American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

| | | |
|---|---|---|
| Bi County Medical Diagnostics PC (Applicant) | AAA Case No. | 17-16-1029-4839 |
| | Applicant's File No. | |
| - and - | Insurer's Claim File No. | 32-6R60-104 |
| | NAIC No. | 25178 |
| State Farm Mutual Automobile Insurance Company (Respondent) | | |

## ARBITRATION AWARD

I, Valerie D. Greaves, 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: Patient

1. Hearing(s) held on 06/27/2017
   Declared closed by the arbitrator on 06/27/2017

   Andrew Bruskin, Esq. from Munawar & Andrews-Santillo LLP participated in person for the Applicant

   Martin Dolitsky, Esq. from Richard T. Lau & Associates participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **$ 1,832.87**, was NOT AMENDED at the oral hearing.
   Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

   Whether Applicant is entitled to additional reimbursement in the sum of $1832.87 for range of motion and muscle testing performed September 15, 2015 through October 13, 2015, allegedly in connection with the treatment of injuries sustained by Patient in a motor vehicle accident on July 5, 2015.

   Respondent denied reimbursement based on its interpretation of the applicable fee schedule rates of reimbursement.

4. Findings, Conclusions, and Basis Therefor

The decision below is based on the documents contained in the ADR Center as of the date of the hearing and the oral arguments of the parties. No witnesses testified at the hearing.

New York State Courts have determined that Applicant establishes a prima facie case of entitlement to reimbursement by submitting a completed proof of claim. Applicant has established a prima facie case of entitlement to reimbursement by submission of completed proof of claim documenting the fact of the loss and the amount due. Since Applicant has established a prima facie case of entitlement to reimbursement, the burden of proof shifts to Respondent to prove its defense by a preponderance of the credible evidence.

Applicant seeks additional reimbursement for range of motion and muscle testing performed September 15, 2015 through October 13, 2015, allegedly in connection with the treatment of injuries sustained by Patient in a motor vehicle accident on July 5, 2015. Respondent denied reimbursement based on its interpretation of the applicable fee schedule rates of reimbursement.

Applicant's counsel maintains that Respondent's fee schedule adjustment is not substantiated by the record. Respondent's counsel asserts that the adjustment was appropriate and reflects the applicable fee schedule. Medical necessity is not at issue.

When the issue in dispute involves the fee schedule, Respondent must first demonstrate that it has timely and credibly established the basis for its denials, before the burden of proof shifts to the Applicant to establish that Respondent's adjustment was contrary to No-Fault regulations and/or the applicable fee schedule.

The applicable fee schedule reads in pertinent part that:

CPT 95831 is designated for *"Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk."*

CPT 95833 is designated for *"Muscle testing, manual (separate procedure) with report; total evaluation of body, excluding hands"*.

CPT 95851 is designated for *"Range of motion measurement and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)."*

CPT 97750 is designated for "*"physical performance test or measurement (e.g. musculoskeletal, functional capacity), with written report, each 15 minutes"*.

Respondent submitted the affidavit of M. Acuna, certified fee coder, in support of its fee schedule adjustment.

DOS: 9/15/2015

Applicant seeks reimbursement for 12 units of range of motion billed under CPT 95851 and for 10 units of muscle testing under CPT 95831. It is noted that contrary to the applicable fee schedule Applicant's bill seeks reimbursement for each directional plane tested instead of per body part.

Respondent issued a timely partial denial contending that its adjustment was based on Applicant's documentation. A review of the record reveals that Applicant's documentation indicates that the muscle testing was performed *"…using the JTECH tracker system, a computerized muscle testing evaluation system".* Applicant's submission indicates that it took 40 minutes to complete the computerized muscle test.

Ms. Acuna attests that in accordance with the May 2008 edition of the American Medical Association (AMA) CPT Assistant, CPT 95831 is only to be used for manual muscle testing. Applicant herein performed computerized muscle testing which according to the AMA CPT Assistant should be reimbursed under CPT 97750 when performed with CPT 95851.

The 2008 CPT Assistant reads in pertinent part:

Question: *Can manual muscle testing (95831-95834), range of motion testing (95851-95852), and physical performance test and measurement (97750) be performed on the same date of service?*

Answer: No. *Codes 95851, Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine), and 95831, Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk, are designated in the code descriptors as separate procedures. Codes designated as separate procedures should not be reported in addition to the code for the total procedure or service for which they are considered an integral component. In this case, because range of motion testing (95851) and manual muscle testing (95831) may be performed as part of a physical performance test or measurement (e.g. musculoskeletal or functional capacity), only code 97750 should be reported. Codes 95851 and 95831 should not be reported separately because both services are designated as separate procedures and, as such, would be considered integral components of a physical performance test (97750).*

Per the above, the fee coder attests that the correct code for this bill is CPT code 97750 (Physical performance test or measurement (e.g. musculoskeletal, functional capacity), with written report, each 15 minutes), and provides the following rationale for her opinion:

· The muscle testing performed by Applicant under CPT 95831 was computerized not manual.

· CPT code 95851 is inclusive of CPT 97750 therefore not reported separately (AMA CPT Assistant May 2008).

· CPT code 97750 is a time based code; the time indicated in the provider's documentation is 40 minutes, therefore Applicant is entitled to three 15 minute increments.

· RVU for CPT code 97750 = 5.41 x $8.45 = $45.71 x 3 units = $137.13.

