AAA® INSURANCE REPORTER

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After a nearly six-year hiatus, it is with great pride that we bring you a new and improved quarterly newsletter, *AAA Insurance Reporter*. We hope you find the information contained within these digital pages informative and helpful, and we welcome your suggestions for future topics. Please feel free to reach out to us at any time with questions or comments. We may not be able to act on your suggestions immediately, and as a neutral organization we must balance the needs of all constituents—but we strive every day to improve our service to you.

I would like to thank those involved in bringing this newsletter to you: DFS for supporting the initiative; Pam Hirschhorn for chairing the editorial board and investing a great deal of time in bringing this newsletter back to life; the editorial board itself, comprised of arbitrators Philip Wolf, Victor Moritz, Nancy Kramer Avalone, and Michael Rosenberger; contributors of award summaries and other columns to the newsletter; and my AAA NYS Insurance team for their contributions to this effort.

— Frank Rossi, Senior Vice President, CFO

2016 Year in Review

2016 proved to be another successful year for the American Arbitration Association's (AAA) New York No-Fault Arbitration Program. New filings increased to nearly 250,000 cases. This continued upward trend in filings represented an 18% increase over the previous year.

Our experienced staff remained committed to delivering high-quality service to our user community. Conciliation continued to provide value to both Applicants and Respondents with 45% of cases settling in under 60 days from filing. Approximately 97,500 additional cases were resolved in arbitration during the same period.

Our Scheduling team is credited with scheduling over 105,000 new hearings in 2016. The Document Indexing team also reached a significant milestone by processing over 1 million documents since the introduction of our new technology platform in November 2014.

The AAA continued the advancement of our technology platform with the implementation of key enhancements to the Hearing Calendar, Document View, and Online Settlement tool, which delivered a more satisfying experience to our end users.

Those are just some of the highlights of 2016. We look forward to the continued success of our New York State Insurance programs in 2017!

Insight into the No-Fault Arbitrator Panel

The AAA's New York State Insurance Program (NYSI) features various arbitration programs. Thanks to the surge in claims filed, NYSI perhaps is best known to law practitioners for its No-Fault Insurance Arbitration Program. While Applicants for No-Fault benefits may file their claims in other forums, many file their requests for arbitration with the AAA partly due to the backlog in the New York courts. Parties' disputes not resolved during the conciliation stage administered by the AAA are escalated to hearings before No-Fault Arbitrators.

According to the No-Fault Regulation, arbitrators must be licensed attorneys with at least five years' experience to be eligible for appointment to the No-Fault Arbitrator Panel. Arbitrator candidates are interviewed by a screening committee consisting of one representative of the New York State Bar Association, one representative of the New York State Trial Lawyer's Association, and

two representatives of the insurance industry. In addition, the committee includes representatives of the Department of Financial Services (DFS) and the AAA in an advisory capacity. No-Fault arbitrators are independent contractors appointed by and serving at the pleasure of the Superintendent of DFS, not employees of the AAA. Arbitrators enter into one-year contracts that may be renewed subject to the committee's annual review of arbitrator performance for the previous year.

Once arbitrators are appointed, they undergo training led by members of the No-Fault Arbitration Panel who volunteer their time, as well as representatives from the DFS. The training agenda includes the No-Fault regulation, arbitrators' best practices, writing awards, and other topics aimed to help the arbitrators succeed. A significant component of the arbitrators' early training is dedicated to observing seasoned AAA No-Fault arbitrators during hearings. The Panel also provides mentoring, annual arbitrator-to-arbitrator CLEs, and the webinar series launched this year. Under the Regulation, arbitrators are required to submit their "well-reasoned" awards within 30 days from the date of the closed hearings.

With each wave of No-Fault arbitrators appointed, the AAA strives to keep pace with the growing number of claims filed. The Panel currently includes over 150 active arbitrators with hearing sites throughout New York State, mostly in Nassau County on Long Island. As a result, the panel is made up of arbitrators with diverse backgrounds. For instance, arbitrators appointed in early 2017 include a Certified Professional Coder, a retired Civil Court Judge, and attorneys experienced in real estate law and employment law. NYSI is proud to continue to build its legacy as the designated administrator for no-fault insurance arbitrations on behalf of DFS.

