AAA® INSURANCE REPORTER

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2017 Year in Review

We take this opportunity to share with you some highlights that made 2017 a banner year for New York State Insurance (NYSI).

Record New No-Fault Filings

The AAA had another record year in new no-fault filings. Our staff processed 290,486 new filings representing a 17% increase over the previous year. In conciliation, the number of resolutions rose 18% over 2016 to close at 123,009 cases. The settlement rate in conciliation remained strong at 45%, with the average case settling within one month of filing.

Increased Panel Size

To keep pace with increases in no-fault claims, the New York State Department of Financial Services (DFS) made the determination to appoint 18 new no-fault arbitrators, increasing the panel size to 152. Many of the newly-appointed arbitrators have diverse prior experiences including Certified Professional Coder, Civil Court Judge, and practices including real estate law and employment law.

Webinar Series Inaugurated

In 2017, NYSI Program premiered its webinar series for no-fault arbitrators. Topics included procedural issues, arbitrator best practices, and case law updates conducted by members of the arbitrator panel.

Consolidated Claims Enhancement

With the support of DFS, we implemented the Consolidated Claims Enhancement (CCE). For one filing fee, applicants now may submit claims involving multiple injured parties and providers as long as they stem from the same accident and involve common issues of fact.

Enrichments to Business Intelligence Data

We continued our efforts to enhance prompt resolution of pending claims. Using business intelligence data, we examined the lead time from filing a no-fault claim to dispute resolution. Reports depicting average hearings required for resolution, continuances, adjournments, settlements, and withdrawals are available for arbitrators seeking to hone their case management techniques. Our business intelligence capabilities also allow us to provide specific caseload data to our clients to assist with bulk settlements in conciliation and arbitration.

Second Case Management Office Opened in Downtown Buffalo

Our second case management location was opened to address the rise in claims filed in northwest New York State. The Buffalo location currently provides intake and document indexing and in the future will support additional case administration functions. In October, we hosted a roundtable event in the new office to answer questions regarding the functions of the Buffalo office and gave tours of the new space.

Increases to the No-Fault Arbitrator Panel

As the caseload volume continued to surge throughout 2017, the Superintendent made the determination to approve the appointment of an additional 33 arbitrators to serve the upstate and downstate regions. These arbitrators will be appointed in 2018. Thirty arbitrators will serve Long Island, and three arbitrators will serve the Northwest area, as the growth in new filings continues to increase. In addition, the DFS approved the replacement of one arbitrator that left the panel in 2017 and two arbitrators who resigned in early 2018.

Case Scheduling Update

Throughout 2017, we continued to receive feedback from our customers expressing concerns about the increase in time frames from filing to resolution. The concerns expressed were a direct result of the growing inventory of cases waiting to be scheduled for a first-time hearing, and those delays were attributed to the number of available hearing slots. The user community expressed that a date scheduled far in the future was preferable to not having any hearing date assigned. As a result, in early 2018, the DFS instructed arbitrators to open calendars for the remainder of the year. As arbitrators are added to the panel, we will continue to backfill party calendars with additional hearing dates. We anticipate that filling the arbitrator calendars through the end of the year, in addition to other initiatives, including fast track hearings, will help to drive more case resolutions in 2018.

We are moving to 32 Old Slip

We are excited to announce that the AAA's New York Insurance Case Management Center in New York City will be moving to 32 Old Slip in the second quarter of 2018. This location is just steps away from the New York State Department of Financial Services in lower Manhattan. Our new location is within walking distance of AAA's corporate headquarters, which remains at 120 Broadway. There are still plenty of transportation options that will get you to our new office. We have been strategically planning our move over the last year to ensure that there is limited business interruption to staff and customers during this transitional period. Please look out for additional information by email as we get closer to our move date.

New Online Payment Feature

AAA will soon offer a more secure and convenient **online** method to submit credit card payments. Parties no longer will be required to submit a credit card authorization form to authorize payment and instead will log in to an online portal to make a payment. This new feature is expected to be available in the second quarter of 2018, at which time usage of the current credit card authorization forms will be discontinued. Additional information and details will be available in the upcoming weeks.

