American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:		
Village Chiropractic / **Applicant_ 1**	AAA Case No.	412010018056
(Applicant)	AAA Assessment No.	17 991 11056 10
- and -	Applicant's File No.	
Clarendon National Insurance Company		
(Respondent)	Insurer's Claim File No.	9FNYA07246

ARBITRATION AWARD

I, Glen A. Wiener, 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:Assignor

1. Hearing(s) held on
☒06/22/10
and declared closed by the arbitrator on 6/22/10.

Alexander Chu-Fong, Esq. participated in person for the Applicant.
Ralph Caio, Esq. participated in person for the Respondent.

2. The amount claimed in the Arbitration Request, **$4,092.39**, 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 Applicant can seek reimbursement for services provided to Assignor, despite its failure to respond to Respondent's verification requests.

Whether Applicant's claim seeking reimbursement for the muscle testing was properly denied based upon the insurance adjuster's unsupported conclusion the services were not medically necessary.

Whether the chiropractic services provided to Assignor after Respondent's termination of benefits on January 21, 2006 were medically necessary?

4. Findings, Conclusions, and Basis Therefor

The decision below is based on the documents on file in the Electronic Case Folder maintained by the American Arbitration Association as of the date of this hearing and on oral arguments of the parties. No witness testimony was produced at the hearing.

Assignor JA was involved in an automobile accident on July 26, 2005. Applicant Village Chiropractic, P.C., as assignee of JA, seeks $4,092.39 reimbursement with interest and counsel fees, under the No-Fault Regulations, for chiropractic services provided to Assignor from August 2, 2005 through September 14, 2006. Respondent **Clarendon National Insurance Company** insured the motor vehicle involved in the accident. Under New York's Comprehensive Motor Vehicle Insurance Reparation Act (the "No-Fault Law"), New York Ins. Law §§ 5101 et seq., Respondent was obligated to reimburse the injured party (or its assignee) for all "reasonable and necessary expenses" and "medical expenses" arising from the use and operation of the insured vehicle. However,

1. Respondent neither paid nor denied Applicant's request for $3,138.67 reimbursement for services provided to Assignor from August 2, 2005 through January 21, 2006 alleging Applicant failed to comply with its requests for additional verification.
2. Respondent denied Applicant's request for $178.62 reimbursement for manual muscle testing performed Assignor on August 6, 2005 alleging "reimbursement is inclusive in evaluation & management services" and "Services are excessive and not medically necessary."
3. Respondent denied Applicant's request for $775.10 reimbursement for chiropractic services performed from January 31, 2006 through August 8, 2006 based upon the opinion of chiropractor Daniel Sposta, D.C. who concluded no further treatment was necessary following his examination of Assignor conducted on January 13, 2006. Based upon this experts report, Respondent terminated Assignor's chiropractic benefits as of January 21, 2006.

The Verification Requests

Applicant seeks $3,138.67 reimbursement for services provided to Assignor from August 2, 2005 through January 21, 2006. Respondent neither paid nor denied the claims alleging Applicant failed to comply with its requests for additional verification. On the dates listed below Respondent sent Applicant a letter requesting all medical records, SOAP notes, and a letter of medical necessity.

Dates of Service	Amount	Received	Verification 1	Verification 2
08/02/05	$266.41	08/23/05	09/06/05	10/07/05
08/04-8/30/05	$404.40	09/06/05	09/07/05	10/07/05
08/13-8/18/05	$873.84	08/25/05	09/06/05	10/07/05
09/01-09/27/05	$337.00	10/03/07	10/07/05	11/11/05
10/01-10/27/05	$404.40	11/02/05	11/08/05	12/08/05
10/04/05	$178.62	10/11/05	10/21/05	11/22/05
11/01-11/29/05	$303.30	12/05/05	12/08/05	01/09/06
12/03-12/29/05	$134.80	01/09/06	01/13/06	02/15/06
01/03-01/21/06	$235.90			

A No-Fault claim must be paid or denied within thirty days or it is "overdue." commencing the accrual of interest and attorney fees. *See,* N.Y. Ins. Law § 5106[a] (McKinney 2000); 11 NYCRR § 65[g][3]; *Presbyterian Hospital v. Maryland Cas. Co.,* 90 N.Y.2d 274, 660 N.Y.S.2d 536 (1997). However, there is an exception to the 30-day rule. Under 11 NYCRR § 65-3.8(a)(1) No-Fault benefits are overdue if not paid within 30 calendar after the insurer receives proof of claim, which shall include verification of all the relevant information requested pursuant to 65-3.5". 11 NYCRR § 65-3.5 (b) provides that, "within 15 business days of receipt of the prescribed verification forms" an insurer may seek additional verification of a claim. "If any requested verifications has not been supplied to the insurer 30 calendar days after the original request, the insurer shall, within 10 calendar days, follow up with the party from whom the verification was requested. . . At the same time the insurer shall inform the applicant and such person's attorney of the reason(s) why the claim is delayed by identifying in writing the missing verification and the party from whom it was requested." 11 NYCRR § 65-3.6 (b).

