

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Bay Medical, P.C.
(Applicant)

- and -

Allstate Property and Casualty Insurance
Company
(Respondent)

AAA Case No. 17-22-1234-4508

Applicant's File No. 86331

Insurer's Claim File No. 0632799929 2SJ

NAIC No. 17230

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-A.P.

1. Hearing(s) held on 05/09/2023
Declared closed by the arbitrator on 05/09/2023

Damin Toell from Law Offices of Zara Javakov, Esq. P.C. participated virtually for the Applicant

John Pallatianos from Law Office Of Lawrence & Lawrence participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,174.84**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant amended the amount in dispute from the original amount of \$1,174.84 to \$1,158.24. Dates of service 7/26/2021 (\$8.81) and 11/16/2021 (\$7.79) were withdrawn with prejudice.

Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

The record reveals that the Assignor-A.P., a 41-year-old male, claimed injuries as the driver of a motor vehicle involved in an accident which occurred on 7/10/2021. Applicant seeks reimbursement for an office visit, a physical therapy evaluation,

physical therapy, and COVID supplies conducted from 7/26/2021 through 11/9/2021. There is no denial for the bill for dates of service 8/17/2021 through 9/2/2021 (\$513.60) in the record. Respondent sought verification of the claims for dates of service 7/26/2021 (\$218.76) and 7/29/2021 through 8/13/2021 (\$410.88). The bill for date of service 11/9/2021 was partially denied premised upon the applicable fee schedule. The issues for determination are 1) whether this arbitration is premature based on outstanding verification, 2) whether Applicant has established a prima facie entitlement to reimbursement for the bill for dates of service 8/17/2021 through 9/2/2021 and 3) whether Applicant billed in accordance with the applicable fee schedule?

4. Findings, Conclusions, and Basis Therefor

Applicant seeks reimbursement for an office visit, a physical therapy evaluation, physical therapy, and COVID supplies. 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 held via Zoom.

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.

Legal Framework - Tolling of claims

The general rule regarding payment of claims is set forth in 11 NYCRR §65-3.8(c), which states that "within 30 calendar days after proof of claim is received, the insurer shall either pay or deny the claim in whole or in part." No-Fault benefits are overdue if not paid within 30 calendar days after the insurer receives proof of claim, which shall include verification of all of the relevant information requested pursuant to 11 NYCRR §65-3.5. 11 NYCRR §65-3.8(a). As such, a claim need not be paid or denied until all demanded verification is provided. *See Nyack Hospital v. General Motors Acceptance Corp.*, 27 A.D.3d 96, 808 N.Y.S.2d 399 (2d Dept. 2005), *mod'd on other*, 8 N.Y.3d 294, 832 N.Y.S.2d 880 (2007).

OUTSTANDING VERIFICATION

Legal Standard

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

11 NYCRR §65-3.5(b), Claim procedure states: "Subsequent to the receipt of one or more of the completed verification forms, any additional verification required by the insurer to establish proof of claim shall be requested within 15 business days of receipt of the prescribed verification forms. Any requests by an insurer for additional verification need not be made on any prescribed or particular form."

11 NYCRR §65-3.6(b), Verification requests states: "At a minimum, if any requested verifications has not been supplied to the insurer 30 calendar days after the original request, the insurer shall, within 10 calendar days, follow up with the party from whom the verification was requested, either by telephone call, properly documented in the file, or by mail. At the same time the insurer shall inform the applicant and such person's attorney of the reason(s) why the claim is delayed by identifying in writing the missing verification and the party from whom it was requested".

NYCRR §65-3.5(c) mandates that the insurer is entitled to receive all items necessary to verify the claim directly from the parties from whom such verification was requested. The insurer has 15 business days from the date it receives the prescribed verification forms to seek additional verification from an Applicant.

Further, 11 NYCRR §65-3.8(l) states:

For the purposes of counting the 30 calendar days after proof of claim, wherein the claim becomes overdue pursuant to section 5106 of the Insurance Law, with the exception of section 65-3.6 of this subpart, any deviation from the rules set out in this section shall reduce the 30 calendar days allowed.

Thus, a request for additional verification pursuant to 11 NYCRR §65-3.5(b) 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).

The obligation to pay or deny a claim is not triggered until the insurer has received all of the relevant information that was requested. *Hospital for Joint Diseases v. State Farm Mut. Auto. Ins. Co.*, 8 AD3d 533, 2004 NY Slip Op 05413 (App. Div., 2 Dept., 2004).

In addition to the above, the Fourth Amendment to 11 NYCRR 65-3, which is applicable to claims for medical services rendered on or after April 1, 2013, introduced a provision ([§65-3.5(o)] that sets a time frame for an applicant to respond to an insurer's verification request(s). In pertinent part, the provision states the following:

An Applicant from whom verification is requested shall, within 120 calendar days from the date of the initial request for verification, submit all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply. The insurer shall advise the applicant in the verification request that the

insurer may deny the claim if the applicant does not provide within 120 calendar days from the date of the initial request either all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply. 11 NYCRR §65-3.5(o).

In relation to this new provision, 11 NYCRR §65-3.8(b)(3) was amended so as to confer upon the insurer the right to deny a claim for non-compliance with §65-3.5(o). In pertinent part, the amendment to §65-3.8(b)(3) states the following:

[A]n insurer may issue a denial if, more than 120 calendar days after the initial request for verification, the applicant has not submitted all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply, provided that the verification request so advised the applicant as required in section 65-3.5(o)...

