

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Health East Ambulatory Surgical Center  
(Applicant)

- and -

American Transit Insurance Company  
(Respondent)

AAA Case No. 17-17-1072-2417

Applicant's File No. 1020775

Insurer's Claim File No. 666537-02

NAIC No. 16616

**ARBITRATION AWARD**

I, Eileen Hennessy, 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-A.F.

1. Hearing(s) held on 05/08/2018  
Declared closed by the arbitrator on 06/16/2018

Tricia Smith from The Law Office of Cohen & Jaffe, LLP participated in person for the Applicant

Cliff Ryan from Bruno Gerbino & Soriano LLP participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 2,718.00**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant amended the amount in dispute from \$2,718.00 to \$2,295.32. Applicant withdrew the portion of the bill seeking \$422.68 for an epidurography under CPT code 72275 on date of service 2/24/2017.

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

The parties stipulated that respondent timely denied the bill at issue.

3. Summary of Issues in Dispute

Was the applicant entitled to reimbursement for the cost of the medical services provided to the Assignor-A.F., a 59-year-old female pedestrian struck by a motor vehicle on 4/3/2016? The services at issue are the Ambulatory Surgery Center (ASC) facility fees for the lumbar epidural steroid injections and epidurography provided to Assignor-A.F. on 2/24/2017. The respondent denied this claim based on a lack of medical necessity per the results of the Independent Medical Evaluation (IME) performed by Dr. Andrew Miller, M.D., and the fees were in excess of the fee schedule. The issues to be determined are 1) Whether the services are medically necessary? and 2) If the services are determined to be medically necessary should the respondent's fee schedule defenses be sustained?

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

The record in this case consisted of claimant's submission and respondent's submission, as well as documents not enumerated within this decision, but which are contained in the electronic case file maintained by the American Arbitration Association.

11 NYCRR 65-4.5 (o) (1) (Regulation 68-D), reads as follows: The arbitrator shall be the judge of the relevance and materiality of the evidence offered and strict conformity to legal rules of evidence shall not be necessary. The arbitrator may question any witness or party and independently raise any issue that the arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department Regulations.

This case is one (1) of three (3) linked cases heard together on 5/2/2018. The 3 linked cases are 17-17-1072-2382, 17-17-1072-2391, and 17-17-1072-2417.

#### **MEDICAL NECESSITY**

##### *Legal Standards for Determining Medical Necessity*

Once applicant has established a prima facie case, the burden then shifts to respondent to establish a lack of medical necessity with respect to the benefits sought. *See, Citywide Social Work & Psychological Services, PLLC v. Allstate Ins. Co.*, 8 Misc3d 1025A (2005). A denial premised on lack of medical necessity must be supported by competent evidence such as an IME, peer review or other proof which sets forth a factual basis and medical rationale for denying the claim. *See, Healing Hands Chiropractic, P.C. v. Nationwide Assur. Co.*, 5 Misc3d 975 (2004).

In evaluating the medical necessity of services with proof of each party, particularly where the conclusion is contradictory; consideration must be given to the evidentiary burdens. Respondent must prove first that the services were not medically necessary. The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment. *Kingsborough Jewish Med. Ctr. v. All State Ins. Co.*, 61 A.D. 3d. 13 (2d. Dep't, 2009), *See also Channel Chiropractic PC v. Country Wide Ins. Co.*, 38 AD 3d. 294 (1st Dep't, 2007). An IME doctor must establish a factual

