American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Accelerated Surgical Center of North Jersey (Applicant)	AAA Case No.	17-19-1126-1948
	Applicant's File No.	230190
- and -	Insurer's Claim File No.	0554719080101020
	NAIC No.	35882
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Cathryn Ann Cohen, 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 06/22/2020
   Declared closed by the arbitrator on 06/22/2020

   Kurt Lundgren, Esq. from Thwaites, Lundgren & D'Arcy Esqs participated by telephone for the Applicant

   Chelsea Waller from Geico Insurance Company participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **$ 5,172.64**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The amount in dispute was amended to $1423.90.

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

3. Summary of Issues in Dispute

   Whether Applicant is entitled to reimbursement for medical services provided to Assignor a 59-year old male driver involved in a motor vehicle accident on November 5, 2018 that Respondent dened based on a peer review opining the services were not medically necessary.

4. Findings, Conclusions, and Basis Therefor

Applicant seeks $1,423.90 reimbursement for facility fees in connection with bilateral lumbar facet joint injections performed at L3-4, L4-5 and L5-S1 and cervical trigger point injections on February 20, 2019 on Assignor a 59-year old male driver involved in a motor vehicle accident on November 5, 2018. Respondent denied reimbursement based on a peer review opining the services were not medically necessary. I have reviewed the documents contained in the ADR Center record of the case maintained by the AAA as of the date of the hearing.

It is well settled that a health care provider establishes a prima facie case of entitlement to recover first-party no-fault benefits by submitting proof that the prescribed statutory billing forms, setting forth the fact and the amount of the loss sustained, had been mailed and received and that payment of no-fault benefits was overdue. (*see Insurance Law Sec. 5106[a]; Mary Immaculate Hosp v. Allstate Ins. Co.,* 5 AD3d 742 [2004]. Respondent's denial(s) indicating receipt of the proof of claim shows that Applicant mailed the proof of claim form(s) to the Respondent (*see Ultra Diagnostic Imaging v. Liberty Mutual Insurance Co.,* 9 Misc3d 97). The evidence is sufficient to make out a prima facie case of entitlement to recovery of Applicant's bill.

Once Applicant has established a prima facie case the burden shifts to the insurer to prove that the medical treatment was not medically necessary (*see Citywide Social Work & Psychological Services v Allstate Ins. Co.*, 8 Misc3d 1025A; *A.B. Medical* Services, *v Geico Ins. Co.*, 2 Misc3d 26). Neither the Insurance Law nor the Regulations define "medical necessity." A review of case law reveals that most courts have evaluated medical necessity based on whether or not services provided were in accord with the generally accepted medical practices. Therefore, to prove that the services were not medically necessary, at a minimum, lack of necessity must be supported by competent evidence such as an IME or peer review or other proof which sets forth a factual basis and medical rationale for denying the claim. A peer review report's medical rationale is insufficient if it is unsupported by or controverted by evidence of medical standards (*see Nir v. Allstate Insurance Company* 7 Misc3d 544).

Where the insurer presents sufficient evidence to establish a defense based on lack of medical necessity, the burden shifts to the plaintiff which must present its own evidence of medical necessity (*see West Tremont Medical Diagnostic, P.C. v Geico Ins. Co.,* 13 Misc3d 131(a)).

Respondent relies on the peer review of Miranda Smith, M.D. The peer notes that Assignor was involved in a motor vehicle accident on November 5, 2018. The peer notes that Assignor was evaluated by Dr. Gorman on January 18, 2019 for persistent neck and low back pain. There was significant tenderness and decreased range of motion in the cervical and lumbar spine. Reflexes were diminished in the right and

