

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Metropolitan Medical and Surgical, P.C.  
(Applicant)

- and -

Integon National Insurance Company  
(Respondent)

AAA Case No. 17-19-1123-0569

Applicant's File No. 00035044

Insurer's Claim File No. 9SINY03367-01

NAIC No. 29742

**ARBITRATION AWARD**

I, Rhonda Barry, 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 12/01/2020  
Declared closed by the arbitrator on 12/01/2020

Justin Rosenbaum, Esq. from Drachman Katz, LLP participated by telephone for the Applicant

John Rossillo, Esq. from Rossillo & Licata LLP participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 2,258.38**, was AMENDED and permitted by the arbitrator at the oral hearing.

At the hearing, the applicant's counsel amended the amount in dispute from \$2,258.38 to \$2,150.38 based upon the applicable fee schedule for medical services in this case.

Stipulations WERE made by the parties regarding the issues to be determined.

The parties stipulated that the denials are timely. If applicable, interest accrues in accordance with 11 NYCRR§65-3.9.

3. Summary of Issues in Dispute

The EIP, "JR" is a 37 year old male injured as a driver in a motor vehicle accident on 3/29/18. There was no loss of consciousness or hospital attention. Applicant seeks \$2,150.38 for lumbar epidural injections, epidurogram, trigger point injections and urine toxicology testing on DOS 10/30/18 and 11/20/18. Respondent denied applicant's claim based upon lack of medical necessity according to the peer reviews of Jay Weiss, MD, PMR. Applicant submits a rebuttal from Mark Gladstein, MD.

#### 4. Findings, Conclusions, and Basis Therefor

I have completely reviewed all timely submitted documents contained in the ADR Center record maintained by the American Arbitration Association and considered all oral arguments. No additional documents were submitted by either party at hearing. No witnesses testified at hearing.

#### ANALYSIS

Applicant has established its prima facie entitlement to reimbursement for no fault benefits based upon the submission of a properly completed claim form setting forth the amount of the loss sustained and that payment is overdue. Mary Immaculate Hospital v. Allstate Insurance Company, 5 AD3d 742, (2<sup>nd</sup> Dept. 2004). Westchester Medical Center v. Lincoln General Ins. Co., 60 AD3d 1045 (2<sup>nd</sup> Dept. 2009).

The burden now shifts to respondent to establish a lack of medical necessity with competent medical evidence which sets forth a clear factual basis (specifics of the claim) and medical rationale for denying the claim. Citywide Social Work and Psych Services, PLLC v. Allstate 8 Misc. 3d 1025A (2005); Healing Hands Chiropractic v. Nationwide Assurance Co., 5 Misc. 3d 975 (2004). Respondent must offer sufficient and credible medical evidence that addresses the standards in the applicable medical community for the services and treatment in issue; explains when such services and treatment would be medically appropriate, preferably with understandable objective criteria; and why it was not medically necessary in the instance at issue.

Respondent's peer review must address all of the pertinent objective findings contained in applicant's medical evidence. It must then clearly explain why, notwithstanding those findings, the disputed service was inconsistent with generally accepted medical or professional practices. Amaze Medical Supply Inc. v. Eagle Insurance Co., 2 Misc. 3d 128(A), Citywide Social Work, et al, v. Travelers Indemnity Company, 3 Misc. 3d 608.

Dr. Weiss considered sufficient medical records including an MRI of the lumbar spine (4/30/18) which revealed multiple herniations with facet arthropathy and compression on exiting nerve roots. Dr. Altai examined the EIP initially on 4/2/18 documenting complaints of low back pain radiating to the buttocks and left knee pain. There was no numbness or tingling. There was spasm, decreased range of motion but a normal neurological examination. Follow-up evaluations noted complaints of pain and the need for trigger point injection. There was reduced range of motion but no further specifics. Dr. Mian examined the EIP on 7/31/18. The EIP complained of low back pain but

without numbness, tingling or weakness. Pain did not radiate to the lower extremities and gait was normal. There was spasm and tenderness over facet joints and decreased range of motion. Straight leg raise was negative. Sensation, muscle strength and reflexes were normal. Dr. Gladstein examined the EIP on 10/30/18; there were complaints of low back pain radiating to the right buttocks with numbness and tingling to the left shin. There was pain on lumbar flexion and extension as well as tenderness and trigger points. Facet loading was positive but there were no abnormalities of strength, sensation and reflexes. Straight leg raise was positive at 50°.

