American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Van Siclen Chiropractic PC (Applicant)	AAA Case No.	17-22-1269-8538
	Applicant's File No.	n/a
- and -	Insurer's Claim File No.	0646217330000004
	NAIC No.	22055
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

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

Injured Person(s) hereinafter referred to as: Assignor

1. Hearing(s) held on 10/10/2023
   Declared closed by the arbitrator on 10/10/2023

   Helen Cohen, Esq. from Law Offices of Hillary Blumenthal LLC (Hoboken) participated virtually for the Applicant

   Heather Pliszak, Claims Representative from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$1,252.50**, was NOT AMENDED at the oral hearing.
   Stipulations WERE made by the parties regarding the issues to be determined.

   The parties stipulated that Applicant established its prima facie case of entitlement to No-Fault benefits and that Respondent's NF-10/Denial of Claim forms were timely issued.

3. Summary of Issues in Dispute

   The Assignor, T.C., a 46 year old female, was the driver of a vehicle involved in a motor accident vehicle on 10/14/21. At issue in this case is $1,252.50 for chiropractic care and personal protective equipment provided on dates of service 10/28/21-6/28/22.
   Respondent denied the claims based on the IME of Dr. Milton Groelinger held on 3/7/22

and also raises fee schedule defenses. The issues to be determined are whether Respondent has established its medical necessity and fee schedule defenses.

4. Findings, Conclusions, and Basis Therefor
This case was conducted using the documents submitted by the parties in the ADR Center, maintained by the American Arbitration Association, and the oral arguments of the parties. Any documents in the ADR Center are hereby incorporated into this hearing. I have reviewed all the relevant documents. No witnesses testified at this hearing.

IME of Dr. Milton Groelinger held on 3/7/22

Respondent denied the claims for chiropractic services on dates of service 3/22/22, 4/7/22, 4/18/22, 4/20/22, 4/21/22, 4/26/22, 5/11/22, 5/24/22, 5/25/22, 6/8/22, 6/9/22 and 6/28/22, based on the IME of Dr. Milton Groelinger held on 3/7/22.

An IME report must set forth a factual basis and medical rationale for the conclusion that further services are not medically necessary. Ying Eastern Acupuncture, P.C. v. Global Liberty Ins., 20 Misc.3d 144(A), 873 N.Y.S.2d 238 (Table), 2008 N.Y. Slip Op. 51863(U), 2008 WL 4222084 (App. Term 2d & 11th Dists. Sept. 3, 2008). If the 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, AJS Chiropractic, P.C. v. Mercury Ins. Co., 22 Misc.3d 133(A), (App. Term 2d & 11th Dist. Feb. 9, 2002), as the ultimate burden of proof on the issue of medical necessity lies with the claimant. See Insurance Law § 5102; Wagner v. Baird, 208 A.D.2d 1087 (3d Dept. 1994).

Where the IME report submitted by the insurer sets forth a factual basis and medical rationale for the conclusion that the assignor's injuries were resolved and that the treatment which is the subject of the claim lacked medical necessity, the report submitted in opposition must meaningfully refer to and rebut the IME findings. E.g., Premier Health Choice Chiropractic, P.C. v. Praetorian Ins. Co., 41 Misc.3d 133(A), 981 N.Y.S.2d 638 (Table), 2013 N.Y. Slip Op. 51802(U), 2013 WL 5861532 (App. Term 1st Dept. Oct. 30, 2013).

In support of its medical necessity defense Respondent submits the IME report of Dr. Milton Groelinger dated 3/7/22. Upon examination Dr. Groelinger found normal ranges of motion in the cervical and lumbar spine. The results of all objective tests performed were negative, no spasms were noted, and motor strength was normal. Based on the examination, Dr. Groelinger diagnosed the Assignor with resolved sprains and determined that no further treatment was medically necessary from a chiropractic standpoint.

Respondent's IME report is sufficient to establish Respondent's lack of medical necessity defense as to this claim. The burden now shifts to the Applicant as it is the Applicant's burden, ultimately, to establish the medical necessity of the services at issue. See Insurance Law § 5102; Shtarkman v. Allstate Insurance Co., 2002 NY Slip Op

50568(U), 2002 WL 32001277 (App. Term 9th & 10th Jud. Dists. 2002) (burden of establishing whether a medical test performed by a medical provider was medically necessary is on the latter, not the insurance company).

In rebuttal Applicant submits a chiropractic re-evaluation report dated 2/1/22. The report notes a decrease in range of motion and positive orthopedic testing of the cervical and lumbar spine. I find that the Assignor's contemporaneous evaluation record adequately refutes the findings of the IME. As such, Applicant has established the medical necessity of the chiropractic services at issue.

Accordingly, these claims are granted.

12 Unit Defense

Additionally, Respondent denied the claim for CPT 98941 billed on date of service 12/23/21 based on the 12 unit defense.

Pursuant to the 2018 Chiropractic New York State Fee Schedule:

> 3. Multiple Physical Medicine Procedures and Modalities: When multiple physical medicine procedures and/or modalities are performed on the same day, reimbursement is limited to 12.0 RVUs per patient per day per accident or illness or the amount billed, whichever is less. **Note:** When a patient receives physical medicine procedures and/or modalities from more than one provider, the patient may not receive more than 12.0 RVUs per day per accident or illness from all providers. The following codes represent the physical medicine procedures and modalities subject to this rule:
>
> 97010 97012 97014 97024 97026 97028
> 97032 97033 97034 97035 97036 97039
> 97110 97112 97113 97116 97124 97139
> 97140 97530 98940 98941 98942

Thus, reimbursement is now limited to a total of 12 units per claimant per day, regardless of the number of specialties provided.

