American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Atlantic Medical & Diagnostic PC (Applicant)	AAA Case No.	17-23-1327-4895
	Applicant's File No.	445-PKT23-124385
- and -	Insurer's Claim File No.	660602212506
	NAIC No.	10791
Plymouth Rock Assurance Preferred Corporation (Respondent)		

ARBITRATION AWARD

I, Gary Peters, 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 08/16/2024
   Declared closed by the arbitrator on 08/16/2024

   Juaquin Lopez from Barshay, Rizzo & Lopez, PLLC. participated virtually for the Applicant

   Clinton Hall from Law Office of William J. Fitzula participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$9,522.00**, 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 Assignor was a 20 year old male who was a restrained passenger in a motor vehicle and involved in an accident on 1/5/23.

   Applicant is seeking payment for medical services performed from 1/6/23 through 6/26/23. Respondent denied payment of the claim for lack of medical necessity, based on its Independent Peer Review Report.

4. Findings, Conclusions, and Basis Therefor

This hearing was conducted using the Electronic Case Folder maintained by the American Arbitration Association. All documents contained in that folder are made part of the record of the hearing and I have reviewed the documents contained therein. Any documents submitted after the hearing or at the hearing that have not been entered in the Electronic Case Folder as of the date of this award, will be listed immediately below this language and forwarded to the American Arbitration Association at the time this award is issued for inclusion.

The Assignor was a 20-year-old male who was involved in a motor vehicle accident on 01/05/2023. He sustained multiple bodily injuries.

Dr. Etienne, the treating physician, referenced the following:

The MRI report of cervical spine dated 01/16/2023 noted -

- At C4-C5 level, disc bulge with compression of anterior thecal sac and partial effacement of anterior subarachnoid space.
- Straightening of cervical lordosis, suggestive of pain or muscle spasm, in an appropriate clinical setting.

The MRI report of right shoulder dated 01/16/2023 noted -

- Partial tear of the distal supraspinatus tendon.
- Several sub centimeter subcortical cysts in the humeral head under the insertion of the rotator cuff.
- Mild joint effusion consistent with recent trauma or synovitis, in an appropriate clinical setting.

The MRI report of lumbar spine dated 01/19/2023 noted -

- At L5-S1 level, disc bulge with compression of anterior thecal sac with encroachment of neural foramina.
- Posterior mid lower back subcutaneous soft tissue swelling and edema, consistent with recent trauma, in an appropriate clinical setting.
- Transitional lumbosacral junction.

Evaluation reports by Ajin Matthew, PA and Hiram Emmanuel Luigi-Martinez, MD dated 01/06/2023, 03/13/2023, 05/15/2023 and 06/26/2023 noted chief complaints of -

Headache, Cervical Spine Pain, Shoulder Pain, Thoracic Pain, Lumbar Spine Pain.

Headache was recurrent. Location of headache at onset was Occipital, Unilateral and Bilateral. Assignor reports that he has same episode(s) 1-2 hours in several times per week.

Cervical Spine Pain was bilateral. The pain was described as aching, sharp, stiffness and soreness; the pain is made worse by sitting a long time, turning side to side and bending downward.
Right Shoulder Pain was described as aching, pulling and soreness. The pain is made worse by lifting and laying on area.
Thoracic Pain was bilateral. The pain is aching, hot-burning, pressure-like and tight. The pain is made worse by bending, movement, sitting a long time and standing along time.
Lumbar Spine Pain was bilateral. The pain is aching, hot-burning, pressure like, sharp and tight. Pain radiates to the buttock. The pain is made worse by bending, movement, laying on area, sitting a long time and standing a long time.
Physical Examinations noted following - Cervical spine exam with painful ROM. Thoracic exam noted tenderness at facet joint lines. Lumbar exam noted tenderness and painful ROM. Palpation of the bilateral sacroiliac joint area reveals tenderness erector spinae muscles, multifidus muscles, latissimus dorsi muscles, lumbar interspinal muscles muscle l4-l5 l5-s1 and quadratus lumborum muscles. Right shoulder exam noted deltoid and supraspinatus atrophy; painful ROM.
Assessment - Bulging lumbar disc. Headache, unspecified. Acute cervical sprain. Sprain of thoracic region. Sprain of right shoulder. Bulging of cervical intervertebral disc.

