



AAA® INSURANCE REPORTER

SPRING 2022 EDITION

More Resolutions and Reduction in Time to Hearing

The AAA Insurance Reporter has moved to a twice-yearly schedule, which in turn has provided more time to assess the final results from 2021. Over the last five years, the AAA has experienced a surge in no-fault arbitration filings averaging 10% year-over-year growth. New filings increased from 357,000+ in 2020 to 405,000+ filings in 2021, a 13% growth.

The timeframe from filing to a hearing is one metric the AAA uses to evaluate the health of the insurance programs administered on behalf of the NYS Department of Financial Services. As such, AAA has worked closely with the no-fault arbitrator panel to increase the capacity of hearings. In 2020, the average number of hearings scheduled was over 14,800 monthly. In 2021, the average increased to over 17,700 scheduled hearings. No-fault arbitrators conducted 136,817 hearings in 2021, an increase of 14,766 cases heard or 12.1% from 2020. The panel issued 122,190 reasoned awards, a 22.2% increase from 2020.

The AAA's partnership with the panel as well as initiatives implemented to drive more resolutions in conciliation amounted to a 7% increase in the conciliation rate to 50% and reduced the time from filing to hearing from 389 days to 369 days. The pending inventory of cases awaiting a first-time hearing was lowered by 50%, from over 180,000 at the start of 2021 to under 90,000 by the end of the year.

According to the latest customer satisfaction survey in 2021, 91% of customers indicated they would recommend the AAA. Thank you to all our customers for your continued support and confidence in our administration of the insurance programs.

New Arbitrators Join the SUM Panel

The New York State Insurance Program is pleased to announce the appointments of four new arbitrators to the SUM/UM Arbitrator panel, the first appointments to the panel in over 15 years. The appointments are timely in view of the increase in SUM/UM filings received and attrition to the panel over the last five years. Below are their profiles.

Jonathan Rivera

Jonathan is a graduate of John Jay College of Criminal Justice and Brooklyn Law School. During his tenure at a Brooklyn law firm, he handled automobile liability, labor law, and premises accident matters that resulted in settlements, jury verdicts, and trial and appellate court decisions and opinions. He later was in-house trial counsel for an insurance company in complex litigation matters. Over the course of his career, he gained the experiences of representing injured plaintiffs and assessing liability claims in litigation, mediation, and arbitration. Jonathan joined the SUM/UM Arbitrator panel in November 2021.



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Jay Skelton

Prior to joining the SUM/UM panel in October 2021, Jay Skelton was an AAA no-fault arbitrator for 14 years. Following that, Jay worked for the AAA in the New York State Insurance Division for 5 ½ years before returning to the arbitration panel. Prior to serving as an arbitrator, Jay had his own law practice that focused on personal injury, medical malpractice, and fourth amendment litigation.

Sally Rose Maiolo

An alumnus of Brooklyn Law School, Sally has a B.A. in Spanish and a Certificate in International Marketing Management. She is admitted to practice law in NY, NJ, DC, US District Court, the Eastern and Southern Districts of NY, and the District of NJ. In January 2022, she joined the SUM/UM arbitrator panel after decades of service as a Principal Law Clerk for several NYS Supreme Court Justices handling matters including insurance law, medical malpractice, negligence, commercial litigation, and matrimonial law.

Alana Barran

Alana attended New York University where she was a double major in Political Science and Spanish Literature. After attending Brooklyn Law School, she practiced law for over 20 years as a litigator on behalf of both plaintiffs and defendants. Alana most recently served as a no-fault arbitrator with the New York State Insurance Program for over eight years. She joined the SUM/UM Arbitrator panel in February 2022.

The Great Return

After two years of remote work, with return-to-office plans derailed by new COVID variants, on March 7, 2022, AAA's NYSI division returned to the office in Lower Manhattan, with hybrid and remote work models in place.

The AAA instituted guidelines for engagement in compliance with CDC recommendations and addressed staff needs and concerns, including safe commuting to the office and a mandatory daily symptom checker for employees to fill out before entering the building.

Planning the office re-entry also involved considerations of a new office culture, work-life balance needs, and successful caseload-management practices. Through staff-engagement techniques and feedback from the user community on their remote work models, the AAA gathered valuable feedback to incorporate into practice.

The AAA no-fault community has always maintained a sense of family and unity and during the first month of office re-entry remote and hybrid staff were provided with meals, snacks, beverages, and safety supplies that included hand sanitizer, disinfecting wipes, and masks.



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The AAA community, which also includes our users, has grown stronger and has proven to be even more resilient than prior to the pandemic. We continue to experience caseload growth, as we provide excellent customer service to all users.

Tech Tips: Clear Your Web Browser Cache!

Following is a brief tutorial on what “clearing a cache” means. Before doing so, it is prudent to check with a tech professional.

When there is a new release of a software program due to an upgrade or enhancement, it may come with a recommendation to “clear your cache.” In computing terms, cache is an auxiliary memory from which high-speed retrieval of sites and web pages is possible. Computer web browsers store browsing data in cache memory when one accesses websites and programs in order to provide quicker future responsiveness and an improved user experience. For example, this rapid access is useful when loading images, text, photos, and directions recently viewed. Experience the speed difference in response: visit a website never visited before, revisit it, and compare the speeds.

What does it actually mean to “clear the cache?” This signifies deleting all saved information that has been stored in the cache. After the cache is cleared and a user returns to internet websites previously viewed, the browser will “think” that page has not been visited before and will cache newly updated information from those websites. Generally, cleaning the cache once every month or two and after program application updates should suffice.

Why clear the cache? Clearing the cache can help prevent the use of old forms, protect personal information, and may help improve running applications such as the ADR Center on the computer. Depending on one’s settings, the cache can grow quite big and use a lot of disk space on your computer. Information saved often is for web pages never revisited.

Because cybercriminals are getting more sophisticated with advancing technology, clear the cache for security. Hackers can use cached data to infiltrate private networks to embed malware or virus links to the stored files and attack unsuspecting users. Cache clearing can help reduce online risks and may protect from security breaches.

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The AAA wishes to extend gratitude to you all for your continued support and sends hopes for a happy and safe summer.



