American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

RCK Medical Services PC (Applicant)	AAA Case No.	17-23-1327-7229
	Applicant's File No.	44523-478995
- and -	Insurer's Claim File No.	0620942441 2LE
	NAIC No.	29688
Allstate Fire & Casualty Insurance Company (Respondent)		

ARBITRATION AWARD

I, Kihyun Kim, 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: the Assignor

1. Hearing(s) held on 06/20/2024
   Declared closed by the arbitrator on 06/20/2024

   Joaquin Lopez, Esq. from Barshay, Rizzo & Lopez, PLLC. participated virtually for the Applicant

   Frank Gissaro, Esq. from Law Offices of John Trop participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$491.51**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The amount in dispute was amended to $243.17 to withdraw the portion of Applicant's claims that were previously paid by Respondent.

   Stipulations WERE made by the parties regarding the issues to be determined.

   The parties stipulated to Applicant's prima facie case and to Respondent's timely denial.

3. Summary of Issues in Dispute

   The issue presented is whether the Applicant's claims were properly billed and paid pursuant to fee schedule.

The Assignor (RE) was a 74-year-old female who was a passenger in an automobile that was involved in an accident on March 31, 2021. Applicant seeks reimbursement in the amount of $243.17 for the balance of the charges, which were partially paid by Respondent, for a disability exam of the Assignor conducted on June 15, 2023.

4. Findings, Conclusions, and Basis Therefor

This arbitration was conducted using the documentary submissions of the parties contained in the ADR Center, maintained by the American Arbitration Association. I have reviewed the documents contained therein as of the close of the hearing and such documents are hereby incorporated into the record of this hearing. The hearing was held by Zoom video conference. Both parties appeared at the hearing by counsel, who presented oral argument and relied upon their documentary submissions. There were no witnesses.

At the hearing, Respondent acknowledged receipt of the bill in question and the parties stipulated to Applicant's prima facie case and to Respondent's timely denial.

The Assignor was a 74-year-old female who was injured in an automobile accident on March 31, 2021. Following the accident, the Assignor did not go to the hospital, but she later sought treatment, testing and medication for her injuries from various providers, including Applicant.

On June 15, 2023, the Assignor presented to Charles Nguyen, D.C., MPH/Richard Koffler, M.D., for an office evaluation. Applicant billed Respondent for a disability exam, and Respondent paid Applicant's claims in part but timely denied the remainder based on a fee schedule dispute.

Applicant now seeks reimbursement in the amount of $243.17 for the balance of the charges, which were partially paid by Respondent, for a disability exam of the Assignor conducted on June 15, 2023.

Legal Framework - Fee Schedule

It is well established that a healthcare provider must limit its charges according to the applicable fee schedule. *Goldberg v. Corcoran*, 153 AD2d 113, 117-18 (App Div, 2d Dept 1989). Further, 11 NYCRR §65-3.8(g)(1) provides that, effective April 1, 2013, 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: (i) when the claimed medical services were not provided to an injured party; or (ii) 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.

Notwithstanding the foregoing, the insurer has the burden to come forward with competent evidentiary proof to support its fee schedule defenses. *Robert Physical Therapy, P.C. v. State Farm Mut. Auto. Ins. Co.*, 13 Misc. 3d. 172 (Civ. Ct. Kings Co.

2006). In the absence of such proof, a defense of noncompliance with the appropriate fee schedule cannot be sustained. *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). 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 makes 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).

However, an arbitrator may take judicial notice of the fee schedule. *See Kingsbrook Jewish Med. Ctr v. Allstate Ins. Co.*, 61 AD3d 13 (2d Dept 2009).

Analysis - Fee Schedule - Disability Exam - DOS 6/15/23

In the present case, Applicant billed Respondent in the amount of $491.51 for a disability exam of the Assignor conducted on June 15, 2023. Respondent partially paid Applicant's claims in the amount of $248.34 and timely denied the remainder ($243.17) based on a fee schedule dispute. The EOB/denial stated, in pertinent part, that:

> 99455 and 99456 are by report codes. Code 99423 best describes the services rendered.

In support of its denial, Respondent uploaded a fee schedule/coder affirmation, dated June 8, 2024, by Carolyn Mallory, CPC; the relevant portions of the fee schedule; and the other fee schedule authorities relied upon by Ms. Mallory in her affirmation.

Ms. Mallory determined that the total allowable amount of reimbursement for the services rendered was $36.19, and that Respondent previously overpaid Applicant in the amount of $212.15. Initially, Ms. Mallory found that the medical records "have the DC listed primary, therefore the DC performed the services and should be in box 31 on the CMS form not the MD." Ms. Mallory noted that Applicant billed CPT code 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", which has a BR (By Report) in the RVU column. Using the amount billed and the applicable conversion factor, Ms. Mallory calculated Applicant's asserted relative value for the services rendered to be 62.06 (491.51 / 7.92 = 62.06), and indicated that there is nothing in the Chiropractic Fee Schedule the has such a high a relative value. She maintained that the billed amount of $491.51 was not consistent in relativity with other value units already in the fee schedule, noting, among other things, that CPT code 32854 "Lung transplant, double (bilateral sequential or en bloc); with cardiopulmonary bypass" has an relative value of 35.56.

Ms. Mallory found that the medical documentation indicated that the Assignor was seen for a re-examination and that the Assignor was retired. She asserted that the appropriate CPT code based upon the documentation would be CPT code 99212, which is reimbursable at $36.19 [4.57 RVU x 7.92].

