



AAA® INSURANCE REPORTER

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No-Fault Filings Update

As a leader in alternative dispute resolution (ADR) services, the American Arbitration Association (AAA) continues to successfully administer the New York no-fault caseload. As of August 31, 2017, the AAA has received 177,752 new case filings. We look forward to sharing the full 2017 statistics with the user community in an early 2018 edition of *AAA Insurance Reporter*.

Snapshot of 2016 Statistics. In 2016, there were 248,117 no-fault cases filed with the AAA, a record number! The program size has more than doubled in five years.

- The average claim amount at filing was \$2,455, an increase of \$27 per case from 2015 and \$383 from 2014.
- The total number of conciliated cases also set a record at 104,695.
- The growth in filing volume was most notable in the three adjacent geographic regions of Queens County, Nassau County, and Suffolk County, which together represented 82% of the total annual filings (Nassau County filings 57%, Suffolk filers 17%, and Queens filers 8%). In 2016, Queens filings increased by 60%, or 7,075 filings, over 2015. Nassau County filings increased by 30,580, or 28%, over 2015. Manhattan filings grew by 24%, with an increase of 6,848 filings over 2015.
- There were a total of 97,586 dispositions in no-fault arbitration, of which 70,355, or 72%, were reasoned awards. Other disposition types included consent awards, administrative closings, and withdrawals.

AAA and Innovation

The AAA remains committed to being at the forefront of innovative solutions that best meet the needs of our valued customers.

Raising the Bar with ADR Center. Traditional dispute resolution services were typically handled in person with all parties to the dispute present. However, the new millennium brought a shift in various common conciliation and mediation practices by presenting the use of electronic communications — parties could present and discuss offers and resolve cases via email. To that end, the AAA implemented **ADR Center**, an innovative platform that supports online dispute resolution (ODR) with a settlement tool allowing parties to communicate with each other and resolve cases online.

Mediation Day Initiative. As briefly mentioned in the last issue of this newsletter, Mediation Day provides additional resolution options to our customers. Last year, we tested a pilot Mediation Day with two parties. The effort to close cases was a success, and we witnessed the positive impact on our customers and their business; it also increased our knowledge so that we could refine the process.

Mediation Day begins with a request or a proposal from or to the parties. Once all parties have agreed to the mediation, the selected mediator will schedule and hold a telephone conference with the parties to discuss in advance any information that would be helpful in resolving the disputes. All discussions are confidential throughout the entire mediation process.

On the call, participants are invited to describe the dispute, and, with the help of the mediator, evaluate their goals and provide feasible realistic options. During Mediation Day, the mediator may caucus with each side privately to bring the parties to an amicable resolution.

For the best opportunity to have a positive Mediation Day experience, parties are encouraged to set aside an entire day, keep an open mind, and be prepared to discuss all relevant disputes, concerns, and issues. Mediators can be most effective when they have all information pertaining to the dispute; i.e., the nature of the dispute, the parties' concerns, prior settlement offers



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or negotiations, applicable legal constraints, the history pertaining to the parties' relationship that may affect the result, and any issues that may hinder resolution.

It is worth noting that mediation is not recommended unless both parties are ready to meaningfully discuss resolution.

A successful mediation requires the attendance of parties with authority to settle their dispute. In the event that company members with unlimited discretion may not be able to attend the actual mediations, decision makers should be available or accessible during the entire negotiation process.

- **The AAA believes that everyone needs to be heard and that the opportunity for our customers to engage in in-person discussions can be extremely valuable as they seek to maximize their business decisions.** In best-case scenarios, mediation brings the parties to resolution. But at least, parties will be heard, and the mediator can assist with negotiation. The cases then proceed to arbitration within the same previously scheduled time frames.
- **We offer this initiative at no additional costs to the parties on bulk matters of at least 100 cases.** Cases are selected by the parties, and the AAA can provide Mediation Day proposals that identify cases and include relevant statistical and historical information. Cases scheduled for arbitration that are considered during Mediation Days are not removed from arbitrators' calendars until they are resolved. Cases successfully mediated to resolution do not proceed to arbitration. Disputes that remain at an impasse proceed to arbitration as scheduled.

If you would like to participate in a Mediation Day or have any questions, you may contact Janet Miranda by email at MirandaJ@adr.org or call 917-438-1689.

Looking ahead. The AAA is committed to engaging the community, the industry, and our staff members in identifying areas of opportunity in our process and inspiring our next innovative solutions. We focus on the ADR experience and continually strive to elevate our services to the diverse group of insurance carriers, providers' offices, law firms, and former arbitrators that comprises our client base. We draw inspiration from you, so please continue to provide your feedback. We look forward to hearing from you. Contact us by email at NYSInsurance@adr.org.

What Is—and What Is Not—a TC?

An arbitrator may make a technical correction (TC) to an award, upon the arbitrator's own motion or upon the request of a party, as long as it does not affect the merits of the award. For instance, the arbitrator may make a technical correction if the award template states an award of \$192 as opposed to the \$912 stated in the body of the award. Clearly, this was a typographical error.

Technical corrections can include:

- inconsistencies between the written text and the form responses in the award,
- incorrectly checked or unchecked boxes on award forms,
- mathematical errors,
- typographical errors,
- pronouns (referring to the patient as a "he" instead of "she"), and
- spelling corrections to the name of a party.

Generally, if the requested correction will make a substantive change to the award, it is not likely to be considered a technical correction. For example, a party may state that the arbitrator failed to review a certain document. If that is actually the case, it is a mistake and not a technical correction.



