American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Same Day Procedure LLC (Applicant)	AAA Case No.	17-21-1224-2769
	Applicant's File No.	SDCON-NY-02
- and -	Insurer's Claim File No.	FLQ1764
	NAIC No.	25666
Greenwich Insurance Company (Respondent)		

ARBITRATION AWARD

I, Debbie Thomas, 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

1. Hearing(s) held on 07/19/2022
   Declared closed by the arbitrator on 07/19/2022

   Anna Skowronska from Law Office of Jeffrey Randolph, LLC participated in person for the Applicant

   Sarah Rubin from Lewis Brisbois Bisgaard & Smith LLP participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$976.38**, 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 in the amount of $976.38 for services in connection with a lumbar epidural steroid injection performed October 19, 2019 on Assignor, R.S., a 35-year-old male who was the rear-seat passenger of a motor vehicle involved in an accident on May 13, 2019. Respondent denied the claim based on the peer review report of Sammy Dean, M.D., which concluded that the injection was not medically necessary. The issue presented is whether the services performed by Applicant were medically necessary.

4. Findings, Conclusions, and Basis Therefor

The within award is based upon this arbitrator's review of the record as well as oral argument at the time of the hearing of this matter.

Under Sec. 5102 of the New York Insurance Law (McKinney 1985), No-Fault first party benefits are reimbursement for all medically necessary expenses on account of personal injuries arising out of the use or operation of a motor vehicle.

It is well settled that a healthcare provider establishes its *prima facie* entitlement to No-Fault benefits as a matter of law by submitting evidentiary proof that the prescribed statutory billing forms had been mailed and received and that payment of No-Fault benefits were overdue. *Westchester Medical Center v. Lincoln General Insurance Company*, 60 A.D.3d 1045, 877 N.Y.S.2d 340 (2 Dept. 2009); *Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). Respondent's denial(s) indicating receipt of the proof of claim shows that Applicant mailed the proof of claim form(s) to the Respondent (*see, Ultra Diagnostic Imaging v. Liberty Mutual Insurance Co.*, 9 Misc.3d 97). The evidence is sufficient to make out a *prima facie* case of entitlement to recovery of Applicant's bill.

The burden then shifted to the insurer to come forward with sufficient evidence to rebut the presumption of medical necessity which attached to the providers' claim forms. *See, West Tremont Med. Diagnostic, PC v. Geico Ins. C*o., 13 Misc.3d 131(A) (N.Y. App. Term 2006).

When an insurer relies upon a peer review report to demonstrate that a particular service was not medically necessary, the peer reviewer's opinion must be supported by sufficient factual evidence or proof and cannot simply be conclusory. As per the holding in *Jacob Nir, M.D. v. Allstate Insurance Co.*, 7 Misc.3d 544 (2005), the peer reviewer must establish a factual basis and medical rationale to support a finding that the services were not medically necessary, including setting forth generally accepted standards in the medical community. The opinion of the insurer's expert, standing alone, is insufficient to carry the insurer's burden to prove that the services were not medically necessary. *See CityWide Social Work & Psychological Services, PLLC v. Travelers Indemnity Co.*, 3 Misc.3d 608, 777 N.Y.S.2d 241 (N.Y.Civ. Ct. Kings Co. 2004).

Once Respondent meets this burden of proof then the burden shifts back to Applicant to present competent medical proof as to the medical necessity for the disputed billing by a preponderance of the credible evidence. *West Tremont Medical Diagnostic, P.C. v. GEICO*, 13 Misc.3d 131[A], 824 N.Y.S.2d 759 (Table), 2006 WL 2829826 (App. Term 2d & 11th Jud. Dists. 9/29/06); *A. Khodadadi Radiology, P.C. v. N.Y. Central Fire Mutual Insurance Company*, 16 Misc. 3d 131[A], 841 N.Y.S.2d 824, 2007 WL 1989432 (App. Term 2d & 11th Dists. 7/3/08). Ultimately, the burden of proof rests with the

Applicant (See: Insurance Law §5102). *See Be Well Medical Supply, Inc. v. New York Cent. Mut. Fire Ins. Co*., 18 Misc3d 139(A) (App. Term 2d & 11th Dists. Feb. 21, 2008).

