

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Dean Chiropractic, PC
(Applicant)

- and -

American Transit Insurance Company
(Respondent)

AAA Case No. 17-19-1138-6440

Applicant's File No. QCD-0265

Insurer's Claim File No. 1046672-04

NAIC No. 16616

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 11/18/2020
Declared closed by the arbitrator on 11/25/2020

Gil S. Schapira, Esq. from The Law Office of Gill S. Schapira, P.C participated by telephone for the Applicant

Erisa Ahmedi, Esq. from of counsel to Daniel J. Tucker, P.C. participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 2,428.99**, 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 a 49 year-old male rear seat passenger of a motor vehicle that was involved in an accident on 12/25/18. Following the accident the claimant suffered injuries which resulted in the claimant seeking treatment. At issue is the medical necessity of an office visit and electrodiagnostic testing performed by Applicant on 1/22/19 that Respondent timely denied reimbursement for based on a 5/13/19 peer review by David Trimboli, 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 a 49 year-old male rear seat passenger of a motor vehicle that was involved in an accident on 12/25/18. The claimant reportedly injured his neck and low back. There was no reported loss of consciousness. There were no reported lacerations or fractures. Following the accident the claimant was transported to Elmhurst Hospital where he was evaluated, treated, and released. On 1/2/19 the claimant presented to James Flannigan, D.C. of Health Balance Medical, P.C. with complaints of neck pain rated 4-5/10 and low back pain rated 4-5/10. Cervical examination revealed trigger points, muscle spasms, and restricted range of motion in all planes (quantified). Lumbar examination revealed trigger points, muscle spasms, and restricted range of motion in all planes (quantified). Positive orthopedic tests were Maximum Cervical Compression, Cervical Distraction, Soto Hall, Kemp's, Valsalva, SLR, and Spurling's. Sensation, deep tendon reflexes, and manual muscle strength were normal. The claimant was initiated on chiropractic treatment and was recommended for a cervical traction unit and custom fitted LSO with APL control. On 1/2/19 the claimant presented to Apple Acupuncture, P.C. with a swollen bluish tongue with a sticky white coating and wiry pulse. The claimant was initiated on acupuncture and infrared treatment. On 1/3/19 the claimant presented to Mani Ushyarov, D.O., M.D. with complaints of neck pain rated 4-5/10 with radiation to the right shoulder and low back pain rated 5/10 with radiation to the left leg. Cervical examination revealed muscle spasms and restricted range of motion in all planes (quantified). Foramina Compression test was positive. Lumbar examination revealed muscle spasms and restricted range of motion in all planes (quantified). Straight leg raise was positive bilaterally. Manual muscle strength was normal (5/5); except 4/5 in the lower left extremity. Sensation and deep tendon reflexes were normal. The claimant was recommended for physical therapy, trigger point injections, consultation with a neurologist, ROM testing, and Outcome Assessment (OSWESTRY) Testing. On 1/22/19 Dean Mauro, D.C. of Dean Chiropractic, P.C. (Applicant) conducted an examination preliminary to upper extremities and lower extremities EMG/NCV testing performed the same day that suggested evidence consistent with mild right sensory demyelinating median nerve neuropathy at the wrist consistent with the clinical diagnosis of Carpal Tunnel Syndrome and right C5-C6 radiculopathy. The claimant presented with complaints of neck pain and stiffness radiating to the bilateral shoulders rated 6/10 and lower back pain and stiffness radiating to the bilateral legs rated 6/10; both with associated numbness and tingling. Examination of the cervical spine revealed tenderness, muscle spasms, trigger points and range of motion restricted in all planes (quantified). Examination showed sensory deficit in the distributions of the

bilateral C4-C5 dermatomes. Examination of the lumbar spine revealed tenderness, muscle spasms, trigger points and range of motion restricted in all planes (quantified). Examination showed sensory deficit in the distributions of the bilateral L3-L4 dermatomes. Straight Leg Raise test was positive bilaterally. Neurological evaluation revealed muscle weakness 4/5 that was noted in wrist extensors (C6), hip abductors (L3), and knee extensors (L4). Deep tendon reflexes were diminished +1/2 in the biceps bilaterally, brac/rad on the right side, and patella bilaterally. Sensation was decreased in C4-C5 nerve roots bilaterally in the upper extremities and in L3-L4 nerve roots bilaterally in the lower extremities. At issue is the 1/22/19 office visit and diagnostic testing performed by Applicant.

