American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Timothy D Groth MD PC (Applicant)	AAA Case No.	17-24-1342-4977
	Applicant's File No.	24-002391
- and -	Insurer's Claim File No.	0703462200 2PU
Allstate Insurance Company (Respondent)	NAIC No.	29688

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 (FD)

1. Hearing(s) held on 08/07/2024
   Declared closed by the arbitrator on 08/07/2024

   Robert Bott from The Licatesi Law Group, LLP participated virtually for the Applicant

   Adva White from Law Offices of John Trop participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$2,117.98**, 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 February 16, 2023, in which the Assignor, then a 64-year-old male, was injured. As a result of the impact, he complained of multiple injuries. Thereafter, he sought private medical attention where he was recommended to begin receiving conservative care treatments including chiropractic treatments.

   On October 31, 2023, Assignor underwent a Chiropractic independent medical examination (IME) conducted by Dr. John Johnson who concluded that Assignor's injuries had fully resolved. As a result of the IME, Respondent cut off chiropractic no-fault benefits effective November 24, 2023.

In dispute in this claim are the fees for fifteen (15) bills related to chiropractic treatment services provided to Assignor from 7/20/23 - 4/4/24. Applicant submitted the bills for payment in an amount totaling $2,117.98.

Respondent timely denied payment for DOS 8/1/23, 8/3/23 and 8/8/23 on the grounds that Applicant failed to submit the bills within 45 days after services were rendered.

Respondent timely denied payment for DOS 2/27/23, 2/29/24, 3/5/24, and 3/12/24 based upon the IME of Dr. Johnson.

Respondent denied payment for DOS 3/7/24, 3/19/23, 3/21/24 & 3/26/24 based upon the 8/28/18 IME of Dr. Paul Priolo.

Respondent did not pay or deny the bills for DOS 7/20/23, 3/28/24, 4/2/24 and 4/4/24 on the grounds that it did not receive these bills until they were listed on the AR-1 and included in Applicant's submission. Respondent argued that the claims are not ripe for arbitration and should be dismissed as premature.

Respondent also denied payment on the grounds that Applicant billed in excess of the amounts permitted under the fee schedule.

For the bill dated 7/20/203 Respondent did not pay or deny the bill on the grounds that it did not receive the bill until it was included in Applicant's submission. Respondent asserts that the bill was included in the instant arbitration prematurely and should be dismissed without prejudice. Repsondent also asserted that Aplicant billed in excess of the amounts permitted under the fee schedule.

The issues to be decided in this case are:

Whether Applicant established entitlement to No-Fault compensation for the post IME physical therapy treatment services provided to Assignor.

Whether Applicant provided proof that it submitted the bill for services rendered to Respondent within forty-five (45) days after services were rendered or provided reasonable justification for the late submission of the bill.

Whether Respondent made out a prima facie case of lack of medical necessity and, if so, whether Applicant rebutted it.

Whether Respondent established that Applicant billed in excess of the Fee schedule.

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). This matter was decided based

upon the submissions of the parties as contained in the ECF, as well as upon the oral arguments of the parties at the time of the hearing. All documents contained in the ADR folder that were submitted at least 30 days prior to the hearing date are hereby incorporated into this hearing and were considered in reaching my findings. These submissions constitute the record in this case. Evidence relating to the issues of fraud, staged accidents, fee disputes, proof of paid claims, and policy exhaustion need not be submitted at least 30 days prior to the hearing date. There were no witnesses.

Bills not received - Prima Facie Case

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.

DOS 7/20/23 ($136.70)

Respondent argued that it did not become aware of these bills until after Applicant's AR-1 was filed and said bills were listed in Applicant's arbitration submission.

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).

A review of the ECF revealed that Applicant did not upload any proof of mailing for this bill. At the hearing, Applicant acknowledged that it did not upload any proof of mailing for this bill.

