

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

M & D Elite Pharmacy LLC
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No.	17-19-1137-2419
Applicant's File No.	161656350
Insurer's Claim File No.	0438049220101090
NAIC No.	22055

ARBITRATION AWARD

I, Charles Blattberg, 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: Eligible injured person

1. Hearing(s) held on 01/08/2021
Declared closed by the arbitrator on 01/12/2021

Victoria Tarasova, Esq. from Law Offices of Zara Javakov, Esq. P.C. participated by telephone for the Applicant

Dominic Delorantis, Esq. from Law Office of Goldstein & Flecker participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 10,606.03**, 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 claimant was the 32 year-old female driver of a motor vehicle that was involved in an accident on 2/6/19. Following the accident the claimant suffered injuries which resulted in the claimant seeking treatment. At issue is the medical necessity of medications dispensed by Applicant on 3/20/19-3/21/19, 4/18/19, and 5/15/19 that Respondent timely denied reimbursement for based on peer reviews by Manan Patel, M.D. and Mitchell Ehrlich, M.D.

4. Findings, Conclusions, and Basis Therefor

Based on a review of the documentary evidence, this claim is decided as follows:

An applicant establishes a prima facie case of entitlement to reimbursement of its claim by the submission of a completed NF-3 form or similar document documenting the facts and amounts of the losses sustained and by submitting evidentiary 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 were overdue. See, *Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). I find that Applicant established a prima facie case for reimbursement.

The claimant was the 32 year-old female driver of a motor vehicle that was involved in an accident on 2/6/19. The claimant reportedly injured her neck, bilateral shoulders, and low back. There was no reported loss of consciousness. There were no reported lacerations or fractures. Following the accident the claimant was transported to Jacobi Medical Center where she was evaluated, treated, and released. Purportedly the claimant was initiated on physical therapy, chiropractic treatment, and acupuncture. On 3/19/19 the claimant presented to Isaac J. Kreizman, M.D. of Pain & Rehabilitation Services with complaints of neck pain that radiated into her left shoulder and extended down the arm with associated numbness and tingling sensations rated 10/10 and lower back pain with radiation down to the lower extremities. Cervical examination revealed paraspinal muscle tenderness was most pronounced over the left C5 and left C6 levels, decreased ranges of motion [quantified], positive distraction test and positive Jackson's compression test. Fluoroscopic imaging revealed positive disk space narrowing with osteophyte formation. Lumbar examination revealed paraspinal muscle tenderness was noted over the left side greater than right, decreased range of motion [quantified], positive slump test and positive straight leg raise test. Fluoroscopic imaging revealed positive disk space narrowing with osteophyte formation. Muscle strength was decreased in the upper and lower extremities were documented [specified and quantified]. Decreased deep tendon reflexes and sensation were noted. Dr. Kreizman reviewed a 2/15/19 cervical spine MRI and a 3/8/19 lumbar spine MRI [reports not in evidence here]. Dr. Kreizman performed cervical transforaminal epidural steroid diagnostic injections left C5 and left C6 levels under fluoroscopic guidance with Omnipaque 1ml dye confirmation. Dr. Kreizman prescribed Celecoxib 200mg x60, Cyclobenzaprine 10mg x30, Gabapentin 300mg x60, Diclofenac 3% gel 200gm, and Lidocaine 5% ointment 200gm; that were dispensed by M&D Elite Pharmacy, LLC (Applicant) 3/20/19-3/21/19. On 4/4/19 Dr. Kreizman conducted a follow-up examination noting the claimant "is undergoing a home exercise program, taking Celebrex, Cyclobenzaprine hcl, and Neurontin medications, as well as applying Diclofenac Sodium gel and Lidocaine ointment to affected areas for the pain, which is providing her with only mild pain relief." Dr. Kreizman performed lumbar transforaminal epidural steroid diagnostic injections left L4 and left L5 levels under fluoroscopic guidance with Omnipaque 1ml dye confirmation. The claimant was continued on the medications. On 4/18/19 Dr. Kreizman performed cervical transforaminal epidural steroid therapeutic injections left C5 and left C6 levels under fluoroscopic guidance with Omnipaque 1ml dye confirmation. On 4/18/19 Applicant

dispensed/refilled the subject medications. On 5/7/19 Dr. Kreizman performed lumbar transforaminal epidural steroid therapeutic injections left L4 and left L5 levels under fluoroscopic guidance with Omnipaque 1ml dye confirmation. On 5/15/19 Applicant dispensed/refilled the subject medications. At issue are the medications dispensed by Applicant on 3/20/19-3/21/19, 4/18/19, and 5/15/19.