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 (in light of verification requested and received) denied the subject diagnostic testing and office visit based on the 5/13/19 peer review by David Trimboli, D.C. After reviewing the claimant's history, treatment, and medical records, Dr. Trimboli opines "the nerve testing of the upper and lower extremities and office visit performed on date of service 01/22/19 by provider Dean Chiropractic, P.C., were not medically necessary." Dr. Trimboli asserts "the initial evaluation dated 01/22/19 by Dr. Mauro revealed motor (4/5), sensory (decreased) and reflex (decreased) changes. The evaluation was performed within 8 weeks of the accident. The neurological findings were "non-specific" as it normally takes many weeks or months for true objective neurological deficit to manifest on physical exam findings which was not the case for this claimant. The subjective complaints were neck, low back, and bilateral shoulder pain. There was no significant past medical or surgical history noted and the claimant was not taking any medication. History, subjective complaints and physical exam findings were consistent with a sprain/strain injury of the spine and he was recommended for nerve testing and chiropractic care. It was unclear how nerve testing would alter the treatment plan as there was no indication the claimant was a candidate for surgery or epidural injection at this time. In addition, the nerve testing was performed with less than 6 weeks of conservative treatment which would not be standard of care. It appears that the referring physician was mainly seeking a nerve test and the purpose of the office visit (consultation) was mainly for performing the nerve testing. The office visit (consultation) history and physical examination performed on the same date as the nerve test is merely an extension of the nerve test itself and should not be reimbursed separately... There was no medical necessity for the nerve testing of

the upper and lower extremities performed on date of service 01/22/19. Dr. Trimboli continues an EDX "evaluation is an important and useful extension of the clinical evaluation of patients with disorders of the peripheral and/or central nervous system. EDX tests are often crucial to evaluating symptoms, arriving at a proper diagnosis, and in following a disease process and its response to treatment in patients with neuromuscular (NM) disorders. Unfortunately, these studies have occasionally been abused by some providers, resulting in overutilization and inappropriate consumption of scarce health resources. The peer-review mechanism should be triggered when patterns of EDX test utilization significantly and consistently deviate from established norms for quantity and variety of procedures... EDX studies are performed by physicians, almost exclusively neurologist and physiatrists, as part of an EDX evaluation. The AANEM believes that non-physician providers, including physical therapists, chiropractors physician assistants, and others, lack the appropriate training and knowledge to perform and interpret EMG studies and interpret NCSs. EDX evaluations include history-taking, appropriate physical examination, and the design, performance, and interpretation of EDX studies. EDX studies are an important means of diagnosing motor neuron diseases, myopathies, radiculopathies, plexopathies, neuropathies, and NMJ disorders (e.g., myasthenia gravis and myasthenic syndrome). EDX studies are also useful when evaluating tumors involving an extremity, the spinal cord, and/or the peripheral nervous system, and in neurotrauma, low-back pain, and spondylosis and cervical and lumbosacral disc diseases. The performance of NCSs without needle EMG has the potential of compromising patient care. It is the AANEM's opinion that it is in the best interest of patients, in the majority of situations, for the needle EMG and the NCS examination to be conducted and interpreted on site in real time. The accuracy of needle EMG testing is dependent on the skill of the examiner. Thus, this evaluation constitutes the practice of medicine. For these reasons, it is the position of the AANEM, along with the American Medical Association, the American Academy of Neurology, the American Academy of Physical Medicine and Rehabilitation ... as well as many state medical boards, that only physicians (MD or DO) should perform needle EMG examinations. EDX physicians receive training during residency and/or in special EDX fellowships after residency devoted to the performance of these studies and their interpretation." Dr. Trimboli argues "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. EDX studies can provide information to: 1) identify normal and abnormal nerve, muscle, motor or sensory neuron, and NMJ functioning; 2) localize region(s) of abnormal function; 3) define the type of abnormal function; 4) determine the distribution of abnormalities; 5) determine the severity of abnormalities; 6) estimate the date of a specific nerve injury; 7) estimate the duration of the disease; 8) determine the progression of abnormalities or of recovery from abnormal function; 9) aid in diagnosis and prognosis of disease; 10) aid in selecting treatment options; 11) aid in following response to treatment by providing objective evidence of change in NM function; and 12) localize correct locations for injection of intramuscular agents (e.g., botulinum toxin). NERVE CONDUCTION STUDIES (NCS) OVERVIEW: a typical NCS examination includes the following: 1) development of a differential diagnosis by the EDX physician, based upon appropriate history and physical examination; 2) completion of indicated needle EMG studies to evaluate the differential diagnosis and to

