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2020 AAA INSURANCE REPORTER / ISSUE 1

2019 Q4 Client Satisfaction Survey Responses

Thank you to all who participated in our *No-Fault Client Satisfaction Quarterly Survey*. We value your feedback and continue to make decisions based on that feedback. Following are our responses to selected questions and requests posed in the survey:

What causes the rejection of a no-fault filing?

Essential information missing from a filing, documents that do not correspond to the AR-1, or a third-party administrator (TPA) listed as a carrier could result in non-acceptance of a case into the forum.

The guide *Arbitrator Suggested Best Practices for Document Submission* on the no-fault page of our website offers important advice on this subject. Customers can access the no-fault section by clicking <https://nysinsurance.adr.org/programs/no-fault>.

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.*

What is the policy regarding parties appearing by phone for hearings?

All telephonic hearings requests are reviewed and approved at the discretion of the assigned arbitrator. As the neutral administrator of the caseload, the AAA does not have authority to influence or overrule an arbitrator's decision regarding a party's telephonic hearing request.

What is the best way to contact AAA regarding upcoming requests?

Arbitration: For arbitrator-related matters, such as telephonic-hearing requests, technical-correction requests, and adjournment requests, please contact the arbitration department by telephone at 646-663-3470 or by email at arbitratorsupport@adr.org.

Conciliation: For conciliator-related matters, such as settlement offers in conciliation and document extension requests, please contact your respective conciliation team.

Please see the table below for the contact information of the eight conciliation teams.

ADR Center Team 1		ADR Center Team 2	
Team Telephone:	646-663-3461	Team Telephone:	646-663-3462
Team Email:	ADRCenterTeam1@adr.org	Team Email:	ADRCenterTeam2@adr.org
ADR Center Team 3		ADR Center Team 4	
Team Telephone:	646-663-3463	Team Telephone:	646-663-3464
Team Email:	ADRCenterTeam3@adr.org	Team Email:	ADRCenterTeam4@adr.org



AAA® INSURANCE REPORTER

2020 AAA INSURANCE REPORTER / ISSUE 1

ADR Center Team 5		ADR Center Team 6	
Team Telephone:	646-663-3465	Team Telephone:	646-663-3466
Team Email:	ADRCenterTeam5@adr.org	Team Email:	ADRCenterTeam6@adr.org

ADR Center Team 7		ADR Center Team 8	
Team Telephone:	646-663-3467	Team Telephone:	646-663-3460
Team Email:	ADRCenterTeam7@adr.org	Team Email:	ADRCenterTeam8@adr.org

Why can't the parties choose their hearing location for cases scheduled?

Cases are scheduled based on the location of the applicant or representative, pursuant to DFS interpretation of the regulation section below

65-4.5 (i)(1) of No-Fault Regulation 68 cites the following: *The arbitration hearing shall be held in the arbitrator's office or any other appropriate place selected by the designated organization and, to the extent practicable, within the general locale of the applicant's residence but, in no event, more than 100 miles from such residence.*

What are the rules for notifying AAA that I intend to bring a witness?

65-4.5 (o) (4) of No-Fault Regulation 68 cites the following: *If a party to an arbitration intends to introduce an expert witness at the hearing, the identity of the expert witness must be given to all parties at least seven calendar days prior to the hearing.*

The party making the request must email, send a message in ADR Center, or call the Arbitrator Support team to provide the name of the witness. The Arbitrator Support team can be reached by email at arbitratorsupport@adr.org or by phone at 646 663-3470.

Why does it take longer for the status of my NF Master case to be updated in ADR Center?

The current set-up for the Masters caseload allows for paper (manual) submission of cases, which results in longer timeframes. We currently have a master arbitration pilot program that allows for electronic brief submissions. If you are interested in participating in the pilot program that allows emailing submissions and avoids traditional paper mail, please contact our Master Appeal Team by phone at 917-438-1671 or by email at MasterAppealTeam@adr.org.

Why are there adjournment fees?

Adjournment fees are used to defray the cost of administration of the arbitration forum.

The current process allows for "bulk" adjournments; i.e., adjourning a block of cases on a specific day before the same arbitrator would result in only one fee for the block of cases instead of a fee for each individual case.

65-4.5 (j) of No-Fault Regulation 68 cites the following: *Postponements and adjournments. The arbitrator may for good cause 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 adjournment request is received by the designated organization*



AAA® INSURANCE REPORTER

2020 AAA INSURANCE REPORTER / ISSUE 1

at least two business days prior to the scheduled arbitration. There shall be an adjournment fee of \$50 payable to the designated organization by the party requesting any subsequent adjournment. An adjournment fee of one hundred dollars (\$100) shall be payable to the designated organization by the party causing any adjournment within two (2) business days prior to the scheduled hearing. Such fees shall be used to defray the cost of administration of the arbitration forum.

The No-Fault Arbitration Scheduling Process

No-fault cases that are not resolved in conciliation are escalated to arbitration and the assignment of an arbitrator and a hearing date. The AAA prides itself on its ability to schedule a large volume of cases effectively and efficiently and in an equitable manner. Our scheduling team assigns an average of over 10,000 cases to the hearing calendar every month. In 2019, there were just under 130,000 hearings held in various regions in New York State. We expect the number of hearings to continue to increase in 2020 due to the addition of eight new arbitrators appointed to the panel in late 2019.

Cases are scheduled from oldest to newest utilizing the date of escalation to determine the order in which the cases are assigned for hearing. AAA determines the number of hearing assignments per month for each applicant by calculating their total number of filings for a 12-month period as a percentage of total filings for all applicants.

There are several factors for a scheduler to consider when reviewing a case to schedule. One factor is the number of available resources that a party assigns to appear at hearings, as are location and arbitrator availability. Additional factors include linked cases that require an assignment to the same arbitrator who heard the related case. Conflicts and party availability also can limit the number of arbitrators available to schedule. For example, if a party has a conflict with an arbitrator, the arbitrator is removed from hearing their cases. Similarly, if a party is not available to attend hearings on a particular day of the week, the number of arbitrators that AAA can schedule is reduced. The AAA encourages all parties to maintain an adequate number of resources and availability to ensure the equitable distribution of hearing slots.