Consequently, I find that Applicant has failed to sufficiently establish a prima facie case of entitlement to no-fault benefits for this bill. I also find that Applicant's submission of the bill 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.

Accordingly, this claim is dismissed without prejudice as premature.

DOS 3/28/24 ($141.52); DOS 4/2/24 ($141.52) & DOS 4/4/24($141.52)

During oral argument, Applicant's counsel maintained that in contemplation of the holding in State Farm v. Domotor, 266 AD3d 219 (2nd Dept. 1999), these bills do not have to be timely submitted to Respondent for payment.

In Domotor, the Appellate Division effectively ruled that once a carrier denies liability on a claim, it cannot thereafter insist upon adherence to the terms of the underlying policy. Similar to the case at bar, the carrier in Domotor initially provided benefits to the EIP but terminated same based upon the results of an IME.

Upon finding in favor of the claimant, the Domotor court provided:

"An insured's failure to provide timely written proof of loss is generally an absolute defense to an action to recover on the policy…However, this absolute defense may be waived…An insurance carrier may not insist upon adherence to the terms of its policy after it has repudiated liability on the claim by sending a letter disclaiming coverage….for "once an insurer repudiates liability the insured is excused from any of its obligations under the policy"

Similarly, in the instant case, Applicant's counsel argued that Respondent terminated benefits on 11/10/23 and the disputed services were rendered on 3/28/23, 4/2/24 and 4/2/24, after the IME cutoff date of 11/24/23.

Counsel argued that once Respondent issued the global denial terminating further treatments subsequent to the IME, the Applicant's obligations in terms of cooperating with the policy were extinguished.

However, upon further research of this issue, it should be noted that while Domotor may be applicable in some circumstances, the court in Country-Wide Ins. Co. v. Yao Jian Ping, 2024 NY Slip Op. 24033 (January 22, 2024), recently held that the termination of no-fault benefits based upon an IME cut-off does not automatically relieve an Applicant of the duties or requirements as required by the applicable no fault regulations.

In Country-Wide the carrier sought a trial de-novo subsequent to an arbitration decision which had been upheld by a master arbitrator. In part, the arbitrator and the master both agreed that once Country-Wide terminated further benefits based on an orthopedic IME, "the Applicant [defendant] was no longer required to submit bills to Respondent [plaintiff]."

The insurer argued that Domotor did not relieve an Applicant for benefits from the statutory and regulatory obligations and maintained that despite the IME cut-off, Applicant was still required to, among others, submit its bills to the carrier.

Notably, the Court in Country-Wide vacated the master arbitration award and issued a verdict in regard to the trial de-novo. The Court found in favor of the plaintiff-insurer.

Based on the Appellate Term's decision in Equilibrium of Life Acupuncture, P.C., v MVAIC (74 Misc 3d 129[A], 2022 NY Slip Op 50113[U] [App Term, 1st Dept 2022]), in Court in Country-Wide, the Honorable Richard Tsa held:

[T]he court agrees with plaintiff's reading of Domotor-that the insurer's repudiation of liability does not excuse the provider/eligible injured person from compliance with regulatory or statutory requirements of notice of the loss.

*In this court's view, the regulatory requirement of submission of a claim to a no-fault insurer on a prescribed claim form (or its substantial equivalent) is not identical to the policy [*6]requirement of submission of a proof of loss.[FN4] If no claim form is submitted to the insurer, the insurer has no notice of the loss at all.*

Accepting defendant's reading of Domotor would lead to absurd results, as illustrated by the facts of this case.

Defendant acknowledges that, under defendant's own reading of Domotor, plaintiff would not have any right to seek additional verification from defendant for any information missing from the statement of account which would have been required on the claim forms prescribed by the Department of Financial Services. To accept defendant's argument would, in effect, expand 11 NYCRR 65-3.5 (f) to require the insurer to accept any form that did not contain substantially the same information as the prescribed forms, even if the information was illegibly scribbled on a crumpled cocktail napkin, as plaintiff illustrated. This would be fundamentally unfair to the insurer, which would be left almost completely in the dark as to whether or not such a claim ought to be paid or denied.

