American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Leviathan Wellness PLLC (Applicant)	AAA Case No.	17-23-1305-9639
	Applicant's File No.	BT23-235089
- and -	Insurer's Claim File No.	0511182690003
	NAIC No.	19704
American States Insurance Company (Respondent)		

ARBITRATION AWARD

I, Gary Peters, 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

1. Hearing(s) held on 08/16/2024
   Declared closed by the arbitrator on 08/16/2024

   Heather Landros from The Tadchiev Law Firm, P.C. participated virtually for the Applicant

   Michelle Randazzo from American States Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$9,884.12**, 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 Assignor was a 52 year old female who was a restrained driver of a motor vehicle and involved in an accident on 9/12/22.

   Applicant is seeking payment for medical services/surgical fee wherein the claim was denied by the Respondent for lack of medical necessity, based on its Independent Peer Review Report and for various fee schedule issues.

4. Findings, Conclusions, and Basis Therefor

This hearing was conducted using the Electronic Case Folder maintained by the American Arbitration Association. All documents contained in that folder are made part of the record of the hearing and I have reviewed the documents contained therein. Any documents submitted after the hearing or at the hearing that have not been entered in the Electronic Case Folder as of the date of this award, will be listed immediately below this language and forwarded to the American Arbitration Association at the time this award is issued for inclusion.

The Assignor was injured in a motor vehicle accident on 9/12/22.

The Assignor presented to NP/Noah Godwin, M.D. on 11/30/2022 with complaints of pain in the low back, mid back and neck 6-9/10 in intensity. Her examination findings were noted positive for tenderness and ROM with pain in the cervical spine and lumbar spine and tenderness in the thoracic spine, positive Facet Loading test and Spurling's test in the cervical spine and Facet Loading test and SLR test in the lumbar spine. Diagnoses of cervical facet joint syndrome, cervicalgia, low back pain, lumbar facet joint syndrome, myofascial pain, muscle spasm of back, other cervical disc displacement unspecified level, other intervertebral disc displacement, lumbar region, pain in thoracic spine, radiculopathy, cervical region, radiculopathy, lumbar region and thoracic facet syndrome were made. She was advised to undergo conservative care. She was advised to undergo physical therapy and cervical, thoracic, lumbar epidural steroid injections.

The Assignor received conservative care with chiropractic care from 10/10/2022 until 04/03/2023 as per the medical records.

During the course of treatment assignor was evaluated by Yuri Shimonov, NP on 02/22/2023 and presented with complained of pain in the neck and lower back 7-8/10 in intensity. She was diagnosed with cervicalgia, radiculopathy, cervical region, other cervical disc displacement, unspecified cervical region, other intervertebral disc displacement lumbar region, low back pain, unspecified, vertebrogenic low back pain, myalgia, unspecified site, radiculopathy, lumbar region, spondylosis without myelopathy or radiculopathy, cervical region and spondylosis without myelopathy or radiculopathy, lumbar region were made. She was advised to undergo physical therapy and cervical/lumbar discectomy and annuloplasty, percutaneously.

The Assignor was also seen by Kristin McDonough, PA-C/Milan Sen, MD on 02/24/2023 for complaints of pain in the left shoulder 8/10 in intensity. Her examination findings were noted positive for tenderness and decreased ROM with pain in the left shoulder, positive Impingement test, Neer's test, Hawkins test, Cross Arm test and Speed test in the left shoulder. Diagnoses of left shoulder sprain and left shoulder internal derangement were made. She was advised to undergo physical therapy and MRI of the left shoulder. M.R.I. of the left shoulder on 3/15/23 confirmed tear of anterior labrum and synovitis.

She was seen by Kristin McDonough, PA-C/Milan Sen, MD on 03/23/2023 for complaints of pain in the left shoulder 9/10 in intensity. Her examination findings were noted positive for tenderness and decreased ROM with pain in the left shoulder,

positive Impingement test, Neer's test, Hawkins test, Cross Arm test, O'Brien test and Speed test in the left shoulder. Diagnoses of left shoulder partial thickness rotator cuff tears, left shoulder labral tears and left shoulder traumatic impingement syndrome were made. She was advised to undergo left shoulder arthroscopy.

