

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Staten Island Sports Chiropractic, P.C.
(Applicant)

- and -

Enterprise Rent A Car
(Respondent)

AAA Case No. 17-18-1084-5098

Applicant's File No. 18-000165

Insurer's Claim File No. 01087298

NAIC No. Self-Insured

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-M.M.

1. Hearing(s) held on 11/06/2018
Declared closed by the arbitrator on 11/21/2018

Robert Bott from Super & Licatesi P.C. participated in person for the Applicant

Sarah Labia from Rankin Savidge PLLC participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 2,193.08**, was NOT AMENDED at the oral hearing.
Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

Assignor-M.M., a 53-year-old male, was reportedly injured as a pedestrian involved in a motor vehicle accident on 5/23/2017. Applicant seeks reimbursement for chiropractic treatment, nerve conduction testing, range of motion and manual muscle testing performed from 8/3/2017 through 9/15/2017. There are no denials in the ECF. The issues presented are 1) whether the Respondent has established that the bills were denied, 2) whether the priority of payment was followed, 3) whether Respondent established the insurance limits available under the contract of insurance, 4) whether the policy of insurance is exhausted and if not 5) whether the Applicant billed in accordance with the Fee Schedule?

4. Findings, Conclusions, and Basis Therefor

Applicant seeks reimbursement for chiropractic treatment, nerve conduction testing, range of motion and manual muscle testing. This case was decided based upon the submissions of the Parties as contained in the electronic file maintained by the American Arbitration Association, and the oral arguments of the parties' representatives. There were no witnesses. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

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.

Applicant establishes prima facie showing of entitlement to No-Fault benefits under Article 51 of the Insurance Law by "submitting evidence that payment of no-fault benefits are overdue, and proof of its claim, using the statutory billing form, was mailed to and received by the defendant insurer." Viviane Etienne Med. Care, P.C. v. Country-Wide Ins. Co., 25 N.Y.3d 498, 14 N.Y.S. 3d 283 (Court of Appeals, 2015).

Within 30 calendar days after proof of claim is received, the insurer shall either pay or deny the claim in whole or in part. 11 NYCRR §65-3.8(c).

A Denial of Claim form (NF-10) is sufficient to demonstrate receipt. Eagle Surgical Supply, Inc. v. Allstate Ins. Co., 42 Misc 3d 145(A), 2014 NY Slip Op 50343(U)(App. Term, 2 Dept, 2 , 11 & 13 Jud Dists., 2014).

Once Applicant establishes 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. Eagle Ins. Co., 2 Misc.3d 128(A), 2003 N.Y. Slip Op. 51701(U)(App. Term, 2 Dept, 2 & nd nd 11 Jud Dists., 2003).

Insurance Law § 5102(a) defines basic economic losses reimbursement up to \$50,000.00 per person for all necessary expenses arising from a motor vehicle accident as covered under New York Insurance Law § 5102. An insured is entitled to receive first-party benefits under the No-Fault Law equal to his basic economic loss, up to \$50,000 less the deductions set forth in the Insurance Law and, hence, an insurer may reduce the \$50,000 basic economic loss limit by taking deductions representing Social Security disability benefits received and 20% of lost earnings. Normile v. Allstate Ins. Co., 60 N.Y.2d 1003, 471 N.Y.S.2d 550 (1983), aff'g, 87 A.D.2d 721, 448 N.Y.S.2d 907 (3d Dept. 1982). When an insurer has paid full monetary limits set forth in the policy, however, its duties under the contract of insurance cease. See New York State Department of Insurance General Counsel Opinion Letter, dated July 30, 2008. When an insurer has paid the full monetary limits set forth in the policy, its duties under the contract of insurance cease. Countrywide Ins. Co. v. Swah, 272 A.D.2d 245 (1st Dept. 2000).