basis and medical rationale for his asserted lack of medical necessity for future health care services. E.g., Ying Eastern Acupuncture, P.C. v. Global Liberty Insurance, 20 Misc.3d 144(A), (App. Term 2d & 11th Dists. Sept. 3, 2008). 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. West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc.3d 4(App. Term 2d & 11th Dists. Sept. 29, 2006). For an applicant to prove that the disputed expense was medically necessary, it must meaningfully refer to, or rebut, respondent's evidence. See, Yklik, Inc. v. Geico Ins. Co., 28 Misc3d 133A (2010). The case law is clear that a provider must rebut the conclusions and determinations of the IME doctor with his own facts. Moreover, the Appellate Term, 2d, 11th & 13th Dists., stated: "Assuming the insurer is successful in satisfying its burden, it is ultimately plaintiff who must prove, by a preponderance of the evidence, that the services or supplies were medically necessary." Park Slope Medical and Surgical Supply, Inc. v. Travelers Ins. Co., 37 Misc.3d 19, 22 (App. Term 2d, 11th & 13th Dists. 2012). Where an IME report provides a factual basis and medical rationale for an opinion that services were not medically necessary, and the claimant fails to present any evidence to refute that showing, the claim should be denied, as the ultimate burden of proof on the issue of medical necessity lies with the claimant. See Insurance Law § 5102; AJS Chiropractic, P.C. v. Mercury Ins. Co., 22 Misc.3d 133(A), (App. Term 2d & 11th Dist. Feb. 9, 2002); Wagner v. Baird, 208 A.D.2d 1087 (3d Dept. 1994).

#### Application of Legal Standards

I note the validity of denials based upon negative IME findings have been recognized by several Courts. See e.g. Innovative Chiropractics P.C. v. Mercury Ins. Co., 25 Misc3d 137 (App. Term 2d & 11th Dists. 2009); B.Y. M.D., P.C. v. Progressive Casualty Ins. Co., 26 Misc3d 125 (App. Term 9th & 10th Dists. 2010). An IME report can be the basis of a termination of benefits if ultimately found to be persuasive. Whether an IME report is persuasive, and meets the carrier's burden is a factual decision, which must be rendered on a case by case basis. Therefore when, as here, an insurer interposes a timely denial of claim that sets forth a sufficiently detailed factual basis and adequate medical rationale for the claim's rejection, the presumption of medical necessity and causality attached to the applicant's properly completed claim is rebutted and the burden shifts back to the claimant to refute the IME findings and prove the necessity of the disputed services and the causal relationship between the injuries and the accident. See, CPT Med. Servs., P.C. v. New York Cent. Mut. Fire Ins. Co., 18 Misc.3d 87 (App. Term 1st Dept.); A.Khodadadi Radiology, P.C. v. NY Cent. Mut. Fire Ins. Co., 16 Misc. 3d. 131 (A) (App Term 2d Dept.).

In support of its contention that further treatment was not medically necessary respondent relies upon the examination report of orthopedic surgeon Andrew Miller, MD, conducted on 9/6/2016. A review of the examination report reveals all tests were objectively negative and unremarkable. Dr. Miller diagnosed resolved cervical, thoracic, and lumbar spine sprain/strain, right shoulder sprain, right hip sprain, right knee sprain, and right ankle/foot sprain/strain. From an orthopedic viewpoint, there was no need for any further treatment Based upon Dr. Miller's examination, all orthopedic No-fault benefits were denied effective 10/3/2016. The results of the examination presented a

cogent medical rationale as to why further benefits were terminated in support of respondent's defense. Therefore, the burden shifts to the applicant to establish the services billed were medically necessary.

There is a rebuttal of the IME report by Anson Moise, MD, the treating provider dated 05/18/17. Dr. Moise discusses the patient's past medical history. He states that the patient initially presented to Dr. Orsuville Cabatu, M.D. on 4/8/2016 for treatment for lower back pain, which radiated into the right lower extremity with numbness. Monthly follow-up examinations were conducted at Dr. Cabatu's office through 3/28/2017. A contemporaneous examination to the IME was conducted by Dr. Cabatu on 9/15/2016, which, according to Dr. Moise, revealed decreased range of motion. Dr. Moise did not provide a comparison to what the normal ranges of motion should be. MRI of the lumbar spine was performed on 6/11/2016. EMG/NCV of the lower extremities was conducted on 8/23/2016. Assignor-A.F. was recommended to Dr. Moise, an anesthesiologist and pain management specialist, for pain management, where she was initially examined on 1/18/2017. Dr. Moise recommended Assignor-A.F. for lumbar epidural injections under fluoroscopic guidance with anesthesia. Dr. Moise further recommended continuing physical therapy. Physical therapy progress notes were provided from Electrodiagnostic and Physical Medicine, PC from 4/14/2016 through 4/26/2017. The lumbar epidural steroid injections were performed on 2/24/2017, four months after the IME. Assignor-A.F. was evaluated by orthopedist David Capiola, M.D. in 4/2016, 8/2016 and 9/2016. Right shoulder arthroscopic surgery was planned as of 9/2016.

