AMERICAN ARBITRATION ASSOCIATION®

AAA® INSURANCE REPORTER

SUMMER EDITION

Celebrating the 50th Anniversary of the New York State No-Fault Insurance Regulation

In 1974, the New York State Department of Insurance promulgated Regulation 68, New York's No-Fault law. Since then, the American Arbitration Association® (AAA) has hit many milestones in its handling of no-fault cases within the state. As we celebrate this tremendous landmark as a company, there are a few noteworthy accomplishments to highlight along the way. Evolution of our handling of cases within New York State no-fault began with the administration of both conciliation and arbitration. During the 70s and 80s, the Department of Insurance also handled certain types of no-fault cases, as well as assuming the conciliation function. By 2000, however, AAA assumed responsibility for administering all New York no-fault cases in both conciliation and arbitration, bringing cases with multiple issues under one umbrella.

Since then, there have been changes made that have increased our ability to better serve our customers and make the arbitration process operate more seamlessly.

Here is a timeline of some of these changes:

- **2003:** Migrated to electronic case files, which streamlined workflows and accelerated case processing
- **2005:** Introduced the redacted award search
- **2006:** Introduced email filing, which was a swift and economical alternative to traditional mail and eliminated the need for physical storage and postage
- **2014:** Implemented the ADR Center case management system, simplifying workflows even further, automating routine tasks and improving data management
- **2015:** Created the Business Intelligence team, using analytics to increase quality and efficiency
- **2016:** Settlement Tool incorporated into ADR Center, allowing parties to make and accept offers online
- **2018:** Automation Anywhere and Virtual Workforce (Bots) added to automate tasks and permit utilization of valuable human resources for more intricate aspects of the arbitration process
- **2021:** Hearings entirely virtual, providing more efficient scheduling and resulting in earlier hearing dates
- **2023:** Simple File API (Application Programming Interface) developed for more secure and easier case filing
- **2024:** Received our five millionth no-fault case filing

For 2025 and beyond, we strive to continue to incorporate technology into our business to deliver exceptional customer experiences. The advancements we are working on include ADRC 2.0 that will address existing gaps in current performance, API (Application Programming Interface) integrations with external systems, and exploring AI to uncover secure, relevant, and hallucination-free uses of technology for our future.

AAA® INSURANCE REPORTER

SUMMER EDITION

AAA: Embracing Technology to Modernize the Arbitration Process

The AAA has been a pillar in resolving no-fault disputes throughout its very long history. During this time, technological advancements have revolutionized the way we work. Read on to see how the AAA has leveraged technology to transform the arbitration process—enhancing efficiency, transparency, and customer service.

Going Paperless: Streamlining Case Management

In 2003, the AAA embraced a transformative shift by migrating from paper files to electronic case files (ECF). The move revolutionized document management, fostering better organization and retrieval of information. This not only saved time but also ensured all stakeholders were working with the latest information.

The Evolution of Case Filing

Building on the success of ECF, the AAA continued on to introduce email filing. The accessibility of emailed documents, coupled with the benefits of electronic filing, further propelled the AAA towards a paperless environment. Additionally, email filings provided 24/7 accessibility, reduced environmental impact, and enhanced security.
After many successful years with email filing, we transitioned to Simple File and then Simple File API (Application Programming Interface). This provided even more security and gave the applicants a "drag & drop" option for their cases. In the 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. If your submission was successful, you immediately will receive a case number. Also in the early planning stages are API features that will digitize various aspects of case management for our insurance carriers.

Harnessing the Power of Data for Business Intelligence

Recognizing the power of data, we hired our first Business Intelligence (BI) Analyst and established a BI unit. This empowered data-driven decision-making, allowing the organization to adapt to market changes, identify trends, and optimize operational efficiency. BI fostered a culture of continuous improvement by analyzing employee performance and aligning efforts with key performance indicators (KPIs). Furthermore, BI aided in risk management and regulatory compliance. Notably, the established BI unit played a crucial role in enabling the AAA's seamless transition to a fully remote workforce during the COVID-19 pandemic.

A Modern Case Management Platform: Increased Efficiency and Transparency

In 2014, the AAA implemented a new case management platform, ADRC, replacing the previous outdated system. The ADRC offers a multitude of benefits, primarily focused on enhancing efficiencies. The platform streamlines workflows, automates routine tasks, and reduces manual intervention, minimizing the risk of errors.

Additionally, improved data management capabilities facilitate better organization and foster a more transparent system. Furthermore, advanced reporting and analytics features provide valuable insights for optimizing caseload management.

Virtual Hearings

AAA traditionally maintained the option for remote hearings for parties using phone conference call platforms. With the advent of the COVID-19 pandemic, AAA was seamlessly able to transition from in-person hearings to fully virtual hearings, initially with the help of LoopUp. The program is now completely virtual, with all hearings conducted via Zoom. The virtual hearing process was more efficient for the parties, eliminating travel time and allowing hearings to be scheduled regardless of the region. The AAA now could provide earlier hearing dates as well as a more diverse pool of arbitrators, as they no longer were tied to geographical regions.

Automation and Beyond: The Future of Dispute Resolution

The AAA continues to embrace technological advancements. Tools such as Automation Anywhere and Virtual Workforce (Bots) have significantly modernized case processing. These tools automate the tasks of sending reminders for case escalation, handling time extension requests, and managing bulk withdrawals and settlements. As technology continues to evolve, the AAA is committed to integrating innovative solutions, ensuring the caseload is managed with ever-increasing efficiency.

