American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Avenue C Medical PC (Applicant)	AAA Case No.	17-16-1030-7567
	Applicant's File No.	84571
- and -	Insurer's Claim File No.	770541
	NAIC No.	16616
American Transit Insurance Company (Respondent)		

ARBITRATION AWARD

I, Athena T. Buchanan, 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 04/07/2017
   Declared closed by the arbitrator on 04/07/2017

   Naomi Cohn, Esq. from Ursulova Law Offices P.C. participated in person for the Applicant

   Racquel Williams, Esq. from American Transit Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 3,246.67**, was NOT AMENDED at the oral hearing.
   Stipulations WERE made by the parties regarding the issues to be determined.

   The parties stipulated that Applicant established its prima facie case of entitlement to No-Fault benefits and that Respondent's NF-10/Denial of Claim forms were timely issued in accordance with 11 NYCRR 65-3.8(a)(1).

3. Summary of Issues in Dispute

   The claimant, a 58 year-old male, was involved in a motor vehicle accident on February 9, 2013, as a bicyclist. As a result of the accident, the claimant sustained multiple injuries and was started on a course of rehabilitative care. This dispute arises from

claims for ROM/MMT testing and EMG/NCV studies of the upper and lower extremities performed from February 25, 2013, through June 3, 2013. Respondent timely denied the claims on the ground of lack of medical necessity or fee schedule. The issue to be decided is whether Respondent's defenses can be sustained.

4. Findings, Conclusions, and Basis Therefor

This case was decided on the submissions of the parties as contained in the Electronic Case Folder maintained by the American Arbitration Association and the oral arguments of the parties' representatives. There were no witnesses. I reviewed the documents contained in the ECF for both parties and make my decision in reliance thereon.

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 Dep't., Jan. 20, 2009); Channel Chiropractic, P.C. v. CountryWide Ins. Co., 2007 Slip Op 01973, 38 A.D.3d 294 (1st Dep't. 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 Dep't., 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.

In the present case, Respondent denied the EMG/NCV studies performed on May 16, 2013, based on the Peer Review by Uriel Davis, DO, dated July 12, 2013. With Addendum dated March 30, 2017. In his review, Dr. Davis chronicled the clinical record and noted the referring examination report findings and that the claimant was referred for an EMG/NCV to "assess for radiculopathy." Dr. Davis noted that there was no diagnostic dilemma or inexplicable worsening neurological deficits documented that would suggest a need for the testing herein. According to Dr. Davis, when the diagnosis of radiculopathy is clinically obvious and there is no diagnostic dilemma, then electrodiagnostic testing would not be medically necessary per current medical necessity guidelines.

In opposition to Respondent's Peer Reviews, Applicant relied on examination reports, diagnostic testing reports and a Rebuttal by Salehin Sayeedus, MD, dated October 27, 2016. According to Dr. Sayeedus, the EMG/NCV testing was performed to determine localization and recent peripheral nerve root injury and to better predict prognosis for the recovery and possible residual neurological deficits. He further noted that a clinician's examination is often not adequate to decide whether there is a lesion, the severity of the lesion or the location of the lesion.

The conflicting medical expert opinions submitted by the parties sufficed to raise an issue of fact as to the medical necessity of the treatment underlying the provider's first-party No-Fault claim. *See*, Advanced Orthopedics, PLLC v. New York Cent. Mut.

Fire Ins. Co., 2014 NY Slip Op 50418(U) (App Term, 2d, 11th & 13th Jud Dists., March 11, 2014); Pomona Med. Diagnostics, P.C. v. Praetorian Ins. Co., 2013 NY Slip Op 52131(U) (App Term 1st Dept., Dec. 13. 2013).

After careful review of the record, I find that Respondent set forth a medical rationale and factual basis for denying payment for the upper and lower EMG/NCV and that Applicant did not successfully refute the peer reviewer's assertions. I find that the opinion of Dr. Davis to be consistent with the record and more persuasive that the opinion of Dr. Sayeedus. I further find that the rebuttal by Dr. Sayeedus did not sufficiently address the conclusions of Dr. Davis. Therefore, Respondent's denial of EMG/NCV testing performed on May 16, 2013, is sustained.

As to the remaining claims, Applicant billed for range of motion (ROM) measurements under CPT code 95851 and manual muscle testing under CPT code 95831. Respondent contended that that a plain reading of the fee schedule indicates that code 95831 should be utilized per extremity, regardless of how many points on the extremity were tested. In further support, Respondent submitted an affidavit from Respondent's No-Fault Claims Examiner, Sandra Joseph. Based on Ms. Joseph's assessment, the total fee for the ROM/MMT testing performed on February 25, 2013, and June 3, 2013, is $685.76.

After a review of the documents provided in support of its position, I agree with Respondent. I find that the record and evidence is consistent with Respondent's conclusions.

Once the insurer makes a prima facie showing that the amounts charged by a provider are in excess of the fee schedule, the burden shifts to the provider to show that the charges involved a different interpretation of such schedule or an inadvertent miscalculation or error. *See*, Cornell Medical, P.C. v. Mercury Cas. Co., 24 Misc.3d 58, 884 N.Y.S.2d 558 (App Term 2d, 11 & 13 Dists. 2009).

Here, Respondent met its burden of proof and established that the fees charged by the Applicant were in excess of the applicable fee schedule. Applicant has failed to provide any proof to refute the same.

It is undisputed that Respondent issued a partial reimbursement in the sum of $640.05. Applicant is awarded the balance of $45.71.

Any further issues raised in the record are held to be moot and/or waived insofar as not raised at the time of the hearing. This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator.

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**
	Avenue C Medical PC	**02/25/13 - 06/03/13**	**$3,246.67**	**Awarded: $45.71**
Total			**$3,246.67**	**Awarded: $45.71**

B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 03/21/2016, which is a relevant date only to the extent set forth below.)

The insurer shall compute interest and pay Applicant the amount of interest computed from the filing date as indicated above at the rate of 2% per month, simple, not compounded, calculated on a pro rata basis using a thirty day month and ending with 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

Effective to filings on or after February 6, 2015, this case is subject to the provisions as to attorney fee promulgated in the Sixth Amendment to 11 NYCRR 65-4(Insurance Regulation 68-D). As amended, 11 N.Y.C.R.R. §65-4.6(d) reads: "For all other disputes subject to arbitration or court proceedings, subject to the provisions of subdivision (a) of this section, the attorney's fee shall be limited as follows: 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon, for each applicant per arbitration or court proceeding, subject to a maximum fee of $ 1360. If the nature of the dispute results in an attorney's fee that could be computed in accordance with the limitations prescribed in both subdivision (c) and this subdivision, the higher attorney's fee shall be payable."

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

05/06/2017
(Dated)

Athena T. Buchanan

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:
d160baaf4c0d6a0b6e896a8fc40af5ae

Electronically Signed

Your name: Athena T. Buchanan
Signed on: 05/06/2017