

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Mid-Rockaway Ave Medical PC  
(Applicant)

- and -

American Transit Insurance Company  
(Respondent)

AAA Case No. 17-19-1138-6874

Applicant's File No. None

Insurer's Claim File No. 1000880-3

NAIC No. 16616

**ARBITRATION AWARD**

I, Lester Hill, 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: EIP

1. Hearing(s) held on 02/05/2021  
Declared closed by the arbitrator on 02/05/2021

Robert Cippitelli from Law Offices of Eitan Dagan (Elmhurst) participated in person for the Applicant

Gregory Etienne from American Transit Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 6,313.61**, was NOT AMENDED at the oral hearing.  
Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

Were the electrodiagnostic testing of the upper and lower extremities, range of motion and manual muscle testing, outcome assessment testing and physical performance testing provided to the EIP from August 7, 2017 through November 2, 2017 medically unnecessary based upon the peer report by Dr. Peter Chiu? The 32-year-old EIP was involved in a motor vehicle accident on July 18, 2017 and received treatment for injuries to the neck, low back, and both shoulders.

4. Findings, Conclusions, and Basis Therefor

At issue is whether the electrodiagnostic testing of the upper and lower extremities, range of motion and manual muscle testing, outcome assessment testing and physical performance testing provided to the EIP from August 7, 2017 through November 2, 2017 were medically unnecessary.

The basis of the respondent's denials is the peer report by Dr. Peter Chiu.

I have reviewed the documents submitted by the parties as of February 5, 2021 and make this decision based upon those documents and the arguments of counsel at the hearing on February 5, 2021.

Applicant establishes a prima facie showing of its entitlement to No-Fault benefits as a matter of law by submitting evidentiary proof that the prescribed statutory billing forms had been mailed and received and the payment of No-Fault benefits were overdue. *Westchester Medical Center v. Lincoln General Ins. Co.*, 60 A.D. 3d 1045, 877 N.Y.S.2d 340 (2d Dept. 2009); *Westchester Medical Center v. Clarendon National Ins. Co.*, 57 A.D. 3d 659, 868 N.Y.S. 2d 759 (2d Dept. 2008); *New York and Presbyterian Hosp. v. Allstate Ins. Co.*, 31 A.D. 3d 512, 818 N.Y.S. 2d 583 (2d Dept. 2006); *LMK Psychological Services, P.C. v. Liberty Mut. Ins. Co.*, 30 A.D. 3d 727, 816 N.Y.S. 2d 587 (3d Dept. 2006); *Nyack Hospital v. Metropolitan Property & Casualty Insurance Co.*, 16 A.D.3d 564, 791 N.Y.S. 2d 658 (2d Dept. 2005).

The submission of Respondent's NF-10 denial of claim form established that the insurer received the claim referenced therein as having been submitted by the provider and that the insurer did not pay the claim. *Lopes v. Liberty Mutual Ins. Co.*, 24 Misc.3d 127 (A), 2009 N.Y. Slip Op. 51279(U), 2009 WL 1799812 (App. Term 2d, 11 & 13 Dists. Jan. 26, 2009).

New York's Comprehensive Motor Vehicle Insurance Reparation Act requires an insurance carrier to reimburse an injured party (or his or her assignee) for all "reasonable and necessary expenses" and "medical expenses" arising from the use and operation of the insured vehicle. Lack of medical necessity is a valid defense to an action to recover No-Fault benefits. *Countrywide Ins. Co v. 563 Grand Med., P.C.* 50 A.D. 3d 313 (1st Dept. 2008); *A.B. Med. Servs., PLLC v. Liberty Mut. Ins Co.*, 39 A.D. 3d 779 (2d Dept. 2007), if raised in a denial that is (1) timely, *Presbyterian Hosp. in the City of New York v. Maryland Casualty Ins. Co.*, 226 A.D. 2d 613 (2d Dept. 1996), (2) includes the information called for in the prescribed denial of claim form, 11 NYCRR Section 65-3.4 (11); *Nyack Hosp. v. Metropolitan Prop. & Cas. Ins. Co.*, 16 A.D. 3d 564 (2d Dept. 2005); *Nyack Hosp. v. State Farm Mut. Auto Ins. Co.*, 2004 WL 2394038, 2004 NY Slip Op 07663 (2d Dept. Oct.25 2004), and (3) promptly apprises the Applicant with a high degree of specificity of the ground or grounds on which the disclaimer is predicated, *General Accident Ins. Group v. Cirucci*, 46 N.Y. 2d 862, 414 N.Y.S. 2d 512 (1979); *New York University Hosp. Rusk Ins. V. Hartford Acc. & Indem. Co.*, 32 A.D. 3d 458, 2006 NY Slip Op 06223 (2d Dept. 2006).

