

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Joseph Bater, DC
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No. 17-17-1055-5982
Applicant's File No.
Insurer's Claim File No. 0530957560101016
NAIC No. 22063

ARBITRATION AWARD

I, Evelina Miller, 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: JL

1. Hearing(s) held on 02/13/2018
Declared closed by the arbitrator on 02/13/2018

Abraham Meir Esq from The Geller Law Group PC (Long Island) participated in person for the Applicant

Megan DiMiceli Esq from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 2,330.56**, 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 established entitlement to No-Fault compensation for fees associated with PF-NCS testing of the lower extremities performed on Assignor

Whether Respondent reached its burden in coming forward with competent evidentiary proof to support its fee schedule defenses

4. Findings, Conclusions, and Basis Therefor

Applicant was represented by Abraham Meir Esq., who presented oral arguments and relied upon documentary submissions. Megan DiMiceli Esq., appeared on behalf of Respondent and presented oral arguments and relied upon documentary submissions I have reviewed the submissions contained in MODRIA. These submissions are the record in this case.

The disputes arise from the underlying automobile accident of May 9, 2016, in which the Assignor (JL), a 60-year-old-female was involved. Thereafter, Assignor sought private medical attention and was eventually evaluated Applicant. Patient presented with complaints of headaches, neck pain radiating to both elbows, mid back pain, lower back pain radiating to the left buttock and bilateral knee pain. Patient was recommended to undergo chiropractic treatment. Eventually patient was recommended to undergo PFNCS testing of the lumbar plexus The bill in dispute is for PFNCS testing of the lumbar plexus performed on Assignor on 6/8/16.

I find that Applicant establishes its prima facie showing of entitlement to recover first-party no-fault benefits by submitting evidentiary proof that the prescribed statutory billing forms, setting forth the fact and 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 Co.*, 5 A.D.3d 742, (2d Dept., 2004).

Applicant's proof is also in Respondent's denials, which acknowledged receipt of the bill. Since Applicant establishes its prima facie showing of entitlement to recover first-party no-fault benefits, the burden then shifts to the Respondent to demonstrate a lack of medical necessity for the items at issue. See, *Citywide Social Work & Psychological Services, PLLC v. Allstate Ins. Co.*, 8 Misc 3d 1025 A (2005).

On 8/2/16, Respondent issued a timely denial for PFNCS testing of the lumbar lexus performed on Assignor on 6/8/16 based on a Peer review by Dr. Ronald Csillag D.C. Dr. Csillag reviewed the medical records of the Assignor and concluded that there is no justification for the medical necessity of the PFNCS testing performed on Assignor on 6/8/16.

Medical Necessity:

A denial premised on a lack of medical necessity must be supported by competent evidence such as an independent medical examination, a peer review or other proof which sets forth a factual basis and a medical rationale for denying the claim. *Healing HandsChiropractic, P.C., v. Nationwide Assur. Co.*, 5 Misc., 3d 975, 787 N.Y.S. 2d 645 (Civ.Ct., New York County, 2004); *King's Med. Supply Inc. v. Country Wide Ins. Co.*, 5Misc. 3d 767, 783 N.Y.S. 2d 448.

Once Respondent submits an IME report or peer review that has a sufficient factual basis and medical rationale, then the courts have routinely found that Respondent has established its prima facie defense that the disputed medical service is medically unnecessary. *A Khodadadi Radiology, P.C. v. NY Cent. Mut. Fire Ins. Co.*, 16 Misc.3d 131(A), 841 N.Y.S.2d 824 (Table, Text in WESTLAW), *Unreported Disposition*, 2007 WL 1989432, 2007 N.Y. Slip Op. 51342(U) (N.Y. Sup. App. Term Jul 03, 2007). See

also, Amaze Medical Supply Inc. v. Eagle Insurance Company, 2003NY Slip Op 51701 (U), 2 Misc.3d. 128 (App. Term 2d & 11 Dist.-2003).

The civil courts have held that a defendant's peer review or medical evidence must set forth more than just a basic recitation of the expert's opinion. The trial courts have held that a peer review report's medical rationale will be insufficient to meet respondent's burden of proof if: 1) the medical rationale of its expert witness is not supported by evidence of a deviation from "generally accepted medical" standards; 2) the expert fails to cite to medical authority, standard, or generally accepted medical practice as a medical rationale for his findings; and 3) the peer review report fails to provide specifics as to the claim at issue, is conclusory or vague. See generally, *Nir v. Allstate, 7 Misc.3d 544 (N.Y. City Civ. Ct. 2005)*; *See also, All Boro Psychological Servs. P.C. v. GEICO, 2012 NY Slip Op 50137(U) (N.Y. City Civ. Ct. 2012).*

PEER by Dr. Ronald Csillag D.C.

