American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Ligament Laxity Analysis/ James Lambert, D.C. (Applicant)	AAA Case No.	17-17-1061-9298
	Applicant's File No.	NF 21205
- and -	Insurer's Claim File No.	52-636Q-231
	NAIC No.	25178
State Farm Mutual Automobile Insurance Company (Respondent)		

ARBITRATION AWARD

I, Alina Shafranov, 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: Assignor

1. Hearing(s) held on 02/27/2018
   Declared closed by the arbitrator on 02/27/2018

   Michael Manfredi, Esq. from Law Office of Thomas Tona P.C participated in person for the Applicant

   Anna Bogunova, Esq. from Richard T. Lau & Associates participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 751.52**, 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

   The Assignor, "SM", is a 44 year old female was involved in a motor vehicle accident as a passenger on April 13, 2015. She sought treatment for her injuries sustained in the MVA and eventually came under the care of James Lambert, D.C. Applicant seeks reimbursement for ligament laxity analysis testing for dates of service 1/26/17-1/27/17.Respondent timely denied the claim based on a Fee Schedule defense. The issue at the arbitration was whether the Applicant billed in excess of the fee schedule.

4. Findings, Conclusions, and Basis Therefor

This case was decided on the submissions of the Parties as contained in ADR Center maintained by the American Arbitration Association and the oral arguments of the parties' representatives. There were no witnesses present at the hearing. I reviewed the documents contained in the ADR Center for both parties and make my decision in reliance thereon.

Applicant has established a prima facie case of entitlement to reimbursement of this claim. See, Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). Respondent's denials are found to be timely.

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). See also, Power Acupuncture PC v. State Farm Mutual Automobile Ins. Co., 11 Misc.3d 1065A, 816 N.Y.S.2d 700, 2006 NY Slip Op 50393U, 2006 N.Y. Misc. LEXIS 514 (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).

Notice is taken that Applicant billed $954.96 under CPT Code 76499. Respondent partially paid $203.44 and denied the remainder. Respondent's timely denial is predicated on the following fee schedule defenses: "The procedure/service code billed is not listed in the fee schedule for the provider specialty." The denial also states as follows: "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 state that the insurer shall review all submitted "BR" unit values to ensure that the relativity consistency is maintained. The amount allowed is based on documented time, skill, and equipment."

In support of its fee schedule defense Respondent has submitted the Affidavit of Mercy Acuna, registered nurse, and certified professional sworn to on January 9th, 2017. Ms. Acuna attests as follows:

"For all dates of service, the provider billed CPT code 76499- 22, which is "unlisted diagnostic radiographic procedure". The documentation submitted indicates that the service provided was "computerized radiographic mensuration analysis, a form of digital radiographic analysis.

CPT code 76499 is not listed in the NY Workers' Compensation Chiropractic Fee Schedule

Modifier 22 is not listed as one of the modifiers that can be used in the radiology section of the Chiropractic Fee Schedule.

Per the NY Workers' Compensation Chiropractic Fee Schedule Radiology Ground Rules# 18: "The use of digital or photographic media and/or imaging is not reported separately but is considered to be a component of the basic procedure, and shall not merit any additional payment".

As per the above rule, no additional payment can be made for the digital radiographic analysis.

In order to validate the use of the unlisted code (CPT code 76499) for the "ligament laxity analysis", the CPT book was utilized as reference for coding rules and regulations.

Per the NY Workers' Compensation Chiropractic Fee Schedule, [ntroduction and General Guidelines (paragraph 5) "this edition of the Official New York Workers' Compensation Chiropractic Fee Schedule uses CPT procedure codes, modifiers, and descriptions. Please refer to the CPT book for an explanation of coding rules and regulations not listed in this schedule".

In the CPT Book, under the CPT code 76499, the CPT Assistant is referenced for further instruction.

The CPT Assistant is published by AMA (American Medical Association) which also publishes the CPT Book. The CPT Assistant is an in- depth information for the particular code and is referenced in the CPT Book (arrow symbol) located next to many codes (such as CPT code 76499, copy attached).

