

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Therakinematic PT PC
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No. 17-22-1271-5596
Applicant's File No. TK0137
Insurer's Claim File No. 0405226650101164
NAIC No.

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-F.H.

1. Hearing(s) held on 03/21/2023
Declared closed by the arbitrator on 03/21/2023

Alexander Cohen from Alexander Cohen Law Group, PLLC participated virtually for the Applicant

Katherine Shepardson from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$2,792.41**, 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-F.H., a 54-year-old male, claimed injuries as a driver of a motor vehicle involved in an accident which occurred on 9/29/2021. Applicant billed for physical therapy and COVID supplies provided from 10/5/2021

through 7/18/2022. Respondent denied the claims based on a lack of medical necessity as per the results of the Independent Medical Evaluation (IME) performed by Dr. Pierce J. Ferriter, M.D., effective 3/20/2022, and the applicable fee schedule. The issues to be determined are 1) whether Respondent sustained its fee schedule defense and 2) whether the services are medically necessary?

4. Findings, Conclusions, and Basis Therefor

Applicant seeks reimbursement for physical therapy and COVID supplies. 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 held via Zoom.

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).

An insurer's unilateral decision to re-code or change a medical provider's billed CPT codes, to reimburse disputed medical services at a reduced rate, or to deny a claim in its entirety, is ineffectual when unsupported by a peer review report or by other proof setting forth a sufficiently detailed factual basis and medical rationale for the code changes, fee reductions and denials. *See Amaze Medical Supply v. Eagle Insurance Company*, 2 Misc. 3d 128A (App Term 2d and 11th Jud Dist 2003). 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 establishes 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).

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).

Analysis

Date of Service 3/14/2022

Applicant billed for physical therapy on date of service 3/14/2022 under CPT codes 97014 (\$25.40), 97010 (\$5.25), and 97124 (\$25.02). Respondent paid code 97010 in full and partially denied codes 97014 and 97124 stating, "Based on the information submitted, the procedure code has been changed to more accurately reflect the services rendered".

Respondent has not submitted any competent evidence in support of a fee schedule defense. Further, there is insufficient evidence provided for this Arbitrator to perform my own analysis of whether the Respondent's reduction is supported by the applicable fee schedule.

Thus, the Respondent has failed to submit sufficient evidence to sustain their fee schedule defense and Applicant's claim for date of service 3/14/2022 for CPT codes 97014 and 97124 (\$10.76) is granted.

CPT code 99072

For dates of service 10/5/2021 through 3/15/2022 Applicant sought reimbursement for physical therapy and COVID supplies. Respondent paid the physical therapy in full and denied the COVID supplies stating, "Reimbursement is denied. Based upon guidance received from the New York State Department of Financial Services (DFS), the New York No-Fault law does not contemplate reimbursement of Personal Protective Equipment (PPE). See OGC opinion letter 01-06-07, "No Fault Health Service Reimbursement," stating that only qualifying professional health services licensed under New York Law and provided to the claimant in the treatment of his/her injuries are reimbursable in No-Fault. Further, the New York State Worker's Compensation Fee Schedule Ground Rules state that only supplies and materials provided over and above those usually included with the office visit or other services rendered may be charged for separately" and "Pursuant to New York Physical and Occupational Therapy Fee Schedule, Ground Rule 5, a physical or occupational therapist may only use the procedure codes contained in the Physical and Occupational Therapy Fee Schedule for billing of treatment. There is no allowance for this procedure

in the New York State Worker's Compensation Fee Schedule under the provider's specialty.". Applicant seeks the unpaid balance.

Applicant seeks reimbursement for one unit of "Additional Supplies-Materials" billed under CPT code 99072 (\$24.00) per date of service.

I addressed this issue in the unrelated case of *Ponce Acupuncture, P.C. v. The Standard Fire Ins. Co.*, AAA Case No.: 17-22-1261-1149, [1/4/2023], wherein I determined in pertinent part:

Applicant is not entitled to receive any payment for the PHE supplies that were reported under CPT 99072. Arbitrator Meryem Toksoy conducted an in-depth and well-reasoned analysis into this issue in Promotion Medical Services, PC a/a/o [assignor (JG)] v. Esurance Insurance Co., assigned to AAA Case No.: 17-21-1207-8464 wherein she determined in pertinent part:

DECISION FOR	DEFENSE/ISSUE	TOTAL	RESULT
PHE SUPPLIES	FEE SCHEDULE	\$14.00	DENIED

SUMMARY

Applicant seeks to be paid \$14.00 for Public Health Emergency (PHE) supplies that were used on 04-15-21. These items were reported under CPT 99072.

On its end, Respondent asserts that the fee schedule does not allow payment for PHE supplies and that the claim should be denied.

