

THE HEALTHCARE PROVIDER'S GUIDE TO NEW YORK STATE NO-FAULT INSURANCE



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UPDATE: On April 1, 2019, the 2018 New York Workers' Compensation Fee Schedule will go into effect. Any chiropractor who treats Workers' Compensation or No-Fault patients should be aware of the major changes and how this will impact them.

The Department of Financial Services has adopted Emergency Regulations regarding No-Fault providers and the implementation of the new 2018 Workers' Compensation Fee Schedule. The statement addresses when the new ground rules and increased reimbursement rates will take effect. The ground rules will become applicable to No-Fault providers on April 1, 2019. However, the increased reimbursement rates for medical services rendered will not be implemented until eighteen months later on October 1, 2020. The following will seek to address how the new fee schedule relates to the treatment of No-Fault patients:

This emergency regulation establishes that the Workers' Compensation reporting and procedural requirements found in the Fee Schedules do not apply to No-Fault. Although the general instructions and ground rules are applicable, any instructions that concern Workers' Compensation claim forms, preauthorization approval, or dispute resolution guidelines will not apply to No-Fault unless explicitly specified in the given rule.

One of the most significant additions to the Chiropractic section of the 2018 Workers Compensation Fee Schedule is the new Ground Rule 10, which states that Chiropractors may not bill outside of their section. The significance of the implementation of Ground Rule 10 is that it will limit the services that Chiropractors currently use to treat their No-Fault patients. Chiropractic services that are not specifically found within the Chiropractic Fee Schedule section (such as manipulation under anesthesia, computer radiographic mensuration analysis, and sensory nerve testing such as Pf-NCS or Vs-NCT) will no longer be reimbursable. CPT codes for electrodiagnostic testing (EMG/NCV) have been added to the Chiropractic section and will be billable under No-Fault, albeit at a reduced rate of reimbursement.

Some of the other noteworthy changes that affect No-Fault providers include:

1. All Providers That Administer Physical Modalities: The Maximum reimbursement per day has been increased from 8.0 RVUs to 12.0 RVUs, but there is a limit of 12 RVUs per patient per day, regardless of the number of providers.

2. Range of Motion (ROM) testing and Physical Performance testing: This testing has been given an RVU of 0 and will not be reimbursable for any provider. This testing is now considered part of a comprehensive exam and is not separately reimbursable.

3. Radiologists and MRI Facilities: Radiology Ground Rule #3(F) states that imaging studies taken within 7 days of the first imaging study and related to the injury or problem necessitating the first imaging study, and which could have been reasonably performed at one time, shall be subject to reduction.

The new Fee Schedule does have increased reimbursement rates from the previous fee schedule.

This increase of reimbursement rates has been long overdue and providers will see a sizeable increase in the amount they receive for the treatment of patients involved in motor vehicle accidents. However, the Department of Financial Services, which oversees all No-Fault Insurance Law, has determined in an emergency regulation that these increased rates will not become effective until October 1, 2020, eighteen months after the effective date of the Fee Schedule itself on April 1, 2019.

The Department of Financial Services has stated that the No-Fault Insurers must be given time to account for the increased reimbursement rates and to adjust their premiums accordingly. Although the increased reimbursement rates are not effective until October 1, 2020, the ground rules of the 2018 Workers' Compensation Fee Schedule will be applicable to No-Fault treatment and billing on April 1, 2019. It should be noted that the new fee schedule only applies to healthcare services rendered on or after April 1, 2019, so treatment that was rendered prior will not be subject to the requirements of the new fee schedule.

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Since its inception in 2001, Mr. Tona's law firm, TonaLaw, has built a reputation as one of New York's premier legal firms due to its' expertise and integrity. TonaLaw's consistent track record of uncompromising ethics instills confidence and trust. Mr. Tona's 24+ years of litigation expertise allows him to achieve the very best outcome for his clients.

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Professional Admissions & Certifications

New York State Bar 1994

U.S. District Court for the Eastern & Southern Districts of New York
1994

NYS Trial Lawyers Institute
Brother, Justice Lodge No. 753 F. & A.M

Honors and Memberships

AV Preeminent Rated by Martindale Hubbell
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New York State Bar Association
New York State Bones
New York Chiropractic Council
New York State Chiropractic Association
Suffolk County Columbian Lawyers' Association

5.0 Facebook Rating
5.0 Google Rating

Preface

The New York State Legislature enacted “No-Fault Insurance” in 1974. It is a statutory system of laws and regulations aimed at reducing the cost of automobile insurance and ensuring that those injured in motor vehicle accidents receive medical care for their injuries.

In the over 40 years since the no-fault insurance system first began, the initial regulatory framework has grown and morphed into a complex and convoluted, often confusing, system for healthcare providers.

The purpose of this book is to educate and inform those who care for patients injured in motor vehicle accidents in New York State. It is designed as a quick reference handbook so that the necessary information can be easily located and understood.

After almost a quarter of a century in the practice of law, we have tried to distill down the essential information for you. The most frequently asked questions, and pressing issues that concern no-fault healthcare providers, that we see day in and day out in our no-fault collection practice, will be covered.

It is our sincere hope that the information in this book will help providers obtain compensation for the services they render at the appropriate rate, as quickly as possible, with less frequent denials and ultimately improve the quality of care for the no-fault patient.

Nothing herein is meant as legal advice and if you need legal advice you should speak with an attorney in our office.

**You treat the patients.
We do the rest.**



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Chapter I: The Basics

1.1 What is No-Fault?

When someone refers to "no-fault," in the context of automobile accidents, they are referring to insurance coverage for medical bills, lost wages, and other necessary expenses incurred as a result of a motor vehicle accident. These things encompass "basic economic loss," and are often the most important concerns after someone is injured in a motor vehicle accident. The coverage for lost wages ensures that a person has income post-accident if they cannot work. Medical bills are covered so that the person can get the medical care they need. New York State's aim in creating the "no-fault insurance system" was to make sure every person injured would have access to healthcare and would not be physically or financially crippled by a car accident.

Every car insurance policy issued in New York must, by law, include no-fault coverage.

The minimum amount of no-fault insurance coverage found in every policy is \$50,000.00 per person, per accident. Additional protection can be purchased from an insurance carrier, but every policy must have the \$50,000.00 coverage minimum.

What most injured parties do not realize is that this coverage is afforded to them by their own policy when a motor vehicle accident occurs, regardless of who is "at fault" in causing the accident—hence the name "No-Fault."

Thus, a person could be completely at fault in causing an accident and would still receive no-fault benefits under their own policy.

Conversely, the accident could be entirely someone else's fault and coverage would also be provided by the faultless person's own policy. Who is at "fault" for an accident comes into play with third-party personal injury cases only.

More formally in legal circles, this type of insurance is also referred to as Personal Injury Protection or "PIP". You may also hear reference to NYS Regulation 68, the actual statute that created the system.

1.2 How is a No-Fault Claim Different from a Bodily Injury Claim?

No-fault claims are “first party claims”.

These claims are made against an injured person’s own auto insurance carrier, the “first-party” insurer, or the policy covering the vehicle that person was in (or in the case of a pedestrian, the vehicle that came into contact with them).(1) These are first party claims because they stem from the insurance contract between the injured party and their insurer. A bodily injury claim is made against a “third-party” insurance carrier or the insurance provider of the party whose negligence caused the accident. It is considered a third party claim because the injured party is not privy to the insurance contract between the negligent driver and the negligent driver’s insurance carrier.

