AAA® INSURANCE REPORTER

2020 AAA INSURANCE REPORTER / ISSUE 2

Electronic Forms of Payment

To avoid delays in processing, we are aiming to transition all payments from physical checks to electronic payments and continue to encourage system users to submit all payments electronically. Immediate benefits include tremendous efficiency gains in transmitting, recognizing, and tracking payments, as well as minimizing interruptions that stem from human, organizational, and other unforeseen factors.

Paper checks received via mail continue to be uploaded and posted to respective accounts. However, due to mail delays, processing and posting these payments will be slower.

Credit Card and eCheck. These two options, available on Quick Pay, remain effective methods of payment.

ACH Transfers. Parties that expect to issue payments for quarterly billing assessments are strongly encouraged to use ACH Transfers. Given the confidential nature of the form needed for such transfers, only authorized business users may use this method. To receive this form, please contact the NYSI Finance team at NYSIFinance@adr.org.

FAQs for Carrier Quarterly Assessment Billing

The Department of Financial Services (DFS) and the Optional Arbitration Advisory Committee approve the actuals for the previous year's assessments during the first quarter of every year. At the end of the first quarter of each year, the AAA Finance Department sends out "true-up" balances/assessments for the prior year.

Below are some frequently asked questions associated with this process.

Why are we getting billed for the same case twice? We already paid for this claim.

There is only one assessment fee. This true-up assessment represents a summary of the year's activity at the actual cost per case. Please refer to the cover page included in the invoice for explanation and a breakdown of assessments.

Can I have this invoice in a spreadsheet?

The first quarter true-up invoice contains all of the same cases that were billed throughout the previous year. The spreadsheets previously provided during the quarterly assessment billing should be used to compare with the new cost per case. If you did not receive a quarterly invoice in spreadsheet format and would like one, please email NYSIFinance@adr.org.

How is a credit balance handled?

If there is a credit balance, it appears as a number in brackets, and nothing is due. That credit balance automatically is applied to the next quarterly invoice once assessed at the beginning of Q2 the same year.

Can a refund be issued for the credit balance?

If you would like a refund instead of a credit applied to the next assessment, please email NYSIFinance@adr.org.

What if not all payments made during 2019 are reflected in the year-end invoice?

If this is the case, please give us a call at 917-438-1511 or email us at NYSIFinance@adr.org, and we will be happy to go through the payment history with you.

Below is the contact information for the NYSI Finance Department:

General Line	All Inquiries	NYSIFinance@adr.org	917-438-1511
Zarah Monterrosa	Assistant Vice President	MonterrosaZ@adr.org	917-438-1795
Curtis Smith	Financial Operations Manager	SmithC@adr.org	917-438-1512
Dominick Ripo	Accounts Receivable Coordinator	RipoD@adr.org	917-438-1794
Mostafa Elsayed	Accounts Receivable Coordinator	ElsayedM@adr.org	917-438-1583
Bik Ying Ng	Accounts Receivable Associate	NgB@adr.org	212-484-4139

Should You Consider Filing Electronically?

To avoid delays associated with mail, we encourage applicants to access our e-filing submission option. For additional information, please contact our Customer Service department at NYSInsurance@adr.org.

Additional ways to add funds to your firm's account electronically are available. To ensure quick and secure accessibility at your convenience, click here: https://apps.adr.org/PCIPayment/faces/NYSIHome.jsf.

Questions? Please contact Curtis Smith, Financial Operations Manager at SmithC@adr.org.

More Data at Your Fingertips Translates to More Settlements in Conciliation!

The conciliation department continues to analyze the caseload and provide business intelligence to both applicant and respondent representatives to assist in the resolution of pending cases prior to the hearing.

We will continue to analyze the ever-changing caseload in order to furnish data on how cases are being resolved in conciliation and arbitration–by settlement, consent award, or final award–and look forward to partnering with you.

For more information regarding available caseload data, please contact James Skelton, Vice President, by phone at 917-438-1562 or by email at SkeltonJ@adr.org.

LoopUp Replaces Conference America for Phone Hearings

The American Arbitration Association recently transitioned telephonic hearings from Conference America to LoopUp to provide arbitrators and customers with a simple, seamless, and secure virtual user experience. With LoopUp, arbitrators have more control of their online hearing rooms, adding an extra layer of security for the parties and the arbitrator.

The AAA remains committed to investing in new technology that adds value to customers and arbitrators. We are working with DFS to make videoconferencing available for no-fault hearings. Stay tuned for more information regarding available videoconference platforms!

Adjournments Lead to Aging of Cases

No-Fault Regulation 68 65-4.5 (j) cites that the arbitrator may for good cause postpone or adjourn a hearing upon the request of a party or the arbitrator's own initiative. Adjournment requests received from parties are forwarded to the arbitrator for review and approval. Adjourned cases are removed from the hearing calendar and transferred to the scheduling queue pending a new hearing date. Cases that require a new hearing date may take several more months to make it back on the hearing calendar.

The AAA, in consultation with DFS, decided to move all in-person hearings to phone beginning on March 16 in response to the COVID-19 pandemic. We are pleased to report that, on average, over 2,500 hearings have gone forward weekly since then.

However, we also have encountered an uptick in adjournments resulting from parties requesting in-person hearings. With no decision as to when in-person hearings will be available again, we strongly encourage customers to allow their cases to go forward by phone, or if necessary, video, rather than requesting an adjournment with the resulting delay in receiving a resolution.

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

VERIFICATION OF CLAIM & SUFFICIENCY OF RESPONSE

- *Sheepshead Bay Medical Supplies, Inc. & Country-Wide Ins. Co.*, AAA Case no. 17-18-1097-3100 (3/14/20) (Deepak Sohi, Arb.)
- *Paramus Medical Imaging, LLC & 21st Century National Ins. Co.*, AAA Case no. 17-18-1111-6126 (2/16/20) (Glen Cacchioli, Arb.)
- *Access Medical Diagnostic Solutions, PC & Geico Ins. Co.*, AAA Case no. 17-18-1095-6068 (3/12/20) (Stephen Czuchman, Arb.)
- *Excel Surgery Center, LLC & Geico Ins. Co.*, AAA Case no. 17-18-1093-1105 (1/28/20) (Nancy Kramer Avalone, Arb.)
- *Park Avenue Chiropractic Healthcare, PC & Hereford Ins. Co.*, AAA Case no. 17-18-1098-8222 (3/10/20) (Alina Shafranov, Arb.)

VERIFICATION OF CLAIM & REQUEST PREVIOUSLY COMPLIED WITH

- *Exon Medical Equipment, Inc. & Country-Wide Ins. Co.*, AAA Case no. 17-19-1122-6321 (3/24/20) (Pauline Molesso, Arb.)
- *AOT Chiropractic, PC & Allstate Ins. Co.*, AAA Case no. 17-18-1100-8942 (2/4/20) (Perry Criscitelli, Arb.);
- *Metro Pain Specialists PC & Allstate Ins. Co.*, AAA Case no. 17-18-1084-0168 (4/3/20) (Ellen Weisman, Arb.);
- *Veda Medical, PC & Geico Ins. Co.*, AAA Case no. 17-17-1079-4794 (1/12/20) (Kihyun Kim, Arb.);

VERIFICATION OF CLAIM & TIMING OF REQUESTS

- Ambulatory Surgical Center of Engelwood & Geico Ins. Co., AAA Case no. 17-16-1051-8421 (11/27/17) (Victor Moritz, Arb.);
- Optimus Plus Products Corp & American Transit Ins. Co., AAA Case no. 17-18-1099-0815 (3/23/20) (Aladar Gyimesi, Arb.);
- Advanced Pharmacy, Inc. & Allstate Ins. Co., AAA Case no. 17-18-1103-7318 (12/11/19) (Ellen Weisman, Arb.).

