American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

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| BL Pain Management PLLC (Applicant) | AAA Case No. | 17-19-1137-5717 |
| | Applicant's File No. | 00043413 |
| - and - | Insurer's Claim File No. | 1018882-04 |
| | NAIC No. | 16616 |
| American Transit Insurance Company (Respondent) | | |

**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-C.H.

1. Hearing(s) held on 03/31/2021
   Declared closed by the arbitrator on 04/23/2021

   Andrew Saraga from Drachman Katz, LLP participated in person for the Applicant

   R. Jacob Lamar from American Transit Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 762.53**, 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 claim was mailed to and received by Respondent and (ii) Respondent's denial of the subject claim was timely issued.

3. Summary of Issues in Dispute

   The record reveals that the Assignor-C.H., a 14-year-old female, claimed injuries as a passenger of a motor vehicle involved in an accident which occurred on 2/3/2018. Applicant seeks reimbursement forthe doctor's fee for a lumbar epidural steroid injection (LESI) and epidurography conducted on 4/17/2019. Respondent denied the claim based

on a lack of medical necessity per the results of the Independent Medical Evaluation (IME) performed by Dr. Michael Russ, M.D., effective 9/19/2018. The issues to be determined are 1) whether Respondent supported its medical necessity defense for the bill and, if so, 2) whether the services were medically necessary?

4. Findings, Conclusions, and Basis Therefor

Applicant seeks reimbursement forthe doctor fee for a LESI and epidurography. This hearing was conducted using the documents contained in the Electronic Case Folder (ECF) maintained by the American Arbitration Association. All documents contained in the ECF are made part of the record of this hearing and my decision was made after a review of all relevant documents found in the ECF 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.

**IME CUT-OFF**

Legal Standards for Determining Medical Necessity

Once applicant has established a prima facie case, the burden then shifts to respondent to establish a lack of medical necessity with respect to the benefits sought. *See*, Citywide Social Work & Psychological Services, PLLC v. Allstate Ins. Co., 8 Misc3d 1025A (2005). A denial premised on lack of medical necessity must be supported by competent evidence such as an IME, peer review or other proof which sets forth a factual basis and medical rational for denying the claim. *See*, Healing Hands Chiropractic, P.C. v. Nationwide Assur. Co., 5 Misc3d 975 (2004).

In evaluating the medical necessity of services with proof of each party, particularly where the conclusion is contradictory; consideration must be given to the evidentiary burdens. Respondent must prove first that the services were not medically necessary. The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment. Kingsborough Jewish Med. Ctr. v. All State Ins. Co., 61 A.D. 3d. 13 (2d. Dep't, 2009), *See also* Channel Chiropractic PC v. Country Wide Ins. Co., 38 AD 3d. 294 (1st Dep't, 2007). An IME doctor must establish a factual basis and medical rationale for his asserted lack of medical necessity for future health care services. *E.g.*, Ying Eastern Acupuncture, P.C. v. Global Liberty Insurance, 20 Misc.3d 144(A), (App. Term 2d & 11th Dists. Sept. 3, 2008). 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. West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc.3d 4(App. Term 2d & 11th Dists. Sept. 29, 2006). For an applicant to prove that

the disputed expense was medically necessary, it must meaningfully refer to, or rebut, respondent's evidence. *See*, Yklik, Inc. v. Geico Ins. Co., 28 Misc3d 133A (2010). The case law is clear that a provider must rebut the conclusions and determinations of the IME doctor with his own facts. Moreover, the Appellate Term, 2d, 11th & 13th Dists., stated: "Assuming the insurer is successful in satisfying its burden, it is ultimately plaintiff who must prove, by a preponderance of the evidence, that the services or supplies were medically necessary." Park Slope Medical and Surgical Supply, Inc. v. Travelers Ins. Co., 37 Misc.3d 19, 22 (App. Term 2d, 11th & 13th Dists. 2012). Where an IME report provides a factual basis and medical rationale for an opinion that services were not medically necessary, and the claimant fails to present any evidence to refute that showing, the claim should be denied, as the ultimate burden of proof on the issue of medical necessity lies with the claimant. *See* Insurance Law § 5102; AJS Chiropractic, P.C. v. Mercury Ins. Co., 22 Misc.3d 133(A), (App. Term 2d & 11th Dist. Feb. 9, 2002); Wagner v. Baird, 208 A.D.2d 1087 (3d Dept. 1994).