A claim for injury against a third-party carrier is primarily for pain and suffering, or “non-economic loss,” economic loss greater than \$50,000.00, and other damages, economic or noneconomic, caused by the negligent party’s actions, whereas no-fault claims are against a first-party carrier for “basic economic loss” such as medical bills, lost wages, and necessary expenses up to the \$50,000 limit.

It should be noted that although no-fault and bodily injury claims are often intertwined, in the sense that medical treatment provided under no-fault can be used to establish a bodily injury claim, the payment of each claim will come from separate coverage sources.



1: For an overview of who is covered by first party No-Fault benefits see next section on “Who is covered by no-fault”.

1.3 Who is Covered Under No-Fault?

Article 51 of the New York State Insurance Law explicitly defines who is, and who is not, covered under no-fault insurance.(2) In simplified terms, a covered person is one who is injured through the use or operation of a motor vehicle. When a car insurance policy is purchased in New York, the policy affords no-fault coverage to the named insured and members of his/her household. No-fault coverage is not applicable, and will be excluded by a carrier, in the following common instances (3) :

1. Operation of a motorcycle.
2. Intentionally causing a motor vehicle accident.
3. Injury from operating a motor vehicle accident as a result of intoxication or having impaired abilities, committing a felony, engaging in a race or speed contest, or knowing the vehicle is stolen.
4. Operating a vehicle in the course of employment. (Worker's Compensation Claim)

When no-fault does not cover a person who is injured, reimbursement for medical treatment must be pursued through private health insurance or other applicable coverage, such as Medicare, Medicaid, or Workers' Compensation.



2: "Article 51 of the New York Insurance Law AKA 'The No-Fault Law.'" New York State, http://www.dfs.ny.gov/insurance/r68/r68_art51.htm
See complete Article 51 annexed hereto.

3: For a complete list, see Article 51, Section 5103 annexed hereto.

Chapter II. The No-Fault Claims Process

2.1 The Difference Between an Authorization and an Assignment

Every no-fault provider should be knowledgeable on the differences between accepting an “Authorization to Pay Benefits” (Box 20 of the NF-3) versus an “Assignment of Benefits”(Box 21 of the NF-3).(4) Although both will permit the carrier to pay the provider directly for the services they render, the remedies for bills that are denied vary significantly. Accepting an authorization or assignment during an initial visit can determine if a provider will ultimately get denied bills paid after the denial.

An agreement to accept either an authorization or assignment is always voluntary on the part of the no-fault provider. The significant difference between the two is that the rights and obligations imposed by an Assignment of Benefits do not exist under an Authorization to Pay.

When a patient signs an “Authorization to Pay Benefits” form, they retain all the rights, privileges and remedies under the no-fault provisions of New York’s Insurance Law. This means that the provider can pursue a patient directly for payment should a bill be denied, but precludes the provider from bringing a legal claim against the carrier as the patient has retained this right.

On the contrary, an Assignment of Benefits expressly gives these rights and remedies to the provider but forbids a provider from pursuing the client directly. A provider can bring a claim in arbitration or court against the insurance carrier, but cannot seek reimbursement from the patient. Ultimately, both an assignment and authorization permit a provider to receive payment for approved no-fault bills directly from a carrier.

However, if a patient signs an Authorization to Pay and the bill is denied by the insurer, the provider must seek payment from the patient. Alternatively, if a patient signs an Assignment of Benefits and the bill is denied, the provider must pursue payment from the insurer via arbitration or court proceeding.

4: To view a copy of NF-3 Form please visit http://www.dfs.ny.gov/insurance/r_finala/2004/rf68ca2f.pdf.

2.2 Billing Under No-Fault and the 45-Day Rule

Treatment rendered under no-fault is billed pursuant to the New York No-Fault Fee Schedule (Workers Compensation Schedule). Bills must be submitted to the no-fault carrier within 45 days of the date of service. If bills are not timely submitted within 45 days, the provider may be able to obtain reimbursement if they can provide a “reasonable justification” as to why the bills were not submitted within the 45-day timeframe, though this is difficult to do.

Although each late claim is assessed on an individual basis, cases, where the failure to submit bills timely was not the provider’s fault, can be successful. One such example is where the provider has difficulty ascertaining the insurer’s identity or inadvertently submits a claim to the incorrect insurer.⁵ The provider must explicitly explain these difficulties when submitting the late bills to the carrier.

2.3 How Long Does an Insurance Carrier Have to Pay or Deny a Bill?

Once a no-fault carrier receives a bill, they must pay or deny a claim within 30 calendar days of its receipt. This 30-day time frame is strictly enforced by the courts and at arbitration. A bill that is denied even one day after the 30-day threshold will be awarded.⁶ The carrier may toll this 30-day time frame by requesting additional verification.



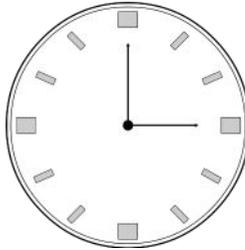
5: Matter of Medical Socy. of the State of New York v Serio, 100 NY2d 854, 863 [2003]

6: A defense based on fee schedule will not be precluded by a late denial.

2.4 Requests for Additional Verification and the 120-Day Rule

Once a no-fault carrier receives a bill, they are entitled to request additional verification within fifteen (15) business days. A request for additional verification pauses the normal 30-day payment/denial time frame for the carrier until the requested verification is received. After an initial request for verification, if the provider does not respond within **30** days from the request, the carrier must issue a second request. If the provider does not respond within **120** days from the date of the initial verification request, the carrier may deny the claim based on the provider's failure to respond.

It is imperative that a provider responds to a verification request in a timely manner. Even if the carrier's verification requests are defective and they make outrageous or impossible demands, it is necessary for a provider to respond with an objection and explanation so to why they cannot comply with the request. Doing this takes the ball and puts it back in the carrier's court, and then it is incumbent upon the carrier to acknowledge and address the provider's contentions. Responding to every request that the carrier has made significantly improves the probability of success at arbitration or trial.



2.5 Can I Be Reimbursed for Treatment After An Independent Medical Exam (IME) When The Carrier Has Denied Benefits?

Under the no-fault regulations, a treatment that is medically necessary is reimbursable. After a motor vehicle accident occurs there is a presumption that the treatment is medically necessary. In order for a no-fault carrier to deny benefits, there must be evidence that the person's injuries have "resolved," meaning that they have returned to the state of physical health they were in prior to the motor vehicle accident. An insurance carrier may request that the injured person undergo independent medical exams (IMEs) as often as reasonably necessary. The injured person must attend an IME once it has been requested and a failure to do so will result in a complete denial of benefits, even retroactively, for treatment that was rendered prior to the person's failure to appear for the IME.

If an IME doctor determines that a patient's injuries have resolved, the carrier will issue a global denial cutting off further treatment. Once this denial has been issued, the carrier will deny further bills that are submitted, but this does not mean that the provider should stop treating a patient. If a provider feels that a patient's injuries have not yet resolved and that further treatment is medically necessary, they should continue to treat the patient and pursue reimbursement from the carrier in court or arbitration.

We advise our clients of the following: “You determine medical necessity of treatment, not the insurance doctors or carriers. Just document your findings well throughout treatment.”



When a provider elects to continue to treat a patient post-IME cutoff, it is crucial that there are contemporaneous exams or records that serve to rebut the IME doctor's report(s).

