American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Alternative PLM Acupuncture, PC (Applicant)	AAA Case No.	17-17-1071-9575
	Applicant's File No.	None
- and -	Insurer's Claim File No.	0516237450101030
	NAIC No.	22055
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Meryem Toksoy, 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 (AL)

1. Hearing(s) held on 02/20/2018
   Declared closed by the arbitrator on 02/20/2018

   Viktoriya Litvenko, Esq. from Viktoriya Litvenko, P.C. participated in person for the Applicant

   Stacey Strum, Esq. from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 1,391.20**, was AMENDED and permitted by the arbitrator at the oral hearing.

   During the hearing, Applicant's counsel adjusted the claim to $857.02.

   Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

   In dispute are claims by Applicant, Alternative PLM Acupuncture, PC, as the assignee of a 22-year-old male who was injured as a driver in a motor vehicle accident on 10-09-16.

Applicant seeks reimbursement in the amount of **$857.02** for services rendered from 11-02-16 to 02-17-17. This consists of **acupuncture, cupping treatment, and one office visit**.

Where applicable, I must decide:

- Whether Respondent has submitted evidence which is sufficient to sustain its **fee schedule** assertion;
- Whether Respondent's defense of **no show IME** precludes Applicant's entitlement to No-Fault benefits.

4. Findings, Conclusions, and Basis Therefor

The case was decided on the submissions of the parties as contained in the electronic file maintained by the American Arbitration Association, the oral arguments of the parties' representatives, as well as the New York State Workers' Compensation Fee Schedule, of which I take judicial notice. Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co., 61 A.D.3d 13, 871 N.Y.S.2d 680 (App Div, 2nd Dept, 2009).

OVERVIEW:

AMOUNT	DOS	SERVICE	AMENDED TO	PAID	BALANCE	DEFENSE
$104.08	11-02-16	Evaluation (CPT code 99203)	$54.74	$20.52	$34.22	Fee Schedule
$700.00	11-07-16 to 01-26-17	Cupping	$700.00 [no adjust]	$194.18	$505.82	Fee Schedule
$394.14	02-06-17 to 02-17-17	Acupuncture & Cupping	$316.98	$0.00	$316.98	No Show IME & Fee Schedule

Note: All of the other charges listed on the bills were withdrawn.

DECISION FOR	DEFENSE/ISSUE	TOTAL	RESULT
EVALUATION PERFORMED ON 11-02-16	FEE SCHEDULE	$34.22	GRANTED

SUMMARY:

The evaluation was originally billed in the amount of $104.08 under CPT code 99203.

During the hearing, Applicant's counsel adjusted the charge to $54.74 (which is the allowed rate of reimbursement under this code).

The evidence shows that Respondent paid Applicant's fee pursuant to CPT code 97810 (i.e., $20.52).

Considering the above, this leaves a balance of $34.22.

In terms of why the evaluation was processed in this manner, the EOB accompanying the denial states:

> *This procedure as billed is considered to be part of a more comprehensive service provided. Reimbursement is based on the more comprehensive service.*

LEGAL FRAMEWORK:

Where the question to be answered turns on the merits of a fee schedule defense, it is necessary for the insurer to come forward with competent evidentiary proof. Continental Medical P.C. v. Travelers Indemnity Company, 11 Misc.3d 145(A), 2006 N.Y. Slip Op. 50841(U)(App Term, 1st Dept., 2006).

Such a defense cannot be sustained in the absence of proof establishing that the charges are in excess of the fee schedule. St. Vincent Med. Care, P.C. v. Country Wide Ins. Co., 26 Misc.3d 146(A), 907 N.Y.S.2d 441 (Table), 2010 NY Slip Op 50488(U)(App. Term, 2nd Dept., 2nd, 11th & 13th Dists., Mar. 19, 2010).

In the event the insurer succeeds in establishing that the charges are in excess of the fee schedule, the burden will shift to the provider to show that the charges involved a different interpretation of such schedule or an inadvertent

miscalculation or error. Cornell Medical, P.C. v. Mercury Casualty Co., 24 Misc.3d 58, 884 N.Y.S.2d 558 (App. Term, 2nd Dept, 2nd, 11th & 13th Jud. Dists, May 22, 2009).

DECISION:

Respondent has not submitted any evidence to substantiate its fee schedule assertion.

