American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Choi Acupuncture, P.C. (Applicant)	AAA Case No.	17-17-1070-6084
	Applicant's File No.	DK17-25839
- and -	Insurer's Claim File No.	0403786740101032
	NAIC No.	35882
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Charles Blattberg, 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: Eligible injured person

1. Hearing(s) held on 11/07/2018
   Declared closed by the arbitrator on 11/11/2018

   John Faris, Esq. from Korsunskiy Legal Group P.C. participated in person for the Applicant

   Farhan Imtiaz, Esq. from Law Office of Goldstein & Flecker participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 980.44**, 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 claimant was the 53 year-old male driver of a motor vehicle that was involved in an accident on 11/30/16. Following the accident the claimant suffered injuries which resulted in the claimant seeking treatment including acupuncture. At issue are acupuncture services provided by Applicant 1/9/17-2/2/17. Respondent raised fee schedule defenses.

4. Findings, Conclusions, and Basis Therefor

THIS HEARING WAS CONDUCTED USING THE ELECTRONIC CASE FOLDER MAINTAINED BY THE AMERICAN ARBITRATION ASSOCIATION. ALL DOCUMENTS CONTAINED IN THAT FOLDER ARE MADE PART OF THE RECORD OF THIS HEARING.

THE ARBITRATOR SHALL BE THE JUDGE OF THE RELEVANCE AND MATERIALITY OF THE EVIDENCE OFFERED.

Based on a review of the documentary evidence, this claim is decided as follows:

An Applicant establishes a prima facie case of entitlement to reimbursement of its claim by the submission of a completed NF-3 form or similar document documenting the facts and amounts of the losses sustained and by submitting evidentiary proof that the prescribed statutory billing forms [setting forth the fact and the 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 Company*, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). I find that Applicant established a prima facie case for reimbursement.

The claimant was the 53 year-old male driver of a motor vehicle that was involved in an accident on 11/30/16. The claimant reportedly injured his neck, right shoulder, and lower back. There was no reported loss of consciousness. There were no reported lacerations or fractures. Following the accident the claimant was transported to LIJ Hospital where he was evaluated, treated, and released. On 12/14/16 the claimant presented to Choi Acupuncture, P.C. (Applicant) and was initiated on acupuncture care. On 12/14/16 the claimant presented to Azu Ajudua, M.D. of Hillcrest Medical Care, P.C. and was initiated on physical therapy. On 12/14/16 the claimant presented to Jongdug Park, D.C. of Your Choice Chiropractic, P.C. and was initiated on chiropractic treatment. On 12/27/16 Hillcrest Medical Care, P.C. conducted computerized range of motion and manual muscle testing (ROM/MMT). On 2/13/17 Hillcrest Medical Care, P.C. conducted ROM/MMT. On 2/21/17 the claimant presented to Daniel Shapiro, M.D. for an examination preliminary to upper extremities and lower extremities EMG/NCV testing which were recommended and lower extremities testing performed the same day suggested evidence consistent with bilateral L4-L5 and L5-S1 radiculopathy. At issue are acupuncture services provided by Applicant 1/9/17-2/2/17.

It is well established that a healthcare provider must limit its charges according to the applicable fee schedule. *Goldberg v. Corcoran*, 153 AD2d 113, 117-18 (App Div, 2d Dept 1989). An insurance carrier's timely asserted defense that the bills submitted were not properly no-fault rated or that the fees charged were in excess of the Workers' Compensation Fee Schedule is sufficient, if proven, to justify a reduction in payment or denial of claim. *New York Hosp. Med. Ctr. Of Queens v. Country-Wide Insurance Company*, 295 A.D.2d 583, 744 N.Y.S.2d 201 (2nd Dept. 2002); *East Coast Acupuncture, P.C. v. New York Central Mutual Insurance*, 18 Misc.3d 139(A), 2008 N.Y. Slip Op. 50344(U) (App. Term 2nd and 11th Jud. Dists. 2008); *A.B. Medical Services, PLLC v. American Transit Insurance Company*, 15 Misc.3d 132(A), 2007 N.Y. Slip Op. 50680(U) (App. Term 2nd and 11th Jud. Dists. 2007).

The insurer has the burden of coming forward with competent evidentiary proof to support its fee schedule reduction or denial. See, e.g., *Roberts Physical Therapy, P.C. v. State Farm Mutual Automobile Insurance Company*, 13 Misc.3d 172, 3006 N.Y. Slip Op. 26240 (N.Y. Civ. Ct. Kings Co. 2006). In the absence of such proof, a defense of noncompliance with the appropriate fee schedule cannot be sustained. *Continental Medical, P.C. v. Travelers Indemnity Company*, 11Misc,3d 145(A), 2006 N.Y. Slip Op. 50841(U) (App. Term 1st Dept. 2006).