New Arbitrators Appointed to No-Fault Panel

If the fourth quarter of 2016 and the first quarter of 2017 are any indication, we are in for a very busy year. In the fourth quarter of 2016, we recruited 12 new arbitrators, who underwent seven weeks of training and began hearing cases in the first week of January 2017. The second group of 11 arbitrators began training in January/February 2017 and will begin hearing cases at the end of March 2017. Three additional arbitrators will begin their training in April and begin hearing cases in the late spring. This brings the total number of arbitrators to 151, the largest number we ever have had on this panel.

With the addition of this very talented group of 26 arbitrators—and a record number of volunteer arbitrators to help with their training and mentoring, the panel has more depth and experience than ever. Filings continue at a record pace, and it is our hope that we will continue to provide the excellent service for which we are known in the user community.

New York State Insurance — Not Just New York *No-Fault* Insurance

The AAA's New York State Insurance (NYSI) Program perhaps is best known for its No-Fault Insurance Arbitration program. The following overview of NYSI's programs addresses the following caseloads: Supplemental Underinsured Motorist (SUM), Accidental Auto Claims, and Health Insurance Matching Program (HIMP).

Supplemental Underinsured Motorist (SUM) Claims

In New York State, insureds have the option of purchasing added protection for bodily injury arising from motor vehicle accidents. In SUM claims, the tortfeasor's policy limits are inadequate to compensate an injured party for bodily injuries resulting from the accident. For instance, where a party's injuries are valued at $275,000 and the tortfeasor tenders the policy limits of $100,000, the injured party may seek SUM coverage for the offset for the vehicle in which the injured party was a passenger limited by the applicable SUM coverage. Among the key conditions precedent for SUM Coverage are: the loss must stem from an accident; plaintiff's bodily injury limits should be greater than the tortfeasor's bodily injury limits; and plaintiff must obtain a policy limit offer from the tortfeasor. In this context, arbitrators consider the parties' evidence and respective arguments to decide whether the injured claimant is entitled to SUM payments.

Accidental Auto Claims

Automobile insurance policies are required to provide protection from personal injury caused by uninsured and "hit-and-run" motorists. Standard uninsured motorist provisions offer payments from the insured's policy to injured parties for damages caused by the owner/operator of an uninsured motor vehicle. Disputes over the amounts payable under this endorsement may be subject to arbitration administered by the AAA. Unlike NYSI's No-Fault and SUM caseloads, the AAA administers these arbitrations at the request of the insurance industry, not on behalf of the Department of Financial Services (DFS).

HIMP (Health Insurance Matching Plan)

In New York State, the Workers' Compensation Board adopted regulations that assist health insurers to identify paid claims that may be the responsibility of the injured party's employer, workers' compensation insurer, or special fund. Under HIMP regulations, the health insurer may receive reimbursement for monies paid for medical/hospital services on the injured employee's behalf. As a prerequisite, the underlying accident must stem from an incident in the course of employment or an occupational disease. Participating health insurers may submit requests for computer searches to the Board within three years from the date of their payments. Where the Board's search results in a "full match" according to established criteria, the Board provides the workers' compensation case number, the carrier's code and case number, and description of the injury/illness, among other items. In the instance of a full match, the insurer will receive notice for future hearings and decisions. The parties' disputes over claims for reimbursement are subject to mandatory arbitration pursuant to the HIMP regulation. The AAA administers these arbitrations on behalf of the Workers' Compensation Board.

Enhancements

Consolidated Claims

In conjunction with the DFS, the AAA recently launched an enhancement to ADR Center, our online case-management platform to accommodate the administration of consolidated claims as depicted in Reg. 65-4.5 (c):

> *The designated organization shall, except where impracticable consolidate disputes for which a request for arbitration has been received, if the claims involved arose out of the same accident and involve common issues of fact.*

Consolidated claims allow for disputed matters involving multiple injured parties, across various providers, to be filed for arbitration proceedings under one submission and one filing fee. This new enhancement allows for greater administrative efficiencies and transparency for all parties. The AAA's document-indexing process also has been enhanced to support consolidation. The scheduled hearing time allocated for consolidated claims is in 15-minute increments for each applicant listed.

Attorney fees for consolidated cases are applicable as set forth in Reg. 65-4.6(b):

> *If the claim is resolved by the designated organization at any time prior to transmittal to an arbitrator and it was initially denied by the insurer or overdue, the payment of the applicant's attorney's fee by the insurer shall be limited to 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon, for each applicant with whom parties have agreed and resolved disputes, subject to a maximum fee of $1,360.*

For additional information regarding consolidated claims, please contact the Customer Service Department at 917.438.1660.