Citing to the New York State Mid and Low Back Injury Medical Treatment Guidelines, Dr. Weiss sets forth a standard of generally accepted medical practice with respect to the LESI.

Applicant opines that Dr. Weiss' reliance on the Workers Compensation Guidelines is at best misplaced. The goal of the Worker's Compensation Medical Treatment Guidelines (and its recommendation for conservative care) is to increase range of motion so as to return the EIP to the workforce as soon as possible while the goal of the no fault law is to return the patient to his pre-accident status. Therefore, Dr. Weiss' reliance upon the Workers Compensation Guidelines is insufficient to sustain respondent's burden of proof.

I agree with applicant to the extent that the Workers Compensation Medical Treatment Guidelines alone are not binding or necessarily dispositive in no-fault cases. However, as Arbitrator Wiener noted, "It is logical to look at the only codified treatment guidelines in New York State, the New York State Workers Compensation Board Treatment Guidelines. These guidelines developed by representatives of the Insurance Department, the Worker's Compensation Board, the Department of Labor and most importantly highly qualified and respected medical professionals... are codified and are contained in the New York codes, rules and regulations at 12 NYCRR part 324." (Elite Medical Care New York, PC v. Allstate Property Casualty Insurance Company, AAA # 412014018767, 10/27/14). At [www.WCB.NY.gov](http://www.WCB.NY.gov), frequently asked questions, Workers Compensation Board specifically states that the medical treatment guidelines of the standard of care for treating injured workers in New York, *and are based on the best available medical evidence and consensus of experienced medical professionals.* (Emphasis added).

The Guidelines offer useful information that may, in consideration of the factual situation presented, provide a generally accepted standard of care for the medical community as a whole, particularly when coupled with the peer reviewer's experience as a physician. Many applicants cite to the Guidelines in rebuttal.

The standard of care in the medical community is that an ESI is not effective for lumbar axial pain or non-radicular pain syndrome. It is not recommended for acute or non-acute back pain in the absence of significant radicular symptoms. Further it is not recommended as a first or second line of treatment in individuals with back pain symptoms that predominate over leg pain.

Citing to other medical authority, Dr. Weiss notes that in patients with persistent radiculopathy due to herniated disc, it is recommended that clinicians discuss risks and benefits of epidural steroid injections as an option.

With respect to the trigger point injections, despite the use of the term trigger point, no actual focal trigger points were noted to be present. Tenderness does not qualify as a trigger point. Trigger point injections are indicated in those patients where well circumscribed trigger points had been consistently observed demonstrating a local twitch response, characteristic radiation of pain pattern and local autonomy reaction such as persistent hyperemia following palpitation.

Dr. Weiss also concluded that the urine drug testing was unnecessary as the EIP was not taking opioid analgesics nor any being contemplated for prescription. Dr. Gladstein's 10/30/18 report notes the EIP uses cyclobenzaprine, diclofenac sodium and naproxen, none of which are opioids.

As to the repeat injection on 11/20/18, Dr. Weiss asserts that the EIP was seen by Dr. Gladstein. There was 1 to 2 weeks of relief with the previous injection and the pain returned. The EIP again presented with low back pain radiating to the left buttock without numbness or tingling. There was pain on flexion and extension, and facet loading. As with the 10/30/18 injection there was no radicular component; no radiation of pain below the level of the buttock. For non-radicular pain, lumbar epidural injections would not be indicated. Furthermore, without significant improvement in the radicular component of pain with the previous injection, repeat injections would not be indicated. Citing again to the New York Mid and Low Back Injury Medical Treatment Guidelines, Dr. Weiss explains that a second epidural injection is not recommended if following the first injection there has been a resolution of symptoms of the acute radicular pain syndrome. If there has been no response, there would be no recommendation for a second injection. Dr. Weiss reiterates the same arguments as to the trigger point injections.

