American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

ARS Medical PC (Applicant)	AAA Case No.	17-16-1035-1422
	Applicant's File No.	BS-10011-1806981
- and -	Insurer's Claim File No.	LA000-032357691-04
	NAIC No.	36447
Liberty Mutual Insurance Company (Respondent)		

ARBITRATION AWARD

I, Amanda R. Kronin, 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: KL

1. Hearing(s) held on 06/14/2017
   Declared closed by the arbitrator on 06/14/2017

   Diana Usten. Esq from Baker Sanders, LLC participated in person for the Applicant

   Charles Schieier from Liberty Mutual Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 200.00**, 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 arbitration arises out of treatment to the Assignor, KL, a 19 year old female, involved in a motor vehicle accident on July 21, 2015. Applicant seeks a total reimbursement in the amount of $200.00 representing the Outcome Assessment Testing (OAT) testing performed on July 29, 2015. The Respondent has issued a timely denials indicating the fees charged by the Applicant exceeded that which is permitted under the Workers' Compensation Fee Schedule, and has submitted a letter by a certified professional coder in support of its position.

4. Findings, Conclusions, and Basis Therefor

This hearing was conducted using documents contained in the ADR CENTER. Any documents contained in the folder are hereby incorporated into this hearing. I have reviewed all relevant exhibits contained in the ADR CENTER maintained by the American Arbitration Association.

The issue presented is whether the Applicant billed appropriately and pursuant to the Worker's Compensation Fee Schedule Guidelines.

Respondent argues that the fees charged by Applicant for the services in were in excess of those permitted under the Workers' Compensation Fee Schedule. Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. See, Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 2006 NY Slip 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006). See also, Power Acupuncture PC v. State Farm Mutual Automobile Ins. Co., 11 Misc.3d 1065A, 816 N.Y.S.2d 700, 2006 NY Slip Op 50393U, 2006 N.Y. Misc. LEXIS 514 (Civil Ct, Kings Co. 2006).

If Respondent fails to demonstrate by competent evidentiary proof that a plaintiff's claims were in excess of the appropriate fee schedules, defendant's defense of noncompliance with the appropriate fee schedules cannot be sustained. See, Continental Medical PC v. Travelers Indemnity Co., 11 Misc.3d 145A, 819 N.Y.S.2d 847, 2006 NY Slip Op 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Term, 1 Dep't, per curiam, 2006). The dispute relates to the fees charged for OAT testing. Respondent's fee schedule dispute is supported, inter alia, by a letter, dated June 16, 2016, from Beth Palisin RN, CPC, a Certified Professional Coder, as well as pertinent sections of the WCFS. Ms. Palisin states that " Regarding code 99358: "Per AMA CPT coding guidelines, CPT code. 99358 is defined as: (enclosure #3 part A) Prolonged evaluation and management service before and/or after direct (face to face) patient care; first hour. Code 99358 as it is above defined is not supported/was not performed, based on provider documentation. Provider documentation supports performance of Outcome Assessment Testing Summary. This summary is a tabulation of questionnaires regarding patient symptoms. Review of symptoms is an integral component of history/physical exam/continuum of care of treating provider. This EIP underwent office visit/exam by this provider on this same date for which provider billed E/M office visit code 99203, which carrier paid to provider in full. Therefore, charges for review of symptoms represent unbundling and code 99358 denied in full. Also of note, time element of time based code 99358 not validated by provider documentation; one hour of services not validated. Per AMA CPT coding guidelines, prolonged services of less than 30

minutes total duration on a given date is not separately reported." I find Ms. Palisin's explanation coherent and sufficient to meet the above burden and warrant the denial as issued by the carrier.