The Use of Indexing

Indexing continues to remain a valuable support for the arbitration process. While the feedback received regarding indexing historically has been positive, there are always ways that we strive to improve. The AAA and the user community must work together for the benefit of the arbitration program. While we are working on innovating the entire indexing process, we also need our users' assistance with ensuring that indexing remains simple and beneficial to all parties. Here are some reminders regarding document submission that will allow the arbitration process to move faster and improve quality:

TIP #1: Organize the submission

A clearly presented submission assures that all points are raised, preserved, and resolved timely. Listed below are some suggested formats to utilize when submitting documents for both Applicants and Respondents:

- Applicant
  - Coversheet with page numbers and AR-1 to verify the accuracy of the information submitted. Failing to itemize bills on AR-1 can interrupt the verification process and delay the process of filing.

- *Exhibit A*: Bills in chronological order
- *Exhibit B:* Medical reports, test results, and other relevant reports in chronological order
- *Exhibit C:* Assignment of benefits
- *Exhibit D:* Proofs of mailing, verification responses, rebuttals and other relevant matters
- *Exhibit E:* Case law, prior arb awards, and other relevant items

- Respondent
  - Coversheet identifying issues and defenses by claim
  - *Exhibit A:* Denials/Explanation of Benefits in chronological order by date of service followed by corresponding verification requests
  - *Exhibit B:* Evidence corresponding to defenses, i.e., Peer reviews, IME reports, proof of policy violation, coder affidavit, etc.
  - *Exhibit C:* Medical literature, case law, prior arbitration awards, and other relevant items.

TIP #2: Verify documents before submitting

Submissions that are disjointed and out of order take a much longer time to process. To avoid unnecessary delays, avoid sending duplicates as well as illegible and poorly oriented documents.

Please Provide Feedback!

We are always seeking feedback regarding our processes, as we are constantly evolving to be more efficient and user friendly. Please use the following survey link to answer a few quick questions about your document indexing experience. Your feedback will help us make sure that we are providing the best possible service for everyone involved.

https://www.surveymonkey.com/r/7WFFFDS

We are currently evaluating the document indexing process and researching ways to make documents simpler to process and access. We need our customers' assistance as we continue to embark on our mission to deliver value-added services.

AAA® INSURANCE REPORTER

SUMMER EDITION

The Long Awaited NYSI Intake API is Here!

As announced in this space last year, AAA has expanded Applicant's Arbitration Request submission options with our latest API (Application Programming Interface).

AAA previously provided the means to submit ADR requests electronically, beginning with our SimpleFile API, which mimicked the manual PDF document submissions in SimpleFile. Case Filing Specialists previously opened each case submission and manually entered the AR-1 data into ADR-Center, which was time consuming.

With the new NYSI Intake API, you can now submit your Arbitration Request documents and AR-1 data directly into ADR Center and receive an immediate response and notification, including your case number if your submission was successful. If it was not, you will be notified via electronic communication of the details you may need in order to correct and resubmit your request.

The API leverages current technology that offers opportunities for streamlining PDF uploads through multi-channel uploading techniques, which means that now you have ways of improving the throughput of the document upload process. Importantly, the API includes multiple layers of built-in security to ensure that your data and document exchange is secure.

We invite you to look into the features of the NYSI Intake API, as it provides opportunities for improved document uploads and provides a direct to ADR-C path for case ingestion. If you are interested, please send an inquiry to NYSInsurance@adr.org. Our support team can answer your questions and provide documentation on how to use the API.

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

TRANSCRANIAL DOPPLER STUDEIS & MEDICAL NECESSITY

- *Alan Beckles, M.D. & Integon National Ins. Co.,* AAA Case no. 17-22-1260-0805 (02/21/24) (Jacques M. Leandre, Arb.)

- *Interventional Medicine & Rehab of NY PLLC, Diagnostic Neurology PC & Unitrin Safeguard Ins. Co.*, AAA Case no. 17-23-1295-9579 (11/08/23) (Michael Rosenberger, Arb.)
- *Sanitas Medical, PC & Allstate Ins. Co.*, AAA Case no. 17-22-1248-9207 (11/29/23) (Joseph Endzweig, Arb.)
- *Sergey Kalitenko, MD & State Farm Mut. Auto. Ins. Co.*, AAA Case no. 17-23-1283-2426 (09/19/23) (Marcie Glasser, Arb.)
- *Queensboro Medical Services & Unitrin Safeguard Ins. Co.*, AAA Case no. 17-23-1286-2728 (10/22/23) (Michael Rosenberger, Arb.)
- *Renan Macias, MD & American Transit Ins. Co.*, AAA Case no. 17-23-1299-5884 (02/23/23) (Corinne Pascariu, Arb.)

FUNCTIONAL CAPACITY EVALUATIONS & FEE SCHEDULE

- *Melikset Vardanyan d/b/a Vardanyan, NP in Family Health PC & Progressive Cas. Ins. Co.*, AAA Case no. 17-23-1303-9586 (02/09/24) (Linda Filosa, Arb.)
- *Morning Star Physical Therapy PC & Geico Ins. Co.*, AAA Case no. 17-23-1294-8967 (02/16/24) (Nancy Linden, Arb.)
- *Unity Care Physical Therapy PC & Geico Ins. Co.*, AAA Case no. 17-23-1304-3182 (01/03/24) (Anthony Joseph Bianchino, Arb.)
- *Step Up Physical Therapy PC & Geico Ins. Co.*, AAA Case no. 17-23-1282-8805 (12/22/23) (Ioannis Gloumis, Arb.)

