

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Golden Healthcare Chiropractic Diagnostic PC (Applicant)	AAA Case No.	17-22-1276-4081
- and -	Applicant's File No.	NA
	Insurer's Claim File No.	AMS1008301
State National Insurance Company (Respondent)	NAIC No.	12831

ARBITRATION AWARD

I, Gregory Watford, 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 (SAF)

1. Hearing(s) held on 08/29/2023, 10/24/2023, 11/01/2023
Declared closed by the arbitrator on 11/15/2023

Walter Pisary from Law Offices of Hillary Blumenthal LLC (Union City) participated virtually for the Applicant

Paris Rosvolos from Brand Glick & Brand, Esqs. participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$5,378.20**, 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

The dispute arises from the underlying automobile accident of December 2, 2021, in which the Assignor, then a 35-year-old male was a passenger. As a result of the impact, he complained of multiple injuries. Thereafter, he sought private medical attention where he was recommended to commence course of conservative care treatments, including chiropractic treatments and was referred for diagnostic testing.

In dispute in this case are twenty (20) bills for chiropractic treatments and electrodiagnostic testing services provided to Assignor from 12/17/21 - 3/3/22.

Applicant submitted a total of eighteen (18) bills for chiropractic treatments and two (2) bills for EMG/NCV testing of the upper and lower extremities in an amount totaling \$5,378.20.

For two (2) bills for DOS 12/17/21 - 12/22/21 (\$415.74), Respondent partially paid \$110.22 and denied payment of the balance on the grounds that Applicant billed in excess of the amounts permitted under the fee schedule.

Respondent timely denied payment for the EMG/NCV bills for two (2) bills for DOS 1/10/22 - 1/13/22 (\$1,841.30) based upon the peer review of Dr. Edward Weilan, dated 2/14/22.

Respondent also denied two (2) bills for DOS 2/22/22 - 2/24/22 (\$415.74) on the grounds that Applicant failed to respond to requests for additional verification within 120 days.

Respondent did not deny or pay the remaining fourteen (14) bills (12/27/21 - 3/3/22) on the grounds that it never received the bills until the instant arbitration was initiated and said bills were included in Applicant's arbitration submission.

The issues to be decided are:

- Whether Applicant established entitlement to No-Fault compensation for twenty (20) bills for chiropractic treatments and electrodiagnostic testing services provided to Assignor.

- Whether Respondent made out a prima facie case of lack of medical necessity for the EMG/NCV services (1/10/22 - 1/13/22) and, if so, whether Applicant rebutted it.

- Whether Respondent established that Applicant did not respond to the requests for additional verification for two (2) bills (2/22/22 - 2/24/22) within 120 days after Respondent's initial requests for additional verification of said claims.

- Whether Applicant failed to establish prima facie entitlement for No-Fault compensation for fourteen (14) bills that were never allegedly received by Respondent.

- Whether Respondent established that Applicant billed in excess of the Fee schedule for two (2) bills 12/17/21 - 12/22/21 and that it partially paid Applicant for these bills.

4. Findings, Conclusions, and Basis Therefor

I have reviewed the submissions and documents contained in the American Arbitration Association's ADR Center Electronic Case File (ECF). These submissions constitute the

record in this case. This case was decided on the submissions of the parties as contained in the ECF and the oral arguments of the parties' representatives. There were no witnesses.

Pursuant to Insurance Law § 5106(a) and the Insurance regulations, an insurer must either pay or deny a claim for motor vehicle no-fault benefits, in whole or in part, within 30 days after an applicant's proof of claim is received (*see* Insurance Law § 5106[a]; 11 NYCRR 65-3.8[c]; *see also* 11 NYCRR 65-3.5). Infinity Health Products, Ltd. v. Eveready Ins. Co., 67 A.D.3d 862, 864, 890 N.Y.S.2d 545, 547 (2d Dept. 2009). A claimant's prima facie proof of claim for no-fault benefits must demonstrate that the prescribed claim forms were mailed to and received by the insurer and are overdue. Viviane Etienne Medical Care, P.C. v. Country-Wide Ins. Co., 25 N.Y.3d 498, 506, 14 N.Y.S.3d 283, 290 (2015). Applicant's proof is also in Respondent's denials, which acknowledged receipt of the bills.

