AMERICAN ARBITRATION ASSOCIATION®

AAA® INSURANCE REPORTER

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Improving Quality within AAA New York State Insurance (NYSI) Division

The AAA NYSI has always striven to provide our customers with a work product that meets or exceeds their expectations with regard to quality. To consistently exceed expectations, the AAA has expanded its focus on quality by integrating its current *quality control (QC)* with *quality assurance (QA)* processes. Many use the terms QC and QA interchangeably, even though they represent different functions in the overall quality management process. The distinction between the two terms is that QC is *work product*-focused and QA is *process*-focused. Another way to view the distinction is that QC is designed to discover flaws or defects in work products or processes, and QA investigates the root causes that led to those flaws and seeks to correct them.

New Quality Initiatives

Some quality initiatives the AAA NYSI has established within its operations are internal error detection, touchpoint surveys, and, most recently, the transcription of our processes into process maps.

Internal error detection allows recorded data to be analyzed for trends. The most common errors then can be investigated to determine a root cause and apply corrective action to prevent a recurrence.

Touchpoint surveys reach out to the parties at different phases of a case, and their feedback communicates to us what we need to improve or change.

Process mapping allows for documenting the step-by-step details of our processes to ensure uniform procedures. This promotes consistency in handling cases, allowing the AAA NYSI to evaluate its practices and determine where opportunities for improvement can be made.

Quality Control/Quality Assurance Department

The quality initiatives put in place are only the start of improving quality at the AAA NYSI. Senior management's recognition of the need for enhanced quality led to the formation of a Quality Control/Quality Assurance department. This department will follow the internationally recognized ISO 9001 quality standards. ISO 9001 provides a quality-management system framework and set of principles that ensure a structured approach to quality management. The goal? To consistently satisfy the needs of our customers and other stakeholders.

Introducing Simple File

The American Arbitration Association® is excited to announce the implementation of our Simple File portal for new case submissions. Simple File will be the designated portal for new case-filing submissions. Effective December 1, 2022, the AAA will no longer accept case filings by email.

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Simple File provides a secure network connection between client browsers and our servers. Simple File is a quick and easy to use platform with several enhanced features, including on-screen receipts, emailed receipts, links to the AR1 form and the payment portal, and access to the filing rules and procedures.

The process is just that: ***Simple.*** Fill out the filing party details, attach the valid PDF, and click **File Now.** The confirmation email is immediately sent to the Filing Party email address once the case is submitted.

In addition to Simple File, we are also exploring an API platform for applicants to utilize for bulk filings. The Application Programming Interface (API) will allow applicants to connect their systems, via HTTPS commands and protocols, to our portal and allow the electronic transmission of case data and documents.

Customer Satisfaction Survey Responses and FAQ's

Thank you to our customers who participated in the **AAA NYSI Q2 Client Satisfaction Survey.** Listening to your feedback is an important opportunity for us to step back and review our process, procedures, and personnel committed to providing you with the best alternative dispute resolution experience. We reviewed your comments; following are our responses to some common questions.

Arbitration Support

Q. On the day of the hearing, if we are unable to connect to the scheduled hearing via Zoom or have an emergency arise, what should we do?

A. Contact the Arbitration Support Team for all issues related to hearing appearances at arbitratorsupport@adr.org. For immediate assistance, call us 646.663.3470.

Q. Why does it take an extended period to process an amendment during the arbitration phase?

A. Amendments submitted during the arbitration phase including an increased amount in dispute must be approved by the assigned arbitrator. If an arbitrator has not been assigned, the Arbitration Support team will monitor the case for arbitrator assignment and follow up accordingly for review.

Scheduling

Q. How long does it take to get a hearing date?

A. AAA NYSI strives to ensure equity in the scheduling process. There are a limited number of hearing slots for each month. Volume, arbitrator, and party availability all factor into the time it takes to receive a hearing date. We remain committed to reducing the timeframe from filing to award and continue to introduce new strategies to increase the number of resolutions in conciliation and available hearing slots in arbitration.

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Q. Can cases with the same respondent be scheduled consecutively instead of in random blocks?

A. The Team attempts to schedule cases that have the same Applicants and Respondents consecutively when possible. However, many factors, such as the age of cases and party availability, may affect how cases are scheduled.

Q. Can Applicants have the opportunity to select 15 or 30-minute time increments for hearing purposes based on how many bills are filed per provider?

A. No-Fault hearings are scheduled in 15-minute increments. Certain types of cases may require additional time. Parties can request additional time by contacting Arbitration Support for the arbitrator's approval.

Payment

Q. How do we make payments for our invoices?

A. We encourage you to issue payment online by using this Quick Pay link, also available on our website, or using ACH Transfers. Due to confidentiality issues, only authorized business users may use the ACH Transfer method. Please contact NYSIFinance@adr.org to receive the ACH transfer form. Mailed payments can be sent to the following address:

American Arbitration Association
32 Old Slip, 33rd Floor
New York, New York 10005

Q. Why are insurance carriers charged an assessment fee?

A. Pursuant to New York State regulation, a case assessment fee is applied when a No-Fault or SUM case closes. Insurance companies are billed a per-case assessment as a portion of the costs of administering the insurance arbitration programs.

Intake

Q. Why are cases returned when the name of the Medical Provider (MP) is correctly listed on the AR-1?

A. Cases may be returned if the MPs listed on the bills provided differ from the MP name listed on the AR-1. Please provide documentation if the named MPs are related.

