American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Bayside Physical Therapy,Chiropractic & Acupuncture PLLC (Applicant)	AAA Case No.	17-17-1075-6394
	Applicant's File No.	STLG17-31687
	Insurer's Claim File No.	046002209019020
- and -	NAIC No.	35882
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, James Hogan, 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 07/31/2018, 10/11/2018
   Declared closed by the arbitrator on 10/11/2018

   John Faris from Law Office Of Stephen A. Strauss, PC participated in person for the Applicant

   Dustin Mule' from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 2,909.58**, 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 EIP, a 35 year old female, was injured in a collision on 8/6/16. This claim is for:

   A follow-up office visit on 11/11/16 billed under CPT code 99212 at $50.22.

   CMT and an unlisted physical medicine service, billed under CPT code 97799 for total billing in the amount of $79.68 for DOS 10/24, 10/26, 11/8, 11/9, 11/21, 11/29, 12/5, and 12/7/16.

   Applicant has also billed for **CMT, under CPT code 98941 at $34.68** on DOS 10/28, 11/11, 11/18, 11/30, 12/12, and 12/14/16.

Nerve testing done on 10/28/16 was billed under CPT code 95999 for testing of the nerves from C2 through S2 for a total of $2,513.40.

Applicant also billed for physical performance testing on 11/11/16 at a total of $182.84.

As per the Applicant's AR-1, it billed $3,409.14; Respondent paid $499.56 leaving an amount in dispute of $2,909.58.

The Respondent denied payment for the follow-up office visit for DOS 11/11/16 billed at $50.22 stating that as of 12/1/10, a re-evaluation by a chiropractor can only be billed 2-3 weeks after an initial E/M code with 3-4 weeks after another re-evaluation. (I note that in another claim filed by this Applicant for services rendered to this EIP, it is billing for a follow-up office visit on 11/9/16 billed at $50.22. Respondent paid for that office visit at $26.41)

Respondent is paying for the CMT, as billed.

As to the DOS where the Applicant billed for CMT and unlisted procedure, the Respondent generally paid for the CMT until the date of the denial based upon the negative IMEs. It denied payment for the unlisted procedure for 2 different reasons; this charge is not reimbursable under the chiropractic fee schedule and/or the charge was the subject of a separate verification.

Then there are some DOS with the Applicant billed for the unlisted physical medicine service under CPT code 97799, and Respondent change that code to 97139 and reimbursed the Applicant at the rate of $11.56 bringing the total amount of reimbursement of $46.24 for those DOS.

As to the nerve testing billed on 10/28/16 at $2,330.56, and the physical performance test, billed on 11/11/16 at $182.84, Respondent denied these services based upon a peer review done by Ronald Csillag, DC, who opined that they were not medically necessary.

On 10/8/18, Respondent uploaded Supplemental Submissions which contained arbitration awards in support of its contentions.

4. Findings, Conclusions, and Basis Therefor

This decision is based upon my review of the electronic file maintained by the American Arbitration Association, and the arguments of the parties set forth in the hearing.

SUMMARY OF THE CASE:

The EIP, a 35 year old female, was injured in a collision on 8/6/16. This claim is for:

A follow-up office visit on 11/11/16 billed under CPT code 99212 at $50.22.

CMT and an unlisted physical medicine service, billed under CPT code 97799 for total billing in the amount of $79.68 for DOS 10/24, 10/26, 11/8, 11/9, 11/21, 11/29, 12/5, and 12/7/16.

Applicant has also billed for **CMT, under CPT code 98941 at $34.68** on DOS 10/28, 11/11, 11/18, 11/30, 12/12, and 12/14/16.

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Respondent is paying for the CMT, as billed.

As to the DOS where the Applicant billed for CMT and unlisted procedure, the Respondent generally paid for the CMT until the date of the denial based upon the negative IMEs. It denied payment for the unlisted procedure for 2 different reasons; this charge is not reimbursable under the chiropractic fee schedule and/or the charge was the subject of a separate verification.

Then there are some DOS with the Applicant billed for the unlisted physical medicine service under CPT code 97799, and Respondent change that code to 97139 and reimbursed the Applicant at the rate of $11.56 bringing the total amount of reimbursement of $46.24 for those DOS.

