

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Lesley Anne Uy Bendigo PT
(Applicant)

- and -

Liberty Mutual Fire Insurance Company
(Respondent)

AAA Case No. 17-16-1037-5033

Applicant's File No.

Insurer's Claim File No. LA00003230935502

NAIC No. 23035

ARBITRATION AWARD

I, Heidi Obiajulu, 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: Injured Party

1. Hearing(s) held on 08/15/2017, 10/23/2017
Declared closed by the arbitrator on 10/23/2017

Olga Sklyut, Esq. from Law Office of Olga Sklyut P.C participated by telephone for the Applicant

Herman Buchanan from Liberty Mutual Fire Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 475.00**, 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

Did Respondent establish its fee schedule defense(s) asserted in its denial of claim form regarding Applicant's claim for reimbursement of the office activity limitation measurement service performed on 11/19/15? The then 36-year-old male patient was involved in a motor vehicle accident occurring on July 12, 2015 and received treatment for injuries to his neck and back.

4. Findings, Conclusions, and Basis Therefor

I have reviewed all relevant documents included in the Modria ADR Center maintained by the American Arbitration Association (hereinafter referred to as AAA) consisting of the submissions made by the parties. No other documentation was submitted by either party at the time of the hearing.

In dispute in this arbitration is Applicant's claim in the amount of \$475.00 for the disputed office activity limitation measurement service (hereafter referred to as ALM test) performed on 11/19/15.

This case arises out of a motor vehicle accident occurring on July 12, 2015, in which the Injured Party (KL), a then 36-year-old male, sustained multiple injuries including to his neck and back.

Applicant performed the disputed ALM test and submitted its claim form to Respondent seeking the reimbursement of no-fault benefits.

Within 30-days of its receipt of Applicant's claim form, Respondent denied reimbursement on the grounds that: (1) the relative value unit (hereafter referred to as RVU) charged by Applicant far exceeded any RVU for like services under the physical medicine section of the New York Workers' Compensation Medical fee schedule; (2) the service is like a function capacity evaluation code and the requirements of Physical Medicine Ground Rule#14 (which applies to such service) were not met; (3) the test is similar to static strength form of muscle testing and such medical service was an integral part of the treating provider's exam/continuum of care; and (4) the charging represented unbundling.

After it received Respondent's denial, Applicant commenced this arbitration seeking the reimbursement of its claim.

At the outset, I find that Applicant established its prima facie case with the submission of its claim form and the copy of Respondent's denial of claim form, which demonstrate that Respondent received Applicant's claim form, that more than 30-days elapsed since its receipt of same, and that Respondent denied reimbursement of Applicant's claim, which shows that Applicant's claim is now due and owing. See Insurance Law section 5106 [a]; Viviane Etienne Medical Care, PC v. County-Wide Ins. Co 25 N.Y.3d. 498, 35 N.E.3d 451, 14 N.Y.S. 3d. 283, 2015 N.Y. Slip Op 04787(NY, June 10, 2015), Westchester Medical Center v. Nationwide Mut. Ins. Co., 78 A.D.3d. 1168, 911 N.Y.S.2d. 907, 2010 N.Y. Slip Op.08933, (N.Y.A.D. 2nd Dept., November 30, 2010).

At issue is whether Respondent met its burden of proof in establishing its above fee schedule defenses.

Respondent's representative argued that Respondent established its fee schedule defense(s) with the opinion by its certified coder, Beth Palisin, RN, BSN, CPC. Therefore, he argued that Respondent's denial should be sustained and Applicant's claim be denied in its entirety.

In her affidavit, Ms. Palisin, RN, BSN, CPC opined that Applicant failed to satisfy the requirements for billing using a "BR" code pursuant to General Ground Rule # [3] of the New York Workers' Compensation Medical fee schedule. She noted that under said ground rule, the RVU used by the provider must be consistent with the established RVUs of similar medical services in terms of time, skill, and equipment, set forth in the same section of the fee schedule. She opined that the above criteria were not met. She further opined that based on the submitted documentation and amount charged, Applicant likened the service to that of Functional Capacity Evaluation, CPT code 97800. However, she argued that the requirements of Physical Medicine Ground Rule#14 were not satisfied. Additionally, she argued that General Ground Rule #6 applied and that this service constituted concurrent care because the Injured Party was receiving physical therapy (at the same location) during the same time for the same condition. She argued that per General Ground Rule #6, concurrent care occurs when more than one physician treats a patient for the same condition during the same period of time. Thus, under that ground rule, she argued that payment is made only to one physician, the one whose specialty is most relevant to the diagnosis. Consequently, she argued that the disputed ALM test should be denied on that basis alone.