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

8 Unit Rule

- *21st Physical Therapy, PC & Geico Ins. Co.*, AAA Case no. 17-16-1037-6496 (2/11/18) (Drew Gewuerz, Arb.)
- *21st Physical Therapy, PC & Geico Ins. Co.*, AAA Case no. 17-16-1037-6505 (9/30/17) (Victor Moritz, Arb.)
- *Triumph PT & Allstate Prop. & Cas. Ins. Co.*, AAA Case no. 17-16-1041-9739 (10/13/17) (Stacey Erdheim, Arb.)
- *Chiropractic Pain Solutions, PC & Geico Ins. Co.*, AAA Case no. 17-16-1039-8234 (12/20/17) (Robyn McAllister, Arb.)

Verification

- *Excel Surgery Center, LLC a/a/o K.L. & Geico Ins. Co.*, AAA Case no. 17-16-1049-6987 (1/8/18) (Stephen Czuchman, Arb.)
- *Prestige Medical Diagnostic, PC a/a/o C.R. & Allstate Ins. Co.*, AAA Case no. 17-15-1014-3809 (3/14/16) (Mitchell Lustig, Arb.)
- *MDAX Inc. a/a/o R.L. & Geico Ins. Co.*, AAA Case no. 17-16-1050-9659 (1/24/18) (Nancy Kramer Avalone, Arb.)

Staged Loss

- *XYJ Acupuncture, PC & American Transit Ins. Co.*, AAA Case no. 17-16-1042-0795 (9/26/17) (Allison Berdnik, Arb.)
- *Axial Chiropractic, PC & State Farm Auto. Ins. Co.*, AAA Case no. 17-16-1048-4073 (11/4/17) (Nicholas Tafuri, Arb.)

Ligament Laxity Analysis (CRMA)

- *Ligament Laxity Analysis/James Lambert, D.C. & Nationwide Mut. Ins. Co.*, AAA Case no. 17-16-1049-4448 (1/20/18) (Lester Hill, Arb.)
- *Northern Physical Therapy Chiropractic & Acupuncture, PLLC & Geico Ins. Co.*, AAA Case no. 17-16-1045-2104 (11/9/17) (Alina Shafranov, Arb.)
- *Park Radiology PC & 21st Century Indemnity Ins. Co.*, AAA Case no. 17-14-9023-8716 (8/14/15) (Rhonda Barry, Arb.)
- *Park Radiology, PC & Geico Ins. Co.*, AAA Case no. 17-16-1041-0761 (12/13/17) (Eileen Casey, Arb.)

SUM: Seatbelt Defense

- *M.N. v. Kemper Ins. Co.*, AAA Case no. 01-17-0001-8382 (2/19/18) (Edward Brozinsky, Arb.)
- *K.M. v. Amica Mut. Ins. Co.*, AAA Case no. 01-16-0003-6808 (6/2/17) (Vernon Welsh, Arb.)

Arbitrator Abstracts

8 Unit Rule

21st Physical Therapy, PC & Geico Ins. Co., AAA Case no. 17-16-1037-6496
https://aaa-nynf.modria.com/loadAwardSearchFilter

