

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Future Medical, PC
(Applicant)

- and -

LM General Insurance Company
(Respondent)

AAA Case No. 17-23-1284-5953

Applicant's File No. 133207

Insurer's Claim File No. 049134664-0001

NAIC No. 36447

ARBITRATION AWARD

I, Hersh Jakubowitz, 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: EIP

1. Hearing(s) held on 07/05/2023
Declared closed by the arbitrator on 07/05/2023

Robert Cippitelli from Law Offices of Eitan Dagan (Woodhaven) participated virtually for the Applicant

Greg Denezzo from LM General Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$2,562.42**, was NOT AMENDED at the oral hearing.
Stipulations WERE made by the parties regarding the issues to be determined.

The Parties stipulated that Applicant had met its prima facie burden of proof and that Respondent's denials were interposed in a timely fashion .

3. Summary of Issues in Dispute

Applicant seeks reimbursement, along with interest and counsel fees, under the No-Fault Regulations, for the costs associated with Applicant administering an outcome assessment tests with office visits on April 22,

2022, June 23, 2022 and November 2, 2022, NCV/EMG studies on July 22, 2022 and August 2, 2022 and physical therapy treatments from June 23, 2022 to July 3, 2022, in connection with injuries allegedly sustained by EIP in a motor vehicle accident on April 13, 2022. The payment, for the outcome assessment test, office visits, NCV/EMG studies and physical therapy treatments was partially denied, based on the Applicant billing in excess of the fee schedule. The denial was timely. This decision is based upon the written submissions of counsel for the respective parties contained within the electronic case file maintained by the American Arbitration Association as well as oral argument at the hearing conducted on July 5, 2023.

4. Findings, Conclusions, and Basis Therefor

History

The dispute arises from a motor vehicle accident on April 13, 2022, in which the EIP, a then 38-year-old male was involved wherein he sustained numerous injuries.

The EIP consulted Applicant with complaints of radiating neck pain, back pain and shoulder pain. Examination revealed restricted range of motion with spasm and tenderness with positive orthopedic tests.

Recommendations included physical therapy treatments. Applicant administered an outcome assessment tests with office visits on April 22, 2022, June 23, 2022 and November 2, 2022, NCV/EMG studies on July 22, 2022 and August 2, 2022 and physical therapy treatments from June 23, 2022 to July 3, 2022, and the no-fault benefits for said medical services is the subject of this arbitration.

Prima Facie

The Applicant established its prima facie case by proof that the prescribed statutory billing forms had been received and that payment of no-fault benefits was not forthcoming. (See, New York & Presbyt. Hosp. v. Countrywide Ins. Co., 44 A.D.3d 729 [N.Y. App. Div. 2d Dep't 2007]). Proof of the receipt of the Applicant's billing is implicit, in the timely denial issued by the Respondent.

Denials

The Respondent argues that the Applicant has billed over the regulated amount as defined in the established fee schedule of the Workers' Compensation Board and must produce sufficient evidence to sustain their fee schedule partial denials.

Analysis

Insurance Law § 5102(a)(1) defines "basic economic loss" as including "all necessary expenses incurred for...professional health services" subject to the limitations of Insurance Law § 5108. Insurance Law § 5108 limits the amounts to be charged by providers of health services, and states that charges for services specified in Insurance Law § 5102(a)(1) "shall not exceed the charges permissible under the schedules prepared and established by the chairman for the workers' compensation board...except where the insurer...determines that unusual procedures or unique circumstances justify the excess charge." 11 NYCRR § 65-3.16(a) provides that "[p]ayment for medical expenses shall be in accordance with fee schedules promulgated under section 5108 of the Insurance Law and contained in Part 68 of this Title (Regulation 83)." 11 NYCRR § 68.1 provides that the "existing fee schedules prepared and established by the chairman of the Workers' Compensation Board...are hereby adopted by the Superintendent of Insurance with appropriate modifications so as to adapt such schedules for use pursuant to section 5108 of the Insurance Law."

The Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 2006 NY Slip 26240 (Civil Ct. Kings Co. 2006). If the Respondent fails to demonstrate by competent evidentiary proof that an Applicant's claims were billed in excess of the appropriate fee schedules, the defense of noncompliance with the fee schedule cannot be sustained. See, Continental Medical PC v. Travelers Indemnity Co., 11 Misc.3d 145A (App. Term 1st Dept. per curiam, 2006).

Date of Service-April 22, 2022

Applicant billed for an initial office visit under CPT 99205 for \$275.00 and outcome assessment test under CPT 99358 for \$280.12. According to the CPT Assistant (Volume 30; Issue 9, September 2020), CPT code 99358 is to be reported on the same date of service as an Evaluation & Management

service, except that it cannot be reported in conjunction with office or other outpatient services which are billed pursuant to CPT codes 99202-99205 and 99212-99215 (emphasis added). Since outcome assessment test was billed on the same date of service as office visit, which is specifically excluded by the fee schedule, I find that Applicant is only entitled to the fee for the office visit. Respondent paid \$95.00, pursuant to the MagnaCare contract, which proof has been submitted. No further reimbursement is due.

