

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Michael George Alleyne, M.D., P.C.
(Applicant)

- and -

Allstate Fire & Casualty Insurance Company
(Respondent)

AAA Case No. 17-17-1070-7868

Applicant's File No. none

Insurer's Claim File No. 0437029770

NAIC No. 29688

ARBITRATION AWARD

I, Paul Israelson, 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: injured person.

1. Hearing(s) held on 04/23/2018
Declared closed by the arbitrator on 04/23/2018

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

Marcia Brin Esq. from Allstate Fire & Casualty Insurance Company participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 3,119.44**, 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

Were the subject EMG NCV tests of the injured person's upper extremities and lower extremities medically necessary?

4. Findings, Conclusions, and Basis Therefor

On April 23, 2018, the hearing for the within arbitration matter was conducted and closed.

At the hearing, the applicant did not raise any argument as to the timeliness of the respondent's denial of the applicant's claim.

At the hearing, the respondent did not articulate any argument as to the propriety or accuracy of the applicant's calculation of its requested fee.

The date of the subject automobile accident was November 21, 2016.

The applicant made a claim in the amount of \$3,119.44 for the January 19, 2017 EMG NCV testing of the injured person's upper extremities and lower extremities. The respondent denied the applicant's claim on the basis that this same testing was not medically necessary.

As to the medical necessity for the subject EMG NCV testing of the injured person's upper extremities and lower extremities, "Medical necessity is presumed upon the timely submission of a no-fault claim (see *All County Open MRI & Diagn. Radiology P.C. v. Travelers Ins. Co.*, 11 Misc.3d 131[A], 2006 N.Y. Slip Op 50318[U] [App Term, 9th & 10th Jud Dists 2006]). Thus, ordinarily it falls to the defense to establish that the billed-for services were not medically necessary.", *Park Slope Medical and Surgical Supply, Inc. v. Progressive Ins. Co.* 34 Misc.3d 154(A), 950 N.Y.S.2d 609 (App. Term, 2nd, 11th and 13th Dists. 2012). In this case there is no question of fact that the applicant timely submitted its proof of claim for the subject EMG NCV testing, and therefore, the applicant may employ this same presumption of medical necessity for this same testing.

Additionally concerning the respondent's challenge to the medical necessity for the subject EMG NCV testing the injured person's upper extremities and lower extremities, "For an expense to be considered medically necessary, the treatment, procedure, or service ordered by a qualified physician must be based on an objectively reasonable belief that it will assist in the patient's diagnosis and treatment and cannot be reasonably dispensed with. Such treatment, procedure, or service must be warranted by the circumstances as verified by a preponderance of credible and reliable evidence, and must be reasonable in light of the subjective and objective evidence of the patient's complaints." *Nir v. Progressive Insurance Co.*, 7 Misc.3d 1006(A), 801 N.Y.S.2d 237 (Table), 2005 N.Y. Slip Op. 50466(U), 2005 WL 782806 (Civ. Ct. Kings Co., Nadelson, J., Apr. 7, 2005).

As well, "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 practices. 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. v. Travelers Indem. Co., 3 Misc.3d 608, 609 supra.). '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 value that define its calling (A.B. Med. Ser. v. New York Central Mut. Fire Ins. Co., 7 Misc.3d 1018[A][Civ. Ct. Kings Co.2005]; Citywide Social Work & Psy Serv. v. Travelers Indemnity Co., supra).", A.R. Medical Art, P.C. v. State Farm Mut. Auto. Ins. Co., 11 Misc.3d 1057(A), 815 N.Y.S.2d 493 (Civ. Ct. Kings Cty. 2006).

The respondent provided the March 27, 2017 peer review report by Dr. Alexander Merson M.D. in support of the respondent's argument that the subject EMG NCV testing of the injured person's upper extremities and lower extremities was not medically necessary. Dr. Merson reviewed the records concerning the injured person's relevant medical history and condition, and noted:

"According to the records reviewed, the claimant, a 56-year old male, who was involved in a MVA on 11/21/2016, as a driver. He denied loss of consciousness. The claimant was transported to the ER LIJ Hospital, where he was examined and released.

On 11/29/2016, the claimant presented to the medical office of Gamil Saad Kostandy, MD, with complaints of low back, shoulder and neck pain. The claimant was examined, diagnosed with Lumbar and Cervical spine sprain, and referred for physical therapy, acupuncture and chiropractic care. He was also referred for the MRIs of the cervical and lumbar spine.

