American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Brooklyn Medical Practice, PC (Applicant)	AAA Case No.	17-23-1293-1003
	Applicant's File No.	172.376
- and -	Insurer's Claim File No.	21-6024270
	NAIC No.	24260
Progressive Casualty Insurance Company (Respondent)		

ARBITRATION AWARD

I, Alison Berdnik, 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: Claimant

1. Hearing(s) held on 08/21/2024
   Declared closed by the arbitrator on 08/21/2024

   Allen Tsirelman, Esq. from Tsirelman Law Firm PLLC participated virtually for the Applicant

   Regina Wilcox from Progressive Casualty Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$861.39**, 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 Claimant, BTM, a 48-year-old female, was a passenger in a motor vehicle involved in an accident on September 23, 2021. At issue in this case is $861.39, which represents the balance of Applicant's claim for physical therapy administered September 27, 2021 through March 21, 2022, together with evaluations performed September 24, 2021, October 7, 2021, and October 25, 2021. Respondent partially reimbursed Applicant for its services and denied the balance asserting that the charges exceed those permitted under the New York State Workers' Compensation Fee Schedule (the "Fee Schedule"). Respondent also contends that $167.01 owed to Applicant for services rendered September 24, 2021 through September 30, 2021 was applied toward a deductible included under the policy.

The issues presented for determination are:

1) Whether Respondent has demonstrated that it appropriately applied reimbursement due Applicant toward a deductible; and,

2) Whether the remaining charges exceed those permitted under the governing fee schedule.

4. Findings, Conclusions, and Basis Therefor

This case was decided based upon 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. There were no witnesses present to testify during the hearing. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

An Applicant establishes its *prima facie* showing of an entitlement to judgment as a matter of law by submitting evidentiary proof that the prescribed statutory billing forms had been mailed, received by the Respondent and that payment of no-fault benefits is overdue. *Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.2d 742, 774 N.Y.S.2d 564 (2nd Dept. 2005). A facially valid claim has been defined as one that sets forth the name of the patient, date of accident, date of service, description of services rendered and the charges for those services. *See, Vinings Spinal Diagnostic P.C. v. Liberty Mutual Insurance Company*, 186 Misc.2d 128(A), 784 N.Y.S.2d 918 (2003).

At issue in this case is $861.39, which represents the balance of Applicant's claim for physical therapy administered September 27, 2021 through March 21, 2022, together with reevaluations performed September 24, 2021, October 7, 2021, and October 25, 2021. No issue has been raised surrounding Applicant's *prima facie* entitlement to reimbursement. Rather, Respondent partially reimbursed Applicant for its services and denied the balance asserting that the charges exceed those permitted under the New York State Workers' Compensation Fee Schedule (the "Fee Schedule"). Respondent also contends that $167.01 owed to Applicant for services rendered September 24, 2021 through September 30, 2021 was applied toward a deductible included under the policy.

As a preliminary matter, Respondent's representative acknowledged that Respondent's denial of the evaluations performed September 24, 2021, October 7, 2021 and October 25, 2021 were improper and, consequently, Applicant is entitled to reimbursement. With respect to the evaluation performed September 24, 2021, Respondent initially denied the claim asserting that the code billed was not included in the Physical and Occupational Therapy Fee Schedule and, therefore, not reimbursable. However, upon further review, Respondent acknowledges that the evaluation was performed by a physician's assistant and, consequently, Applicant is owed $114.10. Noting that the evaluations on October 7, 2021 and October 25, 2021 were performed by a nurse practitioner, Respondent

contends that, under Ground Rule 11, Applicant is entitled to reimbursement in the amount of $70.24 for each of the two dates of service.

After careful review of the evidence offered by the parties, together with Ground Rule 11 of the Fee Schedule, Applicant is awarded an aggregate sum in the amount of $140.48 for the evaluations performed October 7, 2021 and October 25, 2021, together with an additional $114.10 for the initial evaluation performed September 24, 2021.

Deductible

As noted above, Respondent also contends that $167.01 owed to Applicant for services rendered September 24, 2021 through September 30, 2021 was applied toward a deductible included under the policy.

In support of its defense, Respondent offers the insurance policy Declarations Page which, in fact, confirms that a $200.00 deductible is included under the policy. The services at issue were rendered the day following the accident. Respondent offers a payment ledger demonstrating that Applicant's bill was first in line for payment. After careful review, I find the evidence submitted by Respondent sufficient to sustain its defense. The payment to which Applicant was otherwise entitled was appropriately applied toward a deductible.

Fee Schedule

Respondent denied the remaining balance of the claims on the grounds that Applicant's charges exceed those permitted under the governing fee schedule.

The rates charged by Applicant must be in accordance with Insurance Law §5108. The services in dispute were performed subsequent to the effective date of the Fourth Amendment to Regulation 68-C (April 1, 2013). 11 NYCRR 65-3.8(g)(1) now states that proof of fact that the amount of loss sustained pursuant to Insurance Law 5106(a) shall not be deemed supplied by an applicant to an insurer and no payment shall be due for 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 services that exceed the charges permissible pursuant to Insurance Law 5108(a) and (b) and the regulations promulgated thereunder for services rendered by medical providers.

