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No-Fault User Group Town Hall—Save the Date!

Please join our NYSI Executive Management Team at the next No-Fault User Community Town Hall meeting on Thursday, November 15, 2018, at the Garden City Hotel. The meeting will cover a range of topics including the current state of the no-fault program and initiatives affecting program users.

We currently are preparing the agenda for our upcoming meeting. Please reach out to us at CarpenterB@adr.org or SkeltonJ@adr.org regarding any topics that you are interested in having us cover at the meeting.

We will share additional details regarding the upcoming meeting in the near future.

Best Practices for New Case Filings

Our customers often have questions about how to best prepare a case for filing. Our intake team conducts a sufficiency review of all new case filings for accuracy and completeness. The following guide is designed to assist you in filing a no-fault case by providing the information required for a filing to be accepted into the forum.

When preparing the AR1 for submission, it is important to ensure all fields of the AR1 are completed. If the AR1 is lacking necessary information required to initiate a filing, the case will be returned with an explanation of what is needed prior to resubmission.

Following are the recommended best practices for case preparation:

- Ensure that the AR1 form is signed by an authorized person.
- Ensure that your account has sufficient funds to cover the filing fees due at the time of case submission.
- All submissions should be accompanied by the corresponding NF3, HCVA1500, or NF10 that matches the dates of services listed on the AR1.
- Review the AR1 for accuracy to ensure that all case information is correct.
- Confirm that the name of the insurance carrier listed on the AR1 matches the NF10, EOB, or EOR, where available.
- In the event that the NF10 is issued by a third-party administrator (TPA), the information of the primary carrier or self-insured must be listed on the AR1 in order for the filing to be accepted.
- Ensure that all supporting documentation correlates with the parties listed on the AR1.
- If your firm utilizes unique file numbers, it is recommended that you indicate the file number on the upper right-hand corner of the AR1.
- It is recommended that the claim amount is in accordance with the Workers Compensation Fee Schedule rate.

We've invited parties and arbitrators to share their feedback regarding the best practices for filing a case; their recommendations follow:

- Supply a cover sheet with a breakdown of bills in chronological order with dates, descriptions of services, and amounts. You may find a few suggested, but not required, formats below:
 - **AR1:** Please verify accuracy of information provided therein.
 - **Exhibit A:** Bills in chronological order
 - **Exhibit B:** NF10s



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- o **Exhibit C:** Medical reports, test results, and other related documents in chronological order
- o **Exhibit D:** Assignment of benefits
- o **Exhibit E:** Miscellaneous documents such as proofs of mailing, verification responses, and rebuttals
- o **Exhibit F:** Case law, prior arbitration awards, as deemed relevant

This guide can be accessed on our website at <http://info.adr.org/nysinsurance-nofault/>.

If you have additional questions, please feel free to contact our customer service team at 917-438-1660.

Launch of the NYICMC LinkedIn Page

We are pleased to announce the launch of the **AAA New York State Insurance Arbitration Case Management Center** LinkedIn page. You now can find us on LinkedIn at <https://www.linkedin.com/company/aaa-nyicmc/>.

Please visit the page to learn about the services provided by the New York Insurance Case Management Center as well as to discover articles, newsletters, company announcements, upcoming events, and helpful tips.

For any questions, suggestions, feedback, or comments, please email us at NYSICommunications@adr.org.

Ex Parte Communications

In the litigation context, there are occasions when a judge may render an *ex parte* (i.e. from one party) decision where not all parties are present. For instance, criminal cases of abuse often warrant the court to enter an order although the accused offender is not present to declare any defenses.

In litigation and arbitration fora, *ex parte* communications (EPCs) also give rise to complex legal ethical dilemmas arising from a lawyer's direct communication with the fact-finder (e.g. arbitrator or judge) without all parties present at the time of the communication.

One of the primary concerns is that the absent party may be at an unfair disadvantage because the communicating party may have influenced the fact-finder by presenting its case without the other party having a chance to respond. In order to avoid this ethical issue, lawyers generally refrain from contacting the fact-finder or other represented party without alerting opposing counsel. As a guiding principle, fact-finders and parties should avoid any conduct that has the appearance of impropriety.

It is worth noting that not all conversations with a fact-finder outside the presence of the other parties are improper. The following instances generally are not considered EPCs:

1. Scheduling, administrative, or emergency circumstances;
2. Fact-finder reasonably believes the EPC provides no procedural, substantive, or tactical advantage to a party; or
3. Fact-finder directs the present parties to inform all other parties of the nature of the EPC and allows the latter the opportunity to respond accordingly.



