American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:		
Derek Bell DC / **Applicant_ 1** (Applicant)	AAA Case No. AAA Assessment No. Applicant's File No.	412010021107 17 991 12740 10
- and - **LM Property & Casualty Insurance Company** (Respondent)	Insurer's Claim File No.	LA2740059860830 2

ARBITRATION AWARD

I, Kent L. Benziger, Esq., 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: P.S.

1. Hearing(s) held on
☒07/27/10
and declared closed by the arbitrator on 7/27/10.

Greg Vinal participated in person for the Applicant.
William Nadolny participated in person for the Respondent.

2. The amount claimed in the Arbitration Request, **$1,888.08**, 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

Whether the Applicant has made a prima facie showing of necessity for chiropractic treatment.

Applicant has submitted the following documents:
1. AR-1;
2. Applicant's Contentions;
3. Records, Erie County Medical Center;
4. Records, John Weisberg D.C.;
5. Records, Affordable Chiropractic;
6. Bills/Claims;

7. Rebuttal John Weisberg;
8. Prescriptions, Disability Notes.;

Respondent has submitted the following documents:
1. Respondent's Contentions;
2. Examinations, Neil Hedin, D.C.;
3. Examination, Andrew Young, D.C.;
4. NF-10 Denials;
5. Records, Chautauqua MRI;
6. Records, Derek Bell
7. Records, Williamsville Medical Imaging;
8. Records, Buffalo Neurosurgery Group;
9. Examination, David Ribakove, M.D.

This hearing was conducted using the electronic case folder maintained by the American Arbitration Association. All documents contained in that folder are made part of the records of this hearing. I have reviewed the documents contained in the electronic case folder as of the date of this award as well as any documents submitted upon continuance of the case. Any documents submitted after the hearing that have not been entered in the electronic case folder as of the date of this award will be listed immediately below and forwarded to the American Arbitration Association at the time this award is issued for inclusion in said case folder.

4. Findings, Conclusions, and Basis Therefor

This dispute involved the necessity of chiropractic care from Dr. Derek Bell, D.C. administered from May 4, 2005 through November 6, 2008.

On July 10, 2003, the Assignor/Eligible Injured Party, was, by history, involved in a motor vehicle accident. She was taken by ambulance to Erie County Medical Center where she was treated for chest, mid-back and neck pain. On July 18, 2003, She then began treatment with Dr. John Weisberg who found diminished range of motion in both the cervical and lumbar spine. She commenced chiropractic care. In October of 2003, Dr. Weisberg noted the Assignor was treating with him for sternal and rib fractures as well as cervical segmental dysfunction and sprain/strain, along with dorsal tenderness. Through a December 2003 report, Dr. Weisberg noted an MRI noted several disc protrusions, and that the Assignor was disabled.

In July of 2004, the Assignor began treatment with Dr. Derek Bell. Her primary complaints included neck pain, midback pain, chest pain and transient numbness on her face. Restriction of motion and abnormal segmental motion were noted. The diagnosis was of subluxations from C4-C6. The treatment plan called for chiropractic care at 2-4 per month. The Applicant has exchanged progress reports.

<u>Examinations and Denials</u>
On October 21, 2005, Dr. Neil Hedin, a chiropractor, performed a medical examination at the Respondent's request. He had previously performed evaluations on February 11, 2004,

August 31, 2004 and March 8, 2005. At the time of the exam, the Assignor's primary complaints included bilateral neck pain, pain in the right hand with tingling. On examination, he noted the following range of motion: flexion – 45degrees, extension – 45 degrees, rotation 50 degrees to the right with neck pain, 60 degrees to the left with neck pain, lateral bending – 20 degrees to the right with neck pain, 20 degrees to the left with neck pain. Dr. Hedin noted positive results on shoulder depression testing on the right and left, positive Appley's test for the rotator cuff muscles, and right and tender paracervical and parathoracic muscles. The impression included cervical spine strain/sprain with associated cervical intersegmental joint dysfunction and myospasm. Dr. Hedin noted the treatment was necessary and that continued care should continue at a rate of once per week for twelve weeks. He found the Assignor was totally disabled from performing physical work.

