

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Primavera Physical Therapy PC
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No.	17-19-1118-8946
Applicant's File No.	none
Insurer's Claim File No.	0527215130101031
NAIC No.	22055

ARBITRATION AWARD

I, Eileen Hennessy, 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-K.H.

1. Hearing(s) held on 11/03/2020
Declared closed by the arbitrator on 11/03/2020

Walter Pisary from The Law Offices of Hillary Blumenthal P.C. participated by telephone for the Applicant

James DiCarlo from Geico Insurance Company participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 812.86**, was NOT AMENDED at the oral hearing.
Stipulations WERE made by the parties regarding the issues to be determined.

The parties stipulated and agreed that (i) Applicant has met its prima facie burden by submitting evidence that payment of no-fault benefits is overdue, and proof of its claims were mailed to and received by Respondent and (ii) Respondent's denials of the subject claims were timely issued.

3. Summary of Issues in Dispute

The record reveals that the Assignor-K.H., a 37-year-old female, claimed injuries as the driver of a motor vehicle involved in an accident that occurred on 8/11/2017. Applicant billed for physical therapy from 8/23/2017 through 11/3/2017. Respondent partially

denied the claims based on the applicable fee schedule. The issue to be determined is whether the services were billed in accordance with the applicable fee schedule?

4. Findings, Conclusions, and Basis Therefor

Applicant seeks reimbursement for an office visit and physical therapy. This hearing was conducted using the documents contained in the Electronic Case Folder (ECF) maintained by the American Arbitration Association. All documents contained in the ECF are made part of the record of this hearing and my decision was made after a review of all relevant documents found in the ECF as well as the arguments presented by the parties during the hearing.

In accordance with 11 NYCRR 65-4.5(o) (1), an arbitrator shall be the judge of the relevance and materiality of the evidence and strict conformity of the legal rules of evidence shall not be necessary. Further, the arbitrator may question or examine any witnesses and independently raise any issue that Arbitrator deems relevant to making an award that is consistent with the Insurance Law and the Department Regulations.

Fee Schedule

It is respondent's burden to come forward with competent evidentiary proof to support its fee schedule defenses. *See Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co.*, 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 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 N.Y. Misc. LEXIS 1109 (App. Term, 1 Dep't, per curiam, 2006). A respondent may interpose a defense in a timely denial that the claim exceeds the fees permitted by the Workers' Compensation schedules, but respondent must, at minimum, establish, by evidentiary proof, that the charges exceeded that permitted by law. *Abraham v. Country-Wide Ins. Co.*, 3 Misc.3d 130A, 787 N.Y.S.2d 678, 2004 N.Y. Misc. LEXIS 544 (App. Term, 2d Dept. 2004).

Furthermore, I take judicial notice 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) (App Term 2d, 11th & 13th Jud Dists. 2011); *Natural Acupuncture Health, P.C. v. Praetorian Ins. Co.*, 30 Misc.3d 132(A) (App Term, 1st Dept. 2011).

Ground Rule 8 of the Physical Medicine Section of the Medicine Fee Schedule, *Initial Evaluation and Re-evaluation*, reads in pertinent part: "The maximum number of relative value units (Relative Value Units) (including treatment) when billing for an initial evaluation shall be limited to 13.5 RVUs. The maximum number of RVUs (including treatment) when billing for a re-evaluation shall be limited to 11.0 RVUs. The following

codes represent the treatments subject to this rule: 97010 97012 97014 97016 97018 97022 97024 97026 97028 97032 97033 97034 97035 97036 97039 97110 97112 97113 97116 97124 97139 97140 97150 97530 97535 97537 97542 97760 97761 97762".