VERIFICATION OF CLAIM & COMMUNICATION BETWEEN THE PARTIES

- *Scarborough Chiropractic PC & American Transit Ins. Co.*, AAA Case no. 17-18-1098-9192 (12/9/19) (Laura E. Villeck, Arb.);
- *Community Medical Imaging PC & Geico Ins. Co.*, AAA Case no. 17-18-1087-7351 (12/16/19) (Eileen Hennessy, Arb.);
- *Gentle Care Acupuncture, PC & Nationwide Ins. Co.*, AAA Case no. 17-18-1098-6660 (2/6/20) (Marcelo Vera, Arb.);
- *Diagnostic Medicine, PC & Country-Wide Ins. Co.*, AAA Case no. 17-18-1087-3281 (10/9/19) (Jennifer Zeidner, Arb.)
- *Veda Medical, PC & State Farm Mut. Automobile Ins. Co.*, AAA Case no. 17-17-1075-7134 (10/27/19) (Josh Youngman, Arb.).

VERIFICATION OF CLAIM & 120 CALENDAR-DAY DENIALS

- *MZ Acupuncture, PC & Geico Ins. Co.*, AAA Case no. 17-18-1090-0891 (2/3/20) (Josh Youngman, Arb.);
- *Chelsea Medical Care, PC & Progressive Cas. Ins. Co.*, AAA Case no. 17-19-1141-0020 (3/23/20) (Aaron Maslow, Arb.);
- *Metro Pain Specialists, PC & Allstate Fire & Cas. Ins. Co.*, AAA Case no. 17-17-1077-4174 (3/13/20) (Eva Gaspari, Arb.);

SUM AWARDS: SERIOUS INJURY & AGGRAVATION OF PRE-EXISTING CONDITIONS

- *V.Z. & Nationwide Ins. Co.*, AAA Case no. 01-19-0002-2432 (Edward Brozinsky, Arb.);
- *M.P. & New York Central Mut. Fire Ins. Co.*, AAA Case no. 01-19-0000-6024 (Vernon J. Welsh, Arb.);
- *D.P. & USAA Ins. Co.*, AAA Case no. 01-19-0001-1904 (Jodi Zagoory, Arb.);

Arbitrator Abstracts

VERIFICATION OF CLAIM & SUFFICIENCY OF RESPONSE

Sheepshead Bay Medical Supplies, Inc. & Country-Wide Ins. Co., AAA case no. 17-18-1097-3100
https://aaa-nynf.modria.com/loadAwardSearchFilter

(3/14/20) (Deepak Sohi, Arb.) Applicant sought reimbursement for various items of durable medical equipment ("DME") dispensed to the claimant on April 27, 2017. Respondent neither paid nor denied the claim. Respondent argued that it tolled its time to pay or deny the claim by requesting additional verification it deemed necessary to verify the claim. Upon receiving the claim, respondent timely issued an initial verification request dated July 3, 2017 and a follow-up verification request dated August 3, 2017. The verification request letters sought a letter of medical necessity, a wholesale invoice, and NF-3 with a proper signature. On October 17, 2017, applicant responded to the requests by submitting a letter of medical necessity and a hand-signed NF-3. The wholesale invoice was not submitted. By correspondence dated October 26, 2017, respondent acknowledged receipt of the applicant's verification response and reiterated its request for the outstanding wholesale invoice. The arbitrator noted that respondent issued further requests for the invoice on October 26, 2017, November 26, 2017, January 3, 2018, and February 3, 2018. Applicant did not submit any further responses to respondent. The arbitrator found that respondent's request for the wholesale invoice was relevant

and reasonable. Relying upon Dilon Medical Supply Corp. v. Travelers Ins. Co., 7 Misc.3d 927, 796 N.Y.S.2d 872 (Civil Ct. Kings Co. 2005), the arbitrator found that if applicant had any objection to the request for the invoice, it was incumbent upon applicant to respond in writing, which applicant failed to do. Therefore, noting that the claim had not yet been denied, the arbitrator found that applicant's response was insufficient. The claim was dismissed without prejudice pending completion of the verification process.

Paramus Medical Imaging, LLC & 21st Century National Ins. Co., AAA Case no. 17-18-1111-6126
https://aaa-nynf.modria.com/loadAwardSearchFilter

(2/16/20) (Glen Cacchioli, Arb.) Applicant sought reimbursement for an MRI of the cervical spine. Respondent denied the claim based upon applicant's failure to respond to respondent's verification requests within 120 days under 11 NYCRR 65-3.5(o). In support of its defense, respondent submitted timely verification requests seeking a copy of the MRI film and a letter of medical necessity. On June 2, 2016, applicant responded to the request in a document entitled "Medical Necessity Appeal" indicating that respondent should "review all submitted medical documentation from the referring physician outlining the medical necessity for the diagnostic procedure." Subsequently, on July 11, 2016, applicant sent respondent an invoice for the copying and shipping of the MRI films and/or CD. By correspondence dated July 12, 2016, respondent acknowledged receipt of applicant's July 11, 2016 correspondence and reiterated its request for the MRI film, stating "when a carrier or self-insured employer requests X-ray and satisfactory reproductions are furnished in lieu of original films, a fee of $5 may be charged for the first sheet or CD of duplication and $3 for each additional sheet of film or CD." Applicant did not respond to respondent's July 12, 2016 correspondence. At the hearing, applicant argued "substantial compliance" with the verification requests and, therefore, further communication was not necessary. Respondent argued that the applicant cannot remain mute when served with a follow-up verification request that was sent specifically in response to applicant's request. The arbitrator found that, contrary to applicant's contention, sending an invoice in response to a request for MRI films is not "substantial compliance," especially since respondent specifically informed applicant that the fees requested were more than it deemed reasonable. The arbitrator noted that there is no provision in the no-fault regulations that permit a claimant or insurance company to ignore communications from each other without risking its chance to prevail in the matter. The arbitrator stated that there could have been a legitimate issue as to whether the fees for reproduction were reasonable if applicant had raised the issue in prior correspondence to respondent, but applicant failed to do so. Therefore, the arbitrator found that applicant did not properly respond or object to respondent's July 12, 2016 request, and upheld respondent's denial predicated upon applicant's failure to respond to respondent's verification requests within 120 days.

Access Medical Diagnostic Solutions, PC & Geico Ins. Co., AAA Case no. 17-18-1095-6068
https://aaa-nynf.modria.com/loadAwardSearchFilter

(3/12/20) (Stephen Czuchman, Arb.) Applicant sought to recover assigned first-party no-fault benefits for an MRI of the claimant's cervical spine, X-rays of the right shoulder performed January 26, 2018, and an MRI of the lumbar spine performed February 6, 2018. Respondent maintained that the claims were not ripe due to outstanding requests for additional verification. Upon receipt of applicant's claims, on February 28, 2018, respondent issued initial requests for additional verification of the claims, which sought a narrative report from the claimant's initial evaluation, an explanation by the referring physician why the MRI was deemed necessary in the first month of treatment, a completed and signed no-fault application, and billing from the claimant's prescribing/referring physician. On March 8, 2018, counsel for applicant corresponded with respondent, advising that the requested records were not in applicant's possession or control. By correspondence dated April 3, 2018, respondent sent a follow-up request identical to the initial request. By correspondence dated April 12, 2018, counsel for applicant again advised respondent that the information sought was not in applicant's possession or control. By correspondence dated July 3, 2018, respondent sent a letter to applicant acknowledging its correspondence and the fact that the information sought was not in applicant's possession or control, but informed applicant that the documents were necessary to verify the claims and, therefore, the claims would remain pended until the verification was received. Citing to Excel Surgery Ctr., LLC v. Fiduciary Ins. Co. of America, 55 Misc.3d 131(A) (App. Term 2nd, 11th & 13th Jud. Dists. Apr. 3, 2017), the arbitrator found that applicant did not fully comply with respondent's verification requests

and, in relying upon Compas Med., PC v. Travelers Ins. Co., 53 Misc.3d 136(A) (App. Term 2nd, 11th & 13th Dists. Oct. 5, 2016), the arbitrator stated that an insurer is not required to pay or deny a claim upon receipt of an objection letter or partial response to a verification request. Accordingly, the arbitrator dismissed the claim pending completion of the verification process.