In support of its contention that the injections performed by Applicant were not medically necessary, Respondent relies on the peer review report of Sammy Dean, M.D. I previously addressed the peer review report of Dr. Dean in determining medical necessity for the lumbar epidural steroid injection at issue in this arbitration in AAA Case No. 17-21-1204-2761. My award in that matter states, in relevant part:

> Dr. Dean notes that Assignor is a 36-year-old male who, on May 13, 2019, was a rear-seat passenger of a vehicle involved in an accident. The vehicle he was traveling in was struck in the rear by another vehicle. Following the accident, he was seen at Staten Island University Hospital ED where he was evaluated, treated, and released for outpatient care.
> Subsequent to this, he was referred for conservative care modalities and diagnostic imaging. He later came under the care of Arun M. Kandra, M.D., a pain specialist, who performed cervical epidural steroid injection with fluoroscopic localization of needle placement and epidurogram on him on September 19, 2019 due to a diagnosis of cervical radiculopathy.
> Notes dated August 20, 2019 by Dr. Kandra show Assignor complained of neck pain radiating to the bilateral upper extremities. Physical exam findings included painful range of motion (no recorded values) and spasms of the cervical spine. Muscle strength was with hand grip strength slightly decreased on the right as compared to the left. Deep tendon reflexes and sensation tests were not performed. For his injury, Assignor received chiropractic adjustments, pain medications, physical therapy, and injections. He has also had diagnostic tests, including MRIs of the lumbar and cervical spine.
> The purpose of an epidural steroid injection is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. Multimodal care, including manual therapy and exercise, is recommended for early neck pain and symptoms. In the therapeutic phase, an ESI should be repeated only as medically necessary. This includes acute exacerbation of pain, or new onset of radicular symptoms. Literature shows the following in the judgment of the effect of epidural steroid injections: "The primary outcome measure was pain relief (short-term relief = up to 6 months and long-term > 6 months). Secondary outcome measures were improvement in functional status, psychological status, return to work, and reduction in opioid intake." (Benyamin RM, 2012).
> There is insufficient documentation of physical exam findings, symptomatology, and supporting documentation to support an ongoing diagnosis of radiculopathy for which epidural steroid injection and associated services may be indicated. Radiculopathy is defined as a

significant alteration in the function of a nerve root or nerve roots and is usually caused by pressure on one or several nerve roots. The diagnosis requires a dermatomal distribution of pain, numbness, and/or paresthesias. A root tension sign is usually positive. The diagnosis of herniated disk must be substantiated by an appropriate finding on an imaging study. The presence of findings on an imaging study in and of itself does not make the diagnosis of radiculopathy. There must also be clinical evidence as described above.

Evaluation dated August 20, 2019 show Assignor complained of neck pain radiating to the upper extremities without paresthesias complaints. Range of motion of the cervical spine was noted as painful without recorded values. Root tension testing was not performed. Neurological evaluation was not performed/documented, but minimal motor strength decrease was noted. There is no updated evaluation since August 20, 2019, with further supporting evidence of cervical radiculopathy. There is insufficient documentation by the specialist performing the procedure which outlines the failure of conservative modalities and radicular complaints for which a cervical epidural steroid injection would be an appropriate treatment.

With regard to the lumbar spine epidural steroid injections performed on October 19, 2019 there is insufficient documentation of physical exam fin dings, symptomatology, and supporting documentation to support an ongoing diagnosis of radiculopathy for which epidural steroid injection and associated services may be indicated. Lumbosacral radicular pain is characterized by a radiating pain in one or more lumbar or sacral dermatomes; it may or may not be accompanied by other radicular irritation symptoms and/or symptoms of decreased function. There must be clinical evidence as described above.

Evaluation dated August 20, 2019 show Assignor complained of lower back pain radiating to the buttocks without paresthesias complaints or further radiation into the extremities. Range of motion of the lumbar spine was noted as painful without recorded values. Root tension testing was not performed. Neurological evaluation was not performed/documented for the lumbar spine/lower extremities. There is no updated evaluation since August 20, 2019, with further supporting evidence of lumbar radiculopathy. There is insufficient documentation by the specialist performing the procedure which outlines the failure of conservative modalities and radicular complaints for which a lumbar spine epidural steroid injection would be an appropriate treatment.

