

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

|   |                          |                       |
|---|--------------------------|-----------------------|
| NY Med<br>(Applicant)                               | AAA Case No.             | 17-24-1338-3591       |
|   | Applicant's File No.     | 3192079               |
| - and -   | Insurer's Claim File No. | 272 PP<br>IWN4746 002 |
| The Standard Fire Insurance Company<br>(Respondent) | NAIC No.                 | 19070                 |

**ARBITRATION AWARD**

I, Rebecca Novak, 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 ["JM"]

1. Hearing(s) held on 08/20/2024  
Declared closed by the arbitrator on 08/20/2024

Justin Skaferowsky, Esq. from Israel Purdy, LLP participated virtually for the Applicant

Respondent from Law Offices of Tina Newsome-Lee failed to appear for the  
**Respondent**

2. The amount claimed in the Arbitration Request, **\$2,278.19**, was AMENDED and permitted by the arbitrator at the oral hearing.  
Applicant amended the amount in dispute to \$1,867.01 to reflect withdrawn bills and to conform to its interpretation of fee schedule.

Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

Whether Applicant established additional entitlement to No-Fault insurance compensation for physical therapy, an office visit, neuropsychological testing, EMG/NCV testing, and SSEP testing, performed to treat Assignor, a 54-year-old male, from October 16, 2023 to December 18, 2023, subsequent to being injured in a motor vehicle accident on September 26, 2023.

Whether Applicant established entitlement to No-Fault insurance compensation for 1 bill for dates of service November 29, 2023 to December 2, 2023 which lacked a corresponding denial of claim.

Whether to deny compensation for one bill for date of service December 18, 2023 on the basis of lack of medical necessity based on a peer review of Dr. Amit Khaneja dated February 14, 2023.

Whether fees were not in accordance with fee schedule.

#### 4. Findings, Conclusions, and Basis Therefor

In this No-Fault insurance arbitration, Applicant is seeking as additional compensation \$1,867.01 for performing physical therapy, an office visit, neuropsychological testing, EMG/NCV testing, and SSEP testing, from October 16, 2023 to December 18, 2023, to treat Assignor, a 54-year-old male, who was injured in a motor vehicle accident on September 26, 2023. This amount sought by Applicant reflects a reduction from the original amount sought when the arbitration was commenced. Initially, there were 5 bills at issue. At the hearing, Applicant withdrew 2 of the bills, asserting that they were paid in full. Regarding the remaining 3 bills, one of the bills lacked a corresponding denial of claim; partial payment was made on a second bill and Respondent denied payment of the remainder of the bill based on a fee defense; and a third bill was denied based on a lack of medical necessity.

Applicant appeared at the hearing via Zoom by counsel, presented oral argument, and relied upon documentary submissions. Respondent failed to appear. AAA Arbitration support attempted to contact Respondent via telephone and email but there was no response or call back. I proceeded with the hearing and rely on Respondent's written 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 submission by Respondent on August 22, 2022 is 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 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 note that this additional submission was late - submitted two days subsequent to the hearing at which Respondent failed to appear. There was nothing in the record to show that Respondent sought approval for its late submission. The additional submission remains precluded.

Assignor, a 54-year-old male, was a restrained driver of a motor vehicle involved in an accident which occurred on September 26, 2023. The record reflects that that Assignor sustained injuries to the neck, lower back, and left knee. Following the accident, he went

to Queens Hospital where he was evaluated, treated, and released. On October 2, 2023, Assignor presented to Dr. John Ventrudo with complaints of pain in the neck, lower back, and left knee. Based on the evaluation, Assignor was recommended for physical therapy. He was treated with physical therapy and also underwent MRIs of the cervical and lumbar spine, and of the left knee. On December 18, Assignor underwent EMG/NCV testing of the lower extremities, a SSEP study of the upper and lower extremities, and an office visit, all performed by Dr. Aric Hausknecht. Respondent timely denied reimbursement for the services provided and Applicant now seeks reimbursement.