Analysis

Applicant seeks reimbursement for an office visit, physical therapy, and COVID supplies conducted on 7/26/2021 (\$218.76) and 7/29/2021 through 8/13/2021 (\$410.88). Respondent indicates that the claim is premature as Applicant failed to comply with Respondent's verification requests.

Respondent relies on its initial and follow-up verification requests, dated 9/28/2021 and 11/5/2021, issued to Applicant for the above referenced bills. Respondent requested:

We are in receipt of your bill for services rendered to the above patient. Please be advised the bill is being delayed pending the receipt and completion of the information noted below.

...

- 1. A letter of medical necessity for services rendered;*
- 2. The identity of the health care provider who referred the patient to the applicant;*
- 3. Name and license(s) of all person(s) that provided and/or supervised (if applicable) each service/test to the above patient, including the treating healthcare providers, and technicians or assistants;*
- 4. Place of service and address where each of the billed-for services were provided;*
- 5. W-2 and/or 1099 or other verifiable proof concerning the employment status of each of the individuals performing the billed-for services;*
- 6. To the extent not already provided, the complete medical file, including but not limited to any medical reports, medical records, studies, notes, test results, medical, surgical (pre and post-operative) and anesthesiology records and reports relating to any procedures, patient history, diagnosis and evaluation relating to the billed -for services prepared by applicant;*

- 7. Any medical reports, narratives, letters of medical necessity relating to any referrals made by any health care provider to the applicant that resulted in the performance of the billed-for services, surgery and/or any procedure;*
- 8. Any correspondence and medical reports to any referring health care provider relating to any services, surgery and/or procedure performed on the patient that is the subject of the billed -for services;*
- 9. The identity of any health care provider to whom the applicant referred the patient;*
- 10. Names and addresses of all individuals and entities with whom the applicant has entered into agreements for the purchase, lease, repair and/or maintenance of medical equipment. To the extent applicable, please provide copies of any such agreements;*
- 11. Names and addresses of all individuals and entities with whom the applicant has entered into agreements for the purchase, lease, sub-lease, licensing or rental of office or clinical space. To the extent applicable, please provide copies of any such agreements;*
- 12. Names and addresses of all individuals and entities with whom the applicant has entered into agreements for the provision of advertising, marketing, or public relations services; To the extent applicable, please provide copies of any such agreements;*
- 13. Names and addresses of all individuals and entities with whom the applicant has entered into agreements for the provision of management or consulting services. To the extent applicable, please provide copies of any such agreements;*
- 14. Names and addresses of all individuals and entities with whom the applicant has entered into agreements for the provision of accounting services. To the extent applicable, please provide copies of any such agreements;*
- 15. Copies of all fair market value opinions or valuation reports obtained by the applicant in connection with any agreement disclosed in your response to Request No. 10-14 above; and*
- 16. All paperwork regarding the formation, purchase and/or transfer of any business interests with respect to the applicant, including but not limited to ownership agreements, corporate resolutions, correspondence, certificates of incorporation, annual reports and receipts for filing.*

On each verification request Respondent advised Applicant of the following: As per Regulation 68 Section 65-3.5(o), the insurer may deny a claim if an applicant does not provide within 120 calendar days from the date of the initial request all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply. This shall not apply to a prescribed form (NF-Form) as set forth in Appendix 13 of this Title, medical examination request, or examination under oath request.

Applicant submits a copy of Applicant's response and objection letter, dated 11/8/2021, which states in pertinent part:

Dear Claim Adjuster:

Based on your request, which is similar to all claims. We reply with following documentation:

1. All necessity and referral prescribed and indicate by evaluations.
2. N/A
3. Provided
4. 2273 65th Street , Brooklyn NY 11204
5. Provided
6. Provided
7. Provided
8. Provided
9. Provided
10. Lease agreement -Provided
11. N/A
12. N/A
13. N/A
14. N/A
15. N/A
16. N/A

Sincerely,(Billing Dept.)

Applicant argued at the hearing of this matter that Respondent's defense should fail as it replied to Respondent's request. Respondent argued that the verification remains outstanding.

Applicant's prima facie case and the timeliness of the Respondent's verification requests were not disputed by the parties at the hearing.

The issue presented here is whether Applicant has established that they responded to Respondent's requests. Applicant submitted a response, dated 11/8/2021, which, for questions numbered 3 and 5-10, indicated that there were documents attached, none of which have been submitted to the record, including, the "Name and license(s) of all person(s) that provided and/or supervised (if applicable) each service/test to the above patient, including the treating healthcare providers, and technicians or assistants", "W-2

and/or 1099 or other verifiable proof concerning the employment status of each of the individuals performing the billed-for services", the medical file, and the lease agreement. There is no proof that these documents were provided to Respondent with the verification response.

Applicant indicated that the information requested in Respondent's verification requests numbered 3 and 5-10 were in their possession and provided to the Respondent. I find that the requests numbered 3 and 5-10, including a letter of medical necessity, names and license(s) of all person(s) that provided and/or supervised (if applicable) each service/test to the above patient, including the treating healthcare providers, and technicians or assistants", "W-2 and/or 1099 or other verifiable proof concerning the employment status of each of the individuals performing the billed-for services", the medical file, and the lease agreement, constitute a reasonable verification request to which Respondent is entitled. The evidence shows that a proper verification request and follow-up have been made for the bills and that to date, same was never returned. Applicant chose not to provide the requested documentation in response to the verification requests within 120 days and risked dismissal in the event Respondent denied the claim. Applicant has not indicated that the requested verification was not in their control or possession, provided reasonable justification for the failure to provide the requested documentation, or provided proof that Applicant requested Respondent to reconsider the denial based upon a reasonable justification. In fact, Applicant indicated that they were providing the information and did not provide the documentation. The Appellate Term, Second Department has repeatedly held that failure to respond to verification requests shall result in a determination that the claim is premature (in claims prior to the April 1, 2013 amendment to the Regulations) or result in dismissal of the claims premised on the 120-day rule. *See SK Prime Medical Supply, Inc. v. Citiwide Auto Leasing, Inc.*, 2018 N.Y. Slip. Op 50734 (U), Appellate Term, 2nd Dept., May 18, 2018. *See also City Care Acupuncture, P.C. v Allstate Prop. & Cas. Ins. Co.*, 2017 NY Slip Op 51839(U)(App. Term 2d Dept. 2017).