In response to the IME, Dr. Moise states that on 9/15/2016 patient presented to Dr. Cabatu with persistent symptoms in the lower back, which is an indicator that the injuries have not resolved. Neurological examination revealed decreased motor strength and decreased sensation. Furthermore, Dr. Miller failed to review the results of the MRI of the lumbar spine or the EMG/NCV. Dr. Moise goes on to say that prior to diagnosing the patient it would have been crucial for Dr. Miller to review the results of these tests as they provide clear evidence of the nature of the patient's injury. According to Dr. Moise, Dr. Miller did not accurately diagnose the patient.

There is an addendum from Dr. Miller, which confirms his original opinion and states "The subjective complaints and the MRI findings of the cervical and lumbar spine reported by Dr. Moise were not correlated by clinical findings on my examination as a result of the MVA."

All reports, including the respondent's IME doctor and the applicant's reports appear credible and cogent. Thus, I am placed in the position of determining which of these opinions should be accorded the most weight. Comparing the relevant evidence presented by both parties, and upon consideration of the arguments of counsel, I find that Applicant was able to adequately rebut the conclusions of Dr. Miller's IME. Assignor-A.F. had presented for an initial orthopedic IME with Robert Pick, MD on 5/1/2016 at respondent's request. Dr. Pick found Assignor-A.F. suffered multiple sprain/strain injuries because of the accident with decreased ranges of motion in all areas of subjective complaints. Dr. Pick recommended continued physical therapy once a week for eight weeks with a re-evaluation at the end of the eight weeks. The respondent

scheduled a follow-up orthopedic examination with Dr. Miller. The examination by Dr. Miller was complete and objectively unremarkable. The eight areas of sprain/strain diagnosed by Dr. Pick on 5/1/2016 were completely resolved according to Dr. Miller's examination of 9/6/2016. The contemporaneous records presented by applicant in response to the IME, as well as the rebuttal by Dr. Moise, indicate that the patient still presented with objective findings of decreased ranges of motion as well as tenderness and decreased sensation. At the 9/15/2016 examination, contemporaneous to the IME, Assignor-A.F. was experiencing significant pain in the lumbar spine, which radiated to the right leg, which Assignor-A.F. rated as a 9/10 on a pain scale. According to the extensive and detailed medical records provided by the applicant, Assignor-A.F. went for physical therapy consistently with steady progress. Assignor-A.F. followed up with the appropriate specialties and followed the physician's recommended course of treatment. Dr. Moise states that pursuant to medical guidelines patient's subjective complaints and objective findings indicate a medical necessity for lumbar epidural steroid injections. Applicant's evidence is more persuasive.

### **FEE SCHEDULE**

Applicant billed for ASC facility fees for two epidural steroid injections under CPT code 64483 (for which it charged \$1,518.48) and CPT code 64484 (for which it charged \$776.84). Applicant also billed for epidurography using CPT code 72275 (for which it charged \$422.68), which applicant withdrew at the hearing.

The parties agree that the New Jersey Fee Schedule applies to this claim. The services were rendered in zip code 07631, which is in the Northern region of New Jersey.

According to 11:3-29, Appendix Exhibit 1, Physicians' and ASC Fee Schedules, (New Jersey Fee Schedule), ASCs in New Jersey may charge the following fees for use of the facility, when the following coded services are performed:

Code 64483- epidural steroid injection: \$1,012.32

Code 64484- epidural steroid injection: \$517.89

Code 72275- epidurography: \$0

Applicant relies on the affidavit of certified professional coder Danielle M. Watson. Respondent relies on the affidavit of certified professional coder Wanda Dominguez.

