American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

CitiMed Complete Medical Care PC (Applicant)	AAA Case No.	17-23-1314-6943
	Applicant's File No.	RB-204-375954
- and -	Insurer's Claim File No.	223726437
	NAIC No.	24260
Progressive Casualty Insurance Company (Respondent)		

ARBITRATION AWARD

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

Injured Person(s) hereinafter referred to as: Assignor-O.R.V.R.

1. Hearing(s) held on 08/22/2024
   Declared closed by the arbitrator on 08/22/2024

   Elyse R. Ulino from Baker & Narkolayeva Law P.C. participated virtually for the Applicant

   Regina Wilcox from Progressive Casualty Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$1,672.79**, was AMENDED and permitted by the arbitrator at the oral hearing.

   Applicant amended the amount in dispute from the original amount of $1,672.79 to $1,175.73. The bills for dates of service 5/11/2022, 5/16/2022, and 5/23/2022 through 5/24/2022 ($161.24) were withdrawn as paid in accordance with the applicable fee schedule.

   Stipulations WERE made by the parties regarding the issues to be determined.

   The parties stipulated and agreed that (i) Applicant has met its prima facie burden by submitting evidence that payment of no-fault benefits is overdue, and proof of its claims were mailed to and received by Respondent and (ii) Respondent's denials of the subject claims were timely issued.

3. Summary of Issues in Dispute

The record reveals that Assignor-O.R.V.R., a 51-year-old male, claimed injuries as the driver of a motor vehicle involved in an accident that occurred on 4/6/2022.Applicant seeks reimbursement for office visits, outcome assessment testing, EMG/NCV testing, physical therapy, and chiropractic treatment conducted from 5/23/2022 through 10/25/2022. Respondent partially denied the claim based on the bills exceeded the applicable Fee Schedule and based on a lack of medical necessity per the results of Independent Medical Evaluations (IME) performed by Pierce J. Ferriter, M.D., effective 8/29/2022, and Dr. David, D.C., effective 9/9/2022. The issues to be determined are 1) whether Respondent properly partially denied payment of the services based on the New York State Workers' Compensation fee schedule and 2) whether the services are medically necessary?

4. Findings, Conclusions, and Basis Therefor

Applicant seeks reimbursement foroffice visits, outcome assessment testing, EMG/NCV testing, physical therapy, and chiropractic treatment. This case was decided based upon the submissions of the Parties as contained in the electronic file maintained by the American Arbitration Association, and the oral arguments of the parties' representatives at the hearing held via Zoom. There were no witnesses. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

11 NYCRR 65-4.5 (o) (1) (Regulation 68-D), reads as follows: The arbitrator shall be the judge of the relevance and materiality of the evidence offered and strict conformity to legal rules of evidence shall not be necessary. The arbitrator may question any witness or party and independently raise any issue that the arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department Regulations.

Respondent partially paid for the EMG/NCV testing billed on date of service 5/23/2022 and acknowledges that the balance of the bill ($558.51) is due and owing. Furthermore, Respondent partially paid for the office visit billed under CPT code 99214 on date of service 8/17/2022 and acknowledges that the balance of the bill ($36.42) is due and owing.

FEE SCHEDULE

It is well established that a healthcare provider must limit its charges according to the applicable fee schedule. Goldberg v. Corcoran, 153 AD2d 113, 117-18 (App Div, 2d Dept 1989). Amended Regulations section 65-3.8(g)(1) states proof of the fact, and amount of loss sustained pursuant to Insurance Law section 5106(a) shall not be deemed supplied by an applicant to an insurer and no payment shall be due for such claimed medical services under any circumstances: (i) when the claimed medical services were

not provided to an injured party; or (ii) for those claimed medical service fees that exceed the charges permissible pursuant to Insurance Law sections 5108(a) and (b) and the regulations promulgated thereunder for services rendered by medical providers. This subdivision applies to medical services rendered on or after April 1, 2013.