With regard to the two bills for which Respondent did not deny receipt (dates of service October 16, 2023 to October 19, 2023, and date of service December 18, 2023), I find that Applicant did establish its prima facie case. "[A] plaintiff demonstrates prima facie entitlement to summary judgment by submitting evidence that payment of no-fault benefits are overdue, and proof of its claim, using the statutory billing form, was mailed to and received by the defendant insurer." Viviane Etienne Medical Care, P.C. v. Country-Wide Ins. Co., 25 N.Y.3d 498, 501, 14 N.Y.S.3d 283, 286 (2015). I find that based on Respondent's denials and/or partial payment, Applicant did mail the bills and they were received by Respondent who did deny the claims. Therefore, I find that a prima facie case has been established.

*Dates of Service October 16, 2023 to October 19, 2023*

For the bill for physical therapy for dates of service October 16, 2023 to October 19, 2023, Respondent made a partial payment and denied the remaining amount of \$25.02, stating in its denial: "The CPT/HCPCS code(s) reported by the provider are included in another procedure reported on the bill."

Defendant has the burden to come forward with competent evidentiary proof to support its fee schedule defenses. Robert Physical Therapy PC v. State Farm Mutual Auto Ins.Co., 13 Misc.3d 172 (Civ. Ct. Kings Co. 2006). If an insurer presents sufficient evidence to substantiate its fee schedule calculation, the burden shifts to the medical provider to raise a triable issue of fact regarding the insurer's fee schedule interpretation. Natural Acupuncture Health, P.C. v. Praetorian Ins. Co., 30 Misc.3d 132(A), 2011 N.Y. Slip Op. 50040(U) (App. Term 1st Dept. Jan. 14, 2011).

There was nothing in Respondent's submission that provided support for its rejection of Applicant's billed amount, or an explanation of its statement in the denial. An insurer's argument that it is entitled to judgment on the ground that the fees sought exceeded the amount permitted by the fee schedule is devoid of merit where the insurer offers zero evidence to support such a defense. Metro Pain Specialist, P.C. v. Hertz Co., 66 Misc.3d 129(A), 2019 N.Y. Slip Op. 52047(U) (App. Term 2d, 11th & 13th Dists. Dec. 13, 2019).

Furthermore, an arbitrator's award rejecting an argument that the amount billed exceeds the fee schedule is properly sustained where the arbitrator noted that the insurer failed to

submit the requisite affidavit to support its argument. Country-Wide Ins. Co. v. Excel Surgery Center, LLC, 2018 N.Y. Slip Op. 33260(U) (Sup. Ct. New York Co., William Franc Perry, J., Dec. 12, 2018).

I therefore reject Respondent's defense and find that Applicant's prima facie case to entitlement for No-Fault compensation stands. Applicant is awarded \$25.02.

*Dates of Service December 1, 2023 to December 2, 2023*

With regard to dates of service December 1, 2023 to December 2, 2023 (part of the bill for dates of service November 29, 2023 to December 2, 2023), Applicant's counsel asserted that there was no denial. At the hearing there was a question as to whether the bill in the amount of \$212.94 was received by Respondent. Respondent submitted an affidavit by Amy Demarest, the claim litigation representative assigned to the claim at issue, employed by Respondent. In her affirmation, she stated that in her capacity as such representative, she is thoroughly familiar with the business practices of Respondent and attested to having searched and reviewed the system, concluding that Applicant's claim for dates of service December 1, 2023 to December 2, 2023 in the amount of \$212.94 was never received by Respondent.

A health care provider establishes its prima facie entitlement to no-fault benefits by submitting evidentiary proof that the prescribed statutory billing forms were mailed to and received by the insurer and that payment of no-fault benefits are overdue. See Insurance Law § 5106 [a]; 11 NYCRR 65.15 [g]; Viviane Etienne Medical Care, P.C. v. Country-Wide Ins. Co., 25 N.Y.3d 49, 501, 14 N.Y.S.3d 283, 286 (2015).