A defense of no coverage due to the exhaustion of No-Fault insurance policy's limit may be asserted by an insurer despite its failure to issue a NF-10 denial of claim form within the requisite 30-day period. New York & Presby. Hosp. v. Allstate Ins. Co., 12 A.D.3d 579, 580 (2d Dept. 2004); Flushing Traditional Acupuncture, P.C. v. Infinity Group, 2012 NY Slip Op 22345 (App Term 2d, 11th & 13th Jud Dists, November 26, 2012); Crossbridge Diagnostic Radiology v. Encompass Ins., 24 Misc.3d 134(A), 2009 NY Slip Op 5141(U) (App Term 2d, 11th & 13th Jud Dists, 2009). An Arbitrator's award directing payment in excess of the limits of an insurance policy exceeds the arbitrator's power and constitutes grounds for vacatur of the award. Matter of Brijmohan v. State Farm Ins. Co., 92 N.Y.2d 821, 822 (1998); Countrywide Ins. Co. v. Swah, 272 A.D.2d 245 (1st Dept. 2000). Note that the Swah case, supra, has been cited at least six times for this proposition. See, Matter of Motor Vehicle Accident Indemnification Corp. v. Am. Country Ins. Co., 2015 NY Slip Op 02714, 126 A.D.3d 657, 4 N.Y.S.3d 487 (App. Div.); Breeze Acupuncture, P.C. v. Allstate Ins. Co., 2018 NY Slip Op 50138(U), 58 Misc. 3d 1217(A) (Civ. Ct.); Ameriprise Ins. Co. v. Kensington Radiology Grp., P.C., 2017 NY Slip Op 51911(U), 58 Misc. 3d 144(A) (App. Term); Allstate Prop. & Cas. Ins. Co. v. Ne. Anesthesia & Pain Mgmt., 2016 NY Slip Op 50828(U), 51 Misc. 3d 149(A), 41 N.Y.S.3d 448 (App. Term); Allstate Ins. Co. v. Countrywide Ins. Co., 2013 NY Slip Op 33179(U) (Sup. Ct.); Allstate Ins. Co. v. Auto One Ins. Co., 2012 NY Slip Op 50874(U), 35 Misc. 3d 140(A), 953 N.Y.S.2d 548 (App. Term).

Analysis

The issue is whether Respondent denied the claims, whether the Respondent followed the priority of payment for payment of claims, whether Applicant has submitted proof of the insurance limits, and whether the policy has been exhausted?

Applicant submits proof of mailing of the bills at issue by United States Postal Service (USPS) Form 3877 certificates of mailing, addressed to Respondent, date stamped by the USPS, indicating that the bills were timely mailed from 8/8/2017 through 9/20/2017. Each certificate lists the Assignor's name and the dates of service at issue. I find this to be sufficient proof of mailing of the bills at issue. There are no denials for the bills in dispute. Respondent alleges that the insurance limits, as listed in the Respondent's certificate of insurance filed with the State of New York, is exhausted.

In support of the contention that the insurance limits have been exhausted, Respondent submitted a copy of its PIP register evidencing that \$50,669.00 has been paid by the insurer as of the last payment issued by check on 2/19/2018, thereby arguably exhausting the minimum PIP limits. Respondent also submits the affidavit of Miriam Torres, No-Fault Administrator of Enterprise Rent A Car, who advises that "from 5/23/2017, up to the present, Elrac. Inc. maintained a certificate of insurance with the State of New York and did not maintain a policy of insurance." Furthermore, from 5/23/2017, up to the present, the maximum limits of Elrac's certificate of insurance for any one assignor for any one motor vehicle accident is \$50,000.00. Ms. Torres indicates that payments totaling \$50,669.00 were issued for no-fault claims to or on behalf of the Assignor in regard to the motor vehicle accident of 5/23/2017.

