



AAA® INSURANCE REPORTER

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Spotlight on NYSI Internal Departments and Tools

This issue features a detailed look into the AAA's NYSI individual departments with the goal of increasing transparency for the user community.

Intake Department

The NYSI Division Intake Department is the front line for the initiation process of all case filings. Comprised of 32 Case Filing Specialists, 4 Supervisors, and 2 Assistant Supervisors, the intake operations are located in both New York City and Buffalo. Intake consistently explores opportunities to enhance the customer experience with the overall goal of ensuring that all data is accurate, legible, and complete.

To streamline and promote filing consistency, the Department of Financial Services (DFS) and the American Arbitration Association (AAA) collaborated on the redesign of the New AR-1 Form, which you can access on our website [here](#).

You may also view an instructional video for completing the New AR-1 Form by clicking [here](#).

Conciliation Department

Cases that meet the criteria for acceptance into the forum travel to conciliation. During the conciliation phase, parties are invited to commence a dialogue either to resolve the case or move the case into arbitration.

In conciliation, parties are encouraged to explore potential resolutions of claims. To assist parties in finding mutually acceptable outcomes, the Conciliation Department facilitates discussions between the parties, identifies issues, and provides resolution opportunities based on trends.

Conciliators possess a vast knowledge of current trends and case patterns and have access to business analytics, which they use to provide an overview or a more finely detailed analysis of a party's caseload. By working with the parties and using business analytics, conciliators can assist with resolving cases, which increases efficiencies and provides cost savings. Additionally, conciliators provide customer service to the parties throughout the conciliation proceeding.

Indexing Department

Throughout the arbitration process, document analysts within the Indexing Department review and differentiate parties' submissions based on predefined document types, a process known as Indexing.

Indexing assists with facilitating arbitrators' search when they are preparing for and conducting hearings. Additionally, the indexing process provides ease of access to all parties within the forum. While indexing is not defined by the No-Fault Regulation, it is a significant component of the AAA's case administration and management, as it increases the customer service provided to the user community. Authorized ADR Center users may view indexed documents in the "Document View" section within each case in ADR Center.



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SUM Award Search Tool

The SUM Award Search allows parties to search and view redacted awards by New York SUM Arbitrators. Access the Award Search at <https://apps.adr.org/AwardSearch/faces/awardSearch.jsf>. Searches may be customized by case number, arbitrator, and/or case issue. Parties are not required to log in to utilize the SUM Award Search; all issued SUM awards automatically are added in redacted format and do not display names of the injured parties.

Users also may search by specific keywords and/or phrases to narrow their searches. When using this field, it is important to consider whether search results will contain any of the selected words, all words, or an exact phrase. Each of these options will yield different results. Selecting “any” will generate results containing awards with at least one of the words users entered into the field. On the other hand, choosing “all words” will include awards that contain every word in the entered phrase. The “exact” option will yield awards containing the words in the order entered in the field.

Additionally, users may search awards by specific ranges of filing dates or award issue dates. To review awards issued by a specific arbitrator, users may utilize the drop-down menu listing the names of all SUM arbitrators who issued awards since 2009.

Users also may also focus their searches by type of issue through the drop-down menu containing a list of common case issues. For example, if a user is looking for arbitrator awards regarding “economic loss” and “comparative negligence,” the user would select the boxes for both these issues.

For further assistance or for any questions regarding the SUM Award Search, please contact the SUM Supervisor by phone at 917.438.1500 or by email at NYSUMTeam@adr.org.

Incorporating Artificial Intelligence (AI) in the No-Fault Caseload

Whether specific to AAA or business in general, the expanding presence of artificial intelligence (AI) in the workplace cannot be ignored. As our caseload has increased significantly, so has our responsibility to continue to meet the needs of the user community. AI assists us with meeting those needs.

Bots currently utilized by the AAA's NYSI Program allow conciliators to focus on actively looking for resolutions, which directly helps the user community, and to pay more attention to the human aspect of customer service where emotion and in-depth thinking is needed.

Thanks to this technology, our resources are being utilized more efficiently and effectively to help achieve positive results for our valued customers.

No-Fault Fees

The NYSI Case Management Center has received feedback that users would like further clarity to the fees associated with the No-Fault Arbitration program.

- Current filing fee: \$40.00 per case, payable at the time of filing.
- Current projected 2019 fees per case: \$27 for the conciliation assessment and \$249 for the arbitration assessment, calculated based on the number of cases closed within a calendar year.
- Fee for filing a master appeal: \$75 if filed by the applicant, \$325 if filed by the insurer



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Adjournment requests incur fees depending on the following two scenarios:

- Upon the second initiated request: \$50 paid by the requesting party
- Upon a request with less than two business days' notice: \$100 paid by the requesting party

For more information regarding fees, please visit *Frequently Asked Questions* at nysinsurance.adr.org.

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

PRP Injections & Medical Necessity

- *Paramount Med. Services, PC & Geico Ins. Co.*, AAA Case no. 17-18-1087-6273 (9/19/19) (Claire Gallagher, Arb.)
- *DRD Medical, PC & Allstate Fire & Cas. Ins. Co.*, AAA Case no. 17-17-1081-9133 (9/12/18) (John O'Grady, Arb.)
- *Thompson Med., PC & Geico Ins. Co.*, AAA Case no. 17-18-1109-1315 (9/23/19) (Mitchell Lustig, Arb.)
- *Paramount Med. Services, PC & Geico Ins. Co.*, AAA Case no. 17-18-1085-4701 (10/30/18) (Eileen Casey, Arb.)
- *RES Physical Medicine & Rehab. Services & Allstate Property & Cas. Ins. Co.*, AAA Case no. 17-17-1075-9628 (11/20/18) (Tasha Dandridge-Richburg, Arb.)
- *DRD Medical, PC & Allstate Ins. Co.*, AAA Case no. 17-18-1108-5042 (10/12/19) (Bonnie Link, Arb.)

Spinal Fusion-Causality & Medical Necessity

- *Northern Westchester Hospital (NSUH) & Allstate Fire & Cas. Ins. Co.*, AAA Case no. 17-17-1082-1492 (12/11/18) (Tracy Morgan, Arb.)
- *Kaleida Health & Travelers Personal Ins. Co.*, AAA Case no. 17-17-1076-9612 (1/30/19) (Brian Bogner, Arb.)
- *Loubert Suddaby, M.D., PC & Metropolitan Group Property & Cas. Ins. Co.*, AAA Case no. 17-18-1114-5125 (5/29/19) (Michelle Murphy-Louden, Arb.)

Discectomy & Medical Necessity

- *Hudson Regional Hospital & Allstate Ins. Co.*, AAA Case no. 17-18-1098-2285 (10/25/19) (Eileen Casey, Arb.)
- *Bronx Lebanon Hospital & Country-Wide Ins. Co.*, AAA Case no. 17-18-1106-2085 (7/11/19) (Heidi Obiajulu, Arb.)
- *NY Spine Institute & American Transit Ins. Co.*, AAA Case no. 17-18-1114-0044 (10/27/19) (Stephen Czuchman, Arb.)
- *Island Ambulatory Surgery Center & Hereford Ins. Co.*, AAA Case no. 17-18-1111-6129 (10/24/19) (Teresa Girolamo, Arb.)



