American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Atlantic Medical & Diagnostic PC (Applicant)	AAA Case No.	17-24-1359-7314
	Applicant's File No.	JL24-135966
- and -	Insurer's Claim File No.	272 PP IWN 7432 002
The Standard Fire Insurance Company (Respondent)	NAIC No.	19070

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 03/31/2025
   Declared closed by the arbitrator on 03/31/2025

   Andrew Leahy, Esq. from The Licatesi Law Group, LLP participated virtually for the Applicant

   Liz Souza, Esq. from Law Offices of Tina Newsome-Lee participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$5,054.82**, 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 59 year old EIP reported involvement in a motor vehicle accident on December 17, 2023; claimed related injury and underwent an office visit and trigger point injection with guidance and nerve block injections provided by the applicant on May 14, 2024 and an office visit and trigger point injection with ultrasonic guidance on June 16, 2024.

   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 because the applicant was not properly licensed.

The respondent also asserted a fee schedule issue.

The issues to be determined at the hearing are:

Whether the respondent established its coverage defense.

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.

Coverage

The claim at issue was denied on the grounds that the there was no coverage for this claim because the applicant was not properly licensed.

In this matter, as in the related claim, which was decided today, the respondent failed to provide any documentation to support the coverage defense.

Therefore, the respondent failed to establish its coverage defense.

Fee Schedule

In this matter, the respondent denied payment for the services at issue based on its coverage defense. I have already determined that the respondent has failed to establish its defense of a lack of coverage.

The only remaining issue is the appropriate reimbursable amount for these services at issue pursuant to the New York Workers' Compensation Medical 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.

In this instance, the respondent did not provide an affidavit from a certified professional fee coder, medical professional or other expert to support its fee schedule defense. However, this claim is related to another hearing today which involved the same parties and the same issues as those at issue here.

Res Judicata- Collateral Estoppel

Res judicata and collateral estoppel are applicable to no-fault arbitration awards and bar relitigation of the same claim or issue. A.B. Medical Services PLLC v New York Central Mutual Fire Ins. Co., 12 Misc.3d 500, 820 N.Y.S.2d 422 (Civ. Ct. Kings Co. 2006), citing Matter of Ranni, 58 N.Y.2d 715, 458 N.Y.S.2d 910 (1982.)

A determination of the *res judicata* effect of a prior arbitration proceeding is for the arbitrator in a subsequent arbitration proceeding. City School Dist. Of City of Tonawanda v. Tonawanda Educ. Ass'n., 63 N.Y.S.2d 846, 482 N.Y.S.2d 258 (1984.)

It is well settled that any judgment, even judgments entered on default have *res judicata* or collateral estoppel effect. See Eagle Surgical Supply, Inc. v. AIG Indem. Ins. Co., 40 Misc. 3d 139(A) (App. Term 2013) Further, the Appellate Term has held that "[t]he declaratory judgment is a conclusive final determination, notwithstanding that it was entered on default…." Ava Acupuncture, P.C. v NY Central Mut. Fire Ins. Co., 34 Misc. 3d 149(A) (App. Term 2012.)

At a prior hearing today (AAA case no17-24-1355-0126) based on the same parties I found in favor of the respondent on both the coverage issue and the fee schedule issue.

I find that the prior arbitration award is *res judicata* on coverage issue and find that the respondent has failed to establish this defense.

I also find that the respondent established its fee schedule defense. However, the award for the applicant will be different in this instance based on the services rendered.

Based on the applicable fee schedule, the correct reimbursable amount for date of service May 14, 2024 is $1,490.18 (99214 $101.93; 20553 $104.81; 76942 $231.36 and J codes total $527.40 - J1100 $259.10, J0665 $187.50 and J 3490 $247.50)

The correct reimbursable amount for date of service June 11, 2024 is $967.50 (99214 $101.93; 20553 $104.81; 76942 $231.36 and J codes $529.40 - J1100 $239.40, J0665 $125.00 and J3490 $165.00)

Accordingly, the applicant is awarded $2,457.68 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**
	Atlantic	**05/14/24 -**		**Awarded:**

	Medical & Diagnostic PC	**05/20/24**	**$3,110.20**	**$1,490.18**
	Atlantic Medical & Diagnostic PC	**06/11/24 - 06/16/24**	**$1,944.62**	**Awarded: $967.50**
Total			**$5,054.82**	**Awarded: $2,457.68**

B. The insurer shall also compute and pay the applicant interest set forth below. 08/06/2024 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.

04/29/2025
(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:
8f1a48d5a97154d5036914583f30771e

Electronically Signed

Your name: Anne Malone
Signed on: 04/29/2025