



AAA® INSURANCE REPORTER

2019 AAA INSURANCE REPORTER / ISSUE 1

Thank You for Your Feedback!

The AAA would like to thank our valued customers for your feedback in response to our 2018 Client Satisfaction Surveys. Your feedback is important to us and serves as an indicator of how we are doing.

We heard you and want you to know that we are taking measures to address several of the challenges our customers reported.

Online Settlement Tool

One area of concern for users involved the recent update to the Online Settlement Tool. In consultation with the Department of Financial Services (DFS), we will be implementing updates to the tool to make it more user friendly.

Hearing Timeframes

Customers also expressed concerns regarding the increased timeframes to a hearing. We are hopeful that the DFS will appoint additional arbitrators to join the no-fault panel in 2019 to meet the ever-increasing volume. We are also looking at other alternatives to maximize the efficiency of the overall process.

Just one example highlighting our approach to better meet the needs of our customers is the 2018 institution of a new adjournment process to maximize hearing slots. The implementation of this new scheduling process resulted in a sizable reduction in the number of lost hearing slots caused by adjournments.

We continue to work to improve the process and remain open to suggestions from the user community. Customers can provide direct feedback by sending an email to NYSInsurance@adr.org.

We look forward to hearing from you and working together in 2019!

Working toward Having Your Case Resolved with One Hearing?

Customers often report that the timeframe from filing to a first-time hearing can be quite extensive and that cases can take one, two, if not three hearings to reach final resolution.

In investigating this issue, we have found that the lack of party preparedness is a factor that greatly contributes to the delay in scheduling. To this end, it is crucial that the claims and issues are presented in a logical manner that ensures that all points are raised, preserved, and ultimately resolved. The growing complexity of cases and the time constraints of hearings necessitate the issues and evidence to be well organized and clearly presented. This furthers the interest of all participants—applicants, respondents, the AAA, and the arbitrators—to achieve the prompt resolution of claims in a forum that is efficient and fair.

Timeliness is essential for all parties involved. It is important to be on time and be familiar with all document submissions as well as the issues that may come up at the hearing. The submission of late documents after the compilation period leads to adjournments and continuances, further delaying the final resolution of the case.

We encourage all parties to keep these best practices in mind when preparing their cases to go before the arbitrator. This will only help to lead to a more timely resolution of your cases!



AAA® INSURANCE REPORTER

2019 AAA INSURANCE REPORTER / ISSUE 1

NYS No-Fault Regulation 68 Corner

Written Submission Hearings

Occasionally parties ask why their cases went forward on written submission when they did not request a written-submission hearing.

Upon receipt of an inquiry of this nature, an AAA representative refers the party to the no-fault regulation, which identifies the requirements and the authority of the arbitrator to decide a case on the basis of written submission.

65-4.5 No-Fault Arbitration forum procedure. (a) Notice. *If a dispute has been transmitted for arbitration by the Insurance Department or the conciliation center, the parties will be notified by the designated organization, in writing, that the dispute will be resolved by arbitration. At the arbitrator's discretion, if the dispute involves an amount less than \$2,000, the parties shall be notified that the dispute shall be resolved on the basis of written submissions of the parties. All such submissions shall be received by the designated organization within 30 calendar days of the date of mailing of the notice. No oral arguments will be permitted, unless the arbitrator determines that additional evidence or testimony is necessary. In order to facilitate receipt of evidence by the designated organization, the parties may forward their submissions prior to receipt of the above notification.*

In compliance with the regulation, parties will be notified by the AAA if their case has been designated by the arbitrator to be resolved on the basis of written submission.

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

Compound Pain Medication & Medical Necessity

- *Natures First Pharmacy Corp. & Geico Ins. Co.*, AAA Case no. 17-17-1061-7934 (8/7/18) (Glen Wiener, Arb.)
- *Natures First Pharmacy Corp. & Allstate Ins. Co.*, AAA Case no. 17-17-1062-3708 (9/8/18) (Victor Moritz, Arb.)
- *Sunquest Pharmaceuticals, Inc. & Progressive Ins. Co.*, AAA Case no. 17-16-1033-2857 (6/2/17) (Victor Mortiz, Arb.)
- *Gallo's Pharmacy & Allstate Ins. Co.*, AAA Case no. 17-16-1045-6478 (11/12/18) (Aaron Maslow, Arb.)
- *Lakeview Pharmacy & Surgical & Progressive Ins. Co.*, AAA Case no. 17-15-1024-4690 (9/13/16) (Aaron Maslow, Arb.)
- *Shalom's Pharmacy, Inc. & Allstate Fire & Cas. Ins. Co.*, AAA Case no. 17-17-1065-8050 (1/31/19) (Maryann Mirabelli, Arb.)