Q. Is there a suggested filing order recommended by Arbitrators?

A. Parties are encouraged to file a No-Fault case utilizing the prescribed Arbitration Request form (AR-1), listing itemized dispute amounts along with supporting documents. Arbitrators may also request a cover sheet with a breakdown of the bills in chronological order including dates, descriptions of services, and amounts.

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Indexing

Q. What is the suggested format for documents uploaded into the ADR Center?

A. The recommended format for uploading your submissions into ADR Center is PDF Format Version of 1.7 or higher.

Conciliation

Q. How long is a case held in conciliation before it is escalated to arbitration?

A. Conciliation is a 90-day process. Conciliators work with the parties during this period to resolve cases through a settlement. Cases are escalated to arbitration if not resolved within 90 days.

Q. When our adversary is not responding to our inquiries or messages during conciliation, what does the AAA do?

A. Conciliators use ADR Center system messages, emails, and phone calls to the respective parties in each case to help facilitate open communication and potential resolution.

Q. What should we do if we consent to a withdrawal request or settlement offer in error?

A. If you consent to a withdrawal request or settlement offer in error during the conciliation phase, please contact the assigned ADR Center Team immediately using the phone number and email listed on the case. If you consent in error during the arbitration phase or with a pending or scheduled hearing, contact Arbitration Support directly at ArbitratorSupport@adr.org or 646-663-3470.

SUM

Q. What is the fee associated with filing a SUM/UM case?

A. The applicant pays $250 filing fee per case.

We truly appreciate our customers taking the time to complete our surveys. Providing examples help us address your comments. Having the ability to contact you directly helps us focus on your specific situation. We encourage your feedback throughout the year. Please use the following link to access a directory listing contact information for our leadership team:

ADR Center Management Directory

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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

CPT CODE 76942 & FEE SCHEDULE

- *Macintosh Medical, P.C. & Progressive Cas. Ins. Co.*, AAA Case no. 17-21-1193-5999 (07/28/22) (Josh Youngman, Arb.)
- *Macintosh Medical, P.C. & Liberty Mutual Ins. Co.*, AAA Case no. 17-21-1223-8026 (08/06/22) (Patricia Daugherty, Arb.)
- *Macintosh Medical, P.C. & Progressive Cas. Ins. Co.*, AAA Case no. 17-21-1190-9050 (07/17/22) (Giovanna Tuttolomondo, Arb.)

120-DAY DENIAL–CHAPA PRODS. CORP. V. MVAIC

- *FJ Orthopaedics & Pain Management, PLLC & Allstate Fire & Cas. Co.*, AAA Case no. 17-21-1200-6474 (05/06/22) (Kenneth Rybacki, Arb.)
- *Medaid Radiology, LLC & Allstate Ins. Co.*, AAA Case no. 17-21-1191-8098 (06/15/22) (Philip Wolf, Arb.)
- *Sovereign Medical Services, PC & Progressive Casualty Ins. Co.*, AAA Case no. 17-19-1137-1127 (09/06/21) (Richard Martino, Arb.)
- *Van Loon DME USA, Inc. & Progressive Cas. Ins. Co.*, AAA Case no. 17-21-1213-6262 (08/24/22) (Jan Chow, Arb.)

EXTRACORPOREAL SHOCKWAVE TREATMENT (“ESWT”) & MEDICAL NECESSITY

- *Andrew Glyptis, MD & Liberty Mutual Ins. Co.*, AAA Case no. 17-21-1207-0758 (08/12/22) (Rhonda Barry, Arb.)
- *Garden Medical Care, PC & GEICO Ins. Co.*, AAA Case no. 17-21-1221-9184 (07/14/22) (Dinsmore Campbell, Arb.)
- *Community Medical Care of NY, PC & American Transit Ins. Co.*, AAA Case no. 17-21-1214-8991 (07/03/22) (Ellen Weisman, Arb.)

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- *Garden Medical Care, PC & Hereford Ins. Co.*, AAA Case no. 17-21-1218-4455 (07/08/22) (Frank Marotta, Arb.)
- *Multi-Specialty Pain Management, PC & Allstate Fire and Casualty Ins. Co.*, AAA Case no. 17-20-1185-4816 (02/17/22) (Samiya Mir, Arb.)

EXTRACORPOREAL SHOCKWAVE TREATMENT ("ESWT") & FEE SCHEDULE

- *Elena Borisovna Stybel, MD & Geico Ins. Co.*, AAA Case no. 17-21-1218-6834 (04/21/22) (Dimitrios Stathopoulos, Arb.)
- *Dinesh Verma Medical, PC & State Farm Mutual Auto. Ins. Co.*, AAA Case no. 17-21-1204-7431 (06/20/22) (Brian Rudolph, Arb.)
- *Community Medical Care of NY, PC & GEICO Ins. Co.*, AAA Case no. 17-21-1218-2932 (04/28/22) (Lori Ehrlich, Arb.)

REIMBURSEMENT FOR PERSONAL PROTECTIVE EQUIPMENT (PPE)

- *East Tremont Medical Center and GEICO Ins. Co.*, AAA Case no. 17-21-1222-7525 (06/20/22) (Glen Cacchioli, Arb.)
- *Attia Rehabilitation PT & Geico Ins. Co.*, AAA Case no. 17-21-1202-3040 (06/29/22) (Lester Hill, Arb.)
- *RES Physical Medicine & Rehabilitation Services & Geico Ins. Co.*, AAA Case no. 17-21-1219-4453 (07/14/22) (Ioannis Gloumis, Arb.)
- *RES Physical Medicine & Rehabilitation Services & Geico Ins. Co.*, AAA Case no. 17-21-1218-4773 (07/14/22) (Fred Lutzen, Arb.)

