

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Phoenix Medical Services P.C. DBA
Rockville Centre Pain Management &
Rehabilitation
(Applicant)

- and -

American Transit Insurance Company
(Respondent)

AAA Case No.	17-18-1098-9815
Applicant's File No.	SS-80172
Insurer's Claim File No.	1005801-04
NAIC No.	16616

ARBITRATION AWARD

I, James Hogan, 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

1. Hearing(s) held on 08/02/2019
Declared closed by the arbitrator on 08/02/2019

Greg Itingen from Samandarov & Associates, P.C. participated in person for the Applicant

Mark Zemcik from American Transit Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 827.68**, 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 EIP, a 38 year old female, was injured in a collision on 9/14/17. This claim is for services provided to the EIP on 12/1/17 in the form of:

An initial office visit billed under CPT code 99204 at \$148.69;

A lumbar paravertebral sympathetic injection billed under CPT code 64520 at \$325.89;

Ultrasound guidance for needle placement billed under CPT code 76942 at \$262.91;

Supplies billed under CPT code 99070 at \$55.00;

Drug screening billed under CPT code 80104 at \$35.19.

The total amount of the Applicant's claim is \$827.68.

On 4/18/18, Respondent issued an NF-10 in which it denied the Applicant's claim based upon a peer review done by Dr. Peter Chiu who opined that the services provided were not medically necessary. In addition, Respondent claims that the Applicant's billing exceeds the fee schedule.

Applicant has submitted a rebuttal to the peer review.

4. Findings, Conclusions, and Basis Therefor

This decision is based upon my review of the electronic file maintained by the American Arbitration Association, and the arguments of the parties set forth in the hearing.

SUMMARY OF THE CASE:

The EIP, a 38 year old female, was injured in a collision on 9/14/17. This claim is for services provided to the EIP on 12/1/17 in the form of:

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Applicant has submitted a rebuttal to the peer review.

Applicant's submission:

The Applicant has provided a copy of its billing. (see above)

On 12/1/17, the EIP had an initial consultation with the Applicant. She reported being involved in an MVA on 9/14/17. As result of the impact, she suffered injuries to her neck and back.

She presented with complaints of neck pain radiating to the right upper extremity with tingling rated at 4/10. The upper extremity pain was rated at 6/10 in the right arm.

She also complained of low back pain which radiated to the left buttock and the left lower extremity with numbness and tingling. Her low back pain and the pain in the buttock and lower extremity were all rated at 8/10.

She has been undergoing physical therapy, chiropractic and acupuncture at the rate of 3 times per week.

An MRI of the cervical spine done on 10/3/17 did not show any disc abnormalities.

An MRI the lumbar spine done on 10/21/17 showed disc bulges at L4-5 and L5-S1 with a disc herniation at L4-5.

The examination of the neck did not find any evidence of atrophy or asymmetry. Palpation found tightness and tenderness of the bilateral paraspinal musculature and midline bony elements. The range of motion of the cervical spine was quantified as reduced in all planes. There was no evidence of crepitation, laxity or instability. Manual muscle testing found decreased strength.

The examination of the upper extremities did not find any swelling, redness or ecchymosis. There was no tenderness upon palpation. The range of motion was indicated as full. There was no crepitation, laxity or instability. Manual muscle strength testing was 5/5 in all upper extremity joints.

The upper back examination did not find any atrophy or asymmetry. There was tightness and tenderness upon palpation in the bilateral paraspinal muscles and midline bony elements. There was no evidence of crepitation, laxity or instability.

The lower back examination did not find any atrophy or asymmetry. There was tightness and tenderness of the bilateral paraspinal muscles and the midline bony elements. The range of motion was quantified as decreased in all planes. There was no evidence of crepitation, laxity or instability. Strength was decreased secondary to pain.

