

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Joseph A Raia MD PC  
(Applicant)

- and -

Allstate Insurance Company  
(Respondent)

AAA Case No. 17-24-1336-6217

Applicant's File No. n/a

Insurer's Claim File No. 0731800728  
2EM

NAIC No. 19232

**ARBITRATION AWARD**

I, Maureen Callahan, 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: eip

1. Hearing(s) held on 09/18/2024  
Declared closed by the arbitrator on 09/18/2024

Walter Pisary from Law Offices of Hillary Blumenthal LLC (Hoboken) participated virtually for the Applicant

Angela Venetsanos from Law Offices of John Trop participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,462.46**, was NOT AMENDED at the oral hearing.  
Stipulations WERE made by the parties regarding the issues to be determined.

The parties stipulated and agreed that (i) Applicant has met its prima facie burden by submitting evidence that payment of no-fault benefits are overdue, and proof of its claim was mailed to and received by Respondent; (ii) Respondent's denial of the subject claim was timely issued; and (iii) the amount claimed does not exceed the maximum permissible charges under the fee schedule applicable to the disputed services.

3. Summary of Issues in Dispute

**CASE SUMMARY**

The accident occurred on 10/2/23. The eligible injured party (EIP) is a 64-year-old female passenger involved in the accident. Following the accident, assignor suffered injuries which resulted in her seeking medical treatment. Thereafter, a treatment plan was recommended. This claim seeks reimbursement for upper and lower EMG/NC V studies performed on 12/21/23. This claim was denied based upon a peer review by Kevin Curley. Applicant offers a rebuttal from Dr. Leonid Schapiro of 8/5/24. The issue is if respondent meets their burden, and if applicant overcomes same.

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

The accident occurred on 10/2/23. I have reviewed all of the relevant exhibits contained in the electronic file center maintained by the American Arbitration Association. The hearing was held via ZOOM. This decision is rendered upon consideration of the oral arguments made by the parties at the hearing and upon a review of the evidence contained in the case folder as of the date of this hearing.

The Arbitrator, in weighing the evidence, has broad powers and discretion in determining what evidence is relevant and material. The Arbitrator is in the best position to evaluate the evidence and decide on the credibility of the submitted documents."

The records in the case folder indicate the EIP to be a 64-year-old female, seatbelted involved in the accident. There was no loss of consciousness. The initial neurological report of 12/21/23 indicates the EIP was taken to North Valley Stream hospital where x-rays were taken. She presents on 12/21 with complaints of headache, neck pain, shoulder pain, back pain, and bilateral knee pain. There was limitation on range of motion to these body parts. Dr. Olga Givens reviewed MRIs that noted multiple cervical disc herniations and a lumbar disc herniation. The EIP was diagnosed with cervical and lumbar sprains and strains and cervicgia. EMG/NC V studies of the upper and lower extremities were ordered on this initial visit. These studies were performed on 12/21/23. They are the subject of this dispute.

It is well-settled that a health care provider establishes its prima facie entitlement to reimbursement as a matter of law by proof that it submitted a claim, setting forth the fact and the amount of the loss sustained, and that payment of No-Fault benefits was overdue. *Damadian MRI in Canarsie, P.C. a/a/o Tyrone Harley v. General Assurance Co.*, 2006 NY Slip Op 51048U, Supreme Court of NY, App. Term 2d Dept., June 2, 2006; See Insurance Law Section 5106a, *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 & 11 Jud. th Dists.)]. See also 11 NYCRR Section 65-1.1 *Vista Surgical Supplies, Inc. v. Metropolitan Property and Casualty Ins. Co.*, 2005-1328 KC, 2006 NY Slip Op 51047U, June 2, 2006.

