American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Hamza Physical Therapy, PLLC
(Applicant)

- and -

Country-Wide Insurance Company
(Respondent)

AAA Case No.	17-19-1130-2397
Applicant's File No.	none
Insurer's Claim File No.	313276-002
NAIC No.	10839

ARBITRATION AWARD

I, Kevin R. Glynn, 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 03/18/2021
   Declared closed by the arbitrator on 03/18/2021

   Lee-Ann Trupia, Esq. from The Law Offices of Hillary Blumenthal P.C. (Melville) participated in person for the Applicant

   Ellen Maisto, Esq. from Jaffe & Velazquez, LLP participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 1,604.32**, 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

   The Assignor, SN, is a 30yo female driver who was injured in a motor vehicle on 2/8/16. SN suffered injuries which resulted in her seeking treatment. In dispute are the Applicant's claims for a physical therapy evaluation (97001) on 2/11/16 and physical therapy (97010, 97014, 97124) performed on 2/12/16 and 2/17/16 in the total amount of $190.72; for physical therapy (97010, 97014, 97124) performed on ten dates of service from 2/18/16-3/14/16, in the total amount of $589.00; for physical therapy (97010, 97014, 97124) performed on nine dates of service from 3/16/16-4/13/16, in the total amount of $530.10; and for physical therapy (97010, 97014, 97124) performed on four dates of service from 4/20/16-5/11/16, in the total amount of $235.60. Respondent's original defense was that there was outstanding verification of these claims. Respondent

subsequently amended its defense based on the Assignor allegedly failing to appear at two Independent Medical Examinations (IMEs). Therefore, the issue to be determined is if Respondent's defense that the Assignor failed to appear at two IMEs can be sustained, and if not, whether its outstanding verification defense can be sustained.

Also, at issue is Applicant's claim for physical therapy (97010, 97014, 97124) performed on 5/19/16 in the total amount of $58.90. This claim was denied based on the Assignor's failure to appear for two IMEs. Therefore, the issue to be determined is if Respondent's defense that the Assignor failed to appear at two properly scheduled IMEs can be sustained.

Additionally, there is a prior award by Arbitrator Michael B. Parson, dated 9/20/19, under AAA Case No.: 17-17-1075-4570 regarding the IME no-show defense. Therefore, the issue in dispute is whether the doctrine of collateral estoppel is applicable to this arbitration, and if not, the remaining issue is if Respondent can sustain its defenses.

4. Findings, Conclusions, and Basis Therefor

This case was decided based upon the submissions of the Parties as contained in the electronic file maintained by the American Arbitration Association, and the oral arguments of the parties' representatives. There were no witnesses. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon. Only the arguments presented at the hearing are preserved in this decision; all other arguments not presented at the hearing are considered waived. It is noted that Respondent submitted additional proofs on 3/11/21. Applicant objects to this document being considered pursuant to "Rocket Docket." The first Amendment to Regulation 68-D (11 NYCRR § 65-4), commonly known as the "Rocket Docket", provides, in pertinent part, that within thirty (30) calendar days after the American Arbitration Association advises a respondent of its receipt of a request for arbitration, the respondent shall "provide all documents supporting its position on the disputed matter. Such document shall be submitted to the applicant at the same time. The respondent may, in writing, request that the designated organization provide an additional 30 calendar days to respond based upon reasonable circumstances that prevent it from complying." 11 NYCRR § 65-4.2 (3)(ii). § 65-4.2(3) (iii): The written record shall be closed upon receipt of the respondent's submission or the expiration of the period for receipt of the respondent's submission. Documents submitted by either party after the record is closed shall be marked "Late". §65-4.2(3)(iv): Any additional written submissions may be made only at the request or with the approval of the arbitrator**.** The undersigned will consider any evidence that is submitted more than one week before the date of the hearing. Because the additional proofs were not submitted more than one week before this hearing they will not be accepted and considered in this award. However, this is issue is moot pursuant to the collateral estoppel discussion below.

