American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Datta Endoscopic Back Surgery & Pain Center (Applicant)	AAA Case No.	17-18-1095-4225
	Applicant's File No.	2106001
- and -	Insurer's Claim File No.	52-1634-T10
State Farm Mutual Automobile Insurance Company (Respondent)	NAIC No.	25178

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 (CG)

1. Hearing(s) held on 12/17/2019
   Declared closed by the arbitrator on 12/17/2019

   Ryan Berry, Esq. from Israel, Israel & Purdy, LLP (Great Neck) participated in person for the Applicant

   Angelica Barcsansky, Esq. from Rivkin & Radler LLP participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 2,845.02**, was AMENDED and permitted by the arbitrator at the oral hearing.

   Applicant's counsel adjusted the claim to $209.57.

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

3. Summary of Issues in Dispute

   In dispute is a claim by the Applicant, Datta Endoscopic Back Surgery & Pain Center, as the assignee of a 52-year-old female who was injured as a driver in a motor vehicle accident on 12-16-17.

Applicant seeks to be reimbursed the **balance of $209.57** for services that were **performed on 04-04-18** by Aditya Patel, MD at an Ambulatory Surgery Center (ASC) located **in Woodland Park, New Jersey.** More specifically, **the claim is for bilateral lumbar facet joint injections** that targeted levels L3-L4, L4-L5, and L5-S1.

In its denial, **Respondent refers to the 33rd Amendment to 11 NYCRR Part 68 [Regulation 83], and asserts that Applicant was properly paid according to the fee schedule allowance for New York**. I must determine whether the denial should be upheld or whether Applicant is entitled to additional reimbursement.

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, and pursuant to the information obtained from the sources referenced within this award. Judicial notice is taken of each source. *See* Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co., 61 A.D.3d 13, 871 N.Y.S.2d 680 (App Div, 2nd Dept, 2009).

APPLICANT'S CLAIM:

The following reflects how the injections were reported on the claim form and the reimbursement that was issued by the Respondent:

DOS	CODE	AMOUNT BILLED	AMOUNT PAID	BALANCE
04-04-18	64493	$2009.00	$125.97	$1883.03
04-04-18	64494	$218.85	$73.29	$145.56
04-04-18	64495	$222.43	$73.29	$149.14
04-04-18	64495-59	$222.43	$0.00	$222.43
04-04-18	64495-59	$222.43	$0.00	$222.43
04-04-18	64495-59	$222.43	$0.00	$222.43
		$3117.57	$272.55	$2845.02

CPT CODE DESCRIPTIONS:

CODE	DESCRIPTION
64493	Injection(s), diagnostic or therapeutic agent, paravertebral (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
64494	second level (List separately in addition to code for primary procedure)
64495	third and any additional level(s) (List separately in addition to code for primary procedure)

OVERVIEW:

During the hearing, Applicant's counsel amended the claim to $209.57.

This total is based on the affidavit of Jeffrey Futoran, CPC, which has been offered by the Respondent. His audit sets forth the following rates for New Jersey and New York:

NEW JERSEY:

CODE	F/S RATE	BILATERAL PROCEDURE ADJUSTMENT(S)	MULTIPLE PROCEDURE REDUCTION(S)
64493-50	$442.52	$663.78	$663.78
64494-50	$218.85	$328.28	$328.28
64495-50	$222.43	$333.65	$333.65

Total Allowance: $1325.71.

NOTES:

The fees were calculated pursuant to the rates set for the North Region. See Applicant's procedure report; **NJAC §11:3-29.4(b); and NJAC §11:3-29.3(a)(2)**.

