American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

South Ozone Park Medical PC (Applicant)	AAA Case No.	17-15-1019-3819
	Applicant's File No.	TM-15-3213
- and -	Insurer's Claim File No.	E2L2235
	NAIC No.	36137
Travelers (Respondent)		

ARBITRATION AWARD

I, Anthony Kobets, 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

1. Hearing(s) held on 02/11/2016, 10/05/2016, 03/15/2017
   Declared closed by the arbitrator on 03/15/2017

   Thomas Cooke, Esq. from Hanford, Cooke & Associates, P.C. participated by telephone for the Applicant

   Miriam Granov, Esq. from Law Office of Aloy O. Ibuzor participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **$ 1,835.12**, was AMENDED and permitted by the arbitrator at the oral hearing.

   At the hearing, Applicant's counsel amended the amount in dispute down to $1731.04 by crediting the $104.08 payment Respondent made toward date of service 12/9/14. $1835.12 - $104.08 = $1731.04. Accordingly, $1731.04 is the amended amount in dispute herein.

   Stipulations WERE made by the parties regarding the issues to be determined.

   The parties' representatives stipulated to the timely service of the bills and denials and to Applicant's prima facie burden.

3. Summary of Issues in Dispute

In dispute are the Applicant's claims totaling $1835.12 for two medical evaluations performed on 12/9/14 and 3/12/15 and EMG/NCV diagnostic testing of the upper extremities performed on the patient (GN) on 3/12/15 as a result of injuries alleged to have been sustained in a motor vehicle accident on December 8, 2014.

Respondent denied the medical evaluations based upon the N.Y.S. Worker's Compensation Fee Schedule and the electrodiagnostic testing based upon the peer review report of Dr. Daniel Feuer, M.D. dated 4/9/15. Was the Applicant entitled to reimbursement for the services provided to the EIP?

4. Findings, Conclusions, and Basis Therefor

I have reviewed all documents as available in the ADR Center as of the date of this hearing pertaining to this case. This case was decided based on the submissions of the Parties as contained in the electronic case folder maintained by the American Arbitration Association and the oral arguments of the parties at the hearing. There was no witness testimony at the hearing.

The parties' representatives stipulated to the timely service of the bills and denials and to Applicant's prima facie burden.

At the hearing, Applicant's counsel amended the amount in dispute down to $1731.04 by crediting the $104.08 payment Respondent made toward date of service 12/9/14. $1835.12 - $104.08 = $1731.04. Accordingly, $1731.04 is the amended amount in dispute herein.

The EIP (GN) was a 47-year old male who was allegedly involved in a motor vehicle accident on December 8, 2014. Thereafter, he attended medical evaluations on 12/9/14 and 3/12/15 and underwent electrodiagnostic testing of the upper extremities on 3/12/15 performed by the Applicant. Applicant seeks no-fault reimbursement for these services.

A health care provider establishes its *prima facie* entitlement to payment as a matter of law by proof that it submitted a proper claim, setting forth the fact and the amount charged for the services rendered and that payment of no-fault benefits was overdue (see Insurance Law § 5106 a; Mary Immaculate Hosp. v. Allstate Ins. Co., 5 AD 3d 742, 774N.Y.S. 2d 564 [2004]; Amaze Med. Supply v. Eagle Ins. Co., 2 Misc. 3d 128A, 784 N.Y.S. 2d918, 2003 NY Slip Op 51701U [App Term, 2d & 11th Jud Dists]).

Bill for date of service 12/9/2014 in the amount of $200.68

Applicant billed $200.68 for CPT code 99205 for an initial office evaluation performed on 12/9/14. The Respondent issued a partial payment of $104.08 and issued a timely denial NF10 form which indicated that "[p]er documentation received, being reimbursed as 99203". Applicant is seeking the $96.60 balance.

Bill for date of service 3/12/15 in the amount of $181.22

Applicant billed $181.22 for CPT code 99243 for a follow-up office evaluation performed on 3/12/15. The Respondent issued a partial payment of $92.98 and issued a timely denial NF10 form which indicated that "[p]er documentation received, being reimbursed as 99214". Applicant is seeking the $88.24 balance. Respondent's counsel argued that the denials were proper. Applicant's counsel argued that the Respondent has failed to justify their denials by failing to sufficiently substantiate or explain the reasons for the reduction and change in the coding for the 12/9/14 and 3/12/15 dates of service.

"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 disclaimsuccessfully. This uncertainty could prejudice the claimant's ability to ultimately obtainrecovery. In addition, the insure[r]'s responsibility to furnish notice of the specific ground onwhich the disclaimer is based is not unduly burdensome, the insurer being highly experiencedand sophisticated in such matters." General Accident Insurance Group v. Cirucci, 46 N.Y.2d862, 864, 414 N.Y.S.2d 512, 514 (1979).