Application of Legal Standards

I note the validity of denials based upon negative IME findings have been recognized by several Courts. *See e.g.,* Innovative Chiropractics P.C. v. Mercury Ins. Co., 25 Misc3d 137 (App. Term 2d & 11th Dists. 2009); B.Y. M.D. , P.C. v. Progressive Casualty Ins. Co., 26 Misc3d 125 (App. Term 9th & 10th Dists. 2010). An IME report can be the basis of a termination of benefits if ultimately found to be persuasive. Whether an IME report is persuasive, and meets the carrier's burden is a factual decision, which must be rendered on a case-by-case basis. Therefore, when, as here, an insurer interposes a timely denial of claim that sets forth a sufficiently detailed factual basis and adequate medical rationale for the claim's rejection, the presumption of medical necessity and causality attached to the applicant's properly completed claim is rebutted and the burden shifts back to the claimant to refute the IME findings and prove the necessity of the disputed services and the causal relationship between the injuries and the accident. *See,* CPT Med. Servs., P.C. v. New York Cent. Mut. Fire Ins. Co., 18 Misc.3d 87 (App. Term 1st Dept.); A.Khodadadi Radiology, P.C. v. NY Cent. Mut. Fire Ins. Co., 16 Misc. 3d. 131 (A) (App Term 2d Dept.).

In support of its contention that further treatment was not medically necessary, Respondent relies upon the Physical Medicine and Rehabilitation (PMR) and acupuncture examination report of Michael Russ, M.D. conducted on 8/29/2018. Complaints at the time of the accident were pain in the neck and lower back radiating to the right hip. At the IME,the claimant stated her present complaints were of pain in lower back radiating to the right leg. The Traditional Chinese Medicine Examination revealed normal vitality, skin color, tongue examination, auscultation, and pulse. Qi and blood stagnation were resolved. There were no ashi points present. The physical examination of the cervical spine, lumbar spine, and right hip revealed a complaint of mild tendernesson palpation of the paravertebral musculature of the lumbar spine and reduced lumbar flexion. The remaining examination was within normal limits with no swelling, muscle spasm, or tenderness to palpation. There was full range of motion and negative orthopedic testing. On neurological examination, there were no sensory deficits or motor weaknessof theupper or lower extremities. Deep tendon reflexes of the upper and lower extremities were equal and symmetric bilaterally. Muscle strength in each

range was 5/5 bilaterally. There was no atrophy noted in the intrinsic muscles of the upper or lower extremities. Dr. Russ diagnosed resolved post cervical and lumbar spine sprains/strains and resolved post right hip sprain. Stagnation Qi and blood in UB and DUchannels of the cervical and lumbar spine have been resolved. Stagnation Qi and blood in ST and GB channels of the right hip have been resolved. Based on his evaluation, Dr. Russ determined "there was no objective evidence of any disability from a PM&R and acupuncture point of view. The claimant is capable of going to school and performing activities of daily living without any limitations". Dr. Russ notes that the Assignor reports "receiving physical therapy, chiropractic treatment, and massage therapy. From a physiatric and acupuncture viewpoint, there is no need for further physical therapy or any type of further formal treatment including acupuncture. Although there was decreased range motion and lumbar spine, this was due to suboptimal effort. It is my opinion that there is no need for diagnostic testing, household help, medical supplies, or special transportation". Based upon Dr. Russ's examination all PM&R and acupuncture No-fault benefits were denied effective 9/19/2018.

