

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Fast Care Medical Diagnostics PLLC
(Applicant)

- and -

Allstate Property and Casualty Insurance
Company
(Respondent)

AAA Case No. 17-17-1060-3528

Applicant's File No. 1963928

Insurer's Claim File No. 0435885579
2HZ

NAIC No. 17230

ARBITRATION AWARD

I, Paul Israelson, 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: injured person.

1. Hearing(s) held on 10/23/2018
Declared closed by the arbitrator on 10/23/2018

Ryan Berry Esq. from Israel, Israel & Purdy, LLP participated in person for the Applicant

Marcia Brin Esq. from Allstate Property and Casualty Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, \$ **1,791.73**, was AMENDED and permitted by the arbitrator at the oral hearing.

The applicant amended its claim to \$1,571.80.

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

3. Summary of Issues in Dispute

Were the subject cervical and lumbar MRIs medically necessary?

4. Findings, Conclusions, and Basis Therefor

On October 23, 2018, the hearing for the within arbitration matter was conducted and closed.

At the hearing, the applicant did not raise any argument as to the timeliness of the respondent's denial of the applicant's claim.

With the claim amended to \$1,571.80, the respondent did not have any objection to the accuracy of the applicant's calculation of its requested fee.

The date of the subject automobile accident was November 11, 2016.

The applicant made a claim in the amount of \$1,571.80, breaking down as follows: \$659.80 for the January 4, 2017 MRI of the injured person's cervical spine; and \$912.00 for the January 4, 2017 MRI of the injured person's lumbar spine. The respondent denied the applicant's claim on the basis that the subject MRIs were not medically necessary.

As to the medical necessity for the subject cervical MRI and lumbar MRI, "Medical necessity is presumed upon the timely submission of a no-fault claim (see *All County Open MRI & Diagn. Radiology P.C. v. Travelers Ins. Co.*, 11 Misc.3d 131[A], 2006 N.Y. Slip Op. 50318[U] [App. Term, 9th & 10th Jud. Dists. 2006]). Thus, ordinarily it falls to the defense to establish that the billed-for services were not medically necessary.", *Park Slope Medical and Surgical Supply, Inc. v. Progressive Ins. Co.* 34 Misc.3d 154(A), 950 N.Y.S.2d 609 (App. Term, 2nd, 11th and 13th Dists. 2012). In this case there is no question of fact that the applicant timely submitted its proof of claim for the subject cervical MRI and lumbar MRI, and therefore, the applicant may employ this same presumption of medical necessity for the subject cervical MRI and lumbar MRI.

Additionally concerning the respondent's challenge to the medical necessity for the subject cervical MRI and lumbar MRI, "For an expense to be considered medically necessary, the treatment, procedure, or service ordered by a qualified physician must be based on an objectively reasonable belief that it will assist in the patient's diagnosis and treatment and cannot be reasonably dispensed with. Such treatment, procedure, or service must be warranted by the circumstances as verified by a preponderance of credible and reliable evidence, and must be reasonable in light of the subjective and objective evidence of the patient's complaints." *Nir v. Progressive Insurance Co.*, 7 Misc.3d 1006(A), 801 N.Y.S.2d 237 (Table), 2005 N.Y. Slip Op. 50466(U), 2005 WL 782806 (Civ. Ct. Kings Co., Nadelson, J., Apr. 7, 2005).

As well, "A no-fault insurer defending a denial of first-party benefits on the ground that the billed for services were not 'medically necessary' must at least show that the services were inconsistent with generally accepted medical/professional practices. 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 & Psy, Serv. v. Travelers Indem. Co., 3 Misc.3d 608, 609 supra.). 'Generally accepted practice' is that range of practice that the profession will follow in the diagnosis and treatment of patients in light of the standards and value that define its calling (A.B. Med. Ser. v. New York Central Mut. Fire Ins. Co., 7 Misc.3d 1018[A][Civ. Ct. Kings Co.2005]; Citywide Social Work & Psy Serv. v. Travelers Indemnity Co., supra).", A.R. Medical Art, P.C. v. State Farm Mut. Auto. Ins. Co., 11 Misc.3d 1057(A), 815 N.Y.S.2d 493 (Civ. Ct. Kings Cty. 2006).

