

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

SR Wellness PT PC  
(Applicant)

- and -

Liberty Mutual Fire Insurance Company  
(Respondent)

AAA Case No. 17-16-1035-5449

Applicant's File No.

Insurer's Claim File No. LA00003189766803

NAIC No. 23035

**ARBITRATION AWARD**

I, Aaron Maslow, 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: Assignor ["JM"]

1. Hearing(s) held on 01/31/2018  
Declared closed by the arbitrator on 01/31/2018

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

Joseph Kuroly, Esq., from Harris, King, Fodera & Correia 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

- Whether Applicant established entitlement to No-Fault insurance compensation for activity limitation measurement testing performed on Assignor
- Whether the fee for activity limitation measurement testing was not in accordance with fee schedule

4. Findings, Conclusions, and Basis Therefor

Appearances

For Applicant:

Olga Sklyut, Esq. (elected to rely on submission)  
7122 Bay Parkway  
2nd floor  
Brooklyn, NY 11204

For Respondent:

Harris, King, Fodera & Correia  
1 Battery Park Plaza  
29th floor  
New York, NY 10004  
By: Joseph Kuroly, Esq.

Applicant, a professional business entity owned by a self-employed licensed physical therapist, commenced this New York No-Fault insurance arbitration, seeking as compensation \$475.00 which it billed for performing activity limitation measurement testing, billed under CPT Code 97799, on May 26, 2015, on Assignor, a 52-year-old female who allegedly was injured in a motor vehicle accident on April 17, 2015. Respondent denied payment on the ground that fees were not in accordance with fee schedule. Its denial of claim elaborated:

Insurance Law 5108 and Regulation 68, 65-3.16 require that all medical services reimbursed under No Fault are in accordance with Fee Schedules contained in Regulation 83. Further Reg. 83, 68.1 provides that the instructions and ground rules of the NYS Fee Schedule apply to No Fault. Per the NYS Fee Schedule, 97799 is a By Report (BR) code, without an assigned RVU. Per Fee Schedule BR ground rules, documentation must be submitted supporting provider charges. This has not been supplied. Per BR ground rules, the RVU charged must be consistent with like services from the same section of the fee schedule in terms of time, skill, and equipment. Relative value charged far exceeds that of like services of physical medicine section of fee schedule. BR Ground rules not met. Based on submitted documentation and amount charged, provider likens testing to that of Functional Capacity Evaluation (code 97800). FCE criteria not met per Physical Medicine Ground Rule #14. Testing appears as a static strength form of muscle testing. Such determinations are integral to treating providers physical exam/continuum of care. Clmt under regular physical medicine care. Testing by a second provider represents concurrent care per Fee Schedule Ground Rules. Correlation to treatment plan is not documented. Denied in full per codes/fees/ground rules of the Fee Schedule.

This arbitration was conducted under the auspices of the American Arbitration Association, which has been designated by the New York State

Department of Financial Services to administer the mandatory arbitration provisions of Insurance Law § 5106(b), which provides:

Every insurer shall provide a claimant with the option of submitting any dispute involving the insurer's liability to pay first party ["No-Fault insurance"] benefits, or additional first party benefits, the amount thereof or any other matter which may arise pursuant to subsection (a) of this section to arbitration pursuant to simplified procedures to be promulgated or approved by the superintendent.

Applicant elected to submit in lieu of appearing personally at the hearing. Respondent appeared at the hearing by counsel, who presented oral argument and relied upon a documentary submission. I have reviewed the submissions' documents contained in the American Arbitration Association's ADR Center as of the date of the hearing, said submissions constituting the record in this case.

At the hearing, Respondent conceded that Applicant established a prima facie case of entitlement to No-Fault compensation, the bill having been sent by Applicant and received by Respondent, who denied payment. I find that the denial of claim issued by Respondent was timely, i.e., within the 30-day deadline prescribed by Insurance Law §5106(a) and 11 NYCRR 65-3.8(a)(1), the bill having been received on June 29, 2015 and the denial having been issued July 24, 2015.

