

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

SR Wellness PT PC  
(Applicant)

- and -

Geico Insurance Company  
(Respondent)

AAA Case No. 17-16-1025-9380

Applicant's File No.

Insurer's Claim File No. 0295428990101047

NAIC No. 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 ["KS"]

1. Hearing(s) held on 05/01/2017  
Declared closed by the arbitrator on 05/01/2017

Olga Sklyut, Esq., from Law Office of Olga Sklyut P.C participated by written submission for the Applicant

Dustin Mule from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, \$ **327.62**, was NOT AMENDED at the oral hearing.  
Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

- Whether Applicant established entitlement to additional No-Fault insurance compensation for activity limitation measurement testing, billed under CPT Code 97799, performed on Assignor, beyond the amount paid by Respondent
- Whether Applicant established a prima facie case of entitlement to No-Fault compensation for activity limitation measurement testing taking into account the by-report nature of the services provided
- Whether fees for activity limitation measurement testing were not in accordance with fee schedule

- Whether Applicant established entitlement to No-Fault compensation for range of motion-muscle testing performed on Assignor, beyond the amount paid by Respondent
- Whether Respondent properly made partial payment on the basis that Code 97750 physical performance testing more accurately reflected the range of motion-muscle testing performed
- Whether fees were in accordance with fee schedule with respect to the range of motion-muscle testing
- Whether a self-employed licensed physical therapist may bill for range of motion-muscle testing despite such service being listed in the Medicine, rather than the Physical Medicine, section of the Workers' Compensation Medical Fee Schedule

#### 4. Findings, Conclusions, and Basis Therefor

##### Appearances

##### For Applicant:

Olga Sklyut, Esq. (elected to rely on submission)  
7122 Bay Parkway  
2nd floor  
Brooklyn, NY 11204

##### For Respondent:

Dustin Mule  
GEICO Insurance Co.  
750 Woodbury Road  
Woodbury, NY 11797

Applicant, a professional business entity owned by a self-employed licensed physical therapist, commenced this New York No-Fault insurance arbitration, seeking as compensation \$327.62 remaining unpaid from that which it billed for performing activity limitation measurement testing, billed under CPT Code 97799, on May 20, 2015, and range of motion-muscle testing on May 14, 2015, on Assignor. The latter was a 30-year-old female who was injured in a motor vehicle accident on May 1, 2015. With respect to the activity limitation measurement testing, Respondent issued denials indicating that it was treating the service as Code 97750 physical performance testing -- that it more accurately reflected the service -- and paying \$274.32 of the \$475.00 billed, leaving an unpaid balance of \$200.68. With respect to the range of motion-muscle testing, Respondent issued a denial indicating that it was treating the service as Code 97750 physical performance testing -- that it more accurately reflected the service -- and paying \$83.32 of the

\$210.26 billed, leaving an unpaid balance of \$126.94. It also asserted that there is no allowance for range of motion-muscle testing under the provider's specialty. In all instances, Respondent also asserted that fees were not in accordance with fee schedule.

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.

Applicant elected to rely on its submission in lieu of appearing personally at the hearing. Respondent appeared at the hearing by an employee, who presented oral argument and relied upon a documentary submission. 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.

At the hearing, Respondent argued that nothing further should be awarded Applicant with respect to its bill for activity limitation measurement testing on May 20, 2015, because proper by report information for billed Code 97799 was not provided.

CPT Code 97799 is defined in the Workers' Compensation Medical Fee Schedule as "Unlisted physical medicine/rehabilitation service or procedure." It is a "by report" code. The Ground Rules in the Workers' Compensation fee schedules apply to No-Fault unless they require reports specific to Workers' Compensation. 11 NYCRR 68.1(b)(1). Ground Rule 3 to Chapter 1 (Introduction and General Guidelines) of the Workers' Compensation Medical Fee Schedule sets forth reporting requirements for services billed with CPT codes which are "by report":

"BR" in the Relative Value column represents services that are too variable in the nature of their performance to permit assignment of relative value units. Fees for such procedures need to be justified "by report." Pertinent information concerning the nature, extent, and need for the procedure or service, the time, the skill, and equipment necessary, etc., is to be furnished. A detailed clinical record is not necessary, but sufficient information shall be submitted to permit a sound evaluation. It must be emphasized that reviews are based on records, hence the importance of documentation. The original official record, such as operative report and hospital chart, will be given far greater weight than supplementary reports formulated and submitted

at later dates. For any procedure where the relative value unit is listed in the schedule as "BR," the physician shall establish a relative value unit consistent in relativity with other relative value units shown in the schedule. The insurer shall review all submitted "BR" relative value units to ensure that the relativity consistency is maintained. The general conditions and requirements of the General Ground Rules apply to all "BR" items.

