American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Pro Edge Chiropractic, PC / Milagros Rodriguez
(Applicant)

- and -

State Farm Mutual Automobile Insurance Company
(Respondent)

AAA Case No.	17-16-1030-0977
Applicant's File No.	PEC1631.03
Insurer's Claim File No.	326T44927
NAIC No.	25178

ARBITRATION AWARD

I, Heidi Obiajulu, 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: Injured Party

1. Hearing(s) held on 03/27/2017
   Declared closed by the arbitrator on 04/02/2017

   Michael Lamond, Esq. from Akiva Ofshtein PC participated in person for the Applicant

   Scott Schwaber, Esq. from Nicolini, Paradise, Ferretti, Sabella participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 3,949.20**, was AMENDED and permitted by the arbitrator at the oral hearing.

   Applicant amended its claim to $2208.95 to conform to the maximum allowances under the New York State Workers' Compensation Medical fee schedule including the surgery ground rules.

   Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

   This arbitration stems from the treatment of a then 64-year-old female patient who sustained injuries as a passenger in a motor vehicle that was involved in an accident

occurring on July 19, 2015. At issue is whether Respondent established its prima facie case that the disputed manipulations under anesthesia performed on September 16, 2015 (second day of a series of 3) were medically unnecessary.

4. Findings, Conclusions, and Basis Therefor

I have reviewed all relevant documents included in the Modria ADR Center maintained by the American Arbitration Association (hereinafter referred to as AAA) consisting of the submissions made by the parties. No other documentation was submitted by either party at the time of the hearing or thereafter.

In dispute in this arbitration is Applicant's claim in the amended amount of $2208.95 for the disputed manipulations under anesthesia (hereafter referred to as MUAs) performed on September 16, 2015 (the second day of MUAs).

This case arises out of a motor vehicle accident occurring on July 19, 2015, in which the Injured Party (MR), a then 64-year-old female, sustained multiple injuries including to her cervical, thoracic, and lumbar spine, shoulders, hips and pelvis while occupying the insured vehicle as a front seat passenger when it was hit by the adverse vehicle. After the accident, the Injured Party went to a local hospital via ambulance.

Subsequently, the Injured Party received chiropractic care, physical therapy, and acupuncture treatment.

On September 09, 2015, Dr. Gary Stevens, DC initially examined the Injured Party and reported that she presented with complaints of bilateral daily neck pain that radiated to the shoulders with numbness and tingling, bilateral shoulder pain with numbness and tingling, bilateral thoracic pain, bilateral lumbar spine with numbness and tingling, and bilateral gluteal and pyriformis pain and numbness and tingling. His physical examination revealed hypoesthesia bilaterally at the C5 nerve dermatome distribution, and hypoesthesia in the right C6 and S1 nerve dermatome distributions, normal DTRs in the upper and lower extremities, motor deficits in the bilateral deltoids and left biceps, restricted cervical and lumbar spine ranges of motion (see the report for ranges), a positive Foramina Compression test, Hyperflexion compression test, Hyperextension compression test, O'Donahue Maneuver test in the cervical area, Shoulder Depression test bilaterally, cervical distraction test, positive Kemp's test, O'Donahue Maneuver in the lumbar area, SLR test at 50 degrees, Ely's test and Yeoman's test, tenderness and trigger points over the SI joint, Abductor group, Extensor and Piriformis muscles in the gluteal region, restricted ranges of motion in the hip, muscle weakness in the left TFL muscle, a positive Fabere-Patrick test bilaterally, Gaenslens test bilaterally, Hibb's test bilaterally, Goldthwait's test bilaterally, tenderness in the SC joint, supraspinatus tendon, and upper trapezius bilaterally, a positive Shoulder compression test, and restricted ranges of motion of both shoulders (including coupled motion in the scapular and glenohumeral joint), and weakness in the shoulders. Based on his exam, Dr. Stevens, DC diagnosed displacement of cervical IVD without myelopathy, other symptoms referable to shoulder joint secondary to neck pain and cervical spine segmental

biomechanical dysfunction, herniation or displacement of lumbar IVD without myelopathy, contracture of joint of pelvic region and hip secondary to lower back pain and lumbar spine segmental biomechanical dysfunction, and thoracic and thoracolumbar chronic segmental dysfunction. He recommended the disputed MUAs.