Bills Not Received - Lack of Prima Facie Case

Respondent asserts that it did not receive notice of fourteen (14) of Applicant's bills for services rendered on the following dates: (1) 12/27/21 - 12/29/21 (\$236.28); (2) 12/29/21 - 1/3/22 (\$200.65); (3) 1/3/22 - 1/10/22 (\$210.88); (4) 1/10/22 (\$81.28); (5) 2/3/22 - 2/4/22 (\$236.28); (6) 2/4/22 - 2/7/22 (\$179.46); (7) 2/9/22 - 2/10/22 (\$236.28); (8) 2/10/22 - 2/11/22 (\$179.46); (9) 2/15/22 - 2/16/22 (\$236.28); (10) 2/16/22 - 2/17/22 (\$179.48); (11) 2/18/22 (\$138.58); (12) 2/28/22 - 3/1/22 (\$232.07); (13) 3/1/22 - 3/2/22 (\$204.86); (14) 3/2/22 - 3/3/22 (\$153.58)

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. 2nd Dept. 2006) *quoting*, Matter of Rodriguez v Wing, 251 A.D.2d 335 (App. Div. 2nd Dept. 1998). "The presumption may be created by either proof of actual mailing or proof of the standard office practice or procedure designed to ensure that items are properly addressed and mailed." New York and Presbyterian Hospital v. Allstate Insurance Company, 29 AD 3d 547 *quoting* Residential Holding Corp. Scottsdale Insurance Company, 286 A.D. 2d 679 (App. Div. 2nd Dept. 2001). Such "office practice must be geared so as to ensure the likelihood that the [the correspondence] is always properly addressed and mailed." Nassau Insurance Company v. Murray, 46 N.Y. 2d 828 (1978).

It should be noted that at the initial hearing Applicant was given an opportunity to provide proof of mailing for the above-referenced bills and the hearing was continued to 11/1/23. At the continued hearing, Applicant was given another opportunity to make a post hearing submission with its proof of mailing for these bills. Applicant was given until 11/7/23 to upload proof of mailing and failed to submit any documents.

Applicant's counsel did not produce any proof of mailing of the bills in question in the form of an affidavit of mailing or proof of actual mailing. Moreover, Applicant has not

submitted any proof that it mailed the bills in questions prior to the commencement of this arbitration matter. Furthermore, a review of the ECF revealed that there are no NF-10s issued by Respondent for the bills in question.

Consequently, I find that Applicant has failed to sufficiently establish a prima facie case of entitlement to no-fault benefits for the aforementioned fourteen (14) bills in question. I also find that Applicant's submission of the bills in question along with its submission of the properly denied claims is not sufficient to establish that said claims were in fact submitted mailed to and received by Respondent's claim processing offices.

Therefore, Applicant's claims for these dates [(1) 12/27/21 - 12/29/21 (\$236.28); (2) 12/29/21 - 1/3/22 (\$200.65); (3) 1/3/22 - 1/10/22 (\$210.88); (4) 1/10/22 (\$81.28); (5) 2/3/22 - 2/4/22 (\$236.28); (6) 2/4/22 - 2/7/22 (\$179.46); (7) 2/9/22 - 2/10/22 (\$236.28); (8) 2/10/22 - 2/11/22 (\$179.46); (9) 2/15/22 - 2/16/22 (\$236.28); (10) 2/16/22 - 2/17/22 (\$179.48); (11) 2/18/22 (\$138.58); (12) 2/28/22 - 3/1/22 (\$232.07); (13) 3/1/22 - 3/2/22 (\$204.86); (14) 3/2/22 - 3/3/22 (\$153.58)] are dismissed as premature without prejudice.

After reviewing the records, I find that Applicant established its prima facie case of entitlement to No-Fault compensation for the remaining six (6) denied bills. See Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). Once an applicant establishes a prima facie case, the burden then shifts to the insurer to prove its defense. See Citywide Social Work & Psy. Serv. P.L.L.C v. Travelers Indemnity Co., 3 Misc. 3d 608, 2004, NY Slip Op 24034 [Civ. Ct., Kings County 2004]).