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Best Practices for Preparing a Hearing-Ready Case

We gathered sitting arbitrators together to identify issues that could result in the continuance of cases. Though the nature of this high-volume practice may make implementation of these suggestions difficult, they are important. The necessity of **timeliness** and **familiarity with all documentary submissions and potential issues** was stressed.

Submissions. The goal of every submission is to provide clarity to the arbitrator, which will facilitate expediency. Irrelevant and duplicative documents should not be submitted. A cover sheet outlining the documentary submissions, including page numbers, should accompany a detailed AR-1. Parties are encouraged to submit spreadsheets where there are numerous bills. The spreadsheet should particularize and frame each issue presented with relevant defenses.

Applicant's cover sheet list should include

- Dates of service in chronological order,
- Treatment,
- Amounts of bill(s) (utilizing the appropriate fee schedule), and
- Supporting documentation (e.g., medical records).

Respondent's cover sheet list should include

- Date(s) of denial(s) with reason for denial and
- Supporting documentation.

Late submissions. The adversary should be notified of a late submission, which could lead to a delay in the arbitration or a continuance of the hearing. The arbitrator will determine whether to accept the submission and how best to achieve a just result, while also giving all parties the opportunity to fully argue their positions.

In order to avoid the continuance of an arbitration hearing, the arbitrator may schedule a phone conference at a mutually convenient date and time to discuss the late submission or other issues.

Adjournments, continuances, and post-hearing submissions. Arbitrators have been advised to discourage excessive continuances or adjournments. Post-hearing submissions could cloud the issues.

- Adjournment. Parties seeking an adjournment prior to the hearing date should notify the other side and subsequently the AAA. The arbitrator has discretion to grant or deny the request. If a party requests another hearing date at the hearing itself, this may be considered an adjournment request, with a fee imposed by the AAA on the requesting party. Tolling of interest from that hearing date until the next date may be addressed at the time of the request.
- Continuance. If the arbitrator determines at the hearing that another hearing date is necessary, this may be considered a continuance. Parties will be given all the information they need if a date is rescheduled from either an adjournment or a continuance.
- Post-hearing submissions. A case may be kept open for a few days if parties seek to continue their settlement discussions by utilizing a post-hearing submission disposition with a "due by" date. If no settlement takes place by the required due date, the case should be closed and a decision rendered. Post-hearing submissions may enable the arbitrator to make a decision without the need to have another hearing. A telephone conference may ultimately also avoid another hearing.



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Arbitrators' elevator pitch on submissions: Organization and clarity go a long way to achieve a successful outcome. Be brief, be cogent, be courteous, and above all, be prepared to go forward in a professional manner.

Arbitrators who contributed to this article: Joanne Andreotta; Brett Hausthor; Debbie Insdorf; Melissa Melis; John O'Grady; Felix Papadakis; Ann Russo

Keeping Your Information Safe: Password Security

It seems like every day, the news reports a data security breach. Most of us don't realize that we may be to blame for these breaches. The passwords used every day are the first line of defense to both a company and a person's own data. Most data security breaches stem from the use of common or repeated passwords. Sixty-one percent (61%) of people admit to using the same password across multiple sites. While it may be inconvenient to have multiple passwords, a data breach at work can compromise your other accounts. Data breaches can happen to anyone: Mark Zuckerberg's LinkedIn, Twitter, and Pinterest accounts were hacked in 2016 because he was using the same password for all three accounts!

So how do you avoid being part of the problem and create a password that will protect your digital footprint? Keep the following tips in mind:

1. Enforce a password policy that requires users to change their password every 90 days.
 - √ If you have had the same password for any of your accounts for longer than 90 days, take a minute right now to change that password.
2. Create longer, more complex passwords. A complex password is created by using variables, such as upper and lower case letters, numbers, and symbols, along with a password length of at least 16 characters.
 - √ When it comes to creating a complex password, some experts suggest using a phrase as a keycode. For example, if your phrase is "The American Arbitration Association is dedicated to effective, efficient, and economical methods of dispute resolution" your keycode may be AAAd2Ex3ADR!
3. Never share your password with other users or with the Cloud, and do not save your passwords in browsers.
 - √ Remember that most cyber-attacks target browsers as a way into a system. Take another minute now to see if you have any stored passwords in your browser and, if you do, delete them.
4. Stay away from simple patterns; personal data, such as dates and names; as well as common words.
 - √ Believe it or not, 123456 and Password are still two of the most common passwords used today!
5. Do not repeat passwords or use the same password for multiple sites.
 - √ If you are using the same password for multiple accounts, you are making life easy for cyber-criminals. Remember that once they crack one password, the rest will fall like domino pieces.

Data security is a top priority for the American Arbitration Association. Stay tuned for additional information regarding password security in the coming months.



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ADR Center Tech Corner

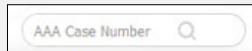
Did you know?

There is a Case Search Feature in ADR Center.

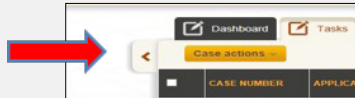
When the party is logged into ADR Center, some cases may be shown immediately in the Tasks section. The Tasks section only shows cases where tasks are generated. However, it does not show *all* of the party's cases. How can a party locate their case(s) in ADR Center?



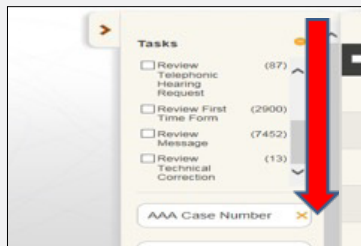
To View One Case: Enter the AAA Case Number on the top left-hand side of the screen (you can enter the full case number or, as a shortcut, enter the last eight digits of the AAA case number) and press Enter on the keyboard.



