



## AAA® INSURANCE REPORTER

SPRING 2023 EDITION

### AAA-ICDR Welcomes New CEO

We are delighted to welcome our new CEO Bridget McCormack to the AAA-ICDR®. She brings a wealth of experience and knowledge from her tenure as Chief Justice of Michigan's Supreme Court and as an adjunct law professor at the University of Michigan Law School. Her current role as a Strategic Advisor at the University of Pennsylvania Law School's Future of the Profession Initiative also speaks to her dedication to advancing the legal profession.

In addition to her impressive background, Bridget is a member of several boards of directors, including Kids Kicking Cancer and the National Association of Treatment Court Professionals, to name a few. She also is actively involved in the American Bar Association as Board of Elections Chair and Vice-Chair of the Council on Legal Education and Admission to the Bar.

Bridget received her Juris Doctorate degree from New York University Law School and holds a bachelor's degree from Trinity College in Hartford, CT, with honors in political science and philosophy.

We are excited to have Bridget join the AAA-ICDR in her new role and look forward to her continued success and strategic leadership!

### Options for Submitting No-Fault Arbitration Requests Evolve

Our New York State Insurance Division and Tyler Technologies are jointly developing an Application Programming Interface (API) for ADR case data-entry. An API is a published set of commands that communicating partners follow to exchange data from one computing platform to another. In our case, Applicants will use this API to file their no-fault arbitration requests electronically. Electronic data entry eliminates data transcription errors, speeds the data entry process, and reduces the time needed to prepare documents for submission.

The current **Simple File** portal, introduced in late 2022, was the first step in this journey. This portal provides a web form to allow Applicants to "Drag & Drop" their arbitration documents and submit them into our forum. Some Applicants have taken advantage of the Simple File API and are using that to bypass the web form and submit their arbitration requests directly from their computer systems. While that process is efficient, there remains a manual data-entry step at our division to transcribe the AR-1 document into ADR-Center.

In this next evolution, the API command "payload" will include the AR-1 form data used in ADR-Center Cases. The submission will go directly into ADR-Center where the digital data will be validated and used to create a case record. You will know right away if your submission was successful and receive a case number. If there are issues that cause the submission to fail, you will have immediate feedback of what field did not meet validation requirements.



## AAA® INSURANCE REPORTER

SPRING 2023 EDITION

We have included those who don't have a large enough caseload to warrant using an API in the future version as well. In a later phase of this project, we will create a front-end web form where AR-1 case data can be entered and submitted directly into our systems. This is in the early design phase, so, as is said, "Stay tuned, more to come."

Respondents—we hear you! Also in the early planning stages are API features that will digitize various aspects of case management for insurance carriers as well.

Future communications will provide details on the scheduling of these exciting advancements in case management.

### **AAA-ICDR's Focus on Cybersecurity and Data Protection**

At AAA-ICDR, protecting our networks and the privacy of customer data transmitted via our networks is of utmost importance. The organization has undertaken several security initiatives to ensure that data, systems, and networks remain safe from cyber threats and malicious attacks. One such initiative is the **NYSI Statistics Dashboard** that provides customers with an external database to review and download case-specific data without the need for transmitting sensitive information via email. Customers can now access this data easily and securely.

**Simple File**, noted earlier, offers an improved method of filing no-fault arbitrations with increased security features. This removes the need for filing using less secure email transmission. As part of Simple File, we also introduced an API feature and have plans to expand to a more robust API to enhance the filing process for higher-volume applicants and respondents.

AAA-ICDR introduced a secure virtual desktop called **CaseShield by AAA-ICDR®** to provide enterprise-grade security for arbitrators working in a remote environment.

Additionally, AAA-ICDR updated its **document and data retention policy** for data stored in the ADR Center, ensuring that all documents and data in cases closed in the system for three years or more will be purged starting Q2 of 2023. Finally, as a yearly training requirement, all AAA-ICDR employees receive **online Security Awareness Training** that includes regular mock phishing tests to keep awareness high. While we are working continuously to protect our assets and sensitive data, it is equally important for customers to remain vigilant in the face of increasing and evolving cybersecurity threats. Let's work together to keep our data protected!

### **The NYSI Division Mentorship and Community Corner**

#### **New Mentorship Program Launched**

In 2022, the NYSI Division launched a new initiative to establish a formal mentorship program. The program was designed to support the professional development of staff members who wish to enhance their skills. The mentees were selected from NYSI while the mentors were drawn from various leadership positions across the organization.



## AAA® INSURANCE REPORTER

SPRING 2023 EDITION

The first cohort of mentees began their mentorships in September 2022 and completed a six-month program with their designated mentor. The feedback received was overwhelmingly positive and led to the program's second cohort of mentees already in progress in 2023.

### **Community Month Initiative Celebrated**

In May, we celebrated our Community Month initiative aimed to engage staff members in various community events throughout New York City and Buffalo. Since most of our staff members currently are working remotely, these events serve as opportunities to meet and interact with each other, thereby maintaining a sense of community and culture.

Our team participated in several events close to our offices in New York City and Buffalo. Our Buffalo colleagues volunteered for diaper drives, parks clean-ups, donations to food banks, and at food distribution sites in the Buffalo area. In New York City, we collaborated with Ronald McDonald House to assemble snack packs and Thanksgiving goodie bags and volunteered with NYC Clean Volunteers to clean the area around Bellevue South Park in lower Manhattan. Participating in these events not only strengthens our sense of community but also fosters collaboration and teamwork.

We are eager to participate in more events as the year progresses and look forward to continuing our commitment to supporting our staff's personal and professional growth.

### **Your Feedback Is Important to Us!**

We wanted to take a moment to inform you about our ongoing efforts to improve our services and ensure your satisfaction.

In the second quarter of the year, we launched a customer service survey to gather your feedback and insights. We greatly appreciated your participation and are reviewing your responses to identify areas where we could better our service.

Moving forward, we also will conduct arbitrator surveys in the second and fourth quarters of the year to gather reactions to the arbitrator panel. This will help ensure that the arbitrators serving on the NYSI Division's panels are meeting your needs and resolving disputes in a fair and efficient manner.

Additionally, we will launch another customer service survey in the fourth quarter of the year to continue gathering your opinions and improving our services.

Your feedback is invaluable to us, and we greatly appreciate your participation in these surveys. Thank you for your continued support and loyalty. We look forward to serving you in the future.



# AAA® INSURANCE REPORTER

SPRING 2023 EDITION

## **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**

#### **LATE NOTICE OF CLAIM**

- *Excellence Medical Care, P.C. & Maya Assurance Co.*, AAA Case no. 17-21-1210-0952 (03/25/22) (John O'Grady, Arb.)
- *Gemini Chiropractic, P.C. & Geico Ins. Co.*, AAA Case no. 17-21-1211-3512 (07/25/22) (Dimitrios Stathopoulos, Arb.)
- *Jamaica Supplies & New South Ins. Co.*, AAA Case no. 17-21-1218-8357 (07/07/22) (Fred Lutzen, Arb.)
- *Bowen MD, PLLC & American Transit Ins. Co.*, AAA Case no. 17-22-1239-7470 (01/04/23) (Alina Shafranov, Arb.)
- *XPERT Supply Corp & Integon National Ins. Co.*, AAA Case no. 17-22-1250-3585 (01/04/23) (Thomas Awad, Arb.)