Collateral Estoppel:

The doctrines of res judicata and collateral estoppel are fully applicable to arbitration proceedings. American Ins. Co., v. Messinger, 43 N.Y.2d 184, 401 N.Y.S.2d 36 (1977);

Clemens v. Apple; 65 N.Y.2d 746, 492 N.Y.S.2d 20 (1985); County of Rockland v. Aetna Casualty & Surety Co., 129 A.D.2d 606, 514 N.Y.S.2d 102 (App. Div., 2nd Dept - 1987); Protocom Devices, Inc. v. Figueora, 173 A.D.2d 177, 569 N.Y.S.2d 80 (App. Div., 1st Dept - 1991), and; Hilowitz v. Hilowitz, 85 A.D.2d 621, 445 N.Y.S.2d 22 (App. Div., 2nd Dept - 1981). 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).

In order for the doctrine to apply, however, it must be first shown that the party against whom collateral estoppel is sought had a full and fair opportunity to contest the determination said to be dispositive of the instant controversy. Moreover, the issue in the prior action must be identical, and thus decisive, to the issue in the action for which application of the doctrine is sought. Gilberg v. Barbieri, 53 N.Y. 2d 285, 441 N.Y.S. 2d 49 (1981); Schwartz v. Public Administrator of County of Bronx, 24 N.Y.2d.65, 68, 298 N.Y.S.2d 955, 958 (1969). 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). The principles of res judicata require that "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". O'Brien v. City of Syracuse, 54 N.Y.2d 353 (1981). 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); Board of Education v. Patchogue-Medford Congress of Teachers, 48 N.Y.2d 812, 424 N.Y.S.2d 122 91979); Matter of Springs Cotton Mills [Buster Boy Suit Co.], 275 App. Div. 196, 88 N.Y.S.2d 295 (App. Div., 1st Dept - 1949) affd. without opinion. 300 N.Y. 586, 89 N.E.2d 877 (1949); Melendez v. Budget Rent-A-Car, 7 Misc. 3d 585, 588, 794 N.Y.S.2d 830 (2005).

On 9/20/19, Arbitrator Michael B. Parson issued an award for AAA Case No.: 17-17-1075-4570, in which he stated:

> *Policy Violation The Respondent issued no denial for the lower extremity testing on 3/9/16, reported in the sum of $1,666.21. The ECF contains nothing to establish Respondent's policy violation defense. There are copies of scheduling letters but no copy of any proof of mailing of any scheduling letter and no proof the SN failed to appear at any scheduled IME. "[I]n order for an insurer to take advantage of the tolling provisions and submit a defense based upon failure to appear for a post claim IME, it must prove that it sent both an original and follow up request and that the injured party failed to appear for both scheduled IMEs." Prime Psychological Services, P.C. v. ELRAC, Inc., 25 Misc.3d 1244(A), 906 N.Y.S.2d 782*

