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### **ADR Center Multi-Factor Authentication Best Practices**

We use Multi-Factor Authentication (MFA) daily without much thought—signing into our computers at work, logging into web browsers, making online purchases, protecting our bank and credit card accounts. MFA has been around since the 1990s and has become increasingly popular in recent years as more data has become accessible online. MFA neutralizes the risks associated with compromised passwords. If your password is phished or hacked, the bad guy still has to get past a second authentication.

On October 28<sup>th</sup>, 2023, the AAA, working with our vendor, deployed MFA as an extra level of security for the ADR Center, the platform we use to administer no-fault cases. With MFA active in ADR Center, we are meeting the security needs of the Department of Financial Services (DFS) and most likely the needs of your own Compliance and Security teams and clients.

In our efforts of strengthening cybersecurity within ADR Center, here are some best practices that have been implemented in our Multi-Factor Authentication deployment:

1. Each user will have their own unique username and password.
2. Each user will have a unique and private authentication method to verify their identity.
3. User accounts will time-out and log users out of the system, to protect sensitive user data.

If needed, individual user accounts also provide a better trail for a review of user actions that occurred on an account. As mentioned in a previous newsletter, you should always take a proactive approach in reviewing your firms' active ADR Center users on a regular basis. Users who no longer require access or leave your firm should be promptly deleted from the ADR Center. Please let us know if you need more information on this process. Together, we can all make a difference in improving our cybersecurity defenses and protecting data.

### **Updates to the Simple File Platform**

In an effort to enhance the user experience with our Simple File platform, the American Arbitration Association® has introduced a significant security update. Earlier this year, we featured the Re-Captcha tool as the primary process for customers submitting new case filings through the portal. However, we quickly recognized that for many of our valued customers, this feature proved to be more of a burden than a boon. We take our commitment to customer satisfaction seriously, and in response to this feedback, our IT development team has formulated a new solution: Authorization Keys for the Simple File platform.



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The Authorization Key feature is designed to provide users with the same high-level security that Re-Captcha offered, but with a streamlined and user friendly approach. Instead of navigating the challenges of Re-Captcha, users will now be required to input a secure alphanumeric sequence to submit their case filings.

A key advantage of the Authorization Keys is their extended one-year lifespan. Users will have ample time to utilize this feature without the hassle of frequent renewals. When the one-year mark approaches, our system will prompt users to renew their Authorization Keys, ensuring that their security remains uninterrupted.

For those interested in learning more about or registering for the Authorization Key program, we encourage you to contact the New York State Insurance Division's Intake Supervisors at [nysiintakesups@adr.org](mailto:nysiintakesups@adr.org). We are dedicated to providing you with a secure and user-friendly experience on our Simple File platform. We look forward to your continued support and feedback as we strive to meet your needs.

### **New Case Filings and Fees**

The American Arbitration Association prides itself on transparency as a cornerstone of its operations, ensuring trust and confidence for all stakeholders. We encourage our user community to consider the following requirements when transmitting new case submissions.

- A filing fee for each case is due at the time the case is submitted.
- Cases submitted without filing fees may be subject to return.
- The ADR Center is an excellent tool for reviewing your account's financial status. In addition to 24-hour access to the platform, the system also allows users to set a low funds alert. The alert will notify you when your account reaches the low fund amount. You may need to replenish your account if you want to continue to file cases.

As a courtesy, we issue a twice-weekly notification to customers whose accounts require immediate attention. These notifications are issued on Mondays and Wednesdays. If the adequate funds are not added for newly filed cases, those cases will be returned by 1:30 p.m. the following business day.

Please note that filings returned due to lack of funds must be resubmitted. If additional time is needed to replenish your account, please contact the Intake supervisors at [nysiintakesups@adr.org](mailto:nysiintakesups@adr.org).



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### **AAA Reducing the Timeframes from Filing to an Award**

Reaching a timely resolution is crucial in any arbitration case. As the volume of no-fault arbitrations spiked over the last several years, so has the timeframe from initial filing to a final award. This timeframe peaked in 2021 when the average life of a case reached approximately 15 months. Through concerted efforts to expand capacity and identify opportunities for early settlement, the AAA successfully reduced the average resolution time to 11.5 months by the end of 2023—shaving nearly a quarter of a year off the process.

Several key initiatives have driven these improvements. First, the AAA significantly increased the number of available hearing slots by working in collaboration with the no-fault arbitrator panel to increase capacity. Additionally, new external tools such as the Statistics Dashboard have been implemented to grant parties access to more detailed caseload data, which presented opportunities to resolve cases earlier in the arbitration process, saving time and cost.

Looking ahead, the AAA plans to continue investing in innovative ways to optimize the arbitration experience for its users. Whether through enhancing virtual capabilities or leveraging technology, the organization remains committed to providing services that deliver the most value to our customers.

### **AAA is Embracing InnovAAAtion**

In today's dynamic business landscape, innovation isn't just a buzzword; it's a strategic imperative. As we navigate the ever-evolving legal landscape, the AAA remains committed to pushing boundaries, embracing novel ideas, and staying ahead of the curve. Innovation begins with creativity. It's about generating fresh ideas, whether they emerge from brainstorming sessions, cross-functional collaborations, or individual insights. We empower our teams to work cohesively, leveraging diverse perspectives and skill sets to drive innovation, as it's not just a strategic initiative but a reflection of our commitment to ensure that our products, services, and processes are continuously evolving to better serve you.

