

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

CPM Medical Supply Inc
(Applicant)

- and -

Country-Wide Insurance Company
(Respondent)

AAA Case No. 17-19-1127-1886

Applicant's File No. 00037620

Insurer's Claim File No. 000337741 001

NAIC No. 10839

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-J.F.

1. Hearing(s) held on 01/12/2021
Declared closed by the arbitrator on 01/12/2021

Mikhail Guseynov from Drachman Katz, LLP participated by telephone for the Applicant

Ellen Maisto from Jaffe & Velazquez, LLP participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 3,706.91**, was NOT AMENDED at the oral hearing.
Stipulations WERE made by the parties regarding the issues to be determined.

The parties stipulated and agreed that (i) Applicant has met its prima facie burden by submitting evidence that payment of no-fault benefits is overdue, and proof of its claims were mailed to and received by Respondent; (ii) Respondent's denials of the subject claims were timely issued; and (iii) the amounts claimed do not exceed the maximum permissible charges under the fee schedule applicable to the disputed services.

3. Summary of Issues in Dispute

The record reveals that the Assignor-J.F., a 53-year-old male, claimed injuries as the driver of a motor vehicle involved in an accident that occurred on 6/17/2018. Applicant seeks reimbursement for durable medical equipment ("DME") prescribed following

right knee arthroscopic surgery conducted on 11/30/2018, including a knee orthosis with adjustable joints provided on 12/2/2018 and the rental of a continuous passive motion (CPM) machine and cold therapy unit (CTU) from 12/2/2018 through 12/29/2018. Respondent denied the claim based on a lack of causal relationship and lack of medical necessity as determined by the peer review report of Andrew Bazos, M.D., dated 1/16/2019. The issues to be determined are 1) whether Respondent's defense is precluded by the doctrine of collateral estoppel, and if not, 2) whether the services are causally related to the accident of 6/17/2018 and medically necessary?

4. Findings, Conclusions, and Basis Therefor

Applicant seeks reimbursement for post-surgical DME. This hearing was conducted using the documents contained in the Electronic Case Folders (ECF) maintained by the American Arbitration Association. All documents contained in the ECFs are made part of the record of this hearing and my decision was made after a review of all relevant documents found in the ECFs as well as the arguments presented by the parties during the hearing.

In accordance with 11 NYCRR 65-4.5(o) (1), an arbitrator shall be the judge of the relevance and materiality of the evidence and strict conformity of the legal rules of evidence shall not be necessary. Further, the arbitrator may question or examine any witnesses and independently raise any issue that Arbitrator deems relevant to making an award that is consistent with the Insurance Law and the Department Regulations.

COLLATERAL ESTOPPEL

The doctrines of res judicata and collateral estoppel are fully applicable to arbitration proceedings. *See American Ins. Co., v. Messenger*, 43 N.Y.2d 184, 401 N.Y.S.2d 36 (1977). Collateral estoppel is a rule of justice and fairness which mandates that issues once tried should not be re-litigated by a party in a subsequent proceeding who had been afforded a full and fair opportunity to contest the issues raised in a prior proceeding. *Commissioners of State Ins. Fund v. Low*, 3 N.Y.2d 590, 595, 170 N.Y.S.2d 795, 800 (1958). One of the primary purposes of the doctrine of res judicata is grounded in public policy concerns intended to insure finality, prevent vexatious litigation and promote judicial economy. *Matter of Hodes v. Axelrod*, 70 N.Y.2d 364 (1987); *Matter of Reilly v. Reid*, 45 N.Y.2d 24 (1978). Two requirements must be met before collateral estoppel can be invoked. There must be an identity of issue which has necessarily been decided in the prior action and is decisive of the present action, and there must have been a full and fair opportunity to contest the decision now said to be controlling (*see, Gilberg v. Barbieri*, 53 N.Y. 2d 285, 291 [1981]). The party seeking the benefit of collateral estoppel must demonstrate that the decisive issue was necessarily decided in the prior action against a party, or one in privity with a party (*see, Gilberg v. Barbieri, supra.*). The party to be precluded from re-litigating the issue bears the burden of demonstrating the absence of a full and fair opportunity to contest the prior determination. *Buechel v. Bain*, 97 N.Y. 2d 295, 303 (2001). Under New York's transactional approach, as a general rule, "once a claim is brought to a final conclusion, all other claims arising out

