American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Guy J. Villano, DC (Applicant)	AAA Case No. Applicant's File No.	17-16-1033-3428
- and -		
Geico Insurance Company (Respondent)	Insurer's Claim File No. NAIC No.	0476058820101031 35882

ARBITRATION AWARD

I, Aaron Maslow, the undersigned arbitrator, designated by the American Arbitration Association pursuant to the Rules for New York State No-Fault Arbitration, adopted pursuant to regulations promulgated by the Superintendent of Insurance, having been duly sworn, and having heard the proofs and allegations of the parties make the following **AWARD:**

Injured Person(s) hereinafter referred to as: Assignor ["CH"]

1. Hearing(s) held on 02/15/2017
   Declared closed by the arbitrator on 02/15/2017

   Michael Krigsfeld, Esq., from The Geller Law Group PC participated in person for the Applicant

   Augustine Ardizzone, Esq., from Law Office of Printz & Goldstein participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 416.16**, was NOT AMENDED at the oral hearing.
   Stipulations WERE made by the parties regarding the issues to be determined.

   The parties stipulated that Applicant established a prima facie case of entitlement to No-Fault compensation with respect to its bills. They also stipulated that Respondent's Form NF-10 denial of claim forms were timely issued, i.e., within the 30-day deadline prescribed by Insurance Law §5106(a) and 11 NYCRR 65-3.8(a)(1). Additionally, they stipulated that should Applicant prevail, interest would accrue as of the filing date set forth by the American Arbitration Association in Part B of the conclusion of the award template.

3. Summary of Issues in Dispute

- Whether Applicant established entitlement to additional No-Fault insurance compensation for chiropractic performed on Assignor beyond the amount paid by Respondent

- Whether Respondent's assertion of the eight-unit rule as a defense was legally sufficient given that the other provider(s) who was paid for physical medicine on the same dates was not identified and neither were the number of relative value units for which Respondent paid

- Whether Respondent made out a prima facie case of lack of medical necessity for further treatment past an IME cutoff and, if so, whether Applicant rebutted it

4. Findings, Conclusions, and Basis Therefor

Appearances

For Applicant:

Geller Law Group, P.C.
1639 East 13 Street
Brooklyn, NY 11229
By: Michael Krigsfeld, Esq.

For Respondent:

Law Office of Printz & Goldstein
170 Froehlich Farm Boulevard
Woodbury, NY 11797
By: Augustine Ardizzone, Esq.

Applicant commenced this New York No-Fault insurance arbitration, seeking as compensation $416.16 remaining unpaid from that which he billed for performing chiropractic services from Oct. 14, 2015 to Dec. 17, 2015, to treat Assignor, a 52-year-old male who was injured in a motor vehicle accident on Sept. 3, 2105. Three bills are at issue. They totaled $739.84, of which Applicant paid $323.68, leaving an unpaid balance of $416.16. The issue sin the case involve the eight-unit rule and an IME cutoff.

This arbitration was conducted under the auspices of the American Arbitration Association, which has been designated by the New York State Department of Financial Services to administer the mandatory arbitration provisions of Insurance Law § 5106(b), which provides:

> Every insurer shall provide a claimant with the option of submitting any dispute involving the insurer's liability to pay first party ["No-Fault insurance"] benefits, or additional first party benefits, the amount thereof or any other matter which may arise pursuant to

subsection (a) of this section to arbitration pursuant to simplified procedures to be promulgated or approved by the superintendent.

Both parties appeared at the hearing by counsel, who presented oral argument and relied upon documentary submissions. I have reviewed the submissions' documents contained in the American Arbitration Association's ADR Center as of the date of the hearing, said submissions constituting the record in this case.

The parties stipulated that Applicant established a prima facie case of entitlement to No-Fault compensation with respect to its bills. They also stipulated that Respondent's Form NF-10 denial of claim forms were timely issued, i.e., within the 30-day deadline prescribed by Insurance Law §5106(a) and 11 NYCRR 65-3.8(a)(1).

With respect to the first two bills (dates of service Oct. 14, 2015-Oct. 30, 2015 and Nov. 25, 2015-Dec. 11, 2015), the dates of service of Oct. 15, 19, 22, 23, 26, 28, and 30, and Nov. 25 had partial payment made. While $46.24 was billed for each of these dates, Respondent paid $34.68, citing the eight-unit rule. (Respondent paid the $46.24 billed for Oct. 14, 2015, and that date of service is not at issue.) For each of these dates, $11.56 remained unpaid.

