

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Northern Bronx Physical Therapy P.C.  
(Applicant)

- and -

Hereford Insurance Company  
(Respondent)

AAA Case No. 17-20-1158-2804

Applicant's File No. n/a

Insurer's Claim File No. 61522

NAIC No. 24309

**ARBITRATION AWARD**

I, Eva Gaspari, 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: E.I.P and/or A.B.

1. Hearing(s) held on 03/09/2021  
Declared closed by the arbitrator on 03/09/2021

Kristin Cahill from Zelli & Cahill, P.C. participated in person for the Applicant

Tasnim Hassanali from Law Offices of Rubin & Nazarian participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 455.52**, 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 dispute arises from an automobile accident which occurred on June 7, 2016 in which the Assignor (A.B.), a 19-year-old female, was a passenger. Following the accident, the assignor was examined and received physical therapy from June 7, 2016 through June 28, 2016. Applicant's claim totaling \$455.52 was received by the Respondent on July 21, 2016 and has been denied based upon the EIP's failure to attend neurology medical examinations (IMEs) which were scheduled for August 23, 2016 and September 20, 2016; and based on the EIP's failure to attend pain management examinations (IMEs) which were scheduled for August 25, 2016 and September 22,

2016. The issue presented is whether the Respondent has demonstrated a meritorious defense based on the assignor's failure to comply with its requests for duly scheduled Independent Medical Examinations.

#### 4. Findings, Conclusions, and Basis Therefor

This matter was decided based upon the submissions of the parties as contained in the electronic file maintained by the American Arbitration Association, as well as upon the oral arguments of the parties at the time of the hearing. All documents contained in the ADR folder are hereby incorporated into this hearing and in reaching my findings I have reviewed all relevant exhibits contained in the ADR Center. By way of procedural history, at the hearing the Respondent indicated that there were linked awards on the issue of the EIP's failure to attend the IMEs at issue. After the hearing was closed the parties were requested to upload any awards or cases pertaining to this EIP, on which they were relying, in response to which several cases were supplemented into the record. These awards have been considered in rendering the award in this matter. These cases were discussed during the hearing, and the sole purpose of supplementing the record was to ensure that they were part and parcel of the record. Aside from linked awards, only evidentiary submissions which were uploaded into the ADR Center at the time of the hearing were considered in making the instant determination. Any law which has been presented has been reviewed. I further note that both parties appeared by counsel who were well prepared and well versed, and who made persuasive arguments on behalf of their clients.

As an initial matter I find that Applicant has demonstrated its prima facie case for the sessions in dispute. (a medical provider establishes a prima facie showing of their entitlement to judgment as a matter of law by submitting evidentiary proof that the prescribed statutory billing forms had been mailed and received and that payment of no fault benefits was overdue.) See, Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept.2004); See also: Viviane Etienne Med. Care v Country-Wide Ins. Co. 2015 NY Slip Op 04787 (proof of mailing is satisfied by an insurer's admission of receipt of bills.) The evidence indicates that the Applicant's claims were received by the Respondent on July 21, 2016. Applicant having established its prima facie case, the burden shifts to the Respondent to demonstrate its articulated defenses.

## **FTC IME**

Under the No-Fault Regulations, an insurer is permitted to seek verification of a claim in the form a medical examination. Pursuant to 11 NYCRR 65-1.1, Conditions, "No action shall lie against the Company unless, as a condition precedent thereto, there shall have been full compliance with the terms of this coverage". Further, the Regulations state "the eligible injured person shall submit to medical examination by physicians selected by, or acceptable to, the Company when, and as often as, the Company may reasonably require." The appearance at an IME is a condition precedent to the insured liability on the policy, and an insurer may deny a claim retroactively to the date of loss for a claimant's failure to attend IMEs, "when, and as often as, the [insurer] may reasonably require". A no-fault claimant's failure to appear for a properly scheduled medical examination (IME) will result in denial of its claim. *See Stephen Fogel Psychological, P.C. v. Progressive Cas. Ins. Co.*, 35 A.D.3d 720 (App Div 2d Dept, 2006). In order to support a defense premised on the failure to appear for an IME, an insurer is required to show that the scheduling letters were timely mailed and that the party failed to appear on two separate occasions for duly scheduled examinations.