Applicant's attorney argued that Respondent failed to establish its fee schedule defense(s) because its certified coder did not discuss the various other similar physical medicine procedures and only considered the functional capacity evaluation procedure when she applied General Ground Rule #3. She noted that even if the certified coder determined that the functional capacity evaluation procedure was the most similar, that she incorrectly concluded that Physical Medicine Ground Rule #14 applied. She argued that General Ground Rule #3 states that the RVU of a similar procedure should be used and not that the "BR" procedure should be treated like the similar medical service. Consequently, she argued that Physical Medicine Ground Rule #14 should not apply and the certified coder's opinion regarding Physical Medicine Ground Rule#14 shouldn't be followed. Alternatively, she argued that the opinion of Applicant's coder, Ms. Yelena Davydkina, should be followed because she correctly discussed the various similar physical medicine procedures and determined that physical performance testing (CPT code 97750) and functional capacity evaluation (CPT code 97800) were comparable services. However, she noted that Ms. Davydkina opined that physical performance testing requires the time spent in performing the service and that she only had information regarding the testing portion of the ALM service. She noted that Ms. Davydkina also opined that ALM testing is most similar to a functional capacity evaluation but that such service (ALM) has a wider purpose and application and billing under that CPT code would be improper. She also argued that functional capacity evaluation only deals with work limitations but not restrictions in activities of daily living. Also, she argued that the ALM service has a training component. She argued that therefore the reimbursement of the ALM service should be greater than that for a functional capacity evaluation. She argued that based on her review of arbitration awards and court decisions, Applicant should be reimbursed the billed amount. Notably, Applicant's billing expert did not address the concurrent care argument raised by Respondent's certified coder.

Reviewing the relevant evidence in the record and considering the oral arguments made by the parties, I find as follows:

I find that although Respondent asserted several fee schedule defenses, it only submitted evidence by its certified coder to show (1) that the disputed ALM service should be denied because Physical Medicine Ground Rule #14 applies and was not met; and (2) that the ALM service constituted concurrent care and was not reimbursable.

Regarding its argument that the disputed ALM service should be denied because Applicant failed to satisfy the requirements of Physical Medicine Ground Rule #14, I find that Respondent failed to demonstrate that said ground rule applies. Notably, Respondent's certified coder opined that the most comparable medical service to the disputed ALM service was a functional capacity evaluation, CPT code 97800 which is reimbursed in the amount of \$475.00. Under General Ground Rule#3, Respondent should have taken the RVU for that service and used it for reimbursement purposes. General Ground Rule#3 does not indicate that any ground rule applicable to the similar medical services used for purposes of establishing the proper RVU apply to the BR procedure. So, I am not persuaded that Respondent's certified coder correctly applied Physical Medicine Ground Rule#14. Instead, her opinion supports the arguments of Applicant's attorney that the disputed ALM service should be reimbursed in the amount of \$475.00.

Regarding the certified coder's opinion that the disputed ALM service constituted concurrent care with physical therapy services performed by a physical therapist (see her opinion for the identity of the physical therapy facility) during the same time period that the ALM was performed, I am not persuaded because her opinion does not demonstrate that she had a sufficient factual basis and rationale. She does not mention the documentation she reviewed to show that the criteria for establishing concurrent care were met. General Ground Rule #6 states that concurrent care occurs when more than one physician treats a patient for the same condition during the same period of time. That rule goes on to state that "[w]here the concurrent care involves **overlapping or common services, the fees payments shall not be increased but prorated....**When the condition of the patient requires the disparate skills of two or more physicians to treat different conditions which do not fall within the scope of other physician treating the patient at the same time (e.g. management of diabetes mellitus in a surgical case), payment is due each physician who plans an active role in the treatment program. The services rendered by each physician shall be distinct, in different disciplines, identifiable, and adequately documented in the records and reports." In this case, the certified coder argued that the ALM and physical therapy services constituted concurrent care because the Injured Party received regular physical medicine care at another facility located at the same physical address during the same time. Notably, the certified coder did not compare or discuss and explain her basis for determining that the medical services were overlapping and not distinct and/or why she concluded that the same condition or parts of the body were treated and the physical therapist's services were more relevant. For instance, the certified coder did not show that physical performance testing was performed by the physical therapist around the same date of

service or some other form of training similar to that provided by Applicant. Based on the fact that the CPT codes used by Applicant are most likely different from the physical therapist performing services in the same location, it would seem that the medical services by Applicant and the physical therapist were distinct or overlapping. So, at most, arguably the reimbursement to Applicant would have been prorated. However, the bottom line is that the certified coder failed to set forth a sufficient factual basis and rationale to demonstrate that the disputed ALM service constituted concurrent care. Finally, I am aware of the case Ying Eastern Acupuncture, P.C. v. Global Liberty Insurance, 20 Misc.3d 144(A), 873 N.Y.S.2d 238 (Table), 2008 N. Y. Slip Op. 51863 (U), 2008 WL 4222084 (App. Term 2d & 11th Dists., September 3, 2008). However, I find that although Respondent submitted an expert to assess whether the ALM and other physical therapy services performed constituted concurrent care, that expert failed to set forth a sufficient factual basis and rationale.

Consequently, for the above reasons, I find that Respondent failed to establish its fee schedule defense.

Accordingly, for the above reasons, I find in favor of Applicant in the amount of \$475.00 for the disputed ALM service performed on 11/19/15.

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

	Lesley Anne Uy Bendigo PT	11/19/15 - 11/19/15	\$475.00	Awarded: \$475.00
Total			\$475.00	Awarded: \$475.00

- B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 06/22/2016, which is a relevant date only to the extent set forth below.)

Applicant's award in the amount of \$475.00 shall bear interest at a rate of two percent per month, calculated on a pro rata basis using a 30-day month from 06/22/16, the date Applicant filed its AR form on AAA, to the date of the payment of the award.

C. Attorney's Fees

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

As this matter was filed **after** February 4, 2015, this case is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant an attorney's fee, in accordance with newly promulgated 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 New York

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

10/27/2017
(Dated)

Heidi Obiajulu

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:
52905d40b2eb4c7faca26c9b503079b5

Electronically Signed

Your name: Heidi Obiajulu
Signed on: 10/27/2017