

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Northern Physical Therapy Chiropractic &
Acupuncture PLLC
(Applicant)

- and -

State Farm Mutual Automobile Insurance
Company
(Respondent)

| | |
|--------------------------|-----------------|
| AAA Case No. | 17-17-1057-5978 |
| Applicant's File No. | NF 20612 |
| Insurer's Claim File No. | 32-762H-570 |
| NAIC No. | 25178 |

ARBITRATION AWARD

I, John O'Grady, 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 07/10/2018
Declared closed by the arbitrator on 07/10/2018

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

Mohammad Rubbani Esq. from Richard T. Lau & Associates participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 900.00**, was AMENDED and permitted by the arbitrator at the oral hearing.

At the hearing the applicant reduced the amount in dispute from \$900.00 to \$787.50, consistent with applicant's contention that \$787.50 is the appropriate amount payable pursuant to the Workers Compensation Fee Schedule.

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

3. Summary of Issues in Dispute

CASE SUMMARY

The motor vehicle accident that gives rise to this arbitration took place on November 8, 2015.

The applicant - assignee makes a claim for a ligament laxity test performed on January 12, 2016.

The respondent denied the claim contending that the applicant billed in excess of the appropriate amount pursuant to the Workers Compensation Fee Schedule, and contending that the appropriate amount payable is \$152.60.

The assignor is a 65 year old female.

ISSUE(S)

The issue in this arbitration is whether respondent demonstrates that the appropriate amount payable pursuant to the fee schedule for this medical service is \$152.60, where applicant billed using CPT Code 76499 for an unlisted diagnostic radiographic procedure.

4. Findings, Conclusions, and Basis Therefor

THIS HEARING WAS CONDUCTED USING THE ADR CENTER MAINTAINED BY THE AMERICAN ARBITRATION ASSOCIATION. ALL DOCUMENTS IN THE CENTER ARE MADE PART OF THE RECORD OF THIS HEARING. I HAVE REVIEWED THE DOCUMENTS CONTAINED IN THE ADR CENTER AS OF THE DATE OF THIS AWARD AS WELL AS ANY DOCUMENTS SUBMITTED UPON CONTINUANCE OF THE CASE. THOSE DOCUMENTS SUBMITTED AFTER THE HEARING THAT HAVE NOT BEEN ENTERED IN THE CENTER AS OF THE DATE OF THIS AWARD WILL BE LISTED IMMEDIATELY BELOW THIS LANGUAGE AND FORWARDED TO THE AMERICAN ARBITRATION ASSOCIATION AT THE TIME THIS AWARD IS ISSUED FOR INCLUSION IN IT.

Applicant billed pursuant to CPT Code 76499, two units, in the total amount of \$900.00. CPT Code 76499 is for an unlisted diagnostic radiographic procedure. It is contained in the Radiology Section of the Medical Fee Schedule but not contained in the Chiropractic Fee Schedule.

Respondent relies chiefly on the affidavit of Matthew Kenyon, a Certified Professional Coder. He concludes that the billing was incorrect for the following reasons.

He explains that CPT Code 76120 is for cineradiography/video radiography, except where specifically included, and best represents the services performed, a Ligament Laxity Analysis. He concludes that reimbursement should be calculated as follows: using the Chiropractic Radiology Region 4 conversion factor of 36.20 and the relative value of 2.81 for CPT Code 76120 reimbursement for one unit should be in the amount of \$101.72. For the second unit, he explains that an additional unit of CPT Code 76120 pursuant to Ground Rule 2 of the New York Workers Compensation Chiropractic Fee Schedule dictates that for two contiguous parts the charge for the second unit should be 50% of the lesser fee. Here the fee for both units was the same. He concludes that, therefore, reimbursement should be made in the amount of (36.20×2.81) \$101.72 + 50% of that amount, \$50.86, for a total payment due of \$152.60.