For questions concerning scheduling, please contact Scheduling Supervisor Linda Tillery at 917 438-1525 or email TilleryL@adr.org.

Best Practices: Priority Arbitration and Special Expedited Arbitration Cases

Pursuant to 11 NYCRR 65-4.5(i)(2), a party may elect Priority Arbitration when the request for arbitration is made within 90 days after either receipt of a denial of claim or the claim became overdue. Additionally, pursuant to 11 NYCRR 65-4.5(b), Special Expedited Arbitration proceedings are available for cases denied based on failure to submit a notice of claim within 30 days of the accident. The Regulation further states that a Special Expedited Arbitration must be requested within 30 days after the mailing of the denial to qualify. Priority Arbitration and Special Expedited Arbitration requests are addressed on page 2 of the revised AR-1 Form under Requests for Special Handling.

To ensure that your case qualifies pursuant to the Regulation for a Priority Arbitration or a Special Expedited Arbitration, one or more of the following verifying documents must be included in your initial submission for each claim: denials, delay letters, and/or proof of mailings. If the necessary verifying documentation is not received within the initial submission, the case will proceed as a normal arbitration.

To learn more about completing the AR-1 Form, please view the instructional YouTube video at <https://youtu.be/WKaOTbVx7XA>. If you have any questions, please contact Deborah Bosketti at BoskettiD@adr.org.



AAA® INSURANCE REPORTER

2020 AAA INSURANCE REPORTER / ISSUE 1

Spotlight on the Arbitrator Support Team

Case administrators on the Arbitrator Support team serve as liaisons between the parties and the arbitrators during the arbitration phase of a no-fault case. Case administrators administer cases in compliance with No-Fault Regulation 68 Subpart 65-4 and ensure that the needs of the parties and the arbitrators are met throughout the process. A case administrator must pay great attention to detail, communicate effectively, demonstrate excellent organizational skills, and remain flexible at all times.

A good portion of a case administrator's time is spent managing cases for the parties and the arbitrators, including coordinating all aspects of a case hearing and ensuring the appropriate steps are taken in a timely fashion throughout the process. In addition, they are responsible for managing hearing deadlines and gathering required documents when directed by the arbitrator. The day-to-day work of a case administrator on the Arbitrator Support team can vary tremendously—even weather-related events can impact how they prioritize their days!

Customers can contact the Arbitrator Support team for assistance with any case-related issues that arise in arbitration including, but not limited to, requests for telephonic hearings, adjournments, and witness requests.

To reach a member of the Arbitrator Support team, please call 646 663-3470 or email ArbitratorSupport@adr.org.

For supervisory support, please contact Chanta Holloway-Bell at 917 438-1713 or email HollowayC@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

Range of Motion/Manual Muscle Testing & Medical Necessity

- *Tandingan PT, PC & American Transit Ins. Co.*, AAA Case no. 17-19-1129-9247 (1/27/20) (Amanda R. Kronin, Arb.);
- *Elmwood Park Medical Group, PC & American Transit Ins. Co.*, AAA Case no. 17-19-1130-3539 (1/23/20) (Paul Weidenbaum, Arb.);
- *Alexander Haselkorn, M.D., & Geico Ins. Co.*, AAA Case no. 17-19-1120-5923 (1/11/20) (Gary Peters, Arb.);
- *Riaz Medical, PC & MVAIC*, AAA Case no. 17-18-1101-6873 (1/8/20) (Andrew Horn, Arb.)

Range of Motion/Manual Muscle Testing & Fee Schedule

- *Quantum Rehab Physical Therapy, PC & Progressive Cas. Ins. Co.*, AAA Case no. 17-18-1104-1307 (11/14/19) (Ellen Weisman, Arb.);
- *MMA Physical Therapy, PC & Allstate Fire & Cas. Ins. Co.*, AAA Case no. 17-18-1115-1819 (12/3/19) (Valerie D. Greaves, Arb.);



AAA® INSURANCE REPORTER

2020 AAA INSURANCE REPORTER / ISSUE 1

- *Chiropractic Testing Services of NY, PC & Geico Ins. Co.*, AAA Case no. 17-18-1113-0660 (1/11/20) (Patricia Daugherty, Arb.);
- *Nassau Queens Medical, PC & Allstate Fire & Cas. Ins. Co.*, AAA Case no. 17-18-1089-9657 (10/14/19) (Drew M. Gewuerz, Arb., CPC).

MRI Studies & Medical Necessity

- *Accelerate Radiology, PC d/b/a Precision Accelerated & Hereford Ins. Co.*, AAA Case no. 17-19-1119-0679 (1/30/20) (Heidi Obiajulu, Arb.);
- *Community Medical Imaging, PC & Geico Ins. Co.*, AAA Case no. 17-17-1064-2037 (9/5/19) (Ritesh Mallick, Arb.);
- *Leadon Radiology, PC & Geico Ins. Co.*, AAA Case no. 17-18-1098-3679 (1/29/20) (Frank Marotta, Arb.);
- *City Wide Health Facility, Inc. & American States Ins. Co.*, AAA Case no. 17-18-1104-2666 (12/13/19) (Ellen Weisman, Arb.).

MRI Studies & Additional Views

- *Stand Up MRI of Melville & Allstate Fire & Cas. Ins. Co.*, AAA Case no. 17-18-1085-4091 (5/25/19) (Robyn McAllister, Arb.);
- *Stand Up MRI of Melville & Allstate Ins. Co.*, AAA Case no. 17-17-1071-4988 (2/5/19) (Matthew Summa, Arb.).