On 01/19/2017 the claimant presented to the medical office of Michael George Alleyne, MD, PC, with complaints of neck pain, radiating to left shoulder, and lower back pain. The claimant was referred for EMG/NCV and on the same date the test was performed. Continuation of the physical therapy was ordered."

Dr. Merson noted that, on November 29, 2016, the injured person did not present with radiating pain, numbness, tingling or extremities weakness, and was diagnosed with cervical spine sprain/strain, however, on January 19, 2017 when examined by the applicant, the injured person had neck pain radiating to the left shoulder and lower back pain without radiation, no other symptoms of a neurological deficit, and there was no indication that conservative treatment had been failing the injured person; and argued that the injured person's relevant medical history and condition did not warrant EMG NCV testing because the injured person did not present with symptoms suggesting a differential neurological diagnosis to be resolved by such testing and did not present with symptoms of a neurological deficit, where he stated, "Definition of Medical Necessity:

AMA(American Medical Academy) defines medical necessity as: Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) Clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider. AMA continues to advocate its policies on medical necessity determinations to government agencies, managed care organizations, third party payers, and private sector health care accreditation organizations. H-320.953 Definitions of "Screening" and "Medical Necessity" (CMS Rep. 13, 1-98; Reaffirmed: BOT Action in response to referred for decision Res. 724, A-99; Modified: Res. 703, A-03).

I conclude the following regarding the Electrodiagnostic tests performed on 01/19/2017 in this case.

Based upon my review of the available records and my 40 years of experience as an internal medicine physician, I have come to the following conclusion. The Electrodiagnostic studies performed on 01/19/2017 were not medically necessary or justified in this case.

According to the records, the claimant sustained his injuries in a motor vehicle accident on 11/21/2016, as a driver. He turned for medical help a few days later, when on 11/29/2016, presented with complaints that included neck and low back pain. This pain was not accompanied by the symptoms of neurological deficit: no pain radiation, no numbness, tingling or extremities weakness were registered. The claimant was examined, and, diagnosed with Lumbar and Cervical spine sprain/strain. This diagnosis does not warrant the electrodiagnostic studies. The claimant was referred for physical therapy, acupuncture and chiropractic care. He proceeded with the therapy, when on 01/19/2017 the claimant was consulted at the medical office of Michael George Alleyne, MD, PC, when the initial complaints were registered of neck pain radiation to the left shoulder, and lower back pain without any radiation or any other symptoms of neurological deficit. The claimant was referred for the EMG/NCV tests and on the same date the tests were performed. Continuation of the physical therapy was simultaneously ordered. There was no necessity to refer the claimant for the EMG/NCV studies in this clinical setting, on the day of the initial registration of the symptoms of neurological deficit. However, during the 01/19/2017 consultation, the claimant was referred for EMG/NCV and on the same date the tests were performed. No clinical data suggested the EMG/NCV studies required for differential diagnosis dilemma. Motor and sensory examinations were registered as normal in the course of several visits. The claimant did not require to be referred for the electrodiagnostic studies in the circumstance of insufficient and non-persistent symptoms, clarity of the diagnosis, and availability of the therapy. This clinical setting did not warrant any electrodiagnostic testing. The diagnosis was registered and the rehabilitation program was prescribed regardless the results of the

EMG/NCV studies performed on 01/19/2017. No signs of therapy failing or any necessity to interfere with this therapy were registered. None of the spinal symptoms were accompanied by the symptoms of neurological deficit. In this clinical setting, there was no necessity to rule out radiculopathy/neuropathy/nerve entrapment pathologies or any other undiagnosed neurological pathology. The diagnosis was clear from the initial evaluation, and the diagnosis of Cervical and Lumbar strain/sprain did not require any further clarifications. No spinal diagnosis registered during the initial evaluation would call for the electrodiagnostic studies. There was no new development registered that would bring any suspicion for the nerve involvement caused by the accident on 11/21/2016."