The lower extremity examination did not find any swelling, redness or ecchymosis. Palpation did not find any tenderness. The range of motion was indicated as decreased, but not quantified. There was no crepitation, laxity or instability. Manual muscle testing was 5/5 in all joints except left knee extension which was 4/5.

The sensory examination to light touch was intact in the upper and lower extremities but was decreased in the left L4 dermatome.

DTRs were symmetrical except for the patella which was 1+ and the Achilles which was trace, bilaterally.

Spurling's test was negative. SLR was positive on the left at 30°.

The Assessment was: 1) radiculopathy, lumbosacral region; 2) other intervertebral disc displacement, lumbar region; 3) radiculopathy, cervical region; 4) other cervical disc displacement, unspecified cervical region; 5) muscle spasm of back; 6) other long term (current) drug therapy; 7) other muscle spasm.

The Plan indicates that various treatment options were discussed with the patient. She has elected to undergo a lumbar ESI. In addition, she will continue with physical therapy and a home exercise program as well as analgesic medicines as directed.

This report contains a Procedure Report for lumbar ESI under ultrasound guidance. This injection was administered to the bilateral L5.

On 5/1/18, the EIP had a re-examination with Dr. Jones. Chief Complaints indicate low back pain radiating to the left lower extremity; neck pain radiating to the right upper extremity; lumbar ESI, pre-op visit.

The EIP's accident history is recorded as well as the results of the MRIs of the cervical spine and lumbar spine.

The examination of the upper back, lower back, lower extremities and the neurological examination finds that the upper back examination was generally unremarkable. The range of motion of the cervical spine was not checked.

As to the lower back, the range of motion was quantified as decreased in all planes. There was no atrophy or asymmetry noted. There was tightness and tenderness of the bilateral paraspinal muscles and the midline bony elements. Strength was decreased secondary to pain.

The lower extremity examination did not find any swelling, redness or ecchymosis. Palpation examination did not find any tenderness. The range of motion was listed as decreased, but not quantified. Muscle testing was 5/5 in all joints except for the left knee extension which was 4/5.

The sensory examination was intact in the upper and lower extremities but was decreased in the L4 dermatome on the left. DTRs was symmetrical except for the patella which was 1+ and the Achilles which was "trace bilaterally."

SLR was positive on the left at 30°.

The Assessment was: 1) radiculopathy, lumbosacral region; 2) other intervertebral disc displacement, lumbar region; 3) radiculopathy, cervical region; 4) other cervical disc displacement, unspecified cervical region; 5) muscle spasm of back; 6) other muscle spasm.

The Plan indicates that various treatment options were discussed with the patient and she has elected to undergo a lumbar ESI.

The Applicant has provided a copy of an Operative Report for a Lumbar Epidural Steroid Injection administered on 5/1/18 by Dr. Jones at EMU Surgical Center in Glendale, NY.

The injection was to the L4-5 and L5-S1 interspace. The injection was carried out under fluoroscopic guidance.

The Applicant has provided a copy of an Operative Report for an Epidurogram administered on 5/1/18 by Dr. Jones at EMU Surgical Center in Glendale, NY.

On 5/14/18, the EIP had a follow-up visit with the Applicant. Since this report was generated approximately 6 months after the DOS at issue and after the Respondent issued its NF-10. It was not reviewed in detail.

Respondent's submission:

The Respondent's position is that the Applicant's claim was properly denied based upon a peer review by Peter Chiu, MD.

The Respondent has provided a copy of its NF-10 dated 4/18/18 in which it denied the Applicant's claim. The NF-10 indicates that the Applicant's billing was received on 1/2/18. The date of the final verification request was 2/27/18. The date that the final verification was received was 3/30/18.

On 1/23/18, Respondent sent a letter to the Applicant referencing DOS 12/1/17 and billing in the amount of \$827.68. This letter advises that the Applicant's claim is delayed pending the EUO of the claimant which was scheduled to verify the claim. In addition, in order to properly evaluate the Applicant's claim, additional items are needed. These include all medical reports, progress notes, office notes, treatment records/notes, diagnostic test reports and medical records referrals for which surgery/procedure was found to be necessary and letter of medical necessity to show causal relationship to the accident of record.

