American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Therapeutic Pathway Physical Therapy PC (Applicant)	AAA Case No.	17-26-1439-4036
	Applicant's File No.	438452
- and -	Insurer's Claim File No.	004742042737WC01
	NAIC No.	24147
Old Republic 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 08/24/2026, 10/19/2026
   Declared closed by the arbitrator on 10/19/2026

   Neil Menashe, Esq. from Neil Menashe Attorney at Law P.C. participated virtually for the Applicant

   No appearance from Gallagher Bassett Services, Inc. failed to appear for the Respondent

2. The amount claimed in the Arbitration Request, **$4,550.32**, 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

   The 57 year old EIP reported involvement in a motor vehicle accident on November 28, 2024; claimed related injury and underwent physical therapy provided by the applicant from April 18, 2025 to August 29, 2025.

   The applicant submitted a claim for these medical services, payment of which appears to have been denied by the respondent based on a fee schedule defense.

   The respondent did not appear at the hearings and did not any evidence prior to the date on which this matter was first scheduled on August 24, 2026 or prior to or at the hearing held on October 19, 2026.

On both occasions, I requested that AAA to attempt to contact the respondent. There was no response from the respondent and no appearance or submissions were forthcoming.

Based on the documents submitted by the applicant, the respondent indicated the amount charged by the applicant and the proper fee schedule amount which appeared to be the same.

However no proof of payments or documents to establish a proper denial were received prior to the date of either of the two scheduled hearings.

The issue to be determined at the hearing is whether the respondent established a fee schedule or other defense to 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.

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.)

There were no submissions by the respondent in this matter. The applicant submitted copies of Provider Bill Detail documents related to each of the bills for physical therapy treatment provided.

It appears from the NF-3 that the billing provider Therapeutic Pathway Physical Therapy, PC had a mailing address at P.O. Box A, New Milford, NJ 07646 and that the EIP received treatment at this provider's facility located at 2430 Davidson Avenue, Bronx, New York.

Although the hearing in this matter was scheduled on two separate occasions and the respondent was directed to provide documentation regarding non-payment of the bills at issue, no submissions were forthcoming.

The Provider Details indicated the charged amount for each of the services rendered, the specific dates of service and also included a column titled "F/S Amount Adjusted" which was the same as the charged amount for each date of service.

The comments on this document related to the billing included:

Reimbursement has been calculated based on the state guidelines

Procedure has exceeded the maximum allowed units of service.

Payment reduced or denied based on Workers Compensation

Jurisdictional Regulations or Payment Policies.

Consult plan benefit documents/guidelines for information about

restrictions for this service.

Payment reduced or denied based on Workers' Compensation

jurisdictional regulations or payment policies.

Other comments included:

Unless otherwise noted, charges were reduced for exceeding

the guidelines of the Schedule of Medical Fees of the State of

New York.

State Claim Adjustment Reason Codes:

Precertification/authorization/notification/pre-treatment absent.

There are also additional similar statements on some of the other Bill Provider Detail documents. However, none of these documentst indicate when each of the bills at issue was received and does not provide information to determine if the "denials" were late.

When this hearing was adjourned the first time, I contacted AAA support to determine if the respondent had contacted AAA regarding its non-appearance at the hearing and its failure to submit any evidence related to this claim.

I also contacted AAA support the second time that there was no appearance by the respondent and no submissions other than those submitted by the applicant. Again, no response was received.

Absent any response, I have determined that the respondent did not establish sufficient support for what appear to be denials based on a fee schedule defense for the bills at issue.

Accordingly, the applicant is awarded $4,500.32 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**	**Status**
	Therapeutic Pathway Physical	**04/18/25 - 08/29/25**	**$4,550.32**	**Awarded: $4,550.32**

	Therapy PC			
Total			**$4,550.32**	**Awarded: $4,550.32**

B. The insurer shall also compute and pay the applicant interest set forth below. 01/16/2026 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 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.

11/16/2026
(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:
b1a28421cc9eabddbc3ef7d8c8f85188

Electronically Signed

Your name: Anne Malone
Signed on: 11/16/2026