American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Goal Physical Therapy P.C (Applicant)	AAA Case No.	17-24-1346-0526
	Applicant's File No.	160588
- and -	Insurer's Claim File No.	23-8003825
	NAIC No.	14800
Progressive Casualty Insurance Company (Respondent)		

ARBITRATION AWARD

I, Alana Barran, 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: Patient

1. Hearing(s) held on 09/13/2024
   Declared closed by the arbitrator on 09/13/2024

   Edilaine D'Arce from Law Offices of Eitan Dagan (Woodhaven) participated virtually for the Applicant

   Christian Guayasamin from Progressive Casualty Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$950.00**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The Applicant amended the amount in dispute to $229.20 to reflect the fee schedule amount of $114.60 per date of service.

   Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

   The patient, KM, was involved in an accident on 12/6/2023. This is a claim for activity limitation measurement to the patient on 12/15/2023 and 1/24/2024. The

Respondent argues that the claim is excessively billed based on the fee schedule. The issue raised is whether the Respondent has sustained its fee schedule defense.

4. Findings, Conclusions, and Basis Therefor

My decision is based on the arguments of the representatives for parties appearing and those documents contained in the ADR Center for this case. The Applicant amended the amount in dispute to $229.20 to reflect the fee schedule amount of $114.60 per date of service.

The respondent argues that this the claim was excessively billed based on the fee schedule and submits statement of Darlene Buttner dated 5/8/2024, a certified coder, in support of its fee schedule defense that the proper fee schedule amount for the services at issue is the sum of $0. Respondent argues that the fee schedule is the only defense. Coder Buttner states that "The procedure billed was 97039 (Unlisted modality (specify type and time if constant attendance). In the New York State Worker's Compensation Fee Schedule CPT procedure code 97039 is listed among the codes subject to Physical & Occupational Therapy Physical Medicine Ground Rule 3 in the Physical & Occupational Therapy Fee Schedule, which limits the maximum allowable reimbursement to 12 relative value units per patient per day…. The code in dispute 97039 is classified in the New York State Worker's Compensation Fee Schedule as a "By Report" (BR) code; the relative value is BR (by report The fee schedule indicates in ground rule #3 of the Introduction and General Guidelines Section regarding By Report codes, "For any procedure where the relative value unit is listed in the schedule as "BR," the physician shall establish a relative value unit consistent in relativity with other relative value units shown in the schedule." The ground rule also states, "Fees for such procedures need to be justified 'by report'." The insurer shall review all submitted "BR" unit values to ensure that relatively consistency is maintained… Since CPT code 97039 is listed with a "By Report" (BR) relative value, the maximum 12 units would apply if another more appropriate code was not applicable to service(s) provided… The provider submitted documentation indicating they are comparing 97039 to 97750- physical performance testing, each 15 minutes at RVU=5.41; 97545-work hardening conditioning initial 4 hours), at RVU=28.00 and 97800-functional capacity evaluation, RVU="refer to Physical Medicine Ground Rule 14- Reg IV = $475.00… . Progressive disagrees with the provider comparison of 97545 (Work Hardening/Conditioning). Per the Physical Medicine Ground Rule #13 Work Hardening Rules: Work hardening programs are interdisciplinary, goal-specific, vocationally-driven treatment programs designed to maximize the likelihood of return to work through functional, behavioral, and vocational management. Not all claimants require

