



AAA® INSURANCE REPORTER

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No-Fault Arbitrator Panel Update

As the caseload volume continues to increase, the need for additional hearings and additional arbitrators also increases. In 2017, the Superintendent approved the recommendation for the appointment of an additional 33 arbitrators to be added this year.

In January, three arbitrators were appointed to serve in the Northwest Region of New York. Those arbitrators started hearing cases in late February.

In February, a group of 12 arbitrators were appointed to serve in Long Island. Those arbitrators began hearing cases in May.

In April, an additional group of 10 arbitrators were appointed to serve on Long Island. Those arbitrators are scheduled to begin hearing cases in mid-June. Additional arbitrators will be appointed in early June.

The new arbitrators have diverse prior experiences, including expertise in no-fault. The addition of 33 new arbitrators will provide the parties with thousands of additional hearing slots and arbitration dispositions.

Impact of Transportation Network Companies on New York State SUM Coverage

Transportation Network Companies (TNC), more commonly known as ride-sharing companies, generally pair passengers via websites and mobile apps with drivers who provide ride-sharing services. Since TNCs are commercial entities, they are required to have commercial insurance coverages similar to livery and taxi cabs. TNCs typically enter into independent contractor agreements with drivers who use their own personal vehicles. Many TNC drivers do not hold a livery driver's license, and their vehicles are not registered or insured as commercial vehicles. Personal automobile insurance policies usually exclude the use of these vehicles for "livery services."

TNCs have operated in New York State since 2016; familiar ones are Uber and Lyft. The New York State Legislature passed a statewide ride-sharing law that defined the amount of Supplementary Uninsured/Underinsured Motorists (SUM) insurance coverage available for ride-share vehicles. The Legislature also introduced changes affecting which insurers would be responsible for providing coverage, namely the TNC group policy or the TNC driver's own policy. Since then, the Department of Financial Services (DFS) and other New York State agencies passed regulations addressing TNCs. The SUM Insurance Regulation 35-D was amended to require TNC insurers to provide \$1.25M SUM coverage for bodily injury/death of one or more persons in an accident while a TNC driver is engaged in a prearranged trip. The regulation further provides that eligible insurers shall offer some amount of SUM coverage while a TNC driver is logged onto the TNC network but not engaged in a prearranged trip.

The SUM coverage offered by an insurer may exceed the minimum limits but shall not exceed liability limits offered under the policy. Additional provisions permit insurers to delineate when SUM coverage is available. For instance, the insurer may specify that SUM coverage applies only to accidents that occur (1) when a TNC driver is engaged in a prearranged trip, (2) when a TNC driver is logged onto a TNC network and is not engaged in a prearranged trip, or (3) when a TNC driver is logged onto a TNC network whether or not the driver is engaged in a prearranged trip. The specific provision will depend on the circumstances where the insurer provides liability coverage.

AAA-ICDR^(SM) Standards of Conduct for Parties and Representatives

The AAA and its international division, the International Centre for Dispute Resolution® (ICDR®) strive at all times to provide dispute resolution services in accordance with our Shared Mission, Vision and Values. Every day AAA employees use conflict-management techniques to assist representatives with case resolutions.



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In October of 2014, the AAA and the ICDR published the Standards of Conduct for Parties and Representatives, which require parties and their representatives to conduct themselves in an appropriate manner when utilizing the AAA's services. Please find a copy of the standards below. A link to the Standards is also available on our website <https://www.adr.org/AAACDRStandardsofConduct.pdf>.

Participants in AAA cases are required to abide by the following standards of conduct. Failure to do so may result in the AAA declining to further administer a particular case or caseload.

- Participants in AAA-administered cases shall treat all employees and others involved in the proceedings in a courteous, respectful and civil manner.
- Participants must respect the AAA's policy against any form of unlawful discrimination based on an individual's gender, race, ethnicity, age, religion, national origin, or any other legally protected characteristic.
- Participants shall not engage in harassing, threatening, or intimidating conduct toward AAA employees or arbitrators/mediators.
- Party representatives shall advise their clients and witnesses of the appropriate conduct that is expected of them during the proceedings.
- Participants shall refrain from using vulgar, profane, or otherwise inappropriate language.
- Participants shall direct case-related communications only to their assigned case management staff at the phone, email, or address provided by AAA staff, and shall copy the other parties on such communications as required by the rules governing the case, or as directed by the AAA. Those assigned case-management staff will raise matters with other AAA executives directly and as necessary.
- Participants shall not contact members of the AAA's Board of Directors on case-related matters. The AAA's Board has no involvement in the day-to-day management of the AAA, and AAA Directors do not have any authority or input regarding the administration or outcome of a particular matter.
- Threats of violence or other unlawful conduct will not be tolerated and will be forwarded to law enforcement authorities.
- Participants shall not repeatedly file unmeritorious demands for arbitration, pleadings, or other papers, or engage in other tactics that the AAA or an arbitrator determines are frivolous, filed for the purpose of harassment, or primarily intended to cause unnecessary delay or increased costs.
- Participants shall not withdraw a previously filed matter for the purpose of refileing the same or similar matter due to their discontent with the actions or decisions of the AAA, its case administrator, or the arbitrator/mediator.
- Participants shall not have previously been declared to be a vexatious litigant or similar equivalent in any state or federal court or by an arbitrator in a prior arbitration.

