American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Touch Stone Chiropractic P.C. (Applicant)	AAA Case No.	17-19-1136-4494
	Applicant's File No.	none
- and -	Insurer's Claim File No.	0539533496 2AL
Allstate Fire & Casualty Insurance Company (Respondent)	NAIC No.	29688

ARBITRATION AWARD

I, Charles Blattberg, 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: Eligible injured person

1. Hearing(s) held on 10/28/2020
   Declared closed by the arbitrator on 11/04/2020

   Roman Kulik, Esq. from Kulik Law Firm, PC participated by telephone for the Applicant

   Peter Graziosi, Esq. from Law Offices Of Karen L. Lawrence participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **$ 1,076.15**, 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

   The claimant was the 25 year-old female restrained driver of a motor vehicle that was involved in an accident on 3/16/19. Following the accident the claimant suffered injuries which resulted in the claimant seeking treatment. At issue is lower extremities EMG/NCV testing performed by Applicant on 4/24/19 that Respondent timely denied reimbursement for based on a 5/30/19 peer review by Bonnie Corey, D.C.

4. Findings, Conclusions, and Basis Therefor

Based on a review of the documentary evidence, this claim is decided as follows:

An applicant establishes a prima facie case of entitlement to reimbursement of its claim by the submission of a completed NF-3 form or similar document documenting the facts and amounts of the losses sustained and 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. See, *Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). I find that Applicant established a prima facie case for reimbursement.

The claimant was the 25 year-old female restrained driver of a motor vehicle that was involved in an accident on 3/16/19. The claimant reportedly injured her neck, left shoulder, mid back, low back, and bilateral knees. There was no reported loss of consciousness. There were no reported lacerations or fractures. There was no reported emergency treatment sought or received. On 3/25/19 the claimant presented to Angelo DiMaggio, D.C. of Touch Stone Chiropractic, P.C. (Applicant) with complaints of neck pain radiating into the left arm rated 10/10, mid back pain rated 9/10, low back pain radiating into the left leg rated 10/10, bilateral knee pain, and left shoulder pain. There was tenderness to digital palpation and muscle tension on both sides of the cervical spine. There was muscle hypertonicity present on both sides of the cervical spine. There was muscle spasm present on both sides of the cervical spine. Digital palpation for trigger points was positive in the cervical area. Multiple active trigger points were stimulated with moderate digital pressure to the cervical muscles and were associated with consistent referred pain. Trigger points were located on semispinalis capitis bilateral. Subluxations were noted at C2, C3, and C5. Cervical range of motion was restricted in all planes (quantified). There was general weakness in the neck flexors and neck extensors. Positive orthopedic tests were Cervical Depression, Shoulder Depression, Soto-Hall, Distraction, Jackson's, Lindner's, and Valsalva's. Biceps reflex evaluating C5-6 roots was 2+ on the right and 1+ on the left, triceps reflex evaluating C7-8 roots was 2+ on the right and 1+ on the left, and brachioradialis reflex evaluating C5-6 roots was 2+ on the right and 2+ on the left. Pinwheel testing of the C5 dermatome on the left demonstrated decreased sensation when compared to the opposite side. There was general weakness in the left biceps. There was tenderness to digital palpation and muscle tension on both sides of the thoracic spine. There was muscle hypertonicity present on both sides of the thoracic spine. There was muscle spasm present on both sides of the thoracic spine. Digital palpation for trigger points was positive in the thoracic area. Multiple active trigger points were stimulated with moderate digital pressure to the thoracic muscles and are associated with consistent referred pain. Trigger points were located on parathoracic bilateral. Subluxations were noted T6 and T7. There was tenderness to digital palpation and muscle tension on both sides of the lumbar spine. There was muscle hypertonicity present on both sides of the lumbar spine. There was muscle spasm present on both sides of the lumbar spine. Digital palpation for trigger points was positive in the lumbar area. Multiple active trigger points were stimulated with moderate digital pressure to the lumbar muscles and are associated with consistent referred pain. Trigger points were located on paralumbar bilateral and quadratus lumborum bilateral. Subluxations were noted at L1, L3, and L5. Lumbar range of

