American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Kings County Physician Group PLLC (Applicant)	AAA Case No.	17-16-1035-6292
	Applicant's File No.	59577
- and -	Insurer's Claim File No.	0396650890101029
	NAIC No.	35882
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Aaron Maslow, 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 ["GA"]

1. Hearing(s) held on 05/08/2017
   Declared closed by the arbitrator on 05/08/2017

   Benjamin Sharav, Esq., from Gitelis Law Firm, PC participated in person for the Applicant

   Philippa Tapada from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 3,045.08**, 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 a prima facie case of entitlement to No-Fault compensation with respect to its bill. They also stipulated that Respondent's Form NF-10 denial of claim form was timely issued, i.e., within the 30-day deadline prescribed by Insurance Law §5106(a) and 11 NYCRR 65-3.8(a)(1). Additionally, they stipulated that should Applicant prevail, interest would accrue as of the filing date set forth by the American Arbitration Association in Part B of the conclusion of the award template.

3. Summary of Issues in Dispute

- Whether Applicant established entitlement to No-Fault insurance compensation for upper and lower EMG/NCV testing performed on Assignor

- Whether Respondent made out a prima facie case of lack of medical necessity for the EMG/NCV NCV testing and, if so, whether Applicant rebutted it

4. Findings, Conclusions, and Basis Therefor

Appearances

For Applicant:

Gitelis Law Firm, P.C.
2004 Coney Island Avenue
Brooklyn, NY 11223
Of counsel: Benjamin Sharav, Esq.

For Respondent:

Philippa Tapada
GEICO Insurance Co.
750 Woodbury Road
Woodbury, NY 11797

Applicant commenced this New York No-Fault insurance arbitration, seeking as compensation $3,045.08 which it billed for performing upper and lower extremity EMG/NCV testing on Jan. 23, 2014 on Assignor, a 31-year-old male who was injured in a motor vehicle accident on Oct. 12, 2013. Respondent denied payment on two grounds: fees not being in accordance with fee schedule and lack of medical necessity. At the hearing, Respondent's representative stated that it was not pursuing a fee schedule issue, so I deem that defense abandoned. Remaining is the defense of lack of medical necessity.

This arbitration was conducted under the auspices of the American Arbitration Association, which has been designated by the New York State Department of Financial Services to administer the mandatory arbitration provisions of Insurance Law § 5106(b), which provides:

> Every insurer shall provide a claimant with the option of submitting any dispute involving the insurer's liability to pay first party ["No-Fault insurance"] benefits, or additional first party benefits, the amount thereof or any other matter which may arise pursuant to subsection (a) of this section to arbitration pursuant to simplified procedures to be promulgated or approved by the superintendent.

Both parties appeared at the hearing by counsel, who presented oral argument and relied upon documentary submissions. I have reviewed the

submissions' documents contained in the American Arbitration Association's ADR Center as of the date of the hearing, said submissions constituting the record in this case. This includes Respondent's late submission of May 5, 2017, which included a fee audit.

The parties stipulated that Applicant established a prima facie case of entitlement to No-Fault compensation with respect to its bill. They also stipulated that Respondent's Form NF-10 denial of claim form was timely issued, i.e., within the 30-day deadline prescribed by Insurance Law §5106(a) and 11 NYCRR 65-3.8(a)(1).

Since Respondent's denial was timely, it was within its rights to assert lack of medical necessity as a defense. Liberty Queens Medical, P.C. v. Liberty Mutual Insurance Co., 2002 WL 31108069 (App. Term 2d & 11th Dists. June 27, 2002); cf. Country-Wide Insurance Co. v. Zablozki, 257 A.D.2d 506, 684 N.Y.S.2d 229 (1st Dept. 1999). "The no-fault law defines 'basic economic loss,' for which accident victims are entitled to reimbursement up to $50,000, as '[a]ll *necessary* expenses incurred for: (i) medical, hospital ... surgical, nursing, dental, ambulance, x-ray, prescription drug and prosthetic services' (Insurance Law § 5102[a][1] [emphasis added]). Like the statute, the regulations promulgated thereunder expressly state that reimbursable medical expenses consist of '*necessary* expenses' (11 NYCRR 65-1-1 [emphasis added])." Long Island Radiology v. Allstate Ins. Co., 36 A.D.3d 763, 765, 830 N.Y.S.2d 192, 194 (2d Dept. 2007).

A peer review report relied upon by an insurer in timely denying a claim is a proper vehicle to assert the defense of lack of medical necessity. S & M Supply, Inc. v. Allstate Ins. Co., 2003 N.Y. Slip Op. 51191(U), 2003 WL 21960336 (App. Term 2d & 11th Dists. July 9, 2003); Rockaway Boulevard Medical P.C. v. Travelers Property Casualty Corp., 2003 N.Y. Slip Op. 50842(U), 2003 WL 21049583 (App. Term 2d & 11th Dists. Apr. 1, 2003). In fact, without a peer review, a defense of lack of medical necessity at the litigation stage cannot survive. See A.B. Medical Services PLLC v. Lumbermens Mutual Casualty Co., 4 Misc.3d 86, 781 N.Y.S.2d 818 (App. Term 2d Dept. 2004).