Excel Surgery Center, LLC & Geico Ins. Co., AAA Case no. 17-18-1093-1105
https://aaa-nynf.modria.com/loadAwardSearchFilter

(1/28/20) (Nancy Kramer Avalone, Arb.) Applicant, an ambulatory surgery center ("ASC"), sought reimbursement for a facility fee associated with manipulation under anesthesia ("MUA"). Respondent argued that applicant commenced the arbitration proceeding prematurely prior to complying with respondent's verification requests. On October 9, 2014, respondent issued a verification request for legible copies of the physician's initial narrative and copies of all SOAP notes. On October 17, 2014, applicant sent a letter stating they were not in possession of documents requested. On November 13, 2014, respondent issued a second verification request. On November 24, 2014, applicant responded stating that the information sought was originally submitted together with proof of claim. By correspondence dated December 16, 2014, respondent advised that the required information had also been requested from the physician. No other communications were noted to have been exchanged between the parties, and the arbitrator found applicant's responses insufficient. Relying upon the Appellate Term's ruling in Excel Surgery Ctr., LLC v. Fiduciary Ins. Co. of America, 55 Misc.3d 131(A) (App. Term 2nd, 11th & 13th Jud. Dists. Apr. 3, 2017), the arbitrator noted that a response by a health service provider to verification requests that states that it is an ambulatory surgery facility and, as such, does not possess all the medical records, and that the insurer should request any additional information directly from the treating provider, constitutes an insufficient response to the verification requests. Therefore, since no denial of claim was issued, the arbitrator dismissed the matter without prejudice pending completion of the verification process.

Park Avenue Chiropractic Healthcare, PC & Hereford Insurance Co., AAA case no. 17-18-1098-8222
https://aaa-nynf.modria.com/loadAwardSearchFilter

(3/10/20) (Alina Shafranov, Arb.) Applicant sought reimbursement for chiropractic services rendered to the claimant. Respondent did not pay or deny the claim. Rather, respondent argued that the claim was not ripe for arbitration as verification remained outstanding. Following receipt of applicant's claim, respondent issued timely verification requests on August 30, 2017, September 7, 2017, September 8, 2017, and October 13, 2017, which sought an initial report by the treating physician. Applicant's counsel argued that applicant timely responded to the verification requests by way of several "verification compliance" letters, which stated that these responses are in full compliance with the verification demands and that applicant is "not in possession of the initial report of the treating physician." By correspondence dated May 24, 2018, respondent acknowledged receipt of applicant's response that it was not in possession of the treating physician's narrative, and that the report was necessary in order to properly evaluate the claim. Respondent contended that, as of the date of the filing of the arbitration proceeding, the verification remained outstanding and, as such, the claim was not ripe for arbitration. Noting that the treating physician was the owner of applicant's facility, the arbitrator found that respondent's request for the treating physician's initial narrative report was reasonable. Therefore, the arbitrator deemed applicant's responses insufficient and not "arguably responsive" and dismissed the matter without prejudice, pending applicant's compliance with respondent's verification requests.

VERIFICATION OF CLAIM & REQUEST PREVIOUSLY COMPLIED WITH

Exon Medical Equipment, Inc. & Country-Wide Ins. Co., AAA Case no. 17-19-1122-6321
https://aaa-nynf.modria.com/loadAwardSearchFilter

(3/24/20) (Pauline Molesso, Arb.) In this case, the arbitrator addressed whether respondent established that verification was outstanding. Respondent contended that it issued verification requests seeking a letter of medical necessity, NF-3, and wholesale

invoice. Respondent acknowledged receipt of the letter of medical necessity and NF-3. However, by a follow-up verification request, respondent advised applicant that the wholesale invoice remained outstanding. In opposition, applicant asserted that it responded by letter advising that the request for the invoice was irrelevant due to the fact that all of the charges were in accordance with the NY DME Medicaid Fee Schedule. No issues were raised with respect to the mailing or timeliness of the verification requests. The arbitrator determined that applicant's response was arguably responsive as it addressed the items sought by respondent and, in turn, respondent was required to take action. As respondent failed to reply to applicant's response or provide further clarification as to why it was seeking the invoice, the arbitrator found in favor of applicant and awarded the claim.

AOT Chiropractic, PC & Allstate Ins. Co., AAA Case no. 17-18-1100-8942 (2/4/20)
https://aaa-nynf.modria.com/loadAwardSearchFilter

(Perry Criscitelli, Arb.) The arbitrator addressed whether respondent's verification requests remained outstanding. Respondent contended that it issued an initial and follow-up request for further verification of claim and that verification remained outstanding. In opposition, applicant argued that it complied with respondent's requests. In further support, applicant submitted a copy of the verification response previously submitted to respondent. There was no evidence that respondent responded to applicant's submission. Accordingly, the arbitrator found that applicant provided the necessary responses and, thereafter, payment was due and owing. Applicant's claim was awarded.

Metro Pain Specialists PC & Allstate Ins. Co., AAA case no. 17-18-1084-0168
https://aaa-nynf.modria.com/loadAwardSearchFilter

(4/3/20) (Ellen Weisman, Arb.) The arbitrator addressed whether respondent could sustain its denial of claim based on a failure to provide verification within 120 days of the initial request. Respondent contended that it received no response to its verification requests seeking corporate, financial, and claim-specific documents, such as the surgical report, referral, and/or letter of medical necessity. No issues were raised regarding the mailing or timeliness of the verification requests. In opposition, applicant argued that it had previously provided corporate and financial documents in a global correspondence involving multiple claims. The arbitrator determined that while applicant may previously have provided corporate and financial documents, it did not provide a substantive response to respondent's claim-specific verification requests. As applicant failed to provide a response to the verification requests, the arbitrator sustained respondent's defense based on failure to provide verification.

Veda Medical, PC & Geico Ins. Co., AAA case no. 17-17-1079-4794
https://aaa-nynf.modria.com/loadAwardSearchFilter

(1/12/20) (Kihyun Kim, Arb.) The arbitrator addressed whether respondent could sustain its denial of claim based on a failure to provide verification within 120 days of the initial request. Respondent contended that it received no response to its verification requests seeking documentation such as a lease agreement, income tax returns, bank statements, and other corporate information. No issues were raised regarding the mailing or timeliness of the verification requests. In opposition, applicant argued that it previously complied with respondent's requests. The arbitrator determined that applicant's prior response was only a partial response and that various financial documents remained outstanding. The arbitrator further determined that applicant made no formal objection to the reasonableness of respondent's requests, and as a result, applicant failed to preserve any argument that the requests for verification were unreasonable. As applicant failed to provide a sufficient response to the verification requests, the arbitrator found in favor of respondent and denied the claim.

VERIFICATION OF CLAIM & TIMING OF REQUESTS

Ambulatory Surgical Center of Englewood & Geico Ins. Co., AAA Case no. 17-16-1051-8421
https://aaa-nynf.modria.com/loadAwardSearchFilter

(11/27/17) (Victor Moritz, Arb.) Upon receiving the claim, respondent issued a timely initial verification request pursuant to 11 NYCRR 65-3.5 (b). However, the follow-up verification request was issued two weeks after it was due. See, 11 NYCRR 65-3.6 (b). The arbitrator determined that this lateness was in violation of 11 NYCRR 65-3.6(b). Furthermore, the arbitrator found that the untimeliness of the follow-up verification request by more than two weeks was not a non-substantive technical or immaterial defect or an inconsequential variance from the mandated time frames and thus 11 NYCRR 65-3.5(p) did not apply.

