

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Stanley-Sangwook Kim D.O. PC  
(Applicant)

- and -

American States Insurance Company  
(Respondent)

AAA Case No. 17-25-1393-4173

Applicant's File No. NF24-104711

Insurer's Claim File No. 0573634830006

NAIC No. 19704

### ARBITRATION AWARD

I, Glen Wiener, 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: Assignor

1. Hearing(s) held on 10/09/2025  
Declared closed by the arbitrator on 10/09/2025

Phillip Kim, Esq. from Horn Wright, LLP participated virtually for the Applicant

Kathleen Raedy, Esq. from American States Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$2,591.41**, was AMENDED and permitted by the arbitrator at the oral hearing.

The total amount requested was amended to \$2,464.00 to reflect prior payments.

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

3. Summary of Issues in Dispute

Assignor W.L. a 52-year-old female passenger was injured in an automobile accident on July 12, 2024. She did not seek any immediate emergency medical attention.

On July 15, 2024, complaining of neck, back, right shoulder, bilateral hand, and right knee pains, Assignor presented to Applicant. Diagnosed with various sprains, she was prescribed medications and referred for physical therapy and medical imaging.

On August 12, 2024, September 16, 2024, and October 21, 2024, Applicant performed and billed for additional evaluations along with outcome assessment testing using CPT 99358 [Prolonged evaluation and management service before and/or after direct patient care; first hour]. Respondent reimbursed Applicant for the evaluations but denied Applicant's requests for additional reimbursement for the outcome assessment testing billed under CPT code 99358 based on its reading of the Fee Schedule.

On October 14, 2024, Assignor was examined by Stuart Hershon, M.D. an orthopedic surgeon selected by Respondent [the "IME"]. The examination did not reveal any abnormalities. Based on the IME report, Respondent terminated Assignor's medical benefits effective October 31, 2024.

On December 16, 2024, January 13, 2025, and February 7, 2025, Applicant performed and billed for additional evaluations along with outcome assessment testing. Respondent denied Applicant's request for reimbursement based on an IME.

The questions presented are:

Whether Respondent established its reading of the Fee Schedule was correct; and

Whether the post-IME services were medically necessary.

#### 4. Findings, Conclusions, and Basis Therefor

The decision below is based on the documents on file in the Electronic Case Folder maintained by the American Arbitration Association as of the date of this hearing and on oral arguments of the parties. No witness testimony was produced at the hearing.

Applicant Stanley-Sangwook Kim, D.O. as assignee of W.L. seeks \$2,464.00 additional reimbursement, with interest and counsel fees, under the No-Fault Regulations, for medical services provided to Assignor.

Respondent American States Insurance Company insured the motor vehicle involved in the automobile accident. Under New York's Comprehensive Motor

Vehicle Insurance Reparation Act (the "No-Fault Law"), New York Ins. Law §§ 5101 et seq., Respondent was obligated to reimburse the injured party (or their assignee) for all "reasonable and necessary" medical expenses arising from the use or operation of the insured vehicle.

### **Facts of the Case**

Assignor W.L. a 52-year-old female passenger was injured in an automobile accident on July 12, 2024. She did not seek any immediate emergency medical attention.

On July 15, 2024, complaining of neck, back, right shoulder, bilateral hand, and right knee pains, Assignor presented to Applicant. Diagnosed with sprains of her left knee, cervical spine, lumbar spine, right shoulder, and wrist/hand along with lumbalgia and cervicalgia, she was prescribed medications and referred for physical therapy and medical imaging.

Magnetic resonance of Assignor's right shoulder performed on July 25, 2024, revealed a focal compression fracture of the humeral head, tears of the supraspinatus and infraspinatus tendons, a labral/slap tear, and bursitis.

The imaging of Assignor's right knee and left shoulder was performed on July 29, 2024 by Sky Radiology. Additional imaging of Assignor's bilateral hands by Sky Radiology was performed on August 4, 2024. A dispute between the provider, Sky Radiology and Respondent was addressed in AAA File number 17-24-1377-6375 (June 3, 2025).

On August 8, 2024, magnetic resonance imaging was performed on Assignor's cervical and lumbar spines revealing C3-C4, C4-C5, C5-C6, C7-T1, L4-L5 disc bulges and C6-C7, L2-L3, L3-L4, and L5-S1 disc herniations. A dispute between the provider, All County LLC and Respondent was addressed in AAA File number 17-24-1369-6754 (Aug. 15, 2025).

