

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Macintosh Medical, P.C.
(Applicant)

- and -

Integon Indemnity Corporation
(Respondent)

AAA Case No. 17-20-1183-8974

Applicant's File No. JL20-123988

Insurer's Claim File No. 200305082-004

NAIC No. 22772

ARBITRATION AWARD

I, Debbie Thomas, 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

1. Hearing(s) held on 05/11/2022
Declared closed by the arbitrator on 05/11/2022

Jared Mallimo from The Licatesi Law Group, LLP participated in person for the
Applicant

Juliya Khodik from Law Offices of Bobbi J. Vilacha participated in person for the
Respondent

2. The amount claimed in the Arbitration Request, **\$1,499.13**, was AMENDED and permitted by the arbitrator at the oral hearing.

Counsel for Applicant amended the amount claimed to \$944.64, reflecting fee schedule reductions.

Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

Applicant seeks reimbursement in the amended amount of \$944.64 for an office visit, outcome assessment testing and trigger point injections with ultrasound guidance performed on August 12, 2020 on Assignor, J.S., a 45-year-old male who was the front-seat passenger of a motor vehicle involved in an accident on August 5, 2020. Respondent partially paid the claim and denied the balance, alleging that Applicant

billed in excess of the applicable fee schedule. The issue presented is whether Respondent has established its fee schedule defenses.

4. Findings, Conclusions, and Basis Therefor

The within award is based upon this arbitrator's review of the record as well as oral argument at the time of the hearing of this matter.

Under Sec. 5102 of the New York Insurance Law (McKinney 1985), No-Fault first party benefits are reimbursement for all medically necessary expenses on account of personal injuries arising out of the use or operation of a motor vehicle.

It is well settled that a healthcare provider establishes its *prima facie* entitlement to No-Fault benefits as a matter of law by submitting evidentiary proof that the prescribed statutory billing forms had been mailed and received and that payment of No-Fault benefits were overdue. *Westchester Medical Center v. Lincoln General Insurance Company*, 60 A.D.3d 1045, 877 N.Y.S.2d 340 (2 Dept. 2009); *Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). Respondent's denial(s) indicating receipt of the proof of claim shows that Applicant mailed the proof of claim form(s) to the Respondent (*see, Ultra Diagnostic Imaging v. Liberty Mutual Insurance Co.*, 9 Misc.3d 97). The evidence is sufficient to make out a *prima facie* case of entitlement to recovery of Applicant's bill.

Once Applicant has made out a *prima facie* case, the burden shifts to Respondent to timely request additional verification, deny, or pay the claim. *Hospital for Joint Diseases v. Travelers Prop. Cas. Ins. Co.*, 9 NY3d 312 (2007). Respondent maintains the charges in dispute are in excess of or not in accordance with the applicable fee schedule.

Respondent maintains the charges in dispute are in excess of or not in accordance with the applicable fee schedule.

Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. In the absence of such proof, a defense of noncompliance with the appropriate fee schedule cannot be sustained. *Continental Medical, P.C. v. Travelers Indemnity Company*, 11 Misc. 3d 145(A), 2006 N.Y. Slip Op. 50841(U) (App. Term 1st Dept. 2006). A lay person is not qualified to evaluate the CPT codes or to change if the code is used by a health provider in its bills. *See Abraham v. Country-Wide Ins. Co.*, 3 Misc. 3d. 130A (App. Term 2d. Dept. 2004). Once the insurer makes a *prima facie* showing that the amounts charged by a provider were in excess of the fee schedule, the burden shifts to the provider to show that the charges involved a different interpretation of such schedule or an inadvertent miscalculation or error.

Cornell Medical, P.C. v. Mercury Casualty Co., 24 Misc. 3d 58, 884 N.Y.S.3d 558 (App. Term 2d, 11th & 13th Dists. 2009).

In support of its fee schedule defense, Respondent submits the affidavit of Jessica E. Borchert, CPC, CRC, CPMA, am a Certified Professional Coder and Certified Risk Adjustment Coder, and Certified Professional Medical Auditor, credentialed with the American Academy of Professional Coders (AAPC). Ms. Bochert's affidavit states, in relevant part:

Applicant properly reported CPT code 99204 for established patient E&M in the amount of \$148. 69.

