

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Malaga Medical, PC
(Applicant)

- and -

Repwest Insurance Company
(Respondent)

AAA Case No. 17-18-1094-7619

Applicant's File No. NA

Insurer's Claim File No. 00885696-2017

NAIC No. Self-Insured

ARBITRATION AWARD

I, Gregory Watford, 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 (SB)

1. Hearing(s) held on 01/31/2019
Declared closed by the arbitrator on 01/31/2019

Dino DiRienzo, Esq. from Dino R. DiRienzo Esq. participated in person for the
Applicant

Amanda Scuder, Esq. from Bryan Cave Leighton Paisner LLP participated in person for
the **Respondent**

2. The amount claimed in the Arbitration Request, **\$ 1,333.22**, 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 Applicant established entitlement to No-Fault compensation for fees associated with physical therapy treatments and electro-diagnostic tests provided to Assignor;

Whether Respondent made out a prima facie case of lack of medical necessity for the electro-diagnostic tests and if so, whether Applicant rebutted it;

4. Findings, Conclusions, and Basis Therefor

Applicant was represented by Dino DiRienzo, Esq., who presented oral arguments and relied upon documentary submissions at the hearing. Amanda Scuder, Esq., appeared on behalf of Respondent and presented oral arguments and relied upon documentary submissions. I have reviewed the submissions contained in the American Arbitration Association's ADR Center Electronic Case File (ECF). These submissions are the record in this case.

Assignor, then a 56 year old male passenger, was involved in a motor vehicle accident that occurred on August 24, 2017. He was subsequently treated in the emergency room of Montefiore New Rochelle Hospital where he was evaluated, treated and released that same day. Thereafter, he sought private medical attention and on August 30, 2017, he was evaluated by Dr. Sonia Armengol where he complained of neck pain radiating to the left shoulder, lower back pain; pain in the left shoulder and left knee. Upon examination there was tenderness and decreased range of motion in the cervical spine, with full range of motion, no trigger points were noted and there were and orthopedic tests were negative. Examination of the thoracic spine was normal with full range of motion. Examination of Assignor's lumbar spine revealed limited range of motion with tenderness and spasms. Examination of Assignor's left shoulder revealed pain and tenderness with full range of motion. Examination of Assignor's hip revealed no complaints of pain. Examination of Assignor's left knee revealed pain and swelling with full range of motion. Deep tendon reflexes were normal and there were no sensory neurological deficits noted. Assignor was diagnosed with Cervicalgia, low back pain-Lumbago, right shoulder joint pain and left knee pain. Assignor was recommended for conservative care including physical therapy and recommended for diagnostic testing including EMG/NCV studies.

On October 24, 2017, Assignor underwent EMG/NCV testing of the upper extremities. Applicant billed for the EMG/NCV testing in the amount of \$1,333.22. Respondent denied payment based upon the peer review of Dr. Eric Roth dated December 11, 2017.

After reviewing the record and evidence presented, I find that Applicant established a prima facie case of entitlement to reimbursement of its claim. Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). Applicant's proof is also in Respondent's denials, which acknowledged receipt of the bills. The burden now shifts to the Respondent to demonstrate lack of medical necessity.

If an insurer asserts that the medical test, treatment, supply or other service was medically unnecessary, the burden is on the insurer to prove that assertion with competent evidence such as an independent medical examination, a peer review or other proof that sets forth a factual basis and a medical rationale for denying the claim. (See A.B. Medical Services, PLLC v. Geico Insurance Co., 2 Misc. 3d 26 [App Term, 2nd & 11th Jud Dists 2003]; Kings Medical Supply Inc. v. Country Wide Insurance Company, 783 N.Y.S. 2d at 448 & 452; Amaze Medical Supply, Inc. v. Eagle Insurance Company, 2 Misc. 3d 128 [App Term, 2nd and 11th Jud Dists 2003]). The courts have held that a peer review report's medical rationale will be insufficient to meet respondent's burden of

proof if: 1) the medical rationale of its expert witness is not supported by evidence of a deviation from "generally accepted medical" standards; 2) the expert fails to cite to medical authority, standard, or generally accepted medical practice as a medical rationale for his findings; and 3) the peer review report fails to provide specifics as to the claim at issue, is conclusory or vague. See, Jacob Nir, M.D. v. Allstate Insurance Co., 7 Misc.3d 544 (N.Y. City Civ. Ct. 2005).

Dr. Roth reviewed numerous medical reports. He then outlined the Assignor's treatment and medical history as it related to the accident. Dr. Roth opined *"based upon my review of the medical records and my clinical experience as a physiatrist and pain management specialist, the EMG/NCV of the upper extremities on 10/24/17 was not medically necessary."*

It should be noted that in the body of his peer review, Dr. Roth stated *"An examination by the physician performing the EMG/NCV study of the upper extremities, Dr. Orenstein, is not documented."*

He then set forth the standard of care for performing NCV/EMG testing.