Further, Dr. Merson noted that the injured person did not present with muscle atrophy, muscle tone for the upper and lower limbs was normal, muscle strength was normal, reflexes were normal, sensory function was normal, and there was no persisting lumbar or cervical pain with constant associated extremity radicular symptoms, and therefore, there was no differential neurological diagnosis to be resolved by the subject EMG NCV testing, where he stated, "No symptoms or pathology needed to be ruled out, as caused by the acute traumatic injuries. As was noted, during the initial visit, and later, during several examinations, no muscle atrophy was noted, muscle tone for upper and lower limbs was found to be within normal limits, muscle strength was within normal limits, and reflexes were normal, with normal sensory function. This clinical setting would not warrant the studies in question, when the therapy addressed the symptoms, and the registered diagnosis did not call for the electrodiagnostic studies. The claimant did not present with persisting lumbar or cervical pain with constant associated extremities radicular symptoms. This differential diagnostic dilemma had no clinical rationale to be raised for discussion in this case. It is well known that NCV studies can determine nerve damage and destruction. Those tests are often used with EMG in order to differentiate a nerve disorder from a muscle disorder. In this case, there was no necessity for this diagnostic clarification, since no clinical signs suggested that any traumatic nerve disorder was sustained on 11/21/2016."

Dr. Merson argued that the standard of care involved conservative treatment with anti-inflammatory medication for a prolonged period of time, and only if there was a deterioration in neurological condition, neurological deficits or other clinical signs of potential radiculopathy/neuropathy presenting a diagnostic neurological dilemma would EMG NCV testing be warranted; and none of these conditions existed for the injured person, where he stated, "The standard of care for the described above types of injuries, would be evaluations by a physician, ordering of plain radiographs (in cases when there are suspicion of fractures or a severe mechanism of injury was documented), prescribing anti-inflammatory medication, rest, conservative physical therapy, for a prolonged period of time. The standard of care for the injuries sustained would not involve a routine use of electrodiagnostic testing, EMG/NCV, unless there is a deterioration in the condition, persistent symptoms of neurological deficit and other clinical signs of possible radiculopathy/neuropathy, and there is a diagnostic dilemma present. In this

case, the clinical data was not sufficient to justify a referral for the electrodiagnostic studies after the therapy was being in progress, and the symptoms were appropriately addressed with positive progress. Therefore, the standards of care were not met."

And finally, Dr. Merson argued that the diagnosis for the injured person was clear, EMG testing is not sensitive for radiculopathy, but rather a complementary test to an MRI, NCV testing is performed to rule out other potential causes for the patient's symptoms and to confirm radiculopathy, and repeated his argument that the injured person did not present with any symptoms or condition for which the treatment would be influenced by the subject EMG NCV testing, where he stated, "The clinical setting in this case, did not warrant any additional tests, since the diagnosis and its origin were clear and the therapy was prescribed and in progress. It also needs to be noted that medical literature, regarding sensitivity of EMG for radiculopathy, suggests: "EMG is not a sensitive study" (Timothy R. Dillingham, MD, MS, Electrodiagnosis of persons with Suspected Cervical and Lumbosacral Radiculopathies, pages: 167-172, in EMG Secrets, 2004) and" It is rather unimpressive. Various studies place the sensitivity of needle EMG for lumbosacral radiculopathies between 50% and 80%, depending on the diagnostic gold standard used - clinical standards, imaging standards, or intraoperative confirmation. For cervical radiculopathies, the sensitivity is roughly 60% to 70%. This renders EMG a suboptimal screening test; rather, it is a confirmatory test. The value of EMG resides in its ability to define. Localize and grade the severity of a radiculopathy with high specificity. This makes EMG a complementary test to MRI and the clinical impression. When MRI suggests an anatomic explanation for a patient's symptoms, such as herniated nucleus pulposus with nerve root impingement, the EMG can provide evidence as to whether there is axonal damage from this lesion" (Timothy R. Dillingham, MD, MS, Electrodiagnosis of persons with Suspected Cervical and Lumbosacral Radiculopathies, pages: 167-172 in EMG Secrets, 2004).

According to the New York State Workers' Compensation Board Medical Treatment Guidelines, "NCV are done in addition to needle EMG to rule out other potential causes for the symptoms (comorbidity or alternate diagnosis involving peripheral nerves) and to confirm radiculopathy" (New York State Workers' Compensation Board, Neck Injury Medical Treatment Guidelines, Third Edition, September, 15, 2014, pages: 19). No such necessity was indicated to be present in this case. The New York State Workers' Compensation Board Medical Treatment Guidelines suggest that "In general, electrodiagnostic studies are complementary to imaging procedures such as CT, MRI, and/or myelography. Whereas X-ray, CT and MRI reflect structural changes, electrodiagnostic studies reflect neurologic functional status", (New York State Workers' Compensation Board, Neck Injury Medical Treatment Guidelines, Third Edition, September, 15, 2014, pages:19).