The burden has shifted to the Respondent as they have raised a medical necessity defense. In order to support a lack of medical necessity defense Respondent must "set forth a factual basis and medical rationale for the peer reviewer's determination that there was a lack of medical necessity for the services rendered." See, *Provvedere, Inc. v. Republic Western Ins. Co.*, 2014 NY Slip Op. 50219(U) (App. Term 2nd, 11th and 13th Jud. Dists. 20140). Respondent bears the burden of production in support of its lack of medical necessity defense, which if established shifts the burden of persuasion to Applicant. See generally, *Bronx Expert Radiology, P.C. v. Travelers Ins. Co.*, 2006 NY Slip Op. 52116 (App. Term 1st Dept. 2006). As a general rule, reliance on rebuttal documentation will be weighed in light of the documentary proofs and the arguments presented at the arbitration. Moreover, the case law is clear that a provider must rebut the conclusions and determinations of the IME/peer doctor with his own facts. *Park Slope Medical and Surgical Supply, Inc. v. Travelers*, 37 Misc.3d 19 (2012).

Respondent timely denied the subject medications (for dispensing dates 3/20/19-3/21/19) based on a 5/14/19 peer review by Manan Patel, M.D. and a 5/15/19 peer review by Manan Patel, M.D. (for dispensing date 4/18/19). These will be discussed together. After reviewing the claimant's history, treatment, and medical records, Dr. Patel asserts "In Regards to the Cyclobenzaprine Tablet, the following should be noted: [citation omitted] "FLEXERIL (CYCLOBENZAPRINE HCl) Tablets INDICATIONS AND USAGE: "FLEXERIL should be used only for short periods (up to two or three weeks) because adequate evidence of effectiveness for more prolonged use is not available and because muscle spasm associated with acute, painful musculoskeletal conditions is generally of short duration and specific therapy for longer periods is seldom warranted." In this clinical setting, the claimant was involved in an MVA dated 02/06/2019. As per the available medical records, the claimant was prescribed with 30 tablets of Cyclobenzaprine 10mg tablets which indicate chronic use. As per the above guideline, FLEXERIL should be used only for short periods (up to two or three weeks) because adequate evidence of effectiveness for more prolonged use is not. In this case, the criterion was not met as per the guideline. Hence, as per the available medical records and above cited guideline, Cyclobenzaprine tablets were not medically necessary." Dr. Patel continues "in Regards to Gabapentin capsules, the following should be noted: [citation omitted] USES: "This medication is used to relieve nerve pain following shingles (a painful rash due to herpes zoster infection) in adults. This condition is called post herpetic neuralgia. Gabapentin belongs to a class of drugs known as anti-seizure drugs (also called anticonvulsant or antiepileptic drugs)." In this clinical setting, the claimant was involved in an MVA dated 02/06/2019. The claimant was prescribed with Neurontin 300mg capsules by Isaac Kreizman, M.D. As per the available medical records, the claimant had pain in the neck and lower back. However, there was no documentation suggesting that the claimant had seizures. Hence, as per the above mentioned citation, Gabapentin capsules were not medically necessary." Dr. Patel recites "In Regards to Lidocaine 5% ointment, the following should be noted: [citation