Optimus Plus Products Corp & American Transit Ins. Co., AAA Case no. 17-18-1099-0815
https://aaa-nynf.modria.com/loadAwardSearchFilter

(3/23/20) (Aladar Gyimesi, Arb.) Respondent sent initial and follow-up verification requests upon receipt of the claim. The claim was not denied as verification remained outstanding. Since there was a lack of evidence as to when respondent received the bill, applicant argued that payment of the claim was overdue as respondent failed to demonstrate the timeliness of its initial verification request. The arbitrator determined that even if it was presumed that respondent received the bill on April 3, 2018, which was the date found on the bill, respondent still had 15 business days to subsequently issue its initial verification request. See, 11 NYCRR 65-3.5 (b). As a result, even if a reduced period of 15 calendar days was utilized, respondent was required to issue its initial verification request no later than April 18, 2018. Respondent issued its initial verification request 14 days thereafter on May 2, 2018. Thus, even if the initial verification request was issued in this untimely manner, it was not issued more than 30 days late, and therefore respondent could still timely issue its denial and the time to do so would merely be reduced. Without evidence of any response to respondent's verification requests, the arbitrator found that the respondent's 30-day period to pay or deny the claim had not yet begun to run and the matter was not ripe for arbitration.

Advanced Pharmacy, Inc. & Allstate Ins. Co., AAA Case no. 17-18-1103-7318
https://aaa-nynf.modria.com/loadAwardSearchFilter

(12/11/19) (Ellen Weisman, Arb.) Upon receipt of the claim, respondent issued its first verification request on January 25, 2017. When applicant failed to adequately respond to the first verification request within 30 days (February 24, 2017), respondent had 10 additional calendar days (March 6, 2017) within which to issue a second verification request. However, the second verification request was not issued until March 8, 2017, which rendered the verification request two days late. The arbitrator found that while the appropriate remedy for a late first-verification request is to abridge respondent's time in which to deny the claim, there is no such remedy with regard to a late second-verification request. Based on the strict construction of the No-Fault Regulation, the arbitrator found the claim to be overdue. The arbitrator supported this decision by citing to Prime Psychological Services, P.C. v. ELRAC, Inc., 25 Misc.3d 1244(A), 906 N.Y.S.2d 782 (Table), 2009 N.Y. Slip Op. 52579(U) (Civ. Ct., Richmond Co. December 4, 2009), in which the court held that the failure to issue a timely second verification request voids the tolling of the insurer's time in which to pay or deny the claim and thereby precludes it from asserting a defense.

VERIFICATION OF CLAIM & COMMUNICATION BETWEEN THE PARTIES

Scarborough Chiropractic PC & American Transit Ins. Co., AAA Case no. 17-18-1098-9192
https://aaa-nynf.modria.com/loadAwardSearchFilter

(12/9/19) (Laura E. Villeck, Arb.) Applicant sought reimbursement for nerve testing and chiropractic services. Respondent denied the chiropractic treatment based on a lack of medical necessity pursuant to the results of an Independent Medical Examination

(IME). The nerve test was neither paid nor denied as respondent alleged that verification requests remained outstanding. The arbitrator cited to the relevant sections of the regulations discussing verification requests and the responsibilities and the duties of each party. In this case, respondent sought medical reports and documentation concerning the CPT coding used. Applicant provided medical reports and an explanation of the fee code used. Respondent failed to acknowledge this response and reiterated their prior demands. Applicant again responded. The arbitrator cited to relevant case law, noting that as long as applicant's response was arguably responsive, the insurer must affirmatively act once it receives this response. In this case, respondent merely reissued their initial demand without acknowledging applicant's response and therefore waived its right to further verification. Consequently, the nerve test was awarded. The additional chiropractic treatments were denied based on the results of the IME.

Community Medical Imaging PC & Geico Ins. Co., AAA Case no. 17-18-1087-7351
https://aaa-nynf.modria.com/loadAwardSearchFilter

(12/16/19) (Eileen Hennessy, Arb.) Applicant sought reimbursement for an MRI study. Respondent sought verification and argued that the claim was premature. The arbitrator cited to the relevant sections of the regulations discussing respondent's obligation to timely demand verification upon receipt of the claim and applicant's responsibility to respond to verification requests. The arbitrator found that upon receipt of this bill, respondent requested from applicant a copy of the narrative report from the patient's initial chiropractic evaluation. This request was also forwarded to the treating chiropractor. Respondent also issued timely follow-up requests. Applicant notified respondent that they did not have this report and that the carrier should follow up with the referring provider. The arbitrator noted relevant case law and found that applicant's response was sufficient in notifying respondent that the report was not in their possession and directing respondent to seek the report from the treating doctor. In this case, respondent forwarded a letter to the treating chiropractor requesting the report. The arbitrator noted that the regulations entitle respondent to this report to verify the claim. Since verification remained pending, the claim was not ripe for arbitration and was dismissed without prejudice.

Gentle Care Acupuncture, PC & Nationwide Ins. Co., AAA Case no. 17-18-1098-6660
https://aaa-nynf.modria.com/loadAwardSearchFilter

(2/6/20) (Marcelo Vera, Arb.) Applicant sought reimbursement for medical services provided to a patient that was denied by respondent based on the failure of applicant to comply with 11 NYCRR 65-3.5 (o), which required responding to verification requests within 120 days from the initial demand or providing reasonable justification for their failure to comply. The arbitrator noted that respondent received applicant's bill on October 30, 2017 and issued a timely verification request on November 3, 2017. No response was received and respondent sent a follow-up request as required by the regulations on December 5, 2017. On March 8, 2018, respondent issued a denial based on applicant's failure to respond. Applicant alleged that they had replied to respondent's verification request on January 18, 2018. The arbitrator reviewed the documents and found that the record revealed that applicant had responded to the verification requests on March 14, 2018 after the denial was issued. Upon reviewing the relevant case law discussing the requirements to communicate responses or objections to verification requests and respondent's right to obtain the requested verification, the arbitrator determined that the response from applicant was after the issuance of the denial and, therefore, the claim was denied.

Diagnostic Medicine, PC & Country-Wide Ins. Co., AAA Case no. 17-18-1087-3281
https://aaa-nynf.modria.com/loadAwardSearchFilter

(10/9/19) (Jennifer Zeidner, Arb.) Applicant sought reimbursement for EMG/NCV testing of the upper and lower extremities. Respondent requested additional verification of the claim in the form of various corporate, licensing, and employment records. The arbitrator noted that the case law on this issue is clear and that the no-fault regulations envision communication, not inaction from both parties with respect to requests for additional verification. Moreover, the courts have held that if a provider objects

to the request for verification, then the issue of whether the requested verification and the objection were proper are preserved and become questions of fact for the trier of fact. Since applicant failed to preserve its objection to the reasonableness of the verification requests and the majority of the requested information remained outstanding, the arbitrator found that the claim was not ripe for arbitration and dismissed the claim without prejudice.

Veda Medical, PC and State Farm Mut. Automobile Ins. Co., AAA Case no. 17-17-1075-7134
https://aaa-nynf.modria.com/loadAwardSearchFilter

(10/27/19) (Josh Youngman, Arb.) Applicant sought reimbursement for physical performance testing, outcome assessment testing, and range of motion/manual muscle testing. Respondent denied the claim, alleging that applicant failed to submit the requested verification within 120 days of the initial requests pursuant to 11 NYCRR §65-3.5(o), which provides that "[a]n applicant from whom verification is requested shall, within 120 calendar days from the date of the initial request for verification, submit all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply." The arbitrator found that applicant failed to submit evidence establishing that it did not receive the verification requests or that it responded to them in any manner. The arbitrator determined that respondent submitted sufficient evidence to substantiate the denials and denied the claim in its entirety.