120 Day Denials (DOS 2/22/22 - 2/24/22 (\$415.74))

"The 30-day period in which to either pay or deny a claim is extended where the insurer makes a request for additional verification within the requisite 15-[business] day time period (see Montefiore Med. Ctr. v Government Empls. Ins. Co., 34 AD3d 771; New York & Presbyt. Hosp. v. Allstate Ins. Co., 31 AD3d 512)." Kingsbrook Jewish Medical Center v. Allstate Insurance Co., 61 A.D.3d 13, 17-18, 871 N.Y.S.2d 680, 683 (2d Dept. 2009). "If the requested verification is not received within 30 days, the insurer must send a follow-up letter within 10 days thereafter (see 11 NYCRR 65.15[e][2])." New York & Presbyterian Hospital v. American Transit Insurance Co., 287 A.D.2d 699, 700, 733 N.Y.S.2d 80, 81-82 (2d Dept. 2001). "Thus, a timely additional verification request tolls the insurer's time within which to pay or deny a claim (see Fair Price Med. Supply Corp. v Travelers Indem. Co., 10 NY3d at 563; New York & Presbyt. Hosp. v. Countrywide Ins. Co., 44 AD3d 729, 730)." Kingsbrook Jewish Medical Center v. Allstate Insurance Co., supra at 18, 871 N.Y.S.2d at 683 (2d Dept. 2009).

Where a requested verification is not provided to an insurer, the claim remains tolled indefinitely; to wit, the insurer need not pay or deny the claim if it never receives the requested verification. See, 11 NYCRR § 65-3.8; NY & Presbyt. Hosp. v Progressive Cas. Ins. Co., 5 AD3d 568 [N.Y. App. Div. 2nd Dept. 2004]. Respondent bears this initial burden in order to properly toll the time to pay or deny the claims.

Since the requests were made after April 1, 2013, 11 NYCRR § 65- 3.5 (o) provides:

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 § 65-3.8 (b)(3) also provides:

An 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) of this Subpart.

Where a Respondent no-fault insurer is relying on the 120-day defense, the Respondent's prima facie burden to demonstrate (1) that verification requests were timely mailed and (2) that the insurer did not receive the requested verification (see 11 NYCRR 65-3.8[a]; Right Aid Med. Supply Corp. v State Farm Mut. Auto. Ins. Co., 58 Misc. 3d 140[A], 2017 NY Slip Op 51857[U] [App Term, 2d Dept, 2d, 11th & 13th Jud Dists 2017]).

The defense that an applicant failed to provide requested verification within 120 days requires the insurer to unequivocally prove that it did not receive the requested verification. Big Apple Medical Supply, Inc. v. Nationwide Affinity Ins. Co. of America, 61 Misc.3d 1221(A), 2018 N.Y. Slip Op. 51659(U) (Civ. Ct. Kings Co., Odessa Kennedy, J., Nov. 21, 2018). With regard to the issue of verification requests, the insurer bears the burden of proving that they remain outstanding. Right Aid Medical Supply, Corp. v. State Farm Mutual Auto. Ins. Co., 56 Misc.3d 681 (Civ. Ct. Kings Co. 2017).

On 3/14/22, Respondent received two (2) bills for dates of service rendered: 2/22/22 - 2/23/22 (\$236.28) & 2/23/22 - 2/24/22 (\$179.46).

Respondent provided the letters requesting addition verification dated 3/28/22 and 4/28/22. Respondent requested the daily physical therapy notes for each date of service to include patient complaints, treatment rendered, patient progress and the daily sign in sheets. "Upon receipt of the requested information your claim will be processed accordingly."

On 7/29/22 Respondent denied the claims. Respondent's denials for each claim as follows:

Request for reimbursement for chiropractic treatment performed February 22, 2022, February 23, 2022, February 24, 2022, is denied in its entirety effective December 2, 2021. Your failure to provide all the requested verification under your control or possession, or written proof providing reasonable justification for your failure to

comply has prevented State National Insurance Company from reviewing the bill for medical necessity and casual relationship to the occurrence as well as directing payment to Golden Health Care Chiropractic for services rendered February 22, 2022, through February 24, 2022. Additionally, all charges for No-Fault treatment are to be billed in accordance with the New York Worker's Compensation Fee Schedule.

At the initial hearing scheduled for 8/29/23, Applicant's counsel argued that it did not receive the verification requests and that Respondent did not provide proof of mailing of the verification requests in order to sustain its burden for the 120-Day denial. Respondent's representative was also provided an opportunity to submit proof of mailing for the verification requests.

At the continued hearing, Respondent relied upon the affidavit of Marcia Hirsch to establish proof of mailing of the verification requests.

