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How Conciliation Can Help You

Throughout its life, a request for no-fault arbitration filed with our New York Insurance Case Management Center ("Center") goes through several stages. Conciliation arguably is one of the most critical stages before a claim is escalated to an arbitration hearing.

Section 65-4.2(b)(2) of the New York No-Fault Regulation 68 ("Regulation") requires the designated organization to design "a conciliation center, which shall review all requests for arbitration and assign file numbers thereto, which shall be used by the designated organization and the parties to identify the case."

In practice, the Center is responsible for administering the conciliation process for all claims for arbitration filed with the Center. Assigned by applicants' attorneys, the Center's conciliation teams' primary focus is providing parties opportunities to resolve their respective no-fault disputes without resorting to arbitration hearings. As defined by the Regulation, conciliation teams' methods may include "telephone, facsimile, e-mail, or other appropriate means."

The conciliation staff employs a combination of research and mediation skills to optimize the parties' ability to dispose of claims during the conciliation stage. In the interest of neutrality, conciliators are bound to presenting unbiased information to the parties that may guide the latter to resolving their disputes before arbitration hearings. For instance, conciliators may present prior awards involving the same parties and issues that may serve as precedents for future reasoned awards.

Perhaps one of the greatest benefits conciliation can offer is the opportunity for parties to settle cases in bulk. In instances where parties are involved in multiple claims in common, conciliators compile and utilize business intelligence data. Parties also may request lists of their claims to identify claims they would like to consider for settlement discussions. This data assists the parties in analyzing their options to settle claims potentially in one fell swoop.

The conciliation process also affords parties the ability to resolve cases using the ADR Center Online Settlement Tool. In this instance, parties may submit offers and counteroffers to settle any pending claims regardless of the pre-hearing stage of the claims.

If you have any questions about the conciliation process, please contact Zarah Monterrosa at MonterrosaZ@adr.org or Janet Miranda at MirandaJ@adr.org.

Launch of the NYICMC YouTube Channel

We are pleased to announce the launch of the AAA NYSI Case Management Center YouTube channel. You can find us on YouTube at https://www.youtube.com/channel/UC_S_vrNETo5em1o3B0V8qUg or by searching AAA NYSI Case Management Center.

The NYICMC YouTube channel currently highlights members of the NYSI Executive Team. In the short videos, you can learn a little about each of our Executive Team members, including their experience, why they work for the AAA, and why they stand behind the ADR services provided by the AAA.

We look forward to creating new content for the YouTube channel in 2019. For any questions or suggestions for future content, please email us at NYSICommunications@adr.org.



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Updated How-To Guides Are Now Available

The how-to guides located in the ADR Center Help Page have been updated. These helpful guides outline various functions users perform while using ADR Center, including adding and removing authorized agents and requesting a time extension.

Additionally, these guides assist users in efficiently using ADR Center by outlining the benefits of the filter feature as well as the document view tab. In the document view tab, documents are organized by frequently used categories. A description of each category can be found under the glossaries section of the help page.

Please review the updated guides at <http://info.adr.org/nofaulthelp/>, and if you need further assistance, please contact ADR Center Customer Support at **646.663.3488** or email NYSInsurance@adr.org.

Happy One-Year Anniversary Buffalo!

On October 23, we celebrated one year at our second case-management office in Buffalo. The Buffalo office currently has 30 employees—and we are actively recruiting for additional staff. We plan to grow the Buffalo office to 50 employees in 2019. Having a second office has helped reduce our backlog and increase our efficiencies. A giant thank-you to all our staff for making year one successful. We look forward to many more.

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

GameReady Units & Medical Necessity

- *Isurply LLC & Allstate Ins. Co.*, AAA Case no. 17-17-1081-4675 (8/9/18) (Anthony Kobets, Arb.)
- *OrthoPro Services, Inc. & Geico Ins. Co.*, AAA Case no. 17-17-1055-0310 (9/24/18) (Amanda R. Kronin, Arb.)
- *Orthocustoms, LLC & Geico Ins. Co.*, AAA Case no. 17-18-1094-9290 (9/16/18) (Yael Aspir, Arb.)
- *OrthoPro Services, Inc. & Geico Ins. Co.*, AAA Case no. 17-16-1046-8712 (9/21/18) (Henry Sawits, Arb.)

Pneumatic Compression DVT Devices & Medical Necessity

- *Princemed Inc. & Liberty Mut. Ins. Co.*, AAA Case no. 17-17-1076-5494 (7/12/18) (Greta Vilar, Arb.)
- *Princemed Inc. & Geico Ins. Co.*, AAA Case no. 17-17-1061-1070 (6/2/18) (Sandra Adelson, Arb.)
- *MiiSupply, LLC & National Liability & Fire Ins. Co.*, AAA Case no. 17-16-1048-6668 (5/21/18) (Steven Greif, Arb.)
- *Ihome Rehab, LLC & American Country Ins. Co.*, AAA Case no. 17-17-1065-7670 (3/20/18) (Corinne Pascariu, Arb.)



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Generic Peer Reviews & Diagnostic Ultrasound

- *JMSK Medical Diagnostic, PC & Allstate Ins. Co.*, AAA Case no. 17-17-1071-1436 (10/14/18) (Pamela Hirschhorn, Arb.)
- *JMSK Medical Diagnostic, PC & Allstate Ins. Co.*, AAA Case no. 17-17-1063-3591 (7/22/18) (Paul Keenan, Arb.)
- *JMSK Medical Diagnostic, PC & Allstate Ins. Co.*, AAA Case no. 99-17-1063-3591 (10/23/18) (Robert Trestman, Master Arb.)
- *JMSK Medical Diagnostic, PC & Allstate Ins. Co.*, AAA Case no. 17-17-1063-3572 (9/22/18) (Michael Korshin, Arb.)