Date of Service-June 23, 2022

Applicant billed for an initial office visit under CPT 99215 for \$203.76 and outcome assessment test under CPT 99358 for \$280.12. According to the CPT Assistant (Volume 30; Issue 9, September 2020), CPT code 99358 is to be reported on the same date of service as an Evaluation & Management service, except that it cannot be reported in conjunction with office or other outpatient services which are billed pursuant to CPT codes 99202-99205 and 99212-99215 (emphasis added). Since outcome assessment test was billed on the same date of service as office visit, which is specifically excluded by the fee schedule, I find that Applicant is only entitled to the fee for the office visit. Respondent paid \$145.00, pursuant to the MagnaCare contract, which proof has been submitted. No further reimbursement is due.

Date of Service-November 2, 2022

Applicant billed for an initial office visit under CPT 99215 for \$203.76 and outcome assessment test under CPT 99358 for \$280.12. According to the CPT Assistant (Volume 30; Issue 9, September 2020), CPT code 99358 is to be reported on the same date of service as an Evaluation & Management service, except that it cannot be reported in conjunction with office or other outpatient services which are billed pursuant to CPT codes 99202-99205 and 99212-99215 (emphasis added). Since outcome assessment test was billed on the same date of service as office visit, which is specifically excluded by the fee schedule, I find that Applicant is only entitled to the fee for the office visit. Respondent paid \$0.00, since the MagnaCare contract has expired Applicant is entitled to billed amount of \$203.76.

Date of Service-July 22, 2022

Applicant billed for NCV study under CPT 95913 for \$653.46 and EMG under CPT for \$404.50 for a total of \$1,058.46. Respondent submits a fee coder, Gina M. Ball, detailed examination of the bill. She opines "*Services were rendered in NYS Fee Schedule geographical region IV for which the conversion factor for the Evaluation and Management section is \$15.06 and the Medicine section is \$11.07. Per NYS Fee Schedule and AMA CPT coding guidelines, code 95911 defined as: Nerve conduction studies; 9-10 studies Per NYS Fee Schedule and AMA CPT coding guidelines, code 95913 defined as: Nerve conduction studies; 13+ studies Provider billed Code 95913. Documentation supports/validates the performance of 10 studies; 6 sensory, 4 F-wave studies and 4 Motor nerve (although all of the Motor nerves are duplicative of the F-Wave Nerves tested and therefore will not be considered for reimbursement here) and carrier reviewed as Code 95911 instead of Code 95913 (total of 10 studies to consider). (Per AMA CPT 2013, nerve conduction study codes 95900, 95903 and 95904 were deleted and seven new codes were created (95907 - 95913). These changes were made in an effort to address the overlap in the pre-test and posttest work involved in the procedures and to further describe the reporting based on the number of studies performed. Each type of nerve conduction study is counted only once when multiple sites on the same nerve are stimulated or recorded. Note that copyright restrictions prohibit copying, photographing, or sharing the AMA CPT Code Book reference. The NYS Fee Schedule allowance for billed codes are as follows: 95886 x2 units: \$404.50 as billed 95911: \$510.44 RVU 46.11 x \$11.07 95913x1 unit: \$0.00 Total eligible amount due: \$914.94.*"

Applicant does not submit a rebuttal to Ms. Ball's detailed explanation.

Applicant is awarded \$914.94

Date of Service-August 23, 2022

See the above explanation for date of service July 22, 2022.

Applicant is awarded \$914.94.

Physical Therapy Treatments

Accounting for payments made by Respondent, deductible amounts and the MagnaCare contract, no further reimbursement is due.

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
	Future Medical, PC	04/22/22 - 11/02/22	\$2,562.42	Awarded: \$2,033.64
Total			\$2,562.42	Awarded: \$2,033.64

- B. The insurer shall also compute and pay the applicant interest set forth below. 01/31/2022 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Based on the submission of a timely denial, interest shall be paid from the above date, until the date that payment is made at a rate of 2% per month.

C. Attorney's Fees

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

As this matter was filed after February 4, 2015, this case is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant an attorney fee, in accordance with newly promulgated 11 NYCRR 65-4(d). After calculating the sum total of the first party benefits awarded in this arbitration plus interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20% of the sum total, subject to no minimum and a maximum of \$1,360.00.

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

08/04/2023

(Dated)

Hersh Jakubowitz

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:
211e29028ebf83311680f62ade11984e

Electronically Signed

Your name: Hersh Jakubowitz
Signed on: 08/04/2023