motion was restricted in all planes (quantified). There was general weakness in the lumbar flexors, lumbar extensors, and left quadriceps femoris. Positive orthopedic tests were Kemp's, Valsalva's, Braggard's Sign, and Milgram's. The claimant couldn't walk on heels or toes. Patellar reflex evaluating L2-4 roots was 2+ on the right and 1+ on the left. Pinwheel testing of the L2 and L5 dermatome on the left demonstrated increased sensation when compared to the opposite side. There was tenderness to digital palpation and muscle tension on the left shoulder. There was tenderness to digital palpation and muscle tension on both knees. The claimant was initiated on chiropractic treatment. On 3/29/19 the claimant presented to Jordan Fersel, M.D. with complaints of headaches, insomnia, neck pain and stiffness rated 10/10, upper back pain and stiffness, and low back pain and stiffness rated 10/10, and bilateral knee pain rated 10/10. Cervical examination revealed tenderness and muscle spasms. Flexion and extension were normal. Thoracic examination revealed tenderness and muscle spasms. Lumbar examination revealed tenderness and muscle spasms. Extension was 75/90° and extension was 25/30°. Kemp's test was positive. Knee examination revealed a normal range of motion and tenderness. The claimant was recommended for physical therapy. On 4/24/19 Dr. DiMaggio conducted an examination (*see rebuttal below*) preliminary to upper extremities and lower extremities EMG/NCV testing that were performed the same day that suggested evidence consistent with right median sensory neuropathy and right C5-6 cervical radiculopathy; and bilateral L5- S1 lumbosacral radiculopathy. At issue is the 4/24/19 lower extremities EMG/NCV testing.

The burden has shifted to the Respondent as they have raised a medical necessity defense. In order to support a lack of medical necessity defense Respondent must "set forth a factual basis and medical rationale for the peer reviewer's determination that there was a lack of medical necessity for the services rendered." See, *Provvedere, Inc. v. Republic Western Ins. Co.*, 2014 NY Slip Op. 50219(U) (App. Term 2nd, 11th and 13th Jud. Dists. 20140. Respondent bears the burden of production in support of its lack of medical necessity defense, which if established shifts the burden of persuasion to Applicant. See generally, *Bronx Expert Radiology, P.C. v. Travelers Ins. Co.*, 2006 NY Slip Op. 52116 (App. Term 1st Dept. 2006). As a general rule, reliance on rebuttal documentation will be weighed in light of the documentary proofs and the arguments presented at the arbitration. Moreover, the case law is clear that a provider must rebut the conclusions and determinations of the IME/peer doctor with his own facts. *Park Slope Medical and Surgical Supply, Inc. v. Travelers*, 37 Misc.3d 19 (2012).

At the hearing it was noted that Respondent uploaded a 7/19/19 general denial based on the assignor's failure to appear for an Independent Medical Examination (IME) on 6/7/19 and 7/1/19. Respondent also uploaded an 11/7/19 general denial based on the assignor's failure to appear for an Examination Under Oath (EUO) on 8/16/19 and 9/4/19. Respondent submitted documents in support of both IME and EUO no show defenses. While I am aware that in *Unitrin Advantage Ins. Co. v. Bayshore Physical Therapy, PLLC*, 82 AD3d 559 (App Div 1st Dept. 2011) lv denied 17 NY3d 705 (2011), the Appellate Division, First Department held that a defense predicated upon an assignor's failure to appear for EUOs was a lack of coverage defense not precluded by an untimely denial and did sustain the insurer's defense where it only issued a general denial, I find that the holding in *Unitrin* is inconsistent and contrary to the decision of the Appellate Division, Second Department in *Westchester Med Center v. Lincoln*

General, 60 AD3d 1045 (App Div 2d Dept 2009). In *Westchester Med Center*, the Second Department noted the failure of a plaintiff's assignor to appear at an EUO did not serve to toll the thirty day period to pay or deny a claim citing *Mt. Sinai Hosp. v. Triboro Coach*, 263 AD 2d 11, 17 (2d. Dep't, 1999) and noting that such an alleged breach of a policy condition does not serve to vitiate the medical provider's right to recover no-fault benefits or to toll the thirty day statutory period. Further, the court noted that such a denial was subject to the preclusion remedy citing to *Central Gen. Hospital v. Chubb Group of Insurance Co.*, as well as *Zappone v. Home Insurance Co.*, 55 NY 2d 131, 136- 137 (1982). In this matter I am inclined to follow *Westchester Med Center*.

In *Matter of Pomona Pain Mgt., P.C. v. Praetorian Ins. Co.*, 2012 NY Slip Op. 30525(U) (Sup Ct Nassau Cty 2012), the insurer sought the court's review, pursuant to CPLR Article 75, of a master arbitrator's award affirming a lower arbitration award issued by Arbitrator Bianchino wherein he precluded Respondent's untimely IME no-show defense. Judge Winslow noted the First Department's decision in *Unitrin* and the Second Department's decision in *Westchester Med Center* appeared in conflict, and sustained Master Arbitrator Merani's award, noting there was sufficient conflicting authority to preclude the finding of an error of law warranting vacatur.

