

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Mark L Delmonte DC, PC
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No.	17-17-1082-1748
Applicant's File No.	17-11977
Insurer's Claim File No.	0584432730101010
NAIC No.	22055

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: E.S.

1. Hearing(s) held on 04/19/2019
Declared closed by the arbitrator on 04/19/2019

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

Jason Ciani, Esq. from Geico Insurance Company participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 2,481.86**, 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 fee schedule defenses for modalities and procedures including: cold laser therapy, the Graston technique/modality and spinal decompression.

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 June 17, 2017, the Assignor/Eligible Injured Party, a 33-year-old male, was, by history, involved in a motor vehicle accident. The Assignor came under the care of Dr. Mark L. Demonte, D.C. for pain in the cervical and lumbar spine. The treatment in dispute is from July 17, 2017 to October 4, 2017 and primarily involves therapy including cold laser therapy, Graston technique and spinal decompression. The Respondent has made partial payments for the treatment based on fee schedule defenses.

Fee Schedule. Pursuant to the Fourth Amendment effective April 1, 2013 to 11 NYCRR 65-3.8(g)(1), the Applicant's fees cannot exceed the charges permitted 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).

7/12/17-7/24/17 For the period, the Applicant billed for chiropractic physical therapy modalities that included the cold laser therapy (billed pursuant to CPT 97039 - unlisted physical therapy procedure) and Graston technique (billed pursuant to "99919"). As to all of the treatment besides the Graston Technique, the Respondent's reimbursement is correct.. The Applicant billed \$50.00 for the cold laser therapy pursuant to an "By Report" unlisted modality code. However, this "BR" code is listed under Ground Rule Three of the Chiropractic Section of the Workers' Compensation Fee Schedule as a modality subject to the eight-unit rule. The Respondent correctly reduced this and the other modalities on a given day to \$35.52 which is the maximum permitted in Region I.

As to Graston modality, the Respondent submitted a verification request to the Applicant for the Proper NYS No-Fault Code for this modality billed by the Applicant pursuant to "99919 - BR, GR". From this arbitrator's review, 99919 is not a valid code. The Applicant submitted a pre-printed "Relative Value Unit Calculation Report" for the Graston technique, but failed to directly respond to the Applicant's request . This arbitrator concurs with Arbitrator Michelle Murphy Loudon who decided the same issue *Mark L. Delmonte, D.C. v. Progressive*, AAA Case No. 17-17-1080-4792 (Arbitrator Michelle Murphy-Louden, November 16, 2018):

With respect to 99919-GR/BR (Graston technique), I have thoroughly reviewed the Fee Schedule and CPT code

99919 is not contained therein. Applicant has not submitted any evidence establishing that it was permitted to bill CPT code 99919 for No-Fault claims and as such Applicant's claim for same is denied.

However, as the Respondent has not directly denied the claim (which it could have done after 120 days), Applicant's claim for reimbursement for the Graston technique is dismissed without prejudice. The remainder of the claim was correctly reimbursed.

7/26/17-8/4/17, 8/7/17-8/16/17, 8/21/17, 8/25/17, 9/6/18-9/8/17. 9/15/17, 9/23/17-9/25/17, 9/29/17. On these dates, the Respondent billed for the same chiropractic and physical therapy modalities as well as cold laser therapy and Graston techniques as discussed above. For the same reasoning as discussed above, the Respondent correctly reimbursed for these dates of service under the eight unit rule, and properly requested additional verification for the non-existing coding for the Graston modality. No further reimbursement is due.

8/21/17 (CPT 97799, \$550), 9/1/17 (CPT 97799 \$550), 9/29/17 (CPT S9090, \$165.35), 10/4/17 (CPT 97799, \$175.91). On the following dates, the Applicant performed Spinal Decompression therapy, but the Applicant billed for the treating under different codes; while the Respondent through its denials offered inconsistent defenses. Therefore, it is necessary to review the bills separately since procedural issues come into play as to fee schedule defenses.