SUM AWARDS: GAP IN TREATMENT

- *Claimant v. American Transit Ins. Co.*, AAA Case no. 01-21-0017-3911 (09/06/22) (Alan H. Krystal, Arb)
- *Claimant "AT" v. American Transit Ins. Co.*, AAA Case no. 01-21-0002-6052 (08/08/22) (Jonathan Rivera, Arb)

Arbitrator Abstracts

CPT CODE 76942 & FEE SCHEDULE

Macintosh Medical, P.C. & Progressive Cas. Ins. Co., AAA Case no. 17-21-1193-5999

(07/28/22) (Josh Youngman, Arb.) Applicant sought reimbursement for ultrasonic guidance under CPT code 76942 administered in conjunction with trigger point injections. Respondent asserted the claimed amount was in excess of

the fee schedule. In support of its contention, respondent relied upon the affidavit of Darlene L. Buttner, a certified medical coder. Ms. Buttner asserted that, upon a plain reading of the CPT Assistant, code 76942 may only be reported once, irrespective of the number of trigger point injections performed. In rebuttal, applicant relied upon the affidavit of Michael Miscoe, a coding and compliance expert. He reasoned that trigger point injections are properly billed per muscle and not per injection. Mr. Miscoe further stated the CPT Assistant is comprised of opinions that are only applicable when such opinions do not conflict with the CPT Coding Manual. In finding for applicant, the arbitrator held that the use of "needle placement" in the singular demonstrates that the code is reportable multiple times where ultrasonic guidance is used to guide needle placement for separate procedures or to guide needle placement associated with the same procedure that is performed at "separate anatomic sites." Thus, the arbitrator found that applicant was entitled to reimbursement for multiple units of code 76942.

Macintosh Medical, P.C. & Liberty Mutual Ins. Co., AAA Case no. 17-21-1223-8026

(08/06/22) (Patricia Daugherty, Arb.) Applicant sought reimbursement for ultrasonic guidance under CPT code 76942 administered in conjunction with trigger point injections. Respondent asserted that applicant was not entitled to reimbursement for multiple units of the code. In support of its defense, respondent relied upon the affidavit of Gina Ball, a certified professional coder, together with the "FAQ" section of the CPT Assistant, which indicated that code 76942 may only be reported once, irrespective of the number of trigger point injections performed. In opposition, applicant submitted the affidavit of Michael Miscoe who contends that code 76942 may be reported more than once depending upon the number of muscles injected. In finding for respondent, the arbitrator held that she was not persuaded by the assertions of Mr. Miscoe and that a plain reading of the CPT Assistant prohibits multiple units of code 76942 from being reimbursed. Thus, the claim was denied.

Macintosh Medical, P.C. & Progressive Cas. Ins. Co., AAA Case no. 17-21-1190-9050

(07/17/22) (Giovanna Tuttolomondo, Arb.) Applicant sought reimbursement for ultrasonic guidance under CPT code 76942. Respondent asserted that the claimed amount was in excess of the fee schedule. In support of its contention, respondent relied upon the affidavit of LeeAnn Morris, a certified professional coder (CPC). In opposition, applicant relied upon the affidavits of Priti Kumar, CPC and Michael Miscoe, JD, CPC. Both of applicant's experts argued that the CPT Assistant is not considered authoritative and that the FAQ section relied upon by respondent should be afforded little weight. In finding for respondent, the arbitrator held that a suggestion that the FAQs in the CPT Assistant are not authoritative is contrary to the determination in *Matter of Global Liberty Ins. Co., v. McMahon,* 2019 NY Slip Op 03692 (App. Div. 1st Dept. 2019). The CPT Assistant is considered in whole, and therefore, is authoritative in its entirety. The arbitrator determined that the FAQs provide depth and substance to the CPT Assistant and found the questions and answers reliable and relevant, which resulted in publication. Therefore, the arbitrator determined that applicant was not entitled to additional reimbursement for multiple units of code 76942. Notably, the arbitrator's decision was upheld on appeal.

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120-DAY DENIAL–CHAPA PRODS. CORP. V. MVAIC

FJ Orthopaedics & Pain Management, PLLC & Allstate Fire & Cas. Co., AAA Case no. 17-21-1200-6474

(05/06/22) (Kenneth Rybacki, Arb.) Applicant sought reimbursement for an office evaluation and X-rays. Respondent denied the claim alleging applicant failed to submit requested verification of the claim within 120 days of the initial request pursuant to 11 NYCRR §65-3.8(b)(3). The arbitrator found that, while the initial and follow-up verification requests were issued within the prescribed timeframes, respondent's denial of claim was not issued within 30 days following the expiration of the 120-day period, thus its defense was precluded. The arbitrator noted that in *Chapa Prods. Corp. v. MVAIC,* 66 Misc. 3d 16; 114 N.Y.S.3d 177 (App. Term 2nd, 11th & 13th Dists 2019), the court held that "a denial of claim form issued following the expiration of the 150-day period after the issuance of the initial request for verification is a nullity with respect to that defense." The arbitrator observed that the court in *Chapa* also recognized the competing interest that an insurer is not obligated to pay or deny a claim until it has received all requested verification and noted that any action where there has been no documented compliance with verification requests would be dismissed as premature. The arbitrator determined that there was no documented compliance with the verification requests and, therefore, dismissed the claim without prejudice.