FEE SCHEDULE UPON WHICH THE CLAIM IS TO BE EVALUATED

Pursuant to sections 5102 and 5108 of the New York Insurance Law, as well as 11 NYCRR Part 68 [Regulation 83], the claim will be evaluated according to the **2018 New York Workers' Compensation Board Medical Fee Schedule**, specifically **the revised printing edition** that went into effect on 01-01-20.

ADDITIONAL SOURCES USED TO ADDRESS THE ISSUE

The CPT code set was developed, and is maintained, by the AMA.

The "**CPT book**"(which is referenced in the Introduction & General Guidelines of the Workers' Compensation Medical Fee Schedule) is published by the AMA on an annual basis. The title of the book is "CPT [year] Professional Edition." This source provides detailed information about CPT codes, and it includes guidelines.

CPT Assistant is a monthly newsletter authored and published by the AMA. It is a source which must be considered when evaluating a claim for No-Fault benefits. Matter of Global Liberty Ins. Co. v. McMahon, 172 AD3d 500, 2019 NY Slip Op 03692 (App. Div., First Dept., May 9, 2019).

CODE DESCRIPTION FOR CPT 99072

CODE	DESCRIPTION
99072	(This code went into effect on 09-08-20.) Additional supplies, materials and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency [PHE] as defined by law, due to respiratory-transmitted infectious disease.

HOW A PUBLIC HEALTH EMERGENCY IS DECLARED IN NEW YORK: BY EXECUTIVE ORDER OF THE GOVERNOR

Executive Law

Article 2-B (State and Local Natural and Man-Made Disaster Preparedness)

Section 28 (State declaration of disaster emergency)

(1) Whenever the governor, on his own initiative or pursuant to a request from one or more chief executives, finds that a disaster has occurred or may be imminent for which local governments are unable to respond adequately, he shall declare a disaster emergency by executive order.

(2) Upon declaration of a disaster arising from a radiological accident, the governor or his designee, shall direct one or more chief executives and emergency services organizations to:

(a) notify the public that an emergency exists; and

(b) take appropriate protective actions pursuant to the radiological emergency preparedness plan approved pursuant to sections twenty-two and twenty-three of this article. The governor, or his designee, shall also have authority to direct that other actions be taken by such chief executives pursuant to their authority under section twenty-four of this article.

(3) The executive order shall include a description of the disaster, and the affected area. Such order or orders shall remain in effect for a period not to exceed six months or until rescinded by the governor, whichever occurs first. The governor may issue additional orders to extend the state disaster emergency for additional periods not to exceed six months.

(4) Whenever the governor shall find that a disaster is of such severity and magnitude that effective response is beyond the capabilities of the state and the affected jurisdictions, he shall make an appropriate request for federal assistance available under federal law, and may make available out of any funds provided under the governmental emergency fund or such other funds as may be available, sufficient funds to provide the required state share of grants made under any federal program for meeting disaster related expenses including those available to individuals and families.

(5) The legislature may terminate at any time a state disaster emergency issued under this section by concurrent resolution.

EXECUTIVE ORDERS (EOs) WHICH DECLARE A PUBLIC HEALTH EMERGENCY (PHE) DUE TO COVID-19

GOVERNOR ANDREW CUOMO (in office from 01-01-11 to 08-23-21)

EO NO.	DATE ISSUED	TITLE OF ORDER(S)
202	03-07-20	Declaring a Disaster Emergency in the State of New York
202.1 to 202.87	03-12-20 to 12-30-20	Continuing Temporary Suspension and Modification of Laws Relating to the Disaster Emergency
202.88 to 202.111	01-04-21 to 06-15-21	Continuing Temporary Suspension and Modification of Laws Relating to the Disaster Emergency
205	06-24-20	

		Quarantine Restrictions on Travelers Arriving in New York
205.1 to 205.3	09-28-20 to 12-30-20	Quarantine Restrictions on Travelers Arriving in New York
210	06-24-21	Expiration of Executive Orders 202 and 205 (All of the Executive Orders under 202 and 205 were rescinded effective 06-25-21.)

Note: Since Governor Cuomo issued more than 100 executive orders under No. 202, it would not be feasible to list each one. Therefore, a range is given based on the year when they were issued.

GOVERNOR KATHLEEN HOCHUL (in office from 08-24-21 to present)

EO NO.	DATE ISSUED	TITLE OF ORDER(S)
11	11-26-21	Declaring a Disaster Emergency in the State of New York
11.1	12-26-21	Continuing Temporary Suspension and Modification of Laws Relating to the Disaster Emergency
11.2	01-15-22	
11.3	02-14-22	
11.4	03-16-22	(Executive Order No. 11.9 expired on 09-12-22.)
11.5	04-15-22	
11.6	05-15-22	

11.7	06-14-22
11.8	07-14-22
11.9	08-13-22

DECISION

Applicant seeks to be paid for PHE supplies that were used on 04-15-21 and which were bill reported with CPT code 99072. At this point in time, the following executive orders by Governor Cuomo were in effect:

202.97

202.98

202.99

202.99

202.100

202.101

While the orders under No. 202 declare a Public Health Emergency (PHE) due to the spread of a respiratory disease (Covid-19), the fact remains that there is no legal support to render the supplies eligible for payment.