As to the nerve testing billed on 10/28/16 at $2,330.56, and the physical performance test, billed on 11/11/16 at $182.84, Respondent denied these services based upon a peer review done by Ronald Csillag, DC, who opined that they were not medically necessary.

On 10/8/18, Respondent uploaded Supplemental Submissions which contained arbitration awards in support of its contentions.

Applicant's submission:

The Applicant has provided a copy of its billing. (see above)

On 8/6/16, the EIP had a Chiropractic Re-Evaluation.

The Applicant has filed a "Response to Peer Review" dated 9/18/17 as part of its original submission. The Applicant recounts the EIP's accident history and the findings of the MRIs of the cervical spine and lumbar spine. Also provided is a summary of the examination findings of the initial examination done on 10/21/16.

The findings of the PF-NCS testing of the cervical spine and lumbar spine, both on 10/28/16 are recorded.

A summary of the follow-up examination done on 11/9/16 was provided along with the notation that the EIP had Physical Performance Testing on 11/11/16.

Dr. Lefcort challenges Dr. Csillag's statement that "there is no indication of radiating pain or paresthesia in the chiropractic office notes and upon chiropractic re-evaluations, the findings do not create what would be one needed for an electrodiagnostic study. (sic) The sensory pinwheel provides adequate information regarding sensation to treat the claimant an additional testing is not necessary. Dr. Csillag quotes Medicare Newsletter stating that "there is insufficient scientific or clinical evidence to consider the sNCT test and device used in performing this test reasonable and necessary."

"With regard to the PPT procedures, the reviewer Ronald Csillag, D.C., states that a physical performance test is a redundant and does not aid in formulating a new goal or treatment plan. (sic) The testing performed provides no beneficial data that will enhance the claimant's condition or treatment of the injuries."

Dr. Lefcort argues that on 10/21 and 11/9/16, the EIP presented with complaints of pain in the neck, with stiffness as well as low back/sacro iliac pain radiating into the right buttock. He then recites the findings of his physical examinations.

Dr. Lefcort then addresses the pf-NCS testing saying that "the description of procedure report states that when pf-NCS tests are positive, they can be used in conjunction with any positive spinal MRI findings to determine if there is the possibility of nerve root injury at the level of a disc injury. This type of differential diagnosis can help to target treatment to the source of the patient's pain and improve treatment outcomes. The results of the pf-NCS testing would be utilized to establish a more effective treatment program and to reach a definitive diagnosis."

He then discusses the benefits of the information gleaned from this test.

Dr. Lefcort refers to the AANEM stating that it suggests further investigation. "It states, 'Etiologies of clinical problems of weakness, atrophy, fatigability, pain, numbness and paresthesias can be investigated by these methods." He then says that the guidelines also say that EDX studies can help establish these conditions (referring to a list of symptoms and possible diagnoses contained on page 2, as well as to indicate other relevant

problems, define severity and chronicity of the disorder and/or provide information useful for treatment. "Clearly, it is only the physician who examines the patient who should make decisions regarding diagnostic testing."

Dr. Lefcort refers to a Textbook of Medical Physiology "states that over 90% of signals transmitted by the (fast pain) A-delta fibers reach the sensory cortex, so they should allow the patient to exactly localize the source of the pain. However, soon after an injury the A-delta fibers become numb, while the poor localizing C-type fibers up-regulate." The authors opined that this explains why so many patients have serious difficulty in localizing the source of some types of chronic pain.

He also refers to May 2012 article found in Practical Pain Management by Peter Carney, MD, who referenced how the pf-NCS was beneficial in the treatment of patients.

Dr. Lefcort also referred to the Regence Medical Policy approved 12/9/2008 describing that the Axon-II pf-NCS device was approved by the FDA as a diagnostic device that allows the quantitative detection of various sensory neurological impairments caused by various pathological conditions." Dr. Lefcort opines that the efficacy of this type of testing has been established.

He then turns his attention to the physical performance testing and refers to a website

https://www.ncbi.nlm.nih.gov/pubmed/19363624, stating that the assessment of somatic parameters through physical performance tests was commonly used to predict outcome, e.g., returned to work.