New Convenient Online Payment Portal "Quick Pay"

In April 2018, the American Arbitration Association launched a new online payment portal to provide parties with a quicker and more convenient way to make payments. The portal is easily accessible and available 24 hours a day to our clients. Customers can access this new payment option by visiting our AAA website <https://info.adr.org/nysinsurance/> and clicking on the *Quick Pay* icon.

Customers will receive an immediate confirmation email that includes an authorization code after completing the payment. It is important to note that all payments received before 3:00 p.m. EST will be posted to your account the same business day. All payments made after 3:00 p.m. EST will post to your account the next business day. For more information regarding how to use the *Quick Pay* option, please contact our finance department at NYSIFinance@adr.org.



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ADR Center Tech Corner: Frequently Asked Questions

How do I gain access to ADR Center?

Our dedicated customer service team will walk new users through the process and request them to email all the information that is needed to register a user to the ADR Center.

We have a registered administrator; do we need to do this?

If a company already has a user registered as an administrator, the administrator can add and remove additional users without the assistance of the AAA. The ADR Center Help Page at <http://info.adr.org/nofaulthelp/> provides instructions on how to easily add or remove additional users.

Can my client gain access?

Any party, including the medical provider, to an arbitration case can request access to the ADR Center. The provider can reach out to the Customer Service Team to set up an account in ADR Center. Medical providers are able to view their case information and case documents but will not have access to any other functions if a legal representative is assigned to represent them.

Can I register myself?

No, users must contact Customer Service to gain access to ADR Center.

To request access to ADR Center, please contact our Customer Service Team by email at NYSInsurance@adr.org or by phone at 917.438.1660.

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

Additional PIP & Submission of NYS Form NF-11

- *Lutheran Medical Center & American Transit Ins. Co.*, AAA Case no. 17-16-1039-7992 (8/14/17) (Andrew Horn, Arb.)
- *AllBody Healing Supplies, LLC & American Transit Ins. Co.*, AAA Case no. 17-16-1046-3401 (3/24/18) (Victor Moritz, Arb.)
- *Jeremy Whitfield, D.C. & American Transit Ins. Co.*, AAA Case no. 17-17-1064-9538 (3/9/18) (Pamela Hirschhorn, Arb.)



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Billing for Massage Therapy

- *Center Island Massage, PC & Allstate Ins. Co.*, AAA Case no. 17-16-1037-6994 (8/18/17) (Drew M. Gewuerz, Arb.)
- *Center Island Massage, PC & Allstate Ins. Co.*, AAA Case no. 17-16-1040-8554 (10/29/17) (Laura Yantsos, Arb.)
- *Expert Massage Therapy, PC & Northbrook Indemnity Ins. Co.*, AAA Case no. 17-17-1055-9054 (12/30/17) (Melissa Melis, Arb.)
- *Port Jefferson Therapeutic Massage & Allstate Property & Cas. Ins.*, AAA Case no. 17-17-1063-5939 (3/8/18) (Charles Blattberg, Arb.)

New Jersey Fee Schedule & ASC Billing for Anesthesia

- *Excel Surgery Center, LLC & Geico Ins. Co.*, AAA Case no. 17-16-1035-2021 (5/13/17) (Glen Cacchioli, Arb.)
- *Excel Surgery Center, LLC & Geico Ins. Co.*, AAA Case no. 17-15-1025-5998 (9/30/16) (Anthony Joseph Bianchino, Arb.)
- *Bethel Interventional Pain Management & Geico Ins. Co.*, AAA Case no. 17-16-1026-7168 (5/17/17) (Lucille S. DiGirolomo, Arb.)

New Jersey Fee Schedule: Anesthesia Performed by an Anesthesiologist at an ASC

- *Tri-State Anesthesia, PC & Geico Ins. Co.*, AAA Case no. 17-17-1066-7728 (1/30/18) (Ellen Weisman, Arb.)
- *5 Borough Anesthesia & Geico Ins. Co.*, AAA Case no. 17-17-1059-3500 (2/1/18) (Samiya Mir, Arb.)
- *North American Partners In Anesthesia, LLP & Geico Ins. Co.*, AAA Case no. 17-16-1041-3721 (5/3/18) (Joseph Endzweig, Arb.)
- *A & E Anesthesia Associates, LLC & Geico Ins. Co.*, AAA Case no. 17-16-1042-6371 (2/19/18) (Meryem Toksoy, Arb.)

