



AAA® INSURANCE REPORTER

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AAA Selected to Administer NY Civil Commotion Mediation Program

The brutal death of George Floyd on May 25, 2020 at the hands of a Minneapolis police officer resulted in waves of protests throughout the United States and internationally. In the course of these protests, property damage and looting occurred, impacting individuals and businesses who already may have been suffering financial loss due to the COVID-19 pandemic.

Subsequently, on June 4, 2020, the New York State Department of Financial Services (DFS) issued an amendment to Insurance Regulation 64, which addresses unfair claims settlement practices and claim cost-control measures. The amendment specifically addresses claims that may have arisen as a result of protests and rioting following the killing of George Floyd. A major provision of the amendment provides for mediation of insurance-claim disputes between either individuals or small businesses in the state of New York and NY-licensed insurers for loss or damage to real or personal property.

The following parameters must be met for a claim to be eligible for the mediation program:

- Claim must have been filed on or after May 30, 2020,
- Claim must have resulted from riot or civil commotion within the state of NY,
- Claim must have been either denied in whole or part, or,
- A settlement was offered and the difference in position between the two parties is \$1,000 or greater, or Insurer has not offered to settle claim and 45 days have passed since all insurer-requested information was provided.

Of note, while the mediation program under the regulation addresses claims for loss or damage to real and personal property, additional language provides that personal injury claims and claims for business interruption may be eligible.

The AAA was chosen by DFS to administer this mediation program, as it also was for the Storm Sandy Mediation Program. In many ways, the procedures for this program track those set up for the Storm Sandy Mediation Program—for example, mediations under the Civil Commotion program remain confidential, require good faith mediation, and have the costs paid by the insurer. Also like the Sandy program, the AAA maintains a pool of experienced mediators who are appointed to hear the matters using a random rotation system.

Unlike Sandy, these mediation hearings will take place in a world where the COVID-19 pandemic has rendered in-person hearings unsafe, and so currently in-person mediations are not available under the program. Fortunately, advances in technology over the past decade have made it possible for these mediations to be conducted virtually using a video platform such as Zoom, with all relevant documents shared electronically.

Given the success of the Storm Sandy Mediation program, which achieved a settlement rate of 63%, the expectation is the Civil Commotion mediation program, while still in early days, will benefit participants as well.

Indexing Team Collaborates with No-Fault Arbitrators

The AAA's New York State Insurance (NYSI) Indexing Team primarily is responsible for reviewing and categorizing No-Fault arbitration parties' submissions by the document types featured on ADR Center, the platform for the no-fault arbitration caseload. This facilitates ADR Center users' searches for particular documents in AAA cases. For example, the identification and labelling of a document as a police report eliminates the necessity of a user scrolling through a party's entire submission to locate this document.



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No-fault arbitrators typically rely on parties' submissions uploaded to the ADR Center to prepare for hearings. These submissions may include an injured party's medical records, no-fault insurance forms, and other documents that support a party's position. These documents also serve as evidence for arbitrators' consideration when drafting awards.

With the aim of better defining and streamlining document types relevant to arbitration hearings, the team is collaborating with a group of no-fault arbitrators to optimize the utility of existing types to arbitrators. Once the team and arbitrators have completed their review, the team will allow a comment period for ADR Center users impacted by proposed changes.

If you have any questions about this initiative, you may contact Denise Stolinski at StolinskiD@adr.org or Frank Cruz at CruzF@adr.org.

ADR Center Online Settlement Tool

The ADR Center Online Settlement Tool can be an effective way to reach an agreement—a chance to shorten the life of the case and potentially save time and money for both parties. Here's a quick look at how the settlement tool works in the ADR Center platform.

Accessed through the **Actions** tab, the Settlement Tool allows parties to negotiate an amount for principal, interest, and attorney fees.

- (1) A party initiates an offer. (Parties initiating offers as well as those rejecting and/or presenting a counteroffer must include their names and phone numbers. The contact information is important if the need for reviewing the settlement should come into play in the future.)

Please note the ADR Center settlement tool does not permit carriers to waive interest following 65-3.9 (b) of the No-Fault Regulation No-Fault Regulation 68 that cites:

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

- (2) The offer is recorded in the timeline.
- (3) A **Review Settlement Task** notice is generated, and notice is sent in an email the next business day to the opposing party.
- (4) The **Retract Settlement Offer** command in the Actions tab removes an open offer as well as the Review Settlement Task, and notice will be sent to the opposing party.
- (5) When reviewing the settlement offer tasks, one can **Accept**, **Reject**, or present a **Counteroffer**. To accept a settlement offer, select the "Accept" option and enter additional comments if needed. Similarly, you may reject the offer and/or present a counter offer.
- (6) Acceptance is logged in the timeline, and a notification letter is sent to both parties the next business day with the final settlement terms. Cases settled in the Conciliation phase close immediately as settled. Arbitrators will issue a consent award based on the agreed terms for cases settled during the Arbitration phase.

The settlement tool is a valuable tool to streamline the no-fault arbitration process. For more information on the online settlement tool, please click [here](#) to contact any of our Conciliation teams through the online directory.



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Introducing Video Hearings for No-Fault Arbitrations

The COVID-19 pandemic changed the way many companies conduct business. For the AAA, it required transition to a remote work environment for staff and a shift to telephone hearings for all no-fault arbitrations.

When DFS determined that in-person hearings would be suspended indefinitely, AAA responded by offering video hearings as an alternative to in-person hearings. Our focus was on making the transition to a remote environment as seamless as possible for our staff and customers.

No-fault cases that meet specific criteria for a video hearing or receive arbitrator approval to go forward by video are scheduled via Zoom or Webex. All other no-fault cases continue going forward by phone via LoopUp.

For more information on scheduling a video hearing, please contact our Customer Service team by phone at 917 438-1660 or email 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

ACTIVITY LIMITATION MEASUREMENT TESTING & FEE SCHEDULE

- *Elmwood Park Medical Group, PC & Geico Ins. Co.*, AAA Case no. 17-19-1119-1903 (7/2/20) (Dimitrios Stathopoulos, Arb.);
- *Tristate Multi-Specialty Medical Services, PC & State Farm Mut. Auto. Ins. Co.*, AAA Case no. 17-19-1121-3158 (7/14/20) (Nicholas Tafuri, Arb.);
- *Elmwood Park Medical Group, PC & Geico Ins. Co.*, AAA Case no. 17-19-1125-6366 (6/26/20) (Gregory Watford, Arb.);
- *Mahmoud Elsayed Dawood Daif PT & Mid-Century Ins. Co.*, AAA Case no. 17-18-1108-7349 (7/8/20) (Nada Saxon, Arb.).

