American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Metro Pain Specialists PC (Applicant)	AAA Case No.	17-20-1188-8595
	Applicant's File No.	N/A
- and -	Insurer's Claim File No.	32-C586-3H7
	NAIC No.	25178
State Farm Mutual Automobile Insurance Company (Respondent)		

ARBITRATION AWARD

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

Injured Person(s) hereinafter referred to as: Assignor(DL)

1. Hearing(s) held on 03/24/2022
   Declared closed by the arbitrator on 03/24/2022

   Lee-Ann Trupia, Esq. from The Law Offices of Hillary Blumenthal P.C. (Melville) participated for the Applicant

   Christine DiGregorio, Esq, from Rivkin & Radler LLP participated for the Respondent

2. The amount claimed in the Arbitration Request, **$832.15**, was NOT AMENDED at the oral hearing.
   Stipulations WERE made by the parties regarding the issues to be determined.

   The parties stipulated that Applicant established a prima facie case of entitlement to No-Fault compensation and that Respondent's NF-10 denial of claim form was timely.

3. Summary of Issues in Dispute

   This no-fault arbitration dispute arises from an automobile accident that occurred on 1/1/20. This claim (along with six other linked claims heard on 3/24/2022) involves medical treatment rendered to DL, a 49-year-old male, by Metro Pain Specialists. (Metro-Pain). This claim (AAA # 17-20-1188-8595) involves treatment provided from 9/25/20-to 9/30/20 including various evaluations and an Outcome Assessment test

(Code 99358). The basis of the State Farm's denial is as follows: *"The claim records, the testimony of Leonid Shapiro, M.D. dated October 25, 2018, and November 5, 2018, documents provided following that testimony, and the report of James Dillard, M.D. indicate that the services were provided without regard to the medical necessity and were of no diagnostic value and therefore, were not medically necessary."*

By way of background, the litigation between Metro Pain and State Farm began sometime in 2018, when State Farm initiated an investigation into the sufficiency of the medical procedures and billing practices of Metro Pain Specialists. The investigation resulted in the owner of Metro Pain, Dr. Leonid Shapiro, giving oral testimony on October 25, 2018, and again on November 5, 2018. Following his testimony, State Farm asked for post-EUO documentation. There are hundreds of awards rendered in connection with the sufficiency of Metro-pain's compliance with those post -EUO document demands, and the legal sufficiency of State Farm's 120-day denial raised in response to perhaps hundreds of claims.

The denial in this claim rests upon a Peer report issued by Dr. Dillard on 7/16/20. The rejection does not rest on the sufficiency of the post verification responses or the 120-day denial. Instead, this denial refers to a Peer review report from Dr. Dillard, who reviewed nearly 1000 claims that Metro Pain submitted. He studied those claims and the testimony given by Dr. Shapiro at his 2 EUOs, documents provided to State Farm in response to its post-EUO verification requests, and medical literature. He issued a report concluding that these disputed claims lacked medical necessity and were of no diagnostic value. I note that the record contains a document from Doug Babin a State Farm employee whose supporting letter in favor of State Farm's defense was considered.

The issue before me is whether the Insurer met its burden of proof supporting its lack of medical necessity defense.

4. Findings, Conclusions, and Basis Therefor

This award is based on my thorough review of the documentary evidence submitted by the parties to the American Arbitration Association and maintained in the MODRIA, electronic case filing system and oral arguments presented by both parties' representatives during the hearing. Pursuant to 11 NYCRR 65-4.5 (o) (1) (regulation 68D), the arbitrator shall be the judge of the relevance and materiality of the evidence offered and strict conformity to legal rules of evidence shall not be necessary. The Arbitrator may question any witness or party and independently raise any issue that the arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department Regulations.

Medical Necessity

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 2, 11 and 13 Jud. Dist 2014). Respondent bears the burden of production in support of it lack of medical necessity defense, which if established shifts the burden of persuasion to the applicant. See generally, Bronx Expert Radiology, P.C. v. Travelers Ins. Co., 2006 NY Slip Op 52116 (App. Term 1 Dept. 2006). The Appellate Courts have not clearly defined what st satisfies this standard except to the extent that "bald assertions" are insufficient.Amherst Medical Supply, LLC v. A Central Ins. Co., 2013 NY Slip Op 51800(U) (App. Term 1st Dept. 2013).