Review of the medical record does not substantiate prolonged evaluation and management services as reported by 99358. CPT code 99358 is a time-based code and at least 30 minutes must be notated. Nowhere within the records does the provider list the time taken to review the documentation.

CPT Assistant states in its August 2012 that guidelines for CPT code 99358:

"Therefore, when reporting prolonged services, time needs to be precise. Documentation should detail important clinical matters and also support coding."

The documentation provided to support the use of this code is entitled "Pain Management Outcome Assessment Report". It is an eight-page self-evaluation questionnaire in which the patient has answered such questions involving the pain scale for specific body areas, the subjective difficulty of daily activities, and a choice of modalities that have helped the pain of that body area.

NYS WC FS states regarding this code, "(t)hese prolonged physician services without direct patient contact may include review of extensive records and tests, and communication (other than telephone calls) with other professionals and/or the patient and family. These are beyond the usual services . . ."

The patient questionnaire is mostly slashed through or blank in this case. Review of a largely blank patient questionnaire is not reasonably understood to be review of extensive records or beyond usual services as required by the fee schedule. Thus, the record does not support code 99358. Hence, reimbursement of this code is not recommended.

Of interest, while not applicable in this immediate instance, effective 01/01/2021 guidelines for CPT code 99358 states that 99358 may not be reported on the same day as E&M services are reported.

The following CPT codes were billed on the same date of service and are defined by the AMA as:

20553- Injection(s); single or multiple trigger point(s), 3 or more muscles
76942- Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation
J1094- Injection, dexamethasone acetate, 1 mg

Review of the medical records shows CPT codes 20553 and 76942 were reported, four units each, for trigger point injections of the lower spine region. Documentation provided describes the trigger point procedure as injections, guided by ultrasound, into multiple muscles on date of service under review.

According to the question and answer section of the CPT Assistant from June 2017, the AMA clarifies its position on the use of how many times to report this code:

"The trigger point injection(s) codes (20552 and 20553) are reported once per session based on the number of muscles injected, regardless of the number of trigger points injected in each muscle. Code 20552 is reported for trigger point(s) injection(s) in 1 or 2 muscles, and code 20553 is reported for trigger points injection(s) in 3 or more muscles."

In this instance, reporting code 20553 is correct. However, due to the definition of the code itself, along with the support of the CPT Assistant, the units have been reduced from four to one. As such, one unit of 20553 is recommended for reimbursement.

The assistance of ultrasonic guidance for these injections was also verified by the medical records. However, as above, it was reported as three and four units; one use for one injection. This, too, is addressed in the same CPT Assistant question and answer section as the 20553 is and states:

"If imaging guidance is utilized, report the appropriate radiology code (76942, 77002, and 77021) in addition to the injection codes."

The morphology of the statement indicates that one radiology code is applicable to several units of injection codes. This is further supported by the CPT Assistant from August 2015 which states:

"Note that code 76942 should be reported only once per session, even though multiple injections...Ultrasound guidance procedures require permanently recorded images of the site to be localized, as well as documented description of the localized process, either separately or within the report of the procedure for which the guidance is utilized."

This is again reiterated in the CPT Knowledge Base. Knowledge Base is a compendium of real life coding questions asked by the coding community and answered by CPT coding experts and professions at the AMA.

"...code 76942, Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation, may only be reported once, irrespective of the number of trigger-point injections performed."

As only one unit of 20553 is recommended for reimbursement, only one unit of 76942 shall be recommended for reimbursement as consistent with the AMA's published guidance.

Code 76942 has professional and technical components of 45% and 55%, respectively. From the medical record it appears that Applicant provided both the professional and technical services involved with the ultrasound guidance and so the entire RV is allowable in this case.