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Timely Filing of Linked Cases

We have received several questions regarding the linking of cases currently in the system. The AAA makes every effort to link cases so that related cases are scheduled and heard at the same time. One reason for linking cases is to avoid inconsistent results in arbitration. For instance, we try to have facility fee cases heard at the same time that the associated surgery is heard. The challenge arises when one case is filed many months before the second case. When this occurs, it is difficult to link two cases where one case has a hearing date and the other case is just entering the conciliation phase of the arbitration process. These cases may end up being heard separately. A new case that is linked to a case that has an award rendered 90 days from the date the new case was escalated to arbitration may also get assigned to a different arbitrator. In addition, linked cases that are filed by different attorneys would typically not be heard together. All arbitrators on the no-fault panel have access to the redacted Award Search to review previously issued awards on linked cases.

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

30-Day & 45-Day Rule Violations & Advisory Language in Denial

- *VSENAM Med. Supply, Corp & Geico Ins. Co.*, AAA Case no. 17-16-1051-1525 (3/27/18) (Elyse Balzer, Arb.)
- *Zwanger & Pesiri Radiology Group, LLP & American States Ins. Co.*, AAA Case no. 17-16-1048-7921 (8/21/17) (Shawn Kelleher, Arb.)
- *Belam Acupuncture, PC & Geico Ins. Co.*, AAA Case no. 17-17-1053-2550 (3/21/18) (Aaron Maslow, Arb.)

Scheduling of IME Pursuant to 11 NYCRR § 65-3.5(d)

- *Helpful Medical Supply Corp. & American Tr. Ins. Co.*, AAA Case no. 17-17-1052-9805 (8/13/18) (Elyse Balzer, Arb.)
- *Bronx Chiropractic Health Services, PC & American Tr. Ins. Co.*, AAA Case no. 17-17-1076-7161 (7/24/18) (Gerry Wendrovsky, Arb.)
- *SB Chiropractic, PC & American Tr. Ins. Co.*, AAA Case no. 17-16-1037-4734 (10/11/17) (Andrew Horn, Arb.)

Infant Cases & Court Orders

- *Omega Diagnostic Imaging, PC & Geico Ins. Co.*, AAA Case No. 17-17-1056-0683 (7/10/18) (Nada Saxon, Arb.)
- *Journey Acupuncture & Geico Ins. Co.*, AAA Case No. 17-18-1089-1219 (8/13/18) (Glen Wiener, Arb.)
- *Choi Physical Therapy, PC & Tri-State Consumer Ins. Co.*, AAA Case No. 17-17-1060-0254 (7/21/18) (Jacques M. Leandre, Arb.)
- *Physical Therapy of North Queens & Geico Ins. Co.*, AAA Case No. 17-16-1051-9906 (7/8/18) (Marcelle Brandes, Arb.)
- *Brooklyn Medical Supply & Geico Ins. Co.*, AAA Case No. 17-17-1060-2792 (6/20/18) (Andrew Horn, Arb.)



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Cupping & Fee Schedule

- *Vivid Acupuncture, PC & Geico Ins. Co.*, AAA Case No. 17-16-1047-5887 (8/8/18) (Michelle Entin, Arb.)
- *Gentle Care Acupuncture, P.C. & Geico Ins. Co.*, AAA Case No. 17-17-1052-8776 (8/8/18) (Frank Marotta, Arb.)
- *Affinity Acupuncture Healthcare, PLLC & Geico Ins. Co.*, AAA Case No. 17-17-1071-5356 (8/3/18) (Heidi Obiajulu, Arb.)
- *XYJ Acupuncture, P.C. & Geico Ins. Co.*, AAA Case No. 17-16-1041-7743 (5/3/2017) (Drew M. Gewuerz, Arb.)
- *Yong Quan Acupuncture, PC & Allstate Fire & Cas. Ins. Co.*, AAA Case No. 17-17-1058-6098 (6/25/18) (Pamela Hirschhorn, Arb.)

Choice of Law & Significant Contacts

- *Specialty Medical Services & Geico Ins. Co.*, AAA Case no. 17-12-9032-4374 (12/14/12) (Glen A. Wiener, Arb.)
- *Integrative Medical Diagnostics, P.C. & American Independent Ins. Co.*, AAA Case no. 17-17-1068-9698 (2/21/18) (Heidi Obiajulu, Arb.)
- *Omni Surgery Center & Nationwide Ins. Co.*, AAA Case no. 17-17-1069-8671 (1/26/18) (Ann Lorraine Russo, Arb.)
- *Good Point Acupuncture & American Independent Ins. Co.*, AAA Case no. 17-17-1058-2076 (8/25/18) (Alana Barran, Arb.)

SUM Awards: Psychological Injury

- *S.S. v. Geico Ins. Co.*, AAA Case no. 01-16-0005-3048 (4/2/18) (Alan H. Krystal, Arb.)
- *T.K., L.K. & V.K. v. State Farm Ins. Co.*, AAA Case no. 01-16-0004-8486 (12/14/17) (Edward Brozinsky, Arb.)