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

An insurer's unilateral decision to re-code or change a medical provider's billed CPT codes, to reimburse disputed medical services at a reduced rate, or to deny a claim in its entirety, is ineffectual when unsupported by a peer review report or by other proof setting forth a sufficiently detailed factual basis and medical rationale for the code changes, fee reductions and denials. *See* Amaze Medical Supply v. Eagle Insurance Company, 2 Misc 3d 128A (App Term 2d and 11th Jud Dist 2003). A lay person is not qualified to evaluate the CPT codes or to change if the code is used by a health provider in its bills. *See* Abraham v. Country-Wide Ins. Co., 3 Misc. 3d. 130A (App. Term 2d. Dept. 2004). Once the insurer makes a prima facie showing that the amounts charged by a provider were in excess of the fee schedule, the burden shifts to the provider to show that the charges involved a different interpretation of such schedule or an inadvertent miscalculation or error. Cornell Medical, P.C. v. Mercury Casualty Co., 24 Misc. 3d 58, 884 N.Y.S.3d 558 (App. Term 2d, 11th &13th Dists. 2009).

Judicial notice of the New York Fee Schedule is taken. *See*, Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co., 61 A.D.3d 13, 20 (2d Dept. 2009); LVOV Acupuncture, P.C. v. Geico Ins. Co., 32 Misc.3d 144(A) (App Term 2d, 11th & 13th Jud Dists. 2011); Natural Acupuncture Health, P.C. v. Praetorian Ins. Co., 30 Misc.3d 132(A) (App Term, 1st Dept. 2011).

ANALYSIS

On 8/17/2022 Applicant billed for an office visit under CPT code 99214 ($117.17) and outcome assessment testing under CPT code 99358 ($257.61). The office visit was partially paid and Respondent acknowledges that the balance of the bill is owed

($36.42). Respondent denied the outcome assessment testing stating, "Per CPT guidelines, code 99358 should not be reported in conjunction with E and M codes 99202-99215". Applicant seeks the balance of $257.61.

Services in dispute were provided to a New York resident and performed in zip code 10601 of New York, which is in Region III. Therefore, the New York Worker's Compensation Fee Schedule applies.

In support of its reductions, Respondent submits a copy of the NYS Workers' Compensation Medical Fee Schedule, Introduction & Guidelines, the Evaluation and Management (E/M) sections, as well as the pertinent pages of the CPT Assistant, 2022, which states, "Codes 99358, 99359 may be used during the same session of an evaluation and management service, except office or other outpatient services (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215)" and "Do not report 99358, 99359 on the same date of service as 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99217".

"An insurer who raises this defense will prevail if it demonstrates that it was correct in its reading of the fee schedules unless the plaintiff shows that 'an unusual procedure or unique circumstance justifies the necessity' for a charge above the schedules fee. 11 NYCRR 68.4." Jesa Medical Supply, Ind. V. Geico Ins. Co., 2009 NY Slip Op. 29386, 25 Misc. 3d 1098, (Civ. Ct. Kings Co. 2009).

I find Respondent's calculations, based on a clear reading of the NYS Workers' Compensation Medical Fee Schedule, the CPT Guidelines, and all applicable sources, sufficient to establish a prima facie showing that the amounts charged by Applicant were in excess of the fee schedule. The burden now shifts to Applicant to show that the charges involved a different interpretation of such schedule or an inadvertent miscalculation or error. *See*, Cornell Medical, *supra*.

Applicant submits a undated generic affidavit from Certified Professional Coder (CPC) Priti Kumar, prepared in relation to a different claimant and bill, which states in pertinent part, "Furthermore, **there is no prohibition in NY WC FS for the Applicant to bill** separately **the non-face-to-face prolonged evaluation under code 99358along withfollow up visit,** and Applicant is entitled for separate payment for the non-face-to-face prolonged evaluation (code 99358) along with the follow-up evaluation at the rates as per NY Workers' Compensation fee schedule performed on DOS at issue" and "CPT code 99358 is located in the Evaluation and Management section of the Medical Fee Schedule; and there is no Ground Rule within this chapter that prohibits a provider from separately billing for an evaluation and prolonged evaluation (OAT) (as defined under CPT code 99358)".

Regarding the outcome assessment testing conducted on each date of service, the 2022 CPT Assistant supports the Respondent's assertion that CPT code 99358 cannot be billed with CPT 99214. New York recognizes CPT Assistant as a source which should be considered when evaluating claims for No-Fault benefits. *See* Matter of Global Liberty Ins. Co. v. McMahon, 172 A.D.3d 500, 99 N.Y.S.3d 310, 2019 NY Slip Op 03692 (App. Div., First Dept., May 9, 2019). I do not find Applicant's generic CPC affidavit credible

or persuasive. Ms. Kumar does not address the referenced CPT Assistant 2022, which directly rebuts her position that there is no prohibition against billing a follow-up office visit with CPT code 99358.

