American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Brentwood Regional Chiropractic, PC , Eastern Suffolk Chiropractic, PC , Hector Melgar PT PC (Applicant)	AAA Case No.	17-18-1100-8011
	Applicant's File No.	2122815
	Insurer's Claim File No.	0283553040101319
- and -	NAIC No.	35882
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Thomas Eck, the undersigned arbitrator, designated by the American Arbitration Association pursuant to the Rules for New York State No-Fault Arbitration, adopted pursuant to regulations promulgated by the Superintendent of Insurance, having been duly sworn, and having heard the proofs and allegations of the parties make the following **AWARD:**

Injured Person(s) hereinafter referred to as: Assignor

1. Hearing(s) held on 05/20/2020
   Declared closed by the arbitrator on 05/21/2020

   Jen Howard from Israel, Israel & Purdy, LLP (Great Neck) participated in person for the Applicant

   Joseph Costa from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 1,768.72**, 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

   This arbitration arises out of medical treatment for the Assignor, a 63-year-old male, related to injuries sustained in a motor vehicle accident that occurred on 12/19/2017. Applicant seeks reimbursement for a physical therapy and chiropractic services provided to the Assignor on 12/26/2017-6/7/2018. Respondent denied these services based on the Workers' Compensation Fee Schedule, non-receipt of bill, and the IME conducted by Dr. Ronald Light, MD on 3/31/2018, cutting off benefits as of 4/12/2018.

4. Findings, Conclusions, and Basis Therefor

This case was decided on the submissions of the parties as contained in the Electronic Case Folder (ECF) maintained by the American Arbitration Association and the oral arguments of the parties' representatives at the hearing. No witnesses testified at the hearing. I reviewed the documents contained in the ECF for both parties and make my decision in reliance thereon.

FEE SCHEDULE

Hector Melgar, PT, PC

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 a claim. East Coast Acupuncture, P.C. v. New York Cent. Mut. Ins., 2008 NY Slip Op 50344(U) (App. Term 2d Dep't., Feb. 21, 2008).

Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. See, Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 2006 NY Slip 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006. If Respondent fails to demonstrate by competent evidentiary proof that an Applicant's claims were in excess of the appropriate fee schedules, Respondent'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 NY Slip Op 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Term, 1st Dep't, per curium, 2006).

Defenses based on the fee schedule can be raised at any time as per the Fourth Amendment to 11 NYCRR 65-3/Insurance Regulation 68-C). The new sections apply to any treatment or service rendered on or after April 1, 2013. Based on 11 NYCRR 3.8(g)(1)(ii). "The purpose of the [no-fault] statute and the fee schedules promulgated thereunder is to significantly reduce the amount paid by insurers for medical services, and thereby help contain the no-fault premium." Saddle Brook Surgicenter, LLC v. All State Ins. Co., 48 Misc.3d 336, 8 N.Y.S.3d 875 (Civ. Ct. Bronx Co. 2015).

I take judicial notice of the New York State Workers' Compensation Board Medical Fee Schedule ("Fee Schedule") because it is of sufficient authenticity and reliability. See, Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co., 61 A.D.3d 13, 871 N.Y.S.2d 680 (2d Dept. 2009); LVOV Acupuncture, P.C. v. Geico Ins. Co., 32 Misc.3d 144(A), 939 N.Y.S.2d 741(Table) (App Term 2d, 11th & 13th Jud Dists. 2011).

Hector Melgar, PT, PC

12/26/2017-1/2/2018

Applicant submitted a bill for services under CPT codes 97010, 97014, and 97112 for each DOS in the amount of $61.60. Respondent reimbursed $54.52 and limited payment for the physical medicine services stating: " Reimbursement for modalities and procedures may not exceed 8 relative value units per day. Physical Medicine Ground Rule 3 & 11 reads as follows: "Multiple Physical Medicine Procedures and Modalities. 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."