Sustained Acoustic Medicine

- *ISupply Medical Inc. & Allstate County Mut. Ins. Co.*, AAA Case no. 17-17-1072-4770 (10/24/18) (Ellen Weisman, Arb.)
- *Reliable Therapy Equipment Inc. & Allstate Fire & Cas. Ins. Co.*, AAA Case no. 17-17-1080-5616 (6/8/18) (Michael Korshin, Arb.)
- *Reliable Therapy Supply Inc. & Geico Ins. Co.*, AAA Case no. 17-17-1082-4589 (9/17/18) (John Kannengieser, Arb.)

Policy Cancellation

- *New York Surgery Center of Queens & New South Ins. Co.*, AAA Case no. 17-17-1058-7137 (8/11/18) (Lisa Abrams, Arb.)
- *New Age Acupuncture, PC & National Liability & Fire Ins. Co.*, AAA Case no. 17-16-1039-4278 (6/18/18) (Phyllis Saxe, Arb.)
- *Precision Medical Diagnostic of NY & Geico Ins. Co.*, AAA Case no. 17-17-1062-3941 (11/6/18) (Eva Gaspari, Arb.)
- *Complete Orthopedic Services Inc. & Geico Ins. Co.*, AAA Case no. 17-17-1059-1088 (9/3/18) (Rebecca Novack, Arb.)
- *Opus Psychological Services, PC & Geico Ins. Co.*, AAA Case no. 17-17-1070-2125 (10/12/18) (Deepak Sohi, Arb.)

Scheduling of EUO & EUO No-Show

- *NYC Acupuncture, PC & State Farm Fire & Cas. Co.*, AAA Case no. 17-17-1059-6741 (9/6/18) (Matthew Summa, Arb.)
- *Vivid Acupuncture, PC & Liberty Mut. Fire Ins. Co.*, AAA Case no. 17-17-1065-7817 (10/16/18) (Andrew Horn, Arb.)
- *Diagnostic Medicine, PC & Encompass Ins. Co.*, AAA Case no. 17-17-1060-5056 (5/21/18) (Allison Schimel, Arb.)
- *Gentle Hands PT, PC & Geico Ins. Co.*, AAA Case no. 17-17-1078-7799 (11/2/18) (Deepak Sohi, Arb.)

SUM Awards: Failure to Disclose Prior Medical History

- *E.H. & C.H. v. Nationwide Ins. Co.*, AAA Case no. 43 200 S 00613 14 (4/27/15) (Richard Kesnig, Arb.)
- *S.B. & A.G. v. State Farm Ins. Co.*, AAA Case no. 43 200 S 02063 13 (8/15/14) (Jodi Zagoory, Arb.)

Arbitrator Abstracts

GameReady Units & Medical Necessity

Isurply LLC & Allstate Ins. Co., AAA Case no. 17-17-1081-4675
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(8/9/18) (Anthony Kobets, Arb.) The arbitrator addressed multiple claims for durable medical equipment including a GameReady device, which was prescribed after right knee arthroscopic surgery. The claim was denied based upon a peer review report in which



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the peer review doctor found that the right knee surgery was not medically necessary. The arbitrator rejected the peer review doctor's suggestion that the surgery was not medically necessary, as the MRI study revealed chronic change within the knee. The arbitrator provided a lengthy and detailed review of the injured person's medical history in support of his conclusion that the right knee surgery and post-operative medical supplies were medically necessary. The arbitrator determined that the peer review failed to meet respondent's burden of proof with respect to the necessity of the GameReady device. Moreover, the arbitrator found that the prescribing doctor set forth the medical basis for the GameReady system in that it speeds injury recovery and rehabilitation.

OrthoPro Services, Inc. & Geico Ins. Co., AAA Case no. 17-17-1055-0310

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(9/24/18) (Amanda R. Kronin, Arb.) The arbitrator was presented with a claim for rental of a GameReady device prescribed three (3) days post-accident. The peer review doctor opined that the device offers the same benefit as a cold pack and that a course of conservative treatment should have been tried prior to the issuance of the prescription for the device. The arbitrator found that applicant's rebuttal was lacking in the requisite specificity necessary to rebut the peer review. Accordingly, the arbitrator sustained respondent's denial based upon a lack of medical necessity.

Orthocustoms, LLC & Geico Ins. Co., AAA Case no. 17-18-1094-9290

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

(9/16/18) (Yael Aspir, Arb.) The arbitrator was presented with a claim for rental of a GameReady device prescribed subsequent to right shoulder surgery. Respondent denied the claim based upon a peer review report. The arbitrator found that the peer review failed to contain a sufficient medical rationale to justify the denial based upon a lack of medical necessity, as the peer review did not specifically discuss the GameReady device.

OrthoPro Services, Inc. & Geico Ins. Co., AAA Case no. 17-16-1046-8712

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(9/21/18) (Henry Sawits, Arb.) The arbitrator was presented with a claim for rental of a GameReady device prescribed subsequent to left knee surgery. Respondent relied on a peer review report in support of its denial. The peer review doctor asserted that the left knee surgery was not medically necessary. The arbitrator discussed the medical evidence, which contradicted the findings of the peer review doctor and which supported a finding that the underlying surgery was medically necessary. The arbitrator also rejected the peer review as lacking specificity as to the GameReady device, which was not addressed in the peer review.