This letter carries the 120 day warning. A copy of this letter was sent to the EIP and her attorney.

On 2/27/18, Respondent sent another letter to the Applicant referencing DOS 12/1/17. This letter was marked Second Request. It reiterates the same information contained in Respondent's 1/23/18 letter.

This letter also carried the 120 day warning and a copy was sent to the EIP and her attorney.

The Respondent has provided a copy of an EUO Notice, dated 1/5/18, which is addressed to the EIP's attorney with a copy being sent to the EIP. This notice indicates that an EUO was scheduled for the EIP and would take place on 2/20/18 at Respondent's office in Brooklyn at 9:00 a.m.

The Respondent has provided proof of mailing of the EUO notice to the EIP.

The Respondent has provided a copy of a 2nd EUO Notice, this one dated 2/21/18, and schedules the EUO for the EIP at its office in Brooklyn on 3/30/18 at 11:00 a.m. This letter was sent to the EIP's attorney with a copy going to the EIP.

The Respondent has provided copies of proof of mailing for the 2nd notice.

The Respondent has provided an EUO transcript of the EIP dated 3/30/18. The Respondent's submission contains 10 pages.

Peer Review:

Peter Chiu, MD, PMR, did a peer review on 4/10/18. The purpose of the peer review was to evaluate the medical necessity for the evaluation, lumbar paravertebral nerve block injection with ECO guidance, injection needle, and drug screening performed on 12/1/17 by the Applicant with billing totaling \$827.68. He is also going to discuss the medical necessity of other services provided by other providers to the EIP.

There is a list of medical records that were reviewed. These include the 12/1/17 evaluation at the Applicant as well as the paravertebral nerve block injection, ECO guidance, and the drug screening.

Also listed are documentation from other providers.

In his Summary Assessment, Dr. Chiu says that after reviewing the medical records, he found them sufficient to arrive at a conclusion, within reasonable degree of medical certainty, that the evaluation, lumbar paravertebral nerve block injection and ECO guidance, injection needle and drug screening performed on 12/1/17 by Phoenix Medical Services, PC, and other services provided to the EIP by other providers were all not medically necessary.

He notes that the EIP was involved in an MVA on 9/14/17 and was evaluated at Brooklyn Hospital had x-rays taken and was subsequently released.

On 9/21/17, she was evaluated by Dr. Onofater. That evaluation revealed normal motor examination and no sensory or reflex examination. There is no specific provocative elbow or wrist exam. There was a non-specific provocative shoulder (impingement test) and knee (McMurray) exam. He listed subjective complaints and notes that the

complaints and the physical examination findings were consistent with a sprain/strain injury of the spine and contusion would strain of the shoulder, elbow, wrist and knee. He notes that physical therapy was recommended as well as MRI testing, ultrasound and supplies. There was no history of drug abuse, narcotic use or controlled substance being prescribed toward toxicology testing.

On his 10/12/17 follow-up evaluation, Dr. Onefater revealed non-specific sensory (decrease) changes, a normal motor exam and no reflex exam. This evaluation was done within 8 weeks of the accident. The neurological findings were non-specific as it normally takes many weeks or months for true objective neurological deficits to manifest on physical examination findings which was not the case for the EIP. There was no specific provocative shoulder exam. The claimant was recommended for nerve testing and physical therapy. There was no history of drug abuse, narcotic use or control substance being prescribed toward toxicology testing.

He then refers to the 12/1/17 evaluation by Dr. Jones saying that it revealed non-specific motor (4/5) and sensory (decrease) changes and a normal reflex exam. The patient was recommended for injection and drug screening. There was no history of drug abuse, narcotic use, or controlled substance being prescribed to warrant toxicology testing.

