American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

JR Medical PC (Applicant)	AAA Case No.	17-22-1256-0609
	Applicant's File No.	DK22-270485
- and -	Insurer's Claim File No.	658654
	NAIC No.	Self-Insured
MVAIC (Respondent)		

ARBITRATION AWARD

I, Robyn McAllister, 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

1. Hearing(s) held on 12/19/2023
   Declared closed by the arbitrator on 12/19/2023

   Artur Finkel, Esq. from Korsunskiy Legal Group P.C. participated virtually for the Applicant

   Jeffrey Kadushin, Esq. from Marshall & Marshall, Esqs. participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$2,690.80**, 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 Respondent properly denied Applicant's claim for performing an office visit and EMG/NCV testing with F Waves for Assignor (HP), a 26 year-old male pedestrian, in connection with treatment of injuries sustained in a motor vehicle accident on July 27, 2021, based on a peer review by Ruben Burshtein, D.O., and the Workers' Compensation Fee Schedule.

4. Findings, Conclusions, and Basis Therefor

Applicant sought reimbursement in the amount of $2690.80 for performing an office visit and EMG/NCV testing with F Waves on December 13, 2021 for Assignor (HP), a 26 year-old male pedestrian, in connection with treatment of injuries sustained in a motor vehicle accident on July 27, 2021. Respondent timely denied Applicant's claim predicated on a peer review dated May 18, 2022 by Ruben Burshtein, D.O., and the Workers' Compensation Fee Schedule.

This decision is based on the oral arguments of counsel at the hearing and the documents submitted. I have reviewed the documents contained in the ADR Center as of the date of this award. Applicant established its prima facie case since Respondent's denial acknowledged receipt of Applicant's bill. *See Viviane Etienne Medical Care, P.C. v. Country-Wide Ins. Co.,* 25 N.Y.3d 498 (2015); *AR Medical Rehabilitation v State-Wide Insurance Company*, 49 Misc.3d 919 (Civil Ct., Kings Co. 2015).

At the hearing, Respondent argued that it properly denied Applicant's claim since the electrodiagnostic testing was not medically necessary. I disagree. I was not persuaded by the peer review report and addendum dated November 21, 2023 by Dr. Burshtein, submitted by Respondent in support of its denial.

Dr. Burshtein noted that "As per the consultation report dated 12/13/2021 by Olga Gibbons, MD., at JR Medical P.C., the claimant presented with complaints of pain, weakness, numbness, and paresthesia in the neck and lower back. The pain intensity was 8/10. Physical examination of the cervical spine revealed decreased range of motion. Physical examination of the lumbar spine revealed decreased range of motion. Neurological examination revealed normal muscle strength and reflexes, and intact sensory dermatomes of the upper and lower extremities. The assessments were cervical spine sprain of ligaments, cervicalgia, lumbar spine sprain of ligaments, and low back pain. The treatment plan included the recommendation for physical therapy and referred for EMG/NCV studies of the upper and lower extremities."

Dr. Burshtein asserted that "the claimant had a normal neurologic examination. He could have been managed with continuous physical therapy and anti-inflammatory medications. These are the current standard of care methods. EMG/NCV studies were not necessary at this time. There was no pending surgery. The claimant did not demonstrate any neurologic impairment from the accident of 07/27/2021. EMG and NCV testing were performed without any evidence of nerve impairment. Also, there was no spinal cord compression and no evidence on examination that would necessitate EMG and nerve conduction studies. Hence, these studies were not medically necessary."

Dr. Burshtein stated that "the records did not indicate how the EMG/NCV studies of the upper and lower extremities were necessary to clarify a credible diagnostic question, and the records did not indicate how the results would modify the claimant's treatment in a

medically significant way. There were no differential diagnoses for which EMG/NCV studies of the upper and lower extremities were indicated."

He added that "an EMG is not necessary for the diagnosis of sprain and pain, rather its value lies in differentiating other types of neuritis, neuropathy, or muscle abnormalities from radicular neuropathy and for the case where the etiology of the pain is not clear. No relevant differential diagnoses were being realistically considered. Therefore, EMG/NCV testing of the upper extremities would not be clinically useful in this case."

Dr. Burshtein explained the use of EMG/NCV testing and the criteria for performing such tests per medical literature and concluded that "No explanation was provided in the medical records which would explain how the results of these tests would alter the treatment course of this claimant. It should be noted that the generally accepted standard to perform studies such as EMG/NCV studies, is to only order that might impact the care or treatment of the claimant."