Pneumatic Compression DVT Devices & Medical Necessity

Princemed Inc. & Liberty Mut. Ins. Co., AAA Case no. 17-17-1076-5494

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(7/12/18) (Greta Vilar, Arb.) Applicant sought reimbursement for a pneumatic compression DVT device prescribed after a right shoulder arthroscopic procedure. The respondent's denial was based on the results of an IME report in which the IME doctor determined that the injured person's right shoulder condition had resolved prior to surgical intervention as well as a peer review report in which the peer review doctor found that the pneumatic compression DVT device was not medically necessary. The arbitrator found that applicant's submission, which included an MRI study of the right shoulder as well as an examination report referencing examination six (6) days after the IME was sufficient to refute the IME doctor's determination that the injured person's condition had resolved. However, the arbitrator agreed with the peer review doctor's determination that the pneumatic



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compression DVT device was not medically necessary. The arbitrator noted that this item is prescribed to prevent blood clot formation and complications that can arise from the onset of deep vein thrombosis, but that the record in this case was insufficient to establish that the injured person was at risk for blood clots due to DVT. Therefore, the claim was denied.

Princemed Inc. & Geico Ins. Co., AAA Case no. 17-17-1061-1070

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

(6/2/18) (Sandra Adelson, Arb.) Applicant sought reimbursement for various items of durable medical equipment, including a pneumatic compression and mechanical DVT prophylaxis cold therapy unit that were prescribed after a right shoulder arthroscopic procedure. The respondent denied the claim based on a peer review report wherein the peer review doctor concluded that there were no complications in the operative report that would provide a basis for this device. The arbitrator noted that the peer review doctor relied in part on an article discussing general risk factors for DVT after shoulder surgeries where there is a history of obesity and thromboembolism. The arbitrator commented that if the peer reviewer had carefully reviewed the medical records, he would have noted that the injured person had a risk factor of obesity. The arbitrator found that the peer review doctor's failure to acknowledge this risk diminished the reliability of the peer review report. The arbitrator reviewed applicant's submission, including the examination reports and letters of necessity and found that the device was medically necessary in that it reduces the risk of clot formation and complications that could arise from the onset of deep vein thrombosis. The arbitrator also found that the examination reports provided a medical basis for the other items prescribed to the injured person post-surgery. The applicant was awarded reimbursement for all of the items prescribed.

MiiSupply, LLC & National Liability & Fire Ins. Co., AAA Case no. 17-16-1048-6668

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(5/21/18) (Steven Greif, Arb.) Applicant sought reimbursement for a pneumatic compression DVT device that was prescribed after a left shoulder arthroscopic procedure. The respondent denied the claim based on a peer review report wherein the peer review doctor found that the surgery was not medically necessary. The peer review doctor opined that the pneumatic compression device was not medically necessary, as the injured person had no history of coagulation disorders, thrombosis, clots, or other conditions that would make the patient a candidate for a postoperative DVT embolism. The peer review doctor also noted that there was no evidence that this device would improve the injured person's prospects after surgery. The arbitrator reviewed the letter of necessity, which stated that the patient was at a higher risk of developing deep venous thrombosis (DVT) due to the type of surgery, combined with risk factors including the inability to ambulate post-surgery. However, the arbitrator noted that the operation was to the shoulder and not the leg. The arbitrator also pointed out that the physician who cleared the injured person for surgery made no mention of any risk factors for DVT. The arbitrator noted that the peer review doctor reviewed pre-operative and intra-operative records, and there was no evidence that the injured party had a problem with blood coagulation. Therefore, the claim was denied.

Ihome Rehab, LLC & American Country Ins. Co., AAA Case no. 17-17-1065-7670

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(3/20/18) (Corinne Pascariu, Arb.) Applicant sought reimbursement for various items of durable medical equipment, including a pneumatic compression device prescribed after a right knee arthroscopic procedure. The respondent denied the claim based on a peer review report in which the peer review doctor made reference to certain medical literature that indicated that a pneumatic compression device is safe, effective, and superior to crushed ice following anterior cruciate ligament surgery and knee arthroplasty. Notwithstanding the reliance on the articles in support of the use of the pneumatic compression device, the peer review doctor concluded that the item was not medically necessary, as an ice pack would serve the same purpose. The peer review doctor further found that the injured person would receive physical therapy and the standard of care for a pneumatic compression



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device after surgery would be to decrease the risk of deep vein thrombosis (DVT). The arbitrator found that the peer review doctor's report failed to meet the burden of persuasion, as the medical literature relied upon by the peer review doctor appeared to support the use of this device. The arbitrator found that the peer review doctor provided no rationale as to why physical therapy would have any bearing on the need for this item and failed to cite to any authority to support the standard of care for prescribing a pneumatic compression device. The applicant was awarded reimbursement for all of the items prescribed.

Generic Peer Reviews & Diagnostic Ultrasound

JMSK Medical Diagnostic, PC & Allstate Ins. Co., AAA Case no. 17-17-1071-1436
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(10/14/18) (Pamela Hirschhorn, Arb.) The arbitrator was presented with a claim for ultrasound studies of the lumbar spine that had been timely denied based upon a generic peer review. Given that the peer review report had been prepared by the peer review doctor prior to the date services were rendered in this case and involved no review of the injured person's medical reports, the arbitrator concluded that the peer review report was insufficient, as it failed to provide specifics of the claim.

JMSK Medical Diagnostic, PC & Allstate Ins. Co., AAA Case no. 17-17-1063-3591
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(7/22/18) (Paul Keenan, Arb.) In assessing the insurance carrier's defense of lack of medical necessity, the arbitrator considered applicant attorney's argument that the peer review report was insufficient because it was written four (4) years prior to the services at issue and was not case-related to the specific assignor or date of service. However, the arbitrator found that the argument was not persuasive. The arbitrator noted that the peer review report contained citation to authorities that opined that diagnostic ultrasound is never medically necessary. Since applicant failed to submit any documentation sufficient to refute the opinion of the peer review doctor, the denial was upheld.