CPT Code 97799 is defined in the Workers' Compensation Medical Fee Schedule as "Unlisted physical medicine/rehabilitation service or procedure." It is a "by report" code. The Ground Rules in the Workers' Compensation fee schedules apply to No-Fault unless they require reports specific to Workers' Compensation. 11 NYCRR 68.1(b)(1). Ground Rule 3 to Chapter 1 (Introduction and General Guidelines) of the Workers' Compensation Medical Fee Schedule sets forth reporting requirements for services billed with CPT codes which are "by report":

"BR" in the Relative Value column represents services that are too variable in the nature of their performance to permit assignment of relative value units. Fees for such procedures need to be justified "by report." Pertinent information concerning the nature, extent, and need for the procedure or service, the time, the skill, and equipment necessary, etc., is to be furnished. A detailed clinical record is not necessary, but sufficient information shall be submitted to permit a sound evaluation. It must be emphasized that reviews are based on records, hence the importance of documentation. The original official record, such as operative report and hospital chart, will be given far greater weight than supplementary reports formulated and submitted at later dates. For any procedure where the relative value unit is listed in the schedule as "BR," the physician shall establish a relative value unit consistent in relativity with other relative value units shown in the schedule. The insurer shall review all submitted "BR" relative

value units to ensure that the relativity consistency is maintained. The general conditions and requirements of the General Ground Rules apply to all "BR" items.

Applicant submitted a two-page document entitled "Activity Limitation Measurement and Training Report." While this document bears Assignor's name at the top of the first page, it is not particularized to Assignor. The contents of the report are identical to others submitted in other cases. It is general in nature as to the procedure. The report maintains that the service known as activity limitation measurement testing rates difficulties an individual may have in the performance of daily activities. It claims that three purposes are served: (1) identify functional weaknesses and strength deficits, allowing for proper rehabilitation, (2) establish an objective measurement of the patient's capabilities for judicial resolution, disability determination, and treatment progress determination, and (3) provide the patient with quantifiable limitations he or she faces.

The document continues by stating that "The patient" was tested using a JTech computerized evaluation system. "Depending on the level of the patient's compliance, the examination takes 30-50 minutes." It is also claimed that the patient received training as to how to deal with limitations.

As for the fee, this document maintains that Code 97799 is the only proper CPT Code, and that there is no code in the fee schedule which would reflect the components of the testing.

I find this document deficient. First, the above cited Ground Rule requires "[p]ertinent information concerning the nature, extent, and need for the procedure or service, [and] the time." This document contained no pertinent information specific to Assignor which would explain why this testing was performed. While there is a signature of Assignor under a statement that written and verbal information had been received in regard to the test results and as well as training, there is no mention of the details of the information, i.e., detailed instructions as to what to do under what circumstances, and what the training entailed. The specific time was not documented for Assignor. A general statement that it takes 30-50 minutes is insufficient.

Also, the Ground Rule emphasizes that original records will be given far greater weight than reports formulated later on. The only original record is a set of computer-generated wavelengths and graphs; it lacks any recordation of specific, tailor-made instructions for Assignor based on the injuries sustained. The skill of the person performing the service was also not documented although the Ground Rule requires it.

Finally, while "a relative value unit consistent in relativity with other relative value units shown in the schedule" must be established by the physician, that did not take place here. In fact, if one were to work backwards arithmetically, and take the flat fee of \$475.00 and divide it by the Region IV relative value of \$7.70 for self-employed physical therapists (Applicant is owned by one), the relative value units would be 61.69. Assuming that 50 minutes were spent (although the exact

amount of time for Assignor is not set forth), assigning 61.69 relative value units is grossly disproportionate to the 28.00 units assigned for four hours of Code 87545 work hardening.

Applicant charged about the same as the prescribed fee for a functional capacity evaluation. There are many requirements for the latter such as that it should not be performed prior to three months post-injury unless there is significant documented change in condition, that the testing be performed in connection with work obligations, and that there be a narrative cover sheet with recommendations. None of these conditions were met in the instant case, so charging \$475.00, which is close to the Region IV \$495.00 fee for a Code 97800 functional capacity evaluation is inappropriate.

In light of the foregoing, I find that the document submitted by Applicant as "Activity Limitation Measurement and Training Report (billed as 97799)" fails to comply with the requirements of Ground Rule 3 to Chapter 1 (Introduction and General Guidelines) of the Workers' Compensation Medical Fee Schedule.

