

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Rockaway Complete Chiropractic PC  
(Applicant)

- and -

American Transit Insurance Company  
(Respondent)

AAA Case No. 17-18-1113-2131

Applicant's File No. RB-46-55967

Insurer's Claim File No. 675337-05

NAIC No. 16616

**ARBITRATION AWARD**

I, Shawn Kelleher, 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: AD

1. Hearing(s) held on 10/29/2020  
Declared closed by the arbitrator on 10/29/2020

Elyse Ulino, Esq. from Baker Law Offices PC participated by telephone for the Applicant

Erisa Ahmedi, Esq. from American Transit Insurance Company participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 1,437.68**, 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 Assignor, AD a 20-year-old male was involved in a motor vehicle accident on 1/29/17. At issue in this case is \$1,437.68, amended by Applicant to \$1,363.76, for chiropractic treatment and a Pf-NCS testing performed on 1/31/17 through 12/21/17. Respondent timely denied the claim based upon a negative IME of Dr. Kevin Portnoy dated 11/10/17 or a negative peer review of Dr. Trimboli. The issue presented is whether the subject services were medically necessary.
4. Findings, Conclusions, and Basis Therefor  
This case was decided based upon the submissions of the parties as contained in the electronic file maintained by the American Arbitration Association, and the oral

arguments of the parties' representatives. There were no witnesses. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

Applicant establishes its prima facie entitlement to reimbursement with proof that it submitted a proper claim, setting forth the fact and the amount charged for the services rendered and that payment of no-fault benefits was overdue. See Insurance Law § 5106 a; Viviane Etienne Med. Care v. Country-Wide Ins. Co., 25 N.Y.3d 498, 501 (2015); Mary Immaculate Hosp. v. Allstate Ins. Co., 5 A.D. 3d 742, 774 N.Y.S. 2d 564 (2<sup>nd</sup> Dept., 2004). Once an Applicant has established its prima facie case, the burden shifts to the insurer to establish that it timely and properly denied the claims, and the basis of its denial.

Based upon a review of the parties' submissions, I find that Applicant established its prima facie entitlement to reimbursement. I also find that Respondent timely denied the subject bills. The sole issue for determination herein is the medical necessity of the subject treatment.

When an insurer asserts that the medical service was medically unnecessary, the burden is on the insurer to establish that the subject service was medical unnecessary by competent evidence such as an independent medical examination or a peer review or other proof that sets forth a factual basis and a medical rationale for denying the claim. See generally, Kings Medical Supply Inc. v. Country Wide Ins. Co., 5 Misc. 3d 767 (N.Y.C. Civ. Ct., 2004); Amaze Medical Supply, Inc. v. Eagle Insurance Company, 2 Misc. 3d 128 (App. Term, 2<sup>nd</sup> Dept., 2003).

The issue of medical necessity cannot be resolved without resorting to medical facts from a medical expert. Kingsborough Jewish Med. Ctr. v. Allstate Ins. Co., 61 A.D.3d 13, (2<sup>nd</sup> Dept., 2009). A peer review report must set forth a factual basis to establish the absence of medical necessity and will be insufficient "if it fails to provide specifics of the claim, is conclusory, or otherwise lacks a basis in the facts of the claim." See Nir v Allstate Ins. Co., 7 Misc. 3d. 544, 547 (Civ. Ct., Kings Co., 2005); see also New Horizon Surgical Ctr., L.L.C. v Allstate Ins. Co., 52 Misc.3 129(a) (App. Term. 2<sup>nd</sup> Dept., 2016). Further, a peer review holding that no-fault services were medically unnecessary must at least show that the services were inconsistent with generally accepted medical/professional practice. Id. 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).