Billing for PF-NCS Testing

- *GC Chiropractic, PC & Geico Ins. Co.*, AAA Case no. 17-17-1053-2186 (2/2/18) (Rhonda Barry, Arb.)
- *PDA NY Chiropractic, PC & Geico Ins. Co.*, AAA Case no. 17-16-1050-2745 (4/4/18) (Regina Anzalone Kurz, Arb.)
- *Sound Chiropractic, PC & State Farm Fire & Cas. Co.*, AAA Case no. 17-16-1050-1939 (3/28/18) (Matthew Maroney, Arb.)
- *RES Physical Medicine & Rehab. Services & Safeco Ins. Co.*, AAA Case no. 17-16-1052-0435 (3/22/18) (Fred Lutzen, Arb.)

SUM Award: Economic Loss

- *J.H. v. Geico Ins. Co.*, AAA Case no. 43 200 S 02043 14 (Edward Brozinsky, Arb.)

SUM Award: Wrongful Death

- *K.B. v. Utica Mut. Ins. Co.*, AAA Case no. 43 200 S 02075 14 (Peter Horenstein, Arb.)

Arbitrator Abstracts

Additional PIP & Submission of NYS Form NF-11

Lutheran Medical Center & American Transit Ins. Co., AAA Case no. 17-16-1039-7992

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(8/14/2017) (Andrew Horn, Arb.) Arbitrator Horn was asked to determine whether an assignor must submit a completed NF-11 in order to trigger additional PIP benefits following exhaustion of the policy. Respondent relied upon 11 NYCRR §65-3.5(h) in support of its position that states: "When benefits are claimed under an additional personal injury protection endorsement, the insurer may require that the applicant execute a prescribed subrogation agreement (NYS Form NF-11) prior to the payment of any benefits." Respondent mailed its first request for the NF-11 on November 2, 2015 but did not issue a follow-up request for more than a year later. Applicant asserted that a request for an NF-11 is a verification request subject to the regulations governing requests for verification, and therefore, the follow-up request was late. In finding for applicant, Arbitrator Horn held that in the absence of a second timely request for verification, the period within which the insurer had to pay or deny the claim was not extended and vacated the denial. Nevertheless, a completed NF-11 was faxed to respondent entitling applicant to additional PIP benefits.

AllBody Healing Supplies, LLC & American Transit Ins. Co., AAA Case no. 17-16-1046-3401
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(3/24/2018) (Victor Moritz, Arb.) The basic PIP policy was nearly exhausted. Applicant argued that it was entitled to additional PIP benefits. Respondent asserted that in order to trigger the additional benefits provision, applicant must submit and execute an NF-11 form, which was requested from applicant through their attorney. In dismissing the portion of applicant's claim seeking additional PIP benefits without prejudice, Arbitrator Moritz held that the requested NF-11 was necessary in order to trigger additional benefits.

Jeremy Whitfield, D.C. & American Transit Ins. Co., AAA Case no. 17-17-1064-9538
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(3/9/2018) (Pamela Hirschhorn, Arb.) Respondent asserted that basic PIP benefits were exhausted and although additional PIP benefits were available under the policy, applicant failed to complete an NF-11 form. Applicant contends it did not receive an NF-11 from respondent. Pursuant to 11 NYCRR 65-3.5(h) the insurer must "deliver" the prescribed agreement to the applicant. In finding for applicant, Arbitrator Hirschhorn held that "respondent failed to submit any evidentiary proof that the NYS Form NF-11 was mailed to the injured person or assignor in this case." In the absence of proof that the NF-11 was "delivered" to applicant, respondent failed to comply with the no-fault regulation and applicant was entitled to reimbursement.

Billing for Massage Therapy

Center Island Massage, PC & Allstate Ins. Co., AAA Case no. 17-16-1037-6994
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(8/18/2017) (Drew M. Gewuerz, Arb.) Arbitrator Gewuerz addressed whether applicant's claims for massage therapy were reimbursable at the physician rate or chiropractic rate. Applicant contended that as a licensed massage therapist, it should be reimbursed at the physician rate, as there is no directly applicable fee schedule. In reliance on the holding in *Great Wall Acupuncture v. Geico Gen. Ins. Co.*, 16 Misc3d 23, 842 NYS2d 131, 2007 NY Slip Op. 27164 (App. Term, 2d Dept. 2007), respondent countered that applicant was entitled to the lesser chiropractic rate. Arbitrator Gewuerz disagreed with both parties' contentions, noting that a third option was available here that was not available to the Appellate Term, namely, the self-employed physical therapist rate. Owing to Applicant's self-employment, arbitrator Gewuerz determined that the self-employed physical therapist rate was the most appropriate rate to utilize.