(2/11/18) (Drew Gewuerz, Arb.) The arbitrator addressed issues concerning the fee schedule as well as medical necessity. With respect to the fee schedule, the Respondent issued partial payment to applicant for physical therapy services but denied a portion of the claim based on the fee schedule. Specifically, another provider treating the assignor also billed for physical therapy modalities on the dates of service at issue and the respondent's denials stated: "Reimbursement for modalities and procedures may not exceed 8 relative value units (RVU) per day." The dispute arose due to competing interpretations of the Physical Medicine and Chiropractic Fee Schedule "8 unit rule." The arbitrator listed all of the physical therapy modality codes in both Ground Rule 11 of the Physical Medicine Section of the New York State Workers' Compensation Medical Fee Schedule and Ground Rule 3 of the Physical Medicine Section of the New York State Workers' Compensation Chiropractic Fee Schedule that are subject to the limitations of eight relative value units per day. Arbitrator Gewuerz noted that in his prior interpretation "…chiropractors and medical doctors/physical therapists/occupational therapists may each be reimbursed 8 units of physical medicine modalities so long as no duplicate services are performed." Notwithstanding the foregoing, the arbitrator acknowledged correspondence dated 1/30/18 from Heather McMaster, Deputy General Counsel for the NYS Workers' Compensation Board (WCB) to Chris Maloney at the Department of Financial Services noting "[t]he 8 RVU limitation is per patient, per day regardless of how many body parts are treated or how many practitioners treat." An exception is noted for chiropractic manipulation (98940-98943) that is not subject to the general physical medicine Section of the medical fee schedule. The arbitrator noted that the WCB interpretation is entitled to deference. For the dates at issue, the respondent paid Hills Chiropractic P.C. 4.57 units for chiropractic manipulations billed under CPT code 98940 and further reimbursed Hills Chiropractic a total of 3.43 units for CPT code 97140 (subject to the "8 unit rule"). The Respondent reimbursed the applicant a total of 4.57 RVU as a self-employed physical therapist. Therefore, the Respondent properly reimbursed eight units of physical therapy modalities excluding chiropractic manipulations to the Providers, and the claim was dismissed. The arbitrator ruled in favor of the applicant for the remaining dates of service that were denied on medical necessity grounds based on the results of an Independent Medical Examination.

21st Physical Therapy, PC & Geico Ins. Co., AAA Case no. 17-16-1037-6505
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(9/30/17) (Victor Moritz, Arb.) The applicant sought reimbursement for physical therapy modalities, and the respondent issued a partial denial noting reimbursement may not exceed eight relative value units (RVU) per day. The Respondent submitted proof of payment to another Provider, Hills Chiropractic P.C for chiropractic manipulation as well as physical therapy modalities billed under CPT codes 97112 and 97140. The applicant conceded that the Respondent reimbursed eight units of physical therapy for each date of service at issue. However, the applicant argued that Hills Chiropractic and the applicant 21st Physical Therapy provided treatment to different body parts and each is entitled to reimbursement for eight units per day. The arbitrator listed physical therapy modalities and chiropractic manipulation codes noted in both Ground Rule 11 of the Physical Medicine Fee Schedule Section and Ground Rule 3 of the New York State Workers' Compensation Chiropractic Fee Schedule. These ground rules provide that reimbursement for physical medicine and procedures are limited to eight relative value units (RVU) per day. Arbitrator Moritz determined that "…if a treating chiropractor and physical therapist both bill for CPT modalities that can be performed by either a licensed physical therapist or chiropractor on the same date, the carrier is not required to pay both bills and the limitation of a combined eight RVU applies." He further cited to *Goodheart Chiropractic, PC & Geico Ins. Co.*, AAA Case no. 17-13-9042-9321 (2/20/14) (Glen Wiener, Arb.), where the arbitrator declined to follow a court decision that allowed each provider to seek

reimbursement for eight units per day, stating that the result "…is a misinterpretation of Ground Rule 11 which clearly limits reimbursement to all providers performing physical medicine services on the same day. To hold otherwise would allow an acupuncturist, chiropractor, medical doctor, and massage therapist to bill and receive reimbursement for a plethora of physical medicine treatments conducted on one individual on a single day (and many times out of the same location as herein)." Arbitrator Moritz found that "this limitation would not apply when a treating Provider is unable to perform the services rendered by another Provider based on licensing restrictions." In this case, the Respondent had properly reduced the applicant's bills based on the prior payments to the other Provider, and the claim was denied.

Triumph PT & Allstate Prop. & Cas. Ins. Co., AAA Case no. 17-16-1041-9739
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(10/13/17) (Stacey Erdheim, Arb.) The applicant sought reimbursement for physical therapy modalities for which the respondent issued denials stating "reimbursement for modalities and procedures may not exceed 8 relative value units per day." A portion of the claim was also denied on medical necessity grounds per the results of an Independent Medical Examination. The arbitrator listed all of the physical therapy modality codes in both Ground Rule 11 of the Physical Medicine Section of the New York State Workers' Compensation Medical Fee Schedule and Ground Rule 3 of the Physical Medicine Section of the New York State Workers' Compensation Chiropractic Fee Schedule that are subject to the limitations of eight relative value units per day. The applicant argued the limitation does not apply when two different medical providers, with different specialties, provide the services. Arbitrator Erdheim disagreed, stating that a plain reading of the Ground Rules and the Fee Schedule establishes that for services listed in both sections, the eight unit limitation applies no matter which Provider rendered the service. In this case, the arbitrator ruled that the Respondent established that it paid another Provider the maximum reimbursable amount for each date of service at issue and therefore the applicant's claim was denied. The arbitrator ruled in favor of the applicant for the remaining dates of service that were denied on medical necessity grounds based on the results of an Independent Medical Examination.