For reference: CMS payment policy allows one unit of service for any of these codes at a single patient encounter regardless of the number of needle placements performed. The unit of service for these codes is the patient encounter, NOT number of lesions, number of aspirations, number of biopsies, number of injections, or number of localizations. The CMS instruction is that imaging guidance is billed once per encounter and not per lesion. Also, the Medically Unlikely edit for this service is "1", indicating that any more units on the same service date should be denied.

HCPCS code J1030 was reported for medications used on 08/12/2020. According to the NYS WC FS Guidelines Ground Rule 4 (Materials Supplied by Physician):

"Surgical services do not include the supply of medications, sterile trays, and other materials which may be reported separately with 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 the delivery from the supplier of the item to the physician's office."

The invoices for the reported medication were not received by this writer, however, the billed charges fall within the reasonable amount for the geographic location. Reimbursement is recommended based on billed charges.

As above, the conversion factor for this location and service is \$229.04 for surgery and \$52.90 for radiology. Therefore, maximally reimbursed under the fee schedule per valid unit is:

$$o \ 20553 = RV \times CF = 0.52 \times \$229.04 = \$119.10$$

$$o \ 76942 = RV \times CF = 4.97 \times \$52.90 = \$262.91$$

The proper reimbursement under the applicable fee schedule would be \$543.20. The total charges billed by Applicant are \$1,893.64. The total fee schedule allowable rate for services in this report is \$543.20. As the provider previously received reimbursement of \$394.51 funds in the sum of \$148.69 would fulfill Applicant's claim under the fee schedule.

I find Respondent's fee evidence sufficient to make a *prima facie* showing that the amounts charged by Applicant were in excess of the fee schedule. The affidavit of Ms. Borchert establishes that the insurer reviewed the charges and reduced in accordance with established fees. The burden now shifts to Applicant to show that the charges involved a different interpretation of such schedule or an inadvertent miscalculation or error. *See, Cornell Medical, supra.*

Applicant submits the affidavits of Priti Kumar, CPC, a Certified Professional Coder credentialed with the American Academy of Professional Coders.

With regard to CPT code 99358, Ms. Kumar contends that there is no prohibition for Applicant to bill separately the non-face-to-face prolonged evaluation under code 99358, and Applicant is entitled for separate payment for the non-face-to-face prolonged evaluation (code 99358) along with the initial evaluation or the routine follow-up evaluation (codes 99203 - 99205 or 99213 - 99215) at the rates as per NY Workers' Compensation fee schedule performed on DOS at issue.

As per Ground Rule 5 of the New York Workers' Compensation Fee-Schedule, Applicant has properly reported a routine evaluation and management service (under codes 99203 - 99205 or 99213 - 99215) performed on this DOS at issue separately, that includes, taking a history, doing a physical exam and medical decision making.

Applicant has also provided an initial evaluation or follow-up evaluation report (billed under codes 99203 - 99205 or 99213 - 99215) of visit performed on these DOS that indicated patient ongoing pain complaints. Past medical history, surgical history, current medications, allergy, and social history were noted. A thorough physical examination was performed, pain management plan was discussed, radiology review was done findings were noted, assessment and plan discussed, and treatments were recommended.

Of note is that Applicant has also provided a separate non-face-to-face prolonged summary evaluation report for the date of service at issue, to establish that it was a distinct non-face-to-face prolonged evaluation. The non-face-to-face prolonged

evaluation at issue was a separate evaluation performed apart from the routine follow-up evaluation discussed above performed on DOS at issue. Applicant has provided two separate reports thereof. The review of the summary report for services (billed under code 99358) at issue demonstrates that this non-face-to-face prolonged evaluation was a detailed evaluation distinct from the initial visit or follow-up visit performed on the same date of service (billed under codes 99203 - 99205 or 99213 - 99215). This non-face-to-face prolonged evaluation was performed to assess the condition of the patient and to decide the treatment plan. At this non-face-to-face prolonged evaluation the patient was evaluated with respect to the complaints sustained as a result of the MVA. Per the report the non-face-to-face prolonged evaluation at issue also included Disability Index Questionnaire related to the body parts having ongoing complaints due to the injuries sustained in MVA. Code 99358 is being billed to report time the provider spent administering and reviewing these assessments as well as planning future adjustments to the treatment plan.