of the same transaction or series of transactions are barred, even if based upon different theories or if seeking a different remedy." Parker v. Blauvelt Volunteer Fire Co., Inc., 93 N.Y.2d 343, 347 (1999) *citing* O'Brien v. City of Syracuse, 54 N.Y.2d 353, 357 (1981). The policies underlying the application of res judicata and collateral estoppel are avoiding relitigation of a decided issue and the possibility of an inconsistent result. Notably, the preclusive effect, if any, to be afforded to an earlier decision in a subsequent arbitration proceeding is for the arbitrator of the second proceeding to determine. City School Dist. v. Tonawanda Education Assoc., 63 N.Y.2d 846, 482 N.Y.S.2d 258 (1984).

Legal Standards for Determining Medical Necessity

To support a lack of medical necessity defense, respondent must "set forth a factual basis and medical rationale for the peer reviewer's determination that there was a lack of medical necessity for the services rendered." *See* Provvedere, Inc. v. Republic Western Ins. Co., 2014 NY Slip Op 50219(U) (App. Term 2nd, 11th and 13th Jud. Dists. 2014). Respondent bears the burden of production in support of its lack of medical necessity defense, which if established shifts the burden of persuasion to applicant. *See generally*, Bronx Expert Radiology, P.C. v. Travelers Ins. Co., 2006 NY Slip Op 52116 (App. Term 1st Dept. 2006).

The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment, Kingsbrook Jewish Medical Center v. Allstate Ins. Co., 61 A.D.3d 13, 871 N.Y.S.2d 680 (2d Dept. 2009), such as by a qualified expert performing an independent medical examination or conducting a peer review of the injured person's treatment. *See* Rockaway Boulevard Medical P.C. v. Travelers Property Casualty Corp., 2003 N.Y. Slip Op. 50842(U), 2003 WL 21049583 (App. Term 2d & 11th Dists. Apr. 1, 2003). The appellate courts have not clearly defined what satisfies the insurer's evidentiary standard except to the extent that "bald assertions" are insufficient. Amherst Medical Supply, LLC v. A Central Ins. Co., 41 Misc.3d 133(A), 981 N.Y.S.2d 633 (Table), 2013 NY Slip Op 51800(U), 2013 WL 5861523 (App. Term 1st Dept. Oct. 30, 2013). However, there are myriad civil court decisions tackling the issue of what constitutes a "factual basis and medical rationale" sufficient to establish a lack of medical necessity. The trial courts have held that a peer review report's medical rationale will be insufficient to meet respondent's burden of proof if: 1) the medical rationale of its expert witness is not supported by evidence of a deviation from "generally accepted medical" standards; 2) the expert fails to cite to medical authority, standard, or generally accepted medical practice as a medical rationale for his findings; and 3) the peer review report fails to provide specifics as to the claim at issue, is conclusory or vague. *See generally* Nir v. Allstate Ins. Co., 7 Misc.3d 544, 547, 796 N.Y.S.2d 857, 860 (Civ. Ct. Kings Co. 2005); *See also*, All Boro Psychological Servs. P.C. v. GEICO, 2012 NY Slip Op 50137(U) (N.Y. City Civ. Ct. 2012).

Where a respondent meets its burden, it becomes incumbent on the claimant to rebut the peer review. Be Well Medical Supply, Inc. v. New York Cent. Mut. Fire Ins. Co., 18 Misc.3d 139(A), 2008 WL 506180 (App. Term 2d & 11 Dists. Feb. 21, 2008); A Khodadadi Radiology, P.C. v. NY Central Mutual Fire Ins. Co., 16 Misc.3d 131(A), 2007 WL 1989432 (App. Term 2d & 11 Dists July 3, 2007. "[T]he insured/provider

bears the burden of persuasion on the question of medical necessity. Specifically, once the insurer makes a sufficient showing to carry its burden of coming forward with evidence of lack of medical necessity, 'plaintiff must rebut it or succumb.'" Bedford Park Medical Practice, P.C. v. American Transit Ins. Co., 8 Misc.3d 1025(A), 2005 WL 1936346 at 3 (Civ. Ct. Kings Co., Jack M. Battaglia, J., Aug. 12, 2005). "Where the defendant insurer presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden shifts to the plaintiff which must then present its own evidence of medical necessity (*see* Prince, Richardson on Evidence §§ 3-104, 3-202 [Farrell 11 ed])." West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc.3d 131(A), 2006 N.Y. Slip. Op. 5187(U) at 2, 2006 WL 2829826 (App. Term 2d & 11 Dists. Sept. 29, 2006).

