

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Anesthesia Solutions PC  
(Applicant)

- and -

LM General Insurance Company  
(Respondent)

AAA Case No.	17-19-1151-4166
Applicant's File No.	00052683
Insurer's Claim File No.	LA000-040389982-03
NAIC No.	36447

**ARBITRATION AWARD**

I, Rhonda Barry, 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 09/09/2021  
Declared closed by the arbitrator on 09/09/2021

Justin Rosenbaum, Esq. from Drachman Katz, LLP participated in person for the Applicant

Kelly Green, Esq. from LM General Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 4,324.40**, was NOT AMENDED at the oral hearing.  
Stipulations WERE made by the parties regarding the issues to be determined.

The parties stipulated that the denial is timely. If applicable, interest accrues in accordance with 11 NYCRR§65-3.9.

3. Summary of Issues in Dispute

The EIP, "NVR" is a 44 year old female injured as a restrained driver in a rear end motor vehicle accident on 7/3/19. Air bags did not deploy and there was no loss of consciousness or lacerations. The EIP was evaluated at an emergency room, treated, and released. Applicant seeks \$4324.40 for office visits, EMG/NCV of the upper and lower extremities on DOS 8/23/19. Respondent denied applicant's claim based upon lack of medical necessity according to the peer review and addendum of Vijay Sidhwani, DO,

PMR. Applicant submits a rebuttal from the treating physician, Sekhar Upadhyayula, MD.

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

I have completely reviewed all timely submitted documents contained in the ADR Center record maintained by the American Arbitration Association and considered all oral arguments. No additional documents were submitted by either party at hearing. No witnesses testified at hearing.

#### ANALYSIS

Applicant has established its prima facie entitlement to reimbursement for no fault benefits based upon the submission of a properly completed claim form setting forth the amount of the loss sustained, and that payment is overdue. Mary Immaculate Hospital v. Allstate Insurance Company, 5 AD 3d 742, (2<sup>nd</sup> Dept. 2004). Westchester Medical Center v. Lincoln General Ins. Co., 60 AD 3d 1045 (2<sup>nd</sup> Dept. 2009).

The burden now shifts to respondent to establish a lack of medical necessity with competent medical evidence which sets forth a clear factual basis (specifics of the claim) and medical rationale for denying the claim. Citywide Social Work and Psych Services, PLLC v. Allstate, 8 Misc. 3d 1025A (2005); Healing Hands Chiropractic v. Nationwide Assurance Co., 5 Misc. 3d 975 (2004). Respondent must offer sufficient and credible medical evidence that addresses the standards in the applicable medical community for the services and treatment in issue; explains when such services and treatment would be medically appropriate, preferably with understandable objective criteria; and why it was not medically necessary in the instance at issue.

The insurer must establish a factual basis and medical rationale for its asserted lack of medical necessity, which is supported by evidence of the generally accepted medical/professional practices. Beal Medea Products Inc. v. Geico, 27 Misc. 3d 1218 (A), 910 NYS 2d 760 (Civ. Ct. Kings County 2010). Medically necessary treatments or services are "treatments or services which are appropriate, suitable, proper and conducive to the end sought by the professional health service in consultation with the patient. It means more than merely convenient or useful treatments or services, but treatments or services that are reasonable in light of the patient's injury, subjective and objective evidence of the patient's complaints of pain and the goals of evaluation and treating the patient." Fifth Avenue Pain Control Center v. Allstate Ins. co., 196 Misc. 2d 801 (Civ. Ct Queens 2003).

Dr. Sidhwani reviewed appropriate medical records, in particular a pain management consultation on 8/23/19. Complaints of back and left leg pain were reported. According to Dr. Sidhwani the EIP was not prescribed any medications and did not take any oral NSAIDs. She had not received physical therapy. According to Dr. Upadhyayula's

8/23/19 report the EIP did in fact use NSAIDs on occasion with some benefit. She also tried muscle relaxants. She participated in chiropractic adjustments and acupuncture treatments but there was no physical therapy. MRI studies were reviewed and Dr. Upadhyayula noted that the MRI of the cervical spine (8/19/19) revealed multiple herniations with thecal sac impingement and annular tears. The MRI the lumbar spine (8/19/19) indicated an L4/5 herniated disc with thecal sac impingement. There is no discussion as to whether or not this was degenerative. Nonetheless, Dr. Sidhwani noted pre-existing disc pathology at L4/5. Upon examination there was decreased range of motion to the lumbar spine. There was positive straight leg raise but pathological reflexes were not indicated. Motor strength was within functional limits and only mildly decreased to the left lower extremity 4/5. According to Dr. Sidhawani there was decreased sensation at L5/S1. The EMG/NCV testing reports were not provided to Dr. Sidhawani.

