American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Van Siclen Chiropractic PC (Applicant)	AAA Case No.	17-24-1335-3433
	Applicant's File No.	n/a
- and -	Insurer's Claim File No.	0706094497 2CI
	NAIC No.	29688
Allstate Fire & Casualty Insurance Company (Respondent)		

ARBITRATION AWARD

I, Amanda R. Kronin, 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: CH

1. Hearing(s) held on 09/25/2024
   Declared closed by the arbitrator on 10/01/2024

   Usam Nawaz, Esq from Law Offices of Hillary Blumenthal LLC (Hoboken) participated virtually for the Applicant

   Dana Nolan, Esq from Law Offices of John Trop participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$942.12**, 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 Assignor, CH, a 68-year-old male, was involved as a driver in a motor vehicle accident on 3/12/23. At issue in this case is $942.12 for treatment provided from 5/3/23 through 11/21/23. Respondent issued partial payments and denied the outstanding claim citing the fee schedule. The question presented is whether the treatment was properly reimbursed in accordance with the 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. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

It is well-settled that a health care provider establishes its prima facie entitlement to judgment as a matter of law by proof that it submitted a claim, setting forth the fact and the amount of the loss sustained, and that payment of No-Fault benefits was overdue. Damadian MRI in Canarsie, PC a/a/o Tyrone Harley v. General Assurance Co., 1006 NY Slip Op. 51048U; Supreme Court of NY, App. Term., 2d Dept., June 2, 2006; See: Insurance Law § 5106 a, Mary Immaculate Hosp. v. Allstate Ins. Co., 5 AD3d 742, 774 N.Y.S.2d 564 (2004); Amaze Med. Supply v. Eagle Ins. Co., 2 Misc. 3d 128A, 784 N.Y.S.2d 918 [2003 NY Slip Op 51701U (App. Term, 2d & 11th Jud. Dists.). See also: 11 NYCRR §65-1.1, Vista Surgical Supplies, Inc. v. Metropolitan Property and Casualty Ins. Co., 2005-1328 K C., 2006 NY Slip Op. 51047U, June 2, 2006.

In support of its position, Applicant submitted claims in the amount of $942.12 for the treatment at issue.

Respondent maintained that it properly reimbursed the applicant in accordance with the fee schedule and the payments were not recognized. Post-hearing I afforded the respondent the opportunity to upload proof of its payments. Respondent uploaded all proof of payment and acknowledged that it owed applicant $.18 for dates of service 11/02/23 through 11/21/23 and $17.78 for for date of service 11/13/23.

PPE

The only remaining issue is whether Applicant is entitled to reimbursement for the balance of charges for PPE used during

treatment performed on Claimant. Applicant seeks reimbursement in the amount of $310.29 for PPE provided to the applicant in the amount of $15.00 per date of service.

During the treatment, Applicant used Personal Protective Equipment (PPE) and billed for those items utilizing CPT code 99072 Upon receipt, Respondent denied payment for these items and maintains that these services are not compensable. CPT code 99072 was added to the Fee Schedule for the very purpose of using it to bill for these items. Code 99072 was released by the AMA and became effective on Sept. 8, 2020. The code, in pertinent part 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. This code was specifically implemented for use when services are performed "during a Public Health Emergency as defined by law". In this case, the New York State Emergency Health Order expired on June 24, 2021. The services at issue were billed following the expiration of the order.

Respondent has the burden of coming forward with competent evidentiary proof to support 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). If Respondent fails to demonstrate by competent evidentiary proof that a plaintiff's claims were in excess of the appropriate fee schedules, Respondent's defense of noncompliance with the appropriate fee schedules cannot be sustained. See, Continental Medical PC v. Travelers Indemnity Co., 11 Misc.3d 145A, 819 N.Y.S.2d 847, 2006 NY Slip Op 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Term, 1st Dep't, per curiam, 2006).