Applicant submits formal rebuttals to the peer review reports of Dr. Dean by Vladimir Gressel, M.D. Dr. Gressel notes that on May 21, 2019, Assignor presented to Dr. Kandra for pain management consultation. At that time he complained of 6/10 constant throbbing neck pain radiating to the bilateral upper extremities as well as pain between the scapular blades. He also reported that his pain exacerbated with sitting and with damp weather. He also had poor sleep at night and difficulty with activities of daily living due to the pain. He was taking over-the-counter NSAIDs for his pain. Examination of the cervical spine revealed positive

cervical paraspinal spasms, positive Cervical Facet Loading test, diminished range of motion and diminished strength on the right compared to the left. Based on the patient's complaints and clinical findings noted upon examination, the clinical impressions were cervical region radiculopathy and injury of nerve root of cervical spine. Assignor was recommended to continue with chiropractic treatment and referred for an MRI study of the cervical spine.
MRI study of the cervical spine performed on June 4, 2019 revealed subcentimeter focus of hyperintensity within the right hemicord at the C3 level, broad-based disc protrusion at the C3-4 level, right foraminal narrowing at C2-3 and C3-4 and bilateral foraminal narrowing at C4-5 and C5-6 levels.

On June 11, 2019 and June 25, 2019, Assignor presented to Dr. Kandra for follow-up evaluations. During those visits, he complained of 6/10 constant throbbing neck pain radiating to the bilateral upper extremities as well as pain between the scapular blades. He also reported that his pain exacerbated with sitting and with damp weather. He also had poor sleep at night and difficulty with activities of daily living due to the pain. He was taking over-the-counter NSAIDs for his pain. Examination of the cervical spine revealed positive cervical paraspinal spasms, positive Cervical Facet Loading test, diminished range of motion and diminished strength on the right compared to the left. Based on the complaints and clinical findings noted upon examination, the clinical impressions were cervical region radiculopathy and injury of nerve root of cervical spine. Assignor was recommended to continue with chiropractic treatment and was also recommended epidural steroid injections if his pain did not improve with conservative treatment alone.
Assignor started on a course of physical therapy along with chiropractic care; however, despite conservative treatment including physical therapy and chiropractic care along with pain medications, he had no complete relief in his complaints of pain. He presented to Dr. Kandra for a follow-up evaluation on August 20, 2019. At that time, he complained of 6/10 constant throbbing neck pain radiating to the bilateral upper extremities as well as pain between the scapular blades. He also reported that his pain exacerbated with sitting and with damp weather. He also had poor sleep at night and difficulty with activities of daily living due to the pain. He was taking over-the-counter NSAIDs for his pain. Examination of the cervical spine revealed positive cervical paraspinal spasms, positive Cervical Facet Loading test, diminished range of motion and diminished strength on the right hand compared to the left. Based on Assignor's complaints and clinical findings noted upon examination, the clinical impressions were cervical region radiculopathy and injury of nerve root of cervical spine. He was recommended to continue with ongoing course of conservative treatment. Considering Assignor's non-improving spinal symptoms despite receiving conservative treatment

along with non- steroidal anti-inflammatory medications, he was recommended cervical epidural steroid injections. In the interim, he continued with the ongoing course of conservative treatment.
On September 19, 2019, Dr. Kandra performed cervical epidural steroid injection with epidurography under fluoroscopic guidance. The injection was performed under MAC. The postoperative diagnosis was same as the preoperative diagnosis.
Dr. Dean stated that there is insufficient documentation of physical exam findings, symptomatology and supporting documentation to support an ongoing diagnosis of radiculopathy for which epidural steroid injection and associated services may be indicated. Assignor presented with signs and symptoms of radiating neck pain after sustaining injuries in the motor vehicle accident on May 13, 2019. Since the evaluation on May 21, 2019 through August 20, 2019, Assignor had complaints of constant throbbing neck pain radiating to the bilateral upper extremities as well as pain between the scapular blades along with positive examination findings such as positive cervical paraspinal spasms, diminished range of motion and diminished strength on the right hand compared to the left. Assignor's examinations and testing revealed cervical radiculopathy that arose from the accident causing him pain. Also, the MRI of the cervical spine revealed disc protrusion and foraminal narrowing. The appropriate standard of care, in this case, was to attempt conservative treatment. However, despite conservative treatment including physical therapy and chiropractic care along with pain medications, Assignor was still experiencing extreme pain in his cervical spine and still had a positive clinical examination. It was also noted that his pain exacerbated with sitting and with damp weather and he also reported to have poor sleep at night and difficulty with activities of daily living because of the pain. As such, more aggressive treatment was appropriate and hence epidural steroid injection was recommended in accordance with the generally accepted standard of medical practice.
Injection therapies play a major role in the management of various pain conditions. Traditional therapies such as intra-articular injections, regional blocks, epidural injections, and selective nerve root blocks are an 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. Conservative care may include patient's education, psychosocial support, oral medications, physical therapy modalities, acupuncture, work hardening, instruction and improving biomechanics, strengthening and flexibility of the affected musculoskeletal systems.
In this case Assignor was recommended cervical epidural steroid injection in conjunction with the conservative treatment to see if he benefited in managing his pain with minimally invasive approach. It was anticipated that window of pain relief will provide him the opportunity to actively participate in the rehabilitation process and prevent him from