Arbitrator Abstracts

30-Day & 45-Day Rule Violations & Advisory Language in Denial

VSENAM Med. Supply, Corp & Geico Ins. Co., AAA Case no. 17-16-1051-1525
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(3/27/18) (Elyse Balzer, Arb.) The denial was predicated on the defense of non-compliance with the Mandatory Personal Injury Protection Endorsement in that written notice of the accident was made more than 30 days from the date of the accident. The arbitrator cited to 11 NYCRR 65-3.3 (e), which provides that such denial must advise the applicant that late notice will be excused where the applicant can provide reasonable justification of the failure to give timely notice. Since the denial failed to advise that late notice would be excused, the arbitrator concluded that the denial did not meet the insurance regulations mandate.

Zwanger & Pesiri Radiology Group, LLP & American States Ins. Co., AAA Case no. 17-16-1048-7921
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(8/21/17) (Shawn Kelleher, Arb.) The arbitrator upheld a denial based upon the 45-day rule, which stated that proof of claim "must be received no later than 45 days" and the applicant "may submit justification for the late submission for review." Although the arbitrator acknowledged that the language in the denial did not explicitly advise that late notice was excusable, the arbitrator determined that the denial was not defective since it is not necessary to provide the exact language as provided in the no-fault regulations, but only to advise that a mechanism existed to review the reason for the late submission.



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Belam Acupuncture, PC & Geico Ins. Co., AAA Case no. 17-17-1053-2550
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(3/21/18) (Aaron Maslow, Arb.) The arbitrator rejected respondent's defense predicated upon the 45-day rule because the language set forth in respondent's denial of claim form stated that the eligible injured person had to submit "written proof that it was impossible to comply with such time limitation due to specific circumstances beyond such person's control." Arbitrator Maslow cited to relevant case law and found that respondent's defense could not be sustained in the absence of the proper advisement required by the regulations.

Scheduling of IME Pursuant to 11 NYCRR § 65-3.5(d)

Helpful Medical Supply Corp. & American Tr. Ins. Co., AAA Case no. 17-17-1052-9805
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(8/13/18) (Elyse Balzer, Arb.) The claim for durable medical equipment was denied based upon the assignor's failure to appear for scheduled IMEs. Relying on a prior award in a related matter, the arbitrator determined that the injured person was noticed for IMEs and failed to appear for IMEs. However, applicant asserted that respondent did not abide by the timeframes for scheduling IMEs as set forth in 11 NYCRR § 65-3.5(d), which requires IMEs to be scheduled to be held within 30 calendar days from the date of receipt of the prescribed verification forms. Pursuant to 11 NYCRR 65-3.5 (d) and *American Tr. Ins. Co. v. Longevity Med. Supply, Inc.*, 131 A.D.3d 841 (1st Dept. 2015), the arbitrator found that respondent's defense was not established with regard to certain bills as the initial IME was scheduled to be held in excess of 30 days from the date the bills were received.

Bronx Chiropractic Health Services, PC & American Tr. Ins. Co., AAA Case no. 17-17-1076-7161
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(7/24/18) (Gerry Wendrovsky, Arb.) Applicant's bills for chiropractic treatment were denied based upon the assignor's failure to appear for scheduled IMEs. The arbitrator found that the injured person was noticed for IMEs and that respondent presented sufficient evidence of non-appearance. However, relying on 11 NYCRR § 65-3.5(d), *American Tr. Ins. Co. v. Longevity Med. Supply, Inc.*, 131 A.D.3d 841 (1st Dept. 2015) and an award in the case of *Medical Impressions Diagnostic, PC & Hereford Ins. Co.*, AAA Case no. 17-16-1049-6903 (10/5/17) (Paul Weidenbaum, Arb.), Arbitrator Wendrovsky determined that the bills that were submitted to the carrier more than 30 days before the first scheduled IME were not timely scheduled and thus respondent could not maintain its defense. With respect to the remaining bills that were submitted within 30 days of the first scheduled IME or subsequent thereto, the arbitrator found that those bills were properly denied.

SB Chiropractic, PC & American Tr. Ins. Co., AAA Case no. 17-16-1037-4734
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(10/11/17) (Andrew Horn, Arb.) The arbitrator was presented with two bills for nerve testing, one of which was denied based upon the assignor's failure to appear for IMEs. The arbitrator held that IMEs are a form of verification subject to the verification protocols as outlined in 11 NYCRR § 65-1.1(b) and 11 NYCRR § 65-3.5(b) and thus must be requested in compliance therewith. Relying on *American Tr. Ins. Co. v. Clark*, 131 AD3d 840 (1st Dept. 2015), the arbitrator also found that an IME must be scheduled to be held within 30 days of receipt of the prescribed verification forms. The arbitrator found that the IME was scheduled to be held more than 30 calendar days after the respondent's receipt of the bill. Thus, the IME was not scheduled in compliance with the regulations.



