

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Mid-Rockaway Ave Medical PC  
(Applicant)

- and -

Hereford Insurance Company  
(Respondent)

AAA Case No. 17-20-1155-8786

Applicant's File No. N/A

Insurer's Claim File No. 72559-01

NAIC No. 24309

**ARBITRATION AWARD**

I, Patricia Daugherty, 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 07/30/2021  
Declared closed by the arbitrator on 07/30/2021

John Faris from Law Offices of Eitan Dagan (Elmhurst) participated in person for the Applicant

Andrew Schiavone from Law Offices of Rubin & Nazarian participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 3,212.69**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant amended the amount in dispute to \$3,012.01 withdrawing the portion of its claim seeking \$200.68 for the initial visit performed on January 27, 2018.

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

The parties stipulated that Applicant has established its prima facie case and that the denials of claims were issued timely. The parties also stipulated that there are no issues regarding the fee schedule.

### 3. Summary of Issues in Dispute

Assignor, "SRV," a 58-year-old male driver, was involved in a motor vehicle accident on December 29, 2017. At issue in this case is a claim in the amended amount of \$3,012.01 for range of motion testing and muscle testing performed on January 31, 2018 and EMG/NCV studies performed on May 31, 2018. Respondent issued a partial payment for the range of motion and muscle testing services, denying the balance therein pursuant to the fee schedule and denied the EMG/NCV studies asserting a lack of medical necessity defense pursuant to the peer review of Debra Ann Pollack, M.D. dated June 27, 2018. The issues to be determined are whether Respondent properly reimbursed Applicant for the range of motion and manual muscle testing pursuant to the fee schedule and whether the EMG/NCV studies were medically necessary.

### 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.

#### **FEE SCHEDULE**

Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. See, Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 2006 NY Slip 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006). See also, Power Acupuncture PC v. State Farm Mutual Automobile Ins. Co., 11 Misc.3d 1065A, 816 N.Y.S.2d 700, 2006 NY Slip Op 50393U, 2006 N.Y. Misc. LEXIS 514 (Civil Ct, Kings Co. 2006).

11 NYCRR 65-3.8(g)(1), in effect as of April 1, 2013, provides that proof of the fact and amount of loss sustained pursuant to Insurance Law section 5106 (a) shall not be deemed supplied by an applicant to an insurer and no payment shall be due for such claimed medical services under any circumstances for those claimed medical service fees that exceed the charges permissible pursuant to Insurance Law sections 5108(a) and(b) and the regulations promulgated thereunder for services rendered by medical providers. As such Respondent is not required to establish that it preserve a fee schedule defense in a timely denial of claim.

Judicial notice of the New York State Worker's Compensation Medical Fee Schedule is taken. See Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co., 61 A.D.3d 13, (2nd Dept. 2009); LVOV Acupuncture, P.C. v. Geico Ins. Co., 32 Misc.3d 144(A), 2011 NY Slip Op 51721(U) (App Term 2d, 11th & 13th Jud Dists. 2011); Natural Acupuncture Health, P.C. v. Praetorian Ins. Co., 30 Misc.3d 132(A), 2011 NY Slip Op 50040(U) (App Term, 1st Dept. 2011).

### **Muscle Testing**

Applicant billed Respondent \$261.60 for six units of muscle testing under CPT 95831 performed on January 31, 2018. Respondent recoded the services to CPT code 95834 (total evaluation of the body including hands) reimbursing Applicant \$114.58 for the muscle testing.

Respondent argued that it properly reimbursed Applicant pursuant to the fee schedule. Applicant argued that Respondent improperly recoded the muscle testing to a service that was not performed. Applicant asserts that the testing was rendered to specific areas and a total evaluation of the body including hands was not performed. Applicant further argues that Respondent has not established its defense as it failed to attach the affidavit of a professional fee coder.

I find that when the calculation of the proper fee for a particular service or procedure is clearly set forth in the schedule, an interpretation of the schedule by a qualified professional is not required. However, when there is more than one reasonable interpretation of the proper fee for a particular service rendered, an interpretation by a qualified professional is required.