To View All Cases: Go to the Tasks section on ADR Center and click on the small arrow on the left.



A **Filter tab** will appear. Scroll down the Filter tab until you get to Status.

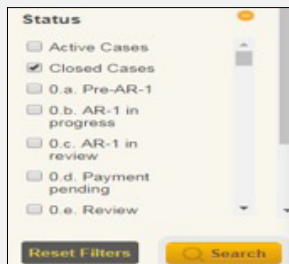


Click on the plus (+) symbol next to Status.



To view all of your closed/settled cases, check on **Closed Cases** and click Search or Enter.

To view all of your active/open cases, check **Active Cases** and click Search or Enter.





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DEVELOPMENTS IN NEW YORK NO-FAULT & SUM ARBITRATION:

Recent Arbitration Awards

The intent of this section is to provide a cross section of recent, well-reasoned arbitration awards that are consistent with current New York precedent and address commonly raised issues in no-fault and SUM arbitrations. The awards were objectively selected by an editorial board consisting of no-fault and SUM arbitrators with a view toward promoting discussion and analysis of relevant issues.

List of Arbitrator Abstracts

Jurisdiction

- *Pain Medicine of NY, PC & HighPoint Ins. Co.*, AAA Case no. 17-15-1025-0954 (4/20/17) (John O'Grady, Arb.)
- *Nitin D. Narkhede, M.D., LLC & ACCC Ins. Co.*, AAA Case no. 17-16-1036-7094 (8/18/17) (Ann Lorraine Russo, Arb.)
- *Long Island Medical Associates & United Automobile Ins. Co.*, AAA Case no. 17-16-1030-9248 (7/13/17) (Stacey Erdheim, Arb.)
- *Jungman Michael Suh, M.D. & Allstate New Jersey Prop. & Cas Inc. Co.*, AAA Case no. 17-16-1030-6516 (7/21/17) (Dinsmore Campbell, Arb.)

Intoxication

- *Engracia O. Lazatin MD d/b/a Advanced Multi-Medicine & Rehab & Progressive Ins. Co.*, AAA Case no. 17-15-1020-1235 (9/12/16) (Ioannis Gloumis, Arb.)
- *Gotto Medical Care, PC & Geico Ins. Co.*, AAA Case no. 17-15-1016-7885 (9/26/16) (Ben Feder, Arb.)
- *New York Presbyterian Hospital/Queens F/K/A Hospital Medical Center of Queens & Geico Ins. Co.*, AAA Case no. 17-16-1050-4985 (6/9/17) (Samiya Mir, Arb.)

New Jersey Certificate of Authority

- *Professional Chiropractic Care, PC & Allstate Ins. Co.*, AAA Case no. 17-15-1015-2747 (5/17/16) (Susan Mandiberg, Arb.)
- *Star of NY Chiropractic Diagnostic, PC & Geico Ins. Co.*, AAA Case no. 17-16-1029-8918 (3/15/17) (John Hyland, Arb.)
- *Professional Chiropractic Care, PC & Geico Ins. Co.*, AAA Case no. 17-14-9052-5118 (2/27/17) (Karen Fisher-Isaacs, Arb.)
- *Albis Chiropractic Care, PC & Geico Ins. Co.*, AAA Case no. 17-15-1018-8478 (5/20/17) (Henry Sawits, Arb.)
- *Albis Chiropractic Care, PC & Geico Ins. Co.*, AAA Case no. 17-16-1026-9669 (3/23/17) (Keith Tola, Arb.)

Surgery Fee Schedule

- *Passaic Orthopedic Group & Allstate Property & Cas. Ins. Co.*, AAA Case no. 17-16-1032-9178 (5/29/17) (Meryem Toksoy, Arb.)
- *New Horizon Surgical Center LLC & Maya Assurance Co.*, AAA Case no. 17-16-1042-1622 (7/9/17) (Meryem Toksoy, Arb.)
- *Surgicare Ambulatory Surgery Center of New York, Alliance Anesthesiology Associates & State Farm Mut. Auto. Ins. Co.*, AAA Case no. 17-16-1047-2649 (8/30/17) (Glen Wiener, Arb.)



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Non-Appearance Under Oath

- *S.C. & The Travelers Home & Marine Ins. Co.*, AAA Case no. 17-16-1030-0147 & 99-16-1030-0147 (3/23/17) (Lori Ehrlich, Arb.)

SUM Awards: Proximate Causation & Exacerbation

- *A.S. v. Geico Ins. Co.*, AAA Case no. 01-16-0003-8058 (3/20/17) (Richard Kesnig, Arb.)
- *J.H. v. Travelers Ins. Co.*, AAA Case no. 01-16-0005-0090 (7/20/17) (Alan Krystal, Arb.)
- *P.B. v. Kemper Ins. Co.*, AAA Case no. 01-16-0002-8373 (8/7/17) (Nancy Hughes, Arb.)