In asserting the eight-unit rule for these dates of service, Respondent used Code MPV: another provider's billing and the appurtenant payment had consumed some of the maximum compensable eight units of physical medicine. The eight-unit rule, contained in Ground Rule 11 of the Physical Medicine chapter of the Workers' Compensation Medical Fee Schedule, and in Ground Rule 3 of the Physical Medicine chapter of the Workers' Compensation Chiropractic Fee Schedule, limits reimbursement to eight relative value units, and specifies the CPT codes subject to the rule. The rule cuts across provider fee schedules such that, for example, if a physical therapist was paid for 5.0 units of physical medicine, only 3.0 units would be available for a chiropractor who performed physical medicine modalities. Respondent used the code "MPV" to indicate in its denials where the eight-unit rule was applied based on payments to another provider or providers. (In fact, since, as discussed below, Respondent did not identify who was paid in the first instance for physical medicine modalities, we are unable to ascertain from the denials whether it was only one provider who was previously paid or multiple providers.)

At the hearing, I raised an issue with respect to the sufficiency of Respondent's denials, to wit, the fact that the denials did not identify the other provider(s) who was (were) paid for units of treatment such that Applicant's billing caused the number of units to exceed eight.* Neither did the denials indicate how many units of physical medicine on the respective dates were already paid for. This is a matter I have raised in prior arbitrations involving more than one respondent insurer.

I note that the Insurance Department regulations governing No-Fault claims processing, in 11 NYCRR 65-3.2(e), provide that an insurer must "[c]learly inform

the applicant of the insurer's position regarding any disputed matter." I also note that the Court of Appeals has held:

> Although an insurer may disclaim coverage for a valid reason (Insurance Law, s 167, subd. 8) the notice of disclaimer must promptly apprise the claimant with a high degree of specificity of the ground or grounds on which the disclaimer is predicated. Absent such specific notice, a claimant might have difficulty assessing whether the insurer will be able to disclaim successfully. This uncertainty could prejudice the claimant's ability to ultimately obtain recovery. In addition, the insurer's responsibility to furnish notice of the specific ground on which the disclaimer is based is not unduly burdensome, the insurer being highly experienced and sophisticated in such matters.

General Accident Insurance Group v. Cirucci, 46 N.Y.2d 862, 864, 414 N.Y.S.2d 512, 514 (1979).

This is a matter of fundamental fairness. When an insurer denies on the basis that another medical provider has already been paid for eight or less than eight physical medicine relative value units, then the respective provider is being paid less than what it billed or nothing. The provider may not know who the other provider is who was paid unless it is set forth in the denial. It is important to know who the other provider is so that the one denied can verify that indeed Respondent's calculations are correct. Errors can be made and a provider who is denied payment should be made aware of who the prior provider is. If the denial does not do this, then the denied provider is prejudiced. Informing the subsequent provider of the identity of the prior provider is "not unduly burdensome," a phrase used in Cirucci.

Additionally, a denial of claim asserting that another provider was paid for physical medicine does not apprise the claimant with a high degree of specificity of the grounds on which the disclaimer is predicated if the insurer does not state the number of units for the date at issue for which payment was already made.

I would note that I have seen instances where an insurer has erred to a small extent, such that the second provider was awarded small dollar amounts by me because of an error in asserting the eight-unit rule.

I also find that the failure to set forth in the denials the identity of the other provider and the number of units for which payment was made frustrates the expeditious resolution of No-Fault disputes. "The primary purpose of the compulsory arbitration provisions under the no-fault law is to effectuate speedy and efficacious determinations of disputes as to first party benefits." Country-Wide Ins. Co. v. Frolich, 119 Misc.2d 1089, 1092, 465 N.Y.S.2d 446, 448 (Civ. Ct. Kings Co. 1983). "A legislative objective in enacting the No-Fault Law was to reduce significantly the burden of automobile personal injury litigation on the courts (Memorandum of State Executive Department, 1977 McKinney's Session Laws of N.Y., at 2445, 2448; Governor's Message of Approval of L.1977, ch. 892, *id.*, at

2534, 2535). . . . Moreover, the clear thrust of [Insurance Law] section 5106 is to provide no-fault claimants with an opportunity for immediate redress, and by arbitration to offer a mechanism where disputes over reimbursable expenses can be resolved more swiftly and economically than is generally possible in plenary suits." Roggio v. Nationwide Mutual Ins. Co., 66 N.Y.2d 260, 264, 496 N.Y.S.2d 404, 406 (1985).