Ground Rule 11 of the Physical Medicine Section of the Medicine Fee Schedule, *Multiple Physical Medicine Procedures and Modalities*, which applies to doctors, physical therapist, and occupational therapists, commonly referred to as the "8-Unit Rule", reads: "When multiple physical medicine procedures and/or modalities are performed on the same day, reimbursement is limited to 8.0 RVUs or the amount billed, whichever is less. The following codes represent the physical medicine procedures and modalities subject to this rule: 97010, 97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028, 97032, 97033, 97034, 97035, 97036, 97039, 97110, 97112, 97113, 97116, 97124, 97139, 97140, 97150, 97530, 97535, 97537, 97542, 97660, 97661, and 97662"

Ground Rule 3 of the Physical Medicine Section of the Chiropractic Fee Schedule, *Multiple Physical Medicine Procedures and Modalities*, which applies to chiropractors, and is also commonly referred to as the "8-Unit Rule", reads: "When multiple physical medicine procedures and/or modalities are performed on the same day, reimbursement is limited to 8.0 RVUs or the amount billed, whichever is less. The following codes represent the physical medicine procedures and modalities subject to this rule: 97010, 97012, 97014, 97024, 97026, 97028, 97032, 97033, 97034, 97035, 97036, 97039, 97110, 97112, 97113, 97116, 97124, 97139, 97140, 97530, 98940, 98941, 98942."

These sections of the New York Workers' Compensation Fee Schedule contain CPT codes which appear in both sections and both sections provide that when multiple physical medicine procedures and/or modalities are performed on the same day, reimbursement is limited to 8.0 RVUs or the amount billed, whichever is less.

Additionally, these services are governed by a conversion rate of 8.45 for medical physicians, 7.70 for physical and occupational therapists who are self-employed, and 5.78 for chiropractors and licensed acupuncturists.

I have stated in the past I believe that if a treating physical therapist and chiropractor both bill for the CPT modalities that can be performed by either a licensed physical therapist or chiropractor on the same date, the carrier is not required to pay both bills and the limitation of a combined eight RVU applies.

As noted by Arbitrator Glen Wiener in *Goodheart Chiropractic, PC v Geico Insurance Co.*, AAA Legacy 412013101975 (February 20, 2014), in discussing whether there is a limitation to eight units based on specialist or CPT modalities, "...I respectfully decline to follow the holding of District Court Judge Hackeling who held only each provider is limited to reimbursement of 8 units per day. See Doctor of Medicine in the House v. Allstate Ins. Co., 41 Misc. 3d 983, 975 N.Y.S.2d 591 (3D District Ct. Suffolk Co Sept. 30, 2013). Judge Hackeling's holding is a misinterpretation of Ground Rule 11 which clearly limits reimbursement to all providers performing physical medicine services on the same day. To hold otherwise would allow an acupuncturist, chiropractor, medical doctor, and massage therapist to bill for and receive reimbursement for a plethora of

physical medicine treatments conducted on one individual on a single day (and many times out of the same location-as herein)."

I agree with Arbitrator Wiener's analysis. If a provider can render a licensed service but chooses not to then the 8-unit limitation will apply. Therefore, the modalities listed above, which can be performed by either a physical therapist or chiropractor are subject to the 8-unit limitation.

Notwithstanding this point, it is further worth mentioning this limitation would not apply when a treating provider is unable to perform the services rendered by another provider based upon licensing restrictions. Therefore, when a treating practitioner is not licensed to provide a specific physical medicine modality (such as chiropractic manipulation or acupuncture), and another healthcare practitioner then provides this service the "8-Unit Rule" should not be imposed to bar recovery. An injured individual should never be precluded from receiving subsequent non-traditional treatment such as chiropractic manipulation or acupuncture when the initial provider was neither licensed nor skilled in this service.

I am guided by an email, dated 1/30/2018, from Heather MacMaster, Deputy General Counsel, NYS Workers' Compensation Board to Chris Maloney of the Department of Financial Services. Ms. MacMaster stated that: "The 8 RVU limitation is per patient per day regardless of how many body parts are treated or how many practitioners treat. The only exception is with chiro and PT. If a chiro renders manipulation only (98940-98943) and does not bill any of the other physical medicine codes, the injured worker could receive chiro and PT on the same day. This scenario is usually performed by a chiro who is affiliated with the Chiropractic Council. They only perform manipulation. The physical medicine codes that are impacted by the 8 RVU limitation are in the chiro physical medicine fee schedule but the codes for spinal manipulation are not in the general physical medicine fee schedule."

