American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Trinity Pain Management of Staten Island, PLLC (Applicant)	AAA Case No.	17-19-1144-5125
	Applicant's File No.	FL19-46285
	Insurer's Claim File No.	0598723280101028
- and -	NAIC No.	35882
Geico Insurance Company (Respondent)		

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 05/19/2021
   Declared closed by the arbitrator on 05/21/2021

   Nancy Orlowski, Esq. from Field Law Group, P.C. participated by telephone for the Applicant

   Justin Addison from Geico Insurance Company participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **$ 4,691.00**, was AMENDED and permitted by the arbitrator at the oral hearing.

   Applicant reduced the total in dispute to $568.02 pursuant to fee schedule.

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

3. Summary of Issues in Dispute

   The claimant was the 50 year-old female restrained driver of a motor vehicle that was involved in an accident on 3/27/19. Following the accident the claimant sought

treatment. At issue is the medical necessity of 7/20/19 radiofrequency ablation (left) lumbar facet medial branch L3/4, L4/5, L5/S1 under fluoroscopic guidance. Respondent timely denied reimbursement based on a 8/21/19 peer review by Jason R. Cohen, 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 50 year-old female restrained driver of a motor vehicle that was involved in an accident on 3/27/19. The claimant reportedly injured her neck, mid back, and low back. There was no reported loss of consciousness. There were no reported lacerations or fractures. There was no reported emergency treatment sought or received. The following day the claimant presented to Montefiore Hospital where X-rays were performed, medications were prescribed, and the claimant was released. On 4/3/19 the claimant presented to Yvette Abraham, M.D. of YA Medical Care, P.C. with complaints of headaches rated 5/10, radiating neck pain rated 5-6/10, mid back pain, and radiating low back pain rated 5/10. The treatment plan included physical therapy 3-4 times per week, ROM/MMT, Outcome Assessment (OSWESTRY) Testing, physical capacity testing, acupuncture, and chiropractic treatment. On 4/3/19 the claimant presented to Riverdale Chiropractic, P.C. and was initiated on chiropractic treatment. On 4/3/19 the claimant presented to Zhentao Wu, L.Ac. of Acupuncture, P.C. and was initiated on acupuncture. On 4/4/19 YA Medical Care conducted ROM/MMT. On 4/5/19 YA Medical Care supervised Outcome Assessment (OSWESTRY) Testing (OAT). On 4/9/19 YA Medical Care conducted physical capacity (NIOSH) testing. On 4/29/19 YA Medical Care supervised OAT. The 4/30/19 cervical spine MRI interpreted by Steve B. Losik, M.D. produced an impression of C3-C4 level disc bulge with compression of anterior thecal sac and partial effacement of anterior subarachnoid space, C4-C5 level posterior central disc herniation with compression of ventral thecal sac and ventral spinal cervical cord and partial effacement of ventral subarachnoid space, C5-C6 level posterior central disc herniation with compression of ventral thecal sac and ventral spinal cervical cord and partial effacement of ventral subarachnoid space, C6-C7 level disc bulge with compression of anterior thecal sac and partial effacement of anterior subarachnoid space, and reversal of cervical lordosis suggestive of pain or muscle spasm in the proper clinical setting. The 4/30/19 thoracic spine MRI interpreted by Steve B. Losik, M.D. produced an impression of mild kyphotic deformity suggestive of pain or muscle spasm in an appropriate clinical setting, T4-T5 posterior central disc herniation with compression of ventral thecal sac and partial effacement of ventral subarachnoid