Please visit our dedicated [InnovAAAtion page](#) to learn more about how the AAA embraces innovation by delivering new products and services and technology enhancements.



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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

#### ASC/EAPG & DISCECTOMIES

- *Rockaways ASC Development, LLC d/b/a ASC of Rockaway Beach & Progressive Cas. Ins. Co.*, AAA Case no. 17-22-1249-0614 (01/24/23) (Debbie Kotin Insdorf, Arb.)
- *Rockaways ASC Development, LLC d/b/a ASC of Rockaway Beach & Progressive Ins. Co.*, AAA Case no. 17-21-1224-6648 (07/26/23) (Charles Blattberg, Arb.)
- *Island Ambulatory Surgery Center, LLC & Progressive Ins. Co.*, AAA Case no. 17-22-1251-0195 (08/10/23) (Antonietta Russo, Arb.)
- *Triborough ASC & Progressive Cas. Ins. Co.*, AAA Case 17-22-1259-6294 (06/16/2023) (Ioannis Gloumis, Arb.)

#### FAILURE TO RETURN SIGNED EUO TRANSCRIPT & CONDITION PRECEDENT TO COVERAGE

- *Macintosh Medical, PC & Infinity Standard Ins. Co.*, AAA Case no. 17-21-1230-7018 (08/27/22) (Jan Chow, Arb.), *aff'd* AAA Assessment no. 99-21-1230-7018 (11/05/22) (A. Jeffrey Grob, Master Arb.)
- *Conrad F. Cean, MD, PLLC & Unitrin Safeguard Ins. Co.*, AAA Case no. 17-22-1277-8240 (06/22/23) (Alise Schor, Arb.)
- *PARS Medical, PC & Unitrin Safeguard Ins. Co.*, AAA Case no. 17-22-1246-2541 (02/22/23) (Kate Cifarelli, Arb.)
- *Bruce L. Feldman, MD, PLLC & State Farm Mut. Auto. Ins. Co.*, AAA Case no. 17-19-1150-1721 (03/07/21) (Drew M. Gewuerz, Arb.)
- *Sanford R. Wert, MD, PC & New York City Trans. Auth.*, AAA Case no. 17-21-1193-0933 (09/07/21) (Giovanna Tuttolomondo, Arb.)

#### VERIFICATION & ISLAND LIFE CHIROPRACTIC, PC V. TRAVELERS

- *Sinai Diagnostics, LLC & Allstate Fire & Cas. Ins. Co.*, AAA Case no. 17-22-1242-8628 (08/30/23) (John Kannengieser, Arb.)



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- *Parkway Ambulatory Surgery Center & Maya Assur. Co.*, AAA Case no. 17-22-1279-9514 (07/27/23) (Darren Sheehan, Arb.)
- *Town Rx, Inc. & GEICO Ins. Co.*, AAA Case no. 17-22-1264-7641 (05/07/23) (Jeffrey Held, Arb.)
- *Quality Orthopedics & Complete Joint Care, PC & Progressive Cas. Ins. Co.*, AAA Case no. 17-23-1285-0356 (09/19/23) (Michael Korshin, Arb.)
- *Women's Medical Care Service, PC & Allstate Ins. Co.*, AAA Case no. 17-22-1273-5524 (08/30/23) (Dimitrios Stathopoulos, Arb.)
- *Kpaul Nurse Practitioner Adult Health Wellness, PLLC & Progressive Cas. Ins. Co.*, AAA Case no. 17-22-1268-0229 (08/07/23) (Glen Wiener, Arb.)

### JURISDICTION

- *Gentle Care Acupuncture, PC & GEICO Ins. Co.*, AAA Case no. 17-22-1266-8153 (05/23/23) (Patricia Daugherty, Arb.)
- *Rapid Imaging Corp. & GEICO Ins. Co.*, AAA case no. 17-21-1191-2903 (05/18/22) (Matthew Brew, Arb.)
- *Sedation Vacation Perioperative Medicine, PLLC & GEICO Ins. Co.*, AAA Case no. 17-22-1276-3098 (09/11/23) (Victor Moritz, Arb.)
- *Ortho Shoes Corp. d/b/a Rego Aid & GEICO Ins. Co.*, AAA Case no. 17-22-1265-3301 (09/01/23) (James Hogan, Arb.)

### SUM AWARDS: LOSS OF ENJOYMENT OF LIFE

- *Claimant v. GEICO Ins. Co.*, AAA Case no. 01-22-0004-5064 (09/18/23) (Alan Krystal, Arb.)
- *Claimant v GEICO Ins. Co.*, AAA Case No. 01- 1-23-0000-4557 (08/08/23) (Sally Rose Maiolo, Arb.)