Our practical advice is to do a reevaluation the week before the IME and the week after if possible to document the extent of the patient's injuries and to rebut the IME doctor's report findings of resolution or normal where the IME doctor is acting more as an advocate for the carrier than the designated "Independent Medical Examiner".

Exams that are performed within a month before or after an IME are extremely valuable because they are used by your lawyer to contradict the findings of an IME doctor and persuade an arbitrator or judge that the treatment was medically necessary. Arbitrators and judges generally focus on objective measures.

Thorough, contemporaneous exams that include quantified range of motion restrictions, provocative orthopedic tests, and neurologic testing, will often rebut the findings of an IME exam and establish that treatment was necessary.

Thus, if a provider continues to treat a patient post-IME, re-exams should be performed frequently, and AT MINIMUM on a monthly basis.



After an IME denial of future treatment, bills for treatment should still be submitted to the carrier, as the denials that the no-fault carrier generates will aid in establishing a case at arbitration. A provider may continue to treat a patient as long as they feel the treatment is necessary. Arbitrators will award reimbursement when the medical record clearly indicates that further treatment was warranted, i.e. medically necessary.

2.6 How do Legal Fees Work for No-Fault Collections?

Legal fees are set forth in 11 NYCRR 65-4.6, which states that attorneys are to be paid 20% of the amount of the claim, with a maximum amount of \$1,360.00 per claim. This fee is paid directly by the insurance carrier to the attorney and is separate and above the amount paid to the healthcare provider. Take, for example, a \$1,000.00 arbitration award for medical treatment...Assuming the case was filed in arbitration 6 months prior, the breakdown of the payout would be as follows:

1. Awarded Amount: \$1,000.00
2. Interest(7) : \$120.00
3. Attorney Fee: \$224.00 [20% of (1 + 2)]
4. Filing Fee Reimbursement(8): \$40.00



In this example, the provider would receive \$1,120.00 (\$1000.00 principal, \$120.00 interest) in reimbursement from the carrier. Some no-fault collections attorneys may also take some or all of a provider's interest or a portion of the principal amount as an additional legal fee.

It must be noted that an attorney is only statutorily entitled to 20% of the amount of the claim. Anything more is a concession made contractually between a no-fault provider and a collections attorney.

It would be wise of any provider to review their retainer agreement to ensure they are getting the maximum reimbursement amount they are entitled to and to question why an attorney would be requesting attorney fees above the statutory rate.

Some comparison shopping between law firms will reveal significant differences in how legal fees are paid!

7: Interest is awarded at 2% per month from the date of filing. In this example (\$1,000.00 x .02= \$20.00 per month, 6 months at \$20.00= \$120.00)

8: There is a \$40.00 filing fee for cases submitted to the American Arbitration Association. This filing fee is paid back by the carrier if a case is settled or an award is made by an Arbitrator. This is either paid direct to the healthcare provider or if paid by the law firm on the provider's behalf, credited back to the provider's overall account expenses.

2.7 Do I Need a Rebuttal to Arbitrate My Claim?

The legal standard for healthcare provider claimants in the dispute over proving medical necessity of treatment or testing is that the totality of the evidence must rebut the findings of an IME or Peer Review doctor's report. A formal written rebuttal letter is not necessary to arbitrate or litigate a claim for no-fault benefits, but the inclusion of a rebuttal will greatly increase the probability of success. A written rebuttal letter that meaningfully and specifically addresses the contentions of a peer or IME report will go a long way in persuading an arbitrator or judge to award in the provider's favor.

2.8 My Patient Failed to Attend an Independent Medical Exam(IME) / Examination Under Oath(EUO), Can I Still be Reimbursed for Treatment Rendered?

An insured is contractually obligated to attend an IME or EUO pursuant to their insurance policy. A no-fault carrier has the right to request that an injured person attend an IME or EUO. Since the failure of an insured to attend an IME/EUO violates a policy condition, the carrier may deny all benefits, even retroactively back to the date of the accident.

However, there are defined regulations on the scheduling of these examinations. If a no-fault carrier does not comply with regulations, a provider may be able to obtain reimbursement through the arbitration or litigation of the claim.

First, scheduling letters must be properly addressed to the injured party. Even a small typographical error in the name or address may render a scheduling letter defective and, therefore, invalid.

Second, the carrier must submit proof of mailing that the scheduling letter was actually sent. If the carrier does not submit evidence in their arbitration or litigation submission, such as a return receipt or an affidavit, it may lose on those grounds.

Third, the carrier must afford the injured person two opportunities to attend the IME/EUO. Thus, an insured must miss two scheduled IME/EUOs in order to be found to have violated the policy condition.

Finally, the carrier must submit evidence of someone with personal knowledge (often the doctor/attorney whom the examination is before) that the insured did not arrive for the examination at the stated time and place. The carrier cannot establish an IME/EUO no-show defense if they don't provide an affidavit of someone who was physically at the location.

If a carrier follows all the aforementioned requirements and submits the proper documentation, their defense will be upheld. However, if the insurance carrier does not perfectly comply with the regulations or fails to submit the proper evidence in arbitration or litigation, a provider could obtain reimbursement for the services rendered. Although bills denied on an IME/EUO no-show are not the result of the actions of the treating provider, it is important to emphasize to patients the importance of attending these examinations from the start of treatment since their failure to do attend can result in the denial of their benefits, and thus, payment of your bills.

2.9 What is Proof of Mailing and Why Do I Need it?

In court and in arbitration, there are rules of evidence that must be followed in order to establish a claim. "Proof of mailing" is proof that a document was sent to the no-fault carrier. Proof that a document was sent to an insurance carrier can come in many forms. The most commonly used are the following:

A Certificate of Mailing, which is a US postal form that is stamped by the post office when a document is mailed. When using this form, it is critical to include the patient's name, policy number, date of service, and amount of bill in dispute.

Certified Mail with return receipt

Fax Cover letters

Affidavit from the person who physically mailed the document
(see sample affidavit)



Proof of mailing of the initial bill is important because absent a denial from the carrier (which itself establishes that a claim exists), providers must show that they mailed the bill within 45 days of service to the carrier. If no corresponding denial is in the submission, the carrier will attempt to get the case dismissed without prejudice to allow the bill to be submitted.

Proof of mailing is also essential when responding to a verification requests. Without proof of mailing that a responsive document was sent, an insurance carrier can claim that they never received it. Insurance carriers must also show proof of mailing for the verification requests they send, and accordingly they have established systems to generate such proof.

Providers should create and establish their own internal systems to track and create proof of mailing for bills and verification responses. It prevents a carrier from asserting, "We never received that", and using that as a defense to your claim for payment. Keeping detailed proof that documents were mailed may require the expenditure of a small amount of effort and expense, but it will ensure that the case be heard on its merits instead of lost on evidentiary technicalities.



2.10 What is the 8-Unit Rule?

The “8-Unit” rule in the Worker’s Compensation Fee schedule limits the reimbursable amount for physical therapy and chiropractic treatment. For example, providers that are in region IV will only be reimbursed \$46.24 for chiropractic treatment per day or \$61.60 for physical therapy per day (\$67.60 if rendered by a physician) regardless of the amount billed. If treatment is rendered on an initial exam, reimbursement will be made at 13.5 units (\$78.03 chiropractic, \$103.95 physical therapy). Subsequent exams with treatment will be reimbursed at 11 units per re-exam with treatment (\$63.58 chiropractic, \$84.70 physical therapy).