Applicant has not submitted competent evidence in response to the Respondent's reductions. I find that Respondent has met its burden and established by a preponderance of credible evidence its fee schedule defense. I am persuaded by a plain reading of the NYS Workers' Compensation Fee Schedule and the CPT Assistant that Applicant's claim for code 99358 is not reimbursable. Therefore, Applicant's claim for CPT code 99358 conducted on date of service 8/17/2022 is denied.

IME CUT-OFF

Legal Standards for Determining Medical Necessity

Once applicant has established a prima facie case, the burden then shifts to respondent to establish a lack of medical necessity with respect to the benefits sought. *See*, Citywide Social Work & Psychological Services, PLLC v. Allstate Ins. Co., 8 Misc3d 1025A (2005). A denial premised on lack of medical necessity must be supported by competent evidence such as an IME, peer review or other proof which sets forth a factual basis and medical rational for denying the claim. *See*, Healing Hands Chiropractic, P.C. v. Nationwide Assur. Co., 5 Misc3d 975 (2004).

In evaluating the medical necessity of services with proof of each party, particularly where the conclusion is contradictory; consideration must be given to the evidentiary burdens. Respondent must prove first that the services were not medically necessary. The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment. Kingsborough Jewish Med. Ctr. v. All State Ins. Co., 61 A.D. 3d. 13 (2d. Dep't, 2009), *See also* Channel Chiropractic PC v. Country Wide Ins. Co., 38 AD 3d. 294 (1st Dep't, 2007). An IME doctor must establish a factual basis and medical rationale for his asserted lack of medical necessity for future health care services. *E.g.*, Ying Eastern Acupuncture, P.C. v. Global Liberty Insurance, 20 Misc.3d 144(A), (App. Term 2d & 11th Dists. Sept. 3, 2008). Where the defendant insurer presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden shifts to the plaintiff which must then present its own evidence of medical necessity. West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc.3d 4(App. Term 2d & 11th Dists. Sept. 29, 2006). For an applicant to prove that the disputed expense was medically necessary, it must meaningfully refer to, or rebut, respondent's evidence. *See*, Yklik, Inc. v. Geico Ins. Co., 28 Misc3d 133A (2010). The case law is clear that a provider must rebut the conclusions and determinations of the IME doctor with his own facts. Moreover, the Appellate Term, 2d, 11th & 13th Dists., stated: "Assuming the insurer is successful in satisfying its burden, it is ultimately plaintiff who must prove, by a preponderance of the evidence, that the services or supplies were medically necessary." Park Slope Medical and Surgical Supply, Inc. v. Travelers Ins. Co., 37 Misc.3d 19, 22 (App. Term 2d, 11th & 13th Dists. 2012). Where an IME report provides a factual basis and medical rationale for an opinion that services were not medically necessary, and the claimant fails to present any evidence to refute that showing, the claim should be denied, as the ultimate burden of proof on the issue of

medical necessity lies with the claimant. *See* Insurance Law § 5102; AJS Chiropractic, P.C. v. Mercury Ins. Co., 22 Misc.3d 133(A), (App. Term 2d & 11th Dist. Feb. 9, 2002); Wagner v. Baird, 208 A.D.2d 1087 (3d Dept. 1994).

Application of Legal Standards

I note the validity of denials based upon negative IME findings have been recognized by several Courts. *See e.g.* Innovative Chiropractics P.C. v. Mercury Ins. Co., 25 Misc3d 137 (App. Term 2d & 11th Dists. 2009); B.Y. M.D., P.C. v. Progressive Casualty Ins. Co., 26 Misc3d 125 (App. Term 9th & 10th Dists. 2010). An IME report can be the basis of a termination of benefits if ultimately found to be persuasive. Whether an IME report is persuasive, and meets the carrier's burden is a factual decision, which must be rendered on a case by case basis. Therefore, when, as here, an insurer interposes a timely denial of claim that sets forth a sufficiently detailed factual basis and adequate medical rationale for the claim's rejection, the presumption of medical necessity and causality attached to the applicant's properly completed claim is rebutted and the burden shifts back to the claimant to refute the IME findings and prove the necessity of the disputed services and the causal relationship between the injuries and the accident. *See,* CPT Med. Servs., P.C. v. New York Cent. Mut. Fire Ins. Co., 18 Misc.3d 87 (App. Term 1st Dept.); A.Khodadadi Radiology, P.C. v. NY Cent. Mut. Fire Ins. Co., 16 Misc. 3d. 131 (A) (App Term 2d Dept.).