However, there are myriad civil court decisions tackling the issue of what constitutes a "factual basis and medical rationale" sufficient to establish a lack of medical necessity. The civil courts have held that a defendant's peer review or medical evidence must set forth more than just a basic recitation of the expert's opinion. The trial courts have held that a peer review report's medical rationale will be insufficient to meet the respondent's burden of proof if: 1) the medical rationale of its expert witness is not supported by evidence of a deviation from "generally accepted medical" standards; 2) the expert fails to cite to medical authority, standard, or generally accepted medical practice as a medical rationale for his findings; and 3) the peer review report fails to provide specifics as to the claim at issue, is conclusory or vague. See generally, Nir v. Allstate, 7 Misc.3d 544 (N.Y. City Civ. Ct. 2005); See also, All Boro Psychological Servs. P.C. v. GEICO, 2012 NY Slip Op 50137(U) (N.Y. City Civ. Ct. 2012).

"Generally accepted practice is that range of practice that the profession will follow in the diagnosis and treatment of patients in light of the standards and values that define its calling." Nir, supra. The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment, Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co., 2009 NY Slip Op 00351 (App Div 2d Dept., Jan. 20, 2009); Channel Chiropractic, P.C. v. Country-Wide Ins. Co., 2007 Slip Op 01973, 38 A.D.3d 294 (1st Dept. 2007); Bronx Radiology, P.C. v. New York Cent. Mut. Fire Ins. Co., 2007 NY Slip Op 27427, 17 Misc.3d 97 (App Term 1 Dept., 2007), such as by a qualified expert performing an independent medical examination, conducting a peer review of the injured person's treatment, or reconstructing the accident. Id. An insurance carrier must, at a minimum, establish a detailed factual basis and a sufficient medical rationale for its asserted lack of medical necessity. Vladimir Zlatnick, M.D., P.C. v. Travelers Indem. Co., 2006 NY Slip Op 50963(U) (App Term 1st Dept., 2006); Delta Diagnostic Radiology, P.C. v. Progressive Casualty Ins. Co., 2008 Slip Op 52450(U), 21 Misc.3d 142(A) (App Term 2d Dept., 2008).

Dr. Dillard explained that he arrived at his conclusions after reviewing hundreds of claims dating from 2019 through 2020. He then advised that he read the EUO testimony by Dr. Shapiro and reviewed medical records including examination reports. DR Dillard noted that in nearly all of the exams the patient had increased pain when bending lifting and prolonged standing and walking. He argued that it this not credible that so many patients would volunteer that exact same sequence of aggravating factors. Similarly .in the portion of the records labeled Aggravating factors, nearly all of the records contained the same language. He argued that the notes are clearly copied and pasted with the result that some make no or little sense. He is suspicious because the conclusions about devices are not found in legitimate practice.

In Dr. Shapiro's EUOs, Dillard notes that Shapiro claimed that each patient received an individually tailored treatment plan. However, Dillard stated that it is not true because upon the examination of the charts the records appear to be highly repetitive and the plans are virtually identical over and over. Dr. Dillard argued that Dr. Shapiro claimed at his EUO at page 21 of the 10/25/20 EUO that if problems don't exist they should be discharged somewhere in the vicinity of four months after conservative treatment. Yet, when he reviewed hundreds of files he was unable to find a single case in which a patient was discharged without undergoing some invasive pain procedure.

As to the Outcome Assessments, Dr. Dillard claims that these assessments are performed in a sloppy manner and that they are not even scored which brings into question that they were not even performed. He argued that the outcome Assessment tests are not considered necessary to inform a treatment plan in fact are not reasons for the need to perform the outcome assessment tests. They are incomplete and lack medical necessity. In fact, Shapiro testified that he did not know the specifics of the outcome assessment questionnaires, and does not even know why such tests were administered.