At the hearing, Applicant's counsel argued that the affidavit is insufficient to establish credible proof of mailing under New York and Presbyterian Hospital v. Allstate Insurance Company, *supra*. Specifically, counsel argued that there is nothing in the affidavit that indicates that Ms. Hirsch detailed her personal knowledge that the items in dispute were mailed. The affidavit did not address each bill or the specific verification requests. The affidavit failed to set forth the policies and procedures that were followed for processing and mailing the verification requests.

Evidence as to proper submission of claims or forms, whether it be by mail or by fax, is a question of fact for the arbitrator. Informal Opinion, State Insurance Department's Office of General Counsel (June 30, 2003).

Comparing the relevant evidence and arguments presented by both parties against each other, I am persuaded by the Applicant's arguments and evidence regarding the insufficiency of Respondent's proof of mailing. As noted above the presumption of receipt for an item mailed may be created by either proof of actual mailing or proof of the standard office practice or procedure designed to ensure that items are properly addressed and mailed. New York and Presbyterian Hospital v. Allstate Insurance Company, *supra* I find that Respondent's affidavit of mailing failed to provide any information regarding the standard office policies, practice, and procedures to ensure that the verification requests in dispute were properly addressed and actually mailed in order for Respondent to benefit of the presumption of receipt by Applicant.

Consequently, I find that Respondent's 120-Day denial cannot be sustained. Applicant is entitled to be reimbursed in an amount consistent with the fee schedule.

Medical Necessity - Peer Review

A presumption of medical necessity attaches to a timely submitted no fault claim. Elmont Open MRI & Diagnostic Radiology, P.C. v. State Farm Ins. Co., 26 Misc.3d 1211(A), 906 N.Y.S.2d 779 (Table), 2010 N.Y. Slip Op. 50053(U) at 3, 2010 WL 157564 (Dist. Ct. Nassau Co., Fred J. Hirsh, J., Jan. 6, 2010).

If an insurer asserts that the medical test, treatment, supply or other service was medically unnecessary, the burden is on the insurer to prove that assertion with competent evidence such as an independent medical examination, a peer review or other proof that sets forth a factual basis and a medical rationale for denying the claim. (See A.B. Medical Services, PLLC v. Geico Insurance Co., 2 Misc. 3d 26 [N.Y. App. Term, 2nd & 11th Jud. Dists 2003]; Kings Medical Supply Inc. v. Country Wide Insurance Company, 783 N.Y.S. 2d at 448 & 452; Amaze Medical Supply, Inc. v. Eagle Insurance Company, 2 Misc. 3d 128 [N.Y. App. Term, 2nd and 11th Jud Dists 2003]).

The purpose of a peer review is to determine whether the service/test provided was medically necessary. The peer reviewer discusses the standard of care in the medical community and offers his/her opinion as to why the service/test at issue falls outside of that standard of care. The peer reviewer buttresses his/her opinion with authoritative texts, treatises, and articles, generally from peer-reviewed publications.

The courts have held that a peer review report's medical rationale will be insufficient to meet respondent's burden of proof if: 1) the medical rationale of its expert witness is not supported by evidence of a deviation from "generally accepted medical" standards; 2) the expert fails to cite to medical authority, standard, or generally accepted medical practice as a medical rationale for his findings; and 3) the peer review report fails to provide specifics as to the claim at issue, is conclusory or vague. See, Jacob Nir, M.D. v. Allstate Insurance Co., 7 Misc. 3d 544 (N.Y. City Civ. Ct. 2005).

A determination of medical necessity must be based on evidence in existence prior to the rendering of the service. Foster Diagnostic Imaging, PC v General Assur Co., 10 Misc. 3d 428 (Civ. Ct. Kings Cty 2005).

Every peer review requires individual scrutiny to determine whether the burden should be shifted back to the claimant to submit contrary expert proof. The conclusory opinions of the peer reviewer, standing alone and without support of medical authorities, will not be considered sufficient to establish the absence of medical necessity. (See, Amaze Medical Supply Inc. v. Eagle Ins. Co., 2 Misc.3d 128(A), 784 N.Y.S.2d 918 (Table), 2003 N.Y. Slip Op. 51701(U), 2003 WL 23310886 (N.Y. App. Term 2nd & 11th Dists. Dec. 24, 2003).

Dr. Weiland - EMG/NCV (DOS 1/10/22 - 1/13/22)

Dr. Weiland drafted a peer review on behalf of Respondent regarding medical necessity of the EMG/NCV services in dispute. He reviewed Assignor's medical records including initial evaluation reports, progress notes, follow-up evaluation reports, and diagnostic test results. He then summarized the accident and outlined the treatment of Assignor.