Ms. Watson, on behalf of applicant, argues that applicant is entitled to \$2,295.32. CPT code 64483- \$1,518.48 (\$1,012.32 X 1.5) and CPT code 64484-\$776.84 (\$517.89 X 1.5). NJ FS Section 11:3-29.4(f)(2) states that certain procedure codes are exempt from the multiple procedure reduction. For CPT Codes 10000 through 69999, the following shall apply: 2. There are two types of procedures that are exempt from the multiple procedure reduction. Codes in CPT that have the note, "Modifier -51 exempt" shall be reimbursed at 100 percent of the eligible charge. In addition, some related procedures contain a specific descriptor that includes the words, "each additional" or "list separately in addition to the primary procedure." These add-on codes cannot be reported as

stand-alone codes but when reported with the primary procedure are not subject to the 50 percent multiple procedure reduction. CPT Code 64484 is one of the codes wherein the descriptor already notes that it is an "additional" procedure, and thus has already been reduced in the fee schedule. CPT code 64484 is also listed in Appendix D, Summary of CPT Add on Codes, annexed to the New Jersey fee schedule, which is included as part of applicant's submissions.

Ms. Watson further argues in paragraph 6 regarding CPT code 64483 and 64484, "it is clear from the operative report that these injections were performed bilaterally". According to NJ FS Section 11:3-29.4(f)(1), reimbursement for bilateral surgeries reported with the modifier "-50" shall be 150% of the eligible charge. Therefore, Ms. Watson argues that applicant is entitled to 150% of the allowable amount under the New Jersey fee schedule for CPT code 64483 and CPT code 64484, which was performed bilaterally.

Ms. Dominguez, on behalf of respondent, relies on N.J.A.C. 11:3-29.5(d) and indicates that the bill for the ASC is subject to the multiple procedure reduction formula. Therefore, the bill should be reimbursed to \$1,318.64. Specifically, CPT code 64483 should be paid at 100% (\$611.76), CPT code 64485 should be paid at 50% (\$134.74) and CPT code 72275 should be paid at 100% (\$572.81). Ms. Dominguez does not explain why CPT code 64483 and CPT code 72275 were both allowed at 100%.

Applicant argues that the amounts referenced in Ms. Dominguez's affidavit for the codes billed are from the Physician Fee column of the New Jersey fee schedule rather than the ASC column, which is inappropriate as the applicant's bill is seeking reimbursement for the facility fees in this case.

### Law

It is well established that a healthcare provider must limit its charges according to the applicable fee schedule. Goldberg v. Corcoran, 153 AD2d 113, 117-18 (App Div, 2d Dept 1989). An insurance carrier's timely asserted defense that the bills submitted were not properly no-fault rated or that the fees charged were in excess of the Workers' Compensation Fee Schedule is sufficient, if proven, to justify a reduction in payment or denial of claim. New York Hosp. Med. Ctr. Of Queens v. Country-Wide Insurance Company, 295 A.D.2d 583, 744 N.Y.S.2d 201 (2nd Dept. 2002); East Coast Acupuncture, P.C. v. New York Central Mutual Insurance, 18 Misc.3d 139(A), 2008 N.Y. Slip Op. 50344(U) (App. Term 2nd and 11th Jud. Dists. 2008); A.B. Medical Services, PLLC v. American Transit Insurance Company, 15 Misc.3d 132(A), 2007 N.Y. Slip Op. 50680(U) (App. Term 2nd and 11th Jud. Dists. 2007).

The insurer has the burden of coming forward with competent evidentiary proof to support its fee schedule reduction or denial. *See, e.g.,* Roberts Physical Therapy, P.C. v. State Farm Mutual Automobile Insurance Company, 13 Misc.3d 172, 3006 N.Y. Slip Op. 26240 (N.Y. Civ. Ct. Kings Co. 2006). In the absence of such proof, a defense of noncompliance with the appropriate fee schedule cannot be sustained. 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).