The respondent provided the February 28, 2017 peer review report and August 22, 2017 peer review addendum each by Dr. Isandr Dumesh M.D. in support of the respondent's argument that the subject cervical and lumbar MRIs were not medically necessary. Dr. Dumesh reviewed the records concerning the injured person's relevant medical history and condition, and noted:

"The claimant is a 36-year-old female, who was involved in a motor vehicle accident on 11/11/16. At the time of the accident the claimant was the driver of a car. The claimant was wearing a seat belt at the time of the collision. There was no head trauma or loss of consciousness in the collision. After the accident, the claimant did not go to a hospital emergency room. Later, she came under the care of her doctors. During the initial medical evaluation by Hudson Pain Associate, PC, on 11/17/16, the claimant was complaining of neck pain, back pain and bilateral shoulder pain. The physical examination revealed musculo-ligamentous injuries and limitation of movements in the cervical, thoracic and lumbar spine and shoulders. The claimant was diagnosed with status post motor vehicle accident, cervical and lumbar posttraumatic sprain/strain syndrome, rule out cervical and lumbosacral disc herniation and radiculopathy, cervical myofascial syndrome and bilateral shoulder pain. Following the evaluation, the claimant was recommended physical therapy treatments, acupuncture and chiropractic consultations, EMG, x-rays of the cervical and lumbar spine, unspecified MRIs after follow up."

Dr. Dumesh argued that the injured person sustained a sprain/strain injury to the cervical and lumbar spines, and therefore, the standard of care would involve physical therapy and rehabilitation treatments for a period of 3 to 4 months, possibly supplemented by NSAID medications and muscle relaxers, and that a left shoulder MRI would not be necessary during this same 3 to 4 month period, where he stated, "The above claimant has sustained sprain/strain injuries to the spine in the above motor vehicle accident. The standard of care for similar injuries would be physical therapy and rehabilitation treatments for a period of three to four months, possibly supplemented by NSAID

medications and muscle relaxers. A diagnostic test, such as a spinal MRI, would be necessary if it potentially enhances the treatment or assists with future diagnostic and treatment-related decisions."

Dr. Dumesh argued that a spinal MRI is warranted where the patient has experienced persistent pain in the neck area for a period of one month or more together with a poor response to physical therapy or where an alternative therapy such as neurosurgical intervention is considered, none of which were the conditions for the injured person, and therefore, the subject MRIs would not have altered the injured person's treatment, where he stated, "In regards to the MRIs of the Cervical and Lumbar Spine, the following should be noted. In general, a spinal MRI could be considered in cases of persistent pain in the cervical and/or lumbar spine area present for a period of one month or longer, despite a standard conservative therapy regimen (such as physical therapy, NSAID medication, and/or chiropractic treatments), and especially when any alternative therapy approach, such as neurosurgical intervention, is being considered. As per the article: "Appropriate Use of MRI for Evaluating Common Musculoskeletal Conditions" by Donald C. Pompan, MD, FAAOS, Salinas, California. Am Fam Physician. 2011 Apr 15;83(8):883-884. "The use of magnetic resonance imaging (MRI) has become routine in the evaluation of musculoskeletal conditions. Originally, MRI was used mainly as a preoperative planning tool for patients thought to have surgical pathology based on history and physical examination. In recent years, however, MRI often has been used solely to establish a diagnosis, in many cases before any conservative treatment has been instituted. This practice raises the following questions: Is MRI overused in patients with musculoskeletal conditions? What are the indications for MRI? For most patients with neck, back, knee, or shoulder pain, a diagnosis can be made with a history, physical examination, and plain film radiography; surgery is not indicated. Neck and back pain have many causes, but the majority of patients will improve with conservative management....The treatment for these common conditions- which usually involves muscle strengthening and stretching, and possibly physical therapy-would not be dependent on MRI results. Most patients will improve within a few weeks or months. MRI often identifies pathology that may have no relationship to a patient's symptoms. Approximately 30 to 40 percent of asymptomatic young and middleaged patients have changes in the intervertebral disks, such as a protrusion or desiccation, and these structural abnormalities increase with aging...MRI may provide information that is confusing to the patient and physician, and does not necessarily identify the source of pain. The patient may be referred to an orthopedist with the expectation of being "fixed" quickly, even though the problem may have been treated successfully without surgery. In these cases, the patient becomes more of a passive bystander, rather than actively participating in a stretching-strengthening program. A surgeon may be willing to perform surgery to satisfy the patient and referring physician, although the procedure may not be curative. The patient may be exposed to unnecessary risks, and the cost of care is increased. The indications for and timing of MRI will depend on whether the problem is emergent, acute, or chronic. Musculoskeletal emergencies that require an immediate MRI are limited primarily to spinal conditions such as suspected cauda equina syndrome and infection. There are certain acute neck, back, shoulder, and knee conditions for which MRI should be considered after four to six weeks of conservative