Mr. Futoran applied a payment adjustment of 150% for each code because the injections were administered to both the left and right facet joints for each level (i.e., bilateral). See **NJAC §11:3-29.4: Application of medical fee schedules:**

> ***(f)*** *Except as specifically stated to the contrary, the following shall apply to physician charges for multiple and bilateral surgeries (CPT 10000 through 69999), co-surgeries and assistant surgeons:*
>
> > ***(1)*** *For multiple surgeries, rank the surgical procedures in descending order by the fee amount, using the fee schedule or UCR amount, as appropriate. The highest valued procedure is reimbursed at 100 of the eligible charge. Additional procedures are reported with the modifier "-51" and are reimbursed at 50% of the eligible charge. If any of the multiple surgeries are bilateral surgeries using the modifier "-50," consider the bilateral procedure at 150 percent as one payment amount, rank this with the remaining procedures, and apply the appropriate multiple surgery reductions.*

Another provision that relates to bilateral procedures is **NJAC §11:3-29.4(f)(3)**:

> *The terminology for some procedure codes includes the terms "bilateral" or "unilateral or bilateral." The payment adjustment rules for bilateral surgeries do not apply to procedures identified by CPT as "bilateral" or "unilateral or bilateral" since the fee schedule reflects any additional work required for bilateral surgeries.* ***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 the modifier "-50" shall be 150 percent of the eligible charge.***

Mr. Futoran also accounted for the Multiple Procedure Reduction Rule (MPRR) [as per NJAC §11:3-29.4(f)(1)]. Since CPT 64493 has the highest allowance, it was not reduced.

As for CPT 64494 and 64495, these are add-on codes and are not subject to this rule. See **NJAC §11:3-29.4(f)(2)** which states:

> *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 are commonly carried out in addition to the primary procedure. These procedure codes 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.*

NEW YORK:

In paragraph 33 of his affidavit, Mr. Futoran sets forth the following table for his calculations: [which results in a total allowance of $482.12]

CPT CODE	RVUs	WCB CONVERSION	MAX FEE	SURGERY GR 5	PHYSICIAN FEE
64493	0.55	$229.04	$125.97	Highest Procedure	$125.97
64493	0.55	$229.04	$125.97	$62.99	$62.99
64494	0.32	$229.04	$73.29	Exempt Code	$73.29
64494	0.32	$229.04	$73.29	Exempt Code	$73.29
64495	0.32	$229.04	$73.29	Exempt Code	$73.29
64495	0.32	$229.04	$73.29	Exempt Code	$73.29

NOTES:

Generally speaking, the rate of reimbursement for a service is calculated by multiplying the Relative Value Units assigned to a code with the applicable Conversion Factor.

CPT 64493, 64494, and 64495 are all located in the Surgery section of the Workers' Compensation Medical Fee Schedule.

The (Surgery) Conversion Factor for Region IV ($229.04) was used to determine the eligible fee. This is pursuant to 11 NYCRR §68.6(b)(1) which was introduced via the 33rd Amendment; in order to compare Applicant's entitlement between the two states, the Conversion Factor with the highest rate must be used.

Based on the above calculations for New York, Applicant seeks to be reimbursed $209.57. This total reflects the difference between Mr. Futoran's audit ($482.12) and the amount that was paid by the Respondent ($272.55).

THE 33RD AMENDMENT TO 11 NYCRR PART 68 [REGULATION 83]:

The 33rd Amendment went into effect on 01-23-18 and it pertains to health services performed outside New York State on or after that date.

Prior to the Amendment, 11 NYCRR §68.6 read as follows:

If a professional health service reimbursable under section 5102(a)(1) of the Insurance Law is performed outside New York State, the permissible charge for such service shall be the prevailing fee in the geographic location of the provider.

