

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

NY Balance Acupuncture PC
(Applicant)

- and -

Maya Assurance Company
(Respondent)

AAA Case No. 17-22-1241-2819

Applicant's File No. LIP-16579

Insurer's Claim File No. 20085508

NAIC No. 36030

ARBITRATION AWARD

I, Meryem Toksoy, 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 (CV)

1. Hearing(s) held on 02/07/2023
Declared closed by the arbitrator on 02/07/2023

Lee-Ann Trupia, Esq. from Law Office of Ilya E. Parnas participated virtually for the Applicant

Arthur De Martini, Esq. from De Martini & Yi, LLP participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$319.20**, 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

In dispute is a claim by the Applicant, NY Balance Acupuncture, PC, as the assignee of a 22-year-old female who was injured as a passenger in a motor vehicle accident on 09-24-20.

Applicant seeks to be paid the **balance of \$319.20** for services that were provided from 09-28-20 to 11-05-20. This consists of **cupping, acupuncture, and an evaluation.**

Where applicable, I must decide:

- Whether to uphold Respondent's **fee schedule** defense.
- Whether Respondent has sustained its defense of a breach of a policy condition, namely the **failure of the Applicant to appear for an Examination Under Oath ("EUO")** that was scheduled for 11-25-20 and 12-09-20.

4. Findings, Conclusions, and Basis Therefor

The case was decided on the submissions of the parties as contained in the electronic file maintained by the American Arbitration Association and the oral arguments of the parties' representatives.

There were no witnesses.

DECISION FOR	DEFENSE/ISSUE	TOTAL	RESULT
CUPPING, PROVIDED FROM 09-28-20 TO 09-30-20, BILLED UNDER CPT 97799	FEE SCHEDULE	\$135.00	DENIED

OVERVIEW

Applicant billed this modality with the following By Report (BR) code, which can be found in the Physical Medicine section of the Medical Fee Schedule:

CPT 97799: *Unlisted physical medicine/rehabilitation service or procedure*

For each of the three (3) dates of services, the cupping was billed as two line item entries totaling \$90.00 (i.e., \$45.00 and \$45.00, respectively).

Respondent paid \$45.00 per session and denied the remaining balance for being in excess of the fee schedule.

LEGAL FRAMEWORK

The Fourth Amendment to 11 NYCRR 65-3, which is applicable to claims for medical services rendered on or after April 1, 2013, includes the following provision:

11 NYCRR 65-3.8(g)(1)(ii):

Proof of the fact and amount of loss sustained pursuant to Insurance Law section 5106(a) shall not be deemed supplied by an applicant to an insurer and no payment shall be due for such claimed medical services under any circumstances . . . for those claimed medical service fees that exceed the charges permissible pursuant to Insurance Law sections 5108(a) and (b) and the regulations promulgated thereunder for services rendered by medical providers.

This means that for those services rendered on or after April 1, 2013, a fee schedule defense is not subject to preclusion. Surgicare Surgical Associates v. National Interstate Ins. Co., 50 Misc.3d 85, 25 N.Y.S.3d 521 (App. Term, 1st Dept., Oct. 8, 2015), aff'g, 46 Misc.3d 736, 997 N.Y.S.2d 296 (Civ. Ct., Bronx Co., 2014).

To be clear, this provision does not change Applicant's prima facie burden. East Coast Acupuncture, P.C. v. Hereford Ins. Co., 51 Misc.3d 441, 26 N.Y.S.3d 441 (Civ. Ct. Kings Co. Feb. 9, 2016).

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

Once an applicant establishes its prima facie case, the burden of proof shifts to the insurer to come forward with admissible evidence demonstrating the existence of a material issue of fact. Amaze Medical Supply Inc. v. Eagle Ins. Co., 2 Misc.3d 128(A), 2003 N.Y. Slip Op. 51701(U)(App. Term, 2nd Dept, 2nd & 11th Jud Dists., 2003).

If the insurer asserts that the applicant's charges are excessive, it must come forward with competent supporting evidence. Continental Medical P.C. v. Travelers Indemnity Company, 11 Misc.3d 145(A), 2006 N.Y. Slip Op. 50841(U)(App Term, 1st Dept., 2006). In the absence of such a showing, the defense will fail. Id.

If the insurer succeeds in establishing that the amount charged for a particular service or supply is excessive, the burden will then shift to the applicant to demonstrate that the amount billed reflects a different interpretation of such schedule or an inadvertent miscalculation or error. Cornell Medical, P.C. v. Mercury Casualty Co., 24 Misc.3d 58, 884 N.Y.S.2d 558 (App. Term, 2nd Dept, 2nd, 11th & 13th Jud. Dists, May 22, 2009).