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Arthroscopic Surgery-Causality & Medical Necessity

- *NYH Brooklyn-CHOB & MVAIC*, AAA Case no. 17-18-1100-1204 (6/28/19) (Frank Marotta, Arb.)
- *Andrew J. Dowd, M.D. & American Transit Ins. Co.*, AAA Case no. 17-19-1127-3155 (10/26/19) (Ellen Weisman, Arb.)
- *Plainview Hospital (NSUH) & Mid-Century Ins. Co.*, AAA Case no. 17-16-1041-5602 (5/19/17) (Ioannis Gloumis, Arb.)
- *Alexios Apazidis, M.D., PC & Safeco Ins. Co.*, AAA Case no. 17-18-1113-9504 (9/12/19) (Dimitrios Stathopoulos, Arb.)

Laminectomy-Causality & Medical Necessity

- *Buffalo General Hospital & State Farm Mut. Automobile Ins. Co.*, AAA Case no. 17-17-1055-6635 (10/2/18) (Fred Lutzen, Arb.)
- *St. Charles Hospital & Rehab. & Allstate Fire & Cas. Ins. Co.*, AAA Case no. 17-18-1114-5908 (10/14/19) (Michael B. Parson, Arb.)
- *University at Buffalo Neurosurgery & Allstate Property & Cas. Ins. Co.*, AAA Case no. 17-17-1060-0593 (12/14/18) (Douglas Coppola, Arb.)

Collateral Estoppel

- *Structural Synergy, PT, PC & Lancer Ins. Co.*, AAA Case no. 17-18-1106-4167 (10/24/19) (Preeti Priya, Arb.)
- *Prompt Medical Spine Care, PLLC & Allstate Fire & Cas. Ins. Co.*, AAA Case no. 17-18-1086-2040 (10/16/19) (Rebecca Novak, Arb.)
- *Manalapan Surgery Center & Country-Wide Ins. Co.*, AAA Case no. 17-18-1100-1731 (10/12/19) (Antonietta Russo, Arb.)

Surgical Procedures & Fee Schedule

- *Integrated Neurological Associates, PLLC & National General Ins. Online, Inc.*, AAA Case no. 17-18-1094-3530 (6/3/19) (Kihyun Kim, Arb.)
- *Aron Rovner, M.D., PLLC & Allstate Ins. Co.*, AAA Case no. 17-18-1096-6524 (10/10/19) (Frank Marotta, Arb.)
- *Surgicore of Jersey City, LLC & American Country Ins. Co.*, AAA Case no. 17-18-1113-2704 (11/12/19) (Aaron Maslow, Arb.)

Sum Awards: Serious Injury & Witness Credibility

- *N.M. & M.M. & Geico Ins. Co.*, AAA Case no. 43-200-S-00240-15 (Peter Horenstein, Arb.)
- *L.D. & State Farm Ins. Co.*, AAA Case no. 43-200-S-00860-15 (Thomas Bogan, Arb.)

Arbitrator Abstracts

PRP Injections & Medical Necessity

Paramount Med. Services, PC & Geico Ins. Co., AAA Case no. 17-18-1087-6273
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(9/19/19) (Claire Gallagher, Arb.) Applicant sought reimbursement for certain services including a platelet rich plasma (PRP) injection procedure. Respondent denied the claim based upon a peer review report in which the insurer's physiatrist referred to medical literature that indicated that there was a lack of scientific data about the beneficial effects of the procedure. However, the



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arbitrator found that the peer review failed to establish a standard of care, since it relied on articles that were either outdated or that indicated that there was some benefit from the injection. Moreover, since the peer review report did not discuss any factual information specific to the provider's assignor, the arbitrator concluded that the peer review was not sufficient to establish a lack of medical necessity and awarded reimbursement for these services.

DRD Medical, PC & Allstate Fire & Cas. Ins. Co., AAA Case no. 17-17-1081-9133

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

(9/12/18) (John O'Grady, Arb.) The provider sought reimbursement for a right shoulder injection with PRP. Respondent denied payment based upon a peer review report in which its physician noted that health insurance carriers are reluctant to cover the treatment, which he considered "experimental and investigational." In addition to a lack of scientific literature to document the efficacy of the subject treatment, the peer reviewer stated that there was a lack of evidence of an acute injury and identified the standard of care for assignor's injury to be six to eight weeks of physical therapy. In a rebuttal, the treating physician pointed out that despite an extensive course of physical therapy, the injured person continued to complain of pain in her shoulder and had tenderness, restricted range of motion, decreased deep tendon reflexes, and positive orthopedic testing. He also cited to articles that supported the use of the disputed injection generally as well as in the treatment of tendinosis. The arbitrator noted that the subject services were performed nine months after the accident and after physical therapy had proved to be unavailing. The arbitrator also noted that at the time of the procedure, there were substantial objective findings of abnormalities. Thus, the arbitrator determined that applicant established the medical necessity of the injection.

Thompson Med., PC & Geico Ins. Co., AAA Case no. 17-18-1109-1315

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

(9/23/19) (Mitchell Lustig, Arb.) The arbitrator addressed whether the provider was entitled to reimbursement for a PRP injection to the left knee, which the insurance carrier had denied based upon a peer review report. Although respondent's orthopedic surgeon acknowledged that the subject treatment is effective to treat injuries to the elbow, he contended that more scientific evidence was needed before it could be determined that PRP injections are effective to treat other conditions. In response, the treating physician asserted that the disputed therapy takes advantage of the blood's natural healing properties to repair damaged tendons, muscles, and ligaments. After consideration of both parties' medical evidence, the arbitrator found that applicant had refuted the opinion of the peer review doctor and established that the performance of the PRP injection was within generally accepted medical practice.

Paramount Med. Services, PC & Geico Ins. Co., AAA Case no. 17-18-1085-4701

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

(10/30/18) (Eileen Casey, Arb.) Applicant sought reimbursement for platelet rich plasma (PRP) injections to the nerve root trapezius trigger point and right shoulder. Respondent denied the claim based upon a peer review report in which the insurer's physiatrist maintained that the services were not medically indicated and that trigger point and epidural steroid injections would be the appropriate treatments. The peer reviewer cited to the Workers' Compensation Board Medical Treatment Guidelines for the proposition that PRP injections are not recommended to treat shoulder impingement. Although the arbitrator acknowledged that the Workers' Compensation Guidelines are not controlling in no-fault cases, she found that they were persuasive in the instant case where the provider submitted no formal rebuttal or other evidence to address the issues raised in the peer review. Thus, the claim was denied.



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RES Physical Medicine & Rehab. Services & Allstate Property & Cas. Ins. Co., AAA Case no. 17-17-1075-9628
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(11/20/18) (Tasha Dandridge-Richburg, Arb.) The arbitrator addressed whether applicant was entitled to reimbursement for PRP injections to the injured person's cervical region, which the insurance carrier had denied based upon a peer review report. While conceding that PRP may have utility in certain conditions, such as in the treatment of tendinopathies, the peer reviewer opined that the injections at multiple levels were not clinically warranted in this case. In support of his position, the peer reviewer referred to the Workers' Compensation New York Neck Injury Medical Treatment Guidelines and ODG Integrated Treatment/Disability Guidelines. The arbitrator noted that prior to the disputed services, the injured person had undergone other types of injections and that improvement had been reported. Since the injured person had reported improvement from the prior injections and the medical authority relied upon by the peer reviewer failed to support the use of PRP in the treatment of chronic pain, the arbitrator upheld the denial.

