American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

| | | |
|---|---|---|
| Ocean Blue Chiropractic, PC (Applicant) | AAA Case No. | 17-22-1265-4287 |
| | Applicant's File No. | 84688 |
| - and - | Insurer's Claim File No. | 8739368200000001 |
| | NAIC No. | 22055 |
| Geico Insurance Company (Respondent) | | |

**ARBITRATION AWARD**

I, Eileen Hennessy, the undersigned arbitrator, designated by the American Arbitration Association pursuant to the Rules for New York State No-Fault Arbitration, adopted pursuant to regulations promulgated by the Superintendent of Insurance, having been duly sworn, and having heard the proofs and allegations of the parties make the following **AWARD:**

Injured Person(s) hereinafter referred to as: Assignor-F.P.

1. Hearing(s) held on 11/08/2023
   Declared closed by the arbitrator on 11/08/2023

   Aleksey Selipanov from The Law Offices of John Gallagher, PLLC participated virtually for the Applicant

   Meredith Adler from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$1,834.40**, 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

   The record reveals that the Assignor-P.F., a 37-year-old male, claimed injuries as the passenger of a motor vehicle involved in an accident that occurred on 10/9/2021. Applicant seeks reimbursement for chiropractic treatment conducted from 10/14/2021 through 2/1/2022, which were denied premised on the Assignor's failure to appear for two duly scheduled Examinations Under Oath (EUO) and based upon the 45-day rule. The issues to be determined are 1)whether the Respondent properly denied the claim based on the Assignor's failure to appear for two EUOs and 2) whether Respondent has sustained its defense of late proof of claim (i.e., the 45-day rule), and if so, whether Applicant provided clear and reasonable justification for the untimely submission?

4. Findings, Conclusions, and Basis Therefor

Applicant seeksâ¯reimbursement for chiropractic treatment.â¯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)…

**EUO NO-SHOW**

Respondent denied the claims based on the Assignor's failure to appear for two duly scheduled EUOs. Under 11 NYCRR § 65-1.1 which prescribes the No-Fault Mandatory Personal Injury Protection (PIP) Endorsement, which must be included in all owners' policies of motor vehicle liability insurance issued in New York, the "Conditions" section of the endorsement contains a "Proof of Claim" provision, which states that:

> …Upon request by the Company, the eligible injured person or that person's assignee or representative shall: …(b) as may reasonably be required submit to examinations under oath by any person named by the Company and subscribe the same…

11 NYCRR § 65-1.1 (Conditions) states "No action shall lie against the Company unless, as a condition precedent thereto, there shall have been full compliance with the terms of this coverage"

The appearance of a claimant at an EUO is a condition precedent to the insurer's liability on the policy. Stephen Fogel Psychological PC v. Progressive Insurance Company, 35, A.D.3d 720; 827 N.Y.S.2d 217 (App. Div. 2ndDept. 2006); Crotona Heights Medical, P.C. v. Farm Family Casualty Ins. Co., 27 Misc.3d 134(A), 910 N.Y.S.2d 404 (Table), 2010 N.Y. Slip Op. 50716(U), 2010 WL 1632086 (App. Term 2d, 11th &13th Dists. Apr. 16, 2010). To establish their defense an insurer must present proof that the EUO scheduling letters were mailed, and that the Assignor failed to appear. *See* Fogel, *supra.*

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 EUO, 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., 2 Dept, 2014).

The Court in Prime Psychological v. Nationwide Prop, 24 Misc. 3d 230, 236 (N.Y. Civ. Ct. 2009) addressed the scheduling of EUOs, prior to the receipt of claims:

> In *Stephen Fogel Psychological* (7 Misc 3d 18), the Appellate Term found that an insurer had the right to conduct an IME prior to its receipt of the statutory claim form or its statutory equivalent which, "under the regulations, triggers the verification process." ( *Id.* at 20.) The insurance regulations first mention the right of an insurer to request an IME (and EUO) in the mandatory personal injury protection endorsement, "which is independent of the verification protocols," and, in light of the broad