The verification requests contain the requisite language from 11 NYCRR §65-3.5(o), advising the Applicant that the claim may be denied "if the applicant does not provide within 120 calendar days from the date of the initial request either all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply." Respondent chose not to deny this claim. As such, verification remains outstanding, this arbitration is premature as to these bills, and the claims for dates of service 7/26/2021 (\$218.76) and 7/29/2021 through 8/13/2021 (\$410.88) are dismissed without prejudice.

Prima Facie

Applicant seeks reimbursement for the bill for dates of service 8/17/2021 through 9/2/2021 (\$513.60) for physical therapy and COVID supplies. There is no denial in the ECF for this bill.

An Applicant establishes prima facie showing of entitlement to No-Fault benefits under Article 51 of the Insurance Law by "submitting evidence that payment of no-fault benefits is 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).

Pursuant to the Mandatory Personal Injury Protection Endorsement contained in 11 NYCRR§65-1.1, one of the conditions for establishing eligibility for No-Fault benefits is the submission of written proof of claim within 45 days after the date of service. Specifically, it states:

Proof of Claim; Medical, Work Loss, and Other Necessary Expenses. In the case of a claim for health service expenses, the eligible injured person or that person's assignee or representative shall submit written proof of claim to the Company, including full particulars of the nature and extent of the injuries and treatment received and contemplated, as soon as reasonably practicable but, in no event later than 45 days after the date of services are rendered. The eligible injured person or that person's representative shall submit written proof of claim for work loss benefits and for other necessary expenses to the Company as soon as reasonably practicable but, in no event, later than 90 days after the work loss is incurred or the other necessary services are rendered. The foregoing time limitations for the submission of proof of claim shall apply unless the eligible injured person or that person's representative submits written proof providing clear and reasonable justification for the failure to comply with such time limitation.

Within 30 calendar days after proof of claim is received, the insurer shall either pay or deny the claim in whole or in part. 11 NYCRR §65-3.8(c).

A Denial of Claim form (NF-10) is sufficient to demonstrate receipt. Eagle Surgical Supply, Inc. v. Allstate Ins. Co., 42 Misc 3d 145(A), 2014 NY Slip Op 50343(U)(App. Term, 2 Dept, 2, 11, & 13 Jud Dists., 2014).

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

Generally, proof that an item was properly mailed gives rise to a rebuttable presumption that the item was received by the addressee. New York and Presbyterian Hospital v. Allstate Insurance Company, 29 A.D. 3d 547 (N.Y. App. Div. 2 Dept. 2006) quoting Matter of Rodriguez v Wing, 251 A.D.2d 335 (App. Div. 2 Dept. 1998).

New York law allows that presumption to be "rebutted by admissible evidence that the document was not mailed, was received late, or was never received." Isacson v. N.Y. Organ Donor Network, 405 F. App'x 552, 553 (2d Cir. 2011) (summary order) (*citing* Sherlock v. Montefiore Med. Ctr., 84 F.3d 522, 526 (2d Cir. 1996); *see also* Vita v. Heller, 467 N.Y.S.2d 652, 653 (App. Div. 1983).

Having reviewed the evidence, I find that Applicant has established its prima facie burden as to the bill for dates of service 8/17/2021 through 9/2/2021 (\$513.60) as Applicant submitted proof of mailing in the form of PS Form 3877 certificate of mailing, which establishes Applicant mailed the bill to Respondent; accordingly, a presumption arises that the NF-3 was received by the insurer. *See, Viviane Etienne Medical Care, P.C. v. Country-Wide Ins. Co.*, 25 N.Y. 3d 498, 508-509 (2015). The certificate of mailing lists Applicant as the sender, Respondent as the addressee, the Assignor's name, dates of service, the amount in dispute, and services rendered. The certificate of mailing is signed for as received by an employee of United States Postal Service (USPS) and is postmarked. The proof of mailing establishes that the bill was timely mailed to the Respondent within 45 days of the dates of service. Notably there is no competent proof from the Respondent in the form of an affidavit attesting to the fact that the bill was not received.

In the instant case, Applicant established a prima facie case and Respondent did not pay or deny the bill or seek further verification of the claim. Therefore, the issue to be determined is whether Applicant billed in accordance with the applicable fee schedule?