The follow-up examination by Dr. Onefater on 12/16/17 did not find any motor, sensory or reflex examination. There was no specific provocative shoulder examination. Physical therapy was recommended.

On 1/26/18, the EIP was evaluated again by Dr. Onefater. There was a normal motor examination, nonspecific sensory (decreased) changes and no reflex exam. There was a non-specific provocative shoulder (impingement sign) exam. Physical therapy was recommended along with an injection into the shoulder.

The results of the MRI report of the lumbar spine are reported. As per Dr. Chiu, the MRI findings do not reveal any acute traumatic condition (e.g., compression fracture, significant spondylolisthesis, etc.) and there was no cause or a related arthritic condition, spinal cord or exiting nerve root involvement to warrant this type of injection.

He opines that it is unclear how the MRI testing of the cervical, lumbar and right shoulder as well as the nerve testing of the upper and lower extremities would alter the treatment plan as there was no indication that the claimant was a candidate for surgery, joint injection or ESI at this time.

He also notes that the MRI testing and nerve tests were performed with less than 6 weeks of conservative (physical therapy) treatment which would not be the standard of care.

He then discusses the medical necessity for the MRI the cervical spine and the MRI the lumbar spine. He opines that neither of these scans were medically necessary. The same is true with regard to the MRI of the right shoulder.

As to the lumbar paravertebral nerve block injection with echo guidance performed on 12/1/17, Dr. Chiu defines what a median branch block injection does and notes that this is often part of a two-step diagnostic and treatment approach. He notes that if the patient experiences marked pain relief immediately after the injection, then the facet joint is determined to be the source of the patient's pain. This procedure is primarily diagnostic, meaning that if the patient has the appropriate duration of pain relief after the medial branch nerve block, then he or she may be a candidate for a subsequent procedure - a medial branch radiofrequency neurotomy (ablation) for longer pain relief.

Second, the role of a medial branch radiofrequency neurotomy (ablation) is that in cases where the medial branch block has confirmed that patient's pain originates from facet joint, this procedure can be considered for longer-term pain relief. It is a type of injection procedure in which a heat lesion is created on the nerve that transmits a signal to the brain. The goal is to interrupt the pain signal to the brain while preserving other functions, such as normal sensation and muscle strength.

Facet joint injections involve an injection of anti-inflammatory steroid solution directly into the joint. If such an injection confirms the facet joint as a likely source of the patient's pain, but this injection - along with other treatments (such as physical therapy, manual manipulation and medications) have not resulted in long-term pain relief, then a medial branch block may be recommended. As evidence evolves on the efficacy of facet joint injections, a medial branch block may also be considered instead of a facet joint injection. A medial branch block might also be considered first if for any reason the patient cannot tolerate the steroid and/or injection directly into the facet joint.

He goes on to note that the medial branch block nerves do not control any major muscle or carry any sensation in the arms or legs so there is no danger of negatively affecting those areas or negatively affecting other sensation processes with the medial branch block. They control small muscles in the neck as well as the mid and lower back but loss of these nerves has not proved harmful. He goes on to describe the procedure and the interaction with the patient thereafter. He also discusses the potential risks involved in such a procedure.

In support of his statements, Dr/ Chiu refers to a website, www.spinehealth.com/treatment/injections/medical-branch-nerve-block.

He then says that there was no indication that this claimant's pain condition was causally related to facet arthropathy (a chronic condition) and the incident; hence, this type of injection was not causally related or medically necessary as related in this incident.

He refers to another article found that the same website entitled Symptoms and Diagnosis of Facet Joint Problems. He then lists a number of symptoms, 5 in all, and then discusses reactions by patients. He also discusses forming the diagnosis and the role played by X-rays, CT and MRI.

He notes that anesthesiologists have been performing facet joint and nerve root blocks for more than 50 years. These procedures have been refined and fluoroscopic and CT

guidance have become popular because they are more precise with regard to the placement of the needle. He discusses some of the problems that might be encountered with various types of patients. In support of the statements he refers to an article entitled Paraspinal Injections - Facet Joint and Nerve Root Blocks updated on 1/26/12. This can be found at a website, <http://emedicine.medscape.com>.