> language authorizing IMEs, the court found there "to be no reason to preclude an insurer from requesting an IME prior to its receipt of the statutory claim form" ( *id.* at 20). The reviewing court stated that such an interpretation furthers "the policies underlying no-fault insurance, including . . . the expeditious processing of claims" ( *Stephen Fogel Psychological, P.C. v Progressive Cas. Ins. Co.*,35 AD3d 720, 722).
> The Appellate Term then found that the right to an IME "at this juncture is not afforded by the verification procedures and timetables" because11 NYCRR 65-1.1 (d)"is not, on its face or contextually, a `verification' provision, and because the detailed and narrowly construed verification protocols are not amenable to application at a stage prior to submission of the claim form." (7 Misc 3d at 21.) In *All-Boro Med. Supplies, Inc. v Progressive Northeastern Ins. Co.* (20 Misc 3d 554[Civ Ct, Kings County 2008]), Judge Sweeney extended this reasoning to EUOs, finding that an insurance company acted within its rights under the endorsement by scheduling an EUO before it had received the claim…
> …
> …Since the appearance of an insured at IMEs (and EUOs) was a condition precedent to the insurer's liability on the policy, an insurer could retroactively deny a claim to the date of loss for a claimant's failure to attend IMEs. ( *See also All-Boro v Progressive*,20 Misc 3d at 556 [where Judge Sweeney opined that a failure to appear for a preclaim EUO was a "valid ground for denying the claim `retroactively to the date of loss'"].) However, once an insurer received a claim, it was "required to adhere to the statutory and regulatory scheme for the processing of no-fault claims" and it therefore had to pay or deny the claim within 30 days of its receipt. ( *Id.*)

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, 2 , 11 and 13 Jud. Dists., 2013).

Pursuant to NYCRR §65-3.5, however, it is additionally incumbent upon Respondent to have a good faith basis to request an EUO of a provider with "specific objective justification" to support the use of such examination. *See* Gegerson v. State Farm Insurance Co., 27 Misc.3d 1207(A), Slip Copy, 2010 WL 1428050 (Table) N.Y. Dist. Ct., 2010, wherein the court held that before an EUO default may be found, the insurer must establish its "specific objective justification supporting the use of such examination." The court in Gegerson cited two other cases in support of its holding: Progressive Northeastern Insurance Co. v. Arguelles Med. P.C., 2009 N.Y. Slip Op 32353 (Sup Ct. N.Y. Co.); and Westchester Medical Center v. GEICO, 2009 N.Y. Slip Op 30914 (Sup Ct. Nassau Co.)

The Regulations require the Respondent to have a good faith basis, but the Regulations do not require the Respondent to share that with the claimant. 11 NYCRR 65-3.5(e); Ins. Dept. Opinion Letters (10/15/02 and 10/22/06).

*Analysis*

The bills for dates of service 12/8/2021 through 12/13/2021 ($114.60) and 2/1/2021 ($57.30) were denied premised on the Assignor's failure to appear for two duly scheduled EUOs. Respondent's scheduling letters establish that the EUOs were scheduled for 11/16/2021 and 12/13/2021 and contain the requisite language required by the regulations. The appearance at an EUO is a condition precedent to coverage, and a claimant's inaction to an insurer's timely notifications vitiates the claim. Back to Back Chiropractor, P.C. v. State Farm Mut. Ins. Co., 35 Misc. 3d. 1241(A). The Courts have held that where there is a failure to submit to an EUO, No-Fault benefits can properly be denied retroactively to the date of loss. A.B. Medical Services, P.C. v. American Transit Ins. Co., 25 Misc. 3d 128A (2009).

In support of this defense, the Respondent has submitted the EUO scheduling letters with certificates of mailing postmarked by the United States Postal Service (USPS) and signed for by an employee of the USPS, certified transcripts of Statements on the Record by the Investigator scheduled to conduct the EUOs for each of the EUO scheduled dates, and the denial.

Applicant argues that the EUO scheduling letters are defective as they fail to comply with 11 NYCRR 65-3.5(e) as they do not advise the claimant that they, "will be reimbursed for any loss of earnings and reasonable transportation expenses incurred in complying with the request". Respondent counters that the, "omission of the 'reimbursement' language in the EUO letters is a de minimis defect and does not make the EUO letters defective" pursuant to 11 NYCRR 65-3.5(p).

I find that the initial and follow-up EUO scheduling letters are properly addressed and mailed to the Assignor. The EUOs were held via video teleconference at the times listed on the EUO scheduling letters. Applicant did not dispute the timeliness of the EUO scheduling letters.