For the reasons outlined below, I find in Respondent's favor.

THERE IS NO PROVISION WITHIN ANY FEE SCHEDULE THAT LENDS ITSELF TO A PROVIDER GETTING PAID FOR PHE SUPPLIES

The Workers' Compensation Board did not amend any of its fee schedules to account for PHE supplies. It did, however, take such steps for telemedicine. On 03-16-20, the Board announced that it had modified 12 NYCRR 325-1.8, 329-1.3, 329-4.2, 333.2, and 348.2. All of these provisions were amended in order for the service to be payable. Since this was done on an emergency basis, the amendments would only be in effect for a period of 90 days. Instead of letting them expire, the Board decided to continue down the same path. Through ten subsequent adoptions, all by emergency rule making, it kept the service in place. (The most recent adoption went into effect on 07-12-22.) The reason why telemedicine has remained on the books for over two and a half years, and why it is likely to become a permanent fixture, is due to Covid-19:

This amendment is adopted as an emergency measure because the Board wants to avoid health and safety risks that can be avoided through social distancing due to COVID-19, including new variants, by allowing telemedicine in some circumstances, and to supersede the previous emergency adoption addressing this topic. Additionally, the Board has seen these emergency measures work efficiently and effectively to provide care for injured workers and plans to adopt a permanent regulation addressing when telehealth may be used to benefit injured workers, and wants to keep the current telemedicine rules in effect during the regulatory process for the permanent telehealth proposal.

To put all of this into perspective:

On 03-07-20, Governor Cuomo responded to the threat posed by this disease.

That day, **hesigned Executive Order No. 202**(Declaring a DisasterEmergency in the State of New York). **Just 9 days later, on 03-16-20, the Board made telemedicine a payable service.**

When the AMA established the code for PHE supplies on 09-08-20, the Board could have taken a similar measure. It chose not to.

On 11-26-21, Governor Hochul signed Executive Order No. 11(Declaring a Disaster Emergency in the State of New York). **It was in response to Covid-19;** due to the Omicron variant, the rate of transmission was hitting levels that had not been seen since the beginning of the pandemic. Considering the health and safety risks involved, **the Board could have taken the step to allow for the payment of PHE supplies. It chose not to.**

Governor Hochul would go on to issue 9 more orders because of Covid-19. The most recent (and final) one was signed on 08-13-22 (No. 11.9). Deciding not to renew the declaration, Governor Hochul let it lapse. As a result, **on 09-12-12, the order expired,** effectively bringing an end to the disaster emergency.

During this time frame - a period spanning over 9 1/2 months - the Board could have acted. Again, it chose not to.

WHY AN APPLICANT'S CLAIM IS NOT HELPED BY 11 NYCRR 68.5

The date of service for which the Applicant seeks to be reimbursed is 04-15-21. At this point in time, there were executive orders by Governor Cuomo that were in effect due to Covid-19, namely EO Nos. 202.97 to 202.101.

Up to this date, the Workers' Compensation Board has not modified any of its fee schedules so that CPT 99072 could be eligible for payment.

Taking stock of this fact, Applicant may argue that there is still a pathway to reimbursement. Turning the focus to 11 NYCRR 68.5, Applicant may assert that if an insurer receives a claim for PHE supplies, it does not have

the option of denying the bill, that a provider who has met the criteria for CPT 99072 is entitled to payment.

Presumably, the steps leading to this conclusion would go as follows:

Section 5102 (a)(1) of the Insurance Law describes the services which are recoverable under the policy.

11 NYCRR 68.5 is framed around this statute; the purpose of the regulation is to account for services that are not listed in any fee schedule.

The Workers' Compensation Board allows payment for CPT 99070, which is another code used to report supplies.

CPT 99070 and 99072 have similar descriptions. A comparison can be drawn between them.

If CPT 99070 is reimbursable, then CPT 99072 must be as well.

This argument can be dismantled. **Section 5102:**

(a) "Basic economic loss" means, up to fifty thousand dollars per person of the following combined items, subject to the limitations of section [5108] of this article:

(1) All necessary expenses incurred for: (i) medical, hospital (including services rendered in compliance with article forty-one of the public health law, whether or not such services are rendered directly by a hospital), surgical, nursing, dental, ambulance, x-ray, prescription drug and prosthetic services;

(ii) psychiatric, physical therapy (provided that treatment is rendered pursuant to a referral) and occupational therapy and rehabilitation;

(iii) any non-medical remedial care and treatment rendered in accordance with a religious method of healing recognized by the laws of this state; and

(iv) any other professional health services; all without limitation as to time, provided that within one year after the date of the accident causing the injury it is ascertainable that further expenses may be incurred as a result of the injury. For the purpose of determining basic economic loss, the expenses incurred under this paragraph shall be in accordance with the limitations of section [5108] of this article.