As a result of the Amendment, 11 NYCRR §68.6 was modified and currently reads as follows:

(a)(1)*If a professional health service reimbursable under Insurance Law 5102 (a)(1) is performed outside this State, the amount that the insurer shall reimburse for the service shall be the lower of the amount charged by the provider and the prevailing fee in the geographic location of the provider with respect to services:*

(i)*that constitute emergency care;*

(ii)*provided to an eligible injured person that is not a resident of this State; or*

(iii)*provided to an eligible injured person that is a resident of this State who, at the time of treatment, is residing in the jurisdiction where the treatment is being rendered for reasons unrelated to the treatment.*

(2)*For purposes of this subdivision, emergency care means all medically necessary treatment initiated within 48 hours of a motor vehicle accident for a traumatic injury or a medical condition resulting from the accident, which injury or condition manifests itself by acute symptoms of sufficient severity such that absence of immediate attention could reasonably be expected to result in: death; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. Medically necessary treatment shall include immediate pre-hospitalization care, transportation to a hospital or trauma center, emergency room care, surgery, critical and acute care. Emergency care extends during the period of initial hospitalization until the patient is discharged from the hospital.*

(b)*Except as provided in subdivision (a) of this section, if a professional health service reimbursable under Insurance Law section 5102 (a)(1) is performed outside this State with respect to an eligible injured person that is a resident of this State, the amount that the insurer shall reimburse for the service shall be the lowest of:*

(1)*the amount of the fee set forth in the region of this State that has the highest applicable amount in the fee schedule for that service;*

(2)*the amount charged by the provider; and*

(3)*the prevailing fee in the geographic location of the provider.*

(c)*If the jurisdiction in which the treatment is being rendered has established a fee schedule for reimbursing health services rendered in connection with claims for motor vehicle-related injuries and the fee schedule applies to the service being provided, the prevailing fee amount specified in subdivisions (a) and (b) of this section shall be the amount prescribed in that jurisdiction's fee schedule for the respective service.*

DETERMINING WHICH SUBDIVISION OF 11 NYCRR §68.6 APPLIES TO THIS CASE:

The facts presented in this matter do not align with any of the scenarios described within subdivision (a). They do, however, align with subdivision (b), in that:

- The claim is for professional health services that are reimbursable under NY Insurance Law § 5102 (a)(1).
- The services were performed outside this State.
- The assignor is an eligible injured person; and
- The submitted documents identify her as a New York State resident.

In addition, I note there is no evidence to suggest that the assignor was residing in New Jersey on 04-04-18 for the purpose of receiving unrelated treatment. [This is a scenario described under §68.6 (a)(3).]

Given the above, and pursuant to paragraphs (b) and (c), Applicant's entitlement for the assignor shall be the lowest of: the amount allowed under the New Jersey fee schedule, the amount allowed under the New York fee schedule, and the amount claimed by the Applicant.

LEGAL FRAMEWORK: FEE SCHEDULE

The Fourth Amendment to 11 NYCRR 65-3, which is applicable to claims for medical services rendered on or after April 1, 2013, includes the following provision:

11 NYCRR 65-3.8(g)(1)(ii):

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.

This means that for those services rendered on or after April 1, 2013, a fee schedule defense is not subject to preclusion. Surgicare Surgical Associates v. National Interstate Ins. Co., 50 Misc.3d 85, 25 N.Y.S.3d 521 (App. Term, 1st Dept., Oct. 8, 2015), aff'g, 46 Misc.3d 736, 997 N.Y.S.2d 296 (Civ. Ct., Bronx Co., 2014).

To be clear, this provision does not change Applicant's prima facie burden. East Coast Acupuncture, P.C. v. Hereford Ins. Co., 51 Misc.3d 441, 26 N.Y.S.3d 441 (Civ. Ct. Kings Co. Feb. 9, 2016).

An applicant demonstrates prima facie 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).

Once an applicant establishes its prima facie case, the burden of proof shifts to the insurer 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, 2nd Dept, 2nd & 11th Jud Dists., 2003).

If the insurer asserts that the applicant's charges are excessive, it must come forward with competent supporting evidence. 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). In the absence of such a showing, the defense will fail. Id.

If the insurer succeeds in establishing that the amount charged for a particular service or supply is excessive, the burden will then shift to the applicant to demonstrate that the amount billed reflects 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:

The evidence shows that Applicant billed in excess of the New Jersey fee schedule.