Dr. Chiu also refers to the NYS WCB Mid and Low Back Medical Treatment Guidelines stating that diagnostic facet joint injections are recommended for patients with pain suspected to be largely facet in origin based upon findings and/or documented evidence of facet disease, and who have completed a documented course of conservative management.

He then discusses the need for the toxicology screen done on 12/1/17. He has lifted a section from a website <http://www.nlm.nih.gov/medlineplus/ency/article/003578.htm> saying that these screens refer to various test to determine the type and approximate amount of legal or illegal drugs a person has taken. It may help determine the cause of acute drug toxicity, to monitor drug dependency, and to determine the presence of substances in the body for medical or legal purposes. He then notes that the drug screen must be done during a certain period after the drug has been taking or while forms of the drug can still be detected.

In the instant case, there was no history of illegal drug use, no history of drug abuse and no history of narcotic use at the time when the screen was performed and the EIP was not being prescribed narcotic medication; hence, it would not be medically necessary or causally related to the accident to perform a toxicology screen. In addition, there was no medical necessity for using narcotics for causally related sprain/strain conditions beyond the first 1-2 weeks post-injury and hence no indication for toxicology testing at this point.

He further supports his arguments by referring to the NYS WCB Medical Treatment Guidelines.

Dr. Chiu then discusses the medical necessity for electrodiagnostic testing of the upper and lower extremities administered to the EIP by a different entity on 10/12/17.

He then discusses the medical necessity for ultrasounds of the elbow and wrists done on 9/21/17.

His next topic is the outcome assessment testing done on 12/16/17 - 01/05/18.

This is followed by range of motion and manual muscle testing that was done on 12/26/17.

He then discusses the medical necessity for the shoulder injection under ultrasonic guidance administered on 1/26/18.

His next topics are the medical necessity for a wrist orthosis and knee orthosis provided to the EIP on 9/29/17.

He concludes that all of the items that he has reviewed were not medically necessary.

The Respondent has provided copies of the Applicant's billing as well as other bills for services that were the subject of the peer review from other providers.

Also provided was a copy of the 12/1/17 report of the examination of the EIP by the Applicant.

Copies of the MRI report for the cervical spine and the lumbar spine have been provided as well as the MRI report for the right shoulder. Also provided are copies of the ultrasound reports for the right wrist and right elbow.

In a Supplemental Submission the Respondent has provided copies of other documents/tests/reports referred to by Dr. Chiu in his peer review.

Also provided are copies of the physical therapy and chiropractic progress notes as well as copies of examination of the EIP by Dr. Onefater.

I noticed that the Respondent has not provided copies of the articles or websites referred to by Dr. Chiu in his peer review report. While this is not a fatal error, it does have a negative impact upon the weight of the report.

Applicant Rebuttal to Peer Review:

Dr. Jones has filed a rebuttal to the peer review. He recounts the EIP's accident history, the findings of the MRI report for the lumbar spine, the findings on his examination dated 12/1/17 and the fact that he administered a lumbar paravertebral nerve block at the bilateral L5 levels under ultrasonic guidance on 12/1/17. He opines that this was medically necessary.

He then refers to the peer review by Dr. Chiu and opines that Dr. Chiu has failed to establish the relevancy of the multiple articles and literature that he cited with the current case. He only stated that the injection was not causally related to the motor vehicle accident and as a result, there was no medical necessity for the injection as well as the office visit.