Respondent, Enterprise-Rent-A-Car, is a self-insured rental company and must provide a minimum of \$50,000 in mandatory personal injury protection benefits (PIP) benefits. "In lieu of filing a surety bond or insurance policy, rental car companies with 25 or more registered vehicles may seek permission from the Commissioner of Motor Vehicles to self-insure. To do so, the rental agency must satisfy the Commissioner that it 'is possessed and will continue to be possessed of financial ability to respond to judgments obtained against such person, arising out of the ownership, maintenance, use or operation of any such person's motor vehicle' (Vehicle and Traffic Law § 370[3])." Elrac v. Gladys Ward, 2001 NY Int. 38, April 3, 2001.

Respondent did not submit a copy of the underlying certificate of insurance to verify the no-fault coverage limits. Respondent also did not submit a copy of the rental agreement between the Respondent and the insured to establish the name of the insured, the date the vehicle was rented and the insurance went into effect, the amount of the insurance limits listed in the rental agreement, whether Additional Personal Injury Protection (APIP) was offered in the contract, and whether the insured paid for APIP. Ms. Torres' affidavit also does not provide this information or indicate that she reviewed rental agreement contract in preparation for the affidavit. Ms. Torres states that from 5/23/2017 through 2/27/2018, the date of the affidavit, the Respondent offered a maximum limit of insurance of \$50,000.00. However, 5/23/2017 is the date of the accident. It is unclear when the contract was entered into and what the maximum insurance limits were on that date. There is no proof that the insured vehicle was rented on 5/23/2017.

The affidavit discusses the certificate of insurance filed with the State of New York in general terms. However, Ms. Torres does not state whether she reviewed the rental agreement contract that was entered into by the insured for this claim. She also does not state whether the Respondent offered the insured APIP or additional coverage as part of the rental agreement, whether the insured took the additional coverage, and whether that coverage is exhausted. Moreover, the affidavit is silent as to how the bills were handled for this claim.

Respondent has not uploaded claim specific denials (NF-10) or a global denial notifying the Assignor that the insurance limits has been exhausted. Respondent's ledger indicates multiple payments were made subsequent to the submission of the bills by Applicant. As of 10/11/2017 there was \$39,425.91 left on the policy.

At the hearing, I noted that the file did not contain proof of the insurance limits, a global denial, or claim specific denials. Respondent was notified that Ms. Torres' affidavit was insufficient to establish the insurance limits as Ms. Torres did not review the rental agreement contract or discuss whether APIP was purchased. It was discussed with the parties at length that these documents are necessary to determine the insurance limits, whether the claims were properly handled in accordance with 11 NYCRR § 65-3.15, priority of payment regulation, and whether the insurance limits were exhausted. Respondent was given the opportunity to submit a post hearing brief as follows:

Respondent to submit a post-hearing brief with a copy of the rental contract/agreement detailing the insurance coverage in the event of an

accident. Respondent to provide a copy of the certificate of insurance covering the Assignor for the accident in question, which details the PIP coverage available under the policy. Respondent to submit a copy of the claim specific denial and global denial pertaining to the exhaustion of the policy, if issued. Respondent may submit supporting case law/arbitration awards regarding adequate proof of insurance coverage/PIP policy limits when a rental vehicle is involved in a motor vehicle accident. Brief to be submitted by 11/20/2018. Hearing will be held closed subsequent to submission deadline.

Respondent chose not to file a brief in response to my directive.

The insurance carrier bears the burden of establishing the policy limits. *See Friedman v. Progressive Direct Ins. Co.*, 100 A.D.3d 591, 953 N.Y.S.2d 293 (2 Dept. 2012). In this case, Respondent has not submitted a copy of the certificate of insurance and/or rental agreement contract and therefore the insurance limits cannot be determined. Ms. Torres' affidavit is insufficient to establish the available insurance limits. She describes the Respondent's certificate of insurance, effective from the date of the accident to the date of her affidavit, for all claimants who rented a vehicle with Respondent, without stating when the contract was entered into. Furthermore, she did not review the rental agreement contract and therefore she has no personal knowledge as to the maximum available insurance limits for the insured and the Assignor in this case, including whether additional coverage was purchased.