Fee Schedule

It is respondent's burden to come forward with competent evidentiary proof to support its fee schedule defenses. *See Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co.*, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006). *See also, Power Acupuncture PC v. State Farm Mutual Automobile Ins. Co.*, 11 Misc.3d 1065A, 816 N.Y.S.2d 700, 2006 N.Y. Misc. LEXIS 514 (Civil Ct, Kings Co. 2006). If Respondent fails to demonstrate by competent evidentiary proof that a plaintiff's claims were in excess of the appropriate fee schedules, defendant's defense of noncompliance with the appropriate fee schedules cannot be sustained. *See Continental Medical PC v. Travelers Indemnity Co.*, 11 Misc.3d 145A, 819 N.Y.S.2d 847, 2006 N.Y. Misc. LEXIS 1109 (App. Term, 1 Dep't, per curiam, 2006). A respondent may interpose a defense in a timely denial that the claim exceeds the fees permitted by the Workers' Compensation schedules, but respondent must, at minimum, establish, by evidentiary proof, that the charges exceeded that permitted by law. *Abraham v. Country-Wide Ins. Co.*, 3 Misc.3d 130A, 787 N.Y.S.2d 678, 2004 N.Y. Misc. LEXIS 544 (App. Term, 2d Dept. 2004).

Furthermore, I take judicial notice of the New York State Workers' Compensation fee schedule. *See, Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co.*, 61 A.D.3d 13, 20 (2d Dept. 2009); *LVOV Acupuncture, P.C. v. Geico Ins. Co.*, 32 Misc.3d 144(A) (App Term 2d, 11th & 13th Jud Dists. 2011); *Natural Acupuncture Health, P.C. v. Praetorian Ins. Co.*, 30 Misc.3d 132(A) (App Term, 1st Dept. 2011).

Analysis

Applicant seeks reimbursement for one unit of "Additional Supplies-Materials" billed under CPT code 99072 (\$15.00) per date of service.

I addressed this issue in the unrelated case of *Ponce Acupuncture, P.C. v. The Standard Fire Ins. Co.*, AAA Case No.: 17-22-1261-1149, [1/4/2023], wherein I determined in pertinent part:

Applicant is not entitled to receive any payment for the PHE supplies that were reported under CPT 99072. Arbitrator Meryem Toksoy conducted an in-depth and well-reasoned analysis into this issue in Promotion Medical Services, PC a/a/o [assignor (JG)] v. Esurance Insurance Co., assigned to AAA Case No.: 17-21-1207-8464 wherein she determined in pertinent part:

DECISION FOR	DEFENSE/ISSUE	TOTAL	RESULT
PHE SUPPLIES	FEE SCHEDULE	\$14.00	DENIED

SUMMARY

Applicant seeks to be paid \$14.00 for Public Health Emergency (PHE) supplies that were used on 04-15-21. These items were reported under CPT 99072.

On its end, Respondent asserts that the fee schedule does not allow payment for PHE supplies and that the claim should be denied.

FEE SCHEDULE UPON WHICH THE CLAIM IS TO BE EVALUATED

Pursuant to sections 5102 and 5108 of the New York Insurance Law, as well as 11 NYCRR Part 68 [Regulation 83], the claim will be evaluated according to the **2018 New York Workers' Compensation Board Medical Fee Schedule**, specifically **the revised printing edition** that went into effect on 01-01-20.

ADDITIONAL SOURCES USED TO ADDRESS THE ISSUE

The CPT code set was developed, and is maintained, by the AMA.

The "**CPT book**"(which is referenced in the Introduction & General Guidelines of the Workers' Compensation Medical Fee Schedule) is published by the AMA on an annual basis. The title of the book is "CPT [year] Professional Edition." This source provides detailed information about CPT codes, and it includes guidelines.

CPT Assistant is a monthly newsletter authored and published by the AMA. It 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).

CODE DESCRIPTION FOR CPT 99072

CODE	DESCRIPTION
99072	<p>(This code went into effect on 09-08-20.)</p> <p>Additional supplies, materials and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency [PHE] as defined by law, due to respiratory-transmitted infectious disease.</p>

HOW A PUBLIC HEALTH EMERGENCY IS DECLARED IN NEW YORK: BY EXECUTIVE ORDER OF THE GOVERNOR

Executive Law

Article 2-B (State and Local Natural and Man-Made Disaster Preparedness)

Section 28 (State declaration of disaster emergency)

(1) Whenever the governor, on his own initiative or pursuant to a request from one or more chief executives, finds that a disaster has occurred or may be imminent for which local governments are unable to respond adequately, he shall declare a disaster emergency by executive order.

(2) Upon declaration of a disaster arising from a radiological accident, the governor or his designee, shall direct one or more chief executives and emergency services organizations to:

(a) notify the public that an emergency exists; and

(b) take appropriate protective actions pursuant to the radiological emergency preparedness plan approved pursuant to sections twenty-two and twenty-three of this article. The governor, or his designee, shall also have authority to direct that other actions be taken by such chief executives pursuant to their authority under section twenty-four of this article.

(3) The executive order shall include a description of the disaster, and the affected area. Such order or orders shall remain in effect for a period not to exceed six months or until rescinded by the governor, whichever occurs first. The governor may issue additional orders to extend the state disaster emergency for additional periods not to exceed six months.

(4) Whenever the governor shall find that a disaster is of such severity and magnitude that effective response is beyond the capabilities of the state and the affected jurisdictions, he shall make an appropriate request for federal assistance available under federal law, and may make available out of any funds provided under the governmental emergency fund or such other funds as may be available, sufficient funds to provide the required state share of grants made under any federal program for meeting disaster related expenses including those available to individuals and families.

(5) The legislature may terminate at any time a state disaster emergency issued under this section by concurrent resolution.