(Table), 2009 N.Y. Slip Op. 52579(U) at 3, 2009 WL Page 2/64. 4894360 (Civ. Ct. Richmond Co., Katherine A. Levine, J., Dec. 4, 2009). An insurer denying payment for services after the date the claimant failed to appear for a physical examination must prove that there was a properly mailed verification notice. Chao v. Country-Wide Ins. Co., 11 Misc.3d 1090(A), 819 N.Y.S.2d 852 (Table), 2006 N.Y. Slip Op. 50794(U) at 1, 2006 WL 1168760 (Dist. Ct. Nassau Co., Anthony W. Paradiso, J., May 3, 2006). The affirmations and affidavits of the medical professionals who were to perform the IMEs can establish that a health care provider's assignor failed to appear for said IMEs. E.g., Tri-Mount Acupuncture, P.C. v. NY Central Mutual Fire Ins. Co., 30 Misc.3d 144(A), 924 N.Y.S.2d 312 (Table), 2011 N.Y. Slip Op. 50335(U), 2011 WL 830762 (App. Term 2d, 11th & 13th Dists. Mar. 2, 2011); Radiology Today, P.C. v. GEICO Ins. Co., 25 Misc.3d 133(A), 901 N.Y.S.2d 910 (Table), 2009 N.Y. Slip Op. 52208(U), 2009 WL 3645541 (App. Term 2d, 11th & 13th Dists. Oct. 23, 2009). An insurer fails to demonstrate that it is entitled to judgment on the ground that the assignor failed to attend IMEs where its papers fail to establish that the assignor failed to appear for such examinations. Canarsie Family Medical Practice, PLLC v. American Transit Ins. Co., 26 Misc.3d 132(A), 906 N.Y.S.2d 778 (Table), 2010 N.Y. Slip Op. 50070(U), 2010 WL 186384 (App. Term 2d, 11th & 13th Dists. Jan. 12, 2010). The insurer is entitled to judgment where it proves that two separate requests for an IME were duly mailed to the assignor and the latter failed to appear on either of the dates. Apollo Chiropractic Care, P.C. v. Praetorian Ins. Co., 27 Misc.3d 139(A), 932 N.Y.S.2d 420 (Table), 2010 N.Y. Slip Op. 50911(U), 2010 WL 2026636 (App. Term 1st Dept. May 24, 2010) [Emphasis added]. If the insurer fails to submit sufficient evidence of the assignor's nonappearance at IMEs, such cannot be sustained as a defense to nonpayment of the health care provider's bill. E.g., LDE Medical Services, P.C. v. Interboro Ins. Co., 31 Misc.3d 146(A), 930 N.Y.S.2d 175 (Table), 2011 N.Y. Slip Op. 50946(U), 2011 WL 2089701 (App. Term 2d, 11th & 13th Dists. May 23, 2011). An affidavit from the receptionist of the doctor who was to perform the IMEs is sufficient to establish that an assignor failed to appear. Alrof, Inc. v. Nationwide Ins. Co., 32 Misc.3d 134(A), 936 N.Y.S.2d 57 (Table), 2011 N.Y. Slip Op. 51451(U), 2011 WL 3370622 (App. Term 2d, 11th & 13th Dists. July 28, 2011). See also, Great Health Care Chiropractic, P.C. v. Citiwide Auto Leasing, 43 Misc.3d 127(A), 990 N.Y.S.2d

437 (Table), 43 Misc.3d 127(A), 2014 WL 1272135 (App. Term 2d, 11th & 13th Dists. Mar. 17, 2014), holding that a presumption of receipt of an IME scheduling letter arises only where there is proof of a proper mailing. Here, Respondent proved nothing except that scheduling letters were generated. Hence, I find that the policy defense has not been established. I also note that a general denial alone is of no effect. See, Unitrin Advantage Ins. Co. v. Bayshore Physical Therapy, PLLC, 82 A.D.3d 559, 918 N.Y.S.2d 473 (1st Dept. 2011)...

Respondent argues that collateral estoppel should not apply as it has submitted additional proofs in support of its defense than at the prior hearing. However, the analysis before me is not whether Respondent submitted additional/different proofs in my hearing as compared to the prior hearing but rather if it had a "full and fair opportunity" to contest this issue in the prior hearing. Respondent had every opportunity to present all evidence submitted herein at the prior hearing both of which were held after the alleged no-shows. There is already an award concerning the subject IME no-show defense. That case involved the same Respondent and the same defense. The seminal issue presented herein is identical to the issue(s) considered previously. Respondent had a full and fair opportunity to present its proofs in the prior hearing. I conclude that the doctrine of collateral estoppel should be applied in this matter and, as such, Respondent cannot sustain this defense.

Therefore, Applicant is awarded reimbursement of the claim for date of service 5/19/16 in the amount of $58.90.

Outstanding Verification:

Pursuant to Insurance Law §5106(a) and 11 NYCRR §65-3.8, No-Fault benefits are overdue if not paid or denied within 30 calendar days after the insurer receives proof of claim, which shall include verification of all the relevant information requested.

