American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Atlantic Medical & Diagnostic PC (Applicant)	AAA Case No.	17-25-1427-7729
	Applicant's File No.	3627218
- and -	Insurer's Claim File No.	HLV25005843
	NAIC No.	24309
Hereford 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 06/26/2026
   Declared closed by the arbitrator on 06/26/2026

   Stacy Mandel Kaplan, Esq. from Israel Purdy, LLP participated virtually for the Applicant

   Chris Fingerhut, Esq. from Law Offices of Ruth Nazarian participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$2,964.08**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The amount claimed was amended by the applicant to $671.18 to conform to the appropriate fee schedule. The respondent did not agree to this amended amount.

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

3. Summary of Issues in Dispute

   The 81 year old EIP reported involvement in a motor vehicle accident on September 2, 2025; claimed related injury and underwent an office visit and trigger point injection with guidance provided by the applicant. These medical services were performed 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 Vijay Sidhwani, M.D. which was performed on June 26, 2025. The IME cut-off was effective on July 31, 2025.

The respondent also asserted a fee schedule defense.

The applicant contends that it is entitled to additional interest from September 16, 2025 to October 16, 2025 because the bill at issue was received on September 16, 2025 which is within 30 days of the date of service.

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.

Whether the applicant is entitled to additional interest for the claim at issue.

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.

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. 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 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. Sidhwani.

After reviewing the EIP's medical records and relying upon his physical examination, Dr. Sidhwani determined that the injuries sustained by the EIP were "only partially related to the motor vehicle accident" because "he had prior degenerative disc disease, which was exacerbated as a result of the injuries sustained" in the subject accident.

Based on the report of the independent medical examination by Dr. Sidhwani, 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 medical services provided by the applicant were 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 1st Dept. 2006.)

Under these circumstances, the respondent has not established that the medical services at issue were not medically necessary.

Therefore, an award will be awarded to the applicant pursuant to the applicable fee schedule.

Fee Schedule

The applicant billed a total of $2,964.08 for the services at issue, payment of which was timely denied by the respondent based on a lack of medical necessity. I have already determined that the respondent did not establish this defense.

Therefore, the issue of fee schedule needs to be determined. At the hearing, the applicant amended the amount in dispute to $671.18 to conform to its calculation of the correct reimbursable amount pursuant to the appropriate fee schedule.

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 John Cerf, CPC, a certified professional coder who submitted a comprehensive analysis and determined that the correct reimbursable amount for the services at issue is $497.66.

Mr. Cerf allowed for the office visit, injections billed under CPT codes 64450 and 20553 and one charge for CPT code 75942 with a 20% reduction because these services were provided by a PA and with a 50% reduction for multiple procedures for one of the injections.

The applicant also submitted the affidavit of Jacqueline Thelian, a certified professional fee coder who only addressed the issue of bulling for multiple units of CPT code 76942. She argued that the CPT Assistant should not be considered in determining the correct number of allowable charges for CPT code 76942.

Ms. Thelian did not state her opinion of the correct reimbursable amount for all of the services at issue but concluded that multiple units of 76942 may be reported, billed and reimbursed. She referred to and disagreed with an affidavit submitted by a fee coder other than Mr. Cerf.

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 John Cerf, CPC and the affidavit of Jacqueline Thelian, CPC submitted on behalf of the applicant.

I find that the submission of Mr. Cerf was more persuasive in this instance. However, I also find that the applicant is entitled to an additional charge for CPT code 76942 because this claim involves two different injections for which guidance was billed. This should be billed at 50% based on the multiple procedure rule.

Based on the foregoing, the applicant is awarded a total of $613.24 in disposition of this claim.

Interest

I also find that interest accrued from September 16, 2025.

Accordingly, the applicant is awarded $613.24 in disposition of this claim with interest as stated above.

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**
	Atlantic Medical & Diagnostic PC	**09/02/25 - 09/04/25**	**$2,964.08**	**$671.18**	**Awarded: $613.24**
Total			**$2,964.08**		**Awarded: $613.24**

B. The insurer shall also compute and pay the applicant interest set forth below. 10/16/2025 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.

07/14/2026
(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:
98b4a06f52debeac3c1f464492bad804

Electronically Signed

Your name: Anne Malone
Signed on: 07/14/2026