He also references the evaluations done on 10/28/16 and 11/11/16 and notes that the records indicate that the EIP sustained musculoskeletal injuries to the spine in the motor vehicle accident and was started on a conservative course of therapy following the initial evaluation. The physical performance testing was necessary to evaluate health status and as an adjunct method of making judgments of patient's performance potential.

The Applicant has provided a copy of the MRI report for the EIP cervical spine dated 9/10/16. The Impression was a bulging disc at C3-4; a disc herniation C4-5; a right paracentral herniation C5-6 and a T2 hyper intense nodule within the right lobe of the thyroid.

The Applicant has provided a copy of the MRI report for the lumbar spine dated 9/10/16. The Impression was: 1) right foraminal herniation at L2-3; 2) bulging disc at L3-4 with right foraminal herniation component impinging upon the exiting L3 root; 3) bulging disc at L4-5; 4) bulging disc at L5-S1 with impingement upon the thecal sac and originating S1 route.

On 10/21/16, the EIP had an Initial Chiropractic Evaluation at the Applicant. She presented with complaints of ringing in the right ear; moderate neck pain and stiffness rated 6/10 and localized; moderate right shoulder pain with difficulty lifting the right arm; severe lower back/sacral-iliac pain radiating into her right buttock.

The EIP advised that she was involved in an accident on 8/6/16.

I note that the PX of the cervical spine found trigger points and multiple joint restrictions from C1 through C7. There was tenderness to percussion throughout the cervical spine. The range of motion was not quantified but simply indicated as "restricted with pain" in all planes.

Foraminal Compression test was positive, bilaterally, without radiation. Hyper Flexion Compression and Hyperextension Compression tests were both positive. Rotary Compression test was positive, bilaterally without radiation. Cervical Distraction test was positive. Valsalva maneuver was negative.

The examination of the lumbar spine simply indicates that palpation found that the musculature was asymmetrical; hypertonicity and trigger points were noted in many muscles; multiple joint restrictions were present from L4 through S1.

Minor's sign was negative; Kemp's test was positive, bilaterally, without radiation; Heel and toe walking was intact. SLR was positive on the right at 45° with radiation to the right buttock. SLR was negative on the left. Ely's test was positive on the right and Yeoman's test was positive, bilaterally.

The range of motion of the lumbar spine was not quantified but simply indicated as "restricted with pain" in all planes.

Trendelenburg's test was positive, bilaterally; Thomas' test for tight hip flexors was positive on the right. Fabere-Patrick test for muscle spasm/low back strain was negative.

DTRs were 2/2+, in the bilateral upper and lower extremities.

The sensory exam was indicated as normal in the bilateral upper and lower extremities.

The motor examination was indicated as 5/5 in a bilateral upper and lower extremities.

There are a number of diagnoses having to do with muscle spasm in the cervical and lumbar spine as well as right shoulder pain.

The Treatment Plan and Recommendations included chiropractic spinal adjustments at the rate of 3 times a week for 6 weeks; computerized ROM assessment and computerized muscle testing. Also recommended is a PMR consultation as well as orthopedic consultation for the right shoulder. DME was also recommended as well as a home exercise program.

The Applicant submission contains copies of **"Physical Therapy Progress Notes,"** which also includes acupuncture progress notes, from 10/8/16 to 2/7/17. These are accompanied by Daily Note/Billing Sheets. On the Daily Note/Billing Sheet, the services provided are indicated as CPT codes 97110, 97140, 97010, 97014 and 29240 (Strapping; shoulder).

In reviewing the physical therapy progress notes, I see that Strapping to the right shoulder is recorded on the notes dated 10/8 and 11/16/16.,

On 10/28/16, the EIP had pf-NCS testing to the cervical/upper area and lumbar/lower area. The Applicant has provided the raw data for the testing as well as report for each test and the graph for each test.

On 11/9/16, the EIP had a Chiropractic Re-Evaluation at the Applicant. The EIP complained of intermittent ringing in the ears; moderate neck pain and stiffness rated at 5-6/10; moderate right shoulder pain with difficulty lifting the right arm up; moderate to severe low back/sacral-iliac pain rated at 6-8/10 and radiating to the right buttock.

The Applicant examined the EIP's cervical spine and administered orthopedic testing. Also examined was the lumbar spine and more orthopedic testing was administered.