On July 21, 2016, Dr. Ronald Csillag D.C. performed a peer review on behalf of Respondent regarding the medical necessity of PFNCS performed on Assignor on 6/8/16. Dr. Csillag reviewed medical records of the Assignor and concluded that based on Assignor's medical history as well as recognized medical guidelines, medical necessity for the PFNCS testing has not been established.

Dr. Csillag states that PFNCS are based upon the subjective perception of an electrical stimulation from an electrode applied to the skin. He further states that sensory examination provides adequate information, therefore additional testing is not necessary.

Dr. Csillag cites to medical literature which states that there is insufficient scientific or clinical evidence to consider the sNCT test reasonable and necessary in diagnosing sensory neuropathy. He further states that there is no efficacy of sNCT on patient management. Furthermore, the testing would not change the diagnosis or significantly alter the treatment plan.

Dr. Csillag further notes that it is unclear why sensory conduction study would be performed the day before EMG/NCV study. EMG/NCV testing is the gold standard of electrodiagnostic studies and additional electrodiagnostic studies would not be necessary above and beyond the testing.

Once Respondent submits an IME report or peer review that has a sufficient factual basis and medical rationale, then the courts have routinely found that Respondent has established its prima facie defense that the disputed medical service is medically unnecessary. *A Khodadadi Radiology, P.C. v. NY Cent. Mut. Fire Ins. Co., 16 Misc.3d 131(A), 841 N.Y.S.2d 824 (Table, Text in WESTLAW), Unreported Disposition, 2007 WL 1989432, 2007 N.Y. Slip Op. 51342(U) (N.Y. Sup. App. Term Jul 03, 2007).* *See also, Amaze Medical Supply Inc. v. Eagle Insurance Company, 2003NY Slip Op 51701 (U), 2 Misc.3d. 128 (App. Term 2d & 11 Dist.-2003).*

In order for an applicant to prove that the disputed expense was medically necessary, it must meaningfully refer to, or rebut, the conclusions set forth in the peer review. High

Quality Medical, P.C. v. Mercury Ins. Co., 2010 N.Y. Slip Op. 50447(U) (App Term 2d, 11th & 13th Dists. Mar. 10, 2010); Pan Chiropractic, P.C. v. Mercury Ins. Co., 24 Misc.3d 136(A), 2009 N.Y. Slip Op. 51495(U) (App Term 2d, 11th & 13th Dists. July 9, 2009).

Rebuttal by Dr. Joseph Bater D.C.

Applicant submits a rebuttal by Dr. Joseph Bater D.C. Dr. Bater discussed the medical history of the Assignor. He states that the testing was recommended to identify the exact location of the neurological injury. He goes on to say that PF-NCS is different and distinctive from Quantitative Sensory Testing (QST). Pf-Ncs is a method of testing to detect pre-ganglionic dorsale nerve-root pathology earlier than other nerve conduction studies in order to allow a better and earlier positive outcome for the patient. The information obtained with this test is very useful to direct manipulative treatment. Regarding Dr. Csillag's contention that the PF-NCS was not medically necessary as the EMG/NCV was being performed the next day, Dr. Bater disagrees with Dr. Csillag's opinion. He states that AASEM compares EMG-type EDX with the pf-NCS. He further states that pf-NCS is sometimes more effective than EMG/NCV at detecting sensory pathology. He cites to a medical study where pf-NCS was approaching 100% in localizing radiculopathy.

Addendum:

Respondent submits an addendum by Dr. Csillag to refute the rebuttal by Dr. Bater. Dr. Csillag cites to medical literature which questions the efficacy of the PF-NCS testing in diagnosing sensory neuropathies.

Conclusion:

After carefully reviewing all the submitted documents and oral arguments presented at the hearing I find the following. Initially I find that Respondent was able to present sufficient factual basis and medical rationale, and as such I find that Respondent has established its prima facie defense that the disputed medical service is medically unnecessary. The crux of Dr. Csillag's peer report is that clinical sensory examination was sufficient, and there was no need for additional testing. Medical literature finds it insufficient to consider the sNCT test reasonable and necessary in diagnosing sensory neuropathy. Furthermore, the testing would not change the diagnosis or significantly alter the treatment plan.