more invasive surgical procedures such as discectomy and vertebral fusion.
A study on the cost-effectiveness of cervical epidural steroid injections found that ESIs provide significant improvement in quality of life within 3 months for patients with cervical radiculopathy and neck pain. ESIs are more cost-effective compared than conservative management alone in the short-term. The durability of these results must be analyzed with longer term cost-utility analysis studies.
Epidural steroid injections are a safe and integral treatment of back and leg or neck and arm pain caused by multiple conditions. It is imperative to note that epidural steroid injections are not necessarily designed to cure back or neck pain, instead, they are intended to provide temporary relief so that the patient may return to normal activities and/or continue their physical therapy regimen. Pain relief from epidural steroid injections may vary from one week to one year, and patients may require either a single or a series of injections for maximum relief." An epidural steroid injection may be completed with only topical local anesthesia or under intravenous (IV) sedation.

Dr. Gressel cites multiple studies demonstrating the efficacy of cervical epidural steroid injections in long-term pain relief:
One study showed MPM (multimodal pain management) based on injections to be an efficient treatment option for cervical radiculopathy. Despite several reports on severe complications published in the literature, MPM appears to be a safe procedure and transforaminal epidural steroid injection may be an important factor of this concept. In the absence of an absolute indication for surgery, this is a treatment option that could be tried before surgery.
A Systematic Review by Laxmaiah Manchikanti, Devi E Nampiaparampil, et al showed Level II evidence, which supports the benefit of cervical interlaminar epidural injections based on at least one high-quality, relevant RCT for each etiology studied: disc herniation, discogenic pain without facet joint pain or disc herniation, central spinal stenosis, and post-surgery syndrome.
The results of a systematic review of the fffectiveness of cervical epidurals in the management of chronic neck pain showed a significant effect in relieving chronic intractable pain of cervical origin and also providing long-term relief with an indicated evidence level of Level II-I.
A North American Spine Society Review and Recommendation Statement in 2011 concluded that "there is fairly consistent Level III and IV evidence that transforaminal and interlaminar cervical epidural steroid injections (CESI) provide relief in 60-70% of patient with cervical radiculitis. This treatment seems to be fairly well maintained over time as demonstrated in studies with greater than one year follow-up."
When performed under fluoroscopic visualization, epidural injections are accurate and clinically useful in the diagnosis and therapeutic management of chronic spinal pain. The diagnostic accuracy of epidural space is strong for cervical facet joints, and moderate for thoracic facet

joints. In contrast to clinical evaluation and imaging techniques, diagnostic injections can identify facet joint pain with a remarkably higher level of certainty.

With regard to the lumbar epidural steroid injection performed on October 190, 2019, Dr. Gressel notes that Assignor was seen by Dr. Kandra on August 20, 2019 with complaints of 6/10 constant throbbing lower back pain radiating to the bilateral buttocks. His pain exacerbated with sitting and with damp weather. He also reported to have poor sleep at night and difficulty with activities of daily living because of the pain. Examination of the lumbar spine revealed diminished range of motion, positive lumbar paraspinal muscle spasms, bilateral sacroiliac joint tenderness upon palpation and positive Lumbar Facet loading test. Based on his complaints and clinical findings noted upon examination, the clinical impressions were lower back pain and other intervertebral disc displacement of lumbosacral region. Assignor was recommended to continue with ongoing course of conservative treatment. Considering his non-improving spinal symptoms despite receiving conservative treatment along with non-steroidal anti- inflammatory medications, he was recommended lumbar epidural steroid injections. In the interim, he continued with the ongoing course of conservative treatment.

On October 19, 2019, Dr. Kandra performed lumbar epidural steroid injection with epidurography under fluoroscopic guidance. The postoperative diagnoses were same as the preoperative diagnoses.

