions, and Basis Therefor

I have reviewed the documents contained in the Electronic Case Folder as of the date of the hearing and this Award is based upon my review of the Record and the arguments made by the representatives of the parties at the Hearing.

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According to the records submitted by the parties, the patient was the driver of a vehicle that was struck in the rear. The patient denied loss of consciousness. He was not taken to a hospital. He presented to Dr. Dong Hwan Lee, chiropractor, on 12/8/15 with complaints of neck pain and low back pain. Physical examination revealed decreased range of motion of the lumbar and the cervical spine. The following orthopedic tests were positive: Jackson's compression, Cervical distraction, Kemps, Yeomen's, and SLR. Neurological tests were normal. Muscle testing was within normal limits except for right C5 which was 4/5. Sensory testing was normal. Treatment plan consisted of chiropractic care. Dr. Lee ordered MRI of the cervical spine on 1/13/16 and MRI of the lumbar spine on 1/25/16. The patient was also treated by Dr. Alan Ng. Initial Consultation was on 12/11/15. MRI of the right shoulder was ordered on 1/5/16.

Respondent submits peer review reports from Dr. Alan P. Wolf and Dr. Ron Amidror.

Dr. Amidror concludes that the MRI's of the cervical and lumbar spine were not medically necessary. He notes that claimant presented with soft tissue (sprain/ strain) injuries mainly to the cervical, thoracic, and lumbar spine. He states that it was appropriate for the chiropractor to start six to eight weeks of conservative chiropractic care (which includes: manipulation, soft tissue treatment with physiomodalities) while knowing that this claimant was also receiving physical therapy (which includes: soft tissue/massage treatment, superficial heat/cold and electrotherapy) multiple times per week. He notes that the claimant presented with soft tissue injuries, without significant neurological findings and/or chiropractic red flags. Dr. Amidror states that according to the New England Journal of Medicine, Low Back Pain, Volume 344 pages 363-370, February 1, 2005, MRI is indicated if substantial pain is still present four to six weeks after the initiation of treatment or if there are progressive neurological deficits. Also MRI study of the lower back is typically ordered if pain persists and objective neurological deficits are found such as diminished or decreased lower extremities DTR'S, decrease in sensation and/or muscle strength diminished. American Family Physician, Neuroimaging in lower back pain, 2002, 2217-2218. Dr. Amidror notes that the current evidence-based guidelines for diagnostic imaging, state that a patient should

be referred for advanced imaging if lumbar pain persists more then 4-6 weeks despite conservative care or if there are progressive neurological signs/ symptoms and a surgical referral is planned. The most common progressive neurologic finding is radicular pain. He states that in the case of cervical radiculopathy which has a patient presentation of severe neck and arm pain according to this article, an MRI study should be rendered only at the presence of progressive neurological deficits or if a patient's pain persists longer than 4-6 weeks despite the fact that the patient has conservative care.

Dr. Alan Wolf concludes that the MRI of the right shoulder was not medically necessary. He notes that according to the records Dr. Ng evaluated the claimant on 12/11/15 with neck pain radiating to the right shoulder and back pain radiating to the left knee. His diagnoses with respect to the right shoulder was right shoulder sprain. Dr. Ng treated the claimant with physical therapy and Motrin. He re-evaluated the claimant on 01/05/16 and recommended continued physical therapy. Dr. Ng ordered MRI of the right shoulder on 1/5/16. It was performed on 1/12/16. Dr. Wolf notes that physical examination findings on 1/5/16 were significant for range of motion restriction of the right shoulder with tenderness in the deltoid. Motor strength was 4/5. There was a positive apprehension test. There was no evidence of instability. Dr. Wolf maintains that the claimant underwent MRI of the right shoulder prematurely, prior to receiving an adequate trial of at least 6 weeks of physical therapy. He notes that there were no red flag findings reported. He states that MRI studies should not be used as screening tools. He states that the claimant did not require more aggressive treatments on an urgent basis. He states that the type of exercises and modalities used within a physical therapy program would not be dependent upon the results of an MRI study. He states that this study was not needed to alter the medical/surgical treatment options for this claimant. Dr. Wolf maintains that the standard of care for MRI studies of the musculoskeletal system after a motor vehicle accident would begin with a reasonable trial of conservative treatment with physical therapy for at least six weeks. If the claimant did not respond to the therapy program and had clinical evidence of a progressive orthopedic deficit, MRI might be indicated. He notes that results of the MRI study would be expected to impact the claimant's treatment options such as surgery. He states that this was not the case for this claimant. Dr. Wolf notes that according to Clinical UM Guidelines, except for suspected total cuff rupture or gross instability, an MRI is appropriate when symptoms are not responsive to 4 weeks of physical therapy, non-steroidal anti- inflammatory drugs and home exercise. Shoulder symptoms and physical assessment indicating the need for MRI after this period of treatment should include at least two of the following: anterior/posterior shoulder instability, external rotation pain or weakness, impingement signs, loss of abduction, and persistent pain with activity.

