

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

OZ Acupuncture, P.C.
(Applicant)

- and -

State Farm Fire and Casualty Company
(Respondent)

AAA Case No. 17-16-1046-8305

Applicant's File No. GS-491643

Insurer's Claim File No. 323F30218

NAIC No. 25143

ARBITRATION AWARD

I, Marina O'Leary, 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: ER

1. Hearing(s) held on 11/29/2017
Declared closed by the arbitrator on 11/29/2017

Steven Palumbo, Esq. from Law Offices Of Gabriel & Shapiro, LLC. participated in person for the Applicant

Michael Poropat, Esq. from Picciano & Scahill, P.C. participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 445.00**, was AMENDED and permitted by the arbitrator at the oral hearing.

The amount in dispute was amended to \$198.00 as requested by applicant to comport with the fee schedule.

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

3. Summary of Issues in Dispute

ER, a 29-year-old male, was purportedly injured in a motor vehicle accident on September 6, 2013. The services in dispute, provided from January 9, 2014 through February 20, 2014, involve the procedure of cupping which was billed under CPT code 97799. Applicant billed for this 6 times. In each instance, the charge was \$50.00.

Respondent issued a partial payment of \$19.07 per procedure, leaving a balance of \$198.00 (as amended). Applicant seeks reimbursement of this balance. In relation to these claims, Respondent asserts that its partial payment/adjustment was proper pursuant to the fee schedule. During the hearing, no arguments were presented with respect to Applicant's prima facie case, or the timeliness of Respondent's denials. In light of the foregoing, the issue to be determined is whether Respondent has sustained its fee schedule defense.

4. Findings, Conclusions, and Basis Therefor

The case was decided on the submissions of the parties as contained in the electronic file maintained by the American Arbitration Association, the oral arguments of the parties' representatives, as well as the New York State Workers' Compensation Fee Schedule, of which I take judicial notice. *Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co.*, 61 A.D.3d 13, 871 N.Y.S.2d 680 (App Div, 2 Dept, 2009). There were no witnesses.

Where the question to be answered turns on the merits of a fee schedule defense, the burden to come forward with competent evidentiary proof rests on the shoulders of Respondent. *Robert Physical Therapy, P.C. v. State Farm Mut. Ins. Co.*, 13 Misc.3d 172, 822 N.Y.S.2d 378 (Civ. Ct. Kings Co. 2006). Failure to present competent evidentiary proof that the fees were in excess of the appropriate fee schedules will cause the defense to fail. *Continental Medical P.C. v. Travelers Indemnity Company*, 11 Misc.3d 145(A), 2006 N.Y. Slip Op. 50841(U)(App Term, 1 Dept., 2006); *st see also St. Vincent Medical Care, P.C. v. Country Wide Ins. Co.*, 26 Misc.3d 146(A), 2010 N.Y. Slip Op 50488(U)(App. Term 2 , 11 & 13 Jud. Dists., March 19, 2010).

CPT code 97799 is a By Report (BR) code which is listed in the Physical Medicine section of the MEDICAL Fee Schedule. It is described as an "[u]nlisted physical medicine/rehabilitation service or procedure." The definition of what constitutes a service assignable as a By Report code, as well as the information that is required to establish it as such, is as follows: Procedures Listed Without Specific Relative Value Units By report (BR) items: "BR" in the relative value column represents services that are too variable in the nature of their performance to permit assignment of relative value units. Fees for such procedures need to be justified "by report." Pertinent information concerning the nature, extent, and need for the procedure or service, the time, the skill and equipment necessary, etc., is to be furnished. A detailed clinical record is not necessary, but sufficient information shall be submitted to permit a sound evaluation. It must be emphasized that reviews are based on records; hence the importance of documentation. The original official record, such as operative report and hospital chart, will be given far greater weight than supplementary reports formulated and submitted at later dates. For any procedure where the relative value unit is listed in the schedule as "BR," the physician [chiropractor] shall establish a relative value unit consistent in relativity with other value units shown in the schedule. The insurer shall review all submitted "BR" unit values to ensure that relativity consistency is maintained. The general conditions and requirements of the General Ground Rules apply to all "BR"

items. - See NY Workers' Compensation Medical Fee Schedule, Introduction & General Guidelines, General Ground Rule 3; See NY Workers' Compensation Chiropractic Fee Schedule, Introduction & General Guidelines, General Ground Rule 2.