JMSK Medical Diagnostic, PC & Allstate Ins. Co., AAA Case no. 99-17-1063-3591
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(10/23/18) (Robert Trestman, Master Arb.) Applicant appealed the award of arbitrator Keenan upholding the denial of diagnostic ultrasound based upon a peer review report that was not case-related to the specific assignor or date of service. While acknowledging that another trier of fact may have determined otherwise, the master arbitrator concluded that the lower arbitrator's determination appeared to be rational and based on the evidentiary record, notwithstanding the lower arbitrator's finding that the peer review doctor did not review the medical records pertinent to the injured person. Accordingly, arbitrator Keenan's award was affirmed.

JMSK Medical Diagnostic, PC & Allstate Ins. Co., AAA Case no. 17-17-1063-3572
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(9/22/18) (Michael Korshin, Arb.) The claim for diagnostic ultrasound was denied based upon a peer review report prepared several years prior to the services performed. The arbitrator rejected respondent's lack of medical necessity defense as it was based upon a "generalized statement" as to the efficacy of ultrasound from April 2009, over six (6) years before the services were provided. The arbitrator found that the peer review report failed to establish a factual basis and medical rationale for denying the disputed services.



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Sustained Acoustic Medicine

ISupply Medical Inc. & Allstate County Mut. Ins. Co., AAA Case no. 17-17-1072-4770
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(10/24/18) (Ellen Weisman, Arb.) The applicant sought reimbursement for a sustained acoustic medicine (SAM) device with ultrasound coupling patches. The claim was denied based upon a lack of medical necessity defense premised on a peer review report. The peer review doctor reviewed the relevant medical reports and concluded that the SAM device and ultrasound coupling patches were not medically necessary, as there were no objective clinical findings that substantiated the need for this device. The peer review doctor opined that the injured person's symptoms were typical of those seen in patients who have sustained soft tissue injuries due to trauma and that they often resolve with conservative treatment. Applicant submitted a rebuttal prepared by the treating physician, who stated that he prescribed the SAM system to the injured person as part of the conservative care regimen. The rebuttal referenced that the SAM system has been proven to enhance the recovery process, reduce inflammation, and mitigate pain. The SAM system can also reduce dependence on non-steroidal anti-inflammatory drugs for pain control and can reduce the need for steroid injections. The rebuttal referenced that the SAM system was not concurrent or excessive, as it is intended to be used along with other conservative measures and was medically appropriate and effective in this case. The arbitrator reviewed the record and noted that the injured person presented with mild to moderate soft tissue injuries following the motor vehicle accident. The injured person was placed on a comprehensive regimen of office-based conservative treatment modalities, including chiropractic care, acupuncture, and physical therapy as confirmed by the treatment notes in all disciplines. The arbitrator found that the rebuttal was not persuasive and that the SAM system was not medically necessary, as the injured person was already receiving concurrent conservative care.

Reliable Therapy Equipment Inc. & Allstate Fire & Cas. Ins. Co., AAA Case no. 17-17-1080-5616
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(6/8/18) (Michael Korshin, Arb.) The arbitrator addressed whether applicant was entitled to reimbursement for sustained acoustic medicine (SAM) with coupling patches. The claim was denied by respondent based upon a peer review report. The arbitrator found that the peer review report was unpersuasive, as the peer review doctor failed to engage in any meaningful medical assessment establishing a lack of medical necessity. Although the peer review doctor opined that the use of ultrasound at home is duplicative of in-office physical therapy treatment, the arbitrator found that the peer review doctor failed to adequately support this contention by showing a deviation from standard of care. The arbitrator also noted that the rebuttal prepared by the treating physician set forth that SAM was prescribed to supplement in-office treatment. Since the peer review failed to set forth a factual basis and medical rationale for the claim's rejection, applicant was awarded reimbursement for the SAM device provided.

Reliable Therapy Supply Inc. & Geico Ins. Co., AAA Case no. 17-17-1082-4589
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(9/17/18) (John Kannengieser, Arb.) The applicant sought reimbursement for a sustained acoustic medicine device (SAM) with coupling patches. The claim was denied by respondent based on a lack of medical necessity defense premised on a peer review report. The peer review doctor opined that there should have been a trial of SAM in the office setting while under appropriate supervision prior to the prescribing of this item. The peer review doctor also noted that SAM is not typical of chiropractic practice. Applicant submitted a rebuttal to the peer review that referenced that SAM was medically necessary, as there was a lack of desirable results from conservative treatment. The rebuttal also referenced that the SAM unit and coupling patches were prescribed in conjunction with office-based treatment and that it is up to the clinician to decide whether the device is appropriate. The rebuttal doctor opined that there was no reason to perform a trial of SAM in the office setting prior to prescribing it. The arbitrator



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considered all of the evidence and found that without a trial of SAM in the office setting, there was no evidence that the device would be beneficial for the patient and thus the device was not medically necessary.

Policy Cancellation

New York Surgery Center of Queens & New South Ins. Co., AAA Case no. 17-17-1058-7137

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(8/11/18) (Lisa Abrams, Arb.) Respondent maintained that the policy was properly terminated prior to the subject motor vehicle accident. Respondent submitted the notice of cancellation dated July 13, 2016, as well as a postmarked certificate of mailing to establish that it complied with the termination notice requirements of VTL §313. The notice reflected a cancellation effective date of August 5, 2016, which complied with the permitted 15-day notice requirement. The arbitrator cited to *Lumbermens Mut. Cas. Co. v. Medina*, 114 A.D.2d 959 (2d Dept. 1985), noting that a certificate of mailing prepared by the insurer and stamped by the post office is conclusive proof of compliance with the termination notice mailing requirements under VTL §313. Based on the foregoing, the arbitrator found that respondent met its burden of establishing that the policy was properly terminated prior to the subject motor vehicle accident.

