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AAA Keeps Cybersecurity in the Forefront

In today's world, cybersecurity attacks are a very real threat to both organizations and individual consumers. Cyber risks are growing exponentially, and attacks are getting more and more sophisticated. The result of an attack can be severe and can include stolen data, locked files, and damaged systems.

The AAA has taken extraordinary measures to safeguard customer confidentiality and data from such risks. Some of these measures include role-based data-viewing privileges in case-management systems, formal acceptable-use policies, clean desk and document retention procedures, extensive use of encryption, web-browsing controls, and advanced firewalls and intrusion detection.

What can you do to help protect yourself against a cyberattack?

10 Common Tips to Help Protect Your Data

1. Always think before you click!
2. Practice good password management.
3. Track all of your online accounts.
4. Install updated antivirus software.
5. Don't click on pop-ups.
6. Use Multi-Factor Authentication.
7. Judge everything.
8. Use skepticism.
9. Update applications and browsers regularly.
10. Back up your data.

Did you know?

Arbitration and Conciliation Teams

In an effort to serve our customers better, we have routed all arbitration matters to the arbitration support group.

Please contact the arbitration team for any arbitrator-related matters, such as telephonic hearing requests, technical correction requests, and adjournment requests. The phone number is 646-663-3470; the email address is arbitratorsupport@adr.org.

Please contact the conciliation group for conciliator-related matters, such as settlement offers in conciliation and document extension requests. Please see the table below for the eight conciliation teams' contact information.

Additionally, we implemented the use of telephone prompts within the conciliation teams' telephone system. These prompts will direct parties to either the arbitration group or the conciliation group.



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ADR Center Teams

ADR Center Team 1
Team Telephone: 646-663-3461
Team Email: ADRCenterTeam1@adr.org

ADR Center Team 4
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ADR Center Team 7
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ADR Center Team 8
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ADR Center Team 3
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Team Telephone: 646-663-3466
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Executive Team Addition and Changes

We are pleased to announce that Simon Kyriakides has joined the NYSI executive team as Vice President, Division Senior Counsel. As part of his legal and compliance role, he will work extensively on the arbitration portion of the NY NF SUM/UM program.

As part of the AAA's cross-collaboration efforts, several changes have taken place among the executive team. Please see the following directory for team members and their current area(s) of responsibility:

Division Vice President

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917-438-1555

Arbitration

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SUM/UM

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Zarah Monterrosa

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Intake

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Business Intelligence and Data Analytics

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Assistant Vice President

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646-240-4675

Buffalo Office

Frank Cruz

Vice President

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Client Satisfaction Survey Responses

Thank you to all of the parties that participated in our *No-Fault Client Satisfaction Quarterly Survey*. Following are our responses to questions and requests posed in the survey.

What are the Program's administrative fees?

Filing fees

- No-fault cases: \$40
- SUM cases: \$250

2019 assessment per case

- Conciliation: \$27
- Arbitration: \$249
- SUM: \$859



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What causes the rejection of a no-fault filing?

Essential information missing from a filing, documents that do not correspond to the AR1, or a TPA listed as a carrier could result in non-acceptance of a case into the forum.

[Suggested Methods for New Case Filings](#) on the No-Fault page of our website presents best practices for filing a no-fault case.

Is there a reason the ADR Center settlement tool will not allow carriers to waive interest when making an offer?

65-3.9 (b) of the No-Fault Regulation 68 cites the following:

The insurer shall not suggest or require, as a condition to settlement of a claim, that the interest due be waived.

Would you please provide more information regarding adjournments and fees?

For good cause, the arbitrator may postpone or adjourn the hearing upon request of a party or upon the arbitrator's own initiative. Each party may cause one adjournment without the payment of an adjournment fee if the AAA receives the adjournment request at least two business days prior to the scheduled arbitration.

For any subsequent adjournment requested at least two full business days prior to the scheduled hearing, the adjournment fee is \$50, payable by the party requesting the adjournment to the designated organization.

An adjournment fee of \$100 is payable to the designated organization by the party causing any adjournment within two business days prior to the scheduled hearing.

In 2014, we instituted the process for "bulk" adjournments so that there would be only one fee for an adjournment of a block of cases before the same arbitrator on a specific day and not a fee for each individual case.

These fees help defray the cost of administration of the arbitration forum.

How long does it take to get a hearing date?

In 2018, with a record 304,620 filings, the average timeframe from filing to first hearing date was 13.5 months. With the sustained volume of growth, the timeframe of filing to the first hearing date has increased. We continue to partner with the DFS (Department of Financial Services) to recommend the appointment of additional arbitrators to the panel.

Best Practices for Filing SUM/UM Cases

We review filings upon receipt to determine whether they meet the criteria for acceptance to the SUM/UM arbitration forum. To avoid delaying your case, please use the following list to help you identify the information required for an acceptable filing. It addresses questions we often field about the correct way to file a SUM/UM case.

Before submitting the Demand for Arbitration, it is important to ensure you have completed all fields of the Demand. If the Demand is missing information required to initiate a case, we will return the filing with an explanation of what you should include with your resubmission.