On November 14, 2006, Dr. Andrew Young, a chiropractor performed an evaluation at the Respondent's request. On that day, the Assignor complained of bilateral cervical pain with occasional radiation down her right arm. She also complained of bilateral sacroiliac pain. On examination, Dr. Young noted the following ranges of motion in the cervical spine: 60/80 for right rotation, 30/45 for left lateral flexion. All other cervical ranges were within normal limits . A cervical compression test elicited complaints of pain with right lateral flexion, shoulder depressor test was positive on the right. The Valsalva maneuver was positive as was the Kemp's test. Dr. Young noted tenderness in the cervical spine and trapezial. The orthopedic test was positive with Kemp's test. Right forward flexion caused sacroiliac pain. Bilateral sacroiliac motion was mildly decreased. The diagnoses included segmental dysfunction of the cervical spine, cervicalgia brachia radiculitis neuritis, segmental dysfunction of the sacrum, and lumbalgia. Dr. Young found a causal relationship but noted the Assignor had previous neck traumas in 1990 and 2002. He concluded the Assignor had reached a medical endpoint for chiropractic care. He found the care has become palliative in nature and no longer corrective.

Treatment Dates

May 4, 2008 -May 18, 2005:

The Respondent denied payment for a chiropractic re-evaluation on May 18, 2005. The basis of the denial was that chiropractic re-evaluations can only be performed and billed once after every eight weeks of treatment.

September 6, 2005 – October 4, 2005:

The Respondent made a partial payment of $141.12 for the claim of $237.90. The basis of the denial is only stated as fee schedule. However, neither the body of the NF-10 Denial nor an accompanying Explanation of Benefits sets forth the specifics of the denial.

March 6, 2006 – July 24, 2006:

The Respondent made partial payment for the above dates. The carrier denied payment for any chiropractic treatment above one visit per week for 12 weeks pursuant to the findings of Dr. Neil Hedin on his October 18, 2005 examination.

April 11, 2007 – November 6, 2008:

The Respondent denied all chiropractic treatment effective March 31, 2007 based on the November 14, 2006 examination by Dr. Andrew Young, D.C.

Analysis

A presumption of medical necessity attaches to a Respondent's admission of the Applicant's timely submission of proper claim forms, and the burden then switches to the Respondent to demonstrate lack of medical necessity. Acupuncture Prime Care, P.C. v. State Farm Mutual Auto Ins. , 2007 N.Y. Slip Op. 522273U; 2007 N.Y. Misc. LEXIS 7860 (Dist. Ct. Nassau Co. 12/3/2007); A.B. Medical Services, PLLC v. N.Y. Central Mutual Fire Ins. Co., 7 Misc. 3d 1018(a), 801 N.Y.S.2d 229 (Civil Ct. Kings Co. 2005); Citywide Social Work & Psychological Services v. Travelers Indemnity, 3 Misc.3d 608, 609 (Civil Ct. Kings Co. 2004).

Respondent thus bears "both the burden of production and burden of persuasion with respect to the medical necessity of the treatment or testing for which payment is sought". See: Bajaj v. Progressive Ins. Co. 14 Misc.3d 1202(A) (N.Y.C. Civ. Ct 2006). The quantum of proof necessary to meet Respondent's burden, at the bare minimum, is to "establish a factual basis and medical rationale for the lack of medical necessity of Applicant's services . Id. See also: A.B. Medical Services, supra.

May 4, 2008 -May 18, 2005:
Pursuant to the Chiropractic Ground Rules of the Workers' Compensation Fee Schedule, a chiropractor can only bill for a further re-evaluation once every eight visits. The Respondent correctly reduced the claim.

September 6, 2005 – October 4, 2005
The Respondent's NF-10 denial states that the claim was not in accordance with fee schedule. However, line 33 of said denial fails to contain an explanation for the reduction. The attached explanation of benefits pain also fails to contain an explanation but refers back to the NF-10. In sum, no explanation of the fee schedule reduction has been attached. Therefore the Applicant is awarded $96.78.

March 6, 2006 – July 24, 2006:
The Respondent has only paid reimbursement for one visit per week based on Dr Hedin's examination and findings. Dr. Hedin's examination is thorough and credible. He fails to give an in-depth explanation as why treatment should be limited to one day per week. However, the Applicant has failed to include any records from Dr. Bell other than an initial examination, x-rays findings and very basis progress notes. Therefore, Dr. Hedin's conclusion is essentially un-rebutted, and reimbursement is denied. Khodadadi Radiology v. Gomez, 16 Misc.3d 131 (2007)

