

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Aharon Gutterman MD, PLLC
(Applicant)

- and -

LM General Insurance Company
(Respondent)

AAA Case No.	17-20-1153-8005
Applicant's File No.	none
Insurer's Claim File No.	LA000-040747685-01
NAIC No.	36447

ARBITRATION AWARD

I, Aaron Maslow, 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 ["ML"]

1. Hearing(s) held on 09/20/2021
Declared closed by the arbitrator on 09/20/2021

Rajesh Barua, Esq., from The Law Offices of Hillary Blumenthal P.C. (Melville)
participated for the Applicant

Alan Zysberg from LM General Insurance Company participated for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 3,119.44**, was NOT AMENDED at the oral hearing.
Stipulations WERE made by the parties regarding the issues to be determined.

The parties stipulated that Applicant established a prima facie case of entitlement to No-Fault compensation with respect to its bill. They also stipulated that Respondent's Form NF-10 denial of claim form was timely issued, i.e., within the 30-day deadline prescribed by Insurance Law §5106(a) and 11 NYCRR 65-3.8(a)(1). Additionally, they stipulated that should Applicant prevail, interest would accrue as of the date that the American Arbitration Association received Applicant's arbitration request.

3. Summary of Issues in Dispute

- Whether Applicant established entitlement to No-Fault insurance compensation for upper and lower extremity EMG/NCV testing performed on Assignor.
- Whether Respondent made out a prima facie case of lack of medical necessity and, if so, whether Applicant rebutted it.

4. Findings, Conclusions, and Basis Therefor

Appearances

For Applicant:

The Law Offices of Hillary Blumenthal P.C.
68 South Service Road
Suite 100
Melville, NY 11747
Of counsel: Rajesh Barua

For Respondent:

Alan Zysberg
LM General Insurance Co.
P.O. Box 5014
Scranton, PA 18505

Applicant commenced this New York No-Fault insurance arbitration, seeking as compensation \$3,119.44 which it billed for performing upper and lower extremity EMG/NCV testing on Oct. 31, 2019, on Assignor, a 52-year-old female who was injured in a motor vehicle accident on July 5, 2019. Respondent denied payment on the ground of lack of medical necessity. While it also asserted that fees were not in accordance with fee schedule, at the hearing this was not pursued.

This arbitration was organized by the American Arbitration Association, which has been designated by the New York State Department of Financial Services to coordinate the mandatory arbitration provisions of Insurance Law § 5106(b), which provides:

Every insurer shall provide a claimant with the option of submitting any dispute involving the insurer's liability to pay first party ["No-Fault insurance"] benefits, or additional first party benefits, the amount thereof or any other matter which may arise pursuant to subsection (a) of this section to arbitration pursuant to simplified procedures to be promulgated or approved by the superintendent.

Both parties appeared at the videoconference hearing (Applicant by counsel and Respondent by an employee), presented oral argument, and relied upon documentary submissions. I have reviewed the submissions' documents contained in

the American Arbitration Association's ADR Center as of the date of the hearing, said submissions constituting the record in this case with the exception that the additional submissions by Applicant on Aug. 26, 2020 and June 17, 2021 remain precluded. Per the No-Fault Regulations, at 11 NYCRR 65-4.5(o)(iii)(2), I determined whether the parties provided and exchanged documents in accordance with the requirements of the "Rocket Docket" rule (11 NYCRR 65-4.2(b)(3)), which requires that an applicant submit and serve its evidentiary documents upon submitting and serving the arbitration request form, and that a respondent submit and file its evidentiary documents within 30 days of being advised by the designated arbitration association of the applicant's submission. I noted at the hearing that these additional submissions were late. Applicant's Aug. 26, 2020 submission was more than seven months late, and its June 17, 2021 submission was more than 17 months late -- after its original submission of Jan. 11, 2020.

There must be finality to the submission of documents. I find no extraordinary reason to accept these late submissions. They are violative of the "Rocket Docket" rule embodied in the regulations promulgated by the State Insurance Department (now the Financial Services Department). A No-Fault arbitrator acts within her discretion in refusing to entertain late submissions. E.g., Matter of Global Liberty Ins. Co. v. Coastal Anesthesia Services, LLC, 145 A.D.3d 644 (1st Dept. 2016) (four days late, per arbitration award in AAA Case No. 17-14-9048-0690); Matter of Mercury Casualty Co. v. Healthmakers Medical Group, P.C., 67 A.D.3d 1017 (2d Dept. 2009) (27 days late, per briefs). At the hearing, when asked why there were late submissions, Applicant responded, "I have no explanation."

The parties stipulated that Applicant established a prima facie case of entitlement to No-Fault compensation with respect to its bill. They also stipulated that Respondent's Form NF-10 denial of claim form was timely issued, i.e., within the 30-day deadline prescribed by Insurance Law §5106(a) and 11 NYCRR 65-3.8(a)(1).