### ASC/EAPG & DISCECTOMIES

*Rockaways ASC Development, LLC d/b/a ASC of Rockaway Beach v. Progressive Cas. Ins. Co.*, AAA Case no: 17-22-1249-0614

(01/24/23) (Debbie Kotin Insdorf, Arb.) Applicant sought reimbursement for facility fees associated with a discectomy (CPT 62287) and annuloplasty (CPT 22526 and 22527). Respondent's coder found CPT code 62287 reimbursable, but that CPT codes 22526 and 22527 were consolidated with CPT 62287 since they belonged to the same APG group, and, as such, no additional reimbursement was due. Although the applicant applied modifier 59 to CPT codes 22526 and 22527, the respondent's coder maintained that use of the modifier was not appropriate since the services were performed at the same anatomic site and during the same patient encounter. Applicant's coder asserted that modifier 59 was appropriate since the annuloplasty (CPT 22526) at the L3-L4 level was performed as a different and separate



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procedure from the discectomy (CPT 62287) and that CPT 22527 is a spinal add-on code performed at a different spinal level. The arbitrator ultimately found the applicant's coder more persuasive and awarded reimbursement accordingly.

*Rockaway ASC Development d/b/a/ ASC of Rockaway Beach v. Progressive Cas. Ins. Co., AAA Case 17-21-1224-6648*

(07/26/23) (Charles Blattberg, Arb.) The applicant sought reimbursement for a facility fee associated with an L4-L5 percutaneous discectomy, nucleus pulposus ablation, annuloplasty, and disc injection with radiographic interpretation. The respondent issued partial payment for the services and denied the annuloplasty in the amount of \$2,605.78 billed under CPT code 22526 and the miscellaneous supplies in the amount of \$50.00 billed under CPT code A4649, asserting that the charges exceeded those permissible under the governing fee schedule. In support of its defense, the respondent submitted a coder affidavit, explaining that the New York Enhanced Ambulatory Patient Grouping ("EAPG") system determines the correct facility fee to be paid to an ambulatory surgical center. Respondent's coder explained that various items are incorporated into this system and calculated the rate of reimbursement. The coder disagreed with the applicant's use of modifier 59 applied to CPT code 22526, noting that NCCI edits indicate that modifier 59 may be utilized where two or more procedures are performed at different anatomical sites or during different patient encounters on the same date. In this case, the procedure was performed at the same anatomical site and during the same patient encounter and, therefore, no additional reimbursement was warranted. Respondent's coder further explained that CPT code A4649 is assigned a predetermined weight of "0" and is not reimbursable. The applicant presented a competing affidavit from a coder who argued that modifier 59 had been correctly applied for distinct and separate multiple services, as the lumbar percutaneous discectomy and annuloplasty procedure were two different surgery types. The applicant did not contest the removal of the \$50.00 fee under CPT code A4649. After reviewing all of the relevant evidence, the arbitrator concluded that CPT code 22526 was included in the same APG group as CPT code 62287 and that the procedure was performed on the same anatomic site during the same patient encounter. Therefore, the arbitrator denied applicant's request for additional reimbursement of the claim.

*Island Ambulatory Surgery Center, LLC v. Progressive Ins. Co., AAA Case no: 17-22-1251-0195*

(08/10/23) (Antionietta Russo, Arb.) Applicant sought reimbursement for facility fees related to a discectomy (CPT 62287) and annuloplasty (CPT 22526). Respondent paid CPT code 62287 in full and denied CPT code 22526, asserting that it was appropriately consolidated in the payment for CPT code 62287. Respondent's coder found this consolidation to be correct since the annuloplasty was performed during the same operative session and at the same levels of the spine. Applicant's coder argued that the use of modifier 59 justified separate reimbursement for CPT code 22526. She noted that the discectomy (CPT 62287) was performed at L5-S1 while the annuloplasty (CPT 22526) was performed at an additional level, L4-L5, thereby warranting separate reimbursement. Applicant's coder noted that the NCCI Policy Manual explicitly states a different spinal level is considered a different anatomic site. The arbitrator ultimately found the applicant's coder more persuasive, noting that while the operative report documents that the discectomies were performed only at the L5-S1 level, the annuloplasty (CPT 22526) was performed at the L4-L5 level, a separate and distinct level, thereby rendering the application of modifier 59 appropriate. As such, the arbitrator awarded additional reimbursement for services billed under CPT code 22526.



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*Triborough ASC & Progressive Cas. Ins. Co., AAA Case 17-22-1259-6294*

(06/16/23) (Ioannis Gloumis, Arb.) The applicant sought reimbursement for a facility fee related to a lumbar discectomy (CPT code 66287), annuloplasty (CPT codes 22526 and 22527), and lumbar epidural steroid injection. The respondent issued partial reimbursement, denying the annuloplasty and services billed under CPT code C2614 and asserting that the charges exceed those permitted under the governing fee schedule. In support of its fee schedule defense, the respondent submitted the CPT Manual defining modifier 59, which states: "Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury and extensive injuries) not ordinarily encountered or performed on the same day by the same individual." The respondent also submitted a coder affidavit that attests that the added codes are included in the total facility payment and do not warrant separate reimbursement. Further, the coder opined that under the NCCI General Ground Rules and Guidelines, the use of modifier 59 is not appropriate in this case because both CPT code 66287 and code 22526 are listed in APG group 28, thus, payment for the codes is consolidated. The coder further maintained that CPT code 22527 is not payable under the NCCI Policy Manual because the primary code, CPT code 22526, is not eligible for payment. Noting that the applicant failed to submit any evidence from a certified professional coder or medical billing expert to refute the opinion of the respondent's coder, the arbitrator denied applicant's claim for additional reimbursement.