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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

OFFICIAL DISABILITY GUIDELINES & WORKERS' COMPENSATION MEDICAL TREATMENT GUIDELINES & MEDICAL NECESSITY

- *Marta Medical Supply, Corp. v. Geico Ins. Co.*, AAA Case no. 17-21-1192-9081 (1/29/22) (Glen Wiener, Arb.)
- *Professional Pain Management, P.C. v. Geico Ins. Co.*, AAA Case no. 17-19-1128-4246 (1/21/21) (Drew Gewuerz, Arb.)
- *Nexray Medical Imaging PC d/b/a Soul Radiology & Hereford Ins. Co.*, AAA Case no. 17-19-1147-9770 (10/5/21) (Lester Hill, Arb.)
- *Integral Assist Medical, PC & Geico Ins. Co.*, AAA Case no. 17-20-1188-3170 (12/23/21) (Christopher Persad, Arb.)
- *North American Partners in Anesthesia LLP & Allstate Ins. Co.*, AAA Case no. 17-20-1172-1131 (12/27/21) (John Hyland, Arb.)

COVID-19 PANDEMIC: EXECUTIVE ORDER & TOLLING

- *Manalapan Surgery Center & Enterprise Rent A Car*, AAA Case no. 17-20-1188-8893 (12/14/21) (Giovanna Tuttolomondo, Arb.)
- *Surgicore Surgical Center LLC & MVAIC*, AAA Case no. 17-20-1188-8868 (11/27/21) (Matthew Cavalier, Arb.)
- *Cohen & Kramer M.D. P.C. and Geico Ins. Co.*, AAA Case no. 17-20-1185-3862 (05/12/21) (Eva Gaspari, Arb.)
- *Olga Gibbons d/b/a Astro Medical Services & American Transit Ins. Co.*, AAA Case no. 17-20-1169-9438 (07/16/21) (Tali Philipson, Arb.)
- *Advanced Comprehensive Laboratory & New York Central Mut. Fire Ins.*, AAA Case no. 17-21-1192-0106 (02/18/22) (Matthew Summa, Arb.)
- *Andrew J. Dowd, MD Orthopedics and Hand Surgery & State Farm Mut. Auto. Ins. Co.*, AAA Case no. 17-20-1177-0186 (08/10/21) (Corinne Pascariu, Arb.)



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NEW JERSEY FEE SCHEDULE & ENTITLEMENT TO REIMBURSEMENT FOR CODES NOT LISTED

- *Barnert Surgical Center, LLC & Geico Ins. Co.*, AAA Case no. 17-20-1179-4349 (7/22/21) (Kent Benziger, Arb.)
- *Manalapan Surgery Center, LLC & Geico Ins. Co.*, AAA Case no. 17-19-1151-8497 (7/20/21) (Debbie Thomas, Arb.)
- *Health East Ambulatory Surgical Center & Progressive Cas. Ins. Co.*, AAA Case no. 17-21-1202-6474 (12/27/21) (Gerry Wendrovsky, Arb.)
- *Surgicore of Jersey City, LLC & State Farm Mut. Auto. Ins. Co.*, AAA Case no. 17-21-1199-0957 (1/25/22) (Michael Resko, Arb.)

FINAL DETERMINATIONS BY WORKERS' COMPENSATION BOARD & DUTY TO NOTIFY NO-FAULT INSURER

- *ElectroDiagnostic & Physical Med PC & American Transit Ins. Co.*, AAA Case no. 17-18-1105-4405 (7/21/21) (Matthew Brew, Arb.), aff'd AAA Assessment no. 99-18-1105-4405 (10/9/21) (Jeffrey Grob, Master Arb.)
- *Advanced Orthopedics & Joint Preservation PC v. American Transit Ins. Co.*, AAA Case no. 17-20-1168-6611 (8/3/21) (Claire Gallagher, Arb.) aff'd AAA Assessment no. 99-20-1168-6611 (10/24/21) (Burt Feilich, Master Arb.)
- *Green Acres Home Care v. American Transit Ins. Co.*, AAA Case no: 17-19-1128-5514 (2/27/20) (Tali Philipson, Arb.) aff'd AAA Assessment no. 99-1128-5514 (6/30/20) (Jonathan Hill, Master Arb.)
- *Omega Diagnostic Imaging, P.C. & Hereford Ins. Co.*, AAA Case no. 17-20-1166-8183 (1/4/22) (Ann Lorraine Russo, Arb.)
- *Cohen & Kramer, M.D., P.C. & American Transit Ins. Co.*, AAA Case no. 17-21-1209-9173 (11/16/21) (Michael Rosenberger, Arb.)
- *Limelite Recovery Inc. & American Transit Ins. Co.*, AAA Case no. 17-20-1183-1825 (2/14/22) (John O'Grady, Arb.)

SUM AWARDS: COMPARATIVE NEGLIGENCE & FAILURE TO USE SEATBELT

- *Claimant & American Alternative Ins. Co.*, AAA Case no. 01-20-0005-4977 (Peter Horenstein, Arb.)
- *J.B. & Utica Mut. Ins. Co.*, AAA Case no. 01-17-0002-8357 (Richard Kesnig, Arb.)



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Arbitrator Abstracts

OFFICIAL DISABILITY GUIDELINES & WORKERS' COMPENSATION MEDICAL TREATMENT GUIDELINES & MEDICAL NECESSITY

Marta Medical Supply, Corp. v. GEICO Ins. Co., AAA Case no. 17-21-1192-9081

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

(1/29/22) (Glen Wiener, Arb.) Applicant sought reimbursement for a lumbar support. Respondent denied the claim on the ground the lumbar support lacked medical necessity. In support of its defense, respondent relied upon the peer review report of Dominick Garofalo, M.S., D.C. Citing to the New York Mid and Low Back Injury Treatment Guidelines, Dr. Garofalo asserted the lumbar support was not warranted because there was no documented evidence of spondylolisthesis, instability, or post-operative treatment. Applicant did not submit a rebuttal in opposition. In finding for respondent, the arbitrator held that, while not dispositive, the Medical Treatment Guidelines are highly persuasive as to the generally accepted medical practices for treatment of neck, back, and knee injuries because they were developed by representatives from the Workers' Compensation Board and selected qualified medical professionals. Thus, the arbitrator determined that the peer review report was sufficient to establish a lack of medical necessity and denied the claim.