## **FINDING OF FACT**

Per 11 NYCRR 65-4.5[o][1], the arbitrator shall be the judge of the relevance and materiality of the evidence offered. Moreover, the arbitrator may determine what evidence to accept or reject and what inferences should be drawn based on the evidence. *See Mott v State Farm*, 55 NY2d 224 (1982). I have considered the Applicant's objections to the proofs offered by Respondent and after careful consideration find that the Respondent's evidence sufficiently satisfies its initial burden of proof to support its defense that the EIP failed to attend two scheduled IMEs. Respondent presents IME scheduling letters and proof of mailing which I find sufficiently establishes that it requested that the EIP attend medical examinations on August 23, 2016, August 25, 2016, September 20, 2016, and September 22, 2016. Specifically, Respondent has demonstrated that a letter dated August 8, 2016 was issued which scheduled an IME for August 23, 2016; that a letter dated August 25, 2016 was issued which scheduled an IME for September 20, 2016; that a letter dated August 8, 2016 was issued which scheduled an IME for August 25, 2016; that a letter dated August 30, 2016 was issued which scheduled an IME for September 13, 2016; and that the September 13, 2016 IME was rescheduled via a letter dated September 6, 2016 which was issued and which

scheduled an IME for September 22, 2016. Moreover, I find as a matter of fact, that the Respondent has set forth evidence which demonstrates that these letters were mailed to the EIP, having set forth the affidavits by David Cosio, along with proof of mailing certificates, both of which indicate that letters were mailed to the EIP and her counsel. Finally, Respondent has set forth affirmations by the scheduled IME doctors, Dr. Sarasvani Jayaram, M.D., and by Dr. Sumankumar Brahmbhatt, which avers that the physicians were scheduled to conduct the IMEs and that the EIP failed to appear. These affirmations are contemporaneously signed on or about the dates of the non-appearance. I find that these affirmations credibly demonstrate the EIP's non-appearance. This evidence is not credibly rebutted, and accordingly, I find that the Respondent has adequately demonstrated that it requested two neurological IMEs and two pain management IMEs for which the EIP failed to appear. In so holding, I note that a similar finding has been reached with concern to this EIP in the matters of the arbitration between CitiMedical I PLLC and Hereford Insurance Company, AAA Case No. 17-17-1073-3303 (Thomas, 10/04/2018); Integrated Neurological Assoc. PLLC and Hereford Insurance Company, AAA Case No. 17-17-1069-9966 (Thomas, 11/28/2018).

On a review of the evidence, the respondent has set forth evidence that Applicant's claim for services was received on July 21, 2016. All requests for the subject IMEs were issued after receipt of the subject claims. Accordingly, there is the necessary issue of whether the first scheduled IME, which was request on August 8, 2016 and which scheduled an IME for August 23, 2016, was a duly scheduled IME with regard to this claim. Pursuant to 11 NYCRR 65-3.5 (d) "if the additional verification required by the insurer is a medical examination, the insurer shall schedule the examination to be held within 30 calendar days from the date of receipt of the prescribed verification forms." A plane reading of the regulation demonstrates that the IME must be scheduled to be held, not merely scheduled in order to constitute a duly scheduled IME.

In the case of American Tr. Ins. Co. v Longevity Med. Supply, Inc., 2015 NY Slip Op 06761, 131 AD3d 841 (App. Div. 1<sup>st</sup> Dept 2015), it was held that an insurer must demonstrate that it complied with the 30-calendar-day time frame for scheduling of the first IME, in order to demonstrate that it was duly scheduled and in order to properly disclaim on the grounds that the assignor failed to appear. The counter to this mandate is that the Regulations allow the insurer to request an IME "when, and as often as, the Company may reasonably require". As the first IME was requested on August 8, 2016, in accordance with the time frames for requesting additional verification, it can be