The neurological examination showed that DTRs were 2/2+, bilaterally in the upper and lower extremities; the sensory examination was normal in the bilateral upper and lower extremities; the motor examination was normal in the bilateral upper and lower extremities.

The Treatment Plan Recommendations included CMT at the rate of 3 times a week for 6 weeks; computerized range of motion testing; computerized muscle testing and a home exercise program.

On 11/11/16, the EIP a Physical Performance Test including computerized muscle testing and range of motion studies.

The Applicant submission contains copies of evaluations of the EIP done by Ketan D. Vora, DO. These are dated from 10/21/16 through 3/21/17.

Respondent's submission:

The Respondent's position is that part of the Applicant's claim was paid in accordance with the fee schedule and part of the Applicant's claim was denied based upon the fee schedule. In addition, the nerve testing and the physical performance testing were denied based upon a peer review done by Ronald Csillag, DC, who determined that they were not medically necessary.

The Respondent's submission contains a copy of the Applicant's billing and corresponding documentation along with corresponding NF-10s.

The Respondent's submission contains copies of **Chiropractic Treatment Notes**.

I see that on the 10/24, 11/9, 11/15, 11/16, 11/29, 12/5/16 Notes they indicate that cervical strapping was administered to the right upper trapezius or lumbar strapping was administered.

The Notes for 10/28, 11/11, 12/12, 1/18/16 (sic) do not indicate any strapping.

Respondent has also provided a copy of the billing for the nerve testing done on 10/28/16 which also includes billing for the Physical Performance Test done on 11/11/16 and the follow-up office visit also done on 11/11/16.

The Respondent's submission contains a Letter of Medical Necessity for the Pain Fiber Nerve Conduction Study (PF NCS). This letter is dated 10/28/16. Also provided is the raw data for the testing as well as the reports and the graphs.

The Respondent has provided a copy of the muscle testing and range of motion study done on 11/11/16.

Peer Review:

Ronald A. Csillag, DC, did a peer review on 12/21/16. The purpose of the peer review was to determine the medical necessity for the upper and lower pf-NCS testing and the physical performance testing.

There is a list of medical records that were reviewed.

Dr. Csillag recounts the EIP's accident history and the findings of the initial chiropractic evaluation on 8/9/16.

He also recounts the findings of the 11/9/16 chiropractic re-evaluation. Also noted is that the chiropractic office notes do not indicate radiating pain or paresthesias. It should also be noted that the EIP had an EMG/NCV study of the upper extremities on 9/23/16.

In the "Conclusion" section of his report, Dr. Csillag says that the upper and lower pfNCS testing are all the same sensory testing as the CPT, sNCT, pfNCS, V-sNCT and SNCT. "All of these tests are based upon subjective perception of an electrical stimulus from the electrode applied to the skin. The perception of the stimulus at a certain level is recorded and a level of perception is determined. A Sensory or Wartenberg wheel (pinwheel) used on the skin gives a similar determination of perception that can be graded. The use of a sensory pinwheel is part of a full examination. The Sensory Pinwheel provides adequate information regarding sensation to treat the claimant and additional testing is not necessary." (sic)

He refers to the 2004 Medicare Newsletter stating that "there is insufficient scientific or clinical evidence to consider the sNCT test and the device used in performing this test reasonable and necessary."

He then refers to the US Dept of HHS, National Guideline Clearinghouse - Guideline Summary, NCG-10121, updated July 2014, stating the current perception threshold (CPT) testing was not recommended.

He also refers to the National Guideline Clearinghouse Guideline Summary, published by the US Dept. of HHS, Work Loss Data Institute, 2011, Agency for Healthcare Research and Quality stating "interventions considered but not recommended for the

assessment and treatment of low back pain - thoracic and lumbar (acute & chronic). These include CPT testing."

He then refers to the Official Disability Guidelines, updated 6/25/15, stating "Current perception threshold (CPT) testing is not recommended. There are no clinical studies demonstrating the quantitative tests of sensation improve the management and clinical outcomes of patients over standard qualitative methods of sensory testing,"

He then refers to an article from the NY Chiropractic College, Continuing Education, "Documentation, Record-Keeping, Practice Guidelines and Clinical Issues in Chiropractic Practice," stating "The standard for taking or ordering a special test includes the following: That the tests will provide you with data or new information that could change the diagnosis or significantly alter the treatment plan. If the test is for detailed objective measurements, are those tests crucial to monitor progress or can the information be approximated by subjective reports or visual analog. If gross assessment is a reasonable indicator, that more extensive measurements are not necessary."