The Fourth Amendment to 11 NYCRR 65-3, which is applicable to claims for medical services rendered on or after April 1, 2013, includes 11 NYCRR 65-3.8(g)(1)(ii) which provides: "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."

As the services at issue were performed on 2/4/2017 a fee schedule defense is not subject to preclusion. Saddle Brook Surgicenter, LLC v. Allstate Insurance Company, 2015 N.Y. Slip Op. 25099 (N.Y. Civ. Ct. Bronx Co. 2015; Surgicare Surgical v. National Interstate Insurance Company, 46 Misc.3d 736, 2014 N.Y. Slip Op. 24362 (N.Y. Civ. Ct. Bronx Co. 2014).

### Analysis

Applicant uploaded the affidavit of Ms. Watson just prior to the hearing. As respondent did not have an opportunity to review applicant's affidavit or prepare a counter-argument prior to the hearing, respondent was given two weeks to submit a post-hearing brief in the interests of fairness. The brief was due on or before May 22, 2018. To date no post-hearing submissions was submitted by respondent.

Applicant's attorney correctly argued at the hearing that the amounts referenced in Ms. Dominguez's affidavit are taken from the Physician Fee Column of the New Jersey fee schedule rather than the ASC Fee column for the services billed. As Ms. Dominguez referenced the incorrect fees, the weight of the affidavit in deciding the proper fee amount is limited.

Contrary to applicant's affidavit, applicant's NF-3 does not indicate that bilateral procedures were performed. Since the NF-3 is an element of the applicant's prima facie case, respondent need not refer to any other documents to establish that reimbursement for a bilateral procedure has not been established. Pursuant to 11:3-29.4(f)(3) "If a procedure is not identified by its terminology as a bilateral procedure (or unilateral or bilateral) and is performed bilaterally, providers must report the procedure with modifier '-50' as a single line item. Reimbursement for bilateral surgeries reported with modifier '-50' shall be 150% of the eligible charge." Applicant's bill does not contain the required "-50" modifier. Regardless, even if applicant billed with modifier "-50", the Applicant would still have overbilled. CPT code 64483 and CPT code 64484, in the AMA's CPT book, do not state "bilateral" or "unilateral or bilateral" but they do state that they apply to the "level." That conveys that they are to be used only once per level. Hence, they cannot be billed separately for left and for right. Therefore, contrary to Ms. Watson's affidavit, applicant is not entitled to 150% of CPT code 64483 or CPT code 64484.

Applicant is correct that pursuant to NJAC § 11:3-29.4, Application of medical fee schedules, (f), (2), CPT Code 64484 is an add-on code that is would not be subject to the 50 percent multiple procedure reduction for purpose of calculating the appropriate fee to

reimburse *the physician* for the services rendered. However, pursuant to the respondent's affidavit, 11:3-29.5 Outpatient surgical facility fees, governs reimbursement for ASC fees. Subsection (d) details the multiple procedure reduction rule for ASCs. Subsection (2) states, "Subchapter, Appendices, Exhibit 1, the Physicians' and ASC Facility Fee Schedule and Exhibit 7, the HOSF Fee Schedule, indicate those CPT codes that, according to Medicate (citations omitted) are exempt from the multiple procedure reduction formula." In fact, according to the State of New Jersey, Department of Banking and Finance, Auto Medical Fee Schedule Frequently Asked Questions, updated 7/21/2015, <http://www.state.nj.us>:

**16. Do the provisions in N.J.A.C. 11:3-29.4(f) (multiple and bilateral surgeries, co-surgeries and assistant surgeons) apply to facility fees billed by ASCs and HOSFs pursuant to N.J.A.C. 11:3-29.5(d)?**

No. The procedures concerning billing for bilateral and co-surgeries and exemptions from the multiple procedure reduction formula listed in N.J.A.C. 11:3-29.4(f) are intended to apply only to services billed pursuant to the Physicians' fees column in Appendix, Exhibit 1. The multiple procedure reduction and bilateral procedures rule for ASCs and HOSFs are found in the text of the rule at N.J.A.C. 11:3-29.5(d).

