

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Chiropractic Evaluation Services PC  
(Applicant)

- and -

Integon National Insurance Company  
(Respondent)

AAA Case No. 17-23-1294-2570

Applicant's File No. RB-235-310009

Insurer's Claim File No. 9WINY07139

NAIC No. 29742

**ARBITRATION AWARD**

I, Rhonda Barry, 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 07/26/2024  
Declared closed by the arbitrator on 07/26/2024

Elyse Ulino, Esq. from Baker & Narkolayeva Law P.C. participated virtually for the Applicant

James Scozzari, Esq. from Law Offices of Eric Fendt participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,340.00**, was NOT AMENDED at the oral hearing.  
Stipulations WERE made by the parties regarding the issues to be determined.

The parties stipulated that the denials are timely. If applicable, interest accrues in accordance with 11 NYCRR§65-3.9.

3. Summary of Issues in Dispute

The EIP, "RB" is a 22 year old male injured as a restrained driver in a rear end motor vehicle accident on 7/28/22. Air bags deployed and there was a claimed loss of consciousness. There was no immediate hospital attention. Applicant seeks \$1340 for disability evaluations on DOS 9/19/22 and 12/16/22. Respondent denied applicant's claim for DOS 9/19/22 based upon lack of medical necessity according to the 11/3/22

peer review of Jay Weiss, MD, PMR. Respondent terminated all no fault benefits effective 11/18/22 pursuant to the IME findings of JI Joon Kim, DC, L.Ac, and denied all subsequent treatment, including for DOS 12/16/22 based upon lack of medical necessity. Applicant submits a rebuttal (to the peer review and the IME report) from Anthony DeSano, DC.

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

I have completely reviewed all timely submitted documents contained in the ADR Center record maintained by the American Arbitration Association and considered all oral arguments. No additional documents were submitted by either party at hearing. No witnesses testified at the hearing.

#### ANALYSIS

Applicant has established its prima facie entitlement to reimbursement for no fault benefits based upon the submission of a properly completed claim form setting forth the amount of the loss sustained, and that payment is overdue. Mary Immaculate Hospital v. Allstate Insurance Company, 5 AD 3d 742, (2<sup>nd</sup> Dept. 2004). Westchester Medical Center v. Lincoln General Ins. Co., 60 AD 3d 1045 (2<sup>nd</sup> Dept. 2009). Respondent's denials establish the applicant's prima facie case. AR Medical Rehabilitation v. Statewide Insurance Co., 99710/06, NYLJ 1202737691469 (Civ. Ct Kings Cty. 8/12/15).

The burden now shifts to respondent to establish a lack of medical necessity with competent medical evidence which sets forth a clear factual basis (specifics of the claim) and medical rationale for denying the claim. Citywide Social Work and Psych Services, PLLC v. Allstate, 8 Misc. 3d 1025A (2005); Healing Hands Chiropractic v. Nationwide Assurance Co., 5 Misc. 3d 975 (2004). Respondent must offer sufficient and credible medical evidence that addresses the standards in the applicable medical community for the services and treatment in issue; explains when such services and treatment would be medically appropriate, preferably with understandable objective criteria; and why it was not medically necessary in the instance at issue.

A no-fault insurer defending a denial of first party benefits on the ground that the billed for services were not medically necessary must at least show that the services were inconsistent with generally accepted medical/professional practice. See Williamsbridge Radiology and Open Imaging v. Travelers Indemnity Company, 14 Misc. 3d 1231 (A), 836 NYS 2d 496.

#### **Peer Review- DOS 9/19/22**

Dr. Weiss considered substantial medical records including multiple valuations as MRI as well as MRI reports and reports of EMG/NCV. He also reviewed progress notes. The medical records establish persistent complaints of pain in the neck, middle and lower

back, and left knees. There was spasm and tenderness and decreased range of motion. Neck pain radiated to both arms. The EIP participated in multiple lumbar injections with good results. MRIs of the shoulders positive for partial tears. MRI of the cervical spine revealed a bulge. EMG/NCV the lower extremities documented an L5 radiculopathy.

According to Dr. Weiss the disability evaluation on 9/19/22 was medically unnecessary. There is no assessment as to whether or not the EIP was working and if so what type of work he performed. This information is essential as a crucial part of disability evaluation is job requirements. A disability evaluation is an intense multifaceted examination that is generally employment specific and also may go by the name of functional capacity evaluation. It generally answers a specific question. An adequate history must be taken noting whether an individual was working and what sort of work they were performing and what if any job requirements they had. Those criteria were not met. Dr. Weiss then provides a detailed description of functional capacity evaluation and notes that the applicant performed isometric lift strength testing and does not qualify as functional capacity evaluation and is in no way employment specific. The information obtained by applicant would not alter the treatment in any significant way. Further it is customary and appropriate that range of motion muscle testing be included in an office visit.

I find Respondent's peer report credible and persuasive. Respondent has sufficiently satisfied its burden of proof of lack of medical necessity for the lumbar MRI. The peer report herein sets forth a factual basis and medical rationale for the services at issue. AJS Chiropractic, PC v. Mercury Ins. Co., 22 Misc. 3d 133 (A), 880 NYS 2d 871 (App Term 2d & 11<sup>th</sup> Jud Dist. 2009). The report is comprehensive, credible, and supported by authoritative sources.

