

NO-FAULT INSURANCE WRAP-UP

Workers' Compensation Board Adopts Fee Schedule Change

In the New York State Register on Nov. 24, 2010, the New York State Workers' Compensation Board published its Notice of Adoption of changes to the Medical, Podiatry, Chiropractic and Psychological Fee Schedules.¹ The schedules govern no-fault insurance reimbursement.²

Overall, the changes reflect a 30 percent increase in the reimbursable amount for evaluation and management services. Other changes include the addition of new billable CPT codes in the chiropractic fee schedule, and added ground rules that adopt Medical Treatment Guidelines as the basis for treatment of the mid- and lower back, neck, shoulder and knee.

In adopting the 30 percent increase, the board noted that New York's evaluation and management rates have not increased in more than 15 years, and are the lowest in the country, and are significantly below the rates allowed by Medicare. According to the board, the increase is necessary, in part, to help retain and attract quality medical providers.

Concerning the changes to the Chiropractic Fee Schedule, a chiropractor's billing for a session of treatment formerly encompassed both the manipulation and therapeutic modalities performed within that one office visit, and was billed using treatment code 99213, at the allowable rate of \$33.70.³ The adopted changes now allow chiropractors to bill for therapeutic modalities in addition to manipulation. Accordingly, the Physical Medicine codes used for these modality treatments have been added to the Chiropractic Fee Schedule.

Concerning the adoption of Medical Treatment Guidelines, it is the expectation of the board that adherence to the frequency of treatment protocols will lead to less utilization and act as a cost reduction measure. Indeed, the

DAVID M. BARSHAY is a partner at Baker, Sanders, Barshay, Grossman, Fass, Muhlstock and Neuwirth in Garden City, and vice-president of NYFAIR—New Yorkers for Fair Automobile Insurance Reform.

By
David M.
Barshay



treatment guidelines set limits on the frequency and duration of various treatments. However, such treatment guidelines do not apply to no-fault claims.⁴

The changes are effective for services rendered on and after Dec. 1, 2010.

Affidavits and Affirmations

To withstand an insurer's motion for summary judgment based upon a peer review or IME, a medical provider must submit competent evidence rebutting the conclusions

In adopting the 30 percent increase, the board noted that New York's evaluation and management rates have not increased in more than 15 years.

set forth in the peer or IME report.⁵ Such evidence should be in the form of an affidavit or affirmation of a medical professional qualified to render an opinion on the issue of medical necessity. The general rule, pursuant to CPLR R.2106, is that physicians, osteopaths and dentists may utilize affirmations rather than affidavits. However, if the physician, osteopath or dentist is a party to the action, the use of an affirmation is prohibited, and an affidavit must instead be used.

A new set of cases out of the Second Department's Appellate Term illustrate the importance of choosing the correct evidentiary vehicle to rebut the insurer's doctor's opinion. In the lead case in this line,⁶ *High Quality Med. PC v. Mercury Ins. Co.*, defendant moved for partial summary judgment based on the allegation of lack of medical necessity of the services provided. In support, defendant attached an

IME report and an affidavit from the IME doctor. In opposition, plaintiff submitted an affirmation, executed by plaintiff's principal, attesting to the medical necessity of the subject services. The lower court held that plaintiff's affirmation raised a triable issue of fact, and defendant appealed. In reversing and granting defendant's motion for summary judgment, the Appellate Term, Second Department, held:

[T]he submission of Dr. Nihamin's affirmation was improper because Dr. Nihamin is a principal of plaintiff Professional Corporation, which is a party to the action. Since the Civil Court should not have considered any facts set forth, or exhibits referred to, in said affirmation, plaintiff failed to proffer any evidence in admissible form which raised an issue of fact.⁷

Plaintiff attempted to argue that the defendant failed to establish that Dr. Nihamin was plaintiff's principal. However, the Appellate Term noted that such argument was belied by the claim form submitted by plaintiff, which named Dr. Nihamin as plaintiff's owner.

The Appellate Term's holding appears to ignore the Court of Appeals' long-ago stated maxim that, "Corporations, of course, are legal entities distinct from their managers and shareholders and have an independent legal existence. Ordinarily, their separate personalities cannot be disregarded." Nevertheless, practitioners would be well served to submit their proofs in affidavit form, to avoid this hyper-technical pitfall.

Acupuncture Reimbursement

In no-fault insurance, fees for services performed by a licensed acupuncturist are governed by the Workers' Compensation Fee Schedule. A brief history of how acupuncture fees were determined was discussed in a prior article in this space.⁸ The Appellate Term, Second Department, has further distinguished which services are compensable for acu- » Page 10

Wrap-Up

«Continued from page 3»
puncturists under the no-fault regulations.

For years, there has been dispute as to whether acupuncturists are entitled to be reimbursed at all for initial visits with their patients. Many insurers refuse to reimburse such, believing that reimbursement is prohibited by the fee schedule. Two recent cases from the Appellate Term have settled the issue, finding that while acupuncture treatment rendered by an acupuncturist may be reimbursed at the rate prescribed for acupuncture performed by a chiropractor, acupuncturists are entitled to be reimbursed additionally for an initial visit.