MRI of the Left Shoulder on 03/15/2023 showed the anterior labrum is avulsed and torn. The biceps tendon is hypoplastic. Impingement. Glenohumeral joint effusion. Tendinosis/tendonitis with intrasubstance tearing of the infraspinatus subscapularis and supraspinatus tendons. AC joint narrowing with acromion spurring. Synovitis of the patulous axillary pouch of the inferior glenohumeral ligament.

July Gaysynsky, MD noted that on 03/25/2023 assignor continues to complain of pain in the left shoulder. She was advised to undergo lab studies, ECG and left shoulder and was advised to undergo left shoulder arthroscopy which was performed on 4/4/23.

Once an Applicant establishes a prima facie showing, the burden shifts to the Respondent. Respondent's denial for lack of medical necessity must be supported by competent medical evidence setting for a clear and factual basis and medical rationale for denying the claim. Citywide Social Work v. Travelers Indemnity Company, 3 Misc.3d 608 (Civil Court, Kings County, 2004).

To successfully support its denial, the Respondent's Peer Review or I.M.E. Report must address all pertinent objective findings contained in the Applicant's medical submissions and set forth how and why the disputed services were inconsistent with generally accepted medical practices. The conclusory opinions of a peer reviewer, standing alone and without support of medical authorities, will not be considered sufficient to establish the absence of medical necessity (Citywide Social Work v. Travelers Indemnity Company,) Supra; Amaze Medical Supply Inc. v. Eagle Insurance Company, 2 Misc.3d 128A, 784 N.Y.S.2d 918 (App. Term 2d 11th Judicial District).

Where Respondent meets its burden, it is incumbent upon the claimant to rebut the findings and recommendations of the Respondent's reports. The insured/provider bears the burden of persuasion on the question of medical necessity. Specifically, once the insurer makes a sufficient showing to carry its burden of coming forward with evidence of lack of medical necessity, plaintiff must rebut it or succumb (Bedford Park Medical Practice, P.C. v. American Transit Insurance Company, 8 Misc.3d 1025A).

It is undisputed that the Applicant has established a prima facie case of entitlement to first party benefits by demonstrating it submitted a timely claim setting forth the fact, amount of loss sustained and that payment of the claim has not been made. As stated above, the burden shifts to the Respondent to set forth a clear and factual basis in medical rationale to deny the claim.

On behalf of the Respondent, Dr. Schlatterer stated the records failed to support the medical necessity of left shoulder major synovectomy, extensive debridement, lysis of adhesions, subacromial decompression with acromion acromioplasty, rotator cuff repair using 1 anchor and assistant services for left shoulder major synovectomy, extensive debridement, lysis of adhesions, subacromial decompression with acromion acromioplasty, rotator cuff repair using 1 anchor and anesthesia.

In a randomized controlled trial conducted by Beard DJ et al it is concluded that, "In conclusion, we showed that, in patients with persistent subacromial shoulder pain due to impingement, improvement in Oxford Shoulder Scores with arthroscopic subacromial decompression did not differ to that achieved with arthroscopy only (placebo surgery). Although both types of surgery provide greater symptom improvement than no treatment, this difference was of uncertain clinical significance. The findings (which should be communicated to patients during the shared treatment decision-making process) question the value of this type of surgery for these indications, and might discourage some surgeons from offering decompression surgery and dissuade some patients from undergoing the surgery." Link Source https:// www.ncbi.nlm.nih.gov/pmc/articles/PMC5803129/.

Overall review of literature has a divided opinion regarding surgical rotator cuff repair. While there are more randomized controlled trials that indicate surgical intervention has not proven to be effective in chronic rotator cuff tear. The standard of care for shoulder pain indicates that the surgical intervention should be considered for patients with persistent shoulder pain even after the trial of conservative care for at least 3-6 months. While intervention for interstitial rotator cuff tears do not have a measurable positive outcome and these should be treated conservatively. Full thickness rotator cuff tears are known to occur more commonly in the elderly and there is a paucity of the literature on the outcome post arthroscopy for these. However full thickness tears often need surgery as these are unlikely to heal on their own.

This Assignor suffered a left shoulder injury post MVA. There were complaints of pain and difficulty to move the shoulder. The physical examination was indicative of decreased ROM in all planes and positive impingement. There was a supraspinatus tendonitis and tendinopathy tear noted on MRI. There is no record of physical therapy prior to the surgery for the right shoulder pain. The standard of care for partial thickness rotator cuff tear indicates that at least 3-6 months of conservative care should be tried before surgery is considered.Therefore the surgery is not medically necessary due to lack of conservative care.