Professional Pain Management, P.C. v. GEICO Ins. Co., AAA Case no. 17-19-1128-4246

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

(1/21/21) (Drew Gewuerz, Arb.) Applicant sought reimbursement for trigger point injections and epidural steroid injections. Respondent denied the claim on the ground the injections lacked medical necessity. In support of its defense, respondent relied upon the peer review report of Mitchell Ehrlich, M.D. Dr. Ehrlich asserted the injections were not warranted because such were not consistent with the standard of care set forth in the Workers' Compensation Medical Treatment Guidelines. In opposition, applicant argued the guidelines were not applicable to no-fault claims and, therefore, respondent failed to meet the burden of production in support of its lack of medical necessity defense. In finding for applicant, the arbitrator held that the Medical Treatment Guidelines were not authoritative and were specifically drafted to only apply to Workers' Compensation claims. The arbitrator noted that he previously addressed the issue at length in *Pain Medical, PLLC v. GEICO Ins. Co.*, AAA Case no. 17-16-1034-2976 (7/3/17), wherein he held that the Regulatory Impact Statement to the guidelines clearly demonstrated they were not intended to apply to no-fault claims. Thus, the arbitrator determined that the peer reviewer failed to present a legally sufficient medical rationale in support of his opinion, and an award was issued in favor of applicant.

Nexray Medical Imaging PC d/b/a Soul Radiology & Hereford Ins. Co., AAA Case no. 17-19-1147-9770

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(10/5/21) (Lester Hill, Arb.) Applicant sought reimbursement for MRIs of the brain and cervical and lumbar spine. Respondent relied upon a peer review of Eric Roth, M.D. to establish a lack of medical necessity. Dr. Roth stated



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that the MRIs were referred prematurely based on insufficient examination findings pursuant to the Official Disability Guidelines (ODG) issued by the Work Loss Data Institute and the NIA guidelines issued by Magellan Healthcare. The arbitrator determined that the peer review did not meet the respondent's burden of establishing a lack of medical necessity for the MRIs, in part because the ODG and NIA guidelines are not reliable standards of care recognized for the treatment of patients under no-fault. Therefore, the arbitrator granted the claim in its entirety.

Integral Assist Medical, PC & Geico Ins. Co., AAA Case no. 17-20-1188-3170

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(12/23/21) (Christopher Persad, Arb.) Applicant sought reimbursement for physician assistant services associated with left shoulder arthroscopic surgery. Respondent denied the claim based on a peer review report by Howard Kiernan, M.D., who reviewed the injured party's medical records and determined that the surgery was medically unnecessary due to an insufficient trial of conservative treatment as set forth in the New York Workers' Compensation Medical Treatment Guidelines. Applicant submitted a rebuttal to the peer review by Paul Ackerman, M.D., the treating surgeon. The respondent submitted an addendum to the peer, and applicant submitted a reply to the addendum. The arbitrator cited an award by Arbitrator Wiener in AAA Case no. 17-17-1071-6148 standing for the proposition that the Workers' Compensation Medical Treatment Guidelines provide a generally accepted standard of care for the medical community, particularly when combined with a peer reviewer's experience as a physician. In finding in favor of applicant, the arbitrator reasoned that while the peer review met respondent's initial burden of establishing a lack of medical necessity for the surgery, the rebuttal refuted the peer, in part, due to the reliance upon more applicable and persuasive medical authority.

North American Partners in Anesthesia LLP & Allstate Ins. Co., AAA Case no. 17-20-1172-1131

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(12/27/21) (John Hyland, Arb.) Applicant sought reimbursement for anesthesia administered in conjunction with left shoulder arthroscopic surgery and manipulation under anesthesia (MUA). Respondent relied upon a peer review by Stuart Springer, M.D. to establish a lack of medical necessity. Dr. Springer reviewed the injured party's medical records and stated that the medical facts did not meet the criteria for shoulder surgery and MUA. The arbitrator rejected the peer review, in part, due to Dr. Springer's reliance on the Magellan and CMS guidelines, which the arbitrator found were neither binding nor reliable evidence of a medical standard of care applicable to no-fault claims. Accordingly, the arbitrator granted the claim in its entirety.

COVID-19 PANDEMIC: EXECUTIVE ORDER & TOLLING

Manalapan Surgery Center & Enterprise Rent A Car, AAA Case no. 17-20-1188-8893

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(12/14/21) (Giovanna Tuttolomondo, Arb.) The applicant sought reimbursement for a facility fee associated with manipulation under anesthesia performed October 6, 2016. The respondent argued the statute of limitations ("SOL")



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barred recovery. The arbitrator noted that the respondent received the provider's responses to respondent's verification requests on May 8, 2017, and that the claim became overdue 30 days later on June 7, 2017 and, therefore, the SOL would normally have expired three years later on June 7, 2020. However, on March 20, 2020 former Governor Andrew M. Cuomo issued Executive Order Number 202.8, tolling "... any specific time limit for the commencement, filing, or service of any legal action, notice, motion, or other process or proceeding, as prescribed by the procedural laws of the state, including but not limited to the criminal procedure law, the family court act, the civil practice law and rules, the court of claims act, the surrogate's court procedure act, and the uniform court acts, or by any other statute, local law, ordinance, order, rule, or regulation, or part thereof..." Subsequent executive orders extended the tolling of the SOL period to November 3, 2020. The arbitrator took note of the decision by the Appellate Division in the matter of *Brash v. Richards*, 195 A.D.3d 582, 149 N.Y.S.3d 560 (2nd Dept. 2021), wherein the court was asked to determine whether the Executive Orders constituted a toll or, alternatively, a suspension of filing deadlines applicable to New York courts. The court concluded that the executive orders constituted a toll of such filing deadlines, stating, "[u]nlike a toll, a suspension does not exclude its effective duration from the calculation of the relevant time period. Rather, it simply delays expiration of the time period until the end date of the suspension." Therefore, the arbitrator determined that the period of the toll was excluded from the calculation of the relevant time period. The arbitrator found that when the order was enacted, the applicant still had 78 days to file its claim. The toll ended November 3, 2020, thus giving applicant an additional 78 days, or until January 20, 2021, to commence the proceeding. The proceeding was filed on December 22, 2020, and, therefore, the arbitrator determined it was timely.