MRI Studies & ACR Guidelines

- *Westchester Radiology & Imaging PC & American Transit Ins. Co.*, AAA Case no. 17-17-1067-0681 (4/13/19) (Vincent Gerardi, Arb.);
- *Eclipse Medical Imaging, PC & Allstate Fire & Cas. Ins. Co.*, AAA Case no. 17-18-1099-1792 (7/3/19) (Allison Schimel, Arb.);
- *Buffalo Diagnostic Imaging & Geico Ins. Co.*, AAA Case no. 17-18-1105-6204 (10/3/19) (Michelle Murphy-Louden, Arb.);
- *Ozone Park Radiology & Imaging, PC & Geico Ins. Co.*, AAA Case no. 17-18-1103-8623 (11/18/19) (James Hogan, Arb.);
- *Columbus Imaging Center & Allstate Ins. Co.*, AAA Case no. 17-18-1085-2397 (11/20/19) (Claire Gallagher, Arb.);
- *Lenox Hill Radiology & Medical Imaging Associates, PC & Liberty Mut. Ins. Co.*, AAA Case no. 17-18-1091-8723 (11/21/19) (Martin Schulman, Arb.).

X-Ray Studies: Medical Necessity & Fee Schedule

- *Niagara Falls Memorial Medical Center & Geico Ins. Co.*, AAA Case no. 17-17-1075-7337 (6/25/19) (Brian Bogner, Arb.);
- *Primary Diagnostic Imaging, PC & MVAIC*, AAA Case no. 17-16-1039-2643 (2/25/18) (Toby Susan DeSimone, Arb.);
- *Advantage Radiology, PC & Geico Ins. Co.*, AAA Case no. 17-18-1088-2951 (12/5/19) (Heidi Obiajulu, Arb.).

SUM Awards: Loss of a Fetus & Serious Injury

- *W.T. & Merchants Ins. Group*, AAA Case no. 43-20-1600-0104 (Sheila R. Patcoff, Arb.);
- *P.P. & Peerless Ins. Co.*, AAA Case no. 01-17-0002-1128 (Nancy Hughes, Arb.).



AAA® INSURANCE REPORTER

2020 AAA INSURANCE REPORTER / ISSUE 1

Arbitrator Abstracts

Range of Motion/Manual Muscle Testing & Medical Necessity

Tandingan PT, PC & American Transit Ins. Co., AAA Case no. 17-19-1129-9247

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(1/27/20) (Amanda R. Kronin, Arb.) Applicant sought reimbursement for range of motion (ROM) and manual muscle testing (MMT). Respondent relied upon a peer review by Peter Chiu, M.D., to establish a lack of medical necessity. Dr. Chiu suggested that these services can easily be provided by a clinical examination, and there is no need for separately performing those tests. The arbitrator found that Dr. Chiu cited to authority in support of his position and factually demonstrated that the services were not medically necessary. Applicant relied on a rebuttal from the treating physician, Dr. Tandingan. Dr. Tandingan argued that the injured person's persistent symptoms despite a course of physical therapy warranted a more in-depth physical evaluation. The rebuttal further asserted that MMT directs the practitioner as to where to focus care. The arbitrator weighed the evidence before her and found the rebuttal persuasive. The arbitrator found that the testing was medically necessary and entered an award in favor of applicant.

Elmwood Park Medical Group, PC & American Transit Ins. Co., AAA Case no. 17-19-1130-3539

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(1/23/20) (Paul Weidenbaum, Arb.) Applicant sought reimbursement for range of motion (ROM) and manual muscle testing (MMT). Respondent relied upon a peer review by Peter Chiu, M.D., to establish a lack of medical necessity. Dr. Chiu stated that the examination by the treating physician should include numerical values for ROM/MMT as part of a regular physical exam. He further stated that treatment plans are not changed based upon the results of ROM/MMT. Applicant relied on a rebuttal authored by Dr. Sangavaram. Dr. Sangavaram argued that the injured person's condition had not improved after five weeks of conservative treatment and thus the ROM/MMT was warranted. Dr. Sangavaram asserted that computerized ROM/MMT provides more accurate and reliable data than manual testing. He also asserted that the testing provides a baseline to provide a more accurate assessment of impairment and progress. Comparing the peer review and the rebuttal, the arbitrator found that applicant established the medical necessity of the computerized ROM/MMT and entered an award in favor of applicant.

Alexander Haselkorn, M.D. & Geico Ins. Co., AAA Case no. 17-19-1120-5923

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

(1/11/20) (Gary Peters, Arb.) Applicant sought reimbursement for range of motion (ROM) and manual muscle testing (MMT). Respondent denied the claim based upon a peer review by Kevin Curley, Jr., M.D., who found the testing to be medically unnecessary. Dr. Curley asserted that the testing was not typically utilized in standard medical practice. He argued that the same information is expected to be obtained in a history and physical examination by the treating physician. Applicant did not provide a rebuttal to the peer review. The arbitrator found the peer review persuasive and denied the claim.

Riaz Medical, PC & MVAIC, AAA Case no. 17-18-1101-6873

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(1/8/20) (Andrew Horn, Arb.) Applicant sought reimbursement for manual muscle testing (MMT). Respondent denied the claim based upon a peer review by Isandr Dumesh, M.D., who found the testing to be medically unnecessary. Dr. Dumesh argued that manual muscle testing is part of any initial examination and should be sufficient to assess muscle strength. Dr. Dumesh stated that the separate computerized testing would not provide any additional diagnostic information that would affect the treatment course



AAA® INSURANCE REPORTER

2020 AAA INSURANCE REPORTER / ISSUE 1

or benefit the claimant in any way. The arbitrator found the peer review sufficient to shift the burden to applicant to establish the necessity of the testing. No rebuttal was offered by applicant. Thus, the arbitrator upheld the denial based upon the peer review and denied the claim.