The expert noted that the examination reports contradict Shapiro's testimony, as Shapiro had testified that Metro Pain's patients receive individualized treatment plans, yet the examination reports routinely contained identical treatment plans and language. Further, the outcome assessment testing performed and billed by Metro Pain raised concerns as the expert noted there was no indication in the files why the testing was ordered or why it was necessary, as the findings were not incorporated anywhere into the clinical notes. In fact, Shapiro testified that he did not know the specifics of the outcome assessment questionnaires, and does not even know why such tests were administered.

As for the pain injections and the EDX diagnostic tests, Dr. Dillard argued that the patients were given their injections without any reason. Some are given on the same day as the EMG.NCV tests were poorly done and in violation of the standards identified in the AANEM. Dr. Dillard argued that virtually all of th patients got the same pre-determined treatment plan. They received DMEs, injections EDX tests, outcome assessment tests, and therapy in a manner inconsistent with the guidelines in support of medical necessity.

Dr. Shapiro's Rebuttal

Dr. Shapiro argues that the Peer itself is conclusory and fails to specifically consider the hundreds of individual claims that he claims lacked medical necessity. For instance, Dr. Shapiro argued that *:*

Dr. Dillard states that he was unable to find a single case in which any patient was just discharged without undergoing some invasive pain procedure. This statement is not credible and false. The very first patient on the list of that Dr. Dillard presents is Claim No 0703N755N. This patient had no procedure and has not been seen since 2019. Also, later patients were seen by pain management who they did not even recommend

procedures too. However, he fails to comment on these patients. Metro Pain doctors pre-Pandemic see and evaluate around 800 patients a month, only 20% of them receive pain management procedures on average. Less than 20% the patients listed in the addendum to the letter received pain management procedures even considering pre-selected patients' claims by State Farm. The overall ratio for State Farm's general patient population remains on par with an average of 20%.

With regard to the files that Dr. Dillard claims to have reviewed, Dr. Shapiro argued that:

There are approximately 1690 bills that, include about 511 patients. Of that, about 1415 are mere office visits and outcome assessment tests. EMG's numbers are about 50 or about 9% and pain procedures about 92, which is about 18%, but it is less because some of the 92 procedures were given to the same individuals. There are about 13 orthopedic surgeries. Of the pain procedures, it is only about 5% of the total bills. Of the procedures, there were a variety including epidurals which were about the slight majority, medial branch blocks next, transforaminal epidurals, and sacral iliac joint injections. On a few occasions, trigger point injections were added to the procedure in another body part to mitigate pain while the other was treated more definitively. Thus, the medical treatment is tailor-made. To claim that there is an overutilization of pain procedures or neurodiagnostic testing is just untrue. It should be noted that Dr. Dillard's assessment is not a practice-wide assessment but only based on the bills he allegedly reviewed which amount to LESS THAN 5% of the total bills that State Farm disputes are pain procedures. As such when Dr. Dillard states virtually all the patients had invasive procedures this statement is false and mendacious.

With regard to the frequency of injections, Dr. Shapiro stated that :

Section D.6.a of the NYS Worker's compensation guidelines titled Therapeutic Spinal Injections Introduction states "Therapeutic spinal injections may be used after initial conservative treatments, such as physical and occupational therapy, medication, manual therapy, exercise, acupuncture, have been undertaken…. Active treatment, which patients should have had prior to injections, will frequently require a repeat of the sessions previously ordered."

Regarding EMG / NCV reports, Dr. Shapiro argued that:

Dr. Dillard's criticism is very general and unclear. The lower back workers' compensation guidelines write that EMG substantiates the diagnosis of radiculopathy or spinal stenosis in patients with back pain and or radiculopathy. It can help determine if the condition is acute or chronic. The associated NCV is done to rule out other potential causes for the symptoms and confirm the radiculopathy. The EMGs are typically done on patients that have some radiating component. The studies are done where there are ongoing complaints of pain, weakness, and or numbness/paresthesia. NYS WC mid and lower back injury medical treatment guidelines page 18 and 19. Dr. Dillard states that

Metro Pain's only reason is that the "patient is not getting better" and another reason is needed which is a patently untrue statement. The WC guidelines are clear that it is indicated for patients with ongoing pain (ie not getting better). The nerves typically tested are consistent with clinical and MRI findings. Dr. Dillard points to no EMG study in question. In fact, one cannot even complain that EMGs in the practice are over-utilized if State Farm does not produce an actual number.

