

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Health East Medical Alliance
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No. 17-17-1079-0229

Applicant's File No. 1022787

Insurer's Claim File No. 0293 9960 9010
1226

NAIC No.

ARBITRATION AWARD

I, Patricia Daugherty, 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 08/13/2018
Declared closed by the arbitrator on 08/13/2018

Steve Cohen from The Law Office of Cohen & Jaffe, LLP participated in person for the Applicant

Christa Varone from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 992.06**, was NOT AMENDED at the oral hearing.
Stipulations WERE made by the parties regarding the issues to be determined.

The parties stipulated that Applicant has established its prima facie case and that the denial of claim was issued timely. The parties also stipulated that there are no issues regarding the fee schedule.

3. Summary of Issues in Dispute

Assignor, "TB," a 54-year old female driver, was involved in a motor vehicle accident on April 30, 2016. At issue in this case is one bill in the amount of \$992.06 for reimbursement of lumbar medial branch blocks performed on April 17, 2017.

Respondent denied the claim asserting a lack of medical necessity defense pursuant to the peer review of Mitchell Ehrlich, M.D. The issue to be determined is whether the services rendered were medically necessary.

4. Findings, Conclusions, and Basis Therefor

This case was decided based upon the submissions of the parties as contained in the electronic file maintained by the American Arbitration Association, and the oral arguments of the parties' representatives. There were no witnesses. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

In the instant matter Assignor was involved in a motor vehicle accident on April 30, 2016 where she sustained injuries to her neck and low back. She sought treatment from Walter F. Pizzi, M.D. on May 11, 2016. Dr. Pizzi diagnosed Assignor with cervical and lumbar sprain/strains, possible cervical and lumbar radiculopathies, and possible cervical and lumbar herniated nucleus pulposus. He started Assignor on a course of physical therapy. Assignor underwent a comprehensive conservative treatment program under the care of Dr. Pizzi.

On June 28, 2016, MRIs of the cervical and lumbar spines were performed.

EMG/NCV testing revealed right C5-6 radiculopathy and left L4-5 and L5-S1 lumbar radiculopathies.

On September 10, 2016, Assignor presented to Anson Moise, M.D. for a pain management evaluation. After his examination, Dr. Moise diagnosed Assignor with cervicalgia, lumbago, myofascial pain syndrome, facet syndrome, herniated nucleus pulposus, radiculitis and radiculopathy which have been intractable to conservative management. Dr. Moise recommended Assignor undergo cervical and lumbar epidural steroid injections under fluoroscopic guidance and anesthesia for management of herniated nucleus pulposus and radiculopathy. For the facetogenic components of her pain, Dr. Moise recommended diagnostic medial branch nerve blocks to assess candidacy for radiofrequency ablation.

Assignor underwent cervical epidural steroid injections on October 3, 2016, January 16, 2017 and April 24, 2017. She underwent lumbar epidural steroid injections on November 7, 2016, May 22, 2017 and July 31, 2017. She underwent lumbar medial branch blocks on April 17, 2017.

As the parties stipulated to Applicant's prima facie case and the timeliness of the denial of claim, the burden is on the insurer to prove that medical treatment performed was not medically necessary. See A.B. Medical Services PLLC v. Geico, 2 Misc.3d 26, 773 N.Y.S.2d 773 (App. Term 2d and 11th Jud Dists 2003).

To establish lack of medical necessity through a peer review report, the peer reviewer's opinion must set forth a factual basis and medical rationale for the lack of medical necessity defense, including evidence of medical standards. Jacob Nir, M.D. v. Allstate Ins. Co., 7 Misc.3d 544, 546-47 (Civ. Ct. Kings Co. 2005).

A peer review report's medical rationale is insufficient if it is unsupported by or controverted by evidence of generally accepted medical practice. See CityWide Social Work & Psychological Servs. v Travelers Indem. Co., 3 Misc 3d. 608 (Civ Ct, Kings County 2004). The generally accepted practice is considered "that range of practice that the profession will follow in the diagnosis and treatment of patients in light of the standards and values that define its calling." Id.

When an insurer 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. See West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc. 3d 131(A) (App. Term 2d & 11th Jud Dists 2006).