omitted] Lidocaine Ointment, USP 5%, for external use only: "Lidocaine 5% ointment is indicated for production of anesthesia of accessible mucous membranes of the oropharynx. It is also used as an anesthetic lubricant for intubation and for the temporary relief of pain associated with minor burns, including sunburn, abrasions of the skin, and insect bites." In this clinical setting, the claimant was involved in an MVA dated 02/06/2019. The claimant was prescribed with Lidocaine 5% topical ointment by Isaac Kreizman, M.D. As per the available medical records, there was no documented evidence that the claimant had pain associated with minor burns, including sunburn, abrasions of the skin, or insect bites. The guideline criteria were not met. Therefore, the Lidocaine 5% ointment prescribed was not medically necessary." Dr. Patel further asserts "In Regards to Diclofenac gel 3% the following should be noted: [*citation omitted*] "Solaraze™ (Diclofenac sodium) Gel is indicated for the topical treatment of actinic keratoses (AK). Sun avoidance is indicated during therapy" [*Citation omitted*] As per NCBI. Diclofenac sodium topical solution with dimethyl sulfoxide, a viable alternative to oral nonsteroidal anti-inflammatories in osteoarthritis: review of current evidence: "Diclofenac is one of the most frequently used NSAIDs in the treatment of osteoarthritis and is the active ingredient in each of the several topical NSAIDs approved for use in the US." In this clinical scenario, the claimant had an MVA on 02/06/2019. As per the above guideline Diclofenac is one of the most frequently used NSAIDs in the treatment of osteoarthritis. However, as per the above medical reports, there is no documented evidence that the claimant had osteoarthritis. Also, as per the available medical records, there was no documented evidence that the claimant had a condition like actinic keratoses (AK). In this case, the claimant's symptoms should have been treated with the use of non-steroidal oral medications or OTC medications. Further, there was no specific reason or indication suggesting why the Diclofenac topical gel was prescribed to the claimant. Hence, as per the above guidelines and available medical records the Diclofenac gel prescribed was not medically necessary." Dr. Patel opines "In Regards to Celecoxib the following should be noted: [*citation omitted*] As per the Medline Plus, Celecoxib: "Celecoxib is used to relieve pain, tenderness, swelling and stiffness caused by osteoarthritis (arthritis caused by a breakdown of the lining of the joints), rheumatoid arthritis (arthritis caused by swelling of the lining of the joints), and ankylosing spondylitis (arthritis that mainly affects the spine)." In this clinical setting, the claimant was involved in an MVA dated 02/06/2019. The claimant was prescribed for Celebrex 200mg capsules by Isaac Kreizman, M.D. As per the available medical records, there was no documented evidence that the claimant had conditions like osteoarthritis, rheumatoid arthritis and ankylosing spondylitis." Dr. Patel asserts "As per FDA strengthens warning that NSAIDs increase heart attack and stroke risk Gregory Curfman, MD Assistant Professor of Medicine: "Many people take NSAIDs to relieve mild to moderate pain. These medications may be particularly effective in conditions in which pain results primarily from inflammation, such as arthritis or athletic injury. Examples of commonly used over-the-counter NSAIDs include ibuprofen (Motrin, Advil) and naproxen (Aleve). Celecoxib (Celebrex), Diclofenac (Cataflam, Voltaren) and others are prescription NSAIDs. The warnings from the FDA point out: Heart attack and stroke risk increase even with short-term use, and the risk may begin within a few weeks of starting to take an NSAID. The risk increases with higher doses of NSAIDs taken for longer periods of time." In this case, as per the available medical records, the claimant had neck, lower back and bilateral shoulder pain. Celecoxib 200 mg capsules for a total of 60 units were prescribed. As per the above guideline, these medications

may be particularly effective in conditions in which pain results primarily from inflammation, such as arthritis or athletic injury. Also, prolonged use may cause risk of heart attack and stroke. In this case, the 60 tablets were prescribed which indicated prolonged use. Hence, as per the above citation, Celecoxib 200 mg capsules were not medically necessary." Dr. Patel concludes "In Regards to Associated services the following should be noted: In this clinical setting, since the Cyclobenzaprine Tablets, Gabapentin capsules, Lidocaine 5% ointment, Diclofenac gel 3% and Celecoxib were not medically necessary, the associated services of Pharmacy compounding and dispensing services were also not medically necessary."