An insurance carrier must establish a detailed factual basis and a sufficient medical rationale for its position that the medical service was not medically necessary. Vladimir

Zlatnick, M.D. P.C. v. Travelers Indem. Co., 2006 NY Slip Op 50963(U) (App Term 1st Dept. 2006).

The EIP was involved in a motor vehicle accident on July 18, 2017. The EIP was treated at the emergency room of Beth Israel Hospital on the day the accident. The EIP presented to the applicant on August 7, 2017 with complaints of radiating in the neck pain and low back pain. The examination reported with reduced range of motion of the cervical and lumbar spine with positive orthopedic testing, positive orthopedic testing for both shoulders and tenderness in the left knee. The EIP underwent outcome assessment testing on August 7, 2017 and range of motion and muscle testing on August 9, 2017. The EIP underwent physical performance testing on August 15, 2017. The EIP underwent an MRI of the left shoulder on August 22, 2017 which reported a tear of the supraspinatus tendon and positive impingement. The EIP was reevaluated by the applicant on August 30, 2017. The examination reported moderate painful range of motion of the cervical and lumbar spine and reduced range of motion of the shoulders with positive orthopedic testing for the lumbar spine. The EIP underwent outcome assessment testing on August 30, 2017, and physical performance testing on September 18, 2017. The EIP underwent MRI testing of the cervical spine on October 3, 2017 which reported disc herniations from C-2 through C4 and C5 through C7. The EIP underwent MRI testing of the right shoulder on October 3, 2017 which reported a Bankhart tear of the labrum. The EIP underwent outcome assessment testing on October 11, 2017, physical performance testing on October 23, 2017 and range of motion manual muscle testing on November 1, 2017. The EIP underwent an MRI of the lumbar spine on October 11, 2017 which reported disc bulges from L1 through L4. The EIP underwent an MRI of the left shoulder on October 11, 2017 which reported a tear of the infraspinatus tendon. The EIP underwent electrodiagnostic testing of the upper extremities on October 19, 2017 which reported a normal study. The EIP underwent an MRI of the thoracic spine on October 25, 2017 which reported disc herniations from T3 through T5. The EIP underwent electrodiagnostic testing of the lower extremities on November 2, 2017 which reported evidence of left tibial neuropathy. The EIP underwent outcome assessment testing on November 22, 2017 and January 12, 2018, physical performance testing on January 18, 2018, and range of motion and manual muscle testing on January 31, 2018.

Dr. Peter Chiu states that the range of motion/manual muscle testing, physical performance testing, outcome assessment testing and electrodiagnostic testing of the upper and lower extremities were medically unnecessary. With respect to the electrodiagnostic testing conducted on November 19, 2017 and November 2, 2017, he states that electrodiagnostic testing is an extension of the clinical examination of the patient. He states that electrodiagnostic testing may be useful in evaluating tumors of the extremity or the spinal cord and the peripheral nervous system and in particular to resolve a differential diagnosis between radiculopathy and peripheral neuropathy, citing the American Association of Neuromuscular & Electrodiagnostic Medicine, 2012. He states there was no differential diagnosis to resolve as there was no evidence of the progressive neurological deficit nor true peripheral nerve involvement. He states that the physical performance testing was medically unnecessary EIP's physical and or functional capabilities, and may be viewed as an assessment of the basic activities of daily living. He states there was no indication that the physical performance testing was

necessary nor would the testing change the treatment plan. He states the range of motion and manual muscle testing is somewhat unreliable particularly at the lower end of the scales (the lesser amount of deficit or diminishment) he states it muscle testing and range of motion testing are part of a comprehensive examination to be done by the physician. He states that the computerized range of motion manual muscle testing would not improve or alter the treatment plan. He states that the outcome assessment testing, billed under CPT code 99358 (prolonged evaluation and management service before or after direct patient care, first hour) including review of extensive records and test communications with other professionals and/or patient and is used as an assessment of the measure of outcome. He states that there was no indication that a prolonged evaluation was indicated nor that the testing would alter the treatment plan.