In the instant matter, I find that Respondent's action of recoding the testing as billed to CPT 95834 must be supported by the opinion of a qualified professional fee coder. As Respondent has not provided an affidavit of a qualified professional fee coder, I find that it has not established that it properly recoded the services provided.

Notwithstanding the foregoing, the fee schedule clearly sets forth that muscle testing is billable per extremity or trunk. Applicant billed more than once per extremity. The testing was rendered to the trunk, bilateral shoulders and one knee.

CPT 95831 has a relative value of 5.16. Applicant is located in Region IV which has a conversion factor of 8.45. ( $5.16 \times 8.45 = \$43.60$ ). Applicant is entitled to reimbursement of \$43.60 per unit. Four units of testing were performed. ( $\$43.60 \times 4 = \$174.40$ ). Applicant was entitled to \$174.40 for the muscle testing services rendered. Respondent previously issued payment of \$114.58 for the muscle testing leaving a remaining balanced owed of \$59.82.

Applicant is awarded \$59.82 for the muscle testing performed on January 31, 2018.

### **Range of Motion Testing**

Applicant billed Respondent \$319.97 for seven units of range of motion testing under CPT 95851 performed on January 31, 2018. Each unit was billed at a rate of \$45.71. Respondent issued a payment of \$91.42 for two units and denied the balance pursuant to the fee schedule.

Having taken judicial notice of the fee schedule, I find that Applicant is not entitled to additional reimbursement pursuant to the fee schedule. The fee schedule clearly sets forth that range of motion testing is billable per extremity or trunk section. The testing

performed was rendered to the cervical and lumbar spine only. This is the equivalent of two units.

CPT 95851 has an assigned relative value unit (RVU) of 5.41. 5.41 multiplied by \$8.45 equals a reimbursement rate of \$45.71 per unit. Therefore, Applicant was only entitled to reimbursement of \$91.42 for the range of motion testing performed.

As such, I find that Applicant is not entitled to any additional money for the range of motion testing performed on January 31, 2018.

### **MEDICAL NECESSITY**

As the parties stipulated to Applicant's prima facie case, the burden is on the insurer to prove that medical treatment performed was not medically necessary. See A.B. Medical Services PLLC v. Geico, 2 Misc.3d 26, 773 N.Y.S.2d 773 (App. Term 2d and 11<sup>th</sup> Jud Dists 2003).

To establish lack of medical necessity through a peer review report, the peer reviewer's opinion must set forth a factual basis and medical rationale for the lack of medical necessity defense, including evidence of medical standards. Jacob Nir, M.D. v. Allstate Ins. Co., 7 Misc.3d 544, 546-47 (Civ. Ct. Kings Co. 2005).

A peer review report's medical rationale is insufficient if it is unsupported by or controverted by evidence of generally accepted medical practice. See CityWide Social Work & Psychological Servs. v Travelers Indem. Co., 3 Misc 3d. 608 (Civ Ct, Kings County 2004). The generally accepted practice is considered "that range of practice that the profession will follow in the diagnosis and treatment of patients in light of the standards and values that define its calling." Id.

When an insurer presents sufficient evidence establishing a lack of medical necessity, the burden then shifts back to the applicant to present its own evidence of medical necessity. See West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc. 3d 131(A) (App. Term 2d & 11<sup>th</sup> Jud Dists 2006).

Respondent denied Applicant's claim for the EMG/NCV studies performed on May 31, 2018 pursuant to the peer review of Debra Ann Pollack, M.D. dated June 27, 2018.

Dr. Pollack determined that Assignor suffered from a soft tissue injury and that the standard of care for these types of injuries includes evaluation, x-ray testing (if there is suspicion of fracture), anti-inflammatory medication, rest and 6-8 weeks of conservative treatment. MRI may be appropriate if there is a deterioration in the patient's condition and, depending upon the results, possibly interventional pain management. She stated that EMG/NCV studies are performed when there is a potential differential diagnosis of radiculopathy, plexopathy, entrapment neuropathy, polyneuropathy or myelopathy and the diagnosis cannot be clarified without the test results. Dr. Pollack determined that there was no diagnostic dilemma based on Assignor's clinical history and examination findings. She noted that there were no worsening neurological complaints.