Surgicore Surgical Center LLC & MVAIC, AAA Case no. 17-20-1188-8868
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(11/27/21) (Matthew Cavalier, Arb.) The applicant sought reimbursement for surgical medical services provided on August 24, 2016. The respondent argued the procedure was not medically necessary and that the statute of limitations ["SOL"] barred recovery. The arbitrator noted that the provider's responses to the respondent's verification requests were received by the respondent by April 18, 2017. The claim was denied on April 28, 2017 based on a lack of medical necessity. The arbitrator noted that Governor Andrew M. Cuomo issued Executive Orders tolling any specific time limit for the commencement, filing, or service of any legal action, notice, motion, or other process or proceeding, as prescribed by the procedural laws of the state, including but not limited to the criminal procedure law, the family court act, the civil practice law and rules, the court of claims act, the surrogate's court procedure act, and the uniform court acts, or by any other statute, local law, ordinance, order, rule, or regulation, or part thereof." The arbitrator noted the ruling by the Appellate Division in *Brash v. Richards*, 195 A.D.3d 582, 149 N.Y.S.3d 560 (2nd Dept. 2021), wherein the court held that the executive orders constituted a toll of such filing deadlines, stating, "[u]nlike a toll, a suspension does not exclude its effective duration from the calculation of the relevant time period. Rather, it simply delays expiration of the time period until the end date of the suspension." The arbitrator noted that the SOL to file a claim against MVAIC is three years from the date of the denial and that MVAIC denied the disputed claim on April 28, 2017. Therefore, the applicant would normally have until April 28, 2020 to file this action. In this case, the Executive Order took effect March 20, 2020, 39 days prior to the expiration of the SOL. The arbitrator determined that the toll expired on November 3, 2020 and, therefore, applicant had an additional 39 days, or until December 12, 2020, to file



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this proceeding. However, the case was filed on December 20, 2020, eight days after the SOL expired. The applicant made additional arguments that, due to the COVID-19 pandemic, the applicant's attorney's office and the healthcare provider's medical office were initially closed and later operating remotely with a scaled-down in-person operation, rationalizing the late filing as an excusable error. After considering various factors, including the fact "the AAA's electronic filing system was up and running the entire time," the arbitrator found no reasonable excuse for the late filing and denied the claim.

Cohen & Kramer M.D. P.C. and Geico Insurance Company, AAA Case no. 17-20-1185-3862
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(05/12/21) (Eva Gaspari, Arb.) Applicant sought reimbursement for a right shoulder arthroscopic surgery. The respondent denied the claim based upon a lack of medical necessity supported by a peer review report. The peer doctor opined that the arthroscopic surgery was not medically necessary because the EIP did not undergo physical therapy, thus, the surgery was performed without a comprehensive attempt at conservative care. At the hearing, the applicant's counsel noted that the underlying motor vehicle accident and treatment period occurred during the COVID-19 pandemic, and counsel argued that the issues of quarantine and avoidance of non-essential interactions effected the EIP's attempts at conservative care. The arbitrator took judicial notice of Governor Andrew M. Cuomo's "New York State on PAUSE" Executive Order, which directed all nonessential businesses statewide to close in-office personnel functions effective 8 p.m. on Sunday, March 22, 2020 and temporarily banned all non-essential gatherings of individuals of any size for any reason. The Executive Order was ultimately extended until June 13, 2020 for regions that did not meet the standards for reopening. The arbitrator reasoned that there was a valid concern for people to avoid all nonessential gatherings, which could certainly include a decision to avoid a physical therapy facility to mitigate risk and exposure to the virus. However, the arbitrator highlighted the fact that the EIP did not have a documented basis for failing to attempt conservative treatment prior to undergoing right shoulder arthroscopy, and that the EIP did attend multiple medical appointments and was receiving acupuncture treatments. Therefore, the arbitrator determined that the facts did not support counsel's argument that the EIP was avoiding all non-essential medical appointments, nor did the medical records indicate that conservative care options were suspended or modified due to considerations of exposure to the Covid-19 virus. The arbitrator concluded that, notwithstanding the unique circumstances presented by Covid-19, there was nothing in the record indicating that it was appropriate to suspend conservative treatment options based on the circumstances. Therefore, the arbitrator denied the claim.

Olga Gibbons d/b/a Astro Medical Services & American Transit Ins. Co., AAA Case no. 17-20-1169-9438
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(07/16/21) (Tali Philipson, Arb.) Respondent timely denied Applicant's claim based upon the assignor's failure to appear at two independent medical examinations ("IMEs"). Respondent originally scheduled the IMEs for March 4, 2020 and April 1, 2020. Due to the COVID-19 pandemic, a third scheduling letter was generated re-scheduling the IME on April 1, 2020 to June 23, 2020. Counsel for the applicant argued that the assignor could have attended the April 1, 2020 IME and that the respondent's proof was insufficient to demonstrate that the assignor failed to do so.



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Respondent's attorney noted that on April 1, 2020, there was a statewide shutdown of all nonessential businesses mandated by Governor Andrew Cuomo's "PAUSE" (Policies that Assure Uniform Safety for Everyone) Executive Order, which went into effect on March 22, 2020. Respondent's counsel argued that in an effort to comply with the statewide mandate, respondent canceled the second IME, since neither the examining physician nor the assignor could have attended as per the PAUSE order, and, therefore, the April 1, 2020 IME was not considered a "missed" appointment. Applicant's counsel argued that physicians were considered essential workers during the pandemic, and, therefore, both the doctor and the assignor could have attended the IME without violating the PAUSE order. The arbitrator agreed that on April 1, 2020, the date of the second IME, Governor Cuomo's PAUSE order was in effect and all nonessential businesses were closed. The order provided a list of "Essential Health Care Operations," which included the following: research and laboratory services, hospitals, walk-in-care health facilities, emergency veterinary and livestock services elder care, medical wholesale and distribution, home health care workers or aides for the elderly, doctor and emergency dental, nursing homes, or residential health care facilities or congregate care facilities, medical supplies, and equipment manufacturers and providers. The arbitrator noted that while IME doctors were not specifically excluded from the list, the services they provided did not fall within any of the categories identified in the PAUSE order. Therefore, the arbitrator concluded that respondent's actions at the time the IMEs were scheduled were proper given the unprecedented global pandemic, the PAUSE order, and the information available regarding who was an essential worker. Finding in favor of the respondent, the arbitrator determined that the IME scheduled April 1, 2020 was a nullity, since it was scheduled during Governor Cuomo's PAUSE order, which prevented either party from attending, and that the respondent sufficiently demonstrated that the assignor missed two IMEs on March 4, 2020 and June 23, 2020.