Respondent was specifically directed to provide a copy of the certificate of insurance and rental agreement contract as proof of the policy limits, PIP, APIP available, and did not comply. At the hearing, Respondent was directed that if the documents were unavailable a statement/supplemental affidavit could be submitted to that effect. In *Schozer v. William Penn Life Ins. Co.* (84 N.Y.2d 639, 1994), the Court of Appeals held that under the "best evidence rule" production of the original document is required unless the party seeking admission of substitute evidence establishes that the original document is unavailable. Under the "best evidence" rule the best evidence of the policy limits is the rental contract agreement and certificate of insurance. Applicant did not allege that the rental contract agreement and/or certificate of insurance were unavailable, and as such, any attempted reliance on Ms. Torres' affidavit to establish the insurance limits does not meet the test necessary to seek consideration of Respondent's affidavit as secondary evidence of the policy limits. While this is an arbitration forum and the rules of evidence are relaxed, these documents are vital to the Respondent's exhaustion defense.

See Spartan Medical Supply v. Enterprise Rent A Car; AAA Assessment No.: 99-17-1057-6177, which is a case directly on point, wherein Master Arbitrator Robyn D. Weisman upheld the lower Arbitrator's determination from AAA Case No.: 17-17-1057-6177 and stated:

Did the Arbitrator err in awarding Applicant reimbursement in the face of claim that the Appellant/Respondent paid the limits of the self-insurance policy?

This is a case involving a claim for \$2969.83 for durable medical equipment. The arbitrator awarded payment. Appellant/Respondent denied payment by letter, without uploading a denial of claim form, stating that the claim had reached the \$50,000 policy maximum and had annexed a payment ledger.

The arbitrator discussed the fact that the Appellant did not submit a copy of the underlying policy to verify the no-fault coverage limits. In addition, a valid denial was not submitted either. The arbitrator found the payment or denial was overdue. Therefore, the arbitrator held in favor of the Appellee/Applicant.

The Appellant/Respondent was met with a burden to prove the exhaustion of the limits of the policy which apparently was not satisfied at the underlying arbitration. The arbitrator found the submission insufficient to provide proof and in fact the arbitrator found a lack of denial and late payment or denial. I turn to the numerous arbitrations on this point. The Master Arbitrator Hershdorfer held in Mark McMahon, M.D. v. USAA Ins. Co., 412011057426 that if funds were available at the time, and a claim is improperly denied, the defense of policy exhaustion fails...

Based on the aforementioned, the arbitrator's decision is affirmed as the decision was based on the evidence submitted.

Respondent has not established the available insurance limits or that the insurance limits have been exhausted and the Respondent's defense of policy exhaustion cannot be sustained.

Furthermore, as Applicant submitted proof of mailing and the claims were not denied, Applicant has not established that the bills were properly processed in accordance with the priority of payment regulation.

I agree with Arbitrator Mitchell Lutsig's analysis in *Cypress Acupuncture, P.C. and Enterprise Rent A Car*, AAA Case No. 17-17-1069-3720, (10/10/2018), which is cited herein.

In addition to establishing payment of the policy limits, the insurance carrier must also demonstrate that the payments which led to the depletion of policy benefits were made in compliance with 11 NYCRR § 65-3.15 (Computation of basic economic loss). See Nyack Hospital v. General Motors Acceptance Corp., 8 N.Y.3d 294 (2007); New York & Presbyterian Hospital v. Allstate Ins.Co., 12 A.D.3d 579, 580 (2 Dept. 2004). See also Doshi Diagnostic Imaging Service P.C. v. State Farm Mutual Automobile Insurance Company, AAA Case No.: 17-15-1014-9374 (Arbitrator Andrew Horn, 12/23/16). 11 NYCRR § 65-3.15 provides that:

(w)hen claims aggregate to more than \$50,000, payments for basic economic loss shall be made to the applicant and/or an assignee in the order in which each service was rendered or each expense was incurred, provided claims therefor were made to the insurer prior to the exhaustion of the \$50,000. If the insurer pays the \$50,000 before

receiving claims for services rendered prior in time to those which were paid, the insurer will not be liable to pay such late claims. If the insurer receives claims of a number of providers of services, at the same time, the payments shall be made in the order of rendition of services.