Complications arise when chiropractors and physical therapists both render treatment on the same day and bill for physical modalities. Codes that are found both in the chiropractic and physical medicine sections of the fee schedule will be subject to the 8-unit rule. However, specialty-specific codes, such as chiropractic manipulation, are only limited within the chiropractic daily limit.

As an example, let’s assume that a patient sees both a physical therapist and a chiropractor on the same day.

The physical therapist provides \$61.60 in physical treatment, including electric stimulation.

The chiropractor provides \$34.68 in chiropractic spinal manipulative treatment, but also provides \$14.16 in electric stimulation.

If the physical therapist submits his bill to a carrier prior to the chiropractor and is reimbursed \$61.60, when the chiropractor submits his bill he will only be entitled to reimbursement in the amount of \$34.68, as the maximum amount 8 units of physical medicine has already been paid out.

If the chiropractor submits his bill prior the physical therapist, the chiropractor will be reimbursed \$46.24 and the physical therapist bill will be reduced by \$14.16, leaving him a reimbursement of \$47.44, as \$14.16 of physical medicine’s \$61.60 daily limit has already been disbursed.

A provider should be mindful of this potential conflict when treating patients who are receiving treatment from multiple providers on the same day.

2.11 Billing “By-Report Codes”

There are some codes in the Workers Compensation Fee Schedule designated as “by-report codes.” A by-report code has no established RVU (relative value unit) like other codes found in the fee schedule. Instead, the provider establishes the amount to be reimbursed and must substantiate this charge with a report.

The report, which must accompany the billing, should attempt to establish an RVU for the amount billed and contain the nature of service or procedure, extent, need, and the time, skill, and equipment used. **The more comprehensive a report is, the greater the chance the code billed will be reimbursed initially by the carrier, and detailed reports often prevail at arbitration.**

Since a provider can set the amount to be billed, it is important to bill a reasonable amount in relation to other providers in the geographic area. Bills priced significantly higher than the customary amounts will almost always trigger fee schedule audits by a professional coder and may be reimbursed at a reduced rate or even denied entirely.



2.12 Exhaustion of a Patient's Policy

Every automobile insurance policy issued in New York State carries with it a minimum of \$50,000.00 in no-fault coverage (PIP - Personal Injury Protection).

When serious injuries occur in a motor vehicle accident, medical bills and lost earnings payment can quickly exhaust this coverage. The exhaustion of a policy may pose a significant problem for a medical provider, especially since there is essentially nothing a medical provider can do to prevent it. When the benefits of an insurance policy are exhausted, providers can be left with thousands of dollars in unpaid no-fault bills. New York State no-fault law clearly establishes that an insurance carrier's obligation to pay is fulfilled when the policy limits have been disbursed.

There are some rare circumstances where a carrier grossly mismanages the handling and payment of claims and in those instances, we have been able to secure payments for healthcare provider clients despite the fact that a policy has been exhausted. These cases are in the minority, however, and arbitrators and courts are generally in agreement that once a policy is exhausted, no further reimbursement must be made absent "improper claims handling leading to exhaustion of benefits".



Chapter III. The Arbitration Process

3.1 How is No-Fault Arbitration Different from Court Proceedings?

Arbitration is an age-old form of alternate dispute resolution (ADR), which, just like its name says, serves as an alternative to litigation of a dispute in court.

In the past decade, arbitration in the No-Fault Collection realm has seen an explosion in popularity, in large part due to the extensive time delays and cost inefficiencies in litigation.

New York State legislation compels insurance carriers to submit to arbitration if that is the forum the no-fault claimant chooses. Arbitration often offers a faster, cheaper, and more efficient way to resolve claims than the court system. Once cases are filed in arbitration, it usually takes months(9 to 12) until a hearing is held as opposed to the years it takes to litigate in court. The cost of filing and resolving cases through arbitration is also significantly cheaper. Another advantage of arbitration over litigation is a “relaxing” of the evidentiary rules.

Every no-fault provider should consider arbitration as a viable avenue to getting improperly denied no-fault claims paid. Our office almost exclusively recommends arbitration over litigation, except in very limited circumstances.

3.2 How Does a Case Proceed Through the Arbitration Process?

From the date of filing a no-fault claim, the typical breakdown is as follows:

- 1-3 days: Initial Review Case documents are reviewed by AAA.
 - 3-5 days: Case File Initiated A file is created in the AAA Modria system.
 - 5-60 days: Conciliation Phase The parties evaluate their positions and attempt to resolve the matter. The majority of cases that settle prior to arbitration will be resolved in this time frame.
 - 60-180 days: Scheduling Period The case is assigned a hearing date and time*
 - 180-360 days: Award A hearing is held and award is issued*
- Thus, a typical claim filed in the no-fault arbitration will be resolved (settled/awarded/dismissed/denied) within one year of filing.

*NOTE: Time frames are averages. AAA is experiencing high volume delays. Remediation is ongoing.

3.3 What Documents Do I Need to Submit a Claim to Arbitration?

The following is a list of records that should be submitted by a provider or their law office for submission of a claim or claims to arbitrations:

- 1. A complete AR-1 (this form is generally filled out by the no-fault collections attorney representing the provider).**
- 2. A fully executed, dated, assignment of benefits signed by the patient and practice (without it the claim will be dismissed for lack of standing).**
- 3. Bills submitted with corresponding denials. If a denial(s) is unavailable, proof of mailing of the bill(s) should be submitted.**
- 4. Entire medical record file.**
- 5. Relevant supporting documentation (responses to verification, invoices for durable medical equipment, fee schedule calculation for by-report codes).**
- 6. A rebuttal report is optional but advisable.**

Keeping thorough, legible, and complete records is ultimately key to a high success rate on your collections. If a case is lost at arbitration, it is almost always because there is a critical piece of missing information that is needed to establish medical necessity or overcome the denial defense of the respondent insurance carrier. There is no good reason why a properly documented file should ever lose at arbitration.

With the advent of electronic medical records and the significantly high volume of arbitrations that arbitrators are being asked to decide on a given day, most arbitrators have expressed a disdain for handwritten records, and have refused to decipher illegible records, costing providers thousands of dollars in denied claims. Our advice is to switch to electronic medical records if you have not already done so.

3.4 How Does an Arbitrator Decide My Case?

When a case initially comes before an arbitrator, they will first determine if the claimant has established a prima facie showing of entitlement to no-fault benefits, meaning the case is sufficient at the outset. This is established by submitting evidentiary proof that the provider mailed the prescribed statutory billing forms (NF-3), the carrier received the forms, and that the payment of no-fault benefits remains overdue (much of this is established by producing the NF-10 denial). The arbitrator will then determine if the carrier denied the provider's bills in a timely and proper manner. If these criteria are met, the arbitrator will then proceed to evaluate the merits or "substance" of the case.

Once the claimant establishes the prima facie case, it is the insurance carrier's burden to show why the bills in question should not be paid. The most common reason asserted is that the services provided were not "medically necessary." The insurance carrier often attempts to establish a lack of medical necessity through the report of an Independent Medical Examination (IME) or peer review. Some cases can be won at this point without ever looking at the provider's records if the arbitrator finds that the IME or Peer Report is not credible, or is substantively or technically defective in some manner.