Arbitrator Abstracts

Jurisdiction

Pain Medicine of NY, PC & HighPoint Ins. Co., AAA Case no. 17-15-1025-0954

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(4/20/17) (John O'Grady, Arb.) Arbitrator O'Grady addressed whether there was jurisdiction to hear the claim and whether, absent jurisdiction, respondent had waived its defense that the arbitration forum lacks jurisdiction. Respondent was a New Jersey insurance company that did not conduct business in New York. The insurer had no offices and no bank accounts in New York and was not licensed to sell insurance in New York. The insured was a resident of New Jersey and garaged the subject motor vehicle in New Jersey. Respondent submitted an affidavit from its Vice President of claims, which set forth that the insurer had not filed any statement with the New York State Superintendent of Insurance agreeing that automobile insurance policies will be deemed to satisfy the financial security requirements of Articles 6 and 8 of the NY Vehicle & Traffic Law. Arbitrator O'Grady found that there was no showing that the insurer was an authorized insurer pursuant to New York Insurance Law Sec. 5107 (a) and 11 NYCRR 65-1.8 (a). Nor was the insurer an unauthorized insurer controlled by or controlling or under the common control of an authorized insurer pursuant to Insurance Law Section 5107 (a) and 11 NYCRR 65-1.8 (b), or an unauthorized insurer who has filed with the Superintendent of Insurance a statement that its automobile insurance policies sold in another state will be deemed to satisfy the financial security requirements of article 6 or 8 of the NY Vehicle and Traffic Law. Arbitrator O'Grady found that New Jersey law applies since the insurance contract was negotiated and made in New Jersey, the insurer was domiciled in New Jersey, the assignor resided in New Jersey and the motor vehicle was registered in New Jersey. Arbitrator O'Grady concluded that the insurer was not required to provide New York No-Fault benefits and that applicant failed to demonstrate otherwise. Arbitrator O'Grady further found that subject-matter jurisdiction cannot be waived and thus the insurer's defense was sustained.

Nitin D. Narkhede, M.D., LLC & ACCC Ins. Co., AAA Case no. 17-16-1036-7094

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(8/18/17) (Ann Lorraine Russo, Arb.) Arbitrator Russo addressed whether there was jurisdiction to hear the claim. The insurer had not issued a denial but had submitted a letter asserting that it was a Texas insurance company that did not conduct business within the State of New York. The defense letter referenced that the company was not a member of arbitration and was not authorized to do business within the State of New York and possessed a policy limit of \$2,500.00. Applicant's attorney argued that pursuant to Article 6 of the NY Vehicle & Traffic Law, Sec. 319, the owner of a motor vehicle operating on a public highway of New York, whether or not the owner's policy was issued in New York, must have financial security in place in accordance with the requirements of New York law. According to applicant's attorney, if the insurer did not issue a New York policy, then pursuant to NY Ins. Law



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Sec. 5107 (a), which is known as a long-arm statute, it was respondent's burden to demonstrate that it did not issue a New York insurance policy or that section 5107 (a) did not apply. Arbitrator Russo reviewed NY Ins. Law Sec. 5107 (a) and found that in order for an insurer to be subjected to New York State insurance and financial security limits, there must be evidence that the insurer was authorized to transact business in New York State or the insurer was transacting business in the state. Arbitrator Russo found that in the instant case, the mandatory requirements contained in the New York State Insurance Law would not apply to respondent, as the evidence and documentation submitted by respondent established that the insurer was a Texas insurance company that did not conduct business in New York. The claim was dismissed, as the insurer's jurisdictional challenge had merit and applicant failed to submit any evidence to refute the insurer's assertions.

Long Island Medical Associates & United Automobile Ins. Co., AAA Case no. 17-16-1030-9248
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(7/13/17) (Stacey Erdheim, Arb.) Arbitrator Erdheim addressed if there was jurisdiction to hear the claim. Respondent submitted evidence that the insurer was a Florida insurance company licensed to conduct business in South Carolina, did not transact business or deliver any contracts of insurance to residents in the State of New York, and did not maintain an office or agency, solicit business, have a telephone listing, bank account, or other property or any employees in the State of New York. In addition, the insurer was not licensed to do business in the State of New York and was not subject to personal service by way of the New York State Department of Financial Services. Respondent's affidavit from its General Counsel set forth that the insurer was a Florida corporation and was a wholly owned subsidiary of the United Automobile Insurance Group, which was also a Florida corporation. Arbitrator Erdheim cited to relevant case law and found that the evidence submitted by respondent was sufficient to establish that respondent is a Florida corporation and is not subject to the jurisdiction of the State of New York. Applicant failed to submit any evidence to refute the respondent's assertions and prove that jurisdiction in this matter was properly obtained, and thus the claim was dismissed.

Jungman Michael Suh, M.D. & Allstate New Jersey Prop. & Cas Inc. Co., AAA Case no. 17-16-1030-6516
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(7/21/17) (Dinsmore Campbell, Arb.) Arbitrator Campbell addressed whether there was a jurisdictional basis for bringing the arbitration in New York. Respondent submitted an affidavit from its claims manager referencing that the insurer was incorporated in the State of Illinois and was authorized to write automobile insurance policies in New Jersey, but not in the State of New York. The affidavit also set forth that Allstate New Jersey was neither licensed nor authorized to conduct business in the State of New York and that Allstate New Jersey was an out-of-state corporation, domiciled in Illinois and did not own, maintain, or possess any offices in New York. In addition to the foregoing, the insured was a resident of the State of New Jersey when the insurance policy was issued to him, and the sole connection to the State of New York was the claimant's treatment at applicant's facility. Arbitrator Campbell cited to relevant case law and found that respondent submitted evidence in support of dismissal. Applicant did not submit any credible evidence in rebuttal, and thus there was no jurisdictional basis for bringing the arbitration in New York and the claim was dismissed.