#### **SPINAL ULTRASOUND AND MEDICAL NECESSITY**

- *Bitachon Diagnostics Inc & LM General Ins. Co.*, AAA Case no. 17-22-1233-3441 (01/27/23) (James Hogan, Arb.)
- *All County LLC & Liberty Mutual Ins. Co.*, AAA Case no. 17-22-1244-0865 (01/27/23) (Jennifer Jacques-Miller, Arb.)
- *Park Avenue Medical Imaging PC & LM General Ins. Co.*, AAA Case no. 17-22-1244-5743 (01/22/23) (Kihyun Kim, Arb.)

#### **SPINAL ULTRASOUND AND FEE SCHEDULE**

- *JTK Chiropractic Care PC & Geico Ins. Co.*, AAA Case no. 17-21-1216-4357 (04/26/22) (Drew M. Gewuerz, Arb.)
- *JTK Chiropractic Care, PC & Hereford Ins. Co.*, AAA Case no. 17-22-1253-1106 (12/21/2022) (Pauline Molesso, Arb.)
- *Massapequa Diagnostic Imaging PC & State Farm Mut. Auto. Ins. Co.*, AAA Case no. 17-22-1237-1798 (06/29/22) (Ioannis Gloumis, Arb.)



## AAA® INSURANCE REPORTER

SPRING 2023 EDITION

### **DISABILITY EXAMS (CPT CODES 99455 & 99456)**

- *Motion Medical Diagnostics, PC & State Farm Mutual Auto. Ins. Co.*, AAA Case no. 17-21-1216-7550 (12/07/22) (Ellen Cutler-Igoe, Arb.)
- *Motion Medical Diagnostics, PC & State Farm Mutual Auto. Ins. Co.*, AAA Case no. 17-21-1216-8754 (12/19/22) (Tali Philipson, Arb.)
- *Terra Chiropractic, PC & Allstate Fire & Casualty Ins. Co.*, AAA Case no. 17-22-1245-5093 (01/08/23) (Athena T. Buchanan, Arb.)
- *Terra Chiropractic, PC & The Automobile Ins. Co. of Hartford*, AAA Case no. 17-22-1242-2435 (11/28/22) (John Talay, Arb.)
- *Motion Medical Diagnostics, PC & State Farm Mut. Auto. Ins. Co.*, AAA Case no. 17-21-1217-5154 (12/18/22) (Kihyun Kim, Arb.)
- *Cross Island Chiropractic Evaluations, PC & Mid-Century Ins. Co.*, AAA Case no. 17-22-1246-2623 (12/28/22) (Kate Cifarelli, Arb.)

### **DRY NEEDLING & FEE SCHEDULE**

- *Wallie Kanishka v. Geico Ins. Co.*, AAA Case no: 17-22-1249-5480 (11/08/22) (Dimitrios Stathopoulos, Arb.)
- *Miran An, NP v. Allstate Prop. & Cas. Ins. Co.*, AAA Case no: 17-21-1203-6055 (09/17/2022) (John Hyland, Arb.)
- *Jules Francois Parisien MD v. New South Ins. Co.*, AAA Case no. 17-20-1167-2362 (12/21/21) (Yael Aspir, Arb)
- *Marilyn Singh, NP v. Geico Ins. Co.*, AAA Case no. 17-22-1256-4033 (01/11/23) (Glen Wiener, Arb.)
- *Prisca John-Ogam, PA v. Clear Blue Ins. Co.*, AAA Case no. 17-22-1238-6478 (12/07/22) (Josh Youngman, Arb.)

### **DRY NEEDLING & MEDICAL NECESSITY**

- *Jules Parisien, MD & Integon National Ins. Co.*, AAA Case no. 17-21-1222-5343 (01/17/23) (Corinne Pascariu, Arb.)
- *Ogechukwu Okezie, NP & Allstate Ins. Co.*, AAA Case no. 17-21-1229-6902 (10/26/22) (Keith Tola, Arb.)
- *Jules Francois Parisien, MD & New York Central Mut. Fire Ins. Co.*, AAA Case No. 17-21-1219-5405 (11/04/22) (Laura Villeck, Arb.)

### **SUM AWARDS: JAW FRACTURES**

- *Claimant v. Nationwide Ins. Co.*, AAA Case no. 01-21-0016-4013 (02/17/23) (Anthony Altimari, Arb.)
- *Claimant v. Farm Family Cas. Ins. Co.*, AAA Case no. 01-21-0017-8631 (02/15/23) (Jonathan Rivera, Arb.)



## AAA® INSURANCE REPORTER

SPRING 2023 EDITION

**Arbitrator Abstracts****LATE NOTICE OF CLAIM**

*Excellence Medical Care, P.C. & Maya Assur. Co., AAA Case no. 17-21-1210-0952*

(03/25/22) (John O’Grady, Arb.) The arbitrator addressed whether respondent could sustain its defense based on the assertion that eligible injured person (“EIP”) failed to provide written notice of claim within 30 days of the motor vehicle accident. Citing to 11 NYCRR §65-1.1, the arbitrator noted that the EIP is required to provide written notice of an accident, together with reasonably obtainable information regarding the time, place, and circumstances of the accident to the insurer no more than 30 days after the date of accident, unless the EIP submits written proof providing reasonable justification for the failure to comply with such time limitation, and that 11 NYCRR §65-3.3(e) permits an insurer to issue a denial for failure to provide timely written notice of claim within 30 days of the accident. The arbitrator noted that where respondent contends it did not receive the required notice within the required timeframe, it is incumbent upon the applicant to come forward with some proof that timely notice was provided or, alternatively, offer a written explanation providing clear and reasonable justification for the failure to do so. If applicant makes such a submission, it will carry a presumption that the required notice was received by the respondent, and it will then be incumbent upon the respondent to come forward with some affirmative proof that it did not receive the notice in question. While respondent acknowledged receiving Applications for No-Fault Benefits (NF-2 forms) from two other eligible injured persons involved in the same motor vehicle accident, the respondent argued that it did not receive adequate notice from the EIP. The applicant argued that timely and sufficient notice of claim was provided and offered timely proof of mailing of three NF-2 forms to respondent, one for the EIP and two for the other injured persons. However, the arbitrator noted that the NF-2 forms were mailed by a different healthcare provider, namely, 1122 Medical Office, and that applicant failed to provide any explanation of the relationship between 1122 Medical Office and Excellence Medical Care, P.C. The arbitrator also noted that the NF-2 form for the EIP was missing the third page and, consequently, there was no evidence demonstrating if and/or when it was signed by the EIP. The arbitrator also noted that the proof of mailing offered by applicant did not identify the documents included in the alleged mailing, thus finding the proof of mailing insufficient to demonstrate that it was, in fact, the NF-2s that were included in the mailing. Finally, while the EIP was identified in the police report, the report failed to indicate that the EIP was injured in the accident. According to the arbitrator, it was not enough for respondent to be aware that an accident occurred. Rather, it was necessary to provide respondent with notice that the EIP was injured in the accident and was presenting a claim for no-fault benefits. Therefore, the arbitrator determined that applicant’s contention that it timely provided written notice of the accident to respondent was not sufficiently established, and the arbitrator sustained respondent’s denial based upon the EIP’s failure to timely file notice of claim.

