American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Bruce Jacobson DC (Applicant)	AAA Case No.	17-15-1019-3952
	Applicant's File No.	27-3861401
- and -	Insurer's Claim File No.	CAp 613714
	NAIC No.	16616
American Transit Insurance Company (Respondent)		

ARBITRATION AWARD

I, Charles Blattberg, 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: Eligible injured person

1. Hearing(s) held on 07/29/2016, 01/13/2017, 07/05/2017
   Declared closed by the arbitrator on 08/07/2017

   Robert Bott, Esq. from Super & Licatesi P.C. participated in person for the Applicant

   David Bendik, Esq. from Short & Billy PC participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 2,480.56**, was AMENDED and permitted by the arbitrator at the oral hearing.

   Applicant amended the amount claimed in dispute to $2,330.56 after the withdrawal with prejudice of its claim for an expert fee in the sum of $150.00.

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

3. Summary of Issues in Dispute

   The claimant was a 36 year-old male unrestrained rear seat passenger of a motor vehicle involved in an accident on 2/10/15. Following the accident the claimant suffered injuries which resulted in the claimant seeking treatment. At issue is cervical and lumbar

pf-NCS testing performed by Applicant on 2/25/15. Respondent contends that the claimant's inconsistent testimony at an Examination Under Oath (EUO) precludes recovery.

4. Findings, Conclusions, and Basis Therefor

THIS HEARING WAS CONDUCTED USING THE ELECTRONIC CASE FOLDER MAINTAINED BY THE AMERICAN ARBITRATION ASSOCIATION. ALL DOCUMENTS CONTAINED IN THAT FOLDER ARE MADE PART OF THE RECORD OF THIS HEARING.

THE ARBITRATOR SHALL BE THE JUDGE OF THE RELEVANCE AND MATERIALITY OF THE EVIDENCE OFFERED.

Based on a review of the documentary evidence, this claim is decided as follows:

Applicant establishes a prima facie case of entitlement to reimbursement of its claim by the submission of a completed NF-3 form or similar document documenting the facts and amounts of the losses sustained and by submitting evidentiary proof that the prescribed statutory billing forms [setting forth the fact and the amount of the loss sustained] had been mailed and received and that payment of no-fault benefits were overdue. See, *Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). I find that Applicant established a prima facie case for reimbursement.

The 7/29/16 hearing was continued for Respondent to "submit a short brief that specifically references the page and line numbers in the claimant's EUO transcript that support the defense stated in the denials. Respondent should upload a copy of the police report, NF-2 and "proof of past accidents" that were uploaded in four related cases heard on the same day. Respondent's short brief should also reference these other documents." In addition Applicant was "free to upload the IHC report of Eli M. Tretola, D.C. or other submission in response to the other defense raised (that the "billed for service was not provided")." Both sides made post hearing submissions. The 1/13/17 hearing was continued. The 7/5/17 hearing was held open for Respondent "to submit a very brief statement/affidavit in support of the argument raised at the hearing that the IHC report of Eli M. Tretola, D.C. should not be considered or afforded less weight. This should be prepared by someone with knowledge of the arbitration the IHC report was prepared for and the documents reviewed by Dr. Tretola. Anything provided beyond this specific directive will not be considered." In addition Applicant was afforded the opportunity "to submit a reply. In addition Applicant is free to submit documents in response to those uploaded by Respondent (fee audit by Elisha Jones of Signet Claims Solutions, LLC, articles and arbitration awards) on 7/5/17 (the day of the hearing)." Both sides made post hearing submissions.

The claimant was a 36 year-old male unrestrained rear seat passenger of a motor vehicle involved in an accident on 2/10/15. The claimant reportedly injured his neck, upper

back, and lower back. There was no reported loss of consciousness. There were no reported lacerations or fractures. Following the accident the claimant was transported to Downstate Medical Center where he was evaluated, treated, and released. On 2/13/15 the claimant presented to Ralph Innovative Medical, PC and was initiated on physical therapy. On 2/25/15 Bruce Jacobson, D.C. performed cervical and lumbar pf-NCS testing that is at issue here.

Respondent timely denied the 2/25/15 electrodiagnostic testing as the "ENTIRE CLAIM IS DENIED ON THE BASIS OF THE INCONSISTENT TESTIMONY AT THE EXAMINATION UNDE OATH CONDUCTED ON 04/28/2015. FEES NOT IN ACCORDANCE WITH FEE SCHEDULES CPT CODE SUBMITTED IS A BR PROCEDURE THAT HAS NO REPRICE VALUE. The allowable reimbursement would be based on the applicable fee scheduled rate pursuant to NYCRR 65-3 (g) (1) (H) FOR MEDICAL SERVICE THAT EXCEED THE CHARGES PERMISSIBLE PURSUANT TO INSURANCE LAW SECTION 5108(a) AND (b) AND THE REGULATIONS PROMULGATED THEREUNDER FOR SERVICES RENDERED BY MEDICAL PROVIDERS."