Dr. Villano, DC performed the disputed MUAs on 09/15/15. 09/16/15, and 09/17/15 with Dr. Dipti Patel, DC as the co-attendant. Applicant submitted its claim forms to Respondent seeking the reimbursement of no-fault benefits.

Within 30-days of its receipt of Applicant's claim forms, Respondent denied reimbursement on the grounds that the MUAs were medically unnecessary based on the peer review by Dr. Sposta, DC.

After it received Respondent's denial for the date of service in dispute in this case, Applicant commenced this arbitration seeking reimbursement of its claim.

At the outset, I find that Applicant established its prima facie case with the submission of its claim form and the copy of Respondent's denial of claim form, which demonstrate that Respondent received Applicant's claim form, that more than 30-days elapsed since its receipt of same, and that Respondent denied reimbursement of Applicant's claim, which shows that Applicant's claim is now due and owing. See Insurance Law section 5106 [a]; Viviane Etienne Medical Care, PC v. County-Wide Ins. Co 25 N.Y.3d. 498, 35 N.E.3d 451, 14 N.Y.S. 3d. 283, 2015 N.Y. Slip Op 04787(NY, June 10, 2015), W estchester Medical Center v. Nationwide Mut. Ins. Co., 78 A.D.3d. 1168, 911 N.Y.S.2d. 907, 2010 N.Y. Slip Op.08933, (N.Y.A.D. 2nd Dept., November 30, 2010).

At issue is whether Respondent met its burden of proof in establishing its lack of medical necessity defense and, if so, whether Applicant rebutted that defense.

Regarding its lack of medical necessity defense, Respondent relies on the peer review report and addendum by Dr. Sposta, DC. To rebut that defense, Applicant relies on the legal arguments of its attorney and the sworn testimony by Dr. Villano, DC offered during the arbitration hearing.

Before turning to the issue of the medical necessity of the MUAs performed on 09/16/15, there is a threshold issue regarding whether Respondent's addendum should be precluded.

Applicant's attorney argued that Respondent's addendum should be precluded because it is a prohibited attempt to cure a fatally defective original peer review as opposed to an expansion of opinions originally expressed. He contended that Respondent failed to establish its lack of medical necessity defense with the original peer review report by Dr. Sposta, DC (dated November 6, 2015) because he failed to set forth a sufficient factual basis and medical rationale. He argued that Dr. Sposta, DC expressly stated that "*there are no examination reports or treatment notes submitted for review [and that] without initial examination findings documenting presenting complaints, subjective and objective findings, prognosis and treatment plan, necessity cannot be established...*" He noted that Dr. Sposta, DC went on to state that there was no corroborative

documentation to substantiate or support the need for the MUAs when posed specific questions by Respondent regarding injuries, diagnoses, and the medical need for the MUAs. Given the above discrepancies in the original peer review, Applicant's attorney argued that the addendum must be precluded because Respondent's addendum is a prohibited "second bite of the apple" because Respondent attempted to cure the deficiencies in Dr. Sposta's original peer review report.

Respondent's attorney argued that Dr. Sposta's addendum should be accepted as part of the record because it was submitted within Respondent's 30-day period to pay or deny the claim. Hence, he argued that the addendum should be considered as part of the record.

Reviewing the relevant evidence in the record and considering the oral arguments made by the parties regarding whether Dr. Sposta's addendum should be accepted into the record, I find that Dr. Sposta's addendum should be considered because it an amendment of the original peer review report **made within Respondent's requisite 30-days to pay or deny the claim, which is permitted.** Notably, Respondent's denial indicates that Applicant's claim was denied on October 27, 2015. The original peer review report is dated November 6, 2015 and the addendum is dated November 12, 2015. Consequently, I find that the addendum was prepared and submitted within Respondent's 30-day period. Consequently, I view the addendum as an amendment made within the requisite 30-days.