*Gemini Chiropractic, P.C. & Geico Ins. Co., AAA Case no. 17-21-1211-3512*

(07/25/22) (Dimitrios Stathopoulos, Arb.) The arbitrator addressed whether respondent could sustain its defense based on the allegation that applicant failed to provide written notice of claim within 30 days of the motor vehicle



## AAA® INSURANCE REPORTER

SPRING 2023 EDITION

accident. The arbitrator noted that 11 NYCRR §65-3.3(e) permits an insurer to issue a denial for failure to provide timely written notice of claim within 30 days of the accident. The arbitrator further noted that respondent received notice of accident via a telephone call from the eligible injured person (“EIP”) 23 days after the accident. Applicant argued that since such notice was provided within 30 days of the accident, the respondent was obligated to forward an Application for No-Fault Benefits (NF-2) form immediately following the telephone call. The respondent argued that the obligation to send an NF-2 form was not triggered as the applicant did not claim any injury during the telephone call. Citing 11 NYCRR §65-3.4(a) and (b), the arbitrator determined that a plain reading of the regulations does not limit the forwarding of an NF-2 form to only reported accidents for which injuries will be claimed. The arbitrator, therefore, determined that respondent failed to comply with its obligation to send applicant NF-1 and NF-2 forms once it received telephonic notice of accident. Accordingly, the arbitrator concluded that respondent’s denial based upon late notice of claim was unsustainable.

*Jamaica Supplies & New South Ins. Co., AAA Case no. 17-21-1218-8357*

(07/07/22) (Fred Lutzen, Arb.) The arbitrator addressed whether the eligible injured person (“EIP”) failed to provide written notice of claim within 30 days of the motor vehicle accident. The respondent submitted an affidavit supporting its position that notice of claim was received beyond 30 days and that no written proof providing clear and reasonable justification for the failure to comply with the time limitation was ever provided. The accident occurred on 5/5/19. According to the affiant, the first notification of the accident was provided when the EIP’s personal injury attorney called to report the loss on 8/8/19, which was 95 days post-accident. Furthermore, according to the affiant, on 1/3/20, respondent received correspondence dated 12/29/19, together with an Application for No-Fault Benefits (NF-2 form) and a police accident report. The applicant argued that it provided reasonable justification for the failure to give timely notice by demonstrating that the claim was initially submitted to a different insurance carrier on 8/29/19. The arbitrator noted, however, that no explanation was provided for why the claim was initially sent to a different insurer. The arbitrator further noted that applicant’s original submission to a different insurer on 8/29/19 was of no moment since the evidence suggested that the EIP’s personal attorney had already been aware of the proper insurance carrier as of 8/8/19. Therefore, the arbitrator determined that applicant failed to provide timely written notice of claim within 30 days of the accident. The arbitrator further determined that applicant’s “reasonable justification” for its untimely notice of claim was insufficient. Accordingly, the arbitrator sustained respondent’s denial based upon the EIP’s failure to provide timely notice of claim.

*Bowen MD, PLLC & American Transit Ins. Co., AAA Case no. 17-22-1239-7470*

(02/03/23) (Alina Shafranov, Arb.) The arbitrator was asked to address whether the eligible injured person (“EIP”) provided timely written notice of claim within 30 days of the motor vehicle accident. Upon receipt of the bills at issue, the respondent issued denials stating that the bills in dispute were denied based on late notice of claim. However, respondent did inform the applicant that late notice of claim would be excused if the applicant could provide reasonable justification for the failure to give timely notice. Applicant argued the bills at issue were originally sent to another insurance carrier and, upon learning of the correct insurer, applicant subsequently mailed the bills to respondent for reimbursement. Applicant argued that its original submission to the incorrect carrier provided





## AAA® INSURANCE REPORTER

SPRING 2023 EDITION

reasonable justification for its late notice of claim to respondent. In support of its position, applicant provided mailing logs demonstrating that the bills at issue were timely mailed to another insurance carrier and that, sometime thereafter, the same bills were mailed to respondent. Citing 11 NYCRR 65-1.1, the arbitrator noted that notice of claim must be submitted as soon as reasonably practicable, but in no event more than 30 days after the accident. Following a review of respondent's NF-10s, the arbitrator determined that the appropriate language was included in respondent's denials, thus rendering the denials sufficient. The arbitrator determined applicant's mailing logs to be insufficient to sustain applicant's reasonable justification for its late notice of claim. Overall, the arbitrator found the applicant's entire submission to be devoid of any documentation demonstrating why applicant originally submitted the bills to another insurer in the first instance and that the submission failed to include any indication as to how and when applicant was eventually able to identify the respondent as the correct no-fault insurer. Based on applicant's lack of supporting evidence, the arbitrator denied the claims.

*XPERT Supply Corp & Integon National Ins. Co.*, AAA Case no. 17-22-1250-3585

(02/18/23) (Thomas Awad, Arb.) Applicant sought reimbursement for durable medical equipment provided on 1/27/22. Upon receipt of the bill at issue, respondent issued a denial based on late notice of claim and informed applicant that late notice of claim would be excused where the applicant could provide reasonable justification for the failure to give timely notice of accident. The underlying accident occurred on December 12, 2021. Respondent argued that the first notice of claim was not submitted to respondent until 2/9/22 when respondent received an NF-2 from the claimant's attorney. Applicant's bill was received subsequently thereafter, and applicant argued that, notwithstanding the late notice of claim provided by the claimant's attorney, under 11 NYCRR section 65-3.4(b), respondent remained obligated to mail NF-1 and NF-2 forms upon receipt of applicant's claims, and that respondent's failure to do so was fatal to its defense. To the contrary, respondent argued that the NF-2 form had already been received by respondent, albeit untimely, and, consequently, it was not necessary to forward another NF-2 form. Citing 11 NYCRR 65-1.1 (Conditions), 11 NYCRR 65-2.4 (Notice), and 11 NYCRR 65-3.4(a) and (b), the arbitrator found applicant's arguments to be without merit. The arbitrator determined that the respondent was under no further obligation to provide another NF-2 to this applicant as a completed NF-2 was already in respondent's possession at the time the applicant's bill was received. The arbitrator reasoned that to provide another NF-2 in this case would be redundant and unnecessary. Therefore, based upon the evidence presented and the arguments presented by both parties, the arbitrator sustained respondent's defense and denied the applicant's claim.