As surgery is not considered medically necessary, related perioperative procedures including anesthesia, assistance services, facility charges and related DMEs and medications are not medically necessary.

Milan Sen, M.D., reviewed the peer review report dated 05/05/2023 by Dr. Daniel Schlatterer, and disagreed with the assessment and stated the patient's clinical picture, the left shoulder arthroscopy and associated services were medically necessary.

Regarding pertinent history of the presenting illness, the patient initiated treatment following an MVA that occurred on 09/12/2022. During consultation on 02/24/2023, the patient presented with left shoulder pain rated 8/10 in severity. The patient reported associated difficulty performing overhead activities, sleeping, and completing activities of daily living (ADLs). The physical exam showed left shoulder with decreased range of motion; tenderness to palpation; muscle weakness (internal rotation and external rotation); and positive Neer, Hawkins, and Speed tests. The clinical impression at this time included internal derangement of the left shoulder. The treatment plan included physical therapy and potential arthroscopic intervention.

The 03/15/2023 MRI of the left shoulder showed the anterior labrum is avulsed and torn, the biceps tendon is hypoplastic, impingement, glenohumeral joint effusion, tendinosis/tendonitis with intrasubstance tearing of the infraspinatus subscapularis and supraspinatus tendons, AC joint narrowing with acromion spurring, and synovitis of the patulous axillary pouch of the inferior glenohumeral ligament.
Regarding conservative treatment targeting the shoulder, the patient underwent NSAID treatment, chiropractic treatment, and physical therapy.

Regarding the difference between the peer reviewer's suggested standard of care for the aforementioned pathologies and the treatment course that was enacted for this patient, Dr. Sen stated that there are conflicting standards of care for rotator cuff injuries, and it is recommended that clinicians use their best judgement for surgical intervention. It has been established that there is "significant variation in surgical decision-making and a lack of clinical agreement among orthopaedic surgeons about rotator cuff surgery." Dunn WR, Schackman BR, Walsh C, Lyman S, Jones EC, Warren RF, Marx RG. Variation in orthopaedic surgeons' perceptions about the indications for rotator cuff surgery. J Bone Joint Surg Am. 2005 Sep;87(9):1978-84.

Regarding an alternative standard of care, the peer reviewer states that "[t]he standard of care for shoulder pain indicates that the surgical intervention should be considered for patients with persistent shoulder pain even after the trial of conservative care for at least 3-6 months." This claim appears to solely represent to peer reviewer's personal opinion, as they fail to provide any of the aforementioned sources. There is a plethora of peer reviewed literature that supports the treatment course that was enacted for this patient. The conservative management prior to intervention was more than adequate given the severity of the patient's injuries, and the risk of further deterioration and impairment without arthroscopic intervention.

Regarding shoulder injuries, the NYS Workers' Compensation Board Medical Treatment Guidelines state: "All operative interventions must be based upon positive correlation of clinical findings, clinical course and imaging and other diagnostic tests […] For surgery to be performed to treat pain, there must be clear correlation between the pain symptoms and objective evidence of its cause." As explained below, there was careful consideration of the patient's subjective findings, clinical course, clinical findings, and imaging prior to moving from conservative treatment to surgical intervention. The aforementioned clinical course included persistent shoulder pain and impairment despite a sufficient trial of conservative management. Thus, in accordance with the NYS Workers' Compensation Treatment Guidelines, it was determined that the patient was an ideal candidate for surgical intervention.

"The cause of shoulder impingement syndrome usually is considered to be compression of the rotator cuff and subacromial bursa against the anterolateral aspect of the acromion. The typical symptom is anterolateral shoulder pain that worsens at night and with overhead activity." Buss DD, Freehill MQ, Marra G. Typical and atypical shoulder impingement syndrome: diagnosis, treatment, and pitfalls. Instr Course Lect. 2009;58:447-57.

Given the patient's history of a traumatic accident in addition to the subjective reports of shoulder pain with associated difficulty performing overhead activities and sleeping,

it was entirely likely that the patient suffered from a rotator cuff tear, impingement syndrome, and a labral tear based on their history and presentation alone.