11 NYCRR § 65-3.15 does not preclude an insurer from paying other providers' claims during a time that the 30-day statutory period in which to pay or deny a claim is tolled pursuant to a request for additional verification, *see Nyack Hospital v. General Motors Acceptance Corp.*, 8 N.Y.3d 294 (2007); *Mount Sinai Hosp. v. Country Wide Ins. Co.* 85 A.D.3d 1136 (2d Dept. 2011), nor does it bar an insurer, following the timely denial of a claim, from paying other providers' undisputed claims pending resolution of the dispute, *see Allstate Prop & Cas. Ins. Co., v. Northeast Anesthesia & Pain Mgt.*, 2016 N.Y. Slip Op. 50828(U) (App. Term 1 Dept. 2016); *Harmonic Physical Therapy, P.C. v. Praetorian Ins. Co.*, 2015 NY Slip Op 50525(U) (App Term 1st Dept., 2015); *AAA Integrated Medical Rehab & Diagnostic P.C. and Geico Ins. Co.*, Case No. 412013081427, AAA Assessment No. 17 991 R 25938 14 (Master arb. Victor J. Hershdorfer, May 9, 2014). In such instances, an insurer's payments are made in compliance with the priority of payment regulation because they were made before the insurer was obligated to pay the disputed claim. *Id.*

However, the Respondent has failed to convince me that a bill which has not been denied despite proof of mailing of same automatically loses its place on the priority-of-payment line. *See Neofitios Stefanidies, MD PC v. New York City Transit Authority*, AAA Case No.: 17-16-032-0153 (Arbitrator Mitchell Lustig, 10/30/17), *aff'd* by Master Arbitrator Robert Trestman, 99-16-1032-0153 (2/10/18).

Such an argument was resoundingly rejected in a case strikingly on point, *Westchester Medical Center v. Philadelphia Indemnity Company*, 69 A.D.3d 613, 892 N.Y.S.2d 484 (2 Dept. 2010), wherein claim forms "were mailed on April 23, 2008, and signed for by the (insurer) on April 28, 2008", at which time, "according to the (insurer's) own records, there were still sufficient funds remaining under the policy to pay (the) bill". In response, the insurance carrier offered "an affidavit, which ... averred that there was no record of the bill in question in (its) computer system". The Appellate Division found that the affidavit "was insufficient" because "the affiant failed to show any knowledge of the office procedures employed in the handling of billing forms received" at the insurer's office, and, accordingly, rejected the insurer's exhaustion defense.

In *Mount Sinai Hospital v. Dust Tr Inc.*, 962 NYS 2d 307, 104 A.D.3d 823 (2 Dept. 2013), the appellate court rejected an insurer's motion to vacate a judgment because of "partial exhaustion of...coverage" because "the evidence submitted in support" was insufficient to establish that the "purported payments were made in compliance with 11 NYCRR Section 65-3.15."

Likewise, the court in *NYU Hospitals Center-Hospital v. State Farm*, NYLJ 12/08/16 (Sup. Ct. Nassau Cty., Steinman, J.), recently ruled that an insurance carrier "cannot rely upon an after-the-fact exhaustion defense"

after it "simply breached the terms of the policy by failing to timely pay (the hospital) the amount properly due."