Per the AMA CPT Assistant April 2004 page 15 issue:

Coding Consultation: Questions and Answers

Radiology, 76499 (Q&A)

Question

Would it be appropriate to report code 76499, Unlisted diagnostic

radiographic procedure, for a digital motion X-ray study procedure?

AMA Comment

From a CPT coding perspective, it would be appropriate to report code 76120,Cineradiographylvideoradiography, except where specifically included, for the digital motion X-ray study procedure. Therefore, this code may be reported instead of the unlisted procedure code 76499, Unlisted diagnostic radiographic procedure.

Also attached is the AMA CPT Assistant September 2000 issue (plus the correction, January 200 I issue) that explains coding for videoradiography/cineradiography.

CPT code 76120 is not listed in the NY Workers' Compensation Chiropractic Fee Schedule. The RVU for CPT code 76120 under the NY Workers' Compensation Medical Fee Schedule is 2.81 x $36.20 = $101.72.

To reiterate, as per Radiology Ground Rules# lB, no additional payment can be made for the digital radiographic analysis.

NOTE: The provider submitted an affidavit that the comparable code for the RVU is CPT code 95812 which is for an EEG which is a medicine service.

I fully disagree using CPT code 95812 since the service provided is a radiological service therefore a "similar service in the radiology section should be used for comparison purposes to maintain the "relative consistency".

The provider submitted the amount of $475.00 for each study which is equivalent to 13.12 RVU (obtained by dividing the amount billed by the conversion factor for radiology $36.20)

There is no RYU equivalent to 13.12 in the Radiology Section of the NY Workers' Compensation Chiropractic Fee Schedule. The highest RVU in the Radiology Chiropractic Fee Schedule is 3.48 for CPT code 72010 (Radiologic examination, spine, entire, survey study, anteroposterior and lateral)

There is no RYU equivalent to 13.12 in the NY Workers' Compensation Medical Fee Schedule Radiology Section, however for comparative purposes, the following examples of radiology services (more extensive than the service billed by the provider) have a lower RYU than the 13.12:

CPT code 71260 (CT scan thorax with contrast material) RVU = 12.64

CPT code 72126 (CT scan cervical spine with contrast material) RVU12.64 CPT code 72131 (CT scan lumbar spine with contrast material) RVU = 12.64
CPT code 77469 (Intraoperative radiation treatment management) RVU = 12.79 CPT code 78205 (liver imaging (SPECT) RYU= 10.46
CPT code 78607 (brain imaging, tomographic SPECT) RVU = 10.94

CPT code 78804 (radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring 2 or more days imaging) RYU 10.20

For all dates of service, the provider billed CPT code 76499- 22, which is "unlisted diagnostic radiographic procedure". The documentation submitted indicates that the service provided was "computerized radiographic mensuration analysis" of the cervical and lumbar spine, which is a form of digital radiographic analysis.

Provider was paid the amount of $10 I .72 per date of service. No additional reimbursement due."

Applicant's counsel countered that the ligament laxity analysis provides a substantial amount of additional information that cannot be obtained from the original x-rays alone. He argued that the software as well as the analysis of a physician result in the preparation of a report summarizing the findings not only of the original x-rays but the digitized version of those x-rays. He argued further that the Ground Rule does not take into account the services that are rendered in addition to the digitization of the x-rays which includes the plotting of points on the Assignor's vertebra, the analysis of those plot points by a medical professional and the preparation of the analysis report for submission to the treating chiropractor. Applicant has submitted the Affidavit of Jacqueline Thelian, certified professional coder, sworn to on September 13, 2016. Ms. Thelian attests:

"*As required by Ground Rule 1B, when an unlisted service or procedure is provided the procedure should be identified and the value substantiated "by report". The report should contain pertinent information concerning the nature, extent and the need for the procedure or service, the time, the skill and the equipment necessary to perform the service.*

Computerized Radiographic Mensuration Analysis (CRMA) and Ligament Laxity is an "objective" analysis of x-rays which is used to determine the exact location of the patient's injury usually, consisting of injured ligaments and/or in the soft tissues of the spine. The generated report allows the provider to accurately and specifically diagnosis the patient with the ICD-10-CM code M24.28 Disorder of ligament, vertebrae and correlates to the AMA (American Medical Association) DRE (Diagnosis Related Estimates) Guidelines 4th,5th and 6th edition.