Chiropractic Pain Solutions, PC & Geico Ins. Co., AAA Case no. 17-16-1039-8234
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(12/20/17) (Robyn McAllister, Arb.) The applicant sought reimbursement for chiropractic treatments that included physical therapy modalities. The Respondent issued partial denials pursuant to the fee schedule. A portion of the claim was also denied on medical necessity grounds per the results of an Independent Medical Examination. Arbitrator McAllister noted that the Respondent had fully reimbursed the applicant for chiropractic manipulation treatments but denied mechanical traction billed under CPT code 97012 based on Ground Rule 3 of the Chiropractic Fee Schedule and Ground Rule 11 of the Medical Fee Schedule, which limits reimbursement for certain physical therapy modalities to eight relative value units per day. The arbitrator ruled that the respondent established that they had paid another Provider the maximum relative value units for the same dates of service and therefore the Respondent had properly partially denied that portion of the applicant's claim. The arbitrator ruled in favor of the applicant for the remaining dates of service that were denied on medical necessity grounds based on the results of an Independent Medical Examination.

Verification

Excel Surgery Center, LLC a/a/o K.L. & Geico Ins. Co., AAA Case no. 17-16-1049-6987
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(1/8/18) (Stephen Czuchman, Arb.) The arbitrator addressed whether the claim was brought prematurely. The applicant sought to recover no-fault benefits consisting of a facility fee for manipulation under anesthesia (MUA). Respondent alleged outstanding verification was pending. There was no issue regarding timeliness or receipt of the verification requests. The Respondent sought

inter alia a copy of the MUA consultation report as well as information regarding when the pelvic injury was initially diagnosed, who made this diagnosis, what treatment plan was initiated, and if the pelvic injury was not diagnosed until the MUA consultation, the basis for not attempting a trial of conscious manipulation of the pelvis. Applicant's response advised that they were an ambulatory surgery facility and that therefore they were not in possession of the requested information and documentation. Following *Excel Surgery Ctr., L.L.C. v. Fiduciary Ins. Co. of Am.*, 55 Misc. 3d 131(A) (App Term 2d Dept. 2017), the arbitrator determined that the requests were reasonable and that the 30-day period within which Respondent had to pay or deny the claim had not begun to run. The claim was dismissed without prejudice.

Prestige Medical Diagnostic, PC a/a/o C.R. & Allstate Ins. Co., AAA Case no. 17-15-1014-3809
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(3/14/16) (Mitchell Lustig, Arb.) The arbitrator addressed whether the Applicant's first-party claim for electrodiagnostic testing was brought prematurely. The Respondent established that timely verification requests were issued seeking further documentation by the referring physician. In response, the Applicant provided the documentation in its possession. The Respondent then acknowledged receipt of certain documents but advised that it still awaited other documents, such as the initial evaluation, prescription for diagnostic testing, and all notes that had not been submitted to date. The Assignor's counsel issued a response to Respondent, advising that they were a medical diagnostic facility and were not in possession of the initial consultation, treatment notes, prescription, and/or any referral documentation from the referring physician and advised them to contact the referring physician, Dr. [name omitted], directly in order to obtain the information. No further communications were generated by the Respondent and the claim was neither paid nor denied. Inasmuch as the Respondent failed to act upon receipt of Applicant's response, the claim was granted to Applicant.