Though not raised by either party, I independently raised the issue at the hearing that the services in dispute, i.e., an LESI under epidurography, and related services, pertain to pain management treatment referred by Beleslav Kosharskyy, M.D., and conducted by Leonid Reyfman, M.D., both Anesthesiologists and pain management specialists. The services were denied premised upon Dr. Russ's IME, who determined there was no further need for PM&R and acupuncture treatment. The issue to be determined is whether claims for pain management services can be denied premised upon a PM& R/acupuncture IME that does not address or discuss the need for further pain management services?

Arbitrator Charles Sloane addressed a similar issue of whether an orthopedist can be the determining factor on whether to cut off PM&R or pain management treatment by virtue of an IME cut-off issued by only an examining orthopedist. In *Island Ambulatory Surgery Center and American Transit Insurance Company*, AAA Case No.: 17-19-1134-7644, issued 2/14/2021, Arbitrator Sloane wrote in a well-reasoned award, in pertinent part:

> *Further, applicant submits a series of complimentary awards on the issue of whether an orthopedist can be the determining factor on whether or not to cut off PMR or Pain Management treatment by virtue of an IME cut-off issued by ONLY an examining orthopedist. They submit the following awards by my colleagues:*
> *LR Medical v. Allstate, AAA Case # 17-17-1067-3970, awarded 12/20/18, Arbitrator Amanda R. Kronin, which found:*
>
> > *"The Assignor presented to Dr. Joseph Stubel performed on 6/23/16, with an IME cutoff date of 7/15/16. My review of the IME report of Dr. Stubel reveals an examination that was thorough and completely normal. However, Dr. Stubel specifically states that the Assignor has no need for further orthopedic treatment. He does not mention pain management. Applicant's records clearly state that he is a "Pain Management Specialist." This is stated in bold lettering at the top of his*

*letterhead. A claimant, aided by the presumption of medical necessity, need not produce a single bit of evidence until the insurer meets its considerable burden under Nir v. Allstate Ins. Co., Elmont Open MRI & Diagnostic Radiology, P.C. v. State Farm Mutual Automobile Ins. Co., 26 Misc.3d 1221(A), 907 N.Y.S.2d 99 (Table), 2010 N.Y. Slip Op. 50202(U) at 1, 2010 WL 457304 (Dist. Ct. Nassau Co., Michael A.Ciaffa, J., Jan. 27, 2010). Therefore, I find that Dr. Stubel's IME is insufficient to cutoff the treatment at issue herein."*

*Dynamic Surgical Center v. Allstate, AAA Case #17-18-1088-2924, Awarded 7/15/19, Arbitrator Stacey Erdheim, which found:*

*"Applicant argues that Respondent's denial cannot be upheld. Applicant argues that the general denial dated 11/9/17 stating that "All further orthopedic, physical therapy, massage therapy, physical medicine and rehabilitation and PAIN MANAGEMENT (emphasis added) will be denied effective 11/16/17" is defective because the IME doctor did not state that no further PAIN MANAGEMENT (emphasis added) will be denied.*

*Applicant argues that a claims examiner improperly inserted those words which are clearly beyond the scope of the IME. Additionally, Applicant makes the same argument with respect to the specific denial dated 1/29/18. Applicant argues that since the service in issue is for pain management services, it must be awarded. A reading of the IME report clearly shows that services for Pain Management were not discussed. Dr. Morrison stated that "from an orthopedic standpoint, there is no medical necessity for further treatment including physical therapy, diagnostic testing, special transportation, household help or durable medical equipment".*

*Island ASC v. Allstate, AAA Case #17-18-1107-5548, Awarded 6/11/20, Arbitrator Christopher Persaud, who found:*

*"I agree with Applicant. I find that a claims examiner inserting the words "Pain Management" is improper. I therefore find the denial defective with regard to continued pain management care. Based on a review of the evidence, I find that the denial herein references an IME that did not and could not cut off the pain management treatment at issue.*