### **SPINAL ULTRASOUND AND MEDICAL NECESSITY**

*Bitachon Diagnostics Inc & LM General Ins. Co.*, AAA Case no. 17-22-1233-3441

(01/27/23) (James Hogan, Arb.) Applicant sought reimbursement for ultrasound studies of the spine and other areas. Respondent offered a peer review report by Anna Krol, M.D. in support of its defense that the services were not medically necessary. Following her review of several of the claimant's medical records, Dr. Krol opined that ultrasound studies of the spine are not the appropriate initial diagnostic modality for treating acute soft tissue injuries. Applicant submitted a rebuttal prepared by Hong Pak, M.D., the referring physician, in opposition to the peer review. Dr. Pak





## AAA® INSURANCE REPORTER

SPRING 2023 EDITION

discussed the findings contained within various reexaminations of the injured party and opined that the ultrasound studies helped diagnose and treat the injured party. The arbitrator determined that Dr. Krol's peer review was conclusory and unsupported by the medical evidence in that she failed to review the interim reports referenced by Dr. Pak in the rebuttal and did not adequately explain why, in her opinion, the services were medically unnecessary. Overall, the arbitrator found Dr. Pak's rebuttal sufficient to refute Dr. Krol's peer review and granted the claim.

*All County LLC & Liberty Mutual Ins. Co., AAA Case no. 17-22-1244-0865*

(01/30/23) (Jennifer Jacques-Miller, Arb.) Applicant sought reimbursement for spinal ultrasound studies. Respondent relied on a peer review by Robert A. Sohn, D.C., to establish a lack of medical necessity of the disputed services. Dr. Sohn reviewed the injured party's medical records and opined that, while ultrasonography does have its benefits when used as guidance for spinal injections, spinal ultrasound is infrequently used or cited in the medical literature as a diagnostic spinal modality, and that there were no neurological deficits warranting diagnostic testing for the injured party. Applicant submitted a rebuttal prepared by David Payne, M.D. in opposition to the peer review. Dr. Payne noted the patient's persistent subjective complaints of radiating neck pain, together with the various diagnoses relative to the cervical spine. He opined that muscle spasms often occur when a muscle is overused or injured, e.g., when a herniated disc irritates the spinal nerves and causes pain and spasm in the back muscles. The arbitrator determined that, based on the injured party's complaints and the initial evaluation findings, the rebuttal offered by applicant was sufficient to refute the respondent's opinion that the services at issue were not medically unnecessary and granted the claim.

*Park Avenue Medical Imaging PC & LM General Ins. Co., AAA Case no. 17-22-1244-5743*

(01/22/23) (Kihyun Kim, Arb.) Applicant sought reimbursement for spinal and other ultrasound studies. Respondent relied on a peer review by Ajendra S. Sohal, M.D., to establish a lack of medical necessity defense. Dr. Sohal reviewed the injured party's medical records and opined that spinal ultrasounds were not indicated in the injured party's setting of whiplash-related injuries because a myofascial component is hardly ever diagnosed; the injured party was already undergoing treatment; and the diagnosis of facet joint inflammatory changes had no clinical rationale. Dr. Sohal opined that spinal ultrasounds are not the standard of care to treat whiplash injuries or low back pain, are not recommended by any medical literature, and have not shown any benefits. Dr. Sohal stated that there was no diagnostic dilemma or need for new interventions warranting diagnostic testing of the spine. Applicant submitted a rebuttal prepared by William King, M.D. in opposition to the peer review. Dr. King opined that, based on his review of the injured party's medical records, including the injured party's history, complaints, and examination findings, together with the generally accepted standards of care in the medical community, spinal ultrasounds were medically necessary to diagnose and confirm the extent of the patient's injuries and to plan future care. Dr. King stated that spinal ultrasounds are a safe, cost-effective, and rapid means of detecting spinal abnormalities and are comparable, or even superior, to MRIs in most aspects of the assessment of musculoskeletal diseases. Dr. King stated that further testing of the spine in addition to a clinical examination was indicated to further evaluate and determine the nature and extent of the injured party's spinal injuries. Upon completion of his review of the evidence presented, the



## AAA® INSURANCE REPORTER

SPRING 2023 EDITION

arbitrator found the peer review to be more credible and persuasive than applicant's supporting medical records and rebuttal and that applicant failed to meet its burden of persuasion. Accordingly, the arbitrator denied the claim.

### **SPINAL ULTRASOUND & FEE SCHEDULE**

*JTK Chiropractic Care PC & Geico Ins. Co., AAA Case no. 17-21-1216-4357*

(04/26/22) (Drew M. Gewuerz, Arb.) Applicant sought reimbursement in the amount of \$590.00 for diagnostic musculoskeletal ultrasound of the lumbar spine billed under CPT code 76999 and \$295.00 for ultrasound performed to the sacroiliac joint, also billed under 76999, both of which were performed in the same session. Respondent denied the claim asserting that the charges exceeded those permitted under the governing fee schedule. In support of its fee schedule defense, respondent submitted an affidavit by Crystal Russo, a certified professional coder who contends that diagnostic musculoskeletal ultrasound billed under "by report" code 76999 has no relative value and therefore is not reimbursable, as there is no comparative CPT code in the 2018 NYS Workers' Compensation Chiropractic Fee Schedule. The arbitrator found that the analysis set forth in the affidavit was not comprehensive, as the coder failed to discuss Ground Rule 5(c) of the Radiology section of the Chiropractic Fee Schedule, which sets forth that CPT code 76999 may be billed for diagnostic ultrasound procedures but should be accompanied by a report. Thus, the arbitrator determined that the respondent failed to submit evidence sufficient to support its fee schedule defense and found in favor of the applicant.