A Form NF-10 denial of claim establishes at the outset for an arbitrator what the parameters of the disputed billing are. If an insurer does not identify the other health service provider who was paid all or part of the eight units for physical medicine and the number of units, then it delays resolution of the dispute. The arbitrator is compelled to sift through voluminous records submitted by the insurer in order to determine what other provider billed for the common dates of service. In some instances, not only is the other health service provider not identified in the denials, but the insurer itself cannot point to submitted evidence which proves who the other provider was and cannot identify the respective dates involved. It is not onerous for an insurer to identify who the other provider is and how many units of physical medicine were paid for. It is in possession of its own records showing who was paid for what dates of service. Setting forth the information on the denials is no more of a hardship than setting forth the dates of IMEs and effective dates of cutoffs, a common occurrence. In any event, the need to adequately inform the arbitrator of the identity of the other provider and how many units were paid for is not the sole basis for my conclusion of law. It merely supplements my main analysis -- that as a matter of fundamental fairness, so that the arbitration applicant can adequately prepare its case, the applicant should be informed as to who the other provider is and how many units were paid for.

Respondent's denials asserting the eight-unit rule never identified who the other provider was that it claims was paid for relative value units such that Applicant's billing caused the total units of physical medicine for the affected dates of service to exceed eight units. Neither were the number of units for which payment was previously made set forth in the denial. If a health care provider is going to adequately defend against an assertion that the eight-unit maximum has been reached, at a minimum the insurer should identify the other provider and the number of units paid for. Respondent here did not do so. Its failure to do so results in the respective denial forms being conclusory and vague. A timely denial alone does not avoid preclusion where said denial is factually insufficient, conclusory, vague or otherwise involves a defense which has no merit as a matter of law. Nyack Hospital v. Metropolitan Property & Casualty Ins. Co., 16 A.D.3d 564, 791 N.Y.S.2d 658 (2d Dept. 2005). Thus, I conclude as a matter of law that the eight-unit rule was not asserted with sufficient specificity. I conclude that the denials which asserted the eight-unit rule were legally defective in that regard.

My position concerning the eight-unit rule was sustained in Matter of Arbitration of Ariel Chiropractic, PC a/a/o "DJ" v. Allstate Ins. Co., AAA Case No. 17-14-9045-4894 (Jan. 5, 2015), when I was affirmed by Master Arbitrator Richard B. Ancowitz, who in his appellate award dated May 17, 2015, wrote:

> At issue before the arbitrator was $416.16 in requested reimbursement for certain chiropractic services allegedly rendered to applicant's assignor. The award indicates that respondent issued a denial based upon respondent's alleged excessive billing as per the so-called "eight-unit rule", as contained in the Workers Compensation Chiropractic Fee Schedule. The arbitrator determined that defense was not viable where no specificity was provided in the denial as to the identity of any "other" provider for who similar services were alleged rendered such as would support said denial. Thus, the arbitrator entered an award in the amount sought.
>
> Respondent seeks review of the award, contending that if the applicant or the arbitrator wanted to confirm that respondent's calculations were correct, all they had to do was ask. Applicant contends that the award was appropriate, given 11 NYCRR 65-3.2 (e), which was cited by the arbitrator.
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> Upon review of all submissions, I see no reason to disturb this award, for the reasons set forth below.
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> It is indeed well-settled that a high degree of specificity is required under law to be present-ed to a claimant in order for such a defense to succeed. General Acc. Ins. Group v Cirucci, 46 NY2d 862, 864 (1979) (denial must "promptly apprise the claimant with a high degree of specificity of the ground or grounds on which the disclaimer is predicated"]; Nyack Hosp. v State Farm Mut. Auto. Ins. Co., 11 AD3d 664 (2d Dept 2004); Apple Tree Acupuncture, P.C. v. Interboro Ins. Co., 34 Misc.3d 134 (A), 2011 NY Slip Op. 52364 (U) (App. Term, Second Dept, I 1 & 13 Jud. Dists.).
>
> Thus, in this case, I do not find any error by the arbitrator which would warrant disturbing the award.
>
> The award is affirmed.

