American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Gemini Chiropractic PC (Applicant)	AAA Case No.	17-22-1254-0044
	Applicant's File No.	90944
- and -	Insurer's Claim File No.	21-4451326
	NAIC No.	24260
Progressive Casualty Insurance Company (Respondent)		

ARBITRATION AWARD

I, Charles Blattberg, 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: Eligible injured person

1. Hearing(s) held on 03/03/2023
   Declared closed by the arbitrator on 03/08/2023

   Ilya Murafa, Esq. from of counsel to Law Offices of Zara Javakov, Esq. P.C. participated virtually for the Applicant

   Iris Ganijan, Esq. from McCormack, Mattei & Holler participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$565.40**, 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

   The claimant was the 36 year-old female driver of a motor vehicle that was involved in an accident on 1/6/21. Following the accident the claimant suffered injuries which resulted in the claimant seeking treatment. At issue is 6/22/21 EMG/NCV testing that Respondent timely denied reimbursement for based "*upon the results of a Medical Examination*"and the "*failure to maintain proper licensure*."

4. Findings, Conclusions, and Basis Therefor

Based on a review of the documentary evidence, this claim is decided as follows:

An applicant establishes a prima facie case of entitlement to reimbursement of its claim by the submission of a completed NF-3 form or similar document documenting the facts and amounts of the losses sustained and by submitting evidentiary proof that the prescribed statutory billing forms [setting forth the fact and the amount of the loss sustained] had been mailed and received and that payment of no-fault benefits were overdue. See, *Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). I find that Applicant established a prima facie case for reimbursement.

The claimant was the 36 year-old female driver of a motor vehicle that was involved in an accident on 1/6/21. The claimant reportedly injured her neck, right shoulder, and low back. There was a reported questionable loss of consciousness. There were no reported lacerations or fractures. Following the accident the claimant was transported to Presbyterian Hospital where she was X-rayed, evaluated, treated, and released. On 1/14/21 the claimant presented to Hank Ross, M.D. "with complaints of headaches, pain in her neck and right shoulder as well as her low back." Right shoulder examination revealed a tender lateral acromion with positive Impingement Sign, O'Brien's sign, and positive Speed's. Range of motion was restricted: Abduction 120/150°, Forward flexion 150/180°, External rotation 80/90°, and Internal rotation 80/90°. Dr. Ross prescribed Flexeril 5 mg, and Volteran XR. Dr. Ross instructed the claimant in stretching and strengthening exercises that she should perform on her own. The claimant was referred for physical therapy. On 1/14/21 the claimant presented to JPM Physical Therapy, P.C. and was initiated on physical therapy. On 1/20/21 Donghui Chen, M.D. performed right cervical paraspinal trigger point injections. On 1/22/21 the claimant presented to Liberty Park Chiropractic, P.C. and was initiated on chiropractic treatment. On 1/23/21 the claimant presented to Hao Acupuncture, P.C. and was initiated on acupuncture care. On 1/26/21 Henry Lin Kim, M.D. supervised and reviewed Outcome Assessment (OSWESTRY) Testing (OAT). The 2/9/21 cervical spine MRI interpreted by B.V. Reddy, M.D. produced an impression of multilevel signal throughout the C-spine more prominent at C4-C5 and C5-C6 with concomitant broad-based posterior central subligamentous herniations impinging upon ventral thecal takeoff of traversing C6 and C7 nerve roots. On 2/15/21 Dr. Kim performed Radial Pressure Wave Therapy (RPWT) to the neck and bilateral shoulders. The 2/17/21 right shoulder MRI interpreted by B.V. Reddy, M.D. produced an impression of low-lying acromion also impinging on both infraspinatus mid supraspinatus: both with concomitant tendinosis with a rim rent tear of the infraspinatus attachment and a broad tear spanning both bursal and articular surfaces toward the supraspinatus attachment. Concomitant mild inflammatory changes of the acromioclavicular joint capsule and mild subacromial bursitis. Minimal glenohumeral effusion with increased signal concerning for tear of the anteroinferior labrum between approximately 5:00 and 6 o'clock position. Hypertensive was also noted at the biceps labral anchor complex for which additional tear is not excluded. Subscapularis tendinopathy and sprain of superior glenohumeral ligament. The 2/21/21 lumbar spine MRI interpreted by B.V. Reddy, M.D. produced an impression of L4-L5 and L5-S1 concentric annular bulges, more prominent at L4-L5 encroaching bilateral extra foraminal spaces impinging on central aspect of bilateral descending L4 nerves.