Applicant appropriately billed services under CPT code 99358, which is used when "a prolonged services is provided that is neither face-to-face in the outpatient, inpatient, or observation setting, nor additional unit/floor time in the hospital or nursing facility setting". In the instant case, the billing is not intended to reimburse just for the patient's filing out of the OAT (Outcome Assessment Testing) rather, the services also represent "extensive record review" related to a previous evaluation and management service performed earlier. Of note is that code 99358 was used to report extended qualifying time of the billing physician and communication with other professionals and/or the patient and family. Therefore, services reported under CPT code 99358 are separately reimbursable.

In view of foregoing, it cannot be said that the non-face-to-face prolonged evaluation and management (E/M) service (code 99358) at issue was included in this initial evaluation of follow-up visit (codes 99203 - 99205 or 99213 - 99215) performed on the same DOS at issue. Thus, Applicant is entitled to code 99358 for prolonged evaluation performed on the DOS at issue.

CPT code 99358 is located in the Evaluation and Management section of the Medical Fee Schedule; and there is no Ground Rule within this chapter that prohibits a provider from separately billing for an evaluation (as defined under CPT 99214) and prolonged evaluation (OAT) (as defined under CPT code 99358).

It is pertinent to note that the section titled as "Prolonged Services (99354-99360)" in Ground Rule 8 of the Evaluation and Management Section of the Workers' Compensation Medical Fee Schedule provides: "Prolonged Provider Service without Direct (Face-to-Face) Patient Contact Use code 99358 to report the first hour and code 99359 for each additional 30 minutes. These prolonged provider services without direct patient contact may include review of extensive records and tests, and communication (other than telephone calls, 99441- 99443) with other professionals and/or the patient and family. These are beyond the usual services and include both inpatient and

outpatient settings. Report these services in addition to other services provided, including any level of EIM service.

Thus, it is evident that CPT 99358 is a separate service which cannot be bundled with any level of any other evaluation service (billed under codes 99203 - 99205 or 99213 - 99215).

The only limitation set forth in this Ground Rule is that a provider may not bill more than one "prolonged" evaluation and management service on the same date of service. In view of the fact that CPT Codes 99203 - 99205 or 99213 - 99215 are not described as a "prolonged" evaluation and management service Applicant could properly bill for both CPT Code 99203 - 99205 or 99213 - 99215 and 99358 on the same date of service.

Per the same Ground Rule 8 of the Evaluation and Management Section of the Workers' Compensation Medical Fee Schedule, CPT 99358 can be reported only once per date of service even if the time spent is not continuous. It is not disputed that CPT 99358 is reported only once per DOS. Per AMA CPT coding guidelines, CPT code 99358 is defined as: Prolonged evaluation and management service before and/or after direct (face to face) patient care; first hour.

Applicant has provided separate testing report for services reported under code 99358. This report itself indicates that the testing took one hour. It indicates on the first page, "... Your answer reflects your condition at time of your questionnaire (approximate time 1 hr)."

CPT code 99358 is defined as "Prolonged evaluation and management service before and/or after direct (face to face) patient care; first hour." The very billing of the code makes it self-evident that the service was for one hour and the billing was for the first hour only (and as stated above the summary test report also indicates this fact.)

It is pertinent to note that the need for time validation would arise only if the service had taken more than one hour and add-on code 99359 had been billed.

With regard to CPT code 76942, Ms. Kumar contends that Respondent did not use the Workers' Compensation fee schedule to arrive at the conclusion denying additional units of code 76942 billed, rather used the CPT Assistant. She argues that external data such as Medicare Policy Manual or Global Service Data or CPT Assistant is not part of New York Workers' Compensation Fee Schedule and therefore cannot be used to determine fees for NY claims.