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- Submit one copy of the Demand for Arbitration signed by an authorized representative and a check for \$250 payable to the American Arbitration Association.
- Include the applicant's name and address in the appropriate section of the Demand.
- Include all direct contact information for the representative attorneys.
- If the insurance company listed on the Demand is a third-party administrator (TPA), include the information for the parent company or issuing company.
- Provide the name and address of the policyholder on the date of the accident, the policy number, and its effective date.
- Provide the date of the accident and the claim file number on the Demand.
- If the policyholder is not a resident of New York State, a copy of the endorsement and declarations page (DEC page) and the policy must be included with the filing.
- Exhibits do not need to be included at the time of filing.

Frequently asked questions:

How long does it take to process a Demand for Arbitration?

The normal processing period after AAA receives a Demand is approximately 15 business days.

What should I do if I have not received any response to a Demand for Arbitration that I have submitted?

If you have not received a response within 21 business days, you should contact AAA by email at NYSUMTeam@adr.org or by phone at 917-438-1600. Ask for the SUM Supervisor to assist you.

Please [click here](#) to access this guide on our website.

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

Fee Schedule & Burden of Proof

- *Sunny Acupuncture, PC & State Farm Fire & Cas. Co.*, AAA Case no. 17-17-1068-2452 (4/28/19) (Kihyun Kim, Arb.)
- *Integrated Neurological Assoc. PLLC & Progressive Ins. Co.*, AAA Case no. 17-14-9025-7117 (10/29/15) (Tali Philipson, Arb.)
- *GW Acupuncture Services, PC & Esurance Ins. Co.*, AAA Case no. 17-17-1066-1589 (4/24/19) (Shawn Kelleher, Arb.)
- *Hands of Hope PT, PC & American Transit Ins. Co.*, AAA Case no. 17-18-1107-4496 (4/29/19) (Bryan Hiller, Arb.)



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EMG/NCV Testing & Medical Necessity

- *Rutland Medical, PC & Geico Ins. Co.*, AAA Case no. 17-17-1064-6818 (2/4/19) (Lisa Abrams, Arb.)
- *Remedy Chiropractic, PC & Geico Ins. Co.*, AAA Case no. 17-18-1094-5586 (3/26/19) (John Hyland, Arb.)
- *Rutland Medical, PC & Geico Ins. Co.*, AAA Case no. 17-17-1075-3368 (1/18/19) (Philip Wolf, Arb.)
- *James C. Hirschy, M.D., PC & MVAIC*, AAA Case no. 17-14-9049-4561 (4/24/15) (Joanne Andreotta, Arb.)

EMG/NCV Testing & F-Waves

- *Eden Medical, PC & Geico Ins. Co.*, AAA Case no. 17-18-1109-2333 (4/17/19) (Ritesh Mallick, Arb.)
- *Sports Medicine & Spine Rehabilitation, PC & Geico Ins. Co.*, AAA Case no. 17-17-1072-0797 (1/12/19) (Jan Chow, Arb.)
- *Premier East Physical Medicine & Rehab & Geico Ins. Co.*, AAA Case no. 17-18-1088-8469 (11/7/18) (Patricia Daugherty, Arb.)

Manipulation Under Anesthesia (MUA) & Medical Necessity

- *Bruce Jacobson, D.C. & Allstate Property & Cas. Ins. Co.*, AAA Case no. 17-17-1079-4408 (3/12/19) (Patricia Daugherty, Arb.)
- *Surgicore of Jersey City, LLC & Allstate Ins. Co.*, AAA Case no. 17-18-1089-7464 (4/16/19) (Preeti Priya, Arb.)
- *Raymond Semente, D.C., PC & Allstate Ins. Co.*, AAA Case no. 17-17-1068-4506 (4/18/19) (Ben Feder, Arb.)
- *Professional Chiropractic Care, PC & Geico Ins. Co.*, AAA Case no. 17-18-1099-6129 (5/3/19) (Allison Schimel, Arb.)

Manipulation Under Anesthesia (MUA) & Fee Schedule

- *Lefcourt MUA Chiropractic, PC & State Farm Mut. Automobile Ins. Co.*, AAA Case no. 17-18-1100-1064 (4/10/19) (Drew M. Gewuerz, Arb., CPC)
- *Pro Edge Chiropractic, PC & National Liability & Fire Ins. Co.*, AAA Case no. 17-16-1030-9126 (10/22/17) (Andrew Horn, Arb.)
- *B & A Chiropractic, PLLC & State Farm Mut. Automobile Ins. Co.*, AAA Case no. 17-17-1068-2277 (3/5/19) (Steven Celauro, Arb.)

SUM Awards: Collateral Estoppel

- *L.F. v. Geico Ins. Co.*, AAA Case no. 43-20-1500-1351 (Peter Horenstein, Arb.);
- *J.H. & N.H. v. State Farm Ins. Co.*, AAA Case no. 43-200-S-01868-14 (Nancy Hughes, Arb.)