Medaid Radiology, LLC & Allstate Ins. Co., AAA Case no. 17-21-1191-8098

(06/15/22) (Philip Wolf, Arb.) Applicant sought reimbursement for MRIs. Respondent denied the claim asserting applicant failed to submit requested verification of the claim within 120 days of the initial request or, alternatively, written proof providing a reasonable justification for the failure to comply pursuant to 11 NYCRR §65-3.8(b)(3). Applicant argued that since respondent issued its denials more than 150 days after the issuance of the initial verification requests, the denials are deemed nullities pursuant to *Chapa Prods. Corp. v. MVAIC,* 66 Misc. 3d 16; 114 N.Y.S.3d 177 (App. Term 2d, 11th & 13th Dists 2019). The arbitrator noted that in *Chapa*, the court held that the deadline to issue a denial of claim on the ground that an applicant failed to provide complete verification is 150 days following the initial verification request, and that a denial issued following the expiration of the 150-dayperiod is a nullity with respect to that defense. The arbitrator noted that the court found that since the denial was deemed a nullity, the action should be dismissed as premature. Therefore, the arbitrator found that respondent issued its denials 206 days after it issued the initial verification request, and, as such, determined the denials were nullities pursuant to *Chapa Prods. Corp. v. MVAIC, supra,* and dismissed the claim without prejudice.

Sovereign Medical Services, PC & Progressive Casualty Ins. Co., AAA Case no. 17-19-1137-1127

(09/06/21) (Richard Martino, Arb.) Applicant sought reimbursement for trigger point injections and impedance mapping services. Respondent denied the claim asserting applicant failed to submit requested verification of the claim within 120 days of the initial request or written proof providing a reasonable justification for the failure to comply pursuant to 11 NYCRR §65-3.8(b)(3). Applicant argued that since respondent issued its denial over 150 days after it issued the initial verification request, the denial is invalid pursuant to *Chapa Prods. Corp. v. MVAIC,* 66 Misc. 3d 16;

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114 N.Y.S.3d 177 (App. Term 2d, 11th & 13th Dists 2019). The arbitrator determined that the respondent issued timely initial and follow-up requests for additional verification and that applicant failed to produce evidence that it responded to the verification requests. The arbitrator declined to follow *Chapa*, finding that, "[t]here is nothing in the *Chapa* decision which entitles an Applicant to an award in its favor if a respondent does not deny the applicant's claim within 30 days after the expiration of the 120-day period to respond to a verification request." The arbitrator determined that respondent was entitled to request additional verification of the claim and issued a valid denial of claim when it failed to receive any response to the verification requests within 120 days of the date the initial verification request. Therefore, the arbitrator upheld respondent's defense and denied the claim.

Van Loon DME USA, Inc. & Progressive Cas. Ins. Co., AAA Case no. 17-21-1213-6262

(08/24/22) (Jan Chow, Arb.) Applicant sought reimbursement for the rental of various items of durable medical equipment. Respondent denied the claims asserting that applicant failed to submit requested verification of the claims within 120 days of the initial request or, alternatively, written proof providing a reasonable justification for the failure to comply pursuant to 11 NYCRR §65-3.8(b)(3). Relying upon the court's ruling in *Chapa Prods. Corp. v. MVAIC,* 66 Misc. 3d 16; 114 N.Y.S.3d 177 (App. Term 2d, 11th & 13th Dists 2019), the applicant argued that respondent issued its denials in excess of 150 days following its initial verification request and, therefore, the denials were invalid. In reviewing the majority's opinion in *Chapa*, together with the specific language contained in the insurance regulations, the arbitrator determined that the court misinterpreted the no-fault regulations and improperly imposed a deadline on an optional claims handling procedure. Concurring with the dissenting opinion, the arbitrator held that the regulations do not specify a deadline in issuing a denial based on the 120-day defense. As such, the plain reading of the statute supports the respondent's right to issue a 120-day denial at any time after 120 days from the first verification. Therefore, the arbitrator determined that the respondent issued timely denials and denied the claims.

EXTRACORPOREAL SHOCKWAVE TREATMENT ("ESWT") & MEDICAL NECESSITY

Andrew Glyptis, MD & Liberty Mutual Ins. Co., AAA Case no. 17-21-1207-0758

(08/12/22) (Rhonda Barry, Arb.) Applicant sought to recover first-party benefits for extracorporeal shockwave treatment (ESWT). Respondent denied claim based upon a peer review report by Bo Headlam, MD. Citing to various studies, Dr. Headlam concluded that ESWT for musculoskeletal and soft tissue injuries is investigative and unproven, and that there is insufficient reliable evidence to establish its efficacy. He further opined that the treatment potential has been acknowledged but further research is necessary. Upon evaluation of the peer review report, the arbitrator found that the report contained references only to case studies that spoke to the efficacy of this form of treatment without any reference to the generally accepted standards of care for when ESWT would be medically necessary, and how the treating doctor deviated from any such standards by using ESWT to treat the claimant's injuries. Comparing the peer review report with applicant's rebuttal, the arbitrator determined that the evidence credibly established that ESWT was not a deviation from generally accepted medical practice and awarded applicant's claim.

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Garden Medical Care, PC & GEICO Ins. Co., AAA Case no. 17-21-1221-9184

(07/14/22) (Dinsmore Campbell, Arb.) The applicant sought to recover first-party benefits for extracorporeal shockwave treatment (ESWT). Respondent offered a peer review report by Dr. Reuben Burshtein in support of its contention that the services were medically unnecessary. In rebuttal, applicant offered affidavits by Dr. Denny Rodriguez and Dr. Drora Hirsch. The arbitrator found that the rebuttals fell short in addressing the opinions as stated by respondent's expert. The arbitrator held that, while the rebuttals provided persuasive narratives surrounding the efficacy of ESWT, neither addressed the paucity of conservative care in the form of physical therapy prior to its performance, which was the central question raised by Dr. Burshtein in his peer review. Weighing the evidence presented by the parties, the arbitrator determined that applicant had failed to meet its burden of persuasion in rebuttal and denied the claim.