care if the findings could alter treatment. In patients who have neck and back pain with persistent radiculopathy or those who have loss of balance and gait problems indicative of cervical myelopathy, MRI can detect disk herniations or spinal stenosis that may benefit from more aggressive treatment." "

Dr. Dumesh argued that the clinical information garnered from a physical examination and taking the injured person's personal history should form the basis for determining whether or not a spinal MRI is necessary, and that certain indicators such as acute fractures, acute dislocations, infection, tumor, progressive neurological deficits, cauda equine syndrome, extraspinal disorders, suspicion of spinal cord injury, suspicion of nerve root compression, disc space infection, disc herniation or cord contusion are all bases for a spinal MRI, none of which pertained to the injured person, where he stated, "As per Worker 's Compensation Board New York Neck Injury Medical Treatment Guidelines, Third Edition, September 15, 2014, page 3 "Clinical information obtained by history taking and physical examination should be the basis for selection and interpretation of imaging procedure results. All diagnostic procedures have variable specificity and sensitivity for various diagnoses."

As per Worker 's Compensation Board New York Neck Injury Medical Treatment Guidelines, Third Edition, September 15, 2014, page 13 "Certain findings, "red flags," raise suspicion of potentially serious and urgent medical conditions. Assessment (history and physical examination) should include evaluation for red flags. In the cervical spine these findings or indicators may include: acute fractures, acute dislocations, infection, tumor, progressive neurological deficit, cauda equina syndrome, and extraspinal disorders. Further evaluation/consultation or urgent/emergency intervention may be indicated and the New York Neck Injury Medical Treatment Guidelines incorporate changes in clinical management triggered by the presence of red flags. Imaging of the cervical spine may be obtained as deemed clinically appropriate. Basic views are the anteroposterior (AP), lateral, right, and left obliques, swimmer's, and odontoid. CT scans may be necessary to visualize C7 and odontoid in some patients. Lateral flexion and extension views are done to evaluate instability but may have a limited role in the acute setting. MRI or CT is indicated when spinal cord injury is suspected. The mechanism of injury and specific indications for the imaging should be listed on the request form to aid the radiologist and x-ray technician. Alert, non-intoxicated patients, who have isolated cervical complaints without palpable midline cervical tenderness, neurologic findings, or other acute or distracting injuries elsewhere in the body, may not require imaging."