argued that the denial of claim was timely in accordance with the no-fault regulations. Support for this argument can be found in the matter of Alev Med. Supply, Inc., v New York Cent. Mut. Fire Ins. Co., 2013 NY Slip Op 50258(U), 38 Misc. 3d 143(A) [App Term. 2<sup>nd</sup> Dept, 2013]. I have carefully reviewed the cases, along with the facts presented, and find that Alev Med. Supply, Inc., v New York Cent. Mut. Fire Ins. Co is not binding on the facts presented. Notably, the facts in Alev Med. Supply are different from that presented in this arbitration. Particularly, unlike the facts of this arbitration, in Alev. Med. Supply there was a requisite finding that the insurer had demonstrated that it had timely mailed the initial and follow-up IME requests. In the case of this arbitration, while it may be argued that there were requests for additional verification in the form of an EUO, that issue has been placed in contention by virtue of the fact that the letters were not signed for by the EIP. Moreover, as to any argument that the Respondent's request for additional verification which is dated August 19, 2016 served to toll the Respondent's time, this is likewise inconsequential. Notably, the Respondent had 15 business days to request additional verification, pursuant to 11 NYCRR 65-3.5(b). I take judicial notice that the 15<sup>th</sup> business date after receipt of this claim was August 11, 2016. This demand was 8 days late. Per 11 NYCRR 65-3.8(l) the deviation reduced the insurer's time to deny by 8 days. Pursuant to 11 NYCRR 65-3.6(b), if the requested verification was not provided to the insurer within 30 calendar days of the original request, the insurer was required to follow up within 10 calendar days. I take judicial notice that the 40<sup>th</sup> day after the first request was September 20, 2016. The record does not indicate that a second request was issued. Instead, on September 29, 2016 the Respondent issued a denial of benefits, thereby waiving any requests for additional verification which had been issued. Accordingly, as to either scenario, it does not comport with the facts in Alev Med. Supply because there is no evidence that the claim was properly tolled pursuant to 11 NYCRR 65-3.5(b) or 11 NYCRR 65-3.6(b). Additionally, in this case the first IME was scheduled to occur within 30 days of the date in which this claim was received.

After careful consideration I find that American Tr. Ins. Co. v Longevity Med. Supply, Inc., 2015 NY Slip Op 06761, 131 AD3d 841 (App. Div. 1<sup>st</sup> Dept 2015), stands for the proposition that the insurer must demonstrate compliance with the 30-calendar-day time frame set forth in 11 NYCRR 65-3.5(d) in order to demonstrate a duly scheduled IME, and in order to successfully defend a claim based on a failure to appear.

While I appreciate the position that an insurer may request IMEs as often as reasonably required, poignantly, American Tr. Ins. Co. v Longevity Med. Supply, Inc. addresses the dichotomy between the insurer's right to request medical examinations as often as it may reasonably require, and the strict time frames imposed by the Regulations. In American Tr. Ins. Co. v Longevity Med. Supply, Inc., 2015 NY Slip Op 06761, 131 AD3d 841 (App. Div. 1<sup>st</sup> Dept 2015), there was no dispute as to whether the insurer had mailed requests for attendance at IMEs, nor was there a dispute as to whether the assignor had failed to appear for IMEs. Rather, the entire dispute amounted to whether the insurer had scheduled the IME within 30 days of the prescribed verification form which was at issue. Still, the Court held that the 30-day period within which the IME must be scheduled is measured from the date that the Insurer receives the prescribed verification form, or the defense must fail as to that claim. In the dissenting opinion, Judge Friedman grappled with the tension between the 30-calendar-day requirement of 11 NYCRR 65-3.5(d) and the mandatory personal injury protection endorsement prescribed by 11 NYCRR 65-1.1(d)(1) (Conditions). Still, even in dissent, there was consensus that "the majority may be correct in taking the position that failure to schedule an IME within the time frame set by section 65-3.5(d) bars an insurer from denying coverage based on the insured's failure to appear for an IME."