Dr. Upadhyayula's 8/23/19 report documented complaints of low back pain radiating to the left leg and neck pain radiating to the left shoulder. There was decreased range of motion to the lumbar spine. Spurling and straight leg raise test were positive. Reflexes were diminished to the left biceps and triceps. Muscle strength was diminished to the left lower extremity by 20% and sensation was altered at left L5/S1.

According to Dr. Sidhwani the vascular testing was secondary to soft tissue injury and medically unnecessary. There was no causality between the testing and the sprain/strain injuries a result of the motor vehicle accident and appears to have been conducted in a routine manner.

As to the EMG/NCV, the EIP was still in the acute phase of treatment and not received adequate treatment. The MRI studies clearly identified a disc pathology which could account for the reported clinical findings. The EDX testing is only necessary when there is a diagnostic dilemma. In this case the EIP sustained soft tissue injury and there was no other diagnosis other than radiculopathy. There was nothing to rule out in the testing would not alter the diagnosis, prognosis, or treatment of the EIP. Even if radiculopathy had been suspected, it can be diagnosed clinically particularly in this case with the treating physician had access to the results of an imaging study.

Dr. Sidhawani's report provides an acceptable standard of generally accepted medical practice for performing the EDX. See, Williamsbridge Radiology and Open Imaging v. Travelers Indemnity Company, 14 Misc. 3d 1231 (A), 836 NYS 2d 496. Respondent established a reasonable factual basis and medical rationale with its expert opinion as to the medical necessity for the disputed treatment. Applicant must now meaningfully refer to or rebut the conclusions set forth in the peer review. Yklik, Inc. v. Geico Ins. Co., 2010 NY Slip Op 51336(u) (App Term 2<sup>nd</sup>, 11<sup>th</sup> and 13<sup>th</sup> Jud Dist. 7/22/10). In the absence of such a rebuttal, the claim may be denied. A. Khodadadi Radiology, PC v. NY Cent Mut. Ins. Co., 16 Misc. 3d 131 (A), 2007 NY Slip Op 51342[U] (App term 2<sup>nd</sup> and 11<sup>th</sup> Jud Dist. 2007).

Dr. Upadhyayula's rebuttal is cogent and sufficient to refute respondent's burden of proof. Initially he discusses the significant positive clinical findings including diminished reflexes, decreased sensation, positive Spurling and positive straight leg raise. There were multilevel disc herniations with annular tearing, foraminal narrowing and thecal sac impingement on the cervical and lumbar MRIs. There is no documentation of any pre-existing history involving the neck and lower back and the EIP was asymptomatic prior to the subject accident. Even if there were pre-existing conditions, exacerbations are covered by the no-fault law. Kingsbrook Jewish Medical Center v. Allstate Insurance Company, 61 A.D. 3d 13, 871 NYS 2d 680 (2d Dept. 2009).

Additionally, he argues that there was a genuine differential diagnosis between radiculopathy versus peripheral neuropathy for which EDX was medically necessary. While the clinical features were suggestive of radiculopathy, the diagnosis was not 100% confirmed based upon exam and MRI alone. Some of the patient's symptoms could be explained by radiculopathy; they can also be explained by sciatic entrapment neuropathy or brachial plexopathy. Further, cervical, and lumbar myofascitis may cause local and radiating pain over the areas of the involved muscles and over the areas of pain referral. The EIP's clinical presentation demanded a neurologic evaluation beyond the capabilities of physical examination and imaging alone. The testing may be helpful in determining the functional significance of a known or suspected radicular nerve root compression. Citing to medical authority, Dr. Upadhyayula opines that nerve conduction studies are indicated primarily to exclude other neuromuscular disorders that may mimic radiculopathy such as peripheral polyneuropathy and mono neuropathies. The EDX also helps determine whether structural abnormalities on MRI are of significance. The EIP suffered for 2 months with radicular manifestations of cervical and lumbar pain coupled with exam and positive MRI findings without substantial improvement. The performance of the EDX was not a deviation from generally accepted medical practice.