On August 12, 2024, September 16, 2024, and October 21, 2024, Applicant performed and billed for additional evaluations along with outcome assessment testing using CPT 99358 [Prolonged evaluation and management service before and/or after direct patient care; first hour]. Respondent reimbursed Applicant for the evaluations but denied Applicant's requests for additional reimbursement for the outcome assessment testing billed under CPT code 99358 based on its reading of the Fee Schedule.

On October 14, 2024, Assignor was examined by Stuart Hershon, M.D. an orthopedic surgeon selected by Respondent [the "IME"]. At the time of the evaluation, she reported pain in her neck, low back, shoulders, right hand, and left knee. The examination did not reveal any abnormalities. Dr. Hershon opined Assignor's sprains/strains resolved and there was no need for any additional

medical treatments or services. Based on the IME report, Respondent terminated Assignor's medical benefits effective October 31, 2024.

On October 14, 2024, Assignor was examined by John E. Johnson Jr. D.C., L.Ac. a chiropractor/acupuncturist selected by Respondent [the "Chiro IME"]. At the time of the examination, Assignor reported she still has neck, back, shoulder, right hand, and knee pains. The examination of Assignor's symptomatic cervical spine revealed tenderness. Dr. Johnson opined Assignor's "sprains/strains" had resolved and there was no need for any additional chiropractic or acupuncture treatments. Based on the IME report, Respondent terminated Assignor's chiropractic and acupuncture benefits effective October 31, 2024. Denials based on the Chiro IME were vacated in *NYS Park Chiropractic P.C. v. Am. States Ins. Co.*, 17-25-1394-5038 (Oct. 9, 2025)

On December 16, 2024, January 13, 2025, and February 7, 2025, Applicant performed and billed for additional evaluations along with outcome assessment testing. Respondent denied Applicant's request for reimbursement based on an IME.

The questions presented are:

Whether Respondent established its reading of the Fee Schedule was correct; and

Whether the post-IME services were medically necessary.

### **Analysis**

Applicant established its prima facie entitlement to benefits by submitting evidence that payment of no-fault benefits is overdue, and proof of its claims, using the statutory billing forms, were mailed to and received by Respondent. *Viviane Etienne Medical Care, P.C. v. Country-Wide Ins. Co.*, 25 N.Y.3d 498, 501, 14 N.Y.S.3d 283 (2015). The proof that Applicant mailed the claim forms to Respondent is embodied in the latter's denials, which reference receipt of the proofs of claim. See *Ultra Diagnostic Imaging v. Liberty Mutual Insurance Co.*, 9 Misc.3d 97, 804 N.Y.S. 2d 532 (App. Term 9th and 10th Jud. Dist. 2005).

### **Fee Schedule Defense**

With respect to the services performed on July 15, 2024, Respondent concedes that Applicant is owed \$401.05 additional reimbursement for the evaluation billed under CPT code 99244 and the outcome assessment testing billed under CPT code 99538.

Applicant also seeks \$840.36 reimbursement for outcome assessment testing billed under CPT code 99538, on August 12, 2024, September 16, 2024, and October 21, 2024, the same days as medical evaluations billed under CPT code

99214. Respondent reimbursed Applicant for the evaluations but denied Applicant's requests for additional reimbursement for the outcome assessment testing billed under CPT code 99358 based on its reading of the Fee Schedule.

An insurer has the burden of showing as a matter of law that said claims reflect the incorrect amount for services provided. *Jamil M. Abraham, M.D., P.C. v. Country Wide Ins. Co.*, 3 Misc.3d 130[A], 787 N.Y.S.2d 678 (App. Term 2d & 11th Jud. Dist 2007); *New Era Massage Therapy, P.C. v. Progressive Cas. Ins. Co.*, 2009 N.Y. Misc. Lexis 2554, 242 N.Y.L.J. 2 (Sup. Ct. Queens Co. June 26, 2009).

Outcome assessment testing entails the patient filling out a series of questionnaires, which are then reviewed and analyzed by the healthcare practitioner. These questionnaires measure things like level of pain, functional limitations in daily living and level of improvement.