DRD Medical, PC & Allstate Ins. Co., AAA Case no. 17-18-1108-5042
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(10/12/19) (Bonnie Link, Arb.) Applicant sought reimbursement for a lumbar nerve block injection with PRP performed seven years after a motor vehicle accident. Respondent denied the claim based upon a peer review in which its physician determined that the subject service was neither medically necessary nor causally related to the accident. The peer reviewer cited to medical authority that referenced that this type of pain injection is considered experimental and is not effective for non-radicular pain. With regard to causality, the peer review doctor asserted that the earliest documented report of any complaints with respect to the lower back was more than three years after the accident. The arbitrator found that the peer review discussed the injured person's findings and set forth how the performance of this procedure deviated from accepted standard of care. Since the peer review was sufficient to meet respondent's burden of proof and there was an absence of a sufficient rebuttal or convincing medical evidence, the arbitrator concluded that applicant failed to refute the peer review and upheld the denial.

Spinal Fusion—Causality & Medical Necessity

Northern Westchester Hospital (NSUH) & Allstate Fire & Cas. Ins. Co., AAA Case no. 17-17-1082-1492
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(12/11/18) (Tracy Morgan, Arb.). Applicant sought reimbursement for an anterior cervical discectomy denied based on the results of a peer review and independent medical examination (IME) by Dr. Ronald Mann. The peer report relied in part on the IME, noting that the cervical spine and upper extremity examination findings were normal. The peer review doctor stated that surgical intervention was not appropriate without evidence of neurological compromise and spinal instability. The peer review doctor noted that EMG/NCV findings were normal and stated that the cervical MRI findings revealed degenerative changes not related to the accident. According to the peer review doctor, standard of care for cervical spine fusion surgery is evidence of cervical radiculopathy or spinal instability, not present herein. Regarding medical necessity, the applicant submitted a rebuttal from Dr. Drora Hirsch stating that conditions for this surgical procedure are met when a patient has a symptomatic disc causing neck or arm pain, weakness, or numbness due to compression on the nerves or the spinal cord. In this case, the patient demonstrated weakness in the biceps and triceps, sensory deficits in the hands, with the presence of a disc herniation and bulge. The rebuttal referenced that the patient's findings were consistent with radiculopathy, and spinal instability is not the only indication for the performance of this procedure. The arbitrator found that the peer review doctor failed to establish that the injuries were not causally related to the accident. The arbitrator noted that case law requires the insurer to establish not only a lack of causation but also that the accident did not exacerbate any pre-existing condition. The arbitrator noted that the patient was asymptomatic before the accident and found that the peer review doctor's opinion on causation was conclusory and that he failed to rule out



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aggravation or exacerbation of a pre-existing condition. However, with regard to the issue of medical necessity, the arbitrator concluded that applicant did not sufficiently refute the peer review doctor's opinion that the surgery was not medically necessary. Thus, the claim was denied.

Kaleida Health & Travelers Personal Ins. Co., AAA Case no. 17-17-1076-9612
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(1/30/19) (Brian Bogner, Arb.) Applicant sought reimbursement for an anterior lumbar interbody fusion surgical procedure performed at the L5-S1 level. Respondent denied the claim based on a lack of causation. The injured person (IP) was involved in an accident on October 17, 2016. The record noted two prior accidents, including an accident in January 2011, in which the IP sustained injuries to the lower back. As a result, she was deemed disabled and had not returned to work at the time of the subject accident. A 2014 lumbar MRI study revealed a disc protrusion at the L5-S1 level extending into the spinal canal and partially effacing the anterior epidural fat and the traversing left S1 nerve root. The IP reported multiple injuries resulting from the subject accident in 2016, noting that lower back pain had increased considerably and was now radiating bilaterally to the lower extremities. Prior to 2016, lower back pain had radiated only to the right leg. An updated MRI of the lumbar spine revealed an L5-S1 annular fissure and small left lateral recess disc herniation. There was also disc dehydration and increased signal within the posterior annulus that was not present in the prior study. The IP was seen by Dr. Cameron Huckell, who referred the patient to Dr. Michael Pell, a vascular surgeon who recommended the anterior lumbar interbody fusion surgery at the L5-S1 level. Before the procedure, an orthopedic independent medical examination (IME) was performed by Dr. Frank Luzi, who concluded that the IP might have aggravated a pre-existing lumbar spine pathology. Thereafter, the IP was seen again by Dr. Huckell, who stated that the 2016 lumbar MRI findings had revealed a worsening of the L5-S1 disc. The surgery took place on February 13, 2017, and the claim was denied based on the results of a peer review by Dr. Steven Hausman, who concluded the disc herniation at L5-S1 was related to the prior 2011 accident and not the subject accident. The peer review doctor acknowledged that there was some evidence of worsening of symptoms, but that there was no evidence of any anatomic injury to the lumbar spine requiring surgery. Further, due to the chronic nature of her pain, the peer review doctor opined that the IP would likely have needed surgery even if the 2016 accident had not occurred. The arbitrator concluded that an exacerbation of a pre-existing condition is covered under no-fault and that the peer reviewer acknowledged that this accident had exacerbated the IP's condition. The arbitrator also found the peer review doctor's contention that the surgery would have taken place regardless of this accident to be speculative. The arbitrator found that Dr. Huckell's report established that the need for the surgery was at least in part caused by the 2016 accident. Since the surgery was causally related to the accident, applicant was awarded reimbursement.

Loubert Suddaby, M.D., PC & Metropolitan Group Property & Cas. Ins. Co., AAA Case no. 17-18-1114-5125
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(5/29/19) (Michelle Murphy-Louden, Arb.) Applicant sought reimbursement for a L4-L5 laminectomy with posterolateral fusion denied by the respondent based on a lack of causality. The record reflected that before the accident, the injured party (IP) hurt her lower back while weight training, leading to pain running down her leg with numbness. She was diagnosed by her primary care physician seven and one-half months before the motor vehicle accident with right-sided sciatica. The IP received treatment, but a reevaluation less than two months before the subject accident noted that her condition was worsening with pain shooting down her right leg, causing numbness. She was recommended for continued conservative care and a steroid pack. Thereafter, the IP was involved in the subject motor vehicle accident leading to further injuries. At least some emergency room records noted that the IP was complaining of low back pain. A lumbar CT scan revealed some instability and L4-L5 spondylosis, central stenosis, and disc herniation. The IP was released and followed up with a chiropractor complaining of left lower back pain radiating to the left buttocks. After that, she was seen by Dr. Loubert Suddaby, a neurosurgeon who noted worsening lower back pain. Dr. Suddaby noted the prior injury to the lower back and following the examination and review of the CT scans diagnosed the IP with lumbar disc displacement, lumbar spinal instability, lumbar stenosis, and lumbar spondylosis with radiculopathy and recommended



