American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Focused Diagnostic Chiropractic PC (Applicant)	AAA Case No.	17-25-1395-1213
	Applicant's File No.	OS-106015
- and -	Insurer's Claim File No.	HLV24004892
	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 10/19/2026
   Declared closed by the arbitrator on 10/19/2026

   Olga Sklyut, Esq. from Law office of Olga Sklyut, PC participated virtually for the Applicant

   Lana Stevens from Hereford Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$2,549.78**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The amount claimed was amended to $1,619.18 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 26 year old EIP reported involvement in a motor vehicle accident on December 3, 2024; claimed related injury and underwent diagnostic ultrasound provided by the applicant on January 24, 2025, February 21, 2025 and March 21, 2025.

The applicant submitted a claim for these medical services. The respondent provided proof of partial payments in the amount of $930.60 for dates of service January 24, 2025, February 21, 2025 and March 25, 2025 based on its calculation of the correct reimbursable amount pursuant to the New York Workers' Compensation Medical Fee Schedule.

The issue to be determined at the hearing is 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.

The applicant billed a total of $2,549.78 for the diagnostic ultrasound at issue, for which the respondent made payment of $960.60 which was not acknowledged in the AR-1. The respondent submitted endorsed checks in this amount and at the hearing, the applicant amended the amount in dispute to $1,619.18.

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 services at issue are all billed as "diagnostic ultrasound" under CPT code 76999. The applicant billed $894.36 for diagnostic ultrasound provided on

January 9, 2023 and February 6, 2025. The ultrasound services billed on March 25, 2025 were billed at $761.06.

The respondent supported its fee schedule defense, with the affidavit of John Cerf, D.C., CPC, CPMA, a medical professional and certified professional coder who submitted a comprehensive analysis and determined that the correct reimbursable amount for the services at issue is $913.56.

He noted that the applicant billed for diagnostic ultrasound imaging studies of different body parts, while incorrectly billing for multiple studies using one CPT code per date of service. There is no listing of separate CPT codes for each study and no listing of the number of units per date of service.

He therefore noted the regions listed in the imaging reports which were lumbar, cervical, thoracic and right sacral in his determination that the correct reimbursable amount for the three dates of service is $913.56.

Based on the submissions, Dr. Cerf noted that the respondent made payment of $930.60 for the three dates of service for which diagnostic ultrasound was provided, which he determined represents an overpayment of $17.40.

The applicant submitted the affidavits of Yelena Davydkina, who received a degree in medical billing at ASA Institute and was employed as a biller and billing manager and Diana Vavikova, D.C. who received education in billing and collection for chiropractic services while taking business classes in Palmer College of Chiropractic in Davenport, Iowa. Dr. Vavikova stated that she has knowledge of correct billing and reimbursement under New York no fault rules and regulations and the New York Workers' Compensation Medical Fee Schedule.

Ms. Davydknia determined that the correct reimbursable amount for the services at issue is $2,549.78.

The submissions indicate that Dr. Vavikova determined that the ultrasound issue involves 5 distinct services billed under CPT code 76800, 76881, 76604, 76536 and 76856. Although it is difficult to calculate the charges which are represented in the 5 CPT codes, it appears that she also determined that the correct reimbursable amount for the services at issue is $2,549.78.

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 Dr. Cerf, the report of Dr. Vavikova and the affidavit by Ms. Davydkina also submitted on behalf of the applicant.

Based on the submissions, I find that the affidavit of Dr. John Cerf, CPC, CPMA was more persuasive in this instance.

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.

11/06/2026
(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:
35a6d181beb365d58245d98f0ab62c4c

Electronically Signed

Your name: Anne Malone
Signed on: 11/06/2026