space, and T5-T6 posterior central disc herniation with compression of ventral thecal sac and partial effacement of ventral subarachnoid space. The 4/30/19 lumbar spine MRI interpreted by Steve B. Losik, M.D. produced an impression of L3-L4 disc bulge with compression of anterior thecal sac and encroachment on bilateral neural foramina, L4-L5 disc bulge with compression of anterior thecal sac and encroachment on bilateral neural foramina, L5-S1 disc bulge with compression of anterior thecal sac and encroachment on bilateral neural foramina, and posterior mid lower back subcutaneous soft tissue swelling and edema consistent with recent trauma. On 5/6/19 Roman L. Zhuchkan, D.C. prescribed a cervical traction unit and a custom fitted lumbosacral orthosis (LSO) with APL control. On 5/7/19 YA Medical Care conducted physical capacity (NIOSH) testing. On 5/16/19 YA Medical Care conducted ROM/MMT. On 5/30/19 Dr. Abraham conducted a follow-up examination. The claimant presented with complaints of radiating neck pain rated 3-7/10, mid back pain, and radiating low back pain rated 4-7/10. The claimant presented with a limping gait. Cervical range of motion was restricted in all planes (quantified). Muscle spasms were noted in the paraspinals (C5, C6, and C7), trapezii, and rhomboids. Examination of the lumbar spine revealed tenderness at the lumbar paraspinal muscles bilaterally, spasms of lumbar paravertebral muscles from L1-S1 disc space bilaterally, and active trigger points were noted on bilateral facet. Range of motion was flexion 40/60°, extension 20°/30°, right and left rotation 35°/45°, right lateral flexion 20°/30°, and left lateral flexion 20°/30° with pain. Left lower lumbar pain; paraspinal muscle tenderness, sacroiliac and facet pain was noted bilaterally. Neurological examination revealed motor examination was normal, deep tendon reflexes were +2 (normal) for all extremities. Sensation for lower extremities noted hyperalgesia in left L5 and S1 dermatomes. Straight leg raise was negative bilaterally. The claimant was recommended physical therapy, chiropractic treatment, acupuncture, EMG/NCV testing, and lumbar medial branch blocks. On 5/31/19 YA Medical Care supervised OAT. On 6/8/19 Yvette Abraham, M.D. of Trinity Pain Management of Staten Island, PLLC (Applicant) performed bilateral L3-4, L4-5 and L5-S1 lumbar facet joint blocks under fluoroscopic guidance. On 6/14/19 YA Medical Care conducted physical capacity (NIOSH) testing. On 6/22/19 Dr. Abraham of Applicant's office performed bilateral L3-4, L4-5 and L5-S1 lumbar facet joint blocks under fluoroscopic guidance. On 6/24/19 Yong Chi, M.D. of YA Medical Care conducted an electrodiagnostic history and physical examination. The claimant presented with complaints of radiating cervical pain rated 7-8/10 with associated numbness and tingling, right shoulder pain rated 7-8/10, radiating thoracic pain, and radiating lumbar pain rated 7-8/10 with associated numbness and tingling. Cervical examination revealed tenderness right paraspinals, trapezius, and supraspinatus. Spurling test was positive. Thoracolumbar examination revealed tenderness in the bilateral paraspinals. SLR was positive bilaterally (unquantified). Range of motion was "limited" (unquantified). Right shoulder examination revealed range of motion was "limited" (unquantified) with positive Empty Can and Hawkin's/Neer. Sensation was "abnormal" in the right upper and lower extremities (unspecified and unquantified). Manual muscle strength was normal (except for right shoulder). Deep tendon reflexes appear to have been normal. The claimant was recommended for upper extremities and lower extremities EMG/NCV testing. On 6/27/19 YA Medical Care conducted ROM/MMT. On 7/8/19 Dr. Chi conducted upper extremities and lower extremities EMG/NCV testing that suggested evidence consistent with left motor ulnar neuropathy and left peroneal motor neuropathy. On 7/9/19 Dr. Abraham conducted a follow-up