Applicant is awarded $34.22.

DECISION FOR	DEFENSE/ISSUE	TOTAL	RESULT
CUPPING, PROVIDED FROM 11-07-16 TO 01-26-17 (14 DOS)	FEE SCHEDULE	$505.82	DENIED

SUMMARY:

This portion accounts for cupping therapy that was provided from 11-07-16 to 01-26-17. For each date of service, Applicant billed for the procedure under CPT 97799, which is a By Report (BR) code, at a rate of $50.00 per charge.

The record reflects that Respondent received the bills, issued a partial payment of $13.87 for each charge, and denied the remaining balance of $36.13.

For the 14 dates of service covering this timeframe, this amounts to $505.82.

Respondent contends that the amount billed ($50.00) is excessive and inconsistent with the Relative Value Units assigned to other codes in the respective fee schedules. To advance this argument, Respondent looks to the affidavit of Steven Schram, LAc, DC.

In opposition, Applicant has submitted an affidavit by Peter Kopach, LAc.

LEGAL FRAMEWORK:

Pursuant to Insurance Law § 5102 (a)(1), No-Fault benefits are reimbursable for:

> *All necessary expenses incurred for: (i) medical, hospital (including services rendered in compliance with article forty-one of the public health law, whether or not such services are rendered directly by a hospital), surgical,*

nursing, dental, ambulance, x-ray, prescription drug and prosthetic services; (ii) psychiatric, physical therapy (provided that treatment is rendered pursuant to a referral) and occupational therapy and rehabilitation; (iii) any non-medical remedial care and treatment rendered in accordance with a religious method of healing recognized by the laws of this state; and (iv) any other professional health services…

Expenses that are incurred for services referenced in Insurance Law § 5102 (a)(1) "shall not exceed the charges permissible under the schedules prepared and established by the chairman of the workers' compensation board..." Insurance Law § 5108 (a).

Further, the Superintendent of Insurance is vested with the authority to promulgate rules and regulations with respect to charges for services covered under Insurance Law § 5102 (a)(1), "including the establishment of schedules for all such services for which schedules have not been prepared and established by the chairman of the workers' compensation board." Insurance Law § 5108 (b).

If there is no fee schedule applicable to a provider of a professional health service, then "the permissible charge for such service shall be the prevailing fee in the geographic location of the provider subject to review by the insurer for consistency with charges permissible for similar procedures under schedules already adopted or established by the superintendent." 11 NYCRR §68.5 (b).

As of this date, there is no fee schedule which has been adopted or established for services performed by acupuncturists. Therefore, the amount an acupuncturist can charge is governed by 11 NYCRR §68.5 (b).

Arguably, the most well-known case relating to 11 NYCRR §68.5 (b) is Great Wall Acupuncture, PC v. Geico, 16 Misc.3d 23, 2007 NY Slip Op 27164 (App. Term 2nd & 11th Jud. Dists. 2007). The disputed claim involved acupuncture treatment that was provided by a licensed acupuncturist. As no fee schedule exists for acupuncture, the insurer reimbursed the provider at a rate that was consistent with similar services contained in the chiropractic fee schedule. The insurer maintained that this was reasonable and appropriate "based upon a comparison of the training and experience of licensed acupuncturists, physicians and chiropractors who perform acupuncture services…" Id. 16 Misc.3d at 28. The Appellate Term agreed and held that the chiropractic fee schedule could be used to process claims for services rendered by acupuncturists.

As for an insurer's right to raise a fee schedule defense, the Fourth Amendment to 11 NYCRR 65-3 which is applicable to claims for medical services rendered on or after April 1, 2013 contains the following provision:

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: 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. 11 NYCRR §65-3.8(g)(1)(ii)

This essentially means that for those services rendered on or after April 1, 2013, a fee schedule defense is non-precludable. It may be asserted at any time, under any circumstance.

DECISION:

In this case, Applicant is seeking to get paid $505.82, which is the balance remaining on its charges for cupping therapy which was provided from 11-07-16 to 01-26-17. Noted earlier, this treatment was billed under CPT 97799.