CUPPING & FEE SCHEDULE

- *NY Earnest Acupuncture, PC & State Farm Mut. Auto. Ins. Co.*, AAA Case no. 17-18-1107-2982 (7/10/20) (Kathleen Sweeney, Arb.);
- *Dahu Acupuncture, PC & Geico Ins. Co.*, AAA Case no. 17-19-1119-6999 (7/10/20) (Farheen Sultan, Arb.);
- *Dahu Acupuncture, PC & Geico Ins. Co.*, AAA Case no. 17-19-1120-5340 (7/9/20) (Eylan Schulman, Arb.);
- *YJR Acupuncture, PC & State Farm Fire & Cas. Co.*, AAA Case no. 17-18-1099-9251 (7/15/20) (Matthew Brew, Arb.);
- *Dahu Acupuncture, PC & Allstate Property & Cas. Ins. Co.*, AAA Case no. 17-19-1118-7035 (7/1/20) (Matthew Summa, Arb.);
- *Harmonized Acupuncture, PC & Mid-Century Ins. Co.*, AAA Case no. 17-18-1102-6002 (6/30/20) (Darren Sheehan, Arb.).



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CUPPING & BILLING OF MULTIPLE SESSIONS

- *Dahu Acupuncture, PC & State Farm Mut. Auto. Ins. Co.*, AAA Case no. 17-19-1121-4513 (6/24/20) (John Langell, Arb.);
- *YJR Acupuncture, PC & State Farm Mut. Auto. Ins. Co.*, AAA Case no. 17-18-1097-1175 (3/16/20) (Sandra Adelson, Arb.);
- *Harmonized Acupuncture, PC & Adirondack Ins. Exchange*, AAA Case no. 17-18-1112-0199 (3/1/20) (Shawn Kelleher, Arb.);
- *Gentle Care Acupuncture, PC & State Farm Mut. Auto. Ins. Co.*, AAA Case no. 17-18-1093-9347 (1/6/20) (Victor Moritz, Arb.).

DENIAL OF CLAIM BASED ON THE DEFENSE THAT WORKERS' COMPENSATION IS PRIMARY

- *Orthopro Services, Inc. & American Transit Ins. Co.*, AAA Case no. 17-19-1117-3832 (7/7/20) (Ritesh Mallick, Arb.);
- *A to Z Physical Therapy, PC & American Country Ins. Co.*, AAA Case no. 17-19-1136-5729 (7/7/20) (Farheen Sultan, Arb.);
- *Salutem Products Corp. & American Transit Ins. Co.*, AAA Case no. 17-18-1103-9932 (7/6/20) (Bernadette Connor, Arb.);
- *Value Care Pharmacy, Inc. & American Transit Ins. Co.*, AAA Case no. 17-18-1112-0017 (7/2/20) (Paul Weidenbaum, Arb.).

DENIAL OF CLAIM & DEFECTS/OMISSIONS

- *Prompt Medical Spine Care, PLLC & Geico Ins. Co.*, AAA Case no. 17-18-1111-2276 (6/16/20) (Bryan Hiller, Arb.);
- *Prompt Medical Spine Care, PLLC & Allstate Fire & Cas. Ins. Co.*, AAA Case no. 17-18-1100-7922 (1/29/20) (Kate Cifarelli, Arb.).

DENIAL OF CLAIM & FAILURE TO REFERENCE IME/EUO DATES

- *Mill Medical, PC & Progressive Cas. Ins. Co.*, AAA Case no. 17-18-1087-7655 (3/25/20) (Glen Wiener, Arb.);
- *Brook Chiropractic of NY, PC & Progressive Cas. Ins. Co.*, AAA Case no. 17-18-1114-3243 (3/25/20) (Victor Moritz, Arb.);
- *C. Edward Robins Psychologist, PC, MD & Utica National Ins. Co. of Texas*, AAA Case no. 17-18-1110-9323 (12/30/19) (Bryan Hiller, Arb.);
- *Sky Radiology, PC & Progressive Cas. Ins. Co.*, AAA Case no. 17-18-1112-8563 (4/5/20) (Farheen Sultan, Arb.).

DENIAL OF CLAIM & ISSUANCE OF SUBSEQUENT DENIALS

- *80th Street Pharmacy, Inc. d/b/a Pure Health Pharmacy & American Transit Ins. Co.*, AAA Case no. 17-19-1138-3463 (7/7/20) (Pauline Molesso, Arb.);
- *Starret City Medical, PC & American Transit Ins. Co.*, AAA Case no. 17-18-1095-1802 (4/24/20) (Ioannis Gloumis, Arb.);
- *Advanced Orthopedics & Joint Preservation, PC & American Transit Ins. Co.*, AAA Case no. 17-20-1157-2742 (7/23/20) (Perry Criscitelli, Arb.).

SUM AWARDS: FRACTURES

- *J.K. & AAA Ins. Co.*, AAA Case no. 01-18-0001-8281 (Vernon J. Welsh, Arb.);
- *K.F. & Liberty Mut. Ins. Co.*, AAA Case no. 01-19-0000-2351 (Nancy Hughes, Arb.).



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Arbitrator Abstracts**ACTIVITY LIMITATION MEASUREMENT TESTING & FEE SCHEDULE**

Elmwood Park Medical Group, PC & Geico Ins. Co., AAA Case no. 17-19-1119-1903

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(7/2/20) (Dimitrios Stathopoulos, Arb.) Applicant sought reimbursement for activity limitation measurement (ALM) testing billed under CPT code 97799, a “by report” code. Respondent substituted six units of code 97750 for code 97799, for six 15-minute increments of physical performance testing, issued a partial payment to applicant, and denied the remaining charges based on the fee schedule. The arbitrator noted that respondent failed to submit an affidavit from a fee-schedule expert substantiating the code substitution or evidence showing how it determined the time spent on the testing. Since the arbitrator found that respondent’s fee schedule defense was not established, the claim was awarded.