*JTK Chiropractic Care, PC & Hereford Ins. Co., AAA Case no. 17-22-1253-1106*

(12/21/22) (Pauline Molesso, Arb.) Applicant submitted a claim in the amount of \$590.00 for a diagnostic musculoskeletal ultrasound billed using CPT code 76999, a code with a "by report" designation. Respondent issued a denial predicated on a fee schedule defense and asserted that, pursuant to Ground Rule 3, for any procedure where the relative value unit is listed as "BR" ("by report"), the physician shall establish a relative unit consistent with other relative value units shown in the fee schedule. In support of its defense, respondent submitted an affidavit by a certified professional coder who asserted that CPT code 76881 is the closest in relative value to musculoskeletal ultrasound of the cervical spine. Respondent's coder noted that the RVU for CPT code 76881 is 4.46, which, when multiplied by a conversion factor of 39.82, results in a rate of reimbursement in the amount of \$177.60. The coder stated further that there is no information offered by the applicant establishing how the relative value of the ultrasound was determined to be 14.82, or how the determined RVU was consistent with other codes similar in relativity to other codes in the Radiology section of the Chiropractic Fee Schedule. Applicant did not submit an audit by a certified professional coder in support of its claim. Rather, applicant offered testimony by the treating physician, Dr. Jacobson, who disputed the fee schedule analysis proffered by the respondent and argued that CPT code 76881 is not applicable to the services performed. Applicant also argued that respondent should have sought verification if additional information or reports were required to demonstrate how applicant determined that the relative value of the ultrasound was 14.82. The arbitrator found that since CPT code 76999 is a "by report" code, the burden was on respondent to seek verification from the applicant if there was uncertainty regarding the nature of the service



## AAA® INSURANCE REPORTER

SPRING 2023 EDITION

performed. The arbitrator also determined that the respondent's coder failed to substantiate that CPT code 76881 is the closest in relative value to the services performed by the applicant and awarded applicant's claim in its entirety.

*Massapequa Diagnostic Imaging PC & State Farm Mut. Auto. Ins. Co.*, AAA Case no. 17-22-1237-1798

(06/29/22) (Ioannis Gloumis, Arb.) Applicant billed \$1,300.00 for diagnostic musculoskeletal ultrasound studies of the lumbar spine, bilateral sacroiliac joints, and bilateral gluteal muscles under CPT Codes 76856, 76881, and 76881, respectively. Respondent denied the claim, asserting that the codes were not included in the Chiropractic Fee Schedule. In support of its denial, respondent offered a fee audit by Antoinette Perrie, DC, L.Ac., a certified professional coder, who stated that the CPT codes billed by the applicant are not found in the Chiropractic Fee Schedule, and, therefore, applicant should have billed for the services under CPT code 76999, and that CPT code 76999 can only be reported once. She further opined that applicant was only entitled to reimbursement for the technical component of the services rather than 100%. Finally, applying Ground Rule 2(c) of the Radiology section of the Chiropractic Fee Schedule, Dr. Perrie determined that the appropriate rate of reimbursement for the multiple procedures was \$39.50, and respondent acknowledged during the hearing that this amount was due to the applicant. Upon taking judicial notice of the Fee Schedule, the arbitrator referenced General Ground Rule 10 of the Chiropractic Fee Schedule, which sets forth that a chiropractor may only use CPT codes contained in the Chiropractic Fee Schedule. The arbitrator also noted General Ground Rule 19 of the Introduction and General Guidelines Section of the NYS Workers' Compensation Medical Fee Schedule, which provides that a chiropractor may not use the CPT coding guidelines contained in the Medical Fee Schedule and should consult the fee schedule relevant to the chiropractor's scope of practice when submitting bills for treatment. Upon completion of his review of the evidence, together with the applicable sections of the NYS Workers' Compensation Fee Schedule, the arbitrator determined that even though the applicant did not bill for the services using CPT code 76999, pursuant to the opinion of respondent's expert, applicant was entitled to reimbursement in the amount of \$39.50 for the services at issue.

### **DISABILITY EXAMS (CPT CODES 99455 & 99456)**

*Motion Medical Diagnostics, PC & State Farm Mut. Auto. Ins. Co.*, AAA Case no. 17-21-1216-7550

(12/07/22) (Ellen Cutler-Igoe, Arb.) Applicant sought reimbursement for a disability impairment assessment billed using CPT code 99456. Relying upon an affidavit from a certified professional coder, respondent argued that the service was not reimbursable under no-fault as the service was not performed to obtain a life or disability insurance certificate. Alternatively, the respondent argued that the service encompassed two components—an initial or follow-up exam and computerized range of motion and muscle testing. Therefore, respondent argued that applicant should be reimbursed CPT code 99204 for the exam, and that the second component was akin to CPT code 97750, which is not reimbursable under the new fee schedule effective 10/1/20. In support of its claim, applicant offered a fee schedule affidavit and argued that CPT code 99456 is reimbursable in the no-fault setting for a medical disability examination. Ultimately, the arbitrator relied upon an opinion by an Independent Health Consultant (IHC) prepared for an unrelated case on this issue. The IHC determined that the RVU for 99456 is best established by aggregating CPT code 99242, an office visit, 95833 for muscle testing, and 95851 for range of motion testing. Therefore, relying upon the IHC opinion,



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SPRING 2023 EDITION

the arbitrator calculated the rate of reimbursement, and the applicant was awarded the balance due in accordance with the IHC methodology, less a prior payment.

*Motion Medical Diagnostics, PC & State Farm Mut. Auto. Ins. Co.*, AAA Case no. 17-21-1216-8754

(12/19/22) (Tali Philipson, Arb.) Applicant sought reimbursement for a disability impairment assessment billed using CPT code 99456. Relying upon an affidavit from a certified professional coder, respondent argued that the service was not reimbursable under no-fault as the service was not performed for the purpose of obtaining a life or disability insurance certificate. Alternatively, respondent argued that the service was most comparable to CPT code 97750, which has an RVU of "0" and, therefore, no reimbursement was due. Applicant offered fee schedule affidavits in support of its claim and argued that CPT code 99456 is reimbursable in the no-fault setting for a medical disability examination. Applicant calculated the RVUs by aggregating the RVUs for the various elements of the service. The arbitrator was persuaded by the applicant that the service is reimbursable under no-fault. However, the arbitrator adopted respondent's position that the RVUs calculated by the applicant were excessive. The arbitrator found that CPT code 99243 (an initial exam) best represented the service rendered and that the remaining components of the disability exam were not contained in the Chiropractic Fee Schedule and, as such, not separately reimbursable. Therefore, the arbitrator awarded reimbursement under CPT code 99243, less a prior payment previously made by the respondent.

*Terra Chiropractic, PC & Allstate Fire & Cas. Ins. Co.*, AAA Case no. 17-22-1245-5093

(01/08/23) (Athena T. Buchanan, Arb.) Applicant sought reimbursement for two disability impairment assessments billed using CPT code 99456. Respondent argued that the service was not reimbursable under no-fault as the service was not performed for the purpose of obtaining a life or disability insurance certificate and offered an affidavit from a certified professional coder in support of its position. Alternatively, respondent argued that the service was inconsistent with RVU limits in the fee schedule. The arbitrator noted that the total RVUs billed by applicant amounted to \$115.92, which, according to the arbitrator, was grossly inconsistent with other values in the fee schedule. While the arbitrator found the service reimbursable under no-fault, the arbitrator was persuaded by the respondent's coder that the service was best described by CPT code 99204 and, therefore, the applicant was awarded \$107.16 for each of the two dates of service.