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

Once Applicant establishes its prima facie case, the burden of proof shifts to Respondent to come forward with admissible evidence demonstrating the existence of a material issue of fact. Amaze Medical Supply Inc. v. Eagle Ins. Co., 2 Misc.3d 128(A), 2003 N.Y. Slip Op. 51701(U)(App. Term, 2nd Dept, 2nd & 11th Jud Dists., 2003). If an insurer asserts that the claim(s) are premature due to outstanding verification, the insurer must demonstrate that the verification request and follow-up verification request were timely issued, and that no response was received. Compas Med., P.C. v. Praetorian, 49 Misc 3d 129(A), 2015 NY Slip Op 51403(U)(App Term, 2nd , 11th and 13th Jud. Dists. 2015). As required by 11 NYCRR §65-3.5(b), the initial request for verification is to be

made within 15 business days of receipt of the claim. A request that is sent beyond the 15 business days is still valid so long as it is issued within 30 days from receipt of the claim; such a deviation will simply reduce the insurer's time to pay or deny by the same number of days. 11 NYCRR §65-3.8(l). See Nyack Hosp. v. General Motors Acceptance Corp., 8 NY3d 294, 2007 NY Slip Op 02439 (Court of Appeals, 2007). On the other hand, if the initial request for verification is made beyond 30 days from receipt of the claim, the request will be deemed a nullity and the time to pay or deny will have expired. Compas Med., P.C. v. Farm Family Cas. Ins. Co., 2015 NY Slip Op 51631(U) (App. Term 2nd, 11th and 13th Jud. Dists. 2015). Additionally, after 30 calendar days from the original request, the insurer has a regulatory duty to issue a second verification request within the following 10 calendar days. 11 NYCRR §65-3.6(b). The obligation to pay or deny a claim is not triggered until the insurer has received all of the relevant information that was requested. Hospital for Joint Diseases v. State Farm Mut. Auto. Ins. Co., 8 AD3d 533, 2004 NY Slip Op 05413 (App. Div., 2nd Dept., 2004). If the insurer can demonstrate that the initial verification request and follow-up verification request were timely issued, and that no response was received, the matter will be deemed premature and not ripe for adjudication. See Mount Sinai Hosp. v. Chubb Group of Ins. Co., 43 AD3d 889, 2007 NY Slip Op 06650 (App. Div., 2nd Dept., 2007).

Furthermore, pursuant to 11 NYCRR §65-3.8(b)(3), "an insurer may issue a denial if, more than 120 calendar days after the initial request for verification, the applicant has not submitted all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply…"

In this case, I find that Applicant has established its prima facie case for each claim, thereby shifting the burden to Respondent.

DOS: 2/11/16-2/17/16

After receiving the claim on 3/21/16, Respondent issued the following verification requests to Applicant:

1st Verification Request: 4/19/16 - The complete narrative report Section 16 verifying treatment; provider name, provider license number and business relationship to PC Section 17 verifying PC owner name with license credentials (Revised 1/04) NF-3. Proper Signature required; No Stamps/Electronic Signatures Hand-signed; No Stamps/Electronic Signatures.

2nd Verification Request: 5/20/16 - The complete narrative report Section 16 verifying treatment; provider name, provider license number and business relationship to PC Section 17 verifying PC owner name with license

> credentials (Revised 1/04) NF-3. Proper Signature required; No Stamps/Electronic Signatures Hand-signed; No Stamps/Electronic Signatures.

Applicant submits a copy of the 4/19/16 verification request with handwritten responses directly on the verification request form wherein the Applicant wrote:

> Physical therapist does not write narrative reports only treatment notes, which we submitted originally with the bills.
>
> Section 16 is fully completed; please review it more carefully.
>
> Enclosed signed NF3

Applicant also submits the FAX TX REPORT establishing that this response was submitted by fax to 12123813106 on 7/25/16. However, there is no explanation provided as to why the response was sent to that fax number and if that fax number is the proper number to submit verification responses. The claims department fax number provided on the verification request was 212-635-0587. Applicant has failed to establish that it had ever submitted this response to Respondent.

