

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

RES Physical Medicine & Rehab. Services
(Applicant)

- and -

LM General Insurance Company
(Respondent)

AAA Case No. 17-22-1236-3958

Applicant's File No. 22-33548

Insurer's Claim File No. 0468272070004

NAIC No. 36447

ARBITRATION AWARD

I, Fred Lutzen, 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: EIP or "Assignor"

1. Hearing(s) held on 11/29/2022
Declared closed by the arbitrator on 11/29/2022

Nicole Jones, Esq., from The Morris Law Firm, P.C. participated for the Applicant

Cheryl Krzywicki, Esq., from LM General Insurance Company participated for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,411.41**, 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 male EIP (first initial "E") was 68-years-old when he was injured as the driver in an automobile accident on 9/5/2021. He subsequently came under the care of Applicant, who seeks reimbursement of \$1,411.41 for unpaid balances after partial payments for services provided on 10/5/2021, 10/29/2021, 11/4/2021, and 11/5/2021.

Respondent partially paid and partially denied the claims citing fee schedule defenses.

The issues to be determined are whether the charges are within fee schedule allowances or were properly paid by Respondent.

4. Findings, Conclusions, and Basis Therefor

This case was decided based upon prevailing law, the written submissions of the parties to the American Arbitration Association, as contained in the MODRIA electronic file, and the oral arguments of the parties' representatives at the time of the hearing.

Counsel appeared at the hearing via Zoom video conference and there were no live witnesses.

Fee Schedule

Pursuant to *11 NYCRR, Section 65-3.16*, Measurement of no-fault benefits, (a) Medical expenses, (1), "Payment for medical expenses shall be in accordance with fee schedules promulgated under section 5108 of the Insurance Law and contained in Part 68 of this Title (Regulation 83).

The Workers' Compensation fee schedule, which is required by law and incorporated by reference into the Insurance Department Regulations, is of such sufficient authenticity and reliability that it may be given judicial notice, and it need not be submitted to the court. Z.A. Acupuncture, P.C. v. Geico Ins. Co., 33 Misc.3d 127(A), 939 N.Y.S.2d 745 (Table), 2011 N.Y. Slip Op. 51842(U), 2011 WL 4949646 (App. Term 2d, 11th & 13th Dists. Oct. 11, 2011); Lvov Acupuncture, P.C. v. Geico Ins. Co., 32 Misc.3d 144(A), 939 N.Y.S.2d 741 (Table), 2011 N.Y. Slip Op. 51721(U), 2011 WL 4424472 (App. Term 2d, 11th & 13th Dists. Sept. 16, 2011).

As such, I take appropriate evidentiary notice of the NY WC Fee Schedule, which includes consideration and reference to the CPT Assistant and/or CPT Code Book consistent with the holding in Global Liberty Ins. v. McMahon, 2019 NY Slip Op 03692 (App. Div. 1st Dept. 2019).

In support of its defenses, Respondent submitted a coding report by Melissa Simon, RN, CPC, dated 4/26/2022.

The disputed charges are broken down below, with Applicant's calculations versus Respondent's calculations. There are five (5) bills in dispute:

DOS	CPT	Billed	RESP Paid:	APPL Seeks:	Comments
10/5/2021	99072	20.00	10.00	10.00	PPE Materials
10/5/2021	76499	468.11	128.62	339.49	= 72052
10/29/2021	95913	525.96	0.00	525.96	Coder: \$115.83

11/4/2021	95913	525.96	0.00	525.96	Coder: \$115.83
11/5/2021	99072	20.00	10.00	10.00	PPE Materials
TOTALS:				= \$1,411.41	

CPT Code 99072

Applicant billed \$20.00 under CPT Code 99072. Respondent paid \$10.00 and denied the balance.

Respondent's explanation for paying \$10.00 towards this charge is stated as:

ALLOWANCE FOR THIS PROCEDURE WAS MADE AT THE USUAL AND CUSTOMARY AMOUNT FOR THIS GEOGRAPHICAL AREA.

The AMA stated that "addition of code 99072 for the additional supplies and clinical staff time required to mitigate transmission of respiratory infectious disease while providing evaluation, treatment, or procedural services during a public health emergency, as defined by law." <https://www.ama-assn.org/practice-management/cpt/covid-19-cpt-coding-and-guidance>.

I take appropriate evidentiary notice of these reliable websites.