Since Applicant was previously reimbursed in the amount of $137.13, Respondent contends that there is no substantiation for additional reimbursement.

Applicant submitted no specific documentation in opposition to Respondent's interpretation of the fee schedule. The rebuttal affidavit fails to directly rebut the contentions asserted in Respondent's certified fee coder affidavit.

DOS: 10/13/2015

Applicant seeks reimbursement for 12 units of range of motion billed under CPT 95851 and for 10 units of muscle testing under CPT 95831. It is noted that contrary to the applicable fee schedule Applicant's bill seeks reimbursement for each directional plane tested instead of per body part.

Respondent issued a timely partial denial contending that its adjustment was based on Applicant's documentation. A review of the record reveals that Applicant's documentation indicates that the muscle testing was performed *"…using the JTECH tracker system, a computerized muscle testing evaluation system".* It is noted that Applicant's submission indicates that it took 40 muscles to complete the computerized muscle test.

Ms. Acuna attests that in accordance with the May 2008 edition of the American Medical Association (AMA) CPT Assistant, CPT 95831 is only to be used for manual muscle testing. Applicant herein performed computerized muscle testing which according to the AMA CPT Assistant should be reimbursed under CPT 97750 when performed with CPT 95851.

Per the above, the fee coder attests that the correct code for this bill is CPT code 97750 (Physical performance test or measurement (e.g. musculoskeletal, functional capacity), with written report, each 15 minutes), and provides the following rationale for her opinion:

· The muscle testing performed by Applicant (CPT 95831) was computerized not manual.

· CPT code 95851 is inclusive of CPT 97750 therefore not reported separately (AMA CPT Assistant May 2008).

· CPT 97750 is a time based code; the time indicated in the provider's documentation is 40 minutes, therefore Applicant is entitled to three 15 minute increments.

· RVU for CPT code 97750 = 5.41 x $8.45 = $45.71 x 3 units = $137.13.

Since Applicant was previously reimbursed in the amount of $91.40, Respondent concedes that Applicant is entitled to additional reimbursement in the amount of $45.73.

Applicant submitted no specific documentation in opposition to Respondent's interpretation of the fee schedule. The rebuttal affidavit fails to directly rebut the contentions asserted in Respondent's certified fee coder affidavit.

The denial of claim for this date of service is untimely. When a claim is untimely denied, the result is the accrual of two periods of interest. The first period of interest accrues from the 30th day after proof of claim was received from Applicant by the Respondent until the date on which the claim is denied. The second period of interest accrues on the date the matter is filed with the American Arbitration Association, except when arbitration commences within 30 days after receipt of the denial, then interest begins to accrue on the date the denial is received by Applicant.

DECISION

Regarding the date of service 9/15/2015, Applicant is not entitled to additional reimbursement.

Regarding the date of service 10/13/2015, Applicant is entitled to additional reimbursement in the amount of 45.73 with interest from December 18, 2015 to February 9, 2016, and from March 9, 2016.

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

5. Optional imposition of administrative costs on Applicant.
Applicable for arbitration requests filed on and after March 1, 2002.

I do NOT impose the administrative costs of arbitration to the applicant, in the amount established for the current calendar year by the Designated Organization.

6. **I find as follows with regard to the policy issues before me:**
   - ☐ The policy was not in force on the date of the accident
   - ☐ The applicant was excluded under policy conditions or exclusions
   - ☐ The applicant violated policy conditions, resulting in exclusion from coverage
   - ☐ The applicant was not an "eligible injured person"
   - ☐ The conditions for MVAIC eligibility were not met
   - ☐ The injured person was not a "qualified person" (under the MVAIC)
   - ☐ The applicant's injuries didn't arise out of the "use or operation" of a motor vehicle
   - ☐ The respondent is not subject to the jurisdiction of the New York No-Fault arbitration forum

Accordingly, the applicant is AWARDED the following:

A.

| Medical | | From/To | Claim Amount | Status |
|---|---|---|---|---|
| | **Bi County Medical Diagnostics PC** | **09/15/15 - 10/13/15** | **$1,832.87** | **Awarded: $45.73** |
| **Total** | | | **$1,832.87** | **Awarded: $45.73** |

B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 03/09/2016, which is a relevant date only to the extent set forth below.)

Since the claim(s) in question arose from an accident that occurred on or after April 5, 2002, the insurer shall compute and pay the applicant the amount of interest computed from 12/18/2015 to 2/9/2016, and from 3/9/2016, at the rate of 2% per month, simple, and ending with the date of payment of the award, subject to the provisions of 11 NYCRR 65-3.9(c) (stay of interest).

C. Attorney's Fees

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

The Respondent shall pay the Applicant an attorney's fee in accordance with 11 NYCRR 65-4.6(e). However, if the benefits and interest awarded thereon is equal to or less than the Respondent's written offer during the conciliation process, then the attorney's fee shall be based upon the provisions of 11 NYCRR 65-4.6(b).

D. The respondent shall also pay the applicant forty dollars ($40) to reimburse the applicant for the fee paid to the Designated Organization, unless the fee was previously returned pursuant to an earlier award.

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of New York
SS :
County of New York

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

07/03/2017
(Dated)

Valerie D. Greaves

**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:**
e3989bdcb7709a3e2b4a84d2660d2f2a

**Electronically Signed**

Your name: Valerie D. Greaves
Signed on: 07/03/2017