Best Practices for Document Submission

The No-Fault Arbitration panel dedicates itself to conducting hearings in an expeditious manner that is fair to all parties involved and consistent with the goals of the No-Fault system and the arbitral forum.

To this end, it is crucial that the claims and issues are presented to the panel in a logical manner that ensures that all points are raised, preserved, and ultimately resolved. The growing complexity of cases and the time constraints of hearings necessitate the issues and evidence to be well organized and clearly presented. This furthers the interest of all participants—Applicants, Respondents, the AAA, and the arbitrators—to achieve the prompt resolution of claims in a forum that is efficient and fair.

Following are "best practices" for the organization and submission of evidence to the ADR Center, compiled by a representative group of arbitrators.

Applicant's Submission

- Cover sheet with breakdown of bills in chronological order. Please include dates, description of services, and amounts.
- Attached are a few suggested, but not required, formats:
    1. AR-1: Verified accuracy of information provided therein
    2. Exhibit A: Bills in chronological order
    3. Exhibit B: Medical reports, test results, etc., in chronological order
    4. Exhibit C: Assignment of benefits
    5. Exhibit D: Misc., *e.g.,* proofs of mailing, verification responses, rebuttal
    6. Exhibit E: Case law, prior arbitration awards, as deemed relevant

Respondent's Submission

- Cover sheet identifying issues and defenses, by claim
- Exhibit A: Denials/EOBs in chronological order by date of service followed by corresponding verification requests
- Exhibit B: Evidence corresponding to defenses, *i.e.,* peer review/independent medical examination reports, proof of policy violation, coder affidavit, etc.
- Exhibit C: Medical literature, case law, prior arbitration awards, as deemed relevant

Both Parties

Things to Avoid:

- Duplication of documents: Relevant documents need only be submitted once.
- Illegible and poorly oriented documents: Scan documents so that they are legible and right-side up.

Initiatives and the Impact on Customers

Conciliation

According to Regulation 68, conciliation is a requirement before the case is scheduled for an arbitration hearing. Over the years, the number of cases filed with the AAA has increased significantly. Despite the growing caseload, the AAA has maintained an approximately 50% conciliation rate.

Speed Although Regulation 68 affords a 90-day conciliation window, the majority of our conciliation settlements take place under 60 days from the date of filing. Our customers expressed that these resolutions have a positive impact on their business.

Critical Information Shared Conciliators now utilize system reports produced by our Business Intelligence Unit (BIU) when reviewing cases and share critical information and data with our customers. Our customer feedback is that this data helps them make stronger business decisions based on fact.

Bulk Settlements Another innovation is the use of bulk settlements, the success of which is increasing. Our BIU now can provide the ability to view pertinent information of multiple disputes in one snapshot. Since launching this initiative, we have seen a rise in customers' interest in bulk discussions. *Our greatest success to date consisted of 5,500 cases settled between two parties totaling approximately $3,000,000.00!*

Win/loss Data Our "win/loss data" is another popular technological innovation that continues to support our resolution efforts. Many parties have reported that, historically, they have not tracked their win/loss data. In 2016, we began to share a summary of our customers' win/loss success. These reports feature the prevailing party and the amount awarded as compared to amount claimed, plus information on particular arbitrators, providers, attorneys, and issues. Customers reported that this is very helpful in their business decision making.

Mediation Day

In 2016, we piloted our first Mediation Day between two parties, and we will continue this effort in 2017. Stay tuned for more information about these initiatives and other related items in the near future.

ADR Center Tech Corner

Did you know?

- You can open up more than one case in your browser by using the following keyboard combination: Hold the "Ctrl" button and left click on a link. This will allow you to view different pages at the same time.
- Since every case has its own unique web address, you can copy and paste that address as with any webpage and share it with a colleague who has access to the ADR Center.
- You can make, counter, and accept settlement offers directly through the ADR Center.
- A carrier has the ability to appoint a law firm directly to a case without the firm having to submit a letter of representation.

For more information, please contact our ADR Center Support Team at 646.663.3488 or email NYSInsurance@adr.org.