VERIFICATION OF CLAIM & 120 CALENDAR-DAY DENIALS

MZ Acupuncture, PC & Geico Ins. Co., AAA Case no. 17-18-1090-0891
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(2/3/20) (Josh Youngman, Arb.) The arbitrator addressed whether respondent's denial of claim based upon applicant's violation of the 120-day rule should be sustained. Upon receiving the no-fault claims at issue, respondent requested an Examination Under Oath (EUO) of applicant. Following the EUO, respondent issued timely requests for additional verification. Respondent requested inter alia: W-2's, retainer agreements, and tax returns. Upon receipt of such requests, applicant partially complied but also objected to a number of the sought-after items. Thereafter, respondent issued a denial-of-claim form based upon a violation of the 120-day rule due to applicant's failure to fully comply. The arbitrator found that respondent prematurely denied the claim based upon the 120-day rule. The arbitrator found that applicant was in "substantial compliance" with the requests for additional verification, and therefore, respondent should have made an attempt to communicate further with applicant rather than deny the claim.

Chelsea Medical Care, PC & Progressive Cas. Ins. Co., AAA Case no. 17-19-1141-0020
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(3/23/20) (Aaron Maslow, Arb.) Respondent denied applicant's claim based upon the 120-day rule. Specifically, respondent issued an additional verification request seeking "the relative value unit consistent in relativity with other relative value units shown in the Fee Schedule" because applicant billed using a by-report code. Applicant responded to the request with medical reports and additional documentation. Upon receipt, respondent issued another request for verification requesting the same information. Thereafter, respondent denied the claim based upon the 120-day rule. The arbitrator found that respondent properly issued the subject verification requests and that applicant failed to provide all that was requested within 120 days. The arbitrator found that respondent's denial of the claim was proper because applicant failed to provide the number of relative value units it was assigning to the billed service.

Metro Pain Specialists, PC & Allstate Fire & Cas. Ins. Co., AAA Case no. 17-17-1077-4174
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(3/13/20) (Eva Gaspari, Arb.) Respondent denied a portion of applicant's claim based upon its failure to furnish responses to its requests for additional verification within 120 days. Upon receipt of applicant's bill, respondent issued timely and proper verification requests. Respondent sought to obtain numerous documents including, but not limited to, referrals, financial disclosures, lease agreements, and medical records. Applicant responded to the requests by letter stating that the information had previously been provided for other claims, and therefore, respondent was seeking redundant information. Thereafter, the claim was denied based upon the 120-day rule. The arbitrator found that applicant's response was sufficient and warranted a response from respondent. Although a "partial" response is insufficient to verify the claim, the arbitrator found that the insurer had a duty to communicate with the applicant rather than deny the claim.

SUM AWARDS: SERIOUS INJURY & AGGRAVATION OF PRE-EXISTING CONDITIONS

V.Z. & Nationwide Ins. Co., AAA Case no. 01-19-0002-2432
SUM Award Search

(Edward Brozinsky, Arb.). This was an underinsured motorist claim with $500,000.00 in SUM coverage subject to a $50,000.00 set-off for the policy payment made on behalf of the underinsured tortfeasor. On October 7, 2018, the claimant, who was 53 years of age, was involved in an accident in Huntington, NY. At the time of the accident, the claimant was stopped at a red light when a vehicle came out of a parking lot and came into contact with a motorcycle. The motorcycle went out of control and came into contact with the passenger side of claimant's stopped vehicle. The police report listed the cause of the accident as the exiting vehicle failing to yield right-of-way. The claimant described the impact to the right side of her vehicle as being heavy. The police arrived at the scene and asked her if she needed medical attention. She said that she had pain in her right side, head, and low back but refused medical attention. The claimant called her husband who came and picked her up. After leaving the scene of the accident, the claimant was taken immediately to an urgent care facility. While being examined, the claimant experienced nausea as well as dizziness and was unsteady on her feet. She was complaining of acute back pain and the physician thought it best to call an ambulance that transported her to St. Joseph's Hospital. Upon arrival at the hospital, the claimant complained of headaches, nausea, and low back pain. She indicated that she was sent from the urgent care to the emergency room for a CT scan because she was taking Xarelto. Following an examination and CT scans, the claimant was discharged. A CT of the head/neck was negative. X-rays of the ribs and lumbar spine were negative for fracture. The claimant presented to Dr. G. on October 10, 2018. She again complained of headaches, dizziness, neck, shoulder, and lower back pain. Following an examination that revealed restricted ranges of motion, Dr. G. recommended that the claimant start physical therapy and also undergo a neurological examination. The claimant presented to a neurologist, Dr. C., on the same date. Dr. C. recommended electrodiagnostic studies of the upper and lower extremities and an MRI of the brain. Electrodiagnostic studies were consistent with chronic degradation of the right C6 nerve root. An MRI of the brain dated October 19, 2018 revealed no significant abnormalities in the brain and represented no change since a prior study dated August 5, 2018. In the beginning of August 2018, prior to this accident, the claimant presented to Dr. H. with complaints of increasing headache over the past month. She said she had headaches for the past 20 years, but that they had become more severe. An MRI of the brain dated August 5, 2018 failed to reveal any abnormalities in the brain. She was placed on medication, and the headaches improved. On October 16, 2018, an MRI of the cervical spine revealed C3/4, C4/5, C5/6, C6/7 and C7/T1 disc herniations deforming the thecal sac, with C4/5 –C6/7 cord abutment. There was C5/6 right neural foraminal narrowing and C6/7 left neural foraminal narrowing. There was mild central spinal stenosis at C3/4 with hypertrophic changes. The MRI of the lumbar spine performed on the same date revealed L1/2 disc herniations deforming the thecal sac abutting the proximal L2 nerve roots bilaterally; L3/4 disc herniation with grade 1 spondylolisthesis deforming the thecal sac with bilateral neural foraminal extension abutting the exiting L3 nerve root as well as disc bulges at L5/S1, L4/5 and L2/3. An MRI of the left shoulder revealed synovial fluid in the glenohumeral joint; supraspinatus tendinosis/tendinopathy; hypertrophic change in the acromioclavicular joint;