The burden has shifted to the Respondent as they have raised a medical necessity defense. In order to support a lack of medical necessity defense Respondent must "set forth a factual basis and medical rationale for the peer reviewer's determination that there was a lack of medical necessity for the services rendered." See, *Provvedere, Inc. v. Republic Western Ins. Co.*, 2014 NY Slip Op. 50219(U) (App. Term 2nd, 11th and 13th Jud. Dists. 20140. Respondent bears the burden of production in support of its lack of medical necessity defense, which if established shifts the burden of persuasion to Applicant. See generally, *Bronx Expert Radiology, P.C. v. Travelers Ins. Co.*, 2006 NY Slip Op. 52116 (App. Term 1st Dept. 2006). As a general rule, reliance on rebuttal documentation will be weighed in light of the documentary proofs and the arguments presented at the arbitration. Moreover, the case law is clear that a provider must rebut the conclusions and determinations of the IME/peer doctor with his own facts. *Park Slope Medical and Surgical Supply, Inc. v. Travelers*, 37 Misc.3d 19 (2012).

Respondent timely denied the subject electrodiagnostic testing based on the 5/30/19 peer review by Bonnie Corey, D.C. After reviewing the claimant's history, treatment, and medical records, Dr. Corey opines "there was no substantiation in the medical records or reports for the referral for the clinical medical decision for EMG/NCV testing of the upper extremities in this particular case from a chiropractic standpoint. The records do establish chiropractic treatment as the primary component of the therapeutic care plan and reflect that chiropractic treatment was rendered without reference to or dependence upon any electrodiagnostic testing results. This test was not needed to make a diagnosis of nerve root compression or radiculopathy or radiculitis, which can be made clinically. There was no diagnostic dilemma that required an electrodiagnostic evaluation. There was no indication from the records that a diagnosis of neuropathy needed to be confirmed based upon the clinical presentation of this claimant. There was no progressive neurological decline including severe muscle weakness, sensory disturbances, and atrophy. There was no inexplicable symptomatology. A sensory

evaluation, motor testing, palpation and ranges of motion are part of a complete detailed examination. This testing was not necessary to provide conservative management for the musculoskeletal soft tissue injuries that were sustained. There was no unexplained peripheral neuropathy with pain of a neuropathic pattern, demonstrated sensory loss, or motor loss on physical examination. There was no clinical evidence of any progressive radiculopathy with clinical documentation showing 4-6 weeks of failed conservative therapy, including physical therapy AND where the etiology of the radicular symptoms is not explained. This is obviously not the case with this particular claimant." Dr. Corey continues "as stated in the guidelines of The American Association of Electrodiagnostic Medicine (Chong and Cros, 2004) "electrodiagnostic studies should not be performed in the information will not potentially enhance the patient's care." EMG/NCV testing may be helpful by determining the functional significance of known suspected compressive lesions of the nervous system in cases in which the claimant is being considered for de-compressive surgery with associated neurological deficits and progressive decline. As stated in the guidelines of The American Association of Electrodiagnostic Medicine (Chong and Cros, 2004) "Indications for EDX testing is used to evaluate the integrity and function of the peripheral nervous system (most cranial nerves, spinal roots, plexi, and nerves), NMJ, muscles, and the central nervous system (brain and spinal cord). EDX testing is performed as part of an EDX evaluation for diagnosis or as follow-up of an existing condition." The referral guidelines for Electrodiagnostic Medicine Consultations (2004) also indicate "the electrodiagnostic studies are a supplement to, not a replacement for, a careful history and physical examination. Electrodiagnostic studies will not be helpful with pain results from joint disease." As per the New York Neck and Low Back Injury Medical Treatment Guidelines, Third Edition, September 15, 2014, Electrodiagnostic Testing (EDX): "EDX include needle EMG, peripheral nerve conduction velocity studies and motor and sensory evoked potentials if significant radiating arm or leg symptoms are present for greater than 4-6 weeks after the onset of injury and no obvious level of nerve root dysfunction is evidence on exam, electrodiagnostic studies may be indicated. Electrodiagnostic studies may also be useful to determine the extent of injury in patient with an established level of injury."" Dr. Corey concludes "there was clearly no clinical necessity for any electrodiagnostic testing in this particular case with regards to continued chiropractic treatment management. The records reviewed in this case do not suggest that this claimant is a pre-surgical candidate. This claimant did not require more aggressive treatment to the cervical and lumbar spine as a result of the EMG/NCV testing such as surgery. The type of treatment being rendered with chiropractic and physical therapy treatment was not dependent upon the results of the electrodiagnostic studies. There was no indication that this claimant was not progressing with conservative treatment and/or is getting worse or has symptoms out of proportion to the findings noted on the comprehensive physical examination."

