

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Hudson Spine and Pain Medicine  
(Applicant)

- and -

Allstate Insurance Company  
(Respondent)

AAA Case No. 17-18-1109-7296

Applicant's File No. 3083751

Insurer's Claim File No. 0313972168  
2CG

NAIC No. 19232

**ARBITRATION AWARD**

I, Kevin R. Glynn, 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

1. Hearing(s) held on 12/30/2020  
Declared closed by the arbitrator on 12/30/2020

Melissa Scotti, Esq. from Costella & Gordon LLP participated in person for the Applicant

Adam J. Kass, Esq. from Peter C. Merani Esq. participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 2,144.48**, was AMENDED and permitted by the arbitrator at the oral hearing.

The amount in dispute was amended to \$510.44. The amended amount acknowledges the prior withdrawal of the charge for the office visit under CPT code 99204 25 and the prior payment in full of the charge under CPT code 95886 in satisfaction of the prior arbitration award under AAA Case No.: 17-15-1018-8236. The amended amount further reflects of the remaining charge under CPT code 95911 to \$510.44, the amount allowable under the appropriate Fee Schedule.

Stipulations WERE made by the parties regarding the issues to be determined.

Respondent stipulated that Applicant established a prima facie case and Applicant stipulated that Respondent issued a timely denial. Both parties stipulated that the amended amount in dispute conforms with the appropriate Fee Schedule.

### 3. Summary of Issues in Dispute

The Assignor, AH, is a 53yo male driver who was injured when involved in a motor vehicle accident on 12/29/17. WF suffered injuries which resulted in his seeking treatment. In dispute is the Applicant's remaining claim for electrodiagnostic tests (95911) performed on 4/25/14, in the total amended amount of \$510.44. The claim was denied based on a peer review report by Dr. Ayman Hadhoud, M.D., dated 5/22/14. Therefore, there is an issue regarding the medical necessity of the claim.

### 4. Findings, Conclusions, and Basis Therefor

This case was decided based upon the submissions of the Parties as contained in the electronic file maintained by the American Arbitration Association, and the oral arguments of the parties' representatives. There were no witnesses. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon. Only the arguments presented at the hearing are preserved in this decision; all other arguments not presented at the hearing are considered waived.

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 2, 11 and 13 Jud. Dists. 2014). 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 1<sup>st</sup> Dept. 2006). The Appellate Courts have not clearly defined what satisfies this standard except to the extent that "bald assertions" are insufficient. Amherst Medical Supply, LLC v. A Central Ins. Co., 2013 NY Slip Op 51800(U) (App. Term 1<sup>st</sup> Dept. 2013). To meet the burden of persuasion regarding medical necessity - in the absence of factually contradictory records - the applicant must submit a rebuttal which meaningfully refers to and rebuts the assertions set forth in the peer review report. See generally, Pan Chiropractic, P.C. v Mercury Ins. Co., 24 Misc 3d 136[A], 2009 NY Slip Op 51495[U] [App Term, 2d, 11th & 13th Jud Dists 2009].

Respondent's evidence established that the bill regarding the tests was timely denied pursuant to a peer review report by Dr. Ayman Hadhoud, M.D., dated 5/22/14. Dr. Hadhoud opines:

...The standard of care for EDS of musculoskeletal system including neck pain after a motor vehicle accident, in the absence of red flags, would consist of evaluation by a physician, prescribing activity modifications if necessary, encouraging return to activity as much as possible, prescription of medications such as anti-inflammatory

medications, and conservative physiotherapy for a period of 4-6 weeks, followed by another modified course of therapy and exercises program if the patient is not responding to the initial course of treatment. If the patient continues to exhibit subjective and objective findings that are consistent with a neurological lesion after the patient receives at least six week period of conservative management including physical therapy and exercises program, further imaging testing should be considered to explore the underlying cause of the patient's neurological presentation. Based on the finding of imaging studies, the need for further interventional procedure such as neurosurgery or epidural steroid injection would be determined.