down sloping acromion abuts the supraspinatus; glenoid chondral thinning with underlying surface irregularity; anterior and posterior glenoid spurring; subscapularis tendinosis/tendinopathy and glenoid labrum deficiency consistent with tear. An MRI of the right shoulder revealed synovial fluid in the glenohumeral joint; supraspinatus tendinosis/tendinopathy; hypertrophic change in the acromioclavicular joint; down sloping acromion abuts the supraspinatus; superior glenoid spurring noted anteriorly and posteriorly with marginal surface irregularity/chondral fraying. There was a superior labral tear and possible posterior labral tear. There was anterior and posterior glenoid marginal spurring and subscapularis tendinosis/tendinopathy. The claimant continued to see Dr. C. through December 26, 2018. The claimant attended physical therapy from October 10, 2018 through December 26, 2018. On November 13, 2018, she received a trigger point injection in the trapezius area and on December 13, 2018, received trigger point injections in the lumbar area. On December 5, 2018, the claimant presented to Dr. G. for pain management. He suggested a cervical epidural steroid injection, which was performed on December 12, 2018. The claimant presented to Dr. O., an orthopedic surgeon on January 2, 2019. The history taken noted that the claimant took five weeks off from work. The claimant also related her treatment following the accident. She presented with chief complaints of pain to the neck, bilateral shoulders, and low back. Dr. O. reviewed the MRIs as well as the X-rays taken in his office. His diagnosis included intervertebral disc displacement, lumbar; cervical disc degeneration and displacement at C5/6 level; impingement syndrome right shoulder and impingement syndrome of left shoulder. Treatment options were discussed with the claimant, and she was referred to Dr. F. in the same office for epidural steroid injections. She was told to continue physical therapy. The claimant was supplied with a custom LSO. Dr. O. also felt that she might eventually be a candidate for C5–C7 ACDF. The claimant saw Dr. F. on January 23, 2019 and received a cervical epidural steroid injection. Following the injection, she reported only mild relief. On January 30, 2019, she received a cortisone injection into the right shoulder. On February 13, 2019, she received occipital nerve block injections. On March 6, 2019, she was examined by Dr. O. As the claimant received little relief from cervical epidural injections and occipital nerve blocks, surgery was recommended and took place on March 21, 2019. The surgery consisted of a C5/6 and C6/7 anterior cervical discectomy and fusion with structural allograft spacers, allograft bone graft and anterior cervical plate. The pre-and postoperative diagnosis was C5/6 and C6/7 herniated discs. On March 28, 2019, the claimant had a post-surgical visit with complaints of frequent headaches and weakness in her hands. She was having back pain and difficulty swallowing. She was having trouble sleeping and using heat compressions for pain in addition to pain medication. On that day, she was fitted for a bone stimulator to aid the cervical fusion. On April 17, 2019, she was told she should resume physical therapy. The claimant testified that she was still under the care of Dr. O. and Dr. F. and continued with physical therapy at a frequency of two to three times per week. The claimant remained under the care of Dr. O. for her neck, back, and shoulders. Due to continued pain and restriction of motion in the right shoulder, which was diagnosed as right shoulder impingement syndrome, the claimant underwent right shoulder arthroscopy with partial synovectomy, debridement of the subacromial space, and subacromial decompression with partial acromioplasty on September 23, 2019. At the time of the accident, the claimant was employed as a pharmacist. She was out of work from October 8, 2018 through October 29, 2018 and subsequently from November 4, 2018 to November 11, 2018. Following the cervical spine surgery, she missed work from March 20, 2019 through April 16, 2019 and thereafter from June 1, 2019 to June 9, 2019. Following the right shoulder surgery, she was out of work from September 23, 2019 to October 14, 2019. The claimant was earning $132,000.00 per year and it was claimed that she lost in excess of $29,000.00. According to the arbitrator's calculation, the claimant lost approximately $35,000.00–$10,000.00 covered under no-fault for a net loss of earnings of approximately $25,000.00. The claimant testified that following the accident, she physically became very limited. She was unable to lift heavy objects at work and could not reach anything over her head. She had to get someone to assist her. At home she was also limited in heavy lifting, vacuuming, and doing laundry. Although she still drove, she testified that she was limited because of the limited range of motion in turning her neck. The claimant underwent a no-fault orthopedic examination performed by Dr. L. on June 22, 2019. At the time of that examination, there was reduced range of motion in the cervical spine and the right shoulder. Following an examination and review of the available medical records, Dr. L. indicated that the cervical and right shoulder injury were not yet resolved and that physical therapy should continue for six weeks with a follow-up examination. Dr. L. re-examined the claimant on September 14, 2019, and found full range of motion in the cervical spine. However, the claimant continued to have reduced range of motion in the right shoulder. Dr. L. opined that the right shoulder injury was not yet resolved and that physical therapy should continue as necessary. At no time in his examinations did Dr. L. feel surgery was necessary. He did not find it necessary for any pain management treatment or massage therapy. He also did not find that the

limitations of motion created any orthopedic disability. On March 15, 2019, the claimant underwent a neurological examination by Dr. M. In addition to reviewing the medical records and taking a history, she performed a neurological examination. On her examination, she found full range of motion in both the cervical and lumbar spine. With regard to causality, Dr. M. opined that the injuries sustained by the claimant and the resulting symptoms of the neck and low back were secondary to the motor vehicle accident and an exacerbation of pre-existing injuries sustained from a Workers' Compensation incident. Her diagnosis was cervical sprain/strain, resolved; cervical radiculopathy, resolved; lumbar sacral sprain/strain, resolved; lumbar sacral radiculopathy, resolved; headaches, cervicogenic and posttraumatic. The claimant reported to Dr. M. that she had two prior Workers' Compensation incidents. In one incident, she injured her neck and low back and injured her left shoulder and knee in the other. Claimant testified that while working in November 2017, a drawer collapsed and she caught it with her knee and injured her knee and shoulder. For that injury, she saw Dr. S. and received physical therapy for two months. She said an MRI of her right shoulder was taken because it was sore. She did not know the results of the MRI but indicated that at all times following the accident, she had full range of motion in the right shoulder. She also testified that in March 2016, she fell and cut her left knee. As a result of that injury, she ended up having knee surgery. Following the surgery, she had difficulty walking and her back began to hurt. Dr. G. reviewed the MRIs and found that the cervical MRI showed chronic findings. He also found disc bulges at C3/4 and C6/7 and stated that given the degree of degenerative changes in the cervical spine, that this was most likely chronic processes. A review of the right shoulder MRI dated October 25, 2018 revealed tendinosis within the distal supraspinatus and subscapularis tendons. There was degenerative osteoarthritis in the acromioclavicular joint with anterior and lateral down sloping of the acromion. There was degenerative osteoarthritis in the glenohumeral joint. Although the original MRI was suggestive of tears in the glenoid labrum, Dr. G. did not find it on his review. His review of the right shoulder MRI dated January 20, 2020 revealed anterior subluxation of the humeral head relative to the glenoid with progressing degenerative changes in the glenohumeral joint. He also found glenohumeral effusion. He said the age was indeterminate. There was degeneration of the glenoid labrum and possible posterior superior labral tear. He found mild tenosynovitis in the biceps tendon sheath. There was tendinosis in the distal supraspinatus tendon with an appearance suggesting a chronic tear. He also found degenerative changes in the acromioclavicular joint. After carefully reviewing the testimony of the claimant together with the medical records presented as well as the Examination Under Oath, the arbitrator found that the claimant sustained serious personal injuries as a result of the accident. The arbitrator found that the claimant sustained severe limitation of motion in the cervical spine and right shoulder that required extensive physical therapy, injections, and surgery. The MRIs of the cervical spine and the right shoulder revealed pre-existing osteoarthritic and degenerative disc conditions. This was also seen by Dr. G. who reviewed the MRIs for the respondent. The arbitrator found that the claimant sustained an aggravation of the pre-existing conditions. As a result of the accident, the claimant underwent immediate treatment and within five months of the accident underwent an anterior cervical decompression and fusion. She had continued treatment for her right shoulder and in September 2019, less than a year following the accident, she underwent arthroscopic surgery. The claimant testified that she was still experiencing limitation of motion in both the cervical spine and right shoulder. She was still receiving physical therapy treatment and seeing a pain management physician as well as an orthopedic surgeon. The arbitrator found that the claimant credibly testified as to her physical limitations and that her husband also testified to these facts. The arbitrator determined that the claimant sustained an aggravation of pre-existing injuries and suffered pain and suffering as well as excess lost earnings and awarded the sum of $450,000.00 subject to a set off of $50,000.00 paid by the underlying tortfeasor for a net award of $400,000.00.

M.P. & New York Central Mut. Fire Ins. Co., AAA Case no. 01-19-0000-6024
SUM Award Search

(Vernon J. Welsh, Arb.). This matter arose out of a motor vehicle accident in Buffalo, N.Y., that occurred on October 27, 2017. The policy provided $250,000.00 in SUM coverage for the underinsured motorist claim, subject to a $25,000.00 set-off for the policy payment made on behalf of the underinsured tortfeasor. The arbitrator concluded that the evidence was insufficient to establish that the claimant sustained a serious injury as defined by the Insurance Law. To satisfy the serious injury requirements of the Insurance Law, where there is persuasive evidence that a claimant's condition relates to a preexisting condition, there must be objective evidence of a new injury or of an aggravation of a preexisting injury–evidence other than complaints of pain.