3.5 What If the Arbitrator Finds the IME or Peer Report Credible?

If the arbitrator finds the IME or peer review report credible, then he will look at the provider's evidence. The most comprehensive evidence, in addition to an initial exam, follow-up exams, and contemporaneous concurrent medical records, will include a rebuttal report written by the treating provider, or a claimant sided medical expert, that specifically addresses the points made by the IME or peer review doctor. All of these items are referred to as "rebuttal evidence." Absent a direct rebuttal report from the provider, the arbitrator will search the provider's medical records for evidence to support the medical necessity of the services that were rendered. Ultimately, a rebuttal report is not required under the current law. The standard is whether the evidence submitted by claimant rebuts that submitted by the respondent carrier.

3.6 What Does an Arbitrator Look for in a Provider's Medical Records?

- a. Independent Medical Exam (IME) Denial Cases: The arbitrator will look for medical reports or records that are contemporaneous with the date of the IME(s). The arbitrator will search the reports for subjective and objective findings. The more detailed the findings, the more likely the arbitrator will find that the patient's symptoms had not resolved, and therefore the treatment rendered after the IME cut-off was medically necessary.
- b. Peer Review Denial Cases: The arbitrator will search for evidence in the record that contradicts or disproves the argument of the peer reviewer. Peer reviewers often put forth boilerplate arguments as to why certain treatment, procedures, tests, or medical equipment is unnecessary.

Detailed medical records can often rebut a peer report when there is:

1. A detailed letter of medical necessity and/or rebuttal that addresses the specifics of the patient's medical case and why they required the given treatment, procedure, test or medical equipment.
2. The referring/prescribing doctor explains why the treatment, or other modality, is being ordered, and/or how the treatment will benefit or affect the patient's treatment.
3. A documented differential diagnosis to be ruled out.
4. Proper citation to medical literature that supports the treatment, procedure, test or medical component.

3.7 The Arbitrator Did Not Find My Records Persuasive - What Does This Mean and Why Did I Lose?

In nearly all cases involving “medical necessity” denials based upon a carrier IME or peer review, the side that wins will be the side whose records are more detailed, credible, and extensive. The arbitrator must make a “finding of fact” and determine whose facts and arguments in the record have persuaded him/her that their position is correct.

In the initial portion of the arbitrator’s written decision, they will set forth the “standard” used to decide the case. This standard is usually followed by citations to controlling court cases or legislative statutes.

A common standard cited regarding medical necessity is:

A treatment or service is medically necessary if it is “appropriate, suitable, proper and conducive to the end sought by the professional health service provider in consultation with the patient. It means more than merely convenient or useful treatment or services, but treatment or services that are reasonable in light of the patient injury, subjective and objective complaints of pain, and the goals of evaluating and treating the patient.”

The arbitrator will weigh the evidence of both parties against the appropriate legal standards and render a decision. This is called a “finding of fact,” or how the law applies to the facts of the specific case. If the arbitrator finds an IME or peer report “more persuasive” and finds against the provider, it means that in the arbitrator’s opinion, there was inadequate or insufficient evidence in the provider’s file to rebut the assertions and findings of the peer review or IME doctor.

A provider may have records contemporaneous with the IME in the patient’s file, but if these records are not submitted to the arbitrator, are illegible, or consist of repetitive and/or boilerplate language, it is difficult to establish that continued treatment is medically necessary.

When writing a referral or prescription, the health care provider may have a valid reason for choosing a course of treatment. However, if the reason isn't explicitly articulated in the medical records, an arbitrator may not have sufficient evidence to support a decision in favor of the provider. Additionally, handwritten medical reports that are illegible cannot be evaluated by the arbitrator, so they cannot be used to establish medical necessity.

3.8 What If the Provider Thinks the Arbitrator's Decision is Incorrect and the Treatment was Medically Necessary? Can the Decision be Appealed?

Every arbitration decision can be appealed, but only a small percentage will be overturned. This is because an arbitrator's "finding of fact" is not reversible unless it is arbitrary, capricious, or so irrational as to prejudice the rights of one of the parties. It is extremely difficult to show that an arbitrator was arbitrary or capricious in making a "finding of fact." Essentially, as long as the arbitrator has a rational basis for their decision, it will be upheld. Only in very rare instances will a decision based on medical necessity, or lack thereof, be overturned.



3.9 What Kind of Decisions Appealed to Master Arbitration are Successful?

The majority of arbitration decisions that are overturned at master arbitration are those where the arbitrator made a mistake of law in their decision. A mistake of law occurs when the arbitrator applies the law incorrectly. Any sentence in an arbitrator's decision that is followed by citation to a court case or statute establishes the law the arbitrator is using to decide the case.

The arbitrator will then apply these laws to the specific facts of a given case. When the arbitrator does not use valid law, law that has been previously overturned, or irrationally applies the law to the facts, a master arbitrator may reverse the decision.

Be warned, however, even if an arbitrator makes an error of fact, a master arbitrator must uphold the determination if it has a rational basis. In other words, if the arbitrator made a determination in a reasonable and logical way the decision will be upheld, regardless of whether it is "factually" correct.

UPDATE: On April 1, 2019, the 2018 New York Workers' Compensation Fee Schedule will go into effect. Any chiropractor who treats Workers' Compensation or No-Fault patients should be aware of the major changes and how this will impact them.

The Department of Financial Services has adopted Emergency Regulations regarding No-Fault providers and the implementation of the new 2018 Workers' Compensation Fee Schedule. The statement addresses when the new ground rules and increased reimbursement rates will take effect. The ground rules become applicable to No-Fault providers on April 1, 2019. However, the increased reimbursement rates for medical services rendered will not be implemented until eighteen months later on October 1, 2020. The following will seek to address how the new fee schedule relates to the treatment of No-Fault patients:

This emergency regulation establishes that the Workers' Compensation reporting and procedural requirements found in the Fee Schedules do not apply to No-Fault. Although the general instructions and ground rules are applicable, any instructions that concern Workers' Compensation claim forms, preauthorization approval, or dispute resolution guidelines will not apply to No-Fault unless explicitly specified in the given rule.

One of the most significant additions to the Chiropractic section of the 2018 Workers Compensation Fee Schedule is the new Ground Rule 10, which states that Chiropractors may not bill outside of their section. The significance of the implementation of Ground Rule 10 is that it will limit the services that Chiropractors currently use to treat their No-Fault patients. Chiropractic services that are not specifically found within the Chiropractic Fee Schedule section (such as manipulation under anesthesia, computer radiographic mensuration analysis, and sensory nerve testing such as Pf-NCS or Vs-NCT) will no longer be reimbursable. CPT codes for electrodiagnostic testing (EMG/NCV) have been added to the Chiropractic section and will be billable under No-Fault, albeit at a reduced rate of reimbursement.

The new Fee Schedule does have increased reimbursement rates from the previous fee schedule.

This increase of reimbursement rates has been long overdue and providers will see a sizeable increase in the amount they receive for the treatment of patients involved in motor vehicle accidents. However, the Department of Financial Services, which oversees all No-Fault Insurance Law, has determined in an emergency regulation that these increased rates will not become effective until October 1, 2020, eighteen months after the effective date of the Fee Schedule itself on April 1, 2019.

The Department of Financial Services has stated that the No-Fault Insurers must be given time to account for the increased reimbursement rates and to adjust their premiums accordingly. Although the increased reimbursement rates are not effective until October 1, 2020, the ground rules of the 2018 Workers' Compensation Fee Schedule will be applicable to No-Fault treatment and billing on April 1, 2019. It should be noted that the new fee schedule only applies to healthcare services rendered on or after April 1, 2019, so treatment that was rendered prior will not be subject to the requirements of the new fee schedule.