MDAX Inc. a/a/o R.L. & Geico Ins. Co., AAA Case no. 17-16-1050-9659
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(1/24/18) (Nancy Kramer Avalone, Arb.) The issue was whether the claim was ripe for arbitration. The Applicant sought to recover no-fault reimbursement for durable medical equipment, to wit: a cervical traction unit. Respondent neither paid nor denied the claim, asserting that outstanding verification was pending. There was no issue regarding the timeliness of the requests; Respondent issued verification requests for an initial report and a letter of medical necessity. In support of its assertion that no response had been received, Respondent submitted an affidavit stating that no documents had been received after a certain date. The arbitrator found that the verification request was not reasonable as required by the insurance regulations, as a letter of medical necessity had been submitted initially with the Applicant's claim and the document was included in the Respondent's submission. As the documentation requested was already in the possession of the Respondent, the claim was awarded to Applicant.

Staged Loss

XYJ Acupuncture, PC & American Transit Ins. Co., AAA Case no. 17-16-1042-0795
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(9/26/17) (Allison Berdnik, Arb.) Arbitrator Berdnik was asked to determine whether a denial of claim form containing the following language was sufficient: "Claimant failed to establish credible proof of claim. In addition insured driver deny [sic] involvement in alleged accident." Respondent asserted it clearly placed the applicant on notice of its defense. Applicant, citing to *General Accident Insurance Group v. Cirucci*, 46 N.Y.2d 862 (1979), argued the language in the denial was not specific enough to appraise the claimant of its defense. In finding the language of the denial sufficient, Arbitrator Berdnik held the "use of the phrase, 'Claimant failed to establish credible proof of claim' is vague. However, when read in conjunction with the next sentence, that

the 'insured operator den[ied] involvement in the alleged accident', one can presume that Respondent, at the most extreme, is alleging that the underlying loss was a staged event or, alternatively, at the very least, that the Claimant's injuries did not arise out of the use or operation of a motor vehicle. Nonetheless, Respondent asserts a coverage defense, which does not require a denial of claim at all." In support of its staged loss defense, respondent submitted an Examination Under Oath Transcript and an automobile loss notice. Respondent noted that inconsistent statements were made during the EUO, and therefore, the accident did not occur as alleged. In finding for applicant, Arbitrator Berdnik found that Respondent relied upon a number of unpersuasive fraud indicators that were insufficient to support the defense alleged.

Axial Chiropractic, PC & State Farm Auto. Ins. Co., AAA Case no. 17-16-1048-4073
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(11/4/17) (Nicholas Tafuri, Arb.) Respondent asserted that upon its investigation, the accident was not a covered loss because, *inter alia*, the insured made material misrepresentations during her EUO and played a role in causing the loss. Respondent, relying in part upon the EUO testimony, asserted the insured was acting suspiciously during the accident and also made a number of inconsistent statements about the particulars of the accident. In finding for respondent, Arbitrator Tafuri found the testimony contained in the EUO transcript coupled with the police report and photographs of the vehicles were sufficient to meet Respondent's evidentiary burden of its founded belief that the underlying accident was a staged loss.

Ligament Laxity Analysis (CRMA)

Ligament Laxity Analysis/James Lambert, D.C. & Nationwide Mut. Ins. Co., AAA Case no. 17-16-1049-4448
https://aaa-nynf.modria.com/loadAwardSearchFilter

(1/20/18) (Lester Hill, Arb.) The arbitrator addressed whether the ligament laxity analysis (computerized radiographic mensuration analysis) was properly billed pursuant to a by-report code, CPT Code 76499 (unlisted diagnostic radiographic procedure) in the amount of $475.00 for each date of service. Both sides submitted an affidavit from its certified professional coder. Respondent's fee audit set forth that the most similar procedure is CPT Code 76376, which is a 3-D rendering with interpretation reporting of computed tomography, magnetic resonance imaging, ultrasound or other graphic modality that has a relative value and would be reimbursed in the amount of $159.28 per date of service. Applicant's fee audit referenced that the services were properly billed pursuant to by-report code 76499, as ligament laxity analysis is an objective analysis of X-rays that utilizes the computer and software system to enhance the radiographic film. According to applicant's fee audit, once the image is transferred to the software, the technician uses his or her knowledge of anatomy, range of motion, and spinal region as well as the software to "plot points" on each vertebra indicating ligament damage to the spine, which takes 30-45 minutes. Applicant's fee audit further referenced that CPT Code 76499 can be billed by a chiropractor even though it is not found in the radiographic section of the chiropractic fee schedule. The arbitrator found that applicant's fee audit was more persuasive, as it explained the time and skill required to generate each report. Since the arbitrator found that applicant's fee audit was more persuasive, applicant was awarded reimbursement.

