American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

RES Physical Medicine & Rehab Services (Applicant)	AAA Case No.	17-22-1266-4956
	Applicant's File No.	22-40214
- and -	Insurer's Claim File No.	0571929736 2BE
Allstate Fire & Casualty Insurance Company (Respondent)	NAIC No.	29688

ARBITRATION AWARD

I, Evelina Miller, the undersigned arbitrator, designated by the American Arbitration Association pursuant to the Rules for New York State No-Fault Arbitration, adopted pursuant to regulations promulgated by the Superintendent of Insurance, having been duly sworn, and having heard the proofs and allegations of the parties make the following **AWARD:**

Injured Person(s) hereinafter referred to as: JLL

1. Hearing(s) held on 05/08/2023
   Declared closed by the arbitrator on 05/08/2023

   Nicole Jones Esq from The Morris Law Firm, P.C. participated virtually for the Applicant

   Chloe McKinzie Esq from Law Offices of John Trop participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$14.12**, was NOT AMENDED at the oral hearing.
   Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

   The dispute arises from the underlying automobile accident on November 12, 2019, in which the Assignor (JLL), a 33-year-old female was involved. Thereafter, Assignor sought private medical attention and was eventually evaluated by Applicant with complaints of headaches, neck pain, middle back pain and lower back pain. Eventually patient was recommended to undergo conservative care including office visits. The bill in dispute is for an office visit performed on 6/30/22. Respondent partially paid and partially denied Applicant's bill for date of service of 6/30/22 based on the New York Workers' Compensation Fee Schedule.

The issue presented at the hearing is whether Respondent reached its burden of coming forward with competent evidentiary proof to support its fee schedule defenses.

4. Findings, Conclusions, and Basis Therefor

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

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

FEE SCHEDULE;

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

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

Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. See, *Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 2006 NY Slip 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006)*. If Respondent fails to demonstrate by competent evidentiary proof that a plaintiff's claims were in excess of the appropriate fee schedules, defendant's defense of noncompliance with the appropriate fee schedules cannot be sustained. See, *Continental Medical PC v. Travelers Indemnity Co., 11 Misc.3d 145A, 819 N.Y.S.2d 847, 2006 NY Slip Op 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Term, 1st Dep't, per curiam, 2006).*

Effective April 1, 2013, 11 NYCRR 65-3.8(g)(1) has been amended so that the application of the New York State Worker's Compensation fee schedule is no longer a precludable defense and no payment is due on those claims in excess of the fee

schedule. Per 11 NYCRR 65-3.8(g), where the services were rendered after April 1, 2013, a defense of excessive fees is not subject to preclusion *Surgicare Surgical Associates v. National Interstate Ins. Co.*, Misc.3d,N.Y.S.3d, 2015 N.Y. Slip Op. 25338 (App. Term 1st Dept. Oct. 8, 2015), aff'g, 46 Misc.3d 736, 997 N.Y.S.2d 296 (Civ. Ct. Bronx Co. 2014) (New Jersey fee schedule). The insurer is entitled to reduce the bills to the proper fee schedule amount.

Modifier 1B

Applicant billed for office visits with CPT code 99213 (1D) in the amount of $84.72 for office visit performed on 6/30/22. Respondent contends that Applicant improperly billed for services using modifier (1D), not reimbursable under No-Fault. Respondent contends that Applicant is entitled to reimbursement in the amount of $70.60.

I am permitted to take judicial notice of the New York Workers' Compensation Fee Schedule.

Modifier 1B under the New York State Worker's Compensation Behavioral Health fee schedule ground rules permits a provider to an enhanced reimbursement increase of 20% for these CPT codes when rendered by licensed clinical social workers and providers with specific Worker's Compensation board rating codes enumerated in the schedule. As such, it appears that based on the ground rules the Applicant would be entitled to 20% enhanced reimbursement for these CPT codes.