Applicant submitted a two-page document entitled "Activity Limitation Measurement and Training Report." While this document bears Assignor's name at the top of the first page, it is not particularized to Assignor. The contents of the report are identical to others submitted in other cases. It is general in nature as to the procedure. The report maintains that the service known as activity limitation measurement testing rates difficulties an individual may have in the performance of daily activities. It claims that three purposes are served: (1) identify functional weaknesses and strength deficits, allowing for proper rehabilitation, (2) establish an objective measurement of the patient's capabilities for judicial resolution, disability determination, and treatment progress determination, and (3) provide the patient with quantifiable limitations he or she faces.

The document continues by stating that "The patient" was tested using a JTech computerized evaluation system. "Depending on the level of the patient's compliance, the examination takes 30-50 minutes." It is also claimed that the patient received training as to how to deal with limitations.

As for the fee, this document maintains that Code 97799 is the only proper CPT Code, and that there is no code in the fee schedule which would reflect the components of the testing.

I find this document insufficient to constitute a required report for a by report code. First, the above cited Ground Rule requires "[p]ertinent information concerning the nature, extent, and need for the procedure or service, [and] the time." This document contained no pertinent information specific to Assignor which would explain why this testing was performed. While there is a signature of Assignor under a statement that written and verbal information had been received in regard to the test results and as well as training, there is no mention of the details of the information, i.e., detailed instructions as to what to do under what circumstances, and what the training entailed. The specific time was not documented for Assignor. A general statement that it takes 30-50 minutes is insufficient.

The Ground Rule emphasizes that original records will be given far greater weight than reports formulated later on. The only original record is a set of computer-generated wavelengths and graphs; it lacks any recordation of specific, tailor-made instructions for Assignor based on the injuries sustained. The skill of the person performing the service was also not documented although the Ground Rule requires it.

Finally, while "a relative value unit consistent in relativity with other relative value units shown in the schedule" must be established by the physician, that did not take place here.

Applicant charged about the same as the prescribed fee (\$495.00) for a functional capacity evaluation. There are many requirements for the latter such as that it should not be performed prior to three months post-injury unless there is significant documented change in condition, that the testing be performed in connection with work obligations, and that there be a narrative cover sheet with recommendations. None of these conditions were met in the instant case, so charging \$475.00, which is close to the Region IV \$495.00 fee for a functional capacity evaluation is inappropriate.

In light of the foregoing, I find that the document submitted by Applicant as "Activity Limitation Measurement and Training Report" fails to comply with the requirements of Ground Rule 3 to Chapter 1 (Introduction and General Guidelines) of the Workers' Compensation Medical Fee Schedule.

As a means of containing the cost of No-Fault automobile liability insurance, the Legislature provided for the establishment of schedules of maximum permissible charges for medical, hospital, and other professional health services payable under No-Fault insurance benefits. Tucciarone v. Progressive Ins. Co., 204 A.D.2d 864, 612 N.Y.S.2d 461 (3d Dept. 1994). In order to contain the cost of providing medical services to patients treated under New York's No-Fault law, the state legislature set limits on the fees health care providers may charge patients who sustain injuries by incorporating into the No-Fault scheme the fee schedules established by the Worker's Compensation Board for industrial accidents. John Giugliano, DC, P.C. v. Merchants Mutual Ins. Co., 29 Misc.3d 367, 907 N.Y.S.2d 569 (Civ. Ct. Kings Co. 2010). Other court decisions have also recognized that one of the purposes for enacting the No-Fault system for motor vehicle accidents in the first instance was to save on the cost of insurance premiums. E.g., Matter of Medical Society v. Serio, 100 N.Y.2d 854, 860, 768 N.Y.S.2d 423, 426 (2003); Goldberg v. Corcoran, 153 A.D.2d 113, 118, 549 N.Y.S.2d 503, 506 (2d Dept. 1989); Palmer v. Allstate Ins. Co., 101 A.D.2d 127, 132-133, 475 N.Y.S.2d 436, 441 (2d Dept. 1984).