AAA® INSURANCE REPORTER

2019 AAA INSURANCE REPORTER / ISSUE 1

Compound Pain Medication & Fee Schedule

- *Sunquest Pharmaceuticals, Inc. & State Farm Mut. Automobile Ins. Co.*, AAA Case no. 17-17-1057-7584 (3/11/18) (Drew M. Gewuerz, Arb.)
- *RX For You Corp. & State Farm Mut. Automobile Ins. Co.*, AAA Case no. 17-16-1043-2086 (6/26/17) (Drew M. Gewuerz, Arb.)
- *Friendly RX Inc. DBA Friendly RX Pharmacy & Progressive Cas. Ins. Co.*, AAA Case no. 17-17-1079-3125 (12/10/18) (Pauline Molesso, Arb.)

Medical Supplies & Licensing by N.Y.C. Department of Consumer Affairs

- *Empi Inc. & Geico Ins. Co.*, AAA Case no. 17-15-1005-2382 (3/21/17) (Gillian Brown, Arb.)
- *AVA Custom Supply, Inc. & Progressive Cas. Ins. Co.*, AAA Case no. 17-18-1084-1778 (12/17/18) (Paul Weidenbaum, Arb.)
- *AVA Custom Supply, Inc. & Progressive Cas. Ins. Co.*, AAA Case no. 17-17-1066-3173 (10/5/18) (Susan Mandiberg, Arb.)
- *Brooklyn Medical Supply & Progressive Cas. Ins. Co.*, AAA Case no. 17-17-1060-1510 (3/20/18) (Heidi Obiajulu, Arb.)

Medical Supplies & Medical Necessity

- *Sheepshead Bay Medical Supplies, Inc. & Geico Ins. Co.*, AAA Case no. 17-17-1070-2828 (1/31/19) (Drew M. Gewuerz, Arb.)
- *Ba2Ro Inc. & Geico Ins. Co.*, AAA Case no. 17-16-1038-8660 (9/15/17) (Ioannis Gloumis, Arb.)
- *OrthoPro Services, Inc. & First Liberty Ins. Corp.*, AAA Case no. 17-17-1054-0862 (10/25/18) (Alison Berdnik, Arb.)

Medical Supplies & Market Research

- *Isurply, LLC & Travelers Personal Ins. Co.*, AAA Case no. 17-18-1086-4040 (1/23/19) (Eva Gaspari, Arb.)
- *Isurply, LLC & St. Paul Fire & Marine Ins. Co.*, AAA Case no. 17-17-1054-5365 (11/27/17) (Teresa Girolamo, Arb.), aff'd AAA Assessment no. 99-17-1054-5365 (4/2/18) (Peter J. Merani, Master Arb.)
- *AllBody Healing Supplies, LLC & St. Paul Travelers Ins. Co.*, AAA Case no. 17-17-1071-1950 (6/6/18) (Shawn Kelleher, Arb.)

SUM Awards: Scarring & Serious Injury

- *A.J. & National General Ins. Co.*, AAA Case no. 43-20-1500-1288 (4/20/16) (Howard Bushin, Arb.)
- *E.F. & Farmers Ins. Group*, AAA Case no. 01-16-0001-6619 (3/28/18) (Jodi Zagoory, Arb.)

Arbitrator Abstracts

Compound Pain Medication & Medical Necessity

Natures First Pharmacy Corp. & Geico Ins. Co., AAA Case no. 17-17-1061-7934
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(8/7/18) (Glen Wiener, Arb.) The insurer denied the claim for compound pain cream based upon a peer review conducted by a board-certified neurologist. The peer review doctor cited to the New York State Workers' Compensation Board Mid and Low Back



AAA® INSURANCE REPORTER

2019 AAA INSURANCE REPORTER / ISSUE 1

Injury Medical Treatment Guidelines and the New York State Neck Injury Medical Treatment Guidelines, which state that compound creams are not medically necessary. While the arbitrator acknowledged that these guidelines are not controlling in no-fault cases, he nonetheless found that they are highly persuasive as to the generally accepted medical practice for the treatment of neck, back, and knee injuries. The arbitrator also noted that the Federal Drug Administration (FDA) has advised that compound drugs are not FDA-approved and may have health risks. Although the prescribing neurologist cited to certain articles supporting the efficacy and benefits of compounding creams, the arbitrator found that they were insufficient to support the routine use of those creams. Accordingly, the claim for compound pain cream was denied.