examination. The claimant presented with complaints of headaches rated 7/10, radiating neck pain rated 5/10, mid back pain, and radiating low back pain rated 5/10. The claimant presented with a limping gait. Cervical and lumbar ranges of motion were marked as "improved" and were reduced in all planes (quantified). Examination of the lumbar spine revealed tenderness at the lumbar paraspinal muscles bilaterally, spasms of lumbar paravertebral muscles from L1-S1 disc space bilaterally, and active trigger points were noted on bilateral facet. Straight leg raise was negative bilaterally. Hypersensitivity was noted on left L5-S1 levels. No deficits in deep tendon reflexes and manual muscle strength were documented. The claimant was prescribed a medication [*illegible*]. On 7/20/19 Dr. Abraham of Applicant's office performed Radiofrequency Ablation (Left) Lumbar Facet Medial Branch L3/4, L4/5, L5/S1 under fluoroscopic guidance. On 7/27/19 Dr. Abraham of Applicant's office performed Radiofrequency Ablation (Right) Lumbar Facet Medial Branch L3/4, L4/5, L5/S1 under fluoroscopic guidance. At issue is the 7/20/19 Radiofrequency Ablation (Left) Lumbar Facet Medial Branch L3/4, L4/5, L5/S1 under fluoroscopic guidance.

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 services at issue based on the 8/21/19 peer review by Jason R. Cohen, M.D. After reviewing the claimant's history, treatment, and medical records, Dr. Cohen opines "based upon the medical records presented for independent review, including consultation by Dr. Abraham, as well as the radiological studies of the lumbar spine, there is no indication for fluoroscopy guided radiofrequency ablation of right lumbar facet medial branch under performed on 07/20/2019. "The primary indication is to confirm a clinical suspicion of the facet syndrome. Clinical signs include local paraspinal tenderness; pain that is brought about or increased on hyperextension, rotation, and lateral bending; absence of neurologic deficit; absence of root tension signs; and hip, buttock, or back pain when the straight leg is raised. Symptoms of facet syndrome also include cramping leg pain involving the thigh but not radiating below the knee, low back stiffness, and absence of paranesthesia. The back stiffness is typically most marked in the morning. Low back pain is brought about or increased by maintenance of certain positions, such as sitting erect for a long period of time. Focal tenderness over a facet joint is a strong indication in the appropriate settings, besides the presence of signs of paravertebral spasm or deformity in patients, with abnormal facet joints on imaging studies. Cervical facet pain is often characterized by chronic headaches, restricted motion and axial neck pain, which may radiate sub-occipitally to

the shoulders or mid-back" [*Citation omitted*]. Dr. Cohen asserts "there is no evidence on examination by Dr. Abraham of any focal tenderness overlying the lumbar facet joints at the levels blocked on 7/20/2019. Finally, there are no abnormal facet joints identified on any imaging studies of the lumbosacral spine referenced by Dr. Abraham. "There is limited literature on the therapeutic efficacy as most of the available data is based on non-controlled and observational studies. The evidence of intra-articular injections of local anesthetics and steroids from randomized trials, complemented with that of non-randomized trials (prospective and retrospective evaluations), provided moderate evidence of short-term relief and limited evidence of long-term relief of chronic neck and low back pain" [*Citation omitted*]. Dr. Cohen continues "With regard to test validity criteria, a single intraarticular facet block with local anesthetics is not useful to prove a FJS (Facet Joint Syndrome) and has to be abandoned from preoperative testing and indication finding. Although several studies have been performed in the last decades, evaluation of FJI (Facet Joint Injection) remains difficult due to lack of reliable clinical and radiological predictors. Comparative FJ blocks with local anesthetics and placebo-controls give no proper diagnosis on FJ being main pain generator" [*Citation omitted*]. Facet joint medial branch blocks do not provide a proper diagnosis for the facet joint being the main pain generator." Dr. Cohen concludes "based on review of available medical records, fluoroscopy guided radiofrequency ablation of right lumbar facet medial branch under performed on 07/27/2019 is not medically necessary along with medication, supplies, facility fee, anesthesia, imaging and all services related to injection procedure."