Where the Defendant insurer presents sufficient evidence to establish a defense based on lack of medical necessity, the burden shifts to the Plaintiff which must then present its own evidence of medical necessity (see Prince on Evidence section 3-104, 3-202). *West Tremont Medical Diagnostic PC v. Geico*, 13 Misc.3d 131, 824 N.Y.S. 2d 759.

Applicant submitted a 7/16/19 peer rebuttal by Angelo DiMaggio, D.C. who asserts "in determining to proceed with EDX testing I followed NYS WCB Mid and Lower Back

Medical Treatment Guidelines, NYS Neck Injury Medical Treatment Guidelines, recommending electrodiagnostic studies (EDS) "where there is failure of suspected radicular pain to resolve or plateau after waiting 4 to 6 weeks (to provide for sufficient time to develop EMG abnormalities as well as time for conservative treatment to resolve the problems), the EDX studies was established to perform for this patient due to chronic pain, various problems and/or deficits caused by injuries in the car accident. The patient lingering complaints, history, and objective findings reveal a mixed clinical presentation of a whiplash injury and/or plexopathy without fractures or dislocations." Dr. DiMaggio avers "the claimant was examined by me on 04/24/2019. At the time, the patient complained of severe neck pain radiating to the left arm with a grade pain of 9/10, moderate-severe mid back pain with a grade pain of 7/10, and severe lower back pain radiating to the left leg with a grade pain of 9/10. In addition, the patient also mentioned experiencing pain in her left shoulder and both knees. Examination of the lumbar spine revealed tenderness to digital palpation and muscle tension on both sides of the lumbar spine, in addition to muscle hypertonicity and muscle spasm. Digital palpation for trigger points was positive in the lumbar area with trigger points being located on the paralumbar bilateral. Examination of the patient's knees revealed tenderness to digital palpation and muscle tension on both knees. Subluxations were noted at the L2 and L4 levels and the sacrum. ROM of the lumbar spine was reduced in all ranges with pain: flexion of 35/60, extension and bilateral lateral of 15/25, and bilateral rotation of 25/45. [*The claimant*] also reported lower back pain on flexion, extension, lateral bending bilaterally, and rotation bilaterally. Manual muscle testing of the lumbar spine revealed lumbar flexors and lumbar extensors were grade 2 with generalized weakness. Manual muscle testing of the lower extremities revealed the quadriceps femoris muscles were grade 3 on the right and grade 2 on the left with generalized weakness. Further testing of the lumbar spine revealed positive results for the following tests: Kemp's, Valsalva's, Braggard's, and Milgram's. It was also observed that the claimant could not walk on her heels and toes. Deep tendon reflexes were also evaluated, revealing that the patellar reflex evaluating L2-4 roots was 1+ on the left. Pinwheel testing of the L2 and L5 dermatome on the left revealed decreased sensation when compared to the opposite side." Dr. DiMaggio continues "electrodiagnostic study is an essential extension of the clinical examination for the reasons that it is essential for patients with pain to differentiate between nerve injury due to nerve entrapment, plexopathy or radiculopathy in cases of radiating pain and paresthesia (Preston, D.C., M.D., Electromyography and Neuromuscular Disorder, 2005) and electrodiagnostic study provides helpful information in the evaluation of motor, sensory and autonomic neurons, nerve roots, brachial and lumbar plexi, peripheral nerves, neuromuscular junction and muscle (American Association of Neuromuscular & Electrodiagnostic Medicine, Referral Guidelines for Electrodiagnostic Medicine Consultations, August 1996). [*The claimant*] had an obvious presentation of the traumatic lumbar sprain/strain with myofascitis and/or radiculopathy, both of which may cause local and radiating pain and change skin sensation over the involved muscles and in the areas of pain radiation. Differentiating a radiculopathy from a more distal lesion is clinically difficult because the clinical presentation for both conditions is very similar and/or they could coexist. "The major use of electromyography is to diagnose radiculopathy in cases where it is uncertain whether the patient has any neurologic lesion, or in distinguishing cervical/lumbar radiculopathy from other lesions where they cannot be distinguished clinically." (Cervical Radiculopathy, Ellenberg, M.D., Maury R., Honet, Joseph, M.D.