Northern Physical Therapy Chiropractic & Acupuncture, PLLC & Geico Ins. Co., AAA Case no. 17-16-1045-2104
https://aaa-nynf.modria.com/loadAwardSearchFilter

(11/9/17) (Alina Shafranov, Arb.) The arbitrator addressed whether the ligament laxity analysis of the cervical and lumbar spine was properly billed pursuant to CPT Code 76499, which is a by-report code. Therein, respondent argued that applicant failed to submit the proper documentation in support of its billing. Applicant submitted a fee audit from its certified professional coder, which referenced that computerized radiographic mensuration analysis (CRMA) and ligament laxity is an objective analysis of x-rays used to determine the exact location of the patient's injury. The fee audit referenced that the generated report allows the provider to

accurately and specifically diagnose the patient. According to applicant's fee audit, ligament laxity analysis utilizes a computer and a software system to enhance the radiographic films. Once enhanced, the image is transferred to the software and the provider by use of the technician's knowledge of anatomy, range of motion, spinal regions and specialized knowledge of the software to plot the points on each vertebra indicating ligament damage of the spine. Applicant's fee audit further referenced the amount of time required. According to applicant, the service is separate and distinct and goes beyond that of a simple radiograph or digital image and is not a duplication of an X-ray or a component of an X-ray. A statement from the chiropractor who performed the services set forth that ligament laxity analysis is not a duplication of the professional component of an X-ray but instead is an entirely distinct diagnostic procedure. According to the chiropractor's statement, the digitizing software system or DXD allows for the computerized enhancement of plain radiographic film, and ligament laxity analysis allows the provider to qualify and quantify the degree to which a traumatic injury has affected the patient's health. Respondent failed to submit an expert opinion in support of its fee schedule defense. Since the arbitrator was persuaded by applicant's fee audit, applicant was awarded reimbursement.

Park Radiology PC & 21st Century Indemnity Ins. Co., AAA Case no. 17-14-9023-8716
https://aaa-nynf.modria.com/loadAwardSearchFilter

(8/14/15) (Rhonda Barry, Arb.) The arbitrator addressed whether the ligament laxity analysis (CRMA) was medically necessary. Therein, the peer review doctor acknowledged that the injured person had ongoing neck and back pain since the date of accident. The progress notes reviewed also indicated that the injured person had ongoing complaints. X-rays were taken of the lumbar spine following the accident. According to the peer review doctor, the only reason why a chiropractor would recommend CRMA is to determine if there is any evidence of ligament instability, and if so, then an MRI scan would be a better diagnostic tool for that purpose. The arbitrator found that the peer review doctor failed to discuss whether the MRIs performed were sufficient in this case or if further testing was necessary. Although the peer review doctor questioned the efficacy of CRMA, applicant's rebuttal cited to AMA guidelines noting that CRMA provides mechanical analysis with a high degree of accuracy for purposes of chiropractic diagnosis and protocols. According to applicant's rebuttal, CRMA is also utilized to determine aberrant spinal motion related to ligament damage. The arbitrator found that applicant's rebuttal established that ligament laxity analysis (CRMA) was medically necessary. With regard to the fee charged for these services, respondent relied upon a fee audit in which its coder suggested that the appropriate billing code was CPT Code 72114 (radiologic examination spine, lumbosacral, complete including bending views minimum six views) and CPT Code 72052 (radiologic examination spine, cervical complete including oblique and flexion and/or extension studies). Respondent's fee audit also referenced that pursuant to Radiology Ground Rule 3B, the services should have been billed in the amount of $270.98. The arbitrator noted that the services performed were not radiological examinations but were digitalization of the X-rays. Since the services performed were more than a simple conversion of an X-ray into some other form and is a computer analysis to assess biomechanical components related to neck and back injuries, the arbitrator found that applicant provided sufficient information to establish its fee in accordance with the by-report rules. The arbitrator further found that applicant's fee audit was more persuasive, as the fee audit referenced the distinction between digitalized radiographs and digitized radiographs. The arbitrator noted that a digital radiograph is an enhanced X-ray, whereas a digitalized radiograph is a motion study comparing flexion/extension images with assessment of impairment due to loss of motion and/or segment integrity. Reimbursement was awarded in accordance with Ground Rule 3B (multiple procedures rule).