The physical exam findings following a traumatic injury to the shoulder are an essential part of the diagnostic process. The American Academy of Orthopaedic Surgeons states that: "Strong evidence supports that clinical examination can be useful to diagnose or stratify patients with rotator cuff tears; however, combination of tests will increase diagnostic accuracy." Additionally, "Evidence from 8 high quality studies (Liu 2016, Lin 2015, Castoldi 2009, Park 2005, Litaker 2000, Villafane 2015, Holtby 2004, Gillooly 2010) indicate that the following tests are useful to diagnosis full thickness rotator cuff tear: bear hug test, belly press test, empty can test, external rotator lag sign, external rotation resistance test, full can test, Hawkins test, Hug up test, internal rotation lag sign (IRLS) test, internal rotation resistance test (IRRT) test, Internal rotation resistance test at maximal 90 degrees of abduction and maximal external rotation (IRRTM) test, Jobe Test, Lateral Jobe Test, Lift off test, NEER test, Patte Test, and Yocum test. Generally, these tests are better to diagnose (rule in), than screening (rule out) full thickness rotator cuff tears." Management of rotator cuff injuries - American Academy of Orthopaedic Surgeons. (n.d.). https://www.aaos.org/globalassets/quality-and-practice-resources/rotator-cuff/rotator-cuff-cpg-final-12-20-19.pdf

Additionally, it has been established that "patients who demonstrate full passive ROM but a limitation in active ROM may have impingement syndrome or a rotator cuff tear. Weakness in external rotation (infraspinatus/teres minor), forward elevation (supraspinatus), and internal rotation or liftoff (subscapularis) could indicate a tear of the rotator cuff." Ponnappan, Ravi K. MD; Khan, Mustafa MD; Matzon, Jonas L. MD; Sheikh, Emran S. MD; Tucker, Bradford S. MD; Pepe, Matthew D. MD; Tjoumakaris, Fotios P. MD; Nassr, Ahmad N. MD. Clinical Differentiation of Upper Extremity Pain Etiologies. Journal of the American Academy of Orthopaedic Surgeons: August 2015 - Volume 23 - Issue 8 - p 492-500.

The patient's clinical exam was positive for decreased range of motion, weakness in internal rotation and external rotation, and Hawkins and Neer tests, indicating that there was a rotator cuff tear that would benefit from surgical repair.

Regarding physical exam tests used to diagnose subacromial impingement syndrome (SIS), "the best combination of tests for making the diagnosis of impingement disease of any degree are a positive Hawkins-Kennedy impingement sign, a positive painful arc sign, and weakness in external rotation" .

Regarding physical exam tests used to diagnose a labral tear such as a SLAP, please see the following: "When clinicians suspect the presence of a labral tear, the [O'Brien's] active compression test should be chosen first, crank test second, and Speed test third […] Sensitivity values of the active compression test ranged from 47% to 78%. Crank test sensitivity values ranged from 13% to 58%. Speed test sensitivity values were the lowest, ranging from 4% to 48% […] Positive crank and Speed test results strongly suggest the presence of a labral tear. No test in the analysis strongly excluded the presence of labral tear." Meserve BB, Cleland JA, Boucher TR. A Meta-analysis Examining Clinical Test Utility for Assessing Superior Labral Anterior Posterior

Lesions. The American Journal of Sports Medicine. 2009;37(11):2252-2258. Additionally, "For SLAP tears (ie, superior labral tear from anterior to posterior), the shoulder relocation test and the Yergason test are used." Ponnappan, Ravi K. MD; Khan, Mustafa MD; Matzon, Jonas L. MD; Sheikh, Emran S. MD; Tucker, Bradford S. MD; Pepe, Matthew D. MD; Tjoumakaris, Fotios P. MD; Nassr, Ahmad N. MD. Clinical Differentiation of Upper Extremity Pain Etiologies. Journal of the American Academy of Orthopaedic Surgeons: August 2015 - Volume 23 - Issue 8 - p 492- 500.

As mentioned previously, the patient's clinical exam was positive for Speed test, indicating that there was a labral tear that would benefit from surgical repair. Regarding impingement syndrome, it has been shown that "MRI is a valuable method capable of demonstrating partial tears and tendinitis in stage 1 and 2 SIS." CaliÅ M, Akgün K, Birtane M, Karacan I, CaliÅ H, Tüzün F. Diagnostic values of clinical diagnostic tests in subacromial impingement syndrome. Ann Rheum Dis. 2000 Jan;59(1):44-7.

