American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Atlas Chiro of S.I. (Applicant)	AAA Case No.	17-22-1263-0540
	Applicant's File No.	n/a
- and -	Insurer's Claim File No.	1091278-04
	NAIC No.	16616
American Transit Insurance Company (Respondent)		

ARBITRATION AWARD

I, Meryem Toksoy, 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 (AW)

1. Hearing(s) held on 04/11/2023
   Declared closed by the arbitrator on 04/11/2023

   April Mittleman, Esq. from April Mittleman Esq. participated virtually for the Applicant

   Erisa Ahmedi, Esq. from American Transit Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$750.00**, 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

   In dispute is a claim by the Applicant, Atlas Chiro of S.I., as the assignee of a 23-year-old female who was injured as a passenger in a motor vehicle accident on 12-30-20.

   Applicant seeks to be paid **$750.00** for **evaluations** that were performed on 01-06-21 and 01-27-21. For each date, the service was **billed under CPT 99455, which is a By Report code that describes the performance of a work-related or disability exam.**

   Respondent asserts a **fee schedule** defense and argues the claim is not reimbursable.

4. Findings, Conclusions, and Basis Therefor

The case was decided on the submissions of the parties as contained in the electronic file maintained by the American Arbitration Association and the oral arguments of the parties' representatives.

FEE SCHEDULE USED FOR THIS MATTER:

The claim is governed by the 2018 New York Workers' Compensation Board Chiropractic Fee Schedule, specifically the revised printing edition that went into effect on 01-01-20. This is consistent with the 34th and 35th Amendments to 11 NYCRR 68 [Regulation 83].

ADDITIONAL SOURCES:

Current Procedural Terminology, more commonly known as CPT, is a code set that is used in the field of healthcare. It was created by the American Medical Association (AMA) to standardize the language used to report medical services and procedures.

The "CPT book" - mentioned at the beginning of the fee schedule - is published by the AMA on an annual basis. (The title of the book is "CPT [year] Professional Edition.") This source is meant to be used as a supplement, ie, for coding rules and guidelines that are not listed in the fee schedule.

The AMA also publishes a monthly newsletter, namely CPT Assistant. As a matter of law, it must be considered when evaluating a claim for No-Fault benefits. Matter of Global Liberty Ins. Co. v. McMahon, 2019 NY Slip Op 03692 (App. Div., First Dept., May 9, 2019).

CODE DESCRIPTIONS FOR CPT 99455 AND 99456:

There are two codes listed in the Chiropractic Fee Schedule for a work related or medical disability exam, CPT 99455 and 99456. They are defined as follows:

CODE	DESCRIPTION	RVUs
99455	**Work related or medical disability examination by the treating physician** that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.	BR

99456	**Work related or medical disability examination by other than the treating physician** that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.	BR

Noted above, Applicant billed for its services under CPT 99455.

CPT ASSISTANT ARTICLES THAT DISCUSS THESE CODES:

CPT Assistant, *Special Evaluation and Management Services Added to CPT 1995*, Summer 1995 issue, page 14:

> *A new series of codes, Basic Life and/or Disability Evaluation Services and Work Related or Medical Disability Evaluation Services, was added to CPT in 1995.* ***These codes were added to report specific services that occur when completing evaluations for life insurance and/or disability claims, as well as work related or other medical disability examinations.***
>
> *The life insurance industry estimates that about $5 billion is paid each year for medical examinations and evaluations performed on applicants for life insurance. In addition, the role of the independent medical examiner is important when accidental medical trauma covered by casualty carriers, has occurred. It is a specific type of examination and evaluation that is financed as the cost of doing business (the "expense" side of a life/disability insurer), rather than from the funds for the treatment of the injured policy holder (the "loss" side).*
>
> ***These services are separate and distinct from other evaluation and management services. These codes are to be used to report evaluations performed in order to establish baseline information, prior to life or disability insurance certificates being issued.*** *The service is performed in an office or other setting, and applies to both new and established patients. When using these codes, NO active management of the problem(s) is undertaken during the encounter.*
>
> *If other evaluation and management services and/or procedures are performed on the same date, the appropriate evaluation and management or procedure code(s) can be reported in addition to these codes. In this case Modifier -25 should be appended to the evaluation and management service, if performed on the same date.*
>
> *Basic Life and/or Disability Evaluation Services*

99450 Basic life and/or disability examination that includes:

- *measurement of height, weight and blood pressure;*
- *completion of a medical history following a life insurance pro forma;*
- *collection of blood sample and/or urinalysis complying with "chain of custody" protocols; and*
- *completion of necessary documentation/certificates.*

Work Related or Medical Disability Evaluation Services

99455 Work related or medical disability examination by the treating physician that includes:

- *completion of a medical history commensurate with the patient's condition;*
- *performance of an examination commensurate with the patient's condition;*
- *formulation of a diagnosis, assessment of capability and stability and calculation of impairment;*
- *development of future medical treatment plan; and*
- *completion of necessary documentation/certificates and report.*

99456 Work related or medical disability examination by other than the treating physician that includes:

- *completion of a medical history commensurate with the patient's condition;*
- *performance of an examination commensurate with the patient's condition;*
- *formulation of a diagnosis, assessment of capability and stability, and calculation of impairment;*
- *development of future medical treatment plan; and*
- *completion of necessary documentation/certificates and report.*

For Example:

A patient makes an appointment to see his family physician for a physical examination, required to qualify for a new life insurance policy. The physician completes a medical history, as required by the Life Insurance

Company, which consists of an abbreviated examination of height, weight, and blood pressure, as well as collection of specimen samples required for laboratory tests. The physician also completes several forms, provided by the life insurance company, to certify that the information is complete. If this is the only service provided, then the physician should use CPT 99450 for this evaluation and management service. The ICD-9 diagnosis coded would be V70.3, "other medical examination for administrative purposes." This is located in the index under "Examination," subterm "Medical," subterm "Insurance certification."

