American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

FJ Orthopaedics & Pain Management PLLC (Applicant)	AAA Case No.	17-16-1037-5967
	Applicant's File No.	
- and -	Insurer's Claim File No.	0393160980AJC
	NAIC No.	29688
Allstate Fire & Casualty Insurance Company (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 10/04/2017
   Declared closed by the arbitrator on 10/04/2017

   Nurseda Kuculkarca, Esq. from Revaz Chachanashvili and Associates PC participated in person for the Applicant

   John Palatianos, Esq. from Allstate Fire & Casualty Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 2,844.31**, was AMENDED and permitted by the arbitrator at the oral hearing.

   At the hearing, Applicant's counsel amended the amount in dispute down to $1954.26 total, based on the fee schedule. Accordingly, $1954.26 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, to Applicant's prima facie burden and to the amended amount in dispute being in accordance with the applicable provisions of the fee schedule.

3. Summary of Issues in Dispute

In dispute are the Applicant's bills totaling $2844.31 for an interlaminar cervical epidural steroid injection and a trigger point injection with guidance performed on the patient (EW) on 3/25/16 and 4/6/16 as a result of injuries alleged to have been sustained in a motor vehicle accident on November 29, 2015.

Respondent denied the claims based upon a peer review report by Dr. Ajendra Sohal, M.D. dated 5/5/16. 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. This case is linked with AAA case no. 171610359958.

At the hearing, Applicant's counsel amended the amount in dispute down to $1954.26 total, based on the fee schedule. Accordingly, $1954.26 is the amended amount in dispute herein.

The parties' representatives stipulated to the timely service of the bills and denials, to Applicant's prima facie burden and to the amended amount in dispute being in accordance with the applicable provisions of the fee schedule.

The parties' representatives agreed that medical necessity was the sole issue in dispute herein.

The EIP (EW) was a 50-year old female driver who was allegedly involved in a motor vehicle accident on November 29, 2015. Thereafter, on 3/25/16 and 4/6/16 the patent underwent an interlaminar cervical epidural steroid injection and a trigger point injection with guidance 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]). Once plaintiff has established its prima facie case, the burden of proof shifts to

Respondent to come forward with admissible evidence demonstrating the existence of a material issue of fact. Amaze Medical Supply Inc. v. Allstate Insurance Co, 3 Misc 3d 133 (A) (App. Term 2d and 11th Jud. Dists, 2003).

Respondent timely denied payment of the bills in dispute herein based upon the peer review report of Dr. Ajendra Sohal, M.D. dated 5/5/16. Dr. Sohal reviewed the patient's medical records and indicated, inter alia, that "I am unable to see the medical necessity for the services except the trigger point injections on both days and trigger point injections can be done in an office setting, they do not require surgical center. My rationale for that is as following. If there is a myofascial component on the trigger points they should be treated first and that treatment can be done in the office with minimal complications and if the myofascial component is there, there is no need to do any further treatment. It is not necessary to perform multiple injections on the same day because each injections serve the dual purpose being diagnostic and therapeutic. If multiple procedures are done on the same day, we do not know, which one is effective or not and this can be counterproductive. Cervical ESI is warranted if there is a classical cervical radiculopathy and/or spinal neuropathic pain they are not needed for axial pain. It should be noted that in this case in spite of subjective complaints there is no evidence of any sensory/motor/reflex changes in any dermatomal or myotomal pattern with documentation of corresponding imaging and/or other tests to reflect radiculopathy. Spurling was positive, but it is not clear if there was pain radiating to any particular dermatomes. There was no documentation of appropriate conservative care in the form of pharmacotherapy such as oral steroids, gabapentin etc. There is no documentation of significant functional impairment caused by the motor vehicle accident as well as inability to participate in a rehabilitative process and significant functional impairment or surgical sparing interaction of the procedures. The causal relationship and the medical necessity of the procedure is not there except trigger point injections CPT code: 20552." Respondent's counsel argued that the peer report sufficiently met its burden of demonstrating that the services herein were not medically necessary.

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.

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 IndemnityCo., 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 peer review report failed to meet its burden regarding the lack of medical necessity for the services rendered by disregarding the patient's subjective complaints as well as the objective findings.