Noted above, Applicant reported the injections in the following manner:

DOS	CODE	AMOUNT BILLED
04-04-18	64493	$2009.00
04-04-18	64494	$218.85
04-04-18	64495	$222.43
04-04-18	64495-59	$222.43
04-04-18	64495-59	$222.43
04-04-18	64495-59	$222.43
	TOTAL:	$3117.57

I would like to point out that code 64495 can only be reported once per session. This is addressed by the American Medical Association (AMA) in a CPT Assistant article:

August 2010; Volume 20: Issue 8

Surgery: Nervous System

Question: Lumbar medial branch blocks were performed on the right at L3, L4, and L5. Would codes 64490, 64491, and 64492 be reported because three different levels were injected?

Answer: No. The L3, L4, and L5 medial branch nerves innervate the L4-L5 and L5-S1 facet joints. Therefore, code 64493, Injection(s), diagnostic or therapeutic agent, paravertebral (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level, is reported for the first joint injected or blocked (L4-L5). Code 64493 is reported for a single or initial level treated. Add-on code 64494, Injection(s), diagnostic or therapeutic agent, paravertebral (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure),

is reported for the second joint or level injected or blocked (L5-S1). In this specific instance only, CPT codes 64493 and 64494 should be used, provided the injections were performed in the lumbar spine with fluoroscopic (or CT) guidance, as required to use codes 64490-64495.

To further clarify, ***add-on code 64495****, Injection(s), diagnostic or therapeutic agent, paravertebral (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure),* ***is reported only once per day for injections at the third and any additional lumbar or sacral level(s) treated*** *(which does not apply to this case). Codes 64494 and 64495 should only be used in conjunction with code 64493.*

CPT codes 64490-64492 are reported in the same way for cervical-thoracic facet injections or blocks. In addition, add-on codes 64492,*Injection(s), diagnostic or therapeutic agent, paravertebral (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure),* ***and 64495 are reported once per day as a singular item irrespective of the number of spinal levels treated.***

Both New Jersey and New York recognize CPT Assistant as a source which should be considered when evaluating claims for No-Fault benefits. See NJAC §11:3-29.4(g); and Matter of Global Liberty Ins. Co. v. McMahon, 172 A.D.3d 500, 99 N.Y.S.3d 310, 2019 NY Slip Op 03692 (App. Div., First Dept., May 9, 2019).

In this case, Applicant injected the facet joints at L3-L4, L4-L5, and L5-S1 and not the medial branch nerves innervating those joints. In the first paragraph of this article, the AMA offers insight about the latter form of procedure (medial branch blocks) and how it should be reported, i.e., based on the facet joints and not according to the number of nerves injected.

In an older CPT Assistant article, the AMA explains the anatomy of facet joint nerves: [publication: September 2004; Volume 14: Issue 9]

Each facet joint is supplied by two medial branch nerves. As each main spinal nerve exits the spine and passes through the intervertebral foramen of the spine, it gives off a branch (posterior primary ramus) that supplies the structures at the back of the spine, while the main spinal nerve (anterior primary ramus) continues onward to supply peripheral structures. The posterior primary ramus then typically divides into three branches: medial, intermediate, and lateral. Each medial branch supplies sensation to one half of each facet joint above and below the spinal nerve of origin, the multifidus

muscle, the spinal ligaments, and a small area of skin in the midline of the back. The intermediate and lateral branches supply back muscles farther away from the midline.

Turning back to the subject claim: The second and third paragraphs of the AMA's response in the 2010 article clearly demonstrates that **it was improper of the Applicant to report CPT code 64495 four times.**

Moreover, I am mindful of the fact that Modifier 59 was listed with three of the entries. Considering its definition and the submitted documents, I find that it has no practical significance to the issue of reimbursement. The mere act of appending a modifier does not serve to validate a charge.