The electrodiagnostic testing may be useful in cases where clinical findings are unclear; there is a discrepancy in imaging, or to identify other etiologies. According to New York State Workers' Compensation Board New York Mid and Low Back Injury Medical Treatment Guidelines 2010, section C.2.a.i: 18). "EDS is recommended 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), equivocal imaging findings, e.g. on CT or MRI studies, and suspicion by history and physical examination that a neurologic condition other than radiculopathy may be present instead of or in addition to radiculopathy." In this clinical context, in the reports of 4/25/14 the examining physician, Dr. Pak documented positive findings on the neurological examination that is consistent with cervical radiculopathy and determined its level without the need to perform an electrodiagnostic study. Therefore, there was no reason to perform an invasive study to establish a diagnosis that was already confirmed by the positive clinical findings, especially, if there was no presentation of a differential diagnosis that warrants performing such invasive testing. In patients with classic localizable symptoms of radiculopathy, focal neurologic deficits, and appropriately positioned structural abnormalities on neuro-imaging studies, clinical decisions can be made without the confirmatory findings provided by the EMG examination. Also, according to (New York State Workers' Compensation Board, Neck Injury Medical Treatment Guidelines, First Edition, June 30, 2010, page 18, C.2.a)"If significant radiating arm symptoms are present for greater than 4-6 weeks after the onset of injury and no obvious level of nerve root dysfunction is evident on examination, electrodiagnostic studies may be

indicated. " In this claimant's case, Dr. Pak clinically diagnosed radiculopathy and determined its level without the need to perform these electrodiagnostic studies.

Furthermore, there was no presentation of a valid non-explained differential diagnosis that warrants performing an invasive electrodiagnostic testing. According to AANEM position statement published in (Muscle Nerve 33: 436-439, 2006) "The AANEM's Recommended Policy for Electrodiagnostic Medicine outlines the necessary steps for an appropriate electrodiagnostic consultation as follows: Development of a differential diagnosis by the electrodiagnostic physician, based upon an appropriate history and physical examination performed by this physician." which was not the case here.

My opinion is further confirmed by the fact that reviewing the EMG/NCV reports of the upper extremities, dated 4/25/14, does not show any special recommendations or treatment modifications, despite the documented positive electrodiagnostic findings. This fact shows that these studies had no role in modifying claimant's management plan. In order for a test to be medically justified, that test must at least have an impact upon the course of therapy a patient is receiving. According to the (Referral Guidelines for Electrodiagnostic Medicine Consultations, Approved by the American Association of Neuromuscular & Electrodiagnostic Medicine, August 1996), the guidelines clearly stated "electrodiagnostic studies should not be performed if the information will not potentially enhance the patient's care". This was not indicated upon reviewing this claimant's documentation and therefore the medical necessity of these studies was not appreciated...

Respondent has presented a medical rationale and factual basis to support its defense of lack of medical necessity. Accordingly, the burden now shifts to Applicant, who bears the ultimate burden of persuasion. See, Bronx Expert, supra.

Applicant relies upon the rebuttal report dated by Dr. Jonathann C. Kuo, M.D., dated 11/2/20, in which Dr. Kuo responds to Dr. Hadhoud, stating:

... Prior to the EMG/NCV studies in dispute being performed, my office conducted FIVE (5) comprehensive medical evaluations of Mr. [AH] in stark contrast to the carrier's peer review doctor who never even examined our patient. In fact, even Dr. Hadhoud concurs that my re-exam of the patient performed on 4/25/14 (which recommended the upper EMG testing) was accurate, coded properly and medically necessary.

e The insurance company's peer reviewer cites non-authoritative and unreliable industry publications. For example, the primary standard of care that Dr. Hadhoud propounds is conclusory in that it relies on the New York Workers' Compensation Guidelines, which are neither authoritative nor reflective of recognized standards of care. In fact, the Workers' Compensation Guidelines are promulgated for the express purpose of advising practitioners what, whether and under what circumstances services by providers treating Workers' Compensation patients will be reimbursed. They do not set forth standards of care and are in no way authoritative in that respect. The Insurance Department, since subsumed in the Department of Financial Services (DFS), issued an opinion on 3/7/03 to the effect that a departure from the Workers' Compensation Guidelines does not establish a deviation from generally accepted medical practice, Ops. Ins. Dept. 03/03/16. Moreover, DFS I position was further clarified in a 6/03/14 email which read, 'While the general instructions and ground rules in the Workers' Compensation Board's medical fee schedules have been adopted by the Superintendent for applicability to No-Fault claims, those rules which refer to the Medical Treatment Guidelines implemented by the Workers' Compensation Board have NOT been adopted by the Superintendent for applicability to No-fault claims'. Respectfully, without evidence of accepted and contemporaneous medical practices, a peer reviewer's opinion is simply a different professional judgment which, in and of itself, does NOT establish that Mr. [AH]'s EMG/NCV studies were allegedly unnecessary to accurately and diagnosis our patient's spinal injuries.

