American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Advanced Recovery Equipment & Supplies, LLC (Applicant)	AAA Case No.	17-16-1043-9226
	Applicant's File No.	BS-9993-1877286
	Insurer's Claim File No.	0371355199 2CT
- and -	NAIC No.	29688
Allstate 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 12/06/2017
   Declared closed by the arbitrator on 12/06/2017

   Joaquin Lopez, Esq. from Baker Sanders, LLC participated in person for the Applicant

   Jonathan Hack, Esq. from Peter C. Merani Esq. participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 1,575.00**, was NOT AMENDED at the oral hearing.
   Stipulations WERE made by the parties regarding the issues to be determined.

   At the hearing, the parties' representatives stipulated to the timely service of the bill and denial and to Applicant's prima facie burden and to the amount in dispute being in accordance with the applicable provisions of the New York State Workers' Compensation Fee Schedule.

3. Summary of Issues in Dispute

In dispute is the Applicant's bill totaling $1575.00 for the (21) day rental of continuous passive motion machine (CPM) to the patient (DG) from 7/28/15 - 8/17/15 as a result of injuries alleged to have been sustained in a motor vehicle accident on May 19, 2015. 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.171610264374.

At the hearing, the parties' representatives stipulated to the timely service of the bill and denial and to Applicant's prima facie burden and to the amount in dispute being in accordance with the applicable provisions of the New York State Workers' Compensation Fee Schedule.

The EIP (DG) was a 25-year old male passenger who was allegedly involved in a motor vehicle accident on May 19, 2015. On 7/28/15, she began utilizing a CPM for her right knee, provided by the Applicant. Applicant seeks no-fault reimbursement for these supplies.

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]).

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 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.

Bill for dates of service 7/28/15 - 8/17/15 in the amount 1575.00.

Respondent timely denied the above referenced bill based upon the peer review report of Dr. Maury Harris, M. D. dated 8/31/15. Dr. Harris reviewed the available medical records and indicated that "[t]here was no medical necessity for the knee surgery. Based on the MRI report of the right knee, there was no meniscus tears; only degenerative menisci not associated with any acute trauma. A partial ACL tear causing no instability should be treated conservatively with prolong therapy, strengthening and possible injection. There was no justification for surgery at this time; therefore it was not medically necessary….The standard of care does not involve surgical intervention prior to a sustained course of conservative care especially if there are no fractures or overt instability. There was no medical necessity for the anesthesia performed on 07/24/15 because the surgery was not medically necessary."Respondent's counsel argued that the

peer review met its burden in demonstrating that the services herein were not medically necessary.

If the insurer presents sufficient evidence establishing a lack of medical necessity, then the burden shifts back to the Applicant to present its own evidence of medical necessity. See: *West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co.*, 13 Misc3d 131A (2006). Once the insurer [Respondent] makes a sufficient showing to carry its burden of coming forward with evidence of lack of medical necessity, "[Applicant] must rebut it or succumb." See, Bedford Park Med. Practice P.C. v American Transit Tr. Ins. Co., 8 Misc. 3d 1025 (A), 2005, 2005 NY Slip Op 51282 citing Bauman v Long Island Railroad, 110AD2d 739, 741, [2d Dept 1985]).

Applicant's counsel argued that the peer review failed to meet Respondent's burden of proving that the post-surgery services in dispute herein were not medically necessary. In addition, Applicant submitted a rebuttal from Dr. Michael Tamburo, D.O. wherein Dr. Tamburo discussed the patient's medical records, including the peer review by Dr. Harris, and indicated that "[i]n the peer review, Dr. Harris has denied the arthroscopy performed on 07/24/2015, but has not clearly denied any post- operative care including the medical equipment in question. Hence, the denial is not justified. The physical examination indicated the need for the supply in question as the patient complained of consistent pain in right knee. The evaluation revealed decreased and painful range of motion, positive tenderness to palpation at the medial joint line and paeripatellar area; McMurray, Steinmann and bounce tests were positive. The patient continued to experience discomfort and mechanical symptoms in spite of conservative care. Additionally, MRI report of right knee revealed grade 2 abnormal signal throughout the meniscus, a partial thickness tear of the ACL and an effusion. Accordingly, the supply the patient received on 07/28/2015 consequent to the right knee arthroscopy was within the generally accepted standards of medicine/medical necessity and should not have been denied. CPM devices are used during the first phase of rehabilitation following a soft tissue surgical procedure or trauma. The goals of phase 1 rehabilitation are: control post- operative pain, reduce inflammation, provide passive motion in a specific plane of movement, and protect the healing repair or tissue." Dr. Tamburo concluded that "[t]he Peer Review report does not establish that the supply would not be medically necessary. Moreover, based on the foregoing, the service provided on 07/28/2015 was, in fact, medically necessary as an appropriate part of treatment for this patient who continued to present with chronic pain and the need for alleviation through the use of the supply in question."