Applicant submitted proof of mailing by way of a certificate of mailing indicating the name of Respondent, Assignor, and amount of the bill, as well as an affidavit of mailing by Gregory Fuller attesting to the mailing of the bill on December 20, 2023. Pursuant to 11 NYCRR 65-4.5(o)(1), the arbitrator shall be the judge of the relevance and materiality of the evidence offered and strict conformity to legal rules of evidence shall not be necessary.

I determine in this case that the certificate of mailing and affidavit submitted are in fact credible and more persuasive than Ms. Demarest's affirmation of non-receipt. I find Applicant's evidence sufficient to establish a prima facie case. Respondent offered no explanation or proof establishing that it complied with the 30 day pay or deny rule, or that it sent timely verification requests to toll the 30 day pay or deny rule.

Accordingly, I award Applicant \$212.94 for dates of service December 1, 2023 to December 2, 2023 (part of the bill for dates of service November 29, 2023 to December 2, 2023).

*Date of Service December 18, 2023*

Since Respondent's denial was timely, 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, 684 N.Y.S.2d 229 (1st Dept. 1999).

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).

"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), 824 N.Y.S.2d 759 (Table), 2006 N.Y. Slip Op. 51871(U) at 2, 2006 WL 2829826 (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.

Respondent relied upon the peer review of Dr. Amit Khaneja dated February 14, 2023, as well as an addendum dated June 20, 2024, in asserting lack of medical necessity. After noting the medical records which he reviewed, Dr. Khaneja related in detail the evaluations performed on Assignor, including all the findings on examination. He discussed in length both EMG/NCV testing and SSEP studies, and cited to medical articles to support his determination that both services were not medically necessary for this Assignor.

With regard to the EMG/NCS testing, Dr. Khaneja cited to medical sources and declared that the standard of care is that the testing is recommended as a neural testing option following at least 4 weeks of conservative therapy. Furthermore, EMG (electromyography) is not a substitute for careful neurologic examination, so referral should always be supported by clear documentation of dermatomal pain, reflex loss, and myotomal weakness abnormalities. He asserted that lumbosacral EMG should generally be reserved for suspected radiculopathy, using the test to predict potential success and determine patient selection prior to epidural steroid injections (ESIs). "EMG is not recommended for well-established chronic radiculopathy unless there has been significant recent symptom worsening associated with clear deterioration of neurologic findings."

Dr. Khaneja maintained that the differential diagnoses presented in this case are insufficient to justify performing this test. If a radiculopathy is suspected, one does not need an EMG/NCV

test to further clarify it unless a precise localization is required for surgical purposes. If no other peripheral mono-neuropathic lesion or plexus lesion is suspected in conjunction with a radiculopathy, just performing this test to confirm suspicions of a radiculitis is not necessary and is wasteful. In addition, he stated that any services including supplies or any associated/derivative services including the follow up visit would not meet the standard of care and are therefore should also be denied.

With regard to the Quantitative Sensory Testing (SSEP), Dr. Khaneja stated that the standard of care for SSEP is that they are recommended as a diagnostic option for spondylotic myelopathy and for unconscious spinal cord injury patients. He asserted that these studies are not recommended for radiculopathies and peripheral nerve lesions where standard nerve conduction velocity studies are diagnostic.

He cites to medical literature and stated that SSEP is only done when there was a question of spinal cord injury, they don't have any application these days, and are done as a continuous monitoring intraoperatively for spinal cord surgeries and other cases. He asserted that they do not change management and do not provide any additional information which will result in a change in patient management or course of treatment. In fact, if SSEP was done, it would need to be demonstrated how the information provided by this test altered patient management in any significant fashion. Finally, there is no indication that these are useful specifically after a motor vehicle accident.

I find that Dr. Khaneja's peer review was imbued with a factual basis and that he conveyed that the testing and associated services performed did not follow generally accepted medical practice, thereby containing a proper medical rationale. Thus the peer review made out for Respondent a prima facie case of lack of medical necessity. Per the case law, the burden of proof shifted to Assignor to rebut the peer review and affirmatively prove medical necessity.