Although Ms. MacMaster's advisory may not be an official position, nonetheless, I am guided by Ms. MacMaster's email and defer to the Workers' Compensation Board. I find that the WCB interpretation is entitled to deference. *See Matter of 427 W. 51st St. Owners Corp. v. Division of Hous. & Community Renewal*, 3 N.Y.3d 337, 342 (2004) ("[T]he interpretation given to a regulation by the agency which promulgated it and is responsible for its administration is entitled to deference if that interpretation is not irrational or unreasonable.").

I note that I do not apply payments made for code 98940-98943 towards the 8.0 unit maximum contained in Ground Rule 11 of the Physical Medicine Section of the New York State Workers' Compensation Medical Fee Schedule.

As my colleague, Arbitrator Antonietta Russo, in AAA Case Number 17-16-1039-3636 stated:

Eight units are eight units unless treatment is rendered by a medical doctor/physical therapist/occupational therapist and chiropractor on the same day. In that circumstance, the chiropractor may be reimbursed a maximum of 8 units of spinal manipulation (CPT

codes 98940-98943) even when a medical doctor/physical therapist/occupational therapist has already been reimbursed 8 units.

Legal Analysis

Applicant billed for an office visit and physical therapy treatment from 8/23/2017 through 11/3/2017 in the amount of \$2,677.30. Respondent paid \$1,864.44. Applicant seeks the balance of \$812.86.

Applicant is a self-employed physical therapist in Region IV and the regional conversion factor of 7.70 is applicable, resulting in an 8-unit daily total maximum of \$61.60. Applicant argues they properly billed the maximum daily amount of \$61.60 per date of service for a combination of CPT codes 97014 (\$22.48), 97124 (\$20.21), and 97010 (\$20.03).

Respondent properly paid the maximum reimbursable 13.5 units for date of service 8/23/2017 (\$78.03) in accordance with Ground Rule 8 of the Physical Medicine Section of the Medicine Fee Schedule,

Respondent contends that, in addition to the defenses referenced below, the total maximum reimbursement for the codes billed is \$58.90 per day as the codes billed by Applicant equal 7.65 RVUs. Specifically, the maximum amount of reimbursement is \$20.48 for CPT code 97014 (2.66 RVUs), \$20.17 for CPT code 97124 (2.62 RVUs), and \$18.25 for CPT code 97010 (2.37 units) for a total reimbursement of 7.65 units. According to Ground Rule 11 of the Physical Medicine Section of the Medicine Fee Schedule, "reimbursement is limited to 8.0 RVUs or the amount billed, *whichever is less* ." (Emphasis added.) I agree that Applicant is entitled to reimbursement for the number of RVUs billed (7.65 units). Applicant's claim for reimbursement in excess of the maximum allowable reimbursement for each individual code is denied.

Respondent paid \$58.90 for dates of service 11/2/2017 and 11/3/2017. Applicant seeks the balance of \$3.83 for each date of service, which is denied.

Respondent paid \$46.20 each for dates of service 9/18/2017, 9/19/2017, and 9/20/2017 and denied the remaining \$15.40 stating, "Reimbursement for modalities and procedures may not exceed 8 relative value units per day. Previously reviewed bill amount has been applied". Applicant seeks the balance of \$15.40 per date of service. Respondent has not provided any proof of payment to a separate provider for these dates of service. As Respondent paid a total of 6 units to Applicant, Applicant is entitled to additional reimbursement for 1.65 units (in accordance with the 7.65 units billed) in the amount of \$12.71 for each date of service. Accordingly, Applicant's claim is granted in the amount of \$38.13 for dates of service 9/18/2017, 9/19/2017, and 9/20/2017.

For the 9 dates of physical therapy treatment from 10/2/2017 through 10/12/2017, Respondent paid the maximum amount of reimbursement of \$20.17 for CPT code 97124 (2.62 RVUs) and denied the remaining \$41.43 stating, "Provider's fee exceeds the maximum allowance under the applicable fee schedule and is reduced accordingly. As per section 5108 of the New York State Insurance Law, Providers shall not exceed the

charges permissible under the schedules prepared and established by the chairman of the Worker's Compensation Board". Respondent provides copies of an EOB and payment screen indicating that payment was issued to a chiropractor for the same dates of service for CPT code 97012 (\$11.56) (in addition to the chiropractic manipulation billed under CPT code 98941, which is not subject to the 8-unit rule). Applicant seeks the balance of \$29.87 each for the 9 dates of service.

