American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Mount Hollis Medical PC (Applicant)	AAA Case No.	17-21-1223-5417
	Applicant's File No.	82200
- and -	Insurer's Claim File No.	0584698707 2AG
Allstate Insurance Company (Respondent)	NAIC No.	29688

ARBITRATION AWARD

I, Michael Resko, 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: Claimant

1. Hearing(s) held on 09/06/2022
   Declared closed by the arbitrator on 09/06/2022

   Marissa Monteiro Esq. from Law Offices of Eitan Dagan (Elmhurst) participated in person for the Applicant

   Joseph Palmerson Esq. from Law Offices Of Karen L. Lawrence participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$3,281.52**, was NOT AMENDED at the oral hearing.
   Stipulations WERE made by the parties regarding the issues to be determined.
   The parties stipulated and agreed that (i) Applicant has met its *prima facie* burden by submitting evidence that payment of no-fault benefits is overdue, and proof of its claim was mailed to and received by Respondent; and (ii) Respondent's denials of the subject claims were timely issued.

3. Summary of Issues in Dispute

   The EIP/Assignor is referred to herein as Claimant. Claimant is a 19-year-old male driver injured in a motor vehicle accident on 04/25/20.

There are three (3) separate claims at issue in this case. In chronological order, the first claim is for an office evaluation and EMG/NCV testing of Claimant's upper and lower extremities on date of service 05/28/20.

Respondent paid for the office evaluation as billed and denied payment for the testing based on a peer review report by Isandr Dumesh, MD (dated 07/29/20).

Applicant had submitted a rebuttal of the peer review report (by Max Jean-Gilles, MD) but that submission was made on 09/07/22 - after the hearing and record of this matter was closed. Therefore, I will not consider the rebuttal in deciding the issue of medical necessity for the EMG/NCV testing.

The next claim at issue is for Range of Motion (ROM) and Manual Muscle Testing (MMT) performed on date of service 07/22/20. Respondent paid for the ROM testing as billed, and reimbursed the MMT - for which Applicant billed four (4) units of code 95831 - as one (1) unit of code 95834.

The third and last claim is for physical therapy (PT) rendered to Claimant on eight (8) dates of service from 07/24/20 through and including 08/25/20.

Respondent partially denied this claim based on the "8-unit rule".

Respondent has also submitted a "global" denial based on Claimant's failure to attend an independent medical examination (IME) on 08/18/20 and 10/14/20.

The following evidence was submitted, reviewed, and considered: All documents contained in the ADR Center as of the date the hearing was declared closed.

4. Findings, Conclusions, and Basis Therefor

As an initial matter, Respondent's IME no-show defense is precluded/inapplicable because it was not raised and preserved in timely denials specific to the subject claims. See, e.g., *Westchester Medical Center v. Lincoln General Ins. Co.*, 60 A.D.3d 1045, 1046-47, 877 N.Y.S.2d 340, 342 (2d Dept. 2009).

I will address the claims and services at issue in the same order as they are set forth in section "3" above.

(1) EMG/NCV Testing - Medical Necessity

Respondent denied Applicant's claim for EMG/NCV testing of Claimant's upper and lower extremities s based on the peer review report of Dr. Dumesh. Dr. Dumesh reviewed Applicant's "Initial Neurodiagnostic Evaluation" of Claimant and wrote, in relevant part:

> *During the neurological consultation by Mount Hollis Medical, PC on 05/28/20 the claimant was complaining of neck pain radiating to right shoulder and arm and lower back pain radiating to both lower extremities. The claimant was diagnosed with cervical radiculopathy and lumbar radiculopathy and underwent the Upper and Lower Extremities EMG/NCV/F/H testing.*

Dr. Dumesh then wrote "[i]n general, electrodiagnosis can only be an extension of the history and physical examination. It assists to narrow the differential diagnosis and at times confirm the diagnosis. To perform the electrodiagnosis efficiently, one should have a clear reason for each and every step in the study." He cited and quoted from *Cervical Radiculopathy* and *Lumbar Radiculopathy*, both by Gerard Malanga, MD" for the relevant point(s): "The timing of the EMG evaluation is important because positive sharp waves and fibrillation potentials first occur 18-21 days after the onset of a radiculopathy; therefore, it is best to delay this study until 3 weeks after an injury, to ensure that the results are as accurate as possible"; and "Electrodiagnostic studies (eg, nerve conduction studies and needle electromyography) should be considered an extension of the history and physical examination in patients with lumbosacral radiculopathy and not merely a substitute for detailed neurologic and musculoskeletal examinations. These studies are helpful when the diagnosis remains unclear (eg, peroneal neuropathy vs radiculopathy) in the evaluation of patients who have limb pain or when attempting to localize the patient's symptoms to a specific nerve root level. Electrodiagnostic studies are also helpful for excluding other causes of sensory and motor disturbances, such as peripheral neuropathy and motor neuron disease. Additionally, these studies can provide useful prognostic information by quantifying the extent and acuity of axonal involvement in radiculopathies."