these programs to reach a level of function that will allow successful return to work. Only those programs that meet all of the specific guidelines will be defined as work hardening programs. Programs will be reimbursed per the fee schedule after meeting all other requirements". Per ground rule 13 the goal of the program is return to work. As the bill submitted and the documentation does not indicate that the patient is out of work or returning to work, they would not meet the requirements for code 97545. In addition, code 97545 is for the initial 4 hours. Providers documentation states time needed for testing took between 40-55 minutes total, which clearly does not meet the 4 hours of time it takes for CPT code 97545… . Progressive disagrees with the provider comparison of CPT 97800 (Functional Capacity Evaluation). Based on Physical Medicine Ground Rule 14" The Functional Capacity Evaluation, when medically necessary and indicated, may be performed only at the point of maximum medical improvement in the opinion of the attending physician. The specific requirements must meet at least one of the following criteria for all claimants: 1) claimant is preparing to return to previous job 2) claimant has been offered a new job (verified) 3) claimant is working with a rehabilitation provider and a vocational objective is established 4) claimant is expected to be classified with a non-schedule permanent partial disability. Reports must include 1) patient demographics including work history 2) indication for evaluation 3) type of evaluation performed 4) raw and tabulated data 5) normative data values 6) narrative cover sheet with recommendations… The documentation submitted by the provider did not indicate any of the above criteria needed to bill CPT code 97800. Based on the information submitted by the provider, New York State Fee Schedule and CPT Assistant, the proper code to use for the procedure performed would be procedure code 97750. . The CPT Assistant May 2008 further provides that CPT Code 97750 is reported according to the time spent performing the service, not according to the number of areas tested. Therefore, if during an investigational session a number of body areas are tested, time spent is the criterion used to determine the number of times to report CPT Code 97750. The Fee Schedule requires the records in support of CPT Code 97750 to document time in fifteen-minute increments… According to the Fee Schedule, it is the provider's responsibility to comply with the code specific requirements and to verify the amount of time spent testing the patient. The documentation submitted by the provider indicates that 40-55 minutes was the total time spent. If using the greatest amount of time listed as 55 minutes, this would equal [four] units of 97750. Based on the documentation/report submitted by the provider and the New York State Fee Schedule, the proper code to use for the procedure performed would be procedure code 97750. Progressive verified physical performance testing was performed. Per the New York Workers Compensation Fee Schedule effective 10/1/20 procedure code 97750 has an RVU of 0.00, therefore no payment would be allowed. Based on my review of the claim and the claim handling for the bills in dispute for dates of service November 8, 2023, and December 6, 2023, the allowable fee schedule amount is $0, and the

remainder of the claim should be dismissed as billed in excess of the Worker's Compensation Fee Schedule pursuant to 11 NYCRR 65-3.8(g)(1)(ii) and 11 NYCRR 68.7."

The Respondent argues that Applicant's own documentation provided that a comparison was made of CPT codes 97750, 97545 and 97800 which are analyzed and discussed in coder Butnner's report, that based on the evidence the claim is reimbursable in the sum of $0.

As part of the medical report a document entitled "Activity Limitation Measurement and Training Report {billed as 97039} which states that "the examination takes 40-55 minutes…the only proper CPT code to be used to bill for the procedure is 97039…;" that 97800 may not be billed because it has a more limited purpose and the testing here has a wider purpose and includes a training component and should therefore have a greater RVU than functional capacity evaluation; that a majority of the providers in the area are charging $475.00 and it is the proper amount to bill. The Applicant argues that the services were performed, are to be reimbursed as the fee schedule allows for 12 units per day which has not been paid here, and that coder Buttner opted to apply CPT code 97750 because the RVU is 0.

I have reviewed and considered both the Applicant and Respondent submitted awards by no-fault arbitrators on this specific issue which are unrelated to this claim as well as the arguments made by the parties and the credible relevant evidence.

I find persuasive the language in coder Buttner's report that "*Since CPT code 97039 is listed with a "By Report" (BR) relative value, the maximum 12 units would apply* ***if another more appropriate code was not applicable to service(s) provided.*****"**Additionally, I find persuasive similar rationale by Arb. Richard Martino in AAA Case No: 1723-1283-3533 stating that "Therefore since the Respondent has not proven their Fee Schedule defense with regard to the code billed by the applicant (CPT Code 97039), I find that the Applicant is entitled to be reimbursed for the activity limitation measurement in dispute. However , the Applicant billed CPT code 97039 for "Activity Limitation Measurement." Although CPT code 97039 has an RVU of "BR," the code itself is listed in Physical Medicine Ground Rule 3 as subject to a maximum limit of 12.0 RVUs per patient per day. The conversation factor for this service $9.55 per RVU. $9.55 multiplied by 12.0 RVUs equals $114.60 ($9.55 x 12 = $114.60). Therefore I find that the Applicant is entitled to be reimbursed for the activity limitation measurements in dispute for each date of service in the amount of $114.60."