The claimant in this case was initiated upon the intensive rehabilitation program when the tests were performed. There were no indications within the records that the

management of the claimant was to be influenced in any way by the results of the electrodiagnostic testings performed on 01/19/2017 since the spinal symptoms were insufficient and should have been addressed by the therapy.

Therefore, I find the Electrodiagnostic Testings performed on 01/19/2017 as not medically necessary or justified in this case."

As such, pursuant to the above cited authorities, Dr. Merson's March 27, 2017 peer review report sustained the respondent's burden of demonstrating that the subject EMG NCV testing of the injured person's upper extremities and lower extremities was not medically necessary.

The applicant provided the July 17, 2017 peer review rebuttal by Dr. Elizabeth Kulesza M.D. in support of the applicant's claim for the subject EMG NCV testing of the injured person's upper extremities and lower extremities. Dr. Kulesza reviewed the injured person's relevant medical history and condition, and noted:

"[The injured person], a 56-year-old male was a restrained driver of a car involved in a motor vehicle accident on 11/21/2016. As a result of the impact, he sustained multiple injuries, including injuries to his neck and lower back. Following the accident the patient was taken to the emergency room of LIJ Hospital where he was evaluated, treated and referred for outpatient care.

[The injured person] developed complaints of pain and presented to Dr. Gamil Kostandy on 11/29/2016 for an evaluation. At that time, he complained of neck pain radiating to the left shoulder and lower back pain. Examination of the cervical spine revealed decreased range of motion due to pain. Examination of the lumbosacral spine revealed decreased range of motion and tenderness. Based on aforementioned complaints and findings upon evaluation, Dr. Gamil Kostandy diagnosed sprain/strain of cervical and lumbar spine sprain/strain. Dr. Kostandy therefore recommended the patient to start on a course of physical therapy and have consultation for other conservative modalities. The patient was also referred the patient for various diagnostic tests.

The patient then started on a course of physical therapy, acupuncture and chiropractic modalities. He also had various diagnostic tests including, ROM/MT and MRI studies.

MRI of the cervical spine performed on 12/29/2016 revealed disc herniation at C2-C3, C3-C4, C4-C5, C5-C6, C6-C7 and C7-T1 and mucosal thickening of the right inferior maxillary sinus.

MRI of the lumbar spine performed on 12/29/2016 revealed disc herniation at L3-L4, L4-L5 and

L5-S1 and disc bulging at L2-L3 and T11-T12.

Despite receiving conservative treatment the patient conditions did not improve there on 1/19/2017, the patient presented to me for a neurological consultation. The neurological evaluation revealed following findings:

Complaints:

- 8/10 neck pain radiating to the left shoulder
- 8/10 lower back pain
- Radiating shoulder pain and
- Exacerbation of pain by movements

Findings upon Examination:

General Appearance:

- The patient appears to be moderately distress due to pain and discomfort

Cervical Spine:

- Moderate restricted active range of motion due to pain
- Tenderness upon palpation over the spinous process
- Moderate painful spasm of the paravertebral musculature bilaterally.
- Moderate palpation upon tenderness at C2-C7 levels
- Positive Maximal Cervical Compression test bilaterally
- Positive Distraction test

- Positive Jackson Compression test
- Positive Soto Hall test and
- Multiple trigger point.

Lumbar spine:

- Restricted active range of motion due to pain and stiffness.
- Palpable tenderness over the spinous process at L1-S1 levels
- Moderate to severe tenderness muscle spasm at L1-S1 levels
- Multiple trigger points
- Positive Straight Leg Raising test bilaterally
- Positive Lasegue test
- Positive Braggard's test and
- Positive Bechterew's test

Neurological Examination:

Muscle strength:

- Decrease muscle strength in the upper and lower extremities.