Center Island Massage, PC & Allstate Ins. Co., AAA Case no. 17-16-1040-8554
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(10/29/2017) (Laura Yantsos, Arb.) In Center Island Massage, Arbitrator Yantsos noted that there is no fee schedule designated for services performed by massage therapists. In assessing whether massage therapy should be reimbursed at the physical therapist or chiropractic conversion rate, Arbitrator Yantsos reviewed a massage therapist's background, education, modality of care, education law and the regulations. Based on her review, she concluded that the types of medical services that a massage therapist may perform, along with a massage therapist's education and training, are limited and subordinate to that of a chiropractor and physical therapist. Therefore, Arbitrator Yantsos concluded that massage therapy should be reimbursed at the lesser chiropractic conversion rate.

Expert Massage Therapy, PC & Northbrook Indemnity Ins. Co., AAA Case no. 17-17-1055-9054
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(12/30/2017) (Melissa Melis, Arb.) Arbitrator Melis addressed whether massage therapy should be reimbursed at the higher self-employed physical/occupational therapist rate or at the reduced conversion factor utilized for chiropractors. Arbitrator Melis cited to *Great Wall Acupuncture v. Geico Gen. Ins. Co.*, 16 Misc3d 23, 842 NYS2d 131, 2007 NY Slip Op. 27164 (App. Term, 2d Dept. 2007), wherein the Court held that, "in light of the licensure requirements, we hold, as a matter of law, that an insurer may use the Workers' Compensation Fee Schedule for acupuncture services performed by chiropractors to determine the amount which a licensed acupuncturist is entitled to receive for such acupuncture services." Arbitrator Melis agreed with respondent's contention that a licensed acupuncturist is reimbursed at a rate used for chiropractors and, notably, a massage therapist has less training, education, and expertise than an acupuncturist, thereby entitling applicant to reimbursement at the reduced chiropractic rate.

Port Jefferson Therapeutic Massage & Allstate Property & Cas. Ins., AAA Case no. 17-17-1063-5939
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(3/8/2018) (Charles Blattberg, Arb.) Applicant contended that there is no fee schedule that has been adopted or established for services performed by a massage therapist and thus applicant was entitled to reimbursement at the physical therapy rate. Arbitrator Blattberg awarded applicant's claim, noting that respondent failed to submit a coder affidavit in support of its decision to issue payment at the chiropractic rate.

New Jersey Fee Schedule & ASC Billing for Anesthesia

Excel Surgery Center, LLC & Geico Ins. Co., AAA Case no. 17-16-1035-2021
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(05/13/2017) (Glen Cacchioli, Arb.) The arbitrator addressed whether an Ambulatory Surgery Center (ASC) is permitted to bill for anesthesia services under the New Jersey Fee Schedule (fee schedule). Therein, respondent argued that according to the fee schedule, an ASC may only bill for CPT codes that appear in the ASC fee columns. The applicant sought to recover no-fault reimbursement for anesthesia services under CPT code 00640. Arbitrator Cacchioli highlighted that N.J.A.C. 11:3-29.5 titled "Outpatient surgical facility fees" states "(a) ASC facility fees are listed in appendix, Exhibit 1, by CPT code. Codes that do not have an amount in the ASC facility fee column are not reimbursable if performed in an ASC." The arbitrator ruled in favor of the respondent and found that since the CPT codes billed by the applicant do not appear in the ASC column of the fee schedules, the anesthesia services are not reimbursable.

Excel Surgery Center, LLC & Geico Ins. Co., AAA Case no. 17-15-1025-5998
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(09/30/2016) (Anthony Joseph Bianchino, Arb.) The applicant sought reimbursement for a facility fee for a manipulation under anesthesia procedure and an anesthesiologist fee. The respondent argued that based upon the New Jersey Fee Schedule, an



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Ambulatory Surgery Center (ASC) may not bill for a facility fee plus anesthesia services performed by an employee, since these services are included in the facility fee. Arbitrator Bianchino noted that N.J.A.C. 11:3-29.5(a) at subparagraph (2) specifically indicates that "included in the facility fee are all services and procedures in connection with covered procedures furnished by nurses, technical personnel involved in the patient's care." The arbitrator found that applicant was entitled to reimbursement for the facility fee but not for anesthesia services since they are included in the facility fee.