New Age Acupuncture, PC & National Liability & Fire Ins. Co., AAA Case no. 17-16-1039-4278

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

(6/18/18) (Phyllis Saxe, Arb.) The arbitrator addressed whether respondent duly cancelled the subject policy in accordance with Vehicle and Traffic Law Sec. 313(2), which requires that the insurer file a copy of the notice of termination with the Department of Motor Vehicles (DMV) within 30 days of the effective date of the termination. As proof of notice of cancellation, respondent offered an underwriting affidavit and a document, which it claimed was downloaded from the internet, entitled "Dial in Web Application." Applicant argued that respondent failed to sufficiently demonstrate that it filed a copy of the notice of termination with the Department of Motor Vehicles within 30 days of the effective date of termination pursuant to VTL 313(2). See, also, *Advanced Med. Care PC v. Allstate Ins. Co.*, 50 Misc.3d 137(A), 2016 N.Y. Slip Op 50130(U) (App Term 9th and 10th Jud. Dists. 2016). The arbitrator found that respondent failed to meet its burden, as the affidavit failed to mention any procedure for contacting the DMV and a close reading of the affidavit failed to advise whether the web page that it supplied was the acceptable procedure for giving the DMV notice of policy cancellation.

Precision Medical Diagnostic of NY & Geico Ins. Co., AAA Case no. 17-17-1062-3941

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(11/6/18) (Eva Gaspari, Arb.) The arbitrator addressed policy cancellation as against an assignor who was not a listed policy holder or member of the insured's household. The arbitrator found in favor of respondent, as the evidence, which included an affidavit, testimony, and a Motor Vehicle Report (MVR) established that cancellation of the subject policy was submitted by the respondent and received by the Department of Motor Vehicles on April 8, 2011, advising that the policy was cancelled effective April 6, 2011, pursuant to VTL §313 (3).

Complete Orthopedic Services Inc. & Geico Ins. Co., AAA Case no. 17-17-1059-1088

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(9/3/18) (Rebecca Novack, Arb.) The arbitrator addressed whether there was a lack of coverage due to the cancellation of the policy. Applicant conceded that the policy had been cancelled but argued that on June 17, 2016, when the service at issue had been performed, the policy was in effect. In opposition, respondent contended that the policy was cancelled on June 8, 2016,



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prior to the date and time of the accident and therefore there was no coverage in effect at the time of the accident on June 13, 2016. It was further noted that the policy was later reissued but that there was a lapse in coverage on the date of the loss. The arbitrator determined that the assignor was not an eligible injured person because the insurance policy was not in effect at the time of the subject accident.

Opus Psychological Services, PC & Geico Ins. Co., AAA Case no. 17-17-1070-2125
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(10/12/18) (Deepak Sohi, Arb.) The arbitrator determined that the policy declaration page, termination notice, and proof of mailing were sufficient evidence to establish *prima facie*, that respondent timely and properly terminated the policy in accordance with Vehicle and Traffic Law Sec. 313. Having found that respondent met its burden, the arbitrator cited to *Queens Medical Supply, Inc. v. New York Central Mut. Fire Ins. Co.*, 35 Misc.3d 146(A), 954 NYS2d 761 (Table) 2012 NY Slip Op 51060(U) (App Term 2d, 11th & 13th Jud. Dists. 2012) and shifted the burden to applicant to show that the cancellation was not in accordance with the statutory requirements or that a valid policy of insurance for the claim existed. As applicant failed to come forward with any such proof, the arbitrator denied applicant's claim.

Scheduling of EUO & EUO No-Show

NYC Acupuncture, PC & State Farm Fire & Cas. Co., AAA Case no. 17-17-1059-6741
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(9/6/18) (Matthew Summa, Arb.) Applicant sought reimbursement for acupuncture treatment. With regard to the majority of the bills, respondent asserted that the assignor breached a condition precedent to coverage by failing to appear for two (2) EUOs. The arbitrator noted that the insurer must demonstrate both the timeliness of its verification requests and its denial of claim forms. See 11 NYCRR §65-3.5 (b), §65-3.6 (b); See, also, *Westchester Medical Center v. Lincoln General Ins. Co.*, 60 A.D.3d 1045 (2d Dept. 2009). The arbitrator found that with regard to a portion of the claim, the denials could not be upheld as the initial EUO scheduling letter was sent more than 30 days after receipt of the respective bills and thus respondent failed to toll the 30-day period within which it was required to pay or deny the claim. See, *Neptune Medical Care, PC v. Ameriprise Auto & Home Ins.*, 48 Misc.3d 139(A), 2015 N.Y. Slip Op. 51220(U) (App. Term 2nd, 11th and 13th Jud. Dists. 2015).

Vivid Acupuncture, PC & Liberty Mut. Fire Ins. Co., AAA Case no. 17-17-1065-7817
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(10/16/18) (Andrew Horn, Arb.) Applicant sought reimbursement for acupuncture treatment. Respondent denied the claim based upon a policy violation in that the assignor failed to appear for scheduled EUOs on January 12, 2016 and February 4, 2016. The arbitrator found that the first and second EUO scheduling letters were not mailed to the correct address, as they were not mailed to the address referenced in the bills or police accident report. Respondent failed to provide a basis for mailing the EUO letters to a different address, and there was no proof to support respondent's allegation that an additional mailing had been sent to the correct address or to the assignor's attorney. Although a third EUO letter dated March 2, 2016, for an EUO scheduled for March 17, 2016, was mailed to the correct address, the arbitrator found that the EUO request was not made in accordance with the time frame pursuant to 11 NYCRR §65-3.5(b). The arbitrator also found that since the prior EUO notices were not sent to the correct address, respondent would be unable to establish its defense that the assignor failed to appear for the first two (2) EUOs. The arbitrator found that the denials failed to reference the assignor's alleged failure to appear for EUO scheduled for March 17, 2016, and thus applicant was not sufficiently informed of the basis for the denial. See, *Unitrin Advantage Ins. Co. v. All of NY, Inc.*, 158 A.D.3d 449 (1st Dept. 2018). Although respondent issued delay letters to applicant, the arbitrator found that these delay letters,



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which did not request any information but merely advised of the delay in the processing of the claim, could not be relied upon to toll the 30-day claim determination period.