Dr. Csillag then says that there was no indication of radiating pain or paresthesias in the chiropractic office notes. Upon chiropractic re-evaluation, the findings do not create what would be the need for an electrodiagnostic study. It should also be noted that an EMG/NCV study was performed on the upper extremities on 9/23/16.

Dr. Csillag then discusses the physical performance testing done on 11/11/16, "which consisted of range of motion and muscle testing, it is normal for claimants who sustain soft tissue issues to the spine to have decreased ranges of motion and muscle strength following their injuries. A physical performance test is a redundant and does not aid in formulating a new goal or treatment plan. (sic) A practitioner may utilize a goniometer and inclinometer to attain these measurements. These devices will provide an accurate range of motion without utilizing special testing procedures. The testing performed provides no beneficial data that will enhance the claimant's condition or treatment of the injuries."

He then refers to a 2005 article found in the Journal of Manipulative and Physiological Therapeutics stating "Both single inclinometry and double inclinometry for clinical use are reliable measurement methods for cervical lateral flexion between raters and for repeated measures. Rater and reliability and concurrent validity of single and dual bubble inclinometry to assess cervical lateral flexion." (sic)

"Excellent test-retest reliability for grip strength measurement was measured in patients with cervical radiculopathy, demonstrating that a hydraulic hand dynamometer could be used as an outcome measure for these patients." Referring to a 2014 article found in the Journal of Manipulative Physiological Therapy.

In his conclusion, Dr. Csillag recommends that reimbursement for the nerve testing and the physical performance testing be disallowed.

The Respondent's submission contains copies of the documents reviewed by Dr. Csillag in his peer review.

Respondent submission contains copies of the articles relied upon by Dr. Csillag. I note that the Guideline Summary NCG-10121 is based upon the Work Loss Data Institute, Low Back - lumbar & thoracic, 2011 and reference the ODG Return-To-Work Pathways.

Affidavit of Steven Schram, L.Ac., DC. Dr. Schram is a licensed acupuncturist and, as of the date of his affidavit, 7/11/16, he was serving as the Chair of the NYS Acupuncture Board.

He describes his background and notes that there are 3 types of modalities that are used in conjunction with regular acupuncture treatment. These are "cupping" "moxibustion" and "acupressure."

He describes what each of these modalities entails and then he notes that none have established CPT codes and RVUs.

He sets forth his opinion as to the number of RVUs appropriate for each of these modalities. For cupping, he opines that 2.40 RVUs is appropriate; for moxibustion, 2.41 RVUs is appropriate and for acupressure, 2.62 RVUs is appropriate.

At the hearing:

The Applicant's billing was discussed and the Respondent's NF-10s were analyzed.

FINDINGS:

The Applicant has established its prima facie case.

This claim is for:

A follow-up office visit on 11/11/16 billed under CPT code 99212 at $50.22.

CMT and an unlisted physical medicine service, billed under CPT code 97799 for total billing in the amount of $79.68 for DOS 10/24, 10/26, 11/8, 11/9, 11/21, 11/29, 12/5, and 12/7/16.

Applicant is also billing for **CMT, billed under CPT code 98941 at $34.68** on DOS 10/28, 11/11, 11/18, 11/30, 12/12, and 12/14/16.

Nerve testing done on 10/28/16 billed under CPT code 959994 testing of the nerves from C2 through S2 for a total of $2,513.40.

Applicant also billed for physical performance testing on 11/11/16 at a total of $182.84.

As per the Applicant's AR-1, it billed $3,409.14; Respondent paid $499.56 leaving an amount in dispute of $2,909.58.

The Respondent denied payment for the follow-up office visit for DOS 11/11/16 billed at $50.22 stating that as of 12/1/10, a re-evaluation by a chiropractor can only be billed to-3 weeks after an initial evaluation and management code with 3-4 weeks after another re-evaluation. (I note that in another claim filed by this Applicant for services rendered to this EIP, it is billing for a follow-up office visit on 11/9/16 billed at $50.22. Respondent paid for that office visit at $26.41)

Respondent is paying for the CMT, as billed.