Arbitrator Abstracts

Fee Schedule & Burden of Proof

Sunny Acupuncture, PC & State Farm Fire & Cas. Co., AAA Case no. 17-17-1068-2452
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(4/28/19) (Kihyun Kim, Arb.) The arbitrator addressed whether applicant's claims for cupping were properly billed and paid pursuant to the fee schedule. For each date of service, applicant billed for two cupping sessions. By affidavit from its certified coder, respondent contended that physical medicine codes are divided into codes that are reimbursable once per encounter as they



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contain the description "to 1 or more areas" and codes for which multiple units are reimbursable per encounter as they contain the description "each 15 minutes." It was respondent's position that per the AMA's CPT Assistant (Dec. 1998), cupping falls within the first group allowing only one unit to be reimbursable per date of service. Applicant countered that the recommended CPT code is a time-based code and because respondent did not request additional verification regarding the actual time spent performing the service, respondent could not meet its burden of proof and applicant, at the very least, was entitled to bill for more than one session of cupping per day. The arbitrator cited to numerous awards supporting both the position of the applicant and that of the respondent. Ultimately, the arbitrator determined that respondent's uncontroverted evidence set forth a sufficient basis for the denial of the second cupping modality for each date of service. It was further noted that the recommended CPT code was an unlisted therapy modality, which required the provider to "specify type and time if constant attendance." Thus, it would appear that it was not "time-based" in all circumstances. Applicant's claim was denied in its entirety.

Integrated Neurological Assoc., PLLC & Progressive Ins. Co., AAA Case no. 17-14-9025-7117
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(10/29/15) (Tali Philipson, Arb.) The arbitrator addressed whether respondent properly reduced the claims pursuant to the Workers' Compensation Fee Schedule. For each date of physical therapy, applicant billed under CPT codes 97014, 97110, and 97010. These three codes totaled \$76.04, which exceeded the \$67.60 limit permitted under Ground Rule 11. Ground Rule 11 provides in pertinent part that when multiple physical medicine procedures and/or modalities are performed on the same day, reimbursement is limited to 8.0 RVUs or the amount billed, whichever is less. Applicant billed less than what is permitted under CPT Code 97110 and reduced each bill to the allowable maximum amount of \$67.60. In turn, respondent made a further reduction and argued that its calculation is based upon RVUs and not monetary amounts. Based on respondent's calculation, 8 RVUs equaled the sum of \$59.15 per date of service. The arbitrator found respondent's argument and calculations to be unsubstantiated by the record and that applicant properly reduced the daily amount to \$67.60 as permitted under the Workers' Compensation Fee Schedule. Applicant's claim was awarded in its entirety.

GW Acupuncture Services, PC & Esurance Ins. Co., AAA Case no. 17-17-1066-1589
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(4/24/19) (Shawn Kelleher, Arb.) The arbitrator addressed whether applicant billed in excess of the fee schedule. Applicant billed for treatment under a by-report code and submitted treatment notes with its claim. The arbitrator noted that under the New York State Workers' Compensation Fee Schedule, there is no relative value unit associated with by-report codes. To determine the proper amount of reimbursement, records must be submitted with the bills to determine a relative value unit consistent in relativity with other relative value units shown in the schedule. Respondent argued that it did not have to reimburse applicant based on applicant's submission, but failed to proffer any evidence in support of its position. The arbitrator cited to *Gaba Medical, P.C. v. Progressive Specialty Ins. Co.*, 36 Misc. 3d 139(A), 957 N.Y.S.2d 264 (Table), 2012 N.Y. Slip Op. 51448(U)(App. Term 2d, 11th & 13th Dists. July 25, 2012), wherein the court held that, "[s]ince this determination by defendant is without any factual basis, as defendant never requested verification from plaintiff seeking information regarding the amount of time it had taken plaintiff to perform the services billed for, such a reduction has not been shown to be warranted." Based on the foregoing, the arbitrator found that if respondent was not satisfied with the documents submitted in support of the bill, respondent should have requested further verification. Applicant's claim was awarded in its entirety.

Hands of Hope PT, PC & American Transit Ins. Co., AAA Case no. 17-18-1107-4496
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(4/29/19) (Bryan Hiller, Arb.) The arbitrator addressed whether respondent properly reimbursed applicant for Activity Limitation Measurement testing. Upon receipt of the claim, respondent changed the procedure code to more accurately reflect the services rendered. The newly assigned code was reimbursable at \$41.66 per area tested. Applicant argued that respondent's supporting



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affidavit was not credible as the fee coder was an employee of the respondent. Applicant's counsel also argued that the changing of the codes was not supported by any rationale. The arbitrator found that respondent has the burden to come forward with competent proof to support its fee schedule defense and cited to *Robert Physical Therapy, P.C. v. State Farm Mutual Automobile Ins. Co.*, 13 Misc.3d 172, 822 N.Y.S.2d 378, (Civ. Ct., Kings Co. 2006). Applicant's claim was reduced to \$41.66 per area tested, as the arbitrator determined that respondent's fee coder provided a thorough explanation and fully established the reimbursable rate for the CPT codes billed in this case.

EMG/NCV Testing & Medical Necessity

Rutland Medical, PC & Geico Ins. Co., AAA Case no. 17-17-1064-6818
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(2/4/19) (Lisa Abrams, Arb.) The arbitrator addressed whether respondent established its lack of medical necessity defense. Respondent relied upon the peer review report of Dr. Ayman Hadhoud, M.D., in support of its contention that the EMG/NCV testing was not medically necessary. Dr. Hadhoud concluded, *inter alia*, that "there was no presentation of a plausible differential diagnosis that warranted performing this invasive testing." Applicant argued that the peer review was factually insufficient to meet the burden of production because Dr. Hadhoud relied upon The Official Disability Guidelines and the New York State Workers' Compensation Treatment Guidelines. The arbitrator found that the peer review presented a cogent medical rationale as Dr. Hadhoud also relied upon the AANEM Guidelines in support of his conclusions. Applicant submitted the rebuttal of Dr. Marvin Moy, in opposition to the peer review. Dr. Moy opined that the testing was necessary to rule out a diagnosis that might procure similar symptoms, ascertain the exact level of nerve root trauma, and confirm clinical suspicions by acting as an extension of the physical examination. The arbitrator found that applicant's medical records evidenced objective findings that required differentiation and thus the testing was medically necessary.