Finally, I find that the facts of this case are analogous to the type of case discussed by the court in the case A.B. Med. Servs. PLLC v. American Mfrs. Mut. Ins. Co.6 Misc. 3d 133 [A], 800 N.Y.S.2d. 341 (Table), 2005 WL 265158, 2005 NY Slip Op 50114[U], (N.Y. Sup. App Term, 2d &11th Jud Dists, February 02, 2015), in which the court determined that a peer review report may not be determined to be legally deficient where the insurer shows that it sought to obtain needed information by means of a verification request and nothing was provided (however I note that the court ruled against the insurer because it failed to demonstrate it sought the missing information). Consequently, I find that the cases Park Neurological Servs., P.C. v. GEICO 4 Misc. 3d 95, 782 N.Y.S.2d 507, 2004 N.Y. Slip OP. 24210 (App. Term, 9th & 10th Jud. Dists., 2004), All County Open MRI & Diagn. Radiology P.C. v. Travelers Ins. Co. 11 Misc. 3d 131(A), 815 N.Y.S.2d 493 (Table), 2006 WL 543132 , 2006 N.Y. Slip Op. 503181 (N.Y. Sup. App. Term, March 3, 2006), and Dugo v. State Farm Mut. Auto. Ins. Co., 38 Misc.3d 1205(A), 969 N.Y.S.2d 802, 2012 WL 6761595, 2012 N.Y. Slip Op. 52375(U), (N.Y.City Civ.Ct., December 26, 2012) do not apply (which stand for the proposition that a peer review is legally insufficient when it indicates that a medical service was medically unnecessary based on a lack of documentation needed to determine the medical necessity of the service). Consequently, for the above reasons, I find that Dr. Sposta's addendum is not precluded.

Now turning to the medical necessity of the MUAs:

In his peer review report and addendum, Dr. Sposta, DC opined that the MUAs were medically unnecessary because they were performed inconsistent with the applicable

standard of care. He argued that the standard of care is that *"[MUAs] may be indicated in patients where manipulation is the treatment of choice, but manipulation cannot be performed because of severe pain, voluntary contracture, or muscle splinting during conventional manipulation."* He opined that there was no evidence in the chiropractic treatment notes submitted for his review to indicate there was difficulty manipulating the Injured Party using conventional chiropractic treatment. He cited medical authority for the proposition that it can take 6 to 16 weeks for a patient to return to "pre-episode" status. He noted that the MUAs were performed approximately 7 weeks following the initial chiropractic exam on 07/24/15. He also argued that there was no documentation to substantiate why MUA as performed so early in the treatment plan, which allowed very little time to ascertain whether conventional chiropractic treatment, would have altered the Injured Party's symptoms or could have accomplished exactly the same goals accomplished with MUA. Regarding Dr. Villano's cited standard of care (the NAMUAP treatment protocols), Dr. Sposta argued that the medical records did not demonstrate that the Injured Party manifested muscle guarding or a fibro-adhesive condition prior to the MUA procedures. Further, he argued that Applicant's records failed to demonstrate that the pre-procedure clearance and protocols were followed. He noted that a patient who is a candidate for MUAs has had an examination and a second opinion from a physician; he specified what tests needed to be performed (see the report for specifics). Also, he argued that the criteria under "Guidelines for establishing Clinical Justification [History and Physical Examination]" was not met because there were no referrals or second opinions submitted for review. He also noted that none of the examination reports or treating providers other than Dr. Stevens recommended the MUAs. Dr. Sposta, DC also noted that there was no prescription for the anesthesia. Also, he argued that there was no evidence to indicate why serial MUAs were performed. **He noted that serial MUAs require chronicity, which is defined as 3-6 months subsequent to an injury**. Also, he argued that MUAs of the shoulders were performed in a manner outside the scope of the chiropractic practice as defined under NYS Education Law S6551. Further, he argued that there was no documentation to substantiate that the symptoms of the hip joint and shoulder pain related to nerve interference related to distortion, misalignment or subluxation of the vertebral column (the circumstances under which manipulation can be performed by a chiropractor). Also, he argued that Applicant used the incorrect CPT codes. He noted that CPT code 27194 relates to manipulation of the sacroiliac joint and CPT code 27294 related to the hip joint and not the bone. For the above reasons, He argued that the criterion for performing MUA weren't established.