An insurer is not obligated to pay or deny a claim until it has received verification of all relevant information requested (*see* 11 NYCRR 11 NYCRR 65-3.8 (b) (3)]; *St. Vincent's Hospital Richmond v. American Transit Insurance Company,* 299 A.D.2d 338 (2nd Dept. 2002); *New York Hosp. Med. Ctr. of Queens v Country-Wide Ins. Co.*, 295 A.D.2d 583, 744 N.Y.S.2d 201 (2nd Dept 2002). "Just as the insurer has a duty to speedily process claims, the claimant for benefits has a duty of cooperation in supplying information reasonably requested by the insurer to process the claim." *Dilon Medical Supply Corp. v. Travelers Ins. Co*., 2005 Slip Op 25113, 7 Misc.3d 927, 796 N.Y.S.2d 872 (Civ. Ct. Kings Co., Arlene Bluth, J., March 24, 2005) Applicant "cannot simply rest on its laurels and ignore a verification request . . . Since the [Applicant] desires to be paid the onus is on it to insure that the [Respondent] has all of the required information to verify and pay the claim." *D&R Medical Supply, Inc. v. Clarendon Nat. Ins. Co.*, 22 Misc.3d 1127(a), 881 N.Y.S.2d 362, 2009 Slip Op 50306(U)(Civ. Ct. Kings Co., Gennie Edwards, J. Feb. 6, 2009). "Any confusion on the part of [an applicant] as to what was being sought should [be] addressed by further communication, not inaction." *Westchester County Medical Center v. New York Central Mut. Ins. Co*., 262 A.D. 553, 692 N.Y.S.2d 665 (2d Dept 1999). "Even when a claimant believes it need not comply with a verification request, the claimant still has a duty to communicate with the insurer regarding the request. . . The [insurer] should not be put in a position to second guess the reason or reasons why the [claimant] has failed to respond to the request." *Canarsie Chiropractic, P.C. v. State Farm Mut. Auto. Ins. Co*., 2010 Slip Op 50950U (Civ. Ct. Kings Co. Silvia Ash, J. May 25, 2010). A failure to raise an objection to the request will even result in a waiver of the defense the notices were defective and unreasonable. *Canarsie Chiropractic, P.C. v. State Farm Mut. Auto. Ins. Co*., 2010 Slip Op 50950U (Civ. Ct. Kings Co. Silvia Ash, J. May 25, 2010).

Applicant failed to respond to Respondent's timely verification requests. Hence, the 30-day period within which Respondent was required to respond has not begun to run. Accordingly, Applicant's claim seeking $3,138.67 reimbursement for the services provided to Assignor from August 2, 2005 through January 21, 2006 is dismissed without prejudice, pending Applicant's response to Respondent's requests for additional verification.

The Services Performed on August 6, 2005

Applicant also seeks $178.62 reimbursement for manual muscle testing performed Assignor on August 6, 2005. Respondent denied the claim alleging "reimbursement is inclusive in evaluation & management services. Services are excessive and not medically necessary."

However, Respondent did not submit any evidenced establishing it reimbursed Applicant for any evaluation & management service conducted on the same day and the determination that the services were not medically necessary appears to be based upon the unsupported opinion of the claim's adjuster.

An insurance carrier claim's adjuster is not legally competent to render medical opinions and should not determine the appropriateness or breadth of medical treatment provided an injured individual. *See*, Adams *Place Physician Associate, PC, v AIU Insurance*, 17 991 04173 04 (MARCH 25, 2004) Insurance adjusters should seek the advice, opinion, and assistance of competent medical professionals when evaluating a medical claim. Professional opinions integrating published studies, guidelines and/or procedures, with the facts of the claim are most advantageous.