In AAA Case No. 17-15-1024-1751 Arbitrator Richard Kokel was presented with the same eligible injured person, the same Respondent, the same 4/28/15 EUO as the grounds for the denial; but a different Applicant (there range of motion/muscle testing 4/10/15 and Activity Limitation Measurement 4/13/15 was at issue). In his well reasoned decision Arbitrator Kokel held:

"*The EIP was examined on April 28, 2015. A transcript of the testimony was submitted in evidence. I have reviewed the transcript. It does not contain any inconsistent testimony that warrants the denial of the within claim. The EIP answered all question put to him. He did fail to remember some things, but these were inconsequential, in my view. For example, the EIP was not sure of distances/proximity to another passengers house, and was unsure about the departure point (again, as compared to another passengers Examination under Oath testimony). The Police Report verified the happening of the accident and the EIP's presence at the scene. The minor lapses noted above do not correlate to 'inconsistent' testimony warranting a denial of the claim. Based on my reading of the examination under oath transcript, I find the Respondent's defense to the claim invalid.*"

This Arbitrator finds himself in complete agreement with his learned colleague, Arbitrator Kokel, and finds that the claimant's EUO defense will not stand.

Respondent also raised a fee schedule defense. In its brief Respondent's counsel asserts "Arbitrators Philip Wolf, Regina Kurz and Brett Hausthor requested that an Independent Health Consultant be sent the underlying, identical documents from the electrodiagnostic testing performed, and the IHCs reached the same conclusion - that this test should not be billed under code 95904 and the clinical utility for this test does not exist. Arbitrator Gary Peters agreed that the Applicant in his case did not perform an NCV test, and that applicant improperly chose to bill a VsNCT test pursuant to code 95904. He further stated that code 95904 is grouped with 95900 and noted the requirements to bill under this code. Arbitrator Peters stated, in summary, that "[t]here is

no basis for such billing and that the use of code #95904 is incorrect." Arbitrator Maureen Callahan, when deciding the same issue between Bronx Chiropractic and Geico, stated that respondent had met their burden in demonstrating that the inappropriate code was used and denied applicant's claim as well. Arbitrator Esposito noted the CMS decision indicating this test was "useless" and also commented on the incorrect code being used to bill for this service. Arbitrator Jackie Gallers issued a decision with an identical issue - whether V-sNCT testing should be billed under code 95904. He noted that the Centers for Medicare & Medicaid do not feel V-sNCT testing is reasonable and necessary, and likened the testing to surface EMG's, which were determined to be "absolutely useless." He goes on to cite various research into the testing and states, unequivocally, "[o]ne thing for certain is that Applicant did not use the proper CPT code." Respondent's counsel notes that "Arbitrator Kenneth Horowitz also likened the V-sNCT testing to surface EMG's in deciding that the wrong code was used. Respondent's counsel also notes that Arbitrator Philip Wolfe, when deciding whether an EUO was required of the provider, noted that the test billed for did not appear to match the title on the examination report and cited to the peer review to note some potential differences in the testing."

Ioanna Zevgaras, Esq. also argues on behalf of the Respondent that "the electrodiagnostic testing performed in the instant case is different from NCV tests. The Applicant should have utilized the proper Category III Code, specifically codes 0106T thru 0110T. The fee schedule specifies that where a Category III code is available, this code must be reported instead of using a Category I unlisted code. In fact, the proper Category III codes require that the Applicant test and bill per extremity, once for each arm and once for each leg. Therefore, if the Applicant is conducting only an upper extremity study or only a lower extremity study, they would bill a total of 2 units per day. Instead, the provider billed multiple nerve levels per day. The Applicant chose to bill an improper code, one that bills per nerve instead of extremity, in order to inflate his billing. The test performed by the Applicant is not an NCV test and it should not have been billed under fee schedule code 95904. It should be noted that in the CPT 2007 under "Instructions for Use of the CPT Codebook" states, "Select the name of the procedure or service that accurately identifies the service performed. Do not select a CPT code that merely approximates the service provided. If no such procedure or service exists, then report the service using the appropriate unlisted procedure or service code (emphasis added)." Current Procedural Terminology (CPT 2007, Professional Edition, American Medical Association, Chicago, Illinois, page xiv). See CPT 2007, attached as Exhibit 10. Further, the CPT Assistant clearly states that 95904 is not the proper code for this test." Ms. Zevgaras also notes that "Applicant relies extensively upon material from an organization labeled the AASEM. It should be noted that the AASEM is an organization that was started by various individuals who had an interest in promoting the Axon-II devices. The organization, which "certifies" individuals to become "technicians" has no recognition in the medical community, nor by the American Medical Association. The Axon II machine is one that is based upon a patent from Dr. Hedgecock, who appears to have been involved with the marketing of the machines. It is noteworthy that certificates of this organization have been signed by Dr. Hedgecock using the title of AASM Chairman of pf-NCS Certification. This is not an independent organization when the inventor of the AASM is the one who issues these certificates." Ms. Zevgaras concludes "The applicant billed for a nerve conduction