Most medical services provided for in the Workers' Compensation fees schedules have specific relative values which, when multiplied by the appropriate conversion factor, yield maximum permissible charges. There are some services, however, which lack specific relative values. They could be billed under the miscellaneous by report codes and they will be compensated for under the No-Fault system. However, the fees must be justified by the health service providers who perform them. That requirement is consistent with the aforecited legislative history. Allowing health service providers to bill for unspecified procedures at flat rates where the information provided fails to comply with the requirements to individually particularize how those rates were arrived at would contravene the legislative intent in enacting the No-Fault system in the 1970s. Applicant here has not provided sufficient information to justify its flat rate of \$475.00.

In the past, Applicant's counsel argued that it was the burden of Respondent, as the insurer, to seek from Applicant -- via a verification request -- the by report information which must be submitted pursuant to Ground Rule 3. I reject that argument. In Interboro General Hospital v. AllCity Ins. Co., 149 A.D.2d 569, 540 N.Y.S.2d 447 (2d Dept. 1989), the court held that where an assignor-health service provider has failed to set forth various items of required information on claim forms, including reasonably obtainable information regarding the description of the accident, whether the treatment was rendered solely as a result of injuries arising out of an automobile accident, as well as the particulars of the injuries and treatment received, it has not submitted proper proof of claim. This would apply likewise to ancillary information such as the written report which must accompany billings of by report codes and detail the skills necessary and convey how the fee was determined by reference to relative unit values for other services in the Workers' Compensation fee schedule.

In promulgating a new 11 NYCRR 65-3.8(g) in the Fourth Amendment to Insurance Regulation 68-C, the State Financial Services Department shifted the burden of proof to health service providers with regard to No-Fault fees charged. This amendment took effect on Apr. 1, 2013, which was prior to the dates of service at issue in this case. The new provision states:

(g) (1) Proof of the fact and amount of loss sustained pursuant to Insurance Law section 5106(a) shall not be deemed supplied by an applicant to an insurer and no payment shall be due for such claimed medical services under any circumstances:

(i) when the claimed medical services were not provided to an injured party; or

(ii) for those claimed medical service fees that exceed the charges permissible pursuant to Insurance Law sections 5108(a) and (b) and the regulations promulgated thereunder for services rendered by medical providers.

(2) This subdivision shall apply to medical services rendered on or after April 1, 2013.

Crucial to an understanding of the impact of this new regulation are nine words: "Proof of the fact and amount of loss sustained." These nine words track the language in Insurance Law § 5106(a), where it states: "Such benefits are overdue if not paid within thirty days after the claimant supplies proof of the fact and amount of loss sustained." All four Appellate Divisions included benefits being overdue as an element of a claimant's prima facie case of entitlement to judgment. See Sunshine Imaging Association/WNY MRI v. Government Employees Ins. Co., 66 A.D.3d 1419, 885 N.Y.S.2d 557 (4th Dept. 2009); Countrywide Ins. Co. v. 563 Grand Medical, P.C., 50 A.D.3d 313, 855 N.Y.S.2d 439 (1st Dept. 2008); LMK Psychological Services, P.C. v. Liberty Mutual Ins. Co., 30 A.D.3d 727, 816

N.Y.S.2d 587 (3d Dept. 2006); Nyack Hospital v. Metropolitan Property & Casualty Ins. Co., 16 A.D.3d 564, 791 N.Y.S.2d 658 (2d Dept. 2005). So did the Court of Appeals, in Viviane Etienne Medical Care, P.C. v. Country-Wide Ins. Co., 25 N.Y.3d 498, 501, 14 N.Y.S.3d 283, 286. Therefore, the statutory and regulatory provisions, when considered together, yield the conclusion of law that if the fees for a health service are excessive, then proof of the fact and amount of loss sustained is deemed not supplied, and further that benefits are not overdue. And if the benefits are not overdue then the health service provider has not made out a prima facie case in support of its claim.

As applied to a coded service listed as "BR" (by report) in the Workers' Compensation Fee Schedule, we start with the proposition that a health service provider is entitled to \$0 because no specific fee is set forth. It is then up to the provider to submit a proper report complying with the by report requirements in Ground Rule 3 to Chapter 1. But without a proper report explaining how the fee for the by report service was determined, "proof of the fact and amount of loss sustained" has not been supplied by an applicant. Ergo, benefits are not overdue pursuant to Insurance Law section 5106(a). Thus, in the case at bar Applicant has failed to make out a prima facie case of entitlement to No-Fault compensation with respect to its billed service; it has not met its burden of proof of justifying the amount it charged and, therefore, benefits are not overdue.