Dr. Trimboli opines that the Pf-NCS test was medically unnecessary. He states:

There was no medical necessity for the Pf-NCS testing performed on date of service 03/23/17. "Quantitative sensory testing is a potentially useful tool for measuring sensory impairment for clinical and research studies. However, quantitative sensory testing results should not be the sole criteria used to diagnose pathology. Because malingering and other nonorganic factors can influence the test results, quantitative sensory testing is not currently useful for the purpose of resolving medicolegal matters. The American Academy of Neurology and the American Association of Electrodiagnostic Medicine have both concluded that quantitative sensory threshold testing standards need to be

developed and that there is as yet insufficient evidence to validate the usage of current perception threshold testing." Quantitative Sensory Testing, Shy, et. al. Neurology, March 2003, 60: 898-904. "Centers for Medicare and Medicaid Services concludes that the use of any type of sNCT device (eg. current perception threshold (CPT), pain perception threshold (PPT), pain tolerance threshold (PTT) testing or "voltage input" type device used for voltage-nerve conduction threshold (v-NCT testing) to diagnose sensory neuropathies or radiculopathies in Medicare beneficiaries is not reasonable and necessary." Centers for Medicare and Medicaid Services (CMS). Medicare National Coverage Determinations Manual: Sensory Nerve Conduction Threshold Tests (sNCTs), effective April 1, 2004. There was no medical indication for sNCT testing especially in sprain/strain injuries or even if there was suspicion for radicular pathology as sNCT testing would not be used in these conditions. In addition, sNCT testing would not alter treatment plan (eg. surgery, epidural steroid injection) and the results would not enhance patient care. Hence, due to lack of valuable medical information from which to be obtained, there was no causal relationship or medical necessity for sNCT testing.

The Centers for Medicare and Medicaid Services (CMS) concludes that the scientific and medical literature do not demonstrate that the use of sensory nerve conduction threshold (sNCT) to diagnose sensory neuropathies in Medicare beneficiaries is reasonable and necessary. Evaluating the function of sensory nerves may be of clinical importance for individuals who suffer from metabolic, hereditary, or acquired disorders, as well as those who have experienced a traumatic injury. There are several methods of evaluating sensory nerve function. Such tests include: (1) nerve conduction studies (NCS); (2) sensory nerve biopsy; and (3) sensory nerve conduction threshold (sNCT). Of these, NCS is the most commonly used and widely-accepted diagnostic test. "Sensory nerves, which carry impulses from sensory receptors to the brain, are composed of one or more of the following three fibers: (1) small unmyelinated (C fibers) fibers conduct temperature and slow pain; (2) small myelinated (A delta fibers) fibers conduct pressure, temperature, and fast pain; and (3) large myelinated (A beta fibers) fibers conduct cutaneous touch and pressure. "Decision Memo for Electrodiagnostic Sensory Nerve Conduction Threshold", CMS.gov (Feb 2002). In essence, sensory nerve conduction threshold (sNCT) or current perception threshold (CPT) include pain fibers which is what pf-NCS really is. <https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=25&NCDId=270&ncdver=2&IsPopup=y&bc=AAAAAAAAAgAAAA%30%3D&>

The Workers' Compensation Medical Treatment Guideline (MTG) for the neck states on page 20 (C.2.a.iii) that current perception threshold evaluation (CPT) may be useful as a screening tool, but its diagnostic efficacy in the evaluation of cervical spine pain has not been determined. Therefore, CPT is not recommended as a diagnostic tool. There is no MTG for the mid-back and low back with regards to current perception threshold evaluation (CPT). Note: the history and exam findings were indicative of a sprain/strain condition and they do not support any differential diagnoses which would require current perception

threshold evaluation of any type. The American Association of Sensory Electrodiagnostic Medicine (AASEM) is an organization incorporated on May 1, 2016. The sole purpose of this organization is through which physicians and technicians can become certified in small pain fiber electrodiagnosis. This means that practitioners have to pay to attend these pf-NCS courses directly from this organization. This type of testing is not taught in medical residency programs. The AASEM website noted a few "studies" which have very little to do with any valid benefits of pf-NCS testing and the "studies" were not from any valid research. Note: the Centers for Medicare and Medicaid Services (CMS) had already concluded that the scientific and medical literature do not demonstrate that the use of sensory nerve conduction threshold (sNCT) to diagnose sensory neuropathies in Medicare beneficiaries as reasonable and necessary. On the other hand, the American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) was founded in 1953 and is the largest organization worldwide dedicated solely to the scientifically based advancement of neuromuscular (NM) medicine. EMG/NCV tests are taught in medical residency programs. Coincidentally, there was no mention of pf-NCS testing (or its benefits) in their "Position Statement - recommended policy for electrodiagnostic medicine".