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continued conservative care. Dr. Suddaby stated that the motor vehicle accident appeared to have aggravated the underlying spondylosis. A lumbar MRI with extension/flexion x-rays revealed multiple positive findings, including L4-L5 severe canal stenosis. The x-rays revealed L4-L5 degenerative disease and grade I spondylolisthesis. The IP continued with conservative care without improvement, and Dr. Suddaby opined that the L4-L5 stenosis was the cause of the IP's pain. Physical therapy and epidural nerve blocks were initially recommended and the IP ultimately underwent the L4-L5 laminectomy with posterolateral fusion. The surgery was denied based on the results of the peer review by Dr. James Greenspan. Although the peer review doctor noted that the operation would appear to be necessary given the length of time and the failure of conservative care, the peer review doctor found that the surgery was not causally related to the subject motor vehicle accident. The peer review doctor noted the history of lower back pain worsening before the accident despite conservative care and that the MRI and CT scan appeared to show that the injuries were chronic and not related to the motor vehicle accident. The arbitrator noted the presumption of causality and found that the burden was on the insurer to establish that the condition was unrelated to the subject accident. The arbitrator noted that the peer review doctor failed to review the IP's complete pre-accident medical records and could only make assumptions concerning her condition on the date of the subject accident. Also, while the imaging findings revealed the IP's condition to be chronic, the arbitrator noted that aggravation of a pre-existing condition is a covered loss under no-fault. The arbitrator found that the peer review doctor never addressed the issue of aggravation. Additionally, Dr. Suddaby found that the accident appeared to aggravate the underlying spondylosis, and the arbitrator noted that before the accident, the IP was complaining of right-sided radiating lumbar pain and that post-accident she complained of left-sided radiating lower back pain. Based on these findings, the arbitrator found in favor of the applicant.

Discectomy & Medical Necessity

Hudson Regional Hospital & Allstate Ins. Co., AAA Case no. 17-18-1098-2285
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(10/25/19) (Eileen Casey, Arb.) Applicant sought reimbursement for a facility fee associated with a lumbar percutaneous discectomy. Respondent relied upon the peer review of Syed Iqbal Hosain, M.D., to establish a lack of medical necessity. Dr. Hosain stated that lumbar percutaneous discectomy has not been established as an effective procedure for treatment of lumbar disc herniation and radicular pain. Dr. Hosain cited to the official disability guidelines for percutaneous discectomy in support of his position. He also argued that percutaneous lumbar discectomy procedures are rarely performed in the U.S. and that no studies have demonstrated the procedure to be as effective as discectomy and microsurgical discectomy. Applicant relied on a rebuttal from Mark Gladstein, M.D. Dr. Gladstein noted that the authority relied upon by Dr. Hosain was inappropriate for no-fault claims. Dr. Gladstein argued that percutaneous lumbar discectomy is associated with improvement of back pain and lower limb symptoms post operation. Dr. Gladstein cited studies that found percutaneous lumbar discectomy to be a safe and effective treatment for radicular pain of discogenic origin. Dr. Gladstein also noted that the injured person responded positively to prior lumbar epidural steroid injection and trigger point injections, which confirmed the diagnosis of radiculopathy and myofascial pain as the pain generator. The arbitrator weighed the evidence before her and found the rebuttal persuasive. The arbitrator found the procedure medically necessary and entered an award in favor of applicant.

Bronx Lebanon Hospital & Country-Wide Ins. Co., AAA Case no. 17-18-1106-2085
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(7/11/19) (Heidi Obiajulu, Arb.) Applicant sought reimbursement for an anterior cervical discectomy and fusion. Respondent denied the claim based upon an independent medical exam (IME) by Jacquelin Emmanuel, M.D. The arbitrator made a detailed review of the assignor's treatment history, which included physical therapy and an EMG, which revealed evidence of a C7 radiculopathy. The injured person then underwent a cervical spine MRI, which revealed herniation's at the C4-5 and C5-6 levels. A disc bulge at C6-7 was also noted. The injured person then chose to undergo the surgical procedure after consultation with the treating physician.



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Applicant submitted a rebuttal by Dr. Auerbach, the treating surgeon. The arbitrator weighed the evidence presented, noting that the IME doctors failed to review important medical records, including the EMG/NCV studies. The arbitrator also noted that the injured person took pain medication on the day of the IME and that there were positive findings in the IME. The arbitrator considered the rebuttal as well, where the treating surgeon referenced that the injured person underwent an extensive course of conservative care that did not resolve the injured person's neck pain and radicular symptoms. The arbitrator found that the procedure was medically necessary and entered an award in favor of applicant.

NY Spine Institute & American Transit Ins. Co., AAA Case no. 17-18-1114-0044
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(10/27/19) (Stephen Czuchman, Arb.) Applicant sought reimbursement for an L4-S1 discectomy, laminectomy, and fusion. Respondent denied the claim based upon a peer review by Richard Weiss, M.D., who found the procedures to be medically unnecessary. Dr. Weiss opined that surgery was not medically necessary because disc herniations are not traumatic in nature. He cited to medical authority in support of his opinion. Dr. Weiss also noted that there was no documented spinal instability following the accident. The arbitrator found that the peer review was conclusory and was not persuasive. The arbitrator found that the peer review doctor failed to adequately discuss the medical necessity of the surgery and that the peer review doctor failed to apply the facts to the quoted medical authority. Since the arbitrator found that the peer review was insufficient and that the surgery was medically necessary, applicant was awarded reimbursement for the surgery performed.

Island Ambulatory Surgery Center & Hereford Ins. Co., AAA Case no. 17-18-1111-6129
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(10/24/19) (Teresa Girolamo, Arb.) Applicant sought reimbursement for a facility fee associated with a lumbar percutaneous discectomy. Respondent denied the claim based upon a peer review by Vijay Sidhwani, D.O., who found the surgery to be medically unnecessary. Dr. Sidhwani detailed the treatment history of the injured person, which included an emergency room visit the day after the accident. The injured person presented at that visit with full range of motion in the cervical and lumbar spine and no neurological deficits. The diagnosis was a neck and back sprain. The peer reviewer then reviewed the reports of the treating physician. No radiating pain was noted in these exams, straight leg raise was negative bilaterally, and a normal neurological examination was noted. Dr. Sidhwani also reviewed an independent medical exam (IME) by Dr. Margulies. The peer reviewer noted that the IME was normal. Considering the lack of radicular symptoms, normal neurological exams, and negative IME, the peer review doctor found that the lumbar percutaneous discectomy was not medically necessary. The arbitrator accepted the findings of the peer review doctor and denied the claim.

Arthroscopic Surgery—Causality & Medical Necessity

NYH Brooklyn-CHOB & MVAIC, AAA Case no. 17-18-1100-1204
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(6/28/19) (Frank Marotta, Arb.) The arbitrator addressed whether the left shoulder arthroscopic surgery was medically unnecessary pursuant to respondent's peer review report. The peer review doctor reviewed the clinical record and noted that the pre-operative diagnosis was left shoulder labral tear. The peer doctor opined that the findings were not indicative of a causally related need for surgery and the findings at surgery were inconsistent and incompatible with the mechanism of injury. Although applicant failed to submit a formal rebuttal, the arbitrator reviewed the record and noted numerous instances where the peer reviewer's assertions were contradicted by the record. The arbitrator also noted that the peer review doctor failed to establish the standard of care for the injuries revealed in the injured person's MRI. Since the arbitrator found that the peer review was unpersuasive and insufficient to meet its burden of proof, applicant's claim was awarded.