Tristate Multi-Specialty Medical Services, PC & State Farm Mut. Auto. Ins. Co., AAA Case no. 17-19-1121-3158

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

(7/14/20) (Nicholas Tafuri, Arb.) Applicant sought reimbursement for activity limitation measurement (ALM) testing billed under procedure code 97799. Respondent substituted four units of code 97750 for 60 minutes of physical performance testing and denied the balance of applicant’s charges based on the fee schedule. Respondent relied upon the affidavit of Lori Ercolini, RN, CPC, in support of the fee schedule defense. Ms. Ercolini referenced that code 97799 is a “by report” code with no relative value and that applicant’s documentation indicated that 40-to-55 minutes of computerized range of motion and muscle testing was provided to the patient. Ms. Ercolini referenced that four units of code 97750 should be allowed for the billed testing and that respondent previously paid applicant the proper fee for the testing. The arbitrator found Ms. Ercolini’s affidavit persuasive and determined that applicant failed to refute respondent’s fee schedule interpretation. The arbitrator denied the claim in its entirety.

Elmwood Park Medical Group, PC & Geico Ins. Co., AAA Case no. 17-19-1125-6366

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

(6/26/20) (Gregory Watford, Arb.) Applicant sought reimbursement for activity limitation measurement (ALM) testing billed under code 97799. Respondent changed the billed code to CPT code 97750, issued a partial payment, and denied the balance of applicant’s charges, alleging code 97750 more accurately reflected the services rendered. The arbitrator noted that code 97750 is listed as “BR” code with no specified unit value under the applicable New York Workers’ Compensation Medical Fee Schedule. The arbitrator also noted that general Ground Rule 3 of the fee schedule requires providers to submit documentation justifying BR charges. The arbitrator found that applicant submitted a document discussing the test, its purpose, how it was conducted, and how the amount billed was calculated in support of the bill. The arbitrator concluded that since code 97750 is a time-based code, respondent was required to seek additional verification of the claim to determine the time spent on the testing. See, *Gaba Medical, PC v. Progressive Specialty Ins. Co.*, 36 Misc.3d 139(A), 957 NYS2d 264, 2012 NY Slip Op 51448(U) (App. Term 2d, 11th and 13th Jud. Dists. 2012). The arbitrator noted that respondent provided no proof that it requested additional verification of the claim and did not provide a coder affidavit or fee audit supporting the fee-schedule defense. Thus, applicant’s claim was awarded.

Mahmoud Elsayed Dawood Daif PT & Mid-Century Ins. Co., AAA Case no. 17-18-1108-7349

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(7/8/20) (Nada Saxon, Arb.) Applicant sought reimbursement for activity limitation measurement (ALM) testing billed under code 97799, a “BR” code. Respondent substituted CPT code 97750 for code 97799, issued a partial payment, and denied the balance of



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applicant's charges based on the fee schedule. The arbitrator discussed general Ground Rules 2 and 3 of the New York Workers' Compensation Medical Fee Schedule, which set forth requirements for billing BR items, including the submission of information justifying the procedure and the amount billed. The arbitrator noted that under 11 NYCRR §68.5(a), the insurer may review BR charges for consistency with charges permissible for procedures with established relative values. The arbitrator noted that applicant submitted a document describing the ALM testing and explaining the billed amount. Respondent submitted the affidavit of Bonnie Xie, a certified professional coder and certified medical auditor in support of the fee schedule defense. Ms. Xie referenced that CPT code 97750 was most consistent in relativity with the procedure performed. Since the complete examination took 40-to-55 minutes, Ms. Xie determined that a maximum of four units of code 97750 was allowable. Ms. Xie concluded that respondent properly paid applicant for the billed services. Applicant argued that pursuant to *Bronx Acupuncture Therapy, PC v. Hereford Ins. Co.*, 54 Misc.3d 135(A), 52 NYS3d 245, 2017 NY Slip Op. 50101 (U) (App. Term 2d, 11th and 13th Jud. Dists. 2017), respondent should have requested additional verification to determine the actual amount of time spent on the testing. The arbitrator found that *Bronx Acupuncture Therapy, PC v. Hereford Ins. Co.*, supra, was not applicable to the facts of the case, as there was no indication that respondent had insufficient documentation. The arbitrator noted that applicant's own submission justifying its by report billing indicated that the test took from 40-to-55 minutes to perform. The arbitrator found Ms. Xie's affidavit was sufficient to establish respondent's fee schedule defense. Since applicant failed to rebut respondent's evidence, the claim was denied.

CUPPING & FEE SCHEDULE

NY Earnest Acupuncture, PC & State Farm Mut. Auto. Ins. Co., AAA Case no. 17-18-1107-2982
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(7/10/20) (Kathleen Sweeney, Arb.) Applicant sought reimbursement for the balance of its claims for cupping therapy. Applicant originally submitted claims to respondent for cupping therapy administered under CPT code 97799 in the amount of \$50.00 per session. Respondent reimbursed applicant \$19.07 for each date of service and denied the balance asserting that applicant's charges exceeded those permitted under the governing fee schedule. In support of its defense, respondent offered an affidavit by James Lee, a Certified Professional Coder. Mr. Lee opined that respondent properly converted CPT code 97799 to CPT code 97039, and then determined that the closest related CPT code for that procedure or service was CPT code 97016, described under the fee schedule as use of a vasopneumatic device with a relative value of 3.30. In applying the chiropractic conversion factor of 5.78, Mr. Lee opined that the appropriate rate of reimbursement for cupping therapy is \$19.07 per day, regardless of the number of areas of the body to which the cups are applied. In support of its claim, applicant offered an affidavit by Jeffrey Futoran, a Certified Professional Coder, which was originally prepared for an unrelated proceeding, and, as noted by the arbitrator, did not support the rate of reimbursement sought by applicant, as Mr. Futoran also opined that cupping therapy is appropriately reimbursed at \$19.07 per day. The arbitrator found that the weight, credibility, and persuasiveness of the evidence favored respondent. The arbitrator found that applicant offered insufficient documentation to support its position that it was entitled to reimbursement in the amount of \$50.00 per session for cupping therapy and denied applicant's claim for additional reimbursement.

