

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Carla Danielson DC
(Applicant)

- and -

Allstate Property and Casualty Insurance
Company
(Respondent)

AAA Case No. 17-23-1296-2408

Applicant's File No. N/A

Insurer's Claim File No. 0423848811
2EX

NAIC No. 17230

ARBITRATION AWARD

I, Cathryn Roberts, 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 12/12/2023
Declared closed by the arbitrator on 12/12/2023

Joseph Armao, Esq. from Law Office of Anna Goldman P.C. participated virtually for the Applicant

Olga Gromyko, Esq. from Law Offices of John Trop participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$3,091.95**, was NOT AMENDED at the oral hearing.
Stipulations WERE made by the parties regarding the issues to be determined.
3. Summary of Issues in Dispute

The EIP, (Y.M.) was a then 42 year old female, driver, involved in a motor vehicle accident on 07/20/16. At issue in this case is \$3,091.95 for reimbursement of chiropractic treatment and EMG/NCV testing, performed 10/12/16-06/24/17. Respondent denied the EMG/NCV testing performed on 10/12/16 and 10/15/16, based upon a lack of medical necessity with a peer review by Christopher Ferrante, D.C., dated 04/10/17. The remainder of this claim, for treatment performed 03/04/17-06/24/17, was denied based upon an independent medical examination (hereafter "IME") by Janice C. Salayka, D.C. L.Ac., performed on 10/17/16, with an effective cut-off date for treatment of 11/02/16.

Therefore, the issue presented is whether Respondent satisfied the medical necessity defenses asserted.

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.

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, 2nd Dept., 2003].

DOS 10/12/16-10/15/16

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, (2nd 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. 2nd 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).

In support of their contention that the EMG/NCV testing performed was not medically necessary, Respondent relies on the peer review of Dr. Ferrante, dates 04/10/17. Dr. Ferrante stated that the EIP underwent a follow-up chiropractic evaluation on 10/12/16, in which she was recommended the EMG/NCV testing performed. The testing was recommended due to the EIP's condition showing only minimal improvement in some symptoms, with decline in others. It was reported that chiropractic treatment was changed to reduce rotary movements and a reduction in force. Yet, he stated that it was unclear from the submitted documents, why the treating doctor recommended the EMG/NCV testing. Dr. Ferrante stated that the treating chiropractor indicated that

chiropractic care had failed to resolve the EIP's symptomology. Yet, the appropriate standard of care following a failure of care would be a referral to an appropriate specialist, not the performance of diagnostic testing. Dr. Ferrante stated that the need for EMG/NCV testing is not necessary for the diagnosis of intervertebral disk disease with radiculopathy, rather it is utilized for differentiating other types of neuritis, neuropathy or muscle abnormalities from radicular neuropathy. Dr. Ferrante opined that from a chiropractic point of view, the physical findings and MRI results would be adequate to identify the cause or possibility of radiculopathy, without the need for neurodiagnostic testing.

In Jacob Nir, M.D. v Allstate Insurance Co., 7 Misc3d 544, 2005 NY Slip Op 25090, the Court held that in order for a Peer Review Report to be valid and to refute the findings of the treating doctor, it must set forth a sufficiently detailed factual basis and medical rationale to justify the denial for the service, or in this case the item at issue. It must also be supported by uncontroverted evidence of generally accepted medical standards citing Citywide Social Work & Psy. Serv. P.L.L.C. v Travelers Indemnity Co., 3 Misc3d 608, 2004 NY Slip Op 24034 (Civ. Ct., Kings Co. 2004). I find that Dr. Ferrante's peer report does not meet these standards. Dr. Ferrante did not provide a general standard of care for when EMG/NCV testing is considered medically necessary, from which the Applicant deviated. The peer review of Dr. Ferrante fails to set forth a factual basis and medical rationale for his determination that the services were not medically necessary.

This portion of Applicant's claim is granted.