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Andrew J. Dowd, M.D. & American Transit Ins. Co., AAA Case no. 17-19-1127-3155
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(10/26/19) (Ellen Weisman, Arb.) The arbitrator addressed whether a right shoulder surgery was medically necessary. In support of its defense, respondent relied on a peer review report and applicant submitted a rebuttal to the peer review. Respondent's counsel argued that as stated by the peer review doctor, surgery was performed prematurely as the injured person had not undergone an adequate course of conservative care and was referred for surgery at the initial visit. Applicant's counsel countered that the attending surgeon examined the injured person seven weeks after the accident and recommended surgery because there was no improvement following conservative care and there were positive exam findings including impingement sign, weakness, tenderness, and decreased range of motion. Applicant also argued that the peer review doctor did not review all of the necessary records to render an informed decision. The arbitrator noted that despite a course of conservative treatment, the injured person continued to report significant pain with multiple positive findings on examination. In addition, intra-operatively, two soft tissue tears were repaired. The arbitrator found that the peer review failed to provide a sufficient basis for the peer review doctor's conclusion that the surgery was not medically necessary. Based on the weight of the evidence, it was determined that the surgery was reasonable and medically necessary.

Plainview Hospital (NSUH) & Mid-Century Ins. Co., AAA Case no. 17-16-1041-5602
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(5/19/17) (Ioannis Gloumis, Arb.) The arbitrator addressed whether a left shoulder arthroscopic surgery was medically necessary. In support of its defense, respondent relied on a peer review. The arbitrator noted that the peer doctor listed various reports that were reviewed but that the subject operative report was not listed. In opposition, applicant relied on the left shoulder MRI report and evaluations performed prior to the arthroscopic surgery. The reports indicated that diagnostic arthroscopy was recommended due to the injured person's continued restricted range of motion and pain despite receiving cortisone injections and physical therapy over the course of several months. The arbitrator found that the peer review was insufficient in that the peer review doctor failed to review the operative report for a procedure that was recommended for "diagnostic" purposes and thus applicant's claim was awarded.

Alexios Apazidis, M.D., PC & Safeco Ins. Co., AAA Case no. 17-18-1113-9504
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(9/12/19) (Dimitrios Stathopoulos, Arb.) The arbitrator addressed whether a right knee arthroscopic surgery was causally related to the subject accident. In support of its defense, respondent relied on a peer review report. The peer review doctor noted that the pre-hospital care report failed to document any conditions, injuries, pain, or discomfort to the knee and contended that the meniscal tears were not related to the accident of record and are common in the fifth decade of life. In opposition, applicant relied on a rebuttal. Based on his evaluation of the record, the arbitrator concluded that the peer review was insufficient to sustain respondent's burden of proof. The arbitrator noted that the peer reviewer failed to review any pre-hospital records to support his assertions and failed to offer any medical rationale to support his conclusion that the alleged pre-existing injuries were not exacerbated by the accident of record. Accordingly, applicant's claim was awarded.

Laminectomy–Causality & Medical Necessity

Buffalo General Hospital & State Farm Mut. Automobile Ins. Co., AAA Case no. 17-17-1055-6635
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(10/2/18) (Fred Lutten, Arb) Based upon the peer review report of Dr. Joseph C. Elfenbein, M.D., respondent denied the claim for services that included a lumbar laminectomy and discectomy. The peer review doctor found that the services were not medically



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necessary and not causally related to the subject accident. The peer review doctor noted that the injured person underwent X-rays as well as an MRI of the lumbar spine immediately following the accident, which revealed “degenerative changes to the lumbar spine” and mild disc disease but no evidence of any neurological compromise of the bilateral lower extremities. The peer review doctor stated that despite the injured person’s prolonged complaints of radiculopathy, there was no objective clinical evidence of muscle atrophy of the lower extremities or deep tendon reflex changes that would support the injured person’s persistent complaints. The peer review doctor stated that lumbar fusion is recommended as a treatment for spinal stenosis when concomitant instability has been proven and that lumbar fusion is not recommended for spinal stenosis without instability. The arbitrator noted that the peer review doctor relied heavily on a total absence of positive or abnormal clinical neurological findings in order to reach his conclusion that the surgery was not medically necessary. However, the arbitrator found that the records demonstrated that there were positive clinical neurological deficits and findings reported by several other physicians, including the IME doctors who examined the injured person, and thus respondent failed to demonstrate prima facie that the surgery was not medically necessary. As for causality, the arbitrator cited to relevant case law finding that an exacerbation of a pre-existing condition is expressly covered by the no-fault law and that the peer review doctor failed to discuss whether there was any aggravation/exacerbation of the injured person’s condition as specifically mentioned by the IME doctors. Based on the foregoing, applicant was awarded reimbursement for the services rendered.

St. Charles Hospital & Rehab. & Allstate Fire & Cas. Ins. Co., AAA Case no. 17-18-1114-5908
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(10/14/19) (Michael B. Parson, Arb.). The arbitrator addressed whether the pre-operative laboratory work and a laminectomy were causally related to the subject motor vehicle accident. An IME was performed on January 23, 2017, with an effective cut-off date of May 4, 2017 with regard to further neurological treatment. Subsequent to the IME, the IME doctor prepared an addendum to the IME report. The addendum formed the basis for respondent’s denials of applicant’s bills seeking reimbursement for the facility fees based on a lack of causal connection with the subject accident and treatment. The arbitrator noted that the IME report referenced that the injured person’s diagnosed injuries were causally related to the subject accident. However, the addendum to the IME set forth that based upon a review of the MRI of the lumbar spine, the condition was chronic and not related to the subject accident. The arbitrator found that the opinion rendered in the addendum contradicted the IME doctor’s earlier opinion as to causality. The arbitrator also noted that in the addendum, the doctor never discussed the question of aggravation or exacerbation of the pre-existing condition, despite the fact that the medical records reflected that the injured person had a left lumbar discectomy several years prior to the accident. The arbitrator found that that the peer review was insufficient, since aggravation and exacerbation of a pre-existing injury was not addressed. See, 11 NYCRR 65-3.14. Based on the foregoing, applicant was awarded reimbursement for the services rendered.

University at Buffalo Neurosurgery & Allstate Property & Cas. Ins. Co., AAA Case no. 17-17-1060-0593
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(12/14/18) (Douglas Coppola, Arb.) Respondent denied the claim for a lumbar laminectomy based upon a peer review report by John Shiau, M.D. The peer review doctor stated that standard of care prior to surgery would have been conservative treatment, such as physical therapy and possible epidural steroid injections, with the goal of avoiding surgery. The arbitrator noted that the resulting X-rays showed “mild degenerative changes.” The peer review doctor failed to comment on the MRIs or any of the records of the applicant. The peer review doctor concluded that the laminectomy with fusion was not medically necessary. The arbitrator noted that there was no review of the facts nor the actual medical records and no explanation as to how the procedure deviated from accepted standard of care. The peer review doctor also failed to discuss an aggravation or exacerbation of a pre-existing and “presumably” asymptomatic degenerative condition. The arbitrator referenced relevant case law and found that the no-fault insurer must demonstrate not only a lack of causation but that the accident did not exacerbate or aggravate any pre-existing



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condition or injury. The arbitrator found that the peer review was insufficient to satisfy the burden of proof and applicant was awarded reimbursement for the services rendered.