Respondent has the burden of coming forward with "competent evidentiary proof" supporting its fee schedule defenses. See, Continental Med., P.C. v. Travelers Indem. Co., 11 Misc.3d 145a (2006); see also, Abraham v. Country-Wide Ins. Co., 3 Misc 3d 130A, (2004); Power Acupuncture, P.C. v. State Farm Mut. Auto. Ins. Co., 11 Misc 3d 1065a, (2006). The defense of fees not being in accordance with the fee schedule must be rejected where the insurer fails to address how the amount charged by the provider was in excess of the fee schedule. E.g., Jesa Medical Supply, Inc. v. GEICO Ins. Co., 25 Misc.3d 1098, 887 N.Y.S.2d 482 (Civ. Ct. Kings Co. 2009); An insurer fails to establish the existence of an issue of fact with respect to a defense that fees charged were excessive and not in accordance with the Worker's Compensation fee schedule in the absence of proof establishing the defense. St. Vincent Medical Care, P.C. v. Countrywide Ins. Co., 26 Misc.3d 146(A), 907 N.Y.S.2d 441 (Table), 2010 N.Y. Slip Op. 50488(U), 2010 WL 1063914 (App. Term 2d, 11th & 13th Dists. Mar. 19, 2010). An insurer fails to raise a triable issue of fact with respect to a defense that the fees charged were not in conformity with the Workers' Compensation fee schedule when it does not specify the actual reimbursement rates which formed the basis for its determination that the claimant billed in excess of the maximum amount permitted. Vincent Medical Services, P.C. v. GEICO Ins. Co., 29 Misc.3d 141(A), 907 N.Y.S.2d 441 (Table), 2010 N.Y. Slip Op. 52153(U), 2010 WL 5116892 (App. Term 2d, 11th & 13th Dists. Dec. 8, 2010).

In the case herein, Respondent failed to seek verification, adequately explain or provide sufficient proof that its interpretation of the billing for these services warranted a reduction of the $200.68 billed for date of service 12/9/14 and a reduction of the $181.22 billed for date of service 3/12/15. Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. See,

Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 2006 NY Slip 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006). "As defendant failed to demonstrate upon its motion that it had requested any additional verification from plaintiff seeking the information it required in order to review plaintiff's claims for services billed under codes 97039 and 99199 of the workers' compensation fee schedules, defendant was not entitled to summary judgment dismissing so much of the complaint as sought to recover for services rendered under those codes (see Gaba Med., P.C. v. Progressive Specialty Ins. Co., 36 Misc.2d 139[A], 2012 NY Slip Op 51448[U][App Term, 2d Dept, 2d, 11 & 13 Jud Dists 2012]; see generally Rogy Med., P.C. v. Mercury Cas. Co., 23 Misc.3d 132[A], 2009 NY Slip Op 50732[U][App Term, 2d Dept, 2d, 11 & 13 Jud Dists 2009])." Bronx Acupuncture Therapy, PC v. Hereford Ins. Co., 54 Misc.3d 135(A), 2017 WL 416732 (Table), 2017 NY Slip Op. 50101(U)(App. Term, 2 Dept., Jan. 20, 2017)

Accordingly, after a careful review of the records and consideration of the parties' oral arguments, I find that the Respondent offered insufficient evidence or justification regarding the fee schedule defense and therefore failed to sustain the denial of payment for these claims. Pursuant to the NYS Worker's Compensation Medical Fee Schedule, code 99205 has a Relative Value of 18.26 when multiplied by the Region IV Conversion factor of $10.99 = $200.68. Accordingly, Applicant's claim for the $96.60 balance of the 12/9/14 date of service is granted. Likewise, pursuant to the NYS Worker's Compensation Medical Fee Schedule, code 99243 has a Relative Value of 16.49 when multiplied by the Region IV Conversion factor of $10.99 = $181.22. Accordingly, Applicant's claim for the $88.24 balance of the 3/12/15 date of service is granted. $96.60 + $88.24= $184.84. Applicant is therefore awarded $184.84.