Applicant submits a rebuttal from Dr. Dean Olsen. With respect to the right shoulder MRI Dr. Olsen cites the New York State Workers' Compensation Board Proposed Medical Treatment Guidelines-Shoulder Injury (1-19-2010), Section D which states: "Adjunctive testing should be considered when shoulder pain is refractory to 4-6 weeks of non-operative conservative treatment and the diagnosis is not readily identified by standard radiographic techniques, then sonography, arthrography or MRI may be indicated. MRI should be performed sooner (e.g., 1-2 weeks), when there is clinical suspicion of full-thickness rotator cuff tear." It should be noted that the MRI was

ordered on 1/5/16, less than four weeks after conservative treatment was commenced. Moreover there was nothing in the medical records to indicate suspicion of a rotator cuff tear. Dr. Olsen further states "As the clinical suspicion for a rotator cuff tear, impingement or other pathology that could have been worsened by physical therapy was present and documented along with the severity of this particular accident, the need for further diagnostic testing is present." Again, there was nothing in the medical reports to indicate suspicion for a rotator cuff tear, impingement or other pathology that could have been worsened. In fact the patient did continue with physical therapy prior to the performance of the MRI. It should be noted that Dr. Olsen was not the patient's treating physician and therefore clearly has no first-hand insight regarding why the MRI of the right shoulder was prescribed for this patient at the time that it was prescribed.

It is Applicant's prima facie burden to establish its entitlement to payment for the disputed MRI's.

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 § 5106 a; Mary Immaculate Hosp. v. Allstate Ins. Co., 5 AD 3d 742, 774N.Y.S. 2d 564 [2004]; Amaze Med. Supply v. Eagle Ins. Co., 2 Misc. 3d 128A, 784 N.Y.S. 2d918, 2003 NY Slip Op 51701U [App Term, 2d & 11th Jud Dists]).*

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,* 783 N.Y.S. 2d at 448 & 452; *Amaze Medical Supply, Inc. v. Eagle Insurance Company,* 2 Misc. 3d 128 [App Term, 2nd and 11thJud Dists 2003]).

Since Applicant submitted a timely and proper claim the burden is on the respondent to prove that the services were not medically necessary.

In the event an insurer relies on a peer review report to demonstrate that a particular service was medically unnecessary the peer reviewer's opinion must be supported by sufficient factual evidence or proof and cannot simply be conclusory or may be supported by evidence of generally accepted medical/professional practice or standards. See Nir v. Allstate Insurance Company, 2005 NY Slip Op 25090; 7Misc.3d 544; 796 N.Y.S.2d 857; 2005, N.Y.Misc. LEXIS 419 and Citywide Social Work & Psy. Serv. P.L.L.C. v. Travelers IndemnityCo., 3 Misc. 3d 608; 777 N.Y.S.2d 241; 2004 NY Slip Op 24034.

When an insurer interposes a timely denial of claim that sets forth a sufficiently detailed factual basis and adequate medical rationale for a claim's rejection, the presumption of medical necessity attached to the applicant's properly completed claim is rebutted and the burden shifts back to the claimant to refute the peer review and prove the necessity

of the disputed services. Id. See, e.g., CPT Med. Servs., P.C. v. New York Cent. Mut. Fire Ins. Co., 2007 NY Slip Op 27526, 18 Misc.3d 87 (App. Term 1st Dept.); Eden Med., P.C. v. Progressive Cas. Ins. Co., 2008 NY Slip Op 51098(U), 19 Misc.3d 143(A) (App Term 2d & 11th Jud Dists., 2008); Bath Med. Supply, Inc. v. New York Cent. Mut. Fire Ins. Co., 2008 NY Slip Op 50347(U) (App. Term 2d Dept., Feb. 26, 2008) (since the provider failed to rebut peer review's showing of a lack of medical necessity, defendant was entitled to dismissal of complaint). Where Respondent has set forth a medical rationale and factual basis in support of its contention that the treatment was not medically necessary, the burden then shifts to Applicant, who bears the ultimate burden of persuasion.

With respect to the cervical and lumbar MRI's I find that Respondent has failed to meet its burden of demonstrating that the disputed services were not medically necessary. The peer cites authority which states that MRI of the lumbar or cervical spine is indicated if substantial pain is still present four to six weeks after the initiation of treatment. Here the MRI's were ordered subsequent to completion of four weeks of conservative treatment and the patient was still experiencing substantial pain.

With respect to the right shoulder MRI I find that Respondent has submitted sufficient evidence to raise a substantial question of fact as to whether the disputed MRI was medically necessary so as to require the applicant to come forward with additional evidence in support of the need for said testing. Respondent sets forth a factual basis and a medical rationale for denying the claim. I find that Applicant's proof fails to meet its burden of refuting the peer review and proving the necessity of the disputed services. Both the peer and Dr. Olsen cite authority which states that shoulder MRI should not be considered before 4-6 weeks of conservative treatment. Here the MRI was ordered prior to the patient completing 4 weeks of physical therapy. The initial evaluation was 12/11/15. The MRI was ordered on 1/5/16. There was no instability in the shoulder nor were there any red flag findings prior to ordering the MRI.

Accordingly, I find in favor of the Applicant with respect to the cervical and lumbar MRI. The claim for the right shoulder MRI is denied. The Applicant is awarded the sum of $1,791.73.

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**
	Kissena Medical Imaging PC	**01/12/16 - 01/26/16**	**$2,670.40**	**Awarded: $1,791.73**
Total			**$2,670.40**	**Awarded: $1,791.73**

B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 08/18/2016, which is a relevant date only to the extent set forth below.)

Interest shall run from date of filing.

C. Attorney's Fees

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

The insurer shall pay the applicant an attorney's fee in accordance with 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 New York
SS :
County of Nassau

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

10/29/2017
(Dated)

Joseph Endzweig

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:
bab47547b2291b63d9fce2632af84df8

Electronically Signed

Your name: Joseph Endzweig
Signed on: 10/29/2017