Range of Motion/Manual Muscle Testing & Fee Schedule

Quantum Rehab Physical Therapy, PC & Progressive Cas. Ins. Co., AAA Case no. 17-18-1104-1307
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(11/14/19) (Ellen Weisman, Arb.) Applicant sought reimbursement for range of motion (ROM) testing and muscle testing. Respondent asserted a fee-schedule defense premised on the New York Workers' Compensation Medical Fee Schedule. Applicant billed for ROM testing twelve (12) times pursuant to CPT code 95851 at \$41.66 each, including four (4) units of cervical ROM testing, two (2) units each of thoracic and lumbar ROM testing, and four (4) units of bilateral shoulder ROM testing. Respondent paid for five (5) units of ROM testing at \$41.66 each, which included testing of the cervical spine, thoracic spine, lumbar spine and both shoulders, for a total of \$208.30. Respondent then denied seven (7) units of ROM testing, based on the fee schedule. Additionally, applicant billed for muscle testing nine (9) times pursuant to CPT code 95831 at \$39.73 each, including two (2) units for cervical muscle testing, one (1) unit for trunk muscle testing, and six (6) units for bilateral shoulder muscle testing. Respondent paid for three (3) units of muscle testing at \$39.73 each, including the cervical spine, trunk and one shoulder, for a total of \$119.19, and denied six (6) units of muscle testing based on the fee schedule. In support of its reduction, respondent submitted the affidavit of Ms. LeeAnn Morris, Medical Coder, in which she stated that ROM and muscle testing were billed improperly, as they should have been billed per body part and not for each motion that is measured. Applicant submitted the affidavit of Ms. Estrella Lorilita Pena, P.T., Corporate Officer and Owner, in which she stated that this type of testing is not time-based and that billing is permitted for each extremity and trunk section that is tested. The arbitrator found that respondent properly reduced the bill for ROM testing. The arbitrator noted that the plain language of the fee schedule permits billing for each region that is tested, not for each motion that is measured. The arbitrator also found that applicant was entitled to bill once for muscle testing for each section of the body that was tested rather than for each motion that was measured. The arbitrator found that respondent properly paid for testing of each region that was measured.

MMA Physical Therapy, PC & Allstate Fire & Cas. Ins. Co., AAA Case no. 17-18-1115-1819
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(12/3/19) (Valerie D. Greaves, Arb.) The arbitrator addressed whether the respondent established its fee-schedule defense predicated on the New York Workers' Compensation Medical Fee Schedule. Applicant sought reimbursement for range of motion (ROM) testing and activity limitation measurement testing. Respondent asserted that the fee schedule for CPT codes designated for ROM and muscle testing procedures sets forth that billing is allowed per body part and not per directional position measured/ tested. With respect to the activity limitation measurement testing, applicant billed under CPT code 97999, a "By Report" code requiring a written report to substantiate reimbursement. Applicant's submission contained the medical report documenting the testing performed. For this testing, respondent asserted that applicant billed an incorrect CPT Code, and that CPT Code 97750 would be the proper code to be utilized for this testing. Applicant's counsel asserted that respondent's submission failed to substantiate how respondent reached the determination that CPT 97750 was more appropriate. The arbitrator found that respondent failed to substantiate its fee-schedule defenses, as no fee coder affidavit or coding expert analysis was submitted to establish that ROM should be billed per body part or to corroborate its code change.



AAA® INSURANCE REPORTER

2020 AAA INSURANCE REPORTER / ISSUE 1

Chiropractic Testing Services of NY, PC & Geico Ins. Co., AAA Case no. 17-18-1113-0660
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(1/11/20) (Patricia Daugherty, Arb.) Applicant sought reimbursement for five (5) units of range of motion (ROM) testing under CPT 95851 at a rate \$31.27 per unit and ten (10) units of muscle testing under CPT 95831 at a rate of \$29.82 per unit. Respondent based its denials upon a fee-schedule defense premised upon the New York Workers' Compensation Medical Fee Schedule and changed the codes billed by applicant to reflect physical performance testing under CPT Code 97750. Respondent asserted that applicant was properly reimbursed pursuant to the fee schedule. Applicant argued that respondent improperly changed the code for ROM and muscle testing to a code for a service that was not performed. Applicant submitted the affidavit of Frank Keane, a Certified Professional Coder (CPC), in support of its billing. The arbitrator was not persuaded by Mr. Keane's affidavit and found that the fee schedule sets forth that muscle testing is billable per extremity or trunk, and range of motion testing is billable per extremity or trunk section. The arbitrator found that since the medical records indicated that the muscle testing was rendered to four (4) extremities, applicant would be entitled to reimbursement for only four (4) units of muscle testing. With respect to the ROM testing, the arbitrator found that the medical records indicated that the ROM testing was rendered to the cervical and lumbar spine only. Therefore, applicant was only entitled to reimbursement for two (2) units of range of motion testing.

Nassau Queens Medical, PC & Allstate Fire & Cas. Ins. Co., AAA Case no. 17-18-1089-9657
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(10/14/19) (Drew M. Gewuerz, Arb., CPC) Applicant sought reimbursement for range of motion (ROM) and muscle testing billed under CPT codes 95831 and 95851. Respondent reimbursed applicant for seven (7) units of ROM testing and an amount equivalent to a total body evaluation for muscle testing. The arbitrator took judicial notice of the CPT Assistant, which sets forth that ROM and muscle testing should be billed under code 97750, a timed code of 15-minute increments. Elements involved in physical performance tests or measurements, as reported by code 97750, include the test or measurement procedure itself, as well as the time required to analyze and interpret the resulting data while the patient is present. Each increment is considered one (1) unit and reimbursed at \$41.66. The arbitrator found that codes 95851 and 95831 should not be reported separately because both services would be considered integral components of a physical performance test (97750). The arbitrator found that since applicant did not list the amount of time spent performing the disputed services in its reports, an equitable solution would be to reimburse at the rate for CPT code 97750 and frequency of CPT Codes 95851 and 95831. The arbitrator found that since the applicant performed four (4) units of ROM testing (bilateral upper extremities, cervical, and lumbar spine) and three (3) units of muscle testing (bilateral upper extremities, trunk), the maximum permissible amount was \$291.62 per date of service.

MRI Studies & Medical Necessity

Accelerate Radiology, PC d/b/a Precision Accelerated & Hereford Ins. Co., AAA Case no. 17-19-1119-0679
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(1/30/20) (Heidi Obiajulu, Arb.) The arbitrator addressed whether a spinal MRI study was medically necessary. In support of its defense, respondent relied on a peer review. In opposition, applicant relied on a rebuttal. In reviewing the record, the arbitrator found that the cervical MRI study was medically necessary and performed consistent with the standards of care cited by the peer review doctor, as the medical evidence revealed that the injured party continued to experience persistent neurological deficits after undergoing over six weeks of physical therapy. The arbitrator further noted that the peer review doctor's main argument was that he was not provided with a copy of any follow-up examination reports by the prescribing provider, which the arbitrator found was not an appropriate basis to deny the claim. Consequently, the arbitrator determined that the peer review doctor had an insufficient factual basis upon which to render his opinion. Applicant's claim was awarded in its entirety.