The Court of Appeals decision in Nyack Hosp. v. General Motors Acceptance Corp., 8 N.Y.3d 294, 301 (2007) is also instructive. In that action, the no-fault insurer paid out other claims after its receipt of the plaintiff hospital's claim- substantially exhausting its policy- while it awaited additional verification from the hospital. The Appellate Division granted summary judgment to the insurer based on the exhaustion defense. The Court of Appeals modified the decision, finding that that the insurer was entitled to pay subsequent verified claims while awaiting information from the hospital, but that the insurer's obligation to pay the hospital arose when the insurer received the requested information.

The Court in Nyack denied the insurer's summary judgment motion and remitted the case back to the trial court, holding, that, pursuant to 11 NYCRR Section 65-3.15 "the insurer should have paid the hospital ahead of any unpaid verified claims for services rendered or expenses occurred later than the services billed by the hospital, up to the policy limits." Of course, if 11NYCRR 65-3.15 had no teeth and the exhaustion of the policy in and of itself was a complete defense for the insurer, there would be no reason for the Court to reverse the grant of summary judgment and remand the matter to the trial court.

As noted by Arbitrator Shawn Kelleher in *Paul Brisson M.D. v. Selective Insurance Company of America*, AAA Case No.: 17-16-1050-3111 (8/20/18):

"The Court in Nyack could have adopted a strict "50 is 50" rule (advocated by the Respondent's counsel in the within matter). However, the Court of Appeals specifically rejected same by remanding the matter to the trial court to determine the amount available on the policy when the subject claim became verified. Had the Court adopted a rigid "50 is 50" approach, it would have not mattered that the carrier paid the bill late, i.e. more than 30 days after the bill was verified. Therefore, it matters not that there were no funds available at the time of the hearing; it only matters if there were funds available at the time the claim was verified."

Adopting Respondent's position, which would permit an insurer to improperly delay paying or denying claims "runs counter to the no-fault regulatory scheme, which is designed to promote prompt payment," *see Nyack Hosp v. General Motors Acceptance Corp.*, 8 N.Y.2d 294, 300 (2007).

As the court explained in NYU Hospitals Center-Hospital v. State Farm Mut. Auto Ins. Co., NYLJ 12/08/16 (Sup. Ct. Nassau Cty., Steinman, J.), "(p)olicy considerations militate against (the insurance carrier's) position" and concluded that the "loss ... should fairly fall upon the insurer, which breached its obligation under the policy and violated the regulatory payment scheme."

After careful review of the record, I find that Respondent has failed to establish that there were insufficient funds to pay the bills that were not denied by the Respondent.

In reaching my determination herein, I am also persuaded by the reasoning of my fellow No-Fault arbitrators, who have held similarly.; *Doshi Diagnostic Imaging Service P.C. v. State Farm Mutual Automobile Insurance Company*, AAA Case No.: 17-15-1014-9374 (Arbitrator Andrew Horn, 12/23/16); *Friendly RX Inc. D/BA Friendly RX Pharmacy v. State Farm Mutual Automobile Insurance Company*, AAA Case No.: 17-15-1004-8062 (Arbitrator Corinne Pascariu, 4/3/17), aff'd by Master Arbitrator Victor Hershdorfer, 99-15-1044-8062; *Lutheran Medical Center v. American Transit Insurance Company*, AAA Case No.: 17-15-1022-1541 (Arbitrator Andrew Horn, 12/16/16), aff'd by Master Arbitrator Richard Ancowitz, 99-15-1022-1541; *City-Wide Rehab PT PC v. Ameriprise Insurance Company*, AAA Case No.: 17-14-9021-9518 (Arbitrator Rhonda Barry, 11/23/15).

Applicant submitted proof of payment of the bills. Respondent did not deny the bills yet continued to make payments for no-fault claims for five months. Respondent failed to comply with 11 NYCRR § 65-3.15 for the bills in dispute.