Respondent also timely denied the subject medications (dispensing date 5/15/19) based on the 6/24/19 peer review by Mitchell Ehrlich, M.D. After reviewing the claimant's history, treatment, and medical records, Dr. Ehrlich opines "based upon review of the medical records and the medical guidelines for appropriateness of the services in question, I have come to the determination that the standard of care for medical necessity of the Cyclobenzaprine, Gabapentin, and Celecoxib has not been met. This is because the benefit window for the use of muscle relaxants, anti-inflammatory, and neural agents had passed in this case. That is because prior prescriptions had not been efficacious. On top of that, the claimant had been subjected to repeated epidural injections as well as manipulation under anesthesia. As such, there was no medically related reason to continue medications that were not effective and risk significant side effects." Dr. Ehrlich continues "I have come to the determination that the standard of care for medical necessity of the Lidocaine 5% ointment has not been met. This is because the use of this topical anesthetic preparation has not been shown to be efficacious for the neck and back injuries as well as the subsequent treatment procedures presented in this case. Topical anesthetics have limited efficacy with multi-focal spinal complaints, as they act locally. Topical anesthetics do not penetrate spinal joints. Furthermore, there was no chronic neurogenic pain or cutaneous irritations to treat, which is the actual medical indication for this preparation. I have come to the determination that the standard of care for medical necessity of the Diclofenac 3% gel has not been met. This is because Diclofenac 3% gel is a topical anti-inflammatory preparation. In general, topical anti-inflammatories are used when there is a relative contraindication to oral anti-inflammatories, which are more efficacious following the neck and back injuries presented in this case. However, there was no such contraindication and oral anti-inflammatories had already been provided without sustained efficacy. As such, there was no medically related reason to continue additional anti-inflammatories in a less efficacious topical form. Furthermore, it should be noted that the 3% strength of Diclofenac gel is actually recommended for a dermatologic condition known as actinic keratosis and not for injury" [Citations omitted]. Dr. Ehrlich asserts "Nonsteroidal anti-inflammatory drugs (NSAIDs), including both traditional nonselective NSAIDs and the selective cyclooxygenase (COX)-2 inhibitors, are widely used for their anti-inflammatory and analgesic effects. NSAIDs are a necessary choice in pain management because of the integrated role of the COX pathway in the generation of inflammation and in the biochemical recognition of pain. This group of drugs has recently come under scrutiny because of recent focus in the literature on the various adverse effects that can occur when applying NSAIDs [*Citation omitted*]. An update of gastrointestinal, cardiovascular and renal complications; [*citation omitted*]. Non-steroidal anti-inflammatory drugs (NSAIDs) are used chronically to reduce pain

and inflammation in patients with arthritic conditions, and also acutely as analgesics by many patients. Both therapeutic and adverse effects of NSAIDs are due to inhibition of cyclooxygenase (COX) enzyme. NSAIDs are classified as non-selective and COX-2-selective inhibitors (COXIBS) based on their extent of selectivity for COX inhibition. However, regardless of their COX selectivity, reports are still appearing on the GI side effect of NSAIDs particularly on the lower gastrointestinal (GI) tract and the harmful role of their controlled release formulations. Presently, the major side effects of NSAIDs are the GI complications, renal disturbances and CV events" [*Citations omitted*]. Dr. Ehrlich asserts [*citation omitted*] "At this time, guidelines do not recommend chronic use of muscle relaxants for musculoskeletal pain [*Citation omitted*]. Skeletal muscle relaxants are widely used in treating musculoskeletal conditions. However, evidence of their effectiveness consists mainly of studies with poor methodological design. In addition, these drugs have not been proven to be superior to acetaminophen or nonsteroidal anti-inflammatory drugs for low back pain. Systematic reviews and meta-analyses support using skeletal muscle relaxants for short-term relief of acute low back pain when nonsteroidal anti-inflammatory drugs or acetaminophen are not effective or tolerated. Adverse effects, particularly dizziness and drowsiness, are consistently reported with all skeletal muscle relaxants. The potential adverse effects should be communicated clearly to the patient" [*Citation omitted*]. Dr. Ehrlich concludes "Lidocaine patch (5%) is no more potent than placebo in treating chronic back pain when tested in a randomized double blind placebo controlled brain imaging study. The patch itself induces a potent placebo effect in a significant proportion of Chronic Back Pain patients [*Citation omitted*]. INDICATIONS & USAGE: "the temporary relief of pain associated with minor burns, including sunburn, abrasions of the skin, and insect bites" [*Citation omitted*]. Evidence also supports the use of topical lidocaine in the treatment of post-herpetic neuralgia and diabetic neuropathy [*Citation omitted*]. Disadvantages of topical NSAID formulations are primarily related to local skin irritation and difficulty in formulation development. For a drug to be effective when applied topically, the drug molecules must be small (<500 Da) in order to diffuse across the stratum corneum and penetrate to the site of action. In addition, formulations must have aqueous and lipid solubility. Individual differences between patients may also impact efficacy, as the permeability of skin varies among individuals and between healthy and diseased skin. Lastly, enzymes in skin may metabolize some drugs before cutaneous absorption can occur [*Citation omitted*]. In acute and chronic low back pain, widespread musculoskeletal pain, and in peripheral neuropathic pain syndromes, the current evidence does not support the use of topical NSAIDs."