As for the claim which forms the basis of this arbitration, it is undisputed that the prescribed NF-3 claim was received by the insurer on July 21, 2016. Further, I take judicial notice that the Respond scheduled the first IME for which it has disclaimed coverage, that being the August 23, 2016 and August 25, 2016 exams, to be held more than 30 days after receipt of the subject claim. Particularly, thirty days after the receipt of the claim fell on a weekend, and accordingly, the thirtieth day within which to schedule the IME, with concern to this claim, would have been on August 22, 2016. Accordingly, while there are certain claims not before me which may have been duly scheduled and properly denied, I find that the insurer is barred from denying coverage for the claim which forms the basis of this arbitration on the grounds of the EIP's failure to attend the August 23, 2016 and August 25, 2016 IMEs. This holding is based on a careful review of the herein referenced case law, and regulations. While I appreciate that the regulatory time frames are disharmonious with the Mandatory PIP Endorsement prescribed by 11 NYCRR 65-1.1(d)(1) (Conditions), the regulations and case law are clear. These regulations enumerate clear time frames for the reasonable scheduling of medical examinations. Simply stated, whether they think it fair or not, the insurer is well

aware that these time frames govern scheduling, and they may not disclaim coverage where they have not adhered to the same regulations to which they seek compliance. To the contrary, the law seems clear that a claim may not be disclaimed on the grounds of a non-appearance at an IME which has not been duly scheduled, and that in order to be duly scheduled all regulatory time requirements must be adhered to.

The New York State No Fault Regulations provide for various rights and responsibilities for both insurers and eligible injured parties and their assignees. For example, insurers are provided the right to seek additional verification including an examination under oath or medical examination. They are also tasked with certain responsibilities when requesting additional verification, including certain time limitations within which they must seek such verification. The New York State No Fault Regulations provide for various rights and responsibilities for both insurers and eligible injured parties and their assignees. For example, insurers are provided the right to seek additional verification including an examination under oath or medical examination. They are also tasked with certain responsibilities when requesting additional verification, including certain time limitations within which they must seek such verification. With regard to the issue of whether a denial based upon failure to provide verification in the form of a medical exam or EUO must be issued in a timely manner, there are conflicting lines of cases. The effect of a denial premised upon a failure to comply with an EUO or IME, and whether such a denial must be raised in a timely manner, differs dependent upon a split in the New York State Courts First, Second and Fourth Departments. In Unitrin Advantage Ins. Co. v. Bayshore Physical Therapy, PLLC, 82 A.D.3d 559, 918 N.Y.S.2d 473 (1st Dept. 2011), the First Department held that as a condition precedent to coverage, failure to comply with a request for a medical examination is sufficient to allow an insurance company the right to deny all claims retroactively to the date of loss, regardless of whether the denials were timely issued. However, as the Court has enumerated through the line of cases following Unitrin, although the failure of a person eligible for no-fault benefits to appear for a properly noticed EUO constitutes a breach of a condition precedent vitiating coverage, the insurer must still demonstrate that it has satisfied the foundational timeliness requirements of 11 NYCRR 65-3.5 (b) and 11 NYCRR 65-3.6 (b). *See, Unitrin Advantage Ins. Co. v All of NY, Inc.*, 2018 Slip Op 00810, 158 AD3d 449 (App Div. 1st Dept. 2018) In contrast, the Second Department in Westchester Medical Center v. Lincoln General Insurance Company, 2009 NY Slip Op 2598, 60 A.D.3d 1045, 877 N.Y.S.2d 340 (2 Dept. 2009), held that a denial of liability based upon failure to appear at an examination under oath, "does not serve to vitiate the