Furthermore, the bust statements indicated that Respondent's Investigator was present via video teleconference as listed on the EUO scheduling letters for the EUOs he was scheduled to conduct on 11/16/2021 and 12/13/2021 and would have conducted the respective EUOs if Assignor-P.F. appeared. These bust statements are sufficient to establish the non-appearance of the Assignor at the scheduled EUOs held via video teleconference on 11/16/2021 and 12/13/2021. I note there is no transcript of the Assignor's EUO submitted by either party.

The issue to be determined is whether the omission of the required statutory language from the EUO scheduling letters renders the letters defective?

11 NYCRR 65-3.5, Claim Procedure

(e) states:All examinations under oath and medical examinations requested by the insurer shall be held at a place and time reasonably convenient to the applicant and medical examinations shall be conducted in a facility properly equipped for the performance of the medical examination. The insurer shall inform the applicant at the

time the examination is scheduled that the applicant will be reimbursed for any loss of earnings and reasonable transportation expenses incurred in complying with the request. When an insurer requires an examination under oath of an applicant to establish proof of claim, such requirement must be based upon the application of objective standards so that there is specific objective justification supporting the use of such examination. Insurer standards shall be available for review by department examiners.

(p) states: With respect to a verification request and notice, an insurer's non-substantive technical or immaterial defect or omission, as well as an insurer's failure to comply with a prescribed time frame, shall not negate an applicant's obligation to comply with the request or notice. This subdivision shall apply to medical services rendered, and to lost earnings and other reasonable and necessary expenses incurred, on or after April 1, 2013.

There is no dispute that the letters do not comply with 11 NYCRR 3.5(e) as they do not informthe applicant "at the time the examination is scheduled", that they "will be reimbursed for any loss of earnings and reasonable transportation expenses incurred in complying with the request".

Rather, Respondent argues that the omission is a deminimus non-substantive defect pursuant to 11 NYCRR 65-3.5(p) and does not negate the claimant's, "obligation to comply with the request". I addressed this issue in the linked case of *VUA Pharmacy, Inc. v. Geico Ins. Co.*, AAA Case No.: 17-22-1246-4454, involving Assignor-P.F. and heard on 5/26/2023. In that case, Respondent was given an opportunity to submit a post-hearing brief with supporting case-law in support of their position. Respondent submitted a brief, which referenced 11 NYCRR 65-3.5(p), but did not reference or submit any supporting case law or arbitration decisions in support of their position.

Where statutory rights are at stake, it is extremely important that any notice clearly and unambiguously apprises a party of its obligations and rights.

The courts have held the failure to advise a party they would be reimbursed for any loss of earnings and reasonable transportation costs in attending the examination under oath renders the notice defective. J.K.M. Medical Care P.C. v. Ameriprise Ins. Co., 54 Misc.3d 54 (App Term, 2d Dept, 2d, 11th & 13th Jud. Dists 2016). One judge rejected the defense, when the initial letter advised the recipient of the right to reimbursement, but the follow-up notice did not. Unitrin Direct Ins. Co. v. A.C. Medical P.C., 2016 Slip Op. 30822 (U) (Sup. Cit. N.Y. Co. Coin, J. May 3, 2016). See also *Triborough Orthopedics P.C. and State Farm Mutual Automobile Insurance Company*, AAA Case No. 17-21-1192-1954 [Arbitrator Glen Weiner, 8/24/2021].

"It is well established that "[e]ach notice scheduling an EUO issued by an insurer must include requisite language advising the person required to appear at an EUO of that person's right to reimbursement for lost earnings and transportation costs incurred in attending the EUO, in order for such notice to be deemed effective under the regulation" (*Encompass Ins. Co. v Rockaway Family Med. Care, P.C.*, 2013 WL 8149430

[Arbitration Award] [Sup Ct, NY County 2013]; *see also* Opinion Letter by Ins. Dept, Betancourt Aff in Opp, Exh B)." Unitrin Direct Ins. Co. v. A.C. Medical P.C., 2016 Slip Op. 30822 (U) (Sup. Cit. N.Y. Co. Coin, J. May 3, 2016).