Treanor, Walter, M.D., ArchPhysMedRehabil Vol.75, March 1994.)" Dr. DiMaggio opines "although radiculopathy can be diagnosed clinically, at times, there are circumstances, as in this case, where the neurological deficits, as mentioned above, have overlapping symptoms of radiculopathy and neuropathy. These two conditions require a different treatment plan as well as different period of time of such treatment. In my opinion, EMG/NCV studies were necessary in order to rule out lower radiculopathy. Presented clinical radiculopathy may be limited to a solitary myelin sheath compression (neuropraxic) or may also progress to axonal loss (axonometric). Neuropraxic lesions heal in weeks, do not cause residual neurological deficits and do not require invasive treatment. Axonometric lesions heal in months, may cause neurological deficits and may require invasive treatments. The differentiation between them is extremely difficult based on history and physical exam findings only. Therefore, EMG/NCV was necessary in order to, at the very least, confirm radiculopathy by eliminating any potential neuropathy. If there is an axonal loss found on electrodiagnostic study, a decision of choosing the most efficient treatment plan and accurate determination of the patient's prognosis will be possible. If the study reveals positive findings it will also allow to establish the precise spinal nerve root entrapment, address this specific segment (or these segments) in further conservative treatments (chiropractic manipulations, Williams or McKenzie back exercise program, spinal distraction procedures, etc.) or may require consultation of a neurosurgeon." Dr. DiMaggio concluded "based on the above mentioned reasoning, it is my opinion that the patient was in need of EMG/NCV testing of the Lower Extremities performed on 04/24/2019 for treatment of her pain and therefore all associated services in relation to the procedure were necessary. Therefore, the procedure was medically necessary and the testing does not violate medical protocol and deserves to be reimbursed by the respondent."

Respondent submitted a 9/13/19 peer addendum by Bonnie Corey, D.C. In regard to the 7/16/19 peer rebuttal (*see above*) Dr. Corey opines "there is no new clinical information provided to warrant the medical necessity in this particular case based upon the clinical presentation of this claimant and for continued chiropractic treatment management. I have reviewed my report dated 5/30/19 and the records contained therein and found my determination was accurate and cannot be changed. There was a clear clinical neurological picture of this claimant. The AANEM does NOT support screening testing. The standard of care in medicine does not involve the routine use of electrodiagnostic testing unless there is deterioration in the condition. As stated in the guidelines of the American Association of Electrodiagnostic Medicine "electrodiagnostic studies should not be performed in the information will not potentially enhance the patient's care."" Dr. Corey concludes "the records reviewed in this case do not suggest that this claimant is a pre-surgical candidate. This claimant did not require more aggressive treatment to the cervical and lumbar spine as a result of the EMG/NCV testing such as surgery. The type of treatment being rendered with chiropractic and physical therapy treatment was not dependent upon the results of the electrodiagnostic studies."

After reviewing all the evidence and listening to the oral arguments of the parties I find that Dr. DiMaggio's peer rebuttal specifically addresses the points set forth by Dr. Corey and rebuts them with a contrary medical rationale. Applicant demonstrated that the performance of the 4/24/19 EMG/NCV testing of the lower extremities was within generally accepted medical standards and established that the services were medically

necessary. The medical rationale proffered by Applicant is sufficient to meet the burden of persuasion in rebuttal.

Accordingly, Applicant is awarded $1,076.15.

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**
	Touch Stone Chiropractic P.C.	**04/24/19 - 04/24/19**	**$1,076.15**	**Awarded: $1,076.15**
Total			**$1,076.15**	**Awarded: $1,076.15**

B. The insurer shall also compute and pay the applicant interest set forth below. 07/25/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest runs from 7/25/19 (the date that arbitration was requested) until the date that payment is made at two percent per month, simple interest, on a pro rata basis using a thirty day month.

C. Attorney's Fees

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

Pursuant to 11 NYCRR §65-4.6 (d), ". . . 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 for arbitration or court proceeding, 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, Charles Blattberg, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

12/07/2020
(Dated)

Charles Blattberg

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:
80e34c4fb799ad8a3e04bfa7ff33c73c

Electronically Signed

Your name: Charles Blattberg
Signed on: 12/07/2020