This is all to say that the MRI can be a useful component in diagnosing a rotator cuff tear or shoulder pathology. However, the results must be used in conjunction with the patient's subjective presentation and physical exam findings. In this case, the presence of the anterior labrum is avulsed and torn, the biceps tendon is hypoplastic, impingement, glenohumeral joint effusion, tendinosis/tendonitis with intrasubstance tearing of the infraspinatus subscapularis and supraspinatus tendons, AC joint narrowing with acromion spurring, and synovitis of the patulous axillary pouch of the inferior glenohumeral ligament on MRI results of the shoulder confirmed the suspicion that the patient was suffering from an acute shoulder injury that necessitated surgical intervention.

Research also supports the treatment of impingement syndrome (compression of the rotator cuff muscles/tendons) via surgical intervention: "Impingement-type symptoms of pain brought on by overhead activities […] can be treated by arthroscopic or min-open subacromial decompression that involves removal of the thickened bursa, thus alleviating the compression that is the cause of chronic irritation and inflammation. In more advanced cases with associated partial- or full-thickness rotator cuff tears, a tendon debridement or repair is performed during the same procedure. This provides substantial pain relief and functional improvement in 75-86% of patients" Gomoll AH, Katz JN, Warner JJ, Millett PJ. Rotator cuff disorders: recognition and management among patients with shoulder pain. Arthritis Rheum. 2004 Dec;50(12):3751-61.

"Impingement on the tendinous portion of the rotator cuff […] is responsible for a characteristic syndrome of disability of the shoulder […] Anterior acromioplasty may offer better relief of chronic pain in carefully selected patients with mechanical impingement, while it provides better exposure for repairing tears of the supraspinatus, and may prevent further impingement and wear at the critical area without loss of deltoid power." Neer CS 2nd. Anterior acromioplasty for the chronic impingement syndrome in the shoulder: a preliminary report. J Bone Joint Surg Am. 1972 Jan;54(1):41-50.

"The rotator cuff impingement is the most important single source of chronic shoulder complaints in orthopaedic patients. The anterior acromioplasty described by Neer is accepted as efficient method if conservative treatment fails. Besides their good results the arthroscopic technique of subacromial decompression is increasingly gaining popularity due to less surgical morbidity, decreased hospital stay and quicker rehabilitation." Schröder J, van Dijk CN, Wielinga A, Kerkhoffs GM, Marti RK. Open versus arthroscopic treatment of chronic rotator cuff impingement. Arch Orthop Trauma Surg. 2001 May;121(5):241-4.

Finally, published literature also supports the treatment of labral tears via surgical intervention: "[F]avorable clinical outcomes can be anticipated in the majority of patients after arthroscopic SLAP lesion repair… patients with a distinct traumatic etiology have a higher level of satisfaction with regard to their outcome […] The median patient-reported satisfaction rating was 9 (of 10); forty-one patients (87%) rated the outcome as good or excellent. The median patient- reported satisfaction rating was significantly higher for patients with a discrete traumatic etiology than for those with an atraumatic etiology." Brockmeier SF, Voos JE, Williams RJ 3rd, Altchek DW, Cordasco FA, Allen AA; Hospital for Special Surgery Sports Medicine and Shoulder Service. Outcomes after arthroscopic repair of type-II SLAP lesions. J Bone Joint Surg Am. 2009 Jul;91(7):1595-603. In other words, surgical intervention to treat a labral tear resulting from a traumatic injury, e.g., a motor vehicle accident, has a higher satisfaction rating than surgically treating labral tears resulting from non-traumatic origins.

After reviewing all the evidence, I find the Respondent has failed to establish that the treating physicians deviated from standard accepted medical practice. Dr. Sen cited to a multiple medical literature including journals, treatises and other materials to establish that the surgical intervention was in the best interest of the patient after non-surgical treatment failed

Clearly, there are opinions, articles, journals, and other materials that both support and/or recommend against the surgical procedures for persons with injuries such as the ones sustained by the Assignor in the instant case. The Respondent has failed to establish that the Applicant deviated from standard accepted medical practice.

Lastly, the Respondent maintained that the Applicant billed improperly and that the proper reimbursement should be $6,424.40.

On behalf of the Respondent, Gillian Rollins, submitted a detailed analysis as to what the proper billing should be. She stated that as per NYS Fee Schedule Introductions and General Guidelines, the Relative Value column lists the relative value units (RVU) used to calculate the fee amount for a service. Except as otherwise provided in the schedule, the maximum fee amount is calculated by multiplying the relative value units by the applicable conversion factor. Conversion factor for Region IV is $251.94 for surgery.