Applicant billed an additional \$280.12 on each of the three days, beyond the fee for the comprehensive evaluation, for reviewing these questionnaires.

In support of its position that the services billed for under CPT code 95938 are not separately reimbursable, Respondent cited to and produced a copy of the September 2020, Vol 30, Issue 9 CPT Assistant indicating:

*Codes 99358 and 88359 may be reported on the same day as E/M service, **except** office or other outpatient services (99202-99205, 99212-99215). Codes 99358 and 88359 may also be reported on a different date than the primary service to which it is related, including office or other outpatient services (99202-99205, 99212-99215). For example, extensive record review may relate to a previous office E/M/ service performed on an earlier date or an upcoming E/M service on a future date.*

The "CPT Assistant is incorporated by reference into the CPT book, which is incorporated by reference into the Official New York Workers' Compensation Medical Fee Schedule applicable to this claim under the No-Fault Law, [any] award rendered without consideration of CPT Assistant is incorrect as a matter of law." *Matter of Global Liberty Ins. Co. v McMahon*, 2019 NY Slip Op 03692 (1st Dept. 2019)

Based on the CPT Assistant quoted above, a medical provider cannot bill evaluations under CPT code 99214 and a prolonged evaluation under CPT code 99358, when done on the same day.

Moreover, logic mandates the same result. Most patients fill out copious forms and questionnaires when visiting a healthcare professional. Nothing in the fee schedule indicates this common practice should result in higher reimbursement.

Applicant's request for additional reimbursement for outcome assessment testing performed on August 12, 2024, September 16, 2024, and October 21, 2024, the same days as medical evaluations billed under CPT code 99214 is denied and Respondent's denials are sustained.

Hence, Applicant is awarded \$401.05 reimbursement for the services performed on July 15, 2024, and Respondent denials are otherwise sustained.

#### Medical Necessity

Applicant also seeks \$1,222.59 reimbursement for the services provided on December 16, 2024, January 13, 2025, and February 7, 2025. Respondent denied Applicant's request for reimbursement based on an IME.

Once Applicant established a prima facie case the burden shifted to Respondent to prove the services were not medically necessary. See *Citywide Social Work & Psychological Services, PLLC v. Allstate Ins. Co.*, 8 Misc.3d 1025A, 806 N.Y.S.2d 444 (App. Term 1st Dept. 2005); *A.B. Medical Services, PLLC v. Geico Ins. Co.*, 2 Misc.3d 26, 773 N.Y.S.2d 773 (App. Term 2d & 11th Jud Dist. 2003); *Fifth Ave. Pain Control Center v. Allstate Ins. Co.*, 196 Misc.2d 801, 766 N.Y.S.2d 748 (Civ. Ct. Queens Co. 2003).

"A denial premised on lack of medical necessity must be supported by competent evidence such as an independent medical examination, peer review or other proof which sets forth a factual basis and medical rationale for denying the claim." *Healing Hands Chiropractic, P.C. Franklin v. Nationwide Assurance Company*, 5 Misc.3d 975, 787 N.Y.S. 645 (Civ. Ct. NY Co. 2004).

Dr. Hershon's IME report provides a sufficient factual basis and medical rationale for the opinion that the services billed for were not necessary and therefore established prima facie the services billed for were not medically necessary. See *Delta Diagnostic Radiology, PC v. Progressive Casualty Ins. Co.*, 21 Misc.3d 142A (App. Term 2d & 11th Jud. Dist. 2008); *Crossbridge Diagnostic Radiology, PC v. Progressive Casualty Ins. Co.*, 20 Misc.3d 143A (App. Term 2d & 11th Jud Dist. 2008).

Once Respondent established a factual basis and medical rationale for the determination there was lack of medical necessity for any further treatment and testing, the burden shifted to Applicant to present evidence as to why the post-IME services were needed either because Assignor's condition had changed after the IME or because the IME doctor's opinion was erroneous. *New Horizon Surgical Center, LLC v. Allstate Ins. Co.*, 52 Misc.3d 139(A) (App. Term 2d, 11th & 13th Jud. Dist. 2016).

In response Applicant submitted follow-up evaluations, wherein it is documented Assignor continued to complain of neck, back, and shoulder pains and exhibited abnormal findings corresponding to these complaints.