In the instant matter, Respondent chose to arbitrarily reimburse code 97112 and 97014 at the full amount and then reduce code 97010 based on 8-unit rule limitation. It is clear that Applicant properly billed for codes 97112 (29.53 or 3.89 units), 97010 ($18.25 or 2.37 units), and then reduced the third and final code billed 97014 which would have normally been billed at $20.48 or 2.66 units to ($13.82 or 1.74 units. The Applicant purposefully reduced code 97014 to 1.74 units to comply with the 8-unit rule limitation. For Respondent to then reimbursed code 97014 in full and then apply the full units in an attempt to limit payment in further is not proper. Applicant clearly billed $61.60 or 8 units and is due the full 61.60 per DOS. Since Respondent already reimbursed the Applicant $54.52 per DOS, Applicant is due the remainder of $7.08 per DOS for a total of **$21.24**.

1/9/2018-1/15/2018

Applicant submitted a bill for services under CPT codes 97010, 97014, and 97112 for each DOS in the amount of $61.60. Respondent reimbursed $54.52 and limited payment for the physical medicine services stating: " Reimbursement for modalities and procedures may not exceed 8 relative value units per day. Physical Medicine Ground Rule 3 & 11 reads as follows: "Multiple Physical Medicine Procedures and Modalities. 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."

In the instant matter, Respondent chose to arbitrarily reimburse code 97112 and 97014 at the full amount and then reduce code 97010 based on 8-unit rule limitation. It is clear that Applicant properly billed for codes 97112 (29.53 or 3.89 units), 97010 ($18.25 or 2.37 units), and then reduced the third and final code billed 97014 which would have normally been billed at $20.48 or 2.66 units to ($13.82 or 1.74 units. The Applicant purposefully reduced code 97014 to 1.74 units to comply with the 8-unit rule limitation. For Respondent to then reimbursed code 97014 in full and then apply the full units in an attempt to limit payment in further is not proper. Applicant clearly billed $61.60 or 8 units and is due the full 61.60 per DOS. Since Respondent already reimbursed the Applicant $54.52 per DOS, Applicant is due the remainder of $7.08 per DOS for a total of **$21.24**.

1/24/2018-2/1/2018

Applicant submitted a bill for services under CPT codes 97110, 97010, and 97014 for each DOS in the amount of $61.60. Respondent reimbursed $53.90 and limited payment for the physical medicine services stating: " Reimbursement for modalities and procedures may not exceed 8 relative value units per day. Physical Medicine Ground Rule 3 & 11 reads as follows: "Multiple Physical Medicine Procedures and Modalities. 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."

In the instant matter, Respondent chose to arbitrarily reimburse code 97110 and 97014 at the full amount and then reduce code 97010 based on 8-unit rule limitation. It is clear that Applicant properly billed for codes 97110 (30.80 or 3.97 units), 97010 ($18.25 or 2.37 units), and then reduced the third and final code billed 97014 which would have normally been billed at $20.48 or 2.66 units to ($12.78 or 1.66 units. The Applicant purposefully reduced code 97014 to 1.66 units to comply with the 8-unit rule limitation. For Respondent to then reimbursed code 97014 in full and then apply the full units in an attempt to limit payment in further is not proper. Applicant clearly billed $61.60 or 8 units and is due the full 61.60 per DOS. Since Respondent already reimbursed the Applicant $53.90 per DOS, Applicant is due the remainder of $7.70 per DOS for a total of **$23.10**.

1/24/2018, 2/12/2018, and 2/19/2018

Applicant submitted a bill for services under CPT codes 97002, 97112, 97010, 97014 in the amount of $84.70 or 11 units. Respondent reimbursed $46.82, leaving an amount in dispute of $37.88. Again, just like the dates of service above, the Respondent improperly applied payment to certain codes, while denying payment for other. Since there was an evaluation, Applicant reduced each code so the total amount billed would be $84.70 or 11 units as required by Physical Medicine Ground Rule 8. Since Respondent has not come forward with a coder affidavit to explain it denial of payment for code 97002 and limitation of the other codes. Therefore, I find in favor of the Applicant for each DOS.