Since Respondent's denial was timely (as stipulated by the parties), it was within its rights to assert lack of medical necessity as a defense. Liberty Queens Medical, P.C. v. Liberty Mutual Insurance Co., 2002 WL 31108069 (App. Term 2d & 11th Dists. June 27, 2002); cf. Country-Wide Insurance Co. v. Zablocki, 257 A.D.2d 506 (1st Dept. 1999). "The no-fault law defines 'basic economic loss,' for which accident victims are entitled to reimbursement up to \$50,000, as '[a]ll necessary expenses incurred for: (i) medical, hospital ... surgical, nursing, dental, ambulance, x-ray, prescription drug and prosthetic services' (Insurance Law § 5102[a][1] [emphasis added]). Like the statute, the regulations promulgated thereunder expressly state that reimbursable medical expenses consist of 'necessary expenses' (11 NYCRR 65-1-1 [emphasis added])." Long Island Radiology v. Allstate Ins. Co., 36 A.D.3d 763, 765 (2d Dept. 2007).

A peer review report relied upon by an insurer in timely denying a claim is a proper vehicle to assert the defense of lack of medical necessity. S. & M Supply, Inc.

v. Allstate Ins. Co., 2003 N.Y. Slip Op. 51191(U) (App. Term 2d & 11th Dists. July 9, 2003); Rockaway Boulevard Medical P.C. v. Travelers Property Casualty Corp., 2003 N.Y. Slip Op. 50842(U) (App. Term 2d & 11th Dists. Apr. 1, 2003). In fact, without a peer review, a defense of lack of medical necessity at the litigation stage cannot survive. See A.B. Medical Services PLLC v. Lumbermens Mutual Casualty Co., 4 Misc.3d 86 (App. Term 2d Dept. 2004).

A peer reviewer must establish a factual basis and medical rationale for his asserted lack of medical necessity of the health care provider's services. See Amaze Medical Supply Inc. v. Allstate Ins. Co., 12 Misc.3d 142(A), 2006 N.Y. Slip Op. 51412(U) (App. Term 2d & 11th Dists. July 12, 2006); Prime Psychological Services, P.C. v. Progressive Casualty Ins. Co., 24 Misc.3d 1244(A), 2009 N.Y. Slip Op. 51868(U) at 3 (Civ. Ct. Richmond Co., Katherine A. Levine, J., Aug. 5, 2009); A.M. Medical Services, P.C. v. Deerbrook Ins. Co., 18 Misc.3d 1139(A), 2008 N.Y. Slip Op. 50368(U) (Civ. Ct. Kings Co., Sylvia G. Ash, J., Feb. 25, 2008).

"A no-fault insurer defending a denial of first-party benefits on the ground that the billed-for services were not 'medically necessary' must at least show that the services were inconsistent with generally accepted medical / professional practice. The opinion of the insurer's expert, standing alone, is insufficient to carry the insurer's burden of proving that the services were not 'medically necessary'." CityWide Social Work & Psy. Serv., P.L.L.C. v. Travelers Indemnity Co., 3 Misc.3d 608, 609 (Civ. Ct. Kings Co. 2004). "Generally accepted practice is 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. at 616; accord, Prime Psychological Services, P.C. v. Progressive Casualty Ins. Co., supra; Millennium Radiology, P.C. v. New York Central Mutual Fire Ins. Co., 23 Misc.3d 1121(A), 2009 N.Y. Slip Op. 50877(U) (Civ. Ct. Richmond Co., Katherine A. Levine, J., Apr. 30, 2009). Without a recitation to generally accepted medical practice, a peer reviewer's opinion is simply a different professional judgment which, in and of itself, does not establish that the disputed services were medically unnecessary to treat the injured person's condition.

If the peer review satisfies these standards, it becomes incumbent on the claimant to rebut the peer review. See Be Well Medical Supply, Inc. v. New York Cent. Mut. Fire Ins. Co., 18 Misc.3d 139(A), 2008 N.Y. Slip Op. 50346(U) (App. Term 2d & 11th Dists. Feb. 21, 2008); A Khodadadi Radiology, P.C. v. NY Central Mutual Fire Ins. Co., 16 Misc.3d 131(A), 2007 N.Y. Slip Op. 51342(U) (App. Term 2d & 11th Dists. July 3, 2007), because the ultimate burden of proof on the issue of medical necessity lies with the claimant. Dayan v. Allstate Ins. Co., 49 Misc.3d 151(A), 2015 N.Y. Slip Op. 51751(U) (App. Term 2d, 11th & 13th Dists. Nov. 30, 2015); Park Slope Medical and Surgical Supply, Inc. v. Travelers Ins. Co., 37 Misc.3d 19, 22 n. (App. Term 2d, 11th & 13th Dists. 2012).