Applicant stated in the evaluation reports that "[a]dditional supplies, materials, and clinical staff over and above those usually included in an office visit were needed to perform today's visit due to the COVID-19 Pandemic."

The NYS WC Fee Schedule, Introduction and General Guidelines states in its opening paragraph to "[p]lease refer to the CPT book for an explanation of coding rules and regulations *not listed in the schedule*" [emphasis added] and "CPT is a registered trademark of the American Medical Association (AMA)."

It should also be noted that between publications of the fee schedule and/or amendments, there are sometimes code changes. When this occurs, providers and coders refer to documentation outside of the fee schedule (the AMA's CPT Assistant updates, etc.) to determine the correct code and/or rate. This supports that a bill need not reflect a code that is specifically listed in the schedule. If a code is changed by the AMA's CPT

Assistant, then the correct code would not be in the schedule. Likewise, since the code is brand new due to the Public Health Emergency as defined by law, it would not be in the WC Fee Schedule

In prior cases deciding this same issue, I did not detail or document within the award a review of the supporting evidence from Applicant intended to justify the \$20.00 or \$30.00 charge.

Based on the evidence submitted, I find that Applicant has not established a cost of \$20.00 per patient for additional materials and labor covered under CPT Code 99072. Applicant does not provide information on what it costs per patient, per visit, or how many patients are seen per day. **The amount of no-fault patients seen per day would be necessary in order to determine the exact cost involved per visit.**

CPT Code 99072 is not a By Report [BR] code for which the verification process applies. I have now issued dozens of awards applying the correct analysis.

The Office of General Counsel issued OGC Op. No. 09-04-02, representing the position of the New York State Insurance Department, "For those medical providers, the directive states that billing and reimbursement will instead follow "the ground rules" set forth in the fee schedule. With respect to the reimbursement of medical providers, Ground Rule No. 4 of the Medical Fee Schedule reads in pertinent part as follows: [¶] Supplies and materials provided by the physician...over and above those usually included with the office visit or other service rendered may be charged for separately.... Payment shall not exceed the invoice cost of the item." The language of the ground rules may have changed since this OGC Opinion, but the directive that reimbursement shall not exceed the invoiced cost remained. Since codes 99070 and 99072 are not By Report [BR] codes, Respondent was not obligated to seek additional verification.

There is a prior arbitration award by Arbitrator Tasha Dandridge-Richburg. In **AAA Case No. 17-21-1204-9071**, Arbitrator Dandridge-Richburg stated, in part:

In addressing Respondent's argument in **AAA Case No.:17-21-1212-1526** that no-fault claims are reimbursed according to the NYS WC Fee Schedules and not the AMA. Arbitrator Lutzen wrote:

However, the NYS WC Fee Schedule, Introduction and General Guidelines states in its opening paragraph to "[p]lease refer to the CPT book for an explanation of coding rules and regulations not listed in the schedule" [emphasis added] and "CPT is a registered trademark of the American Medical Association (AMA)." [¶] It should also be noted that between publications of the fee schedule and/or amendments, there are sometimes code changes. When this occurs, providers and coders refer to documentation outside of the fee schedule (the AMA's CPT Assistant updates, etc.) to determine the correct code and/or rate. This supports that a bill need not reflect a code that is specifically listed in the schedule. If a code is changed by the AMA's CPT Assistant, then the correct code would not be in the schedule.

I find Arbitrator Lutzen's analysis to be well-reasoned on this issue. I hereby adopt his sound reasoning and conclude that CPT 99072 is reimbursable. However, in light of the fact that the code is not presently contained within the Fee Schedule, I find that an analysis of the proper relative value/fee for the service should be determined in a manner similar to when an Applicant has billed a "By Report" code. Under those circumstances Applicant must justify its fee. I find that Applicant fee of \$20 was excessive. The American College of Allergy, Asthma & Immunology reported on December 21, 2020 that the AMA asked the Center for Medicare and Medicaid Services (CMS) to reimburse code 99072 in the amount \$6.57. (<https://college.acaai.org/cms-declines-payment-for-code-99072/>). While CMS declined separate reimbursement for this code at that time, I find that \$6.57 is proper reimbursement for this expense.

It is important to note that the only reason I find CPT Code 99072 reimbursable is due to the AMA's implementation of the code and its guidance. I noted above that the NYS WC Fee Schedule refers providers and coders to the CPT Book, which is a registered trademark of the AMA. Arbitrator Dandridge-Richburg recently noted that the AMA provided further guidance and requested that the reimbursement rate should be \$6.57.