FUNCTIONAL CAPACITY EVALUATIONS & MEDICAL NECESSITY

- *Beach Medical Rehabilitation, PC & Allstate Ins. Co.*, AAA Case no. 17-22-1264-4862 (10/22/23) (Lisa Abrams, Arb.)
- *Gamma Physical Therapy, PLLC & MVAIC*, AAA Case no. 17-23-1288-2448 (09/13/23) (Keith Tola, Arb.)

ELECTRONIC PRESCRIPTIONS

- *EZRX Chemists Corp & Nationwide General Ins. Co.*, AAA Case no: 17-22-1274-3824 (08/09/23) (Maureen Callahan, Arb.)
- *Floral Park Drugs, Inc. & Nationwide General Ins. Co.*, AAA Case no. 17-21-1222-3401 (05/02/22) (Lisa Abrams, Arb.)
- *Floral Park Drugs Inc. & Nationwide General Ins. Co.*, AAA Case no. 17-21-1216-8787 (10/05/22) (Douglas Coppola, Arb.)
- *Floral Park Drugs Inc. & Nationwide General Ins. Co.*, AAA Case no. 17-22-1235-6756 (01/06/23) (Rhonda Barry, Arb.)

ENTITLEMENT TO NO-FAULT REIMBURSEMENT BY A NON-PROFESSIONAL SERVICE CORPORATION

- *Global Tech Diagnostic, Inc. & Nationwide Ins. Co.*, AAA Case no. 17-22-1273-1287 (03/06/24) (Bonnie Link, Arb.)
- *Doctors United, Inc. & Hereford Ins. Co.*, AAA Case no. 17-23-1307-0794 (04/14/24) (Yael Aspir, Arb.)
- *Titan Diagnostic Imaging Services, Inc. & Allstate Ins. Co.*, AAA Case no. 17-23-1295-8722 (03/03/24) (Heidi Obiajulu, Arb.)

SUM AWARDS: COMPARATIVE NEGLIGENCE

- *Claimant v. Progressive Ins. Co.*, AAA Case no 01-23-0002-2906 (03/04/24) (Philip J. De Bellis, Arb.)
- *Claimant v. Liberty Mutual Ins. Co.*, AAA Case No 01-23-0002-1504 (04/11/24) (Jodi Zagoory Arb.)

TRANSCRANIAL DOPPLER STUDIES & MEDICAL NECESSITY

Alan Beckles, M.D. & Integon National Ins. Co., AAA Case no. 17-22-1260-0805 (02/21/24) (Jacques M. Leandre, Arb.) The arbitrator addressed the medical necessity of transcranial Doppler ("TCD") studies. The respondent offered a peer review report by Edward Weiland, M.D. in support of their position that the TCD studies at issue were not medically necessary. Dr. Weiland noted that TCD studies are a non-invasive ultrasound study used to measure cerebral blood flow velocity in the major intracranial arteries. Dr. Weiland noted that, according to the medical records reviewed, there was no evidence of any vascular abnormalities in the head, neck, or facial region. Dr. Weiland further noted that the treating physician did not indicate how the utilization of the TCD studies at issue would clarify any specific differential diagnosis, alter any treatment protocols, or accelerate the recovery from any trauma or injuries. The applicant offered a report by David Carmili, M.D. in rebuttal to the peer review. According to Dr. Carmili, the patient presented with complaints of pain in the neck, mid-back, lower back, right knee, and left shoulder and that the patient's pain was aggravated by bending down, carrying objects, flexing/turning the neck, getting up from a seated position, going up and down stairs, grasping, lifting heavy objects, lying down, lumbar rotation, laying on side, overhead maneuvers, opening bottles, prolonged sitting, pushing, pulling, reaching, running, standing, straining and walking. Dr. Carmili further noted that physical examination revealed muscle spasm. Dr. Carmili concluded that the TCD studies at issue were justifiably recommended to further evaluate the patient's symptoms and to help distinguish the origination of the patient's current symptoms (central vs. peripheral). Following a careful and thorough review of the evidence, the arbitrator determined that applicant met its burden and established the medical necessity of the TCD studies.

Interventional Medicine & Rehab of NY PLLC, Diagnostic Neurology PC & Unitrin Safeguard Ins. Co., AAA Case no. 17-23-1295-9579 (11/08/23) (Michael Rosenberger, Arb.) The arbitrator addressed the medical necessity of transcranial Doppler ("TCD") studies. In support of its position that the TCD studies at issue were not medically necessary, respondent offered a peer review report by Christopher Burrei, D.O. Upon reviewing the applicant's medical records,

Dr. Burrei noted that the patient was not suffering from headaches, dizziness, or vertigo and further noted that there was no significant head trauma and no neurological examination performed. Therefore, Dr. Burrei opined that the performance of the TCD studies was a deviation from accepted standards of care. In support of its claim, the applicant offered a rebuttal report by Sergey Zhivotenko, M.D. The arbitrator noted that while Dr. Zhivotenko provided a general discussion surrounding TCD studies, he neglected to address the lack of complaints regarding headaches, dizziness, or vertigo noted by Dr. Burrei. The arbitrator was persuaded by Dr. Burrei that the patient did not have any symptoms warranting performance of TCD studies. Therefore, the arbitrator determined that the applicant failed to rebut the peer reviewer's conclusion that the TCD studies at issue were not medically necessary and sustained respondent's denial.