Natures First Pharmacy Corp. & Allstate Ins. Co., AAA Case no. 17-17-1062-3708

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

(9/8/18) (Victor Moritz, Arb.) The claim for compound topical pain medication was denied based upon a peer review. The peer review doctor cited to the New York State Workers' Compensation Board Mid and Low Back Injury Medical Treatment Guidelines in support of his position that the topical pain medication was not medically necessary. The peer review doctor also asserted that topical medication is warranted only when a patient is unable to use conventional oral medications. The provider's rebuttal disputed that it was necessary to determine that a patient cannot utilize oral medications and referred to numerous medical journal articles with regard to the efficacy of compound medications. The rebuttal also discussed the benefits of topical pain methods including faster and more localized relief and reduced side effects. The arbitrator did not find the New York State Workers' Compensation Board Treatment Guidelines controlling and found that the prescribing neurologist effectively refuted the peer review doctor's opinion. Accordingly, applicant was awarded reimbursement for the topical pain medication provided.

Sunquest Pharmaceuticals, Inc. & Progressive Ins. Co., AAA Case no. 17-16-1033-2857

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(6/2/17) (Victor Mortiz, Arb.) The claim for compound pain medication was denied based upon a peer review. The peer review doctor cited to the New York State Workers' Compensation Board Medical Treatment Guidelines and maintained that the disputed compound medication would not provide any better results than a common oral NSAID and muscle relaxants. The peer review doctor also discussed each of the ingredients and asserted that they were either not appropriate or of undetermined effectiveness. Although the provider submitted a rebuttal that suggested that topical agents provide a safe and effective alternative to oral pain medication, the arbitrator found it insufficient to establish the benefits of topical medication *vis-à-vis* a regimen of conservative treatment and oral NSAIDs. Accordingly, the claim for compound pain medication was denied.

Gallo's Pharmacy & Allstate Ins. Co., AAA Case no. 17-16-1045-6478

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(11/12/18) (Aaron Maslow, Arb.) The claim for compound pain cream was denied based upon a peer review. The peer review doctor opined that there was no documentation as to how medications in the form of a cream would provide better results than oral NSAIDs and muscle relaxants. The arbitrator found that the factual basis of the peer review was insufficient since the peer review doctor did not take into account how the accident occurred or the four-month history of lower back pain prior to the prescription of the compound pain cream. Accordingly, applicant was awarded reimbursement for the compound pain cream provided.

Lakeview Pharmacy & Surgical & Progressive Ins. Co., AAA Case no. 17-15-1024-4690

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(9/13/16) (Aaron Maslow, Arb.) The claim for compound pain cream was denied based upon an independent medical examination (IME), which was negative with the exception of spasm in the lumbar spine and limited range of motion of the right knee. The IME



AAA® INSURANCE REPORTER

2019 AAA INSURANCE REPORTER / ISSUE 1

doctor concluded that there was no need for further treatment except for these areas, and that, with respect to the lower back and right knee, only additional physical therapy was required. The arbitrator noted that the compound pharmaceutical cream was ordered six (6) weeks later and the prescription failed to state where on the body to place the cream. Given the absence of rebuttal evidence, the claim for compound pain cream was denied.

Shalom's Pharmacy, Inc. & Allstate Fire & Cas. Ins. Co., AAA Case no. 17-17-1065-8050

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(1/31/19) (Maryann Mirabelli, Arb.) The claim for compound medication was denied based upon a peer review report. The peer review doctor found that the prescription for compound medication deviated from standard of care, which does not include the routine prescribing of compound cream for soft tissue and musculoskeletal injuries unless there is evidence that the injured person had allergies or could not swallow a pill. Applicant submitted a rebuttal from a doctor who was not the treating or prescribing doctor, but who cited to authority for the proposition that topical creams can be used as an alternative to oral medication. The arbitrator determined that a preponderance of the evidence supported a finding in favor of respondent and the claim for compound medication was denied.