EXECUTIVE ORDERS (EOs) WHICH DECLARE A PUBLIC HEALTH EMERGENCY (PHE) DUE TO COVID-19

GOVERNOR ANDREW CUOMO (in office from 01-01-11 to 08-23-21)

EO NO.	DATE ISSUED	TITLE OF ORDER(S)
202	03-07-20	Declaring a Disaster Emergency in the State of New York
202.1 to 202.87	03-12-20 to 12-30-20	Continuing Temporary Suspension and Modification of Laws Relating to the Disaster Emergency
202.88 to 202.111	01-04-21 to 06-15-21	Continuing Temporary Suspension and Modification of Laws Relating to the Disaster Emergency
205	06-24-20	Quarantine Restrictions on Travelers Arriving in New York
205.1	09-28-20 to	Quarantine Restrictions on Travelers Arriving in New York

to 205.3	12-30-20	
210	06-24-21	Expiration of Executive Orders 202 and 205 (All of the Executive Orders under 202 and 205 were rescinded effective 06-25-21.)

Note: Since Governor Cuomo issued more than 100 executive orders under No. 202, it would not be feasible to list each one. Therefore, a range is given based on the year when they were issued.

GOVERNOR KATHLEEN HOCHUL (in office from 08-24-21 to present)

EO NO.	DATE ISSUED	TITLE OF ORDER(S)
11	11-26-21	Declaring a Disaster Emergency in the State of New York
11.1	12-26-21	Continuing Temporary Suspension and Modification of Laws Relating to the Disaster Emergency
11.2	01-15-22	
11.3	02-14-22	
11.4	03-16-22	(Executive Order No. 11.9 expired on 09-12-22.)
11.5	04-15-22	
11.6	05-15-22	
11.7	06-14-22	
11.8	07-14-22	
11.9	08-13-22	

DECISION

Applicant seeks to be paid for PHE supplies that were used on 04-15-21 and which were bill reported with CPT code 99072. At this point in time, the following executive orders by Governor Cuomo were in effect:

202.97

202.98

202.99

202.99

202.100

202.101

While the orders under No. 202 declare a Public Health Emergency (PHE) due to the spread of a respiratory disease (Covid-19), the fact remains that there is no legal support to render the supplies eligible for payment.

For the reasons outlined below, I find in Respondent's favor.

THERE IS NO PROVISION WITHIN ANY FEE SCHEDULE THAT LENDS ITSELF TO A PROVIDER GETTING PAID FOR PHE SUPPLIES

The Workers' Compensation Board did not amend any of its fee schedules to account for PHE supplies. It did, however, take such steps for telemedicine. On 03-16-20, the Board announced that it had modified 12 NYCRR 325-1.8, 329-1.3, 329-4.2, 333.2, and 348.2. All of these provisions were amended in order for the service to be payable. Since this was done on an emergency basis, the amendments would only be in effect for a period of 90 days. Instead of letting them expire, the Board decided to continue down the same path. Through ten subsequent adoptions, all by emergency rule making, it kept the service in place. (The most recent adoption went into effect on 07-12-22.) The reason why telemedicine has remained on the books for over two and a half years, and why it is likely to become a permanent fixture, is due to Covid-19:

This amendment is adopted as an emergency measure because the Board wants to avoid health and safety risks that can be avoided through social distancing due to COVID-19, including new variants, by allowing telemedicine in some circumstances, and to supersede the previous emergency adoption addressing this topic. Additionally, the Board has seen these emergency measures work efficiently and effectively to provide care for injured workers and plans to adopt a permanent

regulation addressing when telehealth may be used to benefit injured workers, and wants to keep the current telemedicine rules in effect during the regulatory process for the permanent telehealth proposal.

To put all of this into perspective:

On 03-07-20, Governor Cuomo responded to the threat posed by this disease.

That day, he **signed Executive Order No. 202** (Declaring a Disaster Emergency in the State of New York). **Just 9 days later, on 03-16-20, the Board made telemedicine a payable service.**

When the AMA established the code for PHE supplies on 09-08-20, the Board could have taken a similar measure. It chose not to.

On 11-26-21, Governor Hochul signed Executive Order No. 11 (Declaring a Disaster Emergency in the State of New York). **It was in response to Covid-19**; due to the Omicron variant, the rate of transmission was hitting levels that had not been seen since the beginning of the pandemic. Considering the health and safety risks involved, **the Board could have taken the step to allow for the payment of PHE supplies. It chose not to.**

Governor Hochul would go on to issue 9 more orders because of Covid-19. The most recent (and final) one was signed on 08-13-22 (No. 11.9). Deciding not to renew the declaration, Governor Hochul let it lapse. As a result, **on 09-12-22, the order expired**, effectively bringing an end to the disaster emergency.

During this time frame - a period spanning over 9 1/2 months - the Board could have acted. Again, it chose not to.

WHY AN APPLICANT'S CLAIM IS NOT HELPED BY 11 NYCRR 68.5

The date of service for which the Applicant seeks to be reimbursed is 04-15-21. At this point in time, there were executive orders by Governor Cuomo that were in effect due to Covid-19, namely EO Nos. 202.97 to 202.101.

Up to this date, the Workers' Compensation Board has not modified any of its fee schedules so that CPT 99072 could be eligible for payment.

Taking stock of this fact, Applicant may argue that there is still a pathway to reimbursement. Turning the focus to 11 NYCRR 68.5, Applicant may assert that if an insurer receives a claim for PHE supplies, it does not have the option of denying the bill, that a provider who has met the criteria for CPT 99072 is entitled to payment.

Presumably, the steps leading to this conclusion would go as follows:

Section 5102 (a)(1) of the Insurance Law describes the services which are recoverable under the policy.

11 NYCRR 68.5 is framed around this statute; the purpose of the regulation is to account for services that are not listed in any fee schedule.