I find unpersuasive the conclusory rationale by coder Buttner that "Based on the information submitted by the provider, New York State Fee Schedule and CPT Assistant, the proper code to use for the procedure performed would be

procedure code 97750… . The CPT Assistant May 2008 further provides that CPT Code 97750 is reported according to the time spent performing the service… The Fee Schedule requires the records in support of CPT Code 97750 to document time in fifteen-minute increments… Based on the documentation/report submitted by the provider and the New York State Fee Schedule, the proper code to use for the procedure performed would be procedure code 97750." Notably, as stated by coder Buttner, maximum of 12 units would apply "*apply* ***if another more appropriate code was not applicable to service(s) provided."***

I find that the Respondent has failed to establish that a more appropriate code is applicable but rather states in a conclusory manner that CPT 99750 applies, and it is analyzed by the time spent on the testing at issue without a clear explanation or comparison of CPT 97750 physical performance test or measurement to the services performed here. I find coder Buttner's report to be persuasive that CPT codes 97545 and 97800 are not more appropriate, and to be unpersuasive and insufficient to establish that CPT code 97750 is more appropriately applied here. I find that the Respondent has failed to sustain its defense that the reimbursable amount is $0, and I find persuasive that the maximum of 12 units would apply and, therefore, that the claim is reimbursable in the sum of $114.60 per date of service. The proof is insufficient to establish that this or another provider have been paid 12 units per date of service at issue. Therefore, the claim is granted in the sum of $229.20.

While the Respondent raised an additional defense in its denial, in the absence of any proof, Respondent failed to establish that the fees charged were excessive and not in accordance with the Workers' Compensation fee schedule. See St. Vincent Medical Care, P.C. v. Country Wide Ins. Co., 2010 NY Slip Op 50488(U) (App Term 2d, 11th & 13th Dists. Mar. 19, 2010).

Respondent has the burden to come forward with competent evidentiary proof to support its fee schedule defenses. See Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co.,13 Misc.3d 172, 822 N.Y.S.2d 378, (Civil Ct, Kings Co. 2006). See, also, Power Acupuncture PC v. State Farm MutualAutomobile Ins. Co., 11 Misc.3d 1065A, 816 N.Y.S.2d 700(Civil Ct, Kings Co. 2006)..

Comparing the relevant evidence presented by both parties against each other and the above referenced standards, based on the foregoing, the Applicant is awarded the sum of $229.20.

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**	**Amount Amended**	**Status**
	Goal Physical Therapy P.C	**12/15/23 - 01/24/24**	**$950.00**	**$229.20**	**Awarded: $229.20**
Total			**$950.00**		**Awarded: $229.20**

B. The insurer shall also compute and pay the applicant interest set forth below. 05/01/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Where a claim is untimely denied, or not denied or paid, interest shall accrue as of the 30th day following the date the claim is presented by the claimant to the insurer for payment. Where a claim is timely denied, interest shall accrue as of the date an action is commenced or an arbitration requested, unless an action is commenced or an arbitration requested within 30 days after receipt of the denial, in which event interest shall begin to accrue as of the date the denial is received by the claimant. (11 NYCRR 65-3.9(c)). The end date for the calculation of interest shall be the date of payment of the claim. In calculating interest, the date of accrual shall be excluded from the calculation. Where a motor vehicle accident occurs after April 5, 2002, interest shall/be calculated at the rate of two percent per month, simple, calculated on a pro rata basis using a 30-day month.

(11 NYCRR 65-3.9(a)). Where the claim is submitted electronically after the close of business or on the weekend, I find that the claim is deemed received on the next day of business following the electronic submission, and interest is awarded as of the next day of business following the electronic submission of the claim.

C. Attorney's Fees

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

For cases filed prior to February 4, 2015, 20 percent of the amount of first party benefits awarded herein, plus interest thereon, subject to a minimum of $60 and a maximum of $850. For cases filed on or after February 4, 2015, 20 percent of the amount of first party benefits awarded herein, plus interest thereon, subject to no minimum and a maximum of $1360 (11NYCRR65-4).

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 NJ
SS :
County of Essex

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

09/14/2024
(Dated)

Alana Barran

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:
e78803c2773fe4e5629cb754ab5143ad

Electronically Signed

Your name: Alana Barran
Signed on: 09/14/2024