Respondent relies upon various arbitration decisions. I rely the decision by Arbitrator Meryum Toksoy AAA #17-21-1207-8464, therein she states: that CPT 99072 was not adopted by the Workers' Compensation Code 99072 represents a new practice expense code

specifically intended for use during a declared PHE, as defined by law, due to a respiratory-transmitted infectious disease. It was established in response to the significant additional practice expenses related to in-person activities required to provide medical visits or services to patients safely during a PHE. Code 99072 was designed to capture the following practice-expense components over and above those usually included with an office visit or other services rendered: Additional clinical staff time(registered nurse [RN]/licensed practical nurse [LPN]/medical technical assistant [MTA]) to conduct a pre-visit phone call to screen the patient (symptom check), provide instructions on social distancing during the visit, check patients for symptoms upon arrival, apply and remove PPE, and perform additional cleaning of the examination/procedure/imaging rooms, equipment, and supplies; Three surgical masks; and Additional supplies, including additional quantities of hand sanitizer and disinfecting wipes, sprays, and cleansers. Code 99072 should only be reported when the service is rendered in a non-facility place of service (POS) setting, and in an area where it is required to mitigate the transmission of the respiratory disease for which the PHE was declared. A comprehensive list of POS codes and their facility/non-facility designations are available at: https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_c . In contrast to code 99070, Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided), code 99072 is reported only during a PHE and only for additional items required to support a safe in-person provision of evaluation, treatment, or procedural service(s). These items differ significantly from those items that are typically reported with code 99070, which focus on additional supplies provided over and above those usually included with a specific non-PHE service, such as drugs, intravenous (IV) catheters, or trays. In addition, code 99072 is meant to account for and capture the additional time required by clinical staff to provide their services safely. To ensure that code 99070 is not used incorrectly to report time and supplies during a PHE, a parenthetical note was added after code 99070 to direct users to code 99072 when the required use of additional supplies, materials, and preparation time are related to a PHE, as

defined by law, due to a respiratory-transmitted infectious disease. Code 99072 should be reported only once per in-person patient encounters per provider identification number (PIN), regardless of the number of services rendered at that encounter. In instances in which these noted clinical staff activities are performed by a physician or other qualified healthcare professional (eg, in practice environments without clinical staff or a shortage of available staff), the activity requirements of this code would be considered as having been met; however, the time spent on these activities should not be counted in any other time-based visit or service reported during the same encounter. QUESTIONS AND ANSWERS Question: Code 99072 is stated as being applicable "during a PHE." What information should be used to verify when a PHE is in effect? Answer: A PHE is in effect when declared by law by officially designated relevant public health authority(ies). Question: For what type of patient encounters or services should code 99072 be reported? Answer: Code 99072 may be reported for an in-person patient encounter for an office visit or other non-facility service, in which the implemented guidelines related to mitigating the transmission of the respiratory disease for which the PHE was declared are required. Usage of this code is not dependent on a specific patient diagnosis. For a list of POS codes with facility or non-facility designations, visit: https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_c . Question: What documentation is required to report code 99072? Answer: Given that code 99072 may only be reported during a PHE, do not report this code in conjunction with an evaluation and management (E/M) service or procedure when a PHE is not in effect.

Therefore, code 99072 is reported only when health and safety conditions applicable to a PHE require the type of supplies and additional clinical staff time explained in the code descriptor. Documentation requirements may vary among third-party payers; therefore, contact the specific third-party payers for their documentation requirements. CPT Assistant, Frequently Asked Questions, February 2021 newsletter, page 13: [excerpt] Medicine: Miscellaneous Medicine Services Question: May new code 99072 be reported by physicians and other QHPs? Answer: Yes, both physicians and other QHPs, such as optometrists, may report new

code 99072, 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 (PHE) as defined by law, due to respiratory-transmitted infectious disease, when additional practice expenses are incurred during a PHE. "Other QHP" is defined as an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable), who performs a professional service within his or her scope of practice and independently reports that professional service (eg, NP, PA, optometrist, social worker, PT). Per CPT Assistant Special Edition: September Update (2020), "Code 99072 is to be reported only once per in-person patient encounter per provider identification number (PIN), regardless of the number of services rendered at that encounter. In the instance in which the noted clinical staff activities are performed by a physician or other qualified health care professional (eg, in practice environments without clinical staff or a shortage of available staff), the activity requirements of this code would be considered as having been met." CIRCULAR LETTER NO. 14 FROM THE DEPARTMENT OF FINANCIAL SERVICES (DFS) Insurance Circular Letter No. 14 (2020) August 5, 2020 TO: All Insurers Authorized to Write Accident and Health Insurance in New York State, Article 43 Corporations, Health Maintenance Organizations, Student Health Plans Certified Pursuant to Insurance Law § 1124, Municipal Cooperative Health Benefit Plans and Prepaid Health Services Plans RE: Charges for Personal Protective Equipment by Participating Providers 4. STATUTORY AND REGULATORY REFERENCES: N.Y. Insurance Law §§ 2601, 3217-a, 3221, 4305, and 4324; N.Y. Public Health Law § 4408; 11 NYCRR 52 (Insurance Regulation 62) I. Purpose After a period of offering primarily telehealth visits during the COVID-19 pandemic, many physicians, dentists, and other health care providers (collectively, "providers") have resumed seeing patients in person. As COVID-19 transmission poses a risk in provider office settings, providers are putting necessary protective measures in place, including sanitizing exam rooms and using personal protective equipment, such as masks, gowns, and gloves (collectively, "PPE"). The Department of Financial Services ("Department") has recently received complaints regarding participating providers charging insureds fees for the providers' use of PPE during in-person visits for