Applicant also relied upon a rebuttal report by Dr. Steven Horowitz, M.D. dated 7/2/17, wherein he reviewed the patient's medical records, including the peer review report by Dr. Ajendra Sohal, M.D., and indicated that "the medical reference quoted does not support Dr. Sohal's denial of the 3/25/16 and 4/6/16 CESIs, but rather supports the medical necessity of the injections. The Guidelines lists a criteria to warrant the medical necessity for ESI treatment, including '(1) radiculopathy must be documented. Objective findings on examination need to be present; (2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDS, muscle relaxants & neuropathic drugs); (3) Injections should be performed using fluoroscopy and injection of contrast for guidance.' All of these criteria directly correlate with my patient, [EIP]. As detailed below, [EIP's] complaints, symptomology, physical examination, and positive Stretch Root and Spurling's tests, all show the presence of radicular symptoms. Additionally, it should be noted, that the 3/17/16 pain management visit to my office and 3/25/16 and 4/6/16 CESIs procedure in discussion were conducted following over 3 months of conservative treatment, including acupuncture, chiropractic care, physical therapy, and medications including Naproxen and Flexeril, and the injections performed

were done using fluoroscopy and injection of contrast for guidance. Therefore, the 3/25/16 and 4/6/16 CESIs were entirely justified and completely medically necessary, as per the Guidelines."

Dr. Horowitz also explained that "[a]t the time of procedures in discussion, I found my patient, [EIP], to be suffering from both radicular and myofascial pain, and therefore, did not want to hold off on providing treatment that could address the full scope of her pain and symptomology. As detailed below, my patient was suffering from acute radicular and myofascial pain lower back pain and thus, it was determined medically necessary to provide both ESI and TPI treatment in order to thoroughly address all sources of pain and aid in full recovery. Dr. Sohal's peer review fails to provide medical literature to deny treatment for separate symptoms which the patient was in need of intervention for, and thus Dr. Sohal's assessment should not be viewed as a valid basis to deny the service in dispute."

The evidence herein demonstrated that on 12/2/2015, the patient presented at Morris Park Chiropractic, PLLC with complaints of neck pain and stiffness radiating to right shoulder, mid back pain and low back pain and stiffness. Examination of the cervical spine revealed decreased range of motion and positive foraminal compression test and shoulder depression test. Examination of the lumbar spine revealed decreased range of motion and positive Kemp's test bilaterally, Leg Raise test and Ely's test. The remaining orthopedic tests were negative. Muscle testing of the upper and lower extremities was 5/5 with no weakness noted, reflexes were normal and sensation was within normal limits. The patient was diagnosed with cervical sprain/strain, thoracicalgia, lumbalgia, cervico- thoracic joint dysfunction and lumbar Joint dysfunction. The treatment plan included chiropractic care 3 times a week with a reevaluation in one month, x-rays, MRI and CT testing "to rule out herniated discs and/or internal derangement."

On 12/11/15, the patient was examined by Dr. Alexandre Grigorian, D.O and recommended starting a physical therapy program, various medical supplies, continuing with medication, acupuncture/chiropractic evaluations and an MRI of the cervical spine to rule out discogenic injury. The patient was prescribed a thermophore, cervical pillow and cervical collar. On 12/11/15, the patient also underwent PFNCS testing of the upper and lower extremities.

An MRI of the lumbar spine performed on 1-13-2016 revealed straightening of the normal lumbar lordosis, at L1/2 a subligamentous disc bulging, at L3/4 a peripheral disc bulging with narrowing of both neural foramina and abutment of the undersurface of the exiting left L3 nerve root, at L4/5 a diffuse subligamentous disc bulging with flattening of the ventral thecal sac, abutment of both traversing L5 nerve roots within the lateral recesses, a bilateral foraminal disc herniations with impingement of the undersurfaces of both exiting L4 nerve roots, at L5/S1 a broad posterior subligamentous disc herniation with annular tear flattening of the ventral thecal sac and impinging on both traversing S1 nerve roots within the lateral recesses, an abutment of both exiting L5 nerve roots within their respective neural foramina, enlarged myomatous uterus with endometrial stripe thickening, and enlarged myomatous uterus with endometrial stripe thickening.

An MRI of the cervical spine performed on 1-13-2016 revealed straightening of the normal cervical lordosis, a C2/3 broad-based central disc herniation impressing on the ventral thecal sac, a C3/4 prominent central disc herniation abutting the ventral cord, a C4/5 focal central disc herniation impressing on the ventral thecal sac, a C5/6 broad-based central disc herniation impressing on the midline ventral spinal cord, a C6/7 broad based central subligamentous disc herniation impressing on the ventral cord, and a C7/T1 subligamentous disc bulging abutting the ventral cord.

EMG/NCV testing performed on 2-3-2016 revealed evidence of left L5 radiculopathy. Acupuncture treatment notes from December 2015, documented the patient's complaints of pain and the treatments rendered. Chiropractic treatment notes from December 2015, documented the patient's complaints of pain, the treatments rendered and that there were no new findings.

