American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

RCK Medical Services PC (Applicant)	AAA Case No.	17-24-1337-1899
	Applicant's File No.	FDNY24-73610
- and -	Insurer's Claim File No.	066825-GP
	NAIC No.	23760
Nationwide General Insurance Company (Respondent)		

ARBITRATION AWARD

I, Shawn Kelleher, 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: FRP

1. Hearing(s) held on 10/28/2024
   Declared closed by the arbitrator on 10/28/2024

   Todd Fass, Esq. from Fass & D'Agostino, P.C. participated virtually for the Applicant

   Kavon Lewis, Esq. from Law Offices of Brian Rayhill 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.

   Applicant amended the amount in dispute to $403.71 to reflect a prior payment.

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

3. Summary of Issues in Dispute

   The Assignor, FRP, a 42-year-old female, was involved in a motor vehicle accident on 9/25/23. At issue in this case is $491.51, amended by applicant to $403.71, for a work-related examination performed on 12/14/22. Respondent timely denied the claim based upon the fee schedule. The issue presented is what is the proper reimbursement under the New York State Workers' Compensation 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. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

Applicant establishes its prima facie entitlement to reimbursement with proof that it submitted a proper claim, setting forth the fact and the amount charged for the services rendered and that payment of no-fault benefits was overdue. See Insurance Law § 5106 a; Viviane Etienne Med. Care v. Country-Wide Ins. Co., 25 N.Y.3d 498, 501 (2015); Mary Immaculate Hosp. v. Allstate Ins. Co., 5 A.D. 3d 742, 774 N.Y.S. 2d 564 (2nd Dept., 2004). Once an Applicant has established its prima face case, the burden shifts to the insurer to establish that it timely and properly denied the claims, and the basis of its denial.

Applicant established its prima case in this matter by submission of the subject bills evidencing the amount charged.

Insurance Law § 5102(a)(1) defines "basic economic loss" as including "all necessary expenses incurred for…professional health services" subject to the limitations of Insurance Law § 5108. Insurance Law § 5108 limits the amounts to be charged by providers of health services, and states that charges for services specified in Insurance Law § 5102(a)(1) "shall not exceed the charges permissible under the schedules prepared and established by the chairman for the workers' compensation board…except where the insurer…determines that unusual procedures or unique circumstances justify the excess charge." 11 NYCRR § 65-3.16(a) provides that "[p]ayment for medical expenses shall be in accordance with fee schedules promulgated under section 5108 of the Insurance Law and contained in Part 68 of this Title (**Regulation 83)**." 11 NYCRR § 68.1 provides that the "existing fee schedules prepared and established by the chairman of the Workers' Compensation Board…are hereby adopted by the Superintendent of Insurance with appropriate modifications so as to adapt such schedules for use pursuant to section 5108 of the Insurance Law."

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 a plaintiff's claims were in excess of 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 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).

Applicant herein billed CPT code 99456.

> CPT code 99456 is defined as a 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".

Under the New York State Workers' Compensation Fee Schedule, there is no relative value unit associated with CPT code 99456. Said code is a By-Report Code. Per the fee schedule, "[s]ome services do not have a relative value unit assigned because they are too variable or new. These by report services are identified with a 'BR'."

Further, the Fee Schedule states:

> **By report (BR) items:** "BR" in the relative value column represents services that are too variable in the nature of their performance to permit assignment of relative value units. Fees for such procedures need to be justified "by report." Pertinent information concerning the nature, extent, and need for the procedure or service, the time, the skill, and equipment necessary, etc., is to be furnished. A detailed clinical record is not necessary, but sufficient information shall be submitted to permit a sound evaluation. It must be emphasized that reviews are based on records; hence the importance of documentation. The original official record, such as operative report and hospital chart, will be given far greater weight than supplementary reports formulated and submitted at later dates. For any procedure where the relative value unit is listed in the schedule as "BR," the chiropractor shall establish a relative value unit consistent in relativity with other relative value units shown in the schedule. The insurer shall review all submitted "BR" unit values to ensure that the relativity consistency is maintained. The general conditions and requirements of the General Ground Rules apply to all "BR" items.

As such, to determine the proper amount of reimbursement, records must be submitted with the bills to determine "a relative value unit consistent in relativity with other relative value units shown in the schedule."