In response to the peer review, Applicant submitted a rebuttal by Dr. Aric Hausknecht dated April 19, 2024. As the treating physician, Dr. Hausknecht reviewed his examination of Assignor on December 18, 2023, noting reduced range of motion, and lumbosacral muscular spasm. MRI revealed disc bulging, and degenerative changes. Impressions included lumbosacral derangement. He noted the need to rule out peripheral nerve damage, myelopathy, radiculopathy, and spinal cord damage.

While Dr. Khaneja stated that the differential diagnosis was "insufficient" and that EMG/NCV is not required when radiculopathy is suspected, Dr. Hausknecht stated that these tests are necessary to confirm nerve root involvement and assess the precise levels affected, thus allowing for a more effective treatment plan. He asserted that in conjunction with the clinical evaluation and imaging studies, this testing can assist in the diagnosis, prognosis, and treatment of various disease processes. "As radiculopathy was suspected in this case, the testing was medically necessary. Dr. Khaneja then cited to AANEM Guidelines which concluded that electrodiagnostic tests (EDX) 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. The AANEM has further held that the only person that can determine the appropriate tests to investigate a particular patient's clinical symptoms is the evaluating physician.

Dr. Hausknecht also cited to the Centers for Medicare and Medicaid Services (CMS), stating that "The presence of damage to the motor nerve cell bodies and peripheral axons is detected by a carefully performed AMG. Neurogenic disorders are distinguishable from myopathic disorders by EMG testing, and then he listed common disorders in which EMG with NCS would be helpful in diagnosis. Dr. Hausknecht explained in detail why MRI is not the best way to diagnose radiculopathy, and stated that depending on the diagnosis and the severity of the condition, the treatment recommendations could range from conservative measures to immediate referral to a neurosurgeon, such as in the case of a severe radiculopathy. He concluded that based on the symptoms and findings noted, he determined that the EDX testing at issue was medically necessary. The EDX examination was necessary to follow all stages of clinical course of radiculopathy as well as to assist in determining the prognosis, the nerve conduction study was also important to discover entrapment syndrome, brachial plexus, and nerve root damage. "EMG/NCV is important in that a treatment plan can be prescribed by providing the most accurate diagnosis and the level of injury of the nerve root. In this case, the etiology of Assignor's pain was not clear and thus there was a diagnostic dilemma requiring the EMG/NCV studies.

With regard to the SSEP testing, Dr. Hausknecht stated that according to the NYS Workers' Compensation Board (NYSWCB) Neck Injury Medical Treatment Guidelines, SSEP is useful for the evaluation of myelopathy and is increasingly used intra-operatively. He asserted that SSEP was performed in accordance with the guidelines in order to assess for possible myelopathy and the need for potential spinal cord decompression surgery. Dr. Hausknecht discussed its efficacy and listed the uses of SSEP studies. He then set forth the AMA medical definition of medical necessity, and noted that in this case, the services rendered were medically necessary in accordance with those guidelines. These services included the office visit, EMG/NCV testing, SSEP studies, and associated services. Lastly, he declared that as Assignor's treating physician, he was in the best position to determine a proper course of treatment for this patient.

As noted above, Respondent also submitted an addendum to Dr. Khaneja's peer review dated June 20, 2024. Dr. Khaneja reiterated much of what he stated in his peer review, taking issue with several statements made by Dr. Hausknecht in his rebuttal. He disagreed with his assessment and stated that the EMG would not change management for this patient.

Having carefully considered the submissions of the parties, including the peer review, rebuttal, and addendum, as well as the relevant case law, I conclude that the preponderance of the credible evidence supports a finding in favor of the Applicant, who has submitted sufficient evidence to refute Respondent's peer review. In addition, I note that a necessary medical expense under the No-Fault Law is one incurred for a treatment, procedure, or service ordered by a qualified physician based on the physician's objectively reasonable belief that it will further the patient's diagnosis and treatment. The use of the treatment, procedure, or service must be warranted by the circumstances and its medical value must be verified by credible and reliable evidence. Medical Expertise, P.C. v. Trumbull Ins. Co., 196 Misc.2d 389, 765 N.Y.S.2d 171 (Civ. Ct. Queens Co. 2003). I find that Dr. Hausknecht possessed an objectively reasonable

belief that the services rendered would aid in Assignor's diagnosis and treatment. I therefore find that Applicant has established by a preponderance of the credible evidence the finding of medical necessity and thereby prevails over Respondent's case for lack of medical necessity.