**FAILURE TO RETURN SIGNED EUO TRANSCRIPT & CONDITION PRECEDENT TO COVERAGE**

*Macintosh Medical, PC & Infinity Standard Ins. Co., AAA Case no. 17-21-1230-7018*

(08/27/22) (Jan Chow, Arb.) The arbitrator addressed whether the assignor's failure to sign his examination under oath (EUO) transcript violated a condition precedent to coverage. Respondent argued that it never received an executed EUO transcript from the assignor or his attorney despite the issuance of timely verification requests seeking same. Respondent's verification requests stated that "[I]f a signed transcript is not returned within 120 days of this request, our client reserves the right to deny coverage for failure to provide an executed transcript within the allotted time period." Respondent therefore asserted that its denial of claim based on the assignor's failure to sign and return his EUO transcript was appropriate under 11 NYCRR and the court's rulings in *Hereford v. Forest Hills Med.*, 172 A.D.3d 567 (1<sup>st</sup> Dept. 2019) and *Hertz v. Gejo*, 161 A.D.3d 659 (1<sup>st</sup> Dept. 2018). The arbitrator determined that the respondent's defense was not adequately preserved within a denial of claim as its correspondence merely stated that respondent was "reserving the right" to deny coverage rather than expressly denying coverage on this basis. The arbitrator, therefore, determined that since respondent's denial of claim failed to adequately preserve the defense that a condition precedent to coverage was breached, the respondent waived the defense. Finally, the arbitrator determined that the respondent's defense was also invalid, since the denial of claim was issued prior to the expiration of the 120-day allotted time period set forth in the verification requests. The arbitrator ultimately concluded that respondent's defense based on the assignor's failure to sign and return his EUO transcript could not be sustained. Notably, the lower arbitrator's decision was affirmed on appeal (see AAA Assessment no. 99-21-1230-7018).



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*Conrad F. Cean, MD, PLLC & Unitrin Safeguard Ins. Co.*, AAA Case no. 17-22-1277-8240

(06/22/23) (Alise Schor, Arb.) The arbitrator addressed whether the assignor's failure to sign her examination under oath (EUO) transcript violated a condition precedent to coverage. The respondent asserted that it never received an executed EUO transcript from the assignor despite the issuance of emails seeking same and, therefore, respondent argued that it properly denied the applicant's claim based on the assignor's failure to sign and return the transcript. Relying upon the court's holding in *Kemper Independence Ins. Co. v. Cornerstone Chiropractic, P.C.*, 185 A.D.3d 468 (1<sup>st</sup> Dept. 2020), the arbitrator determined that the failure to subscribe and return an EUO transcript is a violation of a precedent to coverage warranting a denial of claim, notwithstanding an insurer's failure to present proof of proper delivery of the denial. The arbitrator further noted that an applicant stands in the shoes of its assignor and takes the assignment of benefits at its own peril. The arbitrator ultimately sustained respondent's defense that a condition precedent to coverage was breached and denied the applicant's claim.

*PARS Medical, PC & Unitrin Safeguard Ins. Co.*, AAA Case no. 17-22-1246-2541

(02/22/23) (Kate Cifarelli, Arb.) The arbitrator addressed whether the assignor's failure to sign his examination under oath (EUO) transcript violated a condition precedent to coverage. The arbitrator initially noted that the respondent established timely issuance of its denials pursuant to a stipulation between the parties. The evidence revealed that an EUO of the assignor was conducted on 11/16/21. The evidence further revealed that on 11/29/21 and 12/29/21, respondent mailed a copy of the transcript to the assignor's attorney seeking the return of an executed transcript before a notary public. Respondent asserted that it never received an executed EUO transcript from the assignor or his attorney and, therefore, argued that the assignor's failure to sign and return the EUO transcript breached a condition precedent to coverage. Respondent's denial of claim stated as follows: "In addition, claimant has not yet signed their examination under oath transcript, which violates a condition precedent to coverage. If a signed transcript is not received within 120 days of it being sent, we reserve the right to deny coverage on this ground." Applicant argued that the denial was insufficient, as the basis for the denial indicated a 120-day defense, yet the denials were issued less than 120 days from the date of the first verification request. Respondent argued that its defense is not strictly a 120-day defense, but, rather, a breach of condition precedent based upon the assignor's failure to submit the signed transcript, regardless of the 120-day time period. Respondent further argued that the denials had to be issued within 30 days of 2/24/22, pursuant to the above-referenced stipulation. The arbitrator determined that while respondent preserved a 120-day defense, it also preserved its defense that the assignor violated a condition precedent to coverage. Citing *Kemper Independence Ins. Co. v. Cornerstone Chiropractic, P.C.*, 185 A.D.3d 468 (1<sup>st</sup> Dept. 2020), the arbitrator determined that the assignor's failure to subscribe and return the EUO transcript violated a condition precedent to coverage and warranted denial of the claim, thus sustaining the respondent's defense that a condition precedent to coverage was breached.