Compound Pain Medication & Fee Schedule

Sunquest Pharmaceuticals, Inc. & State Farm Mut. Automobile Ins. Co., AAA Case no. 17-17-1057-7584

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

(3/11/18) (Drew M. Gewuerz, Arb.) Applicant sought reimbursement for a compound cream topical analgesic. Respondent reimbursed applicant \$1,581.24, in partial satisfaction of the claim and denied the remainder. The arbitrator found that the respondent must conclusively demonstrate the proper fee schedule payment in a coherent manner. The arbitrator noted that it was respondent's burden to establish the "Average Wholesale Price" (AWP) of the drug on the date it was dispensed. The arbitrator referred to the New York State Workers' Compensation Board Pharmacy Fee Schedule, which authorizes the use of the Red Book or the Medi-Span Drug Database to determine the AWP. Citing to the Workers' Compensation Board Pharmacy Fee Schedule, the arbitrator found that the formula for determining the maximum reimbursement for prescription drugs was the AWP for the drug on the day it was dispensed minus 12 percent of the AWP plus a dispensing fee of \$4 for brand-name drugs or minus 20 percent of the AWP plus a dispensing fee of \$5 for generic drugs or medicines. Respondent submitted an affidavit of a certified professional coder (CPC) who applied the formula for generic drugs (AWP minus 20% plus \$5). The arbitrator found that the affidavit was persuasive. The arbitrator noted that the affidavit was supplemented by evidence of the Red Book AWP and set forth whether the ingredients were generic or brand name. Applicant submitted a breakdown of the ingredients, quantity, and alleged AWP, but the AWP was not supported by evidence from an authorized source. Accordingly, the arbitrator found that applicant failed to rebut respondent's reimbursement amount and denied the claim.

RX For You Corp. & State Farm Mut. Automobile Ins. Co., AAA Case no. 17-16-1043-2086

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(6/26/17) (Drew M. Gewuerz, Arb.) Applicant sought reimbursement for a topical compound cream. Respondent denied the claim based upon a peer review. The arbitrator found that the peer review was legally insufficient insofar as the citations relied upon by the peer doctor did not support the conclusory assertions in the body of the peer review. The arbitrator then addressed the proper fee reimbursement for the pain medication. Respondent asserted that the maximum allowable reimbursement was \$1,547.84. Respondent relied on an affidavit of a certified professional coder (CPC) who utilized the formula for generic drugs (AWP minus 20 percent plus \$5 dispensing fee). The CPC also stated that the "Average Wholesale Price" (AWP) was obtained from the Red Book.



AAA® INSURANCE REPORTER

2019 AAA INSURANCE REPORTER / ISSUE 1

The arbitrator found that respondent's evidence conclusively demonstrated in a coherent manner that the maximum payment was \$1,547.84. Applicant was reimbursed in accordance with respondent's fee analysis.

Friendly RX Inc. DBA Friendly RX Pharmacy & Progressive Cas. Ins. Co., AAA Case no. 17-17-1079-3125
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(12/10/18) (Pauline Molesso, Arb.) Applicant sought reimbursement for pharmaceuticals in the amount of \$1,492.83. Respondent asserted a fee schedule defense. The arbitrator found that it was respondent's burden to establish that the fees charged by applicant exceeded the amounts set forth in the applicable fee schedule. Respondent argued that pursuant to 12 NYCRR § 440 and 442 the correct reimbursement is the "Average Wholesale Price" (AWP) listed in the Red Book or Medi-Span Master Drug Database minus 12% plus a dispensing fee of \$4 for brand- name drugs and AWP minus 20% plus a dispensing fee of \$5 for generic drugs. Respondent relied on an affidavit of a certified professional coder (CPC) in support of the proposed fee reduction. The CPC calculated the reimbursement based upon the aforementioned formula. Respondent also submitted the relevant portion of the Red Book relied upon in their calculations. Applicant argued that respondent failed to utilize the timely version of the Red Book in determining the reimbursable amount. The arbitrator rejected applicant's argument, finding that respondent's evidence was sufficient to shift the burden of proof to applicant to rebut or refute respondent's evidence. The arbitrator found that applicant failed to establish that the timeframe utilized by respondent in their calculation was incorrect. Since applicant neither refuted respondent's calculation nor rebutted respondent's fee evidence, the arbitrator awarded reimbursement pursuant to respondent's fee calculation.

Medical Supplies & Licensing by N.Y.C. Department of Consumer Affairs

Empi Inc. & Geico Ins. Co., AAA Case no. 17-15-1005-2382
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(3/21/17) (Gillian Brown, Arb.) Applicant sought reimbursement for durable medical equipment and supplies provided to a resident of one of the five boroughs of New York City. Respondent maintained that applicant was not licensed to sell or distribute durable medical equipment in that municipality and that the lack of the appropriate licensing from the N.Y.C. Department of Consumer Affairs required dismissal of the claim. The arbitrator found that licensing is a condition precedent to the payment of no-fault benefits and that the burden of proof with respect to this condition precedent is on the applicant. The arbitrator noted that even if respondent bore the burden of proof on the issue of licensing, respondent submitted evidence of its search of the online records of the N.Y.C. Department of Consumer Affairs indicating that there was no record of a license having been issued to applicant. The arbitrator found that the lack of a N.Y.C. Department of Consumer Affairs license did not need to be raised by respondent in its initial denial, since proof of proper licensing is necessary for the establishment of a prima facie case. The arbitrator opined that The New York City Administrative Code section requiring licenses for sellers of products for the disabled applies to the applicant who is not licensed and that the municipal statute is not preempted by any other state or federal law. The arbitrator concluded that since applicant did not provide proof that it is exempt from the licensing requirement, applicant was not entitled to reimbursement.

