American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Alpha Ambulatory Surgery Center, LLC (Applicant)	AAA Case No.	17-26-1445-2868
	Applicant's File No.	BT26-347652
- and -	Insurer's Claim File No.	0807359492
	NAIC No.	29688
Allstate Fire & Casualty 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 09/21/2026
   Declared closed by the arbitrator on 09/21/2026

   Heather Landeras, Esq. from The Tadchiev Law Firm, P.C. participated virtually for the Applicant

   Abanobe Barsoum, Esq. from Law Offices Of Richard Schoenberg participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$11,567.49**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The amount claimed was amended by the applicant to $5,677.77 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 37 year old EIP reported involvement in a motor vehicle accident on September 13, 2025; claimed related injury and underwent right shoulder arthroscopy provided at the applicant's facility on January 6, 2026.

The applicant submitted a claim for these facility services, payment of which was timely denied by the respondent based upon peer reviews by Howard Levy, M.D. dated January 29, 2026 and March 13, 2026. In response, the applicant submitted a rebuttal dated August 14, 2026 by Graeme Whyte, M.D. the EIP's treating surgeon.

The respondent also asserted a fee schedule defense.

The issues to be determined at the hearing are:

Whether the respondent established that the right shoulder arthroscopy and related facility 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 medical services provided by the applicant were not medically necessary, respondent relies upon the peer review by Dr. Levy, who reviewed the medical records of the EIP, noted the injuries claimed and the treatment rendered to him. Dr. Levy considered possible arguments and justification for the need for the right shoulder arthroscopy and related facility services at issue and determined that they were not warranted under the circumstances presented.

Dr. Levy submitted a comprehensive report in which he discussed the surgery and related medical services provided and his reasons for determining that they were not medically necessary for this EIP.

He specifically noted that the EIP had sustained a prior right shoulder injury and that the MRI reported early degenerative changes. However, the EIP was asymptomatic prior to the subject accident, therefore Dr. Levy determined that his injuries were causally related to the motor vehicle accident on September 13, 2025.

Nevertheless, Dr. Levy determined that the left shoulder arthroscopy and related services, including the facility services were not medically necessary because the EIP did not meet the standard of care for right shoulder arthroscopy because there was no evidence in the MRI studies of a full-thickness tear and the EIP did not receive even a single session of physical therapy for the right shoulder prior to the surgery.

He supported, with relevant medical literature, his opinion that the right shoulder surgery and related services, including the facility services at issue were not medically necessary.

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. Whyte, who disagreed with the conclusions reached by Dr. Levy and discussed in detail the injuries sustained by the EIP and the treatment rendered to him.

He specifically determined that there are conflicting standards of care for rotator cuff injuries and that clinicians should use their best judgment regarding surgical intervention.

It was Dr. Whyte's opinion that the conservative management prior to the intervention was more than adequate given the severity of the EIP's injuries and the risk of further deterioration.

Dr. Whyte supported with relevant medical citations his opinion that the right shoulder arthroscopy and related facility services at issue were medically necessary.

After a review of all the evidence submitted an issue of fact remains as to whether the right shoulder arthroscopy and related facility services were

medically necessary. Conflicting opinions have been presented in the peer review by Dr. Levy and the reports by Dr. Whyte who submitted a rebuttal on behalf of the applicant.

In this instance, the rebuttal meaningfully refers to and rebuts the findings of Dr. and the medical reports submitted are sufficient to establish medical necessity for the services at issue.

Based on the foregoing, I find that the respondent has failed to establish that the right shoulder arthroscopy and related facility services at issue were not medically necessary.

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

Fee Schedule

The respondent denied the bill for the facility services for the right shoulder arthroscopy based on the peer review by Dr. Levy. I have already determined that the respondent did not establish this defense. The applicant billed a total of $11,567.49 for the services at issue, which was amended at the hearing to $5,677.77 to conform to the appropriate fee schedule.

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 Becky Neve, R.N., CPC a medical professional and certified professional coder who submitted a comprehensive analysis.

The respondent argued that CPT code 29821 billed at $5,677.77 was not reimbursable based on NCCI edits and that pursuant to the calculations of Becky Neve, R.N, CPC, the correct reimbursable charge was CPT code 29823 billed at $3,026.24.

The applicant submitted the affidavit of Naira Margaryan, CPC, CPMA, a certified professional fee coder who determined that the correct reimbursable amount for these services is $5,677.77. Ms. Margaryan found that the correct reimbursable CPT code is 29821 for arthroscopy of the shoulder with extensive synovectomy.

Both coders determined that the charge for CPT code 29825 was not reimbursable.

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 Becky Neve, R.N. CPC and the affidavit of Naira Margaryan, CPC, CPMA who submitted an affidavit on behalf of the applicant.

After a review of the expert's submissions, I find that the determination of the applicant's fee coder is more persuasive in this instance.

Accordingly, the applicant is awarded $5,677.77 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**
	Alpha Ambulatory Surgery Center, LLC	**01/06/26 - 01/06/26**	**$11,567.49**	**$5,677.77**	**Awarded: $5,677.77**
Total			**$11,567.49**		**Awarded: $5,677.77**

B. The insurer shall also compute and pay the applicant interest set forth below. 03/04/2026 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.

09/23/2026
(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:
5ec479811663098c39cec3c202088820

Electronically Signed

Your name: Anne Malone
Signed on: 09/23/2026