Bethel Interventional Pain Management & Geico Ins. Co., AAA Case no. 17-16-1026-7168
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(05/17/2017) (Lucille S. DiGirolomo, Arb.) The arbitrator addressed whether an Ambulatory Surgery Center (ASC) can bill separately for anesthesia services under the New Jersey Fee Schedule (fee schedule). Respondent argued that under the applicable fee schedule, applicant was not entitled to bill separately for anesthesia services. Respondent cited to N.J.A.C. 11:3-29.5 governing reimbursement of Ambulatory Surgery Center fees and argued that this provision states (a) that "ASC facility fees are listed in Appendix, Exhibit 1, by CPT code. Codes that do not have an amount in the ASC facility fee column are not reimbursable if performed in an ASC." Arbitrator DiGirolomo noted that this section of the fee schedule sets forth that ASC facility fees include services that would be covered if the services were furnished in a hospital on an inpatient or outpatient basis as detailed in (a) (2) "All services and procedures in connection with the covered procedures furnished by nurses, technical personnel and others involved in the patient care" and in (a)(7) "Anesthesia materials, including the anesthetic itself, and any materials whether disposable or re-usable, necessary for its administration." The arbitrator denied applicant's claim for anesthesia services, finding that the fee schedule is clear that these services are not separately reimbursable at an ASC.

New Jersey Fee Schedule: Anesthesia Performed by an Anesthesiologist at an ASC

Tri-State Anesthesia, PC & Geico Ins. Co., AAA Case no. 17-17-1066-7728 (1/30/18)
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(01/30/18) (Ellen Weisman, Arb.) In this case, applicant sought reimbursement of its claim for anesthesia that was administered in connection with left shoulder surgery. In addition to its defense that the claim should be denied based upon an IME, respondent asserted that applicant was not entitled to reimbursement for its anesthesia services performed at an Ambulatory Surgery Center (ASC) in New Jersey. With regard to the IME, Arbitrator Weisman applied the doctrine of collateral estoppel and found in favor of the Applicant. With regard to respondent's fee schedule defense, arbitrator Weisman referred to NJAC §11:3-29.5 and found that respondent's argument was without legal support. She noted that under New Jersey law, the bar to reimbursement for ancillary services and supplies (i.e., anesthesia and anesthesia materials) is limited to ASCs. Arbitrator Weisman held that the applicant, who is a legal entity separate and apart from the ASC, was entitled to reimbursement for its services.

5 Borough Anesthesia & Geico Ins. Co., AAA Case no. 17-17-1059-3500 (2/1/18)
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(02/01/18) (Samiya Mir, Arb.) In this case, applicant sought reimbursement for anesthesia that was administered in connection with a lumbar epidural steroid injection and a sacroiliac joint injection. Respondent argued that the claim was properly denied pursuant to a peer review report. Respondent also cited to NJAC §11:3-29.5 and averred that applicant should not be entitled to any payment for its services because the procedure was performed at an Ambulatory Surgery Center (ASC) in New Jersey. With respect to the peer review and the defense of lack of medical necessity, arbitrator Mir found in favor of the applicant. As for respondent's fee schedule argument, Arbitrator Mir agreed with the applicant and found that respondent's interpretation of NJAC §11:3-29.5 was incorrect. The Arbitrator determined that NJAC §11:3-29.5 does not prohibit an anesthesiologist from seeking reimbursement for his or her services performed at an ASC. On this issue, it was also noted that Master Arbitrator Hon. Alfred J. Weiner (Ret.) vacated



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an award for an insurer in an action that was based on similar facts. See, *Horizon Anesthesia Group, PC & Country-Wide Ins. Co.* (AAA Assessment No.: 99-16-1026-7570).

North American Partners In Anesthesia, LLP & Geico Ins. Co., AAA Case no. 17-16-1041-3721
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(05/03/18) (Joseph Endzweig, Arb.) In this case, applicant sought reimbursement for the performance of an injection to the left elbow and for anesthesia that was administered in connection with MUA procedures. Respondent asserted the defense of lack of medical necessity based upon peer review reports. Respondent also noted that the MUA procedures were performed at an Ambulatory Surgery Center (ASC) in New Jersey. Based on this fact, respondent cited to NJAC §11:3-29.5 and argued that reimbursement is prohibited for such services. With respect to the issue of medical necessity for the left elbow injection, Arbitrator Endzweig sustained the denial and found that the peer review was sufficient to carry respondent's defense. As for applicant's submission, he determined that the evidence did not serve to rebut the peer doctor's assessment. Consequently, this portion of the claim was denied. On the issue of medical necessity for the anesthesia that was provided in connection with the MUA procedures, Arbitrator Endzweig applied the doctrine of collateral estoppel and found in favor of the applicant. He noted that he had already decided this very issue in related matters involving the same peer review report. With regard to respondent's fee schedule defense, Arbitrator Endzweig rejected the argument that NJAC §11:3-29.5 prohibits reimbursement for anesthesia services. In addressing this issue, the arbitrator referred to the following response that was published on the website of the New Jersey Department of Banking & Insurance (see Auto Medical Fee Schedule Frequently Asked Questions, effective January 4, 2013, updated July 21, 2015, FAQ 6):