Dr. Dumesh concluded:

> *In this particular case, the claimant sustained injuries in the motor vehicle accident, and was started on the conservative therapy following the initial evaluation. The EMG/NCV/F/H testing was performed approximately 1 month later. According to the records, the claimant has been undergoing the conservative therapy regimen on a continuous basis. There was no indication that any alternative treatment options were considered at that time. There was no evidence that any future therapy decisions were dependent upon the information obtained from the performance of the Upper and Lower Extremities EMG/NCV testing. The diagnoses in this case could have been made clinically. Summarizing, there was no evidence that the results of the Upper and Lower Extremities EMG/NCV/F/H testing could have been incorporated into the treatment course at that point or affect any future treatment-related decisions. Therefore, I consider the above electrodiagnostic studies not medically necessary in this case.*

Notably, the neurological evaluation of Claimant on 05/28/20 was normal with intact motor, reflexes and sensory function. Based on the totality of the evidence before me I find the EMG/NCV testing performed on 05/28/20 was not medically necessary. There

is no evidence of any diagnostic dilemma or treatment decisions that required or were dependent upon the test results. This claim is denied.

(2) MMT - Partially Paid

Applicant billed for four (4) units of MMT of Claimant's shoulder, knee, neck, and trunk. MMT is correctly billed as one (1) unit for the entire spine/trunk and 1 unit per extremity tested. In this case, Applicant should have billed for three (3) units total, not 4.

Respondent reimbursed Applicant for 1 unit of code 95834, which is MMT of the whole body. Respondent has not offered any evidence in support of its decision to change the code billed to the code it paid.

The correct reimbursement amount for 3 units of code 95831 is $130.80. Respondent paid $125.69. Based on the evidence before me, Applicant is entitled to and shall be awarded the difference which is **$5.11.**

(3) PT - 8-Unit Rule

The "8-unit rule" is codified in the Ground Rules of the Physical Medicine sections of both the Medical and Chiropractic fee schedules (Ground Rules 11 and 3, respectively). The Ground Rules provide that when multiple physical medicine procedures and/or modalities are performed on the same day, reimbursement is limited to the lesser of the amount billed or 8.0 relative value units (RVU). The Ground Rules lists multiple CPT codes to which the 8.0 RVU maximum applies. Certain of these codes are listed in both the Medical and Chiropractic Ground Rules. As to these services, if multiple providers in different specialties - e.g. a physical therapist and chiropractor - render services on the same date of service then the aggregate reimbursement is limited to a maximum of 8.0 RVU for all providers.

Respondent partially paid Applicant's claim herein and has submitted evidence that on the same dates of service at issue it had reimbursed another provider (Hudson Valley Chiropractic Health Services) for PT modalities up to the 8.0 RVU daily maximum. Therefore, based on the evidence before me I find Applicant is not entitled to any further or additional reimbursement for this claim.

This Award is in full disposition of all claims and issues before me in this proceeding.

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**
	Mount Hollis Medical PC	**05/28/20 - 08/25/20**	**$3,281.52**	**Awarded: $5.11**
Total			**$3,281.52**	**Awarded: $5.11**

B. The insurer shall also compute and pay the applicant interest set forth below. 10/20/2021 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Pursuant to the Court of Appeals decision in LMK Psychological Services P.C. v. State Farm, 12 N.Y.3d 217, 879 N.Y.S.2d 14 (2009), interest is tolled until the filing date where the 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 Insurance Department regulations" (11 NYCRR 65-3.9[c]).

C. Attorney's Fees

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

The insurer shall pay the applicant an attorney's fee in accordance with 11 NYCRR 65-4.6(e). 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 Westchester

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

09/28/2022
(Dated)

Michael Resko

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:
6b0121f22ef3569e442713ee20b3a134

Electronically Signed

Your name: Michael Resko
Signed on: 09/28/2022