The claim also fails to properly account for bilateral procedures, which is covered under NJAC §11:3-29.4(f)(3). In pertinent part, it states:

*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 the modifier "-50" shall be 150 percent of the eligible charge.*

This provision is consistent with AMA coding guidelines. To that end, I refer the parties' attention to the following CPT Assistant articles:

Surgery: Nervous System

May 2018; Volume 28: Issue 5

Question: Facet joint injections are made to the median branch nerves at L3-L4, L4-L5, and L5-S1 on both the right and left sides on the same day. How is this reported?

*Answer: **Codes 64493**, Injection(s), diagnostic or therapeutic agent, paravertebral (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level and add-on codes **64494**, second level (List separately in addition to code for primary procedure) and **64495**, third and any additional level(s) (List separately in addition to code for primary procedure), should all be reported. **Modifier 50 should be appended to each code to indicate that bilateral injections were performed.***

FAQ: Modifiers

August 2015; Volume 25: Issue 8

Question: ***How should a bilateral procedure be reported when the code description only includes the word 'unilateral,' and there are no bilateral codes?*** *For example, when an ultrasound of both breasts is performed, code 76641, Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete, is reported; however, should the procedure be reported with modifier 50 as a single-line item or as separate line items with an anatomic modifier to indicate each side?*

Answer: If the term 'unilateral' is included in the code description and there is no code for 'bilateral' work, modifier 50, Bilateral procedure, should be appended to the code, if anatomically appropriate.

From a coding perspective, unless otherwise noted in the CPT code set, bilateral procedures performed on the same operative session should be identified by adding modifier 50 to the appropriate CPT code. ***CPT coding guidelines recommend using a single-line entry with modifier 50 appended to the appropriate unilateral code as a one-line entry on the claim form, with a '1' in the units-box to indicate that the procedure was performed bilaterally.***

Although this reporting method reflects the recommendation for reporting CPT codes, third-party payers may request that these services should be reported differently.

Having carefully reviewed the evidence, I find as follows:

For New Jersey, the eligible fee equates to $1325.71.

My decision accounts for:

- The relevant provisions of the Administrative Code (referenced above).
- Chapter 12 of the Medicare Claims Processing Manual [Physicians/Non Physician Practitioners], §40 [Surgeons and Global Surgery], specifically § 40.6 [Claims for Multiple Surgeries] and §40.7 [Bilateral Surgeries].
- Information provided by the Medicare Physician Fee Schedule Database (MPFSDB).

  (NJAC §11:3-29.4(g) mandates the use of the Medicare Claims Processing Manual for interpreting the fee schedules; and by extension, this would necessarily include the database.)

For New York, the eligible fee equates to $408.84. That is:

CPT CODE	RVUs	CONVERSION FACTOR (REGION IV)	F S RATE	BILATERAL PROCEDURE ADJUSTMENT(S)	MULTIPLE PROCEDURE REDUCTION(S)
64493-50	0.55	$229.04	$125.97	$188.96	$188.96
64494-50	0.32	$229.04	$73.29	$109.94	$109.94
64495-50	0.32	$229.04	$73.29	$109.94	$109.94

Regarding bilateral procedures:

Ground Rule 20 of the Surgery section [Modifiers] states, in pertinent part:

> *Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code.*

Within the same Ground Rule, under **Modifier 50 [Bilateral Procedure]**, it states:

> *Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding modifier 50 to the appropriate five-digit code.*

(Notice that the word "code" is singular.)

Ground Rule 5 of the Surgery section indicates a payment adjustment of 150% for such services.

In the first paragraph of this rule [Multiple or Bilateral Procedures], it states:

> *When multiple procedures, unrelated to the major procedure and adding significant time or complexity, are provided at the same operative session, payment is for the procedure with the highest allowance plus half of the lesser procedures. The same rule applies for bilateral procedures when such are not specifically identified in the schedule.* [emphasis added]

This paragraph is basically the functional equivalent of NJAC §11:3-29.4(f)(1) and (3) (the New Jersey regulations that address multiple and bilateral procedures).