In this case, there is one denial which encompass all of the dates of service for Applicant's billing under CPT code 97799. The accompanying Explanation of Benefits (EOB) sets forth the reason for Respondent's adjustment of the cupping charges. They are as follows: "21 - In accordance to New York No-Fault Law, Regulation 68, this base fee was calculated according to the New York Workers' Compensation Board Schedule of Fees, pursuant to Regulation 83 and/or Appendix 17-C of 11 NYCRR. 129 - The procedure/service code billed is not listed in the fee schedule for the provider specialty. X628 - Per New York Workers' Compensation fee schedule General Rule #3 titled "Procedures Without Specified Unit Values", for any procedure where the unit value is listed in the schedule as "BR", the physician shall establish a unit value consistent in relativity with other unit values shown in the schedule. The ground rules also states that the insurer shall review all submitted "BR" unit values to ensure that the relativity consistency is maintained. The relative value charged appears excessive and inconsistent in relativity with like procedures taken from Radiology Section of the New York Worker's Compensation Fee Schedule. The amount allowed is based on documented time, skill, and equipment. X896 - This fee was calculated based upon Section 68.5(b) of Regulation 83 which states:"If the superintendent has not adopted or established a fee schedule applicable to the provider, then the permissible charge for such service shall be the prevailing fee in the geographic location of the provider subject to review by the insurer for consistency with charges permissible for similar procedures under schedules already adopted or established by the superintendent".

The Office of General Counsel's opinion letter dated 10/6/04 states, "since the No-Fault fee schedule now includes the October 1, 2003 permissible fees established for acupuncture services provided by doctors and chiropractors licensed to perform acupuncture, it would be reasonable and appropriate, as well as consistent with the intent of Section 68.6(b), for an insurer to reduce a prevailing regional rate when there is an established fee schedule for similar services."

I am guided by the affidavit of Kimberly Spahr, a Certified Professional Coder, that has been submitted into evidence. Provider billed CPT code 97799 for cupping therapy ... A research of how cupping is performed, the appropriate CPT code would be 97039 (unlisted therapeutic procedure)(Acupuncture Today, April 2010 Vol. 11, Issue 4). The RVU for 97039 = 3.30 [RVU] x \$5.78 [Conversion Factor] = \$19.07.

DECISION

Taking into consideration the fee schedule descriptions, and well-established case law, I find it interesting that Applicant chose to use CPT code 97799 to bill for its cupping therapy. Noted earlier, CPT code 97799 is located in the Physical Medicine section of the medical Fee Schedule. It's listed as a By Report code and is described as an "[u]nlisted physical medicine/rehabilitation service or procedure." No reason has been

offered by the Applicant to explain why it chose to utilize this particular code instead of billing for its service under CPT 97039 or 97139 pursuant to the Chiropractic Fee Schedule. Based on the article in Acupuncture Today, these would be the recommended codes for cupping therapy. The descriptions set forth in the fee schedule are comparable: CPT code 97039 is described as "Unlisted modality (specify type and time if constant attendance)." CPT code 97139 is described as "Unlisted therapeutic procedure (specify)." During the hearing, Applicant's counsel argued that Applicant is not prohibited from using a code listed in the Medical Fee Schedule.

I recognize that a medical provider is not limited to any particular fee schedule, or to any section contained within a fee schedule. See *Robert Physical Therapy, P.C. v. State Farm Mut. Ins. Co.*, 13 Misc.3d 172, 822 N.Y.S.2d 378 (Civ. Ct. Kings Co. 2006). However, I'm also aware that an insurer may utilize the Chiropractic Fee Schedule to process claims for services rendered by acupuncturists. *Great Wall Acupuncture, PC v. Geico*, 16 Misc.3d 23, 2007 NY Slip Op 27164 (App. Term, 2 Dept., April 24, 2007).