On 2/26/21 Dr. Kim performed RPWT to the neck and bilateral shoulders. On 3/12/21 Dr. Kim performed RPWT to the neck and bilateral shoulders. On 3/19/21 Dr. Kim performed RPWT to the neck and bilateral shoulders. On 3/23/21 the claimant was required to present to Stuart Hershon, M.D. for an independent orthopedic evaluation (IME) and Dr. Hershon concluded, in part, that "no medical necessity for prescription medications, injections, surgery, massage therapy, diagnostic testing, household help, durable medical equipment or special transportation." On 3/31/21 Dr. Chen performed C7-T1 cervical interlaminar epidural steroid injection under fluoroscopic guidance, epidurogram, and lumbar paraspinal trigger point injections. On 4/27/21 Rummel Mendoza, D.C. of Gemini Chiropractic, P.C. (Applicant) conducted an examination preliminary to upper extremities EMG/NCV that may have performed the same day [*report not in evidence*]. On 5/18/21 the claimant was required to present to Robert Snitkoff, D.C. for an independent chiropractic re-examination (IME) that was purportedly negative and Respondent determined "The results of the applicant's medical examination conclude further chiropractic treatment is not medically necessary and is denied. In addition, the examiner finds no evidence of disability, therefore further loss of earnings benefits are denied. This denial is effective for services rendered or benefits for losses incurred 06/01/2021 and after." On 5/19/21 Dr. Ross performed right shoulder arthroscopy, synovectomy, debridement glenoid labrum tears, debridement rotator cuff tears, and subacromial decompression with acromioplasty. The preoperative diagnosis was partial tear supraspinatus right shoulder. The postoperative diagnosis was partial tear supraspinatus, partial tear subscapularis, tear anterior and superior glenoid labrum, synovitis, subacromial bursitis, and impingement. Dr. Ross prescribed the use of a continuous passive motion (CPM) unit and a GameReady cold compression unit with right shoulder wrap. On 6/22/21 Rummel Mendoza, D.C. of Gemini Chiropractic, P.C. (Applicant) conducted an examination preliminary to lower extremities EMG/NCV that was performed the same day that produced a substantially normal study. The claimant presented for an evaluation on 6/22/2021 with the complaints of lower back pain, right knee pain and bilateral hip pain. Examination of the lumbar spine revealed tenderness, muscle spasm and muscle guarding with taut bands/trigger points/nodules. Range of motion of the lumbar spine was decreased and painful. SLR test, Fabere-Patrick test, Hibb's test and Braggard's test were positive. Manual muscle strength testing revealed decreased muscle strength in the hip flexors, hip abductors, knee extensors, ankle extensors and ankle flexors on the left. At issue is the 6/22/21 EMG/NCV testing. Respondent timely denied the testing "*[b]ased on your failure to maintain proper licensure your billing is hereby denied*" and *"[b]ased upon the results of a Medical Examination, these services are denied*." It is noted that Respondent's brief states "*the affirmed Medical Examination report of Robert Snitkoff DC, dated 5/18/21…has met its burden of establishing a lack of medical necessity for the services at dispute in this case*."

The burden has shifted to the Respondent as they have raised a medical necessity defense. In order to support a lack of medical necessity defense respondent must "set forth a factual basis and medical rationale for the peer reviewer's determination that there was a lack of medical necessity for the services rendered." See, *Provvedere, Inc. v. Republic Western Ins. Co.*, 2014 NY Slip Op. 50219(U) (App. Term 2nd, 11th and 13th Jud. Dists. 2014). Respondent bears the burden of production in support of its lack

of medical necessity defense, which if established shifts the burden of persuasion to Applicant. See generally, *Bronx Expert Radiology, P.C. v. Travelers Ins. Co.*, 2006 NY Slip Op. 52116 (App. Term 1st Dept. 2006). As a general rule, reliance on rebuttal documentation will be weighed in light of the documentary proofs and the arguments presented at the arbitration. Moreover, the case law is clear that a provider must rebut the conclusions and determinations of the IME/peer doctor with his own facts. *Park Slope Medical and Surgical Supply, Inc. v. Travelers*, 37 Misc.3d 19 (2012).