Dr. Csillag further notes that the test was performed a day prior to the EMG/NCV testing. Since EMG/NCV test is gold standard in electrodiagnostic studies and additional electrodiagnostic studies would not be necessary above and beyond the testing. Dr. Bater disagrees with Dr. Csillag's opinion. He states that AASEM compares EMG-type EDX with the pf-NCS. He further states that pf-NCS is more often more effective than EMG/NCV at detecting sensory pathology. He cites to a medical study where pf-NCS was approaching 100% in localizing radiculopathy.

Based on the above I find that Applicant has been able to adequately rebut the conclusion of the peer doctor. Dr. Csillag may disagree with Dr. Bater and find that to perform both the PF-NCS and the EMG/NCV was not medically necessary as EMG is the gold standard in EDX studies. However, here Dr. Bater was able to establish that PFNCS is better at diagnosing sensory deficits. Perhaps performing the EMG/NCV test the next day was not medically necessary. However, that test is not at issue in this case.

Accordingly, Applicant's claim for reimbursement is granted.

Fee Schedule:

The rates charged by Applicant must be in accordance with Insurance Law § 5108, as the charges for services rendered "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."

In addition, § 5108 (c) states that, "no provider of health services... may demand or request any payment in addition to the charges authorized pursuant to this section."

Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. See, *Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co.*, 2006 NY Slip 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct. Kings Co. 2006). If Respondent fails to demonstrate by competent evidentiary proof that a plaintiff's claims were in excess of the appropriate fee schedules, defendant's defense of noncompliance with the appropriate fee schedules cannot be sustained. See, *Continental Medical PC v. Travelers Indemnity Co.*, 11 Misc.3d 145A, 819 N.Y.S.2d 847, 2006 NY Slip Op 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Term. 1st Dep't. per curiam, 2006).

Effective April 1, 2013 11 NYCRR 65-3.8(g)(1) has been amended so that the application of the New York State Worker's Compensation fee schedule is no longer a precludable defense and no payment is due on those claims in excess of the fee schedule. Per 11 NYCRR 65-3.8(g), where the services were rendered after April 1, 2013, a defense of excessive fees is not subject to preclusion *Surgicare Surgical Associates v. National Interstate Ins. Co.*, Misc.3d, N.Y.S.3d, 2015 N.Y. Slip Op. 25338 (App. Term 1st Dept. Oct. 8, 2015), *aff'g*, 46 Misc.3d 736, 997 N.Y.S.2d 296 (Civ. Ct. Bronx Co. 2014) (New Jersey fee schedule). The insurer is entitled to reduce the bills to the proper fee schedule amount.

Respondent does not submit a coder affidavit, but does upload a decision by Arbitrator Paul Weidenbaum in *AAA Case #17-17-1056-8824 in CHC Chiropractic PC v. Geico Ins. Co.* In that decision Arbitrator Weidenbaum cites to opinions by Dr. Aaron Maslow in two different cases. He states:

"...decision issued by Arbitrator Aaron Maslow which addressed the subject matter we are dealing with in the instant case. *Matter of Arbitration of Pro Edge Chiropractic, P.C. a/a/o 'CEH' v. Geico Ins. Co., AAA Case No. 17-16-1035-7760 [4/20/17]*.

In the case before me, as was true in the case before Arbitrator Maslow, the bill sent to Respondent for claims processing asserted that a Code 95904 service was performed. Code 95904 is to be used for NCV testing, per the Workers' Compensation Fee Schedule. Each entry listed a particular nerve. Respondent's counsel raised the issue of the propriety of Applicant's billing for pf-NCS testing under CPT Code 95904, as pf-NCS testing is not NCV testing.

In the instant case, the Applicant billed for the services at issue under CPT Code 95904. In the Workers' Compensation Medical Fee Schedule, Code 95904 is defined as 'Nerve conduction, amplitude and latency/velocity study; each nerve; sensory'. It is commonly known as 'NCV testing'. In NCV testing, the speed [velocity] with which an electrical impulse travels from one point to another is measured. However, the medical records listing the services performed in the instant case identified the services as pain fiber nerve

conduction studies [pf-NCS]. This testing is also referred to as V-sNCT, CPT, or QST. This voltage-actuated sensory nerve conduction threshold testing evaluates the sensitivity, specificity, and predictive value of A-delta fibers in order to assess and localize pain sources. Pf-NCS testing-as distinguished from NCV testing-measures how long it takes to elicit a reaction from a person when stimulated with electrical current. This is, by definition, subjective, as the results depend on when the patient being tested starts to feel the stimulus. There is no objective testing of time from one point to another. Pf-NCS testing is not nerve conduction testing with amplitude and latency/velocity studies. It is electrical current perception threshold testing.