I do not find the omission of the statutory reimbursement language to be a deminimus " non-substantive technical or immaterial defect or omission" as described under 11NYCRR 65-3.5(p). This statutory language is required by 11 NYCRR 65-3.5(e) and must be included for the EUO scheduling letters to be valid.

Respondent's notices are defective as they fail to properly and clearly advise Applicant that they, "will be reimbursed for any loss of earnings and reasonable transportation expenses incurred in complying with the request". Accordingly, Respondent's defense cannot be sustained.

Applicant's claim for dates of service 12/8/2021 through 12/13/2021 ($114.60) and 2/1/2021 ($57.30), denied premised upon the Assignor's failure to appear for two duly scheduled IMEs, is granted.

**45-Day Rule**

Respondent indicates the remaining bills for dates of service 10/14/2021 through 12/29/2021 and 1/3/2022 through 1/6/2022 were not timely submitted within 45 days of the dates of service. The bills were received on 9/14/2022 and denied on 10/13/2022 premised on the 45-day rule. The denials indicates that late notice will be excused if the Applicant can provide clear and reasonable justification for late submission of the bills.

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).

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 & nd nd 11 Jud Dists., 2003).

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.

As required by 11 NYCRR§65-3.3(e):

> When an insurer denies a claim based upon the failure to provide timely written notice of claim or timely submission of proof of claim by the applicant, such denial must advise the applicant that late notice will be excused where the applicant can provide reasonable justification of the failure to give timely notice.

When a claim is submitted beyond the statutorily prescribed time frame, it is incumbent upon the claimant to provide the insurer with written justification for the untimely submission for it to be excused. Bajaj v. MVAIC, 49 Misc.3d 145(A), 2015 NY Slip Op 51661(U)(App. Term, 2 Dept., 2, 11, & 13 Jud. Dists., Nov. 12, 2015).

The reason provided for the untimely submission must be adequately detailed. Unelaborated assertions will not suffice. Synergy First Med. PLLC v. Elrac, Inc., 26 Misc.3d 131(A), 2010 NY Slip Op 50048 (App. Term, 1 Dept., Jan. 14, 2010).

Applicant has not submitted proof of mailing for the bills.

Having reviewed the evidence, I find that Respondent's denials establish receipt of the bills. The denials are timely and proper and comply with 11 NYCRR§65-3.3(e). Respondent's assertion, through the denials, that it did not receive the proof of claim for dates of service 10/14/2021 through 12/29/2021 and 1/3/2022 through 1/6/2022 within 45 days is sufficient to establish a prima facie showing the claim was not timely received. Liriano v. Eveready Ins. Co., 65 A.D.3d 524, 525 (2d Dept. 2009). Applicant failed to rebut Respondent's proof that the bills were not submitted within 45 days through proof of mailing. Applicant also failed to come forward with evidence to demonstrate "reasonable justification" for its late submission of the bills.

Applicant's claim for date of service 10/14/2021 through 12/29/2021 and 1/3/2022 through 1/6/2022 is denied.

**CONCLUSION**

Accordingly, Applicant's claim is granted in the amount of $171.90. 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** | **Status** |
|---|---|---|---|---|
| | **Ocean Blue Chiropractic, PC** | **10/14/21 - 11/11/21** | **$974.90** | **Denied** |
| | **Ocean Blue Chiropractic, PC** | **11/15/21 - 11/29/21** | **$286.50** | **Denied** |
| | **Ocean Blue Chiropractic, PC** | **12/08/21 - 12/13/21** | **$114.60** | **Awarded: $114.60** |
| | **Ocean Blue Chiropractic, PC** | **12/20/21 - 12/29/21** | **$171.90** | **Denied** |

| | | | | |
|---|---|---|---|---|
| | **Ocean Blue Chiropractic, PC** | **01/03/22 - 01/06/22** | **$229.20** | **Denied** |
| | **Ocean Blue Chiropractic, PC** | **02/01/22 - 02/01/22** | **$57.30** | **Awarded: $57.30** |
| **Total** | | | **$1,834.40** | **Awarded: $171.90** |

B. The insurer shall also compute and pay the applicant interest set forth below. 09/07/2022 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.

12/08/2023
(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:**
2344ec8f9e9ea06700d66fa847a7f254

**Electronically Signed**

Your name: Eileen Hennessy
Signed on: 12/08/2023