*Therefore, Respondent's denial is improper as it adds language not used by its IME doctor in its denial. Additionally, Dr. Scarpinato's report does not recommend denial of benefits for pain management services. Therefore, the IME fails to set forth an adequate factual basis and medical rationale for the rejection of the disputed claim and thus is not sufficient to rebut the presumption of medical necessity attached to it. See East Coast Acupuncture Servs. P.C. v. American Tr. Ins. Co., 2007 NY Slip Op 50213(U) (App. Term 1 Dept., st Feb. 8, 2007);*

*Vladimir Zlatnick, M.D., P.C. v. Travelers Ins. Indemnity Co., 12 Misc. 3d 128A (App. Term 1 Dept. 2006).*
*Dr. Scarpinato does not sufficiently address essential factual issues in particular the EIP's subjective complaints of pain and/or tenderness throughout the examination. The EIP's subjective complaints cannot be summarily disregarded. See, Novacare Medical, PC v. Traveler's Property Casualty Ins. Co., 31 Misc. 3d 1205(A), 927 NYS 2d 817(Dist. Ct. Nassau Cty. 2011)."*

*I am faced with conflicting opinions concerning the medical necessity for the disputed testing and treatment herein. There are no legal issues to resolve. This dispute involves solely an issue of fact, that is, whether or not the testing and treatment was medically necessary. Resolution of that fact is determined by which opinion is accepted by the trier of fact. I have carefully studied the reports, documents and opinions for each side.*
*Therefore, despite the negative ORTHOPEDIC IME exam conducted by Dr. Nipper, as it relates to the cervical spine, though positive as it relates to the lumbar spine and right shoulder, and based upon the in-depth credible, specific and blistering rebuttal submitted by Dr. Reyfman as to the continued need for pain management treatment to the claimant's cervical spine, AND, in light of the above awards in which my colleagues found that an orthopedist is not qualified on the need for continued Pain Management treatment, I find that the applicant has met their burden of proof to rebut the IME cut-off of Dr. Nipper. I find that the records submitted by the applicant clearly show that the claimant had sufficient and multiple continuing symptoms, chronic cervical pain with both physical and neurological deficits noted prior to undergoing the procedure herein.*
*Therefore, I find that the treatment rendered herein was medically necessary and that the applicant is entitled to the sum of $1,548.90, in full reimbursement of the within claim.*

Arbitrator Amanda R. Kronin also addressed this issue in *NY Med and State Farm Mutual Automobile Insurance Company*, AAA Case No. 17-17-1070-9534, issued 1/14/2019. The well-reasoned award stated in pertinent part:

***Medical Necessity of Chiropractic Treatment from 4/19/17 through 6/13/17, timely deniedâ¯onâ¯an IMEâ¯byâ¯Dr. Michael Russ, M.D.***
*However, I find that said denial is defective based upon the proofs submitted. Dr.â¯Russ specifically states in his IME report: "from a physiatric point of view, there is no need for further PMR treatment including physical therapy….there is no need for further chiropractic treatment." However, Dr. Russ is a physiatrist not a chiropractor and I do not find that his IME is suffices to cut-off further chiropractic treatment. As the parties were in dispute regarding the validity of the IME cutoff with regard to chiropractic treatment, I afforded them the opportunity to upload supporting caselaw. The only case uploaded by the respondent was Allstate Social Work and Psychological Svcs PLLC v. Utica, 22 Misc.3d 723 (2008) which states: "there appears to be no case law addressing the point," and*

*refers to the Opinion Letter dated March 12, 2004, representing the position of the New York State Insurance Department. The Opinion Letter, uploaded by Respondent states: "there is no requirement in the regulation that a claim denial must be based upon a medical examination conducted by a health provider of the same specialty area as the treating provider. An arbitrator or court may consider the qualifications of the health provider performing the IME in determining the validity of a claim denial."*