Applicant's counsel also makes what would appear to be a Domotor argument. Applicant's counsel argues that there was a global denial based on the alleged failure of the Assignor to appear at IMEs and that therefore the Applicant had no obligation to respond to the verification requests. However, I do not follow the Appellate Division decision in State Farm Ins. Co. v Domotor, 266 AD2d 219 (2nd Dept. 1999). Following this decision an opinion letter was issued by the Office of General Counsel of the Insurance Department dated 9/2/04, which states that "there is no provision in either the no-fault statute or regulation which relieves an insurer of the obligation to pay or issue a denial at all claims for benefits submitted. Neither does the statute or regulation relieve an applicant for benefits of their responsibility to submit claims in order to be eligible for the payment of benefits, even after receiving the denial of all future benefits." Furthermore, the New York State Court of Appeals has held that "The superintendent's interpretation, if not irrational or unreasonable, will be upheld in deference to a special competence and expertise with respect to the insurance industry, unless it runs counter to the clear wording of a statutory provision." See LMK Psychological Services, P.C., v. State Farm Mut. Auto. Ins. Co., 12 NY 3d. 217, 223 (2009). Just as an Applicant is still required to submit claims after receiving a denial of all future benefits, it must also respond to requests for verification.

As such, this claim is denied without prejudice.

DOS: 2/18/16-3/14/16

After receiving the claim on 3/31/16, Respondent issued the following verification requests to Applicant:

1st Verification Request: 4/29/16 - The complete narrative report Section 16 verifying treatment; provider name, provider license number and business relationship to PC Section 17 verifying PC owner name with license credentials (Revised 1/04) NF-3. Proper Signature required; No Stamps/Electronic Signatures Hand-signed; No Stamps/Electronic Signatures.

2nd Verification Request: 5/30/16 - The complete narrative report Section 16 verifying treatment; provider name, provider license number and business relationship to PC Section 17 verifying PC owner name with license credentials (Revised 1/04) NF-3. Proper Signature required; No Stamps/Electronic Signatures Hand-signed; No Stamps/Electronic Signatures.

Applicant submits a copy of the 5/30/16 verification request with handwritten responses directly on the verification request form wherein the Applicant wrote:

> Physical therapist does not write narrative reports only treatment notes, which we submitted originally with the bills.
>
> Section 16 is completed fully. Please review it more carefully.
>
> Enclosed signed NF3

However, Applicant has failed to establish that it had ever submitted this response to Respondent.

Applicant's counsel also makes what would appear to be a Domotor argument. Applicant's counsel argues that there was a global denial based on the alleged failure of the Assignor to appear at IMEs and that therefore the Applicant had no obligation to respond to the verification requests. However, I do not follow the Appellate Division decision in State Farm Ins. Co. v Domotor, 266 AD2d 219 (2nd Dept. 1999). Following this decision an opinion letter was issued by the Office of General Counsel of the Insurance Department dated 9/2/04, which states that "there is no provision in either the no-fault statute or regulation which relieves an insurer of the obligation to pay or issue a denial at all claims for benefits submitted. Neither does the statute or regulation relieve an applicant for benefits of their responsibility to submit claims in order to be eligible for the payment of benefits, even after receiving the denial of all future benefits." Furthermore, the New York State Court of Appeals has held that "The superintendent's interpretation, if not irrational or unreasonable, will be upheld in deference to a special competence and expertise with respect to the insurance industry, unless it runs counter to the clear wording of a statutory provision." See LMK Psychological Services, P.C., v. State Farm Mut. Auto. Ins. Co., 12 NY 3d. 217, 223 (2009). Just as an Applicant is still

required to submit claims after receiving a denial of all future benefits, it must also respond to requests for verification.

As such, this claim is denied without prejudice.

DOS: 3/16/16-4/13/16

After receiving the claim on 5/2/16, Respondent issued the following verification requests to Applicant:

> **1st Verification Request: 5/27/16** - The complete narrative report (Revised 1/04) NF-3. Proper Signature required; No Stamps/Electronic Signatures Hand-signed; No Stamps/Electronic Signatures.

> **2nd Verification Request: 6/27/16** - The complete narrative report (Revised 1/04) NF-3. Proper Signature required; No Stamps/Electronic Signatures Hand-signed; No Stamps/Electronic Signatures.