AVA Custom Supply, Inc. & Progressive Cas. Ins. Co., AAA Case no. 17-18-1084-1778
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(12/17/18) (Paul Weidenbaum, Arb.) The arbitrator addressed whether respondent properly denied the claim based upon applicant's lack of a valid license from the N.Y.C. Department of Consumer Affairs as of the date durable medical equipment was dispensed to the assignor. Respondent argued that pursuant to 11 NYCRR Section 65-3.16(a) (12), an applicant is not eligible



AAA® INSURANCE REPORTER

2019 AAA INSURANCE REPORTER / ISSUE 1

to obtain reimbursement of no-fault benefits if the applicant fails to meet any applicable New York State or local licensing requirement necessary to perform such services in New York. The arbitrator found that applicant lacked standing to seek reimbursement of no-fault benefits with respect to the durable medical equipment provided as the evidence showed that applicant did not obtain its N.Y.C. Department of Consumer Affairs licensing until four (4) weeks after the dispensing of those items to the injured person.

AVA Custom Supply, Inc. & Progressive Cas. Ins. Co., AAA Case no. 17-17-1066-3173

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

(10/5/18) (Susan Mandiberg, Arb.) Applicant sought reimbursement for durable medical equipment that was denied by respondent based on a lack of proper licensure. Respondent argued that applicant lacked standing, as applicant lacked a valid license from the N.Y.C. Department of Consumer Affairs. Respondent argued that pursuant to the New York City Administrative Code, in order to sell and/or distribute durable medical equipment or other orthotic devices, a provider must possess a license from the N.Y.C. Department of Consumer Affairs. Respondent further argued that proper licensing is a condition precedent to coverage pursuant to 11 NYCRR § 65-3.16(a)(6) and 11 NYCRR § 65-3.16(a) (l 2). The arbitrator noted that the New York City Administrative Code provides in relevant part that "it shall be unlawful for any dealer to engage in the selling, renting, fitting, repairing or servicing of, or making adjustments to, products for the disabled without a license therefore." The arbitrator further noted that an Opinion Letter of The State of New York Insurance Department dated August 1, 2003, indicated that "[w]hen a provider of health services... gives an assignment by an eligible injured person pursuant to Section 65-3.11(a) of the Regulation and therefore, as assignee, becomes the claimant for purposes of reimbursement for covered services, that assignee must adhere to all applicable New York State statutes which grant the authority to provide health services in New York State. If a locality requires licensing (such as New York City, where the Department of Consumer Affairs requires sellers of durable medical supplies to be licensed) the assignee must be licensed in that jurisdiction in order to be reimbursed for services provided." The arbitrator found that applicant did not have the requisite standing to arbitrate the claim and dismissed the case without prejudice as respondent submitted evidence that applicant's license was effective only after the durable medical equipment was dispensed.

Brooklyn Medical Supply & Progressive Cas. Ins. Co., AAA Case no. 17-17-1060-1510

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(3/20/18) (Heidi Obiajulu, Arb.) The applicant sought reimbursement for durable medical equipment. Respondent's attorney argued that applicant was ineligible to receive no-fault benefits because it did not possess the requisite local license from the N.Y.C. Department of Consumer Affairs to furnish durable medical equipment. Specifically, respondent's attorney argued that pursuant to the New York City Administrative Code, applicant was required to possess a license from the N.Y.C. Department of Consumer Affairs. Applicant's attorney asserted that applicant appeared for an examination under oath and answered all questions posed regarding licensure. Applicant's attorney argued that respondent failed to submit sufficient evidence to show that applicant lacked the requisite license or that it had requested such information and thus failed to establish that applicant was ineligible to receive no-fault benefits under 11 NYCRR section 65-3.16(a)(12). The arbitrator found that a provider that dispenses durable medical equipment is required to obtain a license from the N.Y.C. Department of Consumer Affairs in order to distribute such equipment, otherwise it is ineligible to receive no-fault benefits. The arbitrator found that respondent's evidence, which consisted of a screen shot of a live chat with the Department of Consumer Affairs, was insufficient to establish that applicant lacked the requisite licensing. The arbitrator found that the screen was difficult to read and noted that the Department of Consumer Affairs was not asked if applicant had a license on the date the medical equipment was dispensed. Accordingly, applicant was awarded reimbursement for the durable medical equipment provided.