*It well settled that a no-fault insurer is bound by the "four corners of the denial" and "must "stand or fall upon the defense upon which it based its refusal to pay." Todaro v.Geico General Insurance Company, 46 A.D.3d 1086, 848 N.Y.S.2d 393 (3rd Dept. 2007). Moreover, a denial must "promptly apprise the claimant with a high degree of specificity of the ground or grounds on which the disclaimer is predicated." General Accident Insurance Company v. Cirucci, 46 N.Y.2d 862, 414 N.Y.S.2d 512 (1979).*

*In this matter, from a review of Respondent's submission, Respondent's Explanation of Benefits (EOB) attempts to deny the chiropractic manipulation on the basis of a physiatric IME by Dr.â¯Russ. A timely denial alone does not avoid preclusion where said denial is factually insufficient, conclusory, vague or otherwise involves a defense which has no merit as a matter of law (see Nyack Hospital v. Metropolitan Property & Casualty Ins. Co., 16 A.D.3d 564, 791 N.Y.S.2d 658 (2d Dept. 2005).*

*Based on a review of the evidence, I find that the denial herein references an IME that did not and could not cut off the chiropractic treatment at issue. Therefore, Applicant's denial is improper as it lists an IME performed by a physician of a different specialty than the services at issue. See St. Vincent's Hospital & Medical Center v. New Jersey Manufacturers Ins. Co., 82 A.D.3d 871, 918 N.Y.S.2d 356 (2nd Dept. 2011).*

*11 NYCRR 65-4.5 (o) (1) (Regulation 68-D), reads as follows: The arbitrator shall be the judge of the relevance and materiality of the evidence offered and strict conformity to legal rules of evidence shall not be necessary. The arbitrator may question any witness or party and independently raise any issue that the arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department Regulations.*

*Therefore, based upon the above, Applicant is awarded $329.24 for the chiropractic treatment at issue. This is in full disposition of the claims herein.*

Dr. Russ is a physiatrist, which according to the website for the American Academy of PM&R,https://www.aapmr.org, PM&R physicians, also known as physiatrists, treat a wide variety of medical conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. PM&R physicians are medical doctors who have completed training in the specialty of PM&R, and may be subspecialty certified in Brain Injury Medicine, Hospice and Palliative Medicine, Neuromuscular Medicine, Pain Medicine, Pediatric Rehabilitation Medicine, Spinal Cord Injury Medicine, and/or Sports Medicine. In this case Dr. Russ was tasked with conducting a PM&R and acupuncture examination. Dr. Russ conducted a thorough examination, according to the PM&R/acupuncture standard of care and determined that those services were no longer

medically necessary. The result of the IME presented a cogent medical rationale as to why further *physical therapy and acupuncture benefits* were terminated in support of Respondent's defense. However, physical therapy and acupuncture require different training and expertise than the LESI referred by Dr. Kosharskyy and conducted by Dr. Reyfman, pain management specialists and anesthesiologists. As indicated in the rebuttal by Dr. Boleslav Kosharskyy, Dr. Russ did not comment on whether the Assignor required further pain management services in general or injections in particular and Respondent's reliance on this IME carries no weight in my opinion.

*In Allstate v. Utica Mut. Ins. Co.*, 22 Misc. 3d 723, 727-28 (N.Y. Civ. Ct. 2008), the Court held:

> *"The question then is may any health provider perform an IME of an eligible injured person or, as the endorsement appears to require, only a physician?"Though there appears to be no case law addressing the point, in an opinion letter dated March 12, 2004, the State Insurance Department answered the following question:*
> *"When a No-Fault eligible person is being treated by a chiropractor and the person's insurer has requested a medical examination (`IME') of that person in order to evaluate the medical necessity of the chiropractic services performed, must the medical examination be performed by a chiropractor, or may it be performed by a medical doctor?" (2004 Ops Gen Counsel NY Ins Dept No. 04-03-10.)*
> *In holding that an "insurer's medical examination of an eligible injured person to evaluate the medical necessity of health services provided by a chiropractor may be performed by a medical doctor, and need not be performed by a licensed chiropractor" ( id.) the Insurance Department stated "[t]here is no requirement in the regulation that a claim denial must be based upon a medical examination conducted by a health provider of the same specialty area as the treating health provider" ( id.). Implicit in the Insurance Department's interpretation, which is entitled to great deference unless it is "irrational or unreasonable" (Matter of John Paterno, Inc. v Curiale,88 NY2d 328, 333, quoting Matter of New York Pub. Interest Research Group v New York State Dept. of Ins.,66 NY2d 444, 448; cf. Matter of Gaines v New York State Div. of Hous. Community Renewal,90 NY2d 545, 548-549), is that an independent medical examination of an eligible injured person may be performed either by a physician, as the term is defined in the Education Law and used in the endorsement, or by any other licensed health provider selected by or acceptable to the insurer. It is for the court or an arbitrator to "consider the qualifications of the health provider performing the IME in determining the validity of a claim denial" (2004 Ops Gen Counsel NY Ins. Dept No. 04-03-10). A contrary conclusion would frustrate the core objective of the no-fault scheme by limiting the universe of health providers who could perform IMEs, thereby delaying the processing of no-fault claims (see Stephen Fogel Psychological, P.C. v Progressive Cas. Ins. Co.,35 AD3d 720).*

Pursuant to 11 NYCRR 65-3.8(b)(2) (2): Notwithstanding paragraph (1) of this subdivision, if the insurer has information which clearly demonstrates that the applicant is no longer disabled, the insurer may discontinue the payment of benefits by forwarding to the applicant a prescribed denial of claim form. As Dr. Russ did not discuss pain management services, I find that the results of Dr. Russ' examination did not present a cogent medical rationale as to why further pain management benefits were terminated in support of Respondent's defense. *See* Ying Eastern Acupuncture, P.C. v. Global Liberty Insurance, 20 Misc.3d 144(A), (App. Term 2d & 11th Dists. Sept. 3, 2008). Respondent's denial based on lack of medical necessity is not supported by a medical determination of a peer doctor or an Independent Medical Examination that discusses the services in dispute. Respondent failed to "support its lack of medical necessity defense" and the "burden of persuasion" did not therefore shift to applicant. *See generally*, Bronx Expert Radiology, P.C. v. Travelers Ins. Co., 2006 NY Slip Op 52116 (App. Term 1st Dept. 2006). In this case, Dr. Russ did not indicate that he specializes in pain management, was not asked to determine whether further pain management services were necessary and did not determine that the Assignor was no longer disabled from a pain management perspective. This is not an instance where a practitioner from a different specialty was asked to comment on the medical necessity of services outside of their specialty. Rather, Respondent is attempting to utilize a PM&R and acupuncture IME to deny pain management services, which were not discussed. Therefore, I hold that the denial is invalid and cannot be sustained as Dr. Russ was not asked and did not comment on whether the Assignor required further pain management treatment, including injections.

As such, Respondent has not sustained its defense. I find in favor of Applicant.

Respondent did not raise any fee schedule defenses in the record or at the hearing.

**CONCLUSION**

Accordingly, Applicant's claim is granted in the amount of $762.53 for the reasons set forth above. Any further issues raised in the hearing record are held to be moot and/or waived insofar as not raised at the time of hearing.

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** |
|---|---|---|---|---|
| | **BL Pain Management PLLC** | **04/17/19 - 04/17/19** | **$762.53** | **Awarded: $762.53** |
| **Total** | | | **$762.53** | **Awarded: $762.53** |

B. The insurer shall also compute and pay the applicant interest set forth below. 08/05/2019 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.

05/24/2021
(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:**
b841b10eb87e262f7ff04101da0c8d54

**Electronically Signed**

Your name: Eileen Hennessy
Signed on: 05/24/2021