

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

A to Z Physical Therapy PC  
(Applicant)

- and -

MVAIC  
(Respondent)

AAA Case No. 17-24-1362-9088

Applicant's File No. 3135077

Insurer's Claim File No. 707871

NAIC No. Self-Insured

**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 06/09/2025  
Declared closed by the arbitrator on 06/09/2025

Melissa Scotti, Esq. from Law Offices of Andrew J. Costella Jr., Esq. participated virtually for the Applicant

Craig Marshall, Esq. from Marshall & Marshall, Esqs. participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,229.66**, 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 42 year old EIP was involved in a motor vehicle accident on October 18, 2023; claimed related injury and underwent physical therapy treatment provided by the applicant from January 31, 2024 to April 9, 2024.

The applicant submitted a claim for these medical services. The respondent contends that it did not receive bills for dates of service January 31, 2024 to February 6, 2024.

The respondent denied the bills for dates of service March 21, 2024 to April 9, 2024 based on the IME of the EIP by Stuart Hershon, M.D. which was

performed on March 11, 2024. The IME cut-off was effective March 25, 2024. In response, Chinweike Izeogu, M.D. submitted a rebuttal dated April 10, 2025.

The respondent also asserted a fee schedule defense.

**The issues to be determined at the hearing are:**

**Whether the applicant established its *prima facie* entitlement to no fault benefits for dates of service January 31, 2024 to February 6, 2024.**

**Whether the whether the respondent established that the medical services provided from March 21, 2024 to April 9, 2024 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 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.

##### Applicant's *prima facie* case of entitlement to no-fault benefits

It is well settled that an applicant establishes its *prima facie* showing of entitlement to No-Fault benefits by submitting evidentiary proof that the prescribed statutory billing forms had been mailed, received by the respondent and that payment of no fault benefits were overdue. Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D. 3d 742, 774 N.Y.S.2d 564 (2d Dept. 2004.)

An insurer in a no-fault matter will be precluded as a matter of law from asserting a defense based upon the untimely submission of the bill/bills at issue if such defense is not raised in a timely denial. See New York and Presbyterian Hospital v. Empire Ins. Co., 286 A.D.2d 322 (2d Dept.2001.)

If respondent has preserved such defense in a timely denial, respondent will still be precluded from proffering such defense as a matter of law unless respondent advised applicant that late submission of the bill/bills will be excused where the applicant can provide a reasonable justification of the failure to timely submit the bill/bills. 11 NYCRR 65-3.3(e). See also Radiology Today, P.C. v. Citiwide Auto Leasing, Inc., 2007 NY Slip Op 27111 (App. Term 2<sup>nd</sup> and 11<sup>th</sup> Jud. Dists. 2007.)

The respondent contends that it did not receive the bills for dates of service January 31, 2024 to February 6, 2024.

The applicant submitted two affirmations by Abel Mendez who stated that he was the custodian of records and medical biller for the applicant. However the first affirmations related to bills for services rendered from October 30, 2023 to December 4, 2023 and the second affirmation did not address mailing of bills and only addressed the applicant's non-receipt of verification request for dates of service December 12, 2023 to March 5, 2023. Neither of the affirmations are related to this claim for services rendered from January 31, 2024 to February 6, 2024.

Based on the foregoing, the applicant did not establish timely mailing to the respondent of bills for dates of service January 31, 2024 to February 6, 2024.

Under these circumstances, the applicant has failed to establish its *prima facie* entitlement for no fault benefits for the claim at issue.

**Therefore, the claim for dates of service January 31, 2024 to February 6, 2024 is dismissed with prejudice.**

#### 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, 11<sup>th</sup> and 13<sup>th</sup> 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 1<sup>st</sup> 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.) All other ranges of motion were within normal limits.

To support its contention that the physical therapy treatment provided to the EIP was not medically necessary, the respondent relied upon the report of the independent medical examination of the EIP by Dr. Hershon, which documented some restricted range of motion in the cervical spine with minimal muscle spasm

and tenderness and no motor or sensory deficits, negative cervical compression with no radiating pain to the back.

Dr. Hershon determined that the cervical spine sprain/strain was resolving and that the EIP had a mild orthopedic disability to the cervical spine.

Based upon the physical examination and medical records reviewed, Dr. Hershon determined that despite her subjective complaints, the EIP was not disabled and that she could perform her activities of daily living and working without some restrictions including heavy lifting, pushing and pulling.

Dr. Hershon determined that the EIP was four months post-accident and had reached an end point in further physical therapy. He recommended that she follow-up with an orthopedist once in six weeks to discuss alternative treatment options. It was his opinion that there was no medical necessity for further physical therapy, massage therapy, diagnostic testing, durable medical equipment, household help or special transportation.

Based on the report of the independent medical examination by Dr. Hershon, I find that he did not address the positive findings documented in the IME report or the findings of the EIP's treating physicians and the medical treatment provided at their recommendation. The respondent has not factually demonstrated that the physical therapy treatment provided by the applicant was not medically necessary. Accordingly, the burden does not shift to the applicant. See Bronx Expert Radiology, P.C. v. Travelers Ins. Co., 2006 NY Slip Op 52116 (App. Term 1<sup>st</sup> Dept. 2006.)

Although it was not necessary under these circumstances, Dr. Izeogu submitted a rebuttal.

Based on the foregoing, the respondent has not established that the physical therapy treatment at issue was not medically necessary.

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

#### Fee Schedule

The applicant billed a total of \$1,229.66 for the services at issue, which included \$227.77 for services rendered on January 31, 2024 and February 6, 2024. The respondent has established that the bills for these dates of service were not received by the respondent. Therefore, a total of \$1,001.89 remains of the amount billed by the applicant.

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 former scenario and does not require an expert opinion.

After a review of the charges and the applicable fee schedule, I have determined that the correct reimbursable amount for this claim at \$114.60 for each of the remaining 7 dates of service is \$802.20.

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

**Accordingly, the applicant is awarded \$802.20 and the remainder of 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 applicant is AWARDED the following:

A.

Medical		From/To	Claim Amount	Status
	A to Z Physical Therapy PC	01/31/24 - 04/09/24	\$1,229.66	Awarded: \$802.22
Total			\$1,229.66	Awarded: \$802.22

- B. The insurer shall also compute and pay the applicant interest set forth below. 08/29/2024 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 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.

07/01/2025

(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:**  
7f188255aa82c2ebc283d683f1d21f60

### Electronically Signed

Your name: Anne Malone  
Signed on: 07/01/2025