2/19/2018-2/28/2018

Applicant submitted a bill for services under CPT codes 97110, 97010, and 97014 for each DOS in the amount of $61.60. Respondent reimbursed $53.90 and limited payment for the physical medicine services stating: " Reimbursement for modalities and procedures may not exceed 8 relative value units per day. Physical Medicine Ground Rule 3 & 11 reads as follows: "Multiple Physical Medicine Procedures and Modalities. 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."

In the instant matter, Respondent chose to arbitrarily reimburse code 97110 and 97014 at the full amount and then reduce code 97010 based on 8-unit rule limitation. It is clear that Applicant properly billed for codes 97110 (30.80 or 3.97 units), 97010 ($18.25 or 2.37 units), and then reduced the third and final code billed 97014 which would have normally been billed at $20.48 or 2.66 units to ($12.78 or 1.66 units. The Applicant purposefully reduced code 97014 to 1.66 units to comply with the 8-unit rule limitation. For Respondent to then reimbursed code 97014 in full and then apply the full units in an attempt to limit payment in further is not proper. Applicant clearly billed $61.60 or 8 units and is due the full 61.60 per DOS. Since Respondent already reimbursed the Applicant $53.90 per DOS, Applicant is due the remainder of $7.70 per DOS for a total of **$23.10**.

MEDICAL NECESSITY

HECTOR MELGAR, PT, PC - DOS 4/17/2017-4/24/2018, 4/30/2018-5/10/2018. 5/14/2018-5/16/2018, and 5/30/2018-6/7/2018

Applicant has established its prima facie case with proof that it submitted a proper claim, setting forth the fact and the amount charged for the services rendered and that payment of no-fault benefits was overdue (see Insurance Law § 5106 a; Mary Immaculate Hosp. v. Allstate Ins. Co., 5 AD 3d 742, 774 N.Y.S. 2d 564 [2004]; Amaze Med. Supply v. Eagle Ins. Co., 2 Misc. 3d 128A, 784 N.Y.S. 2d 918, 2003 NY Slip Op 51701U [App Term, 2d & 11th Jud Dists]). The burden shifts to the insurer to prove that the services were not medically necessary.

If an insurer asserts that the medical test, treatment, supply or other service was medically unnecessary, the burden is on the insurer to prove that assertion with competent evidence such as an independent medical examination, a peer review or other proof that sets forth a factual basis and a medical rationale for denying the claim. (See A.B. Medical Services, PLLC v. Geico Insurance Co., 2 Misc. 3d 26 [App Term, 2nd & 11th Jud Dists 2003]; Kings Medical Supply Inc. v. Country Wide Insurance Company, 783 N.Y.S. 2d at 448 & 452; Amaze Medical Supply, Inc. v. Eagle Insurance Company, 2 Misc. 3d 128 [App Term, 2nd and 11th Jud Dists 2003]). An IME report must set forth a factual basis and medical rationale for the conclusion that further services are not medically necessary. E.g., Ying Eastern Acupuncture, P.C. v. Global Liberty Insurance, 20 Misc.3d 144(A), 873 N.Y.S.2d 238 (Table), 2008 N.Y. Slip Op. 51863(U), 2008 WL 4222084 (App. Term 2d & 11th Dists. Sept. 3, 2008).

The IME was conducted by Dr. Light on 3/31/2018 - approximately three months post-accident. Dr. Light's diagnosis is as follows: "Cervical spine sprain/strain - resolved. Lumbar spine sprain/strain - resolved. Right shoulder sprain/strain - resolved. Bilateral knee sprain/strain - resolved." Range of motion findings were within normal limits. Neurological testing was normal. Orthopedic testing was normal. Dr. Light determined: "Based on my examination, there is no need for continued orthopedic treatment, including physical therapy. There is no need for massage therapy. There is no indication for surgery or injections. There is no need for household help, special transportation, durable medical equipment, or diagnostic tests."