DEVELOPMENTS IN NEW YORK NO-FAULT:

Recent Arbitration Awards

The intent of this section is to provide the No-Fault community with a cross section of recent, well-reasoned arbitration awards that are consistent with current New York precedent and address commonly raised issues in the No-Fault forum. The awards were objectively selected by an editorial board consisting of No-Fault arbitrators with a view toward promoting discussion and analysis of relevant issues.

Workers' Compensation Board Decision is Final (ILDF)

M.J. & American Transit Ins. Co. AAA Case no. 171510182414 & 991510182414

Workers' Compensation Board Decision (Form NCEC-101) Constitutes a Final Determination on the Issue of Coverage

The lower arbitrator found that a determination by the Workers' Compensation Board (Form NCEC-101) that a self-employed independent livery driver did not qualify for benefits from the Independent Livery Driver's Fund (ILDF) is a final determination on the issue of coverage and thus the claimant was entitled to first party no-fault benefits. *See, M.J. & American Transit Ins. Co.,* AAA Case no. 17-15-1018-2414 (3/10/16) (Michael Resko, Arb.). The lower arbitrator noted that the New York State Workers' Compensation Board has established a process for the preliminary review of applications under the ILDF and that following the claimant's submission of an application, was issued a determination that the claimed injuries did not meet the qualifying criteria required by Executive Law as outlined in Sec. 160-ddd "Use of the Fund." Master Arbitrator Victor Hershdorfer found that the lower arbitrator's award was not arbitrary, capricious, irrational and/or incorrect as a matter of law. *See,* AAA Assessment no. 99-151018-2414 (7/5/16) (Victor Hershdorfer, Master Arb.)

IME NO-SHOW

Levittown Imaging PC a/a/o M.R. & Allstate Ins. Co. AAA Case no. 171510112668

Stand Up MRI of Lynbrook a/a/o F.S. & American Transit Ins. Co., AAA Case no. 171610274500

Kingston Medical PC/Moon Rehab PT, PC a/a/o P.B. & Geico Ins. Co., AAA Case no. 171610339720

In *Levittown Imaging, PC a/a/o M.R. & Allstate Ins. Co.,* AAA Case no. 17-15-1011-2668 (6/21/16)(Lucille S. DiGirolomo, Arb.), Arbitrator DiGirolomo addressed whether the insurer's defense based upon a policy violation in that the injured person failed to appear for scheduled IMEs can be sustained in the absence of a specific denial. Arbitrator DiGirolomo noted that pursuant to *Westchester Medical Center v. Lincoln General Ins. Co.,* 60 AD3d 1045 (2d Dept. 2009), the Appellate Division, Second Department, found that an insurer that timely denies a claim based upon an assignor's failure to satisfy a condition precedent to coverage is not precluded from raising such defense. Although in *Unitrin Advantage Ins. Co. v. Bayshore Physical Therapy, PLLC,* 82 AD3d 559 (1st Dept. 2011), the Appellate Division, First Department, found that the insurer had the right to deny all claims retroactively to the date of loss, regardless of whether the denials were timely issued, Arbitrator DiGirolomo found that *Central Gen. Hosp. v. Chubb Group of Ins. Cos.,* 90 NY2d 195 (1997), does not fully support the holding in Unitrin, supra, and concluded that the insurer's defense of failure to appear for IMEs is subject to preclusion.

In *Stand Up MRI of Lynbrook a/a/o F.S. & American Transit Ins. Co.*, AAA Case no. 17-16-1027-4500 (11/18/16) (Ellen Weisman, Arb.), Arbitrator Weisman addressed whether the insurer's defense based upon a policy violation in that the injured person failed to appear for scheduled IMEs should be considered regardless of the timeliness or propriety of the specific denials. Arbitrator Weisman cited to *Unitrin Advantage Ins. Co. v. Bayshore Physical Therapy, PLLC,* 82 A.D.3d 559 (1st Dept. 2011), and found that the timeliness of the denials is not relevant since the insurer raised the defense of lack of coverage retroactive to the date of loss. However, Arbitrator Weisman found that since the insurer was attempting to void coverage which would result in preclusion of all claims stemming from the subject loss, the criteria as set forth in *Stephen Fogel Psychological PC v. Progressive Cas. Ins. Co.* 35 AD3d 720 (2d Dept. 2006), must be met in that the insurer must establish that the injured person was afforded sufficient notice of the IME request and that the injured person failed to comply with that request. Arbitrator Weisman reviewed the insurer's documentary evidence and found that the insurer met its burden pursuant to Fogel, supra.