Some of the other noteworthy changes that affect No-Fault providers include:

- 1. All Providers That Administer Physical Modalities:** The Maximum reimbursement per day has been increased from 8.0 RVUs to 12.0 RVUs, but there is a limit of 12 RVUs per patient per day, regardless of the number of providers.
- 2. Range of Motion (ROM) testing and Physical Performance testing:** This testing has been given an RVU of 0 and will not be reimbursable for any provider. This testing is now considered part of a comprehensive exam and is not separately reimbursable.
- 3. Radiologists and MRI Facilities:** Radiology Ground Rule #3(F) states that imaging studies taken with 7 days of the first imaging study and related to the injury or problem necessitating the first imaging study, and which could have been reasonably performed at one time, shall be subject to reduction.

Conclusion

In the world of auto insurance, as it applies to the payment of no-fault claims, and specifically with regard to no fault collections, whether you are a healthcare provider seeking payment for wrongly denied healthcare services bills, or an injured party seeking payment of wrongly denied lost wages claims or other basic economic loss claims, it is easy to get frustrated and feel lost. It can be stressful for all sides – dealing with insurance adjusters, denied medical bills, lost time from work and compromised emotional and physical health. Whether you are a provider or an injured person, don't get tangled in these issues. Let an experienced lawyer guide you through the maze.

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APPENDIX

Article 51 of the New York Insurance Law aka "The No-Fault Law"

Section 5101. Title.

5102. Definitions.

5103. Entitlement to first party benefits; additional financial security required.

5104. Causes of action for personal injury.

5105. Settlement between insurers.

5106. Fair claims settlement.

5107. Coverage for non-resident motorists.

5108. Limit on charges by providers of health services.

5109. Unauthorized providers of health services.

5101. Title.

This article shall be known and may be cited as the "Comprehensive Motor Vehicle Insurance Reparations Act".

5102. Definitions. In this chapter:

(a) "Basic economic loss" means, up to fifty thousand dollars per person of the following combined items, subject to the limitations of section five thousand one hundred eight of this article:

(1) All necessary expenses incurred for:

(i) medical, hospital (including services rendered in compliance with article forty-one of the public health law, whether or not such services are rendered directly by a hospital), surgical, nursing, dental, ambulance, x-ray, prescription drug and prosthetic services;

(ii) psychiatric, physical and occupational therapy and rehabilitation*;

NOTE: Section 5102(a)(1)(ii) of the New York Insurance Law has been amended, effective November 23, 2006, to read as follows:

(ii) psychiatric, physical therapy (provided that treatment is rendered pursuant to a referral) and occupational therapy and rehabilitation;

(iii) any non-medical remedial care and treatment rendered in accordance with a religious method of healing recognized by the laws of this state; and

(iv) any other professional health services; all without limitation as to time, provided that within one year after the date of the accident causing the injury it is ascertainable that further expenses may be incurred as a result of the injury. For the purpose of determining basic economic loss, the expenses incurred under this paragraph shall be in accordance with the limitations of section five thousand one hundred eight of this article.

(2) Loss of earnings from work which the person would have performed had he not been injured, and reasonable and necessary expenses incurred by such person in obtaining services in lieu of those that he would have performed for income, up to two thousand dollars per month for not more than three years from the date of the accident causing the injury. An employee who is entitled to receive monetary payments, pursuant to statute or contract with the employer, or who receives voluntary monetary benefits paid for by the employer, by reason of the employee's inability to work because of personal injury arising out of the use or operation of a motor vehicle, is not entitled to receive first party benefits for "loss of earnings from work" to the extent that such monetary payments or benefits from the employer do not result in the employee suffering a reduction in income or a reduction in the employee's level of future benefits arising from a subsequent illness or injury.

(3) All other reasonable and necessary expenses incurred, up to twenty-five dollars per day for not more than one year from the date of the accident causing the injury.

(4) "Basic economic loss" shall not include any loss incurred on account of death; subject, however, to the provisions of paragraph four of subsection (a) of section five thousand one hundred three of this article.

(5) "Basic economic loss" shall also include an additional option to purchase, for an additional premium, an additional twenty-five thousand dollars of coverage which the insured or his legal representative may specify will be applied to loss of earnings from work and/or psychiatric, physical or occupational therapy and rehabilitation after the initial fifty thousand dollars of basic economic loss has been exhausted. This optional additional coverage shall be made available and notice with explanation of such coverage shall be provided by an insurer at the first policy renewal after the effective date of this paragraph, or at the time of application.

(b) "First party benefits" means payments to reimburse a person for basic economic loss on account of personal injury arising out of the use or operation of a motor vehicle, less:

(1) Twenty percent of lost earnings computed pursuant to paragraph two of subsection (a) of this section.

(2) Amounts recovered or recoverable on account of such injury under state or federal laws providing social security disability benefits, or workers' compensation benefits, or disability benefits under article nine of the workers' compensation law, or Medicare benefits, other than lifetime reserve days and provided further that the Medicare benefits utilized herein do not result in a reduction of such person's Medicare benefits for a subsequent illness or injury.

(3) Amounts deductible under the applicable insurance policy.

(c) "Non-economic loss" means pain and suffering and similar non-monetary detriment.

(d) "Serious injury" means a personal injury which results in death; dismemberment; significant disfigurement; a fracture; loss of a fetus; permanent loss of use of a body organ, member, function or system; permanent consequential limitation of use of a body organ or member; significant limitation of use of a body function or system; or a medically determined injury or impairment of a non-permanent nature which prevents the injured person from performing substantially all of the material acts which constitute such person's usual and customary daily activities for not less than ninety days during the one hundred eighty days immediately following the occurrence of the injury or impairment.

(e) "Owner" means an owner as defined in section one hundred twenty-eight of the vehicle and traffic law.

(f) "Motor vehicle" means a motor vehicle as defined in section three hundred eleven of the vehicle and traffic law and also includes fire and police vehicles. It shall not include any motor vehicle not required to carry financial security pursuant to article six, eight or forty-eight-A of the vehicle and traffic law or a motorcycle, as defined in subsection (m) hereof.

(g) "Insurer" means the insurance company or self-insurer, as the case may be, which provides the financial security required by article six or eight of the vehicle and traffic law.

(h) "Member of his household" means a spouse, child or relative of the named insured who regularly resides in his household.

(i) "Uninsured motor vehicle" means a motor vehicle, the owner of which is (i) a financially irresponsible motorist as defined in subsection (j) of section five thousand two hundred two of this chapter or (ii) unknown and whose identity is unascertainable.

(j) "Covered person" means any pedestrian injured through the use or operation of, or any owner, operator or occupant of, a motor vehicle which has in effect the financial security required by article six or eight of the vehicle and traffic law or which is referred to in subdivision two of section three hundred twenty-one of such law; or any other person entitled to first party benefits.

(k) "Bus" means both a bus and a school bus as defined in sections one hundred four and one hundred forty-two of the vehicle and traffic law.

(l) "Compensation provider" means the state insurance fund, or the person, association, corporation or insurance carrier or statutory fund liable under state or federal laws for the payment of workers' compensation benefits or disability benefits under article nine of the workers' compensation law.

(m) "Motorcycle" means any motorcycle, as defined in section one hundred twenty-three of the vehicle and traffic law, and which is required to carry financial security pursuant to article six, eight or forty-eight-A of the vehicle and traffic law.