The Appellate Term, Second Department has held that the Civil Court was incorrect in granting an insurer's motion for summary judgment after the carrier argued it "**fully"** paid CPT codes 97029 and 99199 (two by-report codes). The Court held that:

> The workers' compensation fee schedules do not assign a relative value to either of those codes, but instead have assigned them a "By Report" designation, which requires a provider to furnish certain additional documentation to enable the insurer to determine the appropriate amount of reimbursement. Plaintiff did not provide such documentation with its claim forms and defendant did not, within 15 business days of its receipt of the claim forms, request "any additional

> verification required by the insurer to establish proof of claim" (11 NYCRR 65-3.5 [b]). As defendant failed to demonstrate upon its motion that it had requested any additional verification from plaintiff seeking the information it required in order to review plaintiff's claims for services billed under codes 97039 and 99199 of the workers' compensation fee schedules, defendant was not entitled to summary judgment dismissing so much of the complaint as sought to recover for services rendered under those codes.

Bronx Acupuncture Therapy P.C. v. Hereford Ins. Co., 2017 N.Y. Slip. Op. 50101(U) (App. Term. 2nd Dept., 2017). In this matter, Applicant submitted the evaluation/report and an affidavit from Michael Miscoe, CPC.

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.

Further, it was noted by the CPT assistant that:

> CPT Assistant, Frequently Asked Questions: Evaluation and Management: Special E/M Services, August 2013 issue, page 13:
>
> 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 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 both 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 additional to codes 99455 and 99456. Modifier 25 may be appended to the E/M service code. Codes 99455 and 99456 would not be used if the complete services as identified for disability evaluations are not performed. Instead, the appropriate code from the 99201-99215 code series may be used to identify the services rendered.

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."

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.

Respondent submits a coder report from Russell Arnold. He states:

> That Applicant billed CPT Code 99456 for services allegedly provided on December 26, 2023, in the amount of $491.51. Based on the NY Workers' Compensation FeeSchedule, E & M Section, Rule #8: 99455 and 99456 are to be used to report evaluations in order to establish baseline information for insurance certification and/or work-related or medical disability. The American Medical Association's CPT guidelines state that these codes are "used to report evaluations performed to establish baseline information prior to life or disability insurance certifications being issued." These codes are not valid for NY No-Fault claims. Also, the code billed is a By Report (BR) code. Based on the fee-schedule rules, the fee for BR procedures is to be consistent in relativity with the closest similar procedure that has a value in the schedule. The service performed is equivalent to a standard E & M office visit with the following components: History, exam & medical decision making. Therefore, the closest similar procedure in the feeschedule is 99213, which carries a fee of $87.80 (Relative Value 5.83 x Conversion Factor $15.06).

As I have held in a similar matter:

> Respondent submits a coder report who states that the reimbursement shoulder be zero. I disagree with said argument as work was performed. 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. As noted by Respondent's coder, CPT code 99243 is an appropriate code to use for this visit as same is consistent in relativity with other codes. CPT code 99750, 95831, 95832 and 95833 are not meant to be reimbursed no matter how billed and should not be included in any calculation for reimbursement. As such, Applicant is awarded $248.34.

See 17-22-1275-0150.

Mr. Miscoe's affidavit is wholly unconvincing insofar as he uses CPT codes specifically deleted by the Workers Compensation Board (CPT codes 95831, 95851) to justify his RVU. Under no circumstance should codes not in the fee schedule be using to establish a relative value unit "consistent in relativity without units." If he were to use those codes to establish an RVU, it would be zero as the Board deemed those codes as unreimbursable. CPT code 99456 cannot be used to establish an end run around the fee schedule. A similar holding has been found by multiple arbitrators. See #

17-22-1237-1991 (Arbitrator Moritz); 17-22-1259-1671 (Arbitrator Frankola); 17-21-1229-1206 (Arbitrator Brandes).

The claim is denied as Respondent paid the claim at $87.80.

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

10/29/2024
(Dated)

Shawn Kelleher

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:
797cfbab67b51f833aefb99ae1043ec5

Electronically Signed

Your name: Shawn Kelleher
Signed on: 10/29/2024