I find that the peer review report of Dr. Pollack sets forth a sufficient factual basis and medical rationale as to why the EMG/NCV studies were not medically necessary. Respondent has shifted the burden to Applicant to establish the medical necessity of the EMG/NCV studies.

Applicant submitted a rebuttal by Dr. Osei-Tutu dated February 28, 2020 to refute the findings of Dr. Pollack. Dr. Tutu disagreed with Dr. Pollack's conclusions and determined that the EMG/NCV studies were medically necessary based upon Assignor's clinical symptomology and treatment history. Dr. Tutu discussed the positive neurological findings from Dr. Boppana's May 31, 2018 neurological consultation in detail and explained their radicular components as well as the MRI findings. He explained that the testing can be performed to rule out radiculopathy versus neuropathy as well as establish the origin of pain, determine the level of nerve root damage and assess the severity of radiculopathy if confirmed.

Respondent submitted an addendum from Dr. Pollack addressing Dr. Tutu's rebuttal. Dr. Pollack's opinion remained unchanged.

After a thorough review of the record, I am persuaded by the rebuttal of Dr. Tutu and find that Applicant has refuted the findings of Dr. Pollack and established the medical necessity of the EMG/NCV testing.

Applicant is awarded \$2,636.44 for the EMG/NCV testing performed on May 31, 2018.

Based on the foregoing, Applicant is awarded \$2,696.26 and the remainder of the claim is denied.

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.

<b>Medical</b>		<b>From/To</b>	<b>Claim Amount</b>	<b>Amount Amended</b>	<b>Status</b>
	<b>Mid-Rockaway Ave Medical PC</b>	<b>01/27/18 - 01/27/18</b>	<b>\$200.68</b>	<b>\$0.00</b>	<b>Withdrawn with prejudice</b>
	<b>Mid-Rockaway Ave Medical PC</b>	<b>01/31/18 - 01/31/18</b>	<b>\$375.57</b>	<b>\$375.57</b>	<b>Awarded: \$59.82</b>
	<b>Mid-Rockaway Ave Medical PC</b>	<b>05/30/18 - 05/31/18</b>	<b>\$2,636.44</b>	<b>\$2,636.44</b>	<b>Awarded: \$2,636.44</b>
<b>Total</b>			<b>\$3,212.69</b>		<b>Awarded: \$2,696.26</b>

- B. The insurer shall also compute and pay the applicant interest set forth below. 02/05/2020 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant is awarded interest pursuant to the no-fault regulations. See generally, 11 NYCRR §65-3.9. 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. A plain reading of this provision indicates that if an applicant requests arbitration within 30 days of receiving a denial of claim, then interest is not tolled. When arbitration is not requested within 30 days of receiving a denial of claim, the interest is tolled until "such action is taken." The language used refers to the conduct of the Applicant. When Applicant acts, the interest is no longer tolled. The act of requesting the arbitration triggers the accrual of interest. As such interest shall accrue as of the date the AR-1 was filed. To the extent that the AR-1 was filed outside the business hours of the forum, then interest shall accrue the following business day.

C. Attorney's Fees

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

Respondent shall pay Applicant an attorney's fee, in accordance with 11 NYCRR §65-4.6. Therefore, the insurer shall pay the applicant an attorney's fee of 20% of benefits plus interest, with no minimum fee and a maximum fee of \$1,360. However, if the benefits and interest awarded thereon is equal to or less than the respondent's written offer during the conciliation process, then the attorney's fee shall be based upon the provisions of 11 NYCRR 65-4.6(b).

- 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 Suffolk

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

08/22/2021  
(Dated)

Patricia Daugherty

**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:**  
e52a9797c5b56514d7373d6a22d11f39

### **Electronically Signed**

Your name: Patricia Daugherty  
Signed on: 08/22/2021