Collateral Estoppel

Structural Synergy, PT, PC & Lancer Ins. Co., AAA Case no. 17-18-1106-4167

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(10/24/19) (Preeti Priya, Arb.) Respondent filed a declaratory judgment action against applicant in Supreme Court, New York County prior to the filing of the arbitration. At the hearing, respondent relied on a decision and order of the Supreme Court, New York County, in which the Hon. Anthony Parga found that respondent owed no duty to provide no-fault benefits to applicant. Respondent asserted that the default judgment barred applicant from seeking benefits in arbitration under the doctrine of collateral estoppel. Arbitrator Priya found that the claim was barred because the matter involved the same parties and issues. Moreover, the fact that the judgment was entered on default was of no consequence, as the Appellate Term has ruled that such an order shall have preclusive effect.

Prompt Medical Spine Care, PLLC & Allstate Fire & Cas. Ins. Co., AAA Case no. 17-18-1086-2040

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(10/16/19) (Rebecca Novak, Arb.) Applicant sought to recover first party no-fault benefits. Respondent issued a timely denial based upon a negative medical examination, which terminated benefits. The examination was performed by Dr. Regina Hillsman on June 30, 2016. Applicant asserted that an award should be issued in its favor, as a previous award issued by Arbitrator Sandra Adelson found that further treatment was medically necessary. The prior award involved the same injured party, and the claim was denied based upon the identical examination report of Dr. Hillsman. Arbitrator Novak was asked to determine whether the doctrine of collateral estoppel should apply. Arbitrator Novak noted that in order for the award to have preclusive effect, the identical issue must have been decided in the prior action and the party to be precluded from re-litigating the issue, must have had a full and fair opportunity to contest the previous decision. In issuing an award in favor of applicant, Arbitrator Novak found that the prior award involved the same applicant, injured party, and defense. Therefore, since all of the elements were met and the parties had a full and fair opportunity to litigate the issue in the prior action, Arbitrator Novak found that the doctrine of collateral estoppel should apply.

Manalapan Surgery Center & Country-Wide Ins. Co., AAA Case no. 17-18-1100-1731

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(10/12/19) (Antonietta Russo, Arb.) Respondent denied the claim based upon a policy violation in that the injured person failed to appear at two scheduled Independent Medical Examinations (IMEs). In support of its defense, Respondent submitted two prior awards issued by Arbitrator Pauline Molesso, which dismissed applicant's claim for failure to appear at two IMEs. Respondent argued that the doctrine of collateral estoppel should apply as the underlying award involved the identical parties and issue. In finding in favor of respondent and dismissing the claim, Arbitrator Russo found that the doctrine of res judicata should be applied in this proceeding and that the issue as to whether a policy violation was established had already been fully adjudicated in favor of the respondent.



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Surgical Procedures & Fee Schedule

Integrated Neurological Associates, PLLC & National General Ins. Online, Inc., AAA Case no. 17-18-1094-3530
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(6/3/19)(Kihyun Kim, Arb.) Applicant sought reimbursement for ultrasound guided facet joint injections to the L4-L5 level of the lumbar region. The procedure was performed bilaterally and was reported under 0216T, a Category III code. Respondent partially paid applicant's claim, and timely denied the remainder based on a fee schedule defense. To uphold its assertion, the respondent offered the affidavit of a Certified Professional Coder (CPC). Within the affidavit, it was noted that 0216T is a "By Report" code and, as such, it does not have any assigned Relative Value Units (RVUs). The coder referred to General Ground Rule 3 of the Introduction & General Guidelines of the Medical Fee Schedule. The ground rule pertains to By Report items, and it directs providers to establish a value that is consistent in relativity with other services that are listed in the fee schedule. The coder explained that the RVUs assigned to CPT 64493 could be used to calculate reimbursement since it describes a comparable service; *i.e.*, lumbar facet joint injection(s) performed with imaging guidance (fluoroscopy or CT). She noted that the only difference between 0216T and 64493 is the guidance, with the latter being the more complex form of imaging technique. By using the RVUs assigned to CPT 64493, the coder calculated the reimbursement rate as \$125.97. She then pointed out that because the procedure was performed bilaterally, it would be appropriate to append modifier 50 and adjust the fee to 150% of the eligible charge. This adjustment applies when the description for a CPT code does not include terms that identify the service as bilateral. The adjustment takes into account the additional work that was needed to carry out the procedure. As a result of the adjustment, the coder advised that the appropriate amount of reimbursement was \$188.96. The coder went on to note that the applicant had reported the service as two (2) line item entries under 0216T, and that respondent had paid \$125.97 for each line item, resulting in a total of \$251.94. Considering how the fee for bilateral procedures is calculated, the coder pointed out that respondent had overpaid for the service. The arbitrator found that respondent's proof was sufficient to uphold its fee schedule defense. Accordingly, the arbitrator turned his attention to the coder affidavit submitted by the applicant. Within this document, applicant's coder explained that code 0216T accounts for both the surgical component (the facet joint injection[s]) and the radiologic component (the ultrasound guidance) of the procedure. She asserted that it was appropriate to use the RVUs assigned to CPT 62311 and 72275 to calculate applicant's fee. For Region IV, this equates to a total of \$762.53. The coder also referenced 0217T, which is an add-on code that accounts for a second level of injection(s). The coder pointed out that add-on codes are not subject to the multiple procedure reduction rule. She went on to state that the same RVUs should be used to calculate the fee for 0217T. Respondent addressed her opinion by offering a second affidavit from its coder. In this document, the coder voiced her disagreement with applicant's valuation. She informed that CPT 62311 is not comparable because it refers to epidural injection(s). Since the service performed by the applicant was an entirely different type of procedure (*i.e.*, injections to the facet joints), the coder advised that it would not be appropriate to use the RVUs assigned to CPT 62311. The coder reiterated her opinion that the fee should be calculated according to CPT 64493. She also pointed out that CPT 0216T and CPT 64493 both account for imaging guidance. In addition, she noted that applicant's coder addressed additional levels when the underlying claim was for a procedure that targeted just one level (*i.e.*, the facet joints at the L4-L5 level).

Based on the evidence presented, the arbitrator found in favor of the respondent and denied applicant's claim.