N.J.A.C. 11:3-29.5(a) and 29.4(e)3 state that when there is no fee in the ASC facility fee column of Appendix, Exhibit 1 for a service, the facility fee for that service is not reimbursable if performed in an ASC. Stated another way, the only facility fees that are reimbursable for services performed in an ASC are those CPT and HCPCS codes that have facility fees listed in the ASC Facility Fee Column of Appendix, Exhibit 1. The fact that, subsequent to the promulgation of the fee schedule rule, CMS may have authorized additional procedures to be performed in an ASC does not permit an ASC to be reimbursed for those services unless there is an amount listed in the ASC Fee Column on Appendix, Exhibit 1 for the corresponding CPT code. However, certain codes that do not have fees in the ASC facility fee column have "N1" in the payment indicator column. The "N1" payment indicator means that the service can be performed in an ASC but a facility fee is not separately reimbursable because the service is included in another procedure. N.J.A.C. 11:3-29.5(a) and 29.4(e)3 apply only to facility fees and do not apply to physician services (emphasis added).

Based on the foregoing, Arbitrator Endzweig found that under New Jersey law, only the ASC would be prohibited from receiving no-fault benefits for anesthesia services. Consequently, this portion of the claim was granted in full.

A & E Anesthesia Associates, LLC & Geico Ins. Co., AAA Case no. 17-16-1042-6371
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(02/19/18) (Meryem Toksoy, Arb.) In this case, applicant sought reimbursement for anesthesia that was administered in connection with a lumbar epidural steroid injection. Respondent argued that the claim was properly denied pursuant to a peer review. In addition, Respondent noted that the injection procedure took place at an Ambulatory Surgery Center (ASC) in New Jersey. Based on this fact, Respondent argued that Applicant was not entitled to be paid for the anesthesia pursuant to NJAC §11:3-29.5(a)(2),(7) as well as NJAC §11:3-29.4(e)(3); and that applicant had failed to establish its prima facie case because no evidence was offered to demonstrate that the billed fee was the "usual, reasonable and customary" rate for the service [referring to NJAC §11:3-29.4(e)(1)]. With respect to the peer review and the defense of lack of medical necessity, arbitrator Toksoy found in favor of the applicant, as the medical records and rebuttal affirmation by the treating provider were sufficient to demonstrate the need for the injection. As for respondent's fee schedule arguments, arbitrator Toksoy explained why each of the cited provisions could not be used to limit and/or deny applicant's claim. In terms of the amount to be awarded, arbitrator Toksoy audited the bill, which was \$518.82,



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and determined that applicant miscalculated the fee. Providing a step-by-step guide, she concluded that the award must be limited to \$480.85.

Billing for PF-NCS Testing

GC Chiropractic, PC & Geico Ins. Co., AAA Case no. 17-17-1053-2186

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(2/2/18) (Rhonda Barry, Arb.) The arbitrator determined that the respondent failed to sufficiently sustain their burden of proof with respect to the medical necessity of upper and lower extremity pf-NCS testing. The arbitrator then addressed the fee schedule reimbursement for the testing. Arbitrator Barry relied on the Worker's Compensation Fee Schedule as well as the CPT Assistant to determine the appropriate fee for pf-NCS testing. The Applicant billed using CPT code 95999, a "by-report code." Arbitrator Barry determined that CPT code 95904 was inappropriate to apply to the services in question, as the code descriptor mandates that both amplitude and velocity must be measured for the provider to bill using this code. Arbitrator Barry then found that CPT code 0110T, a Category III code, is a more accurate descriptor of the services provided, thus holding that the billing is more appropriate on a per- extremity as opposed to a per-nerve basis. Arbitrator Barry then applied the relative value for CPT code 95904 to determine that the appropriate reimbursement is \$72.83 per extremity.

PDA NY Chiropractic, PC & Geico Ins. Co., AAA Case no. 17-16-1050-2745

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(4/4/18) (Regina Anzalone Kurz, Arb.) The arbitrator determined that the respondent failed to sufficiently sustain their burden of proof with respect to the medical necessity of upper and lower extremity pf-NCS testing. The arbitrator then addressed the fee schedule reimbursement for the testing. Applicant billed the services using CPT code 95999. The arbitrator considered a fee coder affidavit submitted by applicant that asserted that the testing should be reimbursed at \$72.83 per nerve. The arbitrator found applicant's fee evidence persuasive. Respondent argued that the testing should be reimbursed on a per-extremity basis. However, respondent's position was not supported by expert evidence. In finding that respondent had failed to meet its burden to establish a fee reduction, the arbitrator awarded the full amount billed.