AAA® INSURANCE REPORTER

2020 AAA INSURANCE REPORTER / ISSUE 1

Community Medical Imaging, PC & Geico Ins. Co., AAA Case no. 17-17-1064-2037
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(9/5/19) (Ritesh Mallick, Arb.) The arbitrator addressed whether an MRI study of the cervical spine was medically necessary. In support of its defense, respondent relied on a peer review report and applicant submitted a rebuttal. The peer review doctor found that upon an examination of the clinical record, the cervical spine MRI was not medically necessary, as the results would not have enhanced the claimant's care and the claimant's complaints of pain were not chronic in nature. The peer review doctor also opined that MRI studies of patients with relatively less severe whiplash symptoms reveal a low frequency of abnormalities apart from spondylosis and loss of lordosis, both of which have limited prognostic value in the short-term. The arbitrator found that the peer review doctor's rationale on the issue of medical necessity was inconsistent and contrary to the substance of the authority relied upon. The arbitrator noted that the referenced authority did not state that an injured person's complaints of pain must be chronic in nature prior to consideration of a spinal MRI referral, nor did it state that findings consistent with spondylosis and loss of lordosis are bereft of clinical value. As such, the arbitrator concluded that the peer review doctor's opinion was conclusory and insufficient to meet respondent's burden of proof. Applicant was awarded reimbursement.

Leadon Radiology, PC & Geico Ins. Co., AAA Case no. 17-18-1098-3679
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(1/29/20) (Frank Marotta, Arb.) The arbitrator addressed whether a cervical spine MRI was medically unnecessary pursuant to respondent's peer review report. The peer review doctor recited the clinical record and set forth the standard of care for the medical necessity of the spinal MRI. The peer review doctor determined that the standard of care was not met as the subject imaging was recommended approximately 10 days following the date of injury. The arbitrator found that the peer review report was sufficient to rebut the presumption of medical necessity that attached to the applicant's submitted bill. Applicant failed to rebut that presumption, in that it failed to submit a formal rebuttal and its examination reports failed to address the MRI at issue. Accordingly, the arbitrator found that there was no proof to contradict the opinion of the peer review doctor, and applicant failed to establish the medical necessity of the MRI by a preponderance of the evidence. Applicant's claim was denied.

City Wide Health Facility, Inc. & American States Ins. Co., AAA Case no. 17-18-1104-2666
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(12/13/19) (Ellen Weisman, Arb.) The arbitrator addressed whether MRI studies of the cervical spine and lumbar spine were medically necessary. Respondent's representative argued that the spinal MRI studies were ordered prematurely on the initial visit and before the patient had attempted any conservative care. It was noted that the standard of care calls for conservative treatment for four to six weeks prior to ordering advanced imaging, as was asserted in respondent's peer review report. Applicant countered that there was no standard of care enunciated by the peer review doctor, and its rebuttal confirmed that the failure to respond to conservative care for two to three weeks justified the MRI studies due to the patient's inadequate response to treatment. The arbitrator determined that neither applicant's medical records, the rebuttal report, nor the evidence collectively rebutted the respondent's credible and cogent peer review. The arbitrator was persuaded by the peer review doctor's opinion that the MRI studies were ordered prematurely on the initial visit. Based on the weight of the evidence, applicant's claim was denied.

MRI Studies & Additional Views

Stand Up MRI of Melville & Allstate Fire & Cas. Ins. Co., AAA Case no. 17-18-1085-4091
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(5/25/19) (Robyn McAllister, Arb.) Applicant sought reimbursement for MRI studies of the cervical and lumbar spine with additional flexion and extension views. Respondent denied the claim based on the peer review report of Dr. Kevin Portnoy, D.C. The peer



AAA® INSURANCE REPORTER

2020 AAA INSURANCE REPORTER / ISSUE 1

review doctor stated that there was no indication from the referring chiropractor that he needed to confirm, rule out, or follow the status of a lesion of the spinal cord, intervertebral discs, tumor processes, syrinx, demyelinating disease, bony, or other soft tissue structures in or around the spine or that he suspected any of these conditions. The peer review doctor asserted that the MRI studies would not aide in devising, altering, reducing the number of visits to his office, or enhance the clinical prognosis of the injured person. There were no records from the referring chiropractor to indicate that at the time he referred the injured person for the lumbar MRI, there were any positive neurological findings that would indicate disc pathology. The peer review doctor stated that standard of care would be evaluation by a chiropractor, ordering of plain radiographs (if there is suspicion of fracture or severe mechanism of injury), rest and/or conservative therapy for a period of six to eight weeks. Since there were no clear-cut neurological deficits or suspected ligamentous instability, and the injured person was still in the acute stage of treatment, the peer review doctor found that the MRI study of the cervical spine was not necessary. The peer review doctor also stated that the additional views were not medically necessary since the referring doctor failed to indicate that he suspected any ligament laxity, ligamentous instability, or aberrant spinal movement. The arbitrator found that the peer review was sufficient to support respondent's defense of lack of medical necessity. Applicant failed to submit a rebuttal or letter of medical necessity to refute the peer review doctor's determination. The arbitrator also noted that at the time the injured person was referred for the MRI studies, a follow-up evaluation was not performed. The arbitrator found that applicant failed to provide a medical basis for the additional views. Since applicant failed to meet its burden of persuasion in rebuttal, the claim was denied.