Dr. Weiss provided a highly detailed standard of generally accepted medical practice for performing the LESIs and associated services. See, Williamsbridge Radiology and Open Imaging v. Travelers Indemnity Company, 14 Misc. 3d 1231 (A), 836 NYS 2d 496 Further Dr. Weiss' report successfully correlates the medical necessity of the LESIs and associated services to this EIP. See, James Ligouri Physician, PC v. State Farm Mutual Automobile Insurance Company, 2007 NY Slip op 50465 (U) (New York District Court 2007).

Respondent established a reasonable factual basis and medical rationale with its expert opinion as to the medical necessity of the disputed treatment. Applicant must now meaningfully refer to or rebut the conclusions set forth in the peer review. Yklik, Inc v. Geico Ins Co, 2010 NY Slip Op 51336(u) (App Term 2<sup>nd</sup>, 11<sup>th</sup> and 13<sup>th</sup> Jud Dist. 7/22/10). In the absence of such a rebuttal, the claim may be denied. A. Khodadadi Radiology, PC v. NY Cent Mut Ins Co, 16 Misc. 3d 131 (A), 2007 NY Slip Op 51342[U] (App term 2<sup>nd</sup> and 11<sup>th</sup> Jud Dist. 2007).

At hearing, respondent opines that there is no signature on Dr. Gladstein's rebuttal. Rather the rebuttal states "Electronically Signed: Mark Gladstein, MD." While there is no requirement for a peer review and/or rebuttal to be affirmed under the penalties of perjury or notarized, it is incumbent on the arbitrator to evaluate the evidence as submitted and determine whether or not there is probative value. See, Bronx Medical & Diagnostic, PC v. GEICO, AAA # 99-16-1027-3809(Master Arbitrator Hershdorfer).

The rules of evidence are necessarily relaxed at arbitration but the credibility of documents submitted must be carefully considered. The parties are still obliged to offer evidence that adequately and reliably sustains their respective burdens of proof. It is not outside the bounds of rationality to require assurance of the genuineness of documents presented.

Courts have held that an insurer fails to establish a prima facie case of lack of medical necessity where its peer review report is unsigned. Altair Medical, PC v. Clarendon National Insurance Company, 29 Misc. 3d 127 (A), 958 NYS 2d 306 (App. Term 2d, 11th and 13th Districts 2010). A letter of medical necessity which is not sworn or even signed is of no probative value. Innovative MR Imaging, PC v. Praetorian Insurance Company, 49 Misc. 3d 129 (A), 20 NYS 3d 292, 2015 NY Slip op 51402 (U) (App. Term 2d, 11th and 13th Districts 2015).

To the contrary, the 1st Department has held that a physician's affirmation containing an electronic signature complied with CPLR 2106 and that requiring additional evidence is not necessary. Martin v. Portexit Corp., 98 AD 3d 63 (1st Dept. 2012). Likewise, the 1st Department has held that an arbitrator should not adhere to strict conformity to the legal rules of evidence by failing to give weight to a chiropractic IME which was not notarized. See, Auto One Insurance Company v. Hillside Chiropractic, PC 126 AD 3d 423 (1st Dept. 2015).

Initially, I find that there is no need for the rebuttal to be notarized as Dr. Gladstein is a physician. Further, Dr. Gladstein's rebuttal provides a detailed review of his own medical records. The rebuttal corroborates the reports included in the parties' submissions. After careful consideration of the parties' vigorous arguments, the rebuttal is admissible and afforded full weight.

Dr. Gladstein's rebuttal and supporting medical reports is sufficient to refute respondent's burden of proof. Dr. Weiss was not provided with the opportunity to consider the findings on MRI of the lumbar spine. The lumbar MRI (4/30/18) revealed herniated disc at L2/3 with facet arthropathy and compression on the right exiting nerve root. There is a bulge at L3/4 with facet arthropathy and compression on the exiting nerve roots. There was also a bulge at L4/5 and a herniation at L5/S1. Dr. Gladstein opines that the positive MRI findings are indicative of radiculopathy. Further the EIP exhibited positive straight leg raise to out his examinations prior to the LESI. The physical examination findings pointed very clearly to a diagnosis of radiculopathy. As to Dr. Weiss's arguments that there were no abnormalities of strength, sensation and reflexes, Dr. Gladstein argues that lumbar sacral radicular pain is a pain in the

distribution area of one of the nerves of the lumbar sacral plexus with or without sensory and/or motor impairment. The absence of the symptoms does not exclude a diagnosis of lumbosacral radiculopathy.