*Bruce L. Feldman, MD, PLLC & State Farm Mut. Auto. Ins. Co.*, AAA Case No. 17-19-1150-1721

(03/07/21) (Drew M. Gewuerz, Arb.) The arbitrator was asked to address whether the assignor's failure to sign and return an examination under oath transcript violated a condition precedent to coverage, thus warranting a





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denial of the applicant's claim at arbitration. The respondent argued that the applicant's claim should be denied on the grounds that the assignor failed to return an executed transcript of his examination under oath testimony. Alternatively, the respondent argued that the claim should be dismissed without prejudice because verification of the claim remained outstanding based on the same inaction by the assignor to return the signed EUO transcript. The arbitrator determined that the failure of a party to return an executed EUO transcript is not the equivalent of outstanding verification. The arbitrator further determined that verification was deemed to have been received by the insurer the day the EUO was held. The arbitrator also noted that the respondent issued a denial shortly after mailing the EUO transcript to the assignor's attorney based upon grounds other than the assignor's failure to return the signed transcript. Therefore, the arbitrator determined that, by issuing the denial, the respondent partially repudiated the contract of insurance, thus relieving the assignor from its obligation to return the executed transcript. Ultimately, the arbitrator held that the respondent was precluded from asserting that a condition precedent to coverage was violated because it failed to preserve the defense in a timely denial of claim form. As such, an award was entered in favor of the applicant.

*Sanford R. Wert, MD, PC & New York City Trans. Auth.*, AAA Case No. 17-21-1193-0933

(09/07/21) (Giovanna Tuttolomondo, Arb.) The arbitrator was asked to address whether the assignor's failure to sign and return an examination under oath transcript violated a condition precedent to coverage, thus warranting a denial of the applicant's claim at arbitration. For the first time at the hearing, the respondent raised a defense based on a breach of a condition precedent to coverage on the grounds that the assignor failed to execute his examination under oath transcript. The arbitrator noted that a violation of a condition precedent to coverage is not analogous to a lack of coverage defense. The arbitrator determined that a lack of coverage defense, such as a staged accident, is nonwaivable, whereas a violation of a condition precedent to coverage, such as the failure to return an executed transcript, is a waivable defense that must be preserved in a timely denial. Therefore, the arbitrator held that since the respondent did not issue a timely specific denial predicated upon a breach of a policy condition, the defense was not properly preserved.

### **VERIFICATION & ISLAND LIFE CHIROPRACTIC, PC V. TRAVELERS**

*Sinai Diagnostics, LLC & Allstate Fire and Cas. Ins. Co.*, AAA Case no. 17-22-1242-8628

(08/30/23) (John Kannengieser, Arb.) In this case, the arbitrator was asked to determine whether the respondent submitted sufficient evidence to establish that it properly issued requests for additional verification and that the verification remained outstanding, thus leaving the case unripe for adjudication. In opposition to respondent's defense, the applicant relied on the ruling in *Island Life Chiropractic, PC v. Travelers Ins. Co.*, 64 Misc.3d 143(A), 2019 N.Y. Slip Op. 51273(U) (App. Term 2<sup>nd</sup>, 11<sup>th</sup> & 13<sup>th</sup> Dists. Aug. 2, 2019), wherein the court noted that when a no-fault insurer is relying on the defense that verification is outstanding, it is the insurer's prima facie burden to demonstrate (1) that verification requests were timely mailed and (2) that the defendant did not receive the requested verification. After reviewing the evidence and considering the parties' arguments, the arbitrator applied a more relaxed



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evidentiary burden noting that the matter was in arbitration rather than in court. Consequently, the arbitrator did not require the respondent to provide proof that the verification was not received as part of its initial burden and found in favor of respondent.

*Parkway Ambulatory Surgery Center & Maya Assur. Co.*, AAA Case no. 17-22-1279-9514

(07/27/23) (Darren Sheehan, Arb.) Applicant sought reimbursement for a facility fee associated with left shoulder arthroscopic surgery. Upon receipt of the bill, the respondent issued requests for additional verification. Respondent subsequently denied the claim, alleging that applicant failed to submit either the requested verification within 120 days from its initial request or, alternatively, reasonable justification for the failure to comply with the requests pursuant to 11 NYCRR 65-3.8(b)(3). Applicant acknowledged that it never replied to respondent's verification requests. Rather, relying on *Island Life Chiropractic, P.C. v. Travelers Inc. Co.*, 64 Misc.3d 143(A), 2019 N.Y. Slip Op. 51273(U) (App. Term 2<sup>nd</sup>, 11<sup>th</sup> & 13<sup>th</sup> Dists. Aug. 2, 2019), the applicant argued that the respondent failed to meet its prima facie burden regarding the "120-day rule" defense because it did not demonstrate that the verification requests were timely mailed to the applicant in the first instance. The arbitrator noted that the rules of evidence applied in court are relaxed in no-fault arbitration. Relying on prior determinations, the arbitrator found that properly addressed verification requests were sufficient to establish proper and timely mailing. The arbitrator held that if applicant intended to raise the issue of mailing of the verification requests at the hearing, it should have, in good faith, notified the respondent during the six-month period between the date respondent uploaded its written arbitration submission and the hearing date that the issue would be raised, rather than raising the issue for the first time at the hearing. Accordingly, the arbitrator sustained the respondent's denial.