Additionally, I note that at least 18 No-Fault insurance arbitrators now hold that a denial of claim form asserting the eight-unit rule as a defense is defective if the medical provider who previously was paid for some or all of the eight units is not identified therein. E.g., Matter of Arbitration of Hempstead Regional Chiropractic, PC v. Allstate Fire & Casualty Ins. Co., AAA Case No. 17-15-1021-9417 (Richard Martino, Arb., Jan. 4, 2017); Matter of Arbitration of Stay In Touch Massage Therapy PC v. Allstate Ins. Co., AAA Case No. 17-16-1026-9423 (Vincent Girardi, Arb., Jan. 3, 2017); Matter of Arbitration of RestorAlign Chiropractic P.C./Northern Medical Care PC v. GEICO Ins. Co., AAA Case No. 17-16-1027-3844 (Joseph Endzweig, Arb., Dec, 20, 2016); Matter of Arbitration of Multi-Specialty Pain Management PC v. Farmington Casualty Co., AAA Case No. 17-15-1019-1097 (James Hogan, Arb., Dec. 7, 2016); Matter of Arbitration of Carle Place Chiropractic v. Allstate Fire & Casualty Ins. Co., AAA Case No. 17-15-1016-6100 (Corinne

Pascariu, Arb., Nov. 21, 2016); Matter of Arbitration of Stay In Touch Massage Therapy PC v. MVAIC, AAA Case No. 17-15-1013-6009 (Antonietta Russo, Arb., Nov. 19, 2016); Matter of Arbitration of State Chiropractic, P.C. v. GEICO Ins. Co., AAA Case No. 17-15-1023-2179 (Natia Pavel, Arb., Oct. 28, 2016); Matter of Arbitration of Valor Chiropractic Wellness, PC v. Allstate Fire & Casualty Ins. Co., AAA Case No. 17-15-1021-7692 (Wendy Bishop, Arb., Aug. 20, 2016); Matter of Arbitration of Nitin Narkhede GP MD v. Allstate Ins. Co., AAA Case No. 17-15-1019-3076 (Athena T. Buchanan, Arb., July 27, 2016); Matter of Arbitration of Avenue C Medical PC v. Maya Assurance Co., AAA Case No. 17-15-1022-9542 (Rebecca Novak, Arb., June 19, 2016); Matter of Arbitration of New Way Massage Therapy PC v. GEICO Ins. Co., AAA Case No. 17-15-1014-9730 (Jeffrey Held, Arb., June 1, 2016); Matter of Arbitration of Ralph Bendigo PT, PC v. Allstate Ins. Co., AAA Case No. 17-15-1016-6752 (Thomas Stock, Arb., May 29, 2016); Matter of Arbitration of Dana Care Physical Therapy PC v. GEICO Ins. Co., AAA Case No. 17-15-1006-9324 (Ioannis Gloumis, Arb., Apr. 7, 2016), aff'd, AAA Case No. 99-15-1006-9324 (Victor Hershdorfer, Master Arb., June 15, 2016) (denial did not meet Cirucci standard requiring insurer to apprise with high degree of specificity grounds on which disclaimer predicated); Matter of Arbitration of Dana Care Physical Therapy, P.C. v. GEICO Ins. Co., AAA Case No. 17-15-1008-8100 (Evelina Miller, Arb., Jan. 7, 2016); Matter of Arbitration of Harden Street Medical PC v. GEICO Ins. Co., AAA Case No. 17-15-1009-6223 (Alise Schor, Arb., Dec. 6, 2015); Matter of Arbitration of Grand Concourse Chiropractic, PC v. GEICO Ins. Co., AAA Case No. 17-14-1001-3406 (Bonnie Link, Arb., Oct. 20, 2015); Matter of Arbitration of Ahava Medical PC v. Geico Ins. Co., AAA Case No. 17-14-9049-9754 (Mary Anne Theiss, Arb., Mar. 16, 2015); Matter of Arbitration of Ariel Chiropractic, PC v. GEICO Ins. Co., AAA Case No. 412013108708 (Stacy A. Presser, Arb., Feb. 10, 2014).