Where the Defendant insurer presents sufficient evidence to establish a defense based on lack of medical necessity, the burden shifts to the Plaintiff which must then present its own evidence of medical necessity (see Prince on Evidence section 3-104, 3-202). *West Tremont Medical Diagnostic PC v. Geico*, 13 Misc.3d 131, 824 N.Y.S. 2d 759.

Applicant submitted two undated peer rebuttals by Mark Gladstein, M.D. that will be discussed together. After reviewing the claimant's history, treatment, and medical records, Dr. Gladstein asserts the "Cyclobenzaprine, Gabapentin, Lidocaine ointment, Diclofenac sodium gel and Celecoxib provided to the patient was denied based on the peer review performed by Dr. Ehrlich [*and Dr. Patel*]. However, Dr. Ehrlich [*and Dr. Patel*] did not personally examine the patient, but based his opinion solely on review of

certain documents provided to [them]. Dr. Ehrlich states in his peer review report dated 6/24/2019 that the Cyclobenzaprine, Gabapentin and Celecoxib were not medically necessary as there was no medically related reason to continue medications that were not effective and risk significant side effects. I disagree with Dr. Ehrlich's [and Dr. Patel's] conclusion that the Cyclobenzaprine, Gabapentin and Celecoxib were not medically necessary as there was no medically related reason to continue medications that were not effective and risk significant side effects since he fails to support his conclusion with any authoritative literature, it is the treating consultant's discretion to decide which course of treatment he wants the patient to use, as long as it works for the patient's aim to reduce her/his complaints; does not result in any side effects and is safe for the patient to use. Accordingly, great deference should be given to the treating provider charged with the responsibility to examine, diagnose and treat a patient who presents with symptoms and positive clinical findings... In this case, the patient had subjective complaints and positive clinical findings, which warranted the prescription of Cyclobenzaprine. The patient was prescribed Cyclobenzaprine as it is a muscle relaxant and used with rest, physical therapy, and other measures to relax muscles and relieve pain and discomfort caused by strains, sprains, and other muscle injuries [*Citation omitted*]. In this case, the patient was prescribed Gabapentin since it is also used to alleviate night time symptoms of pain and exert neuroprotective effects. When used topically Gabapentin has better absorption and does not exert its typical side effects of weight gain, sedation and renal stone formation. Gabapentin has been shown to be effective in treating neuropathic pain in topical medications. Gabapentin is in a class of medications called anticonvulsants. The patient was prescribed Gabapentin as it relieves the pain by changing the way the body senses pain [*Citation omitted*]. The patient was prescribed Celecoxib as it is useful for pain, inflammation, swelling, stiffness and joint pain. Celecoxib works by reducing hormones that cause inflammation and pain in the body. The patient was prescribed Celecoxib as it is a selective cyclo-oxygenase-2 (COX-2) inhibitor that has been fully subsided with restriction, since June 1, 2017. Celecoxib may be considered for the treatment of patients with acute pain, arthritic conditions and an alternative to the non-selective non-steroidal anti-inflammatory drugs (NSAIDs) e.g. Naproxen and Ibuprofen. The inhibition of COX-2 prevents the production of the prostaglandins that mediate pain, inflammation and fever. Celecoxib is a type of NSAID introduced to the market as safer alternatives to aspirin or ibuprofen (Motrin, Advil). Celecoxib are easier on the stomach. Celecoxib produces significant improvements in pain and inflammation and these effects are maintained during treatment for up to 24 weeks in clinical trials." Dr. Gladstein further asserts "the ultimate decision regarding the appropriateness of prescribing medications must be made by the referring physician in light of all the circumstances presented in an individual examination. Topical creams give prescribers the opportunity to treat patients, right at the site of their pain providing high local concentrations resulting in a greater analgesic effect. All the while eliminating possible side effects associated with traditional oral medications. The benefits of topical medications are: Superior therapeutic outcome through locally enhanced topical delivery; improved patient compliance; fewer overall side effects than typically found with oral medications; reduced risk of dependency/abuse; concentration of therapeutic levels of medications in tissues while maintaining low serum concentration; reduced systemic toxicity; avoidance of first pass metabolism and 01 upsets; decreased risk of drug-to-drug interactions. A patient has the right to use topical cream/patches in lieu of oral medications. Topical administration of