Triers of fact such as Arbitrator's "cannot allow [themselves] to be in the position of having to decide such difficult issues without the benefit of any evidence, but solely on the basis of a defendant's speculation or wishful thinking. Only an expert's [report] can give the courts [or this tribunal] the proper guidance in such specialized scientific matters . . ." *Mount Sinai Hospital, as Assignee of Maria Figuerdov, Respondent, v. Triboro Coach, Incorporated*, 263 A.D.2d 11, 699 N.Y.S.2d 77 (2d Dept. 1999)

Respondent's failure to conduct a peer review is inexcusable and Applicant's bill remains unchallenged. I am constrained to render an awarded consistent with the evidence submitted in this case. *See*, *A.B. Medical Services PLLC v. Lumberman's Mutual Casualty Co.*, N.Y.L.J., September 30, 2003, p.19, col. 1 (Civ. Ct. Kings Co)(Insurance claim's adjuster's speculative conclusion, "our investigation of the accident does not support the injury claimed", without any support from an expert report is insufficient to defeat plaintiff's motion for summary judgment.) Applicant's prima facie case prevails over Respondent's flawed opposition. Respondent's denial dated September 30, 2005 is vacated and Applicant is awarded $178.62 for the muscle testing conducted on Assignor on August 6, 2005.

The Cut-Off Based Upon the Physical Examination

Dates of Service	Amount	Date of Denial
01/31/06	33.70	02/08/06
01/31-02/21/06	$134.80	03/14/06
02/28-03/28/06	$168.50	04/07/06
04/04-05/30/06	$303.30	06/20/06
06/20-06/27/06	$67.40	07/13/06
07/13/06	$33.70	08/14/06
08/08/06	$33.70	09/14/06

Applicant seeks $775.10 reimbursement for chiropractic services provided to Assignor from January 31, 2006 through August 8, 2006. Respondent denied Applicant's requests for reimbursement based upon the opinion of chiropractor Daniel Sposta, D.C. who opined no further chiropractic treatment was necessary following his examination of Assignor conducted on January 13, 2006. Based upon this experts report, Respondent terminated Assignor's benefits as of January 21, 2006.

Applicant establishes "a prima facie showing of their entitlement to judgment as matter of law by submitting evidentiary proof that the prescribed statutory billing forms [setting forth the fact and the amount of the loss sustained] had been mailed and received and that payment of no-fault benefits were overdue." *Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004).

Once Applicant has established a prima facie case the burden is on the insurer to prove the treatment was not medically unnecessary. *See, Citywide Social Work & Psychological Services, PLLC a/a/o Gloria Zhune v. Allstate Ins. Co.,* 8 Misc.3d 1025A, 806 N.Y.S.2d 444 (App. Term 1st Dept 2005); *A.B. Medical Services, PLLC v. Geico Ins. Co.*, 2 Misc 3d 26, 773 N.Y.S.2d 773 (App Term 2nd & 11th Jud Dist 2003); *Fifth Ave. Pain Control Center a/a/o Gladys Quintero v. Allstate Ins. Co*, 196 Misc.2d 801, 766 N.Y.S.2d 748 (Civ. Ct. Queens Co. 2003). "A denial premised on lack of medical necessity must be supported by competent evidence such as an independent medical examination, peer review or other proof which sets forth a factual basis and medical rational for denying the claim." *Healing Hands Chiropractic, P.C. a/a/o Cleeford Franklin v. Nationwide Assurance Company,* 5 Misc.3d 975, 787 N.Y.S. 645, (Civ. Ct NY Co. 2004).

Assignor, a 30-year-old male, was involved in an automobile accident on July 26, 2005. The next day he sought medical attention at North Central Hospital where he was examined and released. On August 2, complaining of intermittent headaches, radiating neck pain, mid back pain, radiating low back pain, right ankle pain, left knee pain, right leg weakness, and swelling of the right foot and ankle, he presented himself to Richard E. Amato, D.C. a chiropractor at Applicant. Diagnosed with post traumatic headaches, post traumatic cervical segmental dysfunction/subluxation, post traumatic thoracic segmental dysfunction/subluxation, post traumatic lumbar segmental dysfunction/subluxation, and post traumatic right ankle sprain, Assignor was directed to begin spinal adjustments, physical modalities such as ice, and exercises.

About five months later, on January 13, 2006, at the request by Respondent, Assignor was examined by Dr. Sposta. At the time of Dr. Sposta's examination, Assignor complained of low back, right foot and right shoulder pain. He was able to get on and off the examining table without difficulty and was observed walking with a normal gait. Examination of the lumbar spine revealed no tenderness or spasms. Reflexes were 2+ in the lower extremities. Motor strength was 5/5 in the hamstring and quadriceps muscles and there were no sensory changes when dermatome testing was performed. The following signs/tests were negative: Romberg's, Lasegue's, Kemp's, Hoover's, Ely's, Minor's, Fabere-Patrick, Linder's, Adam's, and Trendelenberg. Examination of Assignor's right shoulder revealed no tenderness and full range of motion. Apley's scratch test and Lift off tests were normal. Examination of Assignor's right foot revealed tenderness along the lateral aspect of the 5th metatarsal. There was no apparent swelling or bruising. There was full range of motion in all planes. Following this examination (and an eastern medical examination), Dr. Sposta noted, "No further chiropractic care or acupuncture treatment is necessary or warranted." Respondent terminated Assignor's chiropractic and acupuncture benefits effective January 21, 2006. From January 31 through August 8, 2006 Assignor received chiropractic care from Applicant.