*Terra Chiropractic, PC & The Automobile Ins. Co. of Hartford*, AAA Case no. 17-22-1242-2435

(11/28/22) (John Talay, Arb.) In this case, the applicant sought reimbursement for a disability examination billed under CPT code 99456. Respondent raised a fee schedule defense alleging that code 99456 is reserved for evaluations to establish baseline information prior to the issuance of life or disability insurance certificates and was not applicable in the context of no-fault claims. After reviewing the CPT Assistant regarding code 99456, the arbitrator sustained the respondent's denial. The arbitrator determined that the records submitted established that the claimant was being treated for injuries sustained in a motor vehicle accident and that the examination performed was not for the purpose



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of establishing baseline information for the procurement of insurance or disability insurance certificates. Therefore, the arbitrator denied the claim in its entirety.

*Motion Medical Diagnostics, PC & State Farm Mut. Auto. Ins. Co.*, AAA Case no. 17-21-1217-5154

(12/18/22) (Kihyun Kim, Arb.) In this case, the respondent denied reimbursement of a claim for a disability impairment assessment. In support of its defense, respondent relied on a coder's affidavit and relevant portions of the fee schedule. It was the opinion of respondent's coder that CPT code 99456 has an RVU that is plainly inconsistent with the other RVUs in the Chiropractic Fee Schedule and does not apply to no-fault claims because the work-related or medical disability examination described by CPT code 99456 is not intended to treat injuries stemming from a motor vehicle accident. Rather, the coder stated it is intended to provide information necessary to obtain certain disability insurance certificates. Therefore, applicant is only entitled to reimbursement for an office evaluation. In support of its charges, applicant also relied on a coder's affidavit, together with an IHC review. Applicant's coder asserted that respondent's interpretation is contrary to the actual code description. According to the applicant's coder, the code's description is not restricted to a base-line disability/impairment analysis and indicates that the preparation of a certificate is a component of the work only when it is necessary. After considering the evidence offered by each party, the arbitrator found that respondent's coder was more convincing than that offered in the rebuttal or IHC review and awarded reimbursement in accordance with the recommendation of respondent's expert.

*Cross Island Chiropractic Evaluations, PC & Mid-Century Ins. Co.*, AAA Case no. 17-22-1246-2623

(12/28/22) (Kate Cifarelli, Arb.) The arbitrator addressed whether the applicant was entitled to no-fault reimbursement for a disability examination that was denied based on the code's description. Respondent raised a fee schedule defense asserting that code 99456 is reserved for evaluations to establish baseline information prior to the issuance of life or disability insurance certificates and was not applicable in the context of no-fault claims. Respondent offered a coder's affidavit in support of its defense. In opposition, applicant relied on a coder's affidavit wherein the affiant asserted that billing under 99456 was appropriate, as the examination was necessary to establish the nature of the limitations for performing activities of daily living and the degree of improvement. After a review of the record, the arbitrator determined that while the applicant's coder explained the type of examination performed, he failed to substantiate utilizing this specific code in the context of no-fault claims. Therefore, the arbitrator denied applicant's claim in its entirety.

### **DRY NEEDLING & FEE SCHEDULE**

*Wallie Kanishka & Geico Ins. Co.*, AAA Case no. 17-22-1249-5480

(11/08/22) (Dimitrios Stathopoulos, Arb.) Applicant sought reimbursement for dry needling services billed using CPT 20999, a by-report code with no designated relative value unit (RVU). Respondent asserted a fee schedule defense and relied on an expert coder's finding that trigger point injections are the closest similar procedure to dry needling to determine the proper fee amount. With the services being performed in Region IV, and CPT 20553 being the code



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for trigger point injections into three or more muscles, respondent's coder found the total billable amount per day to be \$131.01. Applicant submitted its own fee coder's analysis, wherein the expert disagreed with the respondent's coder based on the contention that dry needling and trigger point injections are different procedures. The arbitrator ultimately found respondent's fee coder to be more compelling, since there were sufficient similarities between dry needling and trigger point injections to justify the use of the RVU assigned to trigger point injections to determine the appropriate rate of reimbursement for dry needling. As such, the arbitrator was persuaded by respondent's expert that it is appropriate to use CPT 20553 to determine the fee amount for dry needling and awarded reimbursement accordingly.

*Miran An, NP & Allstate Prop. & Cas. Ins. Co., AAA Case no: 17-21-1203-6055*

(09/17/22) (John Hyland, Arb.) This matter involved dry needling denied by Respondent based on fee schedule. The arbitrator noted that the AMA introduced two new codes for this type of procedure in its 2020 CPT codes set: CPT 20560 (for 1 or 2 muscle[s]), and CPT 20561 (for 3 or more muscles). Although these codes are not yet adopted and integrated into the NYS Worker's Compensation Fee Schedule, the arbitrator found that they provide guidance as to the appropriate RVUs for dry needling. With the matter at hand involving 3 or more muscles, the arbitrator determined the RVU for CPT 20561 to be the most appropriate RVU to calculate the rate of reimbursement for dry needling and awarded reimbursement accordingly.

*Jules Francois Parisien MD & New South Ins. Co., AAA Case no. 17-20-1167-2362*

(12/21/21) (Yael Aspir, Arb) Applicant billed for dry needling services using CPT 20999, a by-report code. Respondent submitted a fee coder's analysis to support its fee schedule defense. The coder explained that effective January 2020, the proper CPT codes for dry needling are CPT 20560, which is described as needle insertion(s) without injection(s); in one or two muscles, and CPT 20561, which is described as needle insertion(s) without injection(s); in three or more muscles. As such, the coder used CPT 20561 to determine the proper rate of reimbursement. The coder also noted that the terms "dry needling" and "trigger point acupuncture" are synonymous, thus rendering trigger point acupuncture CPT codes comparable and acceptable in ascertaining the appropriate rate of reimbursement. Applicant submitted a rebuttal affirmation wherein the affiant stated that dry needling is not akin to trigger point injection because needling is a technique used to treat pain and movement impairment that has no medication or injections to release or inactivate trigger points. Therefore, with the purpose of needling being different than that of a trigger point injection, applicant's expert opined that there was no justification for using the trigger point codes to determine reimbursement. The arbitrator ultimately found the respondent's coder to be more compelling and determined that CPT 20561 was the most similar to dry needling and that applicant's coder did not adequately explain why dry needling is too unusual or variable to be assigned an RVU especially in light of the January 2020 fee schedule amendment.



