American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

| | | |
|---|---|---|
| Atlantic Medical & Diagnostic PC (Applicant) | AAA Case No. | 17-23-1308-4351 |
| | Applicant's File No. | 445-PKT23-122361 |
| - and - | Insurer's Claim File No. | 0663256105 2G7 |
| | NAIC No. | 19240 |
| Allstate Indemnity Company (Respondent) | | |

**ARBITRATION AWARD**

I, Anne Malone, 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: EIP

1. Hearing(s) held on 06/27/2024
   Declared closed by the arbitrator on 06/27/2024

   Joaquin Lopez, Esq. from Barshay, Rizzo & Lopez, PLLC. participated virtually for the Applicant

   Beth KoldKlang, Esq. from Law Offices of John Trop participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$2,041.81**, 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 27 year old EIP reported involvement in a motor vehicle accident on March 22, 2022; claimed related injury and underwent office visits provided on August 31, 2023 and October 26,2 022 and trigger point injection with fluoroscopic guidance provided by the applicant on October 26, 2022.

   The applicant submitted a claim for these medical services, payment of which was denied by the respondent on the grounds that there was no coverage for this claim/loss due to the failure of the EIP to cooperate with the investigation of the subject accident by failing to respond to post-EUO written requests for information pertaining to the accident at issue.

The respondent also asserted a fee schedule defense.

**The issues to be determined at the hearing are:**

**Whether the respondent established that the EIP failed to respond to requests for documents/information and to cooperate with the respondent's investigation of the subject accident.**

**Whether the respondent established its fee schedule defense.**

4. Findings, Conclusions, and Basis Therefor

This decision is based upon the documents reviewed in the Modria File as well as the arguments made by counsel and/or representative at the arbitration hearing. Only the arguments presented at the hearing are preserved in this decision; all other arguments not presented at the hearing are considered waived.

Lack of cooperation and failure to respond to post-EUO requests for documents/information

The claim was timely denied by respondent based on the testimony of examination under oath of the EIP, the operator of the vehicle which was allegedly involved in the subject accident. The Explanation of Medical Bill Payment which accompanied the denial stated in pertinent part:

Your claims are denied due to the failure of [the EIP]

to cooperate with the investigation by Allstate Insurance

Company concerning the motor vehicle accident by failing

to fully and materially respond to the written

requests forinformation pertaining to this motor

vehicle accident.

The applicant has the burden to establish *prima facie* that the assignor's injuries and the durable medical treatment provided hereunder arose out of the use or operation of a motor vehicle. See Santo v. Government Employees Ins. Co., 31 A.D.3d 525, 819 N.Y.S. 279 (2d Dept. 2006); See also Insurance Law §5103[a][1.]

The applicant submitted the assignor's assignment of benefits form in which the assignor states, under warning of the penalties of filing a false report with an insurance company, that she was injured as a result of a motor vehicle accident that occurred on March 22, 2022 and thereby assigns her rights to benefits to the applicant.

In addition, the applicant submitted the transcript of the EUO of the EIP, who testified on August 4, 2022 regarding the happening of the alleged accident and the injuries which she sustained as a result of it.

Subsequent to the EUO, the respondent contends that on August 11, 2022 it sent correspondence to the EIP and her attorney requesting documents/information related to the subject accident and that follow-up requests were sent on September 15, 2022 and June 22, 2022. The respondent further contends that the applicant did not respond to the post-EUO requests for documents/information.

There have been numerous other claims related to this EIP and this particular issue including (AAA nos. 17-23-1291-4545, 17-23-1283-0024 and17-23-1287-4291) in which I found in favor of the respondent based on the submissions which included the post-EUO requests for information and documentation that were allegedly submitted in the instant matter. However, these prior awards are not *res judicata* as to this particular claim since they did not involve the same applicant.

In the instant matter, the respondent did not submit copies of any of the letters or proof of mailing of post-EUO requests for documents/information to the EIP and/or her attorneys.

Based on the foregoing, the respondent has failed to establish that the EIP failed to respond to any requests for post-EUO requests for documents/information or to cooperate with the investigation of this claim.