Respondent denied the claim based upon a lack of medical necessity pursuant to the peer review of Mitchell Ehrlich, M.D. dated May 17, 2017. After reviewing multiple medical records Dr. Ehrlich concluded that the lumbar medial branch blocks, together with the anesthesia and facility fee, were not medically necessary. Dr. Ehrlich states that it was not demonstrated that the pain was largely facet in origin and that the prior injections were unsuccessful in terms of sustained pain relief and improvement in function and reduction in frequency of treatment. Dr. Ehrlich sets forth the following standards regarding the injections:

1. Medial branch block injections or intra-articular facet joint injections are recommended for: [p]atients with pain suspected to be largely facet in origin based on exam findings (i.e., non-radicular axial pain aggravated by extension-facet loading) and/or [d]ocumented evidence (i.e., imaging study) of facet disease (facet arthropathy/hypertrophy at the targeted level(s) and who have completed a documented course of conservative management as defined in *New York Mid and Low Back Injury Medical Treatment Guidelines*, including but not limited to medication, modalities and active exercises.
2. Repeat injections are not warranted if "the first therapeutic injection does not provide sustained pain relief substantiated by accepted pain scales (i.e. 50% documented pain reduction as measured by accepted pain tools) and improvement in function for at least 4-to-6 weeks..."

In response to Dr. Ehrlich's report, Applicant submitted a rebuttal by Dr. Moise dated October 14, 2017 who disagrees with the conclusion of Dr. Ehrlich. Dr. Moise stated that he diagnosed the Assignor with lumbar facet syndrome which warranted the performance of the lumbar medial branch blocks. He asserts that the patient had relief from the injections and sets forth the standard for diagnostic facet joint injections identified in the New York Mid and Low Back Injury Medical Treatment Guidelines which states:

D.6.e.i. One fluoroscopically guided diagnostic facet joint injection, may be recommended for patients with chronic back pain that is significantly exacerbated by extension

and rotation or associated with lumbar rigidity, and not alleviated with other conservative treatments (e.g., medication, aerobic exercise, other exercise, manipulation) in order to determine whether specific interventions targeting the facet joint are recommended.

Dr. Moise reiterates his examination findings and explains how they fall within this standard. Dr. Moises asserts that the standard regarding repeat injections showing improvement for at least 4 to 6 weeks outlined by Dr. Ehrlich is unsupported by any authority. He also addressed that the New York Mid and Low Back Injury Medical Treatment Guidelines do not impose a time-frame for the determination of medical necessity for further medial branch nerve blocks.

Dr. Ehrlich prepared an addendum to his report, responding to Dr. Moises contentions in his rebuttal. Dr. Ehrlich states that the radicular component should obviate the need for medial branch blocks; that there is no medical basis to suggest a need to assess candidacy for radiofrequency ablation; and that the relief to the Assignor was a brief anesthetic effect. Dr. Ehrlich does not address the standard set forth by Dr. Moise.

After reviewing the medical records and listening to the oral arguments of the parties, I find that the peer review report of Dr. Ehrlich sets forth a sufficient factual basis and medical rationale as to why the lumbar medial branch blocks were not medically necessary. Respondent has shifted the burden to Applicant to establish the medical necessity of the services. I find that the rebuttal by Dr. Moise sufficiently establishes that the services were medically necessary.

Based on the foregoing, Applicant is awarded \$992.06.

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 |
|---------|------------------------------|---------------------|--------------|-------------------|
| | Health East Medical Alliance | 04/17/17 - 04/17/17 | \$992.06 | Awarded: \$992.06 |
| Total | | | \$992.06 | Awarded: \$992.06 |

B. The insurer shall also compute and pay the applicant interest set forth below. 11/07/2017 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. Pursuant to 11 NYCRR 65-3.9(c) If 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 Department of Financial Services regulations, interest shall not accumulate on the disputed claim or element of claim until such action is taken. A plain reading of this provision indicates that if an applicant requests arbitration within 30 days of receiving a denial of claim, then interest is not tolled. When arbitration is not requested within 30 days of receiving a denial of claim, the interest is tolled until "such action is taken." The language used refers to the conduct of the Applicant. When Applicant acts, the interest is no longer tolled. The act of requesting the arbitration triggers the accrual of interest. As such interest shall accrue as of the date the AR-1 was filed. To the extent that the AR-1 was filed outside the business hours of the forum, then interest shall accrue the following business day.

C. Attorney's Fees

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

Respondent shall pay Applicant an attorney's fee, in accordance with 11 NYCRR §65-4.6(e). Therefore, the insurer shall pay the applicant an attorney's fee of 20% of benefits plus interest, with no minimum fee and a maximum fee of \$1,360. However, if

the benefits and interest awarded thereon is equal to or less than the respondent's written offer during the conciliation process, then the attorney's fee shall be based upon the provisions of 11 NYCRR 65-4.6(b).

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

08/24/2018

(Dated)

Patricia Daugherty

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:

a0c419195f8f85d18fb57f25a2b4cf25

Electronically Signed

Your name: Patricia Daugherty
Signed on: 08/24/2018