Bill for date of service 3/12/15 in the amount of $1546.20

Respondent timely denied the above referenced bill based on the peer review by Dr. Daniel Feuer, M.D. dated 4/9/15, wherein Dr. Feuer reviewed the medical records and stated that "[i]n the event that radiculopathy was suspected, there was no presentation of a differential diagnosis that warrants performing invasive electrodiagnostic testing. There was no mention that there was a plan to use the results of the study to pursue more aggressive treatment on the claimant or how the anticipated test results would guide the management of the claimant's treatment program. In order for neurodiagnostic testing to be medically justified, it must at least have an impact upon the course of the therapy a patient is receiving. This is not evident upon reviewing the medical records, as the records do not show that the performance of the neurodiagnostic studies had significantly impacted the therapy and/or delivery of care to this individual. Based on the records, the results of the studies, regardless of the findings, would not alter or impact the course of treatment or patient's outcome at that stage of the claimant's injuries, therefore they were not medically necessary." Dr. Feuer also indicated that "[a] clinical examination reporting significant tenderness or spasms of a particular muscle group would preclude needle EMG of these muscles. If such testing was performed and tolerated then the original clinical evaluation was flawed and this clinical evaluation should not serve as the basis for EMG/NCV".

Respondent also submitted an Addendum by Dr. Daniel Feuer, M.D. dated 11/30/16, wherein he reviewed the rebuttal by Dr. Osei-Tutu and indicated that Dr. Osei-Tutu did not address the conflicting neurological findings documented in his examination of February 4, 2015 which failed to document any focal motor, reflex or sensory deficits of the upper extremities, and Dr. Boppana's March 12, 2015 evaluation, which documented weakness and diminished reflexes. "The conflicting nature of the neurological examinations would be inconsistent with a physiologic syndrome of radicular peripheral nerve dysfunction of the upper extremities. Additionally, the EMG/NCV testing performed March 12, 2015, fails to document skin temperature. Changes in body temperature may alter the result of NCV testing…unless there is a clinical differential diagnosis including peripheral neuropathic/myopathic lesion vs. a root lesion that cannot be resolved with the history, neurologic examination, and imaging studies, there is limited evidence to support the use of EMG/NCS in the evaluation, treatment, and prognosis of patients with spine trauma with radicular symptoms". Respondent's counsel argued that the peer review met its burden regarding the lack of medical necessity for the electrodiagnostic testing.

A treatment or service is medically necessary if it is "appropriate, suitable, proper and conducive to the end sought by the professional health service in consultation with the patient. It means more than merely convenient or useful treatment or services, but treatment or services that are reasonable in light of the patient's injury, subjective and objective evidence of the patient's complaints of pain, and the goals of evaluating and treating the patient." Fifth Avenue Pain Control Center v. Allstate, 196 Misc. 2d 801, 807-808 (Civ. Ct. Queens Cty. 2003). Medically necessary treatment or services must be "consistent with the patient's condition, circumstances and best interest of the patient with regard to the type of treatment or services rendered, the amount of treatment or services rendered, and the duration of the treatment or services rendered." Id. Medical services are compensable where they serve a valid medical purpose. Sunrise Medical Imaging PC v. Lumbermans Mutual, 2001 N.Y. Slip Op. 4009.

A presumption of medical necessity attaches to a Respondent's admission of the Applicant's timely submission of proper claim forms such as in the within case, the burden then switches to the respondent to demonstrate the lack of medical necessity. A.B. Medical Services, PLLC v. Lumbermens Mutual Casualty Company, 4 Misc.3d 86, 2004 N.Y. Slip Op. 24194 (App.Term 2nd and 11th Jud. Dists. 2004); Kings Medical Supply, Inc. v. Country-Wide Insurance Company, 5 Misc.3d 767, 2004 N.Y. Slip Op. 24394 (N.Y. Civ. Ct. Kings Co. 2004); Amaze Medical Supply, Inc. v. Eagle Insurance Company, 2 Misc.3d 128(A), 2003 N.Y. Slip Op. 51701(U) (App Term 2nd and 11th Jud. Dists. 2003). Respondent thus bears the burden of production and persuasion with respect to medical necessity of the treatment for which payment is sought. (see Bajaj v. Progressive, 14 Misc 3d 1202(A) (N.Y.C. Civ Ct 2006).

If an insurer asserts that the medical test, treatment, supply or other service was medically unnecessary the burden is on the insurer to prove that assertion with competent evidence such as an independent medical examination, a peer review or other proof that sets forth a factual basis and a medical rationale for denying the claim. (See A.B. Medical Services, PLLC v. Geico Insurance Co., 2 Misc. 3d 26 [App Term, 2nd &

11th Jud Dists 2003]; Kings Medical Supply Inc. v. Country Wide Insurance Company, 783 N.Y.S. 2d at 448 & 452; Amaze Medical Supply, Inc. v. Eagle Insurance Company, 2 Misc. 3d 128 [App Term, 2nd and 11thJud Dists 2003]).