The Workers' Compensation Board allows payment for CPT 99070, which is another code used to report supplies.

CPT 99070 and 99072 have similar descriptions. A comparison can be drawn between them.

If CPT 99070 is reimbursable, then CPT 99072 must be as well.

This argument can be dismantled.**Section 5102:**

(a) "Basic economic loss" means, up to fifty thousand dollars per person of the following combined items, subject to the limitations of section [5108] of this article:

(1) All necessary expenses incurred for: (i) medical, hospital (including services rendered in compliance with article forty-one of the public health law, whether or not such services are rendered directly by a hospital), surgical, nursing, dental, ambulance, x-ray, prescription drug and prosthetic services;

(ii) psychiatric, physical therapy (provided that treatment is rendered pursuant to a referral) and occupational therapy and rehabilitation;

(iii) any non-medical remedial care and treatment rendered in accordance with a religious method of healing recognized by the laws of this state; and

(iv) any other professional health services; all without limitation as to time, provided that within one year after the date of the accident causing the injury it is ascertainable that further expenses may be incurred as a result of the injury. For the purpose of determining basic economic loss, the expenses incurred under this paragraph shall be in accordance with the limitations of section [5108] of this article.

Section 5108:

(a) The charges for services specified in [section 5102 (a)(1)] of this article and any further health service charges which are incurred as a result of the injury and which are in excess of basic economic loss, shall not exceed the charges permissible under the schedules prepared and established by the chairman of the workers' compensation board for industrial accidents, except where the insurer or arbitrator determines that unusual procedures or unique circumstances justify the excess charge.

(b) The superintendent, after consulting with the chairman of the workers' compensation board and the commissioner of health, shall promulgate rules and regulations implementing and coordinating the provisions of this article and the

workers' compensation law with respect to charges for the professional health services specified in [section 5102 (a)(1)] of this article, including the establishment of schedules for all such services for which schedules have not been prepared and established by the chairman of the workers' compensation board.

(c) No provider of health services specified in [section 5102 (a)(1)] of this article may demand or request any payment in addition to the charges authorized pursuant to this section. Every insurer shall report to the commissioner of health any patterns of overcharging, excessive treatment or other improper actions by a health provider within thirty days after such insurer has knowledge of such pattern.

Section 5102 (a)(1) defines the scope of coverage for No-Fault benefits.

Section 5108, which it refers to, sets the conditions, limiting how a service may be billed and the amount that is recoverable.

The statutes are interlinked and cannot be teased apart. They must be read together.

This is reflected in 11 NYCRR 68.5.

Section 68.5 (Health services not set forth in schedules)

If a professional health service is performed which is reimbursable under section 5102(a)(1) of the Insurance Law, but is not set forth in fee schedules adopted or established by the superintendent, and:

(a) if the superintendent has adopted or established a fee schedule applicable to the provider, then the provider shall establish a fee or unit value consistent with other fees or unit values for comparable procedures shown in such schedule, subject to review by the insurer; or

(b) if the superintendent has not adopted or established a fee schedule applicable to the provider, then the permissible charge for such service shall be the prevailing fee in the geographic location of the provider subject to review by the insurer for consistency with charges permissible for similar procedures under schedules already adopted or established by the superintendent.

Both of these provisions lead to the fee schedule. In order for the service to be eligible for payment, there needs to be a reference point within this source, i.e., a similar service, a procedure that is comparable to the provider's claim.

For an applicant seeking to recover the cost of PHE supplies, it would look as though CPT 99070 fits the bill, so to speak.

It does not.

The description for CPT 99072 is markedly different than what is shown for CPT 99070. They are not approximate to each other.

The articles published by the AMA bear this out.

CODE	DESCRIPTION
99070	Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)
99072	Additional supplies, materials and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency [PHE] as defined by law, due to respiratory-transmitted infectious disease.

CPT Assistant, *New Covid-19 Pandemic Supply Code 99072*, January 2021 newsletter, page 6: [excerpt]

REPORTING CODE 99072

Code 99072 represents a new practice expense code ***specifically intended for use during a declared PHE, as defined by law, due to arespiratory-transmitted infectious disease.*** It was established in

response to the significant additional practice expenses related to in-personactivities required to provide medical visits or services to patients safely during a PHE.

Code 99072 was designed to capture the followingpractice-expense components over and above those usually included with an office visit or other services rendered:

Additional clinical staff time(registered nurse [RN]/licensed practicalnurse [LPN]/medical technical assistant [MTA]) to conduct a pre-visit phone call to screen the patient (symptom check), provide instructions on social distancing during the visit, check patients for symptoms upon arrival, apply and remove PPE, and perform additional cleaning of the examination/procedure/imaging rooms, equipment, and supplies;

Three surgical masks; and

Additional supplies, including additional quantities of hand sanitizer and disinfecting wipes, sprays, and cleansers.

Code 99072 should only be reported when the service is rendered in a non-facility place of service (POS) setting, and in an area where it is required to mitigate the transmission of the respiratory disease for which the PHE was declared. A comprehensive list of POS codes and their facility/non-facility designations are available at:

[https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place of Servi](https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_codes)

In contrast to code 99070, Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided), code 99072 is reported only during a PHE and only for additional items required to support a safe in-person provision of evaluation, treatment, or procedural service(s). These items differ significantly from those items that are typically reported with code 99070, which focus on additional supplies provided over and above those usually included with a specific non-PHE service, such as drugs, intravenous (IV) catheters, or trays. In addition, code 99072 is meant to account for and capture the additional time required by clinical staff to provide their services safely.