AAA® INSURANCE REPORTER

2019 AAA INSURANCE REPORTER / ISSUE 1

Medical Supplies & Medical Necessity

Sheepshead Bay Medical Supplies, Inc. & Geico Ins. Co., AAA Case no. 17-17-1070-2828
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(1/31/19) (Drew M. Gewuerz, Arb.) The arbitrator addressed whether various items of medical supplies and equipment were medically necessary. The arbitrator noted that under N.Y. Ins. Law § 5102, no-fault first-party benefits are reimbursement for all medically necessary expenses on account of personal injuries arising out of the use or operation of a motor vehicle. In support of its defense that the medical supplies and equipment were not medically necessary at the time of referral or supply, the respondent submitted the expert opinions of a chiropractor and medical doctor by way of peer review reports. Applicant opposed the peer reviews with rebuttal affidavits from the treating and prescribing chiropractor and physician. In his determination, the arbitrator reasoned that the medical necessity of the various medical supplies and equipment turned on certain points made or not made by the experts. The medical necessity of each item was analyzed individually and in accordance with each party's respective burdens of proof and persuasion. Applicant was awarded reimbursement for some of the items provided.

Ba2Ro Inc. & Geico Ins. Co., AAA Case no. 17-16-1038-8660
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(9/15/17) (Ioannis Gloumis, Arb.) The claim for various medical supplies and equipment was denied based upon a peer review. The arbitrator cited to relevant case law referencing that the insurer bears the burden of proof with regard to proving lack of medical necessity as a defense. The arbitrator found that in order to establish its defense, respondent must offer sufficient and credible medical evidence that addresses the standards in the applicable medical community for the services and treatment in issue; explains when such services and treatment would be medically appropriate, preferably with understandable objective criteria; and why the services and treatment were not medically necessary in this instance. The arbitrator found that respondent's peer reviews were sufficient to meet its burden of proof and that applicant's rebuttal failed to establish the medical necessity for all the items prescribed beyond the conservative treatment program. Applicant's claim was denied in its entirety.

OrthoPro Services, Inc. & First Liberty Ins. Corp., AAA Case no. 17-17-1054-0862
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(10/25/18) (Alison Berdnik, Arb.) The arbitrator addressed whether the prescription for an LSO, CTU and TENS unit were medically necessary. Respondent relied on a peer review in support of its denial of payment. The arbitrator cited to relevant case law that references that respondent bears the burden of production in support of its lack of medical necessity defense, which, if established, shifts the burden of persuasion to applicant. With regard to the peer review, the arbitrator found that the peer review was facially insufficient to sustain respondent's prima facie burden of establishing a lack of medical necessity for the prescribed medical supplies. The arbitrator stated that the peer review failed to set forth a medical standard applicable to the prescription for the disputed items. The arbitrator found that without evidence of the accepted medical practice, a peer reviewer's opinion is simply a different professional judgment, which, in and of itself, does not establish that the disputed equipment was not medically necessary. Applicant's claim was awarded in its entirety.



AAA® INSURANCE REPORTER

2019 AAA INSURANCE REPORTER / ISSUE 1

Medical Supplies & Market Research

Isurply, LLC & Travelers Personal Ins. Co., AAA Case no. 17-18-1086-4040
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(1/23/19) (Eva Gaspari, Arb.) Applicant sought reimbursement of the balance remaining on its claim for the rental of a Continuous Passive Motion (CPM) device and a Cold Therapy Unit (CTU). Respondent referred to 11 NYCRR §65-3.8 (g) and argued that applicant could not establish its prima facie case because the evidence failed to substantiate the amount that was charged. Respondent maintained that its partial payment was consistent with 12 NYCRR §442.2(b) as it reflected the monthly rental charge to the general public and that applicant was not entitled to any further reimbursement. In support of its position, respondent submitted the affidavit of its SIU investigator. The arbitrator found in favor of the applicant and awarded the claim in its entirety. The arbitrator cited to Insurance Law §5106(a) as well as *Viviane Etienne Med. Care v. Country-Wide Ins. Co.*, 25 N.Y.3d 498 (2015), finding that the evidence required for establishing a prima facie case was limited to proof which demonstrated the claim's submission and that applicant had met its prima facie burden. With regard to 11 NYCRR §65-3.8 (g), the arbitrator found that this regulation afforded insurers the right to assert a fee schedule defense regardless of whether it was preserved in a timely denial but the regulation did not shift the burden to the applicant to validate its fees. The arbitrator found that the SIU investigator's affidavit was insufficient to support respondent's fee schedule defense. The arbitrator noted that the SIU investigator had conducted market research by placing calls to medical supply companies who rent CPMs and CTUs to the general public within the greater New York region and that based on the information he obtained from the phone calls, the SIU investigator calculated the average reimbursement rate for each of the claimed items. The arbitrator found that the SIU investigator neither identified the total number of facilities that were contacted nor did he describe the nature and substance of the conversations. The arbitrator also found that the SIU investigator's assessment was of no probative value because it relied on a very limited pool of data and some of the contacted facilities did not even have pricing information for the respective DME equipment. Since respondent's SIU investigator's affidavit failed to shift the burden to applicant, applicant was awarded the remaining balance.

