American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Ryan D Tichauer DC (Applicant)	AAA Case No.	17-25-1381-2559
	Applicant's File No.	OS-96481
- and -	Insurer's Claim File No.	0758874036 2N1
Allstate Insurance Company (Respondent)	NAIC No.	19232

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 05/27/2026
   Declared closed by the arbitrator on 05/27/2026

   John Faris, Esq. from Law office of Olga Sklyut, PC participated virtually for the Applicant

   Emily La Plante, Esq. v from Law Offices Of Richard Schoenberg participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$539.75**, 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 71 year old EIP reported involvement in a motor vehicle accident on June 14, 2024; claimed related injury and underwent diagnostic ultrasound provided by the applicant on September 16, 2024.

   The applicant submitted a claim for these medical services, payment of which was delayed pending the respondent's investigation and the EUO of the EIP to verify proof of claim.

   The respondent also asserted a fee schedule defense.

The issues to be determined at this hearing are:

Whether the respondent established that the claim is premature.

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.

Outstanding verification

If an insurer requires any additional information to evaluate the proof of claim, such request for verification must be made within 15 business days of the receipt of the bill in order to toll the 30 day period to pay or deny the claim. See 11 NYCRR 65-3.5(b); See also New York Hosp. Med. Ctr. of Queens v. Allstate Ins. Co., 2014 NY Slip Op 00640 (2d Dept. 2014.)

Where there is a timely original request for verification, but no response to the original request for verification is received within 30 days, or the response to the verification request is incomplete, then the insurer, within 10 calendar days after the expiration of that 30 day period, must follow up with a second request for verification. Id.

If there is no response to the second or follow up request for verification, the time in which the insurer must decide whether to pay or deny the claim is indefinitely tolled. Id.

Therefore, when a no-fault medical service provider fails to respond to the requests for verification the claim is premature and should be denied without prejudice.

In the instant matter, the respondent did not provide any formal verification requests, proof of mailing or evidence of non-receipt of the information requested.

Based on the foregoing, the respondent failed to establish that the claim is premature and therefore, the time to pay or deny this bill at issue is not tolled.

Fee Schedule

The respondent billed a total of $1,160.75 for the medical services at issue for which the respondent made partial payment of $621.00, leaving a balance of $539.75.

In order 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 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 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 Carolyn Mallory, CPC, a certified professional coder who submitted a comprehensive analysis and determined that the correct reimbursable amount for the services at issue is $463.72 based on the applicable New York Workers' Compensation Chiropractic Fee Schedule. She noted that the respondent had already paid $621.00 which resulted in an overpayment of $157.28.

The applicant also submitted the affidavit of Jennifer Nestoiter, CBCS a certified professional fee coder who determined that the correct reimbursable amount for the chiropractic services at issue is $1,160.55.

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 Carolyn Mallory, CPC and the affidavit of Jennifer Nestoiter, CBCS who submitted an affidavit on behalf of the applicant. I find that the submission of Ms. Mallory was more persuasive in this instance since it conforms to the provisions of the chiropractic fee schedule.

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

Accordingly, 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 claim is DENIED in its entirety

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.

06/26/2026
(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:
aa4f385a0fa1761967ab4f0c66e27650

Electronically Signed

Your name: Anne Malone
Signed on: 06/26/2026