medical provider's right to recover no fault benefits or to toll the 30-day statutory period". Rather, the court found that a denial premised upon a breach of a policy condition is subject to the preclusion remedy. In so holding, the court cited to Central Gen. Hosp. v Chubb Group of Ins. Cos., 90 N.Y.2d 195 (1997) and Presbyterian Hosp. in City of N.Y. v Maryland Cas. Co., 90 NY2d 274 (1997), two cases decided on the same day by the New York Court of Appeals, and from which the preclusion rule emanates. The cases read in conjunction stand for the proposition that denial of liability based upon lack of coverage within the insurance agreement is distinguishable from disclaimer attempts based on a breach of a policy condition, in that a policy exclusion or policy condition is distinguishable from that in which no contractual relationship exists in the first instance. So, for example, a situation where an insurer disclaims based upon a policy exclusion, as in Presbyterian Hosp., supra, would be subject to preclusion, whereas a denial based upon the position that "the claimant, the vehicle, or the subject event was facially outside of the four corners of the insurance contract" ( Central Gen. Hosp. v Chubb, supra, citing e.g., Zappone v Home Ins. Co., 55 N.Y.2d 131) Most recently, the Fourth Department has weighed in on the issue, in the matter of Nationwide Affinity Ins. Co. of America v. Jamaica Wellness Med. P.C., 2018 NY Slip Op 07850 (App Div 4<sup>th</sup> Dept 2018), holding that the defense of failure to comply with an EUO is a defense which is subject to preclusion. With concern to this split in authority, I follow Westchester Medical Center v. Lincoln General Insurance Company and Nationwide Affinity Ins. Co. of America v. Jamaica Wellness Med. P.C. , and hold that unexcused failure to appear at a medical examination or examination under oath constitutes a breach of a policy condition, which is distinguishable from a lack of coverage in the first instance. Accordingly, respondent must demonstrate that it has timely issued its denial in order to proceed with its defense. *See generally*, Central General Hosp. v. Chubb, 90 NY2d 195 [1997]; Westchester Medical Center v. Lincoln Ins. Co., 60 AD3d 1045 [2d Dept., 2009]). As such, it is not enough to show that this EIP failed to appear for an IME on two occasions, the denial must timely relate to the two non-appearances.

Still, regardless of the department followed, there is a consensus between the two departments that the insurer must demonstrate that it has satisfied the foundational timeliness requirements of 11 NYCRR 65-3.5 (b) and 11 NYCRR 65-3.6 (b) in order to set forth a defense of failure to attend an independent medical examination or examination under oath. Additionally, both departments are in agreement that where an insurer requests an IME, the scheduling must comport with the requirements of 11



NYCRR 65-3.5(d). Naturally, an IME or EUO requests that has been scheduled prior to receipt of a claim is not subject to the notification requirements for verification under 11 NYCRR 65-3.5 and 3.6 and an insurer is well within its rights to request a pre-claim IME or EUO. *See, Hereford Ins. Co. v Lida's Med. Supply, Inc.*, 2018 NY Slip Op 03226, 161 AD3d 442 (App Div. First Dept. 2018). Indeed, 11 NYCRR 65-1.1 makes clear that an insurer may request IMEs when, and as often as it may reasonably require. Accordingly, an insurer may clearly request IMEs after a claim form is submitted as well. *See, Easy Care Acupuncture, P.C. v Praetorian Ins. Co.*, 2015 NY Slip Op 5124 (U), 49 Misc 3d 137 (A), (App Term. 1<sup>st</sup> Dept 2015). However, where an IME is requested after the receipt of a verification of claim form, the claims processing of the claim and subsequent scheduling of the IME is governed by 11 NYCRR 65-3.5 and 3.6.

The 30-calendar-day requirement set forth in 11 NYCRR 65-3.5(d) it is claim specific and is triggered by the receipt of a verification of claim form, a list of which are set forth in Appendix 13 to the No-Fault Regulations. As discussed herein, the issue of whether an IME has been duly scheduled in accordance with the 30-calendar-day requirement is a fact specific inquiry. Accordingly, it is wholly possible for an insurer to properly disclaim based on a failure to appear for an IME on one claim yet be barred from disclaiming on another by the same medical provider, and for the same assignor, based on whether it has complied with the aforementioned regulation. For example, in the case of *Success Rehab, PT, P.C. v Hereford Ins. Co.*, 2019 NY Slip Op 52031 (U), 66 Misc 3d 127(A) (App Term 2<sup>nd</sup> Dept., 2019) the Court reviewed 12 different bills from a medical provider. Citing *Neptune Med. Care, P.C. v Ameriprise Auto & Home Ins.*, 48 Misc 3d 139(A), 2015 NY Slip Op 51220[U] [App Term, 2d Dept, 11<sup>th</sup> & 13<sup>th</sup> Jud. Dists. 2015], the Court held that the insurer was not entitled to judgment on those claims which were denied based on the assignor's failure to appear for IMEs where the IME was not scheduled to be held within 30 days after the insurer received claims. Conversely, on the claims in which the IME had been scheduled to be held within 30 days of receipt of the claims, the court granted the Respondent judgment on the IME no-show defense. Similarly, in *Neptune Med. Care, P.C. v Ameriprise*, the Court reasoned that while a request for an EUO may be timely for certain claims, that it is not necessarily true that the verification will be timely for other bills, as the insurer must request verification in accordance with 11 NYCRR 65-3.5 (b). The Court further went on to reason that this would be the case even where an insurer had properly tolled the 30-day period within which to pay or deny the bills at issue, by timely requesting other verification pursuant to 11 NYCRR 65-3.8(a). In so reasoning the Court stated that "the