Remedy Chiropractic, PC & Geico Ins. Co., AAA Case no. 17-18-1094-5586
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(3/26/19) (John Hyland, Arb.) The arbitrator addressed whether the EMG/NCV testing performed was medically necessary. Respondent relied upon the peer review report of Ronald Csillag, D.C., in support of its contention that the testing was not medically necessary. Dr. Csillag asserted that the testing was not medically necessary, as there was no differential diagnosis present that would warrant this type of testing. The arbitrator found that Dr. Csillag met the burden of production, thereby shifting the burden to applicant. Applicant relied upon the rebuttal affidavit of Yasmin Cosey, D.C., in opposition to the peer review report. Dr. Cosey opined that the testing was medically necessary as the injured person had over nine weeks of unsuccessful conservative treatment and there was a differential diagnosis in that the testing was recommended to rule out any neuropathy. Based upon the rebuttal evidence presented, the arbitrator found that the testing was medically necessary.

Rutland Medical, PC & Geico Ins. Co., AAA Case no. 17-17-1075-3368
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(1/18/19) (Philip Wolf, Arb.) The arbitrator addressed whether the EMG/NCV testing performed was medically necessary. Respondent relied upon the peer review report of Dr. Mitchell Ehrlich, M.D., in support of its contention that the testing was not medically necessary. Dr. Ehrlich asserted that electro diagnostic testing was not needed to supplement or differentiate the diagnosis and invasive management was not an option with this patient's clinical presentation and the MRI results. The arbitrator found that respondent met the burden of production as to its lack of medical necessity defense. In opposition, applicant submitted a rebuttal from Marvin Moy, M.D., who opined that the testing was necessary to rule out a diagnosis that might produce similar symptoms, ascertain the exact level of nerve root trauma, and confirm clinical suspicions by acting as an extension of the physical



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examination. The arbitrator found that applicant did not meet the burden of persuasion in rebuttal because Dr. Moy failed to set forth a differential diagnosis or any findings that would substantiate a diagnosis other than radiculopathy. Accordingly, the claim was denied.

James C. Hirschy, M.D., PC & MVAIC, AAA Case no. 17-14-9049-4561

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

(4/24/15) (Joanne Andreotta, Arb.) The arbitrator addressed whether EMG/NCV testing was medically necessary. Respondent relied upon the peer review report of Dr. Uriel Davis, M.D., in support of its contention that the testing was not medically necessary. Dr. Davis asserted that the testing was not medically necessary because applicant failed to demonstrate the presence of a differential diagnosis. In rebuttal, applicant relied upon an affidavit from Dr. Leonid Shapiro, M.D. Dr. Shapiro asserted that EMG/NCV can be used to rule out cervical and/or lumbar radiculopathy, determine the level of nerve root damage, and establish the origins of the pain. However, the arbitrator found that this assertion was not consistent with the medical records, as the medical records did not contain any significant neurological findings. The arbitrator found that applicant failed to meet the burden of persuasion in rebuttal and denied the claim.

EMG/NCV Testing & F-waves

Eden Medical, PC & Geico Ins. Co., AAA Case no. 17-18-1109-2333

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

(4/17/19) (Ritesh Mallick, Arb.) The claim for EMG/NCV testing with F-waves was denied based upon the peer review report of Dr. Ayman Hadhoud, M.D. The peer review doctor opined that the testing was not medically necessary as there was no differential diagnosis to be developed and the testing would not impact upon the treatment and management of the injured person. Applicant submitted the rebuttal of Dr. Luba Karlin, M.D., which set forth that a diagnostic dilemma is not a necessary prerequisite to the performance of EMG/NCV testing. The rebuttal discussed why pinpointing the extent and location of the claimant's injuries utilizing the EMG/NCV testing was of medical utility and also addressed the utility of F-waves. The arbitrator found that the addendum prepared by the peer review doctor was comprehensive but failed to adequately explicate why the EMG/NCV testing would not have been medically necessary with respect to determining the extent of any abnormal function. The arbitrator was not persuaded by the peer review doctor's opinion that this information can be obtained through clinical examination. As for the F-wave studies performed, the arbitrator noted that the addendum cited to the ODG and other sources that discuss the efficacy of the testing. The arbitrator found that the ODG guidelines have not been adopted in New York, and thus, these guidelines are of limited probative value on the issue of medical necessity. The arbitrator noted that the remaining sources discuss efficacy of F-waves but "...do not state that F-waves are so bereft of utility that they are not deemed medically necessary in any circumstance." Accordingly, applicant was awarded reimbursement for the EMG/NCV testing performed with F-waves.