The case law states that if the insurer presents sufficient evidence establishing a lack of medical necessity, then the burden shifts back to the Applicant to present its own evidence of medical necessity. See: West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc3d 131A (2006).

Applicant relies on the documents in their submission - bills, evaluation reports, daily treatment notes, etc. - and Respondent's records. After careful review of the record, I find upon the evidence provided that Applicant has set forth a medical rationale and factual basis to substantiate the need for the physical therapy services provided post-IME. Applicant has submitted evaluations contemporaneous to the IME up through the date of treatment. I do find the Applicant has established that the Assignor was still experiencing subjective complaints of pain which were corroborated by positive objective findings post-IME. Therefore, based on a preponderance of the evidence submitted, I find in favor of the Applicant and award **$1008.70**.

FEE SCHEDUE

Brentwood Regional Chiropractic

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 a claim. East Coast Acupuncture, P.C. v. New York Cent. Mut. Ins., 2008 NY Slip Op 50344(U) (App. Term 2d Dep't., Feb. 21, 2008).

Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. See, Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 2006 NY Slip 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006. If Respondent fails to demonstrate by competent evidentiary proof that an Applicant's claims were in excess of the appropriate fee schedules, Respondent'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 NY Slip Op 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Term, 1st Dep't, per curium, 2006).

Defenses based on the fee schedule can be raised at any time as per the Fourth Amendment to 11 NYCRR 65-3/Insurance Regulation 68-C). The new sections apply to any treatment or service rendered on or after April 1, 2013. Based on 11 NYCRR 3.8(g)(1)(ii). "The purpose of the [no-fault] statute and the fee schedules promulgated thereunder is to significantly

reduce the amount paid by insurers for medical services, and thereby help contain the no-fault premium." Saddle Brook Surgicenter, LLC v. All State Ins. Co., 48 Misc.3d 336, 8 N.Y.S.3d 875 (Civ. Ct. Bronx Co. 2015).

I take judicial notice of the New York State Workers' Compensation Board Medical Fee Schedule ("Fee Schedule") because it is of sufficient authenticity and reliability. See, Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co., 61 A.D.3d 13, 871 N.Y.S.2d 680 (2d Dept. 2009); LVOV Acupuncture, P.C. v. Geico Ins. Co., 32 Misc.3d 144(A), 939 N.Y.S.2d 741(Table) (App Term 2d, 11th & 13th Jud Dists. 2011).

12/26//2017-1/11/2018

Applicant submitted a bill for services under CPT codes 98940 and 97140 for each DOS in the amount of $46.24. Respondent limited payment for the physical medicine services stating: "Reimbursement for modalities and procedures may not exceed 8 relative value units per day. Physical Medicine Ground Rule 3 & 11 reads as follows: "Multiple Physical Medicine Procedures and Modalities. 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."

I find the Respondent has submitted sufficient evidence showing that a total of 8 units was paid to this and/or another provider. I further find the ground rules apply to the codes billed and not to each provider or body part. The plain reading of the ground rules is clear that the limitation is in place so that the total of physical medicine services that can be billed each day is limited to 8 units. Therefore, Applicant's claim is hereby denied.

1/15/2018-2/1/2018

Applicant submitted a bill for services under CPT codes 98940 and 97140 for each DOS in the amount of $46.24. Respondent limited payment for the physical medicine services stating: "Reimbursement for modalities and procedures may not exceed 8 relative value units per day. Physical Medicine Ground Rule 3 & 11 reads as follows: "Multiple Physical Medicine Procedures and Modalities. 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."

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1/29/2018-1/29/2018

Applicant submitted a bill for services under CPT codes 98940 and 97140 for each DOS in the amount of $46.24. Respondent reimbursed $54.52 and limited payment for the physical medicine services stating: " Reimbursement for modalities and procedures may not exceed 8 relative value units per day. Physical Medicine Ground Rule 3 & 11 reads as follows: "Multiple Physical Medicine Procedures and Modalities. 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."

