American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Precision Pain Management PC (Applicant)	AAA Case No.	17-19-1144-0895
	Applicant's File No.	00047979
- and -	Insurer's Claim File No.	576375
	NAIC No.	Self-Insured
MVAIC (Respondent)		

ARBITRATION AWARD

I, Heidi Obiajulu, the undersigned arbitrator, designated by the American Arbitration Association pursuant to the Rules for New York State No-Fault Arbitration, adopted pursuant to regulations promulgated by the Superintendent of Insurance, having been duly sworn, and having heard the proofs and allegations of the parties make the following **AWARD:**

Injured Person(s) hereinafter referred to as: Injured Party

1. Hearing(s) held on 06/11/2021
   Declared closed by the arbitrator on 06/11/2021

   Sasha Hochman, Esq. from Drachman Katz, LLP participated in person for the Applicant

   Jeff Kadushin, Esq. from Marshall & Marshall, Esqs. participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 922.84**, 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

   Applicant seeks reimbursement of charges for the right-sided lumbar medial branch block injections under fluoroscopic guidance and anesthetic agent performed on 01/10/19, following a motor vehicle accident occurring on 09/19/17. Respondent timely denied claim(s) based upon the peer review by Dr. Ajendra Sohal, MD.

4. Findings, Conclusions, and Basis Therefor

The below decision is based on the documents contained in the Modria ADR Electronic Case folder maintained by the American Arbitration Association (hereinafter referred to as AAA) as of the date of this hearing.

The applicant, as assignee of the Injured Party, seeks the reimbursement, with interest and counsel fees, under the No-Fault Regulations, for the right-sided lumbar facet joint injections under fluoroscopic guidance and anesthetic agent performed on 01/10/19, in the amount of $922.84.

This case arises out of a motor vehicle accident occurring on September 19, 2017, in which the Injured Party (JN), a then 32-year-old male pedestrian sustained multiple injuries including to his back and left hip when he was struck by the insured vehicle while crossing the street. Due to the impact of the collision, he reported he was struck on his left hip, thrown, rolled and landed on his right hip. After the accident, he was transported via ambulance to the emergency room of New York Presbyterian Hospital where he was evaluated, treated with IM morphine sulfate and hydromorphone, x-rayed [chest, pelvis, and left hip] underwent a CT scan of the osseous pelvis, and discharged for outpatient care with a prescription for pain medication [Oxycodone-acetaminophen and naproxen].

On 09/26/17, Dr. Joyce Goldenberg, MD initially evaluated the Injured Party and reported that he presented with neck pain radiating to the bilateral shoulders [rated 6/10], lower back pain radiating to the right lower extremities and numbness tingling in the right foot [rated 7/10], and bilateral hip pain with left rated 10/10 on the pain scale and the right hip rated 6/10 on the pain scale. Physical examination revealed decreased cervical spine ranges of motion [see the report for ranges] with tenderness, trigger points, and muscle spasms in the upper trapezius, levator scapulae, supraspinatus, rhomboids, cervical paraspinal, sternocleidomastoid (SCM) and Teres Minor muscles, restricted lumbar spine ranges of motion [see the report for ranges] with tenderness, trigger points, spasms in the lumbar spine paraspinals, quadratus lumborum, sacroiliac joint, and piriformis muscles, restricted ranges of motion of the left hip, and tenderness in the greater trochanter, iliotibial band (IT band), groin, and iliopsoas muscles, a positive FABERE test bilaterally, SLR test at 25 degrees on the right and 20 degrees on the left, diminished DTRs in the Triceps, Patella, and Achilles, sensory deficits at C5, C6, C7, L4, L5, and S1 on the left, and motor deficits in the upper and lower extremities [see the report for specifics]. Based on her exam, Dr. Goldenberg commenced the Injured Party on conservative care and recommended the use of a cane.

On 09/30/17, an MRI of the left hip was performed and revealed acute nondisplaced acetabular fractures, a small left hip joint effusion/synovitis.On the same date, a right hip MRI was performed and revealed right hip joint effusion/synovitis.