An IME report asserting that no further treatment is not medically necessary must be supported by a sufficiently detailed factual basis and medical rationale, which includes mention of the applicable generally accepted medical/professional standards. *Carle Place Chiropractic v. New York Central Mutual Fire Ins. Co.*, 19 Misc.3d 1139(A), 866 N.Y.S.2d 90 (Table), 2008 N.Y. Slip Op. 51065(U), 2008 WL 2228633 (Dist. Ct. Nassau Co., Andrew M. Engle, J., May 29, 2008).

During the 3/23/21 independent orthopedic evaluation (IME) conducted by Stuart Hershon, M.D. the claimant presented with complaints of headaches, pain in neck which radiated to the right arm and right thumb causing numbness, low back pain, bilateral shoulder pain, and right hand pain. After reviewing the claimant's history, treatment, and medical records cervical examination revealed minimal tenderness to palpation of the cervical paraspinal musculature. There was **minimal tenderness** to palpation of the trapezii. **Minimal muscle spasm** was noted. Range of motion of the cervical spine revealed flexion **45**/50°, extension **45**/60°, (60° being normal), right rotation **60**/80°, left rotation **70**/80°, right lateral flexion **35**/45° and left lateral flexion **40**/45°. Right shoulder examination revealed **tenderness** on palpation of the shoulder. There was no crepitus at the joints. Range of motion of the right shoulder revealed abduction **150**/180°, forward flexion **170**/180°, internal rotation **70**/80° and external rotation **80**/90°. Impingement sign was negative. Neer's sign was negative. O'Brien's, Yergason's, Speed's, Hawkins and Drop Arm tests were all negative. Examinations of the left shoulder, thoracic spine, lumbar spine, bilateral elbows, bilateral wrists, bilateral hands, bilateral hips, bilateral knees, bilateral ankles, and bilateral feet were within normal limits. On neurological examination, there were no sensory deficits in the upper extremities. Deep tendon reflexes of the biceps and triceps are present and equal bilaterally. Muscle strength in each range was 5/5. Neurological examination revealed patellar and Achilles reflexes to be 2+. Muscle strength of the lower extremities was graded at 5/5 bilaterally. Sensory examination of the lower extremities including the medial and lateral thighs, calves and feet were normal. Straight leg raising was negative. The claimant was able to tiptoe and heel walk. Dr. Hershon's diagnosis was cervical spine sprain/strain **resolving**, lumbosacral spine sprain/strain resolved, right shoulder sprain/strain **resolving**, left shoulder sprain/strain resolved, right hand sprain/strain resolved, and right knee sprain/strain resolved.

For its denial of the subject electrodiagnostic testing Respondent appears to be relying on the 5/18/21 independent chiropractic re-examination (IME) conducted by Robert Snitkoff, D.C. After reviewing the claimant's history, treatment, and medical records, Dr. Snitkoff conducts what appears to be a thorough examination. Dr. Snitkoff

documents the claimant's then current complaints as headaches and pain in her neck which radiates to her arms with numbness; and pain in her mid back, low back and right shoulder. Examination of the cervical spine revealed complaints of **minimal tenderness** to palpation over the cervical musculature. Ranges of motion of the cervical spine revealed flexion 50/50°, extension 60/60°, bilateral rotation 80/80° and bilateral lateral flexion is 45/45°. No muscle spasm was noted on palpation of the cervical musculature. Cervical Distraction testing, Soto Hall, Foraminal Compression and Jackson's Compression were negative. Deep tendon reflexes were 2+, equal and symmetrical. There was no evidence of sensory or neurovascular deficiency. Motor strength was 5/5 in the upper extremities. Examination of the thoracic spine revealed no paraspinal tenderness on palpation over the paraspinal muscles. There was no paraspinal spasm. Examination of the lumbosacral spine revealed no tenderness to palpation of the lumbosacral paraspinal muscles. There was no muscle spasm noted. There was no SI joint tenderness or instability. Range of motion of the lumbosacral spine was flexion to 60/60°, extension to 25/25°, bilateral lateral bending 25/25° and bilateral rotation 30/30°. Straight leg raise was negative bilaterally. Minor's sign was absent. Ely's, Nachlas and Fabere-Patrick signs were negative bilaterally. Kemp's test was within normal limits. On neurological examination of the lower extremities, there was no evidence of reflex, sensory or neurovascular deficiency. Motor strength was 5/5 in the lower extremities. Dr. Snitkoff's diagnosis was resolved sprain/strains of the cervical spine, thoracic spine, and lumbar spine. Dr. Snitkoff concluded "based on my examination and lack of objective findings, there is no medical necessity for chiropractic treatment for the cervical spine, thoracic spine or lumbosacral spine. Her subjective complaints were not correlated by objective findings. It is my opinion that there is no medical necessity for diagnostic testing, household help, massage therapy, special supplies or special transportation as it relates to the cervical spine, thoracic spine or lumbosacral spine. The reported diagnostic findings of the neck and back were not correlated by any positive objective clinical findings on examination."

