American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

New York Surgery Center Of Queens (Applicant)	AAA Case No.	17-26-1448-0077
	Applicant's File No.	SS-308534
- and -	Insurer's Claim File No.	250761628-003
	NAIC No.	12130
New South 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 09/16/2026, 11/04/2026
   Declared closed by the arbitrator on 11/04/2026

   James McNamara, Esq. from Samandarov & Associates, P.C. participated virtually for the Applicant

   Morenike Erinkitola, Esq. from Law Offices Of Richard Schoenberg participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$10,095.12**, 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 in a motor vehicle accident on August 13, 2025; claimed related injury and underwent right shoulder arthroscopic surgery provided at the applicant's facility on January 8, 2026.

   The applicant submitted a claim for the facility services, payment of which was timely denied by the respondent based upon a peer review by Pierre Ferriter, M.D. dated February 16, 2026. In response, the applicant did not submit a rebuttal dated March 25, 2026 by Robert Drazic, D.O. the EIP's treating surgeon.

However, a copy of the rebuttal to Dr. Ferriter's February 16, 2026 peer review was submitted at a hearing, on the same date as the instant matter, which included arguments related to both claims for the surgeon's and facility bills.

Over the applicant's objection, I considered the rebuttal by Dr. Drazic, the surgeon who performed the underlying surgery and which included arguments regarding the medical necessity for the right shoulder arthroscopic surgery and related services.

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 services, including the facility services 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.

Medical Necessity

The respondent denied payment for the aforementioned right shoulder arthroscopy and related facility services for a lack of medical necessity.

In order 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.)

In support of its contention that the right shoulder arthroscopy and related services, including facility services provided by the applicant were not medically necessary, respondent relies upon the report of the peer review by Dr. Ferriter, who reviewed the medical records of the EIP, noted the injuries claimed and the treatment rendered to him. Dr. Ferriter considered possible arguments and justification for the need for the surgeon's services at issue and determined that they were not warranted under the circumstances presented.

Dr. Ferriter noted that the EIP received only 16 sessions of physical therapy for the right shoulder before undergoing the arthroscopic surgery. He determined that this was insufficient to determine whether the potential benefits of conservative management could have been achieved.

It was Dr. Ferriter's opinion that the right shoulder arthroscopy was performed prematurely and supported, with relevant medical literature, his opinion that the right shoulder arthroscopy and related services including the physician and facility services provided to the EIP were not medically necessary at the time they were provided.

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 the assignor. Therefore, pursuant to Bronx Expert Radiology, *supra* the burden shifts to the applicant, who bears the ultimate burden of persuasion to establish that the medical services at issue were medically necessary.

In opposition to the peer review, the applicant presented a rebuttal by Dr. Drazic, who disagreed with the conclusions reached by Dr. Ferriter and discussed the treatment provided to the EIP and the positive objective findings he documented at his examination on January 8, 2026. He determined that his review of the EIP's medical records and his evaluation of the EIP provided a sufficient basis for his performance of the right shoulder arthroscopic surgery on that date.

He supported, with relevant medical citations, his opinion that the right shoulder arthroscopy and related services were medically necessary for this particular EIP at the time they were provided.

After a review of all the evidence submitted an issue of fact remains as to whether the right shoulder arthroscopy and related services were medically necessary. Conflicting opinions have been presented in the peer review by Dr. Ferriter and the report of Dr. Drazic, who submitted a rebuttal on behalf of the applicant.

In this instance, the rebuttal by Dr. Drazic meaningfully refers to and rebuts the findings of Dr. Ferriter. In addition, the medical reports submitted are sufficient to establish the right shoulder surgery and related services were medically necessary for this EIP at the time they were provided.

Based on the foregoing, I find that the respondent has failed to establish that the medical services at issue were not medically necessary.

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

Fee Schedule

The respondent denied payment for the right shoulder arthroscopy and related services based on a lack of medical necessity. I have already determined that the respondent did not establish this defense. The remaining issue is the respondent's fee schedule defense.

In order to prevail in its fee schedule defense, the respondent must demonstrate by competent evidentiary proof that the applicant's claims are in excess of the appropriate fee schedule. If the respondent fails to do so, its defense of noncompliance with the New York Workers' Compensation Medical Fee Schedule cannot be sustained. See Continental Medical, P.C. v Travelers Indemnity Co., 11 Misc. 3d 145A (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 expertise 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 a comprehensive affidavit by Becky Neve, RN, CPC, a medical professional and certified professional coder who determined that the correct reimbursable amount for the facility fee for the right shoulder surgery which she determined was reimbursable at $5,577.77.

The applicant submitted a detailed affirmation by Aaron J. Perretta, Esq, CPC which also provided a comprehensive analysis of the proper reimbursable

amount for the facility services at issue and determined that the correct amount of reimbursement is $10,095.12.

I found that the submissions by professional fee coders for both parties provided exhaustive analyses of the fee schedule issues involved in this claim. I also noted that the coders both relied upon acceptable reliable resources in their determinations of the correct amount for the services at issue.

In this instance, the fee code is related solely to the facility fee for the ASC at with the operative services were provided.

In support of the applicant's fee schedule defense, Aaron J. Perretta, Esq., CPC determined that "by utilizing 3M, Applicant actually supports the values it assigns to all of the Codes with documentary proof as endorsed by the Workers' Comp. Board." He determined that although "it is true 3M is endorsed by the Workers' Comp Board but is not required." He noted that "by utilizing 3M, Applicant actually supports the values it assigns to all of the Codes with documentary proof as endorsed by the Workers' Comp. Board."

He concluded that the applicant's expert did not provide anything to her support the values which were the source of her determinations.

In contrast, Becky Neve, RN, CPC relied upon documentation that both parties agreed is permissible, she also determined that the presence of 3M output report does not guarantee accuracy relative to the supporting documentation and does not imply superiority over manual calculations which adhere to the same EAPG rules as the software.

Finally, Becky Neve, RN, CPC noted specifically that "[c]oding for facility services is different from coding for physician services. While a physician may be reimbursed separately for each procedure performed, the facility is reimbursed for the operative session." She further determined that "3M EAPG information states: "[t]he unit of analysis should be the visit, not individual services." and "EAPG reimbursement for the facility is NOT based on each individual service that is provided, but the totality of the visit, thus the methodology for appropriate bundling and consolidation."

I did not find any response to this argument in the applicant's expert's report.

Based on the foregoing, after a review of the submissions, I find that the respondent's expert was more persuasive and that it has established its fee schedule defense.

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**	**Status**
	New York Surgery Center Of Queens	**01/08/26 - 01/08/26**	**$10,095.12**	**Awarded: $5,677.77**
Total			**$10,095.12**	**Awarded: $5,677.77**

B. The insurer shall also compute and pay the applicant interest set forth below. 03/20/2026 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.

11/22/2026

(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:
d17bbf53799fd0a02d11f4555a19f65d

Electronically Signed

Your name: Anne Malone
Signed on: 11/22/2026