Intoxication

Engracia O. Lazatin MD d/b/a Advanced Multi-Medicine & Rehab & Progressive Ins. Co., AAA Case no. 17-15-1020-1235
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(9/12/16) (Ioannis Gloumis, Arb.) The arbitrator determined that the respondent properly denied the applicant's claim based upon a defense that the assignor operator of the vehicle was intoxicated at the time of the accident. Arbitrator Gloumis cited to 11 NYCRR 65-1.1 Exclusions (g) noting "... [Any] person [who] has been convicted of violating section 1192 of the New York Vehicle and Traffic



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Law while operating a motor vehicle in an intoxicated condition or while his or her ability to operate such vehicle is impaired by the use of a drug, and the conviction is a final determination, the Company has a cause of action against such person for the amount of first party benefits that are paid or payable." The assignor was arrested for DWI. Further, the arbitrator noted hospital records, the toxicology report, evidence of conviction for DWI, along with the declaration page of the subject policy established the respondent's defense.

Gotto Medical Care, PC & Geico Ins. Co., AAA Case no. 17-15-1016-7885
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(9/26/16) (Ben Feder, Arb.) The arbitrator stated the evidence established the injured party ran a red light and struck two vehicles and a traffic light. The police reported that he was unable to communicate at the scene and that his blood alcohol level, tested at the hospital immediately after the accident, registered three times the legal limit. Further, a doctor's blood stabilization review of the injured party's blood alcohol level led to a conclusion that such alcohol level would have caused him loss of muscle coordination and a decreased level of consciousness. Arbitrator Feder cited to Section 5103(b)(2) of the Insurance Law: "An insurer may exclude from coverage required by subsection (a) hereof a person who: (2) Is injured as a result of operating a motor vehicle while in an intoxicated condition or while his ability to operate such vehicle is impaired by the use of a drug within the meaning of section eleven hundred ninety-two of the vehicle and traffic law." The arbitrator found unpersuasive the applicant's argument regarding the chain of custody of the blood alcohol testing. The arbitrator noted "the nature of the accident, the stabilization review, and the blood alcohol level provide a reasonable basis to declare that the injured party's intoxication was the proximate cause of the subject accident."

New York Presbyterian Hospital/Queens F/K/A Hospital Medical Center of Queens & Geico Ins. Co., AAA Case no. 17-16-1050-4985
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(6/9/17) (Samiya Mir, Arb.) The arbitrator determined there was insufficient evidence submitted by the respondent to establish their defense that the assignor was intoxicated at the time of the accident. The respondent provided a one-page medical discharge report that shows the Assignor's various blood test results on the date of the accident, alleging it demonstrated that Assignor's ethanol level was elevated. During a recorded interview, the assignor denied drinking or taking any drugs prior to the accident. Arbitrator Mir cited to New York Insurance Law § 5103(b) (2) stating an insurer may exclude from coverage a person who is injured as a result of operating a motor vehicle in an intoxicated condition or while the person's ability to operate the vehicle is impaired by the use of a drug within the meaning of Vehicle and Traffic Law (VTL) § 1192. She also cited to *Westchester Medical Center v. Progressive Insurance Company*, 51 AD 3d 1014, 858 NYS 2d 754 (2d Dept. 2008) noting an insurer who seeks to disclaim benefits on intoxication grounds must not only show that an insured was intoxicated, but that there was a causal relationship between operating the vehicle in an intoxicated condition and the injuries. The arbitrator determined the respondent "...provided no explanation of the medical report or how it came to the conclusion that the ethanol level indicated on the report established that assignor was intoxicated during the accident. There was also no police report or other evidence submitted to establish that assignor was intoxicated, or that there was a causal relationship between the alleged intoxication and the injury."

New Jersey Certificate of Authority

Professional Chiropractic Care, PC & Allstate Ins. Co., AAA Case no. 17-15-1015-2747
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(5/17/16) (Susan Mandiberg, Arb.) Arbitrator Mandiberg was asked to determine whether a New Jersey medical provider was entitled to seek reimbursement of no-fault benefits when such provider failed to obtain a Certificate of Authority from the New Jersey Secretary of State. In finding applicant was not entitled to recover, Arbitrator Mandiberg held, inter alia, "NY law, specifically



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11 NYCRR 65-3.16 (a)(12) states as follows: A provider of healthcare services is not eligible for reimbursement under section 5102(a)(1) of the Insurance Law if the provider fails to meet any applicable New York state or local licensing requirement necessary to perform such service in New York or meet any applicable licensing requirement necessary to perform such service in any other state in which such service is performed." Moreover, "since Applicant (as a corporate entity) billed for these MUA procedures that were performed in the State of New Jersey, it was mandated to follow the laws of the foreign jurisdiction in which it operated, which specifically and unequivocally includes filing for and obtaining a Certificate of Authority."

Star of NY Chiropractic Diagnostic, PC & Geico Ins. Co., AAA Case no. 17-16-1029-8918
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(3/15/17) (John Hyland, Arb.) Respondent asserts applicant was not entitled to recover no-fault benefits because it failed to obtain a Certificate of Authority. Applicant argued that "its failure to pay corporate filing fees and obtain the Certificate of Authority in the State of New Jersey was not a willful or material failure to abide by state and local law." Arbitrator Hyland held, "Applicant's failure to obtain a certificate of authority (without deciding whether it was mandated to do so or not) from the State of New Jersey would be a technical violation that does not prevent Applicant from obtaining no-fault reimbursement for the services provided to this EIP."