I find that Dr. Burshtein's peer review was sufficient to support Respondent's defense of lack of medical necessity except for the office visit, which he failed to discuss. Thus, the burden shifted to Applicant to demonstrate medical necessity for the testing. *See .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 Dist. 2007)*; West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co.,* 13 Misc.3d 131 (A), 2006 N.Y. Slip Op. 51871(U) (App. Term 2d & 11th Dist. 2006).

In support of its claim, Applicant submitted the documents contained in the ADR Center including the consultation report and testing report by Dr. Olga Gibbons, MRI reports and examination report and rebuttal to the peer review dated November 16, 2023 by Dr. Viviane Etienne. I was persuaded by the medical evidence that the upper and lower EMG/NCV testing were warranted.

According to Dr. Gibbons report dated 12/31/21, Assignor presented with subjective complaints of neck and back pain with weakness, numbness, and paresthesia. However, there were no motor, reflex or sensory deficits and no positive orthopedic testing including Straight Leg Raise testing. There was decreased range of motion in the cervical spine but normal range of motion in the lumbar spine. Dr. Gibbon's pre-printed form noted that the EMG/NCV of the upper and lower extremities was ordered to:

Rule out radiculopathy, Sensory nerve impairment/peripheral neuropathy in view of the patient's complaints, physical findings and working diagnosis,

Better predict prognosis for recovery and possible residual Neurological deficit.

Administer appropriate therapy.

If Electro diagnostic study is Positive for neurogenic injury, treatment can be extended to tens for Neck, Back, Cervical and Lumbar traction and paravertebral nerve block.

Dr. Etienne discussed the findings from his examination of Assignor on 10/18/21. She stated:

Examination of the cervical spine revealed stiffness, tenderness, pain and tenderness upon palpation of the facets, decreased range of motion with pain, and trigger points. Examination of the thoracic spine revealed tenderness. Examination of the lumbar spine revealed decreased range of motion with pain. Straight Leg Raising test was positive. Examination of the right shoulder revealed tenderness, painful range of motion, and positive Impingement test. Examination of the left shoulder revealed tenderness, limited range of motion with pain, and positive Impingement test and O'Brien's test. Examination of the bilateral elbows revealed tenderness and moderate end-range pain. Examination of the right wrist revealed crepitus, tenderness, and decreased range of motion. Examination of the bilateral knees revealed tenderness, limited range of motion with pain, and guarding. The patient had asymmetric, abnormal, and antalgic gait with an inability to perform toe walking test. The diagnoses were lumbar disc herniation, sprain of left shoulder, sprain of right shoulder, right femur fracture, cervical disc herniation, thoracic disc displacement, cervical radiculitis lumbar radiculitis, thoracic radiculitis, right wrist fracture, sprain of left elbow, sprain of right elbow, left knee sprain, right knee sprain and posttraumatic headache. The patient was, therefore, recommended physical therapy, trigger point injections, pain medications, medical supplies, and follow-up evaluation in 4 weeks. Mr. Parham received trigger point injections to the lumbar spine muscles on the same day. I also recommended him for EMG/NCV studies consultation to ensure no significant nerve damage was presented.

Dr. Etienne asserted that "the peer reviewer is trying to overlook the severity of the patient's condition. Indeed, in this case, the patient's complaints and findings raised suspicion of radiculopathy and neuropathy. As evident from the patient's medical records, his pain in the neck and lower back did not improve despite receiving a continued course of conservative therapy for more than ten weeks. In fact, when the patient was evaluated on 12/13/2021, he had 8/10 pain in the neck and lower back with associated weakness. numbness. and paresthesia in the upper and lower extremities indicative of nerve root compression and deteriorating and worsening neurological condition. This indicated that the patient was not responding to the conservative treatment and required confirmatory diagnostic testing to formulate a new and better treatment plan. Hence, in my opinion, the electrodiagnostic tests performed in this case were medically necessary."

Dr. Etienne argued that radiculopathy and neuropathy present with many of the same symptoms that require differentiation by EMG/NCV testing. She noted the findings of

disc herniations on the MRI reports and asserted that the Assignor met the criteria for testing set forth by the AANEM. She further noted that the EMG/NCV testing revealed right median sensory and left ulnar sensory neuropathy.

I find that Dr. Etienne's rebuttal meaningfully referred to and rebutted the conclusions set forth in the peer review report. *See High Quality Medical, P.C. v. Mercury Ins. Co.,* 26 Misc.3d 145(A) (App. Term 2d, 11th & 13th Dists. 2010). She explained why she referred Assignor for the testing and that Assignor's persistent symptoms clinically correlated to MRI findings warranted further investigation.