left lower extremities. Weakness was appreciated in the right upper extremity. SLR was positive bilaterally. Right knee exam revealed tenderness and decreased range of motion. Lumbar facet joint injection was planned. On February 20, 2019 bilateral lumbar facet joint injections were performed at L3-4, L4-5 and L5-S1 levels. Cervical trigger point injections were also performed. The peer states the lumbar facet joint injections were not necessary because the diagnosis of facet mediated pain remains speculative. The peer also states targeting three facet joints bilaterally is considered excessive. The peer states that an initial and confirmatory diagnostic injection should be performed with anesthetic alone followed by assessment to the patient's pain response to typically provocative maneuvers during the life of the anesthetic. No such diagnostic injections were performed in this case. Rather a therapeutic procedure with the injection corticosteroid is described. There is no role for therapeutic medial branch block injections. The peer states that in this case there does not appear to be a diagnostic algorithm employed in which limited and selective diagnostic injections were utilized to first diagnose an underlying posterior element pain generator in an effort to assess the patient's candidacy for a possible therapeutic injection or intervention. The peer states that exam findings and imaging are unreliable in assigning a diagnosis of facet mediated pain. The peer notes a study in *Spine* on percutaneous lumbar RFA in management of chronic low back pain that found patients who meet the criteria of positive response to three separate facet joint blocks, RFA was effective. The peer points out that because the exam did not reveal active trigger points and taut bands, medical necessity for cervical trigger point injections was not established adding that the performance of which do not require anesthesia. The peer states further that there was no need for sedation with these spinal injections which may carry added risk.

Applicant submits a rebuttal from Eugene Gorman, M.D. The rebuttal argues the peer incorrectly concluded the lumbar facet injections and trigger point injections were not medically necessary based on her belief that the diagnosis of facet mediated pain remains speculative, that diagnostic medial branch block should be performed with anesthetic alone and there were no taut bands in the cervical area. The rebuttal points out that the references cited by the peer state that exam findings and imaging are not reliable and it is only through diagnostic intra-articular or a diagnostic medial branch block that diagnosis of facet-mediated pain can be confirmed. This patient had persistent lower back pain which failed to respond to conservative treatment including a series of lumbar ESI. Moreover, according to NYSWCB New York Mid and Low Back Injury Medical Treatment Guidelines (2014), the diagnostic component (anesthetic only) may be combined with a steroid into a single diagnostic/therapeutic injection. There is high quality evidence which the rebuttal cites supporting the accuracy of diagnostic facet injections and efficacy of therapeutic facet joint injections in managing lumbar facet joint pain after failure of conservative treatment. Also, the rebuttal points out it is not always necessary to have the classical clinical examination findings of taut bands with local twitch response and referred pain pattern before performing cervical trigger point injections. Assignor had tenderness in the cervical area and myalgia for which trigger point injections may be used. The rebuttal discusses the records including the initial exam by his colleague Allan Weissmna, M.D. on November 12, 2018, his re-evaluation on December 26, 2018 at which time lumbar ESI was performed and

his re-evaluation on January 18, 2019 when repeat lumbar ESI were performed. On February 20, 2019 Assignor reported moderate relief but he still had lower back pain graded 7/10 and decreased range of motion at which time lumbar facet pathology was entertained and the injections were performed. The peer is wrong that no diagnostic injection was performed in the case and that a therapeutic procedure was prescribed. On the contrary, the diagnostic component consists of an anesthetic and the therapeutic component, a corticosteroid. Combining them in a single diagnostic/therapeutic injection is consistent with the guidelines. Facet joint injections are both diagnostic and therapeutic. Disagreeing with the peer that the number of injections was excessive, the rebuttal argues multiple injections are often required. Here, Assignor continued to experience lumbar pain despite months of conservative care including lumbar ESI. If the patient experiences marked pain relief after the injection - such as the case here - then the facet joint is determined to be the source of the pain and may be a candidate for RFA. The rebuttal meaningfully addresses all aspects of the peer's opinion, establishes medical necessity for the disputed services and is sufficient to refute the peer review.

Accordingly, Applicant's request for reimbursement is granted.

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
	Accelerated Surgical Center of North Jersey	02/20/19 - 02/20/19	$5,172.64	$1,423.90	Awarded: $1,423.90
Total			$5,172.64		Awarded: $1,423.90

B. The insurer shall also compute and pay the applicant interest set forth below. 04/17/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

In accordance with 11 NYCRR 65-3.9(c) interest shall be paid on the claim awarded in the amount of $1423.90 from April 17, 2019 the date the arbitration request was received by the AAA.

C. Attorney's Fees

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

In accordance with 11 NYCRR 65-4.6(d) the insurer shall pay Applicant an attorney's fee on the claim awarded in the amount of $1423.90.

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 New York

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

07/02/2020
(Dated)

Cathryn Ann Cohen

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:
6641ce49635d6d858ce9953938ad62c6

Electronically Signed

Your name: Cathryn Ann Cohen
Signed on: 07/02/2020