THE GENERAL GROUND RULE FOR BY REPORT (BR) ITEMS:

Procedures Listed Without Specific Relative Value Units

By report (BR) items: "BR" in the relative value column represents services that are too variable in the nature of their performance to permit assignment of relative value units. Fees for such procedures need to be justified "by report." Pertinent information concerning the nature, extent, and need for the procedure or service, the time, the skill and equipment necessary, etc., is to be furnished. A detailed clinical record is not necessary, but sufficient information shall be submitted to permit a sound evaluation. It must be emphasized that reviews are based on records; hence the importance of documentation. The original official record, such as operative report and hospital chart, will be given far greater weight than supplementary reports formulated and submitted at later dates. For any procedure where the relative value unit is listed in the schedule as "BR," the physician [chiropractor] shall establish a relative value unit consistent in relativity with other value units shown in the schedule. The insurer shall review all submitted "BR" unit values to ensure that relativity consistency is maintained. The general conditions and requirements of the General Ground Rules apply to all "BR" items.

- See: 2012 NY Workers' Compensation Medical Fee Schedule, Introduction & General Guidelines, General Ground Rule 3;
- See: 2012 NY Workers' Compensation Chiropractic Fee Schedule, Introduction & General Guidelines, General Ground Rule 2.

DECISION

With respect to CPT 97799, it was improper of the Applicant to use this code

According to the AMA, cupping is a modality which should be reported under CPT 97039. This is stated in the following CPT Assistant article:

CPT Assistant, Frequently Asked Questions: Physical Medicine and Rehabilitation, November 2016; Volume 26: Issue 11:

Question: Is code 97799, Unlisted physical medicine/rehabilitation service or procedure, the appropriate code to use to report a cupping procedure (suction cups) performed by an acupuncturist?

Answer: No, cupping is considered a modality (i.e., any physical agent applied to produce therapeutic changes to biologic tissue) and should be reported with code 97039, Unlisted modality (specify type and time if constant attendance). When reporting an unlisted procedure code, it is necessary to submit supporting documentation (e.g., procedure report)

along with the claim to provide an adequate description of the nature, extent, and need for the procedure; and the time, effort, and equipment necessary to provide the service.

There is no evidence to support Applicant's method of billing (ie, two line item entries per date of service)

In the following articles, the AMA clarifies how modalities should be reported:

CPT Assistant, *Medicine: Physical Medicine and Rehabilitation*, 97035 (Q&A), November 2010; Volume 20: Issue 11:

Question: How many times may CPT code 97035, Application of a modality to 1 or more areas; ultrasound, each 15 minutes, be reported if treating three body areas, such as the neck, wrist, and knee, on the same date of service?

*Answer: **Both the supervised modality codes (97010-97028) and the constant attendance modality codes (97032-97039) include language in their code descriptors that indicate "application of a modality to one or more areas." The constant attendance codes also have time indicated in their code descriptors (each 15 minutes). Therefore although the number of areas of application is not a consideration in the reporting of these constant attendance codes, the amount of time the provider spent in constant attendance with the patient providing the ultrasound would need to be indicated in order to support the number of units billed.***

For example, if hot packs are placed on two areas, the knee and cervical spine, code 97010, Application of a modality to 1 or more areas; hot or cold packs, is reported once for the patient encounter, despite the fact that two hot packs were placed. If an ultrasound is provided to the upper trapezius and the left lateral quadriceps, CPT code 97035 should be reported once for that patient encounter unless the provider documents to support that the time to provide ultrasound to two areas of the body would support the reporting of more than one unit. Payer policy may dictate how time factors into reporting procedures that have a time descriptor.

The AMA also provides guidance on how to determine the number of units that should be reported for time-based codes. This is addressed in the following articles:

CPT Assistant, *A Review of Reporting Time-Based Codes*, August 2014; Volume 24: Issue 8:

*A comprehensive understanding of the standards used in the measurement of time is crucial for appropriate code selection when reporting time-based CPT codes. To improve clarity and consistency, the standards for reporting time were more clearly defined in CPT 2011. Code-specific revisions were made throughout the code set (eg, changes to code descriptors, additional code range-specific guidelines, parenthetical statements that instruct users on the proper usage of time for specific codes). Furthermore, the addition of the 'time' subheading and corresponding guidelines in the Introduction of the CPT code book continues to provide a standard method of reporting for those codes that lack specific time instructions. Nevertheless, **the reporting of time-based codes has continued to challenge users. This article provides additional clarity with examples from multiple sections of the CPT code set and instructions that apply based on the specific code(s) used.***

...