CAUSATION

Under New York 's Comprehensive Motor Vehicle Insurance Reparation Act (the "No-Fault Law), an insurance carrier is obligated to reimburse an injured party (or his or her assignee), for all "reasonable and necessary expenses" and "medical expenses" arising from the use and operation of the insured vehicle. Unlike negligence actions where claimant must prove causation, claimants seeking No-Fault payments "bear no such initial burden, as causation is presumed." Kingsbrook Jewish Med. Center v. Allstate Ins. Co., 61 A.D.3d 13, 871 N.Y.S.2d 680 (2nd Dept. 2009); Bronx Radiology, P.C. v. New York Central Mutual Fire Insurance Company, 17 Misc.3d 97, 2007 N.Y. Slip Op. 27427 (App. Term 1st Dept. 2007).

Causation is presumed since "it would not be reasonable to insist that (an applicant) must prove as a threshold matter that (a) patient's condition was 'caused' by the automobile accident." Mount Sinai Hospital v. Triboro Coach, 263 A.D.2d 11, 20, 699 N.Y.S.2d 77 (2nd Dept. 1999). Thus, the burden is on the insurer to come forward with proof establishing by "fact or founded belief" its defense that the claimed injuries have no nexus to the accident. Mount Sinai Hospital v. Triboro Coach, 263 A.D.2d 11, 19 (2nd Dept. 199) (*quoting* Central Gen. Hosp. v. Chubb Group of Ins. Cos., 90 N.Y. 2d 195, 199 (1997).

The case law holds that for respondent to show that a patient's treated condition was unrelated to his or her automobile accident, the affidavit of its medical expert must be supported by the evidence and not be conclusory or speculative. E.g., New York & Presbyterian Hospital v. Selective Ins. Co. of America, 43 A.D.3d 1019, 842 N.Y.S.2d 63 (2d Dept. 2007). Once Respondent provides proof that the condition was unrelated to the accident, the burden shifts to the Applicant to address such proof. Pommells v Perez, 4 NY3d 566, 577-578, 830 NE2d 278, 797 NYS2d 380 [2005]; *See also* Campbell v. Drammeh, 2018 NY Slip Op 03643 [161 AD3d 584] and Latus v Ishtarq, 2018 NY Slip Op 01417 (1st Dept. 2018) [Plaintiff's physician provided only a conclusory opinion that plaintiff's injuries were caused by the accident, without addressing the preexisting conditions documented in his own MRI, or explaining why plaintiff's current reported symptoms were not related to the preexisting conditions (*see* Nakamura v Montalvo, 137 AD3d 695, 696 [1st Dept 2016]; Farmer v Ventkate Inc., 117 AD3d 562, 562 [1st Dept 2014]).]

"Exacerbations of preexisting conditions are covered by the No-Fault Law (see Wolf v Holyoke Mut. Ins. Co., 3 AD3d 660, 660-661 [2004]; Mount Sinai Hosp. v Triboro Coach, 263 AD2d at 18), Kingsbrook Jewish Medical Center v. Allstate Ins. Co., 871 N.Y.S.2d 680, 61 AD3d 13, 2009 NY Slip Op 351 (N.Y. App. Div., 2009).

Neither a failure to disclaim nor the issuance of a denial untimely on its face, preclude the Respondent from resisting a claim and asserting that its policy did not contemplate coverage in the first instance. (See, Cent. Gen. Hosp. v. Chubb Group of Ins. Cos., 90 N.Y.2d 195, 201 - 202 [N.Y. 1997]; see also, Fair Price Med. Supply Corp. v. Travelers Indem. Co., 10 N.Y.3d 556 [N.Y. 2008]) St. Vincent's Hospital & Medical Center v. Allstate Ins. Co., 69 A.D. 3d 923, 893 N.Y.S.2d 589 (2d Dept. 2010).