complement the NCSs; and 3) motor, sensory, and mixed NCSs and late responses (F-wave and H-reflex studies) are frequently complementary and performed during the same patient evaluation. **NEEDLE ELECTROMYOGRAPHY (EMG) OVERVIEW:** this portion of the EDX evaluation should always be performed by the physician. A typical EMG examination includes the following: 1) development of a differential diagnosis by the EDX physician, based upon appropriate history and physical examination; 2) completion of indicated NCSs to evaluate the differential diagnosis and to complement the needle EMG studies; 3) needle EMG testing of selected muscles. The final interpretation of the study is a synthesis by the EDX physician of the patient's history, physical examination, and the preceding and following portions of the study. **Late H-REFLEX and F-WAVE STUDIES:** 1) late responses are performed to evaluate nerve conduction in portions of the nerve more proximal (near the spine); 2) F-wave and H-reflex studies provide information in the evaluation of radiculopathies, plexopathies, polyneuropathies (especially with multifocal conduction block or in suspected Guillain-Barre syndrome or chronic inflammatory demyelinating polyneuropathy), and proximal mononeuropathies; 3) H-reflex studies usually must be performed bilaterally because symmetry of responses is an important criterion for abnormality; 4) bilateral gastrocnemius/soleus H-reflex abnormalities are often early indications of spinal stenosis, or bilateral S1 radiculopathies... radiculopathies cannot be diagnosed by NCS alone; needle EMG must be performed to confirm a radiculopathy." Dr. Trimboli concludes the minimum standard is "1) EDX testing should be medically indicated; 2) the needle EMG examination must be performed by a physician specially trained in EDX medicine. NCSs should not be performed without needle EMG except in unique circumstances; 3) it is appropriate for only 1 attending physician to perform or supervise all of the components of the EDX testing (e.g., history taking, physical evaluation, supervision and/or performance of the EDX test, and interpretation) for a given patient and for all the testing to occur on the same date of service." "Recommended Policy for Electrodiagnostic Medicine" American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM; updated July 17, 2017). Note: the history and exam findings were indicative of a sprain/strain condition and they do not support any realistic differential diagnoses which would require this nerve test. The standard of care for a sprain/strain injury is conservative treatment (eg physical therapy, chiropractic care, anti-inflammatory medications, home exercise program, etc). There were no significant progressive neurological deficits, treatment response to conservative care or "red flags" (eg bowel/bladder dysfunction; paralysis; etc). This type of nerve test should not be performed if the information will not potentially enhance the patient's care and/or provide additional information which could not have been obtained from a thorough history and physical examination alone. The records reviewed do not indicate that this form of electrodiagnostic testing was needed to direct or modify the claimant's treatment in any medically significant way (eg. epidural steroid injection, surgical intervention, changed in therapy, etc) as there was no indication in the records of any plausible and realistic treatment plan that was under consideration at the time of the testing that would have been dependent upon the nerve testing results. The claimant had a sprain/strain and contusion/strain injury which would not require this type of nerve test to differentiate (eg. radiculopathy, myopathy [eg muscular dystrophy], peripheral neuropathy [eg ETOH, DM, medications], neuromuscular junction disorder [eg myasthenia gravis], polyneuropathy [eg diabetes], entrapment syndrome [eg carpal tunnel syndrome], etc); hence, there was no medical necessity for this test."

If 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, *West Tremont Medical Diagnostic P.C., v. Geico*, 13 Misc.3d 131 (A), 824 NYS 2d 759 (App. Term 2d & 11th Dists, 2006).