*Town Rx, Inc & GEICO Ins. Co.*, AAA Case no. 17-22-1264-7641

(05/07/23) (Jeffrey Held, Arb.) The respondent sought additional verification of the applicant's claim for prescription medication. Respondent subsequently denied the claim, alleging that applicant failed to either submit the requested verification within 120 days from its initial request or, alternatively, provide reasonable justification for the failure to comply with the requests pursuant to 11 NYCRR §65-3.8(b)(3). On the day before the denial was issued, the applicant's attorneys mailed correspondence to the respondent in response to the verification requests. Respondent acknowledged applicant's communication, advising that it was non-responsive. Applicant subsequently corresponded with the respondent regarding the verification requests after the denial was issued. The arbitrator determined that the respondent's initial and follow-up verification requests and subsequent denial of claim were sufficient to support its "120-day rule" defense, declining to find that an insurer was required to prove mailing of the verification requests in order to support its defense. Specifically, the arbitrator rejected the applicant's argument that the respondent was required to provide proof of mailing of the verification requests, particularly where applicant acknowledged receipt and relied upon the verification responses in support of its claim. Accordingly, the arbitrator denied the claim.



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*Quality Orthopedics & Complete Joint Care & Progressive Cas. Ins. Co.*, AAA Case no. 17-23-1285-0356

(09/19/23) (Michael Korshin, Arb.) The respondent sought additional verification of applicant's claims seeking reimbursement for right shoulder surgery. Respondent ultimately denied the claim, asserting that the verification was not provided within 120 days from the date of the initial request. Relying on *Island Life Chiropractic, PC v. Travelers Ins. Co.*, 64 Misc.3d 143(A), 2019 N.Y. Slip Op. 51273(U) (App. Term 2<sup>nd</sup>, 11<sup>th</sup> & 13<sup>th</sup> Dists. Aug. 2, 2019), the applicant argued that respondent's failure to submit proof that the verification was not received was fatal to its defense. Alternatively, the respondent argued that the NF-10s asserting the 120-day defense were sufficient evidence of non-compliance. While the arbitrator acknowledged the relaxed rules of evidence in arbitration, analogizing the situation to an IME or EUO no show, which requires proof of the failure to appear, the arbitrator determined that the NF-10 asserting a 120-day defense, standing alone, was insufficient evidence of noncompliance and entered an award in favor of the applicant.

*Women's Medical Care Service PC & Allstate Ins. Co.*, AAA Case no. 17-22-1273-5524

(08/30/23) (Dimitrios Stathopoulos, Arb.) The respondent sought additional verification of the applicant's claim for extracorporeal shockwave therapy. Respondent asserted that the verification was not provided and, therefore, denied the claim on the grounds that the applicant failed to provide the requested verification within 120 days. Citing *Island Life Chiropractic, PC v. Travelers Ins. Co.*, 64 Misc.3d 143(A), 2019 N.Y. Slip Op. 51273(U) (App. Term 2<sup>nd</sup>, 11<sup>th</sup> & 13<sup>th</sup> Dists. Aug. 2, 2019), the applicant argued that the respondent failed to submit proof that the verification requests were mailed in the first instance. Respondent argued that the applicant did not submit any proof establishing that the verification requests were not received and that the relaxed evidentiary burden in this forum does not require respondent to submit proof of mailing for the verification requests. The arbitrator determined that the failure by respondent to submit proof of mailing or to establish standard office procedures for mailing of the verification requests was fatal to the respondent's defense. While the arbitrator acknowledged a relaxed evidentiary standard in arbitration, the arbitrator, nevertheless, determined that a 120-day defense requires competent evidence demonstrating that the verification requests were properly mailed to the applicant, which the respondent failed to do. Therefore, an award was entered in favor of the applicant.

*Kpaul Nurse Practitioner Adult Health Wellness, PLLC & Progressive Cas. Ins. Co.*, AAA Case no. 17-22-1268-0229

(08/07/23) (Glen Wiener, Arb.) In this case, the question presented was whether the respondent established that additional verification remained outstanding 120 days from the date of respondent's initial verification request. In support of its defense, the respondent offered its initial and follow-up verification requests. In response, the applicant offered evidence that it submitted responses following receipt of the respondent's initial request, and, subsequently, again following receipt of respondent's follow-up request. Relying on the court's ruling in *Island Life Chiropractic, P.C. v Travelers Ins. Co.*, 64 Misc.3d 143(A), 2019 N.Y. Slip Op. 51273(U) (App. Term 2<sup>nd</sup>, 11<sup>th</sup> & 13<sup>th</sup> Dists. Aug. 2, 2019), the arbitrator noted that, "it remain[s] [the insurer's] initial burden to present testimony to demonstrate that it had not received the requested verification, before the burden shift[s] to [the applicant] to prove that it had provided responses." The arbitrator determined that respondent's failure to submit evidence identifying what, if any,



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information remained outstanding when the denial was issued was fatal to its defense and, consequently, vacated the respondent's denial.