Section 5108:

(a) The charges for services specified in [section 5102 (a)(1)] of this article and any further health service charges which are incurred as a result of the injury and which are in excess of basic economic loss, 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.

(b) The superintendent, after consulting with the chairman of the workers' compensation board and the commissioner of health, shall promulgate rules and regulations implementing and coordinating the provisions of this article and the workers' compensation law with respect to charges for the professional health services specified in [section 5102 (a)(1)] of this article, including the establishment of schedules for all such services for which schedules have not been prepared and established by the chairman of the workers' compensation board.

(c) No provider of health services specified in [section 5102 (a)(1)] of this article may demand or request any payment in addition to the charges authorized pursuant to this section. Every insurer shall report to the commissioner of health any patterns of overcharging, excessive treatment or other improper actions by a health provider within thirty days after such insurer has knowledge of such pattern.

Section 5102 (a)(1) defines the scope of coverage for No-Fault benefits.

Section 5108, which it refers to, sets the conditions, limiting how a service may be billed and the amount that is recoverable.

The statutes are interlinked and cannot be teased apart. They must be read together.

This is reflected in 11 NYCRR 68.5.

Section 68.5 (Health services not set forth in schedules)

If a professional health service is performed which is reimbursable under section 5102(a)(1) of the Insurance Law, but is not set forth in fee schedules adopted or established by the superintendent, and:

(a) if the superintendent has adopted or established a fee schedule applicable to the provider, then the provider shall establish a fee or unit value consistent with other fees or unit values for comparable procedures shown in such schedule, subject to review by the insurer; or

(b) if the superintendent has not adopted or established a fee schedule applicable to the provider, then the permissible charge for such service shall be the prevailing fee in the geographic location of the provider subject to review by the insurer for consistency with charges permissible for similar procedures under schedules already adopted or established by the superintendent.

Both of these provisions lead to the fee schedule. In order for the service to be eligible for payment, there needs to be a reference point within this source, i.e., a similar service, a procedure that is comparable to the provider's claim.

For an applicant seeking to recover the cost of PHE supplies, it would look as though CPT 99070 fits the bill, so to speak.

It does not.

The description for CPT 99072 is markedly different than what is shown for CPT 99070. They are not approximate to each other.

The articles published by the AMA bear this out.

CODE	DESCRIPTION
99070	Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)
99072	Additional supplies, materials and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency [PHE] as defined by law, due to respiratory-transmitted infectious disease.

CPT Assistant, *New Covid-19 Pandemic Supply Code 99072*, January 2021 newsletter, page 6: [excerpt]

REPORTING CODE 99072

Code 99072 represents a new practice expense code specifically intended for use during a declared PHE, as defined by law, due to arespiratory-transmitted infectious disease. It was established in

response to the significant additional practice expenses related to in-personactivities required to provide medical visits or services to patients safely during a PHE.

Code 99072 was designed to capture the followingpractice-expense components over and above those usually included with an office visit or other services rendered:

Additional clinical staff time(registered nurse [RN]/licensed practicalnurse [LPN]/medical technical assistant [MTA]) to conduct a pre-visit phone call to screen the patient (symptom check), provide instructions on social distancing during the visit, check patients for symptoms upon arrival, apply and remove PPE, and perform additional cleaning of the examination/procedure/imaging rooms, equipment, and supplies;

Three surgical masks; and

Additional supplies, including additional quantities of hand sanitizer and disinfecting wipes, sprays, and cleansers.

Code 99072 should only be reported when the service is rendered in a non-facility place of service (POS) setting, and in an area where it is required to mitigate the transmission of the respiratory disease for which the PHE was declared. A comprehensive list of POS codes and their facility/non-facility designations are available at:

https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Servi

In contrast to code 99070, Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided), code 99072 is reported only during a PHE and only for additional items required to support a safe in-person provision of evaluation, treatment, or procedural service(s). These items differ significantly from those items that are typically reported with code 99070, which focus on additional supplies provided over and above those usually included with a specific non-PHE service, such as drugs, intravenous (IV) catheters, or trays. In addition, code 99072 is meant to account for and capture the additional time required by clinical staff to provide their services safely.

To ensure that code 99070 is not used incorrectly to report time and supplies during a PHE, a parenthetical note was added after code 99070 to direct users to code 99072 when the required use of additional supplies, materials, and preparation time are related to a PHE, as defined by law, due to a respiratory-transmitted infectious disease.

Code 99072 should be reported only once per in-person patient encounter per provider identification number (PIN), regardless of the number of services rendered at that encounter. In instances in which these noted clinical staff activities are performed by a physician or other qualified healthcare professional (eg, in practice environments without clinical staff or a shortage of available staff), the activity requirements of this code would be considered as having been met; however, the time spent on these activities should not be counted in any other time-based visit or service reported during the same encounter.