If 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, *West Tremont Medical Diagnostic P.C., v. Geico*, 13 Misc.3d 131 (A), 824 NYS 2d 759 (App. Term 2d & 11th Dists, 2006).

Applicant submitted a 1/16/23 IME rebuttal by Michael Silver, D.C. After reviewing the claimant's history, treatment, and medical records, Dr. Silver opines "it is clear that the patient was responding to the treatment, but her injuries were certainly not resolved as of the date that the insurer determined to deny all future benefits based on the aforementioned IME report. Assuming the IME report is accurate as to findings on the exam, one cannot get an accurate picture of a patient's overall condition without considering all subsequent exams, which apparently is the case, as the IME report did not encompass any subsequent evaluation. Moreover, a patient's condition can appear to improve one day, but exacerbate a subsequent day, particularly as the IME report acknowledged the patient's subjective complaints and revealed positive findings. The treating physician who is responsible for the care and treatment of the patient is in the best position to determine the need for continued treatment. The IME physician, on the other hand, who is retained by the insurance carrier, has no responsibility for the

patient's best interests. In the light, of the positive findings that were revealed during and after the subject IMEs, Dr. Hershon and Dr. Snitkoff incorrectly recommended against further treatment. In this case, on the basis of positive neurological findings, lack of patient's considerable improvement of conservative treatment and patient's medical history, the patient was recommended to undergo the electrodiagnostic study of the upper and lower extremities to confirm the diagnosis of radiculopathy and rule out any peripheral neuropathy. The electrodiagnostic investigation consisting of NCV/EMG of the upper and lower extremities was medically necessary to rule out and determine exact diagnosis, lesion localization and extent of the injury as well as better predict prognosis for recovery and possible residual neurologic deficits; to evaluate the patient's present course of medical treatment and to determine if a modification was necessary; to find specific indications as to why patient's recovery has not been progressive and administer future appropriate physical and medicaments therapy; to help determine that the positive exam findings were not indicative of a possible surgery. Based on the findings, an upper and lower extremities neurodiagnostic evaluation was performed to further evaluate the patient. Needle EMG was performed to evaluate this patient with suspected radiculopathy since according to [*citation omitted*] needle examination is the single most useful procedure to evaluate patients with suspected radiculopathy. Based on the patient's refractory cervical and lumbar spine symptomatology coupled with the upper and lower extremity pain, upper and lower extremity neurodiagnostic evaluation was warranted to aid in further differentiating the diagnostic dilemmas and to determine radiculopathy versus peripheral neuropathy involving the median and/or ulnar nerves." Dr. Silver continues "electromyography aided in the determining chronicity versus acute nature of her radicular complaints. The results of EMG/NCS was valuable in determining appropriate patient treatment and the ultimate extent of the patient's injuries and prognosis. The patient's physical findings were suggestive of cervical and lumbar radiculopathy. While a thorough physical examination was taken, the objective and subjective complaints presented would not have resulted in a spontaneous guess of radiculopathy. The patient's symptoms and signs raised the possibility of cervical and lumbar radiculopathy. Radiculopathy can either be secondary to mechanical compression such as disc bulge or due to direct nerve root injury by means of stretch or avulsion. The diagnosis of radiculopathy is extremely difficult to make out clinically, because the pain of myofascitis mimics the pain of radiculopathy, particularly when there is a coexistence of several traumas to the body, and are thus difficult to separate. The patient's history, subjective complaints and clinical findings demonstrate a clear differential diagnosis consistent with possible radiculopathies for which neurodiagnostic testing can be helpful in confirming or ruling out. The only diagnostic test that can help confirm a definitive diagnosis and thereby allow in altering the treatment plan accordingly is the EMG/NCS study. As indicated in the American Academy of Electrodiagnostic Medicine practice guidelines for the performance of EMG/NCS testing, electrodiagnostic testing is used to evaluate the function and integrity of peripheral nerves, neuromuscular junction and the central nervous system. Electrodiagnostic testing is one of the most valuable techniques in evaluating patients with neuromuscular-skeletal problems or complaints. These tests assess the neurological functions of the peripheral nervous system on the level of nerve roots and peripheral nerves, especially in patients with herniated disks disorders and related conditions, Neurodiagnostic studies are important because they can lead to early detection of traumatic injuries of the peripheral nervous system and can help to plan