Dr. Shapiro argues that:

Dr. Dillard complains that there is overuse of pain procedures but does not produce any evidence to make the claim that Metro Pain itself overuses them. In fact, as stated above less than 20% had procedures. Some patients needed interventional procedures and most of them had 1-2 procedures. A minority had more. However, that is a function of the disease process they suffered with. For example, if we are treating a patient with facet syndrome of the lumbar spine the NYS WC guidelines call for 2 medial branch blocks before a radiofrequency can be done. Then each side is treated with radiofrequency. There is no getting around this process per the guidelines and these are evidence-based. It is more when both the neck and back is involved because they are treated separately. As stated above the average the practice of patients receiving pain management procedures is 20% or less.

Further, at times the pain is mild by the time they get to their consult and there is only mild pain, therefore patients have treatment tailored to- no procedure recommended, and conservative care only recommended. See claim 329677W09, 32B0041Z4, 328723G71 and 325338P37. Or there are times the patient does have severe pain but would like to just do conservative treatment and we tailor the plan based on their preferences. For example, in claim number 326358H99, the physician wrote "Patient elects to continue conservative management only. She will follow up as needed. The following injections are recommended based on an evaluation today:…"

Next, Dr. Shapiro takes issue with Dr. Dillard's attempts to disparage Mr. David Naranjo's treatment - a patient who Shapiro treated (whose claim is not specified in this claim). He (Dillard)appears to infer that Mr. Naranjo's subsequent complaints are not genuine because in the police report was a claim of "no injury". As to this Dr. Shapiro argued that:

The notion that because someone does not have pain immediately after an accident and then cannot subsequently develop pain after a period of time has long been debunked as it may take days to develop pain in whiplash. Gatterman, M. I. (2011). Whiplash - E-Book: A Patient-Centered Approach to Management. United Kingdom: Elsevier Health Sciences, pg 2. Further Dr. Dillard himself writes in his book "You may leave the accident feeling fine but develop stiffness and pain the next day." .Dillard J, The Chronic Pain Solution at location 4763 of 6861 When seen, Mr. Naranjo it was reported that the pain reported was a "moderate 7/10," not 8/10 in the neck with radiation and 4/10 in the lower back without radiation. Before any procedure can go forward the interventional pain manager will make the determination to do the

procedure or not. Dr. Dillard complains that recommending procedures for the patient was inappropriate because nothing else was considered. This statement is once again false. The note clearly and explicitly states that the patient has had chiropractic and physical therapy for several months. It was even recommended that the patient be given additional therapy. However, when the patient was seen several weeks later, there was a change in the patient's level with neck pain being down to a 6/10 and the back pain getting worse and now radiating with a new change in deep tendon reflexes. What is striking here is that the reports are so different documenting the different symptoms presented at each visit. The reports have different exams and discussion of the pain that the patients are feeling. This does not reflect a cookie-cutter practice! Also, consideration is given to the conservative therapies provided explicitly in the notes. Ultimately, the patient elected to not do any procedures.

The Addendum.

Dr. Dillard argued that Dr. Shapiro evaded his challenges and failed to address the nub of the criticism of his practices. Dr. Dillard argues that the Rebuttal does little to refute his main objections. Dr. Dillard argues that even if some of the patients were treated correctly and in line with the treatment guideline most of the patients were not provided medically necessary care. He argues that the sheer volume of patients who were given injections, EDX tests, outcomes assessment tests, and other forms of therapy is conclusive evidence that these claims should be denied as lacking in medical necessity. I also considered the letter from Doug Babin the SIU Investigator. Mr. Babin argued that the facts gleaned from the EUOs and post verification doceumts support the lack of medical necessity defense.

Conclusion

As a threshold matter, I note that this claim was not even listed with the claims that Dr. Dillard reviewed when he prepared his Report. Other claims for DL were reviewed but, these DOS post-date Dr. Dillard's Peer Review Report.