CPT code 76942 is described as "Ultrasound guidance for needle placement (e.g., biopsy, aspiration, injection, localization device) imaging supervision and interpretation". Unlike the description of CPT code series of 20551 20552 20553 listed in NYWC fee schedule, wherein it is clearly specified that the number of injections to be reported under each code at the same session; the description of code 76942 does not prescribe any restriction for the billing of code, when ultrasound guidance is used for needle placement, imaging, supervision and interpretation while performing injection on single or multiple sites. In addition, the New York State Worker's Compensation fee schedule Radiology Ground Rules also does not put any limitation for billing multiple units of radiology codes at the same session. Of note is that Radiology Ground 3c: "For three or more parts, whether contiguous or remote, the charge shall be the greater fee plus 75% of the lesser fees" and permits billing of multiple units of radiology codes at the same session, by applying the reduction for additional units. Since the fee schedule does not bar billing of multiple units of radiology codes when performed at the same session or reference inclusiveness of these procedures in one unit, the denial of additional units is improper.

Although the Workers' Compensation Board has updated its Official New York Workers' Compensation Medical Fee Schedule, effective 4/01/2019 and has carried out several updates therein, no limitation is placed for billing multiple units of CPT 76942 when performed at the same session. Therefore, per updated fee schedule also billing multiple units of CPT 76942 is permissible for the multiple injections procedure performed at the same session, albeit reductions per Ground Rule 3 are still applicable.

A straight reading of Radiology Ground Rule 3 demonstrates that Applicant can perform and bill multiple units of radiology codes for diagnostic procedure as well as for other than diagnostic procedure when performed at the same session. Therefore, Applicant is entitled for additional units of CPT 76942 after applying reductions per Ground Rule 3c.

Applicant also submits an Outcome Assessment Testing Protocol report by Jonathan Landow, M.D. Dr. Landow notes that Outcome Assessment testing is comprehensive and requires attention to detail. It is office policy that the Outcome Assessment Test is reviewed on a date subsequent to the completion date and prior to the next scheduled visit of the patient - reason being that the time required is prohibitive of a same date review. The input of the values themselves requires detailed analysis. While the test is completed on the date of the evaluation (and, therefore, previously billed on the same date) those test results are never reviewed on the same date. The extended assessment required in the review of the results, so as to determine how treatment might be affected, is simply too complex a process to be performed during any same date evaluation.

As such, medical doctors of Macintosh analyze the results of the Patient-reported Outcome Assessment Test on a subsequent date; once those Patient-reported outcome results have been reviewed, the results are then carefully considered and utilized and any

modifications to the patient's treatment plan are made accordingly. This may include discharge, continuation of care or significant treatment changes including referrals for surgery or interventional pain management, changes in medications, etc.

Respondent submits the affidavit of Erin Luke, LPN, CPC. Ms. Luke's affidavit states, in relevant part:

CPT guidelines state, "*Codes 99358, 99359 may be used during the same session of an evaluation and management service, except office or other outpatient services (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215).*" This is because, when performed on the same service date as an office visit, such record review is inclusive to outpatient office visit Evaluation and Management codes listed above.

The Fee Schedule explicitly refers to the CPT coding Manual and Guidelines for further explanation of the codes contained within. Guideline 3 provides:

"Therefore, the appropriate level of encounter should be reported using the descriptions as outlined for explanation of E/M services in the CPT book and this fee schedule rather than the examples. For more examples, please refer to CPT guidelines."

CPT Manual E/M guidelines provide, "*Codes may be selected based upon the 1995 or the 1997 Evaluation and Management Guidelines.*" The E&M guidelines were developed to provide a standardized way of determining the level of service provided during an evaluation service. Each evaluation and management service code is broken down into 3 parts (history, exam, and medical decision making).

History is categorized into four levels, provided by Fee Schedule Ground Rule 5. In this instance, review of the submitted office note reveals that the documentation supports a chief complaint; extended history of present illness; problem-pertinent systems review extended to include limited number of additional systems; pertinent past, family, medical and/or social history directly related to the patient's problems. Such review is also known as a "Detailed Review".