In his sworn testimony, Dr. Villano, DC testified that the MUAs were performed consistent with the generally accepted medical practices followed by the chiropractic community, the National Academy of Manipulation Under Anesthesia Physicians Guidelines (hereafter referred to as NAMUAP). He contended that Dr. Sposta, DC incorrectly argued that all of the criteria under the "Clinical Justification for [MUUA]" had to be satisfied. However, he argued that only one of the criteria needed to be satisfied. He argued that in this case the first category was satisfied ("The patient has responded favorably to conservative, non-invasive chiropractic and medical treatments, but continues to experience intractable pain and/or biomechanical dysfunction. Sufficient care has been rendered prior to recommending MUA (standard is 2-6 weeks))". However, he argued that the current version of the NAMUAP Guidelines call for 6 to 8 weeks. Also, he argued that one of the diagnoses listed under "Diagnosis" had to be

present. He stated that one of the conditions was present, I believe he testified that the following two conditions were present: intervertebral disc syndromes without fragment, sequestration, or significant osseous encroachment with or without radiculopathy and/or paravertebral muscle contraction related to functional biomechanical dysfunction syndromes (vertebral subluxation syndrome). He pointed out where Dr. Gary Steven documented "muscle guarding and the requisite diagnoses." (See page 11/11).

During cross examination, Dr. Villano, DC testified:

When asked why four reports for 3 different patients would be identical (assuming that they were because Respondent's attorney presented the documents at the hearing for the first time and such claim couldn't be verified at the time of the hearing). Dr. Villano, DC testified that the reports should be the same if the identical procedures were performed because the reports solely describe the procedures/protocol he followed in performing the MUAs. He contended that different descriptions of the protocols would be more of a problem. Regarding the serial MUAs, he testified that the guidelines for performing serial MUAs set forth in the NAMUAP Guidelines were followed and that based on his exam before the second day of MUAs, he determined that the Injured Party's condition improved by 51 to 79%. He explained that this determination was made based on the follow-up form and attached sheet completed by the Injured Party. (Since those documents were not contained in the record, Applicant was directed to submit same for my review). He further explained that the patient fills out the pre-exam form listing various factors that when taken together satisfied the criteria. Regarding the third day of MUAs, he noted that the Injured Party did not show 80% improvement in function as required under the NAMUAP protocols for performing serial MUA. He noted that under the section "Pre Procedure Evaluation, he noted that the Injured Party had experienced approximately 51% to 79% improvement "from the first procedure." He had difficulty indicating how the improvement after the second day of MUAs was quantified. Finally, he testified regarding serial MUAs and that a serial MUA will not be performed, despite having staffing present, if the Injured Party's condition does not meet the criteria for serial MUAs. He stated that he has cases where a serial MUA was canceled because the criteria for serial MUAs were not met. He contended that the staff is present for whatever MUAs are performed on that day.

For redirect examination,Dr. Villano, DC testified that the four cases that Respondent's attorney discussed represent a minuscule percentage of his total cases.

At the conclusion of the hearing, I directed Applicant to submit copies of his follow-up exam reports with the form completed by the Injured Party for the MUAs on 09/16/15 and 09/17/15. The record remained open until 03/31/17 for that submission.

As of the writing of this award, Applicant failed to submit any post-hearing submission.