Therefore, with respect to the dates of service (in the first two bills) where Respondent made partial payment, asserting that another provider had been paid some (but not identifying how many) of the available eight units, $92.48 (8 x $11.56) is awarded as No-Fault compensation, Applicant having established a prima facie case of entitlement to No-Fault compensation. This amount was agreed to by the parties as the amount to be awarded should Applicant prevail with respect to the issue of the eight-unit rule.

The remaining dates of service are as follows: Nov. 30; Dec. 2, 7, and 11 (in the bill for dates of service Nov. 25, 2015-Dec. 11, 2015), and Dec. 14, 16, and 17 (in the bill for dates of service Dec. 14, 2015-Dec. 17, 2015). These bills were denied by Respondent based upon an IME cutoff which had been imposed effective Nov. 30, 2015. There was no fee issue with respect to these dates of service.

Since Respondent's denials were timely (as stipulated by the parties), it was within its rights to assert lack of medical necessity for further treatment as a defense. Liberty Queens Medical, P.C. v. Liberty Mutual Insurance Co., 2002 WL 31108069 (App. Term 2d & 11th Dists. June 27, 2002); cf. Country-Wide Insurance Co. v. Zablozki, 257 A.D.2d 506, 684 N.Y.S.2d 229 (1st Dept. 1999).

An IME doctor must establish a factual basis and medical rationale for his asserted lack of medical necessity of further health care services. E.g., Ying Eastern Acupuncture, P.C. v. Global Liberty Insurance, 20 Misc.3d 144(A), 2008 WL 4222084 (App. Term 2d & 11th Dists. Sept. 3, 2008). If he does so, it becomes incumbent on the claimant to rebut the IME review, see AJS Chiropractic, P.C. v. Mercury Ins. Co., 2009 WL 323421 (App. Term 2d & 11th Dist. Feb. 9, 2002), because the ultimate burden of proof on the issue of medical necessity lies with the claimant. See Insurance Law § 5102; Wagner v. Baird, 208 A.D.2d 1087, 617 N.Y.S.2d 919 (3d Dept. 1994); Shtarkman v. Allstate Insurance Co., 2002 WL 32001277 (App. Term 9th & 10th Jud. Dists. 2002) (burden of establishing whether a medical test performed by a medical provider was medically necessary is on the latter, not the insurance company). The insured or the provider bears the burden of persuasion on the question of medical necessity. Bedford Park Medical Practice P.C. v. American Transit Ins. Co., 8 Misc.3d 1025(A), 806 N.Y.S.2d 443 (Table), 2005 WL 1936346 (Civ. Ct. Kings Co., Jack M. Battaglia, J., Aug. 12, 2005). This burden of proof is properly placed on a claimant health care provider because presumably it is in possession of the injured party's medical records.

"Where the defendant insurer presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden shifts to the plaintiff which must then present its own evidence of medical necessity (see Prince, Richardson on Evidence §§ 3-104, 3-202 [Farrell 11th ed])." West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc.3d 131(A), 824 N.Y.S.2d 759 (Table), 2006 WL 2829826 (App. Term 2d & 11th Dists. Sept. 29, 2006). Assuming the insurer establishes a lack of medical necessity based upon an IME doctor's testimony, it is ultimately the claimant who must prove, by a preponderance of the evidence, that the services were medically necessary. Amato v. State Farm Ins. Co., 40 Misc.3d 129(A), 975 N.Y.S.2d 364 (Table), 2013 N.Y. Slip Op. 51113(U), 2013 WL 3497906 (App. Term 2d, 11th & 13th Dists. July 3, 2013), rev'g, 30 Misc.3d 238, 910 N.Y.S.2d 637 (Dist. Ct. Nassau Co. 2010) (district court held that IME cannot form basis for denying benefits unless post-IME records are reviewed); see also Dayan v. Allstate Ins. Co., 49 Misc.3d 151(A), 29 N.Y.S.3d 846 (Table), 2015 N.Y. Slip Op. 51751(U), 2015 WL 7900115 (App. Term 2d, 11th & 13th Dists. Nov. 30, 2015); Park Slope Medical and Surgical Supply, Inc. v. Travelers Ins. Co., 37 Misc.3d 19, 22 n., 952 N.Y.S.2d 372, 374 n. (App. Term 2d, 11th & 13th Dists. 2012).

