American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Skyline Spine & Pain Medicine PC (Applicant)	AAA Case No.	17-25-1424-7398
	Applicant's File No.	TLLG25-180351
- and -	Insurer's Claim File No.	32-76B5-50C
	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 10/19/2026
   Declared closed by the arbitrator on 10/19/2026

   Inna Vilig, Esq. from The Licatesi Law Group, LLP participated virtually for the Applicant

   Lisa Weiss, Esq. from Sarah C. Varghese & Associates participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$5,978.50**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The amount claimed was amended to $2,850.00 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 51 year old EIP reported involvement in a motor vehicle accident on October 28, 2024; claimed related injury and underwent percutaneous annuloplasty with guidance provided at the applicant's facility on June 10, 2025.

The applicant submitted a claim for these medical services, for which the respondent made timely payment based on its calculation of the correct reimbursable amount pursuant to the New York Workers' Compensation Medical Fee Schedule.

The applicant also contends that interest and attorney's fees are due for this claim.

The issues to be determined at the hearing are:

Whether the respondent established its fee schedule defense.

Whether the respondent established that additional interest and attorney's fees are not due for this claim.

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 $5,978.50 for the services at issue for which the respondent made partial payment of $2,738.50, leaving a balance of $3,240.00. At the hearing, the applicant amended the amount in dispute to $2,850.00. The respondent contends that the correct amount in dispute is $1,480.00.

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 Mercy Acuna, R.N., CPC 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 $4,219.30. She noted payment by the respondent of $2,738.50, leaving a balance of $1,480.80.

The applicant submitted the affidavit of Priti Kumar, CPC, a certified professional fee coder who also presented a detailed analysis of this claim and determined that the correct amended amount for this claim is $2,850.00.

In response, the respondent submitted a rebuttal in which she refuted the recalculation of the outstanding amount due for this claim based on a re-adjudication of the claim based on an appeal by the applicant.

The applicant's expert argued:

> Regarding CPT Code 22526: The EOBs dated 07/22/2025 indicates that based on the documentations submitted, the Respondent paid Code 22526 as billed at $2,738.50.
>
> Contrary to this, the Respondent's subsequent fee coder report dated 12/09/2025 issued nearly five months after the EOB attempts to restrict payment to $1,369.30 for the same code.
>
> I disagree with any reduction following the completed payment for this service. If the respondent believed the bill was unclear, timely additional verification was the mechanism available to them.
>
> The Respondent had the opportunity to review the bill, request necessary additional verification, and issue payment within the time frames prescribed by the New

York No-Fault Regulations.

After voluntarily issuing payment, the Respondent is not entitled to offset the balance sought for other codes based upon an alleged overpayment resulting from its prior payment determination.

The respondent's expert respondent's expert stated in the addendum:

I disagree with the statement [by Ms. Kumar] that this is an offset." The claim is re-adjudicated based on the appeal by the provider. There was nothing in the denial that the bill was unclear, the denial merely stated that CPT code 62287 was "bundled" with CPT code 22526 pursuant to a previous guideline from the CPT Assistant. It is correct that prior to March 2025, CPT code 62287 was "bundled" with CPT code 22526 therefore no verification was needed. Surgery Ground Rule # 5 (multiple procedure rule) must be applied in this case since the payment for CPT code 22526 at 100% is not considered an overpayment since this is a re-adjudication of the claim therefore adjustment needs to be made to follow the rule.

CONCLUSION

I re-confirm my original recommendation that the allowable additional amount per the NY Workers' Compensation Medical fee Schedule, Surgery Ground Rule # 5 is $1,480.80.

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 and addendum of Mercy Acuna, R.N. CPC and the affidavit of Priti Kumar, CPC submitted on behalf of the applicant. I find that the submissions of the respondent's expert were more persuasive in this instance.

I find that the determination of the respondent's fee coder is more persuasive in this instance.

Based on the foregoing, the respondent established its fee schedule defense.

Therefore, the applicant is not entitled to additional interest and filing fees for this claim.

Accordingly, the applicant is awarded $1,480.80 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
	Skyline Spine & Pain Medicine PC	**06/10/25 - 06/10/25**	**$5,978.50**	**$2,850.00**	**Awarded: $1,480.80**
Total			**$5,978.50**		**Awarded: $1,480.80**

B. The insurer shall also compute and pay the applicant interest set forth below. 10/22/2025 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

The applicant is not entitled to additional interest for this claim.

C. Attorney's Fees

The insurer shall also pay the applicant for attorney's fees as set forth below

The applicant is not entitled to additonal attorney's fees for this claim.

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.

11/07/2026
(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:
aba1b8406197fc61e2dbbc4d297cc54c

Electronically Signed

Your name: Anne Malone
Signed on: 11/07/2026