Specifically, on September 16, 2024, just 18 days before the IME, Assignor reported continuing neck, back, and shoulder. The examination of Assignor's shoulders revealed reduced ranges of motion along with positive Painful Arc and Impingement Signs. The examinations of Assignor's cervical and lumbar spines revealed tenderness, spasm, and reduced ranges of motion. It was noted that Assignor was improving and she was instructed to continue with physical therapy.

Similar findings and recommendations were documented in the narrative report from the October 21, 2024, evaluation, performed just 17 days after the IME.

These findings are in direct contradiction to the findings and conclusions contained in the IME report but are supported by the other medical reports submitted including the MRI reports noting numerous disc herniations, disc bulges, tears, and a fracture, which were not discussed by Dr. Hershon.

Both experts agree that Assignor complained of continuing pains. The evidence establishes that Applicant was also confronted with certain objective clinical findings relative to Assignor's complaints. Based upon these facts Applicant reasonably opined that further evaluations and treatment were medically necessary.

For the reasons set forth above, Applicant is not awarded reimbursement for the outcome assessment tests performed on the same days as the three evaluations.

Respondent's denials premised on the IME of Dr. Hershon are vacated and Applicant is awarded \$382.23 reimbursement for the medical evaluations performed on December 16, 2024, January 13, 2025, and February 7, 2025.

Accordingly, Applicant is awarded \$783.28 total reimbursement, and Respondent's denials are otherwise denied. This award is in full disposition of all No-Fault benefit claims submitted to 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
	<b>Stanley-Sa ngwook Kim D.O. PC</b>	<b>07/15/24 - 07/15/24</b>	<b>\$401.05</b>		<b>Awarded: \$401.05</b>
	<b>Stanley-Sa ngwook Kim D.O. PC</b>	<b>08/12/24 - 08/12/24</b>	<b>\$280.12</b>		<b>Denied</b>
	<b>Stanley-Sa ngwook Kim D.O. PC</b>	<b>09/16/24 - 09/16/24</b>	<b>\$407.53</b>	<b>\$280.12</b>	<b>Denied</b>
	<b>Stanley-Sa ngwook Kim D.O. PC</b>	<b>10/21/24 - 10/21/24</b>	<b>\$280.12</b>		<b>Denied</b>
	<b>Stanley-Sa ngwook Kim D.O. PC</b>	<b>12/16/24 - 12/16/24</b>	<b>\$407.53</b>		<b>Awarded: \$127.41</b>
	<b>Stanley-Sa ngwook Kim D.O. PC</b>	<b>01/13/25 - 01/13/25</b>	<b>\$407.53</b>		<b>Awarded: \$127.41</b>
	<b>Stanley-Sa ngwook</b>	<b>02/07/25 -</b>			<b>Awarded:</b>

	<b>Kim D.O. PC</b>	<b>02/07/25</b>	<b>\$407.53</b>		<b>\$127.41</b>
<b>Total</b>			<b>\$2,591.41</b>		<b>Awarded: \$783.28</b>

B. The insurer shall also compute and pay the applicant interest set forth below. 03/28/2025 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Since the motor vehicle accident occurred after Apr. 5, 2002, interest shall be calculated at the rate of two percent per month, simple, calculated on a pro rata basis using a 30-day month. 11 NYCRR §65-3.9(a). If an applicant does not request arbitration or institute a lawsuit within 30 days after receipt of a denial of claim form or from the payment of benefits, interest shall not accumulate on the disputed claim or element of claim until such action is taken. 11 NYCRR §65-3.9 (c).

In accordance with 11 NYCRR §65-3.9(c), interest shall be paid on the claim from above noted date, which according to the timeline in the ECF is the date the arbitration was filed with the American Arbitration Association.

C. Attorney's Fees

The insurer shall also pay the applicant for attorney's fees as set forth below

In accordance with 11 NYCRR §65-4.6(d), the insurer shall pay Applicant an attorney's fee equal to 20% of the total amount awarded in this proceeding plus interest, with NO MINIMUM FEE and the maximum fee capped at \$1,360.

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 NY  
 SS :  
 County of New York

I, Glen Wiener, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

10/13/2025  
(Dated)

Glen Wiener

**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:**  
ab8db30212afe1f3a03e12e7e58d0195

**Electronically Signed**

Your name: Glen Wiener  
Signed on: 10/13/2025