Ligament Laxity Analysis utilizes a computer and a software system to enhance the radiographic films. Once enhanced the image is transferred to the software and the provider by use of his knowledge of anatomy, range of motion, spinal regions and specialized knowledge of the software, plots the points on each vertebra indicating ligament damage of the spine.

Approximately a half hour to forty-five minutes is spent plotting points on each vertebra, interpretation and generation of a report. Clearly by the nature and extent of the service as described above the service is separate and distinct and goes beyond that of a simple radiograph or digital image. It is not a duplication of an x-ray or a component of an x-ray. It is a separate and distinct diagnostic procedure.

Total RVU value 32.97. The professional component and the technical component (PC/TC) split is 40/60. Utilizing the professional component, the resulting RVU would be 13.19

13.19 x $36.20 (Region IV for Radiology/Chiropractic)= $477.48

In conclusion Ligament Laxity Analysis as per CPT Guidelines would be reported with the unlisted CPT code 76499 and is best represented with a relative value unit of 13.19 as indicated above."

Applicant has also submitted a statement from James Lambert, D.C. and Bruce Berns, D.C. owners of Ligament Laxity Analysis. Doctors Lambert and Berns stated that a Ligament Laxity Analysis is not a duplication of the professional component of an x-ray, but instead an entirely distinct diagnostic procedure. The digitizing software system, or DXD for short, allows for the computerized enhancement of plain radiographic films. They stated further that Ligament Laxity Analysis allows them to qualify and quantify the degree to which a traumatic injury has affected a patient's health. They asserted said that if they are physically provided with a patient's radiograph films, they place them on an electromagnetic backlit tablet (CAD Digitizer). Biomechanical data is extracted from the plain radiograph and the plain film is digitally reconstructed and displayed on the color monitor. An analysis is performed and a Ligament Laxity Analysis narrative report is generated. The analysis is billed under CPT

code 76499 for each test performed. CPT code 76499 is listed in the New York Workers' Compensation fee schedule as an "unlisted diagnostic procedure" and is a "By Report" code. The time required to read, interpret, and generate a Ligament Laxity Analysis report takes approximately forty-five minutes to an hour. The charge of $475.00 per analysis is based on the time it takes to perform the analysis and the chiropractor's extensive postgraduate training and specialized knowledge of the DXD software. They asserted that $475.00 represents the normal and customary rate practitioner's in their local area charge for such services.

I find that I am persuaded by the Affidavit of Ms. Thelian and the evidence collectively that the ligament laxity analysis test is a separate and distinct procedure, and not duplication or a component of the original x-ray. I find further that the test was properly billed by the chiropractors under CPT Code 76499. Furthermore, the Respondent requires an opinion of a medical expert to support its argument that the services rendered by a health care provider were improperly billed. I find that the Respondent has not sufficiently established its fee schedule defense.

After reviewing all of the documents on file in the ADR Center maintained by the American Arbitration Association, and considering the arguments set forth by both sides, I find in favor of the Applicant.

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**

	Ligament Laxity Analysis/ James Lambert, D.C.	**01/26/17 - 01/27/17**	**$751.52**	**Awarded: $751.52**
Total			**$751.52**	**Awarded: $751.52**

B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 05/19/2017, which is a relevant date only to the extent set forth below.)

Based on the submission of a timely denial, interest shall be paid from the date of filing, until the date that payment is made at a rate of 2% per month.

C. Attorney's Fees

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

As this matter was filed **after**February 4, 2015, this case is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant an attorney's fee, in accordance with newly promulgated 11 NYCRR 65-4.6(d).

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

03/23/2018

(Dated) Alina Shafranov

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:
52f92da0301b8079d9daae407d32f585

Electronically Signed

Your name: Alina Shafranov
Signed on: 03/23/2018