The language of 11 NYCRR §65-3.8(g)(1) does not place any additional requirement on a medical provider to substantiate the calculation of its fees as part of its *prima facie* case; the burden of asserting a defense that a provider billed in excess of the fee schedule remains on the insurer, who need not pay the bill if it determines that the bill contravenes the fee schedule. *East Coast Acupuncture, PC v. Hereford Insurance Company*, 51 Misc.3d 441, 26 N.Y.S.3d 441 (Civil Ct. Kings Co. 2016). To be clear, 11 NYCRR 65-3.8(g)(1) does not require an applicant to prove, as part of its *prima facie* case, that the claimed amount aligns with the fee schedule. In terms of what is required, the most notable case on point is *Viviane Etienne Med. Care, P.C. v. Country-Wide Ins. Co.*, 25 N.Y.3d 498, 14 N.Y.S. 3d 283 (2015), which was decided by the Court of

Appeals after the Fourth Amendment to 11 NYCRR 65-3 was adopted. In *Viviane Etienne, supra,* the Court was asked to determine what a provider must show in order to establish its *prima facie* entitlement to no-fault benefits. As stated by the Court, this is done 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."

In *Saddle Brook Surgicenter, LLC v. All State Ins. Co.*, 48 Misc.3d 336, 8 N.Y.S.3d 875 (Civ. Ct. Bronx Co. 2015), the Court found, "The purpose of the [no-fault] statute and the fee schedules promulgated thereunder is to 'significantly reduce the amount paid by insurers for medical services, and thereby help contain the no-fault premium'" (**48 Misc.3d at 340) (*Goldberg v Corcoran*, 153 A.D.2d 113, 118 [2nd Dept. 1989], *quoting Governor's Program Bill*, 1977 McKinney's Session Laws of NY at 2449, and *citing Governor's Mem in Support of Assembly Bill A7781-A*.)

The burden remains on Respondent, however, to come forward with competent evidentiary proof in support of 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). *See also, Power Acupuncture PC v. State Farm Mutual Automobile Ins. Co.*, 11 Misc.3d 1065(A), 816 N.Y.S.2d 700, 2006 NY Slip Op 50393(U), 2006 N.Y. Misc. LEXIS 514 (Civil Ct, Kings Co. 2006). An insurer who raises a fee schedule defense, "will prevail if it demonstrates that it was correct in is reading of the fee schedules." *Jesa Medical Supply, Inc. v. Geico Ins. Co.*, 2009 N.Y. Slip Op. 29386, 25 Misc.3d 1098, 887 N.Y.S.2d 482 (Civ. Ct. Kings Co. 2009). If Respondent fails to demonstrate by competent evidentiary proof that a plaintiff's claims were more than 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 145(A), 819 N.Y.S.2d 847, 2006 NY Slip Op. 50841(U), 2006 N.Y. Misc. LEXIS 1109 (App. Term 1st Dept. *per curiam*, 2006).

I am, however, also permitted to take judicial notice of the Workers' Compensation Fee Schedule. *Kingsbrook Jewish Medical Center the Allstate Insurance Company*, 61 A.D.3d 13 (2nd Dept. 2009); *LVOV Acupuncture PC v. Geico Insurance Company*, 32 Misc.3d 144(A) (App. Term 2nd, 11th &13th Jud. Dists. 2011); *see also, Natural Acupuncture Health PC v. Praetorian Insurance Company*, 30 Misc.3d 132(A), 2011 N.Y. Slip Op. 50040(U) (App. Term 1st Dept. 2011).

At the outset, Respondent contends that Applicant's charges, standing alone, exceed those permitted under the Fee Schedule as the services were rendered by a physical therapist and, therefore, are reimbursable at the rate assigned to physical therapists rather than a medical doctor as billed by Applicant.

Ground Rule 6 of the Introduction and General Guidelines contained in the Acupuncture and Physical Therapy and Occupational Therapy Fee Schedules, "physical therapists employed by physicians must bill separately from the physician-employer."

Ground Rule 5 of the Physic & Occupational Therapy Fee Schedule reads as follows:

> **Codes in the Physical and Occupational Therapy Fee Schedule**
>
> A physical or occupational therapist may only use CPT codes contained in the Physical and Occupational Therapy Fee Schedule for billing of treatment. A physical or occupational therapist may not use codes that do not appear in the Physical and Occupational Therapy Fee Schedule.

In this instance, a physical therapist employed by Applicant rendered the services at issue. Consequently, Applicant is entitled to reimbursement at the physical therapist rate. The fact that Applicant's facility is owned by a medical doctor is of no consequence. Therefore, after careful review of the evidence, together with the Fee Schedule Ground Rules, I find Respondent's reimbursement at the rate applicable to physical therapists proper. (*See also*, AAA case no. 17-23-1294-0119, Arb. Cathryn Roberts; AAA case no. 17-23-1315-8083, Arb. Matthew Summa; AAA case no. 17-23-1307-9153, Arb. Stacey Charkey; and, AAA case no. 17-23-1311-3799.)