I have reviewed **the extensive file** in this case including the letter from State Farm's SIU investigator, Doug Babin, reports for each side's experts, the claims, the EUOs, the post verification documentation, the medical records and note arguments of counsel. I find that Dr. Dillard's arguments were refuted by Dr. Shapiro's' Rebuttal. I understand the overall allegation that many of the treatment decisions appeared to have been performed without regard to the individual's needs. However, when Dr. Dillard tried to support his assertion, he failed to provide the necessary factual and medical detail linking his overall criticism with sufficient claims. He also failed to supply sufficient medical support for his criticisms. Simply put, citing three of the fifteen hundred claims in dispute and not citing the claims in this dispute is problematic, especially since Dr. Shapiro's Rebuttal contains references to multiple specific claims, an in-depth analysis of persuasive medical literature, and a comprehensive statistical analysis refuting Dr. Dillard's contentions.

The trial courts have held that a peer review report's medical rationale will be insufficient to meet the respondent's burden of proof if:....the peer review report fails to provide specifics as to the claim at issue, is conclusory or vague. See generally, Nir v. Allstate, 7 Misc.3d 544 (N.Y. City Civ. Ct. 2005); See also, All Boro Psychological Servs. P.C. v. GEICO, 2012 NY Slip Op 50137(U) (N.Y. City Civ. Ct. 2012).

Dr. Shapiro was able to point with specificity to multiple claims and persuasive medical literature. Dr. Dillard was unable to connect his general statements to the actual claims presented here. Dr. Dillard pointed to and discussed the details of only 3 patients. That lack of specific analysis renders his opinions about this patient's treatment lacking. His citations to medical literature were not persuasive and failed to explain how the Applicant deviated from the acceptable medical guidelines. Dr. Shapiro provided multiple examples of individual claims to contradict the general conclusions from Dillard and defeated the strength of Dr. Dillard's Peer Review. Specifically, Dr. Dillard was unable to provide sufficient evidentiary support for its lack of medical necessity defense regarding the treatment provided in this claim.

As stated above, Dr. Dillard only commented on the general practices and procedures at the applicant's office by reviewing treatment records of albeit numerous patients that were treated at the Applicant's PC as well as the transcripts of Dr. Shapiro. However, he did not discuss this claim or the precise treatment and testing provided to this Assignor on DOS 9/25/20-9/30/20.

I note that the Insurer failed to provide any evidentiary support in connection with the amounts billed.

Accordingly, the Applicant is awarded $832.15 in full satisfaction of this claim.

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
	Metro Pain Specialists PC	**09/25/20 - 09/25/20**	**$534.76**	**Awarded: $534.76**
	Metro Pain Specialists PC	**09/30/20 - 09/30/20**	**$297.39**	**Awarded: $297.39**
Total			**$832.15**	**Awarded: $832.15**

B. The insurer shall also compute and pay the applicant interest set forth below. 12/22/2020 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

The applicant is awarded interest pursuant to the no-fault regulations. See generally, 11 NYCRR §65-3.9. Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30 day month." 11 NYCRR §65-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. However, the regulations toll the accrual of interest when an applicant "does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations." See, 11 NYCRR 65-3.9(c). The Superintendent and the New York Court of Appeals have interpreted this provision to apply regardless of whether the particular denial at issue was timely. LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 217 (2009).

C. Attorney's Fees

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

Since this case was filed on or after February 4, 2015, this case is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant an attorney's fee, in accordance with newly promulgated 11 NYCRR 65-4.6(d). For claims that fall under the Sixth Amendment to the regulation, the following shall apply: "If the claim is resolved by the designated organization at any time prior to transmittal to an arbitrator and it was initially denied by the insurer or overdue, the payment of the applicant's attorney's fee by the insurer shall be limited to 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon, for each applicant with whom the respective parties have agreed and resolved dispute, 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, Phyllis Saxe, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

04/24/2022
(Dated)

Phyllis Saxe

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:
dae4b6824181feeb9a0d3f477395bd80

Electronically Signed

Your name: Phyllis Saxe
Signed on: 04/24/2022