I will look to Applicant to refute the conclusions reached by the Certified Professional Coder. Applicant argues that the codes were billed accordingly, and relies on the affidavit of Frank Keane, CPC, dated May 6, 2016. Mr. Keane disagrees with the contentions made by the Respondent's position that code 99358 is inclusive of the office visit. Mr. Keane states as follows: "OAT involved several questionnaires that the patient takes home and answers on his/her own. The questionnaires are self-reported by the patient and reviewed and interpreted by the medical provider. The goal of the Assessment is to provide a more comprehensive analysis of the symptoms exhibited, in order to formulate a more specific treatment plan. Validated outcome measures are critical to the evaluation process. Traditionally, outcome measures have been physician derived objective evaluations including range of motion and radiologic evaluations. However, these measures can marginalize a patient's perception of their disability or outcome. As a result of these limitations, patient self-reported outcomes measures have become popular over the last quarter century and are currently primary tools to evaluate outcomes of treatment. 1 A major advantage of outcome assessment testing is that the level of pain, functional limitations in daily living, and level of improvement can be measured and assigned numerical values. 2. The medical providers' interpretation of the Outcome Assessment Testing aids in the formation and furtherance of treatment protocols. This, in turn, leads to more specific and proper diagnoses and treatment plans. Based on the medical records and the symptoms exhibited by the patient, ARS Medical provided proper services and properly billed under CPT code 99358 for the Outcome Assessment Testing performed. Liberty gives no valid reasoning for its denial of payment. If Liberty needed more information to verify the claim at issue, including the time administering and interpreting the testing, it should have requested further verification afforded to it under the Insurance Regulations. I have reviewed the documentation and it verifies the proper billing by ARS Medical. The records support the medical provider's billing. ARS Medical utilized the correct CPT code for the Outcome Assessment Testing and Interpretation provided. The medical provider actually slightly under-bills the allotted Fee Schedule amount for the service provided. Liberty Mutual's rationale in denying full reimbursement is misguided. ARS Medical is owed full amount of its bill."

I find the Applicant's coder affidavit to be credible and coherent as such it supports the Applicant's contentions that the OAT should not be considered part of the office visit, and effectively rebuts the assertions made by the Respondent. Additionally, the insurer should have requested further verification of the OAT if it had questions regarding the provider's charges, Bronx Acupuncture Therapy,

P.C. v. Hereford Insurance Company, 2017 N.Y. Slip Op 50101(U) (App Term, 2d Dept. 2017. I find Applicant's position persuasive based upon the Bronx Acupuncture decision, the Respondent should have requested verification in order to properly determine the relative value of the services.

Accordingly, in light of the foregoing, based on the arguments of counsel and after a thorough review and consideration of all submissions, I find in favor of the Applicant and Applicant's claim is granted in the entirety.Reimbursement as requested is due and owing herein. 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**
	ARS Medical PC	**07/29/15 - 07/29/15**	**$200.00**	**Awarded: $200.00**
Total			**$200.00**	**Awarded: $200.00**

B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 05/20/2016, which 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." 11 NYCRR §65-3.9(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." 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 at issue was timely. LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 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 fees pursuant to the no-fault regulations. See, 11 NYCRR §65-4.5(s)(2). The award of attorney fees shall be paid by the insurer. 11 NYCRR §65-4.5(e). Accordingly, "the attorney's fee shall be limited as follows: 20 percent of the amount of first-party benefits, plus interest thereon, awarded by the arbitrator or the court, subject to a maximum fee of $850." Id. The minimum attorney fee that shall be awarded is $60. 11 NYCRR §65-4.5(c). However, if the benefits and interest awarded thereon is equal to or less than the respondent's written offer during the conciliation process, then the attorney's fee shall be based upon the provisions of 11 NYCRR §65-4.6(i). For claims that fall under the Sixth Amendment to the regulation the following shall apply: "If the claim is resolved by the designated organization at any time prior to transmittal to an arbitrator and it was initially denied by the insurer or overdue, the payment of the applicant's attorney's fee by the insurer shall be limited to 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon, for each applicant with whom the respective parties have agreed and resolved disputes, subject to a maximum fee of $1,360." 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 New York
SS :
County of Nassau

I, Amanda R. Kronin, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

06/18/2017
(Dated)

Amanda R. Kronin

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:
b78ffd1aecf8f004e65d353ea3af5c8b

Electronically Signed

Your name: Amanda R. Kronin
Signed on: 06/18/2017