Dr. Weiland ultimately concluded that the EMG/NCV was not medically necessary. His primary argument was that there was no contemporaneous neuromuscular examination report submitted by the electrophysiologist, Dr. Sasan. According to Dr. Weiland this was a deviation of care because Dr. Sasan did not identify in the medical records submitted for review whether any objective neuromuscular examination was performed or reported.

He further stated in absence of these documents, a recommendation for reimbursement of the EMG/NCV services in dispute "cannot be determined at this time."

A peer review which concludes there was no medical necessity due to the lack of sufficient information upon which the reviewer could make such a determination does not set forth a factual basis and medical rationale sufficient to establish the absence of medical necessity. Park Neurological Services P.C. v. GEICO Ins., 4 Misc.3d 95, 782 N.Y.S.2d 506 (App. Term 9th & 10th Dists. 2004). Based upon the statement of Dr. Weiland, I find that Respondent's denial for the EMG/NCV cannot be sustained.

Fee Schedule

Effective April 1, 2013, 11 NYCRR 65-3.8(g)(1) has been amended so that the application of the New York State Workers Compensation fee schedule is no longer a precludable defense, and no payment is due on those claims in excess of the fee schedule. Respondent may present its defense without regard to a timely NF 10. USAA General Indemnity Co. v. New York Chiropractic & Physical Therapy, PLLC, 60 Misc.3d 254 (Civ. Ct. Richmond Co., Lisa Grey, J., May 1, 2018).

On December 11, 2018, a new Fee Schedule was promulgated with an original effective date of April 1, 2019. However, the 34th Amendment to Regulation 83 delayed the Fee Schedule's effective date to October 1, 2020. The services in dispute are governed by the new Fee Schedule.

Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. Continental Medical PC v. Travelers Indemnity Co., 11 Misc.3d 145A, 819 N.Y.S.2d 847, (N.Y. App. Term, 1st Dep't, 2006); Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 13 Misc.3d 172, 822 N.Y.S.2d 378, (Civil Ct, Kings Co. 2006).

When the issue in contention involves the appropriateness of a billing adjustment based on the fee schedule, Respondent must first demonstrate that it has timely and credibly established the basis for its denial(s) before the burden of proof shifts to the Applicant to establish that Respondent's adjustment was contrary to No-Fault regulations and/or the applicable fee schedule. Applicant must then establish a prima facie case of entitlement to additional reimbursement by demonstrating credible evidence that the adjusted rate of reimbursement was incorrect. (See, Westchester Medical Center v. Nationwide Mut. Ins. Co., 78 A.D.3d 1168, 911 N.Y.S.2d 907 (2d Dept. 2010)). As of April 1, 2013, the effective date of the Fourth Amendment to 11 NYCRR 65-3, Respondent is only required to reimburse Applicant in accordance with the applicable fee schedule.

The "burden remains on the insurer to assert a defense that a provider billed in excess of the fee schedule." East Coast Acupuncture, PC v. Hereford Insurance Company, 51 Misc. 3d 441, 26 N.Y.S. 3d 441, 443 (Civil Ct. Kings County 2016) (holding that the new regulation "does not place any additional requirements on the medical provider, such as a requirement, in the general case, to substantiate the calculation of its fees).

I take judicial notice of the Worker's Compensation fee schedule. See LVOV Acupuncture PC v. Geico Insurance Company, 32 Misc. 3d 144 (A) (N.Y. App. Term 2nd, 11th and 13th Jud. Dists. 2011).

RVU Cap Rule

Under the fee schedule when a patient receives acupuncture, chiropractic, physical or occupational therapy procedures or modalities from more than one provider, the patient may not receive more than 12.0 RVUs per day per accident or illness from all providers combined. The maximum number of RVU's (including treatment) per person per day, per accident or illness when billing for a re-evaluation shall be limited to 15.0. The maximum number of RVU's (including treatment) per person per day, per accident or illness when billing for an initial evaluation shall be limited to 18.0.

A review of the NF-3 revealed that the services in dispute were provided in zip code 10977 which is Region III. Under Region III the cf for chiropractic services is 8.79. Accordingly, Applicant is limited to \$105.48 per day for codes that are covered under the RVU Cap.