individual treatment programs for each patient. The two main procedures used to study neuromuscular functions are electromyography (EMG) and nerve conduction study (NCS) (Robinson, 2000)." Dr. Silver asserts "the usual standard of care for any patient who has persistent pain, in spite of adequate physical therapy, is to have radiculopathy be considered in a differential diagnosis and investigated accordingly. Electrodiagnostic work up is usually considered a necessary extension of clinical evaluation in diagnosis of radiculopathy. Thus, it is fair to say when the patient failed to fully recover vies-a-vie conservative treatment; it became apparent that the patient needed to be evaluated for radiculopathy. This test can be used to precisely clarify the above clinical problems and avoid medical errors that are caused by blind diagnoses or treatments, especially where the test results did reveal that the patient had a radiculopathy. Thus, it was found medically necessary to perform EMG/NCV testing, based on the foregoing reasons and the medical literature available on electrodiagnostic studies. The American Association of Electrodiagnostic Medicine states, "there is no single universally accepted specific protocol or set procedures employed for each diagnostic category. Instead the electrodiagnostic consultant must continually reassess the findings encountered during the performance of electrodiagnostic testing." In addition, "the only person who can responsibly determine the appropriate test to investigate a particular patient's clinical symptom is the physician performing the electrodiagnostic evaluation. EMG/NCS testing is the only test which can show pathophysiological changes. Any lesions, such as radiculopathy, plexopathy, peripheral neuropathies and muscle denervations, can lead to axonal loss and/or demyelination (in terms of predominant process), which in turn leads to corresponding muscle denervation for motor nerves and sensory disturbance for sensory nerves. Electro diagnostically, this differentiation mainly depends on two procedures-Nerves Conduction Study (NCS) and Electromyography (EMS). NCS allows evaluating structural integrity of axon, myelin and supporting structure, determining the nature and extent of the abnormality and drawing up a differential diagnosis. It reveals action potential prolongation failure associated with structural alterations of roots, plexus and peripheral nerve. Needle EMG remains by far the most sensitive Electro diagnostic tool in patients with suspected radiculopathy and peripheral neuropathy. Loss of malfunction even a few axons results in alteration of the electrical activity of the correspondent muscle and reflected by EMG. The objective of ordering the EMG/NCV testing was to get the accurate clinical picture based on the results of the EMG/NCV testing which would help in adjusting the treatment plan to include a modified physical therapy program, pain management or surgical referral. In this case, EMG/NCV testing was ordered 1) to clarify the differential diagnosis and rule in/out radiculopathy, entrapment/peripheral neuropathy, myopathy and plexopathy in view of the patient's complaints, physical findings and working diagnosis 2) to definitively diagnose the patient's condition and determine the extent of injury thereby assisting in directing the delivery of care to patient's needs and administering appropriate therapy 3) to evaluate nerve and muscle function to better predict prognosis for recovery and possible residual neurological deficit." Dr. Silver expounds "based on analyzing the patient's response to conservative treatment, it was found medically necessary to perform EMG/NCS testing in order to evaluate the extent of the injuries the patient sustained. Accordingly, the consultant must be involved in the pretest evaluation of the patient and the plan of the study and should perform only those tests that are medically indicated [*citation omitted*]. Moreover, these tests are often crucial to evaluating symptoms, arriving at a proper diagnosis and in following a disease process