Applicant submitted a 5/30/19 peer rebuttal by Dean Mauro, D.C. After reviewing the claimant's history, treatment, and medical records, Dr. Mauro asserts "with respect to Dr. Trimboli's opinion that chiropractors should not recommend, and perform EMG/NCV testing, I would like to note the following, First, if Dr. Trimboli, a chiropractor, did, in fact, ever perform EMG/NCV testing on a patient, its mere performance would be contradictory to his above statement. If he never performed EMG/NCV testing because he felt that a patient should be referred to a neurologist or Board-Certified Rehabilitation Specialist, it is fair to say that there is a legitimate question as to whether Dr. Trimboli is certified to perform EMG/NCV testing, and in essence, whether he is qualified to opine on the issue of whether the EMG/NCV testing of the upper and lower extremities was medically necessary...I would like to state that I am a chiropractor who is licensed to perform EMG/NCV testing, and the AANEM did not issue any statements prohibiting properly licensed chiropractors from performing EMG/NCV testing. That being said, Dr. Trimboli did not claim that my performance of that Tests deviated from the relevant standard practice of care. Second, the fact that Dr. Trimboli, a chiropractor himself, felt that such Testing should not be performed by chiropractors, but rather by physicians, makes me wonder whether he is licensed to perform such Testing in the first place, and therefore, whether he is qualified to opine on whether the EMG/NCV of the upper and lower extremities were medically necessary in this case." Dr. Mauro continues "Dr. Trimboli's opinion regarding the timeline is vague and conclusory, and not supported by any medical/chiropractic authority. Dr. Trimboli's opinion, standing alone, is insufficient to carry his burden of proving that the EMG/NCV testing was not medically necessary. His opinion is more likely to establish a lack of medical necessity when he provides some reference to the standards in the applicable medical community for these services and treatment at issue with an explanation as to when such services and treatment would be medically appropriate with objective criteria and an explanation why it was not medically necessary in this case. Dr. Trimboli failed to cite an authoritative source that under the medical facts would conclude it was inconsistent with good and accepted practice to perform the EMG/NCV testing in this case. Dr. Trimboli had to demonstrate that the services I rendered were not in agreement with the generally accepted medical/professional practice. Generally accepted standards of medical practice" means standards that are based on the credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment. In this particular case, and with regards to the above statement, Dr. Trimboli did not establish that I deviated from the generally accepted standards of medical/chiropractic practice in performing the EMG/NCV testing of the upper and lower extremities in this case." Dr. Mauro opines "Dr. Trimboli claimed that there was no abnormality on the neurological examination to point to a true peripheral nerve involvement, and there was no progressive neurological deterioration. He also claimed that there was no plausible differential diagnosis to warrant this type of testing as there was nothing to indicate need to differentiate radiculopathy, peripheral

neuropathy, plexopathy, myopathy, neuromuscular junction conditions, etc. He further claimed that there was no indication that this form of electrodiagnostic testing was needed to direct or modify the claimant's treatment in any medically significant way (e.g. epidural steroid injection, surgical intervention, etc.) as there was no indication of any plausible and realistic treatment plan that was under consideration at the time of the testing that would have been dependent upon the nerve testing results...I am a chiropractor, in this case the EMG/NCV testing was not recommended and performed in order to necessarily affect chiropractic treatment alone. [*The claimant*] was referred to me from Mani Ushyarov, D.O., M.D. to evaluate him and determine whether EMG/NCV of the upper and lower extremities was warranted in this case. In the usual course of business, a medical doctor's office would contact me to see and examine a particular patient in order to determine whether it is necessary to perform EMG/NCV testing. The basis for such requests is that the medical provider wants to be assured that in light of the fact that her/his patient had not responded successfully to conservative treatment for several weeks, there is no significant nerve root or peripheral nerve issues before considering more invasive treatments. Before examining such a patient, I review the patient's medical file that is provided to me by said medical office. In cases where the Testing is performed, following the performance of the EMG/NCV, as with all my patients, the respective patient is told to follow-up with her/his primary physician as soon as possible. Said test results are mailed to the respective primary physician between 2-4 days after its performance, as is customary in my practice. With respect to this case, I was contacted by Dr. Ushyarov's front desk secretary (at Dr. Ushyarov's request) to examine [*the claimant*] on 01/22/2019 and determine whether the performance of EMG/NCV testing of the upper and lower extremities was needed. In this case, EMG/NCV testing the upper and lower extremities were recommended and performed. At the conclusion of said Testing, [*the claimant*] was told to follow-up with Dr. Ushyarov as soon as possible. Said test results were mailed to Dr. Ushyarov between 2-4 days after its performance, as is customary in my practice. In this case, I recommended the EMG/NCV testing since [*the claimant's*] examination demonstrated ongoing symptoms and a developed differential diagnosis (as discussed below). Specifically, based on the outcome of my examination of 01/22/2019, I recommended the EMG/NCV testing of the upper and lower extremities to confirm the diagnosis of radiculopathy and rule out peripheral neuropathy. Those recommendations, which included other treatment options, were intended for Dr. Ushyarov, as he was seeing [*the claimant*] on a more regular basis and I assume was monitoring his present and future conservative treatment protocol." Dr. Mauro concludes in this case, there was a valid question of differential diagnosis and the question could not be resolved on the grounds of neurological examination alone. Specifically, in this case there was differential diagnosis based on the above-mentioned neurological deficits that have overlapping symptoms of radiculopathy and neuropathy, EMG/NCV of the upper and lower extremities were ordered to determine localization and extent of peripheral nerve or nerve root damage to rule out cervical & lumbar radiculopathy. With respect to the clinical diagnosis of radiculopathy, the clinical information in this particular case was insufficient to objectively prove or disprove the diagnosis of radiculopathy, determine its location and assess its severity, include or exclude other serious coexisting morbidities that might have been present in this patient, all of these are simply impossible to achieve clinically since all the below conditions including radiculopathies and potential neuropathies present with very similar signs and symptoms, and the human