If we cannot adopt the rate of \$6.57 because *it was merely requested* by the AMA then we would not be able to adopt the implementation of the new code 99072 *merely because this was requested by the AMA*. However, this is the primary reason I find the code reimbursable.

As such, I agree with Arbitrator Dandridge-Richburg's analysis. Applicant is entitled to reimbursement of \$6.57 per date of service, as requested by the AMA - the implementer of the new code.

As stated above, the only similar code in the NYS WC Fee Schedules is code 99070, which is for additional materials as well. The General Ground Rules [4(a) and 4(b)] indicate it should "not exceed the invoice cost of the item, applicable taxes, and any shipping..."

For CPT Code 99072, however, this would logically include the additional labor costs as the materials alone would likely be under \$1.00 per patient.

However, as noted, Applicant did not supply any invoices.

While there are other arbitration awards that reference my own prior award of \$20.00 to this Applicant, I see that my analysis was contrary to the fee schedule and have since awarded \$6.57 in multiple dozens of subsequent cases. The master awards addressing this code do not discuss the fact that Applicant provided no invoices to support reimbursement as required by the General Ground Rules [4(a) and 4(b)].

Since Respondent paid \$10.00 for each date and no additional amount is owed.

CPT Code 76499

Applicant billed \$468.11 under CPT Code 76499. Applicant's Dr. Strut described a 'Ligament Laxity Analysis.' Applicant's submission describes the service as "Radiographic Digitizing," "Radiographic Spinal Analysis," and "X-ray digitalization."

Respondent's coder, Ms. Simon, began, "Per NYS Fee Schedule Introductions and General Guidelines, the Relative Value column lists the relative value units (RVU) used to calculate the fee amount for a service. Except as otherwise provided in the schedule, the maximum fee amount is calculated by multiplying the relative value units by the applicable conversion factor (\$46.77)."

Ms. Simon continued, in relevant part:

Per the NYS Fee Schedule, code 76499 is a By Report (BR) code, without an assigned RVU. Per General Ground Rule #3, it states: "*For any procedure where the relative value unit is listed in the schedule as "BR," the physician shall establish a relative value unit consistent in relativity with other relative value units shown in the schedule*". The physician did establish comparable codes, but codes from the medicine section of the NYS fee schedule. Medical records validate the following: DXD Cervical Radiographic Spinal Analysis (report) generated by a CRMA DXD software along with radiographic images of flexion, extension, and neutral lateral of the cervical spine.

Per AMA CPT coding guidelines, digital motion X-ray is reported with code 76120 - please refer to the April 2004 page 15 of the supplemental AMA CPT Assistant. Since the AMA CPT Assistant is a publication of the AMA noted in the AMA CPT Book which is clearly referenced in the Fee Schedule, it is used as an applicable coding resource.

Code 76120 is defined as: Cineradiography/videoradiography, except where specifically included, which has an established RVU of 2.81, as a fair & reasonable fee per Fee Schedule BR ground rules. [RVU = 2.81 with a 40/60 PC / TC split].

Please note the allowance is for both the TC and PC components of the same procedure.

Further per 2019 NYS fee schedule, Radiology, Ground Rule 3, Multiple Diagnostic Procedures, it states in part that multiple radiology procedures performed on the same day are paid as two contiguous parts with the charge at greater fee schedule plus 50% of the lesser fee.

Carrier has recommended allowing code 76499 at the allowance of codes 72040 and 76120 combined.

[emphasis from original]

Ms. Simon calculated the allowable rate to be \$173.98. This is the highest reimbursable code as CPT Code 76120 (changed from 76499) at \$131.42 [2.81 RVU x \$46.77 CF] and the lesser code was reduced by 50% (being contiguous) of the fee schedule allowance: CPT Code 72040 at \$42.56 [(1.82 RVU x \$46.77) x 50%].