QUESTIONS AND ANSWERS

Question: Code 99072 is stated as being applicable "during a PHE." What information should be used to verify when a PHE is in effect?

Answer: A PHE is in effect when declared by law by officially designated relevant public health authority(ies).

Question: *For what type of patient encounter or services should code 99072 be reported?*

Answer: *Code 99072 may be reported for an in-person patient encounter for an office visit or other non-facility service, in which the implemented guidelines related to mitigating the transmission of the respiratory disease for which the PHE was declared are required. Usage of this code is not dependent on a specific patient diagnosis. For a list of POS codes with facility or non-facility designations, visit:*

[https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place of Servi](https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Servi)

Question: *What documentation is required to report code 99072?*

Answer: *Given that code 99072 may only be reported during a PHE, do not report this code in conjunction with an evaluation and management (E/M) service or procedure when a PHE is not in effect. Therefore, code 99072 is reported only when health and safety conditions applicable to a PHE require the type of supplies and additional clinical staff time explained in the code descriptor. Documentation requirements may vary among third-party payers; therefore, contact the specific third-party payers for their documentation requirements.*

CPT Assistant, 13: [excerpt] *Frequently Asked Questions*, February 2021 newsletter, page

Medicine: Miscellaneous Medicine Services

Question: *May new code 99072 be reported by physicians and other QHPs?*

Answer: *Yes, both physicians and other QHPs, such as optometrists, may report new code 99072, Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed **during a Public Health Emergency (PHE) as defined by law**, due to respiratory-transmitted infectious disease, when additional practice expenses are incurred during a PHE. "Other QHP" is defined as an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable), who performs a professional service within his or her scope of practice and independently reports that professional service (eg, NP, PA, optometrist, social worker, PT). Per CPT Assistant Special Edition: September Update (2020), "Code 99072 is to be reported only once per in-person patient encounter per provider identification number (PIN), regardless of the number of services rendered at that encounter. In the instance in which the noted clinical staff activities are performed by a physician or other qualified health care professional (eg, in practice environments without clinical staff or a shortage of available staff), the activity requirements of this code would be considered as having been met."*

CIRCULAR LETTER NO. 14 FROM THE DEPARTMENT OF FINANCIAL SERVICES (DFS)

Insurance Circular Letter No. 14 (2020)

August 5, 2020

TO: All Insurers Authorized to Write Accident and Health Insurance in New York State, Article 43 Corporations, Health Maintenance Organizations, Student Health Plans Certified Pursuant to Insurance Law § 1124, Municipal Cooperative Health Benefit Plans and Prepaid Health Services Plans

RE: Charges for Personal Protective Equipment by Participating Providers

STATUTORY AND REGULATORY REFERENCES: N.Y. Insurance Law

§§ 2601, 3217-a, 3221, 4305, and 4324; N.Y. Public Health Law § 4408; 11 NYCRR 52 (Insurance Regulation 62)

I. Purpose

After a period of offering primarily telehealth visits during the COVID-19 pandemic, many physicians, dentists, and other health care providers (collectively, "providers") have resumed seeing patients in person. As COVID-19 transmission poses a risk in provider office settings, providers are putting necessary protective measures in place, including sanitizing exam rooms and using personal protective equipment, such as masks, gowns, and gloves (collectively, "PPE"). The Department of Financial Services ("Department") has recently received complaints regarding participating providers charging insureds fees for the providers' use of PPE during in-person visits for covered services under health insurance policies or contracts. These fees for PPE are in addition to the insureds' cost-sharing for covered services.

This circular letter reminds insurers authorized to write accident and health insurance in New York State, Article 43 corporations, health maintenance organizations, student health plans certified pursuant to Insurance Law § 1124, municipal cooperative health benefit plans, and prepaid health services plans (collectively, "issuers") that they should ensure that insureds are not charged fees by participating providers for covered services that go beyond the insureds' financial responsibility as described in the insureds' policies or contracts.

II. Discussion

Insurance Law §§ 3221(a)(6) and 4305(a) require issuers to issue to the group policyholder or contract holder, for delivery to each member of the group, a certificate setting forth in summary form the essential features of the insurance coverage. Furthermore, Insurance Law §§ 3217-a(a)(5) and 4324(a)(5) and Public Health Law § 4408(1)(e) require issuers to disclose in the policy or contract, or through a separate disclosure statement, an explanation of an insured's financial responsibility for payment of premiums, coinsurance, co-payments, deductibles, and any other charges, annual limits on an insured's financial responsibility, caps on payments for covered services, and financial responsibility for non-covered health care procedures, treatments, or services.^[1] Furthermore, to assist consumers in New York State to better understand and evaluate the benefits provided in policies or contracts, issuers must make a full and fair disclosure of policy or contract benefits pursuant to 11 NYCRR §§ 52.1(d) and 52.54. These sections of the Insurance Law and regulations and the Public Health Law clearly require issuers to disclose the insured's financial responsibility for covered services, including any other charges, and such disclosure should be made for medical and dental coverage.

