

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Medex Diagnostic & Treatment Center LLC (Applicant)	AAA Case No.	17-24-1373-9384
- and -	Applicant's File No.	LIP-41307
	Insurer's Claim File No.	24-8683563
Progressive Casualty Insurance Company (Respondent)	NAIC No.	24260

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 06/23/2025
Declared closed by the arbitrator on 06/23/2025

Robin Grumet, Esq. from Law Offices of Ilya E Parnas P.C. participated virtually for the Applicant

Jennifer Kilfoyle from Progressive Casualty Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$747.93**, 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 37 year old EIP reported involvement in a motor vehicle accident on April 11, 2024; claimed related injury and underwent cervical discectomy provided at the applicant's facility on September 25, 2024.

The applicant submitted a claim for these medical services, for which partial payment was made pursuant to the respondent's calculation of the correct reimbursable amount pursuant to the New York Workers' Compensation Medical Fee Schedule.

The issue to be determined at the hearing is whether the respondent established its fee schedule defense.

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.

The applicant billed a total of \$7,003.41 for the services at issue, for which the respondent made partial payment of \$6,255.48 based on its calculation of the correct reimbursable amount pursuant to the appropriate fee schedule, leaving a balance of \$747.93.

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 supported its fee schedule defense with the affidavit of Sarah Lindenauer, AAPC, a certified medical coder who submitted a comprehensive review and analysis relying on the EAPG using #M Grouper software, Workers' Compensation Board and CPT Assistant. She determined, based on the applicable fee schedule that the correct reimbursable amount for the services at issue is \$6,255.48. This is the amount paid by the respondent and acknowledged by the applicant in the AR-1.

The applicant did not submit an affidavit from a certified professional fee coder, medical professional or other expert. However, it included in its submissions a copy of the 3M Health Information Systems document and determined that \$7,003.41 was the correct reimbursable amount for the services at issue.

After a review of all the evidence submitted an issue of fact remains as to the correct reimbursable amount for the services at issue. Conflicting opinions have been presented in the affidavit of Sarah Lindenauer, CPC and the 3M EAPG document without further explanation.

Based on the foregoing, I find that the submission of the respondent's expert was more persuasive in this instance.

Under these circumstances, the respondent has established its fee schedule defense.

Accordingly, the 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.

06/24/2025
(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:
76f087f02d420ef960a1db4306e7419d

Electronically Signed

Your name: Anne Malone
Signed on: 06/24/2025