Diagnosis:

- Sprain of ligaments of cervical and lumbar spine
- Cervical and lumbar radiculopathy
- Spasm of muscle
- Myalgia
- Cervicalgia and

- Lower back pain

Based on aforementioned diagnosis, I recommended the patient for EMG/NCV studies of upper and lower extremities to rule out radiculopathy, sensory nerve impairment/peripheral neuropathy in view of the patients physical findings and working diagnosis. 1) better predict prognosis for recovery and possible residual neurological deficit. 2) administer appropriate therapy. 3) Electro diagnostic study is positive for neurogenic injury, treatment can be extended to tens for neck, back, cervical, lumbar traction and paravertebral nerve block."

Dr. Kulesza argued that the injured person developed spasm, decreased muscle strength, positive orthopedic tests, radiating pain, decreased range of motion and tenderness, all of which did not improve during seven weeks of conservative treatment, indicating a worsening neurological condition, and thus warranting the subject EMG NCV testing, where she stated, "Dr. Alexander Merson denied the medical necessity of the aforementioned studies based on his conclusions in the peer review report. I respectfully disagree with his conclusions for the following reasons:

Dr. Merson stated that standard of care for the injuries sustained would not involve routine use of EDX testing unless there is deterioration in the condition and there is a diagnostic dilemma. As evident from the patient's medical records; despite of receiving continued course of conservative treatment, the radiating pain in the neck and lower back did not improve. The New York State Workers Compensation Board Medical Treatment Guidance suggests that "EDS is recommended where there is a failure of suspected radicular pain to resolve or plateau after waiting 4 to 6 weeks." (New York State Worker's Compensation Board, Mid and Low Back Injury Medical Treatment Guidelines, First Edition, June 30, 2010, pages: 17-18) (New York State Workers' Compensation Board New York Neck Injury Medical Treatment Guidelines June 30, 2010 Effective December 1, 2010).

Additionally, the patient developed many new complaints including spasm, decreased muscle strength and positive orthopedic tests. Also, the patient's complaints of radiating pain, decreased range of motion and tenderness were not improved despite receiving conservative treatment for more than 7 weeks. This all indicated worsening neurological conditions confirming need of electrodiagnostic studies.

Also, the neurological evaluation performed by me on 1/19/2017 documented the following relevant subjective complaints, clinical findings and indications of a potential neurological deficit:

- Radiating Neck pain

- Lower back pain
- Radiating shoulder pain
- Tenderness and spasm
- Limited range of motion of the cervical and lumbar spine
- Positive Maximal Cervical Compression test bilaterally
- Positive Distraction test
- Positive Jackson Compression test
- Positive Soto Hall test
- Positive Straight Leg Raising test bilaterally
- Positive Lasegue test
- Positive Braggard's test
- Positive Bechterew's test and
- Decreased muscle strength"

Dr. Kulesza specified that the positive compression test results and positive straight leg testing results suggested nerve root impingement, thus warranting the subject EMG NCV testing, where she stated, "Compression test is a very specific, but not sensitive physical examination maneuver in diagnosing acute cervical (neck) radiculopathy. If positive, evaluation with EMG/NCV testing can better locate the level of nerve damage and whether peripheral nerve impingement is considered significant enough to warrant more conservative therapy than the patient is currently receiving. Positive Straight Leg testing as part of the neurological exam indicates the presence of a lumbar disc protrusion, sprain or nerve root impingement in the lumbar spine. Better differentiation between these causes of peripheral nerve injury may be obtained by EMG/NCV testing, and even more importantly, how well the nerve(s) affected are functioning, whether there is worsening of function (if functional testing had previously been performed.

The above findings clearly document a potential neurological deficit and are listed as indicators for both neurodiagnostic evaluation and testing according to the AANEM recommended policy for electrodiagnostic medicine.)."

Dr. Kulesza argued that the subject EMG NCV testing was performed to differentiate between cervical radiculopathy and neuropathy, and lumbar radiculopathy and neuropathy, where she stated, "However, the patient's complaints and findings were indeed posing differential diagnosis as per symptoms noted in the AANEM guidelines noted below:

Symptoms: Diagnosis:

Neck pain cervical radiculopathy, Brachial plexopathy, Focal neuropathy (e.g., spinal accessory nerve)

Back Pain Lumbosacral radiculopathy, Lumbosacral plexopathy

The positive clinical findings above evidence a potential diagnostic dilemma sufficient to warrant confirmation via neurodiagnostic testing. Additionally, U.S. National library of Medicine states that clinical manifestation for diagnosis of both radiculopathy and neuropathy includes radicular pain and weakness. The patient exhibited all the aforementioned findings raising suspicion of cervical and lumbar radiculopathy and neuropathy. Hence, EMG/NCV studies were performed to r/o cervical and lumbar radiculopathy and neuropathy. ("REFERRAL GUIDELINES FOR ELECTRODIAGNOSTIC MEDICINE CONSULTATIONS Approved by the American Association of Neuromuscular & Electrodiagnostic Medicine (formerly AANEM)."