Accepting defendant's expansive reading of Domotor would up-end the processing of no-fault claims, and undermine the aims of no-fault, which includes reducing the burden on the courts (Viviane Etienne Med. Care, P.C. v Country-Wide Ins. Co., 25 NY3d 498, 504-05 [2015]). Following defendant's logic, where Domotor would apply (i.e., where the insurer had repudiated coverage), a provider could commence action to recover no-fault benefits without ever having to submit any claim form in advance to the insurer, so long as something less than substantially similar to the information on a prescribed claim form was attached as an exhibit to the complaint. Because the insurer has received such a claim, the insurer would then have to start, and finish claims processing by the time the answer to the complaint was due. Every no-fault claim that would have been submitted in advance to the insurer could now be filed with the courts instead, because the provider would not be required to submit the claim to the insurer before the lawsuit.

For all the reasons above, Domotor does not apply."

Based on the foregoing, I find that Domotor does not apply in the instant matter and Applicant has failed to establish prima facie entitlement to no-fault reimbursement for these three (3) claims in dispute. There is no proof that the disputed claim was ever received by Respondent or that same are now past due. I find that there is nothing in the ECF record that would indicate that the claim in dispute was "overdue" when the arbitration was filed. Viviane Etienne Medical Care, P.C. v. Country-Wide Ins. Co., *supra.* Applicant has therefore failed to satisfy even the most minimal burden imposed upon a provider when seeking to establish its entitlement to no fault payments.

Consequently, the claims for DOS 3/28/24, 4/2/24 and 4/4/24 are dismissed without prejudice.

After reviewing the record and evidence presented, I find that Applicant established a prima facie case of entitlement to reimbursement of the remaining claims in dispute. Viviane Etienne Med Care, PC v. Countrywide Ins. Co., *Id*.

Once an applicant establishes a prima facie case, the burden then shifts to the insurer to prove its defense. See Citywide Social Work & Psych. Serv. P.L.L.C v. Travelers Indemnity Co., 3 Misc. 3d 608, 2004, NY Slip Op 24034 (Civ. Ct., Kings County 2004).

45 Day Rule

DOS 8/1/23, 8/3/23 & 8/8/23

Respondent denied payment for these bills based upon Applicant's failure to timely submit the bill (proof of claim) within 45 days of the date of services.

Respondent relies upon 11 N.Y.C.R.R. § 65-1.1 which provides:

> *"In the case of a health service expense, 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 the services are rendered." (Emphasis added)*

There is a "safety valve" for the above regulations specifically, 11 NYCRR 65 - 3.3 (e) which provides, "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."

An insurer may not invoke the 45-day rule to deny a claim where it fails in its denial form to apprise the claimant that late notice will be excused where it can provide reasonable justification for the failure to give timely notice. SZ Medical P.C. v. Country-Wide Ins. Co., 12 Misc.3d 52, 817 N.Y.S.2d 851 (App. Term 2d & 11th Dists. 2006). When the provider does not establish that it provided the insurer with the written justification for the untimely submission, the insurer should be granted judgment. AR

Medical Rehabilitation, P.C. v. MVAIC, 27 Misc.3d 135(A), 910 N.Y.S.2d 760 (Table), 2010 N.Y. Slip Op. 50828(U), 2010 WL 1910908 (App. Term 2d, 11th & 13th Dists. May 10, 2010).

As per the NF-10, services were rendered on 8/1/23 - 8/8/23. Respondent asserted that it received the bill on 3/27/24.

Respondent's denial states:

"Pursuant to Reg. 68, claims must be submitted 45 days from the date of treatment or 45 days from the date written notice is submitted to the insurer. Therefore, dates of service rendered 45 days prior to receipt of filing are denied. This rule applies to policies effective 4/26/02 (Revised Reg 68, effective 4/5/02)."