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Infant Cases & Court Orders

Omega Diagnostic Imaging, PC & Geico Ins. Co., AAA Case No. 17-17-1056-0683
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(7/10/18) (Nada Saxon, Arb.) The arbitrator acknowledged that she had previously dismissed cases involving infants pursuant to CPLR §1209, which provides that a claim or controversy involving an infant, person judicially declared to be incompetent or a conservatee, shall not be submitted to arbitration except pursuant to a court order made upon application of the representative of such infant, incompetent, or conservatee. The arbitrator noted that in *Matter of Fast Care Med. Diagnostics, PLLC v. Government Employees Ins. Co.*, 161 AD3d 1149 (2d Dept. 2018), the court found that CPLR §1209 does not apply to an arbitration of a no-fault claim where the party commencing the arbitration proceeding was the assignee of an infant assignor. Although respondent also challenged the validity of the assignment of benefits in furtherance of its defense, the arbitrator cited to *Fast Care, supra*, in which the court addressed the issue of an assignment of benefits and noted that the master arbitrator's determination that the assignment of benefits was not effective was not based on any requirement set forth in established law or regulations.

Journey Acupuncture & Geico Ins. Co., AAA Case No. 17-18-1089-1219
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(8/13/18) (Glen Wiener, Arb.) The arbitrator addressed whether applicant can arbitrate an infant-assignor's claim for reimbursement under the no-fault regulations without a court order. The arbitrator noted that issues may arise relating to whether the minor's injuries were causally related to the accident or whether there was a policy violation and thus the minor's negligence action could be negatively impacted or the infant could be exposed to personal liability. Based on the foregoing, the arbitrator chose to adhere to the express language in CPLR §1209, requiring a court order and dismissed the arbitration without prejudice. The arbitrator rejected the holding in *Matter of Fast Care Med. Diagnostics, PLLC v. Government Employees Ins. Co.*, 161 AD3d 1149 (2d Dept. 2018), stating that the court seemed unaware that the infant may become personally liable for no-fault claims under certain circumstances.

Choi Physical Therapy, PC & Tri-State Consumer Ins. Co., AAA Case No. 17-17-1060-0254
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(7/21/18) (Jacques M. Leandre, Arb.) The arbitrator addressed whether there was a proper assignment of benefits that would allow applicant to arbitrate claims arising from treatment rendered to a minor. Citing to relevant case law, the arbitrator noted that CPLR §1209 does not bar an assignment of a no-fault claim from proceeding in arbitration without a court order, as the infant-assignor's no-fault benefits had been assigned and thus the assignor had divested all control and right to the claim. However, the arbitrator determined that since there was no valid assignment of benefits (the assignment of benefits was not signed by a parent or guardian) the case should be dismissed without prejudice.

Physical Therapy of North Queens & Geico Ins. Co., AAA Case No. 17-16-1051-9906
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(7/8/18) (Marcelle Brandes, Arb.) The arbitrator addressed whether the applicant was precluded from proceeding in arbitration owing to the assignor's infant status. The arbitrator noted that the assignment of benefits was signed by the injured party's mother and specifically prohibited the applicant-provider from seeking payment from the assignor unless "benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor." Based on the foregoing, the arbitrator proceeded to adjudicate the case, as she determined that the sole issue before her was medical necessity.



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Brooklyn Medical Supply & Geico Ins. Co., AAA Case No. 17-17-1060-2792
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(6/20/18) (Andrew Horn, Arb.) The arbitrator addressed whether an arbitration may proceed in the absence of a court order when the provider's assignor was a minor at the time the services were rendered. Following a review of numerous awards concerning the presented issue, the arbitrator concluded that he was constrained to follow *Matter of Fast Care Med. Diagnostics, PLLC v. Government Employees Ins. Co.*, 161 AD3d 1149 (2d Dept. 2018). Based on the court's holding, the arbitrator determined that the infant-assignor was not the party in interest, as her mother duly assigned her no-fault benefits to applicant at the time the services were rendered.