Non-Code Specific Instructions

*In instances when time is the basis of code selection but code- or code range specific instructions in the guidelines, parenthetical instructions, or code descriptors do not provide specific increments of time, **refer to the time instructions given in the Introduction section of the CPT code book. According to the codebook's instruction, 'A unit of time is attained when the mid-point is passed. For example, an hour is attained when 31 minutes have elapsed (more than midway between zero and sixty minutes). A second hour is attained when a total of 91 minutes have elapsed. When codes are ranked in sequential typical times and the actual time is between two typical times, the code with the typical time closest to the actual time is used (CPT Pro 2014, page xv).'***

To illustrate further, when reporting Physical Medicine and Rehabilitation code 97110, Therapeutic procedure, 1 or more areas, each 15 minutes;** therapeutic exercises to develop strength and endurance, range of motion and flexibility, a time-based code can be reported for each 15-minute unit. Multiple units can be reported on a date of service for one or more procedures based on the aggregate amount of time spent by a qualified health care professional in direct contact with the patient. As with any 15-minute time-based code, it is important to recognize that a substantial portion of the 15 minutes must be spent in performing the pre-, intra-, and post- service work in order to report the time-based code. If only five minutes are spent performing the physical medicine service, the code should not be reported. **If a person is seen by a physician or qualified health care professional for therapeutic procedure exercises to develop strength, endurance, flexibility, motor control, and cardiopulmonary capacity related to performance of work tasks, and these

exercises are performed for 23 minutes of face-to-face time with the provider, the time guidelines in the Introduction would be the prevailing instruction for reporting the time-based code. Therefore, two units of code 97110 would be reported because 23 minutes is greater than the midpoint between 15 minutes and 30 minutes, qualifying for two units.

Coding Tip:

A minimum of eight minutes of therapeutic exercises is required to report code 97110. Services of less than eight minutes would not be reported.

CPT Assistant, Frequently Asked Questions: Medicine: Physical Medicine and Rehabilitation, March 2014; Volume 24: Issue 3:

Question: When reporting the Physical Medicine and Rehabilitation time-based codes (97110-97548), is it appropriate to report these services with modifier 52, Reduced Services, if less than 15 minutes was spent treating the patient, or when the treatment lasts less than eight minutes? When taking into consideration the following statement published in the August 2005 issue of CPT ® Assistant, 'For the purpose of determining the total time of a service, incremental intervals of treatment at the same visit may be accumulated,' how would the following scenario be reported: At 8 am, the therapist provides seven minutes of treatment described by code 97110; at 8:15 am, the therapist provides 23 minutes of treatment described by code 97112; and at 8:45 am, another eight minutes of treatment described by code 97110 was provided?

Answer: When codes do not contain specific language in the guidelines, code descriptors, or parenthetical statements other than an increment of time, the guidelines for time in the introduction section of the CPT code set provide the following instructions: 'A unit of time is attained when the mid-point is passed. For example, an hour is attained when 31 minutes have elapsed (more than midway between zero and sixty minutes). A second hour is attained when a total of 91 minutes have elapsed. When codes are ranked in sequential typical times and the actual time is between two typical times, the code with the typical time closest to the actual time is used (CPT 2014; page xv).' Therefore, in response to the first question and based on the time guidelines provided in the CPT code set, it is not appropriate to append modifier 52, Reduced Services, to codes 97110-97546. To further clarify, in order to report code 97110, Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility, a minimum of eight minutes of therapeutic exercises need to be performed. Services of less than eight minutes would not be reported.

Code 97110 is a time-based code that may be reported for each 15-minute unit. Multiple units may be reported on a date of service for one or more procedures based on the aggregate amount of time spent by a qualified health care professional in direct (one-on-one) contact with the patient. Therefore, for the scenario described in your question, it is appropriate to report one unit of code 97110 for the 15 minutes of aggregate time the services were performed. It is also appropriate to report two units of code 97112, Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities, because 23 minutes is greater than the midpoint between 15 minutes and 30 minutes, which qualifies the procedures for two units of code 97112.