In this case Respondent issued partial payment to Applicant and asserts that the remaining units were paid to a physical therapy provider for physical therapy modalities. Respondent also submits payment screens documenting the corresponding payments which demonstrate that Respondent paid a full 12 units on date of service 12/23/21. **Accordingly, I find that nothing further is owed for this date of service.**

Fee Schedule Defense-Personal Protective Equipment

Respondent denied the remainder of Applicant's claims for personal protective equipment on the basis that New York No Fault law does not contemplate

reimbursement for these services. In this case Applicant billed code 99072 for additional supplies i.e., personal protective equipment ("PPE"). Code 99072 was released by the AMA and became effective on Sept. 8, 2020. The code descriptor states: *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 as defined by law, due to respiratory-transmitted infectious disease.* Applicant argues that Covid-19 falls within the definition of a public health emergency as contemplated by the new code.

The Department of Financial Services addressed the issue of reimbursement for personal protective equipment in Circular Letter No. 14, issued on August 5, 2020, which states " *This circular letter reminds insurers authorized to write accident and health insurance in New York State… 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…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*." It is noted that permitting providers to bill for PPE depletes the total amount of benefits available to an insured for actual medical treatment and that once the policy of insurance is exhausted, the insured is personally responsible to those providers for any treatment rendered.

With respect to whether code 99072 should be reimbursed, I note that in RES Physical Medicine & Rehab. Services, AAA Case No. 17-21-1220-5816, Arbitrator Laura Yantsos cogently addressed this same issue as follows:

> *The assignee in no fault has only whatever rights to reimbursement the assignor had and as he may not be charged for PPE, there would be no allowable charge by the biller assignee. See Rubin v. Empire Mut. Ins. Co., 25 N.Y.2d 426 at 429. The Code is not contained in the fee schedule and has not been adopted by no-fault. It is a new code fashioned by the AMA during the Covid pandemic. It is not a separate covered expense, as it is by its very nature included in the allowance for the services rendered. See also Ground Rule 17 of the Physical Medicine Section of the governing fee schedule.*
>
> *Further, Medicare, in response to the new code (99072) designed by the AMA, has also barred reimbursement viewing the PPE as a general expense incurred in running a medical office, like, for example hand sanitizing gels, paper cloth covers utilized on patient examining tables, cleaning supplies, gloves, face shields, face masks, etc.) used generally in a medical office setting and not as a "supply" provided to the insured. CMS stated that payment for the items/services described by CPT code 99072 is "always bundled into payment for other services and payment for them is subsumed by the payment for the services to which they are incident."*

The fashioning of a new CPT Code by the AMA does not mean the automatic adoption of such code by the various insurers.

I agree with Arbitrator Yantsos' assessment and further note the CPT Assistant 2020 September Update indicates that eligibility for payment of Code 99072, as well as coverage policy, is determined by each individual insurer or third-party payer. Consequently, I find that there is no authority expressly requiring Respondent to reimburse an Applicant for PPE (and related services contemplated by the code) under the New York No-Fault regulatory system and thus Respondent's denial is upheld.

Accordingly, the remainder of Applicant's claims are denied.

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
	Van Siclen Chiropractic PC	**01/31/22 - 02/23/22**	**$90.00**	**Denied**
	Van Siclen Chiropractic PC	**03/22/22 - 04/07/22**	**$144.60**	**Awarded: $114.60**
	Van Siclen Chiropractic PC	**04/18/22 - 04/21/22**	**$216.90**	**Awarded: $171.90**
	Van Siclen Chiropractic PC	**04/26/22 - 05/11/22**	**$144.60**	**Awarded: $114.60**
	Van Siclen Chiropractic PC	**05/24/22 - 05/25/22**	**$144.60**	**Awarded: $114.60**
	Van Siclen Chiropractic PC	**06/08/22 - 06/28/22**	**$275.54**	**Awarded: $215.54**
	Van Siclen Chiropractic PC	**10/28/21 - 11/16/21**	**$75.00**	**Denied**
	Van Siclen Chiropractic PC	**12/07/21 - 12/15/21**	**$75.00**	**Denied**
	Van Siclen Chiropractic PC	**12/22/21 - 01/06/22**	**$86.26**	**Denied**
Total			**$1,252.50**	**Awarded: $731.24**

B. The insurer shall also compute and pay the applicant interest set forth below. 10/12/2022 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 particular 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, I find the date that interest shall accrue from is 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

The insurer shall also pay the applicant for attorney's fees as set forth below. This case is subject to the provisions as to attorney fee promulgated in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D). Applicant is awarded statutory attorney fees pursuant to the no-fault regulations. See, 11 NYCRR §65-4.6. The award of attorney fees shall be paid by the insurer. 11 NYCRR §65-4.5(d). Accordingly, "the attorney's fee shall be limited as follows: 20 percent of the total amount of first-party benefits and any additional first party benefits, plus interest thereon, for each applicant per arbitration or court proceeding, subject to a maximum fee of $1,360." Id.

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 Queens

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

10/17/2023
(Dated)

Farheen Sultan

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:
2d4c55ab3ae23b23a68f12fb1504fbfa

Electronically Signed

Your name: Farheen Sultan
Signed on: 10/17/2023