

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Stand Up MRI of Deer Park PC (Applicant)	AAA Case No.	17-22-1259-9641
- and -	Applicant's File No.	N/A
	Insurer's Claim File No.	0668451255 2NG
Allstate Fire & Casualty Insurance Company (Respondent)	NAIC No.	29688

**ARBITRATION AWARD**

I, Victor Moritz, 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: IP

1. Hearing(s) held on 06/01/2023  
Declared closed by the arbitrator on 06/01/2023

Dino DiRienzo, Esq. from Dino R. DiRienzo Esq. participated virtually for the Applicant

John Palatianos, Esq. from Law Office Of Lawrence & Lawrence participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,728.97**, was NOT AMENDED at the oral hearing.  
Stipulations WERE NOT made by the parties regarding the issues to be determined.
3. Summary of Issues in Dispute

The applicant seeks reimbursement for the cost of MRI studies of the cervical and lumbar spine provided to the IP (V.L. 52-year-old female) on May 17, 2022, relative to a May 4, 2022 motor vehicle accident. The respondent denied this claim based on a lack of medical necessity per the results of a peer review by Dr. Jay Weiss. The applicant has submitted a rebuttal to this peer review by Dr. Ashraf Salem. This matter is determined after reviewing the submissions and presentations of both sides. I have reviewed the documents contained in the electronic case folder as of the closing of the file. The hearing was held on Zoom.

#### 4. Findings, Conclusions, and Basis Therefor

**I find for the respondent and deny the claim in its entirety.**

##### **Submissions**

The IP was evaluated by Jeanette T. Aranda, PT, with complaints of spinal pain aggravated by movement. The IP had an antalgic gait. The pain radiated to the bilateral arms and right leg. On examination, there was decreased range of motion (ROM), tenderness on palpation; and decreased muscle strength at 3-/5. The diagnoses included cervical-lumbar sprain/strain. The IP was recommended physical therapy.

An evaluation by Dr. James G. McGhee, on May 17, 2022 noted neck pain radiating through both shoulders down the length of the bilateral upper extremities with numbness, tingling and pins and-needles sensations in the bilateral arms and perceived weakness in the bilateral hands and lower back pain radiating into the bilateral gluteal regions, through the hips and down both legs with numbness, tingling and pins-and-needles sensations, and perceived weakness in both legs. The examination of the cervical spine revealed tenderness to palpation of the cervical vertebrae associated with very markedly severe tenderness and tightness of the bilateral cervical paravertebral and trapezius musculature with decreased ROM. The examination of the lumbar spine revealed tenderness to palpation of the lumbar vertebrae and very markedly severe tenderness of the sacral vertebrae and the sacroiliac joints accompanied by severe tenderness and tightness of the bilateral lumbar paravertebral musculature and decreased ROM. The assessment included: neck pain with limitation in range of motion and neurologic abnormalities, rule out cervical radiculopathy versus peripheral neuropathy; low back pain with limitation in range of motion and abnormal neurologic symptoms, rule out lumbosacral radiculopathy versus peripheral neuropathy; cervical sprain; lumbar sprain and sacroiliac sprain. The IP was referred for x-rays of the cervical, thoracic, and lumbar spine; MRI scans of the cervical and lumbar spine; physical therapy; medications and evaluation by a physiatrist in four to five weeks.

The MRI of the cervical spine on May 17, 2022 revealed *C3/4 posterior annular disc bulge approaches the ventral surface of the cord. C4/5 broad posterior disc herniation with (oval right paramedian component deforms the ventral surface of the cord on the right and there is bilateral foraminal extension, foraminal stenosis, and central canal stenosis. C5/6 broad-base central disc herniation abuts the ventral surface of the cord and there is left foraminal extension, left foraminal narrowing, and central canal stenosis. Adjacent uncinat process and facet hypertrophy contribute to foraminal and central stenosis at C4/5 and C5/6. C6/7 posterior annular disc bulge flattens the ventral thecal sac. Reversal of the normal cervical lordosis centered at the C4 and C5 vertebral levels. 7mm cyst or nodule in the right lobe of the thyroid gland. Ultrasound correlation suggested.*

The MRI of the lumbar spine on May 17, 2022 revealed *L3-4 broad posterior disc herniation favoring the right deforms the ventral thecal sac and impinges upon the right greater than left traversing L4 nerve roots. Right foraminal extension and narrowing with impingement upon the exiting right L3 nerve root and moderate central canal stenosis and left greater than right lateral recess stenosis. L4-5 grade I anterolisthesis. A broad posterior disc herniation and central annular tear deforms the ventral thecal sac and increases peripherally with bilateral foraminal extension and left greater than right foraminal stenosis with impingement upon the exiting L4 nerve roots and a marked central canal stenosis and lateral recess stenosis. L5-S1 broad posterior subligamentous disc herniation favoring the right deforms the ventral epidural space and impinges upon the right greater than left traversing S1 nerve roots. Bilateral foraminal extension and foraminal stenosis with impingement upon the exiting L5 nerve roots. Facet hypertrophy contributes to foraminal and central stenosis at L3-4 through L5-S1. Scoliosis of the lumbar spine convex to the left.*

### **Peer Review**

The MRI studies were denied based on the studies of the peer review from Dr. Weiss, who indicated that the initial findings of the MRIs were medically unnecessary or, at best, premature. Although there was some slight motor weakness, there was no evidence of wrecked legs or significant neurological compromise to warrant an immediate imaging study. Dr. Weiss cites sources that discuss the standard of care for the use of MRIs.