In the instant matter, the denial language clearly does not meet the criteria as stated in ARMedical Rehabilitation, P.C. v. MVAIC and SZ Medical P.C. v. Country-Wide Ins. Co., *supra.* I find that Respondent's denial failed to advise Applicant that late notice will be excused where the Applicant can provide reasonable justification of the failure to give timely notice.

Based upon the foregoing, I find that Respondent's denials cannot be sustained. Consequenlty, Applicant's claims are granted.

Accordingly, Applicant is entitled to be reimbursed in an amount consistent with the fee schedule.

IME Cut-off

Dr. Johnson - DOS 2/27/24, 2/9/24, 3/5/24, & 3/12/24

It should be noted that the sufficiency of Respondent's defense based upon the IME of Dr. Johnson has previously been addressed by this arbitrator in a linked award under AAA case # 17-24-1332-0054, dated 7/25/24. In the linked award, this arbitrator found in favor of Applicant. Addressing the Respondent's evidence in the linked award, this arbitrator opined:

"The IME report of Dr. Johnson was relied upon by Respondent and said report set forth those documents that were reviewed, detailed the examination that was performed, the findings of the examination, and concluded that Assignor was found to be within normal limits and without need for further treatment. Based on this report, the Respondent terminated future chiropractic benefits as of 11/24/23. Dr. Johnson rendered a diagnosis of: Resolved sprains/strains of the cervical spine, thoracic spine and lumbar spine.

Dr. Johnson opined:

"There is no evidence of a chiropractic disability at this time. The claimant has reached pre-accident status. The claimant can work and can perform his normal activities of daily living without restrictions or limitations. At this point, there is no necessity for chiropractic care. It is my opinion that there is no necessity for chiropractic care, household help, massage therapy, durable medical equipment, ambulette/ ambulatory

services, special transportation or diagnostic testing. The claimant has reached an end result in chiropractic treatment.

There do not appear to be any prior/pre-existing conditions having an impact on the current injury. . .

There were no objective findings noted at the time of today's examination to correlate with his subjective complaints. On examination of the neck, there were no findings of tenderness, decreased range of motion or objective findings such as spasms. The results of all tests performed were also negative as noted above in my exam. Neurologic examination of the upper extremities was objectively normal, as noted above. On examination of the mid back, there were no findings of tenderness or objective findings such as spasms. Although, on examination of the low back, there were reports of tenderness and decreased range of motion, there were no objective findings such as spasm.

Therefore, no treatment is indicated for the neck, mid back and low back."

I am not persuaded by Dr. Johnson's report, question its credibility and find that it is insufficient to establish lack of medical necessity of post IME chiropractic services. Applicant's counsel argued that there were documented reduced ranges of motion of 5% on all planes of the lumbar spine which were measured with a goniometer. Dr. Johnson also noted during his examination, there was minimal tenderness to palpation of the lumbar spine. As per the ECF, Assignor was a 64 year old male at the time of the accident. According to the IME, Assignor had no prior or pre-existing conditions that had an impact on his current injury.

Although there was documented decreased range of motion (by goniometer) to the lumbar spine on all planes, Dr. Johnson's diagnosis was resolved sprain and strain. I find that this objective finding from an independent source (goniometer) persuasively refutes Dr. Johnson's conclusion that Assignor's injuries to his back had fully resolved and that Assignor had reached pre-accident status.

Under these circumstances, I find that the IME report does not sufficiently set forth a credible factual basis and medical rationale for the conclusion that further chiropractic services are medically unnecessary. See, Ying Eastern Acupuncture, PC v. Global Liberty Insurance, supra.

Based upon the foregoing I find that Respondent has not sufficiently established proof to sustain its burden that the post IME treatment services in this case were not medically necessary. Consequently, the burden does not shift to Applicant to rebut Respondent's proof."