Orthopedic IME

In support of its contention that further treatment was not medically necessary, Respondent relies upon the orthopedic report of Pierce Ferriter, M.D.conducted on 8/16/2022. All tests were objectively negative and unremarkable with no swelling, tenderness or muscle spasm noted. Orthopedic testing was normal. On neurological examination, there were no motor or sensory deficits in the upper or lower extremities. Deep tendon reflexes were 2+ bilaterally. Muscle strength of the upper and lower extremities is graded at 5/5 bilaterally. Range of motion was full. Dr. Ferriter diagnosed all injuries as resolved. There is no evidence of an orthopedic disability. Based upon Dr. Ferriter's examination all orthopedic No-fault benefits were denied effective 8/29/2022.

In this matter, I am faced with conflicting opinions concerning the medical necessity for the medication. There are no legal issues to resolve. This dispute involves solely an issue of fact, that is, whether the medication billed was medically necessary. Resolution of that fact is determined by which opinion is accepted by the trier of fact.

I find the report for the IME conducted by Pierce Ferriter, M.D.on 8/16/2022 to be sufficient for the purpose of establishing Respondent's defense. The report adequately sets forth the factual basis and medical rationale to support the conclusion that the Assignor was not in need of any further treatment. That being so, the burden shifts to the Applicant to counter Respondent's showing.

While the report for the IME conducted by Dr. Ferriter is sufficient to establish Respondent's defense, after comparing the relevant evidence presented by both parties, and upon consideration of the arguments of counsel, the evidence submitted by the

Applicant persuades me to find as a matter of fact that the Assignor's injuries had yet to resolve and that she was in need of continued orthopedic treatment. My decision accounts for the Assignor's subjective complaints of pain and positive objective findings documented in the physiatric examinations reports by Richard A. Badke, M.D., dated 8/17/2022 and 10/31/2022, the pain management examination report by Mark A. Goodstein, M.D., dated 9/20/2022, and the orthopedic examination report by Sunil Kukreja, M.D., dated 9/27/2022, cervical epidural steroid injection procedure reports, dated 8/2/2022 and 9/29/2022, lumbar epidural steroid injection procedure reports, dated 8/18/2022 and 10/13/2022, the EMG/NCV test report, dated 5/23/2022, and outcome assessment test reports, dated 8/17/2022 and 9/20/2022. The findings in these medical records are sufficient to rebut the findings in the IME report. Applicant's evidence is more persuasive. Therefore, Applicant's claim for the bills denied premised upon the IME of Dr. Ferriter, is granted.

Chiropractic IME

In support of its contention that further treatment was not medically necessary, Respondent relies upon the chiropractic examination report of Dr. David Drier, D.C. conducted on 8/25/2022. Dr. Drier notes moderate spasm of the cervical and lumbar spine and a positive Patrick Fabere test. Range of motion was full, the remaining orthopedic tests were negative, and neurological testing was within normal limits. Dr Drier diagnosed "unresolved mild cervical and lumbar sprain/strain", "pre-existing cervical disc disease and spondylosis", and "Normal thoracic, pelvis, and sacrum examination". Dr. Drier determined in the Impression portion of the report:

> Based on the information presented to me, the results of my comprehensive examination, review of the claimant's file, and assuming the history to be accurate as provided by the claimant, it is my professional opinion that objective signs were present to partially substantiate the claimant's subjective symptoms, which are not improving further with chiropractic treatment. It is my chiropractic opinion that the claimant has no spinal disability and may perform his usual work or daily activities with no restrictions. From a chiropractic viewpoint, chiropractic treatment would not be beneficial, and it is not corrective in nature at this time. As noted in my clinical findings, clinical records reporting little clinical progress or functional gains in re-examination notes or in the claimant's self-reported pain levels, additional chiropractic treatment to the cervical, thoracic, or lumbar spine would not be beneficial to the claimant clinically, as they have been treating for over four months for their cervical, thoracic, and lumbar spinal condition with no further improvement. No chiropractic treatment, massage therapy, household help, special transportation, diagnostic testing, or durable medical equipment are medically necessary. The claimant has had a more than adequate regimen of chiropractic treatment according to accepted standards of care such as the Guidelines for Chiropractic Quality Assurance and Practice parameters, edited Haldeman, Jones and Bartlett publishing, Sudbury, Massachusetts 2005, page 117, "treatment care must be documented as having therapeutic necessity." Page 119, "a course of two weeks each of two different types of manual procedures four weeks total after which in the absence of documented improvement, manual procedures