### *Conclusion*

Accordingly, the within arbitration claim is granted in the entirety.

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 | Amount Amended | Status              |
|---------|--------|---------------------|--------------|----------------|---------------------|
|         | NY Med | 10/16/23 - 10/19/23 | \$25.02      |                | Awarded: \$25.02    |
|         | NY Med | 11/29/23 - 12/02/23 | \$212.94     |                | Awarded: \$212.94   |
|         | NY Med | 12/18/23 - 12/18/23 | \$1,629.05   |                | Awarded: \$1,629.05 |
|         | NY Med | 12/18/23 -          | \$108.96     |                | Withdrawn without   |



|              |        |                        |                   |  |                                   |
|--------------|--------|------------------------|-------------------|--|-----------------------------------|
|              |        | 12/21/23               |                   |  | prejudice                         |
|              | NY Med | 12/20/23 -<br>12/20/23 | \$302.22          |  | Withdrawn<br>without<br>prejudice |
| <b>Total</b> |        |                        | <b>\$2,278.19</b> |  | <b>Awarded:<br/>\$1,867.01</b>    |

- B. The insurer shall also compute and pay the applicant interest set forth below. 02/28/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

The date set forth above is the date when the American Arbitration Association received the arbitration request.

**For dates of service 10/16/2023-10/19/2023 and 12/18/2023:**

Applicant did not commence arbitration within 30 days after receipt of the denial(s). Therefore, the interest accrual date shall be the said date the American Arbitration Association received the arbitration request. The end date for the period of interest shall be the date of payment of the claim. Interest shall be calculated at the rate of two percent per month, simple, calculated on a pro rata basis using a 30-day month. See 11 NYCRR 65-3.9, 65-4.5(s)(3).

**For dates of service 11/29/2023-12/02/2023:**

"Pursuant to Insurance Law §5106(a), interest accrues on overdue no-fault insurance claims at a rate of 2% per month. A claim is overdue when it is not paid within 30 days after a proper demand is made for its payment [citations omitted]." LMK Psychological Services, P.C. v. State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 217, 879 N.Y.S.2d 14 (2009). In the instant case, no specific denial was ever issued, per the record. However, as noted above, Applicant did mail the bill to Respondent on a date certain. It was presumptively received five days later (next business day if the fifth day falls on a weekday or legal holiday). The date payment became overdue is the 30th date after the bill was presumptively received. Therefore, the interest accrual date shall be the date payment became overdue, using the said date calculations. The end date for the period of interest shall be the date of payment of the claim. Interest shall be calculated at the rate of two percent per month, simple, calculated on a pro rata basis using a 30-day month. See 11 NYCRR 65-3.9, 65-4.5(s)(3).

C. Attorney's Fees

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

Applicant is entitled to an attorney's fee pursuant to Insurance Law §5106(a). After calculating the sum total of the first-party (No-Fault) benefits awarded in this arbitration plus interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20 percent of that sum total, subject to the following limitations: In the event the above filing date was prior to Feb. 4, 2015, the attorney's fee is subject to a minimum of \$60.00 and a maximum of \$850.00, per 11 NYCRR 65-4.6(e). In the event the above filing date was on or after Feb. 4, 2015, the attorney's fee is subject to a maximum of \$1,360.00, per 11 NYCRR 65-4.6(d). In the event the above filing date was on or after Feb. 4, 2015 and first-party (No-Fault) benefits are awarded to more than one Applicant herein, the attorney's fee shall be calculated separately for each Applicant, each Applicant's attorney fee being subject to the \$1,360.00 maximum.

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

08/27/2024  
(Dated)

Rebecca Novak

### **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:**  
7f113fde78452802c4fa3f1685f370cc

### Electronically Signed

Your name: Rebecca Novak  
Signed on: 08/27/2024