Additionally, Dr. Kulesza argued that a physical examination alone is not adequate to determine whether or not there is a lesion, the severity of a lesion or the location of the lesion, but rather, EMG NCV testing is required for these determinations, where she stated, "Further, Dr. Merson stated that the diagnosis and its origin were clear and the therapy was prescribed and in progress. It should be noted that a positive physical examination finding is always associated with a much higher probability of having a positive EDX test. This indicates that a physical examination finding such as loss of reflex, sensory abnormality or weakness is a strong reason to perform an EDX test and not to find a reason to avoid EMG, which can localize the problem. The AANEM guidelines specifically state that peroneal motor and dural sensory tests are the best means of identifying distal symmetric polyneuropathy. (Am J Phys Med Rehabil2000; 79:60-68. And Arch Phys Med Rehabil2000; 81:436-441.)

Also, the 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. Among many publications, two studies by Cannon and colleagues found that the physical examination has limited

accuracy in predicting EDX study outcomes and EDX testing should not be curtailed by musculoskeletal findings. (Arch Phys Med Rehabil. 2007 Oct;88(10):1256-9.) (Am J Phys Med Rehabil. 2007 Dec;86(12):957-61.)"

Dr. Kulesza argued that EMG NCV testing is highly sensitive for diagnosing cervical and/or lumbar radiculopathy, where she stated, "Further, I disagree with the peer reviewer's contention that EMG is not a sensitive study. However, One masked, double-controlled study found paraspinal EMG 100% specific (83-100% confidence interval) and statistically discriminant for radiculopathy, while another controlled study found over 90% sensitivity and specificity for paraspinal EMG. (Journal of Bone & Joint Surgery-American Volume. 2007;89(2):358-66).

Electrodiagnostic studies such as EMG/NCS testing have been cited as being highly sensitive for diagnosing cervical and/or lumbar radiculopathies reaching a 70-80% accuracy rate. (Radiculopathies. Timothy R. Dillingham, Physical Medicine & Rehabilitation Secrets, Second Edition. Bryan Young, Mark Young, Steven Stiens., p. 132-136)."

Dr. Kulesza repeated her argument that the injured person presented with a differential neurological diagnosis which needed to be resolved by the subject EMG NCV testing, which in turn would influence the injured person's treatment plan, where she stated, "Further, Dr. Merson stated that there were no indications within the records that the management of the claimant was to be influenced in any way by the results of the EMG/NCV testing. It seems Dr. Merson has not carefully reviewed this patient's medical records. I had clearly stated the reason for performance of electrodiagnostic test in this case. (Please see neurological evaluation report by me, dated 1/19/2017).

Arguments that there was no plan of care based on results of EMG/NCV studies are also irrelevant. Also, regardless of how these test results would have ultimately been used, the fact remains that in this case, the subjective complaints, the clinical findings and resulting differential diagnosis point to suspected nerve involvement, the only diagnostic test that can help confirm a definitive diagnosis and thereby allow the treating physician to alter the treatment plan accordingly is the EMG/NCV study.

- American Association of Neuromuscular & Electrodiagnostic Medicine.
- American Academy of Neurology American Academy of Physical Medicine and Rehabilitation.

As indicated in the AANEM guidelines, the physician performing the electrodiagnostic testing determines the necessity of the testing after his examination of the patient. Moreover, it is virtually impossible to foresee or plan how the result of a diagnostic will

be used prior to the inspection and interpretation of the results of this test. Once results have been analyzed, they are then used in conjunction with other collected data such as exams and treatment notes as well as other diagnostic testing to explore whether continuation, modification or termination of treatment is required."