CPT code 97799 is a By Report (BR) code which is listed in the Physical Medicine section of the Medical Fee Schedule. It is described as an "[u]nlisted physical medicine/rehabilitation service or procedure."The definition of what constitutes a service assignable as a By Report code, as well as the information that is required to establish it as such, is as follows:

Procedures Listed Without Specific Relative Value Units

By report (BR) items: "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 [chiropractor] shall establish a relative value unit consistent in relativity with other value units shown in the schedule. The insurer shall review all submitted "BR" unit values to ensure that relativity consistency is maintained. The general conditions and requirements of the General Ground Rules apply to all "BR" items.

- *See* NY Workers' Compensation Medical Fee Schedule, Introduction & General Guidelines, General Ground Rule 3;

- *See* NY Workers' Compensation Chiropractic Fee Schedule, Introduction & General Guidelines, General Ground Rule 2

In its denials, Respondent refers to the above Ground Rule and explains why Applicant's cupping charges were paid at a rate of $13.87:

> *[B]ased on our review of your bill[s], documents you have provided in support of your charges and the relative value of comparable services in the Fee Schedule, we are issuing reimbursement for your performance of cupping at 2.40 RVU (consistent in relativity) and are issuing payment based on that RVU and the conversion factor in the Chiropractic Fee Schedule.*

To explain its position in greater detail, Respondent looks to the affidavit of Steven Schram, LAc, DC.

According to Dr. Schram's analysis, this form of treatment should be billed under CPT 97039 (another By Report code); and considering the time and technical skill required for its performance, the charge for cupping should be calculated based on a Relative Value Unit of 2.40. This is discussed on page 3 of the affidavit:

> *Cupping, moxabustion and acupressure are associated with a concurrent acupuncture treatment so there is no additional diagnostic or examination component to these procedures.*
>
> *In order to derive an appropriate value for each, I compared these procedures to other procedures for which a value is already established. To do this, I looked at the value of the work, which is termed the RVU (relative value unit). Note that only one unit (i.e., line item charge) should be allowed for these procedures.*
>
> *The Fee Schedule provides a list of specific acupuncture and physical therapy procedures as well as their specific RVU units. I have identified the codes and their designated RVU values that I believe to be relevant to my analysis in Appendix "A" to this affidavit. The RVU value is based on the Compensation Board's understanding of the time, technical skill and effort, mental effort and judgment, and stress to provide a particular service.*
>
> *Cupping is a very simple procedure that requires a minimal amount of technical skill. It is typically an unattended procedure, although there are techniques (sliding cups) that would be considered attended. Looking at the RVUs listed in Appendix "A," it is my professional opinion that the Work RVU unit for cupping is 2.40, which is between overhead associated with cupping as it requires very little in the way of supplies other than, potentially, a lubricant on the skin surface to maintain a tight seal. . . .*

Appendix "A" identifies various services and their assigned RVUs:

CODE	SERVICE	RVU
97010	Hot or cold packs therapy	2.37
97012	Mechanical traction therapy	2.71
97014	Electrical stimulation therapy	2.66
97024	Diathermy (e.g., microwave)	2.71
97026	Infrared therapy	2.54
97028	Ultraviolet therapy	2.54
97032	Electrical stimulation (manual)	2.45
97033	Electric current therapy (i.e., iontophoresis)	3.55
97034	Contrast bath therapy	2.37
97035	Ultrasound therapy	2.41
97036	Hydrotherapy	3.89
97810	Acupuncture w/o electrical stimulation (initial 15 minutes)	3.55
97811	Acupuncture w/o electrical stimulation (add'l 15 minutes)	3.04

Based on Dr. Schram's assessment, cupping is a service which is reimbursable at a rate of $13.87 per session for acupuncturists located in Region IV.

Explained a bit further:

The rate of reimbursement for a service is generally calculated by multiplying the Relative Value Unit (RVU) by the Conversion Factor.

The Conversion Factor for acupuncturists (and chiropractors) who are located in Region IV is $5.78.

2.40 Relative Value Units x $5.78 Conversion Factor = $13.87

Having carefully reviewed the affidavit, I find that Respondent has established its fee schedule defense. Consequently, the burden shifts to the Applicant to substantiate the amount that was billed. For that purpose, Applicant looks to the affidavit of Peter Kopach, LAc.