Recently, in Bronx Acupuncture Therapy, P.C. v. Hereford Ins. Co., 54 Misc.3d 135(A), \_\_\_ N.Y.S.3d \_\_\_ (Table), 2017 N.Y. Slip Op.50101(U), 2017 WL 416732 (App. Term 2d, 11th & 13th Dists. Jan. 20, 2017), a case involving by report codes, the Appellate Term in the Second Department held that the No-Fault insurer was not entitled to summary judgment when it had not sought the required by-report documentation in an additional verification request. Records in that case, however, document that the dates of service were prior to the Apr. 1, 2013 effective date of the Fourth Amendment to Insurance Regulation 68-C. In a case which did involve a post-Apr. 1, 2013 date of service, Pavlova v. Allstate Ins. Co., 52 Misc.3d 491, 32 N.Y.S.3d 444 (Civ. Ct. Kings Co. 2016), it was held that as part of its prima facie burden, a health service provider billing a by-report code must submit the information required by the Ground Rule governing by report codes; the Fee Schedule places an affirmative duty on the provider to submit this information, and without it the provider has deprived the insurer of sufficient notice of the claim and the latter should not be expected to evaluate and pay it. I find that the holding in this latter case is applicable; it did involve post-Apr. 1, 2013 services.

I find that Applicant failed to establish a prima facie case of entitlement to additional compensation for its activity limitation measurement testing beyond the amount paid by Respondent. Even if did establish such a prima facie case, I find that its fee was not in accordance with fee schedule because the requisite by-report requirements were not complied with and also because the fee charged is grossly excessive based on my analysis discussed above. By checking Box 18 (fees not in accordance with fee schedules), Respondent preserved all billing practice defenses. Megacure Acupuncture, P.C. v. Lancer Ins. Co., 41 Misc.3d 139(A), 983 N.Y.S.2d 204 (Table), 2013 N.Y. Slip Op. 51994(U), 2013 WL 6360630 (App. Term 2d, 11th

& 13th Dists. Nov. 21, 2013). Respondent's defense that Code 97799 more accurately reflected the services is academic.

The next bill at issue was for the range of motion-muscle testing. Unlike the activity limitation measurement testing, the range of motion testing was billed using CPT codes with specific values. Therefore, "[A] plaintiff demonstrates prima facie entitlement to summary judgment by submitting evidence that payment of no-fault benefits are overdue, and proof of its claim, using the statutory billing form, was mailed to and received by the defendant insurer." Viviane Etienne Medical Care, P.C. v. Country-Wide Ins. Co., 25 N.Y.3d 498, 501, 14 N.Y.S.3d 283, 286 (2015). Respondent's denial of claim referenced receipt of Applicant's bill. Hence, Applicant established a prima facie case of entitlement to No-Fault compensation with respect to the unpaid amount. See Magnezit Medical Care, P.C. v. New York Cent. Mutual Fire Ins. Co., 11 Misc.3d 135(A), 816 N.Y.S.2d 697 (Table), 2006 N.Y. Slip Op. 50473(U), 2006 WL 796963 (App. Term 2nd & 11th Dists. Mar. 27, 2006). While Respondent's denial of claim is untimely, since the services were performed after Apr. 1, 2013, fee related defenses may be considered. See Surgicare Surgical Associates v. National Interstate Ins. Co., 50 Misc.3d 85, 25 N.Y.S.3d 521 (App. Term 1st Dept. 2015), aff'g, 46 Misc.3d 736, 997 N.Y.S.2d 296 (Civ. Ct. Bronx Co. 2014).

The line entries for Codes 95851 and 95831 on Applicant's bill were not completely in accordance with the maximum permissible charges of \$41.66 and \$39.73 respectively. For one of the range of motion line entries, Applicant charged \$41.68 instead of \$41.66. For the muscle testing line entry, Applicant charged \$43.60 instead of \$39.73. Hence, I sustain the defense of fees not being in accordance with fee schedules.