covered services under health or dental insurance policies or contracts. These fees for PPE are in addition to the insureds' cost-sharing for covered services. This circular letter reminds insurers authorized to write accident and health insurance in New York State, Article 43 corporations, health maintenance organizations, student health plans certified pursuant to Insurance Law § 1124, municipal cooperative health benefit plans, and prepaid health services plans (collectively, "issuers") 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. II. Discussion Insurance Law §§ 3221(a)(6) and 4305(a) require issuers to issue to the group policyholder or contract holder, for delivery to each member of the group, a certificate setting forth in summary form the essential features of the insurance coverage. Furthermore, Insurance Law §§ 3217-a(a)(5) and 4324(a)(5) and Public Health Law § 4408(1)(e) require issuers to disclose in the policy or contract, or through a separate disclosure statement, an explanation of an insured's financial responsibility for payment of premiums, coinsurance, co-payments, deductibles, and any other charges, annual limits on an insured's financial responsibility, caps on payments for covered services, and financial responsibility for non-covered health care procedures, treatments, or services.

Furthermore, to assist consumers in [1] New York State to better understand and evaluate the benefits provided in policies or contracts, issuers must make a full and fair disclosure of policy or contract benefits pursuant to 11 NYCRR §§ 52.1(d) and 52.54. These sections of the Insurance Law and regulations and the Public Health Law clearly require issuers to disclose the insured's financial responsibility for covered services, including any other charges, and such disclosure should be made for medical and dental coverage. The Department has been made aware that participating providers, particularly under dental insurance policies or contracts, are charging insureds fees at the time of in-person visits for PPE or other charges related to increased costs due to COVID-19 that are in addition to the insureds' cost-sharing for such covered services. A provider who participates with an issuer's provider network has agreed to accept a reimbursement amount from the issuer for covered services, with the

insured responsible for the cost-sharing set forth in the insured's health or dental insurance policy or contract. 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. Accordingly, issuers should ensure that their participating providers are not charging insureds any fees or other charges beyond the insureds' financial responsibility for covered services as set forth in the insureds' health or dental insurance policies or contracts. Issuers should immediately notify participating providers that they should not charge insureds fees that are beyond the insureds' financial responsibility for covered services, such as fees for PPE, and issuers should instruct participating providers to refund any such fees to insureds. In addition, issuers should notify insureds that they should not be charged fees for PPE when visiting a participating provider and include the issuer's contact information for insureds to submit a complaint regarding PPE charges. Issuers should resolve any issues regarding increased costs due to COVID-19 directly with their participating providers, including for PPE, and insureds should be held harmless for such charges. In order to facilitate resolution, issuers may need to request information from participating providers regarding insureds who were charged fees that exceeded their financial responsibility, and participating providers should report such information to issuers, upon request by issuers. Issuers should work with participating providers to ensure that refunds are provided to insureds. Within 90 days of this circular letter, issuers should report to the Department, at the e-mail address below, the amount of PPE fees that were charged to insureds, the number of insureds impacted, and provide a description of how refunds will be provided. III. Conclusion Issuers 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. In the event an insured has paid such a fee, an issuer should resolve the issue for the insured with its participating provider. The Department will monitor compliance with these requirements, including during market conduct exams. The Department may take action at any time against an issuer for failing to adhere to the requirements of this circular letter. Please direct any questions regarding this circular letter by email to

health@dfs.ny.gov. Very truly yours, Lisette Johnson Chief, Health Bureau [Footnote] [1]: The insurance policy or contract controls in the event of any inconsistency between a separate written disclosure statement and the insurance policy or contract.