As to the DOS where the Applicant billed for CMT and unlisted procedure, the Respondent generally paid for the CMT until the date of the denial based upon the negative IMEs. It denied payment for the unlisted procedure for 2 different reasons; this charge is not reimbursable on the chiropractic fee schedule and/or the charge was the subject of a separate verification.

Then there are some DOS with the Applicant billed for the unlisted physical medicine service under CPT code 97799, and Respondent change that code to 97139 and reimbursed the Applicant at the rate of $11.56 bringing the total amount of reimbursement of $46.24 for those DOS.

I also see that for DOS 11/9/16 Respondent paid for the unlisted therapeutic service, billed on the CPT code 97139 at $2.48 stating that when there is a re-evaluation, the maximum number of RVUs is 11, and Respondent reimbursed the Applicant at 11 RVUs for this DOS.

As to the nerve testing billed on 10/28/16 at $2,330.56, and the physical performance test, billed on 11/11/16 at $182.84, Respondent denied these services based upon a peer review done by Ronald Csillag, DC, who opined that they were not medically necessary.

The purpose of the peer review is to determine whether the service/test provider was medically necessary. The peer reviewer discusses the standard of care in the medical community and offers his/her opinion as to why the service/test at issue falls outside of that standard of care. The peer reviewer buttresses his/her opinion with authoritative texts, treatises and articles, generally from peer-reviewed publications.

Some peer reviews rely upon "guidelines" as a basis for denying a claim. Some "guidelines" are appropriate, while others are not. An example of a "guideline" that is not appropriate in dealing with New York No-fault, is one generated by a healthcare management entity, such as Apollo, who has promulgated a list of DME and has made a determination as to whether or not prescribing these items is medically necessary. This is simply a determination by an insurance entity, in conjunction with its advisors, in determining which devices it chooses to pay for.

Another "guideline" which is not appropriate in dealing with New York No-fault, is the Official Disability Guidelines that have been promulgated by the Work Loss Data Institute. A review of this entity's website finds that the standard of care is not recited. The purpose of the ODG is to return injured workers to the workforce as quickly as

possible. These Guidelines are not dispositive when it comes to people who are injured in motor vehicle accidents and have submitted claims under New York's No-fault insurance.

On 1/3/17, Respondent issued an NF-10 re DOS 10/28 - 11/11/16 and billing in the amount of $2,598.30. Applicant billed for the nerve testing under CPT code 95999 at $2,330.56. Also billed was physical performance testing under CPT code 97750 at $182.84. the Respondent denied both of these claims based upon a peer review done by Ronald Csillag, DC, who opined that the testing was not medically necessary.

The Applicant has filed a rebuttal to the peer review.

After reviewing both the peer review entering bottle, I find in favor of the Applicant, partly because some of the authoritative sources relied upon by Dr. Csillag were based upon the Official Disability Guidelines promulgated by the Work Lost Data Institute. As noted above, these Guidelines are not meant for use in dealing with New York No-fault claims.

This portion of the Applicant's claim is awarded in a manner $2,598.30.

As to the other portion of the Applicant's claim, prior to reviewing the NF-10s there was a discussion with the parties and it was agreed that the Applicant has not justified its billing under CPT code 97799 as it has not met the criteria set forth in the General Ground Rule #3, or Chiropractic Ground Rule #2 as to billing for a "BR" code. Therefore, where the Applicant billed for a CMT and the unlisted procedure, and the Respondent denied the unlisted procedure based upon the fee schedule, no money was due to the Applicant for those DOS. However, if the Respondent denied payment for the 97799 code for a different reason, I am still only allowed to make awards that are in accordance with the fee schedule. Therefore, in those instances, no award for CPT code 97799 would be made.

Review of NF-10s:

NF-10 dated 11/29/16 re DOS 10/24/16 and billing in the amount of **$79.68**. Respondent paid $34.68 leaving amount in dispute of $45.00. The Applicant is billing for CMT and an unlisted physical medicine procedure under CPT code 97799. Respondent paid for the CMT but denied payment for the unlisted service saying that these services were not reimbursable under the Chiropractic Fee Schedule.

No additional payments are due to the Applicant for these DOS.