He also cites to the American Medical Association CPT Assistant from April 2004 where the following Coding Question was asked and answered:

Question: Would it be appropriate to report code 76499, unlisted diagnostic radiographic procedure, for a digital motion x-ray study procedure? The AMA comment was that "From a CPT coding perspective, it would be appropriate to report code 76120, cineradiography/video radiography, 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.

Applicant submits a response by the treating chiropractor, Sangwoo Mah. Dr. Mah explains that the patient underwent Computerized Radiographic Mensuration Analysis (CRMA) of his flexion and extension x-rays of the cervical lumbar spine. He says that the procedure that he performed was different than the procedure pursuant to the Code that Mr. Kenyon applies. He says the video radiography for ligament laxity analysis is a qualitative study when the cervical spine undergoes flexion and extension motion, and the doctor assesses the quality of the movement. Since the exact amount of intervertebral movement cannot be reliably measured in videoradiography, it is not used commonly to determine alteration of motion segment integrity. He says that due to limitation from the power of the machines used in video radiography, the procedure cannot be performed on the lumbar spine.

This procedure is performed primarily to diagnose alteration of motion segment integrity (AOMSI) according to the AMA guidelines and AOMSI is most commonly caused by ligament laxity in trauma patients. He says that the term "ligament laxity" is a qualitative term, like being told you have hypertension where a AOMSI is a quantitative term, like being told the specific numbers of your blood pressure reading.

He says that CRMA is much more involved and requires precision, unlike videoradiography. It does not use videos and uses standard flexion and extension x-rays. However, the intervertebral movement on these x-rays are analyzed in great detail according to AMA guidelines. It is a time-consuming and exacting process and requires the measurements to be within 0.1 mm or 0.1°. This process requires a dedicated flexion and extension x-ray mensuration analysis program such as DXD.

He further explains that using standard lumbar x-rays allows CRMA to be performed on the lumbar spine, unlike videoradiography because x-ray units used for videoradiography are simply not powerful enough to penetrate the lumbar spine for diagnostic quality images. Hence videoradiography is mostly limited to the cervical spine unlike CRMA.

Applicant's contention is that the procedure here does not involve videoradiography but instead requires x-rays and a specific computer program to analyze the x-rays. Further, videoradiography is entirely unsuited to the lumbar spine because of its inherent limitations an analysis of the lumbar spine requires x-rays.

It is noteworthy that the Workers Compensation Chiropractic Fee Schedule Radiology Ground rule #1 B includes the limitation that "The use of digital 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". Also important is the question and answer from the **CPT Assistant in April, 2004** that reads as follows:

Question: Would it be appropriate to report code 76499, unlisted diagnostic radiographic procedure, for a digital motion x-ray study procedure?

Answer: From a CPT coding perspective, it would be appropriate to report code 76120, cineradiography/ videoradiography, 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".

It is also noteworthy that there is no relative value unit equivalent to 13.12 in the radiology section of the Chiropractic Fee Schedule. The highest relative value unit in the radiology chiropractic Fee Schedule is 3.48 for CPT Code 72010 (radiologic examination, spine, entire, survey study, Anteroposterior and lateral).

When a charge for a reimbursable service has not been established by superintendent, although a fee schedule has been set for the profession of the provider, then the provider shall establish a fee or unit value consistent with other fees or unit values for comparable procedures shown in such schedule subject to review by the insurer (**see 11 NYCRR 68.6(a); Studin v Allstate Insurance Co., 152 Misc. 2d 221 (1991)**). Chiropractors have been permitted to use codes outside the chiropractic fee schedule although there is a separate fee schedule exclusively for chiropractors. **See, Introna v. Allstate Ins. Co. (890 F Supp 161, 165-166 (ED NY 1995); Studin v Allstate, *supra***.