Dahu Acupuncture, PC & Geico Ins. Co., AAA Case no. 17-19-1119-6999
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(7/10/20) (Farheen Sultan, Arb.) Applicant sought reimbursement for cupping therapy billed under CPT code 97799 in the amount of \$45.99 per session. Respondent reimbursed applicant \$13.87 per session and denied the balance, asserting that the charges exceeded those permitted under the fee schedule. In support of its defense, respondent offered the affidavit of Steven Schram, D.C., L.Ac. According to Dr. Schram, cupping is a simple procedure that requires a minimal amount of technical skill and typically is an unattended procedure. Dr. Schram estimated that the procedure is between an unattended hot pack, which maintains a relative value unit ("RVU") of 2.37, and attended ultrasound, which maintains an RVU of 2.41. Therefore, in his professional opinion, Dr. Schram opined that 2.40 was a reasonable rate of reimbursement for cupping and, when multiplied by the chiropractic conversion



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factor of 5.78, determined that \$13.87 is an appropriate rate of reimbursement for cupping therapy. In rebuttal, applicant offered an affidavit by Ahram Um, L.Ac. Mr. Um opined that the AMA CPT Assistant supports the use of CPT code 97799 for cupping therapy. The arbitrator noted that Mr. Um's affidavit did not provide an RVU consistent in relativity with other RVUs shown in the fee schedule. Therefore, the arbitrator found Mr. Um's affidavit insufficient to support applicant's billing in the amount of \$45.99 per cupping session. Since the arbitrator found that Dr. Schram's affidavit was more persuasive, the arbitrator denied Applicant's claim for additional reimbursement for the cupping services at issue.

Dahu Acupuncture, PC & Geico Ins. Co., AAA Case no. 17-19-1120-5340 (7/9/20)
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(Eylan Schulman, Arb.) Applicant submitted claims for cupping therapy billed under CPT code 97799 in the amount of \$45.99 per session. Respondent asserted that applicant was appropriately reimbursed \$13.87 for each session and that applicant was not entitled to the additional reimbursement sought. In support of its defense, respondent offered the affidavit of Steven Schram, D.C., L.Ac. In finding that cupping therapy fell between an unattended hot pack with an RVU of 2.37, and attended ultrasound, with an RVU of 2.41, Dr. Schram opined that 2.40 relative value units ("RVUs") should be assigned to cupping, thus resulting in reimbursement in the amount of \$13.87 per session. In support of its claim, applicant offered an affidavit by Ahram Um, L.Ac., who opined that the billed amount was appropriate under CPT code 97799, since all pertinent information concerning the nature, procedure, time, skills, and equipment necessary was provided in applicant's records. After a review of the evidence presented, the arbitrator was persuaded by Dr. Schram's analysis that 13.87 was an appropriate rate of reimbursement for cupping therapy. The arbitrator found the affidavit by Mr. Um to be self-serving in nature and that it failed to demonstrate that reimbursement in the amount of \$45.99 per cupping session was warranted.

YJR Acupuncture, PC & State Farm Fire & Cas. Co., AAA Case no. 17-18-1099-9251
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(7/15/20) (Matthew Brew, Arb.) Applicant sought reimbursement for two sessions of cupping therapy per day, each in the amount of \$50.00, billed under CPT code 97799. Respondent issued payment in the amount of \$19.07 for one unit of cupping per date of service and denied the second unit in full. In support of its defense, respondent relied upon an affidavit by Lori Ercolini, who is a registered nurse and Certified Professional Coder. Noting that the cupping therapy was billed under CPT code 97799, a "by report" ("BR") code, Ms. Ercolini opined that CPT code 97039 was the more appropriate reference code, and, upon application of the CPT Assistant, opined that CPT code 97016, with a relative value unit ("RVU") of 3.30 is applicable to cupping services, thus resulting in a rate of reimbursement in the amount of \$19.07 (3.30 RVUs x 5.78 conversion factor) and not \$50.00 as billed by applicant. The arbitrator also addressed whether applicant is only entitled to reimbursement of one unit of cupping therapy per day, rather than the two units billed by applicant. According to Ms. Ercolini, code 97016 is not a time-based code and, therefore, can only be billed once per session. In considering various decisions by colleagues involving the same issue, the arbitrator found that respondent failed to establish its defense that applicant was only entitled to bill for one unit of cupping per treatment date. Citing to a decision by Arbitrator Sandra Adelson (AAA case no. 17-18-1097-1175), Arbitrator Brew concurred that the CPT Assistant does not preclude two sessions of cupping therapy per day. Arbitrator Brew cited to relevant case law and found that respondent should have issued verification requests seeking the time it took for applicant to perform two cupping sessions to two areas of the body per day. Since respondent failed to establish its defense that applicant was only entitled to bill for one unit of cupping per treatment date, the arbitrator awarded applicant an additional \$19.07 per date of service for the second session of cupping therapy billed by applicant.



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Dahu Acupuncture, PC & Allstate Property & Cas. Ins. Co., AAA case no. 17-19-1118-7035
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(7/1/20) (Matthew Summa, Arb.) Applicant sought the balance of its claim for cupping. Applicant billed \$45.99 for each session of cupping under CPT code 97799. Respondent reimbursed applicant \$23.12 per session, and denied the balance based upon its interpretation of the New York State Workers' Compensation Fee Schedule. The arbitrator noted that CPT code 97799 is described under the fee schedule as "unlisted physical medicine/rehabilitation service or procedure", which is a "By Report" ("BR") code. The arbitrator noted that prior to the Appellate Term's holding in *Bronx Acupuncture Therapy, PC v. Hereford Ins. Co.*, 54 Misc.3d 135(A), 52 N.Y.S.3d 245, 2017 NY Slip Op. 50101 (U) (App. Term 2nd Dept., 2d, 11th & 13th Jud. Dists 2017), he found that Ground Rule 3 of the Fee Schedule placed the burden on the healthcare provider using the "BR" code to establish that its fee was reasonable based on the qualifications of the practitioner, the time expended, the type of equipment used and that the fee was consistent with other values in the fee schedule. Based on the court's holding in *Bronx Acupuncture*, supra, the arbitrator found that respondent has the initial burden of establishing the proper charges under the fee schedule. The arbitrator noted that respondent changed the code from code 97799 to code 97039, then applied "all other ground rules", including Ground Rule 3 of the Physical Medicine section of the fee schedule, which provides, in pertinent part, that, "[w]hen multiple physical medicine procedures and/or modalities are performed on the same day, reimbursement is limited to 8.0 RVUs (Relative Value Units) or the amount billed, whichever is less." The arbitrator noted that code 97799, which was billed by applicant for its cupping services, is not subject to the "8-unit rule", but that respondent changed code 97799 to code 97039, which is subject to the 8-unit limitation. The arbitrator found respondent's position to be without merit and awarded applicant the balance of its claim.