In an award issued by Arbitrator Maslow in Matter of *Arbitration of Brooklyn Precision Chiropractic, P.C. a/a/o 'CM' v. Allstate Ins. Co.*, AAA Case No. 17-15-1016-9222 [4/24/16], the arbitrator quoted from the peer review report of Dr. Robert Sohn [the same peer reviewer in the instant matter], who described pf-NCS testing as follows:

"Quantitative Sensory Testing are techniques employed to measure the intensity of stimuli needed to produce specific sensory perceptions. They are used to evaluate a sensory detection threshold or other sensory response from supra threshold stimulation. The common physical stimuli are touch-pressure, vibration, and coolness, warmth, cold pain, and heat pain. In QST, the subject must be able to comprehend what is being asked by the test, be alert and not taking mind-altering medications, and not biased to the certain test outcome."

Abnormal or elevated QST measurements are not specific in the diagnosis of any particular type of neuropathy, and in fact do not necessarily indicate any form of peripheral neuropathy. There are no prospective clinical studies demonstrating that quantitative tests of sensation improve the management and clinical outcomes of patients over standard qualitative methods of sensory testing."

In another award issued by Arbitrator Maslow, in Matter of Arbitration of *Brooklyn Precision Chiropractic, P.C. a/a/o 'NF' v. GEICO Ins. Co.*, AAA Case no. 17-15-1019-2035 [5/6/16], Arbitrator Maslow wrote: "A document in the record which is a coverage determination by the Centers For Medicare and Medicaid services [CMS] stated "This procedure is different and distinct from assessment of nerve conduction velocity, amplitude and latency. It is also different from short-latency somatosensory evoked potentials."

In the same decision, Arbitrator Maslow noted that the peer reviewer, Dr. Amit Khaneja, asserts in the peer review report "Billing this testing utilizing CPT Code 95904 NCV testing is without basis and incorrect. This code represents the performance of sensory nerve conduction studies which is scientifically based measurement of the velocity of transmissions of nerve impulses and despite the use of the word sensory bears absolutely no resemblance to QST which does not test nerve conduction velocity."

Thus, in billing Code 95904, the Applicant herein billed incorrectly. By billing Code 95904, it billed for a service which it did not actually perform; NCV testing. Under the regulation set forth in 11 NYCRR Section 65-3.8(g)(1)(i) no payment shall be due for claimed medical services when they were not provided to the injured person. The provisions of 11 NYCRR 65-3.8(g), promulgated in the Fourth Amendment to Regulation 68-C, control even where the insurer's denial of claim form does not specifically assert them as an issue. *Surgicare Surgical Associates v. National Interstate Ins. Co.*, 50 Misc. 3d 85, 25 N.Y.S. 3d 521 [App. Term 1st Dept. Oct. 8, 2015], *aff'g* 46 Misc. 3d 736, 997 N.Y.S. 2d 296 [Civil Ct., Bronx Co. 2014]; *Saddle Brook Surgicenter, LLC v. Allstate Ins. Co.*, 48 Misc. 3d 336, 8 N.Y.S. 3d 875 [Civil Ct., Bronx Co. 2015].

Since the Applicant billed for a service it did not perform, then proof of the fact and amount of loss sustained is deemed not supplied, and benefits are not overdue. As the benefits are not overdue, the applicant has not made out a prima facie case in support of its claim. Therefore, I sustain the defense asserted in Respondent's denial of claim form that fees were not in accordance with fee schedule. Here, the billed fees were for another type of service than the one provided.

Having determined that the Applicant failed to establish a prima facie case in support of its claim that it performed the billed service of NCV testing, and having sustained the defense that the fees were not in accordance with fee

schedule, the Applicant's prima facie case has been overcome. Therefore, it is not necessary to determine the separate issue of medical necessity.

Accordingly, the Applicant's claim for No-Fault benefits is denied in its entirety"

Discussion:

Upon review of the records and arguments presented at the hearing I find the following. The PFNCS. Arbitrator Mereym Toksoy in AAA 17-15-1017-5674, *Therapeutic Chiropractic Services P.C. v. Gaico Insurance Company*. Arbitrator Toksoy did an extensive analysis on the PFNCS testing, and the proper billing for this test.