In his rebuttal, Dr. Kopach explains the function and process of cupping. In paragraph 6, he addresses the code that was utilized by the Applicant, as well as the forms that were submitted to the Respondent:

> *Cupping may be billed appropriately under CPT code 97799 because cupping is not specifically listed within the New York Worker's Compensation Fee Schedule. The code description for 97799 is "Unlisted physical medicine/rehabilitation service or procedure." A bill with a charge under CPT code 97799 must satisfy the by-report code requirement. In this case, [the] by-report requirement was satisfied. The NF-3 forms submitted by the Company state that cupping was performed and written report attached. The written report provides a thorough description of cupping, including how the procedure is performed and amount of time spent per session. Additionally, acupuncture treatment notes list the dates in which cupping was performed and the part of the patient's body to which cupping was administered.*

In paragraphs 10 and 11, he writes that CPT 97799 is more appropriate than CPT 97039:

> *Cupping should be billed under CPT code 97799 as opposed to 97039 because cupping is a rehabilitative procedure and not a therapeutic modality. Cupping is often used by [a] licensed acupuncturist in the rehabilitation of [a] patient's suffering from injuries caused by traumatic events, athletic injuries or strokes. . . .*
>
> *. . . The procedure is more fitting towards code 97799 as cupping additionally acts, not just as therapy, but as a way to measure and diagnose the patient through the observation of the patient's skin after the cups are removed. Additionally, one-to-one contact is not necessary as the cups may be placed on the patient and the patient may be left unattended for the duration of the procedure. The service performed in this case is more comprehensive than services that fall under CPT code 97039 and a code requiring a broader application is warranted to accurately describe the services performed. CPT code 97039 is found in the physical therapy portion of the fee schedule. Similar to CPT code 97139, it should be used for unlisted therapeutic modalities and not for rehabilitative procedures such as cupping.*

At the end of his affidavit, Dr. Kopach argues that cupping warrants a higher RVU designation than 2.40:

> *[C]upping requires a high degree of skill by the practitioner. Furthermore, the cups that are used for the procedure must be changed frequently, which adds to the higher cost associated with performing cupping. Practitioners typically charge between $50.00 and $95.00 per session for cupping within*

Region IV. The geographic rate assigned to cupping by my office is $50.00 per session and this charge is both reasonable and common among licensed acupuncturists and falls on the lower side of the charges for cupping within the geographic locale.

I do not find Dr. Kopach's affidavit to be persuasive.

First, I would like to point out that from a monetary standpoint, the main distinction between 97799 and 97039 is that 97039 is subject to the 8-unit rule (see Ground Rule 3 of the Physical Medicine section of the Chiropractic Fee Schedule).

Practically speaking, this would mean that the Applicant, as an acupuncturist who is located in Region IV (and assigned a Conversion Factor of $5.78), would be limited to a maximum reimbursement of $46.24 for each cupping session.

Here, Applicant billed $50.00 for each date of service by utilizing CPT 97799, a By Report code which has no ceiling over its head. In other words, it's not subject to any such limitation.

Nevertheless, the key question in this case is not whether the service should have been charged under CPT 97799 or CPT 97039. The real issue here is whether cupping commands a reimbursement rate of $50.00 or $13.87.

Noted earlier, 11 NYCRR §68.5 (b) gives Applicant the right to bill for its service according to the "prevailing fee in the geographic location of the provider." However, it also provides that the fee is "subject to review by the insurer for consistency with charges permissible for similar procedures under schedules already adopted or established by the superintendent."

The Ground Rule for By Report items takes this one step further; it requires BOTH sides to assess reimbursement in a manner that is "consistent in relativity with other value units" in the fee schedule(s).

The affidavit by Dr. Schram satisfies this burden. It provides a meaningful analysis based on a comparison of other procedures that are listed in the fee schedule(s); and it arrives at a conclusion (2.40 RVUs) that is consistent in relativity with other value units.

Dr. Kopach does not engage in such a discussion. He simply states that practitioners in Region IV charge anywhere from $50.00 to $95.00 for a cupping session, and that such charges are both reasonable and common. At no point does he reconcile these numbers with any other services which have assigned RVUs. There is no showing of consistency.

Given the evidence, I am not persuaded to find that the worth of cupping falls within the range of 8.65 RVUs ($50.00) and 16.44 RVUs ($95.00).

Accordingly, Respondent's defense is upheld. Applicant is not entitled to any reimbursement above and beyond what was already paid.