Dr. Nicholas Ferrante, D.C., wrote the IME report relied upon by Respondent in asserting lack of medical necessity for further treatment. The report is dated Nov. 12, 2015, when he examined Assignor.

At the outset of his report, Dr. Ferrante noted that Assignor was a restrained driver of a vehicle struck in the rear on Sept. 3, 2015. He did not seek emergency medical care. Thereafter Assignor underwent physical therapy and chiropractic. Dr. Ferrante listed the various medical reports concerning Assignor's post-accident treatment which he reviewed. Assignor's gait revealed no limping. Posture was normal.

Assignor complained of pain in the neck and lower back to Dr. Ferrante. Examination of the cervical spine yielded no complaint. There was no muscle spasm. There was complete range of motion: flexion 50/50 degrees, extension 60/60 degrees, right and left rotation 80/80 degrees, and right and left lateral bending 45/45 degrees. Other provocative orthopedic tests were negative: Jackson's, Cervical Distraction, Shoulder Decompression, and Foraminal Compression. The deep tendon reflexes of the brachioradialis, biceps, and triceps were 2+ (within normal limits). Muscle strength was +5/5 (within normal limits). Sensation to light touch was within normal limits.

Palpation of the thoracic spine musculature revealed no spasm. Neither was there a complaint of tenderness. In the lumbar spine, there was no tenderness to palpation of the paraspinal muscles. There was no muscle spasm. There was complete range of motion: flexion 60/60 degrees, extension 25/25 degrees, and right and left lateral bending 25/25 degrees. Other provocative orthopedic tests were negative: Straight Leg Raise seated and supine, Minor's, Yeoman's, Ely's, and Kemp's. Patellar and Achilles reflexes were 2+. Muscle strength was 5/5. Sensation to light touch was within normal limits.

Dr. Ferrante diagnosed resolved sprain/strain of the cervical and lumbar spines. He opined that no further chiropractic treatment was necessary.

I find that Dr. Ferrante's IME report contained a factual basis and a medical rationale. Respondent made out a prima facie case of lack of medical necessity for further chiropractic treatment. Per the case law cited above, the burden of proof shifted to Applicant to rebut the IME report and affirmatively prove medical necessity.

Applicant argued that various treatment notes rebutted the IME report of Dr. Ferrante. I reject this argument. They merely reflect subjective pain complaints, the objective, and the plan. There is no recordation of provocative orthopedic and neurological testing such as that performed by Dr. Ferrante.

If the insurer's examining doctor's IME report and follow-up report set forth a factual basis and medical rationale for her stated conclusion that the assignor's injuries were resolved and that there was no need for further physical therapy treatment, an affidavit of the health service provider's treating physical therapist which fails to meaningfully address the contrary findings made by defendant's examining doctor, including the normal results of the range of motion testing of the assignor's cervical and lumbar spine, is insufficient to raise a triable issue of fact. Rummel G. Mendoza, D.C., P.C. v. Chubb Indemnity Ins. Co., 47 Misc.3d 156(A), 17 N.Y.S.3d 385 (Table), 2015 N.Y. Slip Op. 50900(U), 2015 WL 3767514 (App. Term 1st Dept. June 17, 2015). Hence, a health care provider seeking to rebut an IME report must counter it with its own contrary findings on orthopedic testing.

I find that Respondent's prima facie case of lack of medical necessity for further treatment stands unrebutted. I sustain the defense of IME cutoff asserted in Respondent's denials of claim. That defense was proved by a preponderance of the

credible evidence. It overcomes Applicant's prima facie case of entitlement to No-Fault compensation.

Accordingly, the within arbitration claim is granted to the extent of awarding Applicant $92.48 in health service benefits.

Interest: The parties stipulated that should Applicant prevail, interest would accrue as of the filing date set forth by the American Arbitration Association in Part B of the conclusion of the award template. That date is Apr. 22, 2016. The end date for the calculation of the period of interest shall be the date of payment of the claim. In calculating interest, the date of accrual shall be excluded from the calculation. General Construction Law § 20 ("The day from which any specified period of time is reckoned shall be excluded in making the reckoning.") Where a motor vehicle accident occurs after Apr. 5, 2002, interest shall be calculated at the rate of two percent per month, simple, calculated on a pro rata basis using a 30-day month. 11 NYCRR 65-3.9(a); Gokey v. Blue Ridge Ins. Co., 22 Misc.3d 1129(A), 881 N.Y.S.2d 363 (Table), 2009 N.Y. Slip Op. 50361(U), 2009 WL 562755 (Sup. Ct. Ulster Co., Henry F. Zwack, J., Jan. 21, 2009).