Plan - medication; physical therapy; chiropractic; acupuncture; MRI; follow-up.

On 01/06/2023 and 3/13/23, the assignor was administered TPI (trigger point injections) at a total of 6 site(s). These were located at the Bilateral Quadratus Lumborum Muscle, Bilateral Latissimus Dorsi and Bilateral Erector Spinae Muscles musculature.
The pre and post-operative diagnosis was - Myofascial pain syndrome.

On 05/15/2023, the assignor was administered TPI at a total of 6 site(s). These were located at the Bilateral Trapezius Muscles, Bilateral Levator Scapulae Muscles and Bilateral Splenius Capitis Muscles musculature.

The pre and post-operative diagnosis was - Myofascial pain syndrome.

On 06/26/2023, the patient was administered TPI at a total of 6 site(s). These were located at the Bilateral Trapezius Muscles, Bilateral Latissimus Dorsi Muscle, Bilateral Erector Spinae Muscles musculature.

The pre and post operative diagnosis was - Myofascial pain syndrome.

Evaluation report by other physicians including those at -

O B Acupuncture PC; Robert Berkley Physical Therapy, PC; LR medical PLLC; Pain Physicians NY; Cohen and Kramer, MD PC noted following -

The evaluations noted complaints of pain in neck, upper back, mid back, low back, right shoulder. Pain was radiating. Physical examination noted reduced ROM with pain; muscle spasm; tenderness; muscle weakness. Various orthopedic test was noted positive. Muscle strength was impaired.

Once an Applicant establishes a prima facie showing, the burden shifts to the Respondent. Respondent's denial for lack of medical necessity must be supported by competent medical evidence setting for a clear and factual basis and medical rationale for denying the claim. Citywide Social Work v. Travelers Indemnity Company, 3 Misc.3d 608 (Civil Court, Kings County, 2004).

To successfully support its denial, the Respondent's Peer Review or I.M.E. Report must address all pertinent objective findings contained in the Applicant's medical submissions and set forth how and why the disputed services were inconsistent with generally accepted medical practices. The conclusory opinions of a peer reviewer, standing alone and without support of medical authorities, will not be considered sufficient to establish the absence of medical necessity (Citywide Social Work v. Travelers Indemnity Company,) Supra; Amaze Medical Supply Inc. v. Eagle Insurance Company, 2 Misc.3d 128A, 784 N.Y.S.2d 918 (App. Term 2d 11th Judicial District).

Where Respondent meets its burden, it is incumbent upon the claimant to rebut the findings and recommendations of the Respondent's reports. The insured/provider bears the burden of persuasion on the question of medical necessity. Specifically, once the insurer makes a sufficient showing to carry its burden of coming forward with evidence of lack of medical necessity, plaintiff must rebut it or succumb (Bedford Park Medical Practice, P.C. v. American Transit Insurance Company, 8 Misc.3d 1025A).

It is undisputed that the Applicant has established a prima facie case of entitlement to first party benefits by demonstrating it submitted a timely claim setting forth the fact, amount of loss sustained and that payment of the claim has not been made. As stated above, the burden shifts to the Respondent to set forth a clear and factual basis in medical rationale to deny the claim.

On behalf of the Respondent, Dr. Westerband denied medical necessity of the aforementioned services based on his conclusions in his peer review report.

With regards to TPIs:

Dr. Westerband denies on the ground that *"...the submitted records do not support the need for trigger point injection. The positive findings noted upon evaluation could be easily explained on the basis of trauma and could be treated with other modalities such as oral medications and physical therapy.... Trigger point injections are not indicated for general neck or back pain...."*

Dr. Etienne stated that Dr. Westerband has failed to take into consideration the fact that the Assignor was a 20-year- old person who had been subjected to severe trauma in the subject MVA wherein the he sustained multiple injuries at Headache, Cervical Spine Pain, Shoulder Pain, Thoracic Pain, Lumbar Spine Pain.

Low back pain that radiated to the buttock. The pain was made worse by bending, movement, laying on area, sitting a long time and standing a long time. Other associated symptoms/problems are as follows: difficulty staying asleep due to pain. Lumbar spine exam noted tenderness and painful ROM. Palpation of the bilateral sacroiliac joint area reveals tenderness erector spinae muscles, multifidus muscles, latissimus dorsi muscles, lumbar interspinal muscles muscle L4-L5 L5-S1and quadratus lumborum muscles.

