American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

LN Medical Diagnostic PC (Applicant)	AAA Case No.	17-17-1082-3305
	Applicant's File No.	N/A
- and -	Insurer's Claim File No.	32-953V-562
	NAIC No.	25178
State Farm Mutual Automobile Insurance Company (Respondent)		

ARBITRATION AWARD

I, Paul Israelson, 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: injured person.

1. Hearing(s) held on 07/08/2019
   Declared closed by the arbitrator on 07/08/2019

   Elvira Messina Esq. from Costella & Gordon LLP participated in person for the Applicant

   Ryan Waxon Esq. from Richard T. Lau & Associates participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 3,700.00**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The applicant amended its claim to $3,487.06.

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

3. Summary of Issues in Dispute

   Did the respondent properly reduce the applicant's claim in accordance with the New York Worker's Compensation Fee Schedule ("fee schedule")?

4. Findings, Conclusions, and Basis Therefor

On July 8, 2019, the hearing for the within arbitration matter was conducted and closed.

The date of the subject automobile accident was August 14, 2016.

The applicant made a claim in the amount of $3,700.00 for the pain fiber nerve conduction study ("PF NCS study") of the injured person's upper extremities and lower extremities conducted on August 30, 2016, breaking down as follows:

$1,900.00 for the August 30, 2016 pain fiber nerve conduction study of the injured person's upper extremities; and

$1,800.00 for the August 30, 2016 pain fiber nerve conduction study of the injured person's lower extremities.

The respondent reduced by $1,587.06 the applicant's claim in the amount of $1,800.00 for the pain fiber nerve conduction study of the injured person's lower extremities, and paid the applicant $212.94, on the basis that the applicant's claim was not submitted in accordance with the fee schedule, as more fully set forth below.

The respondent did not pay or deny any portion of the applicant's claim in the amount of $1,900.00 for the pain fiber nerve conduction study of the injured person's upper extremities. The respondent argued that this same portion of the applicant's claim should be reduced to $212.94 on the basis that the applicant's claim was not submitted in accordance with the fee schedule, as more fully set forth below.

The within arbitration matter is for recovery of the unpaid $3,487.06.

The respondent provided the April 10, 2018 fee schedule affidavit by Lori Ercolini RW, CPC in support of the respondent's reduction of the applicant's claim.

The applicant assigned CPT code 95913 to the subject pain fiber nerve conduction studies, which is a new CPT code not found in the New York Workers Compensation Fee schedule. As such, Ms. Ercolini employed ground rule 3 to determine which CPT code in the New York Workers Compensation Fee schedule most closely applies to the subject pain fiber nerve conduction studies.

In this regard, Ground Rule 3 of the fee schedule - by report "BR" reads as follows:

GROUND RULE 3 OF THE FEE SCHEDULE - BY REPORT "BR"

3. Procedures Listed Without Specified Relative Value Units

By report (BR) items:"BR" in the Relative Value column represents services that are too variable in the nature of their performance to permit assignment of relative value units. Fees for such procedures need to be justified "by report." Pertinent information concerning the nature, extent, and need for the procedure or service, the time, the skill, and equipment necessary, etc., is to be furnished. A detailed clinical record is not necessary, but sufficient information shall be submitted to permit a sound evaluation. It must be emphasized that reviews are based on records, hence the importance of documentation. The original official record, such as operative report and hospital chart, will be given far greater weight than supplementary reports formulated and submitted at later dates. 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 general conditions and requirements of the General Ground Rules apply to all "BR" items.

Ms. Ercolini reviewed the applicant's documentation concerning the subject pain fiber nerve conduction studies of the injured person's upper extremities and lower extremities and determined that CPT code 95904 most closely applies to the subject pain fiber nerve conduction studies.

CPT code 95904 the relative value unit of $12.60. The subject pain fiber nerve conduction studies were conducted by a medical doctor in an office located in region IV, thus generating a conversion factor of $8.45. Consequently, the unit billing amount is $106.47, i.e. $12.60 × $8.45 = $106.47.

Ms. Ercolini then determined that the CPT Assistant article May 2011/Volume 21, issue 5, page 10 indicates that codes 0106T and 0110T are to be utilized for pain fiber nerve conduction studies.

