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No-Fault Panel Update

At the recommendation of the No-Fault Screening Committee, the Superintendent of the Department of Financial Services has appointed eight new arbitrators to the panel. These arbitrators will undergo training this fall and will be scheduled for hearings this winter. The new arbitrators will conduct hearings on Long Island, providing thousands of additional resolutions annually.

Seven of the new arbitrators come with extensive experience as no-fault practitioners, and the remaining new arbitrator has a background in medical malpractice litigation.

One arbitrator has resigned from the no-fault panel to serve on the Masters panel starting in late fall. With these additional eight arbitrators and one arbitrator's resignation, there currently are 185 arbitrators serving on the no-fault panel.

Best Practices for Preparing Submissions for SUM/UM Hearings

Pursuant to AAA Rule 19, all document submissions for arbitration shall be simultaneously provided to the other party and the AAA at least 15 calendar days prior to the hearing date. Documents intended for the arbitrator should be sent to the AAA, and the AAA then will forward the submission to the arbitrator. It is important for parties to submit their documents in a timely manner to allow sufficient time for the arbitrator to receive them before the hearing.

If a party intends to introduce a witness, expert witness, or treating physician, that party must provide notice to the opposing party and the AAA at least 15 days prior to the hearing date.

Occasionally, parties will ask questions regarding the proper format for submissions to be considered by the arbitrator. The AAA attaches an information sheet to each hearing notice outlining the procedures for SUM hearings.

We invited arbitrators to share their feedback on how document submissions should be prepared; their recommendations follow:

- All submissions should be indexed, tabbed separately by medical provider, and presented in chronological order commencing with the earliest treatment date.
- Highlighting submissions is helpful. The opposing party should be served with an identical copy.
- Medical records that are illegible (i.e., handwritten), unsigned, or "Dictated but not read" may be given little or no weight as competent evidence in the arbitrator's sole discretion.
- Statements by counsel and/or memoranda of law are optional. If a party submits a statement or memorandum, the party must attach a full copy of any decision(s) referred to therein.
- Any expert witnesses should include their CVs.

Issues regarding late exchange of submissions by either party should be handled prior to the hearing by contacting the case administrator, who then will inform the arbitrator.

If you have any questions, please contact the AAA SUM/UM Team by e-mail at NYSUMTeam@adr.org or by phone at 917-438-1600. Ask for the SUM Supervisor to assist you.



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Changes to the Document-Indexing Process in the ADR Center

In collaboration with the Business Intelligence Team, the Indexing Team is pleased to announce that it has streamlined the indexing process. Effective September 15, 2019, the Indexing Team implemented the use of the Medical Report Document Type to capture documents under the following categories:

- Medical Report
- Medical Progressive / Treatment Notes
- Medical-Radiological Finding
- Medical Referral
- Medical x-ray/MRI Results
- Medical-Test Findings

The Indexing and Business Intelligence Teams are confident this implementation will greatly lessen uncertainty or confusion about where to locate medical documents and related correspondence in a claim file. This will not impact the functionality of the ADR Center platform or your ability to view any documents submitted by the parties. If you have any questions, please contact Frank Cruz by email at CruzF@adr.org or by telephone at 716-389-1775.

ADR Center Update

In late 2014, we introduced the ADR Center (Modria) to serve as the AAA's case management platform. Our presentations on ADR Center usually began with talk of change, with the statement that *"change is good."* Often that statement cannot be appreciated fully until long after the *change* has settled in. Our change included working with Tasks and Actions in a cloud-based system, which required us all to adapt to the learning curve. Thank you for your patience then and now as we continue to go through change together.

In July, we announced a welcome change and update to the "Selection of Attorney's Fee" aspect of the online settlement tool. This update gives users two options for selecting the fee, either entering a dollar amount or choosing static text from a drop-down menu that reads "The insurer shall also pay the applicant for attorney's fees pursuant to 11 NYCRR 65-4.6."

Based on comments received in our surveys and meetings, we will be implementing other changes. We look forward to announcing that **Award Due** information will be available on your dashboard for ease of viewing and that **Claim Number** and **Applicant File Number** will be available for download and export to assist you in search and sorting of your cases.

Change is good. So please keep the suggestions coming on ways we can improve the ADR Center case management platform to serve you better. Should you have any questions, please contact Customer Support by telephone at 917-438-1660 or by email NYSInsurance@adr.org.

Special Announcements

In the coming weeks, the American Arbitration Association will be introducing a new AR1 form, which will be required for all arbitration requests effective January 1, 2020.

For additional information on the new form, please contact Deborah Bosketti by email at BoskettiD@adr.org.



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Your Feedback is Important to Us!

Look for the No-Fault Client Satisfaction Quarterly Survey on November 4th. We look forward to receiving and reviewing your feedback related to the quality of the no-fault arbitrators, our technology, and the quality of service provided by our staff. Your feedback is vital to us—we use it feedback to maintain and improve our case administration as well as identify client needs.

If you have any questions about the No-Fault Client Satisfaction Quarterly Survey, please contact us at NYSICommunication@adr.org.

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

Drug Screening & Medical Necessity

- *Pain Physicians NY PLLC & American Transit Ins. Co.*, AAA Case no. 17-18-1098-0295 (6/6/19) (Kent Benziger, Arb.)
- *Pain Physicians NY PLLC & American Transit Ins. Co.*, AAA Case no. 17-18-1098-0307 (6/13/19) (Michelle Entin, Arb.)
- *Excell Clinical Lab & Allstate Ins. Co.*, AAA Case no. 17-18-1102-6964 (7/9/19) (Eileen Casey, Arb.)
- *Pain Physicians NY PLLC & MVAIC*, AAA Case no. 17-18-1103-5653 (5/31/19) (Cathryn Ann Cohen, Arb.)

Trigger Point Injections & Medical Necessity

- *New York Surgery Center of Queens & National Liability & Fire Ins. Co.*, AAA Case no. 17-17-1081-8204 (7/19/19) (Rhonda Barry, Arb.)
- *Ketan D. Vora, D.O., PC & Geico Ins. Co.*, AAA Case no. 17-17-1081-4377 (6/7/19) (Thomas Eck, Arb.)
- *Elite Medical & Rehab Services, PC & Allstate Fire & Cas. Ins. Co.*, AAA Case no. 17-16-1047-4679 (2/12/18) (Frank Marotta, Arb.)
- *Colin Clarke M.D., PC & Allstate Ins. Co.*, AAA Case no. 17-17-1063-5459 (10/9/18) (John O'Grady, Arb.)