Sports Medicine & Spine Rehabilitation PC & Geico Ins. Co., AAA Case no. 17-17-1072-0797

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

(1/12/19) (Jan Chow, Arb.) The claim for EMG/NCV testing with F-waves was denied based upon the peer review report of Dr. Ayman Hadhoud, M.D. The peer review doctor opined that EMG/NCV testing is medically necessary if there is a differential diagnostic dilemma. The peer review doctor also stated that EMG/NCV testing is medically necessary to identify etiologies of a patient's injuries beyond the capabilities of physical examination. The peer review doctor opined that the positive neurological findings upon examination were consistent with radiculopathy and did not reveal any neurological differential diagnostic dilemma. The peer review doctor also stated that the injured person's symptoms were a result of a motor vehicle accident, and therefore, the diagnoses of plexopathy or peripheral nerve entrapment were not plausible. The peer review doctor also contended that the



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use of F-waves was medically unnecessary since they are “useless in the context of ruling out radiculopathy.” Applicant’s rebuttal from the treating doctor set forth that the testing was necessary to differentiate a right brachial plexus injury from a right cervical radiculopathy. The rebuttal also referenced that there was a plausible differential diagnosis since the injured person had persistent weakness in the right upper extremity with a positive Spurling test that was indicative of possible cervical radiculopathy. Moreover, the rebuttal set forth that the tenderness along the right supraclavicular fossa could be indicative of a brachial plexus trauma. The rebuttal cited to medical references that explained why F-waves are important components of EMG testing. A copy of the AANEM Position Statement was also submitted that supported the use of F-waves in evaluating radiculopathy, plexopathy, and polyneuropathies. The arbitrator found that applicant demonstrated that the testing was required based upon the differential diagnosis to be developed and that the AANEM Position Statement adequately supported the use of F-wave studies. Applicant was awarded reimbursement for the testing performed.

Premier East Physical Medicine & Rehab & Geico Ins. Co., AAA Case no. 17-18-1088-8469
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(11/7/18) (Patricia Daugherty, Arb.) The claim for EMG/NCV testing with F-waves was denied based upon the peer review report of Dr. Ayman Hadhoud, M.D. The peer review doctor found that the EMG/NCV studies of the lower extremities were not medically necessary. The peer review doctor stated that the standard of care for performing the testing would be an evaluation, modification of activities, prescription of medications, and conservative physiotherapy for a period of six weeks. The peer review doctor opined that if positive subjective and objective findings consistent with a neurological lesion were present after this period, further imaging testing should be considered. The peer review doctor stated that electro diagnostic testing may be useful where there are neurological differential diagnoses to consider, but that there was no plausible differential diagnosis in this case. The peer review doctor also stated that the injured person’s symptoms were a result of a motor vehicle accident, and therefore, the diagnoses of plexopathy or peripheral nerve entrapment were not plausible. The peer review doctor stated that F-waves are useless in the context of ruling out radiculopathy. The arbitrator found that the peer review report provided a sufficient factual basis and medical rationale that the testing was not medically necessary and thus the burden shifted to applicant to establish the medical necessity of the testing. Dr. Raj Tolat, M.D., testified at the hearing on behalf of applicant. Dr. Tolat testified that the injured person had positive neurological findings warranting the testing performed. Dr. Tolat stated that the injured person’s symptomology was persistent for three months, which was more than the six-week period identified by the peer review doctor. Dr. Tolat discussed the injured person’s continued complaints of numbness and tingling in the right foot and stated that the overall clinical picture did not indicate that the patient’s decreased sensation was isolated. Dr. Tolat agreed with the treating doctor that the injured person’s symptomology revealed a possible differential diagnosis of radiculopathy, plexopathy or peroneal neuropathy at the fibular head. Dr. Tolat also testified that F-waves are valuable in diagnosing radiculopathy because if the motor waves are found to be normal and the F-waves are abnormal, the F-waves would be indicative of a radiculopathy. Dr. Tolat also testified that the AANEM guidelines support the use of F-waves in diagnosing radiculopathy. The arbitrator found that applicant established the medical necessity for the testing performed and was awarded reimbursement.

Manipulation Under Anesthesia (MUA) & Medical Necessity

Bruce Jacobson, D.C. & Allstate Property & Cas. Ins. Co., AAA Case no. 17-17-1079-4408
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(3/12/19) (Patricia Daugherty, Arb.) Applicant sought reimbursement for manipulation under anesthesia (MUA) procedures. Respondent maintained that the MUA performed was not medically necessary pursuant to a peer review report by Dr. Thomas McLaughlin, D.C. The peer review doctor relied on the MUA Practice Guidelines and found that the MUA was not medically necessary as there was no documentation of intractable pain or an inability to partake in active conservative forms of treatment.



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The peer review doctor noted that the injured person's treatment notes documented ongoing treatment without difficulty and indicated that the injured person was getting better. The peer review doctor discussed the physical therapy evaluation reports, which showed improvement in range of motion and cervical and lumbar ranges of motion within functional limits. The peer review doctor referenced that there was no treatment to the sacral/pelvic region prior to the MUA and no evidence of a fibro adhesive condition. The peer review doctor discussed applicant's lack of co-management with other treating providers. Dr. Bruce Jacobson, D.C., testified on behalf of applicant regarding the injured person's treatment history prior to the MUA procedures. According to Dr. Jacobson, the MUA was medically necessary due to the patient's sub-optimal response to conservative treatment. Dr. Jacobson testified that pursuant to the MUA Practice Guidelines, the injured person met all of the requirements to be a candidate for MUA. Although Dr. Jacobson testified regarding the injured person's sub-optimal improvement in response to conservative treatment, the arbitrator found that the medical record showed that the injured person did not receive the recommended conservative chiropractic treatment to the sacrum prior to the performance of the MUA procedures. Additionally, the arbitrator noted that the medical records from the various treating providers indicated that the injured person was improving. The arbitrator concluded that Dr. Jacobson did not sufficiently explain why the injured person's improvement was considered sub-optimal. The arbitrator was persuaded by the peer review doctor's conclusions and found that the MUA was not medically necessary.