In *Kingston Medical P.C./Moon Rehab, PT, PC a/a/o P.B. & Geico Ins. Co.*, AAA Case no. 17-16-1033-9720 (2/4/17)(Alise Schor, Arb.), Arbitrator Schor addressed whether the insurer established its defense based upon a policy violation in that the injured person failed to appear for scheduled IMEs. Arbitrator Schor noted that pursuant to *Stephen Fogel Psychological, PC v. Progressive Cas. Ins. Co.*, 35 AD3d 720 (2d Dept. 2006), the appearance at an IME is a condition precedent to the insurer's liability on the policy and an insurer may deny a claim retroactively to the date of loss for a claimant's failure to attend IMEs. Arbitrator Schor reviewed the affidavit from the third-party scheduling company as well as the affidavits from the IME doctors and found that the insurer's documentary evidence was sufficient to establish that the IME letters were mailed and that the injured person failed to appear for both IMEs. Thus, a policy violation was established.

Verification Requests

Metropolitan Medical Care PC a/a/o M.A. & American Transit Ins. Co., AAA Case no. 171510242106

Accelerated Surgical Center Of North Jersey a/a/o E.S. & Geico Ins. Co., AAA Case no. 171610272817

In *Metropolitan Medical Care PC a/a/o M.A. & American Transit Insurance Company,* AAA Case no. 17-15-1024-2106 (11/11/2016) (Mitchell Lustig, Arb.) Arbitrator Lustig addressed whether Applicant's claim was premature in view of Applicant's alleged failure to respond to timely verification requests issued by Respondent. Arbitrator Lustig determined that Respondent issued timely verification requests in accordance with 11 NYCRR §65-3.5(b) and 11 NYCRR §65-3.6(b). Arbitrator Lustig further determined that counsel for Applicant, via facsimile, did in fact submit an "arguably responsive" response to the verification requests and Respondent undisputedly did not respond in any manner to counsel for Applicant's facsimile response. Citing to *Westchester County Medical Center v. N.Y. Central Mutual Life Ins. Co.*, 262 A.D.2d 553, 692 N.Y.S.2d 665 (2nd Dept. 1999), Arbitrator Lustig noted that Respondent's "inaction" was not permitted and by failing to respond, Respondent risked its chances to prevail in the matter in accordance with the holding set forth in *Media Neurology, P.C. v. Countrywide Insurance Company,* 21. Misc. 3d 1101(A), 2008 N.Y. Slip Op. 51902(U) (N.Y. Civ. Ct. Kings Co. 2008). Arbitrator Lustig determined that the matter was ripe for arbitration and Applicant's claim was overdue.

In *Accelerated Surgical Center of North Jersey a/a/o E.S. & Geico Insurance Company,* AAA Case no. 17-16-1027-2817 (01/12/2017) (Andrew Horn, Arb.), Arbitrator Horn addressed whether Applicant's claim was premature in view of Applicant's alleged failure to respond to timely verification requests issued by Respondent. Arbitrator Horn determined that Respondent issued timely verification requests in accordance with 11 NYCRR §65-3.5(b) and 11 NYCRR §65-3.6(b). Arbitrator Horn further determined that Applicant, a New Jersey ambulatory surgery facility, submitted a response to the verification and informed Respondent that if "additional clinical documentation" was required it should be requested directly from the treating provider. Arbitrator Horn found that Respondent was aware of the identity of the treating chiropractor and therefore Respondent was not impeded from seeking additional verification directly from a non-party source. Arbitrator Horn distinguished the facts in his matter from *D & R Med.*

Supply v. American Transit. Ins. Co., 32 Misc 3d 144(A), 939 N.Y.S.2d 740 (Table), 2011 N.Y. Slip Op. 51727(U) (App. Term 2d, 11th & 13th Jud. Dists. Sept. 19, 2011). Arbitrator Horn determined that Respondent never requested additional verification directly from the treating doctor in accordance with the holding set forth in *Doshi Diagnostic Imaging Services v. State Farm Ins. Co.*, 16 Misc. 3d 42, 842 N.Y.S.2d 153 (App. Term 9th & 10th Dists. 2007.). Arbitrator Horn ultimately held that Applicant complied with Respondent's verification request and therefore Applicant's claim was ripe for arbitration and Applicant's claim was overdue.