5103. Entitlement to first party benefits; additional financial security required.

(a) Every owner's policy of liability insurance issued on a motor vehicle in satisfaction of the requirements of article six or eight of the vehicle and traffic law shall also provide for; every owner who maintains another form of financial security on a motor vehicle in satisfaction of the requirements of such articles shall be liable for; and every owner of a motor vehicle required to be subject to the provisions of this article by subdivision two of section three hundred twenty-one of the vehicle and traffic law shall be liable for; the payment of first party benefits to:

(1) Persons, other than occupants of another motor vehicle or a motorcycle, for loss arising out of the use or operation in this state of such motor vehicle. In the case of occupants of a bus other than operators, owners, and employees of the owner or operator of the bus, the coverage for first party benefits shall be afforded under the policy or policies, if any, providing first party benefits to the injured person and members of his household for loss arising out of the use or operation of any motor vehicle of such household. In the event there is no such policy, first party benefits shall be provided by the insurer of such bus.

(2) The named insured and members of his household, other than occupants of a motorcycle, for loss arising out of the use or operation of (i) an uninsured motor vehicle or motorcycle, within the United States, its territories or possessions, or Canada; and (ii) an insured motor vehicle or motorcycle outside of this state and within the United States, its territories or possessions, or Canada.

(3) Any New York resident who is neither the owner of a motor vehicle with respect to which coverage for first party benefits is required by this article nor, as a member of a household, is entitled to first party benefits under paragraph two of this subsection, for loss arising out of the use or operation of the insured or self-insured motor vehicle outside of this state and within the United States, its territories or possessions, or Canada.

(4) The estate of any covered person, other than an occupant of another motor vehicle or a motorcycle, a death benefit in the amount of two thousand dollars for the death of such person arising out of the use or operation of such motor vehicle which is in addition to any first party benefits for basic economic loss.

(b) An insurer may exclude from coverage required by subsection (a) hereof a person who:

(1) Intentionally causes his own injury.

(2) Is injured as a result of operating a motor vehicle while in an intoxicated condition or while his ability to operate such vehicle is impaired by the use of a drug within the meaning of section eleven hundred ninety-two of the vehicle and traffic law.

(3) Is injured while he is:

(i) committing an act which would constitute a felony, or seeking to avoid lawful apprehension or arrest by a law enforcement officer, or

(ii) operating a motor vehicle in a race or speed test, or

(iii) operating or occupying a motor vehicle known to him to be stolen, or

(iv) operating or occupying any motor vehicle owned by such injured person with respect to which the coverage required by subsection (a) hereof is not in effect, or

(v) a pedestrian, through being struck by any motor vehicle owned by such injured pedestrian with respect to which the coverage required by subsection (a) hereof is not in effect, or

(vi) repairing, servicing or otherwise maintaining a motor vehicle if such conduct is within the course of a business of repairing, servicing or otherwise maintaining a motor vehicle and the injury occurs on the business premises.

(c) Insurance offered by any company to satisfy the requirements of subsection (a) hereof shall be offered (i) without a deductible and (ii) with a family deductible of up to two hundred dollars (which deductible shall apply only to the loss of the named insured and members of his household). The superintendent may approve a higher deductible in the case of insurance policies providing additional benefits or pursuant to a plan designed and implemented to coordinate first party benefits with other benefits.

(d) Insurance policy forms for insurance to satisfy the requirements of subsection (a) hereof shall be subject to approval pursuant to article twenty-three of this chapter. Minimum benefit standards for such policies and for self-insurers, and rights of subrogation, examination and other such matters, shall be established by regulation pursuant to section three hundred one of this chapter.

(e) Every owner's policy of liability insurance issued in satisfaction of article six or eight of the vehicle and traffic law shall also provide, when a motor vehicle covered by such policy is used or operated in any other state or in any Canadian province, insurance coverage for such motor vehicle at least in the minimum amount required by the laws of that state or province.

(f) Every owner's policy of liability insurance issued on a motorcycle or an all terrain vehicle in satisfaction of the requirements of article six or eight of the vehicle and traffic law or section twenty-four hundred seven of such law shall also provide for; every owner who maintains another form of financial security on a motorcycle or an all terrain vehicle in satisfaction of the requirements of such articles or section shall be liable for; and every owner of a motorcycle or an all terrain vehicle required to be subject to the provisions of this article by subdivision two of section three hundred twenty-one of such law shall be liable for; the payment of first party benefits to persons, other than the occupants of such motorcycle or all terrain vehicle, another motorcycle or all terrain vehicle, or any motor vehicle, for loss arising out of the use or operation of the motorcycle or all terrain vehicle within this state. Every insurer and self-insurer may exclude from the coverage required by this subsection a person who intentionally causes his own injury or is injured while committing an act which would constitute a felony or while seeking to avoid lawful apprehension or arrest by a law enforcement office obligations which are applicable to an insurer subject to this article.

(g) A company authorized to provide the insurance specified in paragraph three of subsection (a) of section one thousand one hundred thirteen of this chapter or a corporation organized pursuant to article forty-three of this chapter may, individually or jointly, with the approval of the superintendent upon a showing that the company or corporation is qualified to provide for all of the items of basic economic loss specified in paragraph one of subsection (a) of section five thousand one hundred two of this article, provide coverage for such items of basic economic loss to the extent that an insurer would be required to provide under this article. Where a policyholder elects to be covered under such an arrangement the insurer providing coverage for the automobile shall be furnished with the names of all persons covered by the company or corporation under the arrangement and such persons shall not be entitled to benefits for any of the items of basic economic loss specified in such paragraph. The premium for the automobile insurance policy shall be appropriately reduced to reflect the elimination of coverage for such items of basic economic loss. Coverage by the automobile insurer of such eliminated items shall be effected or restored upon request by the insured and payment of the premium for such coverage. All companies and corporations providing coverage for items of basic economic loss pursuant to the authorization of this subsection shall have only those rights and obligations which are applicable to an insurer subject to this article.

(h) Any policy of insurance obtained to satisfy the financial security requirements of article six or eight of the vehicle and traffic law which does not contain provisions complying with the requirements of this article, shall be construed as if such provisions were embodied therein.

5104. Causes of action for personal injury.

(a) Notwithstanding any other law, in any action by or on behalf of a covered person against another covered person for personal injuries arising out of negligence in the use or operation of a motor vehicle in this state, there shall be no right of recovery for non-economic loss, except in the case of a serious injury, or for basic economic loss. The owner, operator or occupant of a motorcycle which has in effect the financial security required by article six or eight of the vehicle and traffic law, or which is referred to in subdivision two of section three hundred twenty-one of such law, shall not be subject to an action by or on behalf of a covered person for recovery for non-economic loss, except in the case of a serious injury, or for basic economic loss.

(b) In any action by or on behalf of a covered person, against a non-covered person, where damages for personal injuries arising out of the use or operation of a motor vehicle or a motorcycle may be recovered, an insurer which paid or is liable for first party benefits on account of such injuries has a lien against any recovery to the extent of benefits paid or payable by it to the covered person. No such action may be compromised by the covered person except with the written consent of the insurer, or with the approval of the court, or where the amount of such settlement exceeds fifty thousand dollars. The failure of such person to commence such action within two years after accrual gives the insurer a cause of action for the amount of first party benefits paid or payable against any person who may be liable to the covered person for his personal injuries. The insurer's cause of action shall be in addition to the cause of action of the covered person except that in any action subsequently commenced by the covered person for such injuries, the amount of his basic economic loss shall not be recoverable.