medications for pain management had become increasingly more common. The use of topical medication over other oral options for pain relief can benefit patients in many different ways. Conventional therapies using opioids (hydrocodone, hydromorphone, morphine, oxycodone) can cause systemic adverse effects such as constipation, drowsiness, dizziness, lightheadedness, nausea, vomiting, sedation, and/or confusion. NSAIDs (ibuprofen, naproxen) can increase cardiovascular risk, decrease platelet aggregation, and cause gastrointestinal bleeding or ulcers. Other classes of medications such as antidepressants (nortriptyline, duloxetine) or anticonvulsants (gabapentin) also come with its costs and side effects. Topical medications act only locally since it penetrates the skin and not into the bloodstream. In addition, patients can have one or multiple disease states including renal or hepatic dysfunction which can prevent them from taking ibuprofen (Advil) or acetaminophen (Tylenol) respectively. More importantly, topical medications give physicians an option to provide effective pain relief treatment while avoiding the addictive properties of conventional oral medications." Dr. Gladstein opines "based on these finding, the patient was prescribed Diclofenac gel as it is indicated for relief of pain and inflammation of joints amenable to topical treatment, such as the knees, which was the case here. It provides excellent relief without the side effects of oral medication. Diclofenac is the first prescription topical treatment for pain that has been approved by the U.S. Food and Drug Administration. Diclofenac Gel is a nonsteroidal anti-inflammatory drug or NSAID in topical form. Diclofenac Gel delivers effective pain relief and has a favorable safety profile. Diclofenac Gel receives US Regulatory Approval as the First Approved Topical Prescription treatment for pain. Clinical trials have demonstrated Diclofenac Gel to be highly effective in treating pain. Diclofenac Gel delivers effective pain relief with a favorable safety profile as its systemic absorption is 94% less than the comparable oral Diclofenac treatment [*Citation omitted*]. Topical NSAIDs are considered safe as placebo in the treatment of acute pain and therefore can be safely used by patients who are at a risk of developing complications associate with oral NSAIDs. Blood concentrations of NSAIDs after applying topical products are typically less than 5% of those reached by using oral NSAIDs. Approximately six or seven patients out of ten will experience successful pain control with topical NSAIDs [*Citation omitted*]. Importantly, the Diclofenac gel prescribed to this patient is approved by U.S. Food and Drug Administration (FDA). As mentioned in an article, Topical preparations for pain relief: efficacy and patient adherence published on 2010 Dec 20 "As the understanding of pain pathophysiology and treatment increases, new routes of drug delivery are being discovered with the objective of attempting to block pain at peripheral sites, with maximum active drug and minimal systemic effects. Topical preparations are the result of such exploration. Evidence based on empirical practice has suggested that topically applied medications can be almost as effective as those taken orally, with a good safety profile in terms of adverse effects. The ultimate goal that motivates the development of topical preparations is the improvement of patient compliance to medical treatment, by providing efficient pain relief with less central nervous system effects and minimal drug regimen burden. Topical preparations can potentially benefit the pediatric population, whose chronic pain management is just as challenging in adults. Topical analgesics or anesthetics as defined as liquids, gels, powders, creams, semisolids, emulsions, patches, foams or aerosols containing an analgesic or anesthetic agent applied on and around the painful site. Most topical preparations are available in patches, ointments, or creams and this review will focus on cutaneous applications for adult patients although some studies