Regulations do not provide that such a toll grants an insurer additional opportunities to make requests for verification that would otherwise be untimely." The Court in Neptune Med. Care, P.C. v Ameriprise went on to hold that the untimely "EUO scheduling letters were nullities with respect to the bills at issue." Notably, this holding was made with the caveat that other claims for this provider and assignor may exist, though not before the court in this case, in which the EUO letters may have been timely scheduled and proper to sustain a denial on the grounds of failure to appear.

Neptune Med. Care, P.C. v Ameriprise makes clear that a toll for additional verification does not grant additional opportunities for post-claim IME or EUO demands that would otherwise be untimely. However, when the requests for an IME or EUO are properly scheduled prior to receipt of a claim, an insurer may preserve defenses based upon a failure to comply with these demands, while at the same time seeking other additional verification. Particularly, an insurer will be found to have a valid defense where a claim is tolled for other additional verification and ultimately timely denied on the grounds of the failure to attend the pre-claim IME. *See, Longevity Med. Supply, Inc. v Citiwide Auto Leasing*, 2017 NY Slip Op 51880(U), 58 Misc. 3d 142(A) (App Term, 2<sup>nd</sup> Dept 2017). Likewise, with concern to a pre-claim EUO demand, a timely scheduling letter can serve as an appropriate basis to toll those claims which are subsequently received. *See, Doctor Goldsshteyn Chiropractic, P.C. v ELRAC, Inc.*, 2017 NY Slip Op 50923(U), 56 Misc 3d 132 (A), (App Term. 2<sup>nd</sup> Dept, 2017). However, once a claim is presented the insurer is required to comply with the regulatory scheduling time frames in order to sustain a defense with regard to that particular claim. *See, Mapfre Ins. Co. of NY v Manoo*, 2016 NY Slip Op 04446, 140 AD3d 468 (App Div., First Dept., 2016).

As part and parcel of demonstrating compliance, and in order to succeed on a defense based on a failure to appear for an IME, the insurer must be able to demonstrate that the IME was scheduled to be held within 30 calendar days of the receipt of the specific claim at issue, in accordance with 11 NYCRR 65-3.5(d). *See, Thomas J. Tesi, M.S., D.C., P.C., Hereford Ins. Co.*, 2018 NY Slip Op 50252(U), 58 Misc. 3d 159(A) (App Term 2<sup>nd</sup> Dept. 2018). The requirement of timely compliance with scheduling period is claim specific and absent a showing of timely scheduling and mailing an insurer will have failed to demonstrate that an assignor failed to appear at duly scheduled IMEs. *See, Remedial Med. Care, P.C. v Park Ins. Co.*, 2018 NY Slip Op 50769 (U), 59 Misc 3d 147(A) (App Term, 2<sup>nd</sup> Dept. 2018) (*citing Stephen Fogel Psychological, P.C. v Progressive Cas. Ins. Co.*, 35 AD3d 720, 722 [2006]). As set forth in 11 NYCRR

65-3.5(d), in order for an insurer to demonstrate a duly scheduled IME, they must show that the first independent medical examination which was scheduled, was scheduled to be held within 30 days of receipt of the specific bills to which it has set forth the defense that an EIP failed to attend duly scheduled IMEs. *See, Irina Acupuncture, P.C. v Nationwide Affinity Ins. Co.*, 2017 NY Slip Op 51461(U), 57 Misc. 3d 146(A), (App Term, 2nd Dept, 2017). To that extent, even where the insurer is able to demonstrate that notices were properly mailed and that the EIP failed to appear, they must additionally demonstrate that the scheduling of the IMEs complied with the 30-calendar-day time frame which is set forth in 11 NYCRR 65-3.5(d). *See, American Tr. Ins. Co. v Clark*, 2015 NY Slip Op 06759, 131 AD3d 840 (App. Div. 1<sup>st</sup> Dept, 2015). Having reviewed the facts presented, I find that the Respondent has failed to demonstrate compliance with 11 NYCRR 65-3.5 (d) with concern to this claim, and accordingly, that judgment in favor of the Applicant is warranted.