See, Clark v Perry, 21 AD3d 1373, 1374 (4th Dept 2005). The arbitrator provided an in-depth review and discussion of the medical documentation submitted to support the resolution that the claimant failed to satisfy the "serious injury" threshold of the Insurance Law. The claimant alleged he sustained a concussion, neck injury, shoulder injury, herniated lumbar discs, and right hip labral tear. The claimant underwent right hip surgery, but the operative report of the right hip indicated the tear was degenerative. Respondent's physician stated that if there was an acute trauma such as a labral tear, there would have been immediate pain or pain soon after the injury. The submissions indicated that the first mention of hip pain was on November 13, 2017, seventeen days after the accident. At the time of examination four-days post-accident, the examining physician noted that the right hip had no deformity, no ecchymosis, no tenderness to palpation of the greater trochanter, and the skin was intact. With regard to the shoulder, the claimant testified that his shoulder pain resolved around the first three months after the accident. Medical reports showed full ranges of motion in the cervical and lumbar spine, which appeared to be consistent with claimant's hearing testimony that his neck pain resolved around three months after the accident. The documentation of spinal limitations of motion was equivocal and at best showed that neck and lower back motion was limited enough to constitute a serious injury for only a matter of days after the accident, which is not considered a serious injury. "Proof of a herniated disc, without additional objective medical evidence establishing that the accident resulted in significant physical limitations, is not alone sufficient to establish a serious injury." See, Pommells v. Perez, 4 N.Y.3d 566, 574, 797 N.Y.S. 2d 380, 830 N.E.2d 278 (2005). The arbitrator noted that no electrodiagnostic tests were performed to indicate the diagnosis of radiculopathy and no surgeon was consulted regarding the MRI studies or the herniations. Regarding possible injury following the concussion, the treating physician assessed bilateral occipital neuralgia and posttraumatic vertigo, but because the claimant's symptoms were improving daily, the doctor did not feel that further testing or treatment was needed. The claimant testified that he had not had any neuropsychological, IQ, or cognitive testing since the accident. The arbitrator found that the accident had not interfered with the claimant's ability to perform substantially all of the material acts that constituted his activities of daily living for at least 90 of the 180 days immediately following the accident. The claimant testified that he had not returned to work performing deliveries, although no doctor told him to refrain from working, except around the time of his hip surgery. Accordingly, the arbitrator determined that the $25,000.00 previously received from the tortfeasor's carrier was adequate compensation, and the SUM claim was denied.

D.P. & USAA Ins. Co., AAA Case no. 01-19-0001-1904
SUM Award Search

(Jodi Zagoory, Arb.). This was an underinsured motorist claim with $300,000.00 in SUM coverage subject to a $25,000.00 set-off for the policy payment made on behalf of the underinsured tortfeasor. The claimant, age 69, was retired. He claimed that he injured his neck and left shoulder in an accident that happened in June 2018. The claimant was riding a bicycle at the time and collided with a car. He testified he had been riding and stopped on the right side, adjacent to the curb, for a red light. When the traffic light turned green, the claimant testified that he looked over his left shoulder, started to ride, and signaled with his left arm that he intended to turn left. However, after he started to ride, a car to his left attempted to make a right turn in front of him, causing the claimant to hit the car with his bicycle and his body to be thrown over the car and land on the roadway. The driver of the car involved in the accident told the police that he made a right turn and felt something hit his car. The driver stated that he did not see anyone next to him and never saw the bicycle next to him. The claimant testified there were cars to the left of him as he waited for the traffic light to turn green. However, he did not see the car involved in the accident until it appeared in front of him. He testified that the car made a right turn in front of him and he did not have time to stop or swerve out of the way. He further testified that his left shoulder hit the body of the car and his left elbow hit the right rear wheel well. He hit his head on the ground when he landed face down. He described the impacts as heavy. He suffered abrasions to his face and nose and was bleeding from his chin, nose, left wrist, and left elbow. The claimant was wearing a bicycle helmet. Photographs of the helmet after the accident showed significant damage. Photographs of claimant's bicycle showed significant damage to the front tire. An ambulance took the claimant from the accident scene to the emergency room of a hospital. A review of these records showed that the claimant complained in the emergency room of pain to his left arm and shoulder and of abrasions to his nose, left arm, fingers, and both knees. Numerous diagnostic tests were done. A CT scan of the claimant's facial bones showed no facial fractures. A CT scan of the claimant's cervical

spine showed multilevel degenerative disc/facet change, multilevel foraminal narrowing, spinal canal narrowing, and disc protrusions. A CT scan of the claimant's head showed no evidence of acute intraparenchymal or extra axial hemorrhage. The claimant was admitted to the hospital and was "placed on continuous cardiac and pulse ox monitoring." He was evaluated by a surgical team and admitted to a surgical floor for "a procedure on the laceration to patient's left elbow because there may be joint involvement." On June 12, 2018, the same day as the accident, Dr. I. performed an irrigation and debridement/arthrotomy of claimant's left elbow joint. The postoperative diagnosis was "open left elbow joint." The claimant remained in the hospital until June 15, 2018. The claimant followed up with Dr. I. on June 29, 2018, who noted that the claimant came in "for follow up of treatment of septic left elbow." The doctor removed the sutures and noted that the clamant had "painless full range of motion of the left elbow" and complained "of pain in his neck and left shoulder since his accident." A physical examination revealed "pain with range of motion of the left shoulder and demonstrating multilevel spondylosis with the worst being at C5-C6." The doctor prescribed physical therapy and concluded that if the symptoms persisted after physical therapy for the cervical spine, he would be a candidate for C5-C6 anterior cervical discectomy and instrumented fusion. The claimant followed up with Dr. I. on August 10, 2018, at which time the doctor noted that the claimant had continued pain in the neck that was traveling down the left shoulder that did not resolve with physical therapy. He also noted that the claimant's elbow overall was doing well with full range of motion. The doctor indicated that the claimant felt that the symptoms were limiting his activities of daily living. After examining the claimant, Dr. I. commented that, "At this point my suspicion is given the mechanism of injury where the patient fell and landed directly with his head hitting the ground, he likely has a herniated nucleus pulposus. His cervical spine X-rays demonstrate multilevel spondylosis with the worse being C5-C6. It is likely this is the source of this problem. I would like to at this point send the patient for a cervical spine MRI. He will follow up with this MRI. Of note, the patient does not have any evidence of myelopathy." The claimant underwent the cervical MRI study on August 14, 2018. It was reported that the MRI study showed "multilevel degenerative changes of the cervical spine superimposed on a congenitally stenotic canal. Mild canal stenosis from C3-C5 to C6-C7. Moderate to severe left neural foraminal stenosis at C6-C7. Asymmetric right facet arthrosis at C4-C5 with associated mild degenerative inflammatory changes." Three days later, on August 17, 2018, the claimant followed up with Dr. I. who noted that the claimant still had evidence of left-sided radiculopathy, no right sided arm symptoms, difficulty lifting heavier objects, but was otherwise doing okay. Dr. I. noted that the claimant described his pain as approximately 2/10. He noted the cervical MRI findings and concluded that the claimant should continue physical therapy for his cervical spine, working on range of motion, stretching, and strengthening. The doctor stated that the claimant could follow up in approximately three months. The claimant returned to Dr. I. on December 7, 2018, approximately six months after the subject accident. The doctor noted that the claimant had pain over the left AC joint, radicular symptoms were minimized, the left elbow had good range of motion, and the wound healed well. The doctor noted claimant's main pain was upon cross arm adduction. He also noted that X-rays that were done at the last visit demonstrated some mild arthritic changes at the left AC joint. He recommended that claimant have left shoulder and AC joint range of motion stretching and strengthening treatments. On January 25, 2019, Dr. I. reported that overall the claimant was doing very well with regard to his shoulder and that he had experienced improvement with physical therapy. He didn't have radicular symptoms and had mild neck pain as well as pain over the acromioclavicular joint. The doctor showed the claimant some exercises for his shoulder, specifically pendulum exercises, wall walking, and stretching the AC joint. There was improvement of his shoulder pain, and his elbow was doing extremely well. The records showed that the claimant began a course of physical therapy on July 5, 2018 and presented with complaints of left shoulder, elbow, and neck pain. He had treatments through January 21, 2019, at which time it was noted in the records that he continued to have pain in his left shoulder and cervical spine with difficulty performing heavy lifting/carrying/pulling activities but that the pain and weakness was getting much better. On December 12, 2018, the claimant told the physical therapist that he was feeling better than when he started therapy, but that he still felt a lot of cracking in his left shoulder along with the elbow. On January 11, 2019, the physical therapist recorded that the claimant's pain and weakness was getting much better, but that he lifted something in the backyard the previous day and began to feel some pain. He began another course of physical therapy on October 22, 2019, which continued through January 31, 2020. On January 31, 2020, it was noted that the claimant still had pain and decreased range of motion of the left shoulder and cervical spine. Claimant came under the care of Dr. W., an orthopedic surgeon, on October 4, 2019, for neck pain that radiated down his left arm and left shoulder pain. Dr. W. noted that the pain was frequent; that the neck pain was getting worse and that the pain in the left shoulder was in the