(c) Where there is no right of recovery for basic economic loss, such loss may nevertheless be pleaded and proved to the extent that it is relevant to the proof of non-economic loss.

5105. Settlement between insurers.

(a) Any insurer liable for the payment of first party benefits to or on behalf of a covered person and any compensation provider paying benefits in lieu of first party benefits which another insurer would otherwise be obligated to pay pursuant to subsection (a) of section five thousand one hundred three of this article or section five thousand two hundred twenty-one of this chapter has the right to recover the amount paid from the insurer of any other covered person to the extent that such other covered person would have been liable, but for the provisions of this article, to pay damages in an action at law. In any case, the right to recover exists only if at least one of the motor vehicles involved is a motor vehicle weighing more than six thousand five hundred pounds unloaded or is a motor vehicle used principally for the transportation of persons or property for hire. However, in the case of occupants of a bus other than operators, owners, and employees of the owner or operator of the bus, an insurer which, pursuant to paragraph one of subsection (a) of section five thousand one hundred three of this article, provides coverage for first party benefits for such occupants under a policy providing first party benefits to the injured person and members of his household for loss arising out of the use or operation of any vehicle of such household, shall have no right to recover the amount of such benefits from the insurer of such bus.

(b) The sole remedy of any insurer or compensation provider to recover on a claim arising pursuant to subsection (a) hereof, shall be the submission of the controversy to mandatory arbitration pursuant to procedures promulgated or approved by the superintendent. Such procedures shall also be utilized to resolve all disputes arising between insurers concerning their responsibility for the payment of first party benefits.

(c) The liability of an insurer imposed by this section shall not affect or diminish its obligations under any policy of bodily injury liability insurance.

5106. Fair claims settlement.

(a) Payments of first party benefits and additional first party benefits shall be made as the loss is incurred. Such benefits are overdue if not paid within thirty days after the claimant supplies proof of the fact and amount of loss sustained. If proof is not supplied as to the entire claim, the amount which is supported by proof is overdue if not paid within thirty days after such proof is supplied. All overdue payments shall bear interest at the rate of two percent per month. If a valid claim or portion was overdue, the claimant shall also be entitled to recover his attorney's reasonable fee, for services necessarily performed in connection with securing payment of the overdue claim, subject to limitations promulgated by the superintendent in regulations.

(b) Every insurer shall provide a claimant with the option of submitting any dispute involving the insurer's liability to pay first party benefits, or additional first party benefits, the amount thereof or any other matter which may arise pursuant to subsection (a) hereof to arbitration pursuant to simplified procedures to be promulgated or approved by the superintendent.

(c) An award by an arbitrator shall be binding except where vacated or modified by a master arbitrator in accordance with simplified procedures to be promulgated or approved by the superintendent. The grounds for vacating or modifying an arbitrator's award by a master arbitrator shall not be limited to those grounds for review set forth in article seventy-five of the civil practice law and rules. The award of a master arbitrator shall be binding except for the grounds for review set forth in article seventy-five of the civil practice law and rules, and provided further that where the amount of such master arbitrator's award is five thousand dollars or greater, exclusive of interest and attorney's fees, the insurer or the claimant may institute a court action to adjudicate the dispute de novo.

5107. Coverage for non-resident motorists.

(a) Every insurer authorized to transact or transacting business in this state, or controlling or controlled by or under common control by or with such an insurer, which sells a policy providing motor vehicle liability insurance coverage or any similar coverage in any state or Canadian province, shall include in each such policy coverage to satisfy the financial security requirements of article six or eight of the vehicle and traffic law and to provide for the payment of first party benefits pursuant to subsection (a) of section five thousand one hundred three of this article when a motor vehicle covered by such policy is used or operated in this state.

(b) Every policy described in subsection (a) hereof shall be construed as having the coverage required by subsection (a) of section five thousand one hundred three of this article.

5108. Limit on charges by providers of health services.

(a) The charges for services specified in paragraph one of subsection (a) of section five thousand one hundred two of this article and any further health service charges which are incurred as a result of the injury and which are in excess of basic economic loss, shall not exceed the charges permissible under the schedules prepared and established by the chairman of the workers' compensation board for industrial accidents, except where the insurer or arbitrator determines that unusual procedures or unique circumstances justify the excess charge.

(b) The superintendent, after consulting with the chairman of the workers' compensation board and the commissioner of health, shall promulgate rules and regulations implementing and coordinating the provisions of this article and the workers' compensation law with respect to charges for the professional health services specified in paragraph one of subsection (a) of section five thousand one hundred two of this article, including the establishment of schedules for all such services for which schedules have not been prepared and established by the chairman of the workers' compensation board.

(c) No provider of health services specified in paragraph one of subsection (a) of section five thousand one hundred two of this article may demand or request any payment in addition to the charges authorized pursuant to this section. Every insurer shall report to the commissioner of health any patterns of overcharging, excessive treatment or other improper actions by a health provider within thirty days after such insurer has knowledge of such pattern.

5109. Unauthorized providers of health services.

(a) The superintendent, in consultation with the commissioner of health and the commissioner of education, shall by regulation, promulgate standards and procedures for investigating and suspending or removing the authorization for providers of health services to demand or request payment for health services as specified in paragraph one of subsection (a) of section five thousand one hundred two of this article upon findings reached after investigation pursuant to this section. Such regulations shall ensure the same or greater due process provisions, including notice and opportunity to be heard, as those afforded physicians investigated under article two of the workers' compensation law and shall include provision for notice to all providers of health services of the provisions of this section and regulations promulgated thereunder at least ninety days in advance of the effective date of such regulations.

(b) The commissioner of health and the commissioner of education shall provide a list of the names of all providers of health services who the commissioner of health and the commissioner of education shall deem, after reasonable investigation, not authorized to demand or request any payment for medical services in connection with any claim under this article because such provider of health services:

(1) has been guilty of professional or other misconduct or incompetency in connection with medical services rendered under this article; or

(2) has exceeded the limits of his or her professional competence in rendering medical care under this article or has knowingly made a false statement or representation as to a material fact in any medical report made in connection with any claim under this article; or

(3) solicited, or has employed another to solicit for himself or herself or for another, professional treatment, examination or care of an injured person in connection with any claim under this article; or

(4) has refused to appear before, or to answer upon request of, the commissioner of health, the superintendent, or any duly authorized officer of the state, any legal question, or to produce any relevant information concerning his or her conduct in connection with rendering medical services under this article; or

(5) has engaged in patterns of billing for services which were not provided.

(c) Providers of health services shall refrain from subsequently treating for remuneration, as a private patient, any person seeking medical treatment under this article if such provider pursuant to this section has been prohibited from demanding or requesting any payment for medical services under this article. An injured claimant so treated or examined may raise this as a defense in any action by such provider for payment for treatment rendered at any time after such provider has been prohibited from demanding or requesting payment for medical services in connection with any claim under this article.

(d) The commissioner of health and the commissioner of education shall maintain and regularly update a database containing a list of providers of health services prohibited by this section from demanding or requesting any payment for health services connected to a claim under this article and shall make such information available to the public by means of a website and by a toll free number.

(e) Nothing in this section shall be construed as limiting in any respect the powers and duties of the commissioner of health, commissioner of education or the superintendent to investigate instances of misconduct by a health care provider and, after a hearing and upon written notice to the provider, to temporarily prohibit a provider of health services under such investigation from demanding or requesting any payment for medical services under this article for up to ninety days from the date of such notice.