Surgicore of Jersey City, LLC & Allstate Ins. Co., AAA Case no. 17-18-1089-7464
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(4/16/19) (Preeti Priya, Arb.) The arbitrator addressed whether the applicant established its entitlement to no-fault compensation for fees associated with manipulation under anesthesia (MUA) procedures. Respondent denied payment on the basis of a peer review report prepared by Dr. Robert Snitkoff, D.C. The peer review doctor opined that the documentation provided did not describe the clinical evidence that satisfies the National Academy of MUA Physicians criteria for MUA patient selection. The medical records did not describe a claimant that was failing the conservative therapy treatment program, had an intractable pain syndrome, or biomechanical dysfunction that would necessitate MUA. The peer review doctor cited to the standard of care according to the National Academy of MUA Physicians MUA Practice Guidelines, revised 8/28/09. The applicant submitted a rebuttal by Dr. Alex Khait, D.C. In the rebuttal, Dr. Khait stated that the patient presented with bilateral pelvic pain and that the hip and the pelvis are two distinct but entirely interrelated parts of the human anatomy. Dr. Khait cited to a study on the effects of MUA for patients with lumbopelvic (lumbar spine, sacroiliac and/or pelvic, hip) pain that showed clinically meaningful reduction in low-back pain disability. The arbitrator found that the rebuttal of Dr. Khait was not persuasive regarding the medical necessity for the MUA procedures for the shoulder and pelvis, as there was no evidence in the record to substantiate the MUA procedures of the shoulder and pelvis. However, the arbitrator found that based on the proof presented, respondent failed to establish its defense of lack of medical necessity regarding the cervical, thoracic, and lumbar spine MUA procedures.

Raymond Semente, D.C., PC & Allstate Ins. Co., AAA Case no. 17-17-1068-4506
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(4/18/19) (Ben Feder, Arb.) Applicant sought reimbursement for manipulation under anesthesia (MUA) procedures. Dr. Gary Cullin, D.C., appeared at the hearing and testified on behalf of applicant. Respondent timely denied the claim based upon the peer review report by Dr. Snitkoff, D.C., who asserted that the injured person's medical records did not reach the level of criteria required pursuant to the 2009 National Academy of Manipulation under Anesthesia Physicians guidelines. Dr. Snitkoff asserted that the injured person did not present with fibrous adhesions or scar tissue that needed to be "broken up" through a manipulation under anesthesia procedure and was not a surgical candidate. In addition, Dr. Snitkoff stated that the injured person's medical records from other treating physicians did not reveal a serious injury requiring the MUA procedures. Dr. Snitkoff found that the MUA procedures included treatment to the injured person's shoulders unrelated to a radiating spinal pain syndrome. Dr. Cullin testified that despite physical therapy and manipulation, the injured person still presented with symptomatology that included significant



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complaints of pain, deficits in range of motion, difficulty with daily functionality, positive orthopedic test findings, and positive neurological findings. Dr. Cullin testified that the injured person was an appropriate candidate for MUA procedures pursuant to the American Association of Manipulation Under Anesthesia Providers (AAMUAP) guidelines. Dr. Cullin stated that the injured person's treatment had "plateaued" and that the injured person was experiencing sub-optimal results from the four months of conservative care, including conscious chiropractic manipulation and physical therapy. The arbitrator found that applicant established that the injured person was a candidate for MUA pursuant to the standards promulgated by the AAMUAP and that the MUA was medically necessary.

Professional Chiropractic Care, PC & Geico Ins. Co., AAA Case no. 17-18-1099-6129

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

(5/3/19) (Allison Schimel, Arb.) Applicant sought reimbursement for manipulation under anesthesia (MUA) procedures. Respondent denied the claims based upon the peer review report of Dr. Ayman Hadhoud, M.D. Applicant's counsel argued that as a medical doctor, the peer reviewer was not qualified to review the MUA procedures performed by a chiropractor, and furthermore, that it was prejudicial because a chiropractor cannot refute a medical doctor's conclusions. The arbitrator was not persuaded by this argument because Dr. Hadhoud's peer review stated that he is certified to perform MUA. In his peer review report, Dr. Hadhoud cited to the National Academy of Manipulation Under Anesthesia (NAMUA) guidelines and found that there was no evidence that the injured person responded sub-optimally to conservative chiropractic treatment or medical co-management. The peer review doctor also stated that there was no evidence of intractable pain. Applicant submitted a rebuttal by Dr. Diana Vavikova, D.C., who discussed the protocols of the National Academy of Manipulation Under Anesthesia (NAMUA) in detail and stated that those guidelines were followed in the instant case. Dr. Vavikova maintained that this was a patient where manipulation of the spine or other articulations was the treatment of choice. However, due to the chronicity of the problem and the fibrous tissue adhesions present, conservative manipulation was incomplete. The arbitrator found that the MUA procedures were not medically necessary. Although Dr. Vavikova asserted that all of the criteria for MUA procedures were met, the arbitrator found that there was insufficient evidence of intractable pain and adhesions. Nor was there evidence that the injured person missed work as a result of the accident. The arbitrator concluded that since the injured person was tolerating conservative treatment, the MUA was not medically necessary.