Respondent did not provide proof of the applicable insurance limits, including the rental agreement contract or certificate of insurance, proof that the insurance limits were exhausted, or proof that the claims were denied or processed in accordance with 11 NYCRR § 65-3.15. As Applicant has not established any defense to the claims, the bills are overdue and owing. Therefore, the issue is the proper amount to be reimbursed.

Fee Schedule

Based on a review of the bills and the applicable fee schedule, Applicant has billed in excess of the fee schedule.

It is respondent's burden to come forward with competent evidentiary proof to support its fee schedule defenses. *See Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co.*, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006). *See also, Power Acupuncture PC v. State Farm Mutual Automobile Ins. Co.*, 11 Misc.3d 1065A, 816 N.Y.S.2d 700, 2006 N.Y. Misc. LEXIS 514 (Civil Ct, Kings Co. 2006). If Respondent fails to demonstrate by competent evidentiary proof that a plaintiff's claims were in excess of the appropriate fee schedules, defendant's defense of noncompliance with the appropriate fee schedules cannot be sustained. *See Continental Medical PC v. Travelers Indemnity Co.*, 11 Misc.3d 145A, 819 N.Y.S.2d 847, 2006 N.Y. Misc. LEXIS 1109 (App. Term, 1 Dep't, per curiam, 2006). A respondent may interpose a defense in a timely denial that the claim exceeds the fees permitted by the Workers' Compensation schedules, but respondent must, at minimum, establish, by evidentiary proof, that the charges exceeded that permitted by law. *Abraham v. Country-Wide Ins. Co.*, 3 Misc.3d 130A, 787 N.Y.S.2d 678, 2004 N.Y. Misc. LEXIS 544 (App. Term, 2d Dept. 2004).

An insurer's unilateral decision to re-code or change a medical provider's billed CPT codes, to reimburse disputed medical services at a reduced rate, or to deny a claim in its entirety, 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, fee reductions and denials. *See Amaze Medical Supply v. Eagle Insurance Company*, 2 Misc. 3d 128A (App Term 2d and 11th Jud Dist 2003). A lay person is not qualified to evaluate the CPT codes or to change if the code is used by a health provider in its bills. *See Abraham v. Country-Wide Ins. Co.*, 3 Misc. 3d. 130A (App. Term 2d. Dept. 2004). Once the insurer establishes a prima facie showing that the amounts charged by a provider were in excess of the fee schedule, the burden shifts 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.3d 558 (App. Term 2d, 11th & 13th Dists. 2009).

Furthermore, I take judicial notice of the New York State Workers' Compensation fee schedule. *See, Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co.*, 61 A.D.3d 13, 20 (2d Dept. 2009); *LVOV Acupuncture, P.C. v. Geico Ins. Co.*, 32 Misc.3d 144(A) (App Term 2d, 11th & 13th Jud Dists. 2011); *Natural Acupuncture Health, P.C. v. Praetorian Ins. Co.*, 30 Misc.3d 132(A) (App Term, 1st Dept. 2011).

Ground Rule 3 of the Physical Medicine Section of the Chiropractic Fee Schedule, *Multiple Physical Medicine Procedures and Modalities*, which applies to chiropractors, and is also commonly referred to as the "8-Unit Rule", reads: "When multiple physical medicine procedures and/or modalities are performed on the same day, reimbursement is limited to 8.0 RVUs or the amount billed, whichever is less. The following codes represent the physical medicine procedures and modalities subject to this rule: 97010, 97012, 97014, 97024, 97026, 97028, 97032, 97033, 97034, 97035, 97036, 97039, 97110, 97112, 97113, 97116, 97124, 97139, 97140, 97530, 98940, 98941, 98942."

As Applicant is a chiropractor, these services are governed by a conversion rate of 5.78 for chiropractors and licensed acupuncturists. The maximum permissible daily charge for 8-units of service performed by a chiropractor is \$46.24 (5.78 X 8).

Respondent raised no fee schedule defenses in the submission or at the hearing. However, I take judicial notice of the fee schedule and note certain bills exceed the applicable fee schedule based on simple mathematical calculations and a review of Applicant's medical records.