On 3/17/16, the patient was examined by Dr. Steven Horowitz and presented with complaints including radiating neck pain with numbness and tingling in both hands. Neurological examination showed motor power to be 5/5 and sensation to be intact. Examination of the cervical spine revealed spasms, tenderness, a positive Spurling and stretch root test and a positive facet loading bilaterally. The treatment plan included continuing with conservative care, pain medications and undergoing a cervical epidural steroid injection.

On 3/23/16, the patient presented for an independent medical examination (IME) conducted by Dr. Adam Soyer, D.O. and complained of shooting pain down her arms, in addition to numbness and tingling. Examination of the cervical spine documented tenderness, with decreased range of motion. Dr. Soyer recommended physical therapy to the neck for 6 more weeks followed by an additional evaluation.

On 3/25/16, the patient underwent an interlaminar cervical epidural steroid injection and a trigger point injection with guidance. The preoperative and postoperative diagnoses were cervical radiculopathy; myofascial pain and cervical spondylosis without myelopathy.

On 3/31/16, the patient was reexamined by Dr. Steven Horowitz and presented with complaints including radiating neck pain with numbness and tingling in both hands. Neurological examination showed motor power to be 5/5 and sensation to be intact. Examination of the cervical spine revealed spasms, tenderness, a positive Spurling and stretch root test and a positive facet loading bilaterally. The treatment plan included continuing with conservative care, pain medications and undergoing a second cervical epidural steroid injection.

On 4/6/16, the patient underwent an interlaminar cervical epidural steroid injection and a trigger point injection with guidance. The preoperative and postoperative diagnoses were cervical radiculopathy; myofascial pain and cervical spondylosis without myelopathy.

Physical therapy treatment notes from February 2016 - March 2016, documented the treatments rendered.

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 with regard to the cervical steroid injections and trigger point injections with guidance provided to the patient on 3/25/16 and 4/6/16. Dr. Sohal did not adequately discuss the significance of the patient's complaints and objective findings nor did he provide a sufficiently persuasive factual basis and medical rationale for his conclusion regarding the lack of medical necessity for the services rendered. Specifically, Dr. Sohal did not discuss the relevance of the patient's continued symptomology and objective findings including straightening of the normal cervical lordosis, a C2/3 broad-based central disc herniation impressing on the ventral thecal sac, a C3/4 prominent central disc herniation abutting the ventral cord, a C4/5 focal central disc herniation impressing on the ventral thecal sac, a C5/6 broad-based central disc herniation impressing on the midline ventral spinal cord, a C6/7 broad based central subligamentous disc herniation impressing on the ventral cord, a C7/T1 subligamentous disc bulging abutting the ventral cord, radiating neck pain with numbness and tingling in both hands, tenderness, a positive Spurling and stretch root test and a positive facet loading bilaterally.

Furthermore, I find that the patient's medical records, including the IME report, showed persistent complaints of pain with positive objective findings thereby warranting the additional treatment and disputing the peer review doctor's conclusion that the serves were not medically necessary or causally related. A peer review which concludes there was no medical necessity due to the lack of sufficient information upon which the reviewer could make such a determination does not set forth a factual basis and medical rationale sufficient to establish the absence of medical necessity. Park Neurological Services P.C. v. GEICO Ins., 4 Misc.3d 95, 782 N.Y.S.2d 506 (App. Term 9th & 10th Dists. 2004). In addition, I find that Dr. Sohal's peer review was unpersuasive and overly conclusory without the necessary detailed analysis or factual basis to support its conclusion. I find that the patient's medical records, including the IME report, were more persuasive that the services herein were reasonable and medically necessary to resolve an ongoing condition that was not adequately responding to conservative care. I am also persuaded by Dr. Horowitz's explanation that "[EIP] presented to my office on a consistent basis from 3/17/16 to 4/6/16 with subjective complaints of constant burning and stiffness which radiated down her bilateral upper extremities to her fingertips with numbness and tingling in her bilateral hands and objective findings of spasm and tenderness over the cervical paravertebral musculature, pain with rotation of the cervical spine and positive Stretch Root and Spurling's sign tests, which were correlated with my patient's 1/13/16 MRI of the cervical spine, reportedly reviewed by Dr. Sohal, which clearly revealed multiple disc herniations, lateralizing disc protrusions, indicative of radiculopathy. These MRI findings, along with the patient's complaints, symptomatology and positive physical examination findings, indicated that [EIP] did indeed have a component of 'classical cervical radiculopathy' to her pain. Therefore, in complete concurrence with Dr. Sohal's determination, the 3/25/16 CESI and 4/16/16 repeat CESIs were entirely warranted." A letter of medical necessity which raises a