mind is not equipped to diagnose those conditions. Clinical diagnosis of radiculopathy is an essential prerequisite in the treatment of any patient, and an EMG test can actually prove it. Having said that, even if radiculopathy can be diagnosed clinically at times, in this case [*the claimant's*] neurological deficits had symptoms of both radiculopathy and neuropathy, and in this case, neuropathy could not be diagnosed clinically. Therefore, EMG/NCV was necessary in order to, at the very least, confirm or prove radiculopathy and rule out any potential neuropathy. 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 radiculopathy from other lesions where they cannot be distinguished clinically." See Cervical Radiculopathy, Ellenberg, M.D., Maury R., Honet, Joseph, M.D. Treanor, Walter, M.D., Arch Phys Med Rehabil Vol. 75, March 1994. With respect to the issue of how the EMG/NCV testing would aid any future treatment protocol, first of all, whether the EMG/NCV testing would aid or alter the future treatment protocol of a patient is not necessarily determinative of whether the performance of the EMG/NCV testing was medically necessary, in the first place. Second, Dr. Trimboli did not provide any medical/chiropractic authority and any factual analysis to support his opinion. Third, as I explain below, the Referral Guideline for Electrodiagnostic Medicine Consultation from the AANEM clearly offers a different standard regarding the effect of EMG/NCV testing results on future treatment protocol. As I mentioned above, although I am a chiropractor, in this case the EMG/NCV testing was not recommended and performed in order to necessarily affect chiropractic treatment alone. In this case I recommended the EMG/NCV testing since [*the claimant's*] examination demonstrated ongoing symptoms and a developed differential diagnosis (as discussed above). Specifically, based on the outcome of my examination of 01/22/2019, I recommended the EMG/NCV testing of the upper and lower extremities to confirm the diagnosis of radiculopathy and rule out peripheral neuropathy. Those recommendations, which included other treatment options, were intended for Dr. Ushyarov, as he was seeing [*the claimant*] on a more regular basis and I assume was monitoring his present and future conservative treatment protocol. As with any diagnostic testing, it is imperative to ultimately incorporate test results into a patient's future treatment protocol. Having said that, the suggested Guidelines (that I alluded to above) state that the tests should not be obtained if the information will not potentially enhance the patient's care. In this case, taking into account the above-mentioned neurological deficits and the fact that [*the claimant*] was not responding successfully to conservative treatment for several weeks, in light of the possibility of radiculopathy and/or neuropathy, one would expect that the testing results would, at least potentially, enhance [*the claimant's*] care. In light of the fact that neuropathy could not be diagnosed clinically in this case, there was no way for me to know in advance whether [*the claimant's*] care or management would be altered prior to performing the EMG/NCV of the upper and lower extremities. With regards to how the testing would potentially enhance [*the claimant's*] care, after the test results were reviewed, certain recommendations were made and were attached to the relevant test result(s) for Dr. Ushyarov to review. Those recommendations were not limited to chiropractic care. Whether Dr. Ushyarov actually made any alterations in his treatment protocol is beyond the scope of whether the performance of the EMG/NCV testing was medically necessary...with respect to being a candidate for surgical and/or epidural injections,