- Dr. Hadhoud admits that according to the AANEM position statement, "The AANEM's Recommended Policy for Electrodiagnostic Medicine outlines the necessary steps for an appropriate electrodiagnostic consultation as follows: Development of a differential diagnosis by the electrodiagnostic physician, based upon an appropriate history and physical examination performed by this physician. Indeed, this was absolutely the case here! In addition to conducting five detailed and contemporaneous exams of our patient, we also recorded Mr. [AH]'s chief complaints of radicular manifestations of neck pain RADIATING into his left upper extremity associated with NUMBNESS in the thumb and forearm which WORSENERD with bending of the neck for over THREE MONTHS! Furthermore, my office's medical records clearly set forth a differential diagnosis of radiculopathy versus peripheral nerve injury which is unequivocally was

a valid differential diagnosis. Regardless, EMG/NCV is indeed necessary and indicated when radiculopathy is suspected in order to establish the location and extent of injury, as well as to formulate an optimal treatment plan.

An EMG is a diagnostic study that is used to diagnose, prognosticate and confirm a clinical diagnosis. It is also used to see which level of disc pathology is predominantly causing the patient's radicular symptoms. This would help to guide future treatment options and allow the patient's treating physicians to target their selected treatments to the spinal levels causing these symptoms. This is especially necessary when future nerve blocks, pain management injections, or surgeries are being considered, as they would need to be performed at the specific spinal levels that are causing the radicular symptoms. In fact Mr. [AH] was receiving cervical epidural steroid injections yet he still suffered from radiating neck pain and extremity aresthesia and an EMG would certainly be useful since it appeared that there may have been more than one level of cervical disc pathology. Nevertheless, neither MRI nor CT are not the best way to diagnose radiculopathy, as many muscles have two and some have three nerve root innervations. To find the exact level of radiculopathy, an EMG must be to find the exact level of radiculopathy, an EMG must be performed. EMG can further differentiate between peripheral nerve injury and cervical radiculopathy or any combination thereof. An EMG would also provide a prognosis as to how mild, moderate, or severe a condition may be, and how long the condition may last. Depending on the diagnosis and the severity of the condition the treatment recommendations could range from conservative measures to immediate referral to a neurosurgeon, such as in the case of a severe radiculopathy. Based on the aforementioned symptoms and findings, I believe that the electrodiagnostic testing at issue was medically necessary. Electrodiagnostic studies (EDX) provide information about the location and extent of the neurophysiologic dysfunction. EDX can be used as confirmation of the loss of function especially since our patient's CT was unremarkable. The EDX examination is necessary to follow all stages of clinical course of radiculopathy as well as to assist in determining the prognosis. Nerve conduction study is important to rule out radiculitis vs. peripheral nerve injury. This study is also important to discover entrapment syndrome, brachial plexus and nerve root damage. EMG/NCV is important in that a treatment plan can be prescribed by providing the most accurate diagnosis and the level of injury of the nerve root. EMG/NCV can evaluate the prognosis of the

plan in regards to conservative treatment vs. aggressive treatment and rehabilitation vs. surgery. The precise origin of the patient's symptoms had not yet been established. Without this information, maximizing the benefits of the plan of treatment would be more difficult, and could result not only in inadequate care, but an exacerbation of injuries. The performance of the study was more than appropriate with regards to the onset of injury date, the nature of the injuries sustained, and the symptomatology resulting from those injuries. Moreover, the etiology of the patient's radiating neck pain was not exactly clear, and thus there was a diagnostic dilemma requiring the utility of EMG/NCV studies. According to the AANEM Guidelines, "minimum evaluation for a radiculopathy should include needle EMG examination of a sufficient number of muscles to adequately screen each major myotome in the symptomatic limb. Bilateral studies are often necessary to rule out a central disc herniation with bilateral radiculopathies or spinal stenosis. The EDX evaluation must be extensive enough to differentiate between radiculopathy and plexopathy, polyneuropathy or mononeuropathy, all of which can present with similar signs and symptoms." AANEM Guidelines, (Muscle and Nerve Supplement 8-1999). "Needle EMG examination of muscles is valuable for assessing nerve root lesions and should be considered in the evaluation of most patients with suspected radiculopathies. Abnormalities in a myotomal distribution (muscles innervated by the same spinal nerve root) can define root injury. These studies not only identify the specific level (or levels) of root injury but also differentiate between root injury and other peripheral nerve lesions that might produce similar symptoms. Needle examination can define the severity and duration of a root injury and assess physiologic integrity of the root. Serial studies can follow the course of a radiculopathy, as well as help evaluate the effects of treatment." AANEM Guidelines, (Muscle and Nerve Supplement 8-1999). "EDX studies alone are capable of indicating physiologic dysfunction and, therefore, ongoing injury to nerve roots. Without this information, the more sensitive imaging may only result in inappropriate management based on clinically irrelevant structural abnormalities ... The ability of EDX to diagnose a radiculopathy regardless of etiology also distinguishes these studies from imaging studies. Imaging studies can provide excellent anatomic identification of root deformity with compressive lesions, but cannot evaluate inflammatory or vascular nerve root damage. EDX studies can demonstrate evidence of a radiculopathy with both compressive and non-compressive etiologies because the