Reasonable Justification/45-Day Rule

Radiology Works, PC a/a/o D.G. & Geico Ins. Co., AAA Case no. 171510108671

Beth Israel Medical Center a/a/o H.L. & Geico Ins. Co., AAA Case no. 171510201472

Reasonable Justification for Late Submission Offered by Applicant was Insufficient:

In *Radiology Works, PC a/a/o D.G. & Geico Insurance Company,* AAA Case no. 17-15-1010-8671 (11/17/2015)(Glen Wiener, Arb.), Arbitrator Weiner was asked to determine whether Applicant submitted written proof providing clear and reasonable justification for the failure to submit a timely claim within 45 days of the service provided. (*See,* 11 NYCRR §65-1.1.) Arbitrator Weiner determined that the Applicant's written correspondence merely stating that they had recently received updated insurance information did not constitute "reasonable justification" in that it was vague and lacked any detail, and thus, was insufficient to trigger a review by Respondent. The Arbitrator rejected Applicant's contention that Respondent's failure to give "due consideration" to their written justification should result in an award in Applicant's favor.

Respondent's Failure to Show It Followed Established Standards of Review was Fatal:

In *Beth Israel Medical Center a/a/o H.L.& Geico Insurance Company,* AAA Case no. 17-15-1020-1472 (02/24/2016) (Elyse Balzer, Arb.), Arbitrator Balzer determined that Applicant's submissions clearly showed that the claims were mistakenly submitted to another carrier, MVAIC, thus justifying Applicant's initial delay in submitting the claims to Respondent (see 11 NYCRR § 65-1.1). Applicant submitted a cover letter, proof of mailing to MVAIC, and bill originally submitted to MVAIC. In finding in favor of the Applicant, the Arbitrator declared that Respondent's failure to respond to Applicant's proffered excuse for its late submission is dispositive. In finding that Respondent did not provide evidence to establish that it gave due consideration to applicant's reasonable explanation for the late submission, in violation of the regulations, (*see,* 11 NYCRR § 65-3.5[l]), the Arbitrator issued an award in Applicant's favor.

Medical Necessity

Personal Health Imaging a/a/o O.K. & Allstate Ins. Co., AAA Case no. 171510107838

Sunil Butani Physicians, PC a/a/o L.M. & Geico Ins. Co., AAA Case no. 171610305991

In *Personal Health Imaging a/a/o O.K. & Allstate Ins. Co.,* AAA Case no. 17-15-1010-7838 (12/10/2015) (Greta Boldi, Arb.), Arbitrator Boldi addressed, *inter alia,* whether a formal affidavit was required to meet the burden of persuasion in rebuttal to a lack of medical necessity defense. Arbitrator Boldi determined the Respondent established its initial burden that the MRIs to the left knee, cervical spine, lumbar spine and thoracic spine were not medically necessary based upon the peer review reports of Peter Chiu, M.D. and Kevin Portnoy, D.C. Arbitrator Boldi held that the burden shifted to applicant to "rebut it or succumb." *Beford Park Medical Practice, PC v. American Transit Ins. Co.*, 8 Misc.3d 1025(A), 2005 N.Y. Slip Op. 51282(U) (N.Y. Civ. Ct. King Co. 2005). Arbitrator

Boldi found the medical records submitted by applicant – in the absence of a formal rebuttal affidavit – were sufficient to rebut the determination that the MRI to the left knee was not medically necessary because there "were multiple positive findings noted in the medical records, and although Dr. Chiu states that conservative treatment should be attempted prior to MRI, he does not set forth a timeframe for any such treatment prior to referral." Arbitrator Boldi determined applicant failed to meet the burden of persuasion in rebuttal as to the remaining MRIs at issue finding that "the medical records are not sufficient for the applicant to meet its burden of proof."