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 a 4/24/20 peer rebuttal by Yvette Abraham, M.D. After reviewing the claimant's history, treatment, and medical records, Dr. Abraham asserts "It is an established medical fact that RFN is indicated where- Patient's pain has failed to respond to three (3) months of conservative management which may consist of therapies such as non-steroidal anti-inflammatory medications, acetaminophen, manipulation, physical therapy and a home exercise program; A trial of controlled diagnostic medial branch blocks (3 positive separate blocks or placebo- controlled series of blocks) under fluoroscopic guidance has resulted in at least a 50% reduction in pain; and If there has been a prior successful radiofrequency (RF) denervation, a minimum time of six (6) months has elapsed since prior RF treatment (per side, per anatomical level of the spine). In the instant case, patient had received more than three months physical therapy, acupuncture, and chiropractic treatments and medications therapy but her pain did not improve. As Dr. Cohen is aware the symptoms of facet joint pain include: Decreased extension and pain; pain in hip, bottom and back when lifting a extended leg; local stiffness tenderness. Low back pain from the facet joints often radiates down into the buttocks and down the back of the upper leg. The pain is rarely present in the front of the leg, or rarely radiates below the knee or into the foot, as pain from a disc herniation often does." Dr. Abraham continues "in the instant case patient did have above symptoms of facet joint pain. The same has been noted in the evaluation reports stated below. Lumbar facet syndrome is a painful irritation of the posterior part of the lumbar

spine. Swelling from the surrounding structures, can cause pain due to an irritation of the nerve roots. Little capsular tears can originate at the level of the posterior facet joints due to a trauma. This can lead to a subluxation of the joint. The synovia that surrounds the joint is damaged and leads to a synovitis. Secondly, hypertonic contractions of the surrounding muscles present it. This is a protection mechanism that increases the pain. These changes lead to a fibrosis and osteophyte formation…I would like to state that, lumbar facet medial branch blocks, procedure performed prior to radiofrequency ablation and also radiofrequency ablation dated 07/27/2019 was a medically necessary. Regarding medial branch blocks - My examination dated 05/30/2019 revealed the diagnosis sprain of ligaments of lumbar spine, subsequent encounter; spondylosis without myelopathy or radiculopathy, lumbosacral region; other intervertebral disc displacement, lumbosacral region and low back pain. My operative report clearly stated the pre and post-operative diagnosis as 'Lumbar Facet Joint Syndrome.' Patient had a chief complaint of low back pain 04/10. Patient had restricted passive lumbar ROM; pain was elicited in flexion and extension; ADLs were decreased and prolong sitting / standing was worsening the pain. Examination revealed there was tenderness at the lumbar paraspinal muscles right and left; lumbar paraspinals were severely spastic on both sides; and there were spasms at lumbar paravertebral muscles from L1 to S1 disc space right and left. Focal tenderness over a facet joint is a strong indication [*citation omitted*] in the appropriate settings, besides the presence of signs of paravertebral spasm…the claimant had the facet joint symptoms as stated earlier. The plan included 'Lumbar facet joint block.' Helbig and Lee found that patients with back pain, paraspinal tenderness and reproduction of pain with extension- rotation maneuvers would respond to joint injections. Sometimes the pain would extend to the groin or thigh but less frequently below the knee. In the case of this patient, they met inclusion criteria including back pain, paraspinal tenderness and reproduction of pain with extension and rotation. Medical imaging has been shown to be of little value in diagnosing the facet as a source of pain. In neck pain, the facet can be the source of pain in up to 67% of patients. For lower back pain this can up to 45% of patients. (1) This condition is very prevalent in patients post motor vehicle accidents. Barnsley et al and Lord et al found that 54% of subjects studied after suffering whiplash injuries had facet joint pain. (2) (3).' The extent of this pain is directly related to the accident. Thus, facet joint block injections were rightly recommended and medically necessary. Regarding the radiofrequency ablation my follow-up examination dated 7/09/2019 stated, Lumbar spine range of motion was improved and patient was independent in activities of daily living. Most reviews assert that radiofrequency ablation is effective for lumbar facet joint pain. Dr. Yong Chi's examination stated 'Thoracic/lumbar spine revealed tenderness upon palpation of bilateral paraspinals.' Lumbar pain radiating down to bilateral lower extremities with numbness and tingling was a chief complaint of the patient. Examination did show positive bilateral SLR. The impression stated was also 'Radiculopathy, lumbar region'; but at the same time the 'Plan of care was EMG/NCV lower extremities to r/o radiculopathy vs., neuropathy' The EMG/NCV test dated 07/08/2019, noted the impression, "The above electrodiagnostic study reveals evidence of left peroneal motor neuropathy." The peroneal nerve is a branch of the sciatic nerve, which supplies movement and sensation to the lower leg, foot and toes. Common peroneal nerve dysfunction is a type of peripheral neuropathy (damage to nerves outside the brain or spinal cord). Also, one of the symptoms of a damaged nerve is decreased sensation, numbness, or tingling in the top of the foot or the outer part of the upper or