in children are also mentioned" [*Citation omitted*]. Dr. Gladstein argues "a doctor and his patient can choose any means of care as long as the chosen treatment works for the patient....Also, there are no specific guidelines delineating the absolute structured path for treatment to be universally prescribed to all patients. Treating doctors have a better understanding of the patient's overall medical picture. Accordingly, great deference should be given to the treating provider charged with the responsibility to examine, diagnose and treat a patient who presents with symptoms and positive clinical findings. Importantly Dr. Ehrlich [*and Dr. Patel*] has not presented any evidence or studies proving that Lidocaine does not work in relieving the patient's pain or that it is not effective in minimizing the claimant's symptoms. Also the patient cannot take oral medications any time within 8 hours, however, the topical medication can be used at any time when required. As noted in the records the patient was having pain at the multiple body parts. In such cases, there are instances when the patient gets sudden and severe episodes of pain at a particular injured area which requires urgent medical treatment. At such time, topical preparations play an important role in providing symptomatic pain relief at a targeted body part such as the neck joints and back in this case. The patient was prescribed Lidocaine ointment as Lidocaine is a common local anesthetic that relieves itching, burning, and pain. Topically, it blocks both initiation and conduction of nerve impulses by decreasing ionic flux through the neuronal membrane. Since it penetrates the skin, it creates an anesthetic effect by not just preventing pain signals from propagating to the brain but by stopping them before they begin. Lidocaine stabilizes the neuronal membrane by inhibiting the ionic fluxes required for initiation and conduction of impulses, thereby effecting local anesthetic action. Lidocaine has highest concentration in tendinous tissue, and blocks axonal firing and pain transmission to CNS. Also, it increases compliance due to 12 hours on 12 hours off application and there is no alternative to lidocaine. Lidocaine assists in pain relief by blocking sodium channels. The patient was prescribed Lidocaine as it is used to relieve the pain. Lidocaine is in a class of medications called local anesthetics. It works by stopping nerves from sending pain signals [*Citation omitted*]. A lot of attention surrounds the abuse and addiction rates of prescription oral pain medications. Although a suitable choice for acute pain following traumatic injury or surgery, they may not be the best option for chronic pain. Topical pain medication has the potential to treat chronic pain with fewer side effects. Chronic pain is defined as a disease state that is ongoing, usually lasting longer than 6 months. This type of pain has no anticipated end-date and requires a more comprehensive approach. It's often a complicated search to find lasting relief, requiring multiple forms of treatment. In this article, we will cover topical pain medication along with the different types of pain they address. Topical pain aids come in many forms such as patches, creams, gels, lotions, foams or liquids and are applied to the skin. They are available in both prescription and non-prescription strengths. These dosage forms may target pain more precisely by applying to the specific site of pain. Oral medications travel through the digestive system and then through the bloodstream to the site of pain. This delivery system may take longer to work and comes with a long list of side effects. Side effects include constipation, dizziness, lightheadedness, nausea, vomiting, and possible abuse and addiction. Applying a medication to the site of pain can often provide quicker and more complete pain relief with reduced side effects. A study concluded that topical NSAIDs, when used for treatment of pain resulting from sprains, strains or sports or overuse-type injuries, can provide good levels of pain relief without the systematic adverse events associated with oral NSAIDs [*Citation omitted*].