Citing additional sources, he notes that the MRIs of the cervical spine should not be performed less than six weeks after an injury, absent certain red flags present and a suspicion of such things as a tumor, fracture, or instability. In the absence of myelopathy or progressive neurological changes, imaging is not appropriate until a sufficient period of conservative therapy has been tried and failed, again citing *New York court, see Workers' Compensation Board Neck Injury Medical Treatment Guideline* sources.

He continues that MRIs are only appropriate if they can help with the treatment protocol for a patient and notes, in this case, if the IP was already referred for care, the MRIs would be deemed, at best, premature.

Citing additional studies, he notes that MRIs of the lumbar spine are appropriate for patients with lower back pain with signs or symptoms of radiculopathy or stenosis if they are potential candidates for surgical or epidural injection, none of which are criteria met the IP at this early juncture. Further, Dr. Weiss states imaging studies of the spine within the first six weeks for non-specific acute lower back pain is also not warranted, absent red flags, citing *New York State Workers' Compensation Mid and Low Back Injury Medical Treatment Guidelines*.

The peer notes that many MRIs in asymptomatic individuals are positive, nothing with an increased sign of aging.

Dr. Weiss concludes that there were no red flags here, confirmed by the fact there was no treatment plan contingent on the results of the MRIs. The IP was to commence physical therapy and be seen for a follow-up before the five weeks. Therefore, the MRIs at this early juncture were unwarranted.

### **Rebuttal to Peer Review**

To refute the peer report, I note the rebuttal from Dr. Salem, who reiterated the medical findings herein and disagreed with the assessment of the peer. Initially, he states Dr. Weiss's failure to consider the IP's condition did indicate potential "red flag trauma", noting there was a suspicion of spinal cord injury, given the motor weakness and sensory loss in the arms and legs. He cites sources supporting findings when there is a concern of spinal cord injury, as there was for the IP herein; immediate MRI studies are warranted, citing multiple sources. Dr. Salem continues that the *American College of Radiology ACR-ASNR-SCBT-MR-SSR) Practice Parameter for the Performance of Magnetic Resonance Imaging (MRI) of the Adult Spine* provides various guidelines for when MRIs should be performed with concerns of neurological deficits, including trauma, as sustained by the IP herein. Dr. Salem continued that the results of the MRIs would influence the future treatment plan for the IP and there are no set standards for the performance of diagnostic testing. Therefore, deference should be given to the determinations of the provider rendering care.

Given the medical findings herein, Dr. Salem believed the MRIs were appropriate and were prescribed according to the proper medical standards.

### **Legal Standards for Determining Medical Necessity**

It is well settled that an applicant established its prima facie entitlement to payment by proving it submitted a claim set forth the facts and the amount of the loss sustained and that payment of no-fault benefits were overdue (see Insurance Law § 5106[a]; Viviane Etienne Med. Care v Country-Wide Ins. Co., 25 NY3d 498, 501 (2015); Countrywide Ins. Co. v. 563 Grand Medical PC 50 A.D. 3d. 313 (1<sup>st</sup> Dep't, 2008); Sunshine Imaging Assoc./WNY MRI v. Geico. Ins. Co., 66 A.D. 3d. 1419 (4<sup>th</sup> Dep't, 2009). A facially valid claim is presented when it sets forth the name of the patient; date of accident; date of the services; description of services rendered and the charges for those services. See Vinings Spinal Diagnostic PC v. Liberty Mutual Insurance Company, 186 Misc. 2d 287 (1<sup>st</sup> Dist. Ct. Nass. Co.1996). The applicant has met this burden.

When evaluating the medical necessity of services with proof of each party, particularly the conclusion is contradictory; consideration must be given to the evidentiary burdens. Respondent must prove first that the services were not medically necessary. A peer review report must set forth a factual basis to establish, prima facie the absence of medical necessity.

The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment Kingsborough Jewish Med. Ctr. v. Allstate Ins.

Co. 2009 NY Slip Op. 00351 (2d. Dep't, January 20, 2009), See also Channel Chiropractic PC v. Country Wide Ins. Co. 38 AD 3d. 294 (1<sup>st</sup> Dep't, 2007). An insurance carrier must at a minimum establish a detailed factual basis and a sufficient medical rationale for asserting lack of medical necessity. See Vladmir Zlatnick, M.D. v. Travelers Indem. Co. 2006 NY Slip Op. (50963U) (App. Term 1<sup>st</sup> Dep't, 2006). See also Delta Diagnostic Radiology PC v. Progressive Casualty Ins. Co. 21 Misc. 3d. (142A) (App. Term 2d. Dep't, 2008). In evaluating the medical necessity of services with proof of each party, particularly the conclusion is contradictory; consideration must be given to the evidentiary burdens. Respondent must prove first that the services were not medically necessary. A peer review report must set forth a factual basis to establish, prima facie the absence of medical necessity.