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SPRING 2023 EDITION

*Marilyn Singh, NP & Geico Ins. Co., AAA Case no. 17-22-1256-4033*

(01/11/23) (Glen Wiener, Arb.) Applicant sought reimbursement for dry needling under CPT code 20999, which is a “by report” code. Respondent asserted that the claimed amount was in excess of the fee schedule and that the applicant was properly reimbursed under CPT code 20553. In support of its contention, the respondent relied upon the affidavit of Crystal Russo, a certified medical coder. Ms. Russo asserted that she reviewed the records submitted and, pursuant to Ground Rule 10, determined that the closest similar code for the procedure at issue was for trigger point injections. Moreover, since a nurse practitioner performed the procedure, applicant was only entitled to 80% of the physician rate pursuant to Ground Rule 11. In rebuttal, applicant relied upon the affidavit of Olesya Maluta, a coding expert. Applicant’s expert reasoned that trigger point injections are a different procedure than dry needling because there is no solution injected into the patient. Therefore, she opined that 20999 was the appropriate code; there is no similar code because dry needling takes 45 minutes to one hour to administer, and trigger point injections take only a few minutes. In finding for respondent, the arbitrator held that respondent’s expert was more credible because she provided an equivalent code and cited numerous sources in support of her conclusion and that applicant’s expert failed to do so in rebuttal. Thus, applicant was not entitled to any additional reimbursement.

*Prisca John-Ogam, PA & Clear Blue Ins. Co., AAA Case no. 17-22-1238-6478*

(12/07/22) (Josh Youngman, Arb.) Applicant sought reimbursement for dry needling under CPT code 20999. Respondent partially reimbursed applicant for its services and denied the balance, asserting that applicant was not entitled to additional reimbursement because it was properly reimbursed under CPT code 20553. In support of its defense, respondent relied upon the affidavit of Jamie Drantch, a certified professional coder. Respondent’s expert asserted that trigger point injections (CPT code 20553) were the closest in relativity to the services rendered and that such code can only be billed once, regardless of the number of injections or muscles injected. Moreover, since a nurse practitioner performed the procedure, under Ground Rule 11, applicant was only entitled to 80% of the physician rate. In opposition, applicant relied upon a rebuttal from Bellinger P. Moody, a certified professional coder, together with an affirmation from Jules Parisien, M.D. The arbitrator determined that the issue in dispute was the proper rate of reimbursement for CPT code 20999, which does not have an assigned relative value. The arbitrator was not persuaded by the applicant’s assertion that if CPT code 20553 was, in fact, proper, then applicant would have billed for its services using CPT code 20553. Rather, in finding for respondent, the arbitrator stated that he was not persuaded by the proof submitted by applicant because applicant failed to offer evidence demonstrating that, contrary to respondent’s expert’s opinion, CPT code 20553 is not the closest in relativity to the dry needling performed. Accordingly, the arbitrator sustained respondent’s defense and determined that the respondent had appropriately reimbursed applicant for the services at issue.





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### DRY NEEDLING & MEDICAL NECESSITY

*Jules Parisien, MD & Integon National Ins. Co., AAA Case no. 17-21-1222-5343*

(01/17/23) (Corinne Pascariu, Arb.) The applicant sought to recover first-party benefits for dry needling services. The respondent denied the claim based upon a peer review report that compared dry needling to trigger point injections, stating the indications are the same. The report specified the need for actual trigger points to be present and stated that no actual focal trigger points were found upon examination of the patient. According to the respondent's expert, complaints of "diffuse tenderness" throughout the cervical and lumbar spine do not qualify as trigger points. The peer review also referenced the NYS Workers' Compensation Board Medical Treatment Guidelines, which recommend "a six-week timeframe of conservative care prior to performance of these injections" and again noted that the patient's symptoms did not meet the criteria. The applicant submitted a rebuttal disputing that the injured party did not meet the criteria for dry needling, noting on examination that the patient complained of shooting lower back pain, decreased range of motion, and tenderness on touch. The arbitrator determined the peer report set forth a factual basis with supporting rationale that the medical findings did not qualify as trigger points, and that the applicant failed to refute the opinion of the peer reviewer. Therefore, the claim was denied.

*Ogechukwu Okezie, NP & Allstate Ins. Co., AAA Case no. 17-21-1229-6902*

(10/26/22) (Keith Tola, Arb.) The applicant sought to recover first-party benefits for dry needling services. The respondent denied the claim based upon a peer review stating the proper standard of care for treating musculoskeletal injuries is physical therapy and, if a patient fails to respond to more aggressive treatment, then additional modalities can be applied. The peer opined that the patient did not receive sufficient conservative care, and that dry needling is an invasive treatment and should be reserved for patients who failed conservative therapy. He further opined that not all trigger points require injection or needling, noting that many active trigger points will respond to physical therapy. He stated, however, that injection and needling is an effective treatment for chronic trigger points. According to the peer review, the patient was receiving physical therapy and conservative treatment should have been continued. The applicant submitted a rebuttal stating that dry needling is effectively combined with other therapies. At the time of the service, the patient continued to complain of pain and his activity level was diminished. The patient was recommended for dry needling to decrease pain and improve activities of daily living and quality of life. The rebuttal notes that research shows that dry needling improves pain control and reduces muscle tension and can help speed up the patient's return to active rehabilitation. Additionally, there is no specific timeframe to perform dry needling, and earlier treatment leads to a reduction in inflammation and pain and shortens the time for the patient's recovery. Upon comparing the experts' analyses, the arbitrator noted the positive findings and authorities cited by the treating provider and determined that dry needling was properly used in combination with other conservative treatments to help relieve the patient's pain and speed up recovery. Therefore, the claim was awarded, although the arbitrator agreed with the respondent's coder regarding the appropriate rate of reimbursement for the services at issue.



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SPRING 2023 EDITION

*Jules Francois Parisien, MD & New York Central Mut. Fire Ins. Co., AAA Case no. 17-21-1219-5405*

(11/04/22) (Laura Villeck, Arb.) Applicant sought reimbursement for dry needling services. Respondent denied the claim based on a peer review report by Douglas Petroski, M.D. who found the services medically unnecessary. According to Dr. Petroski, the claimant already was receiving a course of physical therapy, chiropractic, and acupuncture treatments, thus the dry needling would be excessive since there was no indication that the claimant's physiological and neurological status was deteriorating. Upon completion of her review of Dr. Petroski's report, the arbitrator determined that the report failed to sufficiently set forth how and why performance of dry needling was inconsistent with generally accepted medical and/or professional practices. The arbitrator found Dr. Petroski's report to be completely devoid of any standard of care from which the applicant allegedly deviated in performing the services at issue, noting that the expert failed to cite to any medical authority to support his position that the dry needling was not medically necessary. Accordingly, the arbitrator awarded the claim.