The evidence demonstrated that an MRI of the right knee performed on 5/29 /15 revealed a grade II signal throughout the menisci without evidence of communication to the articular surface; a partial thickness tear of the ACL was suspected and associated with intra-articular joint effusion.

On 7/9/15, the patient came under the orthopedic care of Dr. Randall Ehrlich, M.D. and was evaluated for complaints of persistent right knee medial and lateral joint line pain with difficulty in kneeling, squatting, bending, ascending and descending stairs. The patient also stated that he experienced cracking, popping and several episodes

of buckling with severity of pain rated at 9/10 on the pain scale. Dr. Ehrlich noted that the patient completed a two month course of supervised P.T. using appropriate strengthening and range of motion exercises. Examination of the right knee revealed a right antalgic gait, 1+ effusion, evidence of splinting and guarding, decreased range of motion, tenderness, and crepitus. The patient was diagnosed with traumatic arthropathy and pain in joint involving lower leg.

On 7/2315, the patient was reexamined by Dr. Randall Ehrlich, M.D. for complaints of persistent right knee medial and lateral joint line pain with difficulty in kneeling, squatting, bending, ascending and descending stairs. The patient also stated that he experienced cracking, popping and several episodes of buckling with severity of pain rated at 9/10 on the pain scale. Dr. Ehrlich noted that the patient completed a two month course of supervised P.T. using appropriate strengthening and range of motion exercises. Examination of the right knee revealed a right antalgic gait, 1+ effusion with symmetric varus/valgus morphology, evidence of splinting and guarding, decreased range of motion, tenderness, and crepitus. The patient was diagnosed with traumatic internal derangement resulting from motor vehicle accident and elected to proceed with right knee arthroscopy.

On 7/25/15, the patient underwent a right knee arthroscopy, partial lateral meniscectomy; chondroplasty of medial femoral condyle; anterior release and major synovectomy. The preoperative diagnosis was right knee traumatic internal derangement and the postoperative diagnosis was right knee lateral meniscal tear; chondral injury of the medial femoral condyle; anterior interval contracture with suprapatellar adhesion formation; and tricompartmental reactive villous hypertrophic incarcerating synovitis.

On 7/28/15, the patient began utilizing a CPM unit for the right knee.

Based upon a thorough review of the evidence herein and the arguments of the counsel, I find that the Respondent has not met its burden in this case. Dr. Harris did not provide a sufficient factual basis and medical rationale for the lack of medical necessity for the CPM. Respondent's proofs failed to explain why the prescription for the CPM deviated from the appropriate standard of care in the medical profession and did not adequately discuss why this particular patient's symptomology did not warrant the use of the CPM following the right knee surgery. I find that the Repondent's conclusion that the CPM was not medically necessary based on the peer review was overly conclusive and contradicted by the positive objective findings contained in the medical evaluations and diagnostic testing. As per the holding in Jacob Nir, M.D. v. Allstate Insurance Co., 7 Misc.3d 544 (2005), the peer reviewer must establish a factual basis and medical rationale to support a finding that the services were not medically necessary, including setting forth generally accepted standards in the medical community. The opinion of the insurer's expert, standing alone, is insufficient to carry the insurer's burden to prove that the services were not medically necessary. CityWide Social Work & Psychological Services, PLLC v. Travelers Indemnity Co., 3 Misc.3d 608, 777 N.Y.S.2d 241 (N.Y.Civ. Ct. Kings Co. 2004). Furthermore, in AAAMG Leasing Corp. v. Geico 17-991-R-76913 -13 the Master Arbitrator held that "once the surgery is performed the necessity of any DME needed for post-surgical rehabilitation must be evaluated separately and on its own individual merits."

