American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

RCK Medical Services PC (Applicant)	AAA Case No.	17-24-1333-9811
	Applicant's File No.	M07957
- and -	Insurer's Claim File No.	272 PP IWN2898 F
Travelers Personal Insurance Company (Respondent)	NAIC No.	38130

ARBITRATION AWARD

I, John Hyland, 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: EG

1. Hearing(s) held on 10/17/2024
   Declared closed by the arbitrator on 10/17/2024

   Ashley Andrews-Santillo, Esq. from Munawar Law Firm, PLLC participated virtually for the Applicant

   Tamara Lefranc, Esq. from Law Offices of Tina Newsome-Lee participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$486.34**, 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 EG, a 57-year-old male, was injured in a motor vehicle accident that occurred on July 19, 2023. Following the accident, EG suffered injuries to his neck, back, and left shoulder, which resulted in his seeking treatment. In dispute is Applicant's claim for disability testing provided to the Assignor on October 4, 2023 and November 9, 2023. The issue to be determined is whether this testing is reimbursable under the No-Fault laws.

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. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

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). See also, Power Acupuncture PC v. State Farm Mutual Automobile Ins. Co., 11 Misc.3d 1065A, 816 N.Y.S.2d 700, 2006 NY Slip Op 50393U, 2006 N.Y. Misc. LEXIS 514 (Civil Ct, Kings Co. 2006). If Respondent fails to demonstrate by competent evidentiary proof that an Applicant'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).

In that regard, an insurer's unilateral decision to re-code or change a medical provider's billed CPT codes, to reimburse disputed medical services at a reduced rate, or to deny a claim in its entirety, is ineffectual when unsupported by a peer review report or by other proof setting forth a sufficiently detailed factual basis and medical rationale for the code changes, fee reductions and denials. See Amaze Medical Supply v. Eagle Insurance Company, 2 Misc 3d 128A (App Term 2d and 11th Jud Dist 2003).

If an insurer presents sufficient evidence to substantiate its reduction of a bill pursuant to the Workers' Compensation Medical Fee Schedule, the burden shifts to the medical provider to rebut the carrier's fee schedule interpretation. See, Natural Acupuncture Health, P.C. v. Praetorian Ins. Co., 30 Misc 3d 132A (App Term 1st Dept 2011).

Applicant submitted the bills at issue totaling $491.51 utilizing CPT code 99456. This code is not reimbursable for No-Fault billing. CPT Code 99456 is "work related or medical disability examination by other than the treating physician."

The CPT Assistant notes that codes 99245 and 99246 were "added to report specific services that occur when completing evaluations for life insurance and/or disability claims, as well as work related or other medical disability examinations." The CPT Assistant goes on to note that: These services are separate and distinct from other evaluation and management services. These codes are to be used to report evaluations performed in order to establish baseline information, prior to life or disability insurance

certificates being issued. See CPT Assistant, Special Evaluation and Management Services Added to CPT 1995, Summer 1995 issue, page 14.

The August 2103 issue of CPT Assistant (Volume 23, Issue 8), published by the American Medical Association, the creator of the CPT coding system, provides as follows concerning CPT Code 99456:

> "Question: What is the proper way to report evaluation services related to a worker's compensation injury for new and established patients?
> Answer: 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. This service is performed in the office or other setting and applies to new and established patients. When using these codes, no active management of the problem(s) is undertaken during the encounter. These codes are not intended to be used for active E/M services due to work-related injuries. If other E/M services and/or procedures are performed on the same date, the appropriate E/M or procedure code(s) should be reported in addition to codes 99455 and 99456. Modifier 25 may be appended to the E/M service code. Code 99455 and 99456 would not be used if the complete services as identified for disability evaluation are not performed. Instead, the appropriate code from the 99201-99215 code series may be used to identify the services rendered."

I note that the CPT Assistant is a source which must be considered when evaluating a claim for No-Fault benefits. See Matter of Global Liberty Ins. Co. v. McMahon, 2019 NY Slip Op 03692 (App. Div., First Dept., May 9, 2019).

It should also be noted that Ground Rule 8 of the E&M Chapter of the Fee Schedule states that this CPT code is designed for "provider evaluations to establish baseline insurance certification and/or work-related or medical disability."

As Arbitrator Kelleher states in AAA case # 17-22-1253-1607: "The mere fact that this code exists within the fee schedule does not mean it should be billed in a no-fault context. The verbiage of the code, CPT assistant, and Ground Rule 8 make plain the basis for this code is for a baseline for life and disability insurance. That is not the case herein. Despite Mr. Miscoe's exhaustive efforts to discredit the citations to the CPT assistant, the CPT assistant articles and FAQs make plain this code is inapplicable to

no-fault. As noted in Mr. Miscoe's affidavit the "newsletter does not replace the CPT codebook; it only services as a guide." (emphasis supplied). In this instance, it "guides" the conclusion that this code is not to be billed in this context.

Moreover, CPT code 99456 is a BR code and should be billed with an RVU "consistent in relativity" with other relative values in the fee schedule. Using Mr. Miscoe's calculation, Applicant would be entitled to RVUs of 70.45. Same is a significant departure from other relative value units in the fee schedule. His, as well as the IHCs, attempt to justify that code with using CPT code 95831 and 95851, which are no longer reimbursable under the New York State Workers' Compensation fee schedule, demonstrates that Applicant is inflating the RVUs. These codes are not meant to be reimbursed no matter how billed and should not be included in any calculation for reimbursement."

This code description clearly indicates that this CPT code does not apply to No-Fault cases because the work-related or medical disability examination described in the code's description is not intended to treat a patient's injuries. Instead, it is intended to provide information necessary to obtain certain disability insurance certificates.

As this code is not reimbursable, the claim is denied in its entirety.

Any further issues raised in the hearing record are held to be moot and/or waived insofar as not 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 Westchester

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

10/21/2024
(Dated)

John Hyland

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:
7daaf8b377ce7b87eaa5ec43f8c46116

Electronically Signed

Your name: John Hyland
Signed on: 10/21/2024