Conclusions outlined in peer reviews may be insufficient if it fails to provide specifics of the claim, is conclusory or otherwise lacks a basis in the facts of the claim (Amaze Medical Supply v. Allstate Ins. Co. 3 Misc. 3d. 43 (App. Term, 2d Dep't, 2004). A peer review report must set forth a factual basis to establish, prima facie the absence of medical necessity. See Nir v Allstate Ins. Co., 7 Misc. 3d. 544, 547 (Civ. Ct., Kings Co., 2005) which indicates a respondent's peer review defending a denial of first-party benefits on the ground that the billed-for services were not "medically necessary" must at least show that the services were inconsistent with generally accepted medical/professional practice. The opinion of the insurer's expert, standing alone, is insufficient to carry the insurer's burden of proving that the services were not "medically necessary", citing Citywide Social work & Psy. Serv. P.L.L.C. v Travelers Indemnity Co., 3 Misc. 3d. 608, 616 (Civ. Ct., Kings Co. 2004). A peer report must demonstrate that the services rendered were not in agreement with generally accepted medical or professional standards. Generally accepted practice is the range of practice that the profession will follow in diagnosing and treating the patient in light of the standards and values that define it.

Therefore, an opinion offered by a respondent is more likely to establish a lack of medical necessity when it provides some reference to the standards in the applicable medical community for the services and treatment at issue with an explanation as to when such services and treatment would be medically appropriate with objective criteria and an explanation why it was not medically necessary herein.

I am however not so inclined to preclude the medical opinion offered by an insurer that fails to address the accepted medical/ professional practices. "While an expert affidavit cannot be speculative, there is no threshold requirement in an ordinary case, not involving a novel scientific theory, that a medical opinion regarding deviation be based upon medical literature, studies, or professional group rules in order for it to be considered. It can be based upon personal knowledge acquired through professional experience." Mitroyic y Silverman, 2013 NY Slip Op 01465 (1st Dep't 2013), *citing* Diaz vNew York Downtown Hosp., 99 NY2d 542,545 (2002) *and* Limmer v Rosenfeld, 92 AD3d 609,609 (1st Dept 2012). The burden returns to Applicant to rebut Respondent's showing.

Notwithstanding, I am inclined to view proof that does cite to respected medical authorities with much greater weight than one that does not. In any event, if the proof

of the respondent is found to meet its burden, the proof of the applicant must be considered in opposition to it, mindful that it is likely offered by the provider who actually performed examinations, established treatment and diagnostic plans, made diagnoses and performed medical services.

### **Application to This Claim**

When, as here, an insurer interposes a timely denial of claim that sets forth a sufficiently detailed factual basis and adequate medical rationale for the claim's rejection, the presumption of medical necessity and causality attached to the applicant's properly completed claim is rebutted and the burden shifts back to the claimant to refute the peer review and prove the necessity of the disputed services and the causal relationship between the injuries and the accident. See, CPT Med. Servs., P.C. v. New York Cent. Mut. Fire Ins. Co., 18 Misc.3d 87 (App. Term 1st Dept.); Eden Med., P.C. v. Progressive Cas. Ins. Co., 19 Misc.3d 143(A) (App Term 2d & 11th Jud. Dists., 2008). When the provider failed to rebut peer review's showing of a lack of medical necessity, defendant is entitled to dismissal of complaint. Be Well Med. Supply, Inc. v. New York Cent. Mut. Fire Ins. Co., 18 Misc. 3d. 139 (A) (App. Term 2d Dept., Feb. 21, 2008; A. Khodadadi Radiology, P.C. v. NY Cent. Mut. Fire Ins. Co., 16 Misc. 3d. 131 (A) (App Term 2d. Dept.); West Tremont Med. Diagnostic, P.C. v. Geico Ins. Co., 13 Misc. 3d. 131 (A) (App Term 2d Dept., 2006).

In the instant matter, I find for the respondent and deny the claim.

Notwithstanding Dr. Salem's rebuttal, Dr. Weiss has accurately pointed out that the IP's condition, though exhibiting neurological symptoms, was not of such concern that the IP was not referred for immediate conservative treatment. The recommendation was for four to five weeks of care and with a follow-up to ascertain the condition of the IP. This falls in line with the respondent's position that the MRIs herein were, at best, premature. If the IP's condition had worsened after four to five weeks, and there were some indications of neurological deficits, MRIs could be undertaken to determine if a change in the course of care was required. As requested after this initial evaluation, they were, at best, premature.

**Accordingly, the claim is denied in its entirety.**

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 claim is DENIED in its entirety

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of NY

SS :

County of Westchester

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

06/12/2023  
(Dated)

Victor Moritz

### **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:**  
e969eab7653df780469439b9d2829597

### Electronically Signed

Your name: Victor Moritz  
Signed on: 06/12/2023