Advanced Comprehensive Laboratory & New York Central Mutual Fire Ins., AAA Case no. 17-21-1192-0106
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(02/18/22) (Matthew Summa, Arb.) In this case, the arbitrator addressed whether the assignor timely filed a notice of the accident within 30 days under 11 NYCRR 65-1.1. The arbitrator determined that respondent's evidence established that the assignor's notice of claim was received more than 30 days after the subject accident. Therefore, the burden shifted to the applicant to establish timely notice of claim or provide a reasonable excuse for the late notice. In opposition, the applicant argued that pursuant to Governor Cuomo's Executive Order, the assignor was under no obligation to submit notice of the accident within 30 days. In sustaining respondent's denials, the arbitrator determined that based upon a plain reading of the language of the Executive Order, there was no indication that the Executive Order applied to the state regulations regarding the handling of no-fault bills.

Andrew J. Dowd, MD Orthopedics and Hand Surgery & State Farm Mutual Auto. Ins. Co., AAA Case no. 17-20-1177-0186
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(08/10/21) (Corinne Pascariu, Arb.) In this case, respondent defended the arbitration based upon the applicant's failure to attend two scheduled EUOs. The arbitrator noted that the EUOs were scheduled to take place during the



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COVID-19 pandemic and during Governor Andrew M. Cuomo's New York State on PAUSE Executive Order. The arbitrator further noted that the EUO scheduling letters provided a location where the EUO was to be held but that the EUO could be arranged to be held in person, by video conference, or by teleconference. The applicant argued that the respondent's denial must be vacated, as the no-fault regulations were stayed as a result of the COVID-19 pandemic and, therefore, it was improper for the respondent to deny the claim based upon the applicant's failure to attend an EUO while the Executive Order was in effect. Based upon the evidence submitted, the arbitrator determined that the applicant had the opportunity to adjourn the EUOs or to arrange to have the EUO held at a location where he was comfortable in terms of COVID safety. However, due to the applicant's lack of communication, the arbitrator found respondent's evidence sufficient to establish that the claim was timely denied based upon the applicant's failure to attend two EUOs.

NEW JERSEY FEE SCHEDULE & ENTITLEMENT TO REIMBURSEMENT FOR CODES NOT LISTED

Barnert Surgical Center, LLC & Geico Insurance Company, AAA Case no. 17-20-1179-4349

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(7/22/21) (Kent Benziger, Arb.) Applicant sought reimbursement for a facility fee associated with a percutaneous cervical discectomy and decompression of C4-5, C5-6 and ablation of nucleus, and modulation of the annulus under fluoroscopic guidance. After determining that the surgery was medically necessary, the arbitrator addressed the parties' fee schedule arguments. The parties agreed that the 33rd Amendment to 11 NYCRR 68 required a comparison between NY and NJ fees and that the lesser of the two fees would be appropriately awarded. Both parties submitted fee coder affidavits. Respondent's fee coder argued that none of the four codes submitted were reimbursable under the New Jersey Fee Schedule. With respect to CPT codes 63075 and 63076, respondent's coder cited to N.J.A.C. 11:3-29.5(a) and 29.43 for the proposition that a service is not reimbursable when there is no fee listed in the Ambulatory Surgical Center facility fee column of Appendix Exhibit 1. Similarly, respondent's coder argued that CPT code 22526 is not reimbursable because the code is not contained within the New Jersey Fee Schedule. In contrast, the applicant's coder reasoned that CPT code 22526 could be "crosswalked" to CPT code 22521, which is reimbursable under the New Jersey ASC Fee Schedule. In finding the applicant's evidence more persuasive, the arbitrator determined that CPT code 22521 was comparable to 22526 and awarded reimbursement.

Manalapan Surgery Center, LLC & Geico Insurance Company, AAA Case no. 17-19-1151-8497

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

(7/20/21) (Debbie Thomas, Arb.) Applicant sought reimbursement for a facility fee associated with a percutaneous discectomy. After determining that the surgery was medically necessary, the arbitrator addressed the parties' fee schedule arguments. The parties agreed that the 33rd Amendment to 11 NYCRR 68 required a comparison between NY and NJ fees and that the lesser of the two fees would be appropriately awarded. Both parties submitted fee coder affidavits. The arbitrator also sought an Independent Healthcare Consultant opinion. Respondent's fee coder argued that none of the five codes submitted were reimbursable under the New Jersey Fee Schedule. With respect to CPT



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codes 63075, 63076, and 77003, the parties agreed that reimbursement was not allowed as there is no fee in the ASC facility fee column of Appendix Exhibit 1. Respondent's coder argued further that 77003 and 20553 were included in the code for the surgery and, therefore, were not separately reimbursable. With respect to CPT code 0274T, respondent's coder argued that no reimbursement was due as the code is not contained in the New Jersey Fee Schedule. In contrast, the applicant's coder argued that 0274T is reimbursable under the New Jersey Fee Schedule as it falls under the purview of N.J.A.C. §11:3-29.4(e)(1), which states that unlisted CPT codes are reimbursed at either the usual and customary fee of the service or a rate of payment equivalent to that of a similar procedure that is listed within the Fee Schedule; applicant's coder determined the fee for 0274T by utilizing the corresponding New York rate of reimbursement as evidence of the usual and customary fee. Distinguishing the respondent's arguments from the holding in *New Jersey Manufacturers Insurance Company v. Specialty Center of North Brunswick*, 204 A.3d 672 (N.J. App. Div. 2019), the arbitrator agreed with the applicant's analysis that the mere fact that a code is not listed in the fee schedule is not enough to establish that services billed under that code are not reimbursable. Relying upon the applicant's analysis, the arbitrator determined that there must also be a showing that the legislature intended for the code not to be reimbursed. The IHC report adopted the methodology offered by the applicant and determined that 0274T should be reimbursed. However, rather than adopting the IHC's recommendation for reimbursement of the code at 100%, the arbitrator adopted the applicant's analysis and determined that reimbursement for services billed under 0274T should be reduced to 50%, as the code did not represent the primary procedure performed. The arbitrator ultimately awarded the amount sought by applicant, which was less than the amount determined by the IHC.