Dr. Dean stated that there is insufficient documentation of physical exam findings, symptomatology and supporting documentation to support an ongoing diagnosis of radiculopathy for which epidural steroid injection and associated services may be indicated. Assignor indeed presented with signs and symptoms of radiating lower back pain after sustaining injuries in the May 13, 2019 motor vehicle accident. Since the May 21, 2019 evaluation through August 20, 2019, Assignor had complaints of constant throbbing lower back pain radiating to the bilateral buttocks along with positive examination findings such as diminished range of motion, positive lumbar paraspinal muscle spasms and bilateral sacroiliac joint tenderness upon palpation. The examinations and testing revealed lumbar radiculopathy that arose from the accident causing him pain. Also, the MRI of the lumbar spine revealed disc herniations and bulges. The appropriate standard of care, in this case, was to attempt conservative treatment. However, despite conservative treatment including physical therapy and chiropractic care along with pain medications, Assignor was still experiencing extreme pain in his lumbar spine and still had a positive clinical examination. It was also noted that Assignor's pain exacerbated with sitting and with damp weather and he also reported to have poor sleep at night and difficulty with activities of daily living because of the pain. As such, more aggressive treatment was appropriate and hence epidural steroid injection was recommended in accordance with the generally accepted standard of medical practice.

The use of ESI is more effective for alleviating lumbosacral radicular pain than conservative treatments in terms of short-term and

intermediate-term. Patients also reported more successful outcomes after receiving ESI when compared to conservative treatment.

Based on an article by Van Boxem, 2010, Dr. Dean stated the diagnosis of herniated disk must be substantiated by an appropriate finding on an imaging study. The presence of findings on an imaging study in and of itself does not make the diagnosis of radiculopathy. There must also be clinical evidence as described above. Assignor met the criteria noted in the article. There was clear evidence of radiating lower back to the bilateral buttocks and the decision of performing the LESI was taken based on the diagnoses of lumbar and lumbosacral regions radiculopathy. Also, Assignor's MRI study dated June 4, 2019 revealed paracentral disc protrusion at T12-L1, annular disc bulge at L1-L2, annular disc bulge at L2-3 with a superimposed left paracentral to foraminal disc protrusion and canal stenosis due to annular disc bulges and facet arthropathy at L3-4 and L4-5 levels. All these are mechanisms causing radiating pain.

Radiculopathy is a disease involving a spinal nerve root which may result from compression related to intervertebral disc displacement; spinal cord injuries; spinal diseases; and other conditions. Lumbosacral radiculopathy is a term used to describe a pain syndrome caused by compression or irritation of nerve roots in the lower back. It can be caused by lumbar disc herniation, degeneration of the spinal vertebra, and narrowing of the foramen from which the nerves exit the spinal canal. Typical symptoms include radiating lower back pain, which radiates to one or both legs. Other common symptoms of radiculopathy can be numbness, tingling, reflex abnormalities and/or weakness. Radiculopathy can be present, however, even without some of these symptoms. At the time of evaluations, Assignor complained of radiating lower back pain and had MRI findings of disc herniations and bulges which are also likely mechanisms for radiculopathy. By definition, radiculopathy describes pain that radiates down the legs and is often described by patients as electric, burning, or sharp. The most common underlying cause of radiculopathy is irritation of a particular nerve, which can occur at any point along the nerve itself and is most often a result of a compressive force. In the case of lumbar radiculopathy, this compressive force may occur within the thecal sac, as the nerve root exits the thecal sac within the lateral recess, as the nerve root traverses the neural foramina, or even after the nerve root as exited the foramina. It may be related to disc bulging or herniation, facet or ligamentous hypertrophy, spondylolisthesis, or even neoplastic and infectious processes.

Epidural steroid injections (ESIs) have been endorsed by the North American Spine Society and the Agency for Healthcare Research and Quality of the Department of Health and Human Services as an integral part of nonsurgical management of radicular pain from lumbar spine disorders.

Dr. Gressel cites to multiple studies demonstrating the efficacy of lumbar epidural steroid injections for long term pain relief:

The results of an evidence-based study noted: "The indicated evidence is Level II-I for short- term relief and Level II-2 for long-term relief in managing chronic low back and lower extremity pain."
Randomized trials showed strong evidence of short-term pain relief (less than 6 months) after transforaminal epidural injections and moderate evidence for long-term pain relief (more than 6 months). The results of the systemic review evaluating caudal epidural injections in managing patients with varying types of low back pain emanating as a result of disc herniation or radiculitis, chronic low back pain of discogenic origin without radiculitis has shown strong evidence for short and long term relief of pain.
Recent studies, including several reviews and meta-analyses, have shown that transforaminal and interlaminar epidural steroid injections can provide reliable pain relief for patients with low back pain associated with radicular symptoms, but not axial back pain. In some cases, ESIs can provide long-term benefits lasting up to 12 months and surgery sparing effects. For radicular pain secondary to disc herniation the evidence is good with steroids combined with local anesthetics and fair with local anesthetics alone.
A systematic review of whether epidural injections provide short and long term relief for lumbar disc herniation indicates through strong evidence for short-term efficacy from multiple high-quality trials and moderate evidence for long-term efficacy from at least one high-quality trial, we found that fluoroscopic caudal, lumbar interlaminar, and transforaminal epidural injections were efficacious at managing lumbar disc herniation in terms of pain relief and functional improvement.
After careful consideration of the documents submitted and the parties' oral arguments at the hearing, I find in favor of Applicant. I find that the rebuttal of Dr. Gressel meaningfully refers to and rebut the assertions of Dr. Dean and present a cogent medical rationale for the cervical and lumbar epidural steroid injections in opposition to the peer review report. Dr. Dean argues there is insufficient documentation of physical exam findings, symptomatology, and supporting documentation to support an ongoing diagnosis of radiculopathy for which epidural steroid injections would be indicated. Dr. Gressel notes that Assignor had complaints of constant throbbing neck pain radiating to the bilateral upper extremities as well as pain between the scapular blades along with positive examination findings such as positive cervical paraspinal spasms, diminished range of motion and diminished strength on the right hand compared to the left. Also, the MRI of the cervical spine revealed disc protrusion and foraminal narrowing. He also had complaints of constant throbbing lower back pain radiating to the bilateral buttocks along with positive examination findings such as diminished range of motion, positive lumbar paraspinal muscle spasms and bilateral sacroiliac joint tenderness upon palpation. The MRI of the lumbar spine revealed disc herniations and bulges. Assignor started on a course of physical therapy along with chiropractic care; however, despite conservative treatment including physical therapy and chiropractic care along with pain

> medications, he had no complete relief in his complaints of pain. Therefore, following Dr. Kandra's August 20, 2019 evaluation, he was recommended cervical and lumbar epidural steroid injections. I note that in AAA Case No. 17-20-1174-7464, a linked matter before Arbitrator Glen Wiener involving the [s]ame peer review report that was decided in favor of Respondent, there was no rebuttal submitted by Applicant. Arbitrator Wiener denied a different applicant's request for reimbursement is denied based on the un-rebutted conclusions of the peer reviewer. In this matter, Applicant has submitted rebuttals which indicate that Assignor engaged in and failed a sufficient course of conservative care prior to the performance of the subject injections. I am persuaded by the opinion and rationale of Dr. Gressel and find that Applicant has met its burden of persuasion in rebuttal. Accordingly, Applicant's claim for reimbursement is awarded.

After careful consideration of the documents submitted and the parties' oral arguments at the hearing, I find in favor of Applicant. As noted in my previous award, Assignor had complained of constant throbbing lower back pain radiating to the bilateral buttocks along with positive examination findings such as diminished range of motion, positive lumbar paraspinal muscle spasms and bilateral sacroiliac joint tenderness upon palpation. The MRI of the lumbar spine revealed disc herniations and bulges. Assignor started on a course of physical therapy along with chiropractic care; however, despite conservative treatment including physical therapy and chiropractic care along with pain medications, he had no complete relief in his complaints of pain. Although Applicant did not submit a formal rebuttal to the peer report of Dr. Dean in this case, based on my previous findings that Assignor engaged in and failed a sufficient course of conservative care prior to the performance of the subject injection, and that the lumbar epidural steroid injection performed on October 19, 2019 was medically necessary, I find that all associated services, including those at issue in this arbitration, were also medically necessary. Respondent has failed to establish that Applicant billed in excess of the applicable fee schedule. Accordingly, Applicant's claim for reimbursement is awarded.

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**
	Same Day Procedure LLC	**10/19/19 - 10/19/19**	**$976.38**	**Awarded: $976.38**
Total			**$976.38**	**Awarded: $976.38**

B. The insurer shall also compute and pay the applicant interest set forth below. 10/25/2021 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

In accordance with 11 NYCRR 65-3.9(c), interest shall be paid on the claim awarded in the amount of $976.38 from October 25, 2021, the date the arbitration was requested.

C. Attorney's Fees

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

In accordance with 11 NYCRR 65-4.6(d) the insurer shall pay Applicant an attorney's fee on the claim awarded in the amount of $976.38.

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

07/22/2022
(Dated)

Debbie Thomas

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:
e4aed2d69aed9839b3fa5e400bf7061f

Electronically Signed

Your name: Debbie Thomas
Signed on: 07/22/2022