Professional Chiropractic Care, PC & Geico Ins. Co., AAA Case no. 17-14-9052-5118
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(2/27/17) (Karen Fisher-Isaacs, Arb.) Applicant asserted that its failure to obtain a Certificate of Authority from the New Jersey Secretary of State was merely a technical violation and did not prevent it from recovering no-fault benefits. Respondent countered by citing to 11 NYCRR §65-3.16(a)(12), which states that a provider is required to comply with all local licensing laws. In finding for respondent and denying the claim, Arbitrator Fisher-Isaacs held, "Respondent established its defense that Applicant violated 11 NYCRR section 65-3.16(a)(12) because it failed to obtain the certificate of authority needed to transact business in New Jersey."

Albis Chiropractic Care, PC & Geico Ins. Co., AAA Case no. 17-15-1018-8478
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(5/20/17) (Henry Sawitz, Arb.) Applicant argued that "the failure of Applicant to obtain a Certificate of Authority from the State of New Jersey is a de minimus technicality and innocent oversight and therefore does not preclude Applicant from being eligible from receiving reimbursement under Section 5102(a)(1) of the Insurance Law of the State of New York. In this regard, Applicant cites N.J.S.A. 14A:13-11(1) and N.J.S.A. 14A:13-20 for the proposition that the wording of these two statutes limit the applicability of N.J.S.A. Section 14A:13-3 solely to the payment of taxes and access to the Courts of the State of New Jersey and do not affect either the right to conduct business in the state or relate to any issue regarding proper 'licensing.'" Respondent countered by arguing "the failure of Applicant (Albis Chiropractic Care, P.C.) to obtain a Certificate of Authority from the State of New Jersey (at the time these procedures were performed) precludes Applicant from receiving reimbursement under Section 5102(a)(1) of the Insurance Law of the State of New York." In granting the claim in favor of applicant, Arbitrator Sawitz held, "Applicant's position in this matter is correct; i.e., that the fact that Applicant may have acted without a Certificate of Authority at the time that these procedures were performed should not prevent, by itself, Applicant from seeking reimbursement in New York for New York No-Fault benefits available to the patient."

Albis Chiropractic Care, PC & Geico Ins. Co., AAA Case no. 17-16-1026-9669
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(3/23/17) (Keith Tola, Arb.) Respondent "indicated applicant cannot recover because it failed to comply with the governing regulations insofar as it performed the MUA procedures in New Jersey without having filed a Certificate of Authority." Furthermore,



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in New Jersey “a foreign corporation shall not “have the right to transact business in this State until it shall have procured a Certificate of Authority.” (N.J.S.A Section 14A:13-3.) However, applicant asserted “the failure of a foreign corporation to obtain a certificate of authority to transact business in this State shall not impair the validity of any contract or act of such corporation.” (N.J.S.A Section 14A:13-11.) Arbitrator Tola found in favor of applicant and held that “an individual must have a medical license to practice and collect no-fault benefits, but the relied-upon Jersey statute does not address any licensing issues. This is a business corporation issue that is technical in nature and found to be outside of the purview of the regulation. Failure to file a Certificate of Authority does not bar recovery and if there is any penalty to be imposed it is not by a No-Fault Arbitrator but instead by the Attorney General as per the express language of the statute.”

Surgery Fee Detail

Passaic Orthopedic Group & Allstate Property & Cas. Ins. Co., AAA Case no. 17-16-1032-9178

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(5/29/17)(Meryem Toksoy, Arb.) Arbitrator Toksoy addressed the medical necessity and proper fee schedule amount for the services of a physician’s assistant associated with shoulder surgery performed in the State of New Jersey. The Applicant sought reimbursement in the sum of \$15,562.00 as an assistant surgeon. Arbitrator Tolstoy provided a detailed analysis of the applicable sections of the New Jersey Medical Fee Schedule (NJAC §11:3-29-1 et. seq., including the mandated usage of the Medicare Claims Processing Manual, the NCCI Policy Manual for Medicare Services, and CPT Assistant discussed in §11:3-29.4(g)(1). The award explains how the proper fee was arrived at for each of the codes billed, along with charts, for a final fee of \$1,360.00.

New Horizon Surgical Center LLC & Maya Assurance Co., AAA Case no. 17-16-1042-1622

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(07/09/17)(Meryem Toksoy, Arb.) Having determined that the surgery to the left shoulder was medically necessary, Arbitrator Toksoy considered whether Applicant, a New Jersey ambulatory surgery center (“ASC”), was entitled to additional reimbursement for two implanted “Cayenne anchors” while repairing the Assignor’s rotator cuff. The facility fee billed for two anchors under code C1713. The HSPCS description for code C1713 is: “Anchor/screw for opposing bone-to-bone or soft tissue-to-bone-implantable.” Arbitrator Toksoy reviewed the fee audits submitted on behalf of each party by the respective Professional Certified Coders. Arbitrator Toksoy noted that the codes that do not have an amount shown in the table under the “ASC facility” fee column are not reimbursable when performed in an ambulatory surgery center. In making the determination that an ASC is not entitled to reimbursement for anchors/screws provided as part of a surgical procedure, Arbitrator Toksoy reviewed the rule-making history behind the relevant sections of the New Jersey Administrative Code. Arbitrator Toksoy was not persuaded by the arguments set forth in Applicant’s fee audit affidavit and, accordingly, limited reimbursement to the ASC for the surgical procedure(s) performed.