Respondent, in its denial of claim, correctly identified the deficiencies in the report submitted by Applicant to purportedly justify the billed \$475.00.

As a means of containing the cost of No-Fault automobile liability insurance, the Legislature provided for the establishment of schedules of maximum permissible charges for medical, hospital, and other professional health services payable under No-Fault insurance benefits. Tucciarone v. Progressive Ins. Co., 204 A.D.2d 864 (3d Dept. 1994). In order to contain the cost of providing medical services to patients treated under New York's No-Fault law, the state legislature set limits on the fees health care providers may charge patients who sustain injuries by incorporating into the No-Fault scheme the fee schedules established by the Worker's Compensation Board for industrial accidents. John Giugliano, DC, P.C. v. Merchants Mutual Ins. Co., 29 Misc.3d 367 (Civ. Ct. Kings Co. 2010). Other court decisions have also recognized that one of the purposes for enacting the No-Fault system for motor vehicle accidents in the first instance was to save on the cost of insurance premiums. E.g., Matter of Medical Society v. Serio, 100 N.Y.2d 854, 860 (2003); Goldberg v. Corcoran, 153 A.D.2d 113, 118 (2d Dept. 1989); Palmer v. Allstate Ins. Co., 101 A.D.2d 127, 132-133 (2d Dept. 1984).

Most medical services provided for in the Workers' Compensation fees schedules have specific relative values which, when multiplied by the appropriate conversion factor, yield maximum permissible charges. There are some services, however, which lack specific relative values. They could be billed under the miscellaneous by report codes and they will be compensated for under the No-Fault system. However, the fees must be justified by the health service providers who perform them. That requirement is consistent with the aforecited legislative history. Allowing health service providers to bill for unspecified procedures at flat rates where the information provided fails to comply with the requirements to individually

particularize how those rates were arrived at would contravene the legislative intent in enacting the No-Fault system in the 1970s. Applicant here has not provided sufficient information to justify its flat rate of \$475.00.

In Bronx Acupuncture Therapy, P.C. v. Hereford Ins. Co., 54 Misc.3d 135(A), 2017 N.Y. Slip Op. 50101(U), (App. Term 2d, 11th & 13th Dists. Jan. 20, 2017), and Bronx Acupuncture Therapy, P.C. v. Hereford Ins. Co., 57 Misc.3d 145(A), 2017 N.Y. Slip Op. 51452(U) (App. Term 2d, 11th & 13th Dists. Oct. 27, 2017), by report CPT codes were billed by the plaintiff. No reports accompanied the claim forms. In these cases, the court held that an insurer may not reduce payment or deny payment on the ground that no documentation was submitted with the claim forms when it did not seek such documentation as verification requests. In the case at bar, however, a report was sent by Applicant along with the claim form. Hence, these two court decision are inapplicable.

By checking Box 18 (fees not in accordance with fee schedules), Respondent preserved all billing practice defenses. Megacure Acupuncture, P.C. v. Lancer Ins. Co., 41 Misc.3d 139(A), 2013 N.Y. Slip Op. 51994(U) (App. Term 2d, 11th & 13th Dists. Nov. 21, 2013). Its argument that fees were not in accordance with fee schedule, as further elaborated in its denial of claim, is sustained. By failing to justify its fee of \$475.00 in its report which accompanied the claim form, Applicant charged a fee which was not in accordance with the fee schedule, which includes the pertinent Ground Rule governing by report codes. I sustain the defense of fees not being in accordance with fee schedule. That defense overcomes the prima facie case of entitlement to No-Fault compensation, established by Respondent's concession.

Accordingly, the within arbitration claim is denied in its entirety.

This arbitrator has not made a determination that benefits provided for under Article 51 (the No-Fault statute) of the Insurance Law are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of Assignor. As such and in accordance with the provisions of the prescribed NYS Form NF-AOB (the assignment of benefits), Applicant health provider shall not pursue payment directly from Assignor for services which were the subject of this arbitration, notwithstanding any other agreement to the contrary.

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 claim is DENIED in its entirety

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of New York

SS :

County of Kings

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

02/02/2018

(Dated)

Aaron Maslow

#### **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:**  
2cbc5dd3018b85cdcb8f15eec7555d0c

### **Electronically Signed**

Your name: Aaron Maslow  
Signed on: 02/02/2018