Health East Ambulatory Surgical Center & Progressive Casualty Insurance Company, AAA Case no. 17-21-1202-6474
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(12/27/21) (Gerry Wendrovsky, Arb.) Applicant sought reimbursement for a facility fee associated with bone marrow cell therapy. Before addressing the medical necessity of the services, the arbitrator addressed the parties' fee schedule arguments. The parties agreed that the 33rd Amendment to 11 NYCRR 68 required a comparison between NY and NJ fees and that the lesser of the two fees would be appropriately awarded. The crux of the dispute arose over reimbursement for services rendered under CPT code 0263T, which is not listed in the New Jersey Fee Schedule. The arbitrator determined that under a plain reading of *New Jersey Manufacturers Insurance Company v. Specialty Center of North Brunswick*, 204 A.3d 672 (N.J. App. Div. 2019), an ASC is not entitled to reimbursement for services billed under a CPT code that is not listed in the New Jersey Fee Schedule and, accordingly, the arbitrator denied reimbursement for CPT code 0263T.

Surgicore of Jersey City, LLC & State Farm Mutual Insurance Company, AAA Case no. 17-21-1199-0957
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(1/25/22) (Michael Resko, Arb.) Applicant sought reimbursement for a facility fee associated with a lumbar percutaneous discectomy and Intradiscal Electrothermol Therapy. After determining that the surgery was medically necessary, the arbitrator addressed the parties' fee schedule arguments. The parties agreed that the 33rd Amendment to 11 NYCRR 68 required a comparison between NY and NJ fees and that the lesser of the two fees would be appropriately



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awarded. The crux of the dispute involved reimbursement for CPT codes 22526 and 22527. Both parties submitted fee coder affidavits. Relying upon *New Jersey Manufacturers Insurance Company v. Specialty Center of North Brunswick*, 204 A.3d 672 (N.J. App. Div. 2019), respondent argued that the services are not reimbursable because the two codes are not listed in the Physicians' and ASC columns of the New Jersey fee schedule. The arbitrator determined that a plain reading of the court's ruling in *New Jersey Manufacturers* compelled a finding in favor of respondent. The arbitrator characterized the applicant's coder's attempts to distinguish the codes billed in this instance from the regulations and relevant case law as "strained" and denied reimbursement for CPT codes 22526 and 22527.

FINAL DETERMINATIONS BY WORKERS' COMPENSATION BOARD & DUTY TO NOTIFY NO-FAULT INSURER

ElectroDiagnostic & Physical Med PC & American Transit Ins. Co., AAA Case no. 17-18-1105-4405
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(7/21/21) (Matthew Brew, Arb.), aff'd AAA Assessment no. 99-18-1105-4405 (10/9/21) (Jeffrey Grob, Master Arb.) This matter came before Arbitrator Brew on remand, who was asked to determine whether respondent's defense based upon the availability of Workers' Compensation benefits should be sustained. This case was initially heard before another arbitrator, who found the decision by the Workers' Compensation Board (WCB) disallowing the assignor's claim to be dispositive of this issue against the respondent. An appeal by respondent was sustained based on the lower arbitrator's failure to address whether the respondent was given notice of the WCB hearing. This matter was then remanded to a second arbitrator, who found that the respondent was not given notice of the WCB hearing and, therefore, in accordance with the court's determination in *Matter of Lutheran Med. Ctr. v. Hereford Ins. Co.*, 43 A.D.3d 1064 (2nd Dept 2007), the arbitrator held that respondent was not bound by the WCB decision. The applicant then appealed, and the case was remanded to Arbitrator Brew, who found that the respondent was an interested party and, therefore, entitled to notice of the WCB hearing. Ultimately finding in favor of the applicant, however, the arbitrator distinguished the facts in this case from *Matter of Lutheran Med. Ctr.*, *supra.*, noting that the respondent did not take any action to appeal, challenge, or raise any issue with the WCB regarding the lack of notice issue despite receiving notice of the WCB decision. The arbitrator determined the respondent's inaction to be fatal to its defense, noting that under Workers' Compensation Law §23, the respondent had the power and standing to judicially challenge the WCB determination but failed to do so. The respondent then appealed. The master arbitrator concurred with the lower arbitrator that respondent's inaction after receiving notice of the WCB decision distinguished this proceeding from the facts in *Matter of Lutheran Med. Ctr. v. Hereford Ins. Co.* and that further delay would have frustrated the core objective of the no-fault regulations, and would have regulations, rewarding respondent for its protracted failure to act. Accordingly, the award in favor of applicant was affirmed on appeal.

Advanced Orthopedics & Joint Preservation PC & American Transit Ins. Co., AAA Case no. 17-20-1168-6611
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(8/3/21) (Claire Gallagher, Arb.), aff'd AAA Assessment no. 99-20-1168-6611 (10/24/21) (Burt Feilich, Master Arb.) The respondent denied the claim, asserting that the matter first must be referred to the Workers' Compensation Board



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("WCB") for a preliminary determination regarding the claimant's eligibility for workers' compensation benefits. In rejecting the respondent's defense, the lower arbitrator noted that the WCB already had issued an NCEC-101 letter finding that the assignor was ineligible for worker's compensation benefits, as the assignor did not meet the qualifying criteria for the Independent Livery Drivers Benefit Fund. Therefore, relying upon the decision by the WCB that the claimant was ineligible for workers' compensation benefits, the lower arbitrator determined that the primary jurisdiction of the claim properly rested with the no-fault arbitration forum. The respondent appealed, arguing that it was not placed on notice of the WCB hearing and therefore was not given an opportunity to participate and submit evidence in support of its position that 1) the assignor was operating a Black Car dispatched by a Black Car base; 2) the assignor never was covered by the livery fund; and 3) the assignor was injured in the course and scope of his employment. Affirming the lower arbitrator's decision in favor of the applicant, the master arbitrator noted that the respondent raised the above issues for the first time on appeal, and that, contrary to the statement made by respondent in its appellate brief, at no time had the applicant or the assignor argued or represented that the assignor was a Black Car driver operating through a Black Car-affiliated radio base when the accident occurred.