Specifically, Applicant billed 17 dates of chiropractic treatment from 8/3/2017 through 9/15/2017 for CPT codes that are subject to the 8-unit rule at \$54.57 per date of service. Applicant is entitled to \$46.24 per date of service for a total of \$786.08.

Applicant seeks reimbursement for range of motion and manual muscle testing ("ROM/MMT") performed on 8/8/2017 and 8/9/2017. Applicant billed \$288.66 for 6 units of CPT code 95851 (ROM) and \$758.24 for 14 units of CPT code 95831 (MMT). These are clearly excessive amounts and not billed in accordance with the code descriptors.

CPT code 95851 is described as range of motion measurements and report, each extremity (excluding hand) or each trunk section (spine). The RVU is 5.41. The report demonstrates the lumbar spine was tested, which constitutes one trunk section. Therefore, one unit is the most which should have been billed for this code or \$31.26.

The other CPT code 95831 for MMT is billable per extremity or trunk. The report demonstrates the foot and ankle were tested, which is one extremity. According to the report, as both feet and ankles were tested two units is the most which should have been billed or \$54.64 ($5.16 \times \$5.78 = 24.82 \times 2 = \54.64) based on an RVU of 5.16.

Respondent did not raise a fee schedule defense as to the bill for date of service 8/3/2017 in the amount of \$218.49 for nerve conduction testing and Applicant is entitled to this amount.

Accordingly, Applicant's claim is granted in the amount of \$1,090.47 (\$786.08 + \$31.26 + \$54.64 + \$218.49). The remainder of the claim is denied. 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	Status
	Staten Island			

	Sports Chiropractic, P.C.	08/03/17 - 08/04/17	\$273.06	Awarded: \$264.73
	Staten Island Sports Chiropractic, P.C.	08/08/17 - 08/08/17	\$324.96	Denied
	Staten Island Sports Chiropractic, P.C.	08/08/17 - 08/08/17	\$270.80	Denied
	Staten Island Sports Chiropractic, P.C.	08/08/17 - 08/08/17	\$217.05	Awarded: \$100.88
	Staten Island Sports Chiropractic, P.C.	08/09/17 - 08/09/17	\$198.90	Awarded: \$77.50
	Staten Island Sports Chiropractic, P.C.	08/09/17 - 08/11/17	\$198.90	Awarded: \$46.24
	Staten Island Sports Chiropractic, P.C.	08/15/17 - 08/17/17	\$109.14	Awarded: \$92.48
	Staten Island Sports Chiropractic, P.C.	08/22/17 - 08/23/17	\$109.14	Awarded: \$92.48
	Staten Island Sports Chiropractic, P.C.	08/24/17 - 08/25/17	\$109.14	Awarded: \$92.48
	Staten Island Sports Chiropractic, P.C.	08/29/17 - 08/31/17	\$109.14	Awarded: \$92.48

	Staten Island Sports Chiropractic, P.C.	09/06/17 - 09/08/17	\$109.14	Awarded: \$92.48
	Staten Island Sports Chiropractic, P.C.	09/13/17 - 09/14/17	\$109.14	Awarded: \$92.48
	Staten Island Sports Chiropractic, P.C.	09/15/17 - 09/15/17	\$54.57	Awarded: \$46.24
Total			\$2,193.08	Awarded: \$1,090.47

- B. The insurer shall also compute and pay the applicant interest set forth below. 01/19/2018 is the date that interest shall accrue from. This 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. 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 denial at issue was timely. LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 217 (2009). Based on the regulations, interest shall accrue from the date the applicant requested arbitration in this matter. *See*, 11 NYCRR 65-3.9(c).

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.

12/22/2018
(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:
090a10d19cc2f0499a1468c86b54d1ab

Electronically Signed

Your name: Eileen Hennessy
Signed on: 12/22/2018