American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

NY Med (Applicant)	AAA Case No.	17-18-1115-4457
	Applicant's File No.	2168946
- and -	Insurer's Claim File No.	0418580590101017
	NAIC No.	35882
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Evelina Miller, 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: MR

1. Hearing(s) held on 05/26/2020
   Declared closed by the arbitrator on 05/26/2020

   Scott Fisher Esq from Israel, Israel & Purdy, LLP (Great Neck) participated by telephone for the Applicant

   Elizabeth Henley Esq from Geico Insurance Company participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **$ 534.00**, 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 dispute arises from the underlying automobile accident on February 3, 2018, in which the Assignor (MR), an 88-year-old-female was involved. Thereafter, Assignor sought private medical attention and was eventually evaluated by Dr. Seldes with complaints of radiating neck pain and lower back pain. Eventually patient was recommended to undergo conservative care. The bills in dispute are for office visit, epidurogram and supplies received by the patient on 3/19/18 and 4/25/18.Respondent denied Applicant's bills based on the New York Workers' Compensation Fee Schedule.

The issue presented at the hearing is whether Respondent was able to reach its burden in coming forward with competent evidentiary proof to support its fee schedule defenses

4. Findings, Conclusions, and Basis Therefor

I have reviewed the submissions contained in MODRIA which are maintained by the American Arbitration Association. These submissions are the record in this case. My decision is based on my review of that file, as well as the arguments of the parties at the hearing.

Initially I find that Applicant establishes its prima facie showing of entitlement to recover first-party no-fault benefits by submitting evidentiary proof that the prescribed statutory billing forms, setting forth the fact and amount of the loss sustained, had been mailed and received and that payment of no-fault benefits were overdue. See *Mary Immaculate Hospital v. Allstate Insurance Co*.,5 A.D.3d 742, (2d Dept., 2004). Once an applicant establishes a prima facie case, the burden then shifts to the insurer to prove its defense. See *Citywide Social Work & Psy. Serv. P.L.L.C v. Travelers Indemnity Co., 3 Misc. 3d 608, 2004, NY Slip Op 24034 [Civ. Ct., Kings County 2004]).*

Fee Schedule

The rates charged by Applicant must be in accordance with Insurance Law § 5108, as the charges for services rendered "shall not exceed the charges permissible under the schedules prepared and established by the chairman of the Workers Compensation Board for Industrial Accidents, except where the insurer or arbitrator determines that unusual procedures or unique circumstances justify the excess charge."

In addition, § 5108 (c) states that, "no provider of health services… may demand or request any payment in addition to the charges authorized pursuant to this section."

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)*. 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, 1st Dep't, per curiam, 2006).*

Effective April 1, 2013 11 NYCRR 65-3.8(g)(1) has been amended so that the application of the New York State Worker's Compensation fee schedule is no longer a precludable defense and no payment is due on those claims in excess of the fee schedule. Per 11 NYCRR 65-3.8(g), where the services were rendered after April 1, 2013, a defense of excessive fees is not subject to preclusion *Surgicare Surgical Associates v. National Interstate Ins. Co.,Misc.3d,N.Y.S.3d , 2015 N.Y. Slip Op. 25338 (App. Term 1st Dept. Oct. 8, 2015), aff'g, 46 Misc.3d 736, 997 N.Y.S.2d 296 (Civ. Ct. Bronx Co. 2014) (New Jersey fee schedule)*. The insurer is entitled to reduce the bills to the proper fee schedule amount.

DOS 3/19/18

For date of service of 3/19/18 Applicant billed with codes 97001, 97110, 97014, and 97010 in the total amount of $156.32. Respondent reimbursed Applicant in the amount of $103.95 stating that the provider's fee exceeds maximum allowance under the applicable fee schedule.

At the time of the hearing Applicant reduced amount in dispute for date of service of 3/19/18 to $114.08. I find this number to be proper.

Respondent does not submits a coder affidavit, or an affidavit from anyone with expert knowledge of the New York Workers' Compensation Fee Schedule to support its fee schedule reduction.

Ground Rule 8 of the New York Workers Compensation fee schedule states that the maximum number of relative units when billing for an initial evaluation shall be limited to 13.5 units. It then goes on to list all the CPT codes that fall under this rule. It is noted that CPT code 97001 does not fall under the Ground Rule 8. Accordingly, I find that Respondent failed to reach its burden of coming forward with competent evidentiary proof to support its fee schedule defenses.

I further find that Applicant properly reduced its billed amount for the physical therapy modalities as well as the evaluation of the patient to $114.08. Since Applicant was already reimbursed $103.95, I find that Applicant is entitled to reimbursement of the remaining balance in the amount of **$10.13.**

DOS 4/25/18

CPT Code - 72275

For date of service of 4/25/16 Applicant billed CPT code 72275 in the amount of $418.97. Respondent denied Applicant's bill for CPT Code 72275 stating that it is a "by report" code only and a formal report is required for submission of this code.

I am permitted to take note of the New York State Workers' Compensation Fee Schedule. See *Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co*., 61 A.D.3d 13, 20 (2d Dept. 2009); *LVOV Acupuncture, P.C. v. Geico Ins. Co.*, 32 Misc.3d 144(A), 2011 NY Slip Op 51721(U) (App Term 2d, 11th & 13th Jud Dists. 2011); *Natural Acupuncture*

Health, P.C. v. Praetorian Ins. Co., 30 Misc.3d 132(A), 2011 NY Slip Op 50040(U) (App Term, 1st Dept. 2011).