Applicant relies on the rationale provided by Dr. Strut in his report justifying the use of code 76499 and the charge of \$468.11. Dr. Strut explained that Ligament Laxity Analysis is "a digitalized radiograph, is the studied comparison of flexion/extension/neutral images with assessment of impairment due to loss of motion and/or segment integrity. It is an additional tool that provides an objective clarification of the cause of the patient's pain to assess a proper treatment plan, including, regenerative injections, conservative treatment, and pharmacologic regimen." Dr. Strut urges that \$468.11 is the proper rate, which "allows compensation for the following: time to review, time to record and document specified measurements, time to formulate a diagnosis, time to calculate impairment, time for development of the medical treatment plan and the completion of the report. Including discussing with the patient, office visit. Based on the skill, time and equipment used for the Ligament Laxity Analysis, the most analogous code that the [RVU] can be utilized from are CPT codes: 95886 [needle EMG / nerve condition] 95903 [nerve conduction with F-wave study] 95904 [nerve conduction sensory].

Dr. Strut further states that use of CPT code 76120 for this analysis is not appropriate because "it doesn't compensate for time spent on the above-mentioned items."

While Dr. Strut makes a zealous argument for himself in support of further reimbursement, I am more persuaded by Respondent's coder as to CPT Code 76499.

The "time spent" argument is less persuasive when one considers that radiology codes have the technical component and professional component *splits* in the fee schedule. Moreover, Radiology Ground Rules 6 and 7 explain how the expert opinion, evaluation, competent diagnosis, and other integral services are included in the fee scheduled amount for particular radiological services. Respondent's coder is more persuasive when she points out that Applicant's comparable codes "do not seem to be consistent with the tests performed and documented." Applicant compared the radiology codes to medicine codes with much higher rates of reimbursement. The closest code in relativity to the procedure in question is 76120, as both the procedure and the code involve the comparison of radiological images. The codes referred to by Dr. Strut are not radiology codes but are normally used to report nerve tests and electromyography, procedures which bear no resemblance to the disputed analysis herein.

It is also noted that there are other codes in the fee schedule, e.g., 74328 and 75573, which both have much lower rates of reimbursement than the amount proposed by Dr. Strut, included "radiological supervision and interpretation" or "evaluation." The rate proposed by Dr. Strut is inconsistent with other similar units shown in the schedule.

I am more persuaded by Respondent's coder. The partial payment of \$143.12 is shy of Ms. Simon's recommendation by \$30.86, which is awarded.

Regarding CPT Code 95913, billed as "nerve conduction studies", Coder Simon stated:

Medical records do NOT validate a nerve conduction study.

For DOS 10/29/2021: The medical records validate "Cervical Plexus pain fiber NCS / Sensory Pain Fiber NCS Report":

- Bilateral C2 to C8 and T1 to T2 for only "Uv Amplitude".
- Device used is an AXON-II for the quantitative detection of neuro impairments by use of electrical stimulation of A-delta pain fibers... The nerve with the highest amplitude(s) indicate injury.

For DOS 11/4/2021: The medical records validate "Cervical Plexus pain fiber NCS / Sensory Pain Fiber NCS Report":

- Bilateral L1 to L5 and S1 to S2 for only "Uv Amplitude".
- Device used is an AXON-II for the quantitative detection of neuro impairments by use of electrical stimulation of A-delta pain fibers... The nerve with the highest amplitude(s) indicate injury.

This type of testing falls into a class of tests that are more akin to a quantitative sensory test and thus Category III codes 0106T-0110T and HCPC code G0255 offer reporting options. Note that category III codes 0106T-0110T and HCPC code G0255 are reported and reimbursed per extremity.

In support of the above, per AMA CPT coding guidelines as further explained by the Volume 21, Issue 5, May 2011 AMA CPT Assistant supplement, supports that sNCT testing is different and distinct from nerve conduction, velocity, amplitude, and latency. Sensory nerve conduction study recordings must be made from electrodes placed directly over the nerve to be tested. Category III codes 0106T-0110T offer valid reporting options for quantitative sensory testing. Further, HCPC code G0255 defined as current perception threshold/sNCT testing per limb, any nerve expressly includes current perception threshold/sNCT testing. Since the CPT Assistant is a publication of the AMA and clearly noted in the AMA CPT book which is referenced in the NYS fee schedule, it is used as an applicable resource.

Based on the above and the provider's medical records, code 95913 will be priced at The RVU of code 95907 at the conversion factor of a Chiropractor. The 1-2 studies under Code 95907 will be representative of the 2 upper extremities and the 2 lower extremities respective of the two DOS.