It is within the arbitrator's authority to determine the preclusive effect of a prior arbitration. Matter of Falzone v. New York Central Mutual Fire Ins. Co., 15 N.Y.3d 530, 914 N.Y.S.2d 67 (2010), aff'g, 64 A.D.3d 1149, 881 N.Y.S.2d 769 (4th Dept. 2009).

Under the doctrine of collateral estoppel, a party is precluded from relitigating an issue which has been previously decided against it in a prior proceeding where it had a full and fair opportunity to litigate the issue (*see* D'Arata v. New York Cent. Mut. Fire Ins. Co., 76 N.Y.2d 659 [1990]). 'The two elements that must be satisfied to invoke the doctrine of estoppel are that (1) the identical issue was decided in the prior action and is decisive in the present action, and (2) the party to be precluded from relitigating the issue had a full and fair opportunity to contest the prior issue (*see* Kaufman v. Lilly Co. [65 N.Y.2d 449, 455 (1985)])' (*Luscher v. Arrua*, 21 AD3d 1005, 1007 [2005]). 'The burden is on the party attempting to defeat the application of collateral estoppel to establish the absence of a full and fair opportunity to litigate' (*D'Arata*, 76 N.Y.2d at 664; *see also Kaufman*, 65 N.Y.2d at 456)." Uptodate Medical Service, P.C. v. State Farm Mutual Automobile Ins. Co., 22 Misc.3d 128(A), 880 N.Y.S.2d 227 (Table), 2009 N.Y. Slip Op. 50046(U) at 2, 2009 WL 78376 (App. Term 2d & 11th Dists. Jan. 9, 2009).

I find that in the instant matter there are no new facts that warrant reconsideration of the credibility of the IME report. Accordingly, I uphold my prior related award and adopt the findings of fact and conclusions of law therein.

I also find that the standard for Collateral Estoppel is met in this case. There is an identity of issues between the cases, namely, whether chiropractic treatment services provided by Applicant were necessary after the IME. In light of my prior award, it would be inconsistent for me to find Respondent's denial in this case can be sustained. Respondent had a full and fair opportunity to contest the prior decision, prosecuted the claims on the merits, and a decision was made on the merits. I find that Respondent's counsel has not sufficiently satisfied its burden to show the absence of a full and fair opportunity to litigate the issue of medical necessity of the post-IME treatments. Moreover, there are no documents to establish that the prior award has been vacated.

Based upon the foregoing, I find that Applicant is entitled to be reimbursed for these dates of service in an amount consistent with the fee schedule.

IME of Dr. Priolo

DOS 3/7/24, 3/19/24, 3/21/24 and 3/26/24

Applicant argued that Respondent's denial is legally insufficient as it must "promptly apprise the claimant with a high degree of specificity of the ground or grounds on which the disclaimer is predicated", per General Accident Insurance Company v. Cirucci, 46 N.Y.2d 862, 414 N.Y.S.2d 512 (1979).

As to the specifics of a proper denial, it has been held that one which does not correspond to the claim submitted is defective and the insurer is precluded from raising the defense asserted therein. St. Barnabas Hospital v. Auto One Ins. Co., 2009 N.Y. Slip Op. 32819(U) at 4-5, 2009 WL 4617656 (Sup. Ct. Nassau Co., Arthur M. Diamond, J., Nov. 20, 2009).

Here, Applicant submitted claims related to the accident on 2/16/23. A review of the ECF revealed that all of Applicant's claim forms list the claim # **0703462200-01.** It should be noted that all of Applicant's bills reference the date of accident as 2/16/23.

However, Respondent's denials for these bills reference an accident from 5/8/18. Moreover, a review of the specific NF-10s for these dates of service reference an accident date of 5/18/18 along with a claim **# 0501288104-01.** Respondent's denials reference the 8/28/18, IME report of Dr. Priolo. Respondent also uploaded a general denial, dated 9/6/18, terminating chiropractic and massage treatments based upon the IME of Dr. Priolo and an accident date of 5/8/18. Moreover, except for these for dates, there are no other documents which reference the 5/8/18 accident as being the subject of the instant arbitration.