On August 21, 2017, the Respondent billed for two treatments of cervical decompression under

Unlisted Physical Medicine/Rehabilitation Service or Procedure. The Respondent issued a denial that the services performed are not reimbursable under the chiropractic section of the New York Workers Compensation Fee Schedule. This is a vague and improper denial. A chiropractor can utilize and bill for modalities or "By Report" items under the Physical Medicine Section of the Workers Compensation Fee Schedule. See: General Accident Ins. Group v. Cirucci, 46 N.Y.2d 862, 864, 414 N.Y.S.2d 512, 514 (1979). The Respondent has provided no fee coder affidavit and has failed to request any verification as to the service or the "By Report" code. The Respondent has failed to sustain its burden of proof. Applicant is awarded reimbursement of \$275 primarily based on the Respondent's lack of specificity in its denial and the failure to sustain its fee schedule defense. The Applicant did bill twice for spinal decompression on this date, and the two submitted bills appear to be identical and were simply printed twice. Applicant has submitted no documents clarify why two treatments for spinal decompression on the same date were necessary as opposed to have been billed twice. Reimbursement of \$275.00 is awarded.

On September 1, 2017, the Respondent again billed for two sessions of cervical decompression pursuant to CPT 97799. The Respondent issued a denial that the procedure code was changed to more accurately reflect the services rendered. The Code was changed to CPT 97039 which is "Unlisted modality (specify type and time if constant attendance)". No reimbursement was awarded. No coder affidavit or verification request was submitted. As to both the August 21, 2017 and this September 1, 2017 date of service, the Respondent could have stated that the Applicant failed to comply with the applicable Grounds Rules for a "By Report" code or issued denial on numerous grounds with more specificity. A re-coding to another "By Report" code without an explanation fails to meet the Respondent's burden. The Applicant again billed twice for spinal decompression on this date, and the two submitted bills appear to be identical and simply printed twice. Applicant has submitted no documents clarify how these bills for spinal decompression differ. Reimbursement of \$275.00 for one spinal decompression session on this date is awarded.

On September 29, 2017, the Applicant billed under S9090 for vertebral axial decompression (\$165.35) The Respondent re-coded the treatment to CPT 97012 which is for mechanical traction and reimbursed \$12.03 which is the amount permitted under the specific fee schedule code. The Respondent correctly noted that Applicant's billing under S9090 was not permitted under the provider's specialty under the Workers Compensation Fee Schedule. The S9090 code apparently is part of the Healthcare Common Procedure Coding System.

As a finding of fact, there are ample arbitration decisions which have held that spinal decompression is similar to traction billed pursuant to CPT 97012. Mark Delmonte, D.C. v. American States, AAA Case No. 17-17-1082-1519 (Arbitrator Mona Bargnesi, May 7, 2019); Mark Delmonte, D.C. v. Progressive Casualty Insurance Company, AAA Case No. 17-17-1082-1456 (Arbitrator Gillian Brown, May 5, 2019). Finally, as Arbitrator Michelle Murphy-Loudon held in Mark Delmonte, D.C. AAA Case No. 17-17-1063-8644 (December 11, 2018) held:

CPT code 97012, Application of a modality to one or more areas; traction, mechanical, is intended to identify a procedure that creates a force to allow for separation between joint surfaces. The degree of traction is controlled through the amount of force (pounds or Newtons) allowed, duration (time), and angle of pull (degree) using mechanical means. Therefore, code 97012 would be the most appropriate code to report for various types of mechanical traction devices (eg, computerized/motorized) including vertebral axial depression.

As an initial matter it is to be noted that I have access to CPT Assistant's online records and am capable of researching their publications from 1990 to the present, and the above-cited guideline has never been superseded.

The disputed spinal decompression was performed using the DRX9000 which is a computerized decompression system. According to the November 2004 CPT Assistant, CPT code 97012 is the most appropriate code to report for various types of mechanical traction devices "(eg, computerized/motorized)" including vertebral axial depression.

The DRX9000 utilized by Applicant is a computerized traction device which, per the AMA, squarely falls within the definition of CPT code 97012. Therefore, I find that Respondent properly reviewed Applicant's billed CPT code of 97799 as CPT code 97012.