Diagnostic Medicine, PC & Encompass Ins. Co., AAA Case no. 17-17-1060-5056
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(5/21/18) (Allison Schimel, Arb.) Applicant sought reimbursement for EMG/NCV testing. The claim was denied based on the failure of the provider to appear for scheduled EUOs. Applicant's counsel argued that pursuant to *Neptune Medical Care, P.C. v. Ameriprise Auto & Home Ins.*, 48 Misc.3d 139(A), 2015 N.Y. Slip Op. 51220(U) (App. Term 2nd, 11th and 13th Jud. Dists. 2015), the EUO of the provider was improperly scheduled, since the EUO notice was issued more than 30 days after receipt of the claim. The arbitrator was not persuaded by applicant's argument and found that respondent's handling of the claim was proper. The arbitrator noted that in *Neptune Medical Care, P.C. v. Ameriprise, supra*, the court found that even if the insurer tolled the 30-day period within which it was required to pay or deny a claim, the regulations do not provide that such a toll grants additional opportunities to make requests for verification that would otherwise be untimely. However, in the instant case, the arbitrator found that the EUO of the provider was requested within 15 business days of completion of the EUO of the assignor and that the request for EUO was based on the assignor's testimony that some of the billed treatment was never performed. In *Sure Way NY, Inc. v. Travelers Ins. Co.*, 56 Misc.3d 289, 2016 NY Slip Op 26413 (Civ. Ct. Kings Co. 2016), when an insurer obtains new information from an EUO of the assignor, which gives it reason to conduct an EUO of the assignee provider, the insurer must send the EUO request to the assignee within 15 business days of the date the EUO of the assignor was held. The court reasoned that the decision to conduct the EUO of the assignee was based upon new information, causing this to be a new verification request as opposed to a follow-up request upon a party who has not responded or did not respond in full to the initial request for information. See, also *Quality Health Products, Inc. v. Auto One Ins. Co.*, 20 Misc.3d 136(A), 867 N.Y.S.2d 377 (Table), 2008 NY Slip Op. 51530(U) (App Term 2nd and 11th Jud. Dists. 2008). Based upon the foregoing case law, the arbitrator found that the EUO was properly scheduled and upheld respondent's defense.

Gentle Hands PT, PC & Geico Ins. Co., AAA Case no. 17-17-1078-7799
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(11/2/18) (Deepak Sohi, Arb.) Applicant sought reimbursement for physical therapy treatment. Respondent denied the claim based upon a policy violation, as the provider failed to appear for scheduled EUOs. Applicant's counsel cited to *Neptune Medical Care, PC v. Ameriprise Auto & Home Ins.*, 48 Misc.3d 139(A), 2015 N.Y. Slip Op. 51220(U) (App. Term 2nd, 11th and 13th Jud. Dists. 2015) in support of its position that respondent's defense was not established, as the initial EUO letter was not sent within 15 business days of receipt of the bill and that respondent failed to schedule the examination to be held within 30 calendar days from the receipt of the bill. Respondent's counsel argued that *Neptune Medical Care, PC v. Ameriprise, supra*, merely advises that the EUO request be made within 15 business days and that there is no requirement that the EUO must be held within 30 calendar days from the receipt of the bill. Respondent cited to *Eagle Surgical Supply, Inc. v. Progressive Cas. Ins. Co.*, 21 Misc.3d 49, 871 N.Y.S.2d 580 (App. Term 2nd and 11th Jud. Dists. 2008) in support of its position that the scheduling of the EUO was reasonable. The arbitrator found respondent's argument persuasive as the initial EUO letter was sent within 15 business days of receipt of the bill. With regard to the scheduling of EUO, the arbitrator found that applicant was relying on an outdated version of the no-fault regulations. See, 11 NYCRR §65-3.5 (d). The arbitrator found that pursuant to the current regulation, if the additional verification required by the insurer is a medical examination, the insurer shall schedule the examination to be held within 30 calendar days from the date of receipt of the prescribed verification forms. Since the scheduling of EUOs was removed from 3.5 (d), the arbitrator found that the scheduling of the EUO was reasonable. See, also, *Eagle Surgical Supply, Inc. v. Progressive, supra*. Although applicant sent an objection letter requesting specific objective justification for the EUO request, the arbitrator found that respondent's proof, which included an SIU affidavit, provided a reasonable basis for the EUO requested.



