

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

RES Physical Medicine & Rehab. Services
(Applicant)

- and -

Progressive Casualty Insurance Company
(Respondent)

AAA Case No. 17-17-1074-4523

Applicant's File No. n/a

Insurer's Claim File No. 165752796

NAIC No. 32786

ARBITRATION AWARD

I, Kent Benziger, 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: D.D.

1. Hearing(s) held on 01/04/2019
Declared closed by the arbitrator on 01/04/2019

Shannon Fuhman, Esq. from Fuhrman Law participated by telephone for the Applicant

Regina Wilcox, Esq. from Law Offices of Rachel Perry participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 1,199.52**, 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

Whether the Respondent has sustained its burden on its fee schedule defense for sensory nerve conduction studies (also known as pain fiber nerve conduction studies).

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 records of this hearing. I have reviewed the documents contained in the electronic case folder as of the date of this award as well as any documents submitted upon continuance of the case. Any documents submitted after the hearing that have not been entered in the

electronic case folder as of the date of this award will be listed immediately below and forwarded to the American Arbitration Association at the time this award is issued for inclusion in said case folder.

4. Findings, Conclusions, and Basis Therefor

On October 10, 2016, the Assignor/Eligible Injured Party, a 22-year-old female, was, by history, involved in a motor vehicle accident. This dispute involves the proper fee scheduling of sensory nerve conduction studies (also known as pain fiber nerve conduction studies or pf-NCS) of the lower extremities. On February 9, 2017, Dr. Strut of RES Physical Medicine & Rehabilitation performed the pf-NCS testing. The findings that were higher than average were of right (L4) saphenous nerve +2 moderate, left (L4) saphenous nerve +2 moderate right (L5) peroneal nerve +3 marked and left (L5) peroneal nerve +2 moderate. The lower than average measures were of left (S1) sural nerve -1 hyper. The impression was highly suggestive of lumbar radiculopathy involving the right L4 nerve root, left L4 nerve root, right L5 nerve root and left L5 nerve root. The Assignor was scheduled for needle intersegmental EMG targeting multifidi muscle to confirm this pathology.

The medical necessity of the study is not in issue. The Applicant billed for the procedure pursuant to CPT 95999 at \$1199.52. The Respondent issued a partial denial reimbursing \$171.36 with the additional comments:

Based on your response to our verification request, you have indicated that the RVUs for this procedure are comparable to 95904 which have a Relative Value Unit of 12.60 Documentation supports Category III code 0106T. The code description for code 0106T reads, Qualitative sensory testing, testing and interpretation per extremity; using touch pressure stimuli to assess large diameter sensation. Your records indicate that two Extremities were tested. Reimbursement is made at a rate equivalent to two units of 95904.

The Respondent has included a letter from Diane Pochobradsky, professional certified coder, in support of its denial. She noted that the Workers' Compensation Fee Schedule directs a coder to the Current Procedural Terminology book (CPT book) when explanation as to an instruction or ground rule is needed. In turn, the CPT book directs a coder to the Current Procedural Terminology Assistant (CPT Assistant) for additional explanation and clarify. She further noted.

In the matter before you, Progressive received billing for services provided on February 9, 2017. The provider billed procedure code 95999 (Unlisted neurological or neuromuscular diagnostic procedure), this code is listed in the fee schedule with a Relative Unit Value (RVU) of 'BR' (by report). In total, the code was billed for 14 units.

The Introduction and General Guidelines of the fee schedule, Ground Rule #3 "Procedures Listed Without Specified Relative Value Units," it states in part, "For any procedure where the relative value unit is listed in the schedule as "BR," the physician shall establish a relative value unit consistent in relativity with other relative value units shown in the schedule. The insurer shall review all submitted "BR" relative value units to ensure that the relativity consistency is maintained."

The documentation submitted by the provider indicates the code with the closest value is that of code 95904 - this code has a relative value unit (RVU) of 12.60 and is reimbursable per nerve. . Code 95904 measures amplitude and latency/velocity.