"Where 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 Prince, Richardson on Evidence §§ 3-104, 3-202 [Farrell 11th ed])." West Tremont Medical

Diagnostic, P.C. v. Geico Ins. Co., 13 Misc.3d 131(A), 2006 N.Y. Slip Op. 51871(U) at 2 (App. Term 2d & 11th Dists. Sept. 29, 2006). Thus, although Respondent must come forward with prima facie proof of lack of medical necessity, the burden will shift to Applicant to prove medical necessity by a preponderance of the credible evidence if Respondent meets its burden.

Dr. Anna Krol prepared the peer review relied upon by Respondent in asserting lack of medical necessity. At the outset, she listed the numerous medical records pertaining to Assignor's treatment which she reviewed. She noted that Assignor was a restrained driver of a vehicle involved in a collision on July 5, 2019. She did not seek emergency care afterwards.

Dr. Krol then noted that according to the examination report by Aharon Gutterman, M.D., she presented on Oct. 31, 2019 with complaints of pain in the neck and low back. Physical examination of the cervical spine revealed range of motion flexion 30 degrees with pain, extension 20 degrees with pain, bilateral lateral flexion 20 degrees with pain, right rotation 60 degrees with pain, and left rotation 50 degrees with pain. Lumbar spine examination revealed range of motion flexion 65 degrees with pain, extension 10 degrees with pain, bilateral lateral flexion 10 degrees with pain, right rotation 20 degrees with pain and left rotation 20 degrees with pain. Straight Leg Raise was negative on right and positive on left. Neurological examination of the muscle strength was 5/5 bilaterally. Deep tendon reflexes were decreased bilaterally. Sensation was normal bilaterally. The diagnostic impression included cervicalgia, radiculopathy, cervical region, radiculopathy, lumbosacral region, and lumbago. As a part of the treatment plan, the claimant was referred to EMG/NCV study of upper and lower extremities. They were then performed.

Dr. Krol opined that the EMG/NCV testing was not medically necessary. "The standard of care is to make the diagnosis of radiculopathy upon clinical recognition of signs and symptoms consistent with a radiculopathy. Even if this patient had signs and symptoms suggesting radiculopathy, electrodiagnostic testing would not be helpful in excluding the diagnosis of radiculopathy. Electrodiagnostic testing cannot be used to exclude or rule-out a radiculopathy. If the results of the EMG/NCV testing were normal, the claimant could still have a radiculopathy." According to the National Guideline Clearinghouse, "An EMG is not necessary for the diagnosis of intervertebral disk disease with radiculopathy, rather its value lies in differentiating other types of neuritis, neuropathy, or muscle abnormalities from radicular neuropathy and for case where the etiology of the pain is not clear."

Also, "There was no adequate differential diagnosis provided to justify performing this test and it is unclear what benefit occurred to the claimant as a result of this test and what significant or particular change in medical management occurred as a result of this test."

As noted above, a peer review requires a factual basis and a medical rationale. Dr. Krol's peer review contained a more than adequate factual basis, to wit, the numerous medical records reviewed. It also contained a medical rationale. She

stated explicitly that the standard of care is to make the diagnosis of radiculopathy upon clinical recognition of signs and symptoms consistent with a radiculopathy. There being a factual basis and a medical rationale, the burden of proof shifted to Applicant to rebut the peer review and affirmatively prove medical necessity, per the cited case law.

Applicant adverted to a formal rebuttal, but it is contained within a late submission which remained precluded; it is not part of the official record. Applicant also argued that the pre-testing exam and a letter of medical necessity proved medical necessity.

The letter of medical necessity is of no probative value. It is generic in nature and, while it mentions Assignor's name, it references no specific findings of her condition.

The pre-testing exam report of Dr. Hadassah Orenstein is on a preprinted checklist. There is a preprinted conclusion at the end that testing is "clinically indicated to ascertain the presence and degree of denervation second to a possible radiculopathy. The testing serves to establish diagnosis and degree of pathology." I accord this little probative value. It is puzzling how there can be a preprinted reason for performing EDX testing when the patient has not yet been examined. The report does not even contain an option as to why EDX testing would not be indicated.

On balance, Dr. Krol's peer review outweighs Applicant's evidence. Applicant failed to affirmatively prove medical necessity. I sustain the defense of lack of medical necessity, which overcomes Applicant's prima facie case of entitlement to No-Fault compensation.

Accordingly, the within arbitration claim is denied in its entirety.

This arbitrator has not made a determination that benefits provided for under Article 51 (the No-Fault statute) of the Insurance Law are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of Assignor. As such and in accordance with the provisions of the prescribed NYS Form NF-AOB (the assignment of benefits), Applicant health provider shall not pursue payment directly from Assignor for services which were the subject of this arbitration, notwithstanding any other agreement to the contrary.

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 Kings

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

09/25/2021
(Dated)

Aaron Maslow

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:
543649dadbb02a126ead30b499367bfd

Electronically Signed

Your name: Aaron Maslow
Signed on: 09/25/2021