Manipulation Under Anesthesia (MUA) & Fee Schedule

Lefcort MUA Chiropractic, PC & State Farm Mut. Automobile Ins. Co., AAA Case no. 17-18-1100-1064

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

(4/10/19) (Drew M. Gewuerz, Arb., CPC) Applicant sought reimbursement for manipulation under anesthesia (MUA) that was performed by one of two chiropractors at a New Jersey facility. The arbitrator was asked to evaluate respondent's defense of lack of medical necessity that was based on a peer review and to determine whether the claimed charges were excessive. With respect to the first defense, the arbitrator found that the peer review did not suffice to uphold respondent's denial because it contained statements that did not align with the information appearing in the medical records. The arbitrator then noted that the respondent's fee schedule defense was based on the opinion of a Certified Professional Coder (CPC). According to the fee coder's affidavit, the services were performed by an assistant chiropractor, and since a chiropractor is not technically a physician, reimbursement should be calculated pursuant to the rate that is applicable to "non-physician assistant surgeon(s)" and not the rate designated for either a "co-surgeon" or "assistant surgeon." The arbitrator was not persuaded by the fee coder's analysis, as the operative reports described two equally credentialed practitioners who rendered services in tandem, neither one appearing to "assist" the other. The arbitrator also noted that if the claim was assessed in this manner, then each of the chiropractors would have to be considered a "non-physician surgeon." The arbitrator found that the statutes set forth within New Jersey's Administrative



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Code would be rendered meaningless under such an interpretation, and that the statutes' intent is to divide reimbursement between those who engage together in a surgical procedure in proportion to their credentials and involvement. Based on the foregoing, the arbitrator awarded the claim in its entirety.

Pro Edge Chiropractic, PC & National Liability & Fire Ins. Co., AAA Case no. 17-16-1030-9126
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(10/22/17) (Andrew Horn, Arb.) Applicant sought to be reimbursed for manipulation under anesthesia (MUA) that was performed by one of two chiropractors at a New York facility. The issue to be determined was whether applicant billed in excess of the fee schedule. Upon review of the evidence, including a coder's affidavit submitted by the respondent, the arbitrator concluded that the charges were excessive. He noted that the bill contained fees for MUA of the spine (cervical, thoracic, lumbar, CPT 22505), shoulders (CPT 23700), hips (CPT 27275), and pelvis (CPT 27194). Considering the fact that these services were performed by a chiropractor, he found that the reimbursement rate should be 68.4% of the amount that would be allowed for medical doctors performing the same procedure(s). This was based on the coder's reference to a letter that was issued on 8/14/09 by general counsel for the New York State Workers' Compensation Board. The arbitrator also agreed with the portion of the letter advising that when MUA is performed by two trained chiropractors, only one fee should be paid for the services of both. In further support of this, the arbitrator pointed out that the operative report identified the chiropractors as "attending" and "co-attending" surgeons. Based on this information, he determined that the claim should be evaluated according to Ground Rule 12(D) of the Surgery section of the Medical Fee Schedule. This rule pertains to services rendered by co-surgeons, and stating that the total value is to be pro-rated (divided) between the two. The arbitrator also agreed with the coder and found that the claim is subject to Ground Rule 5 (of the same section), which explains how to calculate reimbursement for multiple and/or bilateral procedures. In addition, he relied upon the coder's assessment to conclude that MUA of the spine, which was billed three times by the applicant under CPT 22505, can be charged only once per date of service. The arbitrator declined to adopt the coder's assessment regarding the fee relating to MUA of the pelvis (CPT 27194). The fee coder's view was that reimbursement should not be allowed because the evidence failed to demonstrate that the assignor had the conditions described in CPT 27194. The arbitrator concluded that this was an issue requiring an expert opinion by a physician or chiropractor. As for the amount to be awarded, the arbitrator referenced a linked case that involved the claim by the other chiropractor for the same date of service. Accounting for the total value of the MUA, as well as the sum awarded by him in the linked case, the arbitrator issued a decision in favor of the applicant for the remaining balance.