Dr. Harris' peer review in this matter is deficient, among other reasons, because it lacks sufficient factual support and is contradicted by the patient's medical records, which documented persistent complaints of pain in right knee, an antalgic gait, decreased and painful range of motion, crepitus, tenderness to palpation at the medial joint line and parapatellar area, a positive McMurray test, a positive Steinmann test, a positive bounce test, a positive patellofemoral grind test and MRI results including a grade 2 abnormal signal throughout the meniscus, a partial thickness tear of the ACL and an effusion. I find the treating physicians' medical examinations and analysis of the patient's medical history, more accurately documented the reasonableness for the post-surgery treatment. An insurer may not establish lack of medical necessity if the only reason for the denial was that the peer review doctor did not have enough information in the claim file upon which a determination could be made. Nir v. Allstate Ins. Co., 7 Misc.3d 544, 547, 796 N.Y.S.2d 857, 860 (Civ. Ct. Kings Co. 2005). Furthermore, Dr. Tamburo effectively rebutted Dr. Harris' conclusions, exhibited a sound medical rationale and justified the need for the treatment 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). Based on the foregoing, I find that the Respondent's proofs have failed to sufficiently prove that the post-surgery services were not medically necessary and find in favor of the Applicant.

Fee Schedule

The evidence demonstrated that Applicant billed a total of $1575.00 for CPT code E0935 in the amount of $75.00 per day for (21) days. At the hearing, Respondent's counsel argued that the amounts billed were not inconformity with the applicable provisions of the fee schedule and that they should be reduced accordingly.

In support, Respondent submitted, inter alia, a legal brief, several arbitration decisions and a Fee Schedule Audit by Andrea Marmolejos, CPC,CPMA, wherein she reviewed the bill in dispute herein and indicated that CPT code E0935 should be reimbursed at $21.14 per day. $21.14x (21) days = $443.94.

Ms. Marmolejos provided the following explanation to support her assessment: DME "Code E0935: the provider billed $75.00/day for 21 days totaling $1575.00 for the rental of this durable medical equipment. The rental payment should not exceed the lower of the monthly rental charge to the public or price determined by DOH. Items an assigned a MRA (Maximum Reimbursement Amount) the rental fee is 10% of the listed MRA. For items without an MRA the rental fee is calculated at 1/6th of the Provider's acquisition. *There is no maximum reimbursement amount 'MRA' listed in the DME fee schedule for this code. Without an invoice from the provider, no reimbursement can be provided, per NYS Medicaid Program - DME policy guidelines Section III page 13 Rental of DME pertaining to Basis of Payment for Services provided pertaining to Rental for DME. Based on CMS DMEPOS Fee Schedule for the year 2015, DME code E0935 pays $21.14/day amount for the state of NY. Multiply $21.14 by 21 (number of days DME supply was billed) for a total value of $443.94. Please see the following website for DME fee schedule 2015." Ms. Marmelejos then lists a government Medicare

website address. Applicant's counsel argued that the Respondent failed to meet their burden and regarding their fee schedule defense.

Respondent has the burden to come forward with competent evidentiary proof to support its Fee Schedule defenses. Robert Physical Therapy, P.C. v. State Farm Mut. Auto. Ins. Co., 13 3 Misc.3d. 172(Civ. Ct. Kings Co. 2006). When Respondent fails to demonstrate by competent evidentiary proof that an Applicant's claim was in excess of the appropriate Fee Schedules, Respondent's defense of noncompliance with the Fee Schedule cannot be sustained. Continental Medical, P.C. v. Travels Indemnity Co., 11 Misc. 3d.145A (App. Term 1st Dept. 2006).

According to 12 NYCRR section 442.2, the NY Durable Medical Goods Fee scheduled effective in 2012, the following is noted:

Part F: Durable medical equipment, medical/surgical supplies, orthopedic footware and orthotic and prosthetic appliance equipment schedule:

(a) The maximum permissible charge for the purchase of durable medical equipment, medical/surgical supplies, orthopedic footware and orthotic and prosthetic appliances is the fee payable for such equipment and supplies under the New York State Medicaid program at the time such equipment and supplies are provided. If the New York State Medicaid program has not established a fee payable for the specific item, then the fee payable, in accordance with Medicaid rules, shall be the lesser of (1) the acquisition cost to the provider plus 50%, or (2) the usual and customary price charged to the general public.

(b) The maximum permissible monthly rental charge for such equipment, supplies and services provided on rental basis shall not exceed the lower of the monthly rental charge to the general public or the price determined by the New York State Department of Health area office. The total accumulated monthly rental charges shall not exceed the fee amount allowed under the Medicaid fee schedule.

Importantly, the New York State Department of Health area office has not determined the rental price for the CPM device, nor is the specific item at issue listed in the Medicaid fee schedule. As such, the maximum permissible monthly rental charge is the "rental charge to the general public." I find that this policy applies to DMEs that are listed in the NY State Medicaid Durable Medical Equipment Manual, but were not assigned an MRA. The Codes in this instance are not listed in the manual and therefore the NY State Department of Health's policy is inapplicable.