Stand Up MRI of Melville & Allstate Ins. Co., AAA Case no. 17-17-1071-4988

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(2/5/19) (Matthew Summa, Arb.) Applicant sought reimbursement for MRI studies of the cervical and lumbar spine with additional views. Respondent denied the claim based on the peer review report of Dr. Brian Wolin, D.C. The peer review doctor found that the MRI studies were not medically necessary and discussed the additional flexion and extension imaging. The peer review doctor stated that standard of care was not met with regard to flexion/extension views of the cervical and lumbar spine, as there was no evidence of spondylolisthesis, fracture, and/or instability to require these additional views on MRI. The peer review doctor stated that a contraindication to instability would be chiropractic adjustments and on the date of initial evaluation, the injured person was recommended to have chiropractic treatment. Therefore, the peer review doctor asserted that fracture or instability would not have been considered at that particular time. The arbitrator found that the peer review provided a cogent medical rationale as to why the MRI studies with additional views were not medically necessary. The arbitrator noted that applicant failed to submit a rebuttal to the peer review report and found that the medical records submitted by applicant were insufficient to establish that the MRI studies were medically necessary. The arbitrator also found that the medical records failed to address why the MRI studies were prescribed shortly after the beginning of treatment and contrary to the initial examination recommendations. The arbitrator found that applicant failed to establish that the additional views were warranted. Thus, the claim was denied.

MRI Studies & ACR Guidelines

Westchester Radiology & Imaging PC & American Transit Ins. Co., AAA Case no. 17-17-1067-0681

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(4/13/19) (Vincent Gerardi, Arb.) Applicant sought reimbursement for an MRI study of the cervical spine. Respondent's denial was based on the peer review report of Dr. Richard Coven. The peer review doctor stated that certain criteria must be met in order for the MRI study to be medically necessary; i.e., the MRI must be necessary to determine injury mechanism; determine history of trauma to the neck, acute pain, or whiplash; and search for symptoms of neurological impairment or weakness. The peer review doctor concluded that the medical reports submitted by applicant failed to meet the criteria, and therefore, the MRI study was not medically necessary. Applicant submitted a rebuttal by Dr. Brij Mittal, who noted that the MRI study was ordered based on the injured person's history and findings on examination, which led to a determination that the injured person suffered an acute trauma



AAA® INSURANCE REPORTER

2020 AAA INSURANCE REPORTER / ISSUE 1

necessitating the MRI study. Dr. Mittal cited to American College of Radiology (ACR) guidelines stating that acute trauma is an indicator for an MRI study of the spine. The arbitrator considered all of the evidence and concluded that the respondent failed to establish its defense of lack of medical necessity. Accordingly, applicant was awarded reimbursement for the MRI study performed.

Eclipse Medical Imaging PC & Allstate Fire & Cas. Ins. Co., AAA Case no. 17-18-1099-1792
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(7/3/19) (Allison Schimel, Arb.) Applicant sought reimbursement for an MRI study of the left shoulder. Respondent's denial was based on the peer review report of Dr. Isandr Dumesh, who reviewed the medical records, including the orthopedic test findings, and found that there were no indications of complex ligament damage to the shoulder warranting the MRI study. The peer review doctor stated that standard of care for an MRI study of the shoulder would be four to six weeks of conservative care and a diagnosis not readily ascertainable with standard x-rays. The peer review doctor also stated that there was no indication as to how the results of the studies would affect treatment. Applicant submitted a rebuttal by Dr. Jack Baldassare, who disagreed with the peer review doctor's assertions, noting that there were positive findings on examination. Dr. Baldassare stated that the MRI study of the shoulder was medically necessary to evaluate for various clinical scenarios, including shoulder trauma. Dr. Baldassare cited to American College of Radiology (ACR) guidelines stating that trauma is a sufficient finding when determining whether to order an MRI study of the shoulder. The arbitrator found that respondent's peer review report was sufficient to establish a lack of medical necessity for the MRI study and that applicant's rebuttal failed to refute the peer review doctor's determination. The MRI was ordered after the initial evaluation and before the injured person had begun conservative care. The arbitrator acknowledged applicant's citation to ACR guidelines but was persuaded by the citations set forth in respondent's peer review, which state that there should be four to six weeks of conservative care prior to considering MRI testing. The claim for the MRI of the left shoulder was denied.

Buffalo Diagnostic Imaging & Geico Ins. Co., AAA Case no. 17-18-1105-6204 (10/3/19)
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(Michelle Murphy-Louden, Arb.) Applicant sought reimbursement for an MRI study of the cervical spine. Respondent denied the claim based on the peer review report of Dr. Jeffrey Beer who, after reviewing the medical records and pertinent literature, determined that the MRI study was not medically necessary. The peer review doctor noted that the injured person did not present with any signs or symptoms of cervical radiculopathy and the neurological findings did not reveal any abnormalities. The peer review doctor also noted that American College of Radiology, ACR Appropriateness Criteria guidelines do not support an MRI in patients with whiplash injuries unless neurological findings are present. The arbitrator found that the peer review provided a clear factual basis and medical rationale to deny the MRI study of the cervical spine. Since applicant failed to refute this finding based on the medical records presented, the claim was denied in its entirety.

Ozone Park Radiology & Imaging, PC & Geico Ins. Co., AAA Case no. 17-18-1103-8623
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(11/18/19) (James Hogan, Arb.) Applicant sought reimbursement for an MRI study of the cervical spine. Respondent denied the claim based on the peer review report of Dr. Isandr Dumesh who, after reviewing the medical records and pertinent literature, determined that the MRI study was not medically necessary. The peer review doctor noted that the MRI was done approximately four weeks after the injured person started conservative therapy, absent any indication that he was failing therapy or that alternative treatments were being considered. The peer review doctor concluded that the MRI study was medically unnecessary in the injured person's clinical setting because it would not have changed his therapy or assisted in further diagnosis. The peer review doctor stated that the MRI referral deviated from the standard of care set forth in the medical literature. Applicant submitted a rebuttal by Dr. Colin Clarke, the referring physician, who stated that the MRI study of the cervical spine was medically necessary and that the



AAA® INSURANCE REPORTER

2020 AAA INSURANCE REPORTER / ISSUE 1

patient was referred in accordance with the American College of Radiology (ACR) Appropriateness Criteria Guidelines to further evaluate the spinal cord and determine the extent and nature of the injury. The arbitrator found that the ACR Guidelines were inappropriate in New York No-Fault, as they do not set forth any type of timeline as to when an MRI should be done. The arbitrator concluded that respondent successfully rebutted the applicant's prima facie case and denied the claim.