Harmonized Acupuncture, PC & Mid-Century Ins. Co., AAA Case no. 17-18-1102-6002
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(6/30/20) (Darren Sheehan, Arb.) Applicant submitted a claim to respondent seeking \$45.99 for cupping therapy billed under CPT code 97799. Respondent reimbursed applicant \$19.07 per session and denied the balance, asserting that applicant's charges exceeded those permitted under the governing fee schedule. Noting that the services at issue were rendered by a licensed acupuncturist in what is defined as Region IV of the fee schedule, the arbitrator found that applicant is entitled to reimbursement under the Chiropractic Fee Schedule and that the conversion factor for physical medicine procedures performed in Region IV is \$5.78. The arbitrator noted that CPT 97799 is defined as an "unlisted physical rehabilitation service or procedure" with a relative value identified as "BR." Under Ground Rule 2 of the Chiropractic Fee Schedule, for any procedure where the relative value unit is listed as "BR," the provider shall establish a relative value unit consistent in relativity with other relative value units shown in the fee schedule. The arbitrator found that, in the absence of "BR" criteria submitted by the provider, respondent assigned an RVU of 3.30, thus comparing the service to code 97016, "vasopneumatic devices," which, similar to cupping therapy, incorporates a suction type force to the soft tissue being treated. Therefore, respondent reimbursed applicant \$19.07 (3.30 RVU x 5.78 conversion factor). The arbitrator found that respondent appropriately reimbursed applicant in accordance with the fee schedule and denied the balance of applicant's claim for cupping therapy.

CUPPING & BILLING OF MULTIPLE SESSIONS

Dahu Acupuncture, PC & State Farm Mut. Auto. Ins. Co., AAA Case no. 17-19-1121-4513
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(6/24/20) (John Langell, Arb.) Applicant billed two cupping sessions on each date of service. Respondent reimbursed applicant for only one cupping session and denied the second session based on the fee schedule. Respondent's fee coder asserted that cupping should be billed under CPT 97039. The coder acknowledged that this code may be reimbursed in multiple units per day.



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The fee coder noted that it is a time-based code and must be billed in increments of 15 minutes per unit. Respondent's fee coder denied reimbursement, as applicant did not provide any information regarding the time allotted for each cupping session. Citing to *Bronx Acupuncture Therapy P.C. v. Hereford Ins. Co.*, 57 Misc.3d 145 (A), 71 N.Y.S.3d 921, 2017 NY Slip Op 51452 (U) (App. Term 2d, 11th & 13th Jud. Dists 2017), the arbitrator found that respondent failed to meet its burden since respondent did not request additional verification with regard to the time allotted for each cupping session. Applicant was awarded reimbursement for the second unit of cupping per date of service.

YJR Acupuncture, PC & State Farm Mut. Auto. Ins. Co., AAA Case no. 17-18-1097-1175
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(3/16/20) (Sandra Adelson, Arb). Applicant billed two units of cupping per date of service using "by report" code 97799. Respondent's fee coder found that cupping would have a similar relative value as CPT 97016, and that the proper rate of reimbursement would be \$19.07. Respondent's fee coder found that only one unit of cupping is reimbursable per date of service. The coder found no documentation as to the amount of time spent with regard to each cupping session, and thus found that the second unit of cupping per date of service should be denied. Since respondent failed to issue requests for additional verification with regard to the time spent per cupping session, the arbitrator found that respondent's fee coder's analysis was unpersuasive. Applicant was awarded reimbursement for the second unit of cupping performed with regard to each date of service.

Harmonized Acupuncture, PC & Adirondack Ins. Exchange, AAA Case no. 17-18-1112-0199
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(3/1/20) (Shawn Kelleher, Arb.) Applicant billed two units of cupping per date of service using CPT 97799. Respondent's fee coder found that the appropriate CPT code for cupping is code 97039, which is a by-report code. Respondent's fee coder found that the reference code to determine the relative value unit would be CPT 97016 (application of a modality to one or more areas; vasopneumatic devices), which is not a time-based code and therefore can only be billed once per session as per CPT Assistant November 2010 and June 2010. The arbitrator was persuaded by respondent's fee audit, and the claim for the second cupping session per date of service was denied.

Gentle Care Acupuncture, PC & State Farm Mut. Auto. Ins. Co., AAA Case no. 17-18-1093-9347
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(1/6/20) (Victor Mortiz, Arb.) Applicant sought reimbursement for multiple cupping units per date of service. The cupping sessions were billed under CPT 97799. Respondent's fee coder asserted that the appropriate billing code for cupping is CPT 97039, and that the reference code to determine the proper rate would be CPT 97016. Using this reference code, the coder determined the proper reimbursement for cupping is \$19.07. Respondent's fee coder found that the CPT code which includes language descriptors indicating both the number of areas serviced and the amount of time spent, would not influence the billing, and that the allowance is only for one unit billed per date of service. In support of this interpretation, the fee coder referred to the AMA 2002 CPT Coding Assistant Codes, which note CPT 97010-97028 are intended to be reported only once per modality, per treatment session. The coder also referenced the CPT Assistant Archives Data June 2010 page 8, which revealed that AMA designated unlisted CPT codes (97799) to be reported only once per day. Thus, the coder did not recommend reimbursement for the second unit of cupping per date of service. The arbitrator cited to relevant case law and found that respondent's fee audit was persuasive.