As per Dr. Jones, Dr. Chiu made no attempt to causally relate and establish that the patient had facet joint involvement due to the motor vehicle accident and as a result she should undergo facet joint injection. "It would be like conforming to specific requirements to justify one's actions. (sic)

In fact, the clinical presentation of the patient was the sole guide in assessing the patient's condition objectively. As the patient had no prior low back pain prior to the accident, the presence of low back pain was causally attributed to the motor vehicle accident. Further, to evaluate the cause of the low back pain, appropriate physical examination of the low back region confirmed the facet joint involvement. Reproducible tenderness in the lower back region at multiple levels post MVA warranted careful

evaluation diagnostic confirmation of facet joint involvement. Since the patient was completely asymptomatic prior to the MVA with lumbosacral localized tenderness and paravertebral spasm manifesting only after the accident facet joint involvement would not be completely ruled out." (sic)

He then discusses the propriety of the nerve block and its efficacy in treatment of chronic pain syndromes. "Paravertebral nerve block often helps the treating practitioner determine the anatomic origin of the patient's pain." He refers to a 2009 article found in Pain Physician which says "the evidence for the diagnosis of lumbar facet joint pain with local anesthetic blocks is level I." Dr. Jones then says that the lumbar paravertebral nerve block provided to the patient was to diagnose the posterior elements in pain generator as well as to provide pain relief.

"An article from Pain Physician March/April 2009; 12(2); 437-460; noted that 'Systematic Assessment of Diagnostic Accuracy and Therapeutic Utility of Lumbar Facet Injections' states that evidence for the diagnosis of lumbar facet pain with controlled local anesthetic blocks is level I and II."

Dr. Jones then says that a paravertebral nerve block usually has 2 goals: to help diagnose the cause and location of pain and also to provide pain relief.

He then discusses the diagnostic goal and the goal to relieve pain.

He says that if Dr. Chiu had reviewed the medical records in detail, he would be able to make out that the patient's course of treatment findings were indeed matching these guidelines and articles.

The EIP had complaints of radiating pain in the lower back with other neurological symptoms. The lower back condition failed to improve with conservative therapy. There was a clear need for some modification in the treatment plan. There was an apparent possibility of the need of the lumbar nerve block. Therefore, Dr. Jones decided to perform the paravertebral nerve block to treat pain and to identify the exact nerve generating radiating pain. His decision to perform the nerve blocks was wise, prudent and in the interests of the patient. It was medically necessary and justified.

He also comments on the office visit done on 12/1/17 saying that it, too, was equally medically necessary. Office visits not only allow for the treatment of chronic known disorders but also provide opportunities to screen and prevent other diseases from occurring. Often, a patient will come in with one complaint and leave having another diagnosis made. As per Dr. Jones, through an office interaction patients are screened and examined. Office visits create opportunity. If there are no routine opportunities then the only time the patients are seen is when the disease is present and manifested. So, office visits are essential in providing quality care. It provides an opportunity for impact. The patient encounters offer a chance to make a difference and to use each encounter to its fullest potential.

He then comments on the comprehensive drug screening test. He refers to Dr. Chiu's comments and opines that Dr. Chiu it seems that is not reviewed the patient's medical

records carefully. It is clear from the medical records that the patient was taking analgesic medications. Since these medications are habit-forming, it was necessary to perform the drug screening. In addition, the performance of the drug screening was incorporated into the evaluation report.

Dr. Jones then discusses the need for the drug screening test.

He then refers to the reliance by Dr. Chiu on the NYS WCB Medical Treatment Guidelines saying that these are not peer review authorities and refer to workers compensation claims as compared to No-fault claims. As such, they should not be considered as an authority to support the denial of the services at issue.

Dr. Jones also opines that the peer review by Dr. Chiu was self-serving and biased in the selective use of only the facts that support his conclusions but worse yet as wholesale misrepresentations of selected articles in addition to trying to present other articles as relevant when they are clearly unrelated to the case.

He concludes by saying that the services rendered were medically necessary.

At the hearing:

The Applicant argued that the peer review was not focused on the injection at issue. Dr. Chiu was more interested in the other services that he was reviewing, and only opined that the injection was not medically necessary and not causally related to the MVA.