Applicant submits a copy of the 5/27/16 verification request with handwritten responses directly on the verification request form wherein the Applicant wrote:

> Physical therapist does not write narrative reports only treatment notes, which we submitted originally with the bills.
>
> Enclosed signed NF3

However, Applicant has failed to establish that it had ever submitted this response to Respondent. Applicant's counsel also makes what would appear to be a Domotor argument. Applicant's counsel argues that there was a global denial based on the alleged failure of the Assignor to appear at IMEs and that therefore the Applicant had no obligation to respond to the verification requests. However, I do not follow the Appellate Division decision in State Farm Ins. Co. v Domotor, 266 AD2d 219 (2nd Dept. 1999). Following this decision an opinion letter was issued by the Office of General Counsel of the Insurance Department dated 9/2/04, which states that "there is no provision in either the no-fault statute or regulation which relieves an insurer of the obligation to pay or issue a denial at all claims for benefits submitted. Neither does the statute or regulation relieve an applicant for benefits of their responsibility to submit claims in order to be eligible for the payment of benefits, even after receiving the denial of all future benefits." Furthermore, the New York State Court of Appeals has held that "The superintendent's interpretation, if not irrational or unreasonable, will be upheld in deference to a special competence and expertise with respect to the insurance industry, unless it runs counter to the clear wording of a statutory provision." See LMK

Psychological Services, P.C., v. State Farm Mut. Auto. Ins. Co., 12 NY 3d. 217, 223 (2009). Just as an Applicant is still required to submit claims after receiving a denial of all future benefits, it must also respond to requests for verification.

As such, this claim is denied without prejudice.

DOS: 4/20/16-5/11/16

After receiving the claim on 6/1/16, Respondent issued the following verification requests to Applicant:

1st Verification Request: 6/29/16 - The complete narrative report Section 16 verifying treatment; provider name, provider license number and business relationship to PC Section 17 verifying PC owner name with license credentials (Revised 1/04) NF-3. Proper Signature required; No Stamps/Electronic Signatures Hand-signed; No Stamps/Electronic Signatures.

Respondent fails to submit any follow up to this initial verification request. As such, it will be unable to timely deny the claim. Applicant is awarded reimbursement of this claim in the amount of $235.60.

Therefore, Applicant is awarded the total amount of $294.50.

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
	Hamza Physical Therapy, PLLC	**02/11/16 - 02/17/16**	**$190.72**	**Dismissed without prejudice**
	Hamza Physical Therapy, PLLC	**02/18/16 - 03/14/16**	**$589.00**	**Dismissed without prejudice**
	Hamza Physical Therapy, PLLC	**03/16/16 - 04/13/16**	**$530.10**	**Dismissed without prejudice**
	Hamza Physical Therapy, PLLC	**04/20/16 - 05/11/16**	**$235.60**	**Awarded: $235.60**
	Hamza Physical Therapy, PLLC	**05/19/16 - 05/19/16**	**$58.90**	**Awarded: $58.90**
Total			**$1,604.32**	**Awarded: $294.50**

B. The insurer shall also compute and pay the applicant interest set forth below. 05/31/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

In the instant matter Applicant is awarded interest pursuant to the no-fault regulations. 11 NYCRR 65-3.9 (a) provides that Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30 day month." Pursuant to 11 NYCRR 65-3.9 (c), "if 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 Department of Financial Services regulations, interest shall not accumulate

on the disputed claim or element of claim until such action is taken." Applicant electronically submitted its claim for arbitration on 5/31/19, more than thirty days after receipt of the denial of claim. Therefore, interest shall run effective 5/31/19.

C. Attorney's Fees

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

An attorney's fee of 20% shall be paid on the sum of the awarded claim plus interest, subject to a maximum 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, Kevin R. Glynn, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

03/22/2021
(Dated)

Kevin R. Glynn

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:
f5344f929cb735722057947f25bcc0f9

Electronically Signed

Your name: Kevin R. Glynn
Signed on: 03/22/2021