studies directly measure the effect of the nerve root damage on the peripheral nerve and muscle electrical activity. " AANEM Guidelines, (Muscle and Nerve Supplement 8-1999). According to a relevant study, "nerve conduction studies are useful supportive diagnostic tool for suspected cervical radiculopathy as they are found to have reliable sensitivity and specificity. " Journal Clin Diagn Res. 2013 Dec; 7(12):26803682. Dr. Hadhoud fails to recognize that my office's detailed and contemporaneous physiatric exam reports clearly documented my patient's neurological abnormalities patient's palpable differential diagnosis. The patient's EDX testing would provide other differential diagnosis which may have required a different treatment plan and may also have led to the prognosis of the patient's current condition. Unequivocally, in PM&R-neurology, a differential diagnosis is the distinguishing of a particular disease or condition from others that present similar clinical features. Differential diagnostic procedures are used by physiatrists, like myself, and other trained physicians, in order to diagnose the specific disease in a patient. Often, each individual option of a possible disease is called a differential diagnosis. More generally, a differential diagnostic procedure is a systematic diagnostic method used to identify the presence of a disease entity where multiple alternatives are possible. Moreover, my office's multiple exams of Mr. [AH] with their positive objective physical exam and test findings were practically a textbook example of a diagnostic dilemma and differential diagnosis being presented in order to perform the reasonable and medically-necessary EMG studies...

...Contrary to the peer reviewer's predisposed comments, I unequivocally met the criteria of the 2017 AAEM (American Academy of Electro-Diagnostic Medicine) practice guidelines. It is apparent that the carrier's peer review doctor was NOT mindful of the neurological fact that a clinical differential diagnosis and diagnostic dilemma would also include a peripheral neuropathic and myopathic lesion versus a root lesion that would not be able to be detected and/or resolved with a mere history, neurological exam and MR imaging studies. The EMG studies were extremely helpful in assessing my patient's cervical nerve root dysfunction. Strangely and erroneously, the peer reviewer is unable to see how this testing would have teased out a differential diagnosis conundrum, as a genuine diagnostic dilemma and comorbid condition were in fact presented to justify the patient's upper EMG/NCV studies, and my patient's treatment regimen would be altered following the results



of the testing. It is intellectually dishonest for this insurance company peer review doctor to feign any medical knowledge that the EMG testing which I performed would indeed certainly provide a possible alternative diagnosis other than radiculopathy, plexopathy or other peripheral nerve entrapment syndromes. Furthermore, Dr. Hadhoud fails to mention that although a radiculopathy may be diagnosed clinically, it can ONLY be properly and accurately confirmed via EMG testing. Indeed, the EMG/NCV testing would determine the extent of the impingement and nerve injuries on my patient's cervical spine cord, nerve roots and peripheral nerves, and to thereafter evaluate the patient's neuromuscular presentation. Certainly, these needle EMG/NCV studies would definitively provide other differential diagnosis which may require a different treatment plan and may also lead to the prognosis of the patient's current condition. Hence Dr. Hadhoud's statement, that my medical records and significantly positive objective exam and test findings supposedly did not indicate how the performance of the testing would assist in properly diagnosing and treating our patient, is neurologically meritless. Additionally, focusing on the treatment plan allegedly not being altered after the testing is conducted is NOT a proper medical basis to determine lack of medical necessity, as a determination of lack of medical necessity CANNOT be made retrospectively. Certainly, it is impossible to know the course of a patient's care prior to performing diagnostic testing. I also find it medically inappropriate and irresponsible to second guess a treating-referring physiatrist who decides that EMG/NCV studies are reasonable and necessary, when the only support for the denial is a mere review of records by someone who did not examine my patient and even failed to review my follow-up exam report which recommended the EMG/NCV testing. Mr. [AH] justifiably expected coverage for his testing especially since my patient understandably and correctly trusted that I would only perform reasonable and medically-necessary treatment and testing consistent with good PM&R practices. The peer review doctor also neglected to discuss how problems such as those presented by my patient might have been dealt with by the medical community as a whole. Moreover, Dr. Hadhoud never specifically indicates how I allegedly did not act in accordance with generally-accepted PM&R-medical practices when the testing was conducted. The proper and recognized standard of care for determining medical necessity is neither based upon the peer reviewer's personal biased opinions nor is determined by the non-authoritative and