This portion of the claim is denied.

DECISION FOR	DEFENSE/ISSUE	TOTAL	RESULT
ACUPUNCTURE AND CUPPING, PROVIDED FROM 02-06-17 TO 02-17-17 (3 DOS)	**NO SHOW IME AND FEE SCHEDULE**	**$316.98**	**GRANTED** **[$208.59]**

NOTE:

This portion accounts for three (3) dates of service, with each date of service listing one charge under CPT 97799 (cupping), one charge under CPT 97810 (acupuncture, initial 15 minutes) and two charges under CPT 97811 (acupuncture, each additional 15 minutes). In the aggregate, Applicant billed $394.14 for the treatment that was rendered.

During the hearing, this was amended to $316.98 in order to reflect the correct rate of reimbursement for the acupuncture codes; CPT 97810 was adjusted to $20.52, and CPT 97811 was adjusted to $17.57. [No change was made to the cupping fees, which were billed at a rate of $50.00 per date of service].

SUMMARY:

Applicant's bill was received on 03-10-17 and denied on 04-03-17 based on the failure of the assignor to appear for the following IMEs:

	LETTERS DATED	SCHEDULED FOR	IME TO BE CONDUCTED BY
#1	12-29-16	01-17-17	Gregory Chiaramonte, MD (ortho) Catherine Tortorella, DC (chiro) Iren Shemelyak, LAc (acu)
#2	01-18-17	02-06-17	Frank Oliveto, MD (ortho) Kevin Portnoy, DC (chiro) Scott Cortez, LAc (acu)

Respondent has submitted various documents to sustain its defense, namely:

- Application for No-Fault benefits (NF-2) form
- Assignment of Benefits (AOB) form
- IME Letters. The evidence shows that the letters were issued by a company named MedSource National on behalf of the Respondent. The letters are addressed to the assignor, and carbon copied to Geico.
- Affidavit by Dave Cosio, Vice President at MedSource National (attesting to the generation and mailing of the IME letters).
- Affirmation of Gregory Chiaramonte, MD (attesting to the assignor's non-appearance at the orthopedic IME scheduled for 01-17-17)
- Affidavit of Catherine Tortorella, DC (attesting to the assignor's non-appearance at the chiropractic IME scheduled for 01-17-17)
- Affidavit of Iren Shemelyak, LAc (attesting to the assignor's non-appearance at the acupuncture IME scheduled for 01-17-17)
- Affirmation of Frank Oliveto, MD (attesting to the assignor's non-appearance at the orthopedic IME scheduled for 02-06-17)
- Affidavit of Kevin Portnoy, DC (attesting to the assignor's non-appearance at the chiropractic IME scheduled for 02-06-17)
- Affidavit of Scott Cortez, LAc (attesting to the assignor's non-appearance at the acupuncture IME scheduled for 02-06-17)
- Global denial
- Claim-specific denial

LEGAL FRAMEWORK:

Pursuant to the Mandatory Personal Injury Protection Endorsement of the No-Fault Regulations, "No action shall lie against the Company unless, as a condition precedent thereto, there shall have been full compliance with the terms of this coverage." *See* 11 NYCRR §65-1.1.

The appearance at an IME is a condition precedent to the insured's liability on the policy, and an insurer may deny a claim retroactively to the date of loss for a claimant's failure to attend IMEs, "when, and as often as, the [insurer] may reasonably require." Stephen Fogel Psychological, P.C. v. Progressive Casualty

Ins. Co., 35 A.D.3d 720, 827 N.Y.S.2d 217 (App. Div, 2nd Dept, 2006)(*citing to* 11 NYCRR §65-1.1 wherein it states: "The eligible injured person shall submit to medical examination by physicians selected by, or acceptable to, the Company when, and as often as, the Company may reasonably require.").

Appearance at an IME is required whether the insurance company issues the requests before or after submission of the claim form. Id.

To establish the defense, an insurer must demonstrate that two separate requests for the IME were properly mailed to the assignor, and that the assignor failed to appear for the examination on either of the scheduled dates. Apollo Chiropractic Care, PC v. Praetorian Ins. Co., 27 Misc 3d 139(A), 2010 NY Slip Op 50911(App. Term, 1st Dept., 2010).