Community Medical Care of NY, PC & American Transit Ins. Co., AAA Case no. 17-21-1214-8991

(07/03/22) (Ellen Weisman, Arb.) In this case, the arbitrator was asked to decide whether extracorporeal shockwave therapy and radial pressure wave treatment was medically necessary. In support of its defense, respondent relied on a peer review. The peer reviewer cited literature indicating that the treatment may provide potential benefits with minimal adverse effects and that its use in pain management had been widely established, although long-term benefits were unclear. In opposition, the applicant relied on a rebuttal wherein it was asserted that shockwave therapy is a multi-disciplinary device utilized to obtain fast pain relief and mobility restoration. After reviewing the evidence presented, the arbitrator found that the peer review was insufficient to meet respondent's burden of proof. The arbitrator stated that the peer review essentially supported the use of extracorporeal shockwave and radial pressure wave treatment despite the expert's contrary conclusion that it was ineffective. Therefore, the arbitrator awarded the claim.

Garden Medical Care, PC & Hereford Ins. Co., AAA Case no. 17-21-1218-4455

(07/08/22) (Frank Marotta, Arb.) Respondent denied reimbursement of a claim for extracorporeal shockwave therapy ("ESWT") asserting that the service was medically unnecessary. It was the opinion of the respondent's peer review doctor that, based on the lack of medical based evidence as to the efficacy of this treatment for acute sprain/strain injuries, and the fact that the claimant was in the acute phase of treatment, the treatment was not medically necessary. Applicant submitted a rebuttal in opposition to the respondent's peer review. The rebuttal addressed the peer reviewer's contentions and discussed the beneficial effects of the treatment in relation to the claimant's record. After a review of the evidence submitted, the arbitrator determined that the rebuttal was sufficient to establish that the ESWT was medically necessary, as the authority cited in the rebuttal provided evidence sufficient to refute the peer reviewer's assertion that ESWT is unproven and medically unnecessary for any musculoskeletal or soft tissue indications. Therefore, the arbitrator awarded applicant's claim in its entirety.

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Multi-Specialty Pain Management, PC & Allstate Fire and Casualty Ins. Co., AAA Case no. 17-20-1185-4816

(02/17/22) (Samiya Mir, Arb.) Respondent denied reimbursement of a claim for extracorporeal shockwave therapy ("ESWT"), asserting that the service was medically unnecessary. In support of its defense, Respondent offered a peer review wherein the doctor concluded that the treatment had some limited efficacy in treating cervical spine pain. However, the peer reviewer opined that ESWT was not established as being effective and appropriate for treatment of cervical spine pain. The arbitrator concluded that the peer review was factually insufficient as the peer reviewer failed to set forth the standard of care for the performance of ESWT and failed to discuss sufficiently the claimant's symptoms in relation to the procedure. Therefore, the arbitrator determined that Respondent failed to meet its burden of proof and awarded the claim.

EXTRACORPOREAL SHOCK WAVE TREATMENT ("ESWT") & FEE SCHEDULE

Elena Borisovna Stybel, MD & Geico Ins. Co., AAA Case no. 17-21-1218-6834

(04/21/22) (Dimitrios Stathopoulos, Arb.) Applicant sought reimbursement for extracorporeal shock wave therapy ("ESWT"). After finding the treatment medically necessary, the arbitrator also was asked to consider the merits of Respondent's defense that the charges billed by applicant for ESWT exceeded those permitted under the New York State Workers' Compensation Fee Schedule (the "Fee Schedule"). In support of its defense, Respondent offered an affidavit by Crystal Russo, a certified professional coder. Respondent's expert opines that the appropriate rate of reimbursement for the services in their entirety is $700.39. Respondent's coder contends that the description of the service does not designate an anatomic region or as "each area or section" but, rather, includes the entire musculoskeletal system, which should be reimbursed only once per day in the total sum of $700.39. In support of her position, Ms. Russo referenced CPT code 0102T, the only additional code descriptor specifically delineated within the fee schedule for ESWT, which describes ESWT for the lateral humeral epicondyle with anesthesia. Thus, Ms. Russo contends that, comparing the two codes, CPT 0101T is intended to include the entire musculoskeletal system. In support of its claim, Applicant offered an affidavit of Akeisha Sinanan, also a certified professional coder. Ms. Sinanan contends that where multiple units of ESWT are billed, under the ground rules, reimbursement is 100% for the first procedure, and 50% for each additional procedure. Therefore, applicant's coder concluded that that applicant is entitled to reimbursement in the amount of $700.39 for first unit (cervical), $350.20 for the second unit (lumbar), and $350.20 for the third unit (left shoulder), for an aggregate rate of reimbursement in the amount of $1,400.79. Upon reviewing the evidence, the arbitrator found respondent's coder more persuasive in establishing that ESWT is to be reimbursed only once per day for the entire musculoskeletal system and awarded applicant's claim accordingly.