I find that the peer review rebuts the presumption of medical necessity. Dr. Trimboli provides a "factual basis and a medical rationale for his determination that there was no medical necessity for the services at issue here." Renato M. Capello, DC v. Global Liberty Ins. Co. of New York, 2017 N.Y. Slip. Op. 51415(U) (App. Term. 1<sup>st</sup> Dept., 2017). Where the Respondent presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden then shifts to the Applicant which must then present its own evidence of medical necessity. Andrew Carothers, M.D., P.C. v. GEICO Indemnity Company, 2008 NY Slip Op 50456U, 18 Misc. 3d 1147A, 2008 N.Y. Misc. LEXIS 1121, West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co. 13 Misc.3d 131, 824 N.Y.S.2d 759, 2006 NY Slip Op51871(U) (Sup. Ct. App. T. 2d Dep't 2006)].

Applicant's evidence fails to meaningfully refer to, let alone rebut, the conclusions set forth in the peer/IME report. Pan Chiropractic P.C. v. Mercury Ins. Co., 24 Misc. 3d 136A (App Term, 2d, 11th & 13th Jud Dists 2009). *See also* Flushing Traditional Acupuncture, P.C. a/a/o AK v. GEICO Ins. Co., 36 Misc. 3d 156A, (App Term 2d Dept 2012). Dr. Higuera submits a rebuttal, but it is unclear what his rebuttal is based upon. Dr. Trimboli states that there was no medical indication for this test, but this is never addressed by Dr. Higuera. He argues for the test's utility, but never states why this test was performed. The records indicate that the test was performed without an evaluation beforehand. The closest evaluation in time to the test is approximately a month prior to the test. I find that this rebuttal to be unpersuasive. The claim is denied.

Dr. Portnoy examined the claimant on 11/10/17. The claimant presented with pain in the neck, upper back, low back, left shoulder, and left knee. There were no complaints of radicular pain. Examination of the cervical spine and upper extremities revealed full range of motion, no evidence of muscle spasms, no reflex or sensory deficiency and upper extremity motor strength was graded +5/5. Foraminal compression, cervical distraction, Jackson's compression, Valsalva's maneuver, and shoulder depression were negative. Examination of the lumbar spine revealed minor reduction in forward flexion,

but otherwise full range of motion. Orthopedic testing was negative. The claimant was diagnosed with resolved cervical, thoracic, and lumbar sprain/strains.

Where the Respondent presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden then shifts to the Applicant which must then present its own evidence of medical necessity. Andrew Carothers, M.D., P.C. v. GEICO Indemnity Company, 2008 NY Slip Op 50456U, 18 Misc. 3d 1147A, 2008 N.Y. Misc. LEXIS 1121, West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co. 13 Misc.3d 131, 824 N.Y.S.2d 759, 2006 NY Slip Op51871(U) (Sup. Ct. App. T. 2d Dep't 2006)].

Applicant's evidence fails to meaningfully refer to, let alone rebut, the conclusions set forth in the IME report. Pan Chiropractic P.C. v. Mercury Ins. Co., 24 Misc. 3d 136A (App Term, 2d, 11th & 13th Jud Dists 2009). *See also* Flushing Traditional Acupuncture, P.C. a/a/o AK v. GEICO Ins. Co., 36 Misc. 3d 156A, (App Term 2d Dept 2012). Applicant submits a follow up report dated 11/30/17, about three weeks after the IME. There was no examination of the lumbar spine as only complaints of neck pain were noted. Range of motion was full and noted as normal. This is contrary to the rebuttal which states that range of motion was decreased. No orthopedic testing was performed. Interestingly, this examination notes that the claimant's condition has worsened, when the objective findings indicate that the claimant's condition has actually improved.

It is ultimately Applicant who must prove, by a preponderance of the evidence, the post-IME services in question were medically necessary. Dayan v. Allstate Ins. Co., 39 Misc.3d 151(A) (App. Term 2d, 11th & 13th Dists. 2015); Park Slope Medical and Surgical Supply, Inc. v. Travelers Ins. Co., 37 Misc.3d 19, 952 N.Y.S.2d 372. (App. Term 2d, 11th & 13th Dists. 2012). This was not done herein. The claims are 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 claim is DENIED in its entirety

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of New York  
SS :  
County of Suffolk

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

11/25/2020  
(Dated)

Shawn Kelleher

### **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:**  
c155ceaafec2f27f25676c26c528a734

### **Electronically Signed**

Your name: Shawn Kelleher  
Signed on: 11/25/2020