American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

| | | |
|---|---|---|
| Zwanger-Pesiri Radiology Group LLP (Applicant) | AAA Case No. | 17-23-1288-3369 |
| | Applicant's File No. | CF13023452 |
| - and - | Insurer's Claim File No. | 3557454-2 |
| | NAIC No. | 42376 |
| Technology Insurance Company (Respondent) | | |

**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 12/06/2023
   Declared closed by the arbitrator on 12/06/2023

   Tinamarie Franzoni, Esq. from Choudhry & Franzoni, PLLC participated virtually for the Applicant

   Courtney Napoli, Esq. from McDonnell Adels & Klestzick, PLLC participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$3,085.82**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The claim was amended to $2533.74 per the fee schedule.

   Stipulations WERE made by the parties regarding the issues to be determined.

   The parties stipulated to the amount at issue.

3. Summary of Issues in Dispute

The applicant seeks reimbursement for the cost of MRI studies of the cervical, thoracic and lumbar spine provided to the IP (J.A.V. 21 year old male passenger) on September 20, 2022, relative to an August 23, 2022 motor vehicle accident. Respondent denied this claim based on a defense of lack of medical necessity per the results of a peer review by Dr. Bonnie Corey, D.C., dated October 22, 2022. The parties have stipulated to the Fee Schedule. 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 this claim in its entirety.**

**Submissions**

The record reflects the applicant was involved in an accident on August 23, 2022 sustaining injuries including to the spinal region.

On September 6, 2022, the IP was evaluated by Dr. Dennis Long, D.C., with complaints including neck, middle and lower back pain. There was also noted shoulder pain and right toe pain caused by the incident. The record noted the IP drove himself to Queens General Hospital after the accident. He was given some injections for pain as well as pain pills.

On palpation, there were joint restrictions noted through the cervical, thoracic and lumbar regions with spasms. Range of motion was markedly restricted in the cervical and lumbar regions. There were multiple positive orthopedic test findings through the extremities. More strength evaluations were mainly normal, though restrictions were noted at 4/5 on the left side at C7-C8 and C8-T1 as well as the left side at L4-L5. Deep tendon reflexes were reduced at the right biceps as well as the brachioradialis. The Achilles reflexes were absent. The sensory evaluation was unremarkable. The impression included cervicalgia with cervical subluxations and intervertebral disc displacement with possible radiculopathy, as well as cervical sprains and instability along with spasms; the findings included dorsalgia with thoracic subluxations and thoracic spasms and lower back pain with lumbar subluxations, lumbar instability and spasms and possible lumbar radiculopathy. The doctor's treatment plan would include chiropractic manipulation of the spinal region. MRIs were also ordered.

I note the results of the imaging studies revealed cervical disc herniation flattening of the thecal sac at C3-C4 and C5-C6. Unremarkable thoracic spinal MRI and disc bulge flattening the thecal sac and Schmorl's nodes at L2-L3.

**Peer Review**

The imaging studies were denied based on the peer review results from Dr. Corey, who noted the medical assessment and indicated the MRIs were unnecessary. In this case, the IP findings revealed acute soft tissue injuries through the spinal regions with joint restrictions. The MRIs were ordered contrary to accepted standards at the initial evaluation the same day X-rays were prescribed. There was no diagnostic dilemma or symptomology to warrant the immediate MRIs.

Dr. Corey continued that spinal MRIs are reserved for patients with various criteria on examination, which also would include unrelenting symptoms with focal neurological deficits for which surgery was contemplated. Moreover, diagnostic imaging is reserved for patients who have not improved after a six-to-eight-week period of conservative treatment, which is again our standard of care in the field of chiropractic. In this case, there were no medical findings to warrant the immediate imaging studies that were performed. Dr. Corey also cites articles discussing the criteria for the utilization of MRI studies and indicates there were no findings herein of instability to warrant the immediate MRIs as the IP was being prescribed chiropractic manipulation and the results of conservative treatment had not yet been established.

**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 (1st Dep't, 2008); Sunshine Imaging Assoc./WNY MRI v. Geico. Ins. Co., 66 A.D. 3d. 1419 (4th 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 (1st 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 (1st 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 1st 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.

Further, a negative inference will be taken if the items, including medical reports, test results and other sources that are relied upon by the peer are not part of the respondent's submission. Notwithstanding, these facts impact upon the weight given the report but do not provide a basis to preclude the document.

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 in its entirety.

Dr. Corey has outlined the proper criteria for the utilization of MRI studies in the field of chiropractic. While the IP had objective positive findings, the record established a need for conservative treatment, which was prescribed, including chiropractic manipulation. Only if this conservative treatment failed would the IP fail to progress for the patient's neurological symptoms worsen would an MRI have been justified. In this case, the IP was to implement conservative treatment and the use of the imaging studies at this point was of no benefit and provided contrary to accepted chiropractic standards.

**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.

12/24/2023
(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:**
b3bf2eb4e57ae4b29b779483a8b933a6

**Electronically Signed**

Your name: Victor Moritz
Signed on: 12/24/2023