The provider's documentation outlines the procedure performed was pf-ncs testing. The documentation indicates 'pf-ncs', is a neurological or neuromuscular diagnostic procedure solely concerned with only the amplitude necessary to fire the nerve. "

As outlined above, the CPT Assistant may offer more clarity in coding issues. A CPT Assistant article from May 2011 indicates that Category Codes 0106T-0110T offer valid options for reporting the type of testing performed. These codes are defined, as, Quantitative sensory testing and interpretation per extremity; using touch pressure stimuli, vibration stimuli, cooling stimuli, heat pain stimuli or "other" stimuli.

Since the provide submitted information indicating that the closest RVU for the procedure performed (pf-NCS testing) would be the value of CPT Code 95904 and the Category II code are the most similar to the procedure performed allow payment per extremity. Progressive reimbursed the provider four units in total for the right and left upper extremities testing at the RVA of 12.60

To determine the allowable fee, the place of service zip code 14225, is listed in Region II; the conversion factor

is \$6.80. The allowable fee per extremity is determined by multiplying the RVA (12.60) times the conversion factor

Ms. Pochobradsky then took the Code ((59999/95904) with a Unit Value of 12.60 and a conversion factor of \$6.80 with an allowable fee of \$85.68 (x2) for a total allowable units of \$171.36. Based on the above explanation, She found that Progressive paid the bill in accordance with the ground rule sand the information supplied by the provider.

Analysis. Pursuant to the Fourth Amendment effective April 1, 2013 to 11 NYCRR 65-3.8(g)(1), the Applicant fees cannot exceed the charges permission be pursuant to the Insurance Law 5108 which would incorporate the Workers Compensation Fee Schedule. If there is a dispute that requires an application or interpretation of the fee schedule, the Respondent has the burden to come forward with competent evidentiary proof to support its defenses. Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co, 13 Misc.3d 172 (Civil Ct, Kings Co. 2006). However, when billing "By Report" the burden of proof rests with the Applicant or Provider to submit the information required by the Ground Rules and without it the provider has deprived the insurer of sufficient notice of the claim and the Carrier should be expected to evaluate or pay for it. Pavlova v. Allstate 2016 NY Slip Op 26123 (April 11, 2016):

As a finding of fact, both parties appear to agree that the relative value unit should be consistent with CPT 95904. This arbitrator has previously ruled that the service provided through the performance of pf-NCS does not constitute CPT 95904 which involves sensory nerve conduction, amplitude and latency/velocity study, each nerve. As noted by Arbitrator Rhonda Barry in Nassau Chiropractic Services, P.C. V. Allstate Ins. Co. 17-14-9023-0826 (August 17, 2015):

Determining the appropriate fee schedule for the PF-NCS is challenging as there is no specific workers' compensation code for the services provided. Although applicant billed ...CPT 95904, it did not perform an NCV. In order to bill CPT 95904 Applicant must specifically establish measurements of latency, amplitude and velocity. New York State Worker's Compensation fee schedule CPT 95904 specifically states "nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F wave study, sensory. The word "and" is of great significance. The statute mandates that all three conduction studies - amplitude and latency and velocity must be performed if a provider is to bill under this code. Applicant's own electro diagnostic report fails to establish that all three required

criteria were in fact determined. The PF-NCS included in applicant's submissions notes only measures the amplitude. Latency and velocity are not factors.

The AMA directs a service provider to use Category III codes 0106T to 01100T to report pf-NCS tests. However since these Category III codes are not part of the Workers' Compensation Fee Schedule, CPT code 95999 (unlisted neurological or neuromuscular diagnostic procedure) must be used to report pf-NCS services. See: General Ground Rules Two and Three.