unreliable literature referenced within his peer review report. Simply stated, the peer review report is not medically sound since it is conclusory. The peer review report also does not establish the standard of care and does not adequately explain how that standard of care was deviated from. Furthermore, the carrier's report also does not fully address all of my patient's positive objective exam & test findings NOR does it set forth what treatment and/or testing should have been undertaken in lieu of the reasonable and medically-necessary EMG studies that were conducted. Unequivocally, there are significant deficiencies within the carrier's peer review report. Moreover, contrary to the peer reviewer's egregious statements, the EMG/NCV testing was needed to differentiate and supplement the diagnosis, which may have required alternative treatment regimen and different prognosis. In fact, there were neuromuscular diseases (due to trauma) to differentiate with electrodiagnostic testing following the injuries that were reported in the records. The patient's medical records from the other treating healthcare providers were provided to me, including the cervical CT report as well as the PT and hospital records, and we also conducted examinations of the patient. The reports and EMG test results were all utilized by us in forming the treatment plan, which greatly assisted me in the best therapeutic care and most accurate diagnosis and prognosis of the patient's neurological injuries. Pursuant to our well-respected Treating Physician Rule, we should be given greater weight, deference and credulity in regard to the performance of testing since we were the patient's treating physiatrist whose physical examination findings, test reports and medical records are well-documented. My Rebuttal report and our medical records provide a valid factual basis and sound medical rationale for the patient's EMG studies, which were wrongfully denied by the insurance company... the opinions herein are based upon my office's observations and the result of my clinical PM &R neurological examinations of the patient. Our treatment and the needle EMG/NCV testing of this patient were medically-necessary, and were in accordance with the generally-accepted neurological professional practice...

I find the rebuttal report more persuasive than the peer report; I find that it meaningfully rebuts the opinion by Dr. Hadhoud and by a preponderance of the evidence has established the medical necessity of the tests. Accordingly, Applicant is awarded reimbursement of the claim.

Applicant is awarded reimbursement in the total amended amount of \$510.44.

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	Amount Amended	Status
	<b>Hudson Spine and Pain Medicine</b>	<b>04/25/14 - 04/25/14</b>	<b>\$2,144.48</b>	<b>\$510.44</b>	<b>Awarded: \$510.44</b>
<b>Total</b>			<b>\$2,144.48</b>		<b>Awarded: \$510.44</b>

- B. The insurer shall also compute and pay the applicant interest set forth below. 10/29/2018 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

In the instant matter Applicant is awarded interest pursuant to the no-fault regulations. 11 NYCRR 65-3.9 (a) provides that Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30-day month." Pursuant to 11 NYCRR 65-3.9 (c), "if an applicant does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Department of Financial Services regulations, interest shall not accumulate

on the disputed claim or element of claim until such action is taken." Applicant electronically submitted its claim for arbitration on 10/29/18, more than thirty days after receipt of the denial of claim. Therefore, interest shall run effective 10/29/18.

C. Attorney's Fees

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

An attorney's fee of 20% shall be paid on the sum of the awarded claim plus interest, subject to a maximum of \$1,360.00.

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

01/09/2021

(Dated)

Kevin R. Glynn

**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:**  
333adf39c1f70f4353c2d40c2ea2111b

### **Electronically Signed**

Your name: Kevin R. Glynn  
Signed on: 01/09/2021