Application of Legal Standards

Right knee arthroscopic surgery was conducted on 11/30/2018. In support of its contention that the right knee arthroscopic surgery and post-surgical DME, including the knee orthosis with adjustable joints and the rental of the knee CPM and CTU in dispute, were not medically necessary or causally related to the accident of 6/17/2018, Respondent relies upon the peer review of Dr. Andrew Bazos, M.D., dated 1/16/2019. Applicant relies on the formal rebuttal of treating surgeon Alexios Apazidis, M.D., dated 3/12/2019.

In *Alexios Apazidis, MD, PC and Country-Wide Insurance Company*, AAA Case No.: 17-19-1123-8116, heard on 10/21/2019, Arbitrator John O'Grady was asked to address the causal relationship and medical necessity of the surgeon's fee provided in relation to the right knee surgery that was conducted on 11/30/2018. Upon consideration of the submitted medical records, the same peer review of Dr. Andrew Bazos, M.D., dated 1/16/2019, and a rebuttal affirmation from the treating physician, Arbitrator O'Grady found that the right knee arthroscopic surgery was causally related to the accident of 6/17/2018 and therefore medically necessary. Specifically, Arbitrator O'Grady determined the following in pertinent part:

Summary of Issues in Dispute

CASE SUMMARY

The motor vehicle accident that gives rise to this arbitration occurred on June 17, 2018.

The applicant - assignee makes a claim for surgery for a right knee arthroscopy performed on November 30, 2018.

The respondent denied the claim relying on the peer review by Dr. Andrew Bazos, a Diplomate of the American Board of Orthopedic Surgery.

The assignor is a 52-year-old female [II].

ISSUE(S)

The issue in this arbitration is whether respondent makes out its initial burden to show that the right knee arthroscopic surgery was not medically necessary and, if so, whether applicant's proof is sufficient to overcome that demonstration.

Findings, Conclusions, and Basis Therefor

...

Dr. Bazos notes the physical examination of the assignor's right knee on August 29, 2018 included mild effusion medially with tenderness noted over the medial joint line but there was full range of motion although there was pain on flexion. McMurray's test was positive and strength was slightly reduced. The neurovascular examination was intact. He reviewed the MRI exam of the knee.

He refers to the injury as a "contusion-type injury to the knee". He says that the medical necessity of the knee arthroscopy was not established. The findings seen on the MRI evaluation are consistent with degenerative attrition with the knee as opposed to acute trauma other than the evidence of contusion overlying the patella tendon. The patient's knee complaints are easily explained by extrusion to the knee area as opposed to any form of internal derangement or other findings present. He reasserts his opinion that the injury is the result of a pre-existing condition and degenerative changes.

The MRI exam of the right knee performed on July 6, 2018 revealed a horizontal peripheral tear seen at the posterior body of the medial meniscus with a very prominent soft tissue contusion overlying the patella tendon and extending laterally. There was small joint effusion without evidence of loose body.

The assignor was seen by the treating physician, Dr. Apazides, on August 29, 2018 with right knee pain worse when walking and climbing stairs. He found positive mild effusion immediately, with positive tenderness over the medial joint line and full active range of motion with pain on flexion and a positive McMurray's test. Muscle strength was reduced slightly and he concluded that the patient should continue physical therapy and medication with a home exercise regimen but that based on the patient's history, nature of symptoms and physical exam and the fact the patient is not improving and had a positive MRI exam of failed conservative treatment, surgical intervention was a possibility. The assignor agreed to surgery on that date.

On November 21, 2018 the assignor returned to Dr. Apazides complaining that pain in the knee was not improving. Surgery had not yet been performed. The examination findings were similar to the findings on August 29, 2018 and surgery was again discussed and scheduled for the date of service. An examination was performed on the date of service, November 30, 2018, with similar findings and the surgery was then conducted. The assignor returned to Dr. Apazides a week after the surgery. Physical therapy was recommended as a follow-up treatment for the surgery.

The proof in favor the applicant includes the SOAP (Subjective, Objective, Assessment, Plan) Notes of physical therapy that to the knee between the date of the accident and the date of the surgery.