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FEE SCHEDUE

Eastern Suffolk Chiropractic

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appropriate fee schedules, Respondent'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 NY Slip Op 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Term, 1st Dep't, per curium, 2006).

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2/12/2018-2/22/2018

Applicant submitted a bill for services under CPT codes 98940 and 97140 for each DOS in the amount of $46.24. Respondent limited payment for the physical medicine services stating: "Reimbursement for modalities and procedures may not exceed 8 relative value units per day. Physical Medicine Ground Rule 3 & 11 reads as follows: "Multiple Physical Medicine Procedures and Modalities. 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."

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2/26/2018-3/15/2018

Applicant submitted a bill for services under CPT codes 98940 and 97140 for each DOS in the amount of $46.24. Respondent limited payment for the physical medicine services stating: "Reimbursement for modalities and procedures may not exceed 8 relative value units per day. Physical Medicine Ground Rule 3 & 11 reads as follows: "Multiple Physical Medicine Procedures and Modalities. 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."

I find the Respondent has submitted sufficient evidence showing that a total of 8 units was paid to this and/or another provider. I further find the ground rules apply to the codes billed and not to each provider or body part. The plain reading of the ground rules is clear that the limitation is in place so that the total of physical medicine services that can be billed each day is limited to 8 units. Therefore, Applicant's claim is hereby denied.

3/19/2018-4/4/2019

Applicant submitted a bill for services under CPT codes 98940 and 97140 for each DOS in the amount of $46.24. Respondent limited payment for the physical medicine services stating: "Reimbursement for modalities and procedures may not exceed 8 relative value units per day. Physical Medicine Ground Rule 3 & 11 reads as follows: "Multiple Physical Medicine Procedures and Modalities. 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."

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Non-Receipt of Bill

Eastern Chiropractic

The No-Fault Regulations Mandatory Personal Injury Protection Endorsement states:

> "Proof of Claim; Medical, Work Loss, and Other Necessary Expenses. In the case of a claim for health service expenses, the eligible injured person or that person's assignee or representative shall submit written proof of claim to the Company, including full particulars of the nature and extent of the injuries and treatment received and contemplated, as soon as reasonably practicable but, in no event later than 45 days after the date services are rendered. The eligible injured person or that person's representative shall submit written proof of claim for work loss benefits and for other necessary expenses to the Company as soon as reasonably practicable but, in no event, later than 90 days after the work loss is incurred or the other necessary services are rendered. The foregoing time limitations for the submission of proof of claim shall apply unless the eligible injured person or that person's representative submits written proof providing clear and reasonable justification for the failure to comply with such time limitation."

The Regulations afford an Applicant the opportunity to submit a reasonable justification for any late notice. See: 11 NYCRR § 65-3.3 (a), and must establish procedures to "ensure due consideration of denial of claims based upon late filings" and give "appropriate consideration for situations where the claimant has difficulty ascertaining the insurer's identity or inadvertently submits a claim to the incorrect insurer". See: Matter of Medical Society of the State of New York v. Serio, 298 A.D.2d 255, (1st Dept. 2002), affd. 100 N.Y.2d 854, (2003); Bronx Expert Radiology v. Clarendon Natl. Ins. Co., 2009 NY Slip Op 50747(U), 23 Misc.3d 133(A) (App Term 1st Dept., April 20, 2009).

Furthermore, it is incumbent upon the Applicant to provide the insurer with written justification for its untimely submission in order for it to be excused or the insurer should be granted judgment. See: AAA Chiropractic, P.C. and MVAIC, 2010 NY Slip Op 51896(U) (App Term 2d, 11th & 13th Jud. Dists., Nov. 8, 2010); AR Med.Rehabilitation, P.C. v. MVAIC, 27 Misc.3d 135(A), 910 N.Y.S.2d 760 (Table), 2010 N.Y. Slip Op. 50828(U), 2010 WL 1910908 (App. Term 2d, 11th & 13th Dists. May 10, 2010).