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DENIAL OF CLAIM BASED ON THE DEFENSE THAT WORKERS' COMPENSATION IS PRIMARY

OrthoPro Services, Inc. & American Transit Ins. Co., AAA Case no. 17-19-1117-3832
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(7/7/20) (Ritesh Mallick, Arb.) Applicant sought reimbursement for durable medical equipment. Respondent asserted that the matter required referral to the Workers' Compensation Board (WCB) to determine whether the claimant was in the course of employment at the time of the accident. The arbitrator noted that where a question of fact exists as to whether a claimant was in the course of employment at the time of loss, then the WCB has primary jurisdiction to make a determination on that issue. The arbitrator cited to *Arvatz v. Empire Mut. Ins. Co.*, 171 A.D.2d 262, 575 N.Y.S.2d 836 (1st Dept. 1991). Applying that standard, the arbitrator found that respondent met its burden in support of the defense. Respondent submitted a police report that indicated that the vehicle driven by the claimant had a "TLC" plate. The police report also indicated that the claimant-operated vehicle was listed as a "taxi." Respondent submitted the affidavit of an underwriting manager, which established that the subject policy was a livery policy issued for a "for hire" vehicle. The arbitrator found that the evidence raised an issue of fact as to whether the claimant was in the course of employment at the time of the accident. Thus, the arbitrator dismissed the claim without prejudice.

A to Z Physical Therapy, PC & American Country Ins. Co., AAA Case no. 17-19-1136-5729
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(7/7/20) (Farheen Sultan, Arb.) Applicant sought reimbursement for physical therapy services. Respondent asserted that the matter required referral to the Workers' Compensation Board (WCB) to determine whether the claimant was in the course of employment at the time of the accident. Respondent submitted a copy of a commercial policy and a request from the policyholder to add the assignor as a covered driver under the policy. No evidence was submitted that the vehicle was a "for hire" or livery vehicle. The arbitrator also noted that no affidavit or sworn statement was included in respondent's submission to support the Workers' Compensation defense. The arbitrator found that respondent failed to raise a question of fact as to whether the claimant was in the course of employment at the time of the accident. The arbitrator entered an award in favor of applicant.

Salutem Products Corp. & American Transit Ins. Co., AAA Case no. 17-18-1103-9932
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(7/6/20) (Bernadette Connor, Arb.) Applicant sought reimbursement for durable medical equipment. Respondent asserted that the matter required referral to the Workers' Compensation Board (WCB) to determine whether the claimant was in the course of employment at the time of the accident. The arbitrator found that respondent met its burden in support of the defense. Respondent submitted the affidavit of an underwriting manager, which established that the subject policy was a livery policy issued for a "for hire" vehicle. Respondent also submitted an MV-104, which indicated that there was a passenger in the vehicle at the time of the accident. Applicant submitted a base letter from Unter, LLC, which indicated that the claimant was seeking affiliation with the company. Applicant argued that this letter demonstrated that the claimant was not in the course of employment on the date of accident. The arbitrator was not persuaded by applicant's arguments and found that the evidence raised an issue of fact as to whether the claimant was in the course of employment at the time of the accident. The arbitrator dismissed the claim without prejudice.

Value Care Pharmacy, Inc. & American Transit Ins. Co., AAA Case no. 17-18-1112-0017
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(7/2/20) (Paul Weidenbaum, Arb.) Applicant sought reimbursement for compound pain cream. Respondent asserted that the matter required referral to the Workers' Compensation Board (WCB) to determine whether the claimant was in the course of



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employment at the time of the accident. The arbitrator found that respondent met its burden in support of the defense. The arbitrator noted that the vehicle had Taxi & Limousine Commission license plates and that the relevant policy of insurance was a livery vehicle policy. Respondent also submitted the affidavit of an underwriting manager, which established that the subject policy was a livery policy issued for a "for hire" vehicle. The arbitrator found that the evidence raised an issue of fact as to whether the claimant was in the course of employment at the time of accident. Thus, the arbitrator dismissed the claim without prejudice.

DENIAL OF CLAIM & DEFECTS/OMISSIONS

Prompt Medical Spine Care, PLLC & Geico Ins. Co., AAA Case no. 17-18-1111-2276
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(6/16/20) (Bryan Hiller, Arb.) The arbitrator addressed whether the denial of claim based on the assignor's failure to appear for two scheduled independent medical examinations (IMEs) was fatally defective. Applicant contended that the denial of claim was fatally defective, since it did not specify the type of IME, doctor, or time of the IME that was not attended. Applicant's counsel noted that chiropractic, orthopedic, and acupuncture IMEs all were scheduled for the same days and the denial specifically stated "for medical examination," referring to one of the subject examinations. In opposition, respondent argued that the insurer's non-substantive technical defect or omission shall not affect the validity of the denial of claim. The arbitrator determined that the denial of claim did not sufficiently apprise the applicant as to the reason for the denial. Accordingly, the arbitrator awarded the claim in full.

Prompt Medical Spine Care, PLLC & Allstate Fire & Cas. Ins. Co., AAA Case no. 17-18-1100-7922
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(1/29/20) (Kate Cifarelli, Arb.) The arbitrator addressed whether the denial of claim was fatally defective. The denial of claim was based on an independent medical examination (IME) performed by Regina Hillsman, M.D., on October 5, 2017. However, based on the IME performed on October 5, 2017, Dr. Hillsman recommended that the assignor continue treatment for another six weeks. Respondent argued that the bills should have been denied pursuant to Dr. Hillsman's third IME performed on December 14, 2017, where she denied any further treatment. The arbitrator noted that a global denial of claim, denying all future treatment pursuant to Dr. Hillsman's IME performed on December 14, 2017, was sent to applicant and that this IME was the third IME performed by Dr. Hillsman. The submissions in related matters also revealed that applicant received other denials denying the claim based upon the IME of December 14, 2017. The arbitrator noted that the services in issue were subsequent to the issuance of the global denial and that this would indicate that the date of the IME was simply a typographical error. The arbitrator found that the denial was not fatally defective and the case was decided on the merits.

DENIAL OF CLAIM & FAILURE TO REFERENCE IME/EUO DATES

Mill Medical, PC & Progressive Cas. Ins. Co., AAA Case no. 17-18-1087-7655
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(3/25/20) (Glen Wiener, Arb.) Applicant sought reimbursement for outcome assessment testing. Respondent timely denied the claim based upon applicant's failure to appear at scheduled examinations under oath (EUO). The arbitrator addressed whether respondent's denial of claim form must set forth the dates of the missed EUOs. The arbitrator noted that respondent's submission established that it properly scheduled applicant for the EUOs and that applicant failed to appear. The arbitrator found that respondent clearly and unambiguously set forth the legal grounds for denying applicant's claim and that the failure to set forth the dates of the scheduled examinations in the denial of claim form did not render the denial conclusory, vague, or without merit as a matter of law. The arbitrator found that respondent need only state that applicant's claims were denied based upon applicant's failure to attend multiple scheduled EUOs.