Reviewing the evidence in the record and considering the parties' oral argument concerning the medical necessity of the MUAs performed on 09/16/15, I find as follows:

In determining whether an insurer met its burden of proof in establishing its lack of medical necessity defense, the courts have found that an insurer must submit an IME

report/peer review with a detailed basis and medical rationale for the denial of benefits in order to prevail. SeeVladimir Zlatnick, M.D., P.C. v. Travelers Ins. Indemnity Co., 12 Misc. 3d 128A (App. Term 1st Dept. 2006) and Nir v. Allstate, 7 Misc.3d 544, 546-47, 796 N.Y.S.2d 57, 60 (Civ. Ct., Kings Cty. 2005 ("At a minimum, (Respondent) must establish a factual basis and medical rationale for the lack of medical necessity of (Applicant's) services"). Once Respondent submits an IME report or peer review that has a sufficient factual basis and medical rationale, then the courts have routinely found that Respondent has established its prima facie defense that the disputed medical service is medically unnecessary. A Khodadadi Radiology, P.C. v. NY Cent. Mut. Fire Ins. Co., 16 Misc.3d 131(A), 841 N.Y.S.2d 824 (Table, Text in WESTLAW), Unreported Disposition, 2007 WL 1989432, 2007 N.Y. Slip Op. 51342(U) (N.Y. Sup. App. Term Jul 03, 2007). See also, Dayan v. Allstate Ins. Co, 49 Misc.3d 151(A), 29 N.Y.S.3d 846, 2015 NY Slip Op 51751(U) (App. Term 2d, 11th & 13th Dists. 2015). Then, the burden of persuasion regarding the medical necessity of the medical services shift to the applicant to submit competent medical evidence to refute Respondent's prima facie defense that the disputed medical service/test was medically unnecessary. See Pan Chiropractic PC v. Mercury Ins. Co., 24 Misc.3d. 136 (A), 897 N.Y.S. 2d 671 (Table), 2009 NY Slip Op 51495 (U) (July 9, 2009).

Applying the above law to the facts of this case, I find that Respondent established its prima facie case that the disputed MUAs performed on 09/16/15 were medically unnecessary based on the peer review and addendum by Dr. Sposta, DC because I find that he set forth a sufficient factual basis and medical rationale. Although he did not set forth a sufficient factual basis in his original peer review (in that he indicated that he needed additional documentation), I find that he set forth a sufficient factual basis in his addendum based on his review and discussion of the additional documentation provided by Applicant. I also find that Dr. Sposta, DC set forth a sufficient medical rationale because he cited a standard of care for performing MUAs and showed that it was not followed. Hence, for the above reasons, I find that Respondent established its prima facie case that the MUAs were medically unnecessary.

Thus, the question becomes whether Applicant rebutted that defense.

I find that Applicant rebutted Respondent's defense regarding the initial MUA based on the testimony of Dr. Villano, DC because I find his opinion that the MUAs on 09/15/15 were performed consistent with the applicable standard of care, NAMUAP protocols (see linked case for more in-depth reasoning). However, I am not convinced that the second day of MUAs was performed consistent with the protocols of the NAMUAP for serial MUAs (and specifically for a second day of MUAs) given that the NAMUAP Guidelines require that the condition be chronic and that there be conservative care ("*Serial MUA (more than one) is recommended when conservative care as described in the Academy standards and protocols, has been rendered and when the condition is chronically present*".) In addition, the guidelines provide: "*If the patient regains 50-70% or less of normal biomechanical function during the first procedure and retains only 50-70% of improvement during post MUA evaluations, a second MUA is recommended* ."Although Dr. Villano argued that the latter requirement was met, the former requirements were not. **Accordingly, for the above reasons, I find in favor of**

Respondent. Applicant's claim for reimbursement of the second day of MUAs is denied in its entirety.

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

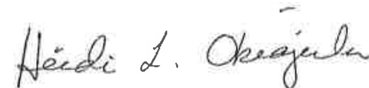
Accordingly, the claim is DENIED in its entirety

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

State of New York
SS :
County of New York

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

04/05/2017
(Dated)



Heidi Obiajulu