lower leg. The report also stated 'functional status' 'the gait was antalgic.' Therefore, I disagree with the peer reviewer." Dr. Abraham continues "typically, several levels of the spine are injected in one procedure. If the patient experiences marked pain relief immediately after the injection, then the facet joint is determined to be the source of the patient's pain. Should the diagnostic block succeed, but pain relief was temporary, we will discuss with the patient some form of denervation procedure. Should the diagnostic block fail, other sources of pain must be examined like discogenic pain, fibromyositis or radiculopathy. This procedure represents the most effective, safe and economical way to treat this patient. The medial branch block is necessary to diagnose and treat the condition of facet syndrome." Dr. Abraham asserts "the Institute for Clinical Systems Improvement (ICSI) entitled "Assessment and Management of Chronic Pain" (Updated November 2011) indicates that Percutaneous radiofrequency (RF) neurotomy is a treatment for neck or back pain generated by facet joints. Properly selected candidates for this procedure should experience complete or nearly complete relief of their pain following fluoroscopically guided, low-volume local anesthetic blocks of the medial branch nerves that innervate the pain-generating joint(s). To minimize false-positive results, an equivalent degree of relief of appropriate pharmacologic duration should be carefully documented on two separate occasions, using two different types of local anesthetic. Radiofrequency neurotomy can provide pain relief for carefully selected patients, but this procedure should be performed only by an experienced pain medicine physician in the context of a longitudinal and comprehensive care plan. Proper patient selection and appropriate technique in positioning the radiofrequency electrodes are absolutely essential to the success of the procedure. RFN - the treatment provided to patient in the instant case, is a neurosurgical procedure that selectively treats problematic nerve roots in the spinal cord, to relieve the symptoms of neuromuscular conditions including facet joint pain. Facet joints connect the vertebrae and guide the spine during movement. Medial branch nerves are found near facet joints and communicate pain from injured facet joints. RFN uses radiofrequency energy to disrupt nerve function. When this is done to a cervical medial branch nerve, the nerve can no longer transmit pain from the injured facet joint. The procedure for an RFN is to insert a thin needle after administering a local anesthetic. Perhaps the most definitive diagnosis of facet joint pain can be made by a facet joint injection (or facet joint block), which injects the suspicious facet joints with a small volume of a combination of X-ray contrast material, local anesthetic, and cortisone. Relief of the acute or chronic problem during the time of action of this combination of drugs is diagnostic. In this procedure, a heat lesion is created on certain nerves with the goal of interrupting the pain signals to the brain, thus eliminating pain. The terms radiofrequency ablation and radiofrequency neurotomy are used interchangeably. Both terms refer to a procedure that destroys the functionality of the nerve using radiofrequency energy. There are two primary types of radiofrequency ablation: A medial branch neurotomy (ablation) affects the nerves carrying pain from the facet joints [*and*] A lateral branch neurotomy (ablation) affects nerves that carry pain from the sacroiliac joints. These medial or lateral branch nerves do not control any muscles or sensation in the arms or legs, so a heat lesion poses little danger of negatively affecting those areas. The medial branch nerves do control small muscles in the neck and mid or low back, but loss of these nerves has not proved harmful…a medial branch nerve block or comparative local anesthetic block temporarily interrupts the pain signal being carried by the medial branch nerves that supply a specific facet joint. If the patient has the appropriate duration of pain relief after