velocity test. No such test was performed. Instead the applicant performed a quantitative sensory test which was not necessary. The claim should be denied."

Respondent also argued in the alternative in its brief that pf-NCS testing should be reimbursed at a reduced amount rate. In its brief Respondent notes that the proper Code for the services rendered by the Applicant is a Category III Code (0106T thru 0110T) because NCV testing measures velocity, latency and amplitude, whereas pf-NCS testing is subjective and does not. Thus, Respondent argues that Applicant did not perform the actual services that it billed for. In further support of its defense, Respondent submissions included the following: 1. Two Independent Health Consultant ("IHC") Reports by Dr. Kevin Toss dated April 13, 2012 and December 12, 2012. In both reports, Dr. Toss concluded that pf-NCS testing was not consistent with conventional nerve conduction velocity testing and should not be billed under CPT Code 95904 because, among other things, pf-NCS testing does not involve the introduction of needles into the skin to measure nerve impulses but instead uses the electrodes on the skin; it measures amplitude of a delivered impulse not velocity or latency of the impulse and because with pf-NCS testing the patient could consciously alter the results. Specifically, in his IHC report dated April 13, 2012, Dr. Toss stated that a pf-NCS test "is not consistent with conventional Nerve Conduction Velocity tests (NCV's) and, in my opinion, this was essentially a different test altogether from the NCV." According to Dr. Toss, "billing code 95904 is for nerve conduction studies such as EMG and NCV;" 2. An IHC Report by Dr. Michael Weintraub, dated March 20, 2012, who also concluded that pf-NCS testing is subjective and is not properly billed under CPT Code 95904; and 3. An IHC Report by Monette G. Basson, M.D. dated 12/22/11 who denied payment for a pf-NCS study billed at the NCV rate, explaining her opinion that the subject testing is not valid and not the same as a legitimate nerve conduction velocity test. 4. The CPT Assistant, May, 2011, Vol.21, Issue 5 that addresses the use of code 95904 for pf-NCS testing. The CPT Assistant states that code 95904 may not be used for this type of testing. According to the CPT Assistant, CPT Code 95904 "requires the recording of amplitude and latency/velocity." The CPT Assistant further notes that pf-NCS testing is "different and distinct from nerve conduction velocity, amplitude and latency."

Respondent submitted a Signet Claim Solutions, L.L.C. fee audit by Elisha Jones. Ms. Jones states that "CPT Code 0110T most closely represents the services performed - Quantitative sensory testing (QST), testing and interpretation per extremity, using other stimuli to assess sensation." Ms. Jones notes that CPT Code 0110T has "BR" as a relative value unit. Per Ground Rule # 3 of the fee schedule, any procedure where the unit value is listed as "BR", the physician shall establish a unit value consistent in relativity with other unit values shown in the schedule. Ms. Jones states that here "CPT Code 95904 nerve conduction, amplitude and latency/velocity study: sensory was used to determine reimbursement." Ms. Jones explains that "CPT code 95904 was not used to identify procedure as not all components of code were met." Ms. Jones explains that "CPT code 0110T is a by extremity reimbursement, chiropractic conversation factor was used 5.78 X relative value 12.60 = 72.83 X 2 extremities - 145.66." So for the four extremities tested here the total would be 12.6 multiplied by $5.78 equals $72.83 x 4 or $291.32.

Applicant submitted an affidavit from Norman J. Sobol, M.D. Dr. Sobol is a physician and a board-certified neurologist in New York State since 1976. Dr. Sobol is familiar with pf-NCS procedures and the Axon II device used in the performance of the study. Dr. Sobol explains the pf-NCS tests the A-delta pain fibers and how the findings assist the treating doctor. As to the proper code for pf-NCS testing Dr. Sobol states "[s]ince the test is only concerned with the amplitude necessary to fire the nerve, the appropriate code for this test is the "by report" code, "unlisted neurological or neuromuscular diagnostic procedure" 95999. The pfNCS is not a Quantitative Sensory Test ("QST") nor is it an experimental or emerging technology that would require a Category III CPT designation. The nature, extent, and need for the procedure, as discussed above, as well as the time, the skill and the equipment necessary to perform the procedure for the provider are identical to that of code 95904 with the relative value of 12.60. Accordingly, 12.60 relative value units should be used for the billing of a pfNCS study. Similar to an EMG/NCV study, the pfNCS is appropriately billed for each individual site on the nerve tested."

