American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

All County Diagnostic Chiropractic Services (Applicant)	AAA Case No.	17-16-1047-5505
	Applicant's File No.	
- and -	Insurer's Claim File No.	0375714276
	NAIC No.	19232
Allstate Insurance Company (Respondent)		

ARBITRATION AWARD

I, Corinne Pascariu, 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 03/01/2018
   Declared closed by the arbitrator on 03/01/2018

   Dino DiRienzo, Esq. from Dino R. DiRienzo Esq. participated in person for the Applicant

   Steve Miranda, Esq. from Allstate Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 1,786.14**, was AMENDED and permitted by the arbitrator at the oral hearing.

   Applicant amended the amount in dispute to $1357.48 so as to comply with the applicable fee schedule.

   Stipulations WERE made by the parties regarding the issues to be determined.

   Responded stipulated that Applicant established a prima facie case. Applicant stipulated that respondent issued a timely denial.

3. Summary of Issues in Dispute

   Background:

Assignor is a 36-year-old male who was a passenger of a motor vehicle involved in an accident on July 4, 2015. Assignor subsequently presented to Eliott Strauss, D.C and commenced a course of chiropractic treatment. Dr. Strauss later referred Assignor to Applicant, for an evaluation by Walter Mendoza, D.C. Dr. Mendoza evaluated assignor on September 22, 2015, and based upon his findings determined that he necessitated an EMG/NCV of the lower extremities which he conducted the same day. Respondent denied reimbursement of the EMG/NCV based upon a peer review by Dr. Portnoy dated November 19, 2015, wherein he opined that it was not medically necessary. Applicant seeks $1357.48 in reimbursement for the EMG/NCV performed.

Issue:

The issue is whether Respondent was justified in denying the claim on the ground that the testing was not medically necessary.

4. Findings, Conclusions, and Basis Therefor

The case was decided on the submissions of the Parties as contained in the ADR Center maintained by the American Arbitration Association and the oral arguments of the parties' representatives. There were no witnesses. I reviewed the documents contained in the file for both parties and make my decision in reliance thereon.

Medical Necessity:

To meet its burden, at a minimum, the No-Fault insurer must establish a factual basis and medical rationale for its asserted lack of medical necessity of the health care provider's services. A.M. Medical Services, P.C. v. Deerbrook Ins. Co., 18 Misc.3d 1139(A), 859 N.Y.S.2d 892 (Table), 2008 N.Y. Slip Op. 50368(U), 2008 WL 518022 (Civ. Ct. Kings Co., Sylvia G. Ash, J., Feb. 25, 2008).

The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment, Kingsbrook Jewish Medical Center v. Allstate Ins. Co., 61 A.D.3d 13, 871 N.Y.S.2d 680 (2d Dept. 2009), such as by a qualified expert performing an independent medical examination or conducting a peer review of the injured person's treatment. See Rockaway Boulevard Medical P.C. v. Travelers Property Casualty Corp., 2003 N.Y. Slip Op. 50842(U), 2003 WL 21049583 (App. Term 2d & 11th Dists. Apr. 1, 2003).

The appellate courts have not clearly defined what satisfies the insurer's evidentiary standard except to the extent that "bald assertions" are insufficient. Amherst Medical Supply, LLC v. A Central Ins. Co., 41 Misc.3d 133(A), 981 N.Y.S.2d 633 (Table), 2013 NY Slip Op 51800(U), 2013 WL 5861523 (App. Term 1st Dept. Oct. 30, 2013). However, there are myriad civil court decisions tackling the issue of what constitutes a "factual basis and medical rationale" sufficient to establish a lack of medical necessity.

The civil courts have held that a defendant's peer review or medical evidence must set forth more than just a basic recitation of the expert's opinion. The trial courts have held that a peer review report's medical rationale will be insufficient to meet respondent's burden of proof if: 1) the medical rationale of its expert witness is not supported by evidence of a deviation from "generally accepted medical" standards; 2) the expert fails to cite to medical authority, standard, or generally accepted medical practice as a medical rationale for his findings; and 3) the peer review report fails to provide specifics as to the claim at issue, is conclusory or vague. *See generally* Nir v. Allstate Ins. Co., 7 Misc.3d 544, 547, 796 N.Y.S.2d 857, 860 (Civ. Ct. Kings Co. 2005); *see also* All Boro Psychological Servs. P.C. v. GEICO, 34 Misc.3d 1219(A), 950 N.Y.S.2d 490 (Table), 2012 NY Slip Op 50137(U), 2012 WL 309328 (Civ. Ct. Kings Co., Reginald A. Boddie, J., Jan. 31, 2012).

"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). Assuming the insurer establishes a lack of medical necessity, it is ultimately the claimant who must prove, by a preponderance of the evidence, that the services or supplies were medically necessary. Dayan v. Allstate Ins. Co., 49 Misc.3d 151(A), 29 N.Y.S.3d 846 (Table), 2015 N.Y. Slip Op. 51751(U), 2015 WL 7900115 (App. Term 2d, 11th & 13th Dists. Nov. 30, 2015); Park Slope Medical and Surgical Supply, Inc. v. Travelers Ins. Co., 37 Misc.3d 19, 22 n., 952 N.Y.S.2d 372, 374 n. (App. Term 2d, 11th & 13th Dists. 2012).