To ensure that code 99070 is not used incorrectly to report time and supplies during a PHE, a parenthetical note was added after code 99070 to direct users to code 99072 when the required use of additional supplies, materials, and preparation time are related to a PHE, as defined by law, due to a respiratory-transmitted infectious disease.

Code 99072 should be reported only once per in-person patient encounter per provider identification number (PIN), regardless of the number of services rendered at that encounter. In instances in which these noted clinical staff activities are performed by a physician or other qualified healthcare professional (eg, in practice environments without clinical staff or a shortage of available staff), the activity requirements of this code would be considered as having been met; however, the time spent on these activities should not be counted in any other time-based visit or service reported during the same encounter.

QUESTIONS AND ANSWERS

***Question:** Code 99072 is stated as being applicable "during a PHE." What information should be used to verify when a PHE is in effect?*

***Answer:** A PHE is in effect when declared by law by officially designated relevant public health authority(ies).*

***Question:** For what type of patient encounters or services should code 99072 be reported?*

Answer: Code 99072 may be reported for an in-person patient encounter for an office visit or other non-facility service, in which the implemented guidelines related to mitigating the transmission of the respiratory disease for which the PHE was declared are required. Usage of this code is not dependent on a specific patient diagnosis. For a list of POS codes with facility or non-facility designations, visit:

[https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place of Servi](https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Servi).

Question: What documentation is required to report code 99072?

Answer: Given that code 99072 may only be reported during a PHE, do not report this code in conjunction with an evaluation and management (E/M) service or procedure when a PHE is not in effect. Therefore, code 99072 is reported only when health and safety conditions applicable to a PHE require the type of supplies and additional clinical stafftime explained in the code descriptor. Documentation requirements may vary among third-party payers; therefore, contact the specific third-party payers for their documentation requirements.

CPT Assistant, 13: [excerpt] *Frequently Asked Questions*, February 2021 newsletter, page

Medicine: Miscellaneous Medicine Services

Question: May new code 99072 be reported by physicians and other QHPs?

Answer: Yes, both physicians and other QHPs, such as optometrists, may report new code 99072, Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed **during a Public Health Emergency (PHE) as defined by law**, due to respiratory-transmitted infectious disease, when additional practice expenses are incurred during a PHE. "Other QHP" is defined as an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable), who performs a professional service within his or her scope of practice and independently reports that professional service (eg, NP, PA, optometrist, social worker, PT). Per CPT Assistant Special Edition: September Update (2020), "Code 99072 is to be reported only once per in-person patient encounter per provider identification number (PIN), regardless of the number of services rendered at that encounter. In the instance in which the noted clinical staff activities are performed by a physician or other qualified health care professional (eg, in practice environments without clinical staff or a shortage of available staff), the activity requirements of this code would be considered as having been met."

CIRCULAR LETTER NO. 14 FROM THE DEPARTMENT OF FINANCIAL SERVICES (DFS)

Insurance Circular Letter No. 14 (2020)

August 5, 2020

TO: All Insurers Authorized to Write Accident and Health Insurance in New York State, Article 43 Corporations, Health Maintenance Organizations, Student Health Plans Certified Pursuant to Insurance Law § 1124, Municipal Cooperative Health Benefit Plans and Prepaid Health Services Plans

RE: Charges for Personal Protective Equipment by Participating Providers

STATUTORY AND REGULATORY REFERENCES: N.Y. Insurance Law

§§ 2601, 3217-a, 3221, 4305, and 4324; N.Y. Public Health Law § 4408; 11 NYCRR 52 (Insurance Regulation 62)

I. Purpose

After a period of offering primarily telehealth visits during the COVID-19 pandemic, many physicians, dentists, and other health care providers (collectively, "providers") have resumed seeing patients in person. As COVID-19 transmission poses a risk in provider office settings, providers are putting necessary protective measures in place, including sanitizing exam rooms and using personal protective equipment, such as masks, gowns, and gloves (collectively, "PPE"). The Department of Financial Services ("Department") has recently received complaints regarding participating providers charging insureds fees for the providers' use of PPE during in-person visits for covered services under health insurance policies or contracts. These fees for PPE are in addition to the insureds' cost-sharing for covered services.

This circular letter reminds insurers authorized to write accident and health insurance in New York State, Article 43 corporations, health maintenance organizations, student health plans certified pursuant to Insurance Law § 1124, municipal cooperative health benefit plans, and prepaid health services plans (collectively, "issuers") that they should ensure that insureds are not charged fees by participating providers for covered services that go beyond the insureds' financial responsibility as described in the insureds' policies or contracts.

II. Discussion

Insurance Law §§ 3221(a)(6) and 4305(a) require issuers to issue to the group policyholder or contract holder, for delivery to each member of the

group, a certificate setting forth in summary form the essential features of the insurance coverage. Furthermore, Insurance Law §§ 3217-a(a)(5) and 4324(a)(5) and Public Health Law § 4408(1)(e) require issuers to disclose in the policy or contract, or through a separate disclosure statement, an explanation of an insured's financial responsibility for payment of premiums, coinsurance, co-payments, deductibles, and any other charges, annual limits on an insured's financial responsibility, caps on payments for covered services, and financial responsibility for non-covered health care procedures, treatments, or services.^[1] Furthermore, to assist consumers in New York State to better understand and evaluate the benefits provided in policies or contracts, issuers must make a full and fair disclosure of policy or contract benefits pursuant to 11 NYCRR §§ 52.1(d) and 52.54. These sections of the Insurance Law and regulations and the Public Health Law clearly require issuers to disclose the insured's financial responsibility for *covered services, including any other charges, and such disclosure should be made for medical and dental coverage.*