In a similar case, AAA Case no. 171610489452, Arbitrator Toksoy explained that "Ms. Marmolejos' conclusion - which relies upon on the Medicaid Provider Manual and Policy Guidelines - is legally irrelevant. 12 NYCRR §442.2(g) states: The Medicaid provider manual and the policy guidance for durable medical equipment are not included as part of the durable medical equipment fee schedule used in workers' compensation cases except to the extent such documents contain the Medicaid durable medical equipment fee schedule. Given this provision, I find that Ms. Marmolejos' audit does not suffice to limit Applicant's reimbursement for any of the billed charges. In

addition, I would like to note that the 1/6 method of calculation was already addressed by me in prior awards involving Allstate. See Advant Orthocare, Inc a/a/o [assignor (MR)] v. Allstate, referenced under AAA #: 17-15-1023-2872; see also Spartan Medical Supply a/a/o [assignor (TM)] v. Allstate, referenced under AAA #: 17-16-1031-1980."

Accordingly, after a thorough review of the evidence herein, I find that the Respondent's proofs have failed to adequately substantiate a reduction of the amounts charged by the Applicant. The E0935 code for the knee CPM unit is not listed in the Medicaid fee schedule, and there is no New York State Department of Health price for these rented units. Therefore, pursuant to 12 NYCRR 442.2(b), the fee should be the monthly rental charge to the general public. I find Respondent's calculation of the fees for the rental inconsistent with the plain meaning of 12 NYCRR § 442.2 and not credible evidence of the monthly rental charge to the general public. I note that my decision is supported by US Tech Rehab Inc., and Liberty Mutual Insurance Company, AAA #:99-14-1001-2311, wherein Master Arbitrator J. D'Ammora reversed an arbitration award based upon only one-sixth of acquisition costs. Master arbitrator J. D'Ammora found that the lower Arbitrator 'erred by allowing the Responder to use a legally prohibited fee schedule to reduce the claim.' Likewise in AAA case no. 991510161303, Master Arbitrator Peter Merani affirmed the lower Arbitrator's decision indicating that "The Respondent insurer argues that the arbitrator below awarded an amount in excess of the Medicaid fee schedule and the award should be reduced to $630.00 which the Respondent alleges is the Medicaid fee schedule rate for the rented equipment. The Applicant alleges that the arbitrator correctly determined the applicable fee for the rental equipment. The lower arbitrator pointed out that both the Respondent insurer and the Applicant provided affidavits from their respective fee coders to support Applicant's billing and Respondent's defense. The lower arbitrator found the Applicant's documents were persuasive and awarded the full amount of the claim. The Respondent insurer argues that the lower arbitrator should have applied the Medicaid rate and in not doing so the award is arbitrary and capricious and incorrect as a matter of law. The lower arbitrator addressed Respondent's position and determined that 'neither NYS nor Medicaid has established a rental fee schedule for this equipment, therefore the proper fee is that charged to the general public… Based on a review of the documents and award I cannot find that the arbitrator's determination was incorrect as a matter of law or arbitrary or capricious… Accordingly, I find the award below was not irrational, arbitrary and capricious or incorrect as a matter of law and is therefore affirmed in its entirety." See also AAA case no.: 991610281663 and AAA case no.: 991510209929.

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). 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's unilateral decision to change an applicant's CPT codes, deny the claim, or pay reduced fees for disputed medical services is ineffectual when unsupported by a peer review report or by other proof setting forth a sufficiently detailed factual basis and medical rationale for the code changes, denials and fee reductions. See, Amaze Medical Supply v. Eagle Ins. Co., 2 Misc.3d 128(A) (App. Term 2d & 11 Jud. Dist. 2003). Based on the foregoing, I find that the Respondent has failed to proffer sufficiently persuasive proof to support its fee schedule defense. Accordingly, the Applicant is awarded $1575.00. 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**	**Status**
	Advanced Recovery Equipment and Supplies	**07/28/15 - 08/17/15**	**$1,575.00**	**Awarded: $1,575.00**
Total			**$1,575.00**	**Awarded: $1,575.00**

B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 09/30/2016, 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).

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.

12/14/2017
(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:
c6923a31adeaa3faf3d467817fcbfdbd

Electronically Signed

Your name: Anthony Kobets
Signed on: 12/14/2017