Park Radiology, PC & Geico Ins. Co., AAA Case no. 17-16-1041-0761
https://aaa-nynf.modria.com/loadAwardSearchFilter

(12/13/17) (Eileen Casey, Arb.) The arbitrator addressed whether the ligament laxity analysis (CRMA) was medically necessary. Therein, the peer review doctor opined that X-ray studies would have been sufficient. Since there were X-ray reports of the cervical and lumbar spine, the peer review doctor found that it was unclear why the information contained in these reports was not sufficient to treat the injured person. The peer review doctor also referenced that there were no "red flags" or unusual findings that would require CRMA. The arbitrator noted that applicant submitted a pre-printed prescription for the CRMA issued by a

chiropractor. The chiropractor "checked off" that the analysis was needed to assess ligament instability, vertebral derangement, confirm ligament laxity, determine frequency and duration of care, determine referral to the appropriate specialty, and provide a differential diagnosis. The CRMA report referenced that CRMA is listed in the National Clearing House Guidelines (NCG) as X-ray digitization and passed NCG screening criteria. The report also set forth that CRMA provides qualitative and quantitative information that can be used in understanding a patient's subluxation complex. The arbitrator considered all of the evidence and found that the peer review doctor established that CRMA deviated from generally accepted chiropractic standards. The arbitrator noted that there was no formal rebuttal submitted by applicant and that applicant's evidence failed to rebut the peer review, as the prescription and report failed to address the peer review doctor's contentions that X-rays would have been sufficient in the treatment and management of the injured person. Accordingly, the claim was denied.

SUM: Seatbelt Defense

M.N. v. Kemper Ins. Co., AAA Case no. 01-17-0001-8382
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(2/19/18) (Edward Brozinsky, Arb.) The accident occurred on May 14, 2016. The Claimant was in the left passenger seat in the middle row of three rows of a Honda Odyssey that was traveling southbound on I-95 in Groton, Connecticut. The other vehicle was traveling in the same direction. It appears that the host vehicle went into the left lane to pass a vehicle traveling in the center lane. At the same time, the other vehicle went into the right lane to pass the center lane vehicle. Both the host vehicle and the other vehicle then merged into the center lane and collided with one another. The host vehicle veered off to its left, entered a ravine filled with shrubbery and debris, and impacted a tree. It appears that in the accident the Claimant, who was not wearing a seatbelt, was thrown forward and her head impacted the windshield. Due to this accident, the Claimant sustained injuries to her head, cervical spine, and right shoulder. The Respondent alleged that Claimant's failure to wear a seatbelt contributed to the severity of her injuries. The Respondent submitted a report by Terrence J. Fischer concerning its seatbelt defense, and Mr. Fisher provided testimony at the arbitration hearing. Mr. Fisher concluded that based upon a reasonable degree of accident reconstruction certainty, the claimant who was not wearing a seatbelt sustained significantly greater injuries than if she had been restrained. He also concluded that the Claimant would not have struck her head or shoulder on the interior of the vehicle and would not have sustained the neck, shoulder, or head injuries that occurred in the accident. Mr. Fischer also concluded that in all probability, the Claimant's injuries would have been reduced significantly had she been restrained. At the arbitration hearing, Mr. Fisher testified that he never saw the vehicle involved in the accident, that he did not take measurements of the vehicle, and that he didn't have information as to the position of the seat at the time of the accident. Mr. Fischer never spoke to any of the parties to the accident and did not take any measurements of distances at the scene of the accident. Mr. Fischer did not know the angle of the slopes and stated that his knowledge of the damage was based on photographs. Although Mr. Fischer knew the weight of the vehicle, there was no information as to the weight of the passengers or luggage. In response to the respondent's expert report, the Claimant introduced a report from Collision Research authored by Richard S. Hermance. As part of his analysis, Mr. Hermance reviewed the police report, deposition of claimant, Terrence Fischer's report, photographs taken at the accident site, photographs of the damaged vehicle, and the specifications for the particular vehicle. He also conducted an examination of the accident site and took multiple photographs. Mr. Hermance concluded that the accident in question was not a simple frontal crash. The vehicle was initially hit by another vehicle and was forced off the road. There was no information as to the severity of that impact. When the vehicle was forced off the road, it went down a ravine, traveled in the ravine, which according to the photographs had rough terrain, brush and debris, and after traveling some distance up and down this ravine, it impacted a tree. Mr. Hermance concluded that the speed of the vehicle on the road, in the ravine, and striking the tree cannot be calculated and would vary along this path and also that there may have been a change of direction. All these factors would account for tightening and releasing of a seatbelt had it been worn, and therefore it would be difficult to establish whether or not the injuries sustained would have been more or less significant. In many of the accident reconstruction investigations, the seatbelt effectiveness could be accurately correlated to the Delta forces by knowing a few simple facts. However, this complicated set of circumstances made it impossible to define just