The first sentence is referring to the Multiple Procedure Reduction rule. That is, the code with the highest allowance is reimbursed at 100% of the eligible fee, and the remaining codes are reimbursed at 50% of the eligible fee.

The second sentence is referring to the 150% payment adjustment for bilateral procedures (which are not defined as such in the code description). The provision is advising that the fee for such services should be calculated with the same method as the Multiple Procedure Reduction rule. In other words, 100% for left facet joint, and 50% for the right facet joint.

In the above table, for example, the fee schedule rate for CPT 64493 is listed as $125.97. This code was used to report the first level of injections, at L3-L4. Since it was performed bilaterally, the calculation would be:

100% for one side ($125.97) and

50% for the other side ($62.99).

In total, this equates to $188.96, which is 150% of the eligible fee.

This code is reported once, with Modifier 50 appended to it.

The calculations and reporting for CPT 64494 and 64495 follow the same method.

Regarding the Multiple Procedure Reduction Rule:

Based on Ground Rule 5, the fee for code 64493 is not reduced as it represents the service with the highest allowance.

As for CPT 64494 and 64495, these are designated as add-on codes. Ground Rule 5 advises that they are not subject to the multiple procedure reduction:

> *Some related procedures supplement the primary procedure or provide additional treatment or diagnostic information. These services may be reported in addition to the primary procedure. Do not add modifier 51 if these services are noted as add-on or modifier 51 exempt services. When the same physician performs these additional or supplemental procedures, the procedures are exempt from the multiple procedure calculation and are not subject to the 50% reduction.*

COMPARISON BETWEEN NEW JERSEY, NEW YORK, AND THE AMOUNT CLAIMED BY APPLICANT:

NEW JERSEY FEE SCHEDULE	NEW YORK FEE SCHEDULE	AMOUNT CLAIMED
$1325.71	$408.84	$3117.57

The "Amount Claimed" reflects the total that was originally billed. It does not account for Respondent's payment ($272.55) or the adjustment that was made by Applicant's counsel during the hearing (from $2845.02 to $209.57).

Pursuant to 11 NYCRR §68.6(b) and (c) of the 33rd Amendment, Applicant's entitlement shall be the lowest of: the amount allowed under the New Jersey fee schedule, the amount allowed under the New York fee schedule, and the amount claimed by the Applicant.

Based on these totals, **reimbursement for the subject claim is governed by the New York fee schedule.**

As Respondent already paid $272.55 for the injections, Applicant is awarded the remaining balance, to wit: $136.29.

$408.84 (NY rate) - $272.55 (amount already paid) = $136.29

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**
	Datta Endoscopic Back	**04/04/18 -**			**Awarded:**

	Surgery & Pain Center	**04/04/18**	**$2,845.02**	**$209.57**	**$136.29**
Total			**$2,845.02**		**Awarded: $136.29**

B. The insurer shall also compute and pay the applicant interest set forth below. 05/17/2018 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.

With respect to the interest accrual date, see specifically, 11 NYCRR §§65-3.9(c), and 65-4.5(s)(3).

In this case, the evidence shows that Respondent issued its Denial of Claim form on 04-25-18 and that Applicant requested arbitration on 05-17-18, which is within 30 days of receipt of said form. Consequently, the interest accrual date is to be computed from the time the claim became overdue (i.e., commencing 30 days after receipt of the bill by the insurer). As the claim was received by the Respondent on 04-16-18, it became overdue on 05-16-18. As for calculating interest, the date of accrual shall be excluded from the calculation. General Construction Law §20. Accordingly, Respondent is directed to pay interest from 05-17-18 up to the date of the payment of the award.

Further, the amount shall be figured "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).

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.

01/19/2020
(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

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Electronically Signed

Your name: Meryem Toksoy
Signed on: 01/19/2020