Dr. Etienne opined that due to the severity of complaints, the Assignor was not in a position to perform much less benefit from therapy at this stage. Therefore rather than allow him to continue with therapy which would not only subject this patient to more pain but might also cause further damage, trigger point injections were administered in order to reduce the pain and inflammation and to help for faster recovery.

Trigger points are discrete, focal, hyperirritable spots located in a taut band of skeletal muscle. They produce pain locally and in a referred pattern and often accompany chronic musculoskeletal disorders. Acute trauma or repetitive micro trauma may lead to the development of stress on muscle fibers and the formation of trigger points.

Patients may have regional, persistent pain resulting in a decreased range of motion in the affected muscles. These include muscles used to maintain body posture, such as those in the neck, shoulders, back and pelvic girdle.

Trigger point injections (TPI) are currently used to treat a wide variety of pain syndromes and other painful conditions. A common application for TPI is treatment of myofascial pain syndrome, a chronic musculoskeletal pain condition in which painful trigger points develop within muscle and fascia, resulting in local and referred pain, restricted range of motion, and autonomic nervous system dysfunction. A number of studies suggest that TPIs may improve quality of life in patients who experience pain as a result of myofascial pain syndrome. TPI improves pain and range of motion.

"*…We obtained better results with TP injections than only a home exercise program and oral medications in patients with radiculopathy and TPs in the gluteal region*." https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5913013/

"Trigger point injection is a valuable procedure for pain relief for patients in both group. Patients with FMS are likely to experience significant but delayed and attenuated pain relief following injection of their active TrPs compared to myofascial pain patients with similar TrPs but without FMS" https://www.ncbi.nlm.nih.gov/pubmed/8931529

Among the invasive therapies, the scientific articles report mixed results. Generally, dry needling, anesthetic injection, steroids… of the trigger point have all been shown

to provide pain relief (Majlesi J, Unalan H. Effect of treatment on trigger points. Curr Pain Headache Rep. 2010 Oct;14(5):353-360 https://www.ncbi.nlm.nih.gov/pubmed/20652653

Trigger point injection (TPI) is a recognized treatment for regional myofascial pain syndrome, and ultrasound is used to assist with the guidance of needles to the general vicinity of clinically identified trigger points. Ultrasound is used to guide proper needle placement in muscle tissue and to avoid adipose or non musculature structures during trigger point injections. Trigger point injections may have serious complications, and direct visualization of surrounding soft tissues and important structures can reduce the risk of such complications. Moreover, ultrasound allows real-time imaging of the spread of the injectate around the relevant structures and increases the success rate of the injection.

Additionally, Dr. Westerband denies ultrasound guidance on the ground that *"...The procedure can be performed by manual palpation and marking the site. Any trained doctor can easily locate the trigger points by simply palpating the area and simultaneously injecting the area if needed. Ultrasound guidance is not generally necessary. Using ultrasound guidance to inject a superficial structure of the body was not appropriate..."*

Although traditionally, TPIs had been performed by blindly needling or injecting a palpable trigger point, blind needling can cause complications resulting in pneumothorax, epidural abscess, skeletal muscle toxicity, and intrathecal injection. Avoiding the risk of radiation, ultrasonography provides real-time visualization of soft tissue, bone, cartilage, and foreign body, and may be used to guide injections. Therefore, TPI under real-time ultrasound guidance is a technique for reducing complications and enhancing needle visualization.

As per Dr. Etienne, Ultrasound is used to assist with the guidance of needles to the general vicinity of clinically identified trigger points. Ultrasound is used to guide proper needle placement in muscle tissue and to avoid adipose or non-musculature structures during trigger point injections. Trigger point injections may have serious complications, and direct visualization of surrounding soft tissues and important structures can reduce the risk of such complications. Moreover, ultrasound allows real-time imaging of the spread of the injectate around the relevant structures and increases the success rate of the injection.