**Therefore, an award will be issued to the applicant pursuant to the appropriate fee schedule.**

Fee Schedule

To prevail in a fee schedule defense, the respondent must demonstrate by competent evidentiary proof that applicant's claims were in excess of the appropriate fee schedules, or otherwise respondent's defense of noncompliance with the appropriate fee schedule cannot be sustained. Continental Medical, P.C. v. Travelers Indemnity Co., 11 Misc.3d 145(A) (App. Term 1st Dept. 2006.)

An insurer fails to raise a triable issue of fact with respect to a defense that the fees charged were not in conformity with the Workers' Compensation fee schedule when it does not specify the actual reimbursement rates which formed the basis for its determination that the claimant billed in excess of the maximum

amount permitted. See St. Vincent Medical Services, P.C. v. GEICO Ins. Co., 29 Misc.3d 141(A), 907 N.Y.S.2d 441 (App. Term 2d, Dec. 8, 2010.)

A fee schedule defense does not always require expert proof. There are two fee schedule scenarios. The first involves the basic application of the fee codes and simple arithmetic. The second scenario involves interpretation of the codes and often requires testimony and evidence beyond that of a lay individual. I find that the fee schedule issue presented in this case is analogous to the latter scenario and requires an expert's opinion.

The respondent failed to support its fee schedule defense with an affidavit from a certified professional fee coder, medical professional or other expert.

To support its billing for the services at issue, the applicant submitted an affidavit from Michael Miscoe, a certified professional coder who submitted a comprehensive review and analysis. He determined that the two office visits billed under 99213 and the trigger point injection were reimbursable as billed and that the first charge for ultrasonic guidance was reimbursable as billed and the remaining five charges for ultrasonic guidance were reimbursable at 75% of the billed amount.

However, Mr. Miscoe did not make any allowance for the fact that all of the services at issue were performed by a nurse practitioner and therefore should have been billed at 80% of the reimbursable amount pursuant to the New York Workers' Compensation Medical Fee Schedule.

The proper calculation of the total reimbursable amount of the services at issue is $1,344.25. This includes $70.24 each for the two office visits; $104.81 for the trigger point injection; $231.36 for the first charge for ultrasonic guidance and $867.60 for the remaining five charges of guidance.

Based on the foregoing, the respondent has established its fee schedule defense.

**Accordingly, the applicant is awarded $1,344.25 for the services at issue.**

Any further issues submitted in the record are held to be moot and/or waived insofar as they were not raised at the time of this hearing. 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** | **Status** |
|---|---|---|---|---|
| | **Atlantic Medical & Diagnostic PC** | **08/31/22 - 08/31/22** | **$87.80** | **Awarded: $70.24** |
| | **Atlantic Medical & Diagnostic PC** | **10/26/22 - 10/26/22** | **$1,954.01** | **Awarded: $1,274.01** |
| **Total** | | | **$2,041.81** | **Awarded: $1,344.25** |

B. The insurer shall also compute and pay the applicant interest set forth below. 07/24/2023 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." See 11 NYCRR §64-3.9(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. Where a claim is untimely denied, or not denied or paid, interest shall accrue as of the 30th day following the date the claim is presented by the claimant to the insurer for payment. Where a claim is timely denied, interest shall accrue as of the date an action is commenced or an arbitration requested, unless an action is commenced or an arbitration requested within 30 days after receipt of the denial, in which event interest shall begin to accrue as of the date the denial is received by the claimant. 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 particular denial was timely. LMK Psychological Servs. P.C. v. State Farm Mut. Auto. Ins. Co., 12 NY3d 217 (2009.)

C. Attorney's Fees

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

Applicant is awarded statutory attorney's fees pursuant to the no fault regulations. For cases filed after February 4, 2015 the attorney's fee shall be calculated as follows: 20% of the amount of first-party benefits awarded, plus interest thereon subject to no minimum fee and a maximum of $1,360.00. See 11 NYCRR §65-4.6(d.)

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 CT
SS :
County of Fairfield

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

07/21/2024
(Dated)

Anne Malone

**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:**
ee77752774a5addff13971506b68406d

**Electronically Signed**

Your name: Anne Malone
Signed on: 07/21/2024