

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Brooklyn Medical Practice, PC
(Applicant)

- and -

State Farm Mutual Automobile Insurance
Company
(Respondent)

AAA Case No. 17-25-1421-9440

Applicant's File No. N/A

Insurer's Claim File No. 32-58T7-47L

NAIC No. 25178

ARBITRATION AWARD

I, Josh Youngman, 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: IP

1. Hearing(s) held on 08/28/2026
Declared closed by the arbitrator on 08/28/2026

Lee-Ann R. Trupia, Esq. from Law Offices of Hillary Blumenthal LLC (Hoboken) participated virtually for the Applicant

Nicole McErlean, Esq. from Freiberg, Peck and Kang, LLP participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,957.57**, 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

This dispute involves a claim for PIP benefits brought by the applicant as an assignee of a 55-year old male (A.M.) who was injured in a motor vehicle accident that occurred on October 11, 2023. The evidence shows following the accident the injured party (IP) sought treatment and underwent arthroscopic surgery on his left shoulder on March 13, 2025.

The respondent further argues the applicant is not entitled to reimbursement for the procedure billed under CPT code 29999 based on a fee schedule defense.

The issues to be decided are whether the applicant submitted sufficient evidence to make out a prima facie case, and if so, whether the respondent submitted sufficient evidence to sustain their billing above the fee schedule defense.

4. Findings, Conclusions, and Basis Therefor

This Award is rendered after diligent review and consideration of the parties' evidence submitted to and maintained by the American Arbitration Association's electronic case filing system, "MODRIA," as well as the parties' oral arguments and any testimony presented at this matter's hearing. Evidence that was submitted after this matter's "closing" and without this Arbitrator's authorization was not considered.

An applicant establishes its prima facie entitlement to reimbursement with proof that it submitted a proper claim, setting forth the fact and the amount charged for the services rendered and that payment of no-fault benefits was overdue. See Insurance Law § 5106a; Viviane Etienne Med. Care v. Country-Wide Ins. Co., 25 N.Y.3d 498 (2015); Mary Immaculate Hosp. v. Allstate Ins. Co., 5 A.D. 3d 742 (App. Div. 2d Dept. 2004). Once an applicant has established its prima facie case, the burden shifts to the insurer to establish that it timely and properly denied the claim(s), and to submit evidence to sustain the basis of its denial(s).

I find that the applicant has submitted sufficient evidence to establish its prima facie case for the claims at issue, thus shifting the burden to the respondent. Further, the respondent may proceed with their fee schedule defense regardless of whether the claim was timely denied (see 11 NYCRR § 65-3.8(g)(1)(ii)).

Insurance Law § 5102(a)(1) defines "basic economic loss" as including "all necessary expenses incurred for...professional health services" subject to the limitations of Insurance Law § 5108. Insurance Law § 5108 limits the amounts to be charged by providers of health services, and states that charges for services specified in Insurance Law § 5102(a)(1) "shall not exceed the charges permissible under the schedules prepared and established by the chairman for the workers' compensation board...except where the insurer...determines that unusual procedures or unique circumstances justify the excess charge." 11 NYCRR § 65-3.16(a) provides that "[p]ayment for medical expenses shall be in accordance with fee schedules promulgated under section 5108 of the Insurance Law and contained in Part 68 of this Title (Regulation 83)." 11 NYCRR § 68.1 provides that the "existing fee schedules prepared and established by the chairman of the Workers' Compensation Board...are hereby adopted by the Superintendent of Insurance with appropriate modifications so as to adapt such schedules for use pursuant to section 5108 of the Insurance Law."

The respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 2006 NY Slip 26240 (Civil Ct. Kings Co. 2006). If the insurer fails to demonstrate by competent evidentiary proof that an applicant's claims were billed in excess of the appropriate fee schedules, the defense of noncompliance with the fee

schedule cannot be sustained. See, Continental Medical PC v. Travelers Indemnity Co., 11 Misc.3d 145A (App. Term 1st Dept. per curiam, 2006).

The respondent submitted a fee schedule review from Jeffrey Futoran, CPC for the disputed claim. Mr. Futoran notes the applicant also submitted a claim seeking reimbursement in the amount of \$4,664.68 for the disputed surgery under CPT codes 29823, 29826, 29825, 29821 and 0232T. Mr. Futoran thus states the claim in dispute seeking reimbursement for the treatment billed under CPT code 29999 was not reimbursable, stating:

It should be noted that the procedure reported under CPT 29999 was a component multiple shoulder procedures rendered during the same operative session by the same physician to the same patient on the same DOS. In order to calculate a fee for the CPT 29999 procedure, it must be reviewed together with all procedures rendered during the surgery.

Mr. Futoran states the evidence shows the applicant billed for an "Arthroscopic Radio Frequency Wand" under CPT code 29999.

Mr. Futoran goes on to provide a summary of why the applicant was not entitled to reimbursement for the treatment billed under CPT code 29999 per the New York and New Jersey fee schedules.

The applicant does not submit any evidence to rebut Mr. Futoran's assertions or in support of the amount they billed.

Thus, the claim is denied.

Further, as stated by the Supreme Court of the State of New York, County of New York in the matter of Country-Wide Ins. Co. v. Sayed Physical Therapy, P.C., 2022 NY Slip Op 31874(U) (Sup. Ct. NY County 2022):

It is not the duty of the arbiter, be it an arbitrator or Court, to parse [through] hundreds of pages of exhibits to make out a claim or defense for a party (*see e.g. Barsella v. City of New York*, 82 A.D.2d 747, 748 [1st Dept 1981]); such duty belongs to counsel, as advocate. Failing to elucidate evidence in support of a party's claim is not error of the arbitrator but is rather error of counsel, and such failure does not render an arbitrator's award arbitrary and capricious (*see Stephen Fogel Psychological, P.C. v. Progressive Cas. Ins. Co.*, 35 A.D.3d 720, 721 [2d 2006]).

Thus, any issues not referenced above are held to be moot and/or waived insofar as they were not sufficiently raised at the time of the hearing.

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 CA

SS :

County of San Diego

I, Josh Youngman, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

09/09/2026

(Dated)

Josh Youngman

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:
2420d796983c98c25195957d88ab35b3

Electronically Signed

Your name: Josh Youngman
Signed on: 09/09/2026