Sanitas Medical PC & Allstate Ins. Co., AAA Case no. 17-22-1248-9207 (11/29/23) (Joseph Endzweig, Arb.) Applicant sought reimbursement for transcranial Doppler ("TCD") studies. Respondent denied the claim based upon a peer review report by Alexander Merson, M.D., who found the testing to be medically unnecessary. Dr. Merson opined that there was no documentation of neurological symptoms, and, in the absence of a diagnostic dilemma, the testing was not medically necessary. In support of its claim, the applicant relied on a rebuttal by Deonarine Rampershad, N.P. Mr. Rampershad argued that the testing would further evaluate the assignor's symptoms and determine whether the symptoms were central or peripheral in origin. After reviewing the medical evidence, the arbitrator found the peer review sufficient to support the respondent's prima facie burden of establishing a lack of medical necessity and further determined that the rebuttal failed to refute the findings of respondent's expert. Consequently, the arbitrator found the testing was medically unnecessary and entered an award in favor of respondent.

Sergey Kalitenko, MD & State Farm Mut. Auto. Ins. Co., AAA Case no. 17-23-1283-2426 (09/19/23) (Marcie Glasser, Arb.) Applicant sought reimbursement for transcranial Doppler ("TCD") studies. Respondent denied the claim based upon a peer review report by Daniel Feuer, M.D., who found the testing to be medically unnecessary. Dr. Feuer opined that TCDs are appropriate to assess cerebrovascular dysfunction in a patient at risk for cerebrovascular disease and that the medical records did not document intracranial or extracranial cerebrovascular dysfunction or condition. In support of its claim, the applicant relied on a rebuttal by Gamil Kostandy, M.D., who examined the assignor prior to the testing. Dr. Kostandy argued that the assignor suffered from headaches, thus rendering the testing necessary. Respondent also submitted a reply to the rebuttal. After considering the evidence, the arbitrator found that the rebuttal failed to establish the necessity of TCDs in this case. The arbitrator found that the rebuttal did not identify any complaints of dizziness or vertigo in the medical reports and that, in the absence of other neurological symptoms beyond headaches, the testing was not justified as determined by the respondent's expert. Therefore, the arbitrator found the testing was medically unnecessary and entered an award in favor of Respondent.

Queensboro Medical Services v. Unitrin Safeguard Ins. Co., AAA Case no. 17-23-1286-2728, (10/22/23) (Michael Rosenberger, Arb.) Applicant sought to recover first-party benefits for, among other types of testing, transcranial Doppler ("TCD") studies. Respondent denied the TCD studies on the grounds that the testing was medically unnecessary and offered a peer review report by Dr. Christopher Burrei in support. Applicant's counsel asserted that the peer review was conclusory, vague, and did not set forth a standard of care from which the applicant is alleged

to have deviated. Upon consideration of the evidence, the arbitrator agreed with applicant and determined that Dr. Burrei's report failed to meet the respondent's burden of production to the extent that the peer review failed to set forth a standard of care from which the doctor who performed the testing deviated. Additionally, the arbitrator noted that the medical records documented a "bevy of abnormal findings," such as headaches, dizziness, vertigo, nausea, sensory deficits, and a positive Romberg test, all of which were disregarded by the peer reviewer when making his determination. Based on the above, an award was issued in the applicant's favor.

Renan Macias, MD v. American Transit Ins. Co., AAA Case no. 17-23-1299-5884, (02/23/23) (Corinne Pascariu, Arb.) The applicant sought to recover first party benefits following submission of its bill for transcranial Doppler ("TCD") studies. Respondent denied reimbursement for the testing based on the peer review of Dr. Peter Chiu, who found the TCD studies to be medically unnecessary. According to Dr. Chiu, the claimant did not have the symptomology necessary to warrant ordering of the testing. In rebuttal, the applicant offered a report by Dr. Soorja Poonawala, which the arbitrator found not only specifically addressed the arguments made by Dr. Chiu, but which also noted that the claimant did, in fact, have complaints of headaches and dizziness which, even according to Dr. Chiu's own criteria, would warrant performance of TCD studies. Therefore, the arbitrator found the evidence sufficient to sustain applicant's burden of persuasion and issued an award in favor of applicant.

FUNCTIONAL CAPACITY EVALUATIONS & FEE SCHEDULE

Melikset Vardanyan d/b/a Vardanyan, NP in Family Health PC & Progressive Cas. Ins. Co., AAA Case no. 17-23-1303-9586 (02/09/24) (Linda Filosa, Arb.) The applicant sought reimbursement for, among other services, a functional capacity evaluation ("FCE"). The respondent denied this claim based on the fee schedule, noting that the specific requirements for FCE state it should not be prescribed within the first three months after the accident unless there is a significant change in the patient's status warranting an earlier test. In this case, the test was conducted one month after the accident and the provider failed to provide a reason to justify earlier performance of the test. The arbitrator noted the reasons FCE is performed and listed both the general and specific requirements established under Ground Rule 14 of the Physical Medicine section of the New York State Workers' Compensation Fee Schedule. While the arbitrator acknowledged the test was performed one month after the accident, she further noted that the requirements indicate that a significant documented change is an exception to the three-month waiting period, and it was the respondent's obligation to establish with competent proof their interpretation was correct. Therefore, the arbitrator determined that the respondent failed to establish there was no significant documented change to the injured party to justify the earlier utilization of the FCE and awarded the claim.