CPT Assistant, FAQ - Medicine: Physical Medicine and Rehabilitation, June 2019; Volume 29: Issue 6:

Question: A flexion/distraction table is used by the provider (one-on-one) to increase a patient's range of motion (ROM) and flexibility while lowering the intrathecal pressure of the intervertebral disc for at least 8 minutes of face-to-face time. To achieve this, the patient's ankles are strapped to the table, the table is then distracted, and, depending on the specific deficits identified during ROM tests, the patient is either placed passively into flexion or extension, with lateral flexion to the right or left, or rotation to the left or right, or a combination of both. When the passive ROM is being performed, manual pressure is applied at S1 while also applying pressure to the lumbar spine starting at L5 to L1. The process is then repeated in reverse order beginning at L1 and working to L5. The procedure is performed 2 to 3 times and typically takes 10 to 15 minutes total time. Should this be reported with code 97110

*Answer: No, it would be incorrect to report **code 97110, Therapeutic procedure, 1 or more areas, each 15 minutes**; therapeutic exercises to develop strength and endurance, range of motion and flexibility, for the procedure described. The correct code to report is **97140, Manual therapy techniques** (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), **1 or more regions, each 15 minutes**. In addition, this is a **time-based code and for each minutes of therapy, at least 8 minutes of face-to-face therapy must be provided to be able to report one unit**. Manual therapy techniques include, but are not limited to, soft tissue mobilization; joint mobilization and manipulation; manual lymphatic drainage; manual traction; craniosacral therapy; myofascial release; and neural gliding techniques.*

Noted above, Applicant has not offered any evidence which serves to explain why the cupping was reported twice for each date of service (i.e., \$45.00 per line item resulting in a total of \$90.00).

As it was explained by the AMA in the foregoing CPT Assistant articles, the number of areas of application are NOT considered a factor for reporting either supervised or constant attendance modality codes.

Furthermore, the AMA clearly spells out how to report modalities that require constant attendance. Those are time-based codes. If the cupping performed on the assignor required constant attendance, there is nothing in the record to show that time was a factor in Applicant's billing method.

The amounts billed by the Applicant are excessive and do not conform to the ground rule for By Report (BR) services

The general ground rule for By Report (BR) items states in pertinent part:

For any procedure where the relative value unit is listed in the schedule as "BR," the physician [chiropractor] shall establish a relative value unit consistent in relativity with other value units shown in the schedule. The insurer shall review all submitted "BR" unit values to ensure that relativity consistency is maintained. The general conditions and requirements of the General Ground Rules apply to all "BR" items.

To reiterate, cupping is a modality that should be reported under CPT 97039.

Within the Physical Medicine section of the fee schedule, **CPT 97039 is listed among the family of codes that describe various modalities, of which there are two types: supervised and constant attendance.**

The Relative Value Units (RVUs) assigned to these codes are informative. They help to determine whether a provider's fee for an unlisted modality aligns with the ground rule for By Report (BR) items.

CODE	SUPERVISED MODALITIES (Does not require direct [one-on-one] patient contact.)	RVUs
97010	Application of a modality to 1 or more areas; hot or cold packs	2.37
97012	. . . traction, mechanical	2.71

97014	. . . electrical stimulation (unattended)	2.66
97016	. . . vasopneumatic devices	3.30
97018	. . . paraffin bath	2.71
97022	. . . whirlpool	2.62
97024	. . . diathermy (eg, microwave)	2.71
97026	. . . infrared	2.54
97028	. . . ultraviolet	2.54

CODE	CONSTANT ATTENDANCE MODALITIES (Requires direct [one-on-one] patient contact. Time based.)	RVUs
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes	2.45
97033	. . . iontophoresis, each 15 minutes	3.55
97034	. . . contrast baths, each 15 minutes	2.37
97035	. . . ultrasound, each 15 minutes	2.41
97036	. . . Hubbard tank, each 15 minutes	3.89

Placed at the end of this group, CPT 97039 is intended to be used for the billing of a modality that is not described by the other codes.

97039	Unlisted modality (specify type and time if constant attendance)	BR
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As a By Report (BR) item, CPT 97039 is essentially an empty shell. This means it is up to the provider to identify the service and to submit records to the insurer which are adequately detailed. In the event the procedure is one that requires constant attendance of the patient, the records should account for the time that was spent in performing the service.

With respect to the fee, the ground rule directs the provider to ascribe a value that is consistent in relativity to the value units that have been assigned to other codes.

