

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Daniel Cox DC PC
(Applicant)

- and -

Allstate Fire & Casualty Insurance Company
(Respondent)

AAA Case No. 17-16-1038-5974

Applicant's File No. 16-5363

Insurer's Claim File No. 03864013682N1

NAIC No. 29688

ARBITRATION AWARD

I, Fred Lutzen, 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: EIP

1. Hearing(s) held on 06/05/2018
Declared closed by the arbitrator on 06/05/2018

Nicole Jones, Esq., from The Morris Law Firm, P.C. participated in person for the Applicant

Meghan McDonough, Esq., from Allstate Fire & Casualty Insurance Company participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 550.00**, 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

Applicant seeks reimbursement in the amount of \$550.00 for chiropractic services provided to the EIP on 12/17/15 and 1/8/16. This male EIP (initials "J.S.") was 35-years-old when he was injured in an automobile accident on 10/3/15. He subsequently came under the care of Applicant. Applicant submitted claims of \$275.00 for each date of service, billing under S9090. Respondent partially reimbursed and partially paid the claims, asserting that "PROCEDURE CODE S9090 IS BEST DESCRIBED AS 97012 AND REIMBURSED AS SUCH. In addition to the foregoing reason for denial, the amount charged and sought to be reimbursed exceeds the amount permitted under the applicable Workers' Compensation Fee schedule and is not reimbursable as billed. The evidence submitted by Respondent clearly demonstrates that

\$12.60 was paid for each of the disputed dates of service. Applicant seeks the unpaid balance of \$524.80.

The issue to be determined is whether the charges sought by Applicant are within fee schedule allowances.

4. Findings, Conclusions, and Basis Therefor

This case was decided based upon the submissions of the parties as contained in the electronic file maintained by the American Arbitration Association, and the oral arguments of the parties' representatives. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon. No witnesses testified at the hearing.

In **AAA Case No. 17-16-1035-3328**, Arbitrator Marcelle Brandes stated that "Applicant billed CPT Code S9090 \$275.00 for the spinal decompression. Respondent's denial states Code S9090 is not contained in the Fee Schedule, and changed the Code to 97102, and paid Applicant \$12.60. Applicant seeks the difference, \$262.40. I find Applicant failed to establish a prima facie case for this date of service. Applicant billed for a Code that does not exist; therefore, Applicant fails to set forth a sufficient basis for payment. Accordingly, this portion of Applicant's claim is denied."

Regarding the use of purported code S9090, in **AAA Case No. 17-16-1029-7495**, Arbitrator Walter Winning, determined that "Applicant erred by submit[ing] a nonexistent code number, rather than arguing that they provided an unlisted modality, and providing a report that included allotted time."

"The workers' compensation fee schedules were adopted by the Superintendent of Insurance for use by those making and processing claims for no-fault benefits. These are contained in a volume entitled Official New York Workers' Compensation Medical Fee Schedule. The medical fee schedule consists of seven sections: evaluation and management, anesthesia, surgery, radiology, pathology and laboratory, medicine, and physical medicine. In addition to the medical fee schedule, the book contains separate schedules appended for psychology, chiropractic, and podiatry. Each service or procedure has a CPT (current procedural terminology) code, and the codes in each section fall in consecutive numerical ranges." Robert Physical Therapy, P.C. v. State Farm Mutual Automobile Ins. Co., 13 Misc.3d 172, 174, 822 N.Y.S.2d 378, 380 (Civ. Ct. Kings Co. 2006).

Fee schedule coding generally acts as an agreed short-hand for the value of services. Pavlova v. Allstate Ins. Co., 2016 N.Y. Slip Op. 26123 at 3 (Civ. Ct. Kings Co., Devin P. Cohen, J., Apr. 11, 2016). I have reviewed all of the current fee schedules and have not found any reference to this code S9090 in any of them.

I have previously decided cases in favor of the Applicant where Respondent did not submit a coder affidavit or other evidence to support its down-coding from one code to

another. However, in this case the code not reimbursed does not exist. The same rationale does not apply.

In support of its billed rate of \$275.00 per session, Applicant provided a "DRX900 RVU Calculation Report", which includes a list of expenses, including \$155,035.00 for the DRX9000 machine, \$1,800.00 for rent expense, \$19,400.00 for two chiropractor salaries, \$1,200.00 for technician travel charges, and numerous additional listed expenses. This calculation report states further, "Prevailing fee in Geographical Region: Our office Decompression, either cervical or lumbar charge amount \$275.00 per session. Conversion Factor (CF): Physical Medicine Conversion factor for our region II is \$4.65."

Applicant also submitted the session or SOAP notes, and each indicates that the machine was "programmed for profile #5 for 18 cycles with a maximum tension of 18 lbs."

Applicant also submitted a letter by Dr. Daniel C. Cox, D.C., that states the "lumbar spinal decompression utilizing the DRX 9000 is the most logical, safest and economical form of therapeutic intervention to address her ongoing condition."

Regarding Applicant's assertion that the charge of \$275.00 is the prevailing fee, I see no support for this. It is not consistent with any of the charges for therapeutic procedures (CPT Codes 97010 to 98943) within the fee schedule. I find that Applicant's evidence does not demonstrate any consistent charge or service that compares to the \$275.00 per session for this "economical form" of treatment. The explanation of total office expenses for a chiropractic practice, salaries and rents, did not suffice to demonstrate a consistent service or comparable charge.

More importantly, in this case Respondent issued payment in accordance with its view of what was the most comparable service, CPT Code 97012 for mechanical traction. By billing a code that does not exist, Applicant did not give Respondent another reasonable option. Further, none of the records submitted by Applicant specifically state who, if anyone, was present with the EIP during the time after the machine was "programmed for profile #5 for 18 cycles." In fact, the report for each date of service is signed by Raymond Corey Evans, DC, with no indication of how much time he spent with the patient.

Having carefully considered the submissions of the parties, the relevant case law and the arguments of respective counsel, I conclude that the preponderance of the credible evidence supports a finding in favor of the Respondent. No further amounts are due.

Since (1) the billed code does not exist, (2) there is no evidence of how much time Dr. Evans spent with the EIP, and (3) none of the available codes have a comparable value to what Applicant seeks to recover, this claim is denied.

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 claim is DENIED in its entirety

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

State of New York

SS :

County of Erie

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

06/23/2018
(Dated)

Fred Lutzen

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:
3f60e70b9b2ab0e87cb7636812cd284a

Electronically Signed

Your name: Fred Lutzen
Signed on: 06/23/2018