Morning Star Physical Therapy PC & Geico Ins. Co., AAA Case no. 17-23-1294-8967 (02/16/24) (Nancy Linden, Arb.) The applicant sought reimbursement for a functional capacity evaluation ("FCE"). The respondent denied the claim alleging that the provider failed to administer the test according to the General and Specific Requirements outlined by Ground Rule 14 of the Physical Medicine section of the New York State Workers' Compensation Fee Schedule. Respondent argued that a plain reading of the fee schedule required a decision in its favor. However, the arbitrator noted the burden is on the respondent to establish with competent evidentiary proof that a claim is billed in excess

of the fee schedule and that it was incumbent upon the respondent to submit an affidavit from a certified professional coder in support of its position, which, the respondent failed to do. Therefore, the arbitrator awarded the claim.

Unity Care Physical Therapy PC & Geico Ins. Co., AAA Case no. 17-23-1304-3182 (01/03/24) (Anthony Joseph Bianchino, Arb.) The applicant sought reimbursement for a functional capacity evaluation ("FCE") billed under CPT code 97800. The respondent denied the claim alleging the billed services did not meet the indications and requirements for an FCE outlined in Ground Rule 14 of the Physical Medicine section of the New York State Workers' Compensation Workers' Compensation Fee Schedule and Ground Rule 6 of the Physical Medicine section of the Physical and Occupational Therapy Fee Schedule. The arbitrator noted that the description for code 97800 in the Fee Schedule references the requirements contained in Ground Rules 6(b) and (c) and Ground Rule 14, which provide that an FCE should not be prescribed prior to three months post injury absent a significant documented change in the claimant's status justifying earlier utilization and is only indicated when the claimant is preparing to return to a previous job, has been offered a new job, is working with a rehabilitation provider and has a vocational objective, or is expected to be classified with a permanent non-scheduled partial disability. The arbitrator determined that the billed services did not meet the requirements for an FCE contained in Ground Rule 6(c) of the Physical and Occupational Therapy Fee Schedule and were ineligible for reimbursement since the patient reported in his no-fault application and to his treating provider that he was not working as a result of the accident, and there was no evidence he was preparing to return to work, had been offered a new job, was working with a rehabilitation provider with an established vocational objection, or was expected to be classified with a non-scheduled partial disability. Accordingly, the arbitrator denied the claim.

Step Up Physical Therapy PC & Geico Ins. Co., AAA Case no. 17-23-1282-8805 (12/22/23) (Ioannis Gloumis, Arb.) Applicant sought reimbursement for a functional capacity evaluation ("FCE"). The respondent denied the claim alleging the billed services did not meet the indications and requirements for an FCE outlined in Ground Rule 6 of the Physical Medicine section of the New York State Workers' Compensation Physical & Occupational Therapy Fee Schedule. The arbitrator took judicial notice of the Fee Schedule and noted that Ground Rule 6 outlines the indications and general and specific requirements for an FCE performed by a physical therapist. According to Ground Rule 6, an FCE should not be prescribed prior to three months post-injury unless there is a significant documented change in the claimant's status that justifies earlier utilization. The arbitrator noted that the disputed FCE was performed less than three months after the motor vehicle accident and found that applicant failed to provide sufficient evidence of a significant documented change in the claimant's status which justified earlier utilization of an FCE. Accordingly, the arbitrator denied the claim.

FUNCATIONAL CAPACITY EVALUATIONS & MEDICAL NECESSITY

Beach Medical Rehabilitation, PC & Allstate Ins. Co., AAA Case no. 17-22-1264-4862 (10/22/23) (Lisa Abrams, Arb.) The applicant sought reimbursement for a functional capacity evaluation ("FCE"). Respondent asserted a lack of medical necessity defense predicated on a peer review report by Dr. Ayman Hadhoud. The arbitrator noted that Dr. Hadhoud emphasized that assessing a patient's functional level is an essential part of a routine physical exam and,

therefore, it is improper to bill for an FCE separately unless the patient's functional level to perform routine work duties have changed, thus requiring vocational rehabilitation, which, according to Dr. Hadhoud, was not the case with this claimant. The arbitrator further noted that the peer review doctor also opined that range of motion testing and manual muscle testing would be sufficient to assess the functional ability of an individual, and, therefore there was no practical reason to perform an FCE. The arbitrator was persuaded by the peer review report and determined that the FCE in this instance should not have been billed separately, was not medically necessary and, therefore, was not reimbursable.