and its response to treatment in patients with Neuromuscular disorders (Recommended Policy for Electrodiagnostic Medicine). In addition, some patients are referred for Electrodiagnostic testing with a provisional diagnosis, others are not. Many patients are referred with merely symptoms and/or clinical findings and there is an expectation that the Electrodiagnostic study will be able to arrive at the correct diagnosis only after the completion of the exam (Recommended Policy for Electrodiagnostic Medicine). Suspected cervical radiculopathies are the most frequent reasons for referring a patient out for an EMG/NCV study. It is the most sensitive clinical neurophysiologic test for evaluating patients with a radiculopathy. In motor vehicle collisions, this is often the case as related to spinal or disc injuries where nerve compression and/or irritation has occurred, resulting in radiating pain or paresthesia as was indicated in the records. The examination report dated 6/22/2021 contains evidence of radiculopathy and paresthesia by way of positive orthopedic and neurological finding consistent with neurological deficits. This was exactly why the EMG/NCV tests were utilized to definitively diagnose the patient's condition and alter the treatment plan accordingly. The use of this testing was in direct accordance with the AANEM guidelines with respect to suspected radiculopathies [*Citation omitted*]. "This review provides evidence from the medical literature that a properly performed and interpreted needle EMG examination confirms a clinical diagnosis of cervical radiculopathy with a moderate degree of sensitivity and a high degree of specificity." This is true with regards to suspected lumbar radiculopathy as well. The AANEM indicates that specific signs and symptoms suggestive of radiculopathy should be always be investigated by an EMG/NCV study. EDX serves to confirm the diagnosis of root compression, to exclude a more distal lesion (plexopathy or mononeuropathy), to localize the compression to either a single or multiple roots to define the age and the activity of the lesion and to define the severity of the lesion [*Citation omitted*]. If significant radiating arm symptoms are present for greater than 4-6 weeks after the onset of injury and no obvious level of nerve root dysfunction is evident on examination, electrodiagnostic studies may be indicated. Electrodiagnostic studies may also be useful to determine the extent of injury in patients with an established level of injury. New York State Workers' Compensation Board New York Mid and Low Back Injury Medical Treatment Guidelines First Edition, June 30, 2010 17, EDS (must include needle EMG and NCS) are recommended where a CT or MRI is equivocal and there are ongoing complaints of pain, weakness, and/or numbness/paresthesia that raise questions about whether there may be a neurological compromise that may be identifiable. This means leg symptoms consistent with radiculopathy, spinal stenosis, peripheral neuropathy, etc. EDS is recommended where there is failure of suspected radicular pain to resolve or plateau after waiting 4 to 6 weeks (to provide for sufficient time to develop EMG abnormalities as well as time for conservative treatment to resolve the problems), equivocal imaging findings, e.g. on CT or MRI studies, and suspicion by history and physical examination that a neurologic condition other than radiculopathy may be present instead of or in addition to radiculopathy. This patient had radicular pain for more than three months and as stated in the guideline above this clearly warranted the testing." Dr. Silver concludes "in this case the patient's physical exam findings and MRI findings were both indicative of radiculopathy, had positive MRI findings including disc herniation/disc bulge indicating radiculopathy/nerve root compression. Thus, EMG was entirely warranted to rule out the suspected radiculopathy as per the medical literature. In addition, Lauder and colleagues, in their articles, found that a positive physical examination finding was associated with a much higher