Applicant may point out that it is seeking to recover the cost of the supplies from the Respondent, not the insured. Based on this distinction, it may argue that Circular Letter No. 14 is irrelevant, that it has no probative value. I would disagree. In Circular Letter No. 14, the Department explains why providers are barred from passing on the cost of supplies to a policy holder. The reason is simple: because it is not the insured's financial responsibility. If a carrier denies reimbursement, the provider may not look to the insured to recover the cost. By engaging in this practice, the provider is going beyond the terms of the policy and asserting a right which does not exist. The Department makes clear that the insured is only responsible for what is outlined in the contract. No more, no less. The Department also advises that it does not approve of terms within the policy or contract which would make the insured responsible for PPE supplies. Circular Letter No. 14 is on point. The only way that Applicant is able to seek payment for No-Fault benefits is because of the policy that was negotiated between the Respondent and its insured. The terms of their agreement are spelled out in this contract, documenting their rights and obligations to one another. By executing the Assignment of Benefits (AOB), the Applicant places itself in the shoes of the assignor. Its entitlement to No-Fault benefits is no greater or less than what the assignor would receive under the policy. It is through this contract that the Applicant is reimbursed. If the Respondent were directed to pay for the PHE supplies, that cost would pass down to the policy holder. It does not matter that the Applicant's fee is $15.00 and not $5000.00.

Due to the high volume of claims, what is paid by the insurer - be it a small or large amount - will get factored into what is paid by its insured. In the vast majority of cases, where a judge or an arbitrator is called upon to decide a claim for No-Fault benefits, the party who is seeking to be reimbursed is the provider. It is worth considering how this issue would be interpreted if the applicant was the insured.

Would a treating provider be able to demand payment for the PHE supplies? No. It is not the insured's responsibility. An Assignment of Benefits (AOB) form does not change the answer.

In this case, Applicant is claiming that it is entitled to be paid for the PHE supplies even though: The Workers' Compensation Board has not included it within any of its fee schedules. An analysis under 11 NYCRR 68.5 shows that it is not reimbursable. The insured is not responsible for the cost of PHE supplies; providers are barred from demanding payment. The Department does not approve of policy terms that would make the insured responsible; PHE supplies cannot be deemed a covered expense under section 5102 of the Insurance Law. Insurers are only obligated to pay for what is covered under the policy. For the reasons stated above, I find in favor of the Respondent. This portion of the claim is hereby denied in full.

This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator.

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	**05/03/23 - 05/23/23**	**$506.10**	**Denied**
	Van Siclen Chiropractic PC	**06/14/23 - 06/28/23**	**$75.27**	**Denied**
	Van Siclen Chiropractic PC	**07/05/23 - 07/19/23**	**$90.00**	**Denied**
	Van Siclen Chiropractic PC	**11/02/23 - 11/21/23**	**$175.92**	**Awarded: $0.18**
	Van Siclen Chiropractic PC	**11/13/23 - 11/13/23**	**$94.83**	**Awarded: $17.78**
Total			**$942.12**	**Awarded: $17.96**

B. The insurer shall also compute and pay the applicant interest set forth below. 02/05/2024 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).

C. Attorney's Fees

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

Applicant is awarded statutory attorney fees pursuant to the no-fault regulations. See, 11 NYCRR §65-4.5(s)(2). The award of attorney fees shall be paid by the insurer. 11 NYCRR §65-4.5(e). For claims that fall under the Sixth Amendment to the regulation the following shall apply: "If the claim is resolved by the designated organization at any time prior to transmittal to an arbitrator and it was initially denied by the insurer or overdue, the payment of the applicant's attorney's fee by the insurer shall be limited to 20 percent of the total amount of first-party benefits and any additional first- party benefits, plus interest thereon, for each applicant with whom the respective parties have agreed and resolved disputes, subject to a maximum fee of $1,360." 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, Amanda R. Kronin, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

10/03/2024
(Dated)

Amanda R. Kronin

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:
ff8cd68e74867c2741bb627e95cb903c

Electronically Signed

Your name: Amanda R. Kronin
Signed on: 10/03/2024