*The Department has been made aware that participating providers, particularly under dental insurance policies or contracts, are charging insureds fees at the time of in-person visits for PPE or other charges related to increased costs due to COVID-19 that are in addition to the insureds' cost-sharing for such covered services. A provider who participates with an issuer's provider network has agreed to accept a reimbursement amount from the issuer for covered services, with the insured responsible for the cost-sharing set forth in the insured's health or dental insurance policy or contract. **A participating provider should not charge the insured fees or other charges in addition to the insured's financial responsibility for covered services. In addition, the Department does not approve policy or contract provisions that hold the insured responsible for the cost of a participating provider's PPE.***

*Accordingly, issuers should ensure that their participating providers are not charging insureds any fees or other charges beyond the insureds' financial responsibility for covered services as set forth in the insureds' health or dental insurance policies or contracts. **Issuers should immediately notify participating providers that they should not charge insureds fees that are beyond the insureds' financial responsibility for covered services, such as fees for PPE, and issuers should instruct participating providers to refund any such fees to insureds. In addition, issuers should notify insureds that they should not be charged fees for PPE***when visiting a participating provider and include the issuer's contact information for insureds to submit a complaint regarding PPE charges. Issuers should resolve any issues regarding increased costs due to COVID-19 directly with their participating providers, including for PPE, and insureds should be held harmless for such charges. In order to facilitate resolution, issuers may need to request information from participating providers regarding insureds who were charged fees that

exceeded their financial responsibility, and participating providers should report such information to issuers, upon request by issuers. Issuers should work with participating providers to ensure that refunds are provided to insureds. Within 90 days of this circular letter, issuers should report to the Department, at the e-mail address below, the amount of PPE fees that were charged to insureds, the number of insureds impacted, and provide a description of how refunds will be provided.

III. Conclusion

Issuers should ensure that insureds are not charged fees by participating providers for covered services that go beyond the insureds' financial responsibility as described in the insureds' policies or contracts. In the event an insured has paid such a fee, an issuer should resolve the issue for the insured with its participating provider. The Department will monitor compliance with these requirements, including during market conduct exams. The Department may take action at any time against an issuer for failing to adhere to the requirements of this circular letter.

Please direct any questions regarding this circular letter by email to health@dfs.ny.gov.

Very truly yours,

*Lisette
Johnson
Chief, Health
Bureau
NYCRR*

WHERE TO FIND EXECUTIVE

ORDERS 9NYCRR

Part 8: Executive Orders for Gov. Andrew
Cuomo Part 9: Executive Orders for Gov.
Kathleen Hochul

See also:

<https://www.governor.ny.gov/executiveorders>

ADDITIONAL SOURCES/WEBSITES

DFS Circular Letters:

https://www.dfs.ny.gov/industry_guidance/circular_letters

DFS Opinion Letters:

https://www.dfs.ny.gov/industry_guidance/interpretations_and_opinions

DFS Insurance Regulations Adopted on an Emergency Basis:

https://www.dfs.ny.gov/industry_guidance/regulations/emergency_insurance

DFS No-Fault Resources:

https://www.dfs.ny.gov/apps_and_licensing/property_insurers/nofault

NY WCB Board Bulletins and Subject Numbers:

<http://www.wcb.ny.gov/content/main/SubjectNos/subjectNos.jsp>

NY State Register:

<https://dos.ny.gov/state-register>

See also General Ground Rule 7 in the 2019 New York Workers' Compensation Board Acupuncture Fee Schedule, specifically the edition that went into effect on 01-01-20.

The services in dispute in this case are in the year 2021 and 2022, i.e., 10/5/2021 through 3/15/2022. After thorough review I concur with and adopt Arbitrator Toksoy's reasoning and agree that Applicant is not entitled to reimbursement for CPT code 99072. Applicant's claim for CPT code 99072 is denied.

Legal Standards for Determining Medical Necessity

Once applicant has established a prima facie case, the burden then shifts to respondent to establish a lack of medical necessity with respect to the benefits sought. *See, Citywide Social Work & Psychological Services, PLLC v. Allstate Ins. Co.*, 8 Misc3d 1025A (2005). A denial premised on lack of medical necessity must be supported by competent evidence such as an IME, peer review or other proof which sets forth a factual basis and medical rationale for denying the claim. *See, Healing Hands Chiropractic, P.C. v. Nationwide Assur. Co.*, 5 Misc3d 975 (2004).