### **SUM AWARDS: JAW FRACTURES**

*Claimant v. Nationwide Ins. Co., AAA Case no. 01-21-0016-4013*

(02/17/23) (Anthony Altimari, Arb) The claimant, KC, was a 9-year-old girl at the time of the accident. The motor vehicle accident giving rise to this claim occurred on February 21, 2020 on Peninsula Boulevard. KC was a rear seat passenger in a forward-facing car seat when the impact occurred. The motor vehicle in which she was a passenger was stopped, or stopping, at a red traffic signal when it was struck on the driver's side front corner by the adverse vehicle. The impact was heavy and forced the claimant's vehicle into the right westbound lane of Peninsula Boulevard, where it was impacted by a second vehicle. The testimony of the infant claimant's mother, photographs, and the police accident report established a prima facie case of negligence against the owner and operator of the underinsured motor vehicle without any comparative fault on the part of the infant claimant. Following the accident, the claimant was taken by ambulance to the emergency room at Mercy Medical Center, where she presented with injuries to the nose, jaw, and left side of the face, and with bleeding from the nose. Photographs presented of the claimant's face during the arbitration hearing were not very clear but did show swelling and bruising of the left side jaw and neck area. The claimant was discharged from the emergency room without any significant treatment. The claimant subsequently began treating with Long Island Orthopedic Solutions for complaints of pain in the neck, bilateral shoulders, left knee, and jaw with difficulty chewing. An MRI of the head performed on February 28, 2020 disclosed a fracture of the left mandible. According to the records, the claimant was diagnosed with a fractured jaw with resultant headaches, concussion, complaints of dizziness, and nausea. Records from Stony Brook Neurology Associates dated September 9, 2020 indicate that the left jaw remained tender, and the diagnosis consisted of concussion and traumatic brain injury. The claimant's treating physicians prohibited strenuous activities for one year and recommended a soft diet. The claimant continued to experience difficulty chewing her food for several months after the accident. The claimant's dentist diagnosed her with temporomandibular joint dysfunction with capsulitis, and he opined that she would require a mandibular TMJ splint in the near future. The Claimant was most recently examined by an oral surgeon on August 30, 2022 for continuing complaints of jaw pain, limited opening of the mouth, pain in



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both left and right joint capsules, occasional headaches, and fatigue. During the hearing, the claimant testified that chewing food continues to cause her some discomfort, and that she experiences headaches once or twice a week. As a result of the injury, the claimant no longer engages in gymnastics, softball, or soccer, in which she participated in three times a week before the accident. The arbitrator found the testimony by the infant claimant to be honest, straightforward, and credible. The respondent's medical evidence acknowledged the fractured jaw but suggested it was a hairline fracture and the examining radiologist described the injury as a non-displaced fracture of the mandible. Upon completion of his review of the medical evidence, the arbitrator determined that since the infant claimant was nine years of age when this trauma occurred, the full effect and ramifications of the fractured jaw may not be known for years to come. Consequently, the arbitrator found that the infant claimant sustained damages in an amount in excess of the \$100,000 underinsured motorist benefits available to her. Therefore, after applying an offset in the sum of \$16,666.66, the arbitrator issued an award in the amount of \$83,333.34.

*Claimant v. Farm Family Cas. Ins. Co.*, AAA Case no. 01-21-0017-8631

(02/15/23) (Jonathan Rivera, Arb.) On June 1, 2020, the claimant, age 18, was a restrained front-seat passenger in a 2011 BMW when wooden debris from a median guardrail separating opposite lanes of travel on the roadway breached the windshield striking him in the face, thus rendering him unconscious. The flying debris was a result of an impact by a 2014 Maserati, which lost control and collided into the median guardrail. The respondent did not contest fault, causation, or the mechanism of the claimant's injuries, and the arbitrator determined that there were no facts to attribute comparative fault to the claimant. The hospital record established that the claimant presented with jaw pain, and physical examination of the claimant's jaw revealed an inability to fully open his mouth, positive dental step off inferior anterior teeth, and positive tenderness and swelling over the right-angle mandible with a positive overlying superficial laceration. A CT scan of the claimant's facial bones was performed, which revealed soft tissue swelling along the right portion of the mandible with a few small foci of air suggesting laceration and a tiny radiodensity (glass) in the skin consistent with foreign body. A fracture of the anterior left portion of the mandible extending through the space adjacent to the root of the lower left canine was seen. The records noted that the claimant would likely require plastics consultation and admission for mandibular fracture. The claimant's final assessment was left parasymphiseal anterior mandibular fracture, malocclusion with patient's inability to occlude. The claimant was admitted to the hospital and scheduled for surgery the following morning. Surgery performed on June 2, 2020 consisted of open treatment of left angle of the mandible fracture with titanium plate and screw fixation as well as maxillomandibular fixation, removal of foreign body/glass from the right cheek, and sharp excisional debridement of the right cheek laceration followed by post debridement complex suture repair. On June 23, 2020, the claimant returned for a second operation, at which time the wires keeping the claimant's jaw closed were removed. On July 6, 2020, the claimant returned for a third operation, which consisted of the removal of screws and superficial arch bars from the maxilla and mandible. The claimant was seen in follow up on three subsequent occasions. During the most recent exam on March 31, 2021, the claimant reported stiffness when opening his mouth, and he was instructed to continue with range-of-motion exercises. Following examination, the IME doctor opined that the claimant suffered from a non-displaced fracture of the left para symphyseal through canine tooth #22 treated with open reduction internal fixation, intermaxillary fixation, and right cheek wound that had been cleaned and sutured. He further noted that the claimant suffered from a small flat, soft scar on the right cheek; that his jaw opens straight and normal; that both condyles



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subluxate; that the left parasymphysis area has two plates that are palpable through the mucosa; that the right and left masseter regions were non-tender; that tooth #23 is rotated, but since not in the fracture line, likely preexisting; and that occlusion was stable and correct. During the hearing, the claimant testified that his jaw was wired closed for about four weeks, and that upon discharge from the hospital, he was given a pair of wire cutters and instructed to carry them at all times in case he could not breathe or choked and needed to open his mouth in an emergency. During the time his jaw was wired, the claimant could hardly speak and needed to write things down to communicate with people. The claimant testified that, prior to the accident, he played football and practiced mixed martial arts, but that following the accident, his parents did not wish for him to resume practice. He testified that MMA provided him with a mental outlet to deal with stress, and he was disappointed that he could not continue with it because he did not want to risk re-injuring his jaw. The claimant testified that while he tries to forget about what happened, it has not been easy to put the accident behind him and that nothing about his face, smile, teeth, confidence, and appearance is the same as it was prior to the accident. On July 11, 2022, the claimant submitted to an independent medical examination ("IME") with respondent's designated physician. During the hearing, the respondent argued that the claimant was adequately compensated for his injuries by the \$100,000 he previously received from the liability insurer and the first SUM carrier and that any further value to be placed on the claim for a fractured jaw and facial laceration falls substantially under the available SUM policy limit of \$900,000. The arbitrator determined that the claimant presented as a credible witness and established, by a preponderance of the evidence, that his fractured jaw, surgically repaired lacerations and wounds, and post-traumatic stress disorder side effects from the incident, operations, and various stages of his recovery were causally related to the motor vehicle accident, and that the claimant's injuries maintained a reasonable compensatory value in the amount of \$400,000, minus a setoff of \$100,000 resulting in a net award to claimant in the amount of \$300,000.

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