A peer reviewer must establish a factual basis and medical rationale for his asserted lack of medical necessity of the health care provider's services. See Amaze Medical Supply Inc. v. Allstate Ins. Co., 12 Misc.3d 142(A), 824 N.Y.S.2d 760 (Table), 2006 N.Y. Slip Op. 51412(U), 2006 WL 2035559 (App. Term 2d & 11th Dists. July 12, 2006); Prime Psychological Services, P.C. v. Progressive Casualty Ins. Co., 2009 N.Y. Slip Op. 51868(U) at 3, 2009 WL 2780152 (Civ. Ct. Richmond Co., Katherine A. Levine, J., Aug. 5, 2009); A.M. Medical Services, P.C. v. Deerbrook Ins. Co., 18 Misc.3d 1139(A), 2008 WL 518022 (Civ. Ct. Kings Co., Sylvia G. Ash, J., Feb. 25, 2008).

"A no-fault insurer 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'." CityWide Social Work & Psy. Serv., P.L.L.C. v. Travelers Indemnity Co., 3 Misc.3d 608, 609, 777 N.Y.S.2d 241, 242 (Civ. Ct. Kings Co. 2004). "Generally accepted practice is that range of practice that the profession will follow in the diagnosis and treatment of patients in light of the standards and values that define its calling." Id. at 616, 248; accord, Prime Psychological Services, P.C. v. Progressive Casualty Ins. Co., supra; Millennium Radiology, P.C. v. New York Central Mutual Fire Ins. Co., 23 Misc.3d 1121(A), 2009 N.Y. Slip Op. 50877(U), 2009 WL 1261666 (Civ. Ct. Richmond Co., Katherine A. Levine, J., Apr. 30, 2009). Without a recitation to generally accepted medical practice, a peer reviewer's opinion is simply a different professional judgment which, in and of itself, does not establish that the disputed services were medically unnecessary to treat the injured person's condition.

If the peer review satisfies these standards, it becomes incumbent on the claimant to rebut the peer review. See Be Well Medical Supply, Inc. v. New York Cent. Mut. Fire Ins. Co., 18 Misc3d 139(A), 2008 WL 506180 (App. Term 2d & 11th Dists. Feb. 21, 2008); A Khodadadi Radiology, P.C. v. NY Central Mutual Fire Ins. Co., 16 Misc.3d 131(A), 841 N.Y.S.2d 824, 2007 WL 1989432 (App. Term 2d & 11th Dists. July 3, 2007), because the ultimate burden of proof on the issue of medical necessity lies with the claimant. See Insurance Law § 5102; Shtarkman v. Allstate Insurance Co., 2002 WL 32001277 (App. Term 9th & 10th Jud. Dists. 2002) (burden of establishing whether a medical test performed by a medical provider was medically necessary is on the latter, not the insurance company). "[T]he 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 Ins. Co., 8 Misc.3d 1025(A), 806 N.Y.S.2d 443 (Table), 2005 WL 1936346 at 3 (Civ. Ct. Kings Co., Jack M. Battaglia, J., Aug. 12, 2005). Assuming the insurer establishes a lack of medical necessity, it is ultimately the claimant who must prove, by a preponderance of the evidence, that the services or supplies were medically necessary. Dayan v. Allstate Ins. Co., 49 Misc.3d 151(A), ___ N.Y.S.3d ___ (Table), 2015 N.Y. Slip Op. 51751(U), 2015 WL 7900115 (App. Term 2d, 11th & 13th Dists. Nov. 30, 2015); Park Slope Medical and Surgical Supply, Inc. v. Travelers Ins. Co., 37 Misc.3d 19, 22 n., 952 N.Y.S.2d 372, 374 n. (App. Term 2d, 11th & 13th Dists. 2012).

"Where the defendant insurer presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden shifts to the plaintiff which must then present its own evidence of medical necessity (see Prince, Richardson on Evidence §§ 3-104, 3-202 [Farrell 11th ed])." West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc.3d 131(A), 824 N.Y.S.2d 759 (Table), 2006 N.Y. Slip Op. 51871(U) at 2, 2006 WL 2829826 (App. Term 2d & 11th Dists. Sept. 29, 2006). Thus, although Respondent must come forward with prima facie proof of lack of medical necessity, the burden will shift to Applicant to prove medical necessity by a preponderance of the credible evidence if Respondent meets its burden.