Green Acres Home Care v. American Transit Ins. Co., AAA Case no. 17-19-1128-5514
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(2/27/20) (Tali Philipson, Arb.), aff'd AAA Assessment no. 99-1128-5514 (06/30/20) (Jonathan Hill, Master Arb.) The arbitrator addressed whether the respondent's defense based upon the claimant's eligibility for workers' compensation benefits should be sustained. The record included a decision from the Workers' Compensation Board (WCB) stating that the assignor's claim was closed, since his injuries did not meet the qualifying criteria. Respondent argued that it was not given notice of the Workers' Compensation hearing, and, therefore, under *Matter of Lutheran Med. Ctr. v. Hereford Ins. Co.* 43 AD 3d 2064 (App Div. 2nd Dept 2007), it was not bound by the decision issued by the WCB. Applicant argued that respondent was given notice as evidenced by the WCB decision, which identified the respondent as one of the recipients of the WCB decision. The arbitrator reasoned that the WCB would not have notified respondent of the decision if the respondent had not initially been identified as an interested party and placed on notice of the hearing. Accordingly, the arbitrator rejected the respondent's defense based upon the claimant's eligibility for workers' compensation benefits. The lower arbitrator's decision was affirmed on appeal.

Omega Diagnostic Imaging, P.C. & Hereford Ins. Co., AAA Case no. 17-20-1166-8183
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(1/4/22) (Ann Lorraine Russo, Arb.) The arbitrator addressed whether the applicant's claim was ripe for adjudication due to applicant's alleged failure to respond to requests for additional verification. Respondent issued verification requests in order to determine whether the assignor, the operator of a livery vehicle, was eligible to receive workers' compensation benefits. The arbitrator noted that the Independent Livery Drivers' Benefit Fund (ILDBF) requires independent livery companies to supply workers' compensation coverage to its independent drivers who meet specific qualifying criteria; drivers not meeting the qualifying criteria are not covered by the ILDBF and may seek no-fault benefits. The arbitrator also noted that the assignor submitted an application to the Workers' Compensation



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Board (WCB) and that the WCB subsequently issued a decision (Form NCEC-101) wherein it determined that the assignor failed to meet the qualifying criteria required by the Executive Law and that he was, in fact, entitled to no-fault benefits. During the arbitration hearing, the Applicant argued that the WCB's decision constituted a final determination rendering the respondent's verification requests moot. Respondent argued that Form NCEC-101 was merely an advisement letter and did not constitute a final determination by the WCB. The respondent further argued that a workers' compensation hearing without notice to the insurer is reversible error. Therefore, the respondent asserted that the applicant's claim for no-fault benefits must be dismissed without prejudice and the matter remanded to the WCB for a determination regarding whether the claimant was in the course of his employment when the accident occurred. In rejecting the respondent's argument, the arbitrator concluded that the NCEC-101 represented a final determination by the WCB. The arbitrator found the evidence in the record adequately demonstrated that the WCB determined that the assignor was not eligible to collect workers' compensation benefits, thus rendering respondent's verification requests regarding the assignor's eligibility for workers' compensation benefits moot. While the arbitrator acknowledged that a final decision by the WCB is subject to appeal, she noted that there was no evidence in the record demonstrating that the assignor appealed the NCEC-101 administrative determination. The arbitrator further noted that respondent failed to offer any evidence demonstrating that the assignor's condition satisfied the qualifying criteria required by the Executive Law for eligibility for benefits under the ILDBF. Therefore, the arbitrator determined that the applicant was entitled to no-fault benefits. Noting that the respondent failed to preserve any additional defenses, the arbitrator awarded the claim.

Cohen & Kramer, M.D., P.C. & American Transit Ins. Co., AAA Case no. 17-21-1209-9173
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(11/16/21) (Michael Rosenberger, Arb.) The arbitrator addressed whether the respondent could sustain its defense that workers' compensation benefits were the primary source of recovery. Respondent alleged that the assignor was in the course of his employment at the time of the underlying accident. In response, applicant submitted a letter from the Workers' Compensation Board ("WCB") on Form NCEC-101 which, according to the Board, "constitutes a final decision by the Workers' Compensation Board that a claimant is ineligible for benefits." The respondent argued that it was never placed on notice of the WCB hearing and, therefore, the present matter should be remanded to the WCB. The arbitrator rejected respondent's argument, noting that the letter clearly represented a "final determination" by the Board and, therefore, the matter could not be remanded to the Board, nor had the respondent offered any evidence suggesting that the WCB would even reconsider its decision. Accordingly, the arbitrator determined that respondent's defense based upon the claimant's eligibility for workers' compensation benefits was unsustainable and that the applicant maintained a viable claim for no-fault benefits.

Limelite Recovery Inc. & American Transit Ins. Co., AAA Case no. 17-20-1183-1825
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(2/14/22) (John O'Grady, Arb.) The arbitrator addressed whether it was permissible for an insurer to restart the processing of a no-fault claim after learning that its original denial of claim based on its position that workers'



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compensation benefits were primary was unsustainable. The respondent originally denied the applicant's claim based on the contention that the assignor was in the course of his employment at the time of the underlying accident. The Workers' Compensation Board subsequently issued a decision (Form NCEC-101) disallowing the assignor's claim for workers' compensation benefits. As a consequence, the respondent withdrew its defense based upon the claimant's eligibility for workers' compensation benefits and issued verification requests to the applicant seeking information to further verify the claim. Relying upon the Appellate Division's ruling in *Todaro v. Geico General Ins. Co.*, 46 A.D.3d 1086 (3rd Dept. 2007)], the arbitrator determined that the respondent was bound by the four corners of its original denial of claim form and could not subsequently create a new basis for its refusal to pay by requesting additional verification upon learning that its original defense based upon the claimant's eligibility for workers' compensation benefits was unfounded. Accordingly, the arbitrator found in favor of the applicant and awarded the claim in full.