In this case, Applicant's assessment for cupping does not fit within the spectrum (2.37 to 3.89 RVUs). Instead, it shows a deviation. Explained a bit further:

The fee for a service is generally calculated by multiplying the Relative Value Units (RVUs) by the Conversion Factor (CF).

$$\text{Relative Value Units (RVUs)} \times \text{Conversion Factor} = \text{Fee}$$

(For acupuncturists, reimbursement is calculated according to the Conversion Factors listed in the Chiropractic Fee Schedule. See 11 NYCRR §68.5 (b) [Regulation 83]; and Great Wall Acupuncture, PC v. Geico, 16 Misc.3d 23, 2007 NY Slip Op 27164 (App. Term 2nd & 11th Jud. Dists. 2007).)

Given this formula, it is possible to determine the RVUs that Applicant assigned to each line item entry. It is simply a matter of dividing the fee by the Conversion Factor:

$$\text{Fee} / \text{Conversion Factor} = \text{Relative Value Units (RVUs)}$$

RVUs assigned by the Applicant for each line item entry of \$45.00:

$$\$45.00 \text{ (Cupping)} / \$5.78 \text{ (Conversion Factor)} = \mathbf{7.79 \text{ RVUs}}$$

RVUs assigned by the Applicant for two line item entries of \$45.00, the sum of which is \$90.00 (billed for each date of service)

$$\$90.00 \text{ (Cupping)} / \$5.78 \text{ (Conversion Factor)} = \mathbf{15.58 \text{ RVUs}}$$

The results show that Applicant's charges are excessive and not consistent in relativity with other value units shown in the fee schedule.

Respondent's defense is sustained.

Applicant was reimbursed \$45.00 per date of service, which is the equivalent of 7.79 RVUs. Considering all of the above, I find that it is not entitled to any further payment. **This portion of the claim is denied in full.**

DECISION FOR	DEFENSE/ISSUE	TOTAL	RESULT
EVALUATION AND ACUPUNCTURE TREATMENT	FAILURE OF THE APPLICANT TO APPEAR FOR AN EUO ON 11-25-20 AND 12-09-20	\$184.20	DENIED

LEGAL FRAMEWORK

AN INSURER'S RIGHT TO REQUEST AN EUO, AND THE SHOWING REQUIRED TO ESTABLISH A BREACH OF THIS POLICY CONDITION:

The Mandatory Personal Injury Endorsement, outlined in 11 NYCRR §65-1.1 confers upon the insurer the right to request the eligible injured person or that person's assignee or representative to submit to examinations under oath as may reasonably be required.

An insurer may deny claims based on the failure to appear for an EUO as it constitutes a breach of a condition precedent to coverage. See Mega Billing, Inc. v. State Farm Fire & Casualty Company, 35 Misc.3d 145(A), 2012 N.Y. Slip Op. 51014(U) (App Term, 2nd, 11th and 13th Jud. Dists. 2012).

An insurer is *not* required to set forth any objective standards in the scheduling notices to specify the reason(s) why an EUO is being requested. Flow Chiropractic, P.C. v. Travelers Home & Mar. Ins. Co., 44 Misc.3d 132(A), 2014 NY Slip Op 51142(U)(App Term, 2nd Dept, 9th & 10th Jud. Dists, 2014); and where the record shows that no response was given to the EUO requests, any objections regarding those EUO requests will be deemed waived. Viviane Etienne Med. Care, P.C. v. State Farm Mut. Auto. Ins. Co., 35 Misc.3d 127(A), 2012, NY Slip Op 50579(U)(App. Term 2nd, 11th and 13th Jud. Dists. 2012).

To sustain the defense of a breach of a condition precedent, to wit, the failure to appear for an EUO, the insurer must demonstrate as a matter of law that it twice duly demanded an examination under oath, that the party twice failed to appear and that the insurer issued a timely denial. Interboro Ins. Co. v. Clennon, 113 A.D.3d 596, 979 N.Y.S.2d 83 (App. Div., 2nd Dept, 2014).

It should be noted, however, that if an EUO is rescheduled by mutual agreement, it does not constitute a failure to appear. DVS Chiropractic, P.C. v. Interboro Ins. Co., 36 Misc.3d 138(A), 2012 N.Y. Slip Op. 51443(U)(App Term, 2nd, 11th and 13th Jud. Dists., 2012).

SCHEDULING OF THE EUOS, TOLLING OF THE CLAIM(S):

An insurer has the right to make such a request before or after the claim (bill) is received. Stephen Fogel Psychological, P.C. v. Progressive Casualty Ins. Co., 35 A.D.3d 720, 827 N.Y.S.2d 217 (App. Div, 2nd Dept, 2006), *rev'g*, 7 Misc.3d 18, 793 N.Y.S.2d 661 (App Term, 2nd and 11th Dists., 2004).