In asserting lack of medical necessity for the EMG/NCV testing, Respondent relied upon a peer review written by Dr. Mitchell Weisman, Board certified in physical medicine and rehabilitation. At the outset of his peer review, Dr. Weisman listed the various medical records relating to Assignor's post-accident treatment which he reviewed. He noted that Assignor was involved in a motor vehicle accident on Oct. 12, 2013. According to the Jan. 23, 2014 pre-testing exam report, Assignor presented with complaints of neck and upper back pain radiating to the shoulders with numbness and tingling sensation on the left shoulder and arm, mid back pain, lower back pain, and left shoulder pain. Examination of the cervical spine revealed paracervical and trapezius tenderness, spasm, and decreased range of motion. Spurling Test was positive. Examination of the lumbar spine revealed tenderness and spasm of the paralumbar muscles and paraspinal points and decreased range of motion. Straight Leg Raise Test was positive. Muscle strength was 5/5 in the upper and lower extremities. Reflexes were noted to be +l in the right and left biceps and patella. There were no sensory deficits noted. Diagnoses was cervical and lumbar sprain/strains, rule out radiculopathy. The diagnostic plan consisted of EMG and nerve conduction studies.

According to Dr. Weisman, the testing was not medically necessary. "This claimant was prescribed a treatment program, and the results of the EMG/NCV testing would not change this course of treatment." Per Dr. Weisman, the "standard of care is to make the diagnosis of radiculopathy upon clinical recognition of signs and symptoms consistent with a radiculopathy. Even if this patient had signs and symptoms suggesting radiculopathy, electrodiagnostic testing would not be helpful in excluding the diagnosis of radiculopathy. Electrodiagnostic testing cannot be used to exclude or rule-out a radiculopathy. If the results of the EMG/NCV testing were normal, the claimant could still have a radiculopathy." He also wrote that electrodiagnostic testing may be indicated when there is a valid question of differential diagnosis between radiculopathy and peripheral nerve injuries or neuromuscular disease. In this case, there was no indication in the history or from physical examination findings that a neuromuscular disease or a peripheral nerve injury related to the accident was present.

Dr. Weisman cited to an authority for the following: EMG is not necessary for the diagnosis of intervertebral disk disease with radiculopathy, but rather its value lies in differentiating other types of neuritis, neuropathy, or muscle abnormalities from radicular neuropathy and for cases where the etiology of the pain is not clear.

"The standard of care to treat this claimant's injuries would be conservative measures, such as analgesics and Physical Therapy regardless of the results of the EMG/NCV studies. If this claimant did not respond to conservative treatments, invasive procedures may have been necessary, but the need for these procedures would be based on the claimant's lack of response to the conservative treatments, not the results of the EMG/NCV testing."

The case law cited above requires that a peer review be imbued with a factual basis and a medical rationale. Dr. Weisman's peer review contained both. The medical records reviewed afforded him a factual basis. His medical rationale took into account generally accepted medical practice -- he cited to standards of care. I find that the peer review made out a prima facie of lack of medical necessity in support of Respondent's denial. Per the case law, the burden of proof shifted to Applicant to rebut the peer review and affirmatively prove medical necessity.

Applicant did not submit a formal rebuttal to Dr. Weisman's peer review. I have reviewed the pre-testing exam report of Dr. Zhanna Nudelman. She was the doctor who performed the EMG/NCV testing. The exam report is in a checklist format. While range of motion was described as limited, it was not quantified. Muscle strength, at 5/5, was normal. Reflexes were claimed to be normal except for +1/+1 for biceps and patella. Dr. Nudelman circled that no sensory impairment was identified.

Under "Diagnostic Plan," Dr. Nudelman circled "EMG/NCV of the Upper extremities" and "EMG/NCV of the Lower extremities." There was no option for not recommending EMG/NCV testing. Preprinted was the statement, "It is necessary to delineate the extend [sic] of radicular involvement and further more [sic] to rule out radiculopathy, plexopathy, peripheral neuropathies and muscle denervations." This preprinted justification in a one-size-fits-all basis is insufficient in my view to rebut the well-reasoned and incisive peer review of Dr. Weisman. In fact, the checklist exam report has already predetermined that the testing would be performed as there is no option for not performing it, and there is no option to check off that such testing is not necessary. Stating that the testing is necessary to rule out muscle denervation makes no sense when clinical muscle strength testing was 5/5.

On balance, I find that Dr. Weisman's peer review was far more credible that the preprinted exam checklist report of Dr. Nudelman. I find as a fact that the EMG/NCV testing was not medically necessary. I sustain the defense of lack of medical necessity asserted in Respondent's denial of claim. That defense overcomes the prima facie case of entitlement to No-Fault compensation established by Applicant at the outset.

Accordingly, the within arbitration 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 Kings

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

05/09/2017
(Dated)

Aaron Maslow

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:
605af3ede61d96dfd509d845759378aa

Electronically Signed

Your name: Aaron Maslow
Signed on: 05/09/2017