steroid injections, candidate, I would like to state that although being a pre-surgical and/or epidural injection candidate is one reason to refer a patient for such testing, there is no medical authority and/or guideline that state that the claimant must necessarily be such a candidate in order for the EMG/NCV testing to be medically necessary. The AANEM clearly states that EMG/NCV tests can define the type of abnormal function, determine distribution of abnormalities, determine severity of abnormalities, aide in the diagnosis and prognosis of the injury or disease, aide in following response to treatment, and identify abnormal nerves, motor or sensory neuron. Dr. Trimboli claimed that there were no progressive deficits or "red flags" (e.g. bowel/bladder dysfunction, paralysis, etc.) noted on physical examination. Apparently, the examples of "red flags" that Dr. Trimboli chose to highlight were some of the most extreme cases. Apparently, he conveniently neglected to note that peripheral neuropathy is also considered a "red flag" and peripheral neuropathy is discussed in this rebuttal extensively. Based on [*the claimant's*] persistent subjective complaints as well as positive neurological findings, EMG/NCV of the upper & lower extremities were recommended to determine localization and extent of peripheral nerve root injury. To better predict prognosis for recovery and possible residual neurological deficit. To administer appropriate therapy. To plan possible nerve blocks and/or neurosurgical consult. The electrodiagnostic study reveals evidence of a mild right sensory demyelinating median nerve neuropathy at the wrist. This is consistent with the clinical diagnosis of Carpal Tunnel Syndrome. The electrodiagnostic study reveals evidence of right C5-C6 radiculopathy. Accordingly, after the test results were reviewed, certain recommendations were made and were attached to the relevant test result(s). The EMG/NCV testing was appropriate and indicated for [*the claimant's*] because of the nature, severity, and persistency of his symptoms. On the basis of the EMG/NCV performed, his diagnosis was clarified and needed to be reviewed by his primary physician who would be expected to tailor his future treatment protocol and specifically treat the source of his injury. For all of these reasons, the EMG/NCV for [*the claimant's*] was medically necessary and should be reimbursed in full."

Here the evidence favors Respondent. In particular Dr. Mauro convincingly argues "the EMG/NCV testing was not recommended and performed in order to necessarily affect chiropractic treatment alone. [*The claimant*] was referred to me from Mani Ushyarov, D.O., M.D. to evaluate him and determine whether EMG/NCV of the upper and lower extremities was warranted in this case", despite the referring doctor section in the subject report being blank. Dr. Mauro explains that the referral was based on the "patient had not responded successfully to conservative treatment for several weeks." The claimant was examined by Dr. Ushyarov on 1/3/19. The examination revealed manual muscle strength was normal (5/5); except 4/5 in the lower left extremity. Sensation and deep tendon reflexes were normal. The only treatment prescribed was physical therapy. Trigger point injections were recommended but there is no report indicating they were performed. The medical reports in evidence indicate that the initial physical therapy examination was conducted on 4/2/19 and treatment sessions began on 4/3/19. There are no medical reports in evidence indicating Dr. Ushyarov conducted a follow-up examination between 1/3/19 and 1/22/19 where he might have determined the "patient had not responded successfully to conservative treatment," especially the physical therapy treatment that had not yet commenced. If Dr. Mauro's reference to conservative care references chiropractic treatment, it must be noted that both the 1/2/19 initial

examination and the 2/4/19 follow-up examination by Dr. Flannigan revealed sensation, deep tendon reflexes, and manual muscle strength were normal; in conflict with the 1/22/19 examination conducted by Dr. Mauro. I am persuaded by Dr. Trimboli's opinion that the subject diagnostic testing and office visit were medically unnecessary.

Accordingly, the 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 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.

12/30/2020
(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:
8d9b2a2972158d3fd2af3e2a9353eabe

Electronically Signed

Your name: Charles Blattberg
Signed on: 12/30/2020