A case report of 2015 on Ultrasound Guided Trigger Point Injections in Myofascial Pain Syndrome Shiva Prasad, Vijay, Gururaj Bangari Priyanka Patil, Spurti N Sagar concludes:

"…Ultrasound guided needling and injections have been used recently in treating trigger points. This has helped in accurate placement of needles with real time visualization of the procedure. Complications involved in blind procedures have been eliminated. Significant pain relief is seen after the procedure without post procedure complications. Prior knowledge of the trigger points in specific muscles is of utmost importance in locating them on ultrasound. The use of ultrasound guided localization

definitely reduces the complications associated with needling and possibly enhances the efficacy of dry needling. Ultrasound guided needling helps in cutting short the time in deactivation of the trigger point than manual therapies in inaccessible areas. Manual therapies are cheaper and less time consuming for the general therapy…" (http://www.jaypeejournals.com/eJournals/ShowText.aspx?ID=12543&Type=FREE&TYP= TOP&IN=&IID=977&isPDF=YES)

A study titled "Ultrasound-guided trigger point injections in the cervicothoracic musculature: a new and unreported technique" by Botwin KP, Sharma K, Saliba R and Patel BC documents: *"…utilizing ultrasound yields multiple advantages technically and practically, including observation of needle placement in real-time, ability to perform dynamic studies, the possibility of diagnosing musculoskeletal pathologies, avoidance of radiation exposure, reduced overall cost, and portability of equipment within the office setting…"*

The study concluded that "…*Ultrasound-guided trigger point injections may help confirm proper needle placement within the cervicothoracic musculature. The use of ultrasound- guided trigger point injections in the cervicothoracic musculature may also reduce the potential for a pneumothorax by an improperly placed injection…"*

Dr. Etienne stated that in view of the foregoing, ultrasound was appropriately used to guide the TPI.

Dr. Westerband with regards to office visits stated that *"...This evaluation was not a specialist evaluation and the claimant had already started on a course of conservative modalities. This evaluation did not contribute to the claimant's treatment and hence it was not medically necessary..."*

Dr. Etienne stated that the office visit at issue were medically necessary to assess the progress made post treatments, review any residual complaints and to provide further treatments in view of the persisting symptoms.

I agree that the peer review lacks the rationale to justify denial of the services provided to the assignor. There are no specific guidelines delineating the absolute structured path for treatment to be universally prescribed to all patients. Great deference should be given to the treating provider charged with the responsibility to examine, diagnose and treat a patient who presents with symptoms and positive clinical findings.

For the reasons as stated above, I find that the Respondent has failed to establish that the treating physicians deviated from standard accepted medical practice. Clearly there are multiple medical authorities which both support and recommend against the use of the services provided to injured persons with injuries similar to those in the instant case.

Lastly, the Respondent has established that there is $4,583.21 remaining on its No-Fault PIP policy.

Accordingly, Applicant is awarded payment in the sum of $4,583.21.

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**
	Atlantic Medical & Diagnostic PC	**01/06/23 - 01/06/23**	**$2,467.47**	**Awarded: $2,467.47**
	Atlantic Medical & Diagnostic PC	**03/13/23 - 03/13/23**	**$2,351.51**	**Awarded: $2,115.74**
	Atlantic Medical & Diagnostic PC	**05/15/23 - 05/15/23**	**$2,351.51**	**Denied**
	Atlantic Medical & Diagnostic PC	**06/26/23 - 06/26/23**	**$2,351.51**	**Denied**
Total			**$9,522.00**	**Awarded: $4,583.21**

B. The insurer shall also compute and pay the applicant interest set forth below. 12/14/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest to be 2% per month simple, not compounded on a pro rata basis using a 30 day month. Respondent shall compute and pay Applicant interest from the day of filing of arbitration to the date of payment of the award.

C. Attorney's Fees

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

The insurer shall pay the Applicant an attorney fee in accordance with 11 NYCRR 65-4.6(d) or "As this matter 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 11NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the Applicant an attorney fee in accordance with the newly promulgated 11 NYCRR 65-4.6(d). This amendment takes into account that the maximum attorney fee has been raised from $850.00 to $1360.00

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 NY
SS :
County of Nassau

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

09/13/2024
(Dated)

Gary Peters

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:
a0930fc2818448b49ecf7155f33d8b0c

Electronically Signed

Your name: Gary Peters
Signed on: 09/13/2024