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Brook Chiropractic of NY, PC & Progressive Cas. Ins. Co., AAA Case no. 17-18-1114-3243
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(3/25/20) (Victor Moritz, Arb.) Respondent denied the claim based on the failure of the injured person to attend scheduled independent medical examinations (IMEs). Applicant argued that respondent's denial was not sufficient to deny the services at issue as the denial failed to provide the name of the independent medical examiner or the date of the missed IMEs. The arbitrator noted that the IMEs were scheduled with two separate specialists--an orthopedist and licensed acupuncturist--and that the insurer only submitted an affidavit of service regarding the missed acupuncture examinations. The arbitrator found the denial to be deficient, since it was not clear as to which missed examinations were the basis for respondent's defense. The arbitrator also found that respondent must inform the applicant of the reason for denying the claim and that a broadly worded statement of failure to submit to multiple examinations without providing the name of the independent medical examiner and the dates of the missed IMEs is legally insufficient.

C. Edward Robins Psychologist, PC, MD & Utica National Ins. Co. of Texas, AAA Case no. 17-18-1110-9323
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(12/30/19) (Bryan Hiller, Arb.) Respondent timely denied the claim for psychological treatment based upon a violation of the conditions of the insurance policy by failure to appear for scheduled Examinations Under Oath (EUO). Applicant's counsel argued that the denial was "fatally defective," since it did not specify the dates of the non-appearance at the EUO and also failed to address whether the missed EUO was by the assignor or the applicant. The arbitrator found that respondent failed to sufficiently apprise the applicant as to the reason for the denial, failed to list the missed EUO dates, and failed to apprise applicant as to whether the EUOs were of the assignor or the applicant.

Sky Radiology, PC & Progressive Cas. Ins. Co., AAA Case no. 17-18-1112-8563
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(4/5/20) (Farheen Sultan, Arb.) Applicant sought reimbursement for MRI studies of the cervical spine and lumbar spine. Respondent timely denied the claim based on the assignor's failure to appear for two scheduled independent medical examinations (IMEs). Applicant argued that respondent's denial was defective as the dates of the missed IMEs were not listed in the denial and the denial merely set forth that the assignor failed to submit to multiple requests for medical examinations. The arbitrator found that respondent sufficiently apprised the applicant of the reason for the denial and that the failure to list the dates of the missed IMEs in the denial was a non-substantive technical omission and immaterial defect.

DENIAL OF CLAIM & ISSUANCE OF SUBSEQUENT DENIALS

80th Street Pharmacy, Inc. d/b/a Pure Health Pharmacy & American Transit Ins. Co., AAA Case no. 17-19-1138-3463
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(7/7/20) (Pauline Molesso, Arb.) Respondent issued an initial timely denial based on the defense that the claimant was eligible for Workers' Compensation benefits as well a lack of medical-necessity defense based upon an IME. Thereafter, respondent issued a subsequent denial based upon a peer review and withdrew its first denial. The arbitrator was asked to determine whether respondent could withdraw an earlier denial even though the second denial was late on its face. The arbitrator found that the second denial was a nullity, as respondent may not withdraw a denial based on a Workers' Compensation defense and thereafter issue a second denial on another basis when that second denial is issued more than 30 days from receipt of claim.



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Starret City Medical, PC & American Transit Ins. Co., AAA Case no. 17-18-1095-1802
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(4/24/20) (Ioannis Gloumis, Arb.) Respondent initially denied applicant's claim based upon the defense that the claimant was acting in the course of employment at the time of the accident. Respondent then issued a second denial, wherein the Workers' Compensation defense was withdrawn and a new defense of lack of medical necessity based upon a peer review report was set forth. Applicant asserted that respondent's handling of the claim was improper. The arbitrator addressed whether respondent's denial of the claim should be upheld. In rejecting the subsequent denial, the arbitrator found that once respondent issued its denial of claim form, the claim was denied. Thus, respondent could not withdraw its first denial and later deny the claim based upon the new defense of lack of medical necessity, which was not timely preserved.

Advanced Orthopedics & Joint Preservation, PC & American Transit Ins. Co., AAA Case No. 17-20-1157-2742
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(7/23/20) (Perry Criscitelli, Arb.) Respondent initially issued a denial based upon a defense that Workers' Compensation was primary. However, the claim for Workers' Compensation was denied, and thereafter, respondent issued requests for applicant to appear at an Examination Under Oath (EUO). After the EUO was conducted, respondent issued a subsequent denial of claim on the ground that the treated condition was unrelated to the motor vehicle accident. Applicant argued that the initial denials should be controlling and that the verification requests should be deemed a nullity as they were issued in excess of 30 days from the date respondent received the Workers' Compensation decision. In rejecting the subsequent denials, the arbitrator found that respondent's requests for verification in the form of an EUO were untimely as to three of the bills. Therefore, the time within which to issue the second denials was not tolled and the subsequent denials were not considered.

SUM AWARDS: FRACTURES

J.K. & AAA Ins. Co., AAA Case no. 01-18-0001-8281
[SUM Award Search](#)