April 11, 2007 – November 6, 2008
Dr. Young found this treatment not necessary because it was palliative in nature and not curative. The issue is, therefore, not the Assignor's conditions or the findings of the provider, but whether as a matter of law treatment can be terminated when it is found to be palliative but not curative. Dr. Young's initial finding that the treatment had reached a logical endpoint is similar to a finding that has been referred to as "maximum medical improvement" The Fourth Department has held that alleged maximum medical improvement of the insured does not justify discontinuation of further benefits which are otherwise "necessary" within the meaning of Insurance Law §5102(a)(1). Hobby v. CNA Ins. Co., 267 A.D.2d 1084, 700 N.Y.S.2d 346(4 Dept., 1999). More recent decisions have side-stepped the use of the term "maximum medical improvement" and held that treatment is no longer necessary where it is not improving or otherwise benefiting a claimant. Treatment

that is not providing any "curative" or palliative" benefits may no longer be necessary. Palliative would be defined in this instance as treatment that lessens the severity of pain and suffering and improving the quality of life without necessarily affecting a cure. See: Merriam-Webster's Collegiate Edition, Eleventh Edition. Therefore, palliative care can be necessary and reimbursable when improve or benefit a claimant pursuant to Hobby v. CNA Ins. Co., supra, AN Ins

This arbitrator will continue to hold that palliative care can, depending on the facts, be reimbursable even if it is no longer curative. The issue is what degree of palliative relief justifies reimbursement under the No-Fault regulations. Does five minutes, one hour, one day or more of relief qualify as palliative relief, and does that relief permit the injured party to do specific daily activities? An arbitrator as the judge of the relevance and materiality of the evidence offered is permitted to make such findings of fact as to whether the treatment qualifies as palliative or curative under specific facts. 11 NYCRR 65-4.5 (o)(1)(i)(ii).

In this instance, Dr. Young has failed to clarify the extent of palliative care. He does not dispute her disability and found limitation of movement as well as positive orthopedic and chiropractic findings. Through his chiropractic examination, the Assignor stated that she did receive relief from chiropractic treatment, but by the time of the next weekly visits, the complaints had returned and she was unable to perform her daily routines. As noted above, the Respondent, through independent examinations bears "both the burden of production and burden of persuasion See: Bajaj v. Progressive Ins. Co. supra. As a finding of fact, the Respondent has failed to document that the palliative care in this case was not necessary or reimbursable.

Attorney's Fees and Interest

The insurer shall compute and pay to the Applicant the amount of interest from the filing date of the Request for Arbitration, at a rate of 2% per month, simple interest (i.e. not componded) using a 30 day month and ending with the date of payment of the award, subject to the provisions of 11 NYCRR 65-3.9(c).

Applicant is awarded attorney's fees for the total amount of first party benefits awarded. Pursuant to 11 NYCRR 65-4.6(c)(e), the Applicant is awarded 20 percent of the amount of the first party-benefits, plus interest thereon with a minimum of $60.00 and a maximum of $850.00 per claim which is the total amount awarded one Applicant in one action from one provider. See: LMK Psychological Services, P.C. v. State Farm Mut. Auto Ins. Co., 12 N.Y.3d 217 Court of Appeals, 2009).

APPLICANT IS AWARDED REIMBURSEMENT TOTALING $1,676.07 CONSISTING OF CHIROPRACTIC TREATMENT FROM SEPTEMBER 6, 2005 THROUGH OCTOBER 4 2005 AND APRIL 11, 2007 THROUGH NOVEMBER 6, 2008, TOGETHER WITH INTEREST AND ATTORNEY'S FEES. THE REMAINDER OF THE TREATMENT IS 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.

Accordingly, the applicant is AWARDED the following:

A.

Benefits	Amount Claimed	Amount Awarded
Health Service Benefits	1,888.08	1676.07

Totals:	$1,888.08	$1,676.07

B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 05/05/2010, which is a relevant date only to the extent set forth below.)

The Respondent shall compute and pay to the Applicant the amount of interest from aforesaid filing date of the Request for Arbitration, at a rate of 2% per month, simple interest (i.e. not componded) using a 30 day month and ending with the date of payment of the award, subject to the provisions of 11 NYCRR 65-3.9(c).

C. Attorney's Fees

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

Pursuant to 11 NYCRR 65-4.6(c)(e), the Applicant is awarded 20 percent of the amount of the total first party-benefits, plus interest thereon with a minimum of $60.00 and a maximum of $850.00 per claim which is the total amount awarded one Applicant in one action per one provider See: LMK Psychological Services, P.C. v. State Farm Mut. Auto Ins. Co., 2009 NY Slip Op 02481 (Court of Appeals, 2009).

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 Erie .

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

8/16/10
(Dated) (Kent L. Benziger, Esq.)

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.