For the remaining services at issue, Respondent also contends that it reimbursed other healthcare providers, namely Unicorn Acupuncture and North Shore Family Chiropractic, for services subject to the ground rules rendered on the same dates on which Applicant rendered its services and for which Applicant now seeks additional reimbursement, such that the total units billed by Applicant, Unicorn Acupuncture, and North Shore Family Chiropractic exceed the maximum permissible amount allowable under the Fee Schedule. Respondent, therefore, distributed the maximum permissible amount of payment to all healthcare providers, leaving Applicant with less than full reimbursement. Applicant now seeks the unpaid balance, while the Respondent defends its payments as proper under the Ground Rules.

Pursuant to the 34th Amendment to Regulation 83, effective October 1, 2020, when multiple physical medicine procedures and/or modalities are performed on the same day, reimbursement is limited to 12.0 relative value units (RVUs) per patient per day per accident or illness. (*See* Ground Rule 3 of the New York State Workers' Compensation Chiropractic Fee Schedule and Ground Rule 11 of the Physical Medicine section of the New York State Workers' Compensation Physical & Occupational Therapy Fee Schedule.)

When performing an initial evaluation, including multiple procedures and/or modalities on the same day, the maximum number of relative value units is limited to 18.0 or the amount billed, whichever is less for all providers combined. (*See*, New York Workers' Compensation Medical Fee, Physical Medicine Ground Rule 8; Chiropractic Fee Schedule, Physical Medicine Ground Rules 2 and 3; Acupuncture Fee Schedule, Medicine Ground Rule 1A; and Physical Therapy and Occupational Therapy Fee Schedule, Physical Medicine Ground Rule 2.)

When performing a reevaluation including multiple procedures and/or modalities on the same day, the maximum number of relative value units is limited to 15.0 or the amount billed, whichever is less for all providers combined. (*See,* New York Workers' Compensation Medical Fee, Physical Medicine Ground Rule 8; Chiropractic Fee Schedule, Physical Medicine Ground Rules 2 and 3; Acupuncture Fee Schedule, Medicine Ground Rule 1A; and Physical Therapy and Occupational Therapy Fee Schedule, Physical Medicine Ground Rule 2.)

A fee schedule defense does not always require expert proof. Often times, such as in this instance, calculation of the appropriate rate of reimbursement involves the basic application of fee codes, ground rules, and simple arithmetic. The Ground Rules cited above identify the modalities by CPT code that are subject to the 12, 15, and 18-Unit Rules. The services for which Applicant seeks reimbursement in this proceeding are included within the Ground Rules.

After careful review, I find that the weight, credibility, and persuasiveness of the evidence favors Respondent. The new Fee Schedule is unequivocally clear: a patient may not receive the benefit of more than 12 RVUs per day per accident from all providers, or, alternatively, 15 or 18 RVUs per day when a reevaluation or an initial evaluation is performed together with treatment. The Ground Rules identify the modalities by CPT code that are subject to the Rules. The services for which Applicant seeks reimbursement in this proceeding are included within the Ground Rules. Respondent has submitted Explanation of Benefit Forms ("EOBs") together with internal payment screens confirming payments to Unicorn Acupuncture and North Shore Family Chiropractic for physical medicine modalities, all of which are subject to the Ground Rules, and which were performed on the same dates on which Applicant rendered its services. No issue has been raised surrounding Respondent's proof. Accordingly, Respondent's denials are sustained.

Accordingly, for the reasons discussed above, Applicant is awarded $254.58 in full satisfaction of its claims at issue.

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**
	Brooklyn Medical Practice, PC	**03/14/22 - 03/21/22**	**$5.98**	**Denied**
	Brooklyn Medical Practice, PC	**01/03/22 - 01/31/22**	**$47.97**	**Denied**
	Brooklyn Medical Practice, PC	**11/01/21 - 11/28/21**	**$223.40**	**Denied**
	Brooklyn Medical Practice, PC	**10/05/21 - 10/25/21**	**$250.68**	**Awarded: $140.48**
	Brooklyn Medical Practice, PC	**12/05/21 - 12/08/21**	**$8.97**	**Denied**
	Brooklyn Medical Practice, PC	**09/24/21 - 09/30/21**	**$324.39**	**Awarded: $114.10**
Total			**$861.39**	**Awarded: $254.58**

B. The insurer shall also compute and pay the applicant interest set forth below. 03/30/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant is awarded $254.58, together with applicable interest computed from the date of the filing of the AR-1 until such time as payment is made.

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's fee in accordance with 11 NYCRR 65-4.6(d).

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 Suffolk

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

08/22/2024
(Dated)

Alison Berdnik

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:
380d142f43f5266d5437884934c1ae1c

Electronically Signed

Your name: Alison Berdnik
Signed on: 08/22/2024