CPT code 97012 is subject to Ground Rule 3 along with CPT codes 98941, 97010, and 97124 which Applicant also billed for dates of service January 16, 2014, February 18, 2014, March 24, 2014, and April 30, 2014, and as Applicant has already been reimbursed for 8.0 RVU's for those dates of service Applicant is not entitled to any further reimbursement. Therefore, Respondent's denials of Applicant's claims for the spinal decompression rendered from January 16, 2014, to April 30, 2014, are upheld.

As a finding of fact, the Respondent has correctly reimbursed the Applicant for said treatment which it properly coded pursuant to CPT 97012.

On October 4, 2017, the Applicant again billed for cervical decompression under the CPT 97799, the "By Report" code and the Respondent recoded the treatment to CPT 97012 as discussed above with reimbursement of \$12.03. No further reimbursement is due.

Again, this arbitrator awarded reimbursement for the first two dates of decompression (August 21, 2017 and September 1, 2017) based on the failure of the Respondent to specify with any clarity its fee schedule defense. As to the final dates of decompression (September 29, 2017 and October 4, 2017, the Respondent did properly recode the treatment and has sustained its burden of proof.

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.

Interest. The insurer shall compute and pay to the Applicant the amount of interest from the filing date of the Request for Arbitration, at a rate of 2% per month, simple interest (i.e. not compounded) using a 30-day month and ending with the date of payment of the award, subject to the provisions of 11 NYCRR 65-3.9(c).

Attorney's Fees. As said case was filed on or after February 4, 2015, Applicant is awarded attorney's fees for the total amount of first party benefits awarded. Pursuant to 11 NYCRR 65-4.6(d)(e), the Applicant is awarded 20 percent of the amount of the first party-benefits, with no minimum fee and a maximum \$1,360.00 which is the total amount awarded one Applicant in one action from one provider. See: LMK Psychological Services, P.C. v. State Farm Mut. Auto Ins. Co., 46 A.D.3d 1290; 849 N.Y.S.2d 310 (3 Dept. 2007).

APPLICANT IS AWARDED \$550.00, TOGETHER WITH INTEREST AND ATTORNEYS' FEES. APPLICANT'S CLAIMS FOR REIMBURSEMENT OF THE GRASTON MODALITY IS DISMISSED WITHOUT PREJUDICE FOR THE APPLICANT'S FAILURE TO RESPOND TO VERIFICATION REQUESTS. APPLICANT'S CLAIMS ARE OTHERWISE 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 applicant is AWARDED the following:

A.

Medical		From/To	Claim Amount	Status
	Mark L Delmonte DC, PC	07/17/17 - 10/04/17	\$2,481.86	Awarded: \$550.00
				Awarded:

Total	\$2,481.86	\$550.00
--------------	-------------------	-----------------

- B. The insurer shall also compute and pay the applicant interest set forth below. 12/19/2017 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest. The insurer shall compute and pay to the Applicant the amount of interest from the filing date of the Request for Arbitration, at a rate of 2% per month, simple interest (i.e. not compounded) using a 30-day month and ending with the date of payment of the award, subject to the provisions of 11 NYCRR 65-3.9(c).

C. Attorney's Fees

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

Attorney's Fees. As said case was filed on or after February 4, 2015, Applicant is awarded attorney's fees for the total amount of first party benefits awarded. Pursuant to 11 NYCRR 65-4.6(d)(e), the Applicant is awarded 20 percent of the amount of the first party-benefits, with no minimum fee and a maximum \$1,360.00 which is the total amount awarded one Applicant in one action from one provider. See: LMK Psychological Services, P.C. v. State Farm Mut. Auto Ins. Co., 46 A.D.3d 1290; 849 N.Y.S.2d 310 (3 Dept. 2007).

- 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 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.

05/13/2019
(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:
dae7a6f1ce79baf785969586ee05d295

Electronically Signed

Your name: Kent Benziger
Signed on: 05/13/2019