12/17/21 - 12/22/21 (\$415.74) (3 DOS)

2/22/22 - 2/24/22 (\$415.74) (3DOS)

Applicant billed under CPT codes 98941, 97140, 97012 and 99072. All codes except CPT code 99072 are covered by the RVU Cap. Therefore, I find that Applicant is limited to \$105.48 per day for these codes.

In support of its fee schedule defense for DOS 12/27/21 - 12/22/21, Respondent relied upon the coder affidavit of Pamela Quigley. She opined, without elaborating, that CPT code 97140 is not reimbursable because it is included in CPT code 98941. Accordingly, she did not recommend payment for this code. She further opined that CPT code 99072 is not reimbursable under the fee schedule. After reviewing the Quigley affidavit, I disagree with her opinion that these codes are not reimbursable.

For CPT code 97140, Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. Continental Medical PC v. Travelers Indemnity Co., supra. I find that her statement, without reference to any supporting authority that this code is included in CPT 98041, is conclusory.

Accordingly, I find that under the RVU cap, Applicant is entitled to \$105.48 for each date of service.

Similarly, I note that CPT Code 99072 is a new AMA CPT code as of September 8, 2020, which is defined as: "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 as defined by law, due to respiratory-transmitted infectious disease."

I take judicial notice of the Insurance Circular Letter No. 14 (2020) "Charges for Personal Protective Equipment by Participating Providers." This letter indicates that it is permissible for medical providers to bill insurance carriers for the PPE but, it is impermissible to bill the insureds directly for the PPE. CPT code 99072 was added to the Fee Schedule for the very purpose of using it to bill for these items. Code 99072 was released by the AMA and became effective on Sept. 8, 2020. The code, in pertinent part states: 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 as defined by law, due to respiratory-transmitted infectious disease. This code was specifically implemented for use when services are performed "during a Public Health Emergency as defined by law."

COVID 19 was a public health emergency in the year 2020. However, the New York State Emergency Health Order expired on June 24, 2021, and was reinstated on November 26, 2021, by the Governor and expired again on May 11, 2023. I find that the services for these dates in dispute were performed during the time period that the New York State Emergency Health Order was in effect.

As Arbitrator Wendrovsky noted, "For all the professed concern for the safety of healthcare providers during the pandemic, to then assert PPE as non-reimbursable is plainly nonsensical." AAA Case # 17-21-1202-8063, dated 8/22/22. I further find that Applicant is entitled to be reimbursed the billed amount of \$15.00 per day for this code.

Accordingly, Applicant is awarded \$105.48 and \$15.00 per day for a total of 120.48 per day billed with these codes.

It should be noted that for the bill for DOS 12/17/21 - 12/22/21 (\$415.74), Respondent asserted that it partially paid \$110.22. However, at the hearings, Respondent was not able to produce any proof of payment to demonstrate that Applicant received and cashed the check. Consequently, I find that a total of \$361.44 (120.48 x 3) is owed to Applicant for this bill.

EMG/NCV

Applicant billed \$1,841.30 for the testing. In support of its fee schedule defense, Respondent relied upon the coder affidavit of Ms. Quigley, she opined that Applicant is limited to \$1,437.72. I agree with Ms. Quigley on all of her calculations except for CPT code 99072. Based upon my discussion above, I find that Applicant is entitled to \$15.00 under this code. Applicant total award for this service is \$1,452.72.

This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator. Any further issues raised in the hearing record are held to be moot, without merit, and/or waived insofar as not raised at the time of the hearing.

5. Optional imposition of administrative costs on Applicant.
Applicable for arbitration requests filed on and after March 1, 2002.

I do NOT impose the administrative costs of arbitration to the applicant, in the amount established for the current calendar year by the Designated Organization.

6. **I find as follows with regard to the policy issues before me:**

- ☐ The policy was not in force on the date of the accident
- ☐ The applicant was excluded under policy conditions or exclusions
- ☐ The applicant violated policy conditions, resulting in exclusion from coverage
- ☐ The applicant was not an "eligible injured person"
- ☐ The conditions for MVAIC eligibility were not met
- ☐ The injured person was not a "qualified person" (under the MVAIC)
- ☐ The applicant's injuries didn't arise out of the "use or operation" of a motor vehicle
- ☐ The respondent is not subject to the jurisdiction of the New York No-Fault arbitration forum

Accordingly, the applicant is AWARDED the following:

A.