If a physician, through the course of a basic life examination on an established patient, finds a patient to be severely overweight with high blood pressure and counsels the patient for 25 minutes during the visit, on weight control, diet, and exercise, the physician may then report an additional code for the counseling. In this case, 99214-25 will be coded in addition to 99450. CPT code 99214 is chosen because counseling domination (more than 50%) the evaluation and management portion of the visit (excludes services provided that are described in this section), therefore time is considered the key or controlling factor to qualify for a particular level of E/M services. The preventive medicine individual counseling code is NOT appropriate because the patient had pre-existing symptoms (overweight, high blood pressure). Refer to the guidelines on page 37 in CPT 1995 and the CPT Assistant article in Winter 1994, for further clarification on reporting preventive medicine individual counseling.

CPT Assistant, *Frequently Asked Questions: Evaluation and Management: Special E/M Services*, August 2013 issue, page 13:

Question: What is the proper way to report evaluation services related to a worker's compensation injury for new and established patients?

Answer: Code 99455*, Work related or medical disability examination by the treating physician,* ***and 99456****, Work related or medical disability examination by other than the treating physician,* ***are used to report evaluations performed to establish baseline information prior to the issuance of life or disability insurance certificates.*** *This service is performed in the office or other setting, and applies to both new and established patients. When using these codes, no active management of the problem(s) is undertaken during the encounter. These codes are not intended to be used for active E/M services due to work-related injuries. If other E/M services and/or procedures are performed on the same date, the appropriate E/M or procedure code(s) should be reported in additional to codes 99455 and 99456. Modifier 25 may be appended to the E/M service code. Codes 99455 and 99456 would not be used if the complete services*

as identified for disability evaluations are not performed. Instead, the appropriate code from the 99201-99215 code series may be used to identify the services rendered.

LEGAL FRAMEWORK:

The Fourth Amendment to 11 NYCRR 65-3, which is applicable to claims for medical services rendered on or after April 1, 2013, includes the following provision:

11 NYCRR 65-3.8(g)(1)(ii):

> *Proof of the fact and amount of loss sustained pursuant to Insurance Law section 5106(a) shall not be deemed supplied by an applicant to an insurer and no payment shall be due for such claimed medical services under any circumstances . . . for those claimed medical service fees that exceed the charges permissible pursuant to Insurance Law sections 5108(a) and (b) and the regulations promulgated thereunder for services rendered by medical providers.*

This means that for those services rendered on or after April 1, 2013, a fee schedule defense is not subject to preclusion. Surgicare Surgical Associates v. National Interstate Ins. Co., 50 Misc.3d 85, 25 N.Y.S.3d 521 (App. Term, 1st Dept., Oct. 8, 2015), aff'g, 46 Misc.3d 736, 997 N.Y.S.2d 296 (Civ. Ct., Bronx Co., 2014).

To be clear, this provision does not change Applicant's prima facie burden. East Coast Acupuncture, P.C. v. Hereford Ins. Co., 51 Misc.3d 441, 26 N.Y.S.3d 441 (Civ. Ct. Kings Co. Feb. 9, 2016).

An applicant demonstrates prima facie entitlement to No-Fault benefits under Article 51 of the Insurance Law by "submitting evidence that payment of no-fault benefits are overdue, and proof of its claim, using the statutory billing form, was mailed to and received by the defendant insurer." Viviane Etienne Med. Care, P.C. v. Country-Wide Ins. Co., 25 N.Y.3d 498, 14 N.Y.S. 3d 283 (Court of Appeals, 2015).

Once an applicant establishes its prima facie case, the burden of proof shifts to the insurer to come forward with admissible evidence demonstrating the existence of a material issue of fact. Amaze Medical Supply Inc. v. Eagle Ins. Co., 2 Misc.3d 128(A), 2003 N.Y. Slip Op. 51701(U)(App. Term, 2nd Dept, 2nd & 11th Jud Dists., 2003).

If the insurer asserts that the applicant's charges are excessive, it must come forward with competent supporting evidence. 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). In the absence of such a showing, the defense will fail. Id.

If the insurer succeeds in establishing that the amount charged for a particular service or supply is excessive, the burden will then shift to the applicant to demonstrate that the amount billed reflects 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.2d 558 (App. Term, 2nd Dept, 2nd, 11th & 13th Jud. Dists, May 22, 2009).

DECISION:

I find in favor of the Respondent.

The fact that CPT 99455 and 99456 are listed in the fee schedule does not mean that Applicant has the right to use either of them. The articles published by the AMA clearly show that these codes do not apply to No-Fault.

Given the record, the claim is hereby denied in full.

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 Nassau

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

09/27/2023
(Dated)

Meryem Toksoy

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:
358e31417aae4f183a2774149731b434

Electronically Signed

Your name: Meryem Toksoy
Signed on: 09/27/2023