Gamma Physical Therapy, PLLC & MVAIC, AAA Case no. 17-23-1288-2448 (09/13/23) (Keith Tola, Arb.) The applicant sought reimbursement for a functional capacity evaluation ("FCE") billed under CPT code 97800. Respondent argued that the evaluation was not medically necessary and offered a peer review report by Thomas Lione, D.O. in support. The arbitrator took issue with Dr. Lione's peer review report, noting that it was solely directed at a discussion surrounding computerized range of motion and muscle strength testing, which was only one component of the FCE. The arbitrator noted that Dr. Lione is a medical expert, rather than a certified professional coder and, consequently, questioned Dr. Lione's qualification to opine when and in what form the services should be performed and compensation due. The arbitrator also questioned Dr. Lione's reliance upon one single piece of medical literature that discussed the medical assessment of an individual for the purpose of returning to sports, rather than for the purpose of providing medical treatment following injuries sustained in a motor vehicle accident. According to the arbitrator, Dr. Lione's discussion of FCE centered around the issue of medical necessity for computerized range of motion and muscle strength testing and overlooked the fact that the FCE, as performed, was intended to be more complex than mere range of motion and muscle strength testing that would be commonly performed as part of a routine physical examination. The arbitrator pointed out that an FCE is designed to determine muscular capabilities following injury and to measure change in a patient's condition over time to assess whether the claimant's injuries have improved, have remained the same, or have deteriorated. Overall, the arbitrator found the peer review report of Dr. Lione unpersuasive and insufficient to carry the Respondent's burden. Finally, the arbitrator opined that irrespective of the sufficiency of the peer review report, the report in rebuttal prepared by Drora Hirsch, M.D., submitted by the applicant was sufficient and persuasive on the issue of medical necessity. Thus, the claim was granted.

ELECTRONIC PRESCRIPTIONS

EZRX Chemists Corp & Nationwide General Ins. Co., AAA Case no: 17-22-1274-3824 (08/09/23) (Maureen Callahan, Arb.) Respondent denied the applicant's claim for prescription medications based on a 120-day defense. During the verification process, the respondent requested a copy of the New York State electronic prescription issued by the prescribing physician to the pharmacy for the disputed medications or alternatively, a copy of the official New York State prescription form for the subject medication along with a waiver issued by the NYS Department of Health excluding the prescriber from using electronic prescriptions. In response, applicant provided a copy of the prescription along with the National Drug Code (NDC) and Average Wholesale Price (AWP). Applicant asserted that such information was sufficient. However, applicant also objected to the request asserting that a prescription can be called into the pharmacy orally and that even if the prescription was not an official prescription, there is nothing in the law that relieves the insurer from paying for medication that was properly dispensed to the patient. In response,

the respondent argued that applicant did not provide a valid prescription in the form of an electronic prescription as required by Public Health Law §281, thus rendering the medication ineligible for no-fault reimbursement. Respondent relied on Ins. Law §5102(a)(1), 11 NYCRR §65-1.1, 18 NYCRR §505.3(a)(iii)(6), Educ. Law §6810, and Public Health Law §281 to support its position. The arbitrator ultimately found the respondent's position compelling and determined that the applicant's verification response and objections were insufficient and sustained the respondent's denial. Notably, this decision was affirmed by a master arbitrator (see AAA Assessment no. 99-22-1274-3824.)

Floral Park Drugs, Inc. & Nationwide General Ins. Co., AAA Case no. 17-21-1222-3401 (05/02/22) (Lisa Abrams, Arb.) Respondent denied the applicant's claim for lidocaine ointment on the grounds that the prescription was not a validly issued prescription, and, consequently, not covered under no-fault. Respondent relied on Public Health Law §281, which states that absent certain limited circumstances, prescriptions written in New York State must be in electronic format. In this case, the owner of the applicant testified during an examination under oath ("EUO") that he did not know if the words "Electronic RX" on a prescription meant the prescription was electronically sent, and that when a prescription is received electronically, there is nothing on the prescription identifying it specifically as an electronic prescription. During an EUO, the prescribing physician testified that she does not write electronic prescriptions for lidocaine. After reviewing the EUO transcripts, taking into consideration the arguments of the parties, and the prescription form at issue, the arbitrator determined that the prescription was not electronically sent in violation of PHL §281 and denied the claim. The arbitrator's determination was affirmed by a master arbitrator (see AAA Assessment no. 99-21-1222-3401.)

Floral Park Drugs Inc. & Nationwide General Ins. Co., AAA Case no. 17-21-1216-8787 (10/05/22) (Douglas Coppola, Arb.) In this case, the arbitrator was asked to determine whether topical medication was dispensed without a legitimate prescription. The respondent denied the subject claim asserting that the medication was dispensed without an electronic prescription and, consequently, it was not a valid prescription under New York State Law. In opposition, the applicant argued that although the prescription was in printed form, it was electronically transmitted, thus satisfying New York State law. Citing the requirements mandated under Public Health Law §281, the arbitrator noted that the prescription itself was stamped "Pharmacy" rather than "Electronic Rx." Further, the arbitrator determined that merely because there is an NPI license number on the prescription does not establish that it was electronically transmitted. Finally, the arbitrator noted that there was no time and date stamp to indicate when the prescription was received and no electronic transmittal information was provided. Therefore, based on the review of the record, including EUO testimony given by the applicant, the arbitrator determined that the prescription was not electronically transmitted and, therefore, was not reimbursable under no-fault.

Floral Park Drugs Inc. & Nationwide General Ins. Co., AAA Case no. 17-22-1235-6756 (01/06/23) (Rhonda Barry, Arb.) In this case, the respondent denied the applicant's claim, asserting that the medication provided was dispensed without a legitimate prescription in violation of Public Health Law §281, which mandates that no person shall issue any prescription unless such prescription is made by electronic prescription from the person issuing the prescription to a pharmacy in accordance with such regulatory standards. The applicant countered that issuing a printed prescription form by the prescribing physician amounted to a mere violation of the Public Health Law and New York Department

of Education, Office of the Professions, rather than a legally recognizable defense to a no-fault action. Noting that the prescription failed to include a time stamp, date stamp, the "Electronic RX" designation, and electronic transmittal indication, the arbitrator determined that the prescription was invalid, thus rendering the medication ineligible for no-fault reimbursement. Notably, the award was affirmed on appeal (see AAA Assessment no. 99-22-1235-6756.)