Medical		From/To	Claim Amount	Status
	Golden Healthcare Chiropractic Diagnostic PC	12/17/21 - 12/20/21	\$236.28	Awarded: \$236.28
	Golden Healthcare Chiropractic Diagnostic PC	12/20/21 - 12/22/21	\$179.46	Awarded: \$125.16
	Golden Healthcare Chiropractic Diagnostic PC	12/27/21 - 12/29/21	\$236.28	Dismissed without prejudice
	Golden Healthcare Chiropractic Diagnostic PC	12/29/21 - 01/03/22	\$200.65	Dismissed without prejudice

	Golden Healthcare Chiropractic Diagnostic PC	01/03/22 - 01/10/22	\$210.88	Dismissed without prejudice
	Golden Healthcare Chiropractic Diagnostic PC	01/10/22 - 01/10/22	\$81.28	Dismissed without prejudice
	Golden Healthcare Chiropractic Diagnostic PC	02/03/22 - 02/04/22	\$236.28	Dismissed without prejudice
	Golden Healthcare Chiropractic Diagnostic PC	02/04/22 - 02/07/22	\$179.46	Dismissed without prejudice
	Golden Healthcare Chiropractic Diagnostic PC	02/09/22 - 02/10/22	\$236.28	Dismissed without prejudice
	Golden Healthcare Chiropractic Diagnostic PC	02/10/22 - 02/11/22	\$179.46	Dismissed without prejudice
	Golden Healthcare Chiropractic Diagnostic PC	02/15/22 - 02/16/22	\$236.28	Dismissed without prejudice
	Golden Healthcare Chiropractic Diagnostic PC	02/16/22 - 02/17/22	\$179.48	Dismissed without prejudice
	Golden Healthcare Chiropractic Diagnostic PC	02/18/22 - 02/18/22	\$138.58	Dismissed without prejudice
	Golden Healthcare Chiropractic	02/22/22 - 02/23/22	\$236.28	Awarded: \$236.28

	Diagnostic PC			
	Golden Healthcare Chiropractic Diagnostic PC	02/23/22 - 02/24/22	\$179.46	Awarded: \$125.16
	Golden Healthcare Chiropractic Diagnostic PC	02/28/22 - 03/01/22	\$232.07	Dismissed without prejudice
	Golden Healthcare Chiropractic Diagnostic PC	03/01/22 - 03/02/22	\$204.86	Dismissed without prejudice
	Golden Healthcare Chiropractic Diagnostic PC	03/02/22 - 03/03/22	\$153.58	Dismissed without prejudice
	Golden Healthcare Chiropractic Diagnostic PC	01/10/22 - 01/13/22	\$1,800.42	Awarded: \$1,452.72
	Golden Healthcare Chiropractic Diagnostic PC	01/13/22 - 01/13/22	\$40.88	Denied
Total			\$5,378.20	Awarded: \$2,175.60

- B. The insurer shall also compute and pay the applicant interest set forth below. 11/28/2022 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant's award shall bear interest at a rate of two percent per month, calculated on a pro rata basis using a 30-day month from the date payment became overdue to the date of the payment of the award pursuant to 11 NYCRR 65-3.9. The end date for the calculation of the period of interest shall be the date of payment of the claim. General Construction Law § 20 ("The day from which any specified period of time is reckoned shall be excluded in making the reckoning.")

Where a claim is timely denied, interest shall begin to accrue as of the date arbitration is requested by the claimant unless arbitration is commenced within 30 days after receipt of the denial, in which event interest shall begin to accrue as of the 30th day after proof of claim was received by the insurer. 11 NYCRR 65-4.5(s)(3), 65-3.9(c); Canarsie Medical Health, P.C. v. National Grange Mut. Ins. Co., 21 Misc.3d 791, 797 (Sup. Ct. New York Co. 2008) ("The regulation provides that where the insurer timely denies, then the applicant is to seek redress within 30 days, after which interest will accrue.")

C. Attorney's Fees

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

Respondent shall pay Applicant a separate attorney's fee, in accordance with 11 NYCRR 65-4.6(d). Since the arbitration request was filed on or after February 4, 2015, this case is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant an attorney's fee, in accordance with 11 NYCRR 65-4.6(d) subject to a maximum fee of \$1,360.00.

- 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 Westchester

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

12/15/2023

(Dated)

Gregory Watford

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:
83c2f19a179a90e611b70cfc75bbcd8

Electronically Signed

Your name: Gregory Watford
Signed on: 12/15/2023