Dr. Sposta's report provides a sufficient factual basis and medical rationale for the opinion that the medical services billed for after November 5, 2007 were not necessary and therefore established prima facie the services billed for were not medically necessary. *See, Delta Diagnostic Radiology, PC v. Progressive Casualty Ins. Co.,* 21 Misc.3d 142A, 2008 Slip Op

52450(U), (App Term 2nd and 11th Jud. Dist. 2008); *Crossbridge Diagnostic Radiology, PC v. Progressive Casualty Ins. Co.*, 20 Misc.3d 143A, 2008 Slip Op 51761(U), (App Term 2nd and 11th Jud. Dist. 2008).

In response Applicant submitted its progress notes and an affidavit. However, no **specific** findings or complaints were recorded in either. Each day of the typed progress notes are identical and merely indicate:

> *Restriction of the Cervical Range of Motion*
> *Restriction of the Lumbar Range of Motion*
> *Palpation reveals multiple subluxation{s} /fixation{s} of the Cervical, Thoracic and Lumbar Spines*
>
> *Today's treatment consisted of full spinal manipulation to the area{s} of complaints*.

Applicant's records fail to fully rebut the findings of Dr. Sposta. The evidence submitted by Applicant makes it difficult to ascertain why the treatments provided to unidentified parts of the spine were necessary. Applicant should have presented records and/or reports describing Assignor's condition in detail, including the specific areas treated and that the treatments provided was beneficial to Assignor and continuing the services was medically necessary.

Moreover, after the onset of trauma, chiropractic care may be effective and appropriate treatment to relieve pain, reduce spasm, and promote healing. However, after close to six months of chiropractic manipulation, Assignor should have exhibited significant improvement. If these therapies were not effective, alternative therapies should have been explored.

Applicant's request for $775.10 reimbursement for chiropractic services provided to Assignor from January 31, 2006 through August 8, 2006 is denied and Respondent's denials are sustained.

DECISION: Accordingly,

Applicant's claim seeking $3,138.67 reimbursement for the services provided to Assignor from August 2, 2005 through January 21, 2006 is dismissed without prejudice, pending Applicant's response to Respondent's requests for additional verification; and

Respondent's denial dated September 30, 2005 is vacated and Applicant is awarded $178.62 for the muscle testing conducted on Assignor on August 6, 2005; and

Applicant's request for $775.10 reimbursement for chiropractic services provided to Assignor from January 31, 2006 through August 8, 2006 is denied and Respondent's denials are sustained.

This award is in full disposition of all No-Fault benefit claims submitted to 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.

Accordingly, the applicant is AWARDED the following:

A.

Benefits	Amount Claimed	Amount Awarded
Health Service Benefits	4092.39	178.62
Totals:	$4,092.39	$178.62

B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 04/19/2010, which is a relevant date only to the extent set forth below.)

Since the motor vehicle accident occurred after Apr. 5, 2002, interest shall be calculated at the rate of two percent per month, simple, calculated on a pro rata basis using a 30-day month. 11 NYCRR 65-3.9(a). If an applicant does not request arbitration or institute a lawsuit within 30 days after receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department Reguslations, interest shall not accumulate on the disputed claim or element of claim until such action is taken. 11 NYCRR 65-3.9 (c).

In accordance with 11 NYCRR 65-3.9(c), interest shall be paid on the claim(s) totalling $178.62 from 4/19/2010, the date the arbitration was commenced.

C. Attorney's Fees

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

In accordance with 11 NYCRR 65-4.6(e), the insurer shall pay Applicant an attorney's fee equal to 20% of the total amount awarded in this proceeding plus interest, with the minumun fee set at $60 and the maximun fee capped at $850.

Given that the within arbitration request was filed on or after Apr. 5, 2002, if the benefits and interest awarded thereon is equal to or less than Respondent's written offer during the conciliation process, then the attorney's fee shall be based upon the provisions of 11 NYCRR 65-4.6(b).

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 New York.

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

7/22/10
(Dated)

(Glen A. Wiener)

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.