glenohumeral joint, acromioclavicular joint, subacromial region, and supraspinatus region. It was noted that the pain worsened with extended activity. Based on his clinical findings, Dr. W.'s assessment was that the claimant was experiencing pain in the cervical spine and left shoulder, tenderness and spasms in the cervical spine and tenderness, swelling, clicking, crepitus and instability in the left shoulder. He prescribed physical therapy, an MRI study of the left shoulder and an EMG of the upper extremities. The claimant returned to Dr. W. on October 25, 2019, at which time Dr. W. noted the same complaints and clinical findings. The EMG of the upper extremities performed on October 11, 2019, showed cervical radiculopathy. A Doppler study of the left upper extremities was performed on October 25, 2019 and showed an increase in tenderness and swelling in the left extremities. An MRI study of the left shoulder performed on October 25, 2019 showed AC joint hypertrophy, high-grade linear tear, tear of the superior labrum, and joint effusion. He prescribed physical therapy, non-steroidal anti-inflammatory medication as needed and follow-up in two weeks. The claimant returned to Dr. W. on November 19, 2019, at which time the doctor noted that the claimant continued to experience tenderness and spasms in his cervical spine and tenderness, swelling, clicking, crepitus and instability in his left shoulder. On November 26, 2019, Dr. W's clinical findings and recommendations remained the same. On February 4, 2020, the claimant continued to have pain frequently in his neck and left shoulder, neck stiffness and a clicking sensation in his left shoulder. In a medical affirmation, based on his review of claimant's medical records and diagnostic films, Dr. W. opined that the claimant sustained a tear of the superior labrum of the left shoulder, a tear of the supraspinatus tendon of the left shoulder, a disc herniation at C3-4 with canal stenosis and bilateral foraminal stenosis, a disc herniation at C4-5 with canal stenosis and right foraminal stenosis, bilateral C5-6 radiculopathy, a disc herniation at T3-4 with mass effect on the thecal sac, bilateral median neuropathy or carpal tunnel syndrome of both wrists, and a laceration at the left elbow joint that required surgical intervention, all as a result of the accident that happened on June 12, 2018. Dr. W. opined that the claimant would continue to require physical therapy and future medical attention, and in the future would need to undergo surgical repair of the tears in the left shoulder. As a result of the subject accident, the claimant claimed that he sustained a permanent scar on his left elbow. At the arbitration hearing, the arbitrator observed a "faint and barely visible scar" of approximately 2 ½ inches. The claimant testified that he had no prior issues/problems/conditions regarding his neck and left shoulder. He was an avid bicycle rider for many years before the June 12, 2018 accident but has not been on a bicycle since the accident mainly because he was unable to look over this left and right shoulders. Respondent submitted some records from the claimant's primary care provider, Dr. F. On February13, 2019, eight months after the accident, in which Dr. F. noted that the claimant told her he was feeling good and seeing an orthopedist and physical therapist for neck and shoulder injuries. Dr. F. did not record any positive objective clinical findings from her physical examination. Both parties submitted the report dated August 28, 2019, of Dr. R., an orthopedic surgeon, who examined the claimant on August 9, 2019, on behalf of respondent. Dr. R. noted that the claimant stopped his treatment in January 2019 and felt better compared to when he started treatments. He also indicated that the claimant continued to have pain which he described as dull and achy and had shooting pain to the upper shoulders. Dr. R. 's physical examination revealed decreased range of motion of claimant's left shoulder but no tenderness, no effusion, no crepitus, and no atrophy. Hawkins and Drop arm tests were negative. Based on his physical examination and review of some medical records, Dr. R. diagnosed the claimant with resolved cervical spine sprain, left shoulder sprain, and left elbow sprain/laceration, status post-surgical repair. He found residuals to the left shoulder and no objective residuals with regard to the cervical spine or left elbow. Dr. P, a radiologist, reviewed the MRI study of the claimant's left shoulder on behalf of respondent. Dr. P. noted that the study was performed on a low-field strength system and was of limited resolution. He found that the study showed degenerative osteoarthrosis of the acromioclavicular joint, tendinosis with a partial thickness tear of the supraspinatus tendon, a tear of the superior labrum, and thickening of the anterior joint capsule. He concluded that since the MRI study was done one year and four months after the subject accident, it was impossible to relate any of the abnormalities to that accident. In response to Dr. P's opinion, the claimant submitted the affirmation of Dr. W. dated February 28, 2020, which stated that he confirmed the presence of a tear of the superior labrum and tear of the supraspinatus tendon on the MRI films of claimant's left shoulder and that Dr. P. also confirmed the tears and disagreed with Dr. P.'s opinion that it was impossible to causally relate the tears to the happening of the subject accident. Dr. W. opined that a radiologist does not have the necessary qualifications to comment on causation and that Dr. P.'s opinion had no merit because he did not examine the claimant or review any of the claimant's medical records. Dr. W. opined that the accident of June 12, 2018 was the proximate cause of the tears in the claimant's left shoulder since there were no reports of any prior injuries/problems regarding the claimant's left shoulder, and the claimant's left

shoulder came into contact with the car involved in the accident, resulting in immediate complaints of left shoulder pain. The arbitrator determined that the subject accident was solely caused by the negligence of the driver of the car who failed to see the claimant on his bicycle and made a right turn in front of claimant's bicycle, causing claimant to collide with the car. The arbitrator also determined that the claimant sustained an injury to his left elbow, as described above, that required surgical repair and resulted in a faint scar; exacerbated preexisting but asymptomatic conditions in his cervical spine that continued to cause him some pain and some but not major limitations; and exacerbated preexisting but asymptomatic conditions in the left shoulder that continued to cause the claimant some pain, discomfort and some limitations. The arbitrator concluded that the medical evidence clearly showed that the claimant made a good recovery within 7 months after the subject accident but that he still continued to have some pain and some limitations up to the time of the arbitration hearing. The arbitrator found Dr. W.'s opinion that the claimant would need future left shoulder surgery to be speculative. The MRI studies of the claimant's cervical spine and left shoulder clearly showed degenerative conditions, which was not uncommon for a person of claimant's age. The claimant did not have any medical attention for eight months, between the end of January of 2019 when the orthopedic surgeon, Dr. I., found the claimant to have only mild pain and disability and when he came under the care of the orthopedic surgeon, Dr. W., for reported continued pain and disabilities in October of 2019. It was undisputed that the claimant had some residual pain and limitations attributed to the accident of June 12, 2018. The arbitrator awarded the sum of $200,000.00, and deducted the set off amount of $25,000.00, for a net award of $175,000.00.

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