Dr. Apazides provides a rebuttal to Dr. Bazos' peer review. He reviews the medical records and his examinations of the assignor, as detailed above. He notes the meniscal tear on the MRI exam. He comments that there is no question that the patient had a meniscal tear considering the

MRI findings and surgical confirmation. The meniscectomy was a particularly warranted and medically indicated procedure because arthroscopic meniscal tears have a very high success rate. He supports that contention with a reference to Knee in Leg-Trauma by Dr. McCarty, Dr. Spindler and Dr. Martz in the American Academy of Orthopedic Surgeons. He comments that the MRI exam is the gold standard for finding meniscal pathologies. He also notes that the Dr. Bazos refers to the MRI exam showing only evidence of degenerative attrition but the Dr. Bazos does not talk about a traumatic meniscal tear and leaves out two glaring indicators of trauma, those being the prominent soft tissue contusion overlying the patella tendon and the joint effusion. He says that the patellofemoral compartment showing mild thinning is actually indicative of frontal impact to the knee most likely against the dashboard. The surgery performed was primarily for the meniscal tear which was post traumatic and not degenerative.

...

If the proof of the respondent is found to meet its burden, the proof of the applicant must be considered in opposition to it, mindful that it is likely offered by the provider who actually performed examinations, established treatment and diagnostic plans, made diagnoses and performed medical services.

Dr. Bazos makes out respondent's initial burden to show that there was no medical necessity for the surgery by his opinion. Applicant's counsel argues that without citations to materials relied upon in Dr. Bazos' profession respondent does not make out that initial demonstration. The question is whether the comments of Dr. Bazos demonstrate that there was no medical necessity for the testing in issue. Applicant largely relies on the case of Nir v Allstate Ins. Co., 7 Misc 3d 544 (Civ. Ct. Kings Co. 2005), in arguing that the peer review does not demonstrate lack of medical necessity because the peer reviewer does not make any reference to any standards in the medical community outside of his own opinion. Important is the conclusion of that court that a respondent may raise triable issues of fact for lack of medical necessity where the peer review report "sets forth a sufficiently detailed factual basis and medical rationale for the claims rejection." That the report "must set forth a factual basis sufficient to establish, prima facie, the absence of medical necessity." Here, respondent has done that, by detailing what was shown in the medical records of the assignor and applicant. Further, the physician, an expert by his practice in the field, establishes as a prima facie matter, that the injury was degenerative and not traumatic and therefore no surgery was necessary.

*The Nir court goes on to say that the medical rationale in a peer review report is insufficient if unsupported by evidence of medical standards or it is controverted in that regard. The court says that the medical rationale may be insufficient if not supported by evidence of the "generally accepted medical/professional practice". The court uses the definition of "generally accepted practice" given by the court in City Wide Social & Psychological Servs. v. Travelers Indem. Co., 3 Misc. 3d at 616, *supra*"*

*i.e., "that range of practice that the profession will follow in the diagnosis and treatment of patients in light of the standards and values that define its calling." The court also notes that a peer review report's factual basis may be insufficient if it fails to provide specifics of the claim, is conclusory, or otherwise lacks a basis in the facts of the claim," citing Amaze Med. Supply v. Allstate Ins. Co., *supra*. That cannot be said to be the case here. The peer reviewer details the facts in the claim and provides specifics of what should have been done as opposed to what was done and why what was done was insufficient to establish the medical necessity of the testing.*

Of significance, is the finding in Nir that the doctor produced by the defendant cited only a review of the medical reports of the assignor and did not cite medical authority, standards or generally accepted medical practice as a medical rationale for his findings. He also was unable to explain how the tests could be medically unnecessary when they did yield positive findings. The Nir Court concludes that such scant factual basis and medical rationale will not sustain defendant's burden of proof. Of significance in that case, however, is that the applicant produced contrary evidence that the testing was in accord with generally accepted practice, specifically the criteria of the American Association of Electrodiagnostic Medicine. (That case involved electrodiagnostic testing.)

For these reasons, the remarks in the peer review report are found to contain sufficient detail to establish the lack of medical necessity.