the medial branch nerve block, that individual may be a candidate for a neurotomy. Since the injured exhibited a positive diagnosis for facet joint pain she was recommended RFN to relieve this chronic and severe pain. Facet joint injections, including intraarticular injections, medial branch nerve blocks, and neurotomy (radiofrequency and cryoneurolysis) are used to manage chronic facet generated spinal pain. Spinal facet joints have been shown to be a source of pain in the neck and referred pain to upper extremity and the head; upper back, mid-back, and referred pain in the chest wall; and the low back with referred pain in the lower extremity…Facet related pain is mostly over the axial spine itself and mostly directed over the region of the affected joints. The pain is exacerbated by extension particularly extension of the spine, which forces the inflamed articular surfaces together. Pain with rotation is also a common feature. The pain may wax and wane with activity. Most importantly is the feature that the pain is axial spine and less so in the extremities. Often these patients have unremarkable imaging" [*Citation omitted*]. Dr. Abraham concludes "facet joints are a clinically important source of cervical, thoracic and lumbar spine pain. The facet joints are innervated by the medial branches of the doral rami. They are capable of causing pain in the cervical, thoracic, and lumbar back. This pain can be referred to the upper extremity, chest wall and lower extremity often mimicking a disc related radiculopathy. Medical imaging has been shown to be of little value in diagnosing the facet as a source of pain. In neck pain, the facet can be the source of pain in up to 67% of patients. For lower back pain this can up to 45% of patients. This condition is very prevalent in patients post motor vehicle accidents. Barnsley et al and Lord et al found that 54% of subjects studied after suffering whiplash injuries had facet joint pain. In the instant case the patient complained of pain in the back the patient had axial low back pain, exertion, prolong sitting, and prolong standing and walking. On a scale of 0-10 the patient rated the pain as 05/10. The patient had received multiple physical therapy, acupuncture, and chiropractic treatments and medications therapy. The patient had been using anti-inflammatory medications with minimum relief. Her clinical impression was Facet joint syndrome; Facet Arthropathy Lumbar, Therefore, the patient was appropriately recommended Radiofrequency Neurolysis of Lumbar Medial Branches Right and Left L3/4, L4/5, L5/S1. The extent of this pain was directly related to the accident. Further investigation with diagnostic studies to diagnose the condition of facet syndrome lacks validity. The gold standard is to perform a diagnostic medial branch block. This first positive block is often considered to be sufficient. A second medial branch block is recommended by some, because of the high false positive rate of the first block. This is determined on a case by case basis. In many situations the purpose of the medial branch block is to diagnosis the condition in anticipation of a procedure to denervate the medial branch nerve for longer lasting relief. However, the block itself can be considered to be therapeutic. In the case of cervical facet pain, Manchikanit studied the results of cervical medial branch blocks with and without steroids. Significant pain relief of more than 50% was observed with functional improvement at 3 months, 6 months and 12 months in more than 83% of patients studied. The duration of the average pain relief was 14+/-6.9 weeks in the nonsteroid group and 16+/-6.9 in the steroid group. Based on the evidence that is available and the current patient's history and physical exam findings this procedure is indicated and medically necessary to both diagnose and therapeutically relieve the pain they are experiencing. Should the diagnostic block succeed, but pain relief be temporary, we will discuss with the patient some form of denervation procedure. Should the diagnostic block fail, other sources of pain must be examined like