In *Sunil Butani Physicians, PC a/a/o L.M. & Geico Ins. Co.*, AAA Case no. 17-16-1030-5991 (2/4/17) (Stephen Czuchman, Arb.), Arbitrator Czuchman was asked to determine whether EMG/NCV studies to the lower extremities were medically necessary. Arbitrator Czuchman found that the peer review of Alan Wolf, M.D., provided "a detailed factual basis and medical rationale for the claim's rejection, the presumption of medical necessity and causality attached to the applicant's claim is rebutted and the burden shifts back to the applicant to refute the peer review." *Lynbrook Medical of New York, PC v. Praetorian Ins. Co.*, 48 Misc.3d 139(A) (2nd Dept. 2015). Arbitrator Czuchman noted there was no formal rebuttal and the letter of medical necessity submitted in opposition failed to "refer to the peer review or rebut any of Dr. Wolf's arguments." Arbitrator Czuchman ultimately held that Applicant failed to present any "credible evidence refuting the peer review" and denied the claim.

Use & Operation

CitiMedical I PLLC a/a/o S.C. & Country-Wide Ins. Co., AAA Case no. 171510046512

South Side Hospital a/a/o A.D. & Unitrin Advantage Ins. Co., AAA Case no. 171490218028

Winthrop U. Hospital a/a/o H.A. & Geico Ins. Co., AAA Case. no. 171510152703

A Bicyclist Injured When Colliding With A Stopped Motor Vehicle Is Afforded Coverage Under New York No-Fault Law:

The No-Fault Arbitrator determined a bicyclist who struck the rear view mirror of a motor vehicle stopped at a traffic light is entitled to No-Fault benefits. In *CitiMedical I PLLC a/a/o S.C. & Country-Wide Ins. Co., AAA Case no. 17-15-1004-6512 (10/22/15) (Aaron Maslow, Arb.)*, the Arbitrator took note of No-Fault regulation 11 NYCRR 65-1.1 (d) incorporating the provision of New York Insurance Law Section 5103(a), requiring every motor vehicle's liability insurance policy to provide payment of No-Fault benefits to "any other person who sustains personal injury arising out of the use or operation of the insured motor vehicle in the State of New York while not occupying another motor vehicle." The Arbitrator discussed numerous cases in the development of New York case law interpreting and defining the phrase "arising out of the use and operation" noting case law holds a bicyclist can be a covered person and No-Fault benefits can be awarded even if the motor vehicle was not in motion when the accident occurred. The decisive factor to be determined is whether the ongoing activity related to the vehicle is in conformity with its intended purpose." *See Yanis v Texaco 85 Misc. 2d. 94, 378 N.Y.S.2d. 570 (Civ. Ct., New York Co., 1975).* The insured vehicle being stopped at a red light constituted ongoing activity and was being used and operated in its normally intended purpose. Further, there was no credible evidence that the assignor intentionally caused the collision. Master Arbitrator Victor J.D'Ammora affirmed, noting the award was not arbitrary, capricious, or incorrect as a matter of law. *See AAA Assessment no. 99-15-1004-6512 (1/8/16) (Victor J. D'Ammora, Master Arb.)*

The Birth Of A Healthy Baby Following A Motor Vehicle Accident Is Not An Injury As Defined Under New York No-Fault Law:

The No-Fault Arbitrator found that medical services provided to a healthy baby born after his mother was involved in a motor vehicle accident do not qualify for reimbursement under New York No-Fault law. *See South Side Hospital a/a/o A.D. & Unitrin Advantage Ins. Co., AAA Case No. 17-14-9021-8028 (6/10/15) (James Skelton, Arb.).* The Arbitrator noted the requirements under Insurance Law § 5102(b) stating payments of first-party benefits require a loss arising out of the use or operation of a motor vehicle and discussed relevant case law that further defined these requirements. The mother was nine-months pregnant at the time and sustained no physical injuries. The birth of a healthy baby is not defined as an injury under New York No Fault law.

Respondent Bears The Burden To Establish The Driver's Injuries Did Not Arise Out Of The Use And Operation Of The Covered Vehicle:

In a matter where there were conflicting versions as to the cause of injuries suffered by a policyholder, the No-Fault Arbitrator determined the burden rests with the insurance carrier to establish that medical injuries did not arise out of the use and operation of the covered motor vehicle. *See Winthrop University Hosp. a/a/o H.A. & Geico Ins. Co., AAA Case no. 17-15-1015-2703 (6/15/16) (Rhonda Barry, Arb.).* The Arbitrator ruled the respondent doctor offered no credible evidence that he considered the possibility the driver was injured as a result of the accident instead of or in addition to a subsequent fall. Inconsistencies in the medical evidence required a more detailed analysis by the peer doctor for the respondent to sustain its burden that the injury did not arise from the motor vehicle accident.