As per Worker 's Compensation Board New York Neck Injury Medical Treatment Guidelines, Third Edition, September 15, 2014, page 16 "MRI is useful in suspected nerve root compression, in myelopathy to evaluate the spinal cord and/or differentiate or rule out masses, infections such as epidural abscesses or disc space infection, bone marrow involvement by metastatic disease, and/or suspected disc herniation or cord contusion following severe neck injury. MRI should be performed immediately if there is a question of infection or metastatic disease with cord compression. MRI is

contraindicated in patients with certain implanted devices. In general, the high field, conventional, MRI provides better resolution. A lower field scan with lower magnetic intensity may be indicated when a patient cannot fit into a high field scanner or is too claustrophobic despite sedation." "

Dr. Dumesh noted that an MRI is considered the gold standard for diagnostic imaging for defining anatomy, most particularly with respect to soft tissue injury, however, a spinal MRI is not recommended for acute back pain or acute radicular pain syndrome within the first six weeks in the absence of red flags such as symptoms of a progressive neurologic deficit, cauda point syndrome, significant trauma with no improvement, a history of cancer, a suggestion of multiple nerve root involvement, acute radicular pain syndromes not trending towards improvement, or where epidural steroid injections are considered for temporary relief of acute or subacute radiculopathy, none of which pertained to the injured person, where he stated, "As per Worker 's Compensation Board New York Mid and Low Back Injury Medical Treatment Guidelines, Third Edition, September 15, 2014, page 15 "MRI is considered the gold standard in diagnostic imaging for defining anatomy because it has the greatest resolution of any test currently available. While CT remains an important analytical tool especially for evaluating bony or calcified structures of the spine, due to the greater resolution of MRI, particularly with respect to soft tissue of the spine (nerve root compression, myelopathy to evaluate the spinal cord and/or differentiate/rule out masses), there is less need for using CT at the current time. Ferrous material/metallic objects in tissue is a contraindication for the performance of an MRI. Inadequate resolution on the first scan may require a second MRI using a different technique. A subsequent diagnostic MRI may be a repeat of the same procedure when the rehabilitation physician, radiologist or surgeon documents that the study was of inadequate quality to make a diagnosis. All questions in this regard should be discussed with the MRI center and/or radiologist.

Recommendations: C.1.b.i. MRI is not recommended for acute back pain or acute radicular pain syndromes in the first 6 weeks, in the absence of red flags. C.1.b.ii. MRI is recommended for patients with acute back pain during the first 6 weeks if they have demonstrated progressive neurologic deficit, cauda equina syndrome, significant trauma with no improvement in atypical symptoms, a history of neoplasia (cancer), or atypical presentation (e.g., clinical picture suggests multiple nerve root involvement). C.1.b.iii. MRI is recommended for acute radicular pain syndromes in the first 6 weeks if the symptoms are severe and not trending towards improvement and both the patient and the physician are willing to consider prompt surgical treatment, assuming the MRI confirms ongoing nerve root compression.

Frequency/Duration: Repeat MRI imaging without significant clinical deterioration in symptoms and/or signs is not recommended. C.1.b.iv. MRI is recommended for patients with non-acute radicular pain syndromes lasting at least 6 weeks, in whom the symptoms are not trending towards improvement, if both the patient and surgeon are considering prompt surgical treatment, assuming the MRI confirms ongoing nerve root

compression. C.1.b.v. In cases where an epidural glucocorticosteroid injection is being considered for temporary relief of acute or subacute radiculopathy, MRI at 3 to 4 weeks (before the epidural steroid injection) may be reasonable (see Section D.6, Injections: Therapeutic). C.1.b.vi. MRI is recommended as an option for the evaluation of select non-acute back pain patients in order to rule out concurrent pathology unrelated to injury. This should rarely be considered before 3 months and failure of several treatment modalities (including NSAIDs, aerobic exercise, other exercise, and considerations for manipulation, and/or acupuncture). C.1.b.vii Standing or weight-bearing MRI is not indicated for any back or radicular pain syndrome or condition. In the absence of studies demonstrating improved patient outcomes, this technology is currently considered experimental/investigational."