Cupping & Fee Schedule

Vivid Acupuncture, PC & Geico Ins. Co., AAA Case No. 17-16-1047-5887
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(8/8/18) (Michelle Entin, Arb.) Applicant sought reimbursement for cupping procedures at \$50.00 per session. Respondent reimbursed applicant \$13.87 per session and through its denials asserted that since applicant billed for an unlisted procedure, a report must be submitted to substantiate the value of the codes billed. The denials also stated that reimbursement was issued based on an RVU of 2.40. In support of its position, respondent submitted the affidavit of Steven Schram, L.Ac., which set forth that cupping does not have an explicit CPT Code assigned to it, but that the AMA CPT Assistant supports utilizing Code 97039 for an unlisted modality. Mr. Schram maintained that although some practitioners use CPT code 97799 (unlisted physical medicine/rehabilitation service or procedure), this code is not entirely accurate because these procedures are not rehabilitative in nature. Mr. Schram also stated that cupping requires a minimal amount of technical skill and concluded that the correct RVU units for cupping should be 2.40. To rebut the affidavit of Mr. Schram, applicant submitted the affidavit of Yelena Vinokur, L.Ac. Ms. Vinokur emphasized that Mr. Schram did not discuss her report in his affidavit. Moreover, she disagreed as to the skill level necessary for performing cupping procedures. Ms. Vinokur maintained that CPT Code 97140 is the most comparable code with regard to cupping services. She noted that CPT Code 97140 has an RVU of 4.23, which when multiplied by the chiropractic conversion rate of 5.78 results in a total reimbursement rate of \$24.45 per session. The arbitrator found the affidavit of Ms. Vinokur more credible as to the RVU value as well as the technical skill required for cupping and thus ruled in favor of the applicant, finding that the appropriate reimbursement rate should be \$24.45 per session.

Gentle Care Acupuncture, P.C. & Geico Ins. Co., AAA Case No. 17-17-1052-8776
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(8/8/18) (Frank Marotta, Arb.) The arbitrator addressed whether applicant was entitled to additional reimbursement for cupping procedures billed at \$90.00 per session. Applicant sought to recover for cupping procedures under CPT Code 97799, a "by report" (BR) code. The arbitrator noted that under Ground Rule 3 entitled "Procedures without Specified Unit Values," the "BR" in the relative value column represents services that are too variable in the nature of their performance to permit assignment of unit values and that fees for such procedures need to be substantiated. Respondent relied on an affidavit by Steven Schram, L.A.c., who stated that cupping involves placing small open mouth jars on the skin and drawing the air out, creating negative pressure. Mr. Schram compared this procedure to other procedures for which relative values have already been established and noted that these relative values are established by the Workers' Compensation Board based on their understanding of the time, technical skills, mental effort, and judgment needed for the service. He further stated that cupping is a very simple procedure that requires a minimal amount of technical skill and is typically an unattended procedure. As such, Mr. Schram concluded that the appropriate relative value is 2.40. Applicant submitted an affidavit and statement letter of Arkady Kiner, L.A.c. Mr. Kiner explained that the cupping procedure is a noninvasive procedure that takes up to 10 minutes. He further explained that he set his fee based on his



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own research on the internet, as well as telephone calls to various acupuncture practitioners, which revealed that fees for cupping can vary from \$70.00 to \$200.00 per session. Based on the required skills and equipment, Mr. Kiner arrived at a fee of \$95.00. The arbitrator found Mr. Schram's affidavit more persuasive and that applicant was properly compensated for the cupping procedures at the rate of \$13.87 per session.

Affinity Acupuncture Healthcare, PLLC & Geico Ins. Co., AAA Case No. 17-17-1071-5356
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(8/3/18) (Heidi Obiajulu, Arb.) Applicant sought reimbursement for cupping procedures under CPT Code 97016. Respondent argued that there was no allowance for the procedure in the New York State Workers' Compensation Fee Schedule under the provider's specialty. Respondent did not submit any evidence from a billing or coding expert to support its argument that a licensed acupuncturist cannot perform cupping. The arbitrator found that respondent failed to establish its fee schedule defense. The arbitrator awarded reimbursement in full under CPT Code 97016 utilizing the chiropractic conversion factor.