Dr. Bernard Osei-Tutu submitted a rebuttal asserting that the outcome assessment testing, range of motion testing, physical performance testing was medically necessary. He states that outcome assessment testing assesses the patient's function in a logical way to assess behavioral effects of the EIP's condition involving questionnaires so as to allow for tracking of the patient's progress. He states that outcome assessment testing establishes a baseline, documents progress and assists in goalsetting and motivating patients, allowing for proper monitoring of the EIP's care. He states that computerized range of motion and manual muscle testing provides a baseline of for the range of motion and muscle strength and incentive superior and more reliable to manual muscle testing and range of motion testing. He states that physical performance testing assesses the EIP's ability to conduct the activities of daily living and provides valuable feedback to guide the treatment protocol.

Prior to the commencement of the hearing, the applicant withdrew all defenses based upon the Worker's Compensation Law.

Additionally, respondent concedes that the physical therapy evaluation billed under CPT code 97001 on August 8, 2017 in the amount of \$80.02 should be reimbursed.

With respect to the electrodiagnostic studies of the upper and lower extremities, I find that the respondent has demonstrated by sufficient factual basis and medical rationale that the electrodiagnostic testing was medically unnecessary. I find the peer report persuasive that electrodiagnostic testing is an extension of the clinical examination and that its utility is for the resolving of a differential diagnosis between peripheral neuropathy and radiculopathy. I find the peer report persuasive that there was no evidence of peripheral neuropathy for this EIP. In fact, there were no neurological findings noted in the evaluations conducted by the applicant. I find the peer report sets forth a credible standard for the use of electrodiagnostic testing when there is a differential diagnosis to be resolved or when there is deteriorating neurological conditions, none of which was present for this EIP. Significantly, the applicant submitted no rebuttal to the assertions contained in the peer report.

I find that the that the respondent has demonstrated by sufficient factual basis and medical rationale that the activity limitations testing and physical performance testing medically unnecessary. I find the peer report persuasive that these tests did not have any effect on the treatment plan. There is no indication in the records of the applicant, or any

other treating physician, of any change in the treatment protocol as a result of the activity limitation testing and physical performance testing. I find the peer report persuasive that testing which does not have an effect on the treatment of the EIP is medically unnecessary.

I find that the respondent has not demonstrated that the range of motion and manual muscle testing provided to the EIP on August 9, 2017 and November 1, 2017 were medically unnecessary. I find the peer report unpersuasive that computerized range of motion and manual muscle testing is more unreliable than manually conducted by a physician. The evaluation of the EIP by the applicant on August 7, 2017 does not quantify the range of motion of the neck, low back, and both shoulders. While it might be preferable for a physician to conduct manual range of motion and muscle testing at the initial evaluation, I do not find it not within the standard of care to conduct the range of motion and manual muscle testing through the computerized methodology at their disposal. I do not find testing on November 1, 2017 excessive as this is four months following the initial testing and this information may be useful to adjust the treatment plan. However, I find the testing conducted on September 6, 2017 to be excessive, as is provided less than 4 weeks from the initial testing on August 9, 2017. I find the peer report persuasive that the September 6, 2017 testing was medically unnecessary in that it would have no effect upon the treatment protocol.

The respondent raised a fee schedule defense with respect to the range of motion and manual muscle testing.

For the two dates of service, August 7, 2017 and November 1, 2017 that the applicant is awarded for range of motion and muscle testing, the applicant billed eight units under CPT code 95851(range of motion) and five units under CPT code 95831 (muscle testing). With respect to the muscle testing, the appropriate billing is under CPT code 95833 (muscle testing, total evaluation of body) and that the applicant billing was an improper unbundling of the service. The applicant is awarded \$114.33 for each date of treatment for the muscle testing. With respect to the range of motion studies, CPT code 95851 provides for range of motion, each extremity, or each trunk section. The range of motion testing was confined to the three trunk sections (cervical, thoracic, and lumbar). Hence, the applicant is entitled to reimbursement for three units of range of motion testing for each of the two dates which the applicant is entitled to reimbursement, specifically, \$137.13 for each date.