### JURISDICTION

*Gentle Care Acupuncture, P.C. v. GEICO Ins. Co.*, AAA Case no. 17-22-1266-8153

(05/23/23) (Patricia Daugherty, Arb.) The arbitrator was asked to determine whether jurisdiction of the case was appropriately placed with the American Arbitration Association. The assignor was a New Jersey resident injured in an accident that occurred within the state of New York. The vehicle was insured under a New Jersey automobile insurance policy. Respondent argued that, pursuant to the forum selection clause in the policy, the matter was required to be resolved by Forthright, the forum designated to resolve disputes in New Jersey. Applicant asserted that since the accident took place in New York, the matter should be heard before the AAA. In finding for respondent, the arbitrator determined that both New Jersey law and the insurance contract itself required the dispute to be resolved in New Jersey and that AAA did not maintain jurisdiction over the claim. Therefore, the arbitrator dismissed the case without prejudice granting the applicant leave to refile in the appropriate forum.

*Rapid Imaging Corp. v. GEICO Ins. Co.*, AAA Case no. 17-21-1191-2903

(05/18/23) (Matthew Brew, Arb.) The arbitrator was asked to consider if the applicant appropriately filed the case with the American Arbitration Association. Respondent argued that the applicant filed the arbitration in the incorrect forum because the policy of insurance was procured in New Jersey and, therefore, pursuant to the terms of the policy, all disputes must be filed with Forthright, the designated New Jersey arbitration forum. Applicant argued that the accident took place in New York, that the claimant resided in New York, and that the respondent does business in New York, all of which confer jurisdiction in New York under a grouping of contacts analysis. In rejecting the respondent's contentions, the arbitrator agreed with the applicant and determined that the loss occurred in New York and the injured claimant was a resident of New York, thus, there maintained a strong interest for the claim to be heard in New York. Moreover, the arbitrator determined that the respondent's failure to offer a copy of the contract provision mandating that the claim be filed with Forthright was fatal to its defense. Therefore, the arbitrator found jurisdiction with AAA to be proper and rendered a decision on the merits in favor of the applicant.

*Sedation Vacation Perioperative Medicine PLLC v. GEICO Ins. Co.*, AAA Case no. 17-22-1276-3098

(09/11/23) (Victor Moritz, Arb.) Applicant sought reimbursement for anesthesia provided during a shoulder arthroscopy. Upon receipt of the bills at issue, Respondent denied the claim based on a negative IME. Immediately prior to the hearing, however, respondent submitted a brief to the arbitrator arguing lack of jurisdiction by the American Arbitration Association with respect to the claim at issue. Respondent argued that the insurance policy was issued within the state of New Jersey and, therefore, the claim must be dismissed and refiled with Forthright, the designated organization for the adjudication of New Jersey no-fault claims. Following the arguments of the



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parties, the arbitrator determined that the respondent had failed to meet its burden with regard to its defense as: (1) the claimant was not the policyholder and respondent had failed to provide any information as to the relationship between the insured and the claimant; (2) the respondent failed to provide any documentation, such as a copy of the police accident report, with regard to the accident; (3) the claimant lived in and received medical treatment in the state of New York, and; (4) the carrier itself did not at any point prior to arguments disclaim coverage. Therefore, an award was entered in favor of applicant.

*Ortho Shoes Corp d/b/a Rego Aid v. GEICO Ins. Co.*, AAA Case no. 17-22-1265-3301

(09/01/23) (James Hogan, Arb.) Applicant sought reimbursement for durable medical supplies provided to the claimant. Upon receipt of the bill at issue, the respondent denied the claim solely on the grounds that the services were medically unnecessary. Immediately prior to the hearing, however, the respondent submitted a brief arguing a lack of jurisdiction by the American Arbitration Association with respect to the claim at issue. Respondent argued that as the insurance policy was issued in the state of New Jersey, the claim must be dismissed for refile with Forthright, the designated organization for the adjudication of New Jersey no-fault claims. Respondent argued that this was a New Jersey automobile insurance policy involving its New Jersey insured, who was also the operator of the vehicle, and, therefore, the claim must be dismissed without prejudice. Following the arguments of the parties, the arbitrator found in favor of the applicant, reasoning that: (1) the accident occurred in New York State; (2) once the accident occurred in the state of New York, the New Jersey policy of insurance converted to a New York policy and, therefore, made the claim subject to jurisdiction of the AAA; and (3) the respondent writes insurance policies in both New York and New Jersey and, consequently, is subject to the jurisdiction of the AAA.