XYJ Acupuncture, P.C. & Geico Ins. Co., AAA Case No. 17-16-1041-7743
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(5/3/2017) (Drew M. Gewuerz, Arb.) The arbitrator addressed whether applicant was entitled to reimbursement for cupping procedures billed at \$50.00 per session under CPT Code 97799. Respondent submitted the affidavit of Steven Schram, L.Ac., in which Mr. Schram opined that cupping, billed under "By Report" code 97799, should be reimbursed at \$13.87 per session and that the relative value should be 2.40 because cupping requires a minimal amount of technical skill. The applicant argued that Mr. Schram's opinion is not sufficient and that a medical coder's testimony should have been proffered instead. Applicant also cited to *Bronx Acupuncture Therapy PC v. Hereford Ins. Co.*, 54 Misc.3d 135(A) (App. Term, 2d Dept. 2017) for the proposition that the respondent has an affirmative duty to request verification when a "By Report" code is billed, and since respondent failed to do so, respondent should be precluded from offering evidence disputing the applicant's charges. The arbitrator found that as a licensed practitioner, Mr. Schram had the credentials to discuss the relative value for cupping and that the Ground Rules pertaining to "By Report" codes direct the practitioner, not a medical coder, to determine the relative value. The arbitrator found that the regulations place an affirmative duty on insurers to request additional verification required to establish proof of claim should that be deemed necessary. The arbitrator also found that an insurer may fail to request additional by-report documentation to determine the appropriate amount of reimbursement and such action does not constitute a waiver of the defense of excessive billing. The arbitrator found that regardless of whether an insurer requests additional verification, an insurer is legally authorized to challenge the proper amount of reimbursement at any time pursuant to 11 NYCRR 65-3.8(g)(1). The arbitrator concluded that respondent's failure to request additional by-report documentation does not preclude respondent from presenting evidence as to the value of those services. The arbitrator found that respondent's evidence was persuasive and not rebutted and thus awarded \$13.87 per cupping session.

Yong Quan Acupuncture, PC & Allstate Fire & Cas. Ins. Co., AAA Case No. 17-17-1058-6098
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(6/25/18) (Pamela Hirschhorn, Arb.) The arbitrator addressed whether applicant was entitled to additional reimbursement for cupping procedures billed pursuant to Code 97799. Respondent issued partial reimbursement pursuant to Code 97039, a physical therapy modality. The arbitrator found that respondent must conclusively demonstrate the proper fee schedule rate of payment for services rendered and that it failed to support its fee schedule defense because no fee audit was submitted. The arbitrator further found that pursuant to *Bronx Acupuncture Therapy, PC v. Hereford Ins. Co.*, 54 Misc.3d 135(A) (App. Term 2d Dept. 2017), if after a



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review of the documentation submitted, the respondent determined that the criteria for Code 97799 had not been met and that additional documentation was necessary, respondent's remedy was to request further documentation. The arbitrator noted that the no-fault regulations provide that an applicant is not to be treated in an adversarial manner citing to 11 NYCRR 65-3.2 (Regulation 68-C). The arbitrator also found that pursuant to 11 NYCRR 65-3.2 (Regulation 68-C), upon receipt of the billing, if respondent determined that there was either insufficient documentation to support the billing submitted or that the services were not billed pursuant to the proper code, respondent could have advised applicant pursuant to a verification request or telephone call properly documented in the file rather than changing the Code to 97039 and issuing partial reimbursement for the services performed. Thus, the arbitrator awarded full reimbursement to the applicant.

Choice of Law & Significant Contacts

Specialty Medical Services & Geico Ins. Co., AAA Case no. 17-12-9032-4374

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(12/14/12) (Glen A. Wiener, Arb.) Applicant sought to be reimbursed for services that were provided in New Jersey to a person who was a resident of New Jersey and who sustained injuries from a motor vehicle accident that occurred in New Jersey. The arbitrator noted that the record did not show whether the claim was presented under a New York or New Jersey policy of insurance. The arbitrator referred to *Allstate Ins. Co. v. Stolarz*, 81 N.Y.2d 219 (1993), in which the court referenced that where there is a potential choice of law issue, a determination must be made as to whether there is an actual conflict between the laws of the jurisdictions involved. Providing historical background, the court noted that in contract cases, the approach was to use the law of the place where the contract was made or was to be performed, while in tort cases, the substantive issues were evaluated according to the law of the place of the tort. In *Allstate v. Stolarz*, *supra*, the court found that these inflexible rules proved unsatisfactory because the location of the controlling event was sometimes fortuitous, did not reflect the parties' intentions, or was insignificant as against the location of other events. The court also noted that traditional approaches failed to accord any significance to the policies underlying the conflicting laws. See, *Allstate v. Stolarz*, *supra*. The arbitrator found that pursuant to *Allstate v. Stolarz*, *supra*, the New York courts now apply a more flexible "center of gravity" or "grouping of contacts" analysis and under this approach, the spectrum of significant contacts rather than a single possibly fortuitous event may be considered. See, *Allstate v. Stolarz*, *supra*. Utilizing the "center of gravity" or "groupings of contacts" analysis, the arbitrator determined that New Jersey would be the more appropriate forum to resolve the dispute and thus dismissed the case without prejudice.