Notably, most of the information listed on the Outcome Assessment questionnaire is included in the review of systems which is documented in the office visit note, including; if the patient is having pain and where it is located, the severity of the pain (current rating and "at worst" rating), how it affects daily living and the type of treatment already provided to the patient. The only information that the Outcome Assessment questionnaire provides that was not obtained by Applicant during the separately reported office visit, was that the patient had also tried PT and Chiropractic therapy.

The purpose of the review of systems is to obtain data regarding a patient's illness, from the patient. This is standard within the scope of Evaluation and Management services.

The physical Exam is also categorized into four levels. Review of the office visit note provides an extensive examination of the affected body areas and other symptomatic or related organ systems. Such exam is also known as a "Detailed Exam".

Notably, the office visit note was assessed using the 1997 Evaluation and Management Musculoskeletal evaluation guidelines to help validate the level of

service described in the fee schedule guidelines. As Applicant did not provide at least three vital signs, exam of peripheral vascular system, palpation of lymph nodes, assessment of strength, stability, and tenderness in the lower extremities, inspection of subcutaneous tissue, examination of deep tendon reflexes, and examination of sensation, the exam does not qualify as comprehensive.

Medical decision making is determined. According to the fee schedule, medical decision making refers to the complexity of establishing a diagnosis or selecting a management option) which can be measured by the number of diagnosis and management options), amount and complexity of data reviewed, and the risk of complications. The Applicant documents diagnosis of pain in the entire spine, as well as, the shoulder and hands and speculates further lumbar diagnosis with additional diagnostic testing recommended.

Review of the E&M note provides an extensive number of diagnosis and treatment options, a low level of identified risk and a minimal amount of data to review (including on the assessment of the lumbar ultrasound, which was separately reported with injections on the same day). Such service qualifies as low complexity Medical Decision making.

Notably, if review of the outcome assessment report were including in the level of E&M service, the review of such document would be included in the assessment of medical decision making. If this review was included, then the amount and complexity of data would increase to a moderate level of service.

For new patient office visits in which a detailed history, detailed exam and medical decision making of moderate complexity were performed, the fee schedule provides code 99203, defined as:

- o 99203: Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.

Therefore, even with the inclusion of the review of information provided in the outcome assessment report, Applicant would still not be entitled to the level of visit reported (99204).

Applicant has not addressed why they are unable to establish a time spent rendering such assessment when reporting a time-based service. Further, CPT guidelines explicitly directs that, "*Prolonged service of less than 30 minutes total duration on a given date, is not separately report.*" Therefore, Applicant has an obligation to show at least 30 minutes spent in order to report code 99358.

Applicant has not provided the total time spent and has provided only one patient questionnaire for review which is almost entirely duplicated in the office visit which Applicant overbilled for. This is not reasonably understood to be an extensive records review or why such review took greater than 30 minutes.

The letter authored by Dr. Landow provides information regarding the rationale and background for the questionnaire yet still does not address how much time review of the questionnaire took. Applicant attests that these reports are analyzed

and the care plan is modified accordingly to recommend discharge, continuation of current treatment plan, changes in the plan or recommendations for additional services. Dr. Landow make no notation of such recommendations other than what is noted in his office visit note and included in reimbursement.

The rationale and background provided by Dr. Landow asserts that these outcome assessment questionnaires allow patients to "directly report their feelings and functions", improving outcomes. However, the history portion of an evaluation and management visit serves this same purpose and, as previously stated, includes the same information as presented in the questionnaire.

The NYS WC FS states regarding this code, "*(t)hese prolonged physician services without direct patient contact may include review of extensive records and tests, and communication (other than telephone calls) with other professionals and/or the patient and family. These are beyond the usual services . . .*"

Considering the above, the services in dispute are not reasonably understood as beyond what is included in the usual E&M service (99204), of which Applicant over billed.