(Vernon J. Welsh, Arb.) This was an underinsured motorist claim with \$250,000.00 in SUM coverage for this underinsured motorist claim, subject to a \$100,000.00 set-off for the policy payment made on behalf of the underinsured tortfeasor. Liability, comparative fault, and possible additional value of the claim were in dispute. In April 2015, claimant was walking on the shoulder of a road in Ulster County, New York, when a sedan struck her. Although its operator was later identified, the vehicle fled the scene of the accident. The evidence sufficed to show that it is more likely that the negligence of the vehicle's driver was a proximate cause of the accident due to failure to stay in the lane. There was insufficient evidence to conclude that the claimant had any responsibility for the accident. Although the claimant had consumed alcohol prior to the accident, there was no evidence that it was a contributing factor and the police report did not employ a code for alcohol involvement or pedestrian error. The multiple medical reports indicated that the 19-year-old claimant sustained serious injury. The claimant was thrown into the air and sustained a loss of consciousness. The claimant was transported to Westchester Medical Center, where she was admitted and later discharged. The injuries sustained consisted of a 1) cerebral concussion with loss of consciousness; 2) a non-displaced fracture through the talus of the left ankle with extensive surrounding marrow signal edema; bone bruises involving a lateral malleolus and distal calcaneus; ankle sprain and strain; mild plantar fasciitis; 3) tears of the anterior cruciate ligaments of both knees; tear of the right knee lateral meniscal root; tear of the left lateral meniscus; severe left ACL sprain; marrow space contusions involving the lateral tibial plateau and the lateral femoral condyle; knee sprain or strain; wound dehiscence of a surgical incision of the right knee; 4) neck, thoracic, and lumbar sprains and strains; apparent cervical and lumbar intervertebral disc displacements; 5) scars. The claimant underwent three surgeries, which were complex in nature, and two required general anesthesia. There was visible scarring on her legs. The surgeries required months of rehabilitation and assistance with activities of daily living. The claimant argued that her claim was



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worth in excess of the insurance coverage, as she required non-simple surgeries involving grafting and she had flashbacks, scars, and ongoing limitations in her ability to engage in activities, including limitation of her ability to kneel, which, based on how long her knees had been symptomatic, was a permanent condition. Respondent maintained that claimant had already been adequately compensated, arguing that the medical records and the report of Dr. Maloney indicated that the claimant had recovered from her accident-related injuries and required no further medical treatment. Dr. Maloney had examined the claimant and had concluded that no further treatment was needed. It was his opinion that the claimant's ongoing symptoms were mild and he did not anticipate that her scarring would cause any future issues or need for treatment. The claimant testified at an EUO and at the hearing of this matter. She was a college student at the time of the accident. She stated that after her discharge from the hospital, she was on seizure medication for about six weeks, during which time she could not drive. For about a month after the accident, she slept a lot to avoid headaches. For about three months, her mother and grandmother helped her with personal hygiene and dressing. In school after the accident, headaches made it more difficult to learn. She graduated from college in December 2017, but graduated late because she could not fit in enough credit hours, having missed time due to medical treatments. She stated that she was still unable to run as far or as frequently and was afraid to ski because she had difficulty on a small slope while skiing cross-country. She attributed this difficulty in part to a tight hamstring. She stated that she gets headaches a couple of times a month that are severe enough to affect her day. She stated that kneeling is difficult. She stated that when exercising she focuses on strengthening rather than on running. With regard to her scars, she said that she often gets knee pain around them and they make her feel self-conscious. She stated that people notice the scars on her legs as well as the one on her face. At the time of the hearing, the claimant was employed as a geologist. The arbitrator surveyed and reviewed motor vehicle accident cases with similar injuries in Erie County. In doing so, the arbitrator concluded that the claimant sustained serious injuries as defined by the Insurance Law, a fracture, and significant disfigurements. The claimant sustained brain injuries depicted by MRI, which warranted hospitalization for four days for observation and admission to an ICU. The arbitrator noted that there were special circumstances in the instant claim, as claimant was a pedestrian who was struck and thrown by a vehicle that left the scene of the accident after first slowing down, suggesting that before the operator left the scene, the operator was aware that someone had been injured. The arbitrator awarded the sum of \$200,000.00, minus the setoff of \$100,000.00, and \$0.00 for claimant's negligence, for a net award of \$100,000.00.

K.F. & Liberty Mut. Ins. Co., AAA Case no. 01-19-0000-2351

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(Nancy Hughes, Arb.) This was an underinsured motorist claim with \$100,000.00 in SUM coverage for this underinsured motorist claim subject to a \$25,000 set-off for the policy payment made on behalf of the underinsured tortfeasor. In February 2018, the claimant, a 63-year-old self-described general contractor was operating a vehicle on Interstate 87 in South Nyack, New York. The underinsured tortfeasor struck claimant's vehicle in the rear, causing claimant's vehicle to cross all lanes of traffic and strike a cement wall. Liability was not an issue. Claimant alleged multiple injuries as a result of the accident. Respondent contended that claimant's failure to utilize a seat belt resulted in the injuries sustained. The claimant was transported to Nyack Hospital via ambulance from the accident scene, where he presented with complaints of facial and tongue lacerations and pain in his ribs. The claimant was diagnosed with five fractured ribs and was admitted to the hospital overnight for observation and pain management. In March 2018, the claimant was examined by Dr. F, and the arbitrator noted that "the assessment was fracture of body of sternum." He noted that the claimant was "...feeling better but still sees stars when he coughs." He was advised by Dr. F. to resume all activities as tolerated. Then on October 16, 2019, the claimant presented to Dr. M., who documented that he was using crutches to ambulate, and the clinical exam revealed restricted ranges of motion in the left shoulder and right knee. There was no prescription for the crutches in evidence. In November 2019, the claimant was examined by Dr. Michael Miller at the request of the respondent. Dr. Miller noted that the claimant alleged that he had sustained injury to his right knee, left shoulder, left buttock, and left flank. He was using crutches to ambulate. After clinical examination, Dr. Miller diagnosed a right knee abrasion and fractures of left ribs 1-5, which he causally related to the subject accident. In an addendum to his report, Dr. Miller opined that: "It is unlikely that the injuries he sustained would have occurred if he was wearing a seatbelt." The addendum was not considered by the arbitrator. Respondent submitted the report of an expert, ARCCA Incorporated, a Philadelphia-based forensic, scientific, and engineering



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solutions company, to support their position. The report concluded that claimant would not have sustained head or rib injuries had he been utilizing a seat belt. The arbitrator found the report to be credible and accepted the conclusions set forth therein. Although the claimant alleged injuries to the head, right hip, both knees and right shoulder, there was insufficient medical evidence to support the allegations. The arbitrator considered the pain and interference with activities of daily living caused by the fractured ribs. The arbitrator determined that claimant's comparative negligence for failure to utilize a seat belt was 35%. The arbitrator awarded the claimant \$50,000.00, minus \$17,500.00 for the comparative negligence and less the \$25,000.00 set off, for a final SUM benefit of \$7,500.00.

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