In this award she states the following:

"Effective January 1, 2013, the AMA published changes to codes relating to nerve conduction velocity ("NCV") studies. Specifically, 95900, 95903 and 95904 were deleted and replaced by seven new codes: 95907-95913.

The changes made by the AMA have yet to be incorporated into the Workers' Compensation Fee Schedule. As set forth in 12 NYCRR §329-1.3(a):

The medical fee schedule for medical, physical therapy and occupational therapy services shall be the Official New York Workers'

Compensation Medical Fee Schedule, updated June 1, 2012, prepared by the board and published by OptumInsight, which is herein incorporated by reference.

As set forth in 12 NYCRR §348.2(a):

The chiropractic fee schedule for chiropractic services shall be the Official New York Workers' Compensation Chiropractic Fee Schedule, updated June 1, 2012, prepared by the board and published by OptumInsight, which is herein incorporated by reference.

This means that a provider who intends to bill for nerve conduction studies must continue to use either 95900, 95903 or 95904. The Medical and Chiropractic Fee Schedule define each of those codes as follows:

Code 95900: Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study.

Code 95903: Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study.

Code 95904: Nerve conduction, amplitude and latency/velocity study, each nerve; sensory.

As such, I will evaluate Applicant's charge according to the parameters of CPT code 95904.

The description for CPT code 95904 is clear and unambiguous. It requires the measurement of amplitude, latency, and velocity. All three components must be recorded. See CPT Assistant, April 2002, Volume 12, Issue 4.

PF-NCS testing is a study that only involves the measurement of amplitude.

In *Bronx Chiropractic Services, PC v. Geico*, AAA #412012010739 (Dec. 23, 2013), Arbitrator Elyse Balzer requested an Independent Health Consultant (IHC) review to determine whether it was appropriate for a claimant to utilize CPT code 95904 for PF-NCS testing; (and in the event it was found to be improper) she wanted to know which code(s) should be used.

In his IHC report, Dr. Kevin Toss answered the inquiry by stating that PF-NCS testing is not consistent with conventional nerve conduction velocity testing and should not be billed under CPT code 95904. He explained that code 95904 is designated for studies such as EMG and NCV testing which require the insertion of needle electrodes into the muscles of the patient to measure specific responses; in contrast, PF-NCS testing involves the placement of electrodes on the skin to deliver superficial electrical impulses which are then measured according to the patient's conscious response. He concluded that it was "a different test altogether." As for what code PF-NCS studies should be billed under, Dr. Toss advised that it should be charged as a Category III code under Quantitative Sensory Testing (QST).

The CPT Assistant also draws a distinction and makes the same recommendation. In its May 2011 publication (Volume 21, Issue 5), the CPT Assistant states that code 95904 requires the measurement of amplitude, latency and velocity. It further notes that sensory nerve conduction studies are "different and distinct." For purposes of billing, it states that Category III codes, namely 0106T-0110T, "offer valid options for quantitative sensory testing."

I find that Applicant's claim for PF-NCS testing of the upper and lower extremities is reimbursable as a Category III code. In terms of the amount of reimbursement, I respectfully agree with my learned colleague Arbitrator Rhonda Barry's analysis as set forth in Nassau Chiropractic Services, PC v. Allstate, AAA #17-14-9023-0826 (Aug. 17, 2015):

The code descriptors contained in the New York State Worker's Compensation fee schedule coupled with the CPT Assistant (a reliable and generally accepted resource) and medical records provided by applicant itself are sufficient to determine the appropriate fee schedule for PF-NCS. The CPT Assistant recommends that Category III codes be used for reimbursement of the service. Category III codes are temporary codes identifying emergency technology "to evaluate the clinical efficacy and outcomes and collect unbiased data." See, Bronx Chiropractic Services, PC

v. Geico Insurance Company, AAA #412012005458 (Arbitrator Sloane, 8/20/12). Category III codes 0106T-0110T offer valid options for reporting the PF-NCS.

A PF-NCS does not measure velocity or latency as specifically required by the code descriptor. The Category III codes for QST (CPT 0106T-0110T) are "by report" and more appropriately reflect the nature of the services rendered. Both the NCV and the QST are different tests than the PF-NCS; but, for billing purposes, the Category III Codes (which permit billing per extremity as opposed to per nerve) offer a more consistent standard for reasonable compensation.