Sound Chiropractic, PC & State Farm Fire & Cas. Co., AAA Case no. 17-16-1050-1939

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(3/28/18) (Mathew Maroney, Arb.) The arbitrator determined that the respondent failed to sufficiently sustain its burden of proof with respect to the fee schedule reduction proposed for upper and lower extremity pf-NCS testing. The arbitrator considered the fee coder affidavits submitted by both applicant and respondent. The arbitrator was persuaded by applicant's fee evidence, which indicated that pf-NCS testing differs from QST and thus Respondent's proposed reduction is inappropriate. The arbitrator held that code 0110T was not an appropriate comparison when measured against applicant's fee evidence. The arbitrator determined that CPT code 95999 was the appropriate code to utilize and awarded the full amount billed by applicant.

RES Physical Medicine & Rehab. Services & Safeco Ins. Co., AAA Case no. 17-16-1052-0435

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(3/22/18) (Fred Lutzen, Arb.) The arbitrator rejected respondent's argument that no reimbursement for pf-NCS testing was appropriate as the applicant billed for a service not provided. In this case, applicant billed using CPT code 95999. The arbitrator considered a fee affidavit from respondent wherein the affiant asserted that since no codes for pf-NCS services are in the fee schedule, no reimbursement is allowed. The arbitrator also considered decisions submitted by respondent indicating that the testing was properly



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denied payment when billed using CPT code 95904. The arbitrator rejected those decisions as the applicant in this case utilized CPT code 95999. The arbitrator then employed his own fee analysis to determine that the proper reimbursement was per extremity and applied the relative value associated with CPT code 95904. The arbitrator relied on the methodology and rationale explicated by arbitrator Barry, as discussed previously. The arbitrator awarded per extremity utilizing the relative value for CPT code 95904.

SUM Award: Economic Loss

J.H. v. Geico Ins. Co., AAA Case no. 43 200 S 02043 14
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(Edward Brozinsky, Arb.) The accident occurred on January 15, 2012. The claimant, age 48, was traveling in a northbound direction and came to a stop for a red traffic signal. When the light changed to green, she looked to her left and right, then entered the intersection and collided with the offending vehicle operator traveling eastbound, who had disregarded the red traffic signal. Following the accident, the claimant experienced increased headaches and pain in her neck, back, and right finger. She presented for treatment two days following the accident. The diagnosis was soft tissue injuries and cerebral concussion, and physical therapy was prescribed. The claimant also sustained a right thumb injury, which was diagnosed as de Quervain's tenosynovitis. The claimant was sent for an MRI of the cervical spine on February 6, 2012. It revealed small disc herniations at C3/4, C4/5, and C5/6. On January 23, 2012, a CT of the lumbar spine revealed impingement at right L4 and left L5 nerve roots and multilevel disc bulges. MRI of the lumbar spine was performed on March 23, 2012 and revealed grade 1 spondylolisthesis at L4/L5 related to developmental hypoplasia. There was mild right facet joint arthropathy at L5/S1 and impingement of exiting right L5 nerve root. An MRI of the right shoulder performed on March 12, 2012, revealed supraspinatus tendinosis with a partial undersurface tendon tear; partial undersurface tears to the subscapularis tendon; tendinopathy of the intraarticular biceps tendon; mild atrophy of the teres minor muscle; and glenohumeral joint effusion and supraspinatus impingement. MRI of the right knee performed on March 12, 2012, revealed tricompartmental arthritis; lateral patella subluxation; femoral trochlear dysplasia; mild posterior tibial subluxation; partial tear of the medial collateral ligament, femoral attachment; medial patellar plica. The claimant also underwent electrodiagnostic studies of the upper and lower extremities on February 29, 2012. The test revealed bilateral distal median sensory neuropathy with regard to the upper extremities. The testing of the lower extremities found a right L4 radiculopathy. The claimant started physical therapy on February 16, 2012 and continued through September 12, 2013. The claimant was subsequently seen by an orthopedist who diagnosed the claimant with a frozen right shoulder. The claimant underwent right shoulder arthroscopic surgery on October 12, 2012. The surgery performed was a diagnostic arthroscopy of the right shoulder; manipulation of right shoulder under general anesthesia; capsular release; partial synovectomy; bursectomy, and a postoperative injection of Marcaine. The postoperative diagnosis was right shoulder partial rotator cuff tear; adhesive capsulitis; synovitis, and bursitis. At the time of the accident, the claimant was employed as a support professional in a group home caring for six young individuals with cerebral palsy. Her duties included getting the individuals in the group home dressed in the morning, preparing their breakfast, and getting them off to the day program. While they were gone, she would clean the area and get the home ready for their return in the afternoon. Due to the accident, she was unable to continue that employment because it required lifting, bending, and carrying many times a day, which she could not do with the multiple injuries she sustained. The claimant had not worked since the accident. The claimant applied for Social Security disability, and following a hearing, the administrative law judge rendered a favorable decision on December 3, 2013, awarding Social Security Disability due to the injuries sustained in the accident. It was argued that the claimant was entitled to no-fault benefits including lost wages for the first three years. The claimant earned approximately \$23,500.00 per year. Her entitlement to no-fault lost-earning benefits came to a close in January 2015; she now is entitled to lost earnings less a credit for the \$738 of Social Security Disability benefits. The claimant further argued that she has 10 years and six months before her retirement on her 67th birthday. The net lost earnings are well in excess of the \$100,000 SUM policy limit. The respondent argued that the claimant is not prevented from working, and although she may not be able to do the same type of work, she should be able to do office or telephone work and mitigate some of the damages. The claimant testified that she is not computer savvy and without retraining, the office work that she would be able to do would be very limited. The claimant testified that although she