Further, this is consistent with AMA instruction regarding this code in combination with an E&M service. In the self-evaluation questionnaire, the patient answered questions such as the pain scale for specific body areas, the subjective difficulty of daily activities, and a choice of modalities that have eased pain in that body area. The use of this self-assessment is similar to such disability questionnaires as the Roland-Morris Low Back Pain and Disability Questionnaire, and the Owestry Disability Questionnaire. It is recommended by the AMA in CPT Assistant Question and Answer from November 2009 that:

"Tests of this type are not separately reported using codes 96101 - 96125 or any other CPT codes; instead, they are part of the Evaluation and Management (E/M) services provided. The tests are completed by the patient and in the public domain, so there are no additional supply costs and the provider work involved falls within the E/M services (or "evaluation" or "re-evaluation" codes for therapists), as part of the collection of information and assessment of the patient."

As such, review of the patient questionnaire does not support the reporting of code 99358 and reimbursement is not recommended. The original payment recommendation of \$148.69 remains unchanged and is recommended as full and final payment for the services in this report.

After careful consideration of the documents submitted and the parties' oral arguments at the hearing, I find in favor of Respondent. With regard CPT code 99358, I agree with Ms. Borchert and Ms. Luke that the patient questionnaire does not substantiate prolonged evaluation and management services as reported by 99358. As noted by Ms. Borchert, the patient questionnaire in this case is mostly slashed through or blank. The review of a largely blank patient questionnaire is not reasonably understood to be review of extensive records or beyond usual services as required by the fee schedule. Ms. Luke notes that most of the information listed on the questionnaire is included in the review of systems which is documented in the office visit note, including; if the patient is having pain and where it is located, the severity of the pain (current rating and "at worst"

rating), how it affects daily living and the type of treatment already provided to the patient. The only information that the Outcome Assessment questionnaire provides that was not obtained by Applicant during the separately reported office visit, was that the patient had also tried PT and Chiropractic therapy. I agree with Ms. Luke's assessment that this is not reasonably understood to be an extensive records review or why such review took greater than 30 minutes. Ms. Kumar indicates in her affidavit, which I note is not specific to the instant matter, that Applicant has provided separate testing report for services reported under code 99358 which indicates that the testing took one hour; however, the report submitted includes no such notation. Ms. Kumar also indicates that the billing is not intended to reimburse just for the patient's filling out of the OAT (Outcome Assessment Testing) rather, the services also represent "extensive record review" related to a previous evaluation and management service performed earlier. Code 99358 was used to report extended qualifying time of the billing physician and communication with other professionals and/or the patient and family. However, there is no clarification by either Ms. Kumar or Dr. Landow regarding what records were reviewed, and whether there was communication with other professionals, Assignor, or his family to substantiate billing for prolonged evaluation and management services in addition to the office visit.

With regard to the proper reimbursement for CPT code 76942, I also find in favor of Respondent. I note, that the CPT Assistant is a source which must be considered when evaluating a claim for No-Fault benefits. *See Matter of Global Liberty Ins. Co. v. McMahon*, 2019 NY Slip Op 03692 (App. Div., 1st Dept., May 9, 2019). Ms. Kumar's explanation does not meaningfully refute Respondent's interpretation, which is reasonable as the CPT Assistant specifically states that CPT code 76942 is not based on the number of injections and is only billed once. In reviewing the evidence and in accordance with the New York State Workers' Compensation Fee Schedule and CPT Assistant, I find that Applicant is entitled to reimbursement for only one unit of code 76942 in conjunction with code 20553, irrespective of how many injections were performed.

Based on the foregoing, Applicant is awarded \$148.69.

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	Amount Amended	Status
	Macintosh Medical, P.C.	08/12/20 - 08/12/20	\$1,499.13	\$944.64	Awarded: \$148.69
Total			\$1,499.13		Awarded: \$148.69

- B. The insurer shall also compute and pay the applicant interest set forth below. 11/04/2020 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

In accordance with 11 NYCRR 65-3.9(c) interest shall be paid on the claim awarded in the amount of \$148.69 from November 4, 2020, the date the arbitration was requested.

C. Attorney's Fees

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

In accordance with 11 NYCRR 65-4.6(d) the insurer shall pay Applicant an attorney's fee on the claim awarded in the amount of \$148.69.

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

05/15/2022
(Dated)

Debbie Thomas

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

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Electronically Signed

Your name: Debbie Thomas
Signed on: 05/15/2022