Applicant also submitted portions of the Chiropractic Fee Schedule. Highlighted is a description for CPT code 95900 which indicates that the billing is done on a per nerve basis; also highlighted is CPT code 95904 which is for a sensory NCV and it carries 12.60 RVUs. Applicant also provided articles in support of the use of the potentiometer. It has also provided a description of the EMG and NCV testing. Applicant provided a document from AASEM dated January, 2010 regarding the Paradoxical Relationship: A-Delta Function and VAS. Also provided is an article from The Internet Journal of Anesthesiology "Predicting Nerve Root Pathology with Voltage-actuated Sensory Nerve Conduction Threshold." The article concludes that the use of V-sNCT is superior to a neurological examination in predicting abnormal nerve-root pathology. There is an article from the same source, this one entitled "Letter to the Editor: Nerve and Root Pathology and the V-sNCT." It references the previous article and asked a number of questions to which the authors respond. Attached to this document is an article entitled Axon-II Accuracy Approaching 100%. Applicant is also submitted a printout from the NYS Education Department, Office of the Professions dealing with the scope of practice of chiropractic under Article 132 and letters from the Education Department as to activities in which a chiropractor may engage. Applicant also submitted a fee audit to demonstrate that use of 95904 to bill for the subject testing is endorsed by independent coding company MedPAS. Applicant also submitted an IHC report by Dr. Eli Tretola who appears to definitively state that QST is not the same as pf-NCS. As noted above, Respondent requested that Dr. Tretola's report should not be considered or afforded less weight because the arbitration it was prepared for (AAA Case No.: 17-14-9050-3893) was held in abeyance pursuant to a court order of the Federal court of the Eastern District of New York (15-cv-7236). While I do take into consideration the circumstances detailed in the post hearing affirmation by Christopher E. O'Donnell, Esq. submitted by Respondent I will still consider Dr. Tretola's report as his expert opinion at the time it was written. As Steven Super, Esq. noted in his post hearing affirmation "Dr. Tretola's expert IHC opinion was never nullified, vacated or altered in any way."

After having evaluated all of the evidence and listening to the arguments of the parties, I find Respondent's evidence more persuasive than Applicant's. I am persuaded by Respondent's evidence and find that the Applicant improperly billed the services at issue

under CPT Code 95904. I am persuaded by Ms. Jones' calculation for the pf-NCS testing. I find that she set forth a breakdown and rationale for the determination that Applicant did not bill the pf-NCS testing correctly. I am convinced by Respondent's evidentiary submissions that these services are properly billed under the Category III code 0110T. These codes are billed per extremity tested; in this case that is 4 extremities at $72.83 per extremity for a total of $291.32. I note that numerous other arbitrators have made similar determinations. See for example AAA Case No.: 17-14-9023-6089 (Arbitrator Burt Feilich), AAA Case No.: 17-14-9023-6089 (Arbitrator Philip Wolf), AAA Case No.: 412011053021 (Arbitrator Vincent Esposito), AAA Case No.: 41011053019 (Arbitrator Gary Peters), AAA Case No.: 41011061502 (Arbitrator Melissa Melis), AAA Case No.: 412010042797 (Arbitrator Richard Horowitz) and AAA Case No.: 412013124961 (Arbitrator Susan Haskel).

Accordingly, Applicant is awarded $291.32.

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**	**Amount Amended**	**Status**
	Bruce Jacobson DC	**02/25/15 - 02/25/15**	**$2,330.56**	**$2,330.56**	**Awarded: $291.32**
Total			**$2,480.56**		**Awarded: $291.32**

B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 09/22/2015, which is a relevant date only to the extent set forth below.)

Interest runs from 9/22/15 (the filing date for this case) until the date that payment is made at two percent per month, simple interest, on a pro rata basis using a thirty day month.

C. Attorney's Fees

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

Pursuant to 11 NYCRR §65-4.6 (d), ". . . the attorney's fee shall be limited as follows: 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon for each applicant for arbitration or court proceeding, subject to a maximum fee of $1,360."

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 Nassau

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

09/05/2017
(Dated)

Charles Blattberg

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:
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Electronically Signed

Your name: Charles Blattberg
Signed on: 09/05/2017