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SUM Awards: Failure to Disclose Prior Medical History*E.H. & C.H. v. Nationwide Ins. Co.*, AAA Case no. 43 200 S 00613 14 (43-200-000613-14)[Sum Award Search](#)

(4/27/15) (Richard Kesnig, Arb.) The accident occurred on December 2, 2011. Claimant, C.H. did not testify at the hearing, and counsel advised that she had dropped her claim. Claimant, E.H. was standing on the sidewalk when a car went onto the sidewalk and struck him. The impact caused his back and head to hit the windshield and he was thrown over the vehicle. E.H. was taken to the hospital and was seen in the emergency room where blood work was performed. A CT scan of the neck, chest, and abdomen was also performed, and no abnormalities were noted. Thereafter, on December 13, 2011, E.H. was examined by an orthopedist with complaints of pain to the cervical spine, lumbar spine, elbows, knees, and shoulders. A lumbar spine MRI showed degenerative disc changes from L2-3 through L5-S1 without significant spinal stenosis. A right knee MRI showed a large tear of the posterior horn of the medial meniscus. An MRI of the right shoulder showed a near full thickness subscapularis tendon tear and a degenerative tear of the anterior-inferior labrum. An MRI of the cervical spine showed a C3-4 small central and right sided disc protrusion, moderate right neural foraminal stenosis at C4-5, bilateral neural foraminal stenosis at C5-6 with a right parasagittal disc herniation abutting the spinal cord and mild central canal, as well as severe bilateral neural foraminal stenosis at C6-7. E.H. subsequently received treatment from an orthopedist and pain management specialist. However, as a result of Hurricane Sandy, E.H. lost his home and could not treat for a two-year period. In 2014, E.H. was seen by an orthopedist, who affirmed that E.H. had suffered causally related injuries to his lumbar, thoracic, and cervical spine regions, right elbow, both knees, and both shoulders. Surgery was recommended for both his knees and shoulders, but the surgery was delayed pending his weight loss. Respondent submitted the report of an examining orthopedist, who determined that there were no specific findings indicating the presence of an ongoing post-traumatic neurologic/orthopedic condition that resulted in impairment of function at any level. However, E.H. testified regarding his inability to perform certain activities of daily living since the accident. E.H. acknowledged that he had a prior workers' compensation case as a result of a "twisted" knee and left shoulder injury but indicated that he had been asymptomatic for eight (8) years since that injury. On cross-examination, E.H. was questioned regarding prior accidents, which included accidents in 1996, 2000 and 2003, in which he injured his back and an accident in 2001, in which he injured his right knee. As a result of the accident that occurred in 2003, E.H. also sustained a left shoulder injury. All of these accidents resulted in E.H. receiving monetary compensation. As a result of the instant accident, E.H. complained of injury to the neck, back, elbow, shoulders, and knees. Given his early treatment and the nature of the regimen undertaken, the arbitrator found that claimant, E.H. suffered a causally related significant limitation of the use of those parts of his body such that he satisfied the threshold requirement of Section 5102 of the Insurance Law, which identifies a "serious injury." It was also noted that it was likely that the claimant's injuries were exacerbations of a prior condition. The arbitrator concluded that it was likely that the aforementioned two-year gap in treatment was due as much to the claimant's familiarity with a long-standing condition as it was to the effects of Hurricane Sandy. The arbitrator found that the subject trauma was responsible for causing at least a portion of the claimed maladies and that the pain, discomfort, and disability merited significant compensation. The claimant, E.H. was awarded the total sum of \$160,000.00 as compensation for his accident-related injuries. As this amount was subject to a setoff of \$25,000.00 (representing payment by the carrier for the underinsured tortfeasor) the net award was \$135,000.00.

S.B. & A.G. v. State Farm Ins. Co., AAA Case no. 43 200 S 02063 13 (43-200-002063-13)[Sum Award Search](#)

(8/15/14) (Jodi Zagoory, Arb.) The claimants, S.B. and A.G., claimed to have been injured in an accident that occurred on October 4, 2011. According to the police accident report, claimant S.B. was driving her vehicle when it was struck on the front left side by an unidentified car. S.B. testified that the collision caused her car to flip onto its roof. S.B. lost consciousness as a result of the accident. She was taken by ambulance from the accident scene to the hospital where she was treated in the emergency room.



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CT scans of the head and cervical spine were performed with no abnormalities reported. According to records submitted by respondent, S.B. suffered prior injuries to her lower back and both knees in an accident that occurred in 2009. S.B. sustained injury to her right shoulder, right knee, and neck in a prior accident that occurred in 2010. Two (2) days after the instant accident, S.B. sought treatment at a medical facility for complaints of pain to her neck, upper back, lower back, right shoulder, and right knee. She was also complaining of headaches, dizziness, nausea, nervousness, anxiety, chest pain, abdomen pain, and difficulty breathing. Examination of the cervical, thoracic and lumbar spines, and right knee reportedly revealed some positive objective clinical findings. However, the examination of the shoulders was completely normal. S.B. did not advise the examining doctor about her prior injuries. The diagnoses were cervical spine sprain/strain, myospasm, thoracic sprain/strain, and derangement of both knees. She was prescribed physical therapy and therapeutic injections. It was recommended that she consult with a chiropractor, acupuncturist, and a pain management specialist. MRI studies were ordered. An MRI study of the knee showed an anterior cruciate ligament sprain, a medial collateral ligamentous strain, and patellar tendinosis/tendinopathy associated with some edema anteriorly in the surrounding soft tissues. An MRI study of the cervical spine showed a subligamentous disc herniation at C3-4 with cord abutment that extended slightly on the right and encroached into the right anterior recess and posterior disc bulges from C4-5 through C6-7 with cord abutment at C4-5 and C5-6. An MRI study of the lumbar spine showed a posterior bulging disc at L4-L5 with reversal of the lumbar lordosis, a transitional disc at L5-S1, and right lumbar convexity. Physical therapy was performed from October 6, 2011 through May 15, 2012. On November 18, 2011, S.B. consulted with an orthopedist for right knee pain. Although the medical report noted that there was no history of a knee injury, the records submitted by respondent indicated that S.B. sustained a prior injury to her right knee. It was also noted that S.B. did not make any complaints regarding her right knee while in the emergency room immediately following the instant accident. The orthopedist diagnosed a "possible lateral meniscus tear." On December 9, 2011, S.B. consulted with an orthopedic surgeon with complaints of right knee pain. The surgeon noted that the MRI suggested the possibility of a lateral meniscal tear, but that the patient did not have pain in that area. S.B. was diagnosed with "right jumper's knee," and physical therapy was prescribed. On February 29, 2012, S.B. consulted with a pain management specialist for lower back pain. S.B. did not advise the pain management specialist of her prior lower back injury. Thus, based on a physical examination, an incomplete/inaccurate medical history, and a review of the report of the lumbar MRI study, S.B. was diagnosed with lumbosacral radiculopathy as well as lumbar disc displacement, and epidural steroid injections were prescribed. The pain management specialist recommended that S.B. undergo a lumbar discography and L4-5 discectomy. The procedure was performed on May 21, 2012. S.B. had no medical treatment after the surgery, and no follow-up medical examinations were performed. S.B. testified that at the time of the accident she had been employed as a home health aide for three (3) years, but that she was unable to return to work for one (1) year due to her alleged accident-related injuries. It was noted that S.B. currently drives a livery car on weekends. S.B. claimed that her lower back still bothers her and that as a result, she is unable to lift her 4-year-old son and cannot bend to do the laundry or make her bed.