SUM AWARDS: COMPARATIVE NEGLIGENCE & FAILURE TO USE SEATBELT DEFENSE

Claimant & American Alternative Insurance Company, AAA Case no. 01-20-0005-4977

[Sum Award Search](#)

(Peter Horenstein, Arb.) This proceeding involved an underinsured motorist claim arising from a head-on collision. The vehicles involved were an ambulance in emergency operation and a Ford Suburban attempting a left turn from a parking lot in front of the oncoming ambulance. At the time of the collision, the claimant was in the rear of the ambulance tending to a patient, and the impact caused the claimant to be thrown about the interior of the ambulance. The claimant was removed from the scene to Stony Brook University Hospital, where she was evaluated for complaints of pain in her neck, left knee, left shoulder, right knee, right shoulder, and right wrist. Four days later, the claimant presented to an orthopedist, "Dr. C", by whom she previously had been treated for prior injuries. "Dr. C" noted her past history of left and right knee arthroscopy, as well as a history of a C5-6 herniation and multi-level disc bulges. Following examination, impression included right and left knee contusion, rule out osteochondral injury and meniscus tear, bilateral shoulder rotator cuff strain with impingement, cervical sprain/strain, and lateral sprain of the left ankle. MRI of the right knee revealed moderate effusion, full thickness defect weight bearing lateral femoral condyle, early patellofemoral arthrosis with chondritic changes of the patella and sulcus. The claimant subsequently underwent arthroscopic surgery to repair the injuries to the right knee. On 2-10-17, the claimant underwent additional arthroscopic surgery of the right knee for additional three-compartment synovitis, lateral meniscus tear, chondrosis of the patella, and lateral and medial femoral condyle. In late August 2018, the claimant was hospitalized for analgesic control of "unretractable right knee pain." She was also experiencing pain in the left knee and leg, was seeing a pain management specialist, and undergoing nerve blocks and radio frequency ablation in an attempt to control the knee pain. On 5-25-19 the claimant underwent another arthroscopy of the right knee. When last seen by "Dr. C," the claimant continued to be totally disabled from work. "Dr. C" attributed all of the claimant's injuries, post-accident treatments, and surgeries to the subject accident, opining that her prior injuries had fully healed. While receiving ongoing treatment for the right knee, the claimant also underwent an MRI of the right shoulder and arthroscopic surgery to repair an AC sprain with tear, a tear of the anterior superior labrum, and a partial thickness rotator cuff tear. The arbitrator noted that office notes also documented continued swelling of the claimant's right ankle, and the claimant was referred to



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"Dr. B," a foot specialist, for evaluation. Following an MRI of the right ankle, the claimant underwent tenolysis of the posterior tendon, and "Dr. B" opined that further surgery would likely be necessary. He described the claimant's ankle injuries to be permanent, "occupationally disabling," and causally related to the subject accident. The respondent commissioned independent radiological reviews of x-rays, a CT scan and MRI of the claimant's cervical spine, and MRI films of the claimant's bilateral knees, shoulders, and right ankle. The independent radiologist attributed the claimant's injuries to age-related degeneration rather than trauma. An orthopedic IME of the claimant on 4-9-18 concluded that the claimant sustained a mild partial orthopedic disability. Among other defenses, respondent proffered a defense of comparative negligence based upon the claimant's failure to use an available seatbelt. In support of its defense, respondent offered a report of "JM," a professional engineer. "Mr. M" determined that "...had [the claimant] been wearing the available seat belt assembly, it would have been extremely effective and would have prevented the injuries sustained." However, the arbitrator took particular note that Mr. McManus failed to examine the ambulance in which the claimant was an occupant, its interior, and the seat belt assembly. Therefore, the arbitrator determined that the engineer's conclusions were speculative and of no probative value. After giving careful attention to the exhibits in evidence, the testimony of the claimant, and the arguments of counsel, the arbitrator awarded the claimant \$350,000.

J.B. & Utica Mutual Insurance Company, AAA Case no. 01-17-0002-8357

Sum Award Search

(Richard Kesnig, Arb.) This matter involved an underinsured motorist claim with \$500,000 in SUM coverage resulting from a motor vehicle accident that occurred on June 30, 2016. "VC," the driver of one of the three vehicles involved in the accident, testified that at the time of the occurrence, he was operating his motor vehicle when another vehicle failed to stop at a stop sign, thus resulting in a collision with his car. "VC" further testified that, at the time of the contact, the claimant's vehicle was stopped at the stop sign, and that the impact between the two vehicles forced each of them to subsequently come into contact with the claimant's car. The claimant, "JB," testified that at the time of the accident, he was stopped at the stop sign when two vehicles collided, causing an impact to the front and driver's side of his vehicle. Photographs documented significant damage to the claimant's vehicle. The claimant acknowledged that he was not wearing a seat belt at the time of this accident. The claimant was removed from the scene by ambulance and transported to Southampton Hospital, where he was evaluated in the emergency room and diagnosed with a fracture of the vertebral column and head injury. The claimant was subsequently transported to Stony Brook University Medical Center where, on July 1, 2016, "Dr. M" performed an anterior cervical discectomy and fusion of the C6 and C7 levels, cage placement, local bone graft, and anterior instrumentation. The claimant remained hospitalized for three days and was subsequently confined to bed for approximately two months. At the request of the respondent, "Dr. H," an orthopedist, examined the claimant on December 6, 2017, following which he diagnosed the claimant with C6 fracture superimposed upon degenerative changes and resolving status post-surgery. On December 11, 2017, "Dr. D," a neurologist, examined the claimant at the request of the respondent. "Dr. D" diagnosed the claimant with status post right-sided C6 facet fracture with C6-7 subluxation, status post-anterior cervical discectomy and fusion, resolved lumbar myofascitis, and resolved post-traumatic headaches. At the request of the respondent, "MM," a mechanical engineer, was asked to determine whether the claimant would have been injured or "less injured" had he been wearing the available seatbelt. "Mr. M" reviewed the incident description, the



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“specifics with regard to [the] claimant’s vehicle,” and the claimant’s alleged injuries. After performing a kinematic analysis, “Mr. M” concluded that had the claimant used the available restraint system, the reported injurious contact with the forward interior structures of the vehicle would have been eliminated. However, the arbitrator found “Mr. M’s” conclusion that the seatbelt would have prevented the violent collision with the airbag unclear. The arbitrator concluded that, had the claimant been wearing his seatbelt, it is likely his injuries may have been alleviated. However, relying upon “Mr. M’s” analysis, the arbitrator stated that he could not determine whether the claimant would have sustained a fracture had he been wearing a seatbelt, nor could the arbitrator determine whether use of the seatbelt would have mitigated the claimant’s suffering. The arbitrator stated that while he could not evaluate with certainty the extent of what the claimant’s injury would have been had he been wearing the available seatbelt, he concluded that the claimant may have deprived himself of an opportunity for less of an injury. Therefore, noting that the claimant was lawfully stopped at a stop sign when this accident occurred, no comparative negligence was assessed against the claimant. The arbitrator determined that the claimant’s injuries were debilitating and would have long-term implications and awarded the claimant \$400,000, less a \$50,000 offset, in full satisfaction of his claim.

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