Aron Rovner, MD, PLLC & Allstate Ins. Co., AAA Case no. 17-18-1096-6524
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(10/10/19)(Frank Marotta, Arb.) Applicant sought to be reimbursed \$9,637.08 for right shoulder surgery that was performed on November 27, 2017 and a follow-up visit that took place on February 6, 2018. The arbitrator was asked to evaluate respondent's defense of lack of medical necessity, which was based on a peer review, and to determine whether the claimed charges for the surgery were excessive. With respect to the first defense, the arbitrator noted that he had already decided the issue of medical



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necessity in a linked matter that was related to the same procedure and that involved the same peer review. In that case, he found that the peer review did not suffice to establish respondent's defense and that the respective applicant was entitled to be reimbursed on its claim. Considering his prior decision, the arbitrator applied the doctrine of collateral estoppel and found that respondent was barred from relitigating this issue. The arbitrator then addressed respondent's fee schedule defense. Pursuant to the affidavit of a Certified Professional Coder (CPC), the respondent asserted that the correct rate of reimbursement for the surgical procedures was \$3,524.93. In the affidavit, the coder discussed the services that were reported under CPT 29827, 29823, 29999, 29821, and 29825. She pointed out that the applicant properly billed \$2,134.65 under CPT 29827. Turning to the next entry, the coder stated that applicant's charge of \$1,878.13 under CPT 29823 failed to take into account the multiple procedure reduction rule. Based on the rule, which is covered under Ground Rule 5 of the Surgery section of the Medical Fee Schedule, the correct rate would be half of the charge, or \$939.07. The coder then referenced CPT Assistant and advised that applicant improperly used CPT 29999 to bill for a bursectomy of the subacromial space. Relying on the cited source, the coder explained that this procedure should be reported under CPT 29826 and billed in the amount of \$451.21. This total was calculated by multiplying the assigned RVUs with the applicable Conversion Factor. As for CPT 29821 and 29825, she stated that the services described under these codes are inclusive of CPT 29823, which would mean that they are not separately reimbursable. Upon review of the affidavit, the arbitrator upheld respondent's fee schedule defense for CPT 29827 and 29823. Citing to relevant case law, he also accorded probative value to the CPT Assistant article that was referenced in connection with code 29999. Based on the article, the arbitrator found that reimbursement for the bursectomy should be limited to the rate allowed under CPT 29826. The arbitrator then addressed CPT 29821 and 29825. For this part of the claim, he found that respondent had failed to meet its burden. He noted that the coder had relied on the NCCI Policy Manual for Medicare Services. The arbitrator explained that, unlike the CPT Assistant, there is no authority that supports the use of the manual for evaluating no-fault claims. In reaching this conclusion, he determined that applicant was entitled to be reimbursed for the services described under CPT 29821 and 29825. Accounting for the foregoing and applying the multiple procedure reduction rule to CPT 29821 and 29825, the arbitrator awarded the sum of \$5,351.53 for the right shoulder surgery and \$92.98 for the office visit.

Surgicore of Jersey City, LLC & American Country Ins. Co., AAA Case no. 17-18-1113-2704

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(11/12/19)(Aaron Maslow, Arb.) Applicant sought to be reimbursed the sum of \$11,160.03 for facility fees relating to a lumbar discectomy that was performed on March 15, 2018 in Jersey City, New Jersey. The insurer asserted that the claim was properly denied in its entirety because none of the reported codes were compensable under the New Jersey Fee Schedule. To address this issue, the arbitrator listed the five HCPCS/CPT codes appearing on the claim form: 63030 (lumbar laminotomy/discectomy), 62290 (injection procedure for discography), 72295 (lumbar discography), 77003 (fluoroscopic guidance), and L8699 (prosthetic implant, not otherwise specified). Considering when and where the surgery took place, the arbitrator advised that the issue of reimbursement would have to be evaluated according to the 33rd Amendment to 11 NYCRR Part 68 [Regulation 83]. The arbitrator clarified that the Amendment pertains to any service that is performed on or after January 23, 2018 at a location outside New York's territorial boundaries. He went on to note that the provisions relating to the 33rd Amendment are set forth under 11 NYCRR 68.6. Based on the evidence, the arbitrator determined that paragraphs (b) and (c) of Section 68.6 were applicable to the instant claim, and thus applicant's entitlement would be limited to the lowest of the amount allowed under the New Jersey Fee Schedule, the amount allowed under the New York Fee Schedule, and the amount claimed by the applicant. With respect to the New York Fee Schedule, the regulation states that reimbursement is to be calculated according to the region that has the highest allowance. The arbitrator's first point of focus was the New Jersey Fee Schedule, which can be found in the state's Administrative Code under Title 11, Chapter 3, Subchapter 29, Appendix. Prior to addressing the instant claim, the arbitrator referred to a notice that had been issued on February 20, 2019 by the New Jersey Department of Banking and Insurance. The notice advised of minor changes to Exhibit 1 of the Appendix, which is the fee schedule designated for physicians and Ambulatory Surgery Centers (ASCs). The Department explained that Exhibit 1 had been revised so it would include payment indicators that had been mistakenly omitted for 17 CPT codes. In the instant case, the arbitrator took into account the location of applicant's facility (Jersey City) and pursuant



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to NJAC §11:3-29.3(a)(2), he evaluated the claim based on the ASC fee schedule for the North Region. Following a careful review, the arbitrator noted the following information for the reported codes: 63030 and L8699 were not listed in the fee schedule; 62290, 72295, and 77003 were all listed, but there was no fee amount published for any of them. Considering the applicable regulations and the relevant case law, the arbitrator determined that applicant was not entitled to payment on its claim. With respect to code 63030, the arbitrator explained that if a service or procedure is not listed in the fee schedule, that means that the ASC is precluded from reimbursement. To elaborate on his point, the arbitrator discussed the lumbar laminotomy/discectomy that applicant had reported under code 63030. He noted that this very procedure was the subject of litigation in two cases that ultimately made their way to the New Jersey Appellate Division. In both matters, the question presented was whether an ASC was entitled to reimbursement for this surgical procedure. The court consolidated the cases and answered the question in the negative. The decision touched upon the legislative history surrounding the procedure. Prior to the adoption of the current fee schedule that went into effect on January 4, 2013, the Department of Banking and Insurance had originally proposed to include lumbar laminotomy/discectomy (CPT 63030). Significantly, the proposal only allowed reimbursement to physicians, not ASCs. Following its receipt of comments and data from the public, the Department decided to exclude CPT 63030 in its final adoption. The court found that the original proposal reflected a clear indication of the Department's intent not to reimburse ASCs for CPT 63030. The court also held that even though Medicare allows ASCs to receive payment under this code, it is the Department, not Medicare, that governs the New Jersey Fee Schedule. The arbitrator then addressed the issue of reimbursement for listed codes that have no published fee, *i.e.*, 62290, 72295, and 77003. He determined that ASCs are not eligible for payment in this scenario. To support his finding, the arbitrator cited to NJAC §11:3-29.5(a) and NJAC §11:3-29.4(e) (3). He also pointed out that all three of these codes have been assigned an N1 payment indicator. This signifies that the service is an "ASC Packaged Procedure no separate payment." Thus, while the service can be performed in an ASC, it is considered to be inclusive of another procedure and therefore a facility fee is not separately reimbursable. As for the prosthetic implant reported under code L8699, the arbitrator found that applicant was not entitled to any payment. To support his view, the arbitrator referenced NJAC §11:3-29.5(a), which states, in pertinent part: "The ASC facility fees include services that would be covered if the services were furnished in a hospital on an inpatient or outpatient basis, including: ... (8) Implantable DME and prosthetics." Considering all of the above, the arbitrator concluded that under the New Jersey Fee Schedule, none of the codes reported by the applicant were reimbursable. Since the claim must be evaluated pursuant to the 33rd Amendment to 11 NYCRR Part 68 [Regulation 83], the arbitrator turned his attention to New York. He advised that under Title 12 NYCRR Subpart 329-2, payment for claims by Ambulatory Surgery Centers must be calculated according to the ambulatory patient groups (APG) methodology. He explained that this requires the use of the APG Software System, which is a program developed and published by the Minnesota Mining and Manufacturing Corporation (3M). With respect to the instant matter, the arbitrator pointed out that respondent had offered an affidavit by a Certified Professional Coder (CPC). The affidavit, which was accompanied by supporting documents, showed that the APG Software System was used to calculate the eligible fee. According to the program, if the surgery had taken place at an ASC in New York, the reimbursable compensation would be \$7,648.76. The arbitrator considered this evidence and noted that applicant had not submitted any proof to address the issue. The arbitrator addressed the 33rd Amendment to 11 NYCRR Part 68 [Regulation 83], and found that the amount allowed under the New Jersey Fee Schedule was \$0.00; the amount allowed under the New York Fee Schedule was \$7,648.76; and the amount claimed by the applicant was \$11,160.03. Based on this information, and pursuant to the 33rd Amendment, the arbitrator denied the claim in its entirety.