From 10/02/2017 through 05/03/2018, the Injured Party attended multiple physical therapy [hereafter referred to as PT] sessions at Central Park Physical Medicine and Rehabilitation with modalities consisting of electrical stimulation, hot/cold packs, and therapeutic exercises.

On 10/13/2017 and 10/24/2017, the Injured Party was seen by Dr. Goldenberg for follow-up. PT and acupuncture therapy were continued.

On 10/18/2017, an MRI of the cervical spine was performed and revealed midline posterior disc herniation at C4-C5. There was a disc bulge larger to the left of the midline at C6-C7. There was straightening of the cervical lordosis. On the same date, an MRI of the lumbar spine from Lenox Hill Radiology showed posterior disc bulge and mild retrolisthesis at L5-S1, above a transitional S1 segment.

On 10/24/2017, an electromyography/nerve conduction study (EMG/NCS) of bilateral lower extremities was performed and revealed evidence of bilateral L5 lumbar radiculitis. An EMG/NCS of bilateral upper extremities was performed and revealed evidence of bilateral C6 cervical radiculopathy.

From 10/25/2017 through 04/03/2018, the Injured Party was seen by Dr. Lon Weiner, M.D. (Orthopedic Surgery). The Injured Party reported an improvement after the rehab.

On 10/30/2017, a Disability Certificate by Dr. Goldenberg indicated the Injured Party was totally incapacitated from 10/31/2017 through 11/30/2017.

On 10/31/2017, a somatosensory study of upper extremities was performed and reported to be normal. However, mild lesion(s) could not be ruled out.

On 11/01/2017, Dr. Ari Lerner, M.D. (Pain Management) evaluated the Injured Party and reported that he presented with complaints of constant pain in the neck, lower back, right shoulder, and left leg. The lower back pain was described as radiating to the right buttock. There was paresthesia described in the form of pins and needles and tingling in the right hand and right foot. There was muscle weakness in the lower back and left leg. The pain was exacerbated with work duties, housework, standing, sitting, walking, lifting, bending, and twisting, while it was relieved with lying down, PT, pain medication, and acupuncture therapy. The cervical spine examination showed moderate tenderness on palpation of the cervical paraspinal musculature bilaterally with the right side being more pronounced than the left with muscle spasm. The lumbar spine examination showed tenderness to palpation of the lumbar paraspinal muscles with the right side being more pronounced than the left muscle spasms. Facet loading test was positive. The lumbar and cervical range of motion [hereafter referred to as ROM] was restricted. The diagnoses were cervicalgia, sprain/strain of the neck and lumbar spine, lower back pain, traumatic spondylopathy of the lumbar region, intervertebral disc displacement of the lumbar region, myositis, and myalgia. PT was continued. The Injured Party was advised to avoid heavy lifting, pulling/pushing, bending, or carrying anything heavy, repetitive forceful, strenuous, twisting, jerky activities, avoid extreme flexion, extension, and rotation of the cervical and lumbar spine. Dr. Lerner administered bilateral trigger point injection (TPI). The Injured Party was referred for an Orthopedic and Neurological evaluation.

On 11/30/2017, Dr. Lerner administered an epidural steroid injection (ESI) at C7-T1.

On 12/08/2017, a Disability Certificate by Dr. Goldenberg indicated the Injured Party was totally incapacitated from 12/01/2017 through 01/11/2018.

On 12/28/2017, Dr. Lerner re-evaluated the Injured Party for continued pain in the neck, lower back, and bilateral arms. The Injured Party reported a 40% decrease in pain after the cervical ESI. He reported a significant increase in functionality with activities including standing and personal hygiene. PT was continued. The treatment included lumbar medial branch blocks (MBB).

On 01/25/2018 and 12/23/2018, Dr. Lerner administered ESI at C7-T1 level.

On 02/02/2018 and 02/21/2018, the Injured Party was seen by Dr. Srino Bharam, M.D. (Orthopedic Surgery) for continued bilateral hip pain. He noted that the Injured Party had completed a trial of PT and acupuncture therapy with minimal relief. The diagnosis was bilateral hip pain. The plan was to continue PT and home exercise program (HEP). The Injured Party was temporarily disabled.