ENTITLEMENT TO REIMBURSEMENT OF NO-FAULT BENEFITS BY A NON-PROFESSIONAL SERVICE CORPORATION

Global Tech Diagnostic, Inc. & Nationwide Ins. Co., AAA Case no. 17-22-1273-1287 (03/06/24) (Bonnie Link, Arb.) The applicant, a provider of diagnostic ultrasound testing acting as a corporation, sought reimbursement for no-fault benefits for the technical component of ultrasound testing performed by a technician. Respondent argued applicant was not entitled to recover no-fault benefits because it was not a professional corporation, and the technician did not possess a license to render professional services. In support of its contention, respondent relied upon 11 NYCRR 65-3.16(a)(12), which sets forth the licensing requirements for an entity to recover no-fault benefits. Explicitly, the statute states that a provider of medical or any other professional health service must be properly licensed and must file as a professional corporation to ensure the services are being rendered by a licensed professional. In opposition, the applicant argued respondent should have sought the licensing information through the verification protocols set forth in the no-fault regulations. In rejecting this assertion, the arbitrator held that the burden falls upon the party seeking to recover no-fault benefits to establish that it is properly licensed ab initio. Furthermore, the arbitrator relied upon an Opinion Letter issued by the Department of Financial Services, which clearly stated that a provider is not entitled to recover no-fault benefits when the services are provided by a technician employed by a corporation, as opposed to a professional corporation. Therefore, the matter was dismissed.

Doctors United, Inc. & Hereford Ins. Co., AAA Case no. 17-23-1307-0794 (04/14/24) (Yael Aspir, Arb.) Applicant, a corporation acting as an Article 28 facility, sought to recover no-fault benefits. Respondent argued that applicant was not entitled to reimbursement because it was neither a licensed Professional Corporation (PC) nor a Professional Limited Liability Corporation (PLLC) as required under 11 NYCRR 65-3.16(a)(12) and NY Ins Law 5102(a)(1). In opposition, applicant asserted that under PHL Article 28, its status as an Article 28 facility permits it to provide healthcare services while operating as a non-professional corporation. Citing Educ. Law §§6512 and 6513, the arbitrator noted that it is a felony for an unlicensed person to practice a licensed profession and, therefore, given these provisions, it is clear that business corporations cannot hire a licensee to provide professional services because the law neither authorizes such action nor provides an exemption, thus serving to protect the public from a business relationship that could place constraints upon professional judgment, unduly limit professional practice, invade the professional integrity of the professional, or permit the business corporation to make professional decisions. In finding in favor of applicant, the arbitrator determined that, pursuant to PHL Article 28, the applicant was, in fact, entitled to recover no-fault benefits because applicant is exempt from New York State's bar on the corporate practice of medicine.

Titan Diagnostic Imaging Services, Inc. & Allstate Ins. Co., AAA Case no. 17-23-1295-8722 (03/03/24) (Heidi Obiajulu, Arb.) Applicant, a provider of diagnostic ultrasound testing acting as a non-professional corporation, sought reimbursement for no-fault benefits. Respondent argued the applicant was not entitled to recover no-fault benefits because the claim was premature. Specifically, respondent sought verification from the applicant to determine whether it was a properly licensed professional service corporation because the owner of applicant did not possess a professional license as required under 11 NYCRR 65-3.16(a)(12). In opposition, applicant objected to respondent's verification requests and argued the requests were not reasonable. In finding in favor of the respondent, the arbitrator determined that the requests were reasonable because respondent was entitled to establish that applicant was properly licensed prior to being entitled to recover no-fault benefits. Therefore, the matter was dismissed without prejudice as premature.

SUM AWARDS: COMPARATIVE NEGLIGENCE

Claimant v Progressive Ins. Co., AAA Case no 01-23-0002-2906 (03/04/24) (Philip J. De Bellis, Arb.) The claim arises out of an accident that occurred late in the evening on June 3, 2021 when the vehicle in which the claimant was a restrained front-seat passenger left the roadway after the operator sharply turned the wheel while attempting to avoid a deer, thus causing the vehicle to spin out of control and crash into a tree. Considering the evidence presented, the arbitrator noted that the scene where the accident occurred was an unlit, two-lane country road with one lane in each direction in a wooded area. Photographs depicted heavy collision damage to the vehicle, indicative of an impact involving considerable physical force. The claimant was removed from the scene by ambulance and transported to a local hospital, where she was admitted for four days for treatment of extensive injuries that included, among others, a displaced left elbow fracture requiring open reduction and internal fixation with a plate and screws, as well as a subsequent surgery for removal of hardware seven months post-accident. The claimant credibly testified to present complaints and residual functional limitations. According to the evidence, the claimant's physician continued to maintain her on anticonvulsant and nerve pain medication (Gabapentin). At the arbitration hearing, the claimant testified that the vehicle was moving at 55 to 60 miles per hour when she saw the deer "10 to 15 [sic] away" in the middle of the road and that there was a lag of five seconds or more between her first observation of the deer in the middle of the road and when the driver turned the wheel to avoid impact. According to the arbitrator, the time, speed, and distance values defied physics, and, consequently, must be regarded as no more than estimates. As to the vehicle speed, the arbitrator also noted that claimant's testimony varied somewhat from what she testified to during an examination under oath. However, the arbitrator held that any inconsistencies do not affect the fact that there was at least some lag between when the claimant first saw the deer and when the driver reacted. According to the arbitrator, of critical significance is that there was a lag from which it may be inferred that the operator was less attentive to the road ahead than his passenger. Hindsight makes clear that prudence required traveling at less than the posted speed limit of 50 miles per hour that evening on this particular section of the narrow, unlit roadway with an upward gradient near a curved section in a wooded region where the presence of deer was hardly surprising. Therefore, citing VT&L §1180, the arbitrator determined that the overriding statutory standard is what was "reasonable and prudent under the conditions and having regard to the actual and potential hazards then existing" and, consequently, the arbitrator concluded that at least some negligence is chargeable against the operator for traveling too fast under the circumstances and for failing to keep a proper lookout. The arbitrator maintained