Topical non-steroidal anti-inflammatory drugs are effective in relieving pain in acute and chronic conditions [*Citation omitted*]. Spine-care physicians and pain specialists may recommend a topical pain-reliever to help relieve the symptoms of various back and neck disorders. For example, a topical medicine may be used to treat the pain associated with osteoarthritis, rheumatoid arthritis, neck or low back strain, whiplash, muscle inflammation and spasms, and some types of nerve pain. Applying topical drugs to the site of the injury theoretically avoids systemic absorption and subsequent side effects. Also, Advantages of topical administration of drugs: Base (cream, ointment, gel, spray) makes application easy and controllable; Onset of symptom relief is usually faster than oral preparations; Symptoms are relieved at a steady rate and relief may last longer; A smaller amount of medicine may be needed when applied in a topical form" [*Citation omitted*]. Dr. Gladstein concludes "as the above Cyclobenzaprine, Gabapentin, Lidocaine ointment, Diclofenac sodium gel and Celecoxib provided to the patient was medically necessary, the dispensing fee was also medically necessary. The peer reviewer has not provided an established medical standard to provide a basis for this claim. The peer doctor's claim is simply an opinion, unsupported by any kind of medical guideline. It is by no means a description of inconsistency with standards of care or guideline. Thus, [*they failed*] to prove that the prescribed medications had deviated from the generally accepted guidelines and standards of medical practice in this case."

After careful review of the record, I find upon the evidence provided that Respondent set forth a medical rationale and factual basis for denying payment for the Diclofenac gel and single agent lidocaine ointment. I am more persuaded by Dr. Ehrlich and Dr. Patel that the standard of care does not support the use of these in treating this claimant's injuries. For example Dr. Ehrlich noted that there was no chronic neurogenic pain or cutaneous irritations to treat and the use of anesthetic preparations has not been shown to be efficacious for the injuries sustained by the claimant. Dr. Gladstein's peer rebuttal is fairly broad in scope as it includes such topics as compound topical analgesics but he fails to sufficiently address the peer reviewers' opinion that the subject Diclofenac gel and lidocaine ointment were not medically necessary in light of this particular claimant's injuries and the fact that oral medication was also provided. However, I find that Respondent failed to establish or sustain its lack of medical necessity defense in regard to the oral medication (Celecoxib, Cyclobenzaprine, Gabapentin) for which billing (with the dispensing fees) totals \$1,287.31 for the four dates of service at issue. It is noted that Respondent uploaded three fee audits which indicate Applicant's billing was consistent with fee schedule.

Accordingly, Applicant is awarded \$1,287.31.

5. Optional imposition of administrative costs on Applicant.
Applicable for arbitration requests filed on and after March 1, 2002.

I do NOT impose the administrative costs of arbitration to the applicant, in the amount established for the current calendar year by the Designated Organization.

6. **I find as follows with regard to the policy issues before me:**

- ☐ The policy was not in force on the date of the accident
- ☐ The applicant was excluded under policy conditions or exclusions
- ☐ The applicant violated policy conditions, resulting in exclusion from coverage
- ☐ The applicant was not an "eligible injured person"
- ☐ The conditions for MVAIC eligibility were not met
- ☐ The injured person was not a "qualified person" (under the MVAIC)
- ☐ The applicant's injuries didn't arise out of the "use or operation" of a motor vehicle
- ☐ The respondent is not subject to the jurisdiction of the New York No-Fault arbitration forum

Accordingly, the applicant is AWARDED the following:

A.

Medical		From/To	Claim Amount	Status
	M & D Elite Pharmacy LLC	03/20/19 - 03/21/19	\$3,565.17	Awarded: \$458.93
	M & D Elite Pharmacy LLC	04/18/19 - 04/18/19	\$3,475.12	Awarded: \$368.88
	M & D Elite Pharmacy LLC	05/15/19 - 05/15/19	\$3,565.74	Awarded: \$459.50
Total			\$10,606.03	Awarded: \$1,287.31

B. The insurer shall also compute and pay the applicant interest set forth below. 08/01/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest runs from 8/1/19 (the filing date for this case) until the date that payment is made at two percent per month, simple interest, on a pro rata basis using a thirty day month.

C. Attorney's Fees

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

Pursuant to 11 NYCRR §65-4.6 (d), ". . . the attorney's fee shall be limited as follows: 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon for each applicant for arbitration or court proceeding, subject to a maximum fee of \$1,360."

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

02/08/2021
(Dated)

Charles Blattberg

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:
b70dd07c7e92f16cb11dc90da8d12cad

Electronically Signed

Your name: Charles Blattberg
Signed on: 02/08/2021