American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

JPCP Medical Diagnostic, PC (Applicant)	AAA Case No.	17-16-1038-3821
	Applicant's File No.	
- and -	Insurer's Claim File No.	0353696684
	NAIC No.	19232
Allstate Insurance Company (Respondent)		

ARBITRATION AWARD

I, Maria Schuchmann, 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: CLaimant

1. Hearing(s) held on 03/29/2017
   Declared closed by the arbitrator on 03/29/2017

   Mark Schwartz, Esq from Nwele & Associates, LLC participated in person for the Applicant

   Allison Lindsey, Esq from Allstate Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 3,118.46**, 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

   Whether upper and lower extremity EMG and NCV studies performed on Claimant as a result of injuries allegedly sustained in a motor vehicle accident was medically necessary.

4. Findings, Conclusions, and Basis Therefor

   Claimant was involved in a motor vehicle accident on December 16, 2014.

On January 16, 2015, she saw Dr. Kulesza complaining of pain in her neck radiating into her trapezius muscles and low back pain. After an examination that was positive for decreased cervical and lumbar ranges of motion pain radiating into her trapezius and positive Soto Hall and Kemps tests, but a normal neurological exam, Claimant was referred for MRIs, x-rays and therapy.

On January 22, 2015, she saw a neurologist, the report of which is unsigned.

At that time, she was complaining of intermittent neck and low back pain. That exam was positive for decreased cervical and lumbar ranges of motion with tenderness, and positive Distraction, Soto Hall, Jackson's, Straight Leg Raise and Braggards tests, decreased shoulder and hip ranges of motion and decreased strength.

Based upon that, she underwent upper and lower extremity EMG and NCV studies that same day that showed a right C5-6 radiculopathy and a bilateral L5-S1 radiculopathy.

Respondent has denied payment for the neurological consult and the testing based upon a peer review by Dr. Dumesh that concluded that it was not medically necessary,

In his report, he noted that these tests can be used to direst treatment. In addition, they should only be used when a diagnosis remains unclear. They should not be used to confirm radiculopathy. Instead, they are used to differentiate radiculopathy from other possible conditions. In cases of clear cut radiculopathy these tests are unnecessary. In this case, there is no indication that any other treatment was being considered. In fact, therapy had only been ordered the week before the testing.

With respect to medical necessity, Applicant has submitted a rebuttal by Dr. Simeon who responded to the peer review.

In that report he set forth that the exam indicated that Claimant could have been suffering from either a radiculopathy or a neuropathy, but he never explains why.

He also pointed out that Claimant had already undergone a month of treatment, but does not discuss the fact that he symptoms were better by the time of the neurological evaluation.

In the end he states that the exam pointed to a radiculopathy. However, if this was the case, why were the tests necessary?

It is now well settled that Applicant establishes "a prima facie showing of their entitlement to judgment as matter of law by submitting evidentiary proof that the prescribed statutory billing forms [setting forth the fact and the amount of the loss sustained] had been mailed and received and that payment of no-fault benefits were overdue." Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). In the case at bar, Applicant has met this burden.

Once Applicant has established a prima facie case the burden is on the insurer to prove that the medical treatment was not medically unnecessary. See, Citywide Social Work & Psychological Services, PLLC a/a/o Gloria Zhune v. Allstate Ins. Co., 8 Misc.3d 1025A, 806 N.Y.S.2d 444 (App. Term 1st Dept. 2005); .A.B. Medical Services, PLLC v. Geico Ins. Co., 2 Misc 3d 26, 773 N.Y.S.2d 773 (App Term 2nd & 11th Jud Dist 2003).

Lack of medical necessity is a valid defense to an action to recover No-Fault benefits, Countrywide Ins. Co. v. 563 Grand Med., P.C., 50 A.D.3d 313 (1st Dept. 2008); A.B. Med. Servs., PLLC v. Liberty Mut. Ins. Co., 39 A.D.3d 779 (2d Dept. 2007), if raised in a denial that is (1) timely, Presbyterian Hosp. in the City of New York v. Maryland Casualty Ins. Co., 226 A.D.2d 613 (2nd Dept. 1996); Central Gen. Hosp. v. Chubb Group of Ins. Co., 90 N.Y.2d 195 (1997), (2) includes the information called for in the prescribed denial of claim form, 11 NYCRR § 65-3.4 (c) (11); Nyack Hosp. v. Metropolitan Prop. & Cas. Ins. Co., 16 A.D.3d 564 (2d Dept. 2005); Nyack Hosp. v. State Farm Mut. Auto. Ins. Co., 2004 WL 2394038, 2004 NY Slip Op 07663 (2d Dept. Oct. 25, 2004); Summit psychological, P.C. v. General Assur. Co., 9 Misc.3d 8, (App Term 9th & 10th Jud Dists., 2005); Shtarkman v. Allstate Ins. Co., 8 Misc.3d 129(A), 2005 NY Slip Op 51028(U) (App Term 2d & 11th Jud Dists.), and (3) "promptly apprise(s) the claimant with a high degree of specificity of the ground or grounds on which the disclaimer is predicated", General Accident Ins. Group v. Cirucci, 46 N.Y.2d 862, 864, 414 N.Y.S.2d 512, 387 N.E.2d 223 (1979); New York University Hosp. Rusk Ins. v. Hartford Acc. & Indem. Co., 32 A.D.3d 458, 2006 NY Slip Op 06223 (2d Dept. 2006).

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 1st 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).

In the event an insurer relies on a peer review report to demonstrate that a particular service was medically unnecessary, the peer reviewer's opinion must be supported by sufficient factual evidence or proof and cannot simply be conclusory and should be supported by evidence of generally accepted medical/professional practice or standards. James M. Ligouri Physician,PC v. State Farm Mut. Auto Ins. Co., 2007 N.Y. Slip Op 50465 (U) (N.Y. Dist. Ct. 2007); JacobNir v. Allstate Insurance Company, 2005 NY Slip Op 25090; 7 Misc.3d 544; 796 N.Y.S.2d 857; 2005 N.Y.Misc. LEXIS 419 and Citywide Social Work & Psy. Serv. P.L.L.C. v. TravelersIndemnity Co., 3 Misc. 3d 608;

777 N.Y.S.2d 241; 2004 NY Slip Op 24034. 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. CityWide Social Work & Psychological Services, PLLCv. Travelers Indemnity Company, 3 Misc. 3d 608, 777 N.Y.S.2d 241 (N.Y. Civ. Ct. 2004).

Respondent has met its burden in this case. The peer review has established that there was a breach of medical standards in performing these tests. It is clear that these tests are used to differentiate neurological diseases and should have an impact on the patient's treatment.

In this case, Dr. Simeon acknowledged that his exam pointed to an existing radiculopathy, so the tests would have been unnecessary. In addition, he never even addressed the fact that the test results should have an impact on the patient's treatment.

Finally, Dr. Simeon's AANEM reference that states that testing should be left up to the treating physician is irrelevant if the testing is not medically necessary on the first place.

Therefore, I find that the testing at issue was not medically necessary.

Accordingly, this 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 New York
SS :
County of Suffolk

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

03/29/2017
(Dated)

Maria Schuchmann

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:
2516e8fee1fa50abc657815b0c0591ab

Electronically Signed

Your name: Maria Schuchmann
Signed on: 03/29/2017