Columbus Imaging Center & Allstate Ins. Co., AAA Case no. 17-18-1085-2397 (11/20/19)

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(Claire Gallagher, Arb.) Applicant sought reimbursement for MRI studies of the cervical and lumbar spine, left ankle, and left knee. Respondent denied the claim based on the peer review report of Dr. Richard Coven, who summarized the injured person's findings at an initial evaluation and stated that the history, subjective complaints, and physical examination findings were consistent with sprain/strain injuries that would not warrant MRI studies at the time they were performed. Applicant submitted a rebuttal by Dr. Drora Hirsch, who cited to the American College of Radiology (ACR) Guidelines and other medical publications in support of her opinion that the MRI studies were appropriate and medically necessary. The arbitrator found that Dr. Hirsch rebutted the conclusions set forth in the peer review through extensive citations to applicable medical standards and the injured person's medical facts. Accordingly, applicant was awarded reimbursement for the MRI studies performed.

Lenox Hill Radiology & Medical Imaging Associates, PC & Liberty Mut. Ins. Co., AAA Case no. 17-18-1091-8723

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(11/21/19) (Martin Schulman, Arb.) Applicant sought reimbursement for MRI studies of the cervical and lumbar spine. Respondent denied the claim based on the peer review reports of Dr. Mitchell Ehrlich, who reviewed the injured person's relevant medical records and determined that the MRI studies deviated from the standard of care set forth in the American College of Radiology (ACR) and New York Workers' Compensation Board Neck Injury Medical Treatment Guidelines in that they were ordered prematurely and in the absence of fracture, injury to the spinal cord, neurological deficits, or a surgical need. The arbitrator found that the peer reviews overcame applicant's prima facie case and noted that applicant made no response to them. The claim for the MRI studies of the cervical and lumbar spine was therefore denied.

X-Ray Studies: Medical Necessity & Fee Schedule

Niagra Falls Memorial Medical Center & Geico Ins. Co., AAA Case no. 17-17-1075-7337

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(6/25/19) (Brian Bogner, Arb.) The arbitrator addressed whether respondent properly paid applicant in accordance with fee schedule. Applicant billed for a number of emergency department services, including X-rays to the nasal cavity and left knee. Respondent didn't submit an affidavit from a professional coder or fee audit in support of its defense. Respondent asserted that its calculations were based upon a plain reading of the fee schedule. With regard to the nasal bone X-ray billed pursuant to Code 70160, the arbitrator found that the fee schedule lists a relative value of 1.28 and a PC/TC (professional component/technical component) split of 40/60. As such, the reimbursement amount for Code 70160 in the applicant's region is \$52.00 ($\40.63×1.28) and the technical component portion is \$31.20 ($\52.00×0.60). However, the arbitrator found that the amount is subject to further reduction pursuant to Radiology Ground Rule 3(B), which states that "[f]or two remote parts, the charge shall be the greatest fee plus 75 percent of the lesser fee." Code 73562 has the greatest fee and, thus the arbitrator found that Code 70160 was properly reduced to \$23.40 ($\31.20×0.75). Based upon a similar analysis, the arbitrator found that that applicant was paid in accordance with fee schedule for the X-ray to the left knee and therefore was not entitled to further reimbursement.



AAA® INSURANCE REPORTER

2020 AAA INSURANCE REPORTER / ISSUE 1

Primary Diagnostic Imaging, PC & MVAIC, AAA Case no. 17-16-1039-2643
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(2/25/18) (Toby Susan DeSimone, Arb.) The arbitrator addressed whether X-rays of the chest and ribs were medically necessary. The injured person also underwent an MRI of the right shoulder. In support of its contention that the X-rays were not medically necessary, respondent relied upon the peer review report of Joseph Cole, M.D. Dr. Cole found that there was no rational basis for ordering the X-rays, as the testing would not aid in diagnosing and treating the patient. With regard to the MRI of the right shoulder, Dr. Cole asserted that the testing was ordered too early and that conservative management should have been implemented prior to ordering diagnostic testing. In opposition to the peer review report, applicant submitted a rebuttal prepared by the reading radiologist, Dr. Alan Greenfield, M.D. Dr. Greenfield asserted that the American Academy of Radiology Guidelines supported the MRI testing, as early detection leads to proper treatment. However, Dr. Greenfield did not address the medical necessity of the X-rays. The arbitrator deferred to the opinion of the treating radiologist and noted that the injured person presented with worsening neurological findings. Thus, the arbitrator found that the MRI study of the right shoulder was medically necessary. However, the arbitrator found that the X-ray studies were not medically necessary.

Advantage Radiology, PC & Geico Ins. Co., AAA Case no. 17-18-1088-2951
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(12/5/19) (Heidi Obiajulu, Arb.) The arbitrator addressed whether an X-ray of the left toe and MRI studies of the cervical spine and left knee were medically necessary. Respondent submitted the peer review report of Harry Jackson, M.D., in support of its defense. Dr. Jackson did not comment on the medical necessity of the X-ray of the left toe, thereby failing to meet its burden. With regard to the MRI study of the left knee, Dr. Jackson asserted that the testing should not have been performed until after a course of physical therapy was attempted, unless there are plain film findings suggestive of a fracture or dislocation, red flags (defined as infection or tumor), or if the results are immediately needed for surgery. In finding for respondent, the arbitrator found that applicant failed to submit evidence that directly addressed the points of the peer review doctor, and thus the claim for the MRI study of the left knee was denied. With regard to the MRI study of the cervical spine, the arbitrator found that Dr. Jackson set forth a sufficient factual basis and medical rationale for rejection of the claim, and applicant failed to submit evidence to refute respondent's evidence. Thus, the claim for the MRI study of the cervical spine was denied. Applicant was awarded reimbursement for the left toe X-ray performed.