No fault benefits are overdue if not paid within 30 calendar days after the insurer receives proof of claim, which shall include verification of all of the relevant information requested pursuant to section 65-3.5. It is well settled than an insurer must

pay or deny a claim within thirty days of receiving proof of claim. Insurance Law § 5106 [a]; 11 NYCRR 65-3.8(a). *Presbyterian Hosp. in City of N.Y. v Maryland Cas. Co.*, 90 NY2d 274 (1997). An insurer may extend the thirty-day period through the verification procedures set forth in 11 NYCRR 65-3.5. Failure to comply with or extend the thirty-day period results in the preclusion of most defenses, including medical necessity. *Presbyterian Hosp. in City of N.Y. v Maryland Cas. Co.*; *Vista Surgical Supplies v. State Farm Mut. Ins. Co.*, 14 Misc. 3d 135(A) (App Term, 2 and 11 Jud. Dists. 2007). The narrow exceptions to the preclusion rule apply and the to lack of coverage and fraud defenses. See *Central Gen. Hosp. v Chubb Group of Ins. Cos.*, 90 NY2d 195(1997); *Matter of Metro Med. Diagnostics v Eagle Ins. Co.*, 293 AD2d 751 (2002). An insurance carrier must at a minimum establish a detailed factual basis and a sufficient medical rationale for asserting lack of medical necessity, *Delta Diagnostic Radiology PC v. Progressive Casualty Ins. Co.*, 21 Misc. 3d. (142A) (App. Term 2d. Dep't, 2008), and "must set forth a factual basis sufficient to establish, prima facie, the absence of medical necessity." *Choicenet Chiropractic P.C. v. Allstate Ins. Co.*, 2003 N.Y. Slip Op. 50672[U], 2003 WL 1904296 (App. Term, 2d and 11th Jud. Dists. 2003).

This claim was concededly timely denied on 1/22/24 based upon a peer review from Dr. Kevin Curley of 1/18/24. A peer review report relied upon by an insurer in timely denying a claim is a proper vehicle to assert the defense of lack of medical necessity. *S & M Supply, Inc. v. Allstate Ins. Co.*, 2003 N.Y. Slip Op. 51191(U) (App. Term 2d & 11th Dists. July 9, 2003); *Rockaway Boulevard Medical P.C. v. Travelers Property Casualty Corp.*, 2003 N.Y. Slip Op. 50842(U) (App. Term 2d & 11th Dists. Apr. 1, 2003). Dr. Curley had many, many records to review in conjunction with the formulation of his opinions. These include and not are not limited to chiropractic exams, neurological exams, spurs prescription for diclofenac, lidocaine, baclofen, delivery receipts for multiple DME's, MRI reports of the cervical, lumbosacral, left and right shoulder left and right knee, outcome assessment test results, trigger point injection procedure notes, physical therapy evaluation reports and progress notes, emergency room records, chiropractic records, the FDNY ambulance call report.

Dr. Curley opined that "After reviewing the available records, I have come to the conclusion in this particular case that: The electrodiagnostic testing performed on 12/21/23 was not medically indicated. An article in *Disease aMonth*, Volume 50, Issue 12, December 2004, was entitled *Discogenic/Radicular Pain* by Smeal et al. This article noted with regard to electrodiagnostic testing that "The electrodiagnostic evaluation is an extension of the physical examination and offers physiologic information to assist in determining the diagnosis and subsequent treatment recommendations. Even with the capabilities of MRI, electrodiagnostic testing maintains a role in the evaluation of radiculopathy as it provides a functional assessment of the nerve. However, electrodiagnostic testing is not required in every patient with a suspected radiculopathy." In this particular case, a specific diagnosis was mentioned ruling out peripheral neuropathy or sensory nerve impairment. In this case however, the examination was not thorough and complete. There were no sensory deficits noted in the upper or lower extremities. No provocative maneuvers were performed or documented to evaluate for entrapment neuropathies such as carpal tunnel syndrome or ulnar nerve entrapment. The Phalen's test and the Tinel's tests were not documented. Electrodiagnostic studies should not be performed in a vacuum, but are meant to evaluate for findings noted on a

thorough physical examination. The American Family Physician, published an article on May 1, 2016, entitled Non-Operative Management In Cervical Radiculopathy. The article states, "There is insufficient evidence to support the routine use of electrodiagnostic testing in the workup of cervical radiculopathy. Electromyography does however have clinical utility when peripheral neuropathy of the upper extremities is a likely alternate diagnosis. It can be challenging to differentiate proximal from distal nerve root impingement, but a working knowledge of common peripheral neuropathies is useful". In this case, however, there was no suggestion that a peripheral neuropathy was a likely diagnosis. Again, the sensory exam was documented to have been normal and there was no detailed examination to evaluate for entrapment neuropathy such as carpal tunnel syndrome or ulnar nerve entrapment. Another article entitled Referral Guidelines For Electrodiagnostic Medicine Consultation, published by The American Association of Neuromuscular and Electrodiagnostic Medicine, 1995-2009, notes that electrodiagnostic testing "Should not be obtained if the information will not potentially enhance the patient's care". In this particular case, there was no evidence that any type of intervention was under active consideration. The Standard of Care for the performance of electrodiagnostic testing in medical practice would be to use in cases where there is an adequate question of differential diagnosis and the question cannot be resolved on the grounds of neurological examination alone. This clearly was not the case here."