However, although CPT 95904 does not accurately pertain or describe pf-NCS tests, this procedure described in the code is comparable as to relative value units for billing purposes. in regard to the time, skill and equipment necessary to conduct the test. The next issue is determining the number of units permitted to be billed. This arbitrator agrees with the analysis of Arbitrator Michael Rosenberg in *Brooklyn Precision Chiropractic, PC. v. Geico*, AAA Case No: 17-16-1030-2594 (March 20, 2017):

A pf-NCS does not measure velocity or latency as specifically required by the code descriptor. The Category III codes for QST (CPT 0106T - 0110T) are "by report" and more appropriately reflect the nature of the services rendered. Both the NCV and the QST are different tests than the PF- NCS; but, for billing purposes, the Category III Codes (which permit billing per extremity as opposed to per nerve) offer a more consistent standard for reasonable compensation. I previously used the relative value for CPT 95904 and applied that amount to CPT 0110T (which permits payment by extremity and not by nerves tested) to determine the proper reimbursement. When applying the Workers Compensation Fee Schedule, there is a significant difference between a code descriptor and its relative value. Applicant has not established that an NCV was performed; the PFNCS does not meet the requirements of the code descriptor to permit billing under CPT 95904.

Since the relative value for CPT 0110T is based on extremity and not the number of nerves, it cannot have the same relative value as CPT 95904. For purposes of determining proper reimbursement, the relative value of a code may be applied to those procedures and tests that are "by report". The code descriptor for CPT 0110T satisfactorily describes the test performed. In the absence of contrary evidence from applicant, the relative value for CPT 95904 is appropriate. Ground Rule 3 provides that the unit value of a similar procedure may be considered. It does not permit billing of a CPT code where the procedure

performed fails to satisfy the language of the code descriptor. There are distinctions between the QST and the PF- NCS, but for billing purposes it offers a more comparable standard than the NCV for reasonable compensation.

Until such time as a CPT code is established for the PF NCS, it would be unreasonable to categorize it under CPT 95904. CPT 0106T is for, "quantitative sensory testing (QST), testing and interpretation per extremity; using touch, pressure stimuli to assess large diameter sensation; CPT 0110T using other stimuli (other than vibration, cooling and heat) to assess sensation. Electricity can certainly be considered other stimuli. Latency and velocity are not an issue. In accordance with the Category III codes billing is appropriately submitted for one unit of service for each extremity rather than each site tested. I find persuasive the reasoning of fellow arbitrators Feilich (AAA# 17-14-9023-6089), Wolf (AAA# 412011053109), Esposito (AAA# 412011053021), Peters (AAA# 41011053019), Melis (AAA# 41011061502), Horowitz (AAA# 412010042797) and Haskel (AAA# 412013124961). (italics added)

As a finding of fact, the Applicant's reference to the American Association of Sensory Electrodiagnostic Medicine Practice Policy Guidelines is misplaced. These Guidelines are not controlling on billing under the New York Workers' Compensation Fee Schedule. Contrary to the Applicant's references to various guidelines, the relative value of CPT 95904 is simply utilized as a comparable procedure for billing purposes. In regard to the time, skill and equipment necessary to conduct the test. However, CPT neither CPT 95904 or related guidelines are controlling on the number of units permitted to be billed for the performance of pf-NCS in dispute.

The AMA originally directed providers using pf-NCS to Category III codes 0106T to 01100T, but since these codes are not part of the Workers Compensation Fee Schedule, the comparable relative value of CPT 95904 is utilized. Yet, Category III Codes are still controlling as to the number of units permitted to be billed which is per extremity - not by nerves. Therefore, the Category III Codes dictate the number of units billed (i.e. per extremity). The Applicant has the burden of proof in using a "By Report" code and failed to recognize the "per extremity" limitation required by this Category III Code procedure. The contention by the Applicant's Coder that billing for testing of more than six nerve C Nerve Fibers is permitted under CPT Code 95999 or through use of the relative value of CPT 95904 is not supported.

Applicant may test numerous C nerve fibers when pf-NCS is done through Axon II testing, but pursuant to the rationale cited above including Arbitrator Michael

Rosenberg's analysis and the limitations imposed by Category III codes, Applicant can only bill pursuant to "per extremity". Numerous additional documents submitted by the Respondent such as Model policies for Needle Electromyography and Nerve Conduction Studies (AANEM), Appendix J pertaining to EMG/NCV testing - have little relevance on the testing in dispute. Further, many arbitrators would find that the Applicant has failed to submit the required information for reimbursement for a "By Report" Code pursuant to Workers Compensation Ground Rules.