After careful consideration of the medical records, peer review and addendum by Dr. Burshtein and rebuttal by Dr. Etienne, I find I am more persuaded by Dr. Etienne's assertion that she properly referred Assignor for the EMG/NCV testing.

Moreover, the treating physician's opinion should be afforded greater weight. *See Oceanside Medical Healthcare, P.C. v. Progressive Ins.,* 2002 N.Y. Slip Op. 50188(U) (Civ. Ct. Kings Co. 2002). Therefore, I find that Applicant satisfied its burden of demonstrating medical necessity and Respondent improperly denied Applicant's claim.

However, I was persuaded by Respondent's assertion that Applicant's bill was in excess of the Fee Schedule. More specifically, Applicant billed code 99203 in the amount $142.62 for the office visit, code 95886 in the amount of $809 for the EMG, code 95905 in the amount of $1085.72 for the F wave testing and code 99513 in the amount of $653.46 for the NCV testing. Respondent argued that code 95905 is not reimbursable when billed with code 95886 and 99513. I agree.

The issue of whether code 95905 is reimbursable with codes 95886 and 99513 was previously addressed by this Arbitrator in multiple cases including *Joseph A Raia MD PC v. Geico Insurance Company,* 17-22-1253-5179. In that case, I stated as follows:

At the hearing on November 2, 2023, no extension of the stay was submitted and the case proceeded as scheduled. Respondent argued that it properly partially denied Applicant's claim based on the Fee Schedule. I agree. More specifically, Applicant billed $142.62 for the office visit under CPT code 99203, for the EMG under code 95886 for four units in the amount of $809, for the NCV under code 95913 in the amount of $653.46 and for the F-wave for four units under code 95905 in the amount of $1085.72. Respondent paid all codes in full except for the F-wave, which was denied. Respondent's explanation of benefits stated as follows:

Paragraph 5 of the NYS WorkersÂ¿ Compensation Guidelines Introduction and 3 General Guidelines states to refer to the CPT book for an explanation of coding rules

and regulation not listed in this schedule. Moreover, guidance from the CPT Book and CPT Assistant is incorporated into the no-fault law pursuant to Insurance Law Â§ 5108 and 11 NYCRR Â§Â§68.0, 68.1[a][1]. See Glob. Liberty Ins. Co. v. McMahon, 172 A.D.3d 500 (2019). CPT Professional has parenthetical instructions stating the following: Report 95905 only once per limb studied and Do not report 95905 in conjunction with 95885, 95886, 95907-95913. The AMAÂ¿s CPT Assistant dated March 2013 supports each of those parenthetical instructions emphasizing that 95905 would be reported for each limb, and it would not be appropriate to report code 95905 in addition to codes 95885, 95886, or 95907-95913. Therefore, this charge for 95905 is denied.

In further support of its defense, Respondent submitted the relevant portion of the CPT Assistant and an arbitration award on this issue.

It was Respondent's burden to establish a prima facie showing that the bill was incorrect, see Cornell Medical P.C. v. Mercury Casualty Co., 24 Misc.3d 58 (App. Term 2d, 11th & 13th Dists. 2009), and I find that Respondent satisfied its burden. The CPT Assistant clearly notes "Do not report 95905 in conjunction with 95885, 95886, 95907-95913." Thus, since Applicant billed codes 95886 and 95913, code 95905 should not have been reported. This is consistent with my prior award in PTJ Medical Services, PC v. Progressive Casualty Insurance Company, 17-22-1275-2060. Therefore, I find that Respondent properly partially denied Applicant's claim.

Thus, in the instant case, for the reasons noted above and in accordance with the plain reading of the Fee Schedule and CPT Assistant, I find that Applicant is not entitled to reimbursement for code 95905.

Accordingly, Applicant is awarded $1605.08, and the remainder of its claim is denied.

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**
		12/13/21 - 12/13/21	**$2,690.80**	**Awarded: $1,605.08**
Total			**$2,690.80**	**Awarded: $1,605.08**

B. The insurer shall also compute and pay the applicant interest set forth below. 06/28/2022 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest shall be computed and paid from June 28, 2022, the date of the request for arbitration, for the Claim awarded above at a rate of 2% per month, simple, ending with the date of payment of the award.

C. Attorney's Fees

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

The insurer shall pay an attorney's fee in accordance with 11 NYCRR 65-4.6.

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 Westchester

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

12/25/2023
(Dated)

Robyn McAllister

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:
1261a6185b08e839e6e4c078969822de

Electronically Signed

Your name: Robyn McAllister
Signed on: 12/25/2023