Dinesh Verma Medical P.C & State Farm Mutual Auto. Ins. Co., AAA Case no. 17-21-1204-7431

(06/20/22) (Brian Rudolph, Arb.) Respondent partially reimbursed applicant's claim for extracorporeal shock wave therapy ("ESWT") and denied the disputed balance asserting that applicant's charges exceed those permitted under the New York State Workers' Compensation Fee Schedule (the "Fee Schedule"). In support of its defense, respondent offered an affidavit by a certified professional coder who opined that it is improper to bill a second unit of ESWT in

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the same session. In support of its claim, the applicant submitted an affidavit by a certified professional coder who opined that the CPT code can be billed more than once per session, since there is nothing in plain language in the Fee Schedule that suggests that multiple units of the code cannot be billed. The arbitrator found the applicant's affidavit more persuasive and noted that the respondent's coder failed to sufficiently cite to authority in support of her contentions. The arbitrator determined that the coder's reliance on the words "musculoskeletal system" is not meant to describe one continuous location/body part. Therefore, the arbitrator awarded reimbursement to applicant for the remainder of the claim.

Community Medical Care of NY, PC and GEICO Ins. Co., AAA Case no. 17-21-1218-2932

(04/28/22) (Lori Ehrlich, Arb.) Applicant sought reimbursement for extracorporeal shock wave therapy ("ESWT"). After finding the treatment medically necessary, the arbitrator also was asked to consider the merits of Respondent's defense that the charges billed by applicant for ESWT exceeded those permitted under the New York State Workers' Compensation Fee Schedule (the "Fee Schedule"). In support of its defense, Respondent offered an affidavit by Crystal Russo, a certified professional coder. Respondent's expert opines that the appropriate rate of reimbursement for the services in their entirety is $700.39. Respondent's coder contends that the description of the service does not designate an anatomic region or as "each area or section" but, rather, includes the entire musculoskeletal system, which should be reimbursed only once per day in the total sum of $700.39. In support of her position, Ms. Russo referenced CPT code 0102T, the only additional code descriptor specifically delineated within the fee schedule for ESWT, which describes ESWT for the lateral humeral epicondyle with anesthesia. Thus, Ms. Russo contends that, comparing the two codes, CPT 0101T is intended to include the entire musculoskeletal system. In support of its claim, Applicant offered an affidavit by Akeisha Sinanan, a certified professional coder. Ms. Sinanan contends that where multiple units of ESWT are billed, under Ground Rule 5 of the Surgery section of the Fee Schedule, reimbursement is 100% for the first procedure, and 50% for each additional procedure. Upon consideration of the evidence submitted by the parties, the arbitrator determined that the existence of CPT code 0102T did not preclude billing for more than one unit of ESWT. Rather, the arbitrator was persuaded by applicant's expert that the appropriate rate of reimbursement is governed by the ground rules and awarded applicant's claim accordingly.

REIMBURSEMENT FOR PERSONAL PROTECTIVE EQUIPMENT (PPE)

East Tremont Medical Center and GEICO Ins. Co., AAA Case no. 17-21-1222-7525

(06/20/22) (Glen Cacchioli, Arb.) The arbitrator addressed whether applicant was entitled to reimbursement for personal protective equipment ("PPE"). The arbitrator noted that, effective September 8, 2020, the American Medical Association (AMA) created a new code, namely 99072, which is described as "[a]dditional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s) when performed during a Public Health Emergency…." The arbitrator further noted that based upon guidance received from the New York State Department of Financial Services (DFS), the New York no-fault law does not contemplate reimbursement of PPE. Noting that PPE consists of cleaning supplies, gloves, facemasks/face shields used generally

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in an office setting, the arbitrator stated that these materials have been used by providers for years prior to COVID-19 and the cost is included in whichever service is rendered. The arbitrator reasoned that PPE is not "provided" to an insured but, rather, is general equipment used by the provider for the prevention of the spread of germs and viruses. Therefore, the arbitrator determined that in order to bill for PPE, it must be used apart from the primary service billed. The arbitrator held that the wearing of facemasks/face shields, the use of gowns, and the use of additional cleaning supplies is the new basic standard for public health considerations and, as such, determined that applicant's charge for PPE was not separately reimbursable.

Attia Rehabilitation PT & Geico Ins. Co., AAA Case no. 17-21-1202-3040

(06/29/22) (Lester Hill, Arb.) The arbitrator addressed whether the applicant may be reimbursed for personal protective equipment (PPE). Applicant started billing for PPE during the COVID-19 pandemic, which was deemed a nationwide public health emergency as of 1/27/20 by the Secretary of Health and Human Services. For each of the nine dates of treatment, applicant billed $9.80 for PPE under CPT code 99072. Respondent argued that applicant may not be reimbursed for PPE because code 99072 was not listed in the New York Workers' Compensation Fee Schedule (the "Fee Schedule"). However, the arbitrator noted that the American Medical Association (AMA) established code 99072 to report additional practice expenses incurred during a Public Health Emergency (*e.g.*, COVID-19), such as PPE. Therefore, the arbitrator determined that although the Fee Schedule had not been modified during the COVID-19 crisis to reflect the entry of code 99072, it would be contrary to the intentions of the AMA to deny a claim for PPE. Accordingly, the arbitrator awarded the applicant's claim.