Arbitrator Drew M. Gewuerz reached a similar conclusion in AAA Case No. 17-16-1050-2850 (March 21, 2018) in which the Applicant designated a value of \$72.83 for that region per unit:

The Respondent's position is that the Applicant's claim charges fees in excess of applicable law. Although it does not support its defense with substantive evidence, its failure is excused by this Arbitrator's past determinations in various prior arbitrations that CPT code 95999 is not the appropriate code to bill the disputed services. See e.g. AAA Case No. 17-16-1050-1926. Category III codes 0106T-0110T offer valid options for reporting quantitative sensory testing (QST), specifically, code 0110T ("Quantitative sensory testing (QST), testing and interpretation per extremity; using other stimuli to assess sensation"), and HCPCS code G0255 ("Current perception threshold/sensory nerve conduction test, (SNCT) per limb, any nerve"), expressly includes CPT/sNCT testing. Therefore, the Respondent is correct and either 0110T or G0255 should have been used to bill for this service. The services should have been reimbursed by extremity/limb under 0110T or G0255. As neither code has a Legislatively set relative value and the Respondent has not offered one, the Applicant is entitled to two (2) units for the two (2) extremities tested for a total of \$145.66."

In sum, this pf-NCS test does not meet the criteria as a Nerve Conduction Study. The proper method of billing is as a Category II code for quantitative sensory testing which is billed per extremity or limb. Although pf-NCS differ from Qualitative Sensory Testing, it is a comparable code for billing. RES Physical Medicine v. Progressive, AAA Case No. 17-17-1062-9357 (Arbitrator Fred Lutzen, September 16, 2018).

Even more recently, Arbitrator Marianne Zack in RES Physical Medicine & Rehab Services v. Progressive, AAA Case No. 17-17-1067-2637 (October 17, 2018) ruled on a very similar Coder's affidavit, and found that that the Applicant failed to comply with the requirements of Ground Rule 3 pertaining to "By Report" codes with its specific

requirements of providing information concerning the nature, extent the need for the procedure or service, the time, the skill and equipment necessary etc. is to be furnished She rejected the Applicant's contentions:

Applicant relies upon the Sensory Pain Fiber Nerve Conduction Study Report in support of its billing practice with respect to the PFNCS testing. Contained within that report, is a section entitled Applicant's "Justification for use of By Report code 95999", wherein Applicant states that CPT code 95999 is the correct code to use because the PFNCS testing is "solely concerned with the amplitude required to fire the subject nerve", and "the test is only concerned with the amplitude necessary to fire the nerve". Applicant continues to state in the report that "the nature, extent, and need for the procedure, as well as the time the skill and the equipment necessary to perform the procedure for the provider are identical to that of code 95904 with the relative value of 12.60". First, outside of Applicant's "Justification for use of By Report code 95999", within the foregoing report, I do not see that Applicant furnished documentation which supports or demonstrates the nature, extent, and need for the testing of this particular claimant; as required when a provider bills under CPT code 95999. In addition, Applicant's report speaks to a relative value but fails to discuss the application of Ground Rule 3 or the Region II conversion factor.

Arbitrator Zack found the Respondent's Coder provided documentation indicating that CPT 95904 was the code with the closest value and that two units for the extremities was properly reimbursed. Applicant's contention that nerves - not extremities - are tested and that the billing should not be limited to two units (per extremity) is without merit. Therefore, as a finding of fact and law, the Applicant has failed to sustain its burden of proof. No further reimbursement is due.

Pursuant to 11 NYCRR 65-4.5 (o)(1)(i)(ii), an arbitrator is the judge of the relevance and materiality of the evidence offered.

APPLICANT'S CLAIM IS DENIED IN ITS ENTIRETY.

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 Orange

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

01/31/2019
(Dated)

Kent Benziger

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:
5eaa7b3253adc717f0295e571e82db93

Electronically Signed

Your name: Kent Benziger
Signed on: 01/31/2019