what happened in this collision; therefore, the analysis by Mr. Fischer was inadequate and his conclusions faulty. The arbitrator concluded that while the failure to wear a seatbelt may have increased the claimant's injury, the injuries may have occurred anyway. The arbitrator concluded that he could not determine what injuries were caused solely by the failure to use the seatbelt other than the laceration of the head striking the windshield. Thus, the arbitrator stated that the laceration of the head would not be considered when deciding the value of the injuries. The arbitrator further found that the analysis of the Respondent's expert was insufficient to conclude that wearing a seatbelt would have prevented the injuries.

K.M. v. Amica Mut. Ins. Co., AAA Case no. 01-16-0003-6808
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(6/2/17) (Vernon Welsh, Arb.) The police report referenced that on July 20, 2014, Claimant was a 66-year-old passenger in a vehicle that was traveling south at an intersection on a road in western New York State when a northbound vehicle turned left into the Claimant's vehicle. The report referenced that the operator of the northbound vehicle stated that as she approached the intersection with her left turn signal activated, her cell phone rang and she looked down at it, then looked back at the roadway and saw she had turned into the path of the southbound vehicle. The report attributed fault only to the driver of the northbound vehicle for failing to yield the right-of-way on making a left turn, failing to pay attention, and being distracted. The Claimant testified at the hearing, stating that the other vehicle turned into the vehicle she occupied, turned sideways, and went up on a curb. The Claimant also testified that the airbags deployed. The Claimant testified that she was sitting in the back seat between two children's car seats and she was not wearing a seatbelt. She explained that the space she was sitting in was very narrow, causing her to "scrunch" sideways and that she couldn't get to the seatbelt because it was behind the car seats. She also testified that the seatbelt was not visible to her. The Claimant said that she did not try to find the seatbelt because the space was so tiny. She stated that she was not concerned about wearing a seatbelt because she was tightly wedged between the two car seats and the trip they were on was only a couple of miles. The Claimant testified that at the moment of the impact, her vehicle was moving at approximately 35 mph, and as the vehicle came to a halt, her body went forward. The Claimant stated that as she put her hand out to stop herself, her right hand came into contact with the console between the two front seats, and she broke a finger. She said her shoulder also made contact with the interior of the vehicle. The Claimant testified there was not a lot of room separating her legs from the console. She said she was the only unrestrained occupant of the vehicle. Respondent's accident reconstructionist, Mr. Scalia, testified that if Claimant had been belted, although her upper body would have been able to move, her waist and hips would have been anchored. Although claimant would have been injured, she would not have sustained fractures. Mr. Scalia explained that although the claimant would have made contact with the center console, she would not have had the weight of her whole body behind the contact. The arbitrator found that Mr. Scalia's opinion was not persuasive, as it appeared to be based on speculation. The arbitrator further found that since Respondent failed to adequately prove its seatbelt defense, there was no basis to hold the Claimant responsible for failing to mitigate damages.