

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Atlantic Medical & Diagnostic PC  
(Applicant)

- and -

LM Insurance Corporation  
(Respondent)

AAA Case No. 17-25-1382-4842

Applicant's File No. 3406670

Insurer's Claim File No. 057979448

NAIC No. 33600

**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

Justin Skaferowsky, Esq. from Israel Purdy, LLP participated virtually for the Applicant

Lisa Tuzzi from LM Insurance Corporation participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$3,368.18**, was AMENDED and permitted by the arbitrator at the oral hearing.

The amount claimed was amended by the applicant to \$1,777.92 to conform to the appropriate fee schedule. The respondent did not agree to this amended amount.

Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

The 34 year old EIP reported involvement in a motor vehicle accident on October 2, 2024; claimed related injury and underwent nerve block injections with ultrasound guidance provided by the applicant on November 4, 2024.

The applicant submitted a claim for these medical services, payment of which was timely denied by the respondent based upon a peer review by Ajendra Sohal, M.D. dated November 27, 2024. In response, the applicant submitted an undated rebuttal by Viviane Etienne, M.D. who was not the EIP's treating medical provider.

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 at issue were not medically necessary.**

**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 from 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.

To support a lack of medical necessity defense respondent must "set forth a factual basis and medical rationale for the peer reviewer's [or examining physician'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. Term2d, 11<sup>th</sup> and 13<sup>th</sup> Jud. Dists. 2014.)

The Civil Courts have held that a defendant's peer review or report of medical examination must set forth more than just a basic recitation of the expert's opinion. The trial courts have held that a peer review or medical examination 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 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 by the applicant were not medically necessary, respondent relies upon the peer review by Dr. Sohal, who reviewed the medical records of the EIP, noted the injuries claimed

and the treatment rendered to him. Dr. Sohal considered possible arguments and justification of the need for the medical services at issue and determined that they were not warranted under the circumstances presented.

Dr. Sohal submitted a comprehensive report in which he determined that the office visit was medically necessary. He also discussed the nerve block injections under ultrasound guidance provided and his reasons for determining that they were not medically necessary for this EIP. He noted that there were no ultrasound-guided images saved and no evidence of bilateral occipital neuralgia. It was his opinion that the appropriate conservative care was not exhausted and that bilateral shoulder pain at this stage did not require suprascapular nerve block.

Dr. Sohal also stated, which was not supported by convincing evidence, that there was no causal relationship between the subject accident and the injuries sustained by the EIP.

Dr. Sohal supported, with relevant medical literature, his opinion that the medical services provided to the EIP were not medically necessary at the time they were provided.

Respondent has met its evidentiary burden. The peer review adequately sets forth the factual basis and medical rationale to support the conclusion that the medical services at issue were not indicated for this EIP at the time they were provided. Therefore, pursuant to Bronx Expert Radiology, *supra* the burden shifts to the applicant, which bears the ultimate burden of persuasion to establish that the services at issue were medically necessary.

In opposition to the peer review, the applicant presented a rebuttal by Dr. Etienne, who reviewed the EIP's medical records, disagreed with the conclusions reached by Dr. Sohal and discussed in detail the injuries sustained by the EIP and the treatment rendered to him.

Dr. Etienne specially objected to the determination by Dr. Sohal that there was no causal relationship between the EIP's injuries and the subject accident. He noted that the initial examination of the EIP documented that the onset of his symptoms was the October 2, 2024 accident.

Dr. Etienne also determined that Dr. Sohal failed to recognize all of the EIP's symptoms and other indications for the injections at issue.

Dr. Etienne supported with relevant medical citations her opinion that the medical services at issue were medically necessary when they were provided.

A review of the applicant's submissions reveals that it has met the burden of persuasion in rebuttal. The medical records and rebuttal by Dr. Etienne submitted in opposition to the findings of Dr. Sohal are sufficient to overcome the burden of production established by the respondent.

Based on the foregoing, I find that the respondent has failed to establish that the services at issue were not medically necessary.

**Therefore, an award will be issued in favor of the applicant pursuant to the applicable fee schedule.**

#### Fee Schedule

This claim was initially denied by the respondent for a lack of medical necessity. I have already determined that the respondent did not establish this defense.

The applicant billed a total of \$3,438.42 for the services at issue, for which the respondent made partial payment of \$70.42 for the office visit based on its calculation of the correct reimbursable amount pursuant to the appropriate fee schedule, leaving a balance of \$3,368.18. At the hearing, the applicant amended the amount in dispute to \$1,777.92.

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 1<sup>st</sup> 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 Gina Ball, R.N. CPC, a medical professional and certified professional coder who submitted a comprehensive review and analysis and determined, based on the applicable New York fee schedule that the total correct reimbursable amount for the services at issue is \$910.32.

The analysis by Ms. Ball included only one payment for CPT code 97642 at \$231.36 and did not allow for the other charges for the ultrasound guidance. This

was based on the New York Workers' Comprehensive Medical Fee Schedule and the CPT Assistant related to CPT code 76942 when reporting ultrasound guidance for trigger point injections.

However, in this instance the guidance was provided with nerve block injections and therefore, the CPT Assistant cited by Ms. Ball does not apply. However, the multiple procedure rule and deductions for services rendered by a NP do apply.

Based on a calculation of the total allowable charges of 100% for the first charge of \$231.36 for ultrasound guidance and 50% of the five other charges at \$115.68 each (\$578.40) the total charge for the guidance is \$809.76.

Therefore the total reimbursable amount would be \$1,488.72.

The applicant submitted the affidavit of Jacqueline Thelian, CPC a certified professional fee coder who submitted a comprehensive analysis of the charges for the services at issue. She discussed the radiology charges for ultrasound guidance for the injections at issue and specifically discussed Radiology Ground Rule 3 (Multiple Diagnostic Procedures.) However, she referred to procedures performed under CPT codes 70010-76499, 76505-76999, 77002-77003, and 78012-78999 which refer to trigger point injections rather than the nerve block injections at issue.

Ms. Thelian did not provide any determination of the total reimbursable amount for the services at issue, including a deduction for services performed by a NP.

Based on the foregoing, I find that in general, the affidavit by Ms. Ball is more persuasive with the exception of the miscalculation of the charges for ultrasound guidance.

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

**Accordingly, the applicant is awarded \$1,488.72 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	Amount Amended	Status
	Atlantic Medical & Diagnostic PC	11/04/24 - 11/06/24	\$3,368.18	\$1,777.92	Awarded: \$1,488.72
Total			\$3,368.18		Awarded: \$1,488.72

B. The insurer shall also compute and pay the applicant interest set forth below. 01/16/2025 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 30<sup>th</sup> 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.

06/25/2025

(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:**  
7557344be7d3cc90ef3b8396c3e3c4f5

### Electronically Signed

Your name: Anne Malone  
Signed on: 06/25/2025