In *Olga Bard Acupuncture, P.C. v. GEICO Ins Co.*,¹⁰ plaintiff moved for summary judgment and defendant cross-moved based on, *inter alia*, the plaintiff's alleged failure to bill in accordance with the fee schedule. The Appellate Term, reaffirming its oft-stated holding that insurers need only reimburse acupuncturists at the chiropractic rate, dismissed the provider's claims which sought more than the allowed amount. However,

the court granted summary judgment to the plaintiff for the initial visit.¹¹

As noted in a previous Wrap-Up,¹² on July 21, 2010, the Insurance Department published notice of the Department's intention to promulgate a fee schedule for treatment provided by licensed acupuncturists, setting the fee as equal to what is allowed for acupuncture services provided by a physician. As of the writing of this article, the department has still not promulgated the new fees. If promulgated, the new fee schedule will take effect 90 days after its publication in the *New York State Register*.

Restoration to Trial Calendar

For many reasons, in no-fault it is not uncommon for the parties to agree to settlement on the trial date, and then for the settlement never to be consummated. When this happens the parties are left with the question of how to get the case back on the trial calendar for final resolution. Specifically, the confusion lies in whether such cases are subject to CPLR 3404.¹³ A recent case from the Appellate Division gives some guidance on this issue.

In *Santana v. Vargas*,¹⁴ the case was marked settled after the parties reached a tentative agreement. However, the settlement was never finalized, and the plaintiff moved to have the case restored to the trial calendar. The defendant opposed the motion, arguing that CPLR 3404 applied and the case should therefore be dismissed. The lower court restored the case to the calendar, and defendant appealed. In affirming, the Appellate Division held:

excuse, meritorious cause of action, lack of intent to abandon, and lack of prejudice in order to have the matter restored to the active trial calendar.¹⁵

Statute of Limitation

In no-fault actions, subject to certain narrow exceptions, the Statute of Limitation is six years.¹⁶ Moreover, like any contract case, the statute begins to run from

A new set of cases out of the Second Department's Appellate Term illustrate the importance of choosing the correct evidentiary vehicle to rebut the insurer's doctor's opinion. The lead case in this line is *High Quality Med. PC v. Mercury Ins. Co.*¹⁷

Contrary to the defendants' contention, the action was not marked "off" or stricken from the trial calendar within the meaning of CPLR 3404. Rather, the Supreme Court's order dated June 1, 2007, indicates that the case was marked "settled" after the parties reached a tentative agreement. Accordingly, CPLR 3404 is inapplicable and the plaintiff was not required to demonstrate a reasonable

the date of the breach.¹⁷ In the no-fault context, the breach date had been assumed to be the date of the insurer's denial, or if the claim was never denied, 30 days after submission of plaintiff's proof of claim.¹⁸ However, the Appellate Term, First Department, in *New Millennium Medical Supply v. Clarendon Nat. Ins. Co.*,¹⁹ has clarified the breach date as 30 days after submission of the plaintiff's proof of claim, regardless of the date

of an insurer's untimely denial. Of note, the plaintiff in that case relied on the Appellate Division case of *Matter of Taggart v. State Farm Mut. Auto. Ins. Co.*,²⁰ which held that plaintiffs had six years "from the date of the denial of claim...to challenge the denial as a breach of defendant's agreement to pay her no-fault benefits." However, such argument was rejected by the Appellate Term because:

[*Taggart*] involved a general denial of claim issued under 11 NYCRR 65.15(g)(2)(ii) (now 65-3.8(b)(2)) terminating no-fault benefits on the ground that the claimant was no longer disabled, while the matter at bar involves the factually and legally distinct situation in which a specific claim for no-fault benefits has been submitted to an insurer for payment or denial.

Accordingly, the rule in the First Department has been greatly simplified, and such should enable insurers to more easily prove their statutes of limitation affirmative defenses. Likewise, plaintiffs in the First Department should no longer rely on *Taggart* as good law.

1. *New York State Activities*, Nov. 24, 20.
2. <http://www.ins.tn.gov> (last visited D
3. For Region IV, New York City and the surr
4. *New York State J Activities*, Nov. 24, 201
5. *For Chiropractic* 24 Misc.3d 136(A) (App. 13th Jud. Dist. 2009).
6. 29 Misc.3d 132 (11th and 13th Jud. Dist. 7. *id.* (Internal citat
8. *Port Chester Elec. t* 40 N.Y.2d 652,656 (1976
9. *No-Fault Insurance* M. Barshay, NYLJ, Aug. 12,
10. 29 Misc.3d 132 (1 and 13th Jud. Dist. 20)
11. See also, *Raz v. AIG Indem. Ins. Co.*, (App. Term 2nd, 11th a 2010).
12. *No-Fault Insurance* M. Barshay, NYLJ, Aug. 1
13. CPLR 3404 provk supreme court or a con "off" or struck from th answered on a clerk's n not restored within on shall be deemed abanck dismissed without cost prosecute. The clerk sha prite entry without th order."
14. 77 A.D.3d 648 (2d D
15. *Id.* (Citations omitt
16. *Mandariano v. Thuse* Co., 37 A.D.3d 775 (2d De; thor's firm was counsel to 46 N.Y.2d 544 (1979).
17. *Kassner & Co. Inc. v* 18. See e.g., *New Era Ac* 18 Misc.3d 139(A) (Ap. 11th Jud. Dist. 2006).
19. 29 Misc.3d 130(A) Dept. 2010).
20. 272 A.D.2d 222 (1st I

Renew

YOUR NEW YORK LAW JOURNAL SUBSCRIPTION BY PHONE! CALL: 1-877-256-2