As a matter of law, I reject the defense that there is no allowance for range of motion-muscle testing in the New York State Workers' Compensation Fee schedule under the provider's specialty. The provider's specialty is physical medicine; as noted above, Applicant is a professional business entity owned by a self-employed licensed physical therapist. It is true that in the Physical Medicine chapter (Chapter 8) of the New York State Workers' Compensation Medical Fee Schedule, range of motion testing and muscle testing are not listed. However, there is persuasive case law which holds that a physical therapist may use CPT Code 95851, found in the Medicine section of the Workers' Compensation Medical Fee Schedule to bill for range of motion testing inasmuch as such testing is not listed in the Physical Medicine Section; so too, a physical therapist may use Code 95831 to bill for muscle testing: Robert Physical Therapy, P.C. v. State Farm Mutual Automobile Ins. Co., 13 Misc.3d 172, 176-177, 822 N.Y.S.2d 378, 381-382 (Civ. Ct. Kings Co. 2006). I have applied this court decision to this defense in numerous arbitrations. I do believe the issue presented was properly determined by the court.

As a matter of law, I reject Respondent's defense that Code 97750 physical performance testing more accurately reflected what was billed as range of motion-muscle testing. Code 97750 (range of motion-muscle testing) is a time-based code, as there is a maximum permissible charge of \$45.71 (Region IV doctors; \$8.45



Region IV conversion factor x 5.41 relative value units) or \$41.66 (Region IV self-employed physical therapists; \$7.70 Region IV conversion factor x 5.41 relative value units) per 15 minutes. It has been held that a reduction by an insurer to the minimum for a time-based procedure is inappropriate in the absence of seeking verification regarding the amount of time it took the health service provider to perform the billed service. See Gaba Medical, P.C. v. Progressive Specialty Ins. Co., 36 Misc.3d 139(A), 957 N.Y.S.2d 264 (Table), 2012 N.Y. Slip Op. 51448(U), 2012 WL 3139780 (App. Term 2d, 11th & 13th Dists. July 25, 2012). Here, Respondent did not seek verification from Applicant. It paid \$83.32 for the range of motion-muscle testing. That reflects 30 minutes. The unilateral assumption that this amount of time was spent on testing, without seeking verification as to how much time was spent, is simply arbitrary.

Inasmuch as Applicant established a prima facie case of entitlement to No-Fault compensation vis-à-vis the range of motion-muscle testing but I found that fees were not in accordance with fee schedule, I will have to recalculate the billing so that it conforms to the Workers' Compensation Medical Fee Schedule:

95851 Range of motion testing - cervical spine.....	\$41.66
95851 Range of motion testing - lumbar spine.....	\$41.66
95851 Range of motion testing - left lower extremity.....	\$41.66
95851 Range of motion testing - right lower extremity...	\$41.66
95831 Muscle testing - neck.....	\$39.73
Sub-total.....	\$206.37
Credit for partial payment.....	\$83.32
Total to be awarded.....	\$123.05

Accordingly, the within arbitration claim is granted to the extent of awarding Applicant \$123.05 in health service benefits.

Interest: Where a claim is timely denied, interest shall begin to accrue as of the date arbitration 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 the denial, in which event interest shall begin to accrue as of the date the denial is received by the claimant. 11 NYCRR 65-3.9(c); Canarsie Medical Health, P.C. v. National Grange Mut. Ins. Co., 21 Misc.3d 791, 797, 865 N.Y.S.2d 499, 503 (Sup. Ct. New York Co. 2008) ("The regulation provides that where the insurer timely denies, then the applicant is to seek redress within 30 days, after which interest will accrue.") The plaintiff health care provider in Canarsie Medical Health, P.C. argued that where a timely issued denial is later found to have been improper, the interest should accrue from when it was issued. The court held that this is not the law, unless the applicant seeks redress within 30 days. Applicant presumptively received Respondent's denial appurtenant to the bill for range of motion-muscle testing a few days after July 23, 2015, when it was issued. Arbitration was commenced, according to the American Arbitration Association, on

Jan. 8, 2016, which was certainly more than 30 days later. Thus, interest must accrue from that date, not from the date that the denial was received by Applicant. 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.

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	Claim Amount	Status
	SR Wellness PT PC	05/14/15 - 05/20/15	\$327.62	Awarded: \$123.05

<b>Total</b>	<b>\$327.62</b>	<b>Awarded: \$123.05</b>
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- B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 01/08/2016, 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 Jan. 8, 2016 to the date of payment of the award, but excluding Jan. 8, 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.

05/06/2017  
(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:**  
98b2d214f94cdeed53b5b50a2f2e04fb

### **Electronically Signed**

Your name: Aaron Maslow  
Signed on: 05/06/2017