Integrative Medical Diagnostics, P.C. & American Independent Ins. Co., AAA Case no. 17-17-1068-9698

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(2/21/18) (Heidi Obiajulu, Arb.) Applicant sought to be reimbursed for an evaluation and EMG/NCV testing. Respondent maintained that the bill was properly denied based upon the assignor's failure to appear for scheduled EUOs and also argued that the case must be decided according to Pennsylvania law. The arbitrator noted that pursuant to respondent's brief, the first step in any case presenting a potential choice of law issue is to determine whether there is an actual conflict between the laws of the jurisdictions involved. See, *Allstate v. Stolarz*, 81 N.Y.2d 219, 223 (1993). Respondent's brief then discussed how the relevant laws of New York and Pennsylvania were distinguishable. Respondent's brief referenced that the insured was a resident of Pennsylvania, that coverage was provided under a Pennsylvania automobile insurance policy, and that the subject vehicle was registered and garaged in Pennsylvania. Although the accident occurred in New York, the arbitrator determined that Pennsylvania had more significant contacts and that Pennsylvania law should apply. Since respondent established its defense pursuant to Pennsylvania law, the claim was denied.



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Omni Surgery Center & Nationwide Ins. Co., AAA Case no. 17-17-1069-8671
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(1/26/18) (Ann Lorraine Russo, Arb.) Applicant sought reimbursement for injections that were administered at its facility in New York. Respondent asserted the defense of policy exhaustion and argued that Texas law applies. The arbitrator found that by using the “center of gravity” or “grouping of contacts” approach, Texas had the greater interest in having its laws applied. The arbitrator noted that the accident occurred in Texas, the insured was a resident of Texas, and coverage was obtained under a Texas policy of insurance. Thus, the arbitrator determined that pursuant to Texas law, the policy limits of \$2,500.00 had been exhausted and the claim was denied.

Good Point Acupuncture & American Independent Ins. Co., AAA Case no. 17-17-1058-2076
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(8/25/18) (Alana Barran, Arb.) Applicant sought reimbursement for acupuncture rendered as a result of the assignor sustaining injuries in a car accident that occurred in New York. Respondent maintained that the bills were properly denied because of the assignor’s failure to appear for an EUO and argued that Pennsylvania law applies. Using the “center of gravity” or “grouping of contacts” approach, the arbitrator found that Pennsylvania had the most significant relationship to the transaction and the parties, as the insured was a resident of Pennsylvania, coverage was obtained under a Pennsylvania insurance policy, and the subject vehicle was registered in Pennsylvania. The arbitrator evaluated respondent’s defense according to Pennsylvania law and determined that the evidence was sufficient to warrant a denial of the claim.

SUM Awards: Psychological Injury

S.S. v. Geico Ins. Co., AAA Case no. 01-16-0005-3048
[SUM Award Search](#)

(4/2/18) (Alan H. Krystal, Arb.) The accident occurred when an unidentified trailer turning westbound struck the rear driver’s side of claimant’s vehicle, which was parked. The claimant received emergency room treatment and complained of nervousness and lower back pain. The claimant was prescribed Motrin and Robaxin prior to being released. The following day, the claimant was preparing breakfast and cut her left thumb, which she claimed was due to anxiety following the accident that caused her hand to tremble. The claimant went to Jamaica Hospital Medical Center, where the laceration to her thumb was repaired. On October 22, 2015, the claimant was seen in orthopedic consultation, where it was determined that the ulnar digital nerve of the left thumb was lacerated. The claimant subsequently underwent surgery at Mercy Hospital for exploration and micro repair of the ulnar distal nerve of the left thumb. The claimant subsequently sought treatment at Behavioral Medicine Associates on November 10, 2015, with complaints of fear of driving, anxiety, and fear for her safety as well as the safety of her children, who were in the vehicle at the time of the accident. The claimant was diagnosed with adjustment disorder with anxiety and post-traumatic stress disorder. The claimant was prescribed a program of relaxation training and attention focusing. The claimant attended six (6) therapy sessions. The claimant submitted an affidavit from her psychologist dated November 29, 2017, which was approximately two (2) years after the accident, referencing the claimant’s thumb injury and setting forth that the claimant had complained that her hand was trembling due to her anxiety and lack of sleep following the accident. It was the psychologist’s opinion that the anxiety tremor experienced by the claimant was causally related to the subject motor vehicle accident. With respect to damages, the issue was whether the claimant had established that her thumb injury was causally related to the motor vehicle accident. The claimant submitted that the accident resulted in post-traumatic stress manifested by tremors, which resulted in her cutting her left thumb. However, the psychological intake form dated November 15, 2015, referred to the motor vehicle accident and made no mention of the claimant cutting her thumb. The psychological report referred to a number of symptoms, but there was no mention of tremors. The reference in



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the treatment record to the thumb injury was contained in the treatment note of November 24, 2015, which referenced that the claimant cut her hand due to anxiety tremor. In assessing the credibility of the evidence presented, the arbitrator noted that there was an absence of any reference to the thumb injury in the psychological evaluation and consultation report. Although the claimant mentioned her thumb injury nine (9) days after the psychological evaluation and intake was performed, the arbitrator found that the claimant's failure to refer to the thumb injury as a result of tremors at the time of intake cast doubt on the claimant's credibility. Nor was the arbitrator persuaded by the affidavit of the claimant's psychologist prepared two (2) years after initial intake in support of claimant's position that the thumb injury was causally related to the subject motor vehicle accident. Accordingly, the arbitrator's award was in favor of respondent.