Based upon the forging, I find that Respondent's denials for these dates of service are defective, confusing and unrelated to the instant arbitration filed by Applicant. General Acc. Ins. Group v. Cirucci, *supra.* Consequently, I find that Respondent's denials related to the 5/8/18 accident cannot be sustained for claims related to the 2/16/23 accident.

Accordingly, Applicant is entitled to be reimbursed in an amount consistent with the fee schedule for these dates of service.

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 2 nd, 11th and 13th Jud. Dists. 2011). Natural Acupuncture Health PC v. Praetorian Insurance Company, 30 Misc. 3d 132 (A), 2011 N Y slip op 50040 (U), (N.Y. App. Term 1st Dept. 2011).

If the fees can be determined from a straightforward reading of the fee schedule, no coder affidavit or fee audit is required. Absent a straight-forward reading confirming the correct rate, Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. See, Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 2006 NY Slip 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006).

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.

Region III

For the remaining eleven bills in dispute for DOS 2/27/23, 8/1/23, 8/3/23, 8/8/23, 2/29/24, 3/5/24, 3/7/24, 3/12/24, 3/19/24, 3/21/24 and 3/26/24, as per the NF-3s, the services were provided in Region III (Zip code 11967)

For these dates of service, Applicant billed $141.52 for each date using CPT codes 98941, 97012, 97014, 97010 and 92140. The codes are all covered by the RVU cap rule. Accordingly, Applicant is limited to $105.48 (8.79cf x 12 RVU) for a total of $1,160.28.

Applicant total award is $1,160.28.

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**
	Timothy D Groth MD PC	**02/27/24 - 02/27/24**	**$141.52**	**Dismissed without prejudice**
	Timothy D Groth MD PC	**02/29/24 - 02/29/24**	**$141.52**	**Awarded: $105.48**
	Timothy D Groth MD PC	**03/05/24 - 03/05/24**	**$141.52**	**Awarded: $105.48**
	Timothy D Groth MD PC	**03/12/24 - 03/12/24**	**$141.52**	**Awarded: $105.48**
	Timothy D Groth MD PC	**07/20/23 - 07/20/23**	**$136.70**	**Awarded: $105.48**
	Timothy D	**03/07/24 -**		**Awarded:**

	Groth MD PC	**03/07/24**	**$141.52**	**$105.48**
	Timothy D Groth MD PC	**03/19/24 - 03/19/24**	**$141.52**	**Awarded: $105.48**
	Timothy D Groth MD PC	**08/01/23 - 08/01/23**	**$141.52**	**Awarded: $105.48**
	Timothy D Groth MD PC	**08/03/23 - 08/03/23**	**$141.52**	**Awarded: $105.48**
	Timothy D Groth MD PC	**08/08/23 - 08/08/23**	**$141.52**	**Awarded: $105.48**
	Timothy D Groth MD PC	**03/21/24 - 03/21/24**	**$141.52**	**Awarded: $105.48**
	Timothy D Groth MD PC	**03/26/24 - 03/26/24**	**$141.52**	**Awarded: $105.48**
	Timothy D Groth MD PC	**03/28/24 - 03/28/24**	**$141.52**	**Dismissed without prejudice**
	Timothy D Groth MD PC	**04/02/24 - 04/02/24**	**$141.52**	**Dismissed without prejudice**
	Timothy D Groth MD PC	**04/04/24 - 04/04/24**	**$141.52**	**Dismissed without prejudice**
Total			**$2,117.98**	**Awarded: $1,160.28**

B. The insurer shall also compute and pay the applicant interest set forth below. 04/01/2024 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.

09/06/2024
(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:
a852e5e3e071176eec3576bb64c111f7

Electronically Signed

Your name: Gregory Watford
Signed on: 09/06/2024