Where the insurer requests an EUO after its receipt of the bill, the insurer must demonstrate that the initial and follow-up requests for verification were timely issued pursuant to 11 NYCRR §§65-3.5(b) and 65-3.6(b). Essential

Acupuncture Services, P.C. v. Ameriprise Auto & Home Ins. Co., 2012 N.Y. Slip Op. 52404(U) (App. Term 2nd, 11th and 13th Jud. Dists. 2012).

Specifically, as required by 11 NYCRR §65-3.5(b), the initial request for verification is to be made within 15 business days of receipt of the claim.

A request that is sent beyond the 15 business days is still valid so long as it is issued within 30 days from receipt of the claim; such a deviation will simply reduce the insurer's time to pay or deny by the same number of days. 11 NYCRR §65-3.8(l). See Nyack Hosp. v. General Motors Acceptance Corp., 8 NY3d 294, 2007 NY Slip Op 02439 (Court of Appeals, 2007).

On the other hand, if the initial request for verification is made beyond 30 days from receipt of the claim, the request will be deemed a nullity and the time to pay or deny will have expired. Compas Med., P.C. v. Farm Family Cas. Ins. Co., 2015 NY Slip Op 51631(U) (App. Term 2nd, 11th and 13th Jud. Dists. 2015).

Per 11 NYCRR §65-3.6(b), after 30 calendar days from the original request, the insurer has a regulatory duty to issue a second verification request within the following 10 calendar days. In the absence of any such second request for verification, the insurer's time to pay, deny or request verification will not be tolled. Westchester Med. Ctr. v. Allstate Ins. Co., 112 AD3d 916, 2013 NY Slip Op 08616 (App. Div., 2nd Dept, 2013).

DEMONSTRATING THE NON-APPEARANCES:

To establish the failure of the party to appear for duly scheduled EUOs, it is incumbent upon the insurer to submit proof by someone with personal knowledge of the non-appearance. Alrof, Inc. v. Safeco Natl. Ins. Co., 39 Misc.3d 130(A), 2013 N.Y. Slip Op. 50458(U)(App Term, 2nd, 11th and 13th Jud. Dists., 2013).

Certified transcripts which document the party's failure to appear for the EUOs have also been deemed sufficient. Active Chiropractic, P.C. v. Praetorian, 43 Misc.3d 134(A), 2014 NY Slip Op 50634(U)(App Term, 2nd, 11th and 13th Jud. Dists., April 7, 2014).

THE DENIAL:

Where an insurer denies liability based upon an alleged breach of a policy condition, to wit, the failure to appear for an Examination Under Oath, such defense must be preserved in a timely denial. Westchester Medical Center v. Lincoln General Insurance Company, 60 A.D.3d 1045, 877 N.Y.S.2d 340 (App. Div., 2nd Dept. 2009). Otherwise, it is subject to the preclusion remedy. Id. Citing to Central General Hospital v. Chubb Group of Ins. Cos., 90 N.Y.2d 195, 659

N.Y.S.2d 246 (Court of Appeals, 1997). See also Nationwide Affinity Ins. Co. of America v. Jamaica Wellness Medical, P.C., 167 A.D.3d 192 (App. Div., 4th Dept., Nov. 16, 2018).

DECISION

The evidence offered by the Respondent qualifies in all respects. The record demonstrates that Respondent duly requested the Applicant's appearance at an EUO, that the Applicant twice failed to appear, and that as a result of failing to comply with a condition precedent to coverage, Respondent issued a timely and proper disclaimer predicated on the breach.

Accordingly, after careful consideration of the submitted documents, I find that Respondent has sustained its burden. Applicant is not entitled to any payment as it relates to this defense.

Note: CPT Assistant is a source which must be considered when evaluating a claim for No-Fault benefits. Matter of Global Liberty Ins. Co. v. McMahon, 172 AD3d 500, 2019 NY Slip Op 03692 (App. Div., First Dept., May 9, 2019).

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 claim is DENIED in its entirety

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of NY
SS :
County of Nassau

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

03/14/2023
(Dated)

Meryem Toksoy

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:
6da4e90d3df90a42b3d6bfb64e7db4d4

Electronically Signed

Your name: Meryem Toksoy
Signed on: 03/14/2023