In conclusion, applicant is awarded \$.

5. Optional imposition of administrative costs on Applicant.  
Applicable for arbitration requests filed on and after March 1, 2002.

I do NOT impose the administrative costs of arbitration to the applicant, in the amount established for the current calendar year by the Designated Organization.

6. **I find as follows with regard to the policy issues before me:**  
☐ The policy was not in force on the date of the accident

- ☐ The applicant was excluded under policy conditions or exclusions
- ☐ The applicant violated policy conditions, resulting in exclusion from coverage
- ☐ The applicant was not an "eligible injured person"
- ☐ The conditions for MVAIC eligibility were not met
- ☐ The injured person was not a "qualified person" (under the MVAIC)
- ☐ The applicant's injuries didn't arise out of the "use or operation" of a motor vehicle
- ☐ The respondent is not subject to the jurisdiction of the New York No-Fault arbitration forum

Accordingly, the applicant is AWARDED the following:

A.

Medical	From/To	Claim Amount	Status
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	<b>Mid-Rockaway Ave Medical PC</b>	<b>08/07/17 - 08/07/17</b>	<b>\$204.41</b>	<b>Denied</b>
	<b>Mid-Rockaway Ave Medical PC</b>	<b>08/09/17 - 08/09/17</b>	<b>\$583.68</b>	<b>Awarded: \$251.46</b>
	<b>Mid-Rockaway Ave Medical PC</b>	<b>08/08/17 - 08/08/17</b>	<b>\$80.02</b>	<b>Awarded: \$80.02</b>
	<b>Mid-Rockaway Ave Medical PC</b>	<b>08/30/17 - 08/30/17</b>	<b>\$204.41</b>	<b>Denied</b>
	<b>Mid-Rockaway Ave Medical PC</b>	<b>09/06/17 - 09/06/17</b>	<b>\$583.68</b>	<b>Denied</b>
	<b>Mid-Rockaway Ave Medical PC</b>	<b>08/15/17 - 08/15/17</b>	<b>\$249.96</b>	<b>Denied</b>
	<b>Mid-Rockaway Ave Medical PC</b>	<b>09/18/17 - 09/18/17</b>	<b>\$249.96</b>	<b>Denied</b>
	<b>Mid-Rockaway Ave Medical PC</b>	<b>10/19/17 - 10/19/17</b>	<b>\$1,546.20</b>	<b>Denied</b>
	<b>Mid-Rockaway Ave Medical PC</b>	<b>10/11/17 - 10/11/17</b>	<b>\$204.41</b>	<b>Denied</b>
	<b>Mid-Rockaway Ave Medical PC</b>	<b>10/23/17 - 10/23/17</b>	<b>\$249.96</b>	<b>Denied</b>
	<b>Mid-Rockaway Ave Medical PC</b>	<b>11/01/17 - 11/01/17</b>	<b>\$583.68</b>	<b>Awarded: \$251.46</b>
	<b>Mid-Rockaway Ave Medical PC</b>	<b>11/02/17 - 11/02/17</b>	<b>\$1,573.24</b>	<b>Denied</b>

<b>Total</b>	<b>\$6,313.61</b>	<b>Awarded: \$582.94</b>
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- B. The insurer shall also compute and pay the applicant interest set forth below. 08/16/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest is awarded from the date of the filing of the AR1 at a rate of 2% per month, simple, ending with the payment of the claim.

C. Attorney's Fees

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

Attorney fees are awarded pursuant to 11NYCRR 65-4.6(e) at a rate of 20% of the awarded claim, including interest, to a maximum of \$1360.00.

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

02/09/2021  
(Dated)

Lester Hill

**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:**  
3cfac6f7809c907fbce9b81706c6b0a4

### **Electronically Signed**

Your name: Lester Hill  
Signed on: 02/09/2021