RES Physical Medicine & Rehabilitation Services & Geico Ins. Co., AAA Case no. 17-21-1219-4453

(07/14/22) (Ioannis Gloumis, Arb.) The arbitrator addressed whether the applicant may be reimbursed for personal protective equipment (PPE). Applicant started billing for PPE during the COVID-19 pandemic, which was deemed a nationwide public health emergency as of 1/27/20 by the Secretary of Health and Human Services. For each date of service, applicant billed $20.00 for PPE under CPT code 99072. Respondent denied the charges arguing that, based upon guidance received from the New York State Department of Financial Services (DFS), New York no-fault law does not contemplate reimbursement of PPE. Applicant argued that a new code (99072) was placed into effect by the American Medical Association (AMA) due to COVID-19 protocols, and the AMA defined code 99072 as follows: "Additional supplies, materials and clinical staff time over and above those usually included in an office visit or other non-facility service(s) when performed during a Public Health Emergency as defined by law due to respiratory-transmitted infectious disease." The arbitrator determined that while code 99072 is not included in the New York Workers' Compensation Fee Schedule (the "Fee Schedule"), the charges can be reimbursed under the existing code 99070 of the Medicine section of the Fee Schedule, a similar code also used for supplies and materials over and above those usually included with an office visit or other services. The arbitrator further determined that since code 99070 does not have a specific relative value unit (RVU) assigned, it should be identified and valued as a "By Report" code in accordance with General Ground Rules 2 and 3 of the Introduction and Guidelines Section of the Fee Schedule. The arbitrator concluded that although the applicant provided evidence in support of the increased costs of cleaning

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supplies, masks, gloves, and labor associated with the COVID-19 pandemic, it did not explain how it determined that the $20.00 charge per date of service was appropriate. Accordingly, the arbitrator dismissed applicant's claim without prejudice.

RES Physical Medicine & Rehabilitation Services & Geico Ins. Co., AAA Case no. 17-21-1218-4773

(07/14/22) (Fred Lutzen, Arb.) The arbitrator addressed whether applicant may be reimbursed for personal protective equipment (PPE) billed under CPT code 99072. For each date of service, applicant billed $20.00 for the PPE and respondent denied reimbursement in its entirety. Respondent argued that based upon guidance received from the New York State Department of Financial Services (DFS), the New York no-fault law does not contemplate reimbursement of PPE. The arbitrator noted that, although code 99072 is not listed in the New York State Workers' Compensation Fee Schedule (the "Fee Schedule"), applicant's bill for services need not reflect a code that is specifically listed in the Schedule. The arbitrator further noted that the American Medical Association (AMA) recently added code 99072 for the additional supplies and clinical staff time required to mitigate transmission of respiratory infectious disease while providing evaluation, treatment, or procedural services during a public health emergency. Applicant argued that 99072 is a new code placed into effect due to COVID-19 protocols and that additional supplies, materials, and clinical staff over and above those usually included in an office visit were needed to perform the services. The arbitrator pointed out that since code 99072 is newly implemented by the AMA due to the public health emergency, it would not be included in the Fee Schedule. Therefore, the arbitrator concluded that 99072 is reimbursable. In order to determine the proper fee for the PPE, the arbitrator referred to the General Ground Rules 4(a) and 4(b) of the Fee Schedule, which indicate that reimbursement should not exceed the invoice cost of the item, applicable taxes, and any shipping. The arbitrator also referred to the American College of Allergy, Asthma & Immunology, which reported on 12/21/20 that the AMA asked the Center for Medicare and Medicaid Services (CMS) to reimburse code 99072 in the amount of $6.57. The arbitrator afforded applicant an opportunity to justify the $20.00 charge for each date of service. However, applicant failed to provide invoices to support the rate of reimbursement requested and, therefore, the arbitrator ultimately concluded that the applicant failed to provide support for reimbursement as required under General Ground Rules 4(a) and 4(b). Accordingly, the arbitrator awarded $6.57 for each of applicant's claims for the PPE.

SUM AWARDS: GAP IN TREATMENT

Claimant v. American Transit Insurance Company, AAA Case No 01-21-0017-3911

(09/06/22) (Alan H. Krystal, Arb) On November 21, 2018, the claimant, age 35, was the operator of a 2019 Toyota and was traveling south on Route 1 & 9 in Newark, New Jersey when her vehicle was struck in the rear by a 2004 Jetta. The claimant first sought treatment on December 13, 2018 at Healthwise Medical Associates, P.C., where she was examined by Dr. O for complaints of neck and back pain. Dr. O reported tenderness at C3-C7 and L2-L4 with restricted ranges of motion. Straight leg raising was positive at 30 degrees on the right and 20 degrees on the left. Dr. O prescribed a course of therapy, which included hot and cold packs, electrical stimulation, and massage, and the claimant attended therapy until June 28, 2019. In addition, Dr. O referred the claimant for MRI studies of the cervical spine and lumbar spine. According to the report, the cervical spine MRI revealed posterior disc herniation at C3-4, a