## **FEE SCHEDULE**

As to the issue of fee schedule, where an insurer sets forth a defense based upon fee schedule they are required to come forward with competent evidentiary proof to support its fee schedule defenses. *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 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 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 curiam, 2006). That being said, an Arbitrator may take judicial notice of the Fee Schedule. *Kingsbrook Jewish Medical Center v. Allstate*, 61 A.D.3d 13 (2 Dept. 2009). In this matter the Respondent did not present evidence such as an affidavit by a fee coder, or other evidence, to demonstrate that the fees at issue exceed those authorized by the fee schedule. Respondent argues that judicial notice of the fee schedule should be taken, which supports its fee reduction. Applicant responds the billing at issue was rendered by a physical therapist, and that its charges are limited by virtue of the New York State Workers Compensation Fee Schedule to the amount of \$398.45. I take judicial notice of the New York State Workers Compensation Fee Schedule and concur with the Respondent's calculations. Accordingly, Applicant's claim is awarded as limited by the New York State Workers Compensation Fee Schedule as

follows: date of service June 7, 2016 through June 9, 2016 is limited to \$152.05; date of service June 13, 2016 through June 10, 2016 is limited to \$123.20; date of service June 27, 2016 through June 28, 2016 is limited to \$123.20.

## **HOLDING**

Based on a review of the aforementioned facts in evidence, I find that the Respondent has not demonstrated that the requests for IMEs were duly scheduled within 30-calendar-days of the subject claim as required by 11 NYCRR 65-3.5(d). Thus, as there may be other claims that are not before me for which the Respondent properly disclaimed coverage on these grounds, I find that the Respondent has failed to demonstrate a meritorious defense to this action. American Tr. Ins. Co. v Longevity Med. Supply, Inc., 2015 NY Slip Op 06761, 131 AD3d 841 (App. Div. 1<sup>st</sup> Dept 2015); American Tr. Ins. Co. v Clark, 2015 NY Slip Op 06759, 131 AD3d 840 (App. Div. 1<sup>st</sup> Dept, 2015). Based on the foregoing, Applicant's claim is granted as limited by the New York State Workers' Compensation Fee Schedule.

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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
	Northern Bronx Physical Therapy P.C.	06/07/16 - 06/09/16	\$182.40	Awarded: \$152.05
	Northern Bronx Physical Therapy P.C.	06/13/16 - 06/20/16	\$136.56	Awarded: \$123.20
	Northern Bronx Physical Therapy P.C.	06/27/16 - 06/28/16	\$136.56	Awarded: \$123.20
Total			\$455.52	Awarded: \$398.45

B. The insurer shall also compute and pay the applicant interest set forth below. 03/01/2020 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." It appears the intent of 65-3.9(c) was to start interest on the date of the request. Therefore, pursuant to N.Y. Comp. Codes R. & Regs. tit. 11, § 65-3.9 (2002), "Interest on overdue payments," the Respondent shall pay interest to the Applicant on the awarded overdue PIP benefit at a rate of two percent (2%) per month calculated on a pro rata basis using a thirty (30) day month, starting 03/01/20.

C. Attorney's Fees

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

As this matter was filed after February 4, 2015, this case is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the

applicant the attorney's fee, in accordance with the newly promulgated 11 NYCRR 65-4.6(d).

- 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, Eva Gaspari, 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)

Eva Gaspari

#### **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:**  
81cabe021c2798406b1e39f28b8fe6fa

### **Electronically Signed**

Your name: Eva Gaspari  
Signed on: 03/22/2021