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would like to work, she is still in pain. The administrative law judge in his decision noted that the claimant is at an age where jobs are not as plentiful, and her background and training does not lend itself to the necessary skills for office and/or computer work. The arbitrator found that the claimant suffered an injury to her right wrist and thumb that required the use of a wrist splint and thumb spica for a period of time and that her wrist and thumb still cause minor problems to date. The arbitrator also found that the claimant had pre-existing cervical and lumbar degenerative disc disease that was aggravated in the accident. The claimant also suffered a torn rotator cuff that required surgery and manipulation under anesthesia. The claimant's complaints to her right knee appeared to be an aggravation of severe osteoarthritis. When all these injuries were taken together, the claimant became disabled and unable to continue the work that she had been performing for a number of years. As the claimant was on Social Security Disability and future employment was unlikely, the arbitrator found that the value of the causally related injuries, an aggravation of pre-existing conditions, and compensable lost wages exceeded the available coverage of \$100,000.00.

SUM Award: Wrongful Death

K.B. v. Utica Mut. Ins. Co., AAA Case no. 43 200 S 02075 14

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(Peter Horenstein, Arb.) On March 22, 2003, at about 4:25 p.m., the claimant's decedent, then 71 years of age, was driving her 1985 Buick sedan when she was struck by a 1987 Toyota sedan, causing her to lose control of her vehicle, cross the oncoming roadway, and strike a tree. According to the Medical Examiner's report, when EMS arrived, no vital signs were noted and severe injuries were detailed, including forehead laceration, multiple mandibular fractures, multiple right arm fractures, pelvic fracture, and "likely right hip fracture." EMS reported that the decedent could not be extricated for 20 minutes and intubation was not possible. However, bilateral tube thoracostomy was achieved via cricothyrotomy, but "vital signs were never regained." The claimant in this uninsured motorist claim is the daughter of the decedent, and the Administratrix of her estate. She testified extensively, as did her two brothers, regarding the love, affection, counsel, guidance, and nurturing they enjoyed throughout the decedent's lifetime, and how the decedent was the "glue that held the family together," with all holidays and birthdays invariably celebrated at the decedent's home. They recounted the emotional support the decedent offered in times of difficulty. During her life, the decedent was steadily employed, having owned and operated a franchise. The decedent's free time was primarily devoted to her children and grandchildren, one of whom had special needs and for whom she frequently baby-sat. A photograph in evidence of the decedent within a year of her demise showed an active and vigorous woman on vacation, swimming with dolphins. The collision that took the decedent's life was not an accident, but rather the result of a felonious scheme devised by the operator of the offending vehicle to stage an accident and defraud his no-fault carrier for his benefit and that of his passengers. The perpetrator was duly convicted and currently is serving a prison sentence. No award can be made for conscious pain and suffering in the absence of some evidence that there was any. There was, however, as evidenced by the report of the police investigation, some five to six car lengths, or at least 50 or more feet, between the point of initial impact by the perpetrator, to the point of the second, fatal impact with the tree. Thus, it was reasonable to assume that, faced with her loss of control of her vehicle and the looming tree ahead, the decedent experienced pre-impact terror, the compensatory value of which the arbitrator assessed at \$100,000.00. The evidence also supported a finding that the pecuniary losses to the decedent's distributees for the loss of her services and the loss of their mother's love, care, guidance, and support was of a compensatory value of \$200,000.00. The claim for funeral expenses in the sum of \$12,275.00 (which included \$275 to have the decedent's name added to an existing family tombstone) was unchallenged by the respondent. The total, including statutory interest, exceeded the available coverage.

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