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posterior disc bulging at C4-5 through C7-T1 and T1-2. The report for the MRI of the lumbar spine documented posterior disc bulges at T11-12 through L4-5. Claimant also received chiropractic treatment from December 20, 2018 to May 16, 2019. The next documented medical treatment occurred on January 12, 2021 when the claimant sought treatment at Community Health Physical Therapy for complaints of neck and back pain. The examination by Dr. S revealed spasm and tenderness of the cervical and thoracic spine and reduced range of motion. The claimant received physical therapy on January 12, 2021 and January 15, 2021. On May 21, 2021, the claimant was evaluated by Dr. G, whose examination revealed moderate spasm, diffuse tenderness, and trigger points in the cervical spine and lumbar spine. Range of motion was restricted on all planes. Dr. G concluded that, "based upon the history obtained, clinical examination, findings, and review of the medical records, it is my professional opinion to a reasonable degree of medical probability that this patient has sustained a permanent partial disability causally related to the accident of November 21, 2018. These injuries are permanent and progressive. Therefore, the patient will need periodic physical therapy treatments." During the hearing, the claimant testified that she was employed as an Uber driver at the time of the accident. She stated that she did not return to work following the accident and remained unemployed. However, the arbitrator noted that the January 12, 2021 record at Community Health Physical Therapy documented that she worked as a Home Health Aide. The claimant testified that she still experiences neck and back pain. Respondent submitted the report of a neurological examination performed by Dr. A on May 31, 2022. Dr. A's examination did not reveal any tenderness or range of motion limitations in the cervical or lumbar spine. The neurological examination did not reveal any abnormalities. Upon completion of his examination, Dr. A concluded that claimant's injuries had resolved and that she could resume her prior activities without limitation. Based upon the evidence presented, the arbitrator found that the accident was due to the negligence of the underinsured vehicle that struck the claimant's vehicle in the rear. However, as to the issue of damages, the arbitrator determined that the claimant was sufficiently compensated by $15,000 previously received from the tortfeasor. In so finding, the arbitrator noted that the claimant did not seek treatment until December 13, 2018, 25 days after the accident, and, after receiving treatment through June 2019, the claimant did not seek any additional treatment until January 2021. Although Dr. G opined that the claimant's injuries were permanent in nature, the arbitrator determined that the gap in treatment rendered Dr. G's opinion speculative and called into question the seriousness of the injuries. While the claimant testified that she was incapacitated and could not return to work, the arbitrator found that her testimony was not corroborated by any evidence documenting her absence from work or by a statement from her treating medical providers that she was incapable of working. Therefore, the arbitrator entered an award in favor of Respondent.

Claimant "AT" v. American Transit Ins. Co., AAA Case no. 01-21-0002-6052

(08/08/22) (Jonathan Rivera, Arb) On June 11, 2017, the claimant was a rear passenger in a taxi struck by a hit-and-run motor vehicle in Bronx County, New York. Following the accident, the claimant was evaluated at Jacobi Hospital and subsequently sought medical treatment on June 13, 2017 at Metropolitan Interventional Medical Services for complaints of neck and back pain, as well as tingling and numbness in his arms and legs. Examination revealed muscle spasm in the cervical and lumbar spine, a positive straight leg raise test and decreased sensation and range of motion of the cervical and lumbar spine. Following examination, the claimant was referred for physical therapy. MRI studies of the cervical and lumbar spine were performed on August 24, 2017, and on July 3, 2017, the claimant underwent an EMG/NCV study of the upper and lower extremities, which revealed evidence of right C5-C6 and bilateral L4-L5

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radiculopathy. During the hearing, the claimant testified that he attended physical therapy approximately five times a week for four months. In support of his testimony, the claimant submitted a physical therapy log, together with acupuncture and chiropractic sign-in sheets, which documented consistent treatment from June 13, 2017 through November 16, 2017. The claimant also submitted range of motion and strength-testing reports from June 2017 through September 2017, together with medical records from Metropolitan Interventional Medical Services for services rendered October 10, 2017. The claimant testified that after four or five months of treatment, he failed to show further improvement, and, as a result, stopped going to physical therapy. He testified that he exercised at home and was also given an "electrode stimulator" that he routinely applied to his neck and back. However, the claimant testified that he continued to experience persistent pain in his neck and back. Therefore, he obtained a referral to Pain Physicians NY and, on February 22, 2018, was examined by Dr. K for complaints of pain in the neck and back with radiating symptoms to his legs, feet, and toes. Examination revealed restrictions in motion in the cervical and lumbar spine and positive orthopedic and neurological testing. Dr. K recommended cervical epidural steroid injections ("CESI"), but the claimant was hesitant. On May 31, 2018, the claimant followed-up with Dr. K at Pain Physicians of NY, at which time CESI was again recommended. The arbitrator noted that the claimant underwent a CESI sometime between March 11, 2019 and April 15, 2019 and subsequently underwent a second CESI also in April 2019. On December 12, 2019, the claimant was evaluated again at Pain Physicians NY [use whatever is the correct name] for continued complaints of neck and back pain. The claimant testified that Dr. K stated his injuries were permanent and that the pain injections would only give him temporary pain relief. Reevaluation by Dr. K on January 6, 2022 revealed tenderness in the lower back and sacroiliac region, the L3-S1 spinous processes, and moderate muscle spasm along the lumbar paravertebral muscles. Straight leg raise was positive. The claimant exhibited mild muscle weakness in the upper and lower extremities, impaired proprioception, segmental sensory changes, and diminished reflexes. Dr. K opined that claimant had an extensive course of conservative treatment with physical therapy, injections, and analgesics without significant pain relief, and that, within a reasonable degree of medical certainty, the claimant's injuries were permanent and causally related to the accident of June 11, 2017. Dr. K opined that while the claimant's pain could be controlled with epidural steroid injections, the pain would never be completely alleviated. Respondent submitted the report of a negative independent medical examination (IME) performed on September 12, 2017, which concluded that the claimant did not suffer a "serious injury". The arbitrator noted that the respondent did not offer any evidence of a subsequent injury as a source of claimant's continued positive findings and radicular pain. Upon consideration of the evidence presented, the arbitrator opined that claimant adequately addressed the gaps in medical treatment, finding the claimant's testimony sufficiently demonstrated that, after months of conservative treatment, he no longer benefited from continued physical therapy in an in-office setting. The arbitrator concluded that the claimant's testimony, together with the January 2022 examination by Dr. K, sufficiently supported his claim that his symptoms had persisted for more than five years since the accident on June 11, 2017. Therefore, upon review of the records by Dr. K, the arbitrator determined that the claimant sustained a significant limitation and permanent consequential limitation causally related to the underlying accident and awarded the claimant $22,500.00.

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