With regard to the assignment of CPT codes 0106T and 0110T to the subject Pain fiber nerve conduction studies, the AMA CPT Assistant Official Source for CPT Coding

Guidance required the assignment of these same CPT codes. In this regard, the pertinent portion of the AMA CPT Assistant Official Source for CPT Coding Guidance reads as follows:

> Medicine: Neurology and Neuromuscular Procedures
>
> Question: The device manufacturer directed me to use code 95904 to report studies, but my claims for multiple units of code 95904 are being denied. Can code 95904, Nerve conduction, amplitude and latency/velocity study, each nerve; sensory, be used to report sensory nerve conduction tests (sNCTs), such as current perception testing?
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> Answer: No. Code 95904 requires recording of amplitude and latency/velocity. sNCT is different and distinct from nerve conduction velocity, amplitude, and latency. In addition, sensory nerve conduction study recordings must be made from electrodes placed directly over the nerve to be tested. Category III codes 0106T-0110T offer valid options for reporting quantitative sensory testing (QST), and HCPCS code G0255 expressly includes current perception threshold/sNCT testing. Medicare created HCPCS code G0255 in concert with section 160.23 of the Medicare National Coverage Determinations Manual. The appropriate Category III code or G code should be used to report this service.

A plain reading of the pertinent portion of the AMA CPT Assistant Official Source for CPT Coding Guidance indicates that Category III codes 0106T-0110T should have been assigned to the subject pain fiber nerve conduction studies.

Further, a plain reading of CPT codes 0106T and 0110T indicates that these same CPT codes should be assigned to the subject pain fiber nerve conduction studies. These CPT codes read as follows:

0106T Quantitative sensory testing (QST), testing and interpretation per extremity, using touch BR pressure stimuli to assess large diameter sensation

0110T Using other stimuli to assess sensation BR

An additional plain reading of CPT codes 0106T and 0110T indicates that these same testing procedures are billed "per extremity", and are not billed per nerve (as the applicant had billed for the subject PF-NCS procedures).

As well, the CPT Assistant March 2013/Volume 23 Issue 3 provides the following coding tip for nerve conduction studies:

> Coding Tip
>
> A nerve conduction study is counted only once when multiple sites on the same nerve are stimulated or recorded. Motor, sensory, mixed motor/sensory, or H-reflex tests are each counted per nerve tested.
>
> Preconfigured electrode array nerve conduction testing (reported with 95905, motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report) is customized to a specific anatomic site. This procedure is reported once per limb studied, regardless of the number of nerves tested in a limb. Code 95905 would be reported for each limb. It would not be appropriate to report code 95905 in addition to code 95885, 95886, or 95907-95913.

I agree with Ms. Ercolini's fee schedule analysis for the subject pain fiber nerve conduction studies, as detailed above.

Therefore, it is clear that pain fiber nerve conduction studies should be billed per limb and not per nerve.

In that the subject pain fiber nerve conduction studies were for the injured person's upper extremities and lower extremities, which are four in number, the applicant may bill four separate unit fees for the subject pain fiber nerve conduction studies of the injured person's upper extremities.

Therefore, in that the unit fee is $106.47, and in that the applicant may bill four separate unit fees for the subject pain fiber nerve conduction studies of the injured person's lower extremities and upper extremities (i.e. one unit fee for each extremity tested), the total fee to be awarded the applicant for the subject PF-NCS of the injured person's lower extremities is $425.88 (i.e. $106.47 × 4 = $425.88).

In that the respondent paid the applicant $212.94 for the August 30, 2016 pain fiber nerve conduction studies of the injured person's upper extremities and lower extremities, the respondent's payment to the applicant was not in the correct amount. The respondent should have paid the applicant $425.88 for said testing. Consequently, the applicant is

owed $212.94 for the August 30, 2016 pain fiber nerve conduction studies of the injured person's upper extremities and lower extremities, i.e. $425.88 - $212.94 = $212.94.

Therefore, the applicant's claim for recovery of the unpaid amount of $3,487.06 for the August 30, 2016 pain fiber nerve conduction studies of the injured person's upper extremities and lower extremities is denied, however, the applicant is awarded $212.94 for said testing.

I have reviewed and considered all other arguments, contentions and evidence from both the applicant and the respondent, and find them to be without merit.

In accordance with the foregoing, the applicant is awarded $212.94.

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**