The letters must be correctly addressed, and pursuant to 11 NYCRR §65-3.5 (e) they must inform the person that he/she will be reimbursed for any loss of earnings and reasonable transportation expenses incurred in complying with the requests.

To demonstrate the non-appearance, the insurer must submit proof by someone with personal knowledge of the non-appearance(s). Alleviation Med. Servs., P.C. v. Hertz Co., 2016 NY Slip Op 50399(U) (App Term, 2nd Dept., 2nd, 11th & 13th Jud. Dists, Mar. 23, 2016).

Such evidence must be adequately detailed. *See* Compas Med., PC v. New York Cent. Mut. Fire Ins. Co., 2016 NY Slip Op 50376(U)(App. Term, 2nd Dept., 2nd, 11th, & 13th Jud. Dists., Mar. 17, 2016)(defendant submitted properly sworn statements by the chiropractor and doctor who were scheduled to perform the IMEs, but the Court found that neither health care professional demonstrated personal knowledge of the nonappearance). *See also* Metro 8 Med. Equip., Inc. v. ELRAC, Inc., 50 Misc.3d 140(A), 2016 NY Slip Op 50174(U)(App. Term, 1st Dept, Feb. 18, 2016)(the affidavit of defendant's chiropractor/acupuncturist was found to be of no probative value because the affidavit failed to explain the basis of the doctor's recollection, some 18 months later, that the assignor did not appear on the scheduled IME dates).

The failure of the claimant to appear for duly scheduled IMEs is a defense which is subject to preclusion; it will not survive in the face of an untimely denial. Clinton Place Medical, PC v. New York Central Mutual Fire Ins. Co., 43 Misc.3d 126(A), 2014 NY Slip Op 50468(U)(App. Term, 2nd Dept., 2nd, 11th & 13th Jud. Dists., March 17, 2014).

DECISION:

Having reviewed the entire record, I find in favor of the Applicant.

While Respondent has come forward with sufficient evidence to demonstrate the mailing of the IME letters, and the timeliness of its denial, it has not offered adequate proof to establish the assignor's failure to appear for the scheduled IMEs. All of the affidavits/affirmations are conclusory and none of them succeed in carrying Respondent's burden. These documents simply state that the assignor did not appear on the scheduled dates and times at the designated address. No explanation is offered to demonstrate personal knowledge of the non-appearances. The IME doctors do not even state whether they were present at the designated location on the scheduled dates and times. Given the record, I find that Applicant is entitled to be paid for its services.

Accordingly, the claim is granted. Applicant is entitled to be paid:

$20.52 for each charge under CPT code 97810;

$17.57 for each charge under CPT code 97811 (this was billed twice [2x] per date of service); and

$13.87 for each charge under CPT code 97799 (cupping, discussed above).

In total, Applicant is awarded $208.59 (i.e., $69.53 per date of service).

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.

		Claim	**Amount**	

Medical		From/To	Amount	Amended	Status
	Alternative PLM Acupuncture, PC	**11/02/16 - 02/17/17**	**$1,391.20**	**$857.02**	**Awarded: $242.81**
Total			**$1,391.20**		**Awarded: $242.81**

B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 09/18/2017, which is a relevant date only to the extent set forth below.)

Applicant is awarded interest pursuant to the No-Fault regulations. *See generally,* 11 NYCRR §65-3.9. 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. "If an applicant does not request arbitration or institute a lawsuit within 30 days after receipt of a denial of claim form or payment of benefits calculated pursuant to Department of Financial Services regulations, interest shall not accumulate on the disputed claim or element of claim until such action is taken." 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).

Interest is to be calculated from the date this case was filed in arbitration: 09-18-17.

C. Attorney's Fees

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

As the claim was filed subsequent to the Sixth Amendment to 11 NYCRR §65-4 (Insurance Regulation 68-D) which took effect on February 4, 2015, Attorney's Fees shall be calculated pursuant to the amended terms, as follows:

20 percent of the amount of first-party benefits, plus interest thereon, subject to a maximum fee of $1,360. [11 NYCRR §65-4.6(d)]. There is no minimum fee.

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

03/23/2018
(Dated)

Meryem Toksoy

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:
b71472afdba8aa57d63e4246bfccd04b

Electronically Signed

Your name: Meryem Toksoy
Signed on: 03/23/2018