probability of having a positive EDX test. This indicates that significant physical examination findings are a strong reason to perform an EDX test and not to avoid EMG, which can localize the problem. The AANEM guidelines specifically state that peroneal motor and sural sensory tests are the best means of identifying distal symmetric polyneuropathy [*Citation omitted*]. In this case, the patient was exhibiting signs of radiculopathy and therefore was an excellent candidate for EDX testing as an extension to the patient's physical examination, to confirm the patient's pathology and alter the treatment plan accordingly. Please note electrodiagnostic studies such as EMG/NCV testing have been cited as being highly sensitive for diagnosing cervical and/or lumbar radiculopathies reaching a 70-80% accuracy rate [*Citation omitted*]. Further, please refer to the American Academy of Emergency Medicine (AAEM) which states: "In order to help confirm nerve root pathology and differentiate a patient's complaints from other causes, EMG is a helpful diagnostic tool. EMG is a useful study to help the physician guide treatment by confirming radiculopathy and the specific involved vertebral levels." In this case it was determined that electrodiagnostic testing was warranted to evaluate and differentiate between possible radiculopathy versus a peripheral or entrapment neuropathy. EMG testing would help to more precisely rule out and identify the pathology of the patient's pain. Thus, the patient was an excellent candidate for EMG in order to confirm radiculopathy as the pain generator and curtail the patient's treatment accordingly. Furthermore, please note that an EMG testing provides for a more accurate diagnosis than MRI testing alone without EMG testing. As per the article study [*citation omitted*], "Despite the accuracy of the history, physical examination and MRI in the lower extremity radicular pain, in some cases for more accurate diagnosis, other diagnostic measures are also needed. Although MRI has sufficient accuracy in the diagnosis of some non-discogenic sciatica such as spinal tumors, epidural varicosis, and infectious spinal stenosis, it is incapable of diagnosis in many far out (extraforaminal) spinal stenosis lesions. Electrodiagnostic tests can especially provide useful information about the exact location of the nerve damage...Among all the electrodiagnostic studies, electromyography (EMG) technique has a very high accuracy and specificity in the diagnosis of nerve root pathologies such as denervation and dysfunction." Therefore, with persistent, severe complaints, positive symptomatology and MRI findings with nerve root pathology, EMG/NCV testing was therefore performed to help establish a more definitive diagnosis and to rule out radiculopathy. A treatment plan was warranted to address the patient's post-traumatic pain and symptomology, and in order to effectively diagnose and treat the pain generator, EMG/NCV was medically necessary. Furthermore, please note there is no requirement to wait multiple weeks prior to conducting EMG testing post-traumatic injury: "One of the most common myths about EMG tests is that one must wait 2-3 weeks following a nerve injury before reliable information can be obtained. It is true that the degree of muscle denervation that occurs after nerve injury cannot be determined until Wallerian degeneration is complete and this can take as short as 1 week or as long as 4 weeks. This is a length-dependent process so that the longer the length of the injured axon, the longer Wallerian degeneration will take. However, when there is significant axonal injury or even a severe neuropraxia (conduction block), a decreased rate of motor unit recruitment will instantaneously become abnormal and a skilled electromyographer can often determine this. These early findings can help to localize the site of injury and to some extent the degree of injury. Nerve conduction studies across an injured segment of nerve will also be abnormal immediately." [

Citation omitted] similarly, please note: "After an acute nerve transection, nerve fibers degenerate from the site of the lesion distally. Muscle fibers themselves remain viable but after a period of 7-10 days become super sensitive and fibrillations will be detectable" [*Citation omitted*]. Based on the patient's complaints, MRI and examination findings, electrodiagnostic testing was warranted to evaluate and differentiate between possible radiculopathy versus a peripheral or entrapment neuropathy. The results of the study would be used to help tailor the physical therapy and pharmacologic treatment for a better patient outcome and would help determine whether it would be appropriate to consider interventional therapies such as epidural steroid injections or perhaps surgery."

A timely denial alone does not avoid preclusion where said denial is factually insufficient, conclusory or vague (*Amaze Med. Supply v. Allstate Insurance Co.*, 3 misc. 3d 43 [App Term, 2d & 11th Jud. Dists. 2004]; see also *Nyack Hosp Metropolitan Prop. & Cas. Ins. Co.*, 16 AD3d 564 [2005])." "A proper denial of claim must include the information called for in the prescribed denial of claim form (see 11 NYCRR 65-3.4(c11) (11)) and must "promptly apprise the claimant with a high degree of specificity of the ground or grounds on which the disclaimer is predicated (*General Accident Insurance Group v. Cirucci*, 46 N.Y.2d 862,387 N.E. 2d 223, 414 N.Y.S. 2d, *Accord Halati v. Evanston Ins. Co.*, 8AP3d 431, 779 N.Y.S. 2d 119; *Hereford Ins. Co. v. Mohammod*, 7 A.D. 3d 490, 776 N.Y.S.2d 87)" *Nyack Hospital v. State Farm Mutual Automobile Ins. Co.*, 11AD 3d 664; 784 N.Y.S.2d 136.