T.K., L.K. & V.K. v. State Farm Ins. Co., AAA Case no. 01-16-0004-8486

[Sum Award Search](#)

(12/14/17) (Edward Brozinsky, Arb.) The infant/claimant was a passenger in a vehicle that was rear-ended while stopped at a red light. At the time of the accident, the infant/claimant's legs were pinned between the infant seat and the back of the front seat. The infant/claimant was removed by ambulance and transported to Nassau University Medical Center, where she was examined in the emergency room with a bruise to the knee. The following day, the infant/claimant was examined at Wantagh Pediatric with complaints of pain and anxiety. On September 22, 2014, the infant/claimant was seen at Bellmore–Merrick Pediatric and Adolescent Medicine, as there was a bump on the infant/claimant's neck that the infant's mother had not noticed previously. The examination was unremarkable, but since the infant/claimant had been involved in a motor vehicle accident a few days prior, follow-up with a pediatric orthopedist was recommended. On September 25, 2014, the infant/claimant was examined at Orlin & Cohen with complaints of headaches and neck pain. The infant/claimant was able to move her neck without pain. According to the mother's testimony, the infant/claimant began experiencing nightmares following the accident and was afraid of being in a car. In addition, the infant/claimant had begun acting out in school and toilet training regression became noticeable. The claimant was evaluated by a social worker on September 22, 2014, at which time it was noted that the infant/claimant was alert but upset and restless during the session. The infant/claimant had been experiencing sleep disturbances (nightmares), loss of energy, increased tearfulness, irritability, fear of cars, fear of crossing the street, flashbacks, difficulty completing tasks, loss of appetite, increased startle response, loss of toilet training skills, anxiety, aggression, and lessened concentration. The infant/claimant continued with weekly sessions through July 18, 2016, when it appeared that the infant/claimant was improving and was better able to manage her feelings. The infant/claimant was examined by the social worker on October 28, 2016, and the social worker found that the infant/claimant had not recovered from her anxiety. The diagnosis was anxiety and adjustment disorder as a direct result of the accident of September 12, 2014. The infant/claimant underwent a no-fault psychological evaluation on December 29, 2016, in which the doctor noted that he had seen the infant/claimant previously on July 21, 2016 and at that time he felt that she had adjustment disorder with anxiety. In the prior report of July 21, 2016, the doctor noted that the claimant seemed to be somewhat overprotected, was functioning at an appropriate age level in terms of the social and physical development but was apprehensive, frightened easily, and was overly dependent upon her mother. He reviewed the updated records of the social worker from April 20, 2016 through October 17, 2016, and noted that the latest report indicated that there had been some improvement in the patient's symptoms and that the infant/claimant was using various relaxation techniques. The doctor noted that the infant/claimant was less disobedient and that her symptoms of anxiety had lessened. The no-fault psychologist put the infant/claimant's functioning on a level between age five and six and motor coordination was very good. Language development was excellent, and she appeared to be less dependent on her mother. Basically, she appeared to be functioning at a five and a half to six-year-old level. She was doing better in school and was less preoccupied with the accident when in a car. The diagnostic impression was that there was no evidence at the present time that the claimant was having adjustment disorder and anxiety therapy had been successful in helping her overcome her difficulties. The infant/claimant had suffered from an anxiety and adjustment disorder that continued from September 12, 2014 through October 2016, but upon re-examination by the no-fault psychologist on December 29, 2016, the doctor concluded that the infant/claimant had been through successful therapy and was no longer suffering from anxiety and



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an adjustment disorder. The arbitrator found that the claimant had suffered from an anxiety and adjustment disorder requiring playacting therapy through October 2016—more than two years—and that this condition significantly limited her at a very crucial time in her life. The arbitrator found that the infant/claimant appeared to have overcome this adjustment anxiety disorder. The arbitrator placed a value of these mental conditions together with the superficial soft tissue neck injury at \$50,000.00.

Section Editor-in-Chief: Pamela Hirschhorn

Section Editorial Board: Nancy Kramer Avalone, Athena Buchanan, Andrew Horn, Michael Korshin, Alan Krystal, Victor Moritz, Michael Rosenberger, Alina Shafranov, Meryem Toksoy, Philip Wolf

Contributors to this issue: Athena Buchanan, Andrew Horn, Michael Korshin, Alan Krystal, Victor Moritz, Alina Shafranov, Meryem Toksoy