SUM Awards: Loss of a Fetus & Serious Injury

W.T. & Merchants Ins. Group., AAA Case no. 43-20-1600-0104
[Sum Award Search](#)

(Sheila R. Patcoff, Arb.) The sole witness was the claimant, a 28-year-old female. This matter arose out of an automobile accident that occurred on November 30, 2012. Per the claimant, the underinsured tortfeasor's motor vehicle made a left turn directly in front of her vehicle, and although she tried to apply the brakes, the vehicles collided. There was no evidence to support any other factual account of the accident, and thus the arbitrator assigned all of the liability to the respondent. The claimant testified that following the accident, she experienced abdominal and back pain, as well as a vaginal discharge. Claimant was four weeks pregnant at the time of the accident. Claimant was taken by ambulance to the local hospital emergency room, where an ultrasound scan was performed that showed early pregnancy and/or fetal issues. The claimant was advised to follow up with her OB-GYN. However, claimant had neither a primary-care doctor nor an OB-GYN. Claimant commenced treatment with a chiropractor and a physiatrist. On January 3, 2012, the claimant presented to the emergency room at the local hospital, reporting vaginal spotting at 10 weeks of pregnancy. A second ultrasound scan was performed, and she was released with the advice to follow up with an OB-GYN. The next day, she returned to the emergency room due to worsening symptoms. At that time, the prior ultrasound scan performed on



AAA® INSURANCE REPORTER

2020 AAA INSURANCE REPORTER / ISSUE 1

the day of the subject accident was reviewed again, and it was determined that it showed evidence of fetal demise characterized by lack of cardiac activity. A third ultrasound scan was performed on that date, which confirmed an intra-uterine pregnancy without evidence of cardiac activity, consistent with fetal demise. A surgical procedure under general anesthesia was performed on the claimant. The claimant was monitored, treated alternately with morphine and oxycodone, and discharged for home on January 5, 2013. The arbitrator concluded that the subject accident was the proximate cause of the loss of the fetus. Respondent asserted that the claimant failed to produce medical evidence sufficient to prove that the subject accident caused claimant to sustain a loss of fetus. However, the arbitrator found that it is axiomatic that claimant need only prove that the negligence of the tortfeasor was a substantial factor in bringing about her injuries. One is not required to exclude every other possible cause, "... but need only offer evidence from which proximate cause may be reasonably inferred." *Fernandez v. State of New York*, 130 A.D.3d 566 (2d Dept 2015) quoting *Burgos v. Aqueduct Realty Corp.*, 92 N.Y.2d 544 (1998). Notably, the claimant's abdominal complaints and vaginal complaints commenced immediately after the subject accident, appeared to have increased intensely with time and were confirmed by diagnostic testing. The initial misdiagnosis at the emergency room was more than adequate evidence from which to reasonably infer that the negligence of the underinsured tortfeasor was a proximate cause of claimant's loss of a fetus. Loss of a fetus is enumerated in Insurance Law §5102 (d) as a serious injury. The arbitrator concluded that the claimant met its burden of proof of sustaining a serious injury, having lost a fetus as a result of the accident. The arbitrator awarded claimant the full \$100,000.00, available on the policy, less a set-off of \$25,000.00 for the policy amount previously received on behalf of the underinsured tortfeasor.

P.P. & Peerless Ins. Co., AAA Case no. 01-17-0002-1128

[Sum Award Search](#)

(Nancy Hughes, Arb.) The arbitrator found that the claimant did not meet her burden of proof with respect to establishing that the accident was the proximate cause of the loss of a fetus. The claimant was a 41-year-old female involved in an auto accident with an underinsured motorist on May 24, 2011. While pregnant and on her way to an appointment with the gynecologist, the claimant was "rear-ended" by the underinsured vehicle. The claimant was seeking damages for loss of a fetus and psychological injury. Respondent contended that due to claimant's pre-existing physical history, the loss of fetus was inevitable and unrelated to the subject accident. Respondent further contended that the claimant had been adequately compensated previously by the settlement received from the underinsured tortfeasor. It was noted that the claimant received the sum of \$50,000.00. Claimant had been awarded partial summary judgment on the issue of liability, and the damages were determined via a settlement agreement. The arbitrator found that the claimant's testimony regarding the mechanics of the motor vehicle accident varied in her EBT, EUO, and testimony at the hearing. The arbitrator noted that the post-accident photographs of the claimant's vehicle showed minimal damage to the rear of the vehicle. In support of her claim, the claimant relied on the report of "Dr. R." an internist. Per "Dr. R.," the claimant's loss of fetus was caused by the subject accident. However, the arbitrator noted that the report failed to enumerate the specific medical records he reviewed, nor was he provided with a complete medical history of the claimant, which included a previous miscarriage, infertility problems, and uterine fibroids. The claimant testified that she had been advised by her physician to obtain genetic testing for the fetus, which was carried out. She was also advised to have an amniocentesis the day before the accident. The arbitrator found that the claimant's expert, "Dr. R." came to his conclusion without the benefit of the police report, and without documentation regarding the claimant's prior problems with pregnancy, such as a miscarriage, fertility treatments, and a uterine cyst that required surgery. In opposition, respondent submitted reports by two physicians. The report by "Dr. C." found that the demise of the fetus was "commonly due to chromosomal abnormality." The claimant's physician did not disagree with this opinion, but stated it was a generality. The defense also relied on the opinion of "Dr. M.," a Board-Certified Gynecologist. "Dr. M." enumerated the documents she received, which included the medical records as well as photographs of the claimant's vehicle post-accident. It was the opinion of "Dr. M." that the claimant's pre-existing history of infertility problems, three failed IVFs, surgery for a fibroid, and a fibroid in the uterus were the causes of a "problem pregnancy," and that the seat belt could not have "hit" a six-week-old fetus. Thus, both physicians opined that the accident was not the proximate cause of the loss of the fetus. With respect to the psychological loss, it was noted that there were only a few counseling visits and no evidence of further damages.



AAA® INSURANCE REPORTER

2020 AAA INSURANCE REPORTER / ISSUE 1

Therefore, the burden of proving that she sustained a permanent injury had not been met. In weighing the reports of the experts, the arbitrator determined that they were somewhat equal in weight and believed that the applicant's expert did not base his opinion on sufficient documentation, considering the lack of knowledge regarding the claimant's entire past history, including past infertility and miscarriage(s). The claim was denied as the arbitrator concluded that the claimant had not met her burden of proof by a preponderance of credible evidence.

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