I note that the services in dispute were provided from June 9, 2014 through February 20, 2014. The Fourth Amendment to 11 NYCRR 65-3, which is applicable to claims for medical services rendered on or after April 1, 2013, introduced the following provision: Proof of the fact and amount of loss sustained pursuant to Insurance Law section 5106(a) shall not be deemed supplied by an applicant to an insurer and no payment shall be due for such claimed medical services under any circumstances: for those claimed medical service fees that exceed the charges permissible pursuant to Insurance Law sections 5108(a) and (b) and the regulations promulgated thereunder for services rendered by medical providers. 11 NYCRR §65-3.8(g)(1)(ii).

This essentially means that for those services rendered on or after April 1, 2013, a fee schedule defense is non-precludable. It does not have to be timely preserved in a denial. In other words, even if there were late denials or no denials, Respondent would be allowed to assert a fee schedule defense. After careful consideration of all of the evidence, I find Respondent's reasoning to be valid. The evidence is sufficient to demonstrate that cupping therapy, provided by licensed acupuncturists, should be billed under either CPT code 97039 or 97139 and calculated according to the rates set forth in the Chiropractic Fee Schedule. This was not done here.

By using a By Report code (97799) listed in the Physical Medicine section of the Medical Fee Schedule, Applicant charged \$50 for each instance of the cupping therapy that was provided to the assignor. By comparison, if Applicant had billed under the recommended codes according to the rates set forth in the Chiropractic Fee Schedule, its reimbursement would be noticeably lower. The following illustrates this point: [Using the Chiropractic Fee Schedule] Generally speaking, the rate of reimbursement for a service is calculated by multiplying the Relative Value Unit (RVU) by the Conversion Factor. CPT codes 97139 and 97039 are both located in the Physical Medicine Section of the Chiropractic Fee Schedule. CPT code 97139 has been assigned a Relative Value Unit (RVU) of 2.89. CPT code 97039 is listed as a By Report (BR) code. The appropriate Conversion Factor for Applicant - as a provider located in Region IV and billing for services contained in the Physical Medicine section of the Chiropractic Fee

Schedule- is \$5.78. If Applicant were to bill for its cupping therapy according to CPT code 97139, the allowable rate of reimbursement would be \$19.07 (3.30 Relative Value Units [according to Kimberly Spahr, CPC] x \$5.78 Conversion Factor = \$19.07)

Accordingly, I find - in this case - that Applicant is entitled to payment of its claims according to the maximum rate of reimbursement that is allowed under CPT code 97039. As Respondent has issued partial payment in the amount of \$19.07 for each cupping session, and according to Respondent's own certified professional coder, an additional \$30.92 is due and owing. Thus, Applicant is awarded the difference of \$30.92 for each of those six sessions. In the aggregate, **Applicant is awarded \$30.92 for its charges relating to cupping therapy.**

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
	OZ Acupuncture, P.C.	01/09/14 - 02/20/14	\$445.00	\$198.00	Awarded: \$30.92
Total			\$445.00		Awarded: \$30.92

- B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 10/25/2016, which is a relevant date only to the extent set forth below.)

Applicant is awarded interest pursuant to the No-Fault regulations. See generally, 11 NYCRR §65-3.9. Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30-day month." 11 NYCRR §65-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. "If an applicant does not request arbitration or institute a lawsuit within 30 days after receipt of a denial of claim form or payment of benefits calculated pursuant to Department of Financial Services regulations, interest shall not accumulate on the disputed claim or element of claim until such action is taken." 11 NYCRR §65-3.9(c). The Superintendent and the New York Court of Appeals has interpreted this provision to apply regardless of whether the particular denial at issue was timely. *LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co.*, 12 N.Y.3d 217 (2009). Interest is to be calculated from the date this case was filed in arbitration.

C. Attorney's Fees

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

As the claim was filed subsequent to the Sixth Amendment to 11 NYCRR §65-4 (Insurance Regulation 68-D) which took effect on February 4, 2015, Attorney's Fees shall be calculated pursuant to the amended terms, as follows: 20 percent of the amount of first-party benefits, plus interest thereon, subject to a maximum fee of \$1,360. [11 NYCRR §65-4.6(d)]. There is no minimum fee.

- 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, Marina O'Leary, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

12/31/2017
(Dated)

Marina O'Leary

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: Marina O'Leary
Signed on: 12/31/2017