that while "the deer bears the lion's share of fault," the few extra seconds to react would have made a difference. Therefore, after considering the evidence, the arbitrator determined that, had the operator been traveling more slowly under the circumstances, he would have had more time to react. The Emergency Doctrine does not absolve this driver 100%. The arbitrator determined that the claimant's damages exceeded the applicable policy limit of $100,000. Therefore, after applying the $25,000 setoff, the arbitrator awarded the claimant $75,000 in underinsured motorist benefits.

Claimant v Liberty Mutual Ins. Co., AAA Case No 01-23-0002-1504 (04/11/24) (Jodi Zagoory, Arb.) The claimant is a 47-year-old female who sustained injuries to her neck, low back, shoulders, and rib cage following a motor vehicle accident that occurred on July 31, 2021. The claimant testified that on the day and time of the accident, she was the operator of a 2016 Mercedes Benz SUV traveling on 123rd Street. She stopped at the stop sign at the intersection of 123rd Street and 9th Avenue. A parked car blocked her view of cars traveling on 9th Avenue from her left, so she moved her car forward in order to see cars traveling on 9th Avenue. Not seeing any cars on 9th Avenue, the claimant entered the intersection, immediately following which her car was struck on the left side by a car traveling on 9th Avenue. According to the police accident report, the driver of the adverse vehicle "was going straight [on 9th Avenue]" and the claimant "did drive through stop sign not stopping." In support of its contention that the accident was caused solely by the negligence of the driver of the adverse vehicle, the claimant submitted the report dated January 9, 2024 of "JS," a professional engineer. According to the report, "JS" reviewed the police report, photographs, Google Earth views, and NYC Department of Transportation traffic rules and concluded the subject accident was caused solely because the adverse vehicle was traveling at 45 miles per hour at the time of impact. He presumed "that the driver of the [adverse vehicle] did not apply the brakes before the T-bone collision" because the police accident report did not mention tire skid marks. However, the arbitrator noted that the engineering report did not discuss the intersection and failed to note that there is a stop sign on 123rd Street at its intersection with 9th Avenue and that there is no traffic control device for cars traveling on 9th Avenue through its intersection with 123rd Street. The claimant also argued that liability should be assessed in her favor because the insurance carrier for the adverse vehicle tendered its policy limits. However, the arbitrator agreed with respondent's counsel that the tender of a policy, especially one with minimal limits of $25,000 as was the case here, did not assume liability against the operator of the adverse vehicle. Citing VTL §1142(a), the arbitrator noted that, "every driver of a vehicle approaching a stop sign shall stop as required by section eleven hundred seventy-two and after having stopped shall yield the right of way to any vehicle which…is approaching so closely on said highway as to constitute an immediate hazard during the time which such driver is moving across or within the intersection." The arbitrator maintained that, pursuant to this section, the claimant had a duty to yield the right of way to the driver of the adverse vehicle traveling on 9th Avenue after claimant stopped at the stop sign on 123rd Street. The arbitrator noted that, although not expressly stated in the VTL, the courts in New York have imposed a duty upon all drivers to see what there is to be seen on the roadway. As such, the arbitrator determined that the claimant had a duty to see the adverse vehicle as it traveled on 9th Avenue. Similarly, the driver of the adverse vehicle had a duty to see the claimant's vehicle as it traveled through the intersection of 123rd Street and 9th Avenue. In fact, the arbitrator noted that, according to the statement furnished to the police at the scene, the operator of the adverse vehicle stated that she saw claimant's car fail to stop at the stop sign on 123rd Street before entering the intersection, and no evidence was submitted demonstrating that the operator of the adverse vehicle took any action to avoid a collision with the claimant's

vehicle. Moreover, the arbitrator noted that, according to claimant's statement to the police and her testimony at the arbitration hearing and at an examination under oath, she failed to see the adverse vehicle at any time prior to the collision. Therefore, the arbitrator found each driver 50% responsible for the accident. Respondent disputed the value of the claimant's injuries and argued that claimant was adequately compensated by the payment to her of $25,000 by the carrier for the adverse vehicle. After reviewing all the medical evidence and considering claimant's testimony, the arbitrator determined the value of claimant's injuries equal to the available SUM policy limit of $250,000. However, the arbitrator reduced the award by 50% to account for claimant's responsibility for the happening of the accident, and, subsequently, applied the offset in the amount of $25,000. Thus, the arbitrator issued a net award in the amount of $100,000.