In response, Dr. Sidhwani opined that there was an inadequate course of conservative care. 6 to 12 weeks, when necessary, before any further invasive treatment would be considered. Further, there was no clinical evidence of a valid diagnostic dilemma needing to be ruled out nor has Dr. Upadhyayula provided any additional evidence of diagnostic dilemma secondary to the soft tissue injuries sustained on 7/3/19. Further, the test should be conducted in a controlled environment as it often results in false positive and false negatives findings. There was no temperature data in this case. Dr. Sidhwani also questions the efficacy of the EDX noting that it often has low combined sensitivity and specificity in confirming root injury. There are no studies that confirm the efficacy of the EMG/NCS in the management of STRS. Regardless, the EIP was in the acute phase of treatment, had not received adequate care and the MRI studies clearly identify disc pathology.

After careful consideration of the party submissions and the arguments at hearing I am more persuaded by Dr. Upadhyayula's rebuttal. The EIP participated in sufficient rehabilitation without improvement of her radicular symptoms. The clinical findings coupled with the MRI suggest more than a soft tissue injury. Dr. Upadhyayula cogently

explains that there was in fact a differential diagnosis as the symptoms of radiculopathy frequently mimics the symptoms of other polyneuropathies or mono neuropathies.

On the issue of medical necessity, I find for applicant.

Lastly, at hearing respondent argued that applicant billed excessively. Specifically, applicant billed CPT 95904 (6 units) CPT 95904 - 59 (6 units) CPT 95886 (4 units) and CPT 95886 - 59 (4 units). In response, applicant argues that respondent has offered no evidence (affidavit of certified professional coder) to support its conclusion and if respondent needed clarification as to the nature of the billing it should have requested additional verification in accordance with 11 NYCRR§ 65 - 3.5 (b). Bronx Acupuncture Therapy v. Hereford Insurance Company, 2017 NY Slip Op 50101 (U) (App. Term 2d Dept., 1/20/17).

As to CPT 95904, I am inclined to agree with applicant. CPT 95904 is for nerve conduction, amplitude and latency/velocity study, *each nerve*, motor, without F wave study, sensory. (Emphasis added). There is nothing inherently questionable and applicant's billing and I agree that if respondent wanted to challenge 12 units of CPT 95904 it could and should have requested additional verification.

However, with respect to CPT 95886 Dr. Sidhawani's peer review clearly documents that CPT 95886 - 59 x4 was a duplicate charge. The code descriptor for CPT 95886 is: "needle electromyography, *each extremity*, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, 5 or more muscles studied, innervated by three or more nerves or four or more spinal levels (list separately in addition to code for primary procedure)." [Emphasis added]. Applicant could not possibly bill for 8 extremities. Its claim for CPT 95886 - 59 is denied.

Total award: \$3706.88.

Interest: Applicant is awarded interest in accordance with 11 NYCRR§65 - 3.9 (a)-(f). Accordingly, interest is calculated at a rate of 2% per month, calculated on a pro rata basis using the 30 day month. A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. 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. 11 NYCRR §65 - 3.9 (c). The Superintendent and the New York Court of Appeals has interpreted this provision to apply regardless of whether the particular denial at issue was timely. LMK Psychological Services PC v. State Farm Mutual Automobile Insurance Company, 12 NY 3d 217 (2009).

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
	Anesthesia Solutions PC	08/23/19 - 08/23/19	\$4,324.40	Awarded: \$3,706.88
Total			\$4,324.40	Awarded: \$3,706.88

- B. The insurer shall also compute and pay the applicant interest set forth below. 12/10/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Based on the submission of a timely denial, interest shall be paid from 12/10/19, the date of filing, on the amount awarded of\$ 3706.88 at a rate of 2% per month, simple, and ending with the date of payment of the award subject to the provisions of 11 NYCRR 65 - 3.9 (e).

C. Attorney's Fees

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

As this matter was filed **after** February 4, 2015, this case is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4.6(d) (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant an attorney's fee, in accordance with newly promulgated 11 NYCRR 65-4.6(d).

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

09/14/2021

(Dated)

Rhonda Barry

### **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:**  
e139758ab4fab56b703558a9f454ca6

### **Electronically Signed**

Your name: Rhonda Barry  
Signed on: 09/14/2021