According to the records reviewed, the claimant was referred for physical therapy immediately following the initial evaluation. Unspecified MRIs were considered after a follow up. However, in this case the follow up visit took place on 01 /12/17, which was eight days after both cervical and lumbar spine MRIs were already performed. There was no evidence that the claimant was failing on the conservative therapy and required the MRIs for alternative treatment plan. The above Cervical and Lumbar Spine MRI would not change the planned therapy course or benefit the claimant in any other way at that time. Therefore, I consider the above Cervical and Lumbar Spine MRI not medically necessary in this case."

As such, pursuant to the above cited authorities, Dr. Dumesh' February 28, 2017 peer review report and August 22, 2017 peer review addendum sustained the respondent's burden of demonstrating that the subject cervical MRI and lumbar MRI were not medically necessary.

The applicant provided the August 22, 2017 peer review rebuttal by Dr. Iosif Aronov M.D. in support of the applicant's claim for the subject cervical and lumbar MRIs. Dr. Aronov reviewed the injured person's relevant medical history, and noted:

"Based on the records reviewed, the patient [the injured person] is a 36-year old female, who was involved in a motor vehicle accident on 11/11/2016. As a result of impact, she sustained injuries to her neck, lower back and bilateral shoulders.

Please note that the findings in this rebuttal pertain only to cervical spine and lumbar spine as the bills in dispute are for cervical spine MRI and lumbar spine MRI. On 11/17/2016, the patient presented to Dr. Cheng with the pertinent complaints of severe neck pain rated at 9/10; and severe lower-back pain rated at 9/10. Examination of the cervical spine and lumbar spine revealed tenderness over the spinous processes; tenderness over the paraspinous muscles; hypertonic

muscle lone; trigger points; and decreased as well as painful ranges of motion. Cervical Compression Test was positive for the cervical spine. The plan of care included but was not limited to the performance of MRI testing of the cervical spine and lumbar spine. (Please see report).

Patient underwent an MRI of the cervical spine on 1/4/2017 performed by Fast Care Medical Diagnostics, PLLC.

Patient underwent an MRI of the lumbar spine on 1/4/2017 performed by Fast Care Medical

Diagnostics, PLLC."

Concerning Dr. Dumesh's argument that a spinal MRI should not be conducted within the first 4 to 6 weeks of conservative treatment absent certain red flags, Dr. Aronov argued that this same guideline cited by Dr. Dumesh applies to patients who have experienced a gradual onset of pain with an unknown cause, which was not the case for the injured person, whose injuries were known to be traumatically caused by the subject automobile accident, and in such instance, a spinal MRI would be an efficient and accurate diagnostic tool for determining the nature and extent of the injured person's spinal injury, where he stated, "The peer reviewer, Dr. Humesh recommended against the reimbursement of MRI studies of the cervical spine and lumbar spine. I respectfully disagree with the peer reviewer's arguments and conclusions. Note the following discussion:

In regards to the cervical spine and lumbar spine MRIs, Dr. Dumesh cites to "Appropriate Use of MRI for Evaluating Common Musculoskeletal Conditions" by Donald C. Pompan, MD., FAAOS, Salinas, California, published at Am Fam Physician, 2011 Apr 15;83(8):883-884" in support of his conclusion that there are certain acute neck, back, shoulder, and knee conditions for which MRI should be considered after four to six weeks of conservative care if the findings could alter treatment.

Firstly, the citation used by Dr. Dumesh is not applicable to this case as it discusses injuries from gradual onset and with pain of an unknown etiology, which follow a different protocol than those from traumatic onset. The clinical scenario that the peer doctor states should be followed is not for trauma patients but for patients with acute pain not caused by a traumatic event such as this patient sustained. In this case, we know what caused the onset of pain, it was the trauma from the accident and the involved structures were needed to be evaluated by MRI. Moreover, this citation discusses about the accuracy and cost incurred on performing an MRI by stating "...the patient may be exposed to unnecessary risks, and the cost of care is increased." Regarding the accuracy/risks of MRI, I have cited several authoritative literatures in favor of the

efficiency of MRI in this rebuttal. However, I disagree that cost should be a presiding factor in the care and treatment of trauma patients. Cost containment is an insurance company issue and in no way should affect the decision making in the treatment of any patient for any condition. It is the doctor's responsibility to prescribe the correct test at the correct time to properly diagnosis and treat patients. Cost should not a factor in these decisions."