Surgicare Ambulatory Surgery Center of New York, Alliance Anesthesiology Associates & State Farm Mut. Auto. Ins. Co., AAA Case no. 17-16-1047-2649

<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(08/30/17)(Glen Wiener, Arb.) The issue was whether Applicant, Surgicare Ambulatory Surgery Center of New York (“Surgicare”), was entitled to additional compensation for shoulder surgery when it billed using CPT code 29823 [arthroscopy, shoulder, surgical; debridement, extensive] and CPT code 29826 [arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament release, when performed]. Respondent reimbursed Surgicare for one code, CPT code 29823, based on the report of a Certified Professional Coder, who concluded that code 29826 is an add-on code and cannot be billed in addition to code 29823. Arbitrator Wiener was persuaded by the analysis provided in the Coder’s affidavit, which the Applicant failed to rebut.



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Non-Appearance at Examination Under Oath

S.C. & The Travelers Home & Marine Ins. Co., AAA Case no. 17-16-1030-0147
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(03/23/17) (Lori Ehrlich, Arb.) Arbitrator Ehrlich addressed whether Assignor's failure to appear for an examination under oath was excusable absent a willful and avowed obstruction involving a pattern of non-cooperation for which no reasonable excuse was offered. Arbitrator Ehrlich established that there was an ongoing dialogue between Assignor's attorney and Respondent and that the parties had previously agreed to adjourn the examination under oath due to Assignor's unavailability. The evidence revealed that on the date of the final rescheduled examination under oath, Assignor underwent a surgical procedure and clearly was unavailable. Arbitrator Ehrlich determined that Assignor's non-appearance was not willful and was in fact excusable. In making her determination, Arbitrator Ehrlich relied on the holdings set forth in *Omega Diagnostic Imaging, P.C. v. Praetorian Ins. Co.*, 51 Misc. 3d 147(A), 2016 NY Slip Op 50762(U) (App. Term 1st Dept. May 13, 2016) and *In the Matter of Country Wide v. Kings County Physicians Group*, 2016 NY Slip Op 30117(U) (Sup. Ct. New York Co., Cynthia S. Kern, J., Jan. 2, 2016). Arbitrator Ehrlich's award was subsequently affirmed by Master Arbitrator Ancowitz. See *S.C. & The Travelers Home and Marine Ins. Co.*, AAA Case no. 99-16-1030-0147 (06/30/17) (Richard B. Ancowitz, Master Arb.).

SUM Awards: Proximate Causation & Exacerbation

A.S. v. Geico Ins. Co., AAA Case no. 01-16-0003-8058
https://www.adr.org/AwardSearch/faces/searchHome.jsessionid=T5y4pMVqKgEGLfkAnPX2GeLFCMV8622jZwpM33CtwFyIVH1muBGB!850968726?_adf.ctrl-state=ju0f8f0n2_4&_afLoop=198042911204029&_afWindowMode=0&_afWindowId=null#!%40%40%3F_afrWindowId%3Dnull%26_afrLoop%3D198042911204029%26_afrWindowMode%3D0%26_adf.ctrl-state%3D12gzewwmfk_4

(3/20/17) (Richard Kesnig, Arb.) Claimant had a history of a lumbar fusion surgery in 2004. On February 23, 2013, Claimant was stopped at a red light when her vehicle was struck in the rear by another vehicle. Her post-accident complaints included back pain. Claimant subsequently underwent a lumbar spine MRI which reported "Spinal fusion at L4-5 and L5-S1 and moderate left central T12-L1 disc protrusion." After a series of three epidural steroid injections, Claimant underwent a lateral lumbar discectomy with posterior removal of hardware L4-S1, posterior lumbar laminectomy and facetectomy L3-4, posterior decompression of the L2 and L3 nerve roots bilaterally, posterior lumbar pedicle fixation L3-4. The surgeon concluded that Claimant "was involved in a MVA on February 23, 2013 which in my opinion exacerbated her lumbar symptoms of lower back and right leg pain, numbness and tingling secondary to a diagnosis of adjacent segment degeneration with lumbar stenosis, lumbar degenerative disc disease, and painful hardware." He further noted "patients who have undergone lumbar fusion surgeries, like A.S., are at increased risk for adjacent segment degeneration in which the level above or below the fusion breaks down due to the increased stress and decreased mobility at the level of the fusion."

Claimant testified that after her surgery in 2004 she did not experience pain, from three months after the surgery until the subject accident, a span of approximately nine years. However, this testimony was rebutted by a statement in a medical report on February 28, 2013 wherein it is stated that Claimant had been taking Flexeril as a current spine medication. Moreover, the police report stated that there were no injuries and claimant's vehicle only sustained minor damage. Based on these facts, the arbitrator found that Claimant's claims of being pain free were not credible. However, the arbitrator stated, "I am convinced that Claimant was headed on a path that likely would have ultimately resulted in surgical intervention, even had she not been involved in this accident. The subject accident is very likely to have hastened the progress of her deteriorating condition, although the extent to which it did so would appear to have been small, by comparison." The arbitrator awarded Claimant \$100,000.00. As this sum was subject to a \$25,000.00 setoff for payment made by the carrier for the underinsured offending vehicle, the net award was \$75,000.00.