Ms. Dominguez does not address applicant's argument that the codes billed are not subject to the multiple procedure reduction rule. My review of Appendix 1 of the New Jersey Fee Schedule reveals a code key on the bottom of the Appendix, which is not included in the applicant's submission, that indicates "N1 = ASC Packaged Procedure no separate payment" and "X = ASC codes Not Subject to Multiple Procedure Reductions". A further review of Exhibit 7, the Hospital Outpatient Facility (HOSF) Fees reveals a separate column for codes "Not subject to multiple procedure reductions." Neither of these charts have an "X" placed to CPT code 64483 or CPT code 64484. Therefore, a very plain reading of the New Jersey Fee Schedule appendix reveals that CPT code 64483 and CPT code 64484 are subject to the multiple procedure reduction rule. Moreover, while applicant withdrew the charge for CPT code 72275, which they billed at \$422.68, this code is blank in the ASC fee schedule, with an N1 payment indicator, which indicates that applicant is not entitled to separate reimbursement for this code, as it is an "ASC Packaged Procedure no separate payment".

Therefore, neither applicant's fee coder affidavit nor respondent's fee coder affidavit provide an accurate analysis of the New Jersey ASC fee schedule for the CPT codes billed. CPT code 64483 should be reimbursed at \$1,012.32 (100% of the code) and CPT code 64484 should be reimbursed at \$258.95 (\$517.89 X 50%). Applicant withdrew CPT code 72275 in the amount of \$442.68 but would not be entitled to reimbursement. Therefore, the total amount due to the applicant is \$1,271.27.

**CONCLUSION**

Having reviewed all the relevant evidence, Applicant has submitted comprehensive medical evaluations that are contemporaneous with and subsequent to the IME. These evaluation reports are sufficient to refute the IME. Therefore, the Applicant is entitled to



reimbursement for the disputed services. However, under the applicable New Jersey fee schedule, Applicant's services are reimbursable at \$1,271.27. This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator.

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
	<b>Health East Ambulatory Surgical Center</b>	<b>02/24/17 - 02/24/17</b>	<b>\$2,718.00</b>	<b>\$2,295.32</b>	<b>Awarded: \$1,271.27</b>
<b>Total</b>			<b>\$2,718.00</b>		<b>Awarded: \$1,271.27</b>

- B. The insurer shall also compute and pay the applicant interest set forth below. 09/12/2017 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

The date set forth above is the date of the initiation letter issued by the American Arbitration Association in accepting this case for filing.

Applicant did not commence arbitration within 30 days after receipt of the denial(s). Therefore, the interest accrual date shall be the said initiation letter date. The end date for the period of interest shall be the date of payment of the claim. Interest shall be calculated at the rate of two percent per month, simple, calculated on a pro rata basis using a 30-day month. *See* 11 NYCRR 65-3.9, 65-4.5(s)(3).

C. Attorney's Fees

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

Applicant is entitled to an attorney's fee pursuant to Insurance Law §5106(a). After calculating the sum total of the first-party (No-Fault) benefits awarded in this arbitration plus interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20 percent of that sum total, subject to the following limitations: In the event the above filing date was prior to Feb. 4, 2015, the attorney's fee is subject to a minimum of \$60.00 and a maximum of \$850.00, per 11 NYCRR 65-4.6(e). In the event the above filing date was on or after Feb. 4, 2015, the attorney's fee is subject to a maximum of \$1,360.00, per 11 NYCRR 65-4.6(d). In the event the above filing date was on or after Feb. 4, 2015 and first-party (No-Fault) benefits are awarded to more than one Applicant herein, the attorney's fee shall be calculated separately for each Applicant, each Applicant's attorney fee being subject to the \$1,360.00 maximum.

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

06/16/2018  
(Dated)

Eileen Hennessy

**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:**  
6fe8b4f03a34cf39e4f0790a8790b195

### **Electronically Signed**

Your name: Eileen Hennessy  
Signed on: 06/16/2018