Attorney's Fee: After calculating the sum total of the first-party benefits awarded in this arbitration plus interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20 percent of that sum total, as provided for in 11 NYCRR 65-4.6(d) (as existing on the filing date of this arbitration), subject to a maximum fee of $1,360.00.

_____

* "The arbitrator may . . . independently raise any issue that the arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department regulations." 11 NYCRR 65-4.5(o)(1). This regulatory provision was validly enacted. Matter of Medical Society v. Serio, 100 N.Y.2d 854, 768 N.Y.S.2d 423 (2003). Insurance Law § 5106(b), requiring only that claimants be provided the option of arbitration, does not preclude an arbitrator from inquiring into issues deemed relevant. Id. at 872, 768 N.Y.S.2d at 434. The provision of 11 NYCRR 65-4.5(o)(1) to the effect that an arbitrator may independently raise any issue that he deems relevant to making an award does not violate the Due Process clause of the United States and New York State Constitutions. 563 Grand Medical, P.C. v. New York State Ins. Dept., 24 A.D.3d 413, 805 N.Y.S.2d 643 (2d Dept. 2005).

5. Optional imposition of administrative costs on Applicant.
Applicable for arbitration requests filed on and after March 1, 2002.

I do NOT impose the administrative costs of arbitration to the applicant, in the amount established for the current calendar year by the Designated Organization.

6. **I find as follows with regard to the policy issues before me:**
   - ☐ The policy was not in force on the date of the accident
   - ☐ The applicant was excluded under policy conditions or exclusions

☐ The applicant violated policy conditions, resulting in exclusion from coverage
☐The applicant was not an "eligible injured person"
☐The conditions for MVAIC eligibility were not met
☐The injured person was not a "qualified person" (under the MVAIC)
☐The applicant's injuries didn't arise out of the "use or operation" of a motor vehicle
☐The respondent is not subject to the jurisdiction of the New York No-Fault arbitration forum

Accordingly, the applicant is AWARDED the following:

A.

	Amount Claimed	**Amount Awarded**
Medical	$ 416.16	$ 92.48
TOTAL	$ 416.16	$ 92.48

B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 04/22/2016, which is a relevant date only to the extent set forth below.)

Respondent shall pay Applicant interest on the total first-party benefits awarded herein, computed from Apr. 22, 2016 to the date of payment of the award, but excluding Apr. 22, 2016 from being counted within the period of interest. The interest rate shall be two percent per month, simple (i.e., not compounded), on a pro rata basis using a 30-day month.

C. Attorney's Fees

The insurer shall also pay the applicant for attorney's fees as set forth below

After calculating the sum total of the first-party benefits awarded in this arbitration plus interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20 percent of that sum total, as provided for in 11 NYCRR 65-4.6(d) (as existing on the filing date of this arbitration), subject to a maximum fee of $1,360.00.

D. The respondent shall also pay the applicant forty dollars ($40) to reimburse the applicant for the fee paid to the Designated Organization, unless the fee was previously returned pursuant to an earlier award.

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of New York
SS :
County of Kings

I, Aaron Maslow, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

02/18/2017
(Dated)

Aaron Maslow

IMPORTANT NOTICE

This award is payable within 30 calendar days of the date of transmittal of award to parties.

This award is final and binding unless modified or vacated by a master arbitrator. Insurance Department Regulation No. 68 (11 NYCRR 65-4.10) contains time limits and grounds upon which this award may be appealed to a master arbitrator. An appeal to a master arbitrator must be made within 21 days after the mailing of this award. All insurers have copies of the regulation. Applicants may obtain a copy from the Insurance Department.

ELECTRONIC SIGNATURE

Document Name: Final Award Form
Unique Modria Document ID:
348f87edfa0a731e1dfe631408fea2cf

Electronically Signed

Your name: Aaron Maslow
Signed on: 02/18/2017