As well, Dr. Aronov argued that the injured person had undergone seven weeks of conservative treatment prior to the performance of the subject cervical MRI and lumbar MRI, which was well within the timeframe cited by Dr. Dumesh as the standard for conducting spinal MRIs, and further argued that the danger in delaying a spinal MRI is continuing an improper treatment plan, whereas conducting spinal MRIs early in the treatment process results in a proper treatment plan which would prevent chronic pain, where he stated, "Further, in this case, the patient had had seven weeks of treatment starting from 11/17/2016 till the performance of cervical spine and lumbar spine MRIs on 1/4/2017, which is well within the time frame of four to six weeks as prescribed by most authoritative literatures.

In fact, because of the accuracy and clarity of MR imaging, it is no longer necessary to wait weeks prior to performing an MRI. An MRI will allow for a clearer picture of the soft tissue and will enable evaluation of injuries to the ligaments, tendons, muscle and disc herniation, thus allowing for a more targeted treatment plan. MRI imaging has revolutionized the diagnosis and treatment of spine related pain syndromes. MRI technology is constantly improving. (Shalen, Philip R., MD. "New MRI Scan Technology." Spine-Health (n.d.): n. pag. Web. 7 June 2013).

Moreover, MRI studies performed early on would show injuries to muscle, ligaments and other soft tissue, which in turn would lead to formulate a correct and complete diagnosis and would therefore result in a proper treatment plan. For example, injury to the neck as occurred in this patient may cause ligamentous tears and inflammation, resulting in associated limitation of motion, ligamentous instability and neurological deficits. (Whiplash injury of the cervical spine--initial evaluation and treatment of late sequelae. Ther Umsch. 2000 Dec; 57(12):716-9). Principal requirement for adequate management of whiplash patients is considerable familiarity with symptoms of whiplash injury and knowledge of risk factors contributing to delayed recovery. In addition, evidence based knowledge of treatment strategies may help promoting an integrative initial assessment leading to therapy, which likely may prevent chronicity.

In regard to the neck injury and low back injury, it is stated in the New York State Workers' Compensation Board New York Medical Treatment Guidelines, Second Edition January 14,

2013, under A.6 Diagnostic Time Frame for Conducting Testing. Clinical judgment may substantiate the need to accelerate or decelerate time frames discussed in this document. Pursuant to Section A.12, Diagnostic Imaging and Testing Procedures, it is stated that clinical information obtained by history taking and physical examination should be the basis for selection interpretation of imaging procedure results. All diagnostic procedures have variable specificity and sensitivity for various diagnoses."

Dr. Aronov argued that a spinal MRI helps determine the size, location and severity of disc protrusions, which serves as a useful tool for the early treatment of whiplash injuries, where he stated, "MRI plays an important role in patients suspected of having disc injuries subsequent to whiplash in that it helps determine size, location, and severity of disc protrusion. Furthermore, it can delineate cases, where there is an associated spinal stenosis with HNP that may or may not compress the spinal cord. An MRI is a useful tool in the early treatment of whiplash injuries. The use of all diagnostic tools in the treatment of all traumatic injuries, such as whiplash, should be left to the discretion of the treating doctor. [Dynamic Chiropractic (July 17, 1997, Vol. 15, Issue 15), Disc Injury Subsequent to Motor Vehicle Collision or Accidents]"

Dr. Aronov argued that Dr. Dumesh's argument that a spinal MRI should be ordered only in the event it will alter the patient's treatment essentially "puts the cart before the horse" because any effect a spinal MRI may have on a patient's treatment will only be determined after the MRI had been conducted, where he stated, "I further disagree with Dr. Dumesh that MR's should be ordered if the findings could alter treatment as any argument that prior to the performance of an MRI a treatment plan can be influenced is flawed thinking. It is only after the MRI can the results be analyzed and the treatment plan adjusted accordingly. Dr. Dumesh has it backwards in this case and his logic is flawed. To state that a test prior to its completion would not in any way influence the immediate therapy course is conclusory and without merit."