However, Respondent's counsel contends that the Superintendent of Financial services when adopting the New York State Worker's Compensation fee schedule for reimbursement of no-fault services for the dates these services were rendered specifically excluded enhanced reimbursement for providers in no-fault.

Modifier 1B - is Behavioral Health Provider Enhanced Reimbursement. It provides a 20 percent reimbursement increase for ELM and medicine services when rendered by providers with the following WCB assigned provider rating codes: PN-P (Psychiatry), PN-ADP (Addiction Psychiatry), PN-PM (Pain Management), and PSY (Psychology).

Modifier 1D - Designated Provider Enhanced Reimbursement. In an effort to increase the number of Board authorized providers in genera medicine (Family Practice, General Practice and Internal Medicine) specialties available to render care and treatment to injured workers, the WCB has established WCB specific modifier 1D which will provide a 20 percent reimbursement increase to providers with WCB assigned rating codes for designated services. Modifier 1D provides an additional 20 percent reimbursement increase for E/M services performed by providers with the following WCB assigned provider rating codes: FP (Family Practice), GP (General Practice) and IM (Internal Medicine).

In support of this contention Respondent's counsel references and submits section 11 CRR-NY 68.1 (b) (1) Adoption of certain Worker's Compensation schedules which states in part:

Per No-Fault Regulation, *11 NYCRR68.1(b)(1)-"*However, references to workers' compensation reporting and procedural requirements in such schedules do not apply to no-fault, e.g. requirements that provide for authorization to perform surgical procedures. The general instructions and ground rules in the workers' compensation fee schedules apply, but those rules that refer to workers' compensation claim forms, pre-authorization approval, time limitations within which health services must be performed, enhanced reimbursement for providers of certain designated services, and dispute resolution guidelines do not apply, unless specified in this Part."

It was Respondent's burden to establish a prima facie showing that the bill was incorrect, see *Cornell Medical P.C. v. Mercury Casualty Co., 24 Misc.3d 58 (App. Term 2d, 11th & 13 Dists. 2009),* and I find that Respondent satisfied its burden. I find that Respondent established that the proper rate of reimbursement is $70.60 per date of service, as modifier 1B or 1D was not appropriate.

Accordingly, the additional 20% enhanced reimbursement Applicant seeks does not apply in this instance. Applicant is not entitled to any further reimbursement. The claim is denied in its entirety.

5. Optional imposition of administrative costs on Applicant.
   Applicable for arbitration requests filed on and after March 1, 2002.

   I do NOT impose the administrative costs of arbitration to the applicant, in the amount established for the current calendar year by the Designated Organization.

6. **I find as follows with regard to the policy issues before me:**
   - ☐ The policy was not in force on the date of the accident
   - ☐ The applicant was excluded under policy conditions or exclusions
   - ☐ The applicant violated policy conditions, resulting in exclusion from coverage
   - ☐ The applicant was not an "eligible injured person"
   - ☐ The conditions for MVAIC eligibility were not met
   - ☐ The injured person was not a "qualified person" (under the MVAIC)
   - ☐ The applicant's injuries didn't arise out of the "use or operation" of a motor vehicle
   - ☐ The respondent is not subject to the jurisdiction of the New York No-Fault arbitration forum

Accordingly, the claim is DENIED in its entirety

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

State of NY
SS :
County of Kings

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

06/07/2023
(Dated)

Evelina Miller

IMPORTANT NOTICE

This award is payable within 30 calendar days of the date of transmittal of award to parties.

This award is final and binding unless modified or vacated by a master arbitrator. Insurance Department Regulation No. 68 (11 NYCRR 65-4.10) contains time limits and grounds upon which this award may be appealed to a master arbitrator. An appeal to a master arbitrator must be made within 21 days after the mailing of this award. All insurers have copies of the regulation. Applicants may obtain a copy from the Insurance Department.

ELECTRONIC SIGNATURE

Document Name: Final Award Form
Unique Modria Document ID:
184f855cbd20ac9ba2fe8dd92a012747

Electronically Signed

Your name: Evelina Miller
Signed on: 06/07/2023