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J.H. v. Travelers Ins. Co., AAA Case no. 01-16-0005-0090

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(7/20/17) (Alan Krystal, Arb.) A 31-year-old Claimant was proceeding into an intersection with a green light when her vehicle was struck on the driver's side by a 2006 Ford on May 1, 2014. Claimant complained of neck pain following the accident. A cervical spine MRI revealed small central and left parasagittal disc herniation at C6-7 with moderate impingement upon the ventral subarachnoid space and a very small disc herniation at C7-T1 without significant impingement upon the ventral subarachnoid space. A subsequent MRI performed after 10 months of treatment revealed mild to moderate central and left-sided disc herniation at C6-7 and mild left-sided cord deformity and moderate left C7 root compression. Since physical therapy and cervical steroid injections did not relieve her pain, Claimant was referred to an orthopedic surgeon who ultimately performed the procedure, which was a C6-7 discectomy and arthrodesis; anterior spinal instrumentation/fixation with placement of Caspar pins; posterior decompression and release of posterior longitudinal ligament; bilateral foraminotomy; bone graft from left iliac crest; and impaction and fixation of interbody cage with mixed bone graft into the C6-7 disc space. The postoperative diagnosis was cervicalgia with radiculopathy, cervical cord decompression/stenosis, and C6-7 degenerative disc disease. In his final narrative report, the surgeon stated Claimant "failed conservative management and underwent an uncomplicated C6-7 anterior cervical discectomy and fusion with instrumentation. She did well postoperatively and has no neurologic deficits. She was working full duty upon her last visit. She may need additional medical treatment, physical therapy, or surgery in the future related to her injury."

The Respondent performed an MRI review in which the radiologist concluded that the conditions she visualized were degenerative in nature and "on none of the MRI scans is there any evidence of bony fractures, marrow edema or annular tear seen to indicate a traumatic osseous or intervertebral disc rupture associated with the 05/01/14 incident." Claimant had been involved in a prior accident in 2008 in which she injured her neck. The MRI noted a focal disc bulge at C5-6, which created an impingement on the canal.

Respondent submitted the report of an orthopedist who examined Claimant on their behalf. The orthopedist concluded that Claimant had a pre-existing condition from the 2008 accident and further concluded there was a lack of supportive evidence indicating that the disc herniation at C6-7 on the MRI films from March 20, 2015 was in any way causally related to the MVA over a year prior on May 1, 2014. He further stated there was no objective evidence of persistent cervical radiculopathy and that claimant had done well from her surgery. He also found no evidence indicating that the May 1, 2014 accident contributed to the new herniation found on the March 20, 2015 MRI.

However, he did state that the surgery performed on Claimant was medically necessary. The arbitrator concluded that while Claimant did sustain a prior neck injury arising from a prior accident, that she failed to disclose this history to her treating physicians. The evidence also reveals that Claimant's treatment from that prior accident was of short duration, there were no similar intervening accidents, and Claimant was asymptomatic at the time of the subject accident. He further stated that "while Claimant may have had a prior condition that made her an 'eggshell plaintiff,' the subject accident was a significant trauma that played a clear role in worsening Claimant's condition, thereby necessitating the ACDF procedure. Despite the success of this procedure, Claimant still experiences neck pain that still affects her activities and quality of life."

Claimant submitted a report from another orthopedist who detailed "extraordinary expenses" that he believed she would require, including physical therapy, medical supplies, medication and orthopedic and psychiatry consultations. The arbitrator found that the report "appears to ascribe a level of certainty that goes beyond the scope of (her surgeon's) conclusions and is therefore speculative. The arbitrator valued Claimant's injuries to be \$600,000.00, which following a \$25,000.00 setoff resulted in a net award of \$575,000.00.



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P.B. v. Kemper Ins. Co., AAA Case no. 01-16-0002-8373

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(8/7/17) (Nancy Hughes Arb.) On January 13, 2015, a 51-year-old Claimant was operating a vehicle that was struck in the rear by the underinsured vehicle while Claimant was stopped for a red light. Her post-accident complaints included back pain. A lumbar spine MRI showed an L5/S1 disc protrusion. Nine months later, Claimant underwent a subsequent MRI, which noted herniation at L5/S1 significantly reducing canal diameter. After several epidural injections, Claimant's neurosurgeon recommended and ultimately performed fusion at the L5/S1 level on January 12, 2015. On January 22, 2016, the neurosurgeon reported that Claimant "...is very happy with the operative result. She is having less back pain and no leg pain." However, by August 2016, he reported that claimant had recurrent back pain, increased numbness, and increased pain. Claimant sustained a prior work-related back injury in 1998, and claimant filed a claim with the Workers' Compensation Board. She was treated at Good Samaritan Hospital on June 10, 1998 for a "sprain of back." The Employer's Report of Injury states the injury was to the left side of Claimant's neck. The Workers' Compensation Board found Claimant had a cervical strain and made an award of \$22.00 in lost time for nine days disability.

Respondent submitted an October 27, 2009 X-ray of the lumbar spine, which was reported as showing no intrinsic bony or articular abnormality. Respondent also submitted the examination by a designated neurosurgeon, who stated there was no objective evidence that Claimant suffered any structural injuries resulting in neurological impairment because of this accident, other than possibly a muscle strain/sprain, and that the imaging studies did not demonstrate any abnormalities causally related to this accident except possibly a tiny annular tear at L5/S1. Claimant's treating neurosurgeon concluded that Claimant has a 30% loss of range of lumbar motion that he believes is permanent.

The arbitrator concluded "while Respondent makes much of the 1998 'injuries,' the medical records submitted do not show any significant injuries, which had, in any event, resolved long before this 2015 accident, almost 17 years later. In fact, the 2009 lumbar X-ray shows quite clearly that prior to the date of this accident, Claimant had no lumbar abnormalities other than a mild postural curvature to the left. While initially Claimant did not think her injuries were serious and she continued to work, within a very short time her condition deteriorated significantly and despite conservative treatment did not improve. While initially satisfied with the lumbar surgery, the improvement was not permanent." The arbitrator valued Claimant's injuries to be \$225,000.00 which following a \$25,000.00 setoff resulted in a net award of \$200,000.00.

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