On 02/13/2018, x-rays of bilateral hips were performed and revealed femoral heads were somewhat under-covered. On the same date, magnetic resonance (MR) arthrogram of the bilateral hip showed mild cam lesion at the superior anterior aspect of the left femoral head-neck junction.

On 02/23/2018, Dr. Lerner noted an improvement in the Injured Party's condition post cervical ESI. However, the Injured Party reported the worst pain in the lower back more on the right side and in the axial region. The plan included right lumbar radiofrequency ablation (RFA) and PT.

On 03/22/2018, Dr. Lerner performed RFA of right L4-L5, L5-S1 medial branch and L5 dorsal primary rami.

On 04/03/2018, x-rays of the left hip were performed and reported to be unremarkable.

On 06/07/2018, Dr. Goldenberg saw the Injured Party for continued pain in the neck, lower back, and bilateral lower extremities. PT was continued. The Injured Party could return to work on 06/11/2018 with restrictions.

On 11/15/2018, Leonid Kol, NP (Nurse Practitioner) saw the Injured Party for a follow-up visit. It was noted that he reported his pain was decreased 60-70%, which lasted for two months. He reported exacerbated back pain, more proximal than radial. He also complained of neck pain with paresthesia. The pain was described as radiating from the neck down to both shoulders and left arm with numbness and burning in the left-hand fingers. Treatment included the administration of lumbar trigger point injection (TPI).

On 12/13/18, Dr. Lerner re-evaluated the Injured Party and performed cervical ESI with epidurogram.

On 01/10/2019, Dr. Lerner performed the disputed lumbar MBB at right L3-L4 medial branch and L5 dorsal ramus.

Thereafter, the applicant submitted its claim form to the respondent seeking the reimbursement of no-fault benefits.

The respondent, under New York's Motor Vehicle Indemnification Corporation, New York Ins. Law § 5208 et seq. is obligated to reimburse qualified persons (or their assignee) for all reasonable and necessary medical expenses arising from the use and operation of the insured vehicle, once certain condition precedents are complied with.

Within 30-days of its receipt of the applicant's claim form, the respondent denied reimbursement on the grounds that the disputed lumbar MBB injections under fluoroscopic guidance were medically unnecessary based on the peer review by Dr. Ajendra Sohal, MD.

After it received the respondent's denial, the applicant commenced this arbitration seeking reimbursement of its claim.

At the outset, I find that the applicant established its prima facie case with the submission of its claim form and the copy of the respondent's denial of claim form, which demonstrates that the respondent received the applicant's claim form, that more than 30-days elapsed since its receipt of same, and that the respondent denied reimbursement of the applicant's claim, which shows that the applicant's claim is now due and owing. See Insurance Law section 5106 [a]; Viviane Etienne Medical Care, PC v. County-Wide Ins. Co 25 N.Y.3d. 498, (NY, June 10, 2015), Westchester Medical Center v. Nationwide Mut. Ins. Co., 78 A.D.3d. 1168, (N.Y.A.D. 2nd Dept., November 30, 2010).

Once an applicant establishes a prima facie case, the burden then shifts to the insurer to prove its defense.

However, even before determining whether the respondent met its burden of proof, it must first be determined whether the respondent's lack of medical necessity defense survives preclusion.

In a no-fault action, a defense (other than one based upon a lack of coverage) survives preclusion only if raised in a denial that is (1) timely, Presbyterian Hosp. in the City of New York v. Maryland Casualty Ins. Co., 90 NY.2d 274, (N.Y., June 10, 1997), Central Gen. Hosp. v. Chubb Group of Ins. Co., 90 N.Y.2d 195 (1997), (2) includes the information called for in the prescribed denial of claim form, 11 NYCRR § 65-3.4 (c) (11); Nyack Hosp. v. Metropolitan Prop. & Cas. Ins. Co., 16 A.D.3d 564 (2d Dept. 2005); Nyack Hosp. v. State Farm Mut. Auto. Ins. Co., 11 A.D.3d 664, (App. Div. 2nd Dept. Oct. 25, 2004), or is not fatally defective, and (3) "promptly apprise(s) the Injured Party with a high degree of specificity of the ground or grounds on which the disclaimer is predicated", General Accident Ins. Group v. Cirucci, 46 N.Y.2d 862, 864, (1979); New York University Hosp. Rusk Ins. v. Hartford Acc. & Indem. Co., 32 A.D.3d 458, (2d Dept. 2006).

