

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Advanced Orthopaedics PLLC
(Applicant)

- and -

Integon National Insurance Company
(Respondent)

AAA Case No. 17-25-1433-3743

Applicant's File No. DDR25-113969

Insurer's Claim File No. 250148495-002

NAIC No.

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 08/10/2026
Declared closed by the arbitrator on 08/10/2026

Michael Galeno, Esq. from Dino R. DiRienzo Esq. participated virtually for the Applicant

James Scozzari, Esq. from Law Offices of Eric Fendt participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$6,319.81**, was AMENDED and permitted by the arbitrator at the oral hearing.

The amount claimed was amended by the applicant to \$5,236.31 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 28 year old EIP reported involvement in a motor vehicle accident on February 11, 2025; claimed related injury and underwent left knee arthroscopy provided by the applicant on September 22, 2025.

The applicant submitted a claim for the surgeon and PA services, payment of which was timely denied by the respondent based upon a peer review by Regina Hillsman, M.D. dated November 21, 2025. In response, the applicant submitted a rebuttal dated July 1, 2026 by Dov Berkowitz, M.D. the EIP's treating physician.

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 physician and PA services at issue 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 from 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 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.)

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.)

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

Dr. Hillsman submitted a comprehensive report in which she discussed the medical services provided and her reasons for determining that they were not medically necessary for this EIP. She specifically discussed the standard of care for the left knee injury sustained by the EIP which included x-rays, conservative care with physical therapy, NSAIDs and home exercises. If pain persists MRI could be considered based on a re-examination. In cases like those presented here, surgery should be considered if they did not respond to consistent conservative care for over 3 months and intermittent conservative care for 6 months.

Dr. Hillsman noted that left knee pain was not part of the EIP's initial complaints and was first mentioned on June 11, 2025. According to the submissions there was no physical therapy for the left knee before June, 2025.

She supported, with relevant medical literature, her opinion that the surgery at issue was not medically necessary due to the lack of documentation to indicate that the EIP had undergone a sufficient course of treatment for the left knee prior to the surgery on September 22, 2025.

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

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

Dr. Berkowitz noted that the medical records documented multiple evaluations of the EIP which documented persistent knee pain, objective deficits and imaging findings which warranted the left knee arthroscopy at issue.

He supported with relevant medical citations his opinion that the medical services at issue were medically necessary for this EIP at the time they were provided.

A review of the applicant's submissions reveals that it has met the burden of persuasion in rebuttal. The medical records and rebuttal by Dr. Berkowitz submitted in opposition to the findings of Dr. Hillsman 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 left knee arthroscopy and related services, including the physician services at issue were not medically necessary.

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

Fee Schedule

The respondent denied payment of the claim at issue for a lack of medical necessity. I have already determined that the respondent did not establish this defense. However, an issue of the correct reimbursable amount for the services at issue remains.

The applicant billed a total of \$6,319.81 for the surgeon and PA services for performance of left knee arthroscopy. The respondent contends that the correct reimbursable amount for these services is \$3,009.30. At the hearing, the applicant amended the amount in dispute to \$5,236.31.

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 EIP is a New York resident and the medical services at issue were provided in New Jersey.

New York State Department of Financial Services Thirty Third Amendment to 11 NYCRR 68 (Insurance Regulation 83) which applies to health services performed outside New York State was effective January 23, 2018. Pursuant to this amendment an analysis of both the New York and New Jersey fee schedules is necessary to determine the appropriate fee schedule. The amendment determined that the correct reimbursable amount is the lesser allowance of the New York and New Jersey fee schedules for the medical services provided.

Based on this analysis, the fee schedule that will be used in accordance with the above regulations will be the New York State Workers' Compensation Fee Schedule.

The respondent supported its fee schedule defense, with the affidavit of Beth Seidman, CPC, CPB, a certified professional coder who submitted a comprehensive analysis and determined that the correct reimbursable amount for the physician and PA services at issue is \$3,009.30.

The applicant submitted the affidavit of Priti Kumar, CPC, a certified professional fee coder who determined that the correct reimbursable amount for the surgeon and PA services is \$6,319.81. The amount was amended by the applicant at the hearing to \$5,236.31.

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 Beth Seidman, CPC on behalf of the respondent and the affidavit of Priti Kumar, CPC who submitted an affidavit on behalf of the applicant. I find that the submission of Ms. Kumar was more persuasive in this instance.

Accordingly, the applicant is awarded \$5,236.31 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	Amount Amended	Status
	Advanced Orthopaedics PLLC	09/22/25 - 09/22/25	\$6,319.81	\$5,236.31	Awarded: \$5,236.31
Total			\$6,319.81		Awarded: \$5,236.31

- B. The insurer shall also compute and pay the applicant interest set forth below. 12/15/2025 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.

08/20/2026
(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:
7fa30a613d65929c85328d88c0cdff79

Electronically Signed

Your name: Anne Malone
Signed on: 08/20/2026