Comparable code 95907 pricing is: 19.02 RVU x \$6.09 (Chiropractic Region II Medicine). Per NYS fee schedule, Chiropractic Fee Schedule, Introduction and General Guidelines, Ground Rule 10 it states in part.. *A chiropractor may only use CPT codes contained in the chiropractic fee schedule...*

I am persuaded by Ms. Simon's affidavit as she makes reference to the AMA's CPT Assistant, which is an authoritative source for fee coding.

Applicant's test records include a description of the device used, the AXON-II Device, which states that the AXON-II is "approved by the FDA for 'the quantitative detection of various sensory neurological impairments...'." Since the device is used for "quantitative detection" of "sensory" impairments, I am not persuaded by Applicant's position that pfNCS and QST testing are not alike. This is not supported by the credible evidence.

Comparing the competing analyses, I find Ms. Simon's opinion more persuasive.

I have previously decided similar cases on a number of occasions. See, **AAA Case Nos. 17-18-1104-4649, 17-18-1103-7984, 17-17-1082-6734**, and others.

Arbitrator Rebecca Feder reached a similar result in **AAA Case No.: 17-15-1014-3990** (11/16/16). Arbitrator Feder relied on the analysis of Arbitrator Michael Rosenberger in **AAA Case No.: 17-15-1016-9201**. In his Award, Arbitrator Rosenberger indicated:

"In regard to fee schedule, I respectfully agree with my learned colleague Arbitrator Rhonda Barry's analysis as set forth in ... 17-14-9023-0826 (8./17/15):

Determining the appropriate fee schedule for the PFNCS is challenging as there is no specific workers compensation code for the services provided. Although applicant billed CPT 95904, it did not perform an NCV. In order to bill CPT 95904, applicant must specifically establish measurements of latency, amplitude and velocity. New York State Workers' Compensation Fee Schedule CPT 95904 specifically states "nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F wave study, sensory." The word "and" is of great significance. The statute mandates that all three conduction studies - amplitude and latency and velocity must be performed if a provider is to bill under this code. Applicant's ... report fails to establish that all three required criteria were in fact determined. The PFNCS report included in applicant's submissions notes only measurements [of] the amplitude. Latency and velocity are not factors.

The NCV (CPT 95904) is completely objective. As Arbitrator Skelton noted (...412011060587 ...), "NCV testing measures the velocity of nerve impulses traveling along the peripheral nerve. The testing performed in this case was sensory threshold testing, which is a study that tests the patient's perception of an electric shock applied to the skin. It is subjective in nature in that the patient reports that he/she has "perceived" a stimulus applied to the skin and involves no testing of nerve impulses and provides no measurement of any characteristic of nerve impulses." Further, while the testing results indicate amplitude, they do not establish measurements of latency or velocity ... Applicant opines that the PFNCS

is not dependent on patient judgment. However, in the first part of the test, the patient's response is used to determine a range of stimulus that causes the nerve fibers to fire; in short, whether or not the patient is in pain (this is subjective) ...

*Thus, it appears that the PFNCS objectifies the subjective portion of the test. Further, NCV testing is sub-percutaneous requiring the insertion of needles whereas the PFNCS simply requires the application of electrodes on the skin and not in or under it. The patient is required to alert the technician when the stimulation is felt. Initially, I find that applicant did not perform an NCV and billing under CPT 95904 was improper. The PFNCS exam is an unlisted procedure ("by report") for purposes of the ... fee schedule. As noted by Arbitrator Link in ... **412013083146** ..., fees that are "by report" must be justified by the provider to perform them. Allowing health service providers to bill for unspecified procedures at flat rates when there is no indication how those rates were arrived at that would contravene the legislative intent in enacting the no-fault system ...*

The Code descriptors contained in the [NYS] Workers' Compensation Fee schedule coupled with the CPT Assistant ... and medical records provided by applicant itself are sufficient to determine the appropriate fee schedule for PFNCS. The CPT Assistant recommends that Category III codes be used for reimbursement of the service. Category III codes are temporary codes identifying emerging technology "to evaluate the clinical efficacy and outcomes and collect unbiased data ... Category II codes 01016T - -11-T offer valid options for reporting the PFNCS ...