> are no longer indicated." It is my determination that the standard of care from the standpoint of chiropractic has been observed with regard to treatment modalities utilized and the time span of treatment and no further treatment from a chiropractic standpoint is warranted for the cervical, thoracic, lumbar spine or pelvis. I defer any non-spinal complaints to the appropriate medical specialist. I defer any further spinal complaints to the appropriate specialty.

Based upon Dr. Drier's examination all chiropractic No-fault benefits were denied effective 9/9/2022.

The results of the examination presented a cogent medical rationale as to why further benefits were terminated in support of Respondent's defense. Therefore, the burden shifts to the Applicant to establish the services billed were medically necessary.

Applicant relies on the examinations of Barrie Paul, D.C., dated 4/12/2022, 6/6/2022, and 7/28/2022, and chiropractic treatment notes, dated 4/14/2022 through 10/25/2022.

In this matter, I am faced with conflicting opinions concerning the medical necessity for the treatment. There are no legal issues to resolve. This dispute involves solely an issue of fact, that is, whether the services billed was medically necessary. Resolution of that fact is determined by which opinion is accepted by the trier of fact.

Comparing the relevant evidence presented by both parties, and upon consideration of the arguments of counsel, I find that Respondent has submitted sufficient evidence to sustain its burden of demonstrating that the services subsequent to 9/9/2022 were not medically necessary. I find Respondent's 8/25/2022 examination report credible. I am persuaded by Dr. Drier that the Assignor was no longer benefitting from treatment or in other words had reached an end result from chiropractic treatment. Therefore, further treatment subsequent to 9/9/2022 was not reasonable or medically necessary.

Dr. Paul's three chiropractic examination reports, dated 4/12/2022, 6/6/2022, and 7/28/2022, indicate complaints to the neck, mid-back, and lower back, reduced ranges of motion in the cervical and lumbar spine, and positive Shoulder Depression, Cervical Compression, Maximal Foraminal Compression, Cervical Distraction, Kemp's, Braggards's, Linder Sign/Soto Hall, and Straight Leg Raise tests. The treatment plan for each of the examinations is for chiropractic spinal manipulative treatment 3-4 times a week for 4 weeks, until re-evaluation. The treatment notes from 4/14/2022 through 10/25/2022 are remarkably similar and each indicate that, "in general, the overall condition has not changed". The notes indicate moderate pain in the neck, mid-back, and low back with a pain scale of 5-8/10, which is described as stiffness, spasm, sharp, achy, and tight/stiff. The chiropractor recommended continuing treatment 3-4 times per week. I agree with Dr. Drier's position that, "As noted in my clinical findings, clinical records reporting little clinical progress or functional gains in re-examination notes or in the claimant's self-reported pain levels, additional chiropractic treatment to the cervical, thoracic, or lumbar spine would not be beneficial to the claimant clinically, as they have been treating for over four months for their cervical, thoracic, and lumbar spinal condition with no further improvement".

Applicant is not free to provide services indefinitely without demonstrating medical necessity for the treatment. Since Dr. Drier's IME report presented sufficient evidence to establish Respondent's defense of lack of medical necessity, the burden shifted to Applicant to demonstrate medical necessity. *See* A. Khodadadi Radiology, P.C. v. NY Central Mutual Fire Ins. Co., 16 Misc.3d 131 (A), 2007 N.Y. Slip Op. 51342(U) (App. Term 2d & 11 Dist. 2007); West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., Misc.3d 131 (A), 2006 N.Y. Slip Op. 51871(U) (App. Term 2d & 11 Dist. 2006). I find that Applicant failed to satisfy its burden in this case. Applicant's medical records are insufficient to rebut the Respondent's IME objective examination or determination that the Assignor had no evidence of functional improvement after more than five months of chiropractic treatment, which would warrant further treatment. When comparing the evidence, I am persuaded by Dr. Drier's determination that the Assignor was no longer benefitting and had therefore reached an end result from chiropractic treatment. Applicant's reports do not serve to overcome the IME. The IME is more credible, detailed, and persuasive than the Applicant's records. The weight of the evidence favors Respondent. Applicant's claim, denied premised upon the IME of Dr. Drier, is denied.