Sum Awards: Serious Injury & Witness Credibility

N.M. & M.M. & Geico Ins. Co., AAA Case no. 43-200-S-00240-15

[Sum Award Search](#)

(Peter Horenstein, Arb.) This matter arose out of an automobile accident that occurred in March 2013 on the ramp onto the Southern State Parkway. The claimant was driving a 1996 Toyota Corolla sedan with her husband beside her, when she was rear-ended by the underinsured 2006 Pontiac sedan. Liability was not in dispute. The police responded to the accident scene and offered an ambulance call, but the claimant reported that she was not injured and declined ambulance transport. Therefore,



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the police report listed that there were no injuries. Later that evening, the claimant reported feeling pain in her back and neck, at which point her husband took her to a local hospital emergency room, where X-rays were taken and were reportedly negative. The claimant was diagnosed with lumbar and cervical sprain, and was released to be followed privately. Subsequently, she also complained of bilateral shoulder pain and left leg pain. The claimant presented three weeks following the accident to a local treatment facility and commenced a course of physical therapy and chiropractic modalities. Two years later, in May 2015, claimant's records indicated that she was still found to have significant range of motion limitations, including a 50% loss of cervical extension and left rotation, a 50% loss of lumbar flexion and a 100% loss of lumbar extension. At the arbitration hearing, claimant testified with the aid of an Urdu interpreter. The arbitrator found that the claimant presented as credible, if somewhat seemingly prone to symptom magnification. The arbitrator found that it was apparent from both her appearance and her testimony that her activities of daily living were accompanied by a level of discomfort. An MRI of the lumbar spine performed in April 2013, showed lordotic straightening and an L5-S1 disc herniation to the left. An MRI study of the cervical spine was "unremarkable," but noted a "probable Chiari malformation and cerebellar tonsillar herniation," a congenital condition. An MRI of the right shoulder showed tendinosis of the supraspinatus, subacromial sub deltoid bursitis and long head of biceps tenosynovitis, but no focal tear. Electrodiagnostic testing performed in May 2013, showed evidence of left peroneal motor neuropathy, but the EMG evaluation failed to reveal any evidence of radiculopathy. No invasive pain management modalities were undertaken. Based on the totality of the credible evidence, including the testimony of the claimant's husband, who added his observations of his wife's limitations and apparent discomfort, the arbitrator found that due solely to the negligence of the underinsured rear-ending tortfeasor, the claimant did sustain pain and significant limitations for an extended period of time, requiring treatment which continued to date, thus satisfying the "serious injury" threshold of the Insurance Law. The claimant was awarded the sum of \$40,000.00, as compensation for her accident related injuries. The arbitrator found that there was insufficient evidence to support a derivative claim award to the claimant's spouse.

L.D. & State Farm Ins. Co., AAA Case no. 43-200-S-00860-15

[Sum Award Search](#)

(Thomas Bogan, Arb.) This case involved a 54-year-old claimant who was involved in an auto accident in July 2013 when she was rear-ended by another vehicle. At the hearing, liability was conceded by Respondent. No airbags were deployed. The claimant declined medical care at the accident scene and after providing the police with the necessary information, the claimant drove to her place of employment. After arriving at her workplace, the claimant was advised to seek medical care. Hence, she left her place of employment and presented to an urgent care facility with complaints of pain in the neck, left shoulder, left arm and left thigh/upper leg. X-rays were taken that revealed "straightening of the cervical lordosis with multilevel degenerative changes and C4-C5 spondylolisthesis." She was diagnosed with cervical strain and multiple contusions, prescribed Ibuprofen, Flexeril, and Norco and advised to apply moist heat to the affected areas. She was advised that if she did not improve within three to four days, she was to contact her primary care physician. The next day, the claimant was examined by her primary care physician, who noted complaints of pain in the neck, back, and left shoulder, as well as "aches and pains in different parts of body including left lower thigh and leg and left forearm." However, the doctor observed that her main complaints were predominantly confined to the neck and left shoulder. He noted that the claimant had previously existing "widespread arthritis in her neck and spine." She had undergone a lumbar discectomy in 2011. He advised her not to work for five days, and requested that she follow-up again the following Monday. The very next day, July 23, 2013, the claimant called this physician to advise that now she had headaches and "pain behind the eyes." He referred her to the local Emergency Room where CT scans of the head and neck were performed with negative results. X-rays of the lumbar spine were performed and negative. She was given a prescription for Toradol. She was re-evaluated again by her primary care physician, and physical therapy was recommended. When evaluated by the physical therapist, the claimant presented with multiple complaints and diffuse pain and tenderness. The therapist noted pain at the slightest touch. The physical therapist noted that the claimant advised of "unclear thinking" and when she described the subject accident was unsure whether she experienced an impact to her head. Approximately one month later, the claimant was evaluated at Mohawk Valley Orthopedics, and when she described the subject accident, the claimant stated that she did not remember much of the



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circumstances of the accident itself and could not remember whether she hit her head upon impact. Her complaints expanded and now included constant, excruciating headaches, along with photosensitivity that caused her to don her sunglasses throughout the examination. Due to concern of post-concussion syndrome, the P.A. referred the claimant to a neurologist, Dr. Tolge. Upon presenting to Dr. Tolge, two months post-accident, the claimant reported that she had no memory of the actual impact of the vehicles at the time of the accident and she “probably did have a brief loss of consciousness.” She had complaints of photophobia, sonophobia, tinnitus, nausea, upset stomach, and dizziness, with pain all over. Dr. Tolge evaluated the claimant and referred her to a neuropsychologist and prescribed medications. Subsequently, the claimant had applied for and was then receiving Social Security Disability benefits. She attempted to return to work as a secretary but stated that the memory deficits and difficulties with concentration prevented her from returning to her employment. The arbitrator considered testimony from the claimant and from her husband, and reviewed the submitted medical documentation. The arbitrator found that the written medical documentation did not support the claimant’s alleged injuries. The arbitrator found that there was a gross disparity between what appeared to have been a minor collision and the large number of painful injuries claimed as a result, which were not supported by objective medical evidence. Accordingly, the arbitrator was not persuaded that the claimant sustained a serious injury or that she sustained a loss in excess of basic economic loss as a result of the subject automobile accident. Therefore, no award was made. The arbitrator noted that even if arguably, the claimant did sustain a serious injury, the previously received \$70,000.00, would be adequate compensation for her damages.

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