American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Bay Ridge Orthopedic Assoc. PC (Applicant)	AAA Case No.	17-25-1421-3516
	Applicant's File No.	N/A
- and -	Insurer's Claim File No.	230911335-004
	NAIC No.	12130
New South Insurance Company (Respondent)		

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

   April Mittleman, Esq. from April Mittleman Esq. participated virtually for the Applicant

   Francis Arevalo Arias, Esq. from Law Offices Of Richard Schoenberg participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$13,205.52**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The amount claimed was amended by the applicant to $7,478.58 to conform to the appropriate fee schedule.

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

3. Summary of Issues in Dispute

   The 61 year old EIP reported involvement in a motor vehicle accident on October 23, 2023; claimed related injury and underwent an office visit on February 27, 2023, and left knee arthroscopic surgery provided by the applicant on March 8, 2023.

The applicant submitted a claim for the surgeon and assistant services, payment of which was timely denied by the respondent based on the peer review by Pierce Ferriter, M.D. dated May 8, 2024. In response, the applicant submitted a rebuttal by Howard Baum, M.D. dated September 30, 2025.

The respondent also asserted a fee schedule defense.

The issues to be determined at the hearing are:

Whether the respondent established that the left knee arthroscopy and related medical services, including surgeon and assistant 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

In order 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, 11th and 13th 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 1st Dept. 2006.)

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.)

In support of its contention that the medical services provided by the applicant were not medically necessary, respondent relies upon the report of the peer review by Dr. Ferriter, who reviewed the medical records of the EIP, noted the injuries claimed and the treatment rendered to her. Dr. Ferriter considered possible arguments and justification for the need for the left knee arthroscopy and related surgeon and assistant services at issue and determined that they were not warranted under the circumstances presented.

He specifically noted that the MRI findings were consistent with degenerative arthritis of the knee, were not traumatic and did not warrant urgent surgical intervention.

Dr. Ferriter determined that there was no evidence that the EIP had completed a full, proper course of conservative treatment before considering the left knee arthroscopy.

He supported, with relevant medical literature, his opinion that the left knee arthroscopy and related surgeon and assistant services provided to the EIP were not medically necessary.

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 the assignor. Therefore, pursuant to Bronx Expert Radiology, *supra* the burden shifts to the applicant, who bears the ultimate burden of persuasion to establish that the medical services at issue were medically necessary.

In opposition to the peer review, the applicant presented a rebuttal by Dr. Baum, who disagreed with the conclusions reached by Dr. Ferriter and discussed in detail the injuries sustained by the EIP and the treatment rendered to her.

He determined that the complaints related to the left knee injury had failed to respond to over four months of conservative care and that the arthroscopic surgery was necessary. The records for physical therapy did not clearly indicate that treatment was for the left knee, but the EIP also received acupuncture treatment for left knee complaints.

Dr. Baum supported, with relevant medical citations, his opinion that the medical services at issue were medically necessary.

A review of the applicant's submissions reveals that it has met the burden of persuasion in rebuttal. The medical records and rebuttal submitted in opposition to the findings of Dr. Ferriter 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 medical 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

The applicant billed $13,205.52 for the surgeon and assistant services and office visit related to the left knee arthroscopy. This amount was amended at the hearing to $7,478.58. The respondent contends that the correct reimbursable amount for the surgeon and assistant bills is $3,097.10.

In order to prevail in its fee schedule defense, the respondent must demonstrate by competent evidentiary proof that the applicant's claims are in excess of the appropriate fee schedule. If the respondent fails to do so, its defense of noncompliance with the New York Workers' Compensation Medical Fee Schedule cannot be sustained. See Continental Medical, P.C. v Travelers Indemnity Co., 11 Misc. 3d 145A (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 expertise 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 a comprehensive affidavit of Jennifer Takac, CPC, CPMA , a certified professional coder who determined that the correct reimbursable amount for the services at issue is $3,097.10.

The applicant submitted the affidavit of Jennifer Nestoiter, CBCS, a certified billing and coding specialist who submitted a detailed analysis of the charges at issue and determined that the correct reimbursable amount for the services at issue is $7,478.45.

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 Jennifer Takac, CPC and the affidavit of Jennifer Nestoiter, CBCS submitted on behalf of the applicant. I find that the submission of applicant's expert was more persuasive in this instance.

Based on the foregoing, the respondent has failed to establish its fee schedule defense.

Accordingly, an award in the amount of $7,478.58 will be issued in favor of the applicant.

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**
	Bay Ridge Orthopedic Assoc. PC	**02/27/24 - 03/12/24**	**$13,205.52**	**$7,478.58**	**Awarded: $7,478.58**
			$13,205.5		**Awarded:**

Total	2		$7,478.58

B. The insurer shall also compute and pay the applicant interest set forth below. 10/01/2025 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 30th 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.

05/01/2026
(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:
700331b3f4e9f755885471b282c39b33

Electronically Signed

Your name: Anne Malone
Signed on: 05/01/2026