American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Rego Supplies Inc (Applicant)	AAA Case No.	17-26-1455-6452
	Applicant's File No.	LIP-57867
- and -	Insurer's Claim File No.	260073539-002
	NAIC No.	29742
Integon National 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 11/04/2026
   Declared closed by the arbitrator on 11/04/2026

   Usman Nawaz, Esq. from Law Offices of Ilya E Parnas P.C. participated virtually for the Applicant

   Joseph Licata, Esq. from Rossillo & Licata LLP participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$3,750.00**, 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 24 year old EIP reported involvement a motor vehicle accident on December 5, 2025; claimed related injury and received a pulsed laser therapy device provided by the applicant on January 31, 2026.

   The applicant submitted a claim for this durable medical equipment (DME), payment of which was denied by the respondent based upon a peer review by Shruti Patel, M.D. dated February 25, 2026.

   The respondent also asserted a fee schedule defense.

The issues to be determined at the hearing are:

Whether the respondent established that the durable medical equipment at issue was 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.

Medical Necessity

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.)

Respondent bears the burden of production in support of its lack of medical necessity defense, which if established shifts the burden of persuasion to applicant. See Bronx Expert Radiology, P.C. v. Travelers Ins. Co., 2006 NY Slip Op 52116 (App. Term 1st Dept. 2006.)

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 DME provided by the applicant was not medically necessary, respondent relies upon the report of the peer review by Dr. Patel, who reviewed the medical records of the EIP and noted the injuries claimed and the treatment rendered to her. Dr. Patel considered possible arguments and justification for the need for the DME at issue and determined that it was not warranted under the circumstances presented.

Dr. Patel specifically noted that the EIP was first examined by Roselyn Conesa, N.P. on December 9, 2025, five days post-accident. The report indicates subjective complaints of pain in the neck, mid-back and right shoulder with painful range of motion.

At the initial evaluation, Roselyn Conesa, N.P. recommended physical therapy, right shoulder MRI studies, oral and topical prescription medication and various items of durable medical equipment.

Dr. Patel specifically discussed the pulsed laser therapy device at issue and determined that it is not recommended as a first-line treatment for any pain and/or specifically low back pain and that his review of the medical standard of care and literature indicated that laser therapy was at best the equivalent of a placebo effect, is not considered to be superior to other heat therapies and is usually not recommended over basic heat therapies.

She supported, with relevant medical literature, her opinion that the DME at issue was not medically necessary for this particular EIP at the time it was provided.

Respondent has factually demonstrated that the DME at issue was not medically necessary. Accordingly, the burden now shifts to the applicant, who bears the ultimate burden of persuasion, pursuant to Bronx Expert Radiology, P.C., *supra.*

In opposition to the peer review, the applicant did not submit a formal rebuttal. However, the applicant relies upon the submissions, including the examination of the EIP on January 13, 2026, a general letter of medical necessity for the DME at issue and physical therapy SOAP notes from January 6, 2026 to January 23, 2026.

The report of the January 13, 2026 evaluation included prescription for topical and oral medications but did not mention the need for the DME at issue. However, the referral/letter of medical necessity for this laser device was dated on January 13, 2026 and this DME was provided on January 31, 2026.

A review of the applicant's submissions reveals that it has met the burden of persuasion in rebuttal. The medical records submitted in opposition to the findings of Dr. Patel are sufficient to overcome the burden of production established by respondent.

Based on the foregoing, I find that the respondent has failed to establish that the DME at issue was not medically necessary for this EIP at the time it was provided.

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

Fee Schedule

The applicant billed $3,750.00 under CPT code E1399, which is a "By Report" (BR) code for the DME at issue for which the respondent denied payment for a lack of medical necessity.

I have already determined that the respondent failed to establish its defense of a lack of medical necessity. The remaining issue is whether the it established its fee schedule defense.

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 Dajah Brown, CPC, a certified professional coder who submitted a comprehensive analysis and determined that the correct reimbursable amount for the DME at issue is $1,553.40.

The applicant did not submit the affidavit of a certified professional fee coder, medical professional or other expert to refute the determination of the respondent's expert.

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

Accordingly, the applicant is awarded $1,553.40 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**
	Rego Supplies Inc	**01/31/26 - 01/31/26**	**$3,750.00**	**Awarded: $1,553.40**
Total			**$3,750.00**	**Awarded: $1,553.40**

B. The insurer shall also compute and pay the applicant interest set forth below. 05/11/2026 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.

11/18/2026
(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:
5b9ee211231472119d1333ac34c55acf

Electronically Signed

Your name: Anne Malone
Signed on: 11/18/2026