The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment, *Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co.*, 2009 NY Slip Op 00351 (App Div 2d Dept., Jan. 20, 2009); *Channel Chiropractic, P.C. v. Country-Wide Ins. Co.*, 2007 Slip Op 01973, 38 A.D.3d 294 (1st Dept. 2007); *Bronx Radiology, P.C. v. New York Cent. Mut. Fire Ins. Co.*, 2007 NY Slip Op 27427, 17 Misc.3d 97 (App Term 1st Dept., 2007), such as by a qualified expert performing an independent medical examination, conducting a peer review of the injured person's treatment, or reconstructing the accident. *Id.* An insurance carrier must, at a minimum, establish a detailed factual basis and a sufficient medical rationale for its asserted lack of medical necessity. *Vladimir Zlatnick, M.D., P.C. v. Travelers Indem. Co.*, 2006 NY Slip Op 50963(U) (App Term 1st Dept., 2006); *Delta Diagnostic Radiology, P.C. v. Progressive Casualty Ins. Co.*, 2008 Slip Op 52450(U), 21 Misc.3d 142(A) (App Term 2d Dept., 2008).

After a thorough review of the peer opinion, I find that it sufficiently meets the Respondent's burden of proving the lack of medical necessity.

"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).

Once respondent meets his burden, "plaintiff must rebut it or succumb." *Bedford Park Medical Practice PC v American Transit Ins. Co.*, 8 Misc.3d 1025(A), 2005 N.Y. Slip Op. 51282(U) (Civ.Ct. Kings Co. Aug. 12, 2005).

To meet their burden that applicant argues in support of a rebuttal from Dr. Leonid Schapiro dated 8/5/24. He opines that the EMG/NCV tests were essential and medically necessary to rule out radiculopathy in view of patient's complaints, physical findings, working diagnosis, to better predict prognosis for recovery and possible residual neurological deficits, to administer appropriate therapy, and if electrodiagnostic study is positive for neurogenic injury, treatment can be extended to tens for the neck, back, cervical and lumbar traction and paravertebral nerve block. "The EMG/NCV studies performed on 12/21 revealed normal findings. Taking into consideration patient's history and complaints, and clinical findings that that the and in accordance with generally accepted standards of care in the community, EMG/NCV studies were certainly medically necessary."

Dr. Shapiro also noted that Dr. Curley opined that there was no evidence that any type of intervention was under active consideration. In response, Dr. Shapiro opined "I would note that surgery is not the only but one of the twelve indications listed by the AANEM for the performance of Electrodiagnostic testing. See AANEM guidelines, page 4. The purpose, among other reasons, for the Electrodiagnostic testing is 1) to distinguish between differential diagnoses 2) to help determine the extent of an abnormal function 3) to help determine and guide treatment options, prognosis, and level of recovery (See AANEM Guidelines page 4, items 1-12). Furthermore, Dr. Curley opined the standard of care for the performance of Electrodiagnostic testing in medical practice would be to use in cases where there is an adequate question of differential diagnosis and the question cannot be resolved on the grounds of neurological examination alone. In response, I would note that the test was prescribed to differentiate between cervical/lumbar radiculopathy and neuropathy. U.S. National library of Medicine states that clinical manifestation for diagnosis of both radiculopathy and neuropathy includes radicular pain. The patient exhibited all the aforementioned findings raising suspicion of cervical/lumbar radiculopathy and neuropathy. Hence, EMG/NCV studies were performed to r/o cervical/lumbar radiculopathy and neuropathy. Also, the patient's complaints and findings were posing differential diagnosis as per symptoms noted in the AANEM guidelines noted below: (AANEM Guidelines; [https://www.aanem.org/getmedia/ec7b8fd9-b6ad-4c78-ae4bae7b3880/referral\\_gl.PDF.asp](https://www.aanem.org/getmedia/ec7b8fd9-b6ad-4c78-ae4bae7b3880/referral_gl.PDF.asp))