Applying the above case law and criteria to the respondent's denial, I find that its lack of medical necessity defense is preserved because the denial was issued in a timely manner, included the information called for in the prescribed denial of claim form, and promptly apprised the applicant with a high degree of specificity of the basis of the denial.

Therefore, the issue is whether the respondent met its burden of proof in establishing its defense.

To establish its lack of medical necessity defense, the respondent relies on the peer review by Dr. Ajendra Sohal, MD. To rebut that defense, the applicant relies on the rebuttal by Dr. Ari Lerner, MD.

Reviewing the relevant evidence in the record and considering the oral arguments made by the parties, I find as follows:

In determining whether an insurer met its burden of proof in establishing its lack of medical necessity defense, the courts have found that an insurer must submit an IME report/peer review with a detailed basis and medical rationale for the denial of benefits to prevail. SeeVladimir Zlatnick, M.D., P.C. v. Travelers Ins. Indemnity Co., 12 Misc. 3d 128A (App. Term 1stDept. 2006) and Nir v. Allstate, 7 Misc.3d 544, 546-47 (Civ. Ct., Kings Cty. 2005). ("At a minimum, (the respondent) must establish a factual basis and medical rationale for the lack of medical necessity of (applicant's) services"). Once the respondent submits an IME report or peer review that has a sufficient factual basis and medical rationale, then the courts have routinely found that the respondent has established its prima facie defense that the disputed medical service is medically unnecessary. A Khodadadi Radiology, P.C. v. NY Cent. Mut. Fire Ins. Co., 16 Misc.3d 131(A), (N.Y. Sup. App. Term Jul 03, 2007). Then, the burden of persuasion regarding the medical necessity of the medical services shift to the applicant to submit competent medical evidence to refute the respondent's prima facie defense that the disputed medical service/test was medically unnecessary. See Pan Chiropractic PC v. Mercury Ins. Co., 24 Misc.3d. 136 (A)(July 9, 2009).

Applying the above case law and criteria to the medical evidence in the record, I find in favor of the applicant because although the respondent rebutted the initial presumption that the disputed facet joint injections/MBB were medically necessary with the peer review by Dr. Ajendra Sohal, MD, I find that Dr. Lerner rebutted the peer reviewer's arguments that: (1) there was no causally related facet mediated pain, (2) conservative care had not been exhausted, (3) there was radiculopathy that should have first been treated; Dr. Lerner persuades me that the chief condition was facet mediated pain, and (4) facet joint injections are only diagnostic for RFAs; however, Dr. Lerner persuades me that **therapeutic RFAs** can be performed post-RFA if the patient had a positive response to the RFA and the pain returns. **Accordingly, for the above reasons, I find in favor of the applicant in the amount of $922.84 as reimbursement of the disputed lumbar facet joint injections/MBB and related medical services on 01/10/19.**

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**
	Precision Pain Management PC	**01/10/19 - 01/10/19**	**$608.16**	**Awarded: $608.16**
	Precision Pain Management PC	**01/10/19 - 01/10/19**	**$314.68**	**Awarded: $314.68**
Total			**$922.84**	**Awarded: $922.84**

B. The insurer shall also compute and pay the applicant interest set forth below. 10/08/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

   Applicant's award in the amount of $922.84 shall bear interest at a rate of two percent per month, calculated on a pro-rata basis using a 30-day month from 10/08/19, the date the applicant initiated this arbitration, to the date of the payment of the award.

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 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 New York

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

06/13/2021
(Dated)

Heidi Obiajulu

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:
03647ee10797933db224c2bfb7023a5f

Electronically Signed

Your name: Heidi Obiajulu
Signed on: 06/13/2021