In evaluating the medical necessity of services with proof of each party, particularly where the conclusion is contradictory; consideration must be given to the evidentiary burdens. Respondent must prove first that the services were not medically necessary. The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment. *Kingsborough Jewish Med. Ctr. v. All State Ins. Co.*, 61 A.D. 3d 13 (2d. Dep't, 2009), *See also Channel Chiropractic PC v. Country Wide Ins. Co.*, 38 AD 3d 294 (1st Dep't, 2007). An IME doctor must establish a factual basis and medical rationale for his asserted lack of medical necessity for future health care services. *E.g., Ying Eastern Acupuncture, P.C. v. Global Liberty Insurance*, 20 Misc.3d 144(A), (App. Term 2d & 11th Dists. Sept. 3, 2008). Where the defendant insurer presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden shifts to the plaintiff which must then present its own evidence of medical necessity. *West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co.*, 13

Misc.3d 4(App. Term 2d & 11th Dists. Sept. 29, 2006). For an applicant to prove that the disputed expense was medically necessary, it must meaningfully refer to, or rebut, respondent's evidence. *See, Yklik, Inc. v. Geico Ins. Co.*, 28 Misc3d 133A (2010). The case law is clear that a provider must rebut the conclusions and determinations of the IME doctor with his own facts. Moreover, the Appellate Term, 2d, 11th & 13th Dists., stated: "Assuming the insurer is successful in satisfying its burden, it is ultimately plaintiff who must prove, by a preponderance of the evidence, that the services or supplies were medically necessary." *Park Slope Medical and Surgical Supply, Inc. v. Travelers Ins. Co.*, 37 Misc.3d 19, 22 (App. Term 2d, 11th & 13th Dists. 2012). Where an IME report provides a factual basis and medical rationale for an opinion that services were not medically necessary, and the claimant fails to present any evidence to refute that showing, the claim should be denied, as the ultimate burden of proof on the issue of medical necessity lies with the claimant. *See Insurance Law § 5102; AJS Chiropractic, P.C. v. Mercury Ins. Co.*, 22 Misc.3d 133(A), (App. Term 2d & 11th Dist. Feb. 9, 2002); *Wagner v. Baird*, 208 A.D.2d 1087 (3d Dept. 1994).

Application of Legal Standards

I note the validity of denials based upon negative IME findings have been recognized by several Courts. *See e.g. Innovative Chiropractics P.C. v. Mercury Ins. Co.*, 25 Misc3d 137 (App. Term 2d & 11th Dists. 2009); *B.Y. M.D., P.C. v. Progressive Casualty Ins. Co.*, 26 Misc3d 125 (App. Term 9th & 10th Dists. 2010). An IME report can be the basis of a termination of benefits if ultimately found to be persuasive. Whether an IME report is persuasive, and meets the carrier's burden is a factual decision, which must be rendered on a case-by-case basis. Therefore, when, as here, an insurer interposes a timely denial of claim that sets forth a sufficiently detailed factual basis and adequate medical rationale for the claim's rejection, the presumption of medical necessity and causality attached to the applicant's properly completed claim is rebutted and the burden shifts back to the claimant to refute the IME findings and prove the necessity of the disputed services and the causal relationship between the injuries and the accident. *See, CPT Med. Servs., P.C. v. New York Cent. Mut. Fire Ins. Co.*, 18 Misc.3d 87 (App. Term 1st Dept.); *A.Khodadadi Radiology, P.C. v. NY Cent. Mut. Fire Ins. Co.*, 16 Misc. 3d. 131 (A) (App Term 2d Dept.).

In support of its contention that further treatment was not medically necessary Respondent relies upon the orthopedic examination report of Pierce J. Ferriter, M.D., which was conducted on 3/7/2022. A review of the examination report reveals all tests were objectively negative. Range of motion was full. Neurological testing was within normal limits. Orthopedic testing was negative. Dr. Ferriter diagnosed all injuries as resolved. Based upon Dr. Ferriter's examination, all orthopedic No-fault benefits were denied effective 3/20/2022.

In this matter, I am faced with conflicting opinions concerning the medical necessity for the treatment. There are no legal issues to resolve. This dispute involves solely an issue of fact, that is, whether the services billed was medically necessary. Resolution of that fact is determined by which opinion is accepted by the trier of fact.

I find the report for the IME conducted by Pierce J. Ferriter, M.D. on 3/7/2022 to be sufficient for the purpose of establishing Respondent's defense. The report adequately sets forth the factual basis and medical rationale to support the conclusion that the Assignor was not in need of any further treatment. That being so, the burden shifts to the Applicant to counter Respondent's showing.

Having carefully reviewed all the evidence I find that Applicant has failed to rebut Dr. Ferriter's assessment and has not succeeded in demonstrating that the claimed services were necessary for the Assignor. Applicant relies on examinations by Glenn Calubaquib, PT, DPT, dated 10/5/2021 and 4/7/2022, along with SOAP notes for the physical therapy treatment dates.