Isurply, LLC & St. Paul Fire & Marine Ins. Co., AAA Case no. 17-17-1054-5365
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(11/27/17) (Teresa Girolamo, Arb.), aff'd AAA Assessment no. 99-17-1054-5365 (4/2/18) (Peter J. Merani, Master Arb.) Applicant sought reimbursement for the rental of a Continuous Passive Motion (CPM) device and a Cold Therapy Unit (CTU). With regard to the claim for the CPM unit, the arbitrator found that the claim was not ripe and should be dismissed without prejudice as the requested verification was outstanding. With regard to the Cold Therapy Unit (CTU), the arbitrator found that applicant was not entitled to the balance remaining on the claim. The arbitrator noted that 12 NYCRR §442.2(b), advises in pertinent part, that the rental fee for equipment "shall not exceed the lower of the monthly rental charge to the general public or the price determined by the New York Department of Health area office." It also states that "[t]he total accumulated monthly rental charges shall not exceed the fee amount allowed under the Medicaid fee schedule." The arbitrator found that neither the Department of Health nor the NYS Medicaid fee schedule have assigned a rental charge for the Cold Therapy Unit. Accordingly, the arbitrator's analysis centered on whether the parties had submitted competent proof regarding the monthly rental charge to the general public. Respondent submitted the affidavit of its SIU investigator. Based on market research conducted by the SIU investigator, respondent asserted that applicant was properly reimbursed for the CTU. Applicant's proof consisted of an affidavit by a certified medical biller. According to the medical biller, the amount charged by the applicant was consistent with the data recorded in the HCPCS Fee Analyzer, a guideline published by the company Ingenix. In denying the claim for the CTU, the arbitrator quoted a segment from the Introduction in the HCPCS Fee Analyzer: "[T]hese data are offered solely as a benchmarking tool to help in the evaluation of fees. Do not assume that a given percentile will translate into an appropriate fee schedule. The process should begin by first



AAA® INSURANCE REPORTER

2019 AAA INSURANCE REPORTER / ISSUE 1

outlining a pricing strategy.” The arbitrator found that there is nothing within the Introduction segment to support the argument that the listed fees are for the general public. In rejecting applicant’s proof, the arbitrator concluded that no further reimbursement was allowed for the CTU.

AllBody Healing Supplies, LLC & St. Paul Travelers Ins. Co., AAA Case no. 17-17-1071-1950
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(6/6/18) (Shawn Kelleher, Arb.) Applicant sought reimbursement for the rental of a Continuous Passive Motion (CPM) device and a Cold Therapy Unit (CTU). Although respondent maintained that the bill was not received, the arbitrator found that applicant submitted proof that established its prima facie case. In addition, the arbitrator addressed whether pursuant to 12 NYCRR §442.2(b), the amount billed for the CPM and CTU accurately reflected the monthly rental charge to the general public. The arbitrator found that the amount charged for the CPM and CTU was substantiated by the data memorialized in the HCPCS Fee Analyzer, which is a guideline published by the company Ingenix. Contrary to respondent’s assertion, the arbitrator concluded that this source was of probative value in determining the cost to the general public. Respondent submitted the affidavit of its SIU investigator in support of its defense. The affidavit from the SIU investigator referenced the market research conducted, which consisted of placing telephone calls to three (3) durable medical equipment (DME) companies located within the tri-state area. The SIU investigator relied upon the quotes that were provided to him for CPMs and CTUs in the calculation of the mean values for these items and determined that these mean values constituted the average monthly cost to the general public. The arbitrator found that respondent’s proof was insufficient to challenge applicant’s fees, since a limited number of companies were contacted and the SIU investigator’s affidavit failed to explain the method by which the quotes were obtained. Accordingly, the claim was awarded in its entirety.

