American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Tri-Borough NY Medical Practice PC (Applicant)	AAA Case No.	17-24-1353-0905
	Applicant's File No.	n/a
- and -	Insurer's Claim File No.	AB949527900
	NAIC No.	23035
Liberty Mutual Fire Insurance 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 02/03/2025
   Declared closed by the arbitrator on 02/03/2025

   Usman Nawaz, Esq. from Law Offices of Hillary Blumenthal LLC (Hoboken) participated virtually for the Applicant

   Elvira Messina, Esq. from Callinan & Smith LLP participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$203.76**, 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 23 year old EIP reported involvement in a motor vehicle accident on October 3, 2023; claimed related injury and underwent an initial evaluation provided by the applicant on December 14, 2023.

   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 because the EIP did not receive treatment from the applicant for injuries related to the subject accident.

   The respondent also asserted a fee schedule defense.

The issues to be determined at the hearing are:

Whether the respondent established that the treatment at issue was not provided to the EIP by the applicant.

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.

Services at issue in this claim

The EIP was involved in a motor vehicle accident on October 3, 2023. It is alleged that he was treatment by the applicant on December 14, 2023. There are several copies of different NF-3s and Explanation of Reviews (EORs)related to this claim.

A general denial dated June 27, 2024 states in pertinent part:

"Claim is denied due to fraud. Further denial details will follow under separate cover. Therefore, all No Fault benefits for the above applicant are denied effective 10/03/2023.

One EOR states in pertinent part:

"Examination Under Oath related. Please see attached Denial of Claim Form (NF-10) for further information."

and

"The Eligible Injured Person was requested to attend an Examination under Oath and subscribe to same, pursuant to Reg. 68, 65-1.1. Eligible injured person appeared as requested on 03/25/2024 and testified that he did not meet with any pain management doctor and denied any discuss (sic) of epidural steroid injections. Based on this testimony, your bill is denied for treatment not rendered as billed."

A second NF-10 dated 04/16/24 states in pertinent part:

"See the attached explanation of review for docid LU0506082"

The reason for denial states: "The Eligible Injured Person was requested to attend an Examination under Oath and subscribe to same, pursuant to Reg. 68, 65-1.1. Eligible injured person appeared as requested on 03/25/2024 and testified that he did not meet with any pain management doctor and denied any discuss (sic) of epidural steroid injections. Based on this testimony, your bill is denied for treatment not rendered as billed."

After a review of the submissions, including the transcript of the EUO testimony the reason for the denial of this claim appears to be the statements on pp.110 ll 5 -17 of the EUO transcript:

Q Did you ever meet with a pain management doctor while you were treating at Pelham?

A No sir.

Q Did you meet with a Dr. Osewa Olatokumbo?

A I don't' recall off the top of my head.

Q Did you every meet with a doctor at the Pelham facility discussing epidural steroid injections?

A No, sir.

The submissions include the report of an initial evaluation of the EIP by Olatokunbo Osewa-Lucas, FNY-BC on December 14, 2023. This report includes a section entitled PAIN MANAGEMENT PROCEDURE:

1. Cervical facet steroid injections to affected levels.

2. Lumbar facet steroid injections to affected levels.

3. Trigger points at the affected trigger points.

The respondent did not provide any additional documentation to establish that the services, including the initial evaluation and injections reference above were not provided to the EIP.

Based on the foregoing, the respondent failed to establish that the applicant did not provide the treatment at issue.

Fee Schedule

This claim was denied based on the grounds that the services at issue were not provided to the EIP. I have already determined that the respondent did not establish this defense. However, the respondent also asserted a fee schedule defense which must be considered.

The applicant billed $203.76 for the initial evaluation which is the subject of this claim. The respondent contends that the correct reimbursable amount for these medical services is $163.01 since they were provided by a Nurse Practitioner rather than a physician.

To prevail in its fee schedule defense, the respondent must demonstrate by competent evidentiary proof that the applicant's claims are in excess of the appropriate fee schedule. If the respondent fails to do so, its defense of noncompliance with the New York Workers' Compensation Medical Fee Schedule cannot be sustained. See Continental Medical, P.C. v Travelers Indemnity Co., 11 Misc. 3d 145A (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 expertise beyond that of a lay individual. I find that the fee schedule issue presented in this case is analogous to former scenario and does not require an expert opinion.

Late denial

The denial of this claim was late on its face. However effective April 1, 2013, 11 NYCRR 65-3.8(g)(1) has been amended so that the application of the New York State Worker's Compensation fee schedule is no longer a precludable defense and no payment is due on those claims in excess of the fee schedule. Per 11 NYCRR 65-3.8(g), where the services were rendered after April 1, 2013, a defense of excessive fees is not subject to preclusion Surgicare Surgical Associates v. National Interstate Ins. Co., Misc.3d, N.Y.S.3d, 2015 N.Y. Slip Op. 25338 (App. Term 1st Dept. Oct. 8, 2015), 46 Misc.3d 736, 997 N.Y.S.2d 296 aff'g (Civ. Ct. Bronx Co. 2014) (New Jersey fee schedule.) The insurer is entitled to reduce the bills to the proper fee schedule amount.

I have taken judicial notice of the applicable fee schedule for the services at issue, which supports the respondent's fee schedule defense.

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

Accordingly, the applicant is awarded $163.01 in disposition of this claim.

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**
	Tri-Borough NY Medical Practice PC	**12/14/23 - 12/14/23**	**$203.76**	**Awarded: $163.01**
Total			**$203.76**	**Awarded: $163.01**

B. The insurer shall also compute and pay the applicant interest set forth below. 06/21/2024 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.

02/04/2025
(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:
3f86f1977129545377af602d4175b186

Electronically Signed

Your name: Anne Malone
Signed on: 02/04/2025