DOS 03/04/17-06/24/17

An IME report asserting that no further treatment is medically necessary must be supported by a sufficiently detailed factual basis and medical rationale, which includes mention of the applicable generally accepted medical/professional standards. Carle Place Chiropractic v. New York Central Mut. Fire Ins Co., 19 Misc.3d 1139(A), 866 N.Y.S.2d 90 (Table), 2008 N.Y. Slip Op. 51065(U), 2008 WL 2228633 (Dist. Ct., Nassau Co., May 29, 2008, Andrew M. Engle, J.). An IME report must set forth a factual basis and medical rationale for the conclusion that further services are not medically necessary. E.g., Ying Eastern Acupuncture, P.C. v. Global Liberty Insurance, 20 Misc.3d 144(A), 873 N.Y.S.2d 238 (Table), 2008 N.Y. Slip Op. 51863(U), 2008 WL 4222084 (App. Term 2d & 11th Dists. Sept. 3, 2008).

Dr. Salayka reviewed several forms of medical documentation and examined the EIP on 10/17/16. At the time of the examination, the EIP reported complaints of pain in the neck, bilateral shoulder and bilateral knee. Dr. Salayka provided a diagnoses of resolved cervical and lumbar strain. Dr. Salayka stated that she found no objective findings on evaluation, to warrant further chiropractic treatment. All ranges of motion were noted to be at normal range, with no objective findings of spasm or positive orthopedic testing.

The case law states that if the insurer presents sufficient evidence establishing a lack of medical necessity, then the burden shifts back to the Applicant to present its own evidence of medical necessity. See: West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc3d 131A (2006).

In response, Applicant relied upon the documentation submitted, which included an initial evaluation on 07/23/16, with progress notes performed 07/27/16-12/28/16. However, I find the treatment notes submitted to be insufficient to justify the need for continued treatment beyond the date of a completely normal IME. I find the treatment notes alone fail to support the need for continued chiropractic treatment. There is very little information contained within these notes and they are in checklist format only.

Based upon a thorough review of the documentation submitted and in consideration of the parties' oral arguments at the hearing, I am persuaded by Dr. Salayka's assessment regarding the lack of medical necessity for the chiropractic treatment at issue. I find Respondent sustained their medically necessity defenses. This portion of Applicant's claim is denied.

Accordingly, Applicant's claim is granted in the amount of \$2,305.87 only. Reimbursement is due and owing. There were no fee schedule issues raised at the hearing. This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator.

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
	Carla Danielson DC	10/12/16 - 10/12/16	\$1,166.14	Awarded: \$1,166.14
	Carla Danielson DC	10/15/16 - 10/15/16	\$1,139.73	Awarded: \$1,139.73
	Carla Danielson DC	03/04/17 - 03/25/17	\$184.96	Denied
	Carla Danielson DC	04/01/17 - 04/29/17	\$231.20	Denied
	Carla Danielson DC	05/06/17 - 05/27/17	\$184.96	Denied
	Carla Danielson DC	06/03/17 - 06/24/17	\$184.96	Denied
Total			\$3,091.95	Awarded: \$2,305.87

- B. The insurer shall also compute and pay the applicant interest set forth below. 04/21/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant is awarded interest pursuant to the no-fault regulations. See generally, 11 NYCRR §65-3.9. Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30 day month." 11 NYCRR §65-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. However, the regulations toll the accrual of interest when an applicant "does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations." See, 11 NYCRR 65-3.9(c). The Superintendent and the New York Court of Appeals has interpreted this provision to apply regardless of whether the particular denial at issue was timely. LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 217 (2009).

C. Attorney's Fees

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

Effective to filings on or after February 6, 2015, this case is subject to the provisions as to attorney fee promulgated in the Sixth Amendment to 11 NYCRR 65-4(Insurance Regulation 68-D). As amended, 11 N.Y.C.R.R. §65-4.6(d) reads: "For all other disputes subject to arbitration or court proceedings, subject to the provisions of subdivision (a) of this section, 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 \$ 1360. 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 Suffolk

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

12/31/2023
(Dated)

Cathryn Roberts

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:
8d3b1afa782e5d4b4cb4ec3903b2a073

Electronically Signed

Your name: Cathryn Roberts
Signed on: 12/31/2023