Per 2018 NYS Fee Schedule Surgery Ground Rules 12F Concurrent Services by More Than One Provider- Physician Assistants and Nurse Practitioners states the following, "*Services of physician assistants assisting during surgical procedures will be paid at two- thirds of the surgical assistant percentage… Physician assistants will receive 10.7% of the total allowance for the surgical procedures…* "

Per 2018 NYS Fee Schedule Surgery Ground Rules 5 Multiple or Bilateral Procedures states the following, "*When multiple procedures, unrelated to the major procedure and adding significant time or complexity, are provided at the same operative session, payment is for the procedure with the highest allowance plus half of the lesser procedures…"*

The

Respondent's

Coder Fee

Summary:

MD

Allowance

Code	F/S Amount	Comment (If Applicable)
29827-LT	**$2,348.08**	**RVU 9.32 x $251.95**
29823-59-51-RT	**$1,032.95**	**RVU 8.20 x $251.95 x 50% (Multiple Procedure)**
29821-59-51-RT	**$895.65**	**RVU 7.77 x $251.94 x 50% (Multiple Procedure)**
29826-59-51-RT	**$496.32**	**RVU 1.97 x $251.94**
29825-59-51-RT	**$1,030.43**	**RVU 8.18 x x $251.94 x 50%**

		(Multiple Procedure)

PA Allowance

Code	F/S Amount	Comment (If Applicable)
29827-83-RT	**$251.24**	**RVU 9.32 x $251.95 x 10.7%** **(PA Allowance)**
29823-83-59-51-RT	**$110.53**	**RVU 8.20 x $251.95 x 50%** **(Multiple Procedure) x 10.7% (PA Allowance)**
29821-83-59-51-RT	**$95.83**	**RVU 7.77 x $251.94 x 50%** **(Multiple Procedure) x 10.7% (PA Allowance)**
29826-83-59-51-RT	**$53.11**	**RVU 1.97 x $251.94 x 10.7%** **(PA Allowance)**
29825-83-59-51-RT	**$110.26**	**RVU 8.18 x x $251.94 x 50%** **(Multiple Procedure) x 10.7% (PA Allowance)**

Total eligible amount due: $6,424.40

The insurer has the burden of proving that the fees charged were excessive and not in accordance with the Worker's Compensation fee schedule. St. Vincent Medical Care PC v. Countrywide Insurance Company, 26 Misc. 3d 146 (A), 907 NYS 2d 441 (App. Term 2d, 11th and 13th Dists. 2010). If the insurer fails to demonstrate, by competent evidentiary proof, that the claims were excess of the appropriate fee schedule, the defense of noncompliance cannot be sustained. See, Continental Medical PC v Travelers Indemnity Company, 11 Misc.3d 145(a), 819 NYS 2d 847 (App Term 1st Dept. 2006).

I find the Respondent has established that the proper payment should be $6,424.40 for the operative procedures and related services including a Physician Assistant Fee.

The Applicant failed to provide its own Fee Coder Report. Accordingly, Applicant is awarded payment in the sum of $6,424.40.

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**
	Leviathan Wellness PLLC	**04/04/23 - 04/04/23**	**$8,928.75**	**Awarded: $5,803.43**
	Leviathan Wellness PLLC	**04/04/23 - 04/04/23**	**$955.37**	**Awarded: $620.97**
Total			**$9,884.12**	**Awarded: $6,424.40**

B. The insurer shall also compute and pay the applicant interest set forth below. 06/30/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest to be 2% per month simple, not compounded on a pro rata basis using a 30 day month. Respondent shall compute and pay Applicant interest from the day of filing of arbitration to the date of payment of the award.

C. Attorney's Fees

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

The insurer shall pay the Applicant an attorney fee in accordance with 11 NYCRR 65-4.6(d) or "As this matter 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 11NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the Applicant an attorney fee in accordance with the newly promulgated 11 NYCRR 65-4.6(d). This amendment takes into account that the maximum attorney fee has been raised from $850.00 to $1360.00

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 nassau

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

09/13/2024
(Dated)

Gary Peters

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:
f17eb46457fe5e685c4edbbb00f22095

Electronically Signed

Your name: Gary Peters
Signed on: 09/13/2024