The claimant A.G., was seated in the front passenger seat when the accident occurred. As a result of the accident, he struck his face on something in the vehicle and felt immediate pain in his entire body. A.G. was taken by ambulance from the accident scene to the hospital where he was treated in the emergency room. A.G. complained of pain in his head, neck, and back. A CT scan of the head was performed, which did not reveal an acute intracranial hemorrhage, mass effect, or midline shift. A CT scan of cervical spine revealed two anterior osteophytes at C4 and C5 and unremarkable prevertebral soft tissues. A.G. did not advise the hospital personnel that he had previously sustained injury to his neck and lower back. According to records submitted by respondent, A.G. sustained injury to his left knee, lower back, left shoulder, and neck in a prior accident that occurred in 2009. A.G. testified at the arbitration hearing that his prior injury was only to his lower back. Following the instant accident, A.G. sought further medical treatment for headaches, dizziness, nausea, vomiting, nervousness, anxiety, chest pain, difficulty breathing, neck pain, tingling sensation in both arms, upper back pain, lower back pain, and face pain. In an initial evaluation report, it was noted that A.G. had a bruise on the left side of his head and a bump near his left eye. A.G. failed to advise the examining doctor about his prior injuries. Examination of the cervical spine was normal. Examination of the thoracic spine revealed muscle spasm and tenderness. Examination of the lumbar spine revealed minimally decreased range of motion, muscle spasm, and tenderness. Examinations



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of the upper and lower extremities and both hips were normal. Physical therapy and therapeutic injections were prescribed, and consultations with a chiropractor, acupuncturist, and pain management specialist were recommended. An MRI study of the right shoulder showed tendinosis. Notwithstanding a normal examination of the cervical spine, an MRI of the cervical spine was ordered. The MRI showed a disc herniation at C3-4 with a radial annular tear that abutted the right ventral margin of the spinal cord and posterior subligamentous disc herniations at C4-5 and C5-6 that impressed on the ventral cord with a radial annular tear at C4-5 and an anterior disc extension at C4-5. A.G. was seen in orthopedic consultation on October 14, 2011. The orthopedist noted that A.G. had received multiple trigger-point injections and had started physical therapy, acupuncture, and chiropractic care but reported that his symptoms were worsening in his neck and both shoulders. A.G. failed to disclose his prior medical history to this doctor as well. The doctor reported positive objective clinical findings throughout the spine and diagnosed A.G. with cervical sprain, right cervical radiculopathy, right upper extremity weakness, and lumbar sprain. It was noted that the clinical findings and diagnoses conflicted with the examination performed on October 6, 2011. The doctor administered a cervical epidural steroid injection and prescribed Mobic. A.G. was prescribed pain relief medication, and the orthopedist discussed surgical options. A.G. consulted with a pain management specialist on February 17, 2012, who noted positive objective clinical findings in the lumbar spine, right shoulder, and cervical spine. A lumbar epidural steroid injection was administered. It was noted that A.G. failed to disclose his prior medical history to this doctor as well. A.G. returned to the office on March 16, 2012, at which time there were decreased ranges of motion. Thereafter, on May 21, 2012, A.G. underwent a discectomy at L4-5 and L5-S1. There was no indication that A.G. sought further medical attention. Physical therapy was performed until May 14, 2012. A.G. worked as a taxi driver at the time of the subject accident and missed nine (9) months of work due to his alleged accident-related injuries. A.G. claimed to have continuing pain in his lower back and as a result was unable to play soccer or lift his young children. With respect to both claims, the arbitrator found that neither claimant had demonstrated by a fair preponderance of credible evidence that they had sustained injuries in the subject accident that met the statutory threshold requirement. The arbitrator found that a review of all of the medical records revealed inconsistent physical complaints by each of the claimants as well as conflicting clinical findings by all of the examining doctors. In addition, the reported diagnostic test results for each of the claimants were not correlated with significant positive objective clinical findings. Although the records reflected that both of the claimants underwent epidural injections and lumbar discectomies, the arbitrator found that these procedures were not medically justified by the reported clinical findings. The arbitrator also noted that neither claimant disclosed their prior medical histories with their treating doctors, and as a result, their doctors did not consider the prior injuries or establish a basis for distinguishing between the prior injuries and the injuries allegedly sustained in the instant accident. Without factoring the prior injuries into their evaluations, the arbitrator found that the opinions of the treating doctors as to causal relationship to the subject accident had no probative value--especially where both of the claimants suffered prior similar injuries within a few years before the subject accident. In addition, the arbitrator noted that with regard to both claimants, the treatments and medical reports were essentially the same, which called into question the credibility of the records reviewed. Therefore, the arbitrator's award was in favor of respondent.

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