

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Downtown Brooklyn PT PC
(Applicant)

- and -

State Farm Mutual Automobile Insurance
Company
(Respondent)

AAA Case No. 17-24-1371-0449

Applicant's File No. GM24-792038

Insurer's Claim File No. 32-50P9-73W

NAIC No. 25178

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 05/12/2025
Declared closed by the arbitrator on 05/12/2025

John Fagan, Esq. from Law Offices of Gabriel & Moroff, P.C. participated virtually for the Applicant

Christine Lee, Esq. from De Martini & Yi, LLP participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,462.91**, 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 48 year old EIP reported involvement in a motor vehicle accident on May 25, 2023; claimed related injury and underwent physical therapy treatment provided by the applicant from August 16, 2023 to January 25, 2024.

The applicant submitted a claim for these medical services. Partial payment of the claim for dates of service August 16, 2023 to January 2, 2024 was timely made by the respondent based on its calculation of the correct reimbursable amount for these services pursuant to the New York Workers' Compensation Medical Fee Schedule.

Payment of the charges for services rendered from January 16, 2024 to January 25, 2024 was timely denied by the respondent based on the IME of the EIP by Ajendra Sohal, M.D. which was performed on October 25, 2023. The IME cut-off was effective on January 7, 2024.

The respondent also asserted a fee schedule defense.

The issues to be determined at the hearing are:

Whether the respondent established that the medical services provided by the applicant from January 16, 2024 to January 25, 2024 were not medically necessary.

4. Findings, Conclusions, and Basis Therefor

This hearing was held on Zoom and the 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.

Medical Necessity

To support a lack of medical necessity respondent must "set forth a factual basis and medical rationale for the IME doctor's determination that there was a lack of medical necessity for the services rendered." Provvedere, Inc. v. Republic Western Ins. Co., 2014 NY Slip Op 50219(U) (App. Term 2d, 11th and 13th Jud. Dists. 2014.) Respondent bears the burden of production in support of its lack of medical necessity defense, which if established shifts the burden of persuasion to applicant. See Bronx Expert Radiology, P.C. v. Travelers Ins. Co., 2006 NY Slip Op 52116 (App. Term 1st Dept. 2006.)

The Civil Courts have held that a defendant's peer review or medical evidence must set forth more than just a basic recitation of the expert's opinion. The trial courts have held that a peer review report's medical rationale will be insufficient to meet respondent's burden of proof if: 1) the medical rationale of its expert witness is not supported by evidence of a deviation from "generally accepted medical" standards; 2) the expert fails to cite to medical authority, standard, or generally accepted medical practice as a medical rationale for his/her findings; and 3) the peer review report fails to provide specifics as to the claim at issue; is conclusory or vague. See Nir v. Allstate, 7 Misc.3d 544 (N.Y. City Civ. Ct. 2005.)

To support its contention that the medical services provided to the EIP were not medically necessary, the respondent relied upon the report of the independent medical examination of the EIP by Dr. Sohal, which was objectively negative and unremarkable. The report presents a factually sufficient, cogent medical rationale in support of respondent's lack of medical necessity defense. Dr. Sohal performed a complete and comprehensive examination of the EIP which did not identify any objective positive findings and determined that his injuries were resolved.

Based upon the physical examination and medical records reviewed, Dr. Sohal determined that despite his subjective complaints, the EIP was not disabled and that he could perform his activities of daily living and continue working without limitations. It was Dr. Sohal's opinion that there was no medical necessity for further physical therapy, massage therapy, surgery, injections, prescription medication, diagnostic testing, durable medical equipment, household help or special transportation.

Respondent has factually demonstrated that the medical services at issue were not medically necessary. Accordingly, the burden now shifts to the applicant, who bears the ultimate burden of persuasion. See Bronx Expert Radiology, P.C. v. Travelers Ins. Co., 2006 NY Slip Op 52116 (App. Term 1 Dept. 2006.)

In response to the report of the physical examination of the EIP by Dr. Sohal, the applicant relied upon the submissions, which included physical therapy progress notes but no contemporaneous evaluations of the EIP to refute the findings of Dr. Sohal.

The applicant failed to document sufficient contemporaneous objective findings that would warrant continued treatment after the IME cut-off date.

In this case, the submitted medical records do not sufficiently address the arguments that are raised in the IME and do not establish that the medical services at issue were medically necessary.

Based on the foregoing, the respondent has established that the physical therapy treatment provided from January 16, 2024 to January 25, 2024 was not medically necessary.

Therefore, the claim for dates of service January 16, 2024 to January 25, 2024 is dismissed with prejudice.

Fee Schedule

The applicant billed a total of \$5,617.16 for which the respondent made payment for dates of service August 16, 2023 to January 2, 2024 of \$4,154.24, leaving a balance of \$1,462.91. The payments did not include dates of service January 16, 2024 to January 25, 2024 which was denied by the respondent for a lack of

medical necessity. I have already determined that the claim for these dates of service is dismissed with prejudice.

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 former scenario and does not require an expert opinion.

Taking judicial notice of a plain reading of the New York Workers' Compensation Medical Fee Schedule payment for all charges was correct, except \$15.00 on each date of service for PPE supplies/services for which no payment was made by the respondent.

Based on the foregoing, the respondent has paid in full for all physical therapy services provided from August 16, 2023 to January 2, 2024.

Therefore, the claim for physical therapy services is dismissed with prejudice.

Billing for PPE for all dates of service

The applicant billed \$15.00 under CPT code 99072 for PPE supplies and services provided on each date of service. The respondent denied payment for the PPE on the grounds that: "[t]his procedure was performed for a condition not related to the motor vehicle accident." The respondent asserts that these supplies are not reimbursable. The applicant contends that these supplies were necessary to treat the EIP due to the COVID-19 pandemic and are therefore reimbursable as billed.

According to the OGC opinion letter dated January 1, 2007 regarding No Fault Health Service Reimbursement, only qualifying professional health services licensed under New York Law and provided to the claimant in the treatment of his/her injuries are reimbursable in no-fault. See also Ground Rule 17 of the New York State Worker's Compensation Physical Medicine Fee Schedule.

The applicant did not submit any documentation to refute the respondent's fee schedule defense.

I find that the applicant is not entitled to charge for the PPE supplies/services under CPT code 99072. The assignee is only entitled to the rights to reimbursement allowed to the assignor. See Rubin v. Empire Mut. Ins. Co., 25 N.Y.2d 426 at 429. CPT code 99702 is a new code adopted by the AMA during the COVID pandemic which is not a separately covered expense. Medicare has barred reimbursement for these services and views PPE supplies/services as a general expense incurred in running a medical office like, for example hand sanitizing gels, paper cloth covers utilized on patient examining tables, cleaning supplies, gloves, face shields, face masks, etc.) used generally in a medical office setting and not as a separate supply provided to the patient. CMS has stated that payment for the items/services described by CPT code 99072 is "always bundled into payment for other services and payment for them is subsumed by the payment for the services to which they are incident." Finally, CPT code 99072 is not contained in the New York Workers' Compensation Medical Fee Schedule and is therefore not reimbursable as charged.

Based on the foregoing, the respondent has established its fee schedule defense regarding reimbursement for the PPE charges at issue.

Therefore, the charges for PPE supplies/services are dismissed with prejudice.

Accordingly, the entire claim is dismissed with prejudice.

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 claim is DENIED in its entirety

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.

06/11/2025

(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:

98c3bcf54f733f18e14a5cf453b8d5f4

Electronically Signed

Your name: Anne Malone
Signed on: 06/11/2025