Peer Review by Kevin Portnoy, D.C.

Respondent's evidence established that the Applicant's claim for the EMG/NCV was timely denied based upon the peer review report by Dr. Portnoy dated November 19, 2015. Dr. Portnoy 's report was based upon a review of the available medical documents and reliance upon cited articles stating when EMG/NCV testing should be performed.

Dr. Portnoy opined that the EMG/NCV was not medically necessary because Dr. Strauss' records do not indicate how performing such tests would aid in devising or altering assignor's treatment or reducing the number of her visits to his office or enhancing his clinical prognosis.

Assignor's medical records do not indicate he had the symptomology to warrant the testing. There is no indication that his condition was worsening or failing to respond to treatment. Chiropractic care is not an intervention that is dependent on the results of EMG/NCV tests. Further, the testing was not necessary to direct or to modify assignor's treatment. Decisions regarding assignor's chiropractic care could have been made without such testing. Moreover, there was no diagnostic dilemma or differential diagnosis that the testing was needed to clarify. Finally, the standard of care for conducting EMG/NCV testing following a motor vehicle accident is conservative treatment. If a patient does not respond to conservative treatment and has clinical evidence of a progressive neurological or orthopedic deficit, an MRI would be

appropriate. With soft tissue injuries such as assignor's, the standard of care, would be an evaluation by a chiropractor, plain radiographs if there is a suspicion of fracture or severe mechanism of injury, rest and/or conservative therapy. If there is a deterioration in the condition or progressive, worsening neurological deficits EMG/NCV testing maybe indicated at that point in time.

I find that Dr. Portnoy's peer review meets the Respondent's burden of proof. As noted, it contains a detailed and credible review of the record as well as the information maintained in the Assignor's medical records. It is based on his educated opinion of the testing conducted and explains when such testing is medically necessary. It clearly indicates the standard of care and cites to the medical authority upon which it is based. It also references the patient, his history, his complaints of pain and clinical findings and contains a factual basis and medical rationale sufficient to establish a lack of medical necessity. In short, I find that Dr. Portnoy's analysis is persuasive and, accordingly, that the burden of proof has shifted to the Applicant to establish that the EMG/NCV was medically necessary.

"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).

Rebuttal by Walter Mendoza, D.C.

Applicant relied upon an affidavit by Walter Mendoza, DC. dated October 19, 2016. Dr. Mendoza addressed each of Dr. Portnoy's arguments. Assignor presented to him on September 22, 2015, with back pain radiating into both of his legs, tenderness, muscle spasms and restricted range of motion. He evaluated assignor and based upon positive findings and diagnosis, he determined that there was a diagnostic dilemma. The testing was necessary to confirm a diagnosis of radiculopathy and to rule out any plexopathy or neuropathy. The testing was also performed in order to establish the origin of the pain and to determine the level of the nerve root damage. Moreover, contrary to Dr. Portnoy's assertion and as evidenced by the EMG/NCV report which was sent to assignor's treating physician, the testing was performed to modify the treatment plan.

In the September 22, 2015 report, Dr. Portnoy indicates that "…if the patient EMG results are positive, treatment will be changed from conservative therapy to more aggressive decompression (traction) of the cervical or lumbar spine or both, as well increase in neuromuscular reeducation."

Addendum by Dr. Portnoy

Dr. Portnoy provided an addendum dated December 14, 2016, in which he reasserts his initial argument and then indicates that Dr. Strauss needs to justify the testing, not Dr. Mendoza, and his records do not indicate how the performance of the tests would ultimately alter assignor's treatment.

Findings

I find that Dr. Mendoza's rebuttal meets the burden of persuasion and rebuts Dr. Portnoy's peer and rebuttal. It addresses each argument raised by Dr. Portnoy, credibly justifies the need for the testing and references numerous studies in support of his argument. I note that Dr. Portnoy makes several references to Dr. Strauss' records which Respondent failed to enter into evidence. While this failure is not dispositive, it effects the weight of his reports. Comparing the relevant evidence presented by both parties against each other and the above referenced medical necessity standard, I find in favor of the Applicant. As such, I find in favor of Applicant and award $1357.48 in satisfaction of the claim.

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**
	All County Diagnostic	**09/22/15 - 09/22/15**	**$1,786.14**	**$1,357.48**	**Awarded: $1,357.48**

	Chiropractic Services				
Total			**$1,786.14**		**Awarded: $1,357.48**

B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 11/16/2016, which is a relevant date only to the extent set forth below.)

Interest runs from the filing date for this case, 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

As the claim was filed subsequent to the Sixth Amendment to 11 NYCRR §65-4 (Insurance Regulation 68-D) which took effect on February 4, 2015, Attorney's Fees shall be calculated pursuant to the amended terms, as follows: 20 percent of the amount of first-party benefits, plus interest thereon, subject to a maximum fee of $1,360. [11 NYCRR §65-4.6(d)]. There is no minimum fee.

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 New York
SS :
County of Nassau

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

03/06/2018
(Dated)

Corinne Pascariu

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:
7e471fed67561c0e3aa8d8fc09aa12c0

Electronically Signed

Your name: Corinne Pascariu
Signed on: 03/06/2018