

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

BE Evergreen Medical PC
(Applicant)

- and -

Hereford Insurance Company
(Respondent)

AAA Case No. 17-22-1248-9099

Applicant's File No. 104886

Insurer's Claim File No. 95580-05

NAIC No. 24309

ARBITRATION AWARD

I, Kathleen Sweeney, 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: IP

1. Hearing(s) held on 03/03/2023
Declared closed by the arbitrator on 03/03/2023

Robin Grumet from Law Offices of Eitan Dagan (Woodhaven) participated virtually for the Applicant

Chris Fingerhut from Law Offices of Rubin & Nazarian participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,157.21**, 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

Whether the EMG/NCV of the upper extremities was medically necessary?

This arbitration arises out of medical treatment for the IP, a 32 year old female, related to injuries sustained in a motor vehicle accident that occurred on 10/25/21. Applicant seeks reimbursement for EMG/NCV testing of the upper extremities that took place between 11/4/21 and 12/6/21. Respondent timely denied payment based upon a peer review by Dr. Golden dated 1/14/22.

4. Findings, Conclusions, and Basis Therefor

Applicant has established its prima facie case with proof that it submitted a proper claim, setting forth the fact and the amount charged for the services rendered and that payment of no-fault benefits was overdue (see Insurance Law § 5106 a; *Mary Immaculate Hosp. v. Allstate Ins. Co.*, 5 AD 3d 742, 774 N.Y.S. 2d 564 [2004]; *Amaze Med. Supply v. Eagle Ins. Co.*, 2 Misc. 3d 128A, 784 N.Y.S. 2d 918, 2003 NY Slip Op 51701U [App Term, 2d & 11th Jud Dists]).

The burden shifts to the insurer to prove that the services were not medically necessary. When an insurer relies upon a peer review report to demonstrate that a particular service was not medically necessary, the peer reviewer's opinion must be supported by sufficient factual evidence or proof and cannot simply be conclusory. As per the holding in *Jacob Nir, M.D. v. Allstate Insurance Co.*, 7 Misc.3d 544 (2005), the peer reviewer must establish a factual basis and medical rationale to support a finding that the services were not medically necessary, including setting forth generally accepted standards in the medical community. The opinion of the insurer's expert, standing alone, is insufficient to carry the insurer's burden to prove that the services were not medically necessary. *CityWide Social Work & Psychological Services, PLLC v. Travelers Indemnity Co.*, 3 Misc.3d 608, 777 N.Y.S.2d 241 (N.Y.Civ. Ct. Kings Co. 2004).

In this case, Dr. Golden asserts that EMG/NCV study was not medically necessary and that the records presented do not establish a differential diagnosis and are insufficient to rely on for the request for an EMG. Specifically, she relies on medical authorities that discuss and support her position that history and symptomology here do not indicate any nerve involvement. She opined that electrodiagnostic testing requires a differential diagnosis and since all the records presented indicate radiculopathy which can be diagnosed without the testing in question. As such there was not a valid question of differential diagnosis, and that MRIs should be done prior to such testing and the Dr. maintained her position that the testing was not medically necessary.

Where the Respondent presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden then shifts to the Applicant which must then present its own evidence of medical necessity. [see *Prince, Richardson on Evidence* §§ 3-104, 3-202 [Farrell 11th ed]], *Andrew Carothers, M.D., P.C. v. GEICO Indemnity Company*, 2008 NY Slip Op 50456U, 18 Misc. 3d 1147A, 2008 N.Y. Misc. LEXIS 1121, *West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co.* 13 Misc.3d 131, 824 N.Y.S.2d 759, 2006 NY Slip Op 51871(U) (Sup. Ct. App. T. 2d Dep't 2006)].

In support of the claim for the EMG/NCV testing, Applicant relies on the IP's medical records, and the Rebuttal of the treating Dr. who relies on the "clinical UM guidelines of 8/12/21" and an evaluation done the same day as the testing. The rebuttal claims there was no explanation for the IP's pain despite the fact that there was an MRI which showed bulging discs and the rebuttal also claims there was no improvement with the PT the IP had been doing for barely 4 weeks. A review of the medical reports provided shows numerous comments noting the IP feels better with PT and on 11/24/21 a record

shows continuation with chiropractic and a re-evaluation in 4 to 8 weeks. The rebuttal relies on medical assertions not substantiated by the actual records in the file.

Comparing the relevant evidence presented by both parties against each other I find I am persuaded by the Respondent. I find that Applicant did not prove medical necessity by a preponderance of the credible evidence. Rather, Respondent proved lack of medical necessity. Accordingly, after reviewing the entire record and after careful consideration of the parties' oral arguments, I sustain the defense asserted in the denials. Applicant's claim is denied. This decision is in full disposition of all claims for No-fault benefits presently before this Arbitrator.

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 NY

SS :

County of Nassau

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

04/02/2023
(Dated)

Kathleen Sweeney

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:
150a00c2a12cbd643cf11b97e6f36d1c

Electronically Signed

Your name: Kathleen Sweeney
Signed on: 04/02/2023