As to whether or not the injured person was a candidate for spinal MRIs, Dr. Aronov argued that the injured person sustained traumatic injury as a result of the subject automobile accident, and therefore, the customary guidelines for determining when to conduct a spinal MRI were not applicable to the injured person's relevant clinical history and condition, and argued that a spinal MRI reveals injury to the muscles, ligaments and other soft tissue which are not revealed in a spinal x-ray, where he stated, "Lastly, in regards to the cervical spine and lumbar spine MRIs, Dr. Dumesh states that for most patients with neck, back, knee, or shoulder pain, a diagnosis can be made with a history, physical examination, and plain film radiography. He cites to "Worker's Compensation Board, Medical Treatment Guidelines" in support of his conclusions.

I disagree with Dr. Dumesh's interpretation of the guidelines and believe that the claimant's presentation was in direct accordance with the ACR guideline, which clearly

mention trauma to be one of the indicators for the MRI of the spine. Additionally, more often than not, the citations and guidelines listed in the -peer review are not specific to injuries that have resulted from traumatic onset such as a motor vehicle accident and therefore are not relevant to the service in dispute. In this case, the injuries sustained by the patient were the direct result of a traumatic car accident dated 11/11/2016 and is not applicable to this case. Most importantly, such guidelines are framed only to assist the practitioners and do not establish a legal standard of care. Eventually, it is up to the clinician to decide, based on the circumstances of the injury and the individual patient's exam findings, whether to order testing.

Though I agree that a diagnosis can be made with a history and physical examination; however, spinal injuries often go undetected or undiagnosed through physical examination and plain film radiography alone. As a result, these undiagnosed injuries can exacerbate over time, leading to more extensive injuries. The likelihood of recovery, therefore, declines as the undiagnosed injury becomes more extensive. I also agree that plain film x-rays should always be done initially to rule out fracture; however, plain radiographs may not be entirely effective in the identification of traumatic injuries and are used mainly to determine injuries such as broken bones and not evaluation of the soft tissue.

As per Richard A. Deyo, M.D., M.P.H and James N. Weinstein, D.O., New England Journal of Medicine, Volume 344:363-370, February 1, 2001, Number 5, "Computed tomography (CT) and MRI are more sensitive than plain radiography for the detection of early spinal infections and cancers. These imaging techniques also reveal herniated disks and spinal stenosis, which plain radiography cannot."

In contrast to plain film radiography, MRI performed early on would show injuries to muscle, ligaments and other soft tissue, which in turn would lead to formulate a correct and complete diagnosis and would therefore result in a proper treatment plan. The MRIs were therefore indicated in this case for further evaluation of the spine to determine the nature and extent of the injuries to it."

Dr. Aronov noted that the injured person presented with complaints of severe neck pain and severe lower back pain, tenderness, trigger points and decreased range of motion in both the cervical spine and lumbar spine and positive cervical compression test, all caused by a traumatic event, thus making the injured person a candidate for a cervical MRI and lumbar MRI, where he stated, "In this case, the patient suffered traumatic injuries to her neck and lower back, which caused her severe neck pain rated at 9/10; and severe lower-back pain rated at 9/10. On further examination of the cervical spine and lumbar spine, tenderness over the spinous processes; tenderness over the paraspinal muscles; hypertonic muscle tone; trigger points; and decreased as well as painful ranges of motion were revealed. Importantly, she tested positive for Cervical Compression Test (which indicates the presence of cervical nerve root compression and

is most useful in establishing a diagnosis of cervical radiculopathy). Thus, as the clinical examination findings of the claimant indicated disc pathology, spinal MRIs were recommended.