### **SUM AWARDS – LOSS OF ENJOYMENT OF LIFE**

*Claimant v GEICO Ins. Co.*, AAA Case No 01-22-0004-5064

(09/18/23) (Alan Krystal, Arb) The arbitrator was asked to assess damages, in part, based upon the claimant's loss of enjoyment of life following a motor vehicle accident that occurred on April 10, 2021 at the intersection of 2<sup>nd</sup> Avenue and East 61<sup>st</sup> Street. According to the claimant, a 61-year-old pedestrian, she was crossing within a crosswalk with the light in her favor when she was struck by a 2019 Nissan making a left turn from 61<sup>st</sup> Street onto 2<sup>nd</sup> Avenue. However, according to the police accident report, the driver of the Nissan stated he had a green light and was turning onto 2<sup>nd</sup> Avenue when the claimant walked out from behind another car while talking on her cell phone. The claimant was taken to New York Presbyterian Weill Cornell Medical Center, where she was admitted from April 10, 2021 through April 14, 2021. MRI studies confirmed fractures at T12 and L3. The claimant was subsequently treated at NYU Langone Medical Center, where she underwent percutaneous kyphoplasty. In addition, the claimant underwent a course of physical rehabilitation and therapy from May 2021 through December 2021. On September 27, 2021, the claimant was evaluated for complaints of pain in the lower back and left thigh. Examination revealed tenderness to palpation in the lumbar paraspinal muscles, pain with left SI joint compression, and discrete trigger points at the bilateral L5 paraspinal muscles. Thoracolumbar flexion was moderately limited. Following examination, impression was wedge compression fracture of the 3rd lumbar vertebra, and the claimant was administered bilateral trigger point injections.



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On August 9, 2023, the claimant underwent a bilateral L4-L5, L5-S1 intra-articular facet joint capsule injection. In support of its defense, the respondent submitted a report of an independent medical examination by an orthopedist, whose impression was status-post T12 and L3 kyphoplasty to repair T12 and L3 compression fractures, which he noted were clinically healed. Therefore, the respondent's IME physician concluded that the claimant did not suffer from any orthopedic disability. The claimant was employed by an advertising agency at the time of the accident and testified that she missed three weeks from work immediately following the accident. The claimant subsequently left her employment and started her own agency because she could not meet the travel demands due to her injuries. During testimony, the claimant described her back pain as 5-6 on a scale from 1-10 and testified that she occasionally experiences spasms and a feeling of being "stuck." Prior to the accident, the claimant led an active lifestyle, participating in biking, hiking, golf, weight training, skiing, tennis, and Pilates. She testified that she has since stopped these activities due to her injuries and is limited to using an elliptical machine. With respect to the issue of liability, the arbitrator concluded that the claimant did not cross within the crosswalk and was, therefore, 50% responsible for the accident. As to the issue of damages, citing PJI 2:280 and relevant case law, the arbitrator noted that a party is entitled to damages for the loss of enjoyment of life, which includes the loss of the ability to perform daily tasks, to participate in the activities that were a part of the person's life before the injury, and to experience the pleasures of life. Therefore, taking into consideration the claimant's active lifestyle prior to the accident, the arbitrator determined that the value of the claimant's accident-related injuries and loss of enjoyment of life was \$500,000. Following a deduction based on the claimant's comparative negligence and after applying a \$100,000 setoff, the net award to the claimant was \$150,000.

*Claimant v GEICO Ins. Co., AAA Case No. 01-23-0000-4557*

(08/08/23) (Sally Rose Maiolo, Arb.) The claimant, a 37-year-old firefighter, testified that on September 13, 2020, he was traveling on Hoyt Avenue in his Jeep Compass when a car initially struck the Jeep in the rear and then subsequently struck the Jeep again on the door. The claimant testified that shortly following the accident, he sought medical treatment for complaints of pain in his right shoulder, neck, and back, claiming he was unable to work due to his pain. Following examination, the examining physician causally related the injuries to the claimant's right shoulder and cervical spine to the underlying accident. The claimant subsequently underwent an EMG/NCV study of the upper extremities, which revealed a right C6 radiculopathy. Thereafter the claimant sought treatment at Northern Interventional Medical PC, where he received 51 sessions of physical therapy. The claimant also sought chiropractic care. Following diagnostic testing, the chiropractor determined that the claimant suffered from more than a 33% loss of range of motion in the cervical spine and right shoulder. The claimant underwent 49 sessions of chiropractic treatment commencing three times a week, then twice a week, then once a week, until no-fault benefits terminated. The claimant also underwent three epidural steroid injections in 2021. In support of its defense, the respondent submitted a report dated October 12, 2022 documenting an independent medical examination by an orthopedist, who concluded that the claimant sustained sprains and strains of the cervical spine and right shoulder as a result of the accident, all of which, he opined, had resolved as of the date of the IME. The claimant testified that he suffers from constant pain in his neck, trapezius muscles and upper back, for which he performs stretching exercises and takes anti-inflammatory medication. Regarding activities of daily living, the claimant testified that, since the accident, he can no longer bicycle ride or lift heavy objects and is limited to lifting a maximum of 30 to 40



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pounds. He stated that before the accident he was “much more active and handier around the house.” He testified that grocery shopping independently is challenging and requires his wife’s assistance. He has difficulty hanging up a picture frame. Upon consideration of the evidence presented, including the credible testimony of claimant, the arbitrator determined that the claimant established a prima facie case of negligence against the offending vehicle without any comparative negligence on the part of the claimant. The arbitrator further determined that the claimant sustained a significant limitation of use to his right shoulder and cervical spine as a result of the accident, and, as such, the arbitrator concluded that the injuries caused pain and suffering and loss of enjoyment of life. The arbitrator, therefore, valued the claimant’s injuries at \$55,000, and, taking into consideration an offset in the amount of \$25,000, the claimant received a net award of \$30,000.

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