*Since the relative value for CPT 0110T is based on extremity and not the number of nerves, it cannot have the same relative value as CPT 95904. For purposes of determining proper reimbursement, the relative value of a code may be applied to those procedures and tests that are "by report." The code descriptor for CPT 0110T satisfactorily describes the test performed ... Until such time as a CPT code is established for the PFNCS, it would be unreasonable to categorize it under CPT 95904. CPT 0106T is for, "quantitative sensory testing ..., testing and interpretation per extremity; using touch, pressure stimuli to assess large diameter sensation; CPT 0110T using other stimuli ... to assess sensation. Electricity can certainly be considered other stimuli. Latency and velocity are not an issue. In accordance with the Category III codes billing is appropriately submitted for one unit of service for each extremity rather than each site tested. I find persuasive the reasoning of fellow arbitrators Feilich (**17-14-9023-6089**), Wolf (**412011053109**), Esposito (**412011053021**), Peters (**41011053019**), Melis (**41011061502**), Horowitz (**412010042797**) and Haskel (**412013124961**).*

I agree with the above analysis and methodology.

Arbitrator Drew M. Gewerz, decided AAA *Case No. 17-16-1050-2850* (decided on 3/21/18). Therein, he stated, in relevant part:

"...The services are billed under CPT code 95999. CPT code 95999 is an unlisted neurological or neuromuscular diagnostic procedure code that has a "By Report" value. The Applicant designated a value of \$72.83 per unit to the service.

The Respondent's position is that the Applicant's claim charges fees in excess of applicable law. Although it does not support its defense with substantive evidence, its failure is excused by this Arbitrator's past determinations in various prior arbitrations that CPT code 95999 is not the appropriate code to bill the disputed services. See e.g. AAA Case No. 17-16-1050-1926. Category III codes 0106T-0110T offer valid options for reporting quantitative sensory testing (QST), specifically, code 0110T ("Quantitative sensory testing (QST), testing and interpretation per extremity; using other stimuli to assess sensation"), and HCPCS code G0255 ("Current perception threshold/sensory nerve conduction test, (SNCT) per limb, any nerve"), expressly includes CPT/sNCT testing. Therefore, the Respondent is correct and either 0110T or G0255 should have been used to bill for this service. The services should have been reimbursed by extremity/limb under 0110T or G0255. As neither code has a Legislatively set relative value and the Respondent has not offered one, the Applicant is entitled to two (2) units for the two (2) extremities tested for a total of \$145.66."

This analysis has also been followed by many other Arbitrators, and I agree with their reasoning. A pf-NCS test is not an NCV, and Applicant should have calculated this consistent with the comparable Category III code for quantitative sensory testing, which is billed per limb.

However, since Respondent initially denied the claims outright, Applicant is awarded \$115.83 per test, or \$231.66.

Conclusion

Respondent's defense, that CPT Code 99072 is not reimbursable at \$20.00, is sustained. Respondent paid appropriately at \$10.00.

Respondent's defense that CPT Code 76499 shall be reimbursed at \$173.98 is sustained. The partial payment of \$143.12 is shy of the recommended amount. Therefore, Applicant is awarded \$30.86.

Respondent's defense that CPT Code 95913 shall be reimbursed at \$115.83, per extremity (and applying 95907), is sustained. Since Respondent did not issue payment, \$331.66 is awarded.

Having carefully considered the submissions of the parties, the relevant case law, and the arguments of respective counsel, I conclude that the preponderance of the credible evidence supports a partial finding in favor of both parties, as explained above.

Applicant is awarded \$362.52.

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
	RES Physical Medicine & Rehab. Services	10/05/21 - 11/05/21	\$1,411.41	Awarded: \$362.52
Total			\$1,411.41	Awarded: \$362.52

- B. The insurer shall also compute and pay the applicant interest set forth below. 01/24/2022 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); and OGC Op. No. 10-09-05 (interest accrues from date Applicant "*actually requests arbitration*" or commences a lawsuit). The Superintendent and the New York Court of Appeals have interpreted this provision to apply regardless of whether the particular denial at issue was timely. LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 217 (2009).

C. Attorney's Fees

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

Applicant is awarded statutory attorney fees pursuant to the no-fault regulations. *See*, 11 NYCRR §65-4.5(s)(2). The award of attorney fees shall be paid by the insurer. 11 NYCRR §65-4.5(e). Accordingly, "the attorney's fee shall be limited as follows: 20 percent of the amount of first-party benefits, plus interest thereon, awarded by the arbitrator or the court, subject to a maximum fee of \$1360." *Id.*

- 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 Onondaga

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

12/05/2022
(Dated)

Fred Lutzen

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:
03045b5ec458ad072cca1a78f19b430b

Electronically Signed

Your name: Fred Lutzen
Signed on: 12/05/2022