question of fact as to the medical necessity of services may serve to rebut the peer review report. E.g., American Chiropractic Care, P.C. v. Praetorian Ins. Co., 42 Misc.3d 145(A), 988 N.Y.S.2d 521 (Table), 2014 N.Y. Slip Op. 50346(U), 2014 WL 996509 (App. Term 9th & 10th Dists. Feb. 28, 2014). 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). Where a peer review opinion rests upon conclusory assumptions and disputed or incorrect facts, the review is insufficient to prove the insurer's entitlement to judgment as a matter of law on its lack of medical necessity defense; in these circumstances, the absence of opposing expert proof from the claimant is immaterial. E.g., 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 5, 2011 WL 1226956 (Dist. Ct. Nassau Co., Michael A. Ciaffa, J., Apr. 1, 2011). Where other reports in the insurer's papers contradict the conclusion of its peer reviewer that a service was not medically necessary, it has failed to make out a prima facie case in support of the defense of lack of medical necessity. Hillcrest Radiology Associates v. State Farm Mutual Automobile Ins. Co., 28 Misc.3d 138(A), 2010 N.Y. Slip Op. 51467(U), 2010 WL 3258144 (App. Term 2d, 11th & 13th Dists. Aug. 13, 2010).

Furthermore, in Mount Sinai v. Triboro Coach, 263 A.D. 2d. 11 (Second Dep't, 1999), the Court stated that the insurer has the burden of coming forward with proof in an admissible form to establish the fact or evidentiary foundation for its belief that the patient's condition was unrelated to the motor vehicle accident. Moreover, the insurer must show that the injury was not related to the accident at all. It must show how, when and where the injury happened and that it was not aggravated or exacerbated by the accident (emphasis added). The insurer's proof may not be vague, conclusory, inconsistent or unsupported by records. In Kingsbrook Jewish Medical Center v. Allstate Ins. Co., 61 A.D.3d 13, (A.D. 2d. Dep't, 2009) the Appellate Division, ruled that exacerbations of pre-existing conditions are covered by No-Fault, and that causation is presumed under the New York No-Fault law. An expert's affirmation is needed to provide a factual foundation for an insurance carrier's good faith belief that an alleged injury did not arise out of an insured accident; speculation or wishful thinking does not suffice. Mt. Sinai Hospital v. Triboro Coach Inc., 263 A.D.2d 11, 699 N.Y.S.2d 77 (2d Dept. 1999). Dr. Sohal's report in this matter is deficient, among other reasons, because it lacks sufficient factual support and medical rationale to justify the position that the services herein were not causally related. I find that the patient's medical records demonstrated that the services herein were causally related and reasonable to resolve an ongoing condition. I am also persuaded that the patient's injuries visualized and treated at the time of the 3/25/16 and 4/6/16 treatments were consistent with the patient's mechanism of injury as a direct result of the motor vehicle accident. An insurer fails to come forward with proof in admissible form to demonstrate the fact or the evidentiary foundation for its belief that the patient's treated condition was unrelated to his or her automobile accident where the affidavit of its medical expert is conclusory, speculative, and unsupported by the evidence. E.g., New York & Presbyterian Hospital v. Selective

Ins. Co. of America, 43 A.D.3d 1019, 842 N.Y.S.2d 63 (2d Dept. 2007). Based upon the aforementioned, I find that the Respondent has failed to sufficiently establish that the services herein were not medically necessary or causally related and grant Applicant's claim in the amended amount of $1954.26. 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**	**Claim Amount**	**Amount Amended**	**Status**
	FJ Orhtopaedics & Pain Mgmt PLLC	**03/25/16 - 04/06/16**	**$2,844.31**	**$1,954.26**	**Awarded: $1,954.26**
Total			**$2,844.31**		**Awarded: $1,954.26**

B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 06/22/2016, 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 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. 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). Where no denial has been issued and no payment has been made, it is clear from the statute that the claim is overdue and interest runs from the thirty first day after the claim was presented to the carrier for payment. New York Presbyterian Hospital v. Allstate Insurance Company, 30 A.D.3d 492, 819 N.Y.S.2d 268, 2006 N.Y. Slip Op. 04815 (2nd Dep't 2006). Hempstead General Hospital v. Insurance Company of North America, 208 A.D.2d 501, 617 N.Y.S.2d 478 (2nd Dep't 1994).

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.

10/10/2017
(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:
99977e0d673ef0fd550a127ae845a0e4

Electronically Signed

Your name: Anthony Kobets
Signed on: 10/10/2017