The American College of Radiology Practice Guidelines for the performance of MRI of the adult spine has various indications for performing an MRI for the evaluation of, the nature of, and extent of injury to the spinal cord, vertebral column, ligaments, and intraspinal and paraspinal soft tissues following trauma. MRI of the spine is medically necessary when any of a number of criteria, such as recent significant trauma, or milder trauma in patients about age 50; any suggestion of abnormal neurologic findings below the level of injury; progressive neurologic deficit; persistent unremitting pain with or without positive neurologic findings. The aforesaid conditions are consistent with the claimant's case and justify the MRIs."

And finally, Dr. Aronov argued that a spinal MRI provides direct visualization of the spinal cord, nerve roots and discs for evaluation of the internal structure of the spinal cord, which cannot be discerned from a spinal x-ray, where he stated, "MRI allows direct visualization of the spinal cord, nerve roots and discs, while their location and morphology can only be inferred on plain radiology and less completely evaluated on myelography. MRI is the only modality for evaluating the internal structure of the cord (ACR-ASNR-SCBT-MR Practice Guideline for the Performance of Magnetic Resonance Imaging (MRI) of the Adult Spine." American College of Radiology (2012 Revised).

In Katzberg RW, et al (Acute cervical spine injuries: prospective MR imaging assessment at a level trauma center. Radiology October 1999;213:203-12), MRI was found to be superior to conventional radiography in the diagnosis of vertebral hemorrhage or edema, anterior and posterior ligamentous injury, traumatic disk herniation, cord edema and cord compression. The authors concluded that MRI provides an accurate assessment of soft tissue injury of the cervical spine. Such injuries may be missed on conventional radiography. Although MRI may be perceived as incompatible with clinical assessment and the intensive monitoring requirements of the acute trauma setting, this study demonstrates the usefulness of MRI in the evaluation of patients with sustained cervical trauma. The authors believe MRI should be strongly considered in the early evaluation of cervical spine injury.

Uhrenholt et al. reported subtle lesions found exclusively in MVA victims including annular fibrosis tears, disc disruption with herniation, avulsions/separations between the endplate and vertebra, articular cartilage microfractures, hemarthrosis, capsular swelling or bruising, new vertebral fractures, bruising of synovial folds. Conclusions from the study were that negative clinical exam and plain film x-rays do not prove the absence of patho-anatomical lesions (Uhrenholt L, Grunnett-Nilsson N, Hartvigsen J: Cervical spine lesions after road traffic accidents. Spine 2002, 27(17):1934-41)."

Overall, Dr. Aronov correlated the injured person's relevant medical history and condition to the need for both a cervical MRI and a lumbar MRI so as to persuasively rebut the conclusions drawn by Dr. Dumesh as expressed in his February 28, 2017 peer review report and September 12, 2017 peer review addendum.

Consequently, the applicant's claim in the combined amount of \$1,571.80 for the January 4, 2017 cervical MRI and lumbar MRI is awarded.

I have reviewed and considered all other arguments, contentions and evidence from both the applicant and the respondent, and find them to be without merit.

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
	Fast Care Medical Diagnostic s PLLC	01/04/17 - 01/04/17	\$1,791.73	\$1,571.80	Awarded: \$1,571.80
					Awarded:

Total	\$1,791.73	\$1,571.80
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- B. The insurer shall also compute and pay the applicant interest set forth below. 04/01/2017 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest will run from the filing date to the date of payment.

C. Attorney's Fees

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

If this matter was filed prior to February 4, 2015, the insurer shall pay the applicant an attorney's fee in accordance with 11 NYCRR 65-4.6 (e). If this matter was filed on or after February 4, 2015, the insurer shall pay the applicant an attorney's fee in accordance with 11 NYCRR 65-4.6(d); and in such same event, if the benefits and interest awarded thereon are 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, Paul Israelson, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

10/27/2018
(Dated)

Paul Israelson

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:
35251c7f29b0d198fdee4e060b47a65

Electronically Signed

Your name: Paul Israelson
Signed on: 10/27/2018