11 NYCRR § 65-3.5 (l) requires the insured to conduct the proper review and supervisor review regarding purpose of reasonable justification. The section goes on to state as follows: "The insured shall establish standards for reviews of its determination that applicants have provided late notice of claim or late proof of claim. … In the case of proof of claim, such standards should include but not limited to appropriate consideration for emergency care providers, demonstrated difficulty in ascertaining the identity of the insurer and inadvertent submission to the incorrect insurer. The insurer shall establish procedures based upon objective criteria, to insure due consideration of denial of claims based upon late notice or late submission of proof of claim, including supervisory review of all such determinations…"

Respondent argues they never received any of the bills in dispute for dates of service 4/9/2018-4/24/2018 in the amount of $184.96. However, Applicant has a POM and a denial from the Respondent in its submission establishing the bill was sent and received. Furthermore, a review of Respondent defense stated in the denial that the Assignor is not a resident relative is not supported by any evidence.

After careful review of the evidence submitted by the parties and arguments at the hearing, I find Respondent has established that the bills in dispute were received. Therefore, I find in favor of the Applicant and award **$184.96**.

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
	Hector Melgar PT PC	**12/26/17 - 01/02/18**	**$21.24**	**Awarded: $21.24**
	Hector Melgar PT PC	**01/09/18 - 01/15/18**	**$21.24**	**Awarded: $21.24**
	Brentwood Regional Chiropractic, PC	**12/26/17 - 01/11/18**	**$79.32**	**Denied**
	Hector Melgar PT PC	**01/24/18 - 02/01/18**	**$37.88**	**Awarded: $37.88**
	Brentwood Regional Chiropractic, PC	**01/15/18 - 02/01/18**	**$73.54**	**Denied**
	Brentwood Regional Chiropractic, PC	**01/29/18 - 01/29/18**	**$19.83**	**Denied**
	Hector Melgar PT PC	**02/12/18 - 02/12/18**	**$37.88**	**Awarded: $37.88**
	Hector Melgar PT PC	**02/19/18 - 02/28/18**	**$37.88**	**Awarded: $37.88**
	Eastern Suffolk Chiropractic, PC	**02/12/18 - 02/22/18**	**$59.50**	**Denied**
	Eastern Suffolk Chiropractic, PC	**02/26/18 - 03/15/18**	**$113.20**	**Denied**
	Eastern Suffolk Chiropractic, PC	**03/19/18 - 04/04/18**	**$73.55**	**Denied**

	Hector Melgar PT PC	**04/17/18 - 04/24/18**	**$246.40**	**Awarded: $246.40**
	Eastern Suffolk Chiropractic, PC	**04/09/18 - 04/24/18**	**$184.96**	**Awarded: $184.96**
	Hector Melgar PT PC	**04/30/18 - 05/10/18**	**$392.70**	**Awarded: $392.71**
	Hector Melgar PT PC	**05/14/18 - 05/16/18**	**$123.20**	**Awarded: $123.20**
	Hector Melgar PT PC	**05/30/18 - 06/07/18**	**$246.40**	**Awarded: $246.40**
Total			**$1,768.72**	**Awarded: $1,349.79**

B. The insurer shall also compute and pay the applicant interest set forth below. 07/27/2018 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest runs from the initiation date for this case until the date that payment is made at two percent per month, simple interest, on a pro rata basis using a thirty-day month.

C. Attorney's Fees

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

After calculating the sum total of the first-party benefits awarded in this arbitration plus interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20 percent of that sum total, as provided for in 11 NYCRR 65-4.6(d), subject to a maximum fee of $1,360.00.

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

06/19/2020
(Dated)

Thomas Eck

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:
6cea2d6999ac5b80080d53dce3a40364

Electronically Signed

Your name: Thomas Eck
Signed on: 06/19/2020