I have listened to the arguments and consider the evidence. It is a question of fact as to the necessity of these tests. The respondent meets their burden with the opinions of Dr. Curley, who opined that these tests were not necessary given the findings on physical examination. The burden then becomes applicant's to show otherwise. Dr. Shapiro reviewed Dr. Curley's opinion (and the eip's medical records) and determined that the tests were necessary to rule out cervical and lumbar radiculopathy and neuropathy. The applicant has met their burden via argument and Dr. Shapiro's opinion that the tests were necessary to rule out neuropathy versus radiculopathy. I will award in favor of applicant: \$1462.46.

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
	Joseph A Raia MD PC	12/21/23 - 12/21/23	\$1,462.46	Awarded: \$1,462.46
Total			\$1,462.46	Awarded: \$1,462.46

- B. The insurer shall also compute and pay the applicant interest set forth below. 02/15/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

INTEREST: 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 (Insurance Law § 5106 [a]; 11 NYCRR 65.15 [g]). The Superintendent's regulation tolls the accumulation of interest if the claimant "does not request arbitration or institute a lawsuit within 30 days after receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations" (11 NYCRR 65-3.9 [c]). The Superintendent has interpreted this provision to mandate that the accrual of interest is tolled, regardless of whether the particular denial at issue was timely. That interpretation was upheld by the Court of Appeals in LMK Psychological Servs, P.C. v. State Farm Mut. Auto. Ins. Co., 2009 NY Slip Op 02481 (April 2, 2009). Where no denial of claim is issued in response

to a proper demand for payment, the insurer does not benefit from the tolling provision and interest will accrue from the date 30 days after the proper demand for payment is made. Interest that accrues when a denial of claim is not issued within 30 days after the proper demand for payment is made will be tolled upon the issuance of a denial of claim, although such denial is untimely, and the failure to request arbitration or institute a lawsuit within 30 days after receipt of that denial of claim form.

### C. Attorney's Fees

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

The insurer shall also pay the applicant for attorney's fees as set forth below  
ATTORNEY'S FEES: 11 NYCRR 65-4.6 establishes a minimum attorneys' fee and further provides that: For cases filed on or before February 4, 2015, the "attorney's fee shall be limited as follows: 20 percent of the amount of first-party benefits, plus interest thereon, awarded by the . . . court, subject to a maximum of \$850" (11 NYCRR 65-4.6 [e]). The October 8, 2003, opinion letter of the Superintendent interpreted that regulation and stated that the minimum amount of attorneys' fees awarded to an assignee health care provider pursuant to Insurance Law § 5106 is "based upon the aggregate amount of payment required to be reimbursed based upon the amount awarded for each bill which had been submitted and denied. The minimum attorney fee . . . is not due and owing for each bill submitted as part of the total amount of the disputed claim sought in the court action" (Ops Gen Counsel NY Ins Dept No. 03-10-04 [Oct. 2003]). For purposes of calculating attorneys' fees, the Superintendent has interpreted a claim to be the total medical expenses claimed in a cause of action pertaining to a single insured, and not each separate medical bill submitted by the provider. The Insurance Department's interpretation of its own regulation was upheld by the Court of Appeals in LMK Psychological Servs, P.C. v. State Farm Mut. Auto. Ins. Co., 2009 NY Slip Op 02481 (April 2, 2009). Attorneys' fees are therefore to be calculated based on the aggregate of all bills for each insured; and Page 4/6 D. For cases filed after February 4, 2015, the attorney's fee is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-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 per arbitration or court proceeding, subject to a maximum fee of \$1,360. If the nature of the dispute results in an attorney's fee that could be computed in accordance with the limitations prescribed in both subdivision (c) and this subdivision, the higher attorney's fee shall be payable

- 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 NY

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

09/23/2024  
(Dated)

Maureen Callahan

### **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:**  
71a381f3cc7f6403ee3847f0e0348865

### **Electronically Signed**

Your name: Maureen Callahan  
Signed on: 09/23/2024