I previously used the relative value for CPT 95904 and applied that amount to CPT 0110T (which permits payment by extremity and not by nerves tested) to determine the proper reimbursement.

For purposes of determining proper reimbursement, the relative value of a code may be applied to those procedures and tests that are "by report." The code descriptor for CPT 0110T satisfactorily describes the test performed. In the absence of contrary evidence from applicant, the relative value for CPT 95904 is appropriate. Ground Rule 3 [of the Introduction & General Guidelines] provides that the unit value of a similar procedure may be considered. It does not permit billing of a CPT code where the procedure performed fails to satisfy the language of the code descriptor. There are

distinctions between the QST and the PF-NCS, but for billing purposes it offers a more comparable standard than the NCV for reasonable compensation.

I concur with Arbitrator's Barry's reasoning and find that the Relative Value Unit for 95904 may be used to calculate reimbursement for PF-NCS testing.

As for the Category III code to be utilized, I also agree that 0110T is appropriate. The five codes designated for Quantitative Sensory Testing (QST),

0106T-0110T, are primarily distinguished by the stimulus that is used to perform the procedure, namely: touch (0106T); vibration (0107T); cooling (0108T); heat-pain (0109T); other stimuli (0110T). Electricity can certainly be considered "other stimuli."

With respect to the amount of reimbursement: Generally speaking, the rate of reimbursement for a service is calculated by multiplying the Relative Value Unit (RVU) by the Conversion Factor. The Relative Value Unit (RVU) for CPT code 95904 is 12.60. The Conversion Factor for Applicant - as a provider located in Region IV and billing for services contained in the Medicine section of the Chiropractic Fee Schedule- is \$5.78. Accordingly, the rate of reimbursement per extremity is \$72.83.

As the testing was performed on the upper and lower extremities,
Applicant is awarded \$145.66."

Conclusion:

Giving great deference to the well-reasoned arbitration award by Arbitrator Toksoy and having considered the Workers' Compensation Fee Schedule and guidelines I find the following. The proper code for billing purposes for the PFNCS testing is 0110T as code 95904 is defined as nerve conduction, amplitude and latency/velocity study, each nerve; sensory. However, PFNCS test only involves the measurement of amplitude. The Category III codes for QST (CPT 0106T-0110T) are "by report" and more appropriately reflect the nature of the services rendered. Both the NCV and the QST are different tests than the PF-NCS; but, for billing purposes, the Category III Codes (which permit billing per extremity as opposed to per nerve) offer a more consistent standard for reasonable compensation.

However, for determining the proper amount of reimbursement for the PFNCS testing Code 95904 should be used and applied that amount to CPT 0110T (which permits payment by extremity and not by nerves tested). The Relative Value Unit (RVU) for CPT code 95904 is 12.60. The Conversion Factor for Applicant - as a provider located in Region IV and billing for services contained in the Medicine section of the Chiropractic Fee Schedule- is \$5.78. Accordingly, the rate of reimbursement per extremity is \$72.83. As such I find that Applicant is entitled to

reimbursement of \$145.66 as the test was performed on the lower extremities.

Since the rate of reimbursement is \$72.83 is per extremity, Applicant would be

entitled to $\$72.83 \times 2 = \145.66 .

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
	Joseph Bater, DC	06/08/16 - 06/08/16	\$2,330.56	Awarded: \$145.66
Total			\$2,330.56	Awarded: \$145.66

- B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 02/17/2017, which is a relevant date only to the extent set forth below.)

Since the motor vehicle accident occurred after April 5, 2002, interest shall be calculated at the rate of two percent per month, simple, calculated on a pro rata basis using a 30

day month. 11 NYCRR 65-3.9(a). In accordance with 11 NYCRR 65-3.9c, interest shall be paid on the claims totaling \$145.66 from the date the arbitration was commenced.

C. Attorney's Fees

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

Respondent shall pay Applicant an attorney's fee upon the amount awarded plus the interest, as calculated in section "B" above, and in accordance with 11 NYCRR 65-4.6(e), i.e., 20 percent of the amount of first party benefits, plus interest thereon. The minimum attorney's fee payable shall be in accordance with 11 NYCRR 65-4.6c. For cases filed after February 4, 2015, there is no minimum attorney's fee but there is a maximum fee of \$1,360.00. 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 Nassau

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

03/15/2018
(Dated)

Evelina Miller

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:
f0fed9e50b96dd58b340249070c743b7

Electronically Signed

Your name: Evelina Miller
Signed on: 03/15/2018