Here, the independent reference materials contained in the CPT Assistant support the respondent's contentions and Mr. Kenyon's opinion. Applicant does not adequately establish a fee or unit value consistent with other fees or unit values for comparable procedures shown in such schedule. Therefore, as respondent did not pay any amount towards the amount claimed, the claim is granted in the amount of \$152.60, as if made on one bill and timely 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 applicant is AWARDED the following:

A.

| Medical | | From/To | Claim Amount | Amount Amended | Status |
|---------|---|---------------------|--------------|----------------|-------------------|
| | Northern Physical Therapy Chiropractic & Acupuncture PLLC | 01/12/16 - 01/12/16 | \$900.00 | \$787.50 | Awarded: \$152.60 |
| Total | | | \$900.00 | | Awarded: \$152.60 |

B. The insurer shall also compute and pay the applicant interest set forth below. 03/08/2017 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

INTEREST: Pursuant to Insurance Law § 5106 (a), interest accrues on overdue no-fault insurance claims at a rate of 2% per month. A claim is overdue when it is not paid within 30 days after a proper demand is made for its payment (Insurance Law § 5106 [a]; 11 NYCRR 65.15 [g]). The Superintendent's regulation tolls the accumulation of interest if the claimant "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 Insurance Department regulations" (11 NYCRR 65-3.9 [c]). The Superintendent has interpreted this provision to mandate that the accrual of interest is tolled, regardless of whether the particular denial at issue was timely. That interpretation was upheld by the Court of Appeals in LMK Psychological Servs, P.C. v. State Farm Mut. Auto. Ins. Co., 2009 NY Slip Op 02481 (April 2, 2009). Where no denial of claim is issued in response to a proper demand for payment, the insurer does not benefit from the tolling provision and interest will accrue from the date 30 days after the proper demand for payment is made. Interest that accrues when a denial of claim is not issued within 30 days after the proper demand for payment is made will be tolled upon the issuance of a denial of claim, although such denial is untimely, and the failure to request arbitration or institute a lawsuit within 30 days after receipt of that denial of claim form.

C. Attorney's Fees

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

ATTORNEY'S FEES: 11 NYCRR 65-4.6 establishes a minimum attorneys' fee and further provides that:

For cases filed on or before February 4, 2015, the "attorney's fee shall be limited as follows: 20 percent of the amount of first-party benefits, plus interest thereon, awarded by the . . . court, subject to a maximum of \$850" (11 NYCRR 65-4.6 [e]). The October 8, 2003, opinion letter of the Superintendent interpreted that regulation and stated that the minimum amount of attorneys' fees awarded to an assignee health care provider pursuant to Insurance Law § 5106 is "based upon the aggregate amount of payment required to be reimbursed based upon the amount awarded for each bill which had been submitted and denied. The minimum attorney fee . . . is not due and owing for each bill submitted as part of the total amount of the disputed claim sought in the court action" (Ops Gen Counsel NY Ins Dept No. 03-10-04 [Oct. 2003]). For purposes of calculating attorneys' fees, the Superintendent has interpreted a claim to be the total medical expenses claimed in a cause of action pertaining to a single insured, and not each separate medical bill submitted by the provider. The Insurance Department's interpretation of its own regulation was upheld by the Court of Appeals in LMK Psychological Servs, P.C. v. State Farm Mut. Auto. Ins. Co., 2009 NY Slip Op 02481 (April 2, 2009). Attorneys' fees are therefore to be calculated based on the aggregate of all bills for each insured; and

For cases filed after February 4, 2015, the attorney's fee 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). 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 per arbitration or court proceeding, subject to a maximum fee of \$1,360. If the nature of the dispute results in an attorney's fee that could be computed in accordance with the limitations prescribed in both subdivision (c) and this subdivision, the higher attorney's fee shall be payable.

- 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 thank you earlier and

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

07/16/2018
(Dated)

John O'Grady

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:
c6c4752e70f5669ca2d8892d495c7c21

Electronically Signed

Your name: John O'Grady
Signed on: 07/16/2018