In the event an insurer relies on a peer review report to demonstrate that a particular service was medically unnecessary the peer reviewer's opinion must be supported by sufficient factual evidence or proof and cannot simply be conclusory or may be supported by evidence of generally accepted medical/professional practice or standards. See Nir v. Allstate Insurance Company, 2005 NY Slip Op 25090; 7 Misc.3d 544; 796 N.Y.S.2d 857; 2005 N.Y.Misc. LEXIS 419 and Citywide Social Work & Psy. Serv. P.L.L.C. v. Travelers Indemnity Co., 3 Misc. 3d 608; 777 N.Y.S.2d 241; 2004 NY Slip Op 24034.

In order for Respondent to meet its burden of establishing the lack of medical necessity, a peer review should (1) set forth applicable accepted medical standards relevant to the services at issue; and (2) comment on whether the Applicant had followed or deviated from those standards in providing the disputed services. This does not necessarily require that the peer review quote or cite medical literature. The Nir decision clearly contemplates that a peer may cite "medical authority, standard, or generally accepted practice as a medical rationale for his findings". Nir, 7 Misc.3d at 548.

"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 N.Y. Slip Op. 51871(U) at 2, 2006 WL 2829826 (App. Term 2d & 11th Dists. Sept. 29, 2006); A. Khodadadi Radiology PC v. NY Central Mutual Fire Ins. Co., 2007 NY Slip Op 51342(U). Applicant's counsel argued that the Respondent failed to meet their burden regarding lack of medical necessity based on the patient's symptomology and medical records.

Applicant also submitted a rebuttal by Dr. Bernard Osei-Tutu, M.D. dated 9/26/16, wherein Dr. Osei-Tutu reviewed the patient's medical records, including the peer review by Dr. Feuer and indicated that neurodiagnostic testing was done to "provide further information as to the functional loss of peripheral nerves and the resultant loss of function in the tissues that these nerves innervate. The extent of any functional loss as well as the distribution of nerves affected can be much more specifically evaluated by electrodiagnostic testing than with clinical examination alone". Dr. Osei-Tutu also indicted that in this case, the EMG/NCV studies were recommended to rule out radiculopathy vs. neuropathy in view of the patient's complaints, physical findings and working diagnosis; to better predict prognosis for recovery and possible residual neurological deficits; and to administer appropriate therapy". Dr. Osei-Tutu concluded that "Electromyography (EMG) and nerve conduction studies (NCS) are special tests used to detect neuromuscular disorders. Neuromuscular disorders by their nature produce such problems as muscle weakness, numbness, spasms, paralysis or pain. EMG should not be performed on patients with normal muscle tone. Therefore, I do not understand the peer doctor's concerns about muscle spasms and the validly of the EMG testing".

The evidence herein demonstrated that the patient was initially examined by Dr. Bernard Osei-Tutu, M.D. on 12/9/14 and presented with complaints, inter alia, of neck pain with tingling. Examination of the cervical spine revealed decreased range of motion and positive orthopedic tests including Deep Neck Flexion and Spine Percussion Test. The diagnosis was cervical paraspinal muscle and ligament sprains/strains and right shoulder muscle and ligament. sprains/strains.

The patient was examined by Dr. Osei-Tutu on February 4, 2015, and reported complaints of neck pain and lower back pain. The clinical examination of the cervical spine was remarkable for decreased range of motion, spasm and positive orthopedic tests. The neurological examination revealed normal motor, reflex and sensory function in the upper extremities. The clinical impression included cervical sprain/strain.

A cervical spine MRI performed on February 17, 2015 revealed a loss of cervical lordosis, disc narrowing at C6-7, disc herniations at C3-4 and C7-T1, a disc herniation at C4-5, a disc herniation at C5-6 and a disc herniation at C6-7 with associated cord deformity.

A clinical evaluation by Dr. Madhu Babu Boppana on March 12, 2015, noted complaints of neck pain with tingling. Examination of the cervical spine revealed decreased range of motion with a positive Cervical Compression test and a positive Spurling's/Jackson's test. The clinical examination reported reduced muscle strength and diminished reflexes in the upper extremities. The sensory examination was within normal limits in the upper extremities. The clinical impression included cervical post-traumatic sprain and strain syndrome as well as post- traumatic cervical radiculopathy due to mechanical injury. The plan of care included the performance of EMG/NCV testing of the upper extremities to rule out radiculopathy vs. neuropathy.

EMG/NCV testing of the upper extremities performed March 12, 2015 revealed evidence of bilateral carpal tunnel syndrome as well as right C5-6 radiculopathy.

