American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Nature SB Plus Inc (Applicant)	AAA Case No.	17-25-1400-1042
	Applicant's File No.	175034
- and -	Insurer's Claim File No.	32-61R1-20F
	NAIC No.	25178
State Farm Mutual Automobile 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 07/24/2026
   Declared closed by the arbitrator on 07/24/2026

   John Gallagher, Esq. from The Law Offices of John Gallagher, PLLC participated virtually for the Applicant

   Jon DePasquale, Esq. from Sarah C. Varghese & Associates participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$2,701.44**, 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 46 year old EIP reported involvement in a motor vehicle accident on January 5, 2024; claimed related injury and underwent thoracic and lumbar ultrasound provided by the applicant on March 12, 2024.

   The respondent made partial payment for these medical services based on its calculation of the correct reimbursable amount pursuant to the New York Workers' Compensation Chiropractic Fee Schedule.

   The denial of this claim is late on its face.

The issues to be determined at the hearing are:

Whether this claim was timely denied.

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 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.

Late denial

The penalty for an insurer's failure to issue a timely and proper denial of claim is that it will be precluded from objecting to the claim. In Viviane Etienne Med. Care, P.C. v Country-Wide Ins. Co., 114 A.D.3d 33 (2d Dept. 2013) the Appellate Division held that:

Challenges and objections regarding whether the services were

in fact rendered, were causally related to a covered accident or

were medically necessary are not available to the defendant insurer

after the onset of litigation unless the insurer proffered a timely and

proper denial of claim within the prescribed time frame.

Under these circumstances, since the respondent did not issue a proper and timely denial within the prescribed time frame of 30 days from receipt of the bill in question therefore, it has not preserved any defense, except for fee schedule, if applicable.

Fee Schedule

The applicant billed a total of $3,024.80 under CPT code 76800 for which the respondent paid $323.40 based its calculation of the correct reimbursable amount pursuant to the New York Workers' Compensation Chiropractic 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.

Chiropractic Fee Schedule - effective 2020

In this instance, the applicant billed a total of $,3024.98 under CPT code 76800 for thoracic and lumbar diagnostic ultrasound. According to the NF-3 this procedure was performed by Serhli Balabanyk, DCA.

This CPT code is not included in the 2020 Chiropractic fee schedule. The correct code for "unlisted ultrasound" procedure (eg, diagnostic, interventional) is 76999. This is a "By Report" (BR) code.

Therefore, the fee for this code must be justified and according to Ground Rule 2 of the chiropractic fee schedule, the chiropractor must establish a relative value unit consistent in relativity with other relative value units in this fee schedule. There are no comparative CPT codes in the chiropractic fee schedule.

According to the EOR submitted with the NF-3 the respondent determined that the correct reimbursable amount for this procedure is $323.40. This appears to be based upon CPT code 76800 which is listed in the general radiology section of the New York Workers' Compensation Medical Fee Schedule.

The applicant contends that the total correct reimbursable amount for these services is $3,024.80 also based on CPT code 76800. This included $2,135.28 for diagnostic ultrasound of the thoracic spinal canal and $889.70 for the lumbar spinal canal.

Neither the applicant nor the respondent made any reference to Ground Rule 10 in the New York Workers' Compensation Medical Fee Schedule which states that: "A chiropractor may only use CPT codes contained in the Chiropractic Fee Schedule for billing of treatment. A chiropractor may not use codes that do not appear in the Chiropractic Fee Schedule."

Based on the submissions, the parties supported their fee schedule defenses on the same CPT code 76800. Using CPT code 76800 for the diagnostic ultrasound of the spinal canal and contents the total reimbursable amount for the services at issue is $323.54. The respondent made payment of $332.20 which included interest for late payment.

Under these circumstances, 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.

08/15/2026 Anne Malone
(Dated)

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:
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Electronically Signed

Your name: Anne Malone
Signed on: 08/15/2026