discogenic pain, fibromyositis or radiculopathy. This procedure represents the most effective, safe and economical way to treat this patient. The medial branch block is necessary to diagnose and treat the condition of facet syndrome. Injection therapies play a major role in management of various pain conditions. Traditional therapies such as intra-articular injections, regional blocks, epidural injections, and selective nerve root blocks are integral part of multidisciplinary approach required to improve and rehabilitate pain patients. Injection therapies are adjunct to aggressive conservative rehabilitative efforts. Injections should not be the only treatment the patient is given but rather should be a part of the combination therapy needed to provide relief and improve the functional abilities of the patient. While frequently targeting the same pain syndromes injection therapy interventions may be separated according to three criteria. Location of the injection and the tissue that is targeted for the injection. The injection can be given into the facet joint, the epidural space, the spinal nerve root, the intervertebral disc, the lumbar sympathetic chain, sacroiliac joint, local ligaments, muscles, or trigger points. The pharmacological agent that is used varies from different types of corticosteroids aimed at reducing inflammation and anesthetics aimed at pain relief to a variety of other medications. The indications for the injections may be different. The injection therapy may be applied in cases of acute, subacute and chronic low back or neck pain with or without signs of nerve root compression. The specific characteristics of the injection therapy with respect to target tissue, pharmacological agent and dosage depend on the presumed pathophysiological mechanisms leading to pain. A systemic review of the literature by Boswell et al., evaluated effectiveness of intraarticular facet joint injections, medial branch nerve blocks and neurolytic procedures separately for each category. The study evaluated primary outcome measures as significant pain relief and secondary outcome measures were functional or psychological improvement, return to work, complications. Based upon systematic review of the studies included for the cervical intraarticular facet joint injections the evidence is limited for short and long-term pain relief. For lumbar intraarticular facet joint injections, there is moderate evidence for short- and long-term relief of pain. For cervical, thoracic, lumbar medial branch nerve blocks, the evidence is moderate for short- and long-term relief of pain. Regarding medial branch blocks for management of facet joint pain, 3 relatively new studies evaluated the effectiveness. Each study separately addressed cervical, thoracic and lumbar facet generated pain. For all three studies the results may be summarized as follows. Statistically significant pain relief and functional status improvement were observed at 3 months, 6 months and 12 months. The average number of treatments for one year was approximately 3 to 4. Duration of average pain relief was about 3-4 months. Based upon these three studies and other reports for medial branch facet nerve blocks, evidence for relief of chronic cervical, thoracic and lumbar facet pain is considered moderate for both short and long-term pain relief. Based on best evidence, long--term relief of facet joint pain with medial branch blocks may require local anesthetic injections at intervals approximately 3 to 4 months, with or without steroids. While facet injection procedures can be used as a diagnostic test to see if the pain is actually coming from facet joints, it is also a treatment to relieve inflammation and pain caused by various spine conditions. The peer review lacks the rationale to justify denial of the services provided to the patient. There are no specific guidelines delineating the absolute structured path for treatment to be universally prescribed to all patients. 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. As the treating physician who is responsible for the care and treatment of the patient I am the best person and in the best position to determine the need of necessary treatment. The peer reviewer on the other hand has no responsibility towards the patient's best interest. Based upon a review of the aforementioned documents, taking into consideration the patient's the history of the injury, the patient's complaints, and the clinical findings and in accordance with the generally accepted standards of care in the relevant medical community, Radiofrequency Ablation of Lumbar Medial Branches Right L3/4, L4/5, L5/S1 provided on 07/20/2019 was medically necessary and should not be denied."

The conflicting medical expert opinions adduced by the parties sufficed to raise an issue as to the medical necessity of the treatment underlying the provider's first-party no-fault claim. See *Advanced Orthopedics, PLLC v. New York Central Mutual Fire Insurance Company*, 42 Misc.3d 150 (A), 2014 N.Y. Slip Op. 50418(U) (App. Term 2nd , 11th and 13th Jud. Dists. 2014); *Pomona Medical Diagnostics, P.C. v. Praetorian Insurance Company*, 42 Misc.3d 126(A), 2013 N.Y. Slip Op. 52131(U) (App Term 1st Dept. 2013). Here the weight of evidence favors Applicant. Dr. Abraham's rebuttal is more persuasive than Dr. Cohen's peer review and is supported by the medical records in evidence.

Accordingly, Applicant is awarded $568.02.

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
	Trinity Pain Management of Staten Island, PLLC	**07/20/19 - 07/20/19**	**$4,691.00**	**$568.02**	**Awarded: $568.02**
Total			**$4,691.00**		**Awarded: $568.02**

B. The insurer shall also compute and pay the applicant interest set forth below. 10/07/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest runs from 10/7/19 (the date that arbitration was requested) 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.

06/18/2021
(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

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Electronically Signed

Your name: Charles Blattberg
Signed on: 06/18/2021