CONCLUSION

Accordingly, Applicant's claim is granted in the amount of $761.81. The remainder of the claim is denied. This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator.

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

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

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

Accordingly, the applicant is AWARDED the following:

A.

Medical		From/To	Claim Amount	Amount Amended	Status
	CitiMed Complete Medical Care PC	05/11/22 - 05/12/22	$161.24		Withdrawn with prejudice
	CitiMed Complete Medical Care PC	05/16/22 - 05/17/22	$161.24		Withdrawn with prejudice
	CitiMed Complete Medical Care PC	05/23/22 - 05/24/22	$161.24		Withdrawn with prejudice
	CitiMed Complete Medical Care PC	05/23/22 - 05/23/22	$558.51		Awarded: $558.51
	CitiMed Complete Medical Care PC	08/17/22 - 08/17/22	$257.61		Denied
	CitiMed Complete Medical Care PC	08/17/22 - 08/17/22	$36.42		Awarded: $36.42
	CitiMed Complete Medical Care PC	09/13/22 - 09/13/22	$80.74		Awarded: $80.74
	CitiMed Complete Medical Care PC	09/14/22 - 09/14/22	$80.62	$78.14	Denied
	CitiMed Complete Medical Care PC	10/25/22 - 10/25/22	$80.62	$78.14	Denied

	CitiMed Complete Medical Care PC	**10/25/22 - 10/25/22**	**$94.55**	**$86.14**	**Awarded: $86.14**
Total			**$1,672.79**		**Awarded: $761.81**

B. The insurer shall also compute and pay the applicant interest set forth below. 09/02/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant is awarded interest pursuant to the no-fault regulations. *See generally*, 11 NYCRR §65-3.9. Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30-day month." 11 NYCRR §65-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. However, the regulations toll the accrual of interest when an applicant "does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations." *See*, 11 NYCRR 65-3.9(c). The Superintendent and the New York Court of Appeals has interpreted this provision to apply regardless of whether the denial at issue was timely. LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 217 (2009). Based on the regulations, interest shall accrue from the date the applicant requested arbitration in this matter. *See*, 11 NYCRR 65-3.9(c).

C. Attorney's Fees

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

Applicant is entitled to an attorney's fee pursuant to Insurance Law §5106(a). After calculating the sum total of the first-party (No-Fault) benefits awarded in this arbitration plus interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20 percent of that sum total, subject to the following limitations: In the event the above filing date was prior to Feb. 4, 2015, the attorney's fee is subject to a minimum of $60.00 and a maximum of $850.00, per 11 NYCRR 65-4.6(e). In the event the above filing date was on or after Feb. 4, 2015, the attorney's fee is subject to a maximum of $1,360.00, per 11 NYCRR 65-4.6(d). In the event the above filing date was on or after Feb. 4, 2015 and first-party (No-Fault) benefits are awarded to more than one Applicant herein, the attorney's fee shall be calculated separately for each Applicant, each Applicant's attorney fee being subject to the $1,360.00 maximum.

D. The respondent shall also pay the applicant forty dollars ($40) to reimburse the applicant for the fee paid to the Designated Organization, unless the fee was previously returned pursuant to an earlier award.

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of NY
SS :
County of Nassau

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

09/23/2024
(Dated)

Eileen Hennessy

IMPORTANT NOTICE

This award is payable within 30 calendar days of the date of transmittal of award to parties.

This award is final and binding unless modified or vacated by a master arbitrator. Insurance Department Regulation No. 68 (11 NYCRR 65-4.10) contains time limits and grounds upon which this award may be appealed to a master arbitrator. An appeal to a master arbitrator must be made within 21 days after the mailing of this award. All insurers have copies of the regulation. Applicants may obtain a copy from the Insurance Department.

ELECTRONIC SIGNATURE

Document Name: Final Award Form
Unique Modria Document ID:
cfbe6f25fb2c0ac9f5978de7078d0655

Electronically Signed

Your name: Eileen Hennessy
Signed on: 09/23/2024