For dates of service (DOS) 1/19/17, 1/23/17 and 1/24/17 Applicant billed $50.00 for infrared light treatment under CPT code 97026 and was reimbursed $5.61 as "Reimbursement for modalities and procedures may not exceed 8 relative value units per day. Previously reviewed bill amount has been applied." For DOS 1/9/17, 1/11/17, 16/17 and 1/17/17 Applicant billed $50.00 under CPT code 97026 which was denied in full based on "Reimbursement for modalities and procedures may not exceed 8 relative value units per day. Previously reviewed bill amount has been applied." For DOS 2/1/16 and 2/2/16 Applicant billed $50.00 under CPT code 97026 and was reimbursed $14.68 as "Provider's fee exceeds the maximum allowance under the applicable fee schedule and is reduced accordingly. As per section 5108 of the New York State Insurance Law, Providers shall not exceed the charges permissible under the schedules prepared and established by the chairman of the Worker's Compensation Board."

It is proper to use the Workers' Compensation Fee Schedule for acupuncture services performed by chiropractors to determine the amount which Applicant is entitled. See *Ava Acupuncture P.C. v. Geico General Ins. Co.*, 2009 NY Slip Op. 51017 (U); [App Term 2d; *Great Wall Acupuncture v. Geico Ins. Co.*, 2009 NY Slip Op. 52538 (U), (App Term 2d Dept 2009). As such, I find that Applicant should be awarded reimbursement for these services at the chiropractic rate of $14.68. More specifically, I note that CPT code 97026 has a corresponding Relative Value of 2.45 and the chiropractic Region IV Conversion Factor is 5.78. Respondent failed to submit any evidence that another provider was reimbursed for physical therapy modalities provided on these dates. As such Applicant is entitled to additional reimbursement of $85.93 for CPT code 97026.

For DOS 1/9/17, 1/10/17, 1/11/17, 1/12/17, 1/16/17, 1/17/17, 1/19/17, 1/23/17, 1/24/17, 2/1/17, and 2/2/17 Applicant billed $45.00 for cupping therapy under CPT code 97039 and was reimbursed $13.87. In support of this being the proper rate of reimbursement, Respondent submitted the affidavit of Steven Schram, LA.c., D.C.

Applicant's counsel argued that Dr. Schram's affidavit should not be considered, as he is not a professional coder. He further argued that the initial evaluation, progress notes and general description of the procedure that was submitted should have sufficed to provide a description of the procedure and if Respondent needed anything further, they had an obligation to request additional verification citing *Bronx Acupuncture Therapy, P.C. v. Hereford Ins. Co.*, 54 Misc. 3d 135A, 2017 WL 416732 (Table), (App. Term 2d, 11th & 13th Jud. Dists. 2017). Respondent's counsel argued that Dr. Schram is a licensed acupuncturist and thus his affidavit is credible. He further argued that Respondent is not obligated to request additional verification every time a claim is submitted, simply because a bill contains a By Report code, and that regardless of whether Respondent requested additional verification, it is entitled to establish the proper amount of

reimbursement. I agree and find that Respondent's failure or declination to request additional documentation regarding a By Report code does not preclude it from presenting evidence as to the service's value. Moreover, the guidelines articulate that "the physician (chiropractor) shall establish a relative value unit consistent in relativity with other relative units consistent in relativity with other relative value units shown in the schedule. The insurer shall review all submitted 'BR' relative units to ensure that the relativity consistency is maintained."

According to Dr. Schram's analysis, this treatment should be billed under CPT code 97039; and considering the time and technical skill required for its performance, the charge for cupping should be calculated based on a Relative Value Unit of 2.40. For acupuncturists located in Region IV, this translates to $13.87 per session. I find Dr. Schram's affidavit sufficient to support Respondent's fee schedule defense. Therefore, the burden shifts to Applicant to substantiate the amount billed. In this case, no proof has been offered to rebut Dr. Schram's assessment. I therefore find that Applicant was properly paid at a rate of $13.87 for each of the eleven cupping charges.

Accordingly, Applicant is awarded $85.93.

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
	Choi Acupuncture, P.C.	**01/09/17 - 02/02/17**	**$980.44**	**Awarded: $85.93**
Total			**$980.44**	**Awarded: $85.93**

B. The insurer shall also compute and pay the applicant interest set forth below. 08/07/2017 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest runs from 8/7/17 (the date that arbitration was requested) until the date that payment is made at two percent per month, simple interest, on a pro rata basis using a thirty day month.

C. Attorney's Fees

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

Pursuant to 11 NYCRR §65-4.6 (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 for arbitration or court proceeding, subject to a maximum fee of $1,360."

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

12/13/2018 Charles Blattberg
(Dated)

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:
97cf8e51d3c47a7a665a1d3870cb6068

Electronically Signed

Your name: Charles Blattberg
Signed on: 12/13/2018