As to the drug screening, Dr. Jones discusses this in his rebuttal. It was noted that the screening was 2 ½ months after the accident, but the patient was taking medication that could have been habit forming. Further, this was the EIP's initial office visit with Dr. Jones.

Respondent argued that, as per Dr. Chiu, there was no indication that the EIP was abusing drugs or using narcotics, so the testing was not medically necessary.

Respondent also argued that the rebuttal was not convincing. The records cited in the rebuttal were in conflict.

FINDINGS:

The Applicant has established its prima facie case.

This claim is for services provided to the EIP on 12/1/17 in the form of:

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The total amount of the Applicant's claim is \$827.68.

On 4/18/18, Respondent issued an NF-10 in which it denied the Applicant's claim based upon a peer review done by Dr. Peter Chiu who opined that the services provided were not medically necessary. In addition, Respondent claims that the Applicant's billing exceeds the fee schedule.

Applicant has submitted a rebuttal to the peer review.

I have reviewed all of the documentation contained in the file and I have listened to the arguments of the parties at the hearing.

I fail to understand why an initial office visit may be deemed medically unnecessary when a patient presents advising she was involved in an MVA 2½ months prior to the visit and had complaints of pain in the neck, back, upper extremities and lower extremities.

I note that the office visit was comprehensive in nature and included quantification of the range of motion of the cervical spine and lumbar spine as well as provocative orthopedic testing in the form of a Spurling's test and SLR. In addition, a neurological examination was recorded.

Further, Dr. Chiu says that much of the services provided by the Applicant were not causally related to the MVA.

It is well-settled that an Applicant may rebut the insurance causality defense by showing that the insurer's determination as a lack of causation was improper. Bronx Radiology, PC v. New York Central Mutual Fire Ins. Co. 847 NYS2d 313, 17 Mics 3d 97, the Applicant says that the court set forth the parties' respective burdens with respect to establishing causation, or lack of causation, in a no-fault action.

"In a typical negligence action, plaintiff's burden to establish causation is met by a showing that the accident was a proximate cause of the claimed injuries (citation omitted). However, in an action to recover first party no-fault benefits, a plaintiff bears no such burden and establishes his or her prima facie case by proof that the claim form was mailed and received, and that the insurer failed to pay within the 30-day statutory period. (citation omitted). In essence, causation is presumed since 'it would not be reasonable to insist that a [medical provider] must prove as a threshold matter that its patient's condition was caused' by the automobile accident. Mount Sinai v. Triboro Coach, 263 AD2d 11, 699 NYS2d 77 (1999). Thus, the burden is on the defendant insurer to come forward with proof established by 'fact or founded belief' its defense that the claimed injuries have no nexus to the accident. Central Gen. Hosp. v Chubb Group of Ins. Cos. 90 NY2d 195, 199, 659 NYS2d 246, 681 NE2d 413 (1999)."

After reviewing the peer review and the rebuttal, I am not convinced that the services provided to the EIP, including the drug screening test was not medically necessary.

The claim is awarded.

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	Total	Status
	Phoenix Medical Services P.C.	12/01/17 - 12/01/17	\$827.68	\$ 827.68	Awarded: \$827.68
Total			\$827.68	Awarded: \$827.68	

- B. The insurer shall also compute and pay the applicant interest set forth below. 06/25/2018 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

I find that the date for interest to accrue is the date of the filing of the arbitration, 6/25/18 as this is the date when the Applicant's filing was processed and notice of the arbitration sent to the Respondent. As per Insurance Regulation 65-3.9, interest is due until such amount is paid, and without demand therefor.

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's attorney as per 11 NYCRR 65-4.6 (e). However, if the award and interest is equal to, or less than, Respondent's written offer during the conciliation process, then the attorney's fee shall be based upon 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 Suffolk

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

08/03/2019

(Dated)

James Hogan

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

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Electronically Signed

Your name: James Hogan
Signed on: 08/03/2019