Based upon a review of the evidence herein and the arguments of counsel, I find that the Respondent has not met its burden in this case. Dr. Feuer failed to adequately discuss the significance of the positive findings contained in the patient's medical records, including the MRI results, which showed multiple disc herniations and the significance of the patient's persistent symptomology despite the conservative treatments. Importantly, the medical records discussed above document the patient's continued complaints of cervical pain with tingling and the physical examination showed that he had restricted range of motion with a positive Cervical Compression test, a positive Spurling's/Jackson's test, reduced muscle strength and diminished reflexes in the upper extremities. I find the Applicant's proofs more persuasive that the patient's symptomology presented a diagnostic dilema and that the results would help in adjusting the treatment plan to include a modified physical therapy program, pain management or surgical referral. I am also persuaded by Dr. Osei Tutu's explanation that neuromuscular disorders by their nature produce problems such as spasms and that the EMG/NCV was necessary to provide further information as to the functional loss of peripheral nerves and to differentiate neuropathy from myopathy or muscle disease. Furthermore, Dr.

Feuer's analysis of the medical records and discussion of the patient's symptomology was conclusory and insufficiently supported by the facts herein to warrant the conclusions contained in the peer review. Every peer review requires individual scrutiny to determine whether the burden should be shifted back to the claimant to submit contrary expert proof. If the claimant can demonstrate, through references to the medical records or otherwise, that the peer review doctor's opinion lacks a sufficient basis and/or medical rationale because it is conclusory or because it fails to address essential factual issues or is based upon disputed or apparently incorrect facts, the insurer has fallen short of its burden of proof. Novacare Medical P.C. v. Travelers Property Casualty Ins. Co., 31 Misc.3d 1205(A), 927 N.Y.S.2d 817 (Table), 2011 N.Y. Slip Op. 50500(U) at 4, 2011 WL 1226956 (Dist. Ct. Nassau Co., Michael A. Ciaffa, J., Apr. 1, 2011). Dr. Osei Tutu successfully rebutted Dr. Feuer's peer review report, exhibited a sound medical rationale and justified the need for the testing in question relying on the records submitted and credible medical authority. Park Slope Medical and Surgical Supply, Inc. v. New York Central Mutual Fire Ins. Co., 22 Misc.3d 141(A), 881 N.Y.S.2d 365 (Table), 2009 N.Y. Slip Op. 50441(U), 2009 WL 679499 (App. Term 2nd, 11th & 13th Dists. Mar. 12, 2009). A Respondent defending a denial of first party benefits on the grounds that the subject medical services or testing were not medically necessary must show that the services were inconsistent with generally accepted medical practice, and here the Respondent has not. The opinion of the insurer's expert standing alone is insufficient to meet the *burden of proving that the services were not medically necessary (see Citywide Social* Work v. Travelers Indem. Co., 3 Misc 3d 608 (Civ Ct Kings County 2004). Based upon the aforementioned, I find that the Respondent has failed to sufficiently establish that the services herein were medically unnecessary and grant Applicant's $1546.20 claim. $184.84 + $1546.20 = $1731.04. Accordingly, the Applicant is awarded the amended amount of $1731.04. This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator. Any further issues raised in the hearing record are held to be moot and/or waived insofar as not raised at the time of the hearing.

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.

Medical	From/To	Amount	Status
South Ozone Park Medical PC	**12/09/14 - 03/12/15**	**$1,835.12**	**Awarded: $1,731.04**
Total		**$1,835.12**	**Awarded: $1,731.04**

B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 09/22/2015, which is a relevant date only to the extent set forth below.)

Where a claim is timely denied, interest shall begin to accrue as of the datearbitration is commenced by the claimant, i.e., the date the claim is received by the American Arbitration Association, unless arbitration is commenced within 30 days after receipt of thedenial, in which event interest shall begin to accrue as of the date the denial is received by the claimant. See generally, 11 NYCRR 65-3.9. Where a motor vehicle accident occurs after Apr. 5, 2002, interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30 day month." 11 NYCRR §65-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. However, the regulations toll the accrual of interest when an applicant "does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations." See, 11 NYCRR 65-3.9(c). The Superintendent and the New York Court of Appeals has interpreted this provision to apply regardless of whether the particular denial at issue was timely. LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 217 (2009).

C. Attorney's Fees

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

As this matter was filed **after** February 4, 2015, this case is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant an attorney's fee, in accordance with newly promulgated 11 NYCRR 65-4.6(d).

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 Nassau

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

03/21/2017
(Dated)

Anthony Kobets

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:
e57a31e10d6db08663d05193fb25cf8a

Electronically Signed

Your name: Anthony Kobets
Signed on: 03/21/2017