CPT code 72275 is not a by-report code, and is listed in the New York Workers' Compensation fee schedule as epidurography, radiological supervision and interpretation. It is reimbursable in the amount of $418.97.

As such, I find that Respondent failed to reach its burden of coming forward with competent evidentiary proof to support its fee schedule defenses,

Accordingly, Applicant's claim for reimbursement is granted for CPT code 72275 in the amount of **$418.97**.

CPT Codes 99070, J1030, S0020

For date of service of 4/25/16 Applicant also billed for supplies used during surgery with CPT Code 99070 in the amount of $40.00, CPT code J1030 in the amount of $20.16 and CPT Code S0020 in the amount of $2.50. Respondent denied Applicant's bill stating that additional documentation, including invoices for the supplies/implants described above, is needed for further review.

Applicant contends that Respondent should not have denied the claim outright, but rather requested verification seeking invoices to determine proper amount reimbursable to Applicant.

I take judicial notice of the New York Workers' Compensation Fee Schedule and find the following. Medical Fee Schedule Surgery Ground Rule 16 "Medical Supplies by Physician" states that a provider does not report supplies that are customarily included in surgical package, such as gauze, sponges, steri-strips and dressings. Surgical services do not include the supply of medications, sterile trays, and other materials which may be reported separately with code 99070. The specific items provided must be identified. Payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping and handling costs associated with delivery from the supplier of the item to the physician's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070.

Applicant contends that Respondent should not have denied the claim outright, but rather requested verification seeking invoices pursuant to holding in *Gaba Med., P.C. v. Progressive Specialty Ins. Co., 36 Misc.3d 139 [A], 2012 N.Y. Slip Op 51448 [U], [App Term, 2d Dept, 2d, 11th & 13th Jud. Dists 2012]; see generally Rogy Med., P.C. v. Mercury Cas Co., 23 Misc.3d 132 [A], 2009 N.Y. Slip Op. 50732 [U] [App Term, 2d Dept, 2d 11th & 13th Jud Dists. 2009]).*

Regarding the court holding in *Gaba* I also note that part of its prima facie burden, a health service provider billing a "by report" code must submit the information required by the Ground Rule governing by report codes; the Fee Schedule places an affirmative duty on the provider to submit this information, and without it the provider has deprived the insurer of sufficient notice of the claim and the latter should not be expected to evaluate and pay it. *Pavlova v. Allstate Ins. Co*., 52 Misc.3d 491, 32 N.Y.S.3d 444 (Civ. Ct. Kings Co. 2016).

Here, the services billed for were not by-report codes. The Workers' Compensation Fee Schedule provides in Ground Rule16 that if these items are to be billed for, and payment is sought, Applicant should submit invoices with its billing. Here, Applicant failed to do so. Applying the holding in *Pavlova*, I find that the Fee Schedule places an affirmative duty on the provider to submit this information, and without it the provider has deprived the insurer of sufficient notice of the claim and the latter should not be expected to evaluate and pay it. Respondent was not under an obligation to seek verification since the obligation to provide supporting document is squarely placed on Applicant by Ground Rule 16. (*see above*). Same reasoning applies to CPT Codes J1030, and S0020.

Since Applicant is the party seeking to be reimbursed, the onus is on Applicant to provide all necessary information to Respondent to determine amount reimbursable. Here, Applicant billed for supplies associated with the surgery performed on the patient on 4/25/18. Here Ground Rule 16 of the New York Workers' Compensation Fee Schedule places an affirmative duty on the provider to submit this information. Applicant failed to do so.

Accordingly, Applicant's claim for reimbursement for CT codes J1030, S0020 and 99070 is denied.

Applicant is entitled to total reimbursement for dates of service of 4/25/18 and 3/19/18 in the amount of **$429.12**.

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**
	NY Med	**03/19/18 - 03/19/18**	**$52.37**	**Awarded: $10.13**
	NY Med	**04/25/18 - 04/25/18**	**$481.63**	**Awarded: $418.99**
Total			**$534.00**	**Awarded: $429.12**

B. The insurer shall also compute and pay the applicant interest set forth below. 12/27/2018 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Since the motor vehicle accident occurred after April 5, 2002, interest shall be calculated at the rate of two percent per month, simple, calculated on a pro rata basis using a 30 day month. 11 NYCRR 65-3.9(a). In accordance with 11 NYCRR 65-3.9c, interest shall be paid on the claims totaling $429.12 from the date the arbitration was commenced.

C. Attorney's Fees

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

Respondent shall pay Applicant an attorney's fee upon the amount awarded plus the interest, as calculated in section "B" above, and in accordance with 11 NYCRR 65-4.6(e), i.e., 20 percent of the amount of first party benefits, plus interest thereon. The minimum attorney's fee payable shall be in accordance with 11 NYCRR 65-4.6c. For cases filed after February 4, 2015, there is no minimum attorney's fee but there is a maximum fee of $1,360.00. 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(b)."

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

06/26/2020
(Dated)

Evelina Miller

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:
bb3840f88ae827b7e08d9aa525ffa48c

Electronically Signed

Your name: Evelina Miller
Signed on: 06/26/2020