Dr. DeSano's rebuttal does not meaningfully or sufficiently refute the conclusions set forth in Dr. Weiss's report. Pan Chiropractic, PC v. Mercury Insurance Co., 24 Misc. 3d 136 (A) (App. Term 2d, 11<sup>th</sup> and 13<sup>th</sup> Jud Dist. 2009). Dr. DeSano details his opinion that range of motion and manual muscle testing were medically necessary. The issue in this case is whether or not a disability evaluation examination was necessary. The fact that the DIA testing is apparently identical to ROM/MMT is irrelevant and dubious. In accordance with the Chiropractic Fee Schedule as amended, chiropractors can no longer bill for range of motion or manual muscle testing (CPT 95851 and CPT95831). It appears that applicant's use of CPT 99456 was an attempt to circumvent the amended fee schedule.

Applicant failed to submit any medical evidence or contemporaneous medical records sufficient to rebut Respondent's showing of lack of medical necessity. As such its claim must fail. Delta Diagnostic Radiology, PC v. American Transit Ins Co., 18 Misc. 3d 128(A) (App Term 2d and 11<sup>th</sup> Jud Dist. 2007).

Where the applicant offers no medical evidence to rebut the insurer's prima facie case of lack of medical necessity, payment of the claim cannot be justified.

**IME**

Dr. Kim's report/examination is objectively unremarkable. The EIP advised that he sustained injuries to his neck, lower back, right shoulder, left shoulder, right hip, and left hip. He participated in a course of conservative care including chiropractic adjustment, medication, and supplies. Present complaints included pain in the neck, and bilateral shoulders. The EIP was employed full-time as maintenance staff at a cemetery. He missed 3 to 4 days from work and was currently working the same job with the same duties. All range of motion was measured by goniometer.

Upon examination, Dr. Kim noted normal appearance and posture. Gait was normal. Examination of the cervical, thoracic, and lumbar spine revealed no tenderness or spasm. Range of motion was normal and the EIP was neurologically intact. All objective orthopedic tests were negative. The acupuncture examination was normal for tongue, pulse, complexion, and breathing. The remainder of the examination of the affected joints was normal. Diagnosis was cervical, thoracic, and lumbar sprain/strain resolved and key and blood stagnation in the channels affecting the cervical spine, lumbar spine, right shoulder, left shoulder, right hip and left hip resolved.

Respondent has sufficiently satisfied its burden of proof of lack of medical necessity for continuing treatment, which is supported by evidence of the generally accepted medical/professional practices. Beal-Medea Products v. GEICO General Ins. Co., 267 Misc. 3d 1218(A), 910 NYS 2d 760 (Civ. Ct Kings Cty. 2010). The IME report herein sets forth a factual basis and medical rationale for its conclusions. AJS Chiropractic, PC v. Mercury Ins. Co., 22 Misc. 3d 133 (A), 980 NYS 2d 871 (App Term 2d & 11<sup>th</sup> Jud Dist. 2009).

Applicant must now meaningfully refer to or rebut the conclusions set forth in the [IME report]. Yklik, Inc. v. Geico Ins. Co., 2010 NY Slip Op 51336(u) (App Term 2<sup>nd</sup>, 11<sup>th</sup>, and 13<sup>th</sup> Jud Dist. 7/22/10). In the absence of such a rebuttal, the claim may be denied. A. Khodadadi Radiology, PC v. NY Cent Mut. Ins. Co., 16 Misc. 3d 131 (A), 2007 NY Slip Op 51342[U] (App term 2<sup>nd</sup> and 11<sup>th</sup> Jud Dist. 2007).

Dr. DeSano refers to his 9/19/22 and 12/16/22 evaluations; however, there were none. The EIP's complaints of pain were documented without any object if clinical findings. While I appreciate the ROM/MMT testing, standing alone without any clinical findings, it is insufficient to refute respondent's burden of proof.

Applicant failed to submit any medical evidence or contemporaneous medical records sufficient to rebut Respondent's showing of lack of medical necessity. Applicant's submission is predominately raw data of the treatment- that the treatment occurred. There is no contemporaneous narrative or other reporting which draws conclusions that establish medical necessity for the ongoing treatment. The treatment records and evaluation reports supplied do not describe in sufficient detail how the treatment positively affected the EIP. There is no narrative reporting which draws conclusions needed to substantiate the ongoing treatment. There is no indication as to how this

treatment affected this patient. As such the applicant has not sustained his burden of proof and its claims must fail. Delta Diagnostic Radiology, PC v. American Transit Ins. Co., 18 Misc. 3d 128(A) (App Term 2d and 11<sup>th</sup> Jud Dist .2007).

Respondent's denials are sustained.

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 NY

SS :

County of Nassau

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

08/01/2024  
(Dated)

Rhonda Barry

**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:**  
e6a7731e255d8d08a21e9f224ed0d2d2

### Electronically Signed

Your name: Rhonda Barry  
Signed on: 08/01/2024