B & A Chiropractic, PLLC & State Farm Mut. Automobile Ins. Co., AAA Case no. 17-17-1068-2277
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(3/5/19) (Steven Celauro, Arb.) Applicant sought to be reimbursed for manipulation under anesthesia (MUA) performed by two chiropractors at a New York facility. The charges accounted for three dates of service. The arbitrator was asked to determine whether respondent issued timely denials, thereby preserving its defense of lack of medical necessity. Upon review of the evidence, the arbitrator found that the claim was not processed within the statutory 30-day period. As a result, he concluded that respondent was barred from challenging the claim on this ground. As a second issue, the arbitrator was asked to decide whether applicant billed in excess of the fee schedule. Considering the record, he found that the claim did exceed the allowed rate of reimbursement. The arbitrator's decision accounted for an affidavit that was prepared by a licensed chiropractor and Certified Professional Coder (CPC). According to the affidavit, which was submitted by the respondent, the MUA was performed by two providers who worked as co-surgeons (rather than one being the primary and the other acting as an assistant). The coder explained that in such a scenario, both of the providers should have appended modifier 62 to the procedure codes. He further noted that the claim must be evaluated pursuant to Ground Rule 12 (D) of the Surgery section of the Medical Fee Schedule. This rule addresses reimbursement for co-surgeons, stating that the total value for the procedure is to be pro-rated (divided) between the two. Based



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on his calculations, the coder advised that the MUA was payable at a rate of \$757.09 per day, or \$2,271.27 for all three dates of service. During the hearing, counsel for the applicant argued that it was inappropriate of the coder to utilize Modifier 62 and that the claim should be granted in the amount of \$4,542.54 (i.e., \$2,271.27 for each chiropractor). The arbitrator rejected this argument. He found that respondent had submitted credible and persuasive proof with regard to its fee schedule defense. He also noted that applicant did not offer any rebuttal evidence to address the issue. Considering all of the above, the arbitrator awarded applicant the sum of \$2,271.27.

SUM Awards: Collateral Estoppel

L.F. v. Geico Ins. Co., AAA Case no. 43-20-1500-1351

[Sum Award Search](#)

(Peter Horenstein, Arb.) Claimant, L.F., brought an SUM claim seeking further payment for damages sustained after a motor vehicle accident in Nassau County, New York, on January 18, 2011. The issue was whether the doctrine of collateral estoppel applied, as the claimant was previously awarded the full amount of the tortfeasor's \$300,000.00 policy—less \$10,004.75, which had been paid out for property damage—as a result of a full jury trial in Supreme Court, Nassau County. The jury, unaware of the coverage, assessed the monetary value of the claimant's injuries and awarded him \$300,000.00. Respondent's position was that the claimant was precluded from re-litigating the issue of damages based on the doctrine of collateral estoppel. The arbitrator agreed and found that the two necessary requirements for the doctrine to apply were met, namely (1) that the identical issue must have been decided in the prior action or proceeding, and (2) that the party to be precluded from re-litigating the issue must have had a full and fair opportunity to contest the prior determination. See, *Kaufman v. Eli Lilly & Co.*, 65 N.Y.2d 449, 492 N.Y.S.2d 584 (1985); *Pinnacle Consultants, Ltd. v. Leucadia Nat'l. Corp.*, 94 N.Y.2d 426, 706 N.Y.S.2d 46 (2000). After applying collateral estoppel, the arbitrator determined that the claimant was entitled to the sum of \$10,004.75, the difference between what the jury awarded and what remained of the tortfeasor's policy. Respondent acknowledged that claimant was entitled to an award in that amount.

J.H. & N.H. v. State Farm Ins. Co., AAA Case no. 43-200-S-01868-14

[Sum Award Search](#)

(Nancy Hughes, Arb.) In this SUM case, the arbitrator addressed whether a prior arbitration award had preclusive effect. Claimant N.H. and the tortfeasor consented to an arbitration of the underlying claim, which took place on June 12, 2014 and resulted in a decision by Arbitrator Jeffrey K. Anderson on July 15, 2014 that awarded N.H. and J.H. \$65,000.00. In that arbitration proceeding, the underinsured tortfeasor also was insured by respondent. Respondent paid the policy limits of \$25,000.00, pursuant to Arbitrator Anderson's decision. Subsequent to Arbitrator Anderson's decision, the claimant N.H. sought further treatment for complaints of neck pain and on January 15, 2015 underwent a cervical MRI that was positive for disc bulges. In an addendum, the treating doctor found that the claimant's neck complaints were consistent with the cervical MRI findings and attempted to causally relate the claimant's subsequent complaints to the subject accident. Arbitrator Hughes noted that the claimant N.H. had complained of radiating neck pain and stiffness in 2011 but was diagnosed with cervical sprain with mild degenerative disc disease and early arthritis. Arbitrator Hughes further noted that the claimant N.H. had been treated for her lumbar spine complaints but had only minimal complaints of neck pain. Moreover, in 2012, the claimant N.H. was reported as having painless range of motion of the cervical spine. Arbitrator Hughes found that the treating doctor failed to mention the 2011 findings of cervical degenerative disc disease and early arthritis, thereby rendering the doctor's opinion on causation speculative. Arbitrator Hughes, relying on *Culpepper v. Allstate Ins. Co.*, 31 A.D.3d 490, 818 N.Y.S.2d 544 (2d Dept. 2006), determined that Arbitrator Anderson's decision was entitled to preclusive effect on the issue of damages. Although claimant N.H. was alleging further injuries, Arbitrator Hughes found that the claimants failed to meet their burden of proof that the further injuries claimed were causally related to the subject accident. The arbitrator further found that the claimants had a full and fair opportunity to litigate the issue of damages and



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declined to disturb Arbitrator Anderson's award. Claimant N.H. was awarded the prior to set-off amounts of \$64,500.00, less a set-off amount of \$25,000.00, and was awarded \$39,500.00. Her husband, J.H., was awarded \$500.00 in connection with his derivative claim.

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