With respect to the subsequent LESI on 11/20/18, Dr. Gladstein persuasively notes that the EIP's pain scale decreased from VAS 8/10 to 5/10. The patient no longer experiences numbness and tingling and no longer tested positive straight leg raise. The fact that the patient responded positively to the 10/30/18 LESI further confirmed radiculopathy as the pain generator.

I am also persuaded by Dr. Gladstein's arguments with respect to the urine toxicology and the trigger point injections. While Dr. Gladstein acknowledges that the EIP was not taking opioid analgesics are being contemplated for prescription, his purpose in performing the you DT was to ensure safe anesthetic used during the LESI. It was essential to know what was in the patient's symptoms in order to guide the appropriate anesthetic and acute intoxication is a contradiction to certain anesthetics.

As to the trigger point injections, Dr. Gladstein explains that he clearly documented identifiable trigger points in the lumbar and gluteal regions bilaterally. Dr. Gladstein explains that when performing epidural and trigger point injection simultaneously, there is a better chance of achieving results. Performing them separately would increase office visit and keep the patient suffering with pain for a longer period of time. Further, location of the injections is different. TPI's are injected into muscles where as ESI's are administered in the epidural space of the spinal vertebrae. Dr. Gladstein determined that the EIP was suffering from both radicular and myofascial pain in the injections were necessary to treat the patient and address all sources of pain.

After careful consideration of the parties' submissions and the arguments at hearing I find that the performance of the LESIs, TPIs, and urine toxicology testing were not a deviation from generally accepted medical practice.

Applicant's claims are awarded.

Interest: Applicant is awarded interest in accordance with 11 NYCRR§65 - 3.9 (a)-(f). Accordingly, interest is calculated at a rate of 2% per month, calculated on a pro rata basis using the 30 day month. A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. 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. 11 NYCRR §65 - 3.9 (c). The Superintendent and the New York Court of Appeals has interpreted this provision to apply regardless of whether the particular denial at issue was timely. LMK Psychological Services PC v. State Farm Mutual Automobile Insurance Company, 12 NY 3d 217 (2009).

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
	Metropolit an Medical and Surgical, P.C.	10/30/18 - 10/30/18	\$1,322.75		Awarded: \$0.00
	Metropolit an Medical and Surgical, P.C.	11/20/18 - 11/20/18	\$935.63		Awarded: \$0.00
	Metropolit an Medical and Surgical, P.C.	10/30/18 - 11/20/18	\$0.00	\$2,150.38	Awarded: \$2,150.38
<b>Total</b>			<b>\$2,258.38</b>		<b>Awarded: \$2,150.38</b>

- B. The insurer shall also compute and pay the applicant interest set forth below. 03/18/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Based on the submission of a timely denial, interest shall be paid from 3/18/19, the date of filing, on the amount awarded of \$2,150.38 at a rate of 2% per month, simple, and ending with the date of payment of the award subject to the provisions of 11 NYCRR 65 - 3.9 (e).

C. Attorney's Fees

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

As this matter was filed ~~after~~ February 4, 2015, this case is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant an attorney's fee, in accordance with newly promulgated 11 NYCRR 65-4.6(d).

- D. The respondent shall also pay the applicant forty dollars (\$40) to reimburse the applicant for the fee paid to the Designated Organization, unless the fee was previously returned pursuant to an earlier award.

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of New York  
SS :  
County of Nassau

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

12/07/2020  
(Dated)

Rhonda Barry

**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:**

7bd4b5b1e68be1e3f4a118732999b86d

### **Electronically Signed**

Your name: Rhonda Barry  
Signed on: 12/07/2020