These documents do not serve to overcome the IME and failed to support continued orthopedic treatment. The IME is more detailed and comprehensive than the Applicant's records. While these records memorialize the Assignor's continuing complaints of pain and provide some insight into his condition, the information is limited, and not as comprehensive as the findings noted within the IME report. I find Respondent's IME report more detailed, thorough, and credible than Applicant's one-page physical therapy re-examination report, dated 4/7/2022, which briefly notes the claimant's complaints, difficulty with activities of daily living, pain scale, range of motion and manual muscle testing is within normal limits, tenderness to palpation, and a plan to continue physical therapy treatment. There are no physical therapy examination reports between 10/5/2021 and 4/7/2022 or after 4/7/2022 in the record.

Applicant is not free to provide services indefinitely without demonstrating medical necessity for the treatment. Since Dr. Ferriter's IME report presented sufficient evidence to establish Respondent's defense of lack of medical necessity, the burden shifted to Applicant to demonstrate medical necessity. *See A. Khodadadi Radiology, P.C. v. NY Central Mutual Fire Ins. Co.*, 16 Misc.3d 131 (A), 2007 N.Y. Slip Op. 51342(U) (App. Term 2d & 11 Dist. 2007) 13th; *West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co.*, Misc.3d 131 (A), 2006 N.Y. Slip Op. 51871(U) (App. Term 2d & 11 Dist. 2006). I find that Applicant failed to satisfy its burden. Therefore, I find that Respondent properly denied Applicant's claim.

Accordingly, in balancing the two positions, I find that the more credible and persuasive proof on the issue of medical necessity resides with the Respondent. Applicant's claim, denied premised upon the IME of Dr. Ferriter, is denied.

CONCLUSION

Accordingly, Applicant's claim is granted in the amount of \$10.76. 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
	Therakinematic PT PC	10/05/21 - 10/11/21	\$72.00	Denied
	Therakinematic PT PC	10/13/21 - 10/13/21	\$24.00	Denied
	Therakinematic PT PC	10/20/21 - 10/20/21	\$24.00	Denied
	Therakinematic PT PC	10/29/21 - 10/29/21	\$24.00	Denied
	Therakinematic PT PC	11/10/21 - 11/15/21	\$48.00	Denied
	Therakinematic PT PC	11/17/21 - 11/17/21	\$24.00	Denied
	Therakinematic PT PC	11/22/21 - 11/22/21	\$24.00	Denied
	Therakinematic PT PC	11/24/21 - 11/24/21	\$24.00	Denied

	Therakinematic PT PC	12/10/21 - 12/14/21	\$48.00	Denied
	Therakinematic PT PC	12/19/21 - 12/23/21	\$48.00	Denied
	Therakinematic PT PC	01/03/22 - 01/03/22	\$24.00	Denied
	Therakinematic PT PC	01/10/22 - 01/16/22	\$48.00	Denied
	Therakinematic PT PC	01/12/22 - 01/12/22	\$24.00	Denied
	Therakinematic PT PC	01/19/22 - 01/19/22	\$24.00	Denied
	Therakinematic PT PC	01/25/22 - 02/06/22	\$72.00	Denied
	Therakinematic PT PC	02/09/22 - 02/14/22	\$48.00	Denied
	Therakinematic PT PC	02/17/22 - 02/27/22	\$120.00	Denied
	Therakinematic PT PC	02/28/22 - 02/28/22	\$24.00	Denied
	Therakinematic PT PC	03/07/22 - 03/07/22	\$24.00	Denied
	Therakinematic PT PC	03/14/22 - 03/14/22	\$34.76	Awarded: \$10.76
	Therakinematic PT PC	03/15/22 - 03/29/22	\$103.67	Denied
	Therakinematic PT PC	04/07/22 - 04/18/22	\$436.55	Denied
	Therakinematic PT PC	04/25/22 - 05/05/22	\$159.34	Denied
	Therakinematic PT PC	04/27/22 - 04/27/22	\$79.67	Denied
	Therakinematic	05/11/22 -		

	c PT PC	05/11/22	\$79.67	Denied
	Therakinemati c PT PC	05/18/22 - 05/26/22	\$239.01	Denied
	Therakinemati c PT PC	06/06/22 - 06/06/22	\$79.67	Denied
	Therakinemati c PT PC	06/09/22 - 06/09/22	\$79.67	Denied
	Therakinemati c PT PC	06/14/22 - 06/14/22	\$79.67	Denied
	Therakinemati c PT PC	06/16/22 - 06/29/22	\$398.35	Denied
	Therakinemati c PT PC	07/05/22 - 07/05/22	\$79.67	Denied
	Therakinemati c PT PC	07/11/22 - 07/18/22	\$174.71	Denied
Total			\$2,792.41	Awarded: \$10.76

- B. The insurer shall also compute and pay the applicant interest set forth below. 10/24/2022 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 NY

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.

04/19/2023
(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:
30def38465b22bbe6ec0054194c67dea

Electronically Signed

Your name: Eileen Hennessy
Signed on: 04/19/2023