Applicant's proof is sufficient to overcome that demonstration. Applicant's proof demonstrates that the assignor injured her knee in the motor vehicle accident; that injury was confirmed by MRI exam; that she had a series of medical examinations with Dr. Apazides between the date of the accident and a week before the surgery and that each time she continued to make complaints of right knee injury and pain and objective findings were consistent with injury to the knee including pain and positive orthopedic testing. Dr. Bazos' comment that the injury was a "contusion-type" injury is not persuasive in light of the MRI findings confirming a meniscal tear. The proof also demonstrates that she did not respond to conservative treatment and that in light of that failure to respond, the surgery was recommended. Dr. Apazides explains that the surgery was performed to address a meniscal tear that was demonstrate on the MRI exam. In all, applicant's proof is sufficient to demonstrate the medical necessity of the surgery performed and for these reasons, the claim is granted as if made on one bill and timely denied.

I find that the standard for Collateral Estoppel is met in this case. There is an identity of issues between the cases, namely, whether the underlying right knee surgery, for which the related service of the post-surgical DME in dispute was provided, was causally related to the accident and medically necessary. Considering Arbitrator O'Grady's prior award, it would be inconsistent for me to find Respondent's denial in this case can be sustained. Respondent had a full and fair opportunity to contest the prior decision, prosecuted the claim on the merits, and decision was made on the merits, which was not

appealed. Respondent presented identical evidence, which was reviewed and considered, including the peer review of Andrew Bazos, M.D., dated 1/16/2019, and the rebuttal of Alexios Apazidis, M.D., dated 3/12/2019. Arbitrator O'Grady determined that Respondent sustained its initial burden for the defenses of lack of medical necessity and lack of causal relationship. As such, Respondent shifted the burden to Applicant to establish the medical necessity and the causal relationship of the services to the accident, which Applicant successfully established. I find that Respondent's counsel has not sufficiently satisfied its burden to show the absence of a full and fair opportunity to litigate the issue of medical necessity and causal relationship of the underlying right knee surgery and related services, including the post-surgical DME in dispute based on the peer review of Andrew Bazos, M.D., dated 1/16/2019.

Since Arbitrator O'Grady previously determined that the Applicant sustained its burden of demonstrating that the subject treatment and related services were medically necessary and causally related to the accident, I am bound by the doctrine of collateral estoppel. The issues in the instant case and in the linked case decided by Arbitrator O'Grady are identical, and therefore, the instant claim is granted under the doctrine of collateral estoppel, thus precluding the Respondent from re-litigating that issue in the instant matter.

I further concur with Arbitrator O'Grady's decision that Applicant was able to persuasively rebut the peer and establish that the underlying surgery and post-surgical supplies in dispute were medically necessary. I find that, were Arbitrator O'Grady's prior decision not entitled to collateral estoppel effect, Applicant's rebuttal and medical records are sufficient to rebut the Respondent's peer review.

Therefore, I find that the Applicant has met its burden of proving that the medical care in dispute was medically necessary for the subject patient and causally related to the accident.

Accordingly, Applicant's claim is granted in its entirety. This decision is in full disposition of all claims for No-Fault benefits presently before this arbitrator.

[\[1\]](#) Dr. Alexios Apazidis' confirms in the rebuttal that his examination report, dated 8/29/2018, had a typographical error indicating that Assignor-J.F. was a female. Dr. Apazidis indicates that Assignor-J.F. is a male.

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
	CPM Medical Supply Inc	12/02/18 - 12/02/18	\$607.55	Awarded: \$607.55
	CPM Medical Supply Inc	12/02/18 - 12/02/18	\$19.50	Awarded: \$19.50
	CPM Medical Supply Inc	12/02/18 - 12/15/18	\$699.86	Awarded: \$699.86
	CPM Medical Supply Inc	12/02/18 - 12/15/18	\$1,190.00	Awarded: \$1,190.00
	CPM Medical Supply Inc	12/16/18 - 12/29/18	\$1,190.00	Awarded: \$1,190.00
Total			\$3,706.91	Awarded: \$3,706.91

- B. The insurer shall also compute and pay the applicant interest set forth below. 04/30/2019 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.

02/03/2021
(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:
5e0841699bd955c5a0c6d67e0b3c5bf9

Electronically Signed

Your name: Eileen Hennessy
Signed on: 02/03/2021