The Department has been made aware that participating providers, particularly under dental insurance policies or contracts, are charging insureds fees at the time of in-person visits for PPE or other charges related to increased costs due to COVID-19 that are in addition to the insureds' cost-sharing for such covered services. A provider who participates with an issuer's provider network has agreed to accept a reimbursement amount from the issuer for covered services, with the insured responsible for the cost-sharing set forth in the insured's health or dental insurance policy or contract. A participating provider should not charge the insured fees or other charges in addition to the insured's financial responsibility for covered services. In addition, the Department does not approve policy or contract provisions that hold the insured responsible for the cost of a participating provider's PPE.

Accordingly, issuers should ensure that their participating providers are not charging insureds any fees or other charges beyond the insureds' financial responsibility for covered services as set forth in the insureds' health or dental insurance policies or contracts. Issuers should immediately notify participating providers that they should not charge insureds fees that are beyond the insureds' financial responsibility for covered services, such as fees for PPE, and issuers should instruct participating providers to refund any such fees to insureds. In addition, issuers should notify insureds that they should not be charged fees for PPE when visiting a participating provider and include the issuer's contact information for insureds to submit a complaint regarding PPE charges. Issuers should resolve any issues regarding increased costs due to COVID-19 directly with their participating providers, including for PPE, and insureds should be held harmless for such charges. In order to facilitate resolution, issuers may need to request information from participating providers regarding insureds who were charged fees that exceeded their financial responsibility, and participating providers should report such information to issuers, upon request by issuers. Issuers should

work with participating providers to ensure that refunds are provided to insureds. Within 90 days of this circular letter, issuers should report to the Department, at the e-mail address below, the amount of PPE fees that were charged to insureds, the number of insureds impacted, and provide a description of how refunds will be provided.

III. Conclusion

Issuers should ensure that insureds are not charged fees by participating providers for covered services that go beyond the insureds' financial responsibility as described in the insureds' policies or contracts. In the event an insured has paid such a fee, an issuer should resolve the issue for the insured with its participating provider. The Department will monitor compliance with these requirements, including during market conduct exams. The Department may take action at any time against an issuer for failing to adhere to the requirements of this circular letter.

Please direct any questions regarding this circular letter by email to health@dfs.ny.gov.

Very truly yours,

*Lisette
Johnson
Chief, Health
Bureau
NYCRR*

WHERE TO FIND EXECUTIVE

ORDERS 9NYCRR

Part 8: Executive Orders for Gov. Andrew
Cuomo Part 9: Executive Orders for Gov.
Kathleen Hochul

See also:

<https://www.governor.ny.gov/executiveorders>

ADDITIONAL SOURCES/WEBSITES

DFS Circular Letters:

https://www.dfs.ny.gov/industry_guidance/circular_letters

DFS Opinion Letters:

https://www.dfs.ny.gov/industry_guidance/interpretations_and_opinions

DFS Insurance Regulations Adopted on an Emergency Basis:

https://www.dfs.ny.gov/industry_guidance/regulations/emergency_insurance

DFS No-Fault Resources:

https://www.dfs.ny.gov/apps_and_licensing/property_insurers/nofault

NY WCB Board Bulletins and Subject Numbers:

<http://www.wcb.ny.gov/content/main/SubjectNos/subjectNos.jsp>

NY State Register:

<https://dos.ny.gov/state-register>

See also General Ground Rule 7 in the 2019 New York Workers' Compensation Board Acupuncture Fee Schedule, specifically the edition that went into effect on 01-01-20.

The services in dispute in this case are in the year 2021. After thorough review I concur with and adopt Arbitrator Toksoy's reasoning and agree that Applicant is not entitled to reimbursement for CPT code 99072. Applicant's claim for six units of CPT code 99072 on dates of service 8/17/2021 through 9/2/2021 and 11/9/2021 (\$90.00) is denied.

Respondent did not raise any fee schedule defense regarding the physical therapy services billed. Applicant's claim for dates of service 8/17/2021 through 9/2/2021 is granted in the amount of \$438.60.

CONCLUSION

Accordingly, in light of the foregoing, based on the arguments of counsels, and after thorough review and consideration of all submissions, Applicant's claim is granted in the amount of \$438.60. The remainder of the claim is denied. This award is in full disposition of all No-Fault benefit claims submitted to this Arbitrator.

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	Amount Amended	Status
	Bay Medical, P.C.	07/26/21 - 07/26/21	\$218.76		Dismissed without prejudice
	Bay Medical, P.C.	07/26/21 - 07/26/21	\$8.81		Withdrawn with prejudice
	Bay Medical, P.C.	07/29/21 - 08/13/21	\$410.88		Dismissed without prejudice
	Bay Medical, P.C.	08/17/21 - 09/02/21	\$513.60		Awarded: \$438.60
	Bay Medical, P.C.	11/09/21 - 11/09/21	\$15.00		Denied
	Bay Medical, P.C.	11/16/21 - 11/16/21	\$7.79		Withdrawn with prejudice
Total			\$1,174.84		Awarded: \$438.60

- B. The insurer shall also compute and pay the applicant interest set forth below. 01/10/2022 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). 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 NY

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.

06/07/2023
(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:
c8095963786bd0781769b5b6ccbe21ec

Electronically Signed

Your name: Eileen Hennessy
Signed on: 06/07/2023