Applicant's counsel argued that Respondent's denial which states "[b]ased upon the results of a Medical Examination, these services are denied" lacks specificity and is defective. In the instant case, the specific denial does not specify the date of the IME, the IME cut-off date or the name and specialty of the doctor who performed the IME. Respondent's counsel disputed the lack of notice argument by pointing out that Applicant did have a copy of the IME report as they submitted an IME rebuttal by Michael Silver, D.C. However, this rebuttal was prepared on 1/16/23; it discusses more than one IME (both the 3/23/21 by IME Stuart Hershon, M.D. and the 5/18/21 IME by Robert Snitkoff, D.C.) and could have been based on the copies of the IMEs that were uploaded to the Modria Case Folder. Notably, Applicant was not carbon-copied on the global denial issued on 6/1/21 (cutting off treatment effective 6/1/21) as it became a medical provider subsequent thereto, and there is no indication from Respondent that a copy of any IME report accompanied the denial at issue herein. Even if the global denial was sent to Applicant it also does not set forth the date of the IME or the name and specialty of the doctor who performed the IME. I find that the denial here is vague and there is no indication that the IME report was sent contemporaneously or incorporated by reference. Thus, I find the denial is defective and did not preserve the lack of medical necessity defense. Even if the denial was somehow found sufficient to support a lack of medical necessity defense, the submitted medical records including Dr. Mendoza's 6/22/21 initial examination and the IME rebuttal by Dr. Silver are factually sufficient to meet the burden of persuasion that further treatment including the testing at issue was medically necessary.

Finally, Respondent's counsel zealously argued that Applicant was not entitled to No-fault benefits because they were not licensed with the New York State Department of Education (DOE). In support of this assertion, Respondent submitted a computer printout, dated 2/7/23, of an online screenshot from the New Your State Office of the Professions. The document indicates that a search for "*gemini chiro*" yielded "*No matching records found*." This document was uploaded four weeks prior to the subject hearing. I find this document devoid of competent evidence that Applicant is not currently licensed with the DOE. Furthermore, this isn't evidence that Applicant was not licensed with the DOE at the time the subject testing was performed. Moreover, this isn't evidence that Applicant was not licensed with the DOE at the time the bill was sent to Respondent or the claim submitted for arbitration. In addition Respondent uploaded what purport to be eighteen pages of searches done for "*gemini*" (and one for "*gemini chiropractic pc*") with the same repeated **cut-off** results done on unspecified dates. While all the results start with "*Genesis Chiropractic PC*" some end with "*Gennaro Family & Sports Chiroparctic PC*", some end with "*Gentle Chiropractic PC*", and some end with "*Gentle Touch Chiropractic Care PLLC*." None are identified as a complete search result. Two of the eighteen pages indicate that the results were updated on 4/25/21 and 2/8/22 which again isn't evidence that Applicant was not licensed with the DOE at the time the subject testing was performed, at the time the bill was sent to Respondent, when the claim was submitted for arbitration or now. None of the other eighteen pages are dated. Respondent should have organized these search results and clearly indicated when the searches were done. While the Court of Appeals in *Andrew Carothers, M.D., P.C. v. Progressive Ins. Co.*, 33 N.Y.3d 389, stated, in dicta, that "(t)he no-fault insurance regulations make providers ineligible for reimbursement when their violations … are more than merely technical," more recent decisions suggest that the failure to have a New York City Department of Consumer Affairs license or to be licensed by the Office of the Professions is enough to find that a provider is not entitled to recover benefits. See *Quality Health Supply Corp. v. Progressive Ins. Co.*, 73 Misc.3d 134(A) (App Term 2d Dept. 2021); *Progressive Cas. Ins. Co. v. Galmar Diagnostic Medicine, P.C.*, Index No. 608048 (Sup. Ct. Nassau Cty., Hon. T. Rademaker, June 1, 2021). Here, I find that Respondent failed to establish that the provider is ineligible for reimbursement of No-Fault benefits. Accordingly, Applicant is awarded $565.40.

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**
	Gemini Chiropractic PC	**06/22/21 - 06/22/21**	**$565.40**	**Awarded: $565.40**
Total			**$565.40**	**Awarded: $565.40**

B. The insurer shall also compute and pay the applicant interest set forth below. 06/12/2022 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest runs from 6/12/22 (the date that arbitration was requested) until the date that payment is made at two percent per month, simple interest, on a pro rata basis using a thirty day month.

C. Attorney's Fees

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

Pursuant to 11 NYCRR §65-4.6 (d), ". . . the attorney's fee shall be limited as follows: 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon for each applicant for arbitration or court proceeding, subject to a maximum fee of $1,360."

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 NY
SS :
County of Nassau

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

04/03/2023
(Dated)

Charles Blattberg

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:
4c947d0fbf6a0135ac75cfa48d2b8317

Electronically Signed

Your name: Charles Blattberg
Signed on: 04/03/2023