Dr. Kulesza argued that EMG NCV testing is a supplement to MRI imaging, where she stated, "The peer reviewer stated that EDX studies are complimentary to imaging procedures such as CT and MRI studies. I would note that electrodiagnostic studies are not a substitute but an addition to the imaging studies (MRI) that evaluate and diagnose damage to anatomical structures. EMG/NCV in combination with MRI together produces higher diagnostic accuracy than that of any of the studies separately.

In fact, use of a reproducible codified technique with norms has resulted in compelling evidence for the value of paraspinal EMG. One masked, double-controlled study found paraspinal EMG

100% specific (83-100% confidence interval) and statistically discriminant for radiculopathy,

while another controlled study found over 90% sensitivity and specificity for paraspinal EMG.^{12,13} This is in great distinction to advanced imaging such as MRI, and thus defines an important and unique role for EMG in spinal disorders.

- Haig AJ. Geisser ME. Tong HC. Yamakawa KS. Quint DJ. Hoff JT. Chiodo A. Miner JA. Phalke VV. Electromyographic and magnetic resonance imaging to predict lumbar stenosis, low-back pain, and no back symptoms. *Journal of Bone & Joint Surgery - American Volume*. 2007; 89(2):358-66.

- Yagci I, Gunduz OH, Ekin G, Diracoglu D, Us O, Akyuz G. The utility of lumbar paraspinal mapping in the diagnosis of lumbar spinal stenosis. *Am J Phys Med Rehabil*. 2009; 88(10):843-851.)"

And finally, Dr. Kulesza argued that the treating provider is in the best position to determine whether or not EMG NCV testing is warranted, where she stated, "Finally, according to the AANEM Guidelines, a leading authority with respect to the performance of electrodiagnostic testing, the treating provider is in the most optimal position to determine the necessity of neurodiagnostic testing for the furtherance of diagnosis and treatment of his/her patient. See Guidelines page 3 column 2, 2nd full paragraph, "For these reasons, the AANEM has traditionally held the position that the only person who can responsibly determine the appropriate tests to investigate a particular patient's clinical symptoms is the physician performing the EDX evaluation", page 7, Item #1: "The ultimate decision about the indication for paraspinal examination should be left to the EDX consultant, as is the decision about what other muscles should

be examined.", page 1 column 2 "it is necessary that physicians have flexibility to design and carry out the appropriate EDX studies", Page 11, Column 2, 1st full paragraph: "The appropriate number of studies to be performed should be left to the judgment of the physician performing the EDX evaluation;"

As the results of the testing can be beneficial for determining and confirming the diagnosis, the testing is justified. See, ELECTRODIAGNOSTIC MEDICINE CONSULTATIONS Approved by the American Association of Neuromuscular & Electrodiagnostic Medicine (formerly AAEM): August 1996. (Last accessed Jan. 5, 2014). Therefore, in summary the EDX studies performed as a supplement to a careful history and physical examination were medically indicated."

Dr. Kulesza provided a persuasive argument that the injured person presented with a differential neurologic diagnosis to be resolved by the subject EMG NCV testing, and therefore, was medically necessary.

I have reviewed and considered all other arguments, contentions and evidence from both the applicant and the respondent, and find them to be without merit.

Consequently, the applicant's claim in the amount of \$3,119.44 for the January 19, 2017 EMG NCV testing of the injured person's upper extremities and lower extremities is awarded .

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
	Michael Alleyne MD PC	01/19/17 - 01/19/17	\$3,119.44	Awarded: \$3,119.44
Total			\$3,119.44	Awarded: \$3,119.44

B. The insurer shall also compute and pay the applicant interest set forth below. 08/18/2017 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest will run from the filing date to the date of payment.

C. Attorney's Fees

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

If this matter was filed prior to February 4, 2015, the insurer shall pay the applicant an attorney's fee in accordance with 11 NYCRR 65-4.6 (e). If this matter was filed on or after February 4, 2015, the insurer shall pay the applicant an attorney's fee in accordance with 11 NYCRR 65-4.6(d); and in such same event, if the benefits and interest awarded thereon are equal to or less than the respondent's written offer during the conciliation process, then the attorney's fee shall be based upon the provisions of 11 NYCRR 65-4.6(b).

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

04/28/2018
(Dated)

Paul Israelson

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:
da2f8f557ae8d4c56b6daee363d0f3ff

Electronically Signed

Your name: Paul Israelson
Signed on: 04/28/2018