"The standard of care for the claimant's lumbar and cervical sprain/strain injuries would be a thorough physical evaluation by a physician, ordering of plain radiographs, anti-inflammatory medications, rest and a course of physical therapy for a period of 6 to 8 weeks. If after this conservative treatment there is deterioration in the condition or progressive, worsening neurological deficits MRI may be indicated. Interventional pain management or surgery may be indicated depending on the results of the MRI studies or the progression of the condition. However, the standard of care in medicine does not involve the routine use of electrodiagnostic testing unless there is neurologic deterioration in the condition and there is a diagnostic dilemma present."

He then noted that there *"was no clinical evidence of a differential diagnosis suggesting a possibility of referred pain/nerve entrapment at an injured joint that would require the performance of electrodiagnostic studies of the upper or lower extremities to exclude. There was no clinical evidence of disease pathology that would predispose the claimant to peripheral neuropathy. The physical examination should clearly direct the electro physiologic examination and also serve as a backdrop in interpreting the electro physiologic findings."* He cited medical literature to support his argument.

Dr. Roth then concluded *"In this case, I see no symptoms or signs that point to neurological dysfunction, no documentation of a diagnostic dilemma, no documentation as to how the results of the study will be used to enhance the patient's care and no documentation of failure to respond to conservative care. For these reasons, I find no medical necessity for this testing."*

Every peer review requires individual scrutiny to determine whether the burden should be shifted back to the claimant to submit contrary expert proof. It should be noted that the peer review, upon which the denial is based, expressly stated *"An examination by the physician performing the EMG/NCV study of the upper extremities, Dr. Orenstein, is not documented."* It should also be noted that the examination report of Dr. Orenstein, dated

10/24/17, is included in Applicant's submission and details the reasons for the EMG/NCV testing in this case.

Based upon the foregoing, I find that the peer review did not set forth a factual basis and medical rationale sufficient to establish the absence of medical necessity. Park Neurological Services v. Geico Ins. Co., 4 Misc. 3d 95 (NY App. Term, 2nd Dept. 2004). A.B. Medical Services, PLLC v. Geico Insurance Co., *supra*; Kings Medical Supply Inc. v. Country Wide Insurance Company, *supra*; Amaze Medical Supply, Inc. v. Eagle Insurance Company, *supra*; Jacob Nir, M.D. v. Allstate Insurance Co., *supra*.

Consequently, the burden does not shift to Applicant to rebut Respondent's proof.

I find that the amount billed \$1,333.22 is consistent with the fee schedule. Therefore, I award Applicant \$1,333.22.

This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator. Any further issues raised in the hearing record are held to be moot, without merit, and/or waived insofar as not raised at the time of the hearing.

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
	Malaga	10/24/17 -		Awarded:

	Medical, PC	10/24/17	\$1,333.22	\$1,333.22
Total			\$1,333.22	Awarded: \$1,333.22

- B. The insurer shall also compute and pay the applicant interest set forth below. 05/10/2018 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant's award shall bear interest at a rate of two percent per month, calculated on a pro rata basis using a 30-day month from the date payment became overdue to the date of the payment of the award pursuant to 11 NYCRR 65-3.9. The end date for the calculation of the period of interest shall be the date of payment of the claim. General Construction Law § 20 ("The day from which any specified period of time is reckoned shall be excluded in making the reckoning.")

Where a claim is timely denied, interest shall begin to accrue as of the date arbitration is requested by the claimant, i.e., the date the American Arbitration Association deems the arbitration claim to have been filed (the initiation letter date), unless arbitration is commenced within 30 days after receipt of the denial, in which event interest shall begin to accrue as of the 30th day after proof of claim was received by the insurer. 11 NYCRR 65-4.5(s)(3), 65-3.9(c); Canarsie Medical Health, P.C. v. National Grange Mut. Ins. Co., 21 Misc.3d 791, 797 (Sup. Ct. New York Co. 2008) ("The regulation provides that where the insurer timely denies, then the applicant is to seek redress within 30 days, after which interest will accrue.")

Applicant initiated the instant arbitration on 5/10/18 which is not within 30 days of any denial related to this matter.

C. Attorney's Fees

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

Respondent shall pay Applicant a separate attorney's fee, in accordance with 11 NYCRR 65-4.6(d). Since the within arbitration request 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 11 NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant an attorney's fee, in accordance with 11 NYCRR 65-4.6(d) subject to a maximum fee of \$1,360.

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

03/03/2019

(Dated)

Gregory Watford

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:
b705952b05b4e8ccd9108abe20a37380

Electronically Signed

Your name: Gregory Watford
Signed on: 03/03/2019