NF-10 dated 12/5/16 re DOS 10/26 - 10/28/16 and billing in the amount of **$114.36**. Applicant billed for CMT on 10/26 and 10/28/16 and Respondent paid $34.16 for each DOS. Applicant also billed for an unlisted procedure under CPT code 97799 which Respondent denied stating that these services were not reimbursable under the Chiropractic Fee Schedule.

No additional payments are due to the Applicant for these DOS.

The Applicant also billed for a follow-up office visit under CPT code 99212 on 11/11/16 at $50.22. Respondent denied this portion of the claim stating that "As of 12/1/10, a re-evaluation (99212) by a chiropractor can only be billed to-3 weeks after an initial evaluation and management code or 3-4 weeks after another re-evaluation.

The Respondent did not demonstrate another re-evaluation therefore the Applicant is owed $26.41.

NF-10 dated 12/19/16 re DOS 11/8 - 11/9/16 and billing in the amount of **$159.36**. Respondent paid $83.40 leaving amount in dispute are $75.96. The Applicant billed for CMT and an unlisted physical medicine modality. Respondent paid for CMT, as billed at $34.68 for each DOS. As to the unlisted modality, for DOS 11/8/16, Respondent converted that charge to CPT code 97139 and paid Applicant $11.56, citing the 8 unit rule. As to DOS 11/9/16, Respondent made the same conversion but only paid $2.48 for CPT code 97139 stating that where there was a re-evaluation there is a limitation of 11 RVUs.

Respondent argued that the payment for CPT code 97799 was done in error. No payment was due. Applicant said that since payment was made, the Respondent does not have any recourse.

I find that no additional payments are due for these DOS.

NF-10 dated 1/9/17 re DOS 11/21 - 11/30/16 and billing in the amount of **$114.36**. Respondent paid $69.36 leaving an amount in dispute of $45.00. Applicant billed for CMT and an unlisted physical medicine procedure under CPT code 97799 on DOS 11/21/16. Respondent paid for the CMT but denied payment for the unlisted procedure stating that those services were not reimbursable under the Chiropractic Fee Schedule. Respondent paid for the CMT administered on 11/30/16.

No additional payments are due to the Applicant for these DOS.

NF-10 dated 1/30/17 re DOS 11/29 - 12/14/16 and billing in the amount of **$149.04.** Applicant billed for CMT and an unlisted physical medicine procedure under CPT code 97799 on DOS 11/29/16. Respondent paid for the CMT but denied payment for the unlisted procedure stating that those services were not reimbursable under the Chiropractic Fee Schedule. Respondent paid for the CMT administered on 12/12 and 12/14/16.

No additional payments are due to the Applicant for these DOS.

NF-10 dated 1/23/17 re DOS 12/5 - 12/7/16 and billing in the amount of **$159.36**. Respondent paid $69.36 leaving amount in dispute are $90.00. The Applicant billed for CMT and an unlisted physical medicine modality for each DOS. Respondent paid for CMT, as billed at $34.68 for each DOS. As to the unlisted modality, Respondent denied

payment saying that the services performed were not reimbursable under the Chiropractic section of the fee schedule.

No additional payments are due to the Applicant for these DOS.

This claim is awarded in the amount of $2,624.71.

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**
	Bayside Physical Therapy,Chiropractic & Acupuncture PLLC	**10/24/16 - 12/07/16**	**$2,909.58**	**Awarded: $2,642.71**
Total			**$2,909.58**	**Awarded: $2,642.71**

B. The insurer shall also compute and pay the applicant interest set forth below. 10/04/2017 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

I find that the date for interest to accrue is the date of the filing of the arbitration, 10/4/17 as this is the date when the Applicant's filing was processed and notice of the arbitration sent to the Respondent. As per Insurance Regulation 65-3.9, interest is due until such amount is paid, and without demand therefor.

C. Attorney's Fees

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

The insurer shall pay the Applicant's attorney as per 11 NYCRR 65-4.6 (e). However, if the award and interest is equal to, or less than, Respondent's written offer during the conciliation process, then the attorney's fee shall be based upon 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 Suffolk

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

10/15/2018
(Dated)

James Hogan

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:
d61f2c3dca176c58d5dcb9d1f36ca983

Electronically Signed

Your name: James Hogan
Signed on: 10/15/2018