Ms. Mallory noted that the Assignor was seen by Applicant on May 27, 2021, December 15, 2022, January 19, 2023, February 16, April 20, 2023, and June 15, 2023, for the same service. Ms. Mallory pointed to E/M Ground Rule 1B and General Ground Rule 7 of the NYS Chiropractic Fee Schedule to support her assertion that CPT code 99212 may be used for a periodic evaluation.

Ms. Mallory noted that the documentation indicated computerized range of motion of the cervical and lumbar spine and computerized muscle testing of both the upper and lower extremities were conducted. Ms. Mallory explained that the appropriate CPT code for computerized range of motion of the cervical and lumbar region would be 95851. However, she asserted that based on General Ground Rule 7 the range of motion would be included the relative value of CPT code 99212. She also noted that CPT code 95851, "Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)", is not found in the Chiropractic section of the fee schedule, and per General Ground Rule 10, a chiropractor may only used CPT codes contained in the Chiropractic Fee Schedule for billing of treatment. Ms. Mallory also explained that CPT Assistant May 2008 / Volume 18 Issue 5 indicated that the appropriate CPT code for computerized muscle testing is CPT code 97750. Ms. Mallory noted that CPT code 97750 is not reimbursable as its assigned relative value is 0.00.

Finally, Ms. Mallory noted that CPT code 99456 is for special evaluation and management services that are utilized to report encounters where baseline information is obtained for life or disability insurance purposes. She explained that CPT® Assistant dated August 2013 / Volume 23 Issue 8 stated that: "Code 99455, *Work related or medical disability examination by the treating physician, and code 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.** She later stated that "As a coder I would not read the report and determine that CPT 99456 would be the appropriate CPT code unless, the notes had stated something which indicated the patient was being seen to determine medical disability prior to returning to work or prior to returning to full duty at work with no restrictions.

In summary, Ms. Mallory stated that the provider "has submitted CPT code 99456 which is found in the Evaluation & Management section of the Chiropractic Fee Schedule. Ground Rule #2 indicates the chiropractor shall establish a unit value consistent in relativity with other unit values shown in the schedule. The insurer shall review all submitted "BR" unit value to ensure that the relativity consistency is maintained…" Ms. Mallory noted that the documentation indicated that the Assignor was being seen for a re-evaluation; that the appropriate CPT code for a re-evaluation would be 99212; and that since this visit was a re-evaluation, the relative value of 99212 is most consistent in relativity.

At the hearing, Applicant's counsel conceded that Applicant did not upload a fee schedule/coder affidavit but maintained that Applicant's claims were appropriately billed for the services rendered.

After careful consideration of the record and the arguments of the parties, I find Ms. Mallory's affirmation along with Respondent's other supporting evidence is sufficient to make a prima facie showing that the amounts charged by Applicant were in excess of the fee schedule. Ms. Mallory details her credentials, basis of knowledge, and how she arrived at his allowable charges for the services rendered. In sum, Respondent billed a "BR" by report code, and Respondent's affirmant established that the insurer reviewed the charges pursuant to the applicable ground rules and reduced Applicant's charges in accordance with established fees. Applicant billed CPT code 99456 in the amount of $491.51, and by dividing the fee by the applicable conversion factor, she determined that Applicant's charges represent the functional equivalent of 62.06 RVUs, which she found was not consistent in relativity with other value units already in the fee schedule. In assessing the medical documentation and services performed, she determined that the relative value of CPT code 99212 was most consistent in relativity for the services performed. Alternatively, Ms. Mallory, citing the CPT Assistant, also indicated that CPT code 99456 "is for special evaluation and management services that are utilized to report encounters where baseline information is obtained for life or disability insurance purposes." She also noted that Applicant had performed the same exact testing on May 27, 2021, December 15, 2022, January 19, 2023, February 16, 2023, and April 20, 2023 for the same service, and pointing to multiple ground rules, asserted that CPT code 99212 would be appropriate for a periodic re-evaluation. Respondent's proof is sufficient to met its initial prima facie burden to come forward with competent evidentiary proof to support its fee schedule defenses; thus, the burden shifted to Applicant to show that the charges involved a different interpretation of such schedule or an inadvertent miscalculation or error. *See, Cornell Medical, supra*. Applicant did not upload its own fee schedule/coder affidavit or put in any other credible or persuasive evidence to support a different fee calculation and/or to otherwise rebut Respondent's fee schedule defenses. Based on the totality of the evidence in the record, Applicant failed to rebut Respondent's fee schedule defenses, and I accept Ms. Mallory's affirmation as persuasive and dispositive on this hearing record. As Respondent has previously paid Applicant in the amount of $248.34 for the services rendered, I find that no further reimbursement is warranted. Accordingly, Applicant's claims for additional reimbursement for the balance of the charges, which were partially paid by Respondent, for the disability exam of the Assignor conducted on June 15, 2023, are denied.

Conclusion

For the reasons set forth herein, Applicant's claims are denied in their entirety. This decision is in full disposition of all claims for no-fault benefits presently before this Arbitrator. Any further issues raised in the hearing record are held to be moot and/or waived insofar as not specifically raised at the time of the hearing.

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 Suffolk

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

07/20/2024
(Dated)

Kihyun Kim

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
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Electronically Signed

Your name: Kihyun Kim
Signed on: 07/20/2024