SUM Awards: Scarring & Serious Injury

A.J. & National General Ins. Co., AAA Case no. 43-20-1500-1288
[Sum Award Search](#)

(4/20/16) (Howard Bushin, Arb.) The 23-year-old claimant was walking home from work when he was struck by the underinsured vehicle. The claimant testified that the underinsured driver went through a stop sign. As a result of the impact, the claimant was knocked to the ground and suffered injuries to his forehead and right hip. Photographs of the claimant’s forehead were reviewed by the arbitrator and were found to verify the claimant’s testimony. The police accident report was also reviewed by the arbitrator and was found to corroborate the claimant’s version of the happening of the accident. The claimant was transported by ambulance from the accident scene to a hospital, where he was treated in the emergency room with complaints of pain in his right hip and headaches. The claimant was bleeding from a 3 cm laceration on his forehead. The laceration was sutured and the claimant was directed to return in one week for suture removal. The claimant subsequently returned to the hospital, and the sutures were removed. Thereafter, the claimant was examined by a plastic surgeon with regard to the scar on his forehead. The plastic surgeon’s report stated that “[t]he scar is mature, and no further change is anticipated. No additional treatment is indicated because it is unlikely that there would be any appreciable improvement in the scar’s appearance. The scar is considered permanent and is consistent with the injury that the patient describes.” The arbitrator examined the claimant’s scar in the middle of his forehead and noted that it was approximately 1¾ inches. The arbitrator found that the claimant sustained a permanent, ugly, and disfiguring scar on his forehead. It was the arbitrator’s finding that the claimant sustained a “serious injury” as defined by the Insurance Law Sec. 5102(d), as it caused a significant facial disfigurement that caused the claimant to be self-conscious. The arbitrator valued the claimant’s injuries in an amount in excess of the available insurance coverage. Since this was an underinsured claim in which the claimant had received \$30,000 from the tortfeasor’s carrier, the claimant was awarded the sum of \$50,000.00 less an off-set of \$30,000.00 previously paid to the claimant, resulting in a net award of \$20,000.00.



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2019 AAA INSURANCE REPORTER / ISSUE 1

E.F. & Farmers Ins. Group, AAA Case no. 01-16-0001-6619

[Sum Award Search](#)

(3/28/18) (Jodi Zagoory, Arb.) The claimant was a 27-year-old rear-seat passenger in a car that hit a puddle and lost control, striking the cement center divider and overturning multiple times. As a result of the accident, the claimant suffered a deep laceration to his right scapular and a laceration to his left hand. An ambulance took claimant from the accident scene to the hospital. In addition to the lacerations to his right scapular and left hand, the claimant complained of pain in his lower back, upper middle back, and right shoulder. The lacerations were repaired with nylon sutures and covered with steristrips. The claimant was discharged from the emergency room in stable condition and was advised to seek follow-up medical attention. Thereafter, the claimant consulted with his primary care physician who noted that the claimant complained of intermittent lower back pain and left-sided chest pain with certain movements. The doctor examined the claimant's wounds, instructed him to keep them clean and dry, and advised him to take Ibuprofen for pain relief. The claimant returned for removal of the right shoulder sutures. The claimant was also treated for thoracic spine pain at a therapy facility at a frequency of 3x per week. At the arbitration hearing, the claimant showed the arbitrator the scar on his right shoulder and on his left hand. The right shoulder scar was about 1½ inches long and slightly raised. The claimant testified that the scar was sensitive and caused him embarrassment as people assumed he suffered a gunshot wound. The claimant also testified that the scar interfered with a tattoo on his upper right arm and that sun exposure irritated the scar. The claimant testified that he consulted with a plastic surgeon about scar revision surgery, but the surgeon advised him that nothing could be done. With respect to the scar on claimant's left hand, the arbitrator observed a scar approximately ½ - ¾ inches long on the top of claimant's hand, near his wrist. In the arbitrator's opinion, both scars, although noticeable, were not unduly unsightly. Although the claimant did not submit any objective evidence to show emotional damage, the arbitrator credited the claimant's testimony regarding shame and ridicule regarding the scar. Accordingly, based on the claimant's testimony regarding his pain and suffering, the arbitrator valued the accident-related scars in the amount of \$65,000.00. Since this was an underinsured claim in which the claimant had received \$50,000 from the tortfeasor's carrier, the offset of \$50,000 was deducted from the award resulting in a net award of \$15,000.

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