

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Community Medical Wellness, PC  
(Applicant)

- and -

Safeco Insurance Company of America  
(Respondent)

AAA Case No. 17-25-1406-3538

Applicant's File No. LOSAS25-81154

Insurer's Claim File No. 05127896703

NAIC No. 19704

### 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 04/20/2026  
Declared closed by the arbitrator on 04/20/2026

Inna Vilig, Esq. from Law Office Of Stephen A. Strauss, PC participated virtually for the Applicant

Christina Mahese-Mosley from Safeco Insurance Company of America participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,003.42**, 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 35 year old EIP reported involvement in a motor vehicle accident on July 9, 2024; claimed related injury and underwent office visits and trigger point injections with guidance provided by the applicant on March 4, 2025 and April 1, 2025. The medical services were provided by a PA.

The applicant submitted a claim for these medical services, payment of which was timely denied by the respondent based on the IME of the EIP by Anju Madnami, M.D. which was performed on October 4, 2024. The IME cut-off was effective on October 20, 2024.

In response, the applicant submitted a rebuttal dated August 29, 2025 by Robert Antoniou, M.D., one of the EIP's treating medical providers.

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 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.

##### 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.)

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. Madnani, which was objectively negative and unremarkable. Range of motion was determined with the assistance of a goniometer. The report presents a factually sufficient, cogent medical rationale in support of respondent's lack of medical necessity defense. Dr. Madnani performed a complete and comprehensive examination of the EIP which did not identify any objective positive findings and determined that her injuries were resolved.

Based upon the physical examination and medical records reviewed, Dr. Mandani noted that the EIP reported that she missed no time from work as a nurse as a result of injuries sustained as a result of the subject accident. He determined that despite her subjective complaints, the EIP was not disabled and that she could perform her activities of daily living and continue working without restrictions. It was Dr. Mandani's opinion that there was no medical necessity for further pain management, physical therapy, massage therapy, injections, surgery, shockwave therapy, prescription pain 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. Mandani, the applicant relied upon a rebuttal by Dr. Antoniou, who submitted a comprehensive report which discussed in detail the injuries sustained by the EIP and the treatment rendered to her.

Dr. Antoniou specifically addressed each of the arguments presented by Dr. Mandani and his reasons for disagreeing with his conclusions regarding the medical services at issue. Dr. Antoniou specifically noted that although Dr. Mandani noted all normal findings, the post-IME medical records clearly established that the EIP had continued complaints of pain and positive objective findings.

After a review of all the evidence submitted an issue of fact remains as to whether the services rendered are medically necessary. Conflicting opinions have been presented in the report of the IME by Dr. Mandani and the report of Dr. Antoniou, who submitted a rebuttal on behalf of the applicant.

In this instance, the rebuttal by Dr. Antoniou meaningfully refers to and rebuts the findings of Dr. Mandani and the medical reports submitted are sufficient to establish the medical necessity for the services at issue.

Therefore, I find that the submissions of Dr. Antoniou were more persuasive.

Under these circumstances, the respondent has failed to establish that the post-IME medical treatment at issue was not medically necessary.

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

Fee Schedule

The applicant billed a total of \$1,003.42 for the medical services at issue. This is the physician rate for these services. According to the submissions, the services at issue were performed by a PA. The bill at issue was denied based on a lack of medical necessity. I have already determined that the respondent did not establish this defense.

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.

The applicant billed a total of \$1,003.42 for the two dates of service. On March 4, 2025 the EIP underwent a trigger point injection with ultrasonic guidance. On April 1, the EIP received on the injection with guidance.

Based on the submissions, it is clear that the medical services provided to the EIP were performed by a PA. Based on the appropriate fee schedule, these charges should have been billed at 80%. The total amount billed was \$1,003.42. The total reimbursable amount for the bills at issue is \$802.73.

Under these circumstances, has established a fee schedule defense.

**Accordingly, the applicant is awarded \$802.74 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      | Status                   |
|--------------|--------------------------------|---------------------|-------------------|--------------------------|
|              | Community Medical Wellness, PC | 03/04/25 - 04/01/25 | \$1,003.42        | Awarded: \$802.74        |
| <b>Total</b> |                                |                     | <b>\$1,003.42</b> | <b>Awarded: \$802.74</b> |

- B. The insurer shall also compute and pay the applicant interest set forth below. 06/27/2025 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.

04/30/2026  
(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:**  
eb08aae3dd3175e673b2e8515619eeff

**Electronically Signed**

Your name: Anne Malone  
Signed on: 04/30/2026