These codes are included in Ground Rule 11 of the Physical Medicine Section of the Medicine Fee Schedule and Ground Rule 3 of the Physical Medicine Section of the Chiropractic Fee Schedule and are therefore subject to 8-unit rule. As Respondent paid a total of 4.65 units to Applicant and a chiropractor combined each for the 9 dates of service from 10/2/2017 through 10/12/2017, Applicant is entitled to additional reimbursement for 3 units per date of service (in accordance with the 7.65 units billed) in the amount of \$23.10 for a total of \$207.90.

For the 7 dates of physical therapy treatment from 10/18/2017 through 11/1/2017, Respondent paid \$46.19 and denied the remaining \$15.41 stating, "Reimbursement for modalities and procedures may not exceed 8 relative value units per day. Previously reviewed bill amount has been applied". Specifically, Respondent paid \$20.48 for CPT code 97014 (2.66 RVUs), \$20.17 for CPT code 97124 (2.62 RVUs), and \$5.54 for CPT code 97010 (0.71 units). Respondent provides copies of an EOB and payment screen indicating that payment was issued to a chiropractor for the same dates of service for CPT codes 97012 (\$11.56). Applicant seeks the balance of .01 cent for each date of service as Respondent paid 7.99 units rather than 8 units. However, as Applicant billed 7.65 units per date of service, that is the maximum reimbursement they are entitled to. Respondent reimbursed in excess of 7.65 units per date of service of 10/18/2017 through 11/1/2017 and Applicant's claim for additional reimbursement is denied.

For the remaining dates of service Applicant was either paid in full or reimbursed \$46.20 (6 units). For the dates of service that Applicant was reimbursed \$46.20, Respondent provides copies of an EOB and payment screen indicating that payment was issued to a chiropractor for the same dates of service for CPT code 97012 (\$11.56 or 2 units) for a total of 8 units. Therefore, additional reimbursement is denied.

CONCLUSION

Accordingly, Applicant's claims are granted in the amount of \$246.03. The remainder of the claim is denied. 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
	Primavera Physical Therapy PC	08/23/17 - 08/31/17	\$131.84	Denied
	Primavera Physical Therapy PC	09/01/17 - 09/15/17	\$138.60	Denied
	Primavera Physical Therapy PC	09/18/17 - 09/29/17	\$46.20	Awarded: \$38.13
	Primavera Physical Therapy PC	10/02/17 - 10/12/17	\$372.87	Awarded: \$207.90
	Primavera Physical Therapy PC	10/18/17 - 11/03/17	\$123.35	Denied
Total			\$812.86	Awarded: \$246.03

B. The insurer shall also compute and pay the applicant interest set forth below. 01/25/2019 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." 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 denial at issue was timely. LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 217 (2009). Based on the regulations, interest shall accrue from the date the applicant requested arbitration in this matter. *See*, 11 NYCRR 65-3.9(c).

C. Attorney's Fees

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

Applicant is entitled to an attorney's fee pursuant to Insurance Law §5106(a). After calculating the sum total of the first-party (No-Fault) benefits awarded in this arbitration plus interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20 percent of that sum total, subject to the following limitations: In the event the above filing date was prior to Feb. 4, 2015, the attorney's fee is subject to a minimum of \$60.00 and a maximum of \$850.00, per 11 NYCRR 65-4.6(e). In the event the above filing date was on or after Feb. 4, 2015, the attorney's fee is subject to a maximum of \$1,360.00, per 11 NYCRR 65-4.6(d). In the event the above filing date was on or after Feb. 4, 2015 and first-party (No-Fault) benefits are awarded to more than one Applicant herein, the attorney's fee shall be calculated separately for each Applicant, each Applicant's attorney fee being subject to the \$1,360.00 maximum.

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

12/03/2020
(Dated)

Eileen Hennessy

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:
737cb44c2d894b566813838dd12639f6

Electronically Signed

Your name: Eileen Hennessy
Signed on: 12/03/2020