Epidural Steroid Injections & Medical Necessity

- *Richmond Pain Management ASC, LLC & Geico Ins. Co.*, AAA Case no. 17-17-1076-9352 (5/1/19) (Andrew Horn, Arb.)
- *SOOD Medical Practice, LLC f/k/a Interventional Pain Consultants of North Jersey, LLC & St. Paul Travelers Ins. Co.*, AAA Case no. 17-17-1082-4150 (4/23/19) (Glen Wiener, Arb.)
- *Non-Surgical Orthopedics of N.J. & American Transit Ins. Co.*, AAA Case no. 17-17-1081-1718 (5/15/19) (Anthony Joseph Bianchino, Arb.)
- *Central Park Physical Medicine, PC & Geico Ins. Co.*, AAA Case no. 17-18-1096-7148 (4/11/19) (Gregory Watford, Arb.)



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Medial Branch Block & Medical Necessity

- *New York Surgery Center of Queens & National Liability & Fire Ins. Co.*, AAA Case no. 17-17-1081-8204 (7/19/19) (Rhonda Barry, Arb.)
- *Accelerated Surgical Center of North Jersey & American Transit Ins. Co.*, AAA Case no. 17-18-1099-5801 (4/24/19) (Andrew Horn, Arb.)
- *NY NJ Anesthesia, LLC & Geico Ins. Co.*, AAA Case no. 17-18-1106-4525 (7/18/19) (Steven Greif, Arb.)

Radiofrequency Ablation/Rhizotomy & Medical Necessity

- *Health East Medical Alliance, Health East Ambulatory Surgical Center, Northeast Anesthesia & Pain Management & Maya Assurance Co.*, AAA Case no. 17-17-1069-3643 (11/20/18) (Aaron Maslow, Arb.)
- *Prompt Medical Spine Care, PLLC & Geico Ins. Co.*, AAA Case no. 17-18-1106-9070 (4/24/19) (Matthew Brew, Arb.)
- *Anesthesia Solutions, PC & Geico Ins. Co.*, AAA Case no. 17-17-1077-4776 (5/28/19) (Thomas Awad, Arb.)
- *Irfan A. Alladin, M.D., PC & Allstate Ins. Co.*, AAA Case no. 17-18-1100-8240 (6/7/19) (Preeti Priya, Arb.)
- *Pain Physicians NY, PLLC & Tri-State Consumer Ins. Co.*, AAA Case no. 17-18-1101-8687 (6/21/19) (Elyse Balzer, Arb.)
- *Island Ambulatory Surgery Center & Geico Ins. Co.*, AAA Case no. 17-18-1084-2179 (7/18/19) (Ellen Weisman, Arb.)

Injections & Fee Schedule

- *Metro Physical Medicine, PC & State Farm Mut. Automobile Ins. Co.*, AAA Case no. 17-17-1082-1244 (7/19/19) (Andrew Horn, Arb.)
- *Integrated Pain Management, PLLC & Geico Ins. Co.*, AAA Case no. 17-18-1097-1699 (6/11/19) (Meryem Toksoy, Arb.)
- *New York Pain Management Group & Liberty Mut. Fire Ins. Co.*, AAA Case no. 17-17-1070-0202 (5/21/18) (Kevin R. Glynn, Arb.)
- *Health Plus Surgery Center, LLC & State Farm Fire & Cas. Co.*, AAA Case no. 17-17-1079-6855 (6/19/19) (Mitchell Lustig, Arb.)

SUM Awards: Fatal Injuries

- *K.B., as the Administratrix of the Estate of D.B. & Kemper/Lumbermans/Unitrin Ins. Co.*, AAA Case no. 43-200-S-00296-11 (Howard I. Bushin, Arb.)
- *K.B., as the Administratrix of the Estate of A.R. & Utica Mut. Ins. Co.*, AAA Case no. 43-200-S-02075-14 (Peter Horenstein, Arb.)
- *G.C., as the Administrator of the Estate of C.C. & Peerless Ins. Co.*, AAA Case no. 43-200-S-02055-10 (Thomas P. Bogan, Arb.)

Arbitrator Abstracts

Drug Screening & Medical Necessity

Pain Physicians NY PLLC & American Transit Ins. Co., AAA Case no. 17-18-1098-0295

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

(6/6/19) (Kent Benziger, Arb.) Applicant sought reimbursement for toxicology drug screening. Respondent relied upon the peer review of Peter Chiu, M.D., in support of its position that the drug screening performed was not medically necessary. The peer



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review doctor stated that toxicology screens are useful to determine the type and approximate amount of legal and illegal drugs a person has taken. The peer review doctor asserted that since there was no documented history of illegal drug abuse or history of narcotic use at the time of the screening, and the injured person was not being prescribed narcotic medication, the drug screening was not medically necessary or causally related to the accident. The peer review doctor also stated that sprain/strain injuries do not call for narcotic intervention beyond the first one to two weeks post-injury, and thus the drug screening was not medically necessary. The peer review doctor relied on the Workers' Compensation Board Medical Treatment Guidelines as authority in support of his position. Applicant relied on a rebuttal prepared by Dr. Michael Ko, who ordered the drug screening. Dr. Ko referenced that the injured person's treatment consisted of pain medication for unresolved neck and lower back pain and cited to the American College of Occupational and Environmental Medicine Practice Guidelines in support of his position that drug screening is appropriate for baseline and comprehensive identification and quantification upon admission of any drug substances, and thus is not limited to patients with a history of opioid therapy. The arbitrator found that the peer review was persuasive. Although the rebuttal referenced that the injured person's treatment consisted of pain medication for unresolved neck and lower back pain, the arbitrator found that Dr. Ko's examination notes established that the injured person was not taking medication. Thus, the arbitrator found that applicant's rebuttal failed to refute the peer review doctor's determination. The arbitrator also found that the amount billed and the number of assays tested were excessive. Since the drug screen was not medically necessary, the claim was denied.

Pain Physicians NY PLLC & American Transit Ins. Co., AAA Case no. 17-18-1098-0307

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

(6/13/19) (Michelle Entin, Arb.) Applicant sought reimbursement for drug screening. Respondent denied the claim based upon a peer review by Dr. Peter Chiu, M.D., who found that the services were not medically necessary. The peer review doctor asserted that the records did not indicate a history of drug abuse and that narcotic pain medication would not be causally related to the accident. Applicant submitted a rebuttal prepared by the prescribing physician, Dr. Tamer Elbaz, M.D. The rebuttal referenced that the injured person was taking Oxycodone and Percocet at the time the drug screening was ordered. The rebuttal referenced that the drug screening was ordered as part of a continuation of the pain medication protocol and that addiction, drug abuse, and diversion are major barriers when managing patients with chronic pain. Thus, drug screening was used as a pain management tool and to monitor opioid compliance. The arbitrator found that the rebuttal was persuasive as the evidence demonstrated a persistence of symptomology with prescribed medications for pain relief. Since the arbitrator found that the drug screening was medically necessary, applicant was awarded reimbursement.

Excell Clinical Lab & Allstate Ins. Co., AAA Case no. 17-18-1102-6964

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

(7/9/19) (Eileen Casey, Arb.) Applicant sought reimbursement for the drug screening performed. Respondent denied the claim based upon a peer review by Ayman Hadhoud, M.D., who found that the drug screening was not medically necessary. The peer review doctor asserted that the standard of care was a course of conservative management such as physical therapy along with oral non-steroidal anti-inflammatory medications (NSAIDs). The peer review doctor also indicated that in severe cases, the use of narcotics may be necessary for a short period of time. Therefore, the peer review doctor found that there was no medical necessity for a drug screen to assess compliance or to plan for future prescription of narcotics. The peer review doctor referred to an evaluation report which indicated that the injured person had no history of drug abuse. The peer review doctor found that opioid medication was not medically necessary and thus the drug screen was not medically necessary. Applicant relied on a rebuttal prepared by Drora Hirsch, M.D., who noted that the injured person's injuries had not resolved after several weeks of conservative therapy. The rebuttal referenced that drug screening must be done routinely as part of an overall best practice program in order to prescribe chronic opioid therapy. The rebuttal also referenced that the drug screen was to identify aberrant behavior, undisclosed



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drug use and/or abuse, and to verify compliance with the treatment. The arbitrator found that the peer review was persuasive as the rebuttal was lacking an adequate factual basis. Since the arbitrator found that the drug screen was not medically necessary, the claim was denied.

Pain Physicians NY PLLC & MVAIC, AAA Case no. 17-18-1103-5653

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

(5/31/19) (Cathryn Ann Cohen, Arb.) Applicant sought reimbursement for comprehensive urine drug testing (“UDT”). Respondent denied the claim based upon a peer review by Jason Lipetz, M.D., who found that the services were not medically necessary. The peer review doctor opined that the testing was not medically necessary because a history of chronic opioid use was not documented and there was no suspicion of non-compliance with a controlled substance regimen. The peer review doctor relied upon the American Academy of Pain Medicine Opioid Guidelines Panel in support of his position. Applicant submitted a rebuttal by Tamer Elbaz, M.D., the injured person’s treating pain management specialist. The rebuttal referenced that the injured person had unresolved pain despite conservative therapy and medication. The rebuttal also referenced that the injured person showed an interest in pain medication for relief and that the testing was necessary to establish a baseline and comprehensive identification and quantification of any drugs which may have adverse interactions. The rebuttal referenced that UDT is not limited to patients who have a history of taking controlled substances and those displaying aberrant behaviors. The arbitrator found that the rebuttal was persuasive and that the services were medically necessary. Thus, applicant was awarded reimbursement.

Trigger Point Injections & Medical Necessity

New York Surgery Center of Queens & National Liability & Fire Ins. Co., AAA Case No. 17-17-1081-8204

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(7/19/19) (Rhonda Barry, Arb.) The arbitrator addressed whether lumbar medial branch blocks and trigger point injections were not medically necessary pursuant to respondent’s peer review report. The peer review doctor noted that a lumbar medial branch block is used to confirm disabling, non-radicular neck or lower back pain suggestive of facet joint origin. The peer review doctor further opined that trigger point injections are indicated for patients who have symptomatic active trigger points that produce a twitch response to pressure and create a pattern of referred pain. Although applicant failed to submit a formal rebuttal to the peer review, the arbitrator reviewed the medical records submitted and determined that respondent failed to establish that the lumbar medial branch blocks were not medically necessary since the medical records cogently established that the criteria as set forth by the peer review doctor had been met. The arbitrator noted that the medical records documented that the injured person had low back pain without radiation, numbness or tingling, a positive facet loading test, and a completely normal neurological examination. However, with regard to the trigger point injections, the arbitrator found that there was insufficient evidence to establish symptomatic active trigger points that produced a twitch response to pressure and created a pattern of referred pain that would justify trigger point injections. The arbitrator awarded reimbursement for the lumbar medial branch blocks performed but denied the claim for trigger point injections.

Ketan D. Vora, D.O., PC and Geico Ins. Co., AAA Case No. 17-17-1081-4377

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

(6/7/19) (Thomas Eck, Arb.) The arbitrator addressed whether the trigger point injections with ultrasound guidance were medically necessary. In support of its defense, respondent relied upon a peer review and addendum report. The arbitrator determined that the peer review doctor set forth a sufficient factual basis and medical rationale in support of his conclusion that the injections were not medically necessary thereby shifting the burden to applicant. In opposition, applicant relied on medical records and a



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rebuttal by the treating doctor. The rebuttal doctor addressed and refuted the contentions raised in the peer review with reference to the clinical record and medical literature. It was noted that the trigger point injections were administered to treat the patient's myofascial pain syndrome, a chronic musculoskeletal pain condition in which painful trigger points develop within muscle and fascia, resulting in local and referred pain, restricted range of motion, and autonomic nervous system dysfunction. The arbitrator found that applicant's rebuttal summarized the generally accepted standard of care, cited to medical authority in support of that standard, and set forth how the trigger point injections performed were in keeping with standard of care.

Elite Medical & Rehab Services, PC & Allstate Fire & Cas. Ins. Co., AAA Case No. 17-16-1047-4679
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(2/12/18) (Frank Marotta, Arb.) The arbitrator addressed whether the trigger point injections performed were medically necessary. Respondent's peer review report set forth that the standard of care regarding the performance of trigger point injections after any trauma would begin with diagnosing the presence of actual trigger points. The peer review doctor stated that there should be documentation of specific physical examination findings pertaining to trigger points in order to establish the diagnosis of myofascial pain syndrome/trigger points. The peer review doctor referenced that there should be documentation of persistent symptoms for more than three months despite treatment with medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs, and muscle relaxants. Based on his evaluation of the peer review and the record, the arbitrator concluded that the peer review was sufficient to sustain respondent's burden of proof. Since applicant failed to submit a formal rebuttal to the peer review or documented evidence of actual trigger points following conservative treatment, the claim for trigger point injections was denied.

Colin Clarke, M.D., PC & Allstate Ins. Co., AAA Case No. 17-17-1063-5459
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(10/9/18) (John O'Grady, Arb.) The arbitrator addressed whether the trigger point injections performed were medically necessary. Respondent relied on a peer review report in support of its defense and applicant submitted a rebuttal to the peer review. The arbitrator noted that both the peer review and rebuttal doctors cited to the New York State Workers Compensation Board Medical Treatment Guidelines, which set forth that trigger point injections may be used to relieve myofascial pain and facilitate active therapy and stretching of the affected areas and also referenced that trigger point injections are to be used as an adjunctive treatment in combination with other treatment modalities such as functional restoration programs. The arbitrator determined that applicant demonstrated that the trigger point injections were medically necessary as the injured person had a persistent lower back and neck injury, complaints and objective findings, and some demonstration of trigger point abnormalities requiring injections to relieve the pain. Thus, applicant's claim was awarded in its entirety.

Epidural Steroid Injections & Medical Necessity

Richmond Pain Management ASC, LLC & Geico Ins. Co., AAA Case no. 17-17-1076-9352
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(5/1/19) (Andrew Horn, Arb.) The applicant sought reimbursement for surgical facility fees related to a lumbar epidural steroid injection (ESI) and epidurography provided to the injured person on September 8, 2016. The respondent denied the claim based upon a peer review report in which the peer review doctor found that the services were not medically necessary. The arbitrator noted that this was a repeat ESI and the peer review doctor cited to the New York Workers' Compensation Board Medical Treatment Guidelines for middle and lower back injuries, noting that ESI is useful in patients with symptoms of lumbar radicular pain syndromes, but if the first injection does not provide a response with temporary and sustained pain relief for at least two



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weeks substantiated by accepted pain scales with improvement in function, repeat injections are not recommended. The peer review doctor also noted the medical findings on August 4, 2016 that established the basis for the first ESI on August 11, 2016 but stated that the outcomes of those injections were not provided to support ongoing injections, including the one repeated on September 8, 2016, at the L5-S1 levels. The arbitrator found that the peer review shifted the burden to the applicant to establish by a preponderance of the evidence that the service was medically necessary. The applicant submitted a rebuttal indicating that the repeat ESI was proper due to failed conservative care, positive objective diagnostic tests, and clinical findings that were sufficient to establish medical necessity. In response to the peer review doctor's finding that there was a lack of information regarding the efficacy of the prior injection, the rebuttal doctor stated that he was not able to ascertain the specifics from the patient in regard to dates and frequency of previous epidurals but that the patient experienced 80% pain relief for two days after the September 8, 2016 injection when the pain returned and he was referred for a surgical opinion. The arbitrator found that the respondent made its showing that the services were not medically necessary and the applicant failed to meaningfully address or refute the peer review doctor's objection to the repeat injection. In the absence of evidence that the prior injection led to temporary and sustained pain relief of at least two weeks, applicant's claim was denied in its entirety.

SOOD Medical Practice LLC f/k/a Interventional Pain Consultants of North Jersey, LLC & St. Paul Travelers Ins. Co.,

AAA Case no. 17-17-1082-4150

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

(4/23/19) (Glen Wiener, Arb.) The applicant sought reimbursement for two lumbar epidural steroid injections (ESI) provided to the injured person on March 24, 2017 and April 21, 2017. The respondent denied these services based on two separate peer reviews. The injured person was involved in an accident on February 7, 2017 and received conservative treatment from multiple providers. The injured person was evaluated on March 22, 2017 with complaints including radiating back pain. The neurological evaluation was intact. The diagnosis was lumbar radiculopathy, and an ESI was administered at the L5-S1 level on March 24, 2017 and again on April 21, 2017. Regarding the ESI performed on March 24, 2017, the peer review doctor noted that epidural steroid injections are an acceptable treatment in cases where radiculopathy has been demonstrated and conservative care has failed. However, the peer review doctor concluded that in this case, there was insufficient documentation of physical exam findings and symptomology by the specialist performing the procedure to support a diagnosis of radiculopathy. The peer review doctor noted that the neurological examination was within normal limits and the injured person had no complaints of paresthesias in the lower extremities. With regard to the ESI performed on April 21, 2017, the peer review doctor found that there was no objective demonstration of functional benefit as a result of the prior ESI and no documentation of decreased need for pain medication following the prior injection. The arbitrator concluded that the peer reviews were sufficient to establish that the services were not medically necessary, thereby shifting the burden to the applicant to establish by a preponderance of the evidence that the epidural steroid injections were medically necessary. Since the applicant failed to submit any proof to refute the peer review doctor's findings, the claim was denied in its entirety.

Non-Surgical Orthopedics of NJ & American Transit Ins. Co., AAA Case no. 17-17-1081-1718

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

(5/15/19) (Anthony Joseph Bianchino, Arb.) The applicant sought reimbursement for a lumbar epidural steroid injection (ESI) performed on August 29, 2016. Respondent's denial was based on a peer review in which the peer review doctor found that the service was not medically necessary as there was no evidence of lumbar radiculopathy. The arbitrator reviewed applicant's submission and noted that the injured person complained of lower back pain radiating to the lower extremities with numbness and tingling. Medical findings included multiple positive orthopedic test findings, decreased deep tendon reflexes, and decreased muscle strength findings in the lower extremities. The treating doctor ordered the ESI to help alleviate the injured person's



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radiating low back pain and help achieve better range of motion and functional gains. The arbitrator found that based on the complaints and examination findings, there was evidence of lumbar radiculopathy, and the ESI was medically necessary. The arbitrator also found that the fee charged was in accordance with fee schedule.

Central Park Physical Medicine, P.C. & Geico Ins. Co., AAA Case no. 17-18-1096-7148

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

(4/11/19) (Gregory Watford Arb.) The applicant sought reimbursement for a lumbar epidural steroid injection (ESI) performed on March 29, 2018. Respondent's denial was based on a peer review report in which the peer review doctor determined that the ESI was not medically necessary since there were no findings consistent with lumbosacral radiculopathy, lumbar radicular pain syndrome, or lumbar spinal stenosis in the physical examination reports reviewed. On the date of the ESI, the peer review doctor noted that there was no diagnosis of radiculopathy or stenosis and cited to the Workers Compensation Board Treatment Guidelines (WCBTG) in support of his position that the ESI was not medically necessary. The applicant argued that the EMG/NCV findings were consistent with acute L5 radiculopathy, which contradicted the peer review. The arbitrator found the peer review doctor relied solely on the WCBTG to support his arguments that performance of the ESI deviated from accepted standards and the arbitrator found these guidelines to be unconvincing. The arbitrator also found that the peer review doctor's opinion was conclusory in that the peer review doctor failed to identify or reference any examination report or diagnostic test to support his position. The arbitrator noted that the peer review doctor failed to address the diagnostic test findings, including the lower extremity EMG/NCV study and the MRI study of the lumbar spine, and applicant was therefore awarded reimbursement for the ESI performed.

Medial Branch Block & Medical Necessity

New York Surgery Center of Queens & National Liability & Fire Ins. Co., AAA Case no. 17-17-1081-8204

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

(7/19/19) (Rhonda Barry, Arb.) The arbitrator addressed whether the medial branch blocks performed were medically necessary. In support of its contention that the medial branch blocks were not medically necessary, respondent relied upon the peer review report of Jason Cohen, M.D., in which he concluded, *inter alia*, that medial branch blocks are meant to confirm disabling non-radicular low back or neck pain suggestive of facet joint origin, if it is documented in the medical record based upon a history consisting of mainly axial and non-radicular pain and physical examination with positive provocative signs of facet disease. The arbitrator found that the peer review failed to meet the burden of production as to respondent's lack of medical necessity defense as the peer review doctor failed to successfully correlate the medical necessity of the injections to this particular injured person. The arbitrator also found that the medical records included in the applicant's submission cogently established that the criteria set forth by the peer review doctor had been satisfied and that the performance of medial branch blocks was not a deviation from generally accepted medical practice.

Accelerated Surgical Center of North Jersey & American Transit Ins. Co., AAA Case no. 17-18-1099-5801

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

(4/24/19) (Andrew Horn, Arb.) The arbitrator addressed whether the lumbar medial branch block performed was medically necessary. In support of its contention that the lumbar medial branch block was not medically necessary, respondent relied upon the peer review report of Anna Krol, M.D., in which she asserted that the medial branch block was not medically necessary primarily because facet joint injections are reserved for patients with axial back pain with non-radiating pain and where facet joint disease is evident in an MRI study. The peer review doctor also asserted that the injured person presented with evidence of



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radiating lumbar spine pain for which the facet joint injections were not a valid treatment option. The arbitrator found that the peer review met the burden of production thereby shifting the burden to applicant. In opposition to the peer review report, applicant relied upon the rebuttal affidavit of Amit Goswami, M.D., who opined that the medical records established the presence of facet arthropathy, indicated by lower back pain and findings of restricted extension and lateral rotation. The rebuttal also set forth that there was tenderness on palpation of bilateral paravertebral muscles and a positive lumbar facet loading test indicative of facet joint dysfunction. The arbitrator found that the rebuttal evidence failed to meet the burden of persuasion as applicant failed to demonstrate that the lumbar medial branch block and associated services were indicated given the injured person's complaints of radicular pain.

NY NJ Anesthesia, LLC & Geico Ins. Co., AAA Case no. 17-18-1106-4525

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

(7/18/19) (Steven Greif, Arb.) The arbitrator addressed whether the medial branch blocks performed were medically necessary. In support of its contention that the medial branch blocks were not medically necessary, respondent relied upon the peer review report of Jason Cohen, M.D., who found that the procedure was not medically necessary as the primary indication for lumbar medial branch blocks is to confirm a clinical suspicion of facet syndrome, which was not present in the medical records reviewed. The arbitrator found that respondent met the burden of production as to its lack of medical necessity defense. Although applicant failed to submit a formal rebuttal to the peer review, the arbitrator found that the medical records were sufficient to meet the burden of persuasion in rebuttal. In finding in favor of applicant, the arbitrator noted that the medical records revealed that the injured person was diagnosed with lumbar facet arthropathy. The arbitrator deferred to the injured person's treating physician who sought to diagnose the source of the injured person's pain and potentially relieve that pain.

Radiofrequency Ablation/Rhizotomy & Medical Necessity

Health East Medical Alliance, Health East Ambulatory Surgical Center, Northeast Anesthesia & Pain Management & Maya Assurance Co., AAA Case no. 17-17-1069-3643

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(11/20/18) (Aaron Maslow, Arb.) In assessing respondent's defense that there was no need for further services based upon an independent medical examination (IME), the arbitrator was persuaded by rebuttal evidence from the treating pain management physician that continued treatment was medically necessary, including the lumbar medial branch nerve radiofrequency ablation (RFA) performed. The arbitrator noted that the various medical reports and rebuttals from the doctor who administered the pain management services referenced that the injured person sustained cervical and lumbar injuries, which had been intractable to conservative management. Since the provider demonstrated that medial branch diagnostic injections had established that the facet joints were the cause of the injured person's pain, the arbitrator found that ablation, which was performed subsequent to the injections, was appropriate to reduce pain and aid in the continued physical rehabilitation of the injured person.

Prompt Medical Spine Care, PLLC & Geico Ins. Co., AAA Case no. 17-18-1106-9070

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(4/24/19) (Matthew Brew, Arb.) The arbitrator addressed whether the rhizotomy ablation procedure was medically necessary. Respondent submitted a peer review report in which the peer review doctor found that there was a lack of facet joint pathology identified on imaging studies of the lumbosacral spine and thus no indication for lumbar radiofrequency ablation. The peer review doctor also stated that there was no evidence of focal tenderness overlying the lumbar facet joints at the levels ablated. Applicant submitted a rebuttal affidavit from one of the treating physicians who stated that the injured person was recommended



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to undergo the rhizotomy ablation procedure based on the fact that pain relief was experienced by the injured person following facet joint blocks and the patient had greater than 50% symptom improvement for more than two weeks. Respondent submitted an addendum to the peer review in which the peer review doctor found that the rebuttal failed to adequately address, resolve, or produce evidence of any facet joint pathology identified on any imaging studies of the lumbosacral spine and also failed to address the negative bilateral facet loading documented on re-examination of the lumbosacral spine. Thus, the peer review doctor maintained that the lumbar radiofrequency ablation of the facet joints was not medically necessary. The arbitrator considered all of the evidence and found that respondent established prima facie that the rhizotomy ablation procedure was not medically necessary, thereby shifting the burden to applicant. The arbitrator found that applicant failed to demonstrate by a preponderance of the evidence that the rhizotomy ablation procedure was medically necessary, and thus the claim was denied.

Anesthesia Solutions, P.C. & Geico Ins. Co., AAA Case no. 17-17-1077-4776

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(5/28/19) (Thomas Awad, Arb.) The arbitrator reviewed the peer review report in which the peer review doctor stated that a cervical medial branch radiofrequency ablation (RFA) was not medically necessary because the injured person had symptoms consistent with myofascial pain but without significant complaints of facet mediated pain. The peer review doctor stated that before the performance of medial branch radiofrequency ablation (RFA), there should be documented findings of a successful response to a diagnostic block, a separate comparative block, and findings indicative of facet syndrome. The peer review doctor also asserted that there should be evidence that the injured person showed 80 to 90% improvement following a diagnostic block. The arbitrator found that the performance of the RFA was within generally accepted medical standards and awarded reimbursement.

Irfan A. Alladin, M.D., PC & Allstate Ins. Co., AAA Case no. 17-18-1100-8240

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(6/7/19) (Preeti Priya, Arb.) The arbitrator addressed whether the lumbar medial branch blocks and radiofrequency ablation performed were medically necessary. Respondent submitted a peer review report in which the peer review doctor found that the lumbar facet radiofrequency ablation (RFA) was not medically necessary. The peer review doctor noted that repeat lumbar medial branch blocks were performed at multiple levels and that there was relief for three days, but that the pain returned. The peer review doctor found that there was no report of significant aggravation of pain with extension and alleviation of pain with flexion as would be expected with facet mediated pain. Applicant submitted a rebuttal from the treating doctor who listed the injured person's findings, diagnosis, and treatment. The rebuttal set forth that the interventional pain management treatments were medically necessary since the injured person was exhibiting lumbar facet-mediated pain in the lower back. There was tenderness at L2-S1 facet joints as well as a positive Kemp's test indicative of facet syndrome. The rebuttal also referenced that the MRI revealed hypertrophic facet changes at the bilateral L5-S1 level. The rebuttal referenced that the injured person underwent lumbar medial branch block that decreased the injured person's pain by 50%, and thus, a subsequent medial branch block was needed to confirm the diagnosis. The arbitrator found that the treating doctor's rebuttal was persuasive and supported with citation to relevant literature. Since applicant demonstrated by a preponderance of the credible evidence that the services were medically necessary, the claim for the injections and related services was awarded.

Pain Physicians NY, PLLC & Tri-State Consumer Ins. Co., AAA Case no. 17-18-1101-8687

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(6/21/19) (Elyse Balzer, Arb.) Respondent denied the claim for radiofrequency ablation (RFA) based upon an independent medical examination (IME) performed in which the IME doctor found that continued treatment was not medically necessary. The arbitrator considered all of the evidence, including a rebuttal from the treating doctor who set forth his examination findings pursuant to



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numerous examinations. The treating doctor referenced that radiofrequency ablation is a procedure used to provide long-term pain relief and that patients who are being considered for this procedure have already undergone simple injection techniques like epidural steroid injection, facet joint injection, sympathetic nerve blocks, or other nerve blocks with pain relief that is less prolonged than desired. The treating doctor referenced that by selectively destroying nerves that carry pain impulses, the painful structure can be effectively denervated and the pain reduced or eliminated. The treating doctor also referenced that radiofrequency ablation leads to a greater reduction in spinal pain compared to conventional treatment options due to the disruption of nerve function that occurs with this procedure. The arbitrator found that applicant's proofs were sufficient to rebut the insurer's evidence that the injured person had recovered from the injuries sustained and applicant was awarded reimbursement for the services rendered.

Island Ambulatory Surgery Center & Geico Ins. Co., AAA Case no. 17-18-1084-2179

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(7/18/19) (Ellen Weisman, Arb.) The arbitrator addressed whether the lumbar facet joint medial branch radiofrequency ablation (RFA) performed was medically necessary. Respondent submitted a peer review report in which the peer review doctor stated that a lumbar medial branch RFA is indicated for patients with back pain where it is suspected that the pain is facet in origin based on examination findings including non-radicular axial pain and/or documented evidence of facet disease as well as for those who have completed a course of conservative management. The peer review doctor found that the injured person did not have a clinical presentation consistent with or suggestive of lumbar facet trauma or low back pain of facet origin. The peer review doctor found that there was no diagnosis related to the lumbar facets and that the lumbar MRI report did not reveal evidence of lumbar facet pathology. Applicant's counsel argued that the literature upon which the peer review doctor relied indicated that RFA is necessary where there is evidence of positive MRI findings and/or lumbar facet disease. After reviewing the provider's medical records which repeatedly confirmed a diagnosis of lumbar facet syndrome, the arbitrator found that the criteria enunciated in the peer review report had been met and that the RFA was medically necessary.

Injections & Fee Schedule

Metro Physical Medicine, PC & State Farm Mut. Automobile Ins. Co., AAA Case no. 17-17-1082-1244

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(7/19/19) (Andrew Horn, Arb.) In this case, the subject claim accounted for a lumbar epidural steroid injection (ESI), trigger point injections (TPIs), and associated services for February 7, 2014, as well as a cervical facet joint injection, TPIs, and associated services for March 4, 2014. The record showed that respondent had issued partial payment for each date and that it had denied the remaining balance for being in excess of the fee schedule. Upon review of the evidence, which included an affidavit by a Certified Professional Coder, the arbitrator agreed with respondent's valuation and found that applicant was not entitled to any further reimbursement. The arbitrator pointed out that both the lumbar ESI (with epidurography) and the cervical facet joint injection had been paid in full. He went on to note that respondent denied payment for seven of the eight units of TPIs charged for each date under CPT code 20553 and that the eighth charge was paid in the amount of \$59.55, a sum that reflects a 50% reduction. The arbitrator concluded that this was proper. As it was explained within the coder's affidavit, CPT 20553 can only be reported once per session. Furthermore, the reduced payment for the eighth charge was justified because it was calculated in accordance with Ground Rule 5 of the Surgery Fee Schedule ("When multiple procedures, unrelated to the major procedure and adding significant time or complexity, are provided at the same operative session, payment is for the procedure with the highest allowance plus half of the lesser procedures.") Considering the fact that the subject claim included a lumbar ESI and a cervical facet joint injection, both of which have a greater allowance than the fee set for TPIs, it was appropriate for respondent to apply a 50% reduction. The arbitrator also agreed with the coder about the remaining charges. He found that, pursuant to Ground Rule 7 of the Surgery Fee



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Schedule, venipuncture is “an inherent portion of a procedure or service” and, as such, “does not warrant a separate charge.” As for that portion of the claim involving the cost of the fluoroscopy, lidocaine, steroid, and syringes, he upheld the coder’s reading of a CPT Assistant article and found that it was included in the allowance for the other procedures.

Integrated Pain Management, PLLC & Geico Ins. Co., AAA Case no. 17-18-1097-1699

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(6/11/19) (Meryem Toksoy, Arb.) In this matter, applicant sought to be reimbursed \$4,361.84 for various injections that were administered on August 24, 2016 and September 21, 2016, at Barnert Surgical Center in Paterson, New Jersey. The arbitrator was asked to evaluate respondent’s defense of lack of medical necessity which was based on peer reviews, and to determine whether the billed charges were excessive. With respect to the first defense, she found that the evidence submitted by applicant was sufficient to demonstrate the need for the claimed services. As for respondent’s fee schedule assertion, the arbitrator determined that applicant was entitled to payment in the amount of \$2,837.15. Her award identified the billed CPT codes (e.g., 20553, 27096, 64493, 62310), the amount awarded for each procedure, and the method by which the amounts were calculated.

New York Pain Management Group & Liberty Mut. Fire Ins. Co., AAA Case no. 17-17-1070-0202

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(5/21/18) (Kevin R. Glynn, Arb.) In this matter, applicant submitted a claim that listed four charges under CPT code 20553 for trigger point injections that were administered on November 28, 2016. Respondent denied the bill in its entirety based upon a fee schedule defense. Respondent asserted that applicant did not comply with Surgery Ground Rule 9 (which calls for the submission of an operative report). Respondent also asserted that CPT code 20553 accounts for trigger point injections to three or more muscles and may not be billed more than once per session, regardless of the number of injections or muscles injected. Furthermore, respondent asserted that modifier 25 could not be used to justify reimbursement for the additional charges, as it is specific to Evaluation and Management (E&M) codes. In support of its position, respondent submitted an affidavit by a Certified Professional Coder (CPC). In the affidavit, the CPC discussed Surgery Ground Rule 9, referring to a CPT Assistant article to demonstrate that code 20553 could only be charged once per session. Upon review of the evidence, the arbitrator determined that applicant was entitled to payment for one charge under CPT 20553 (\$119.10). He found that Surgery Ground Rule 9 could not be used to deny the claim, reasoning that the submission of the operative report was not part of applicant’s prima facie case. The arbitrator cited to relevant case law and found that if such documentation was needed to process the bill, respondent should have requested additional verification. As for awarding applicant the sum of \$119.10, the arbitrator agreed with the respondent and found that CPT code 20553 may not be billed more than once per session.

Health Plus Surgery Center, LLC & State Farm Fire & Cas. Co., AAA Case no. 17-17-1079-6855

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(6/19/19) (Mitchell Lustig, Arb.) In this case, applicant sought to be reimbursed \$1,012.32 under CPT 62321 for facility fees relating to a cervical epidural steroid injection that was administered on July 31, 2017, at applicant’s Ambulatory Surgery Center (ASC) in Saddle Brook, New Jersey. Respondent asserted within its denial that the assignor was in the course of her employment at the time of the accident and therefore, primary jurisdiction resided with the Workers’ Compensation Board. As an alternative defense, respondent pointed out that CPT code 62321 is not listed in the New Jersey Fee Schedule and that pursuant to NJAC §11:3-29.5, the claim was not reimbursable. Upon review of the record, the arbitrator found that respondent had not offered adequate proof to sustain its Workers’ Compensation defense. The arbitrator also determined that applicant was entitled to payment for its facility fees. The arbitrator explained that in January of 2017, the AMA replaced CPT 62310 with CPT 62321. He cited to that portion of NJAC §11:3-29.4(e) which states: “When a CPT, CDT or HCPCS code for the service performed has been changed since the



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fee schedule rule was last amended, the provider shall always bill the actual and correct code found in the most recent version of the American Medical Association's Current Procedural Terminology or the American Medical Association's Current Dental Terminology." He went on to note that the New Jersey Fee Schedule had not been updated since 2013. Considering the mandate set forth under NJAC §11:3-29.4(e), the similar description for both of the codes, and the fact that CPT 62310 was listed in the New Jersey Fee Schedule (with a reimbursement rate of \$1,012.32), the arbitrator concluded that respondent's defense could not be upheld. Accordingly, the claim was granted in full.

SUM Awards: Fatal Injuries

K.B., as the Administratrix of the Estate of D.B. & Kemper/Lumbermans/Unitrin Ins. Co., AAA Case no 43-200-S-00296-11
[Sum Award Search](#)

(Howard I. Bushin, Arb.) In this case, the arbitrator addressed whether the decedent suffered any conscious pain and suffering following the collision and prior to his death. The decedent was a 21-year-old restrained passenger, employed as a retail clerk. The driver was the owner of the underinsured vehicle. On the date of accident, the underinsured driver lost control of the vehicle on the roadway, which caused it to strike a utility pole on the driver's side, then strike a tree on the passenger side, and finally come to a stop in a ditch in the roadway. The driver was found to have a blood alcohol content of 0.10% and pleaded guilty to Vehicular Manslaughter in the first degree, a Class C felony. The decedent's blood alcohol level was reported at 0.169%. The County Medical Examiner concluded that the cause of death was blunt impact trauma to the head, neck, and torso with fractures and internal injuries. No witnesses appeared, and all evidence was taken upon submission. Respondent's report by Charles V. Wetly, M.D., concluded that the accident resulted in "an immediate loss of blood pressure and therefore a near immediate loss of consciousness." Dr. Wetly concluded that there was an immediate loss of consciousness upon impact. The narrative report of Dr. Louis S. Roh, M.D., which was submitted by Claimant, opined that the decedent suffered primary, secondary, and tertiary impact injuries. Dr. Roh stated that the cause of death was multiple trauma and the mechanism of death was blood loss (internal hemorrhages). Dr. Roh addressed each of the three impacts and concluded that when the vehicle finally came to a stop, the decedent was sitting in the passenger side of the vehicle with his seatbelt on, experiencing excruciating pain, hopelessness, fear of pending death, anxiety, fainting sensation, and difficulty breathing, as he was bleeding internally and went into shock and coma gradually. Dr. Roh stated that the decedent was conscious and suffered excruciating pain for approximately 10 to 15 minutes before he lost consciousness from loss of blood. In comparing the reports of the two expert physicians who reviewed multiple documents including the Autopsy and Toxicology Reports, the arbitrator was persuaded by the Claimant's expert and concluded that the decedent suffered conscious pain and suffering for 15 minutes. The arbitrator found that the underinsured motorist was negligent and that his negligence was a substantial factor in causing the accident. The arbitrator also found that the decedent did not contribute to the happening of the accident. The arbitrator found that the damages in this claim were worth the sum of \$300,000.00, and the decedent was awarded the sum of \$300,000.00, less a set-off in the amount of \$100,000.00, leaving a net award of \$200,000.00, which the respondent was directed to pay.

K.B., as the Administratrix of the Estate of A.R. & Utica Mut. Ins. Co., AAA Case no. 43-200-S-02075-14
[Sum Award Search](#)

(Peter Horenstein, Arb.) The case involved an uninsured motorist claim for conscious pain and suffering, wrongful death, and loss of consortium brought by the decedent's daughter and Executrix of the decedent's estate along with her two brothers. On the date of accident, claimant's decedent, then 71 years of age, was driving her 1985 Buick sedan when she was struck by a 1987 Toyota sedan, causing her to lose control of her vehicle, cross the oncoming roadway, and strike a tree. According to the Medical Examiner's report, no vital signs were noted, and severe injuries were detailed by EMS upon arrival. EMS reported that vital signs were never regained. The claimant's daughter testified extensively, along with her two brothers, regarding the love, affection, counsel,



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guidance, and nurturing they enjoyed throughout the decedent's lifetime. During her life, the decedent was steadily employed. According to her family's testimony, in her free time, she was primarily devoted to her children and grandchildren. She babysat for her grandchildren, including a grandchild with special needs. A photograph in evidence of the decedent within a year of her demise showed an active and vigorous woman on vacation, swimming with dolphins. Tragically, the fatal collision was the result of a felonious scheme devised by the operator of the offending vehicle to stage an accident and defraud his no-fault carrier for his benefit and that of his passengers. The perpetrator was duly convicted and was noted to be serving a prison sentence. Based on the medical evidence, the arbitrator found that no award could be made for conscious pain and suffering with the evidence provided. Nonetheless, the arbitrator found that the decedent experienced pre-impact terror when struck by the uninsured vehicle, causing loss of control of her vehicle and the fatal impact with a tree. As evidenced by the report of the police investigation, the decedent's vehicle travelled 5-6 car lengths or at least 50 or more feet between the point of initial impact by the perpetrator to the point of the second fatal impact with the tree. The arbitrator found that it was reasonable to assume that faced with her loss of control of her vehicle and the looming tree ahead, the decedent experienced pre-impact terror, and the compensatory value was assessed at \$100,000.00. The arbitrator also found that the evidence supported a finding that the pecuniary losses to the decedent's distributees for the loss of her services and the loss of their mother's love, care, guidance, and support had a compensatory value of \$200,000.00. The claim for funeral expenses in the sum of \$12,275.00, was unchallenged by the respondent.

G.C., as the Administrator of the Estate of C.C. & Peerless Ins. Co., AAA Case no. 43-200-S-02055-10

Sum Award Search

(Thomas P. Bogan, Arb.) This claim arose out of an accident where the arbitrator found that both the decedent and the underinsured driver were at fault in that the decedent was performing "wheelies" on his motorcycle while driving at a speed of at least 70 mph and the underinsured driver attempted to make a left turn in front of the motorcycle when the crash occurred. The claim was brought by the decedent's parent(s) who sought a pecuniary award based on lost future earnings and the cost of the tasks/services he had been performing on behalf of his seriously ill mother. There was also the issue as to whether there was conscious pain and suffering experienced by the decedent. The arbitrator heard testimony from the Claimant as well as from William C. Blanchfield, Ph.D. A report regarding pain and suffering was prepared by Dr. Louis Roh, a forensic pathologist, on behalf of the Claimant. There were no witnesses presented by the Respondent. The Claimant had recovered \$100,000.00 from the carrier for the underinsured driver. The Claimant's decedent was insured under two separate SUM policies. One of the policies was issued by Progressive with a SUM liability limit of \$250,000.00, and the other was issued by Respondent, Peerless Insurance Company, with a SUM liability of \$500,000.00. The Progressive policy was deemed primary and both insurance companies were joined for the hearing. Following the accident, pursuant to Section 510 of the Vehicle and Traffic Law, a hearing was held to investigate the accident and determine whether there was a traffic law violation by the left-turning driver. The hearing officer determined that the underinsured motorist was guilty of failing to yield the right of way, in violation of VTL 1141, but concluded that no action was warranted against her license. At the arbitration hearing, there was testimony that the decedent's lifetime contributions to the claimants would have been approximately 20% of his earnings. The decedent could have been expected to contribute \$85,435.00, to his parents by age 34 and would have contributed the sum of \$114,474.00, to his parents by age 36. Regarding the pain and suffering experienced by the decedent, Dr. Louis Roh, a forensic pathologist retained by Claimant's attorneys, prepared a report in which he concluded that the decedent "suffered horrified and helpless" pre-impact terror for approximately 3 to 5 seconds from the moment he applied the brake when he saw the other vehicle making a left turn in front of him and skidded for 120 feet before the impact with that vehicle. Dr. Roh concluded that the decedent endured conscious pain and suffering for approximately 5 to 10 minutes until his death. The arbitrator found that the issue was not whether the decedent died immediately but whether he remained conscious following the initial impact, and there was no evidence in the record tending to show that he was conscious at any time following the accident. The arbitrator concluded that both parties involved in the accident were negligent. The arbitrator accepted the conclusion of the state police accident reconstructionist that the primary cause of the accident was the decedent's excessive speed, and the secondary causes of the accident were the reckless manner in which the decedent operated his



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motorcycle, (i.e., performing a “wheelie”) and the underlying tortfeasor’s failure to yield the right of way. Accordingly, the arbitrator apportioned 75% of the liability on the decedent and 25% on the other driver. The arbitrator determined that the full value before apportionment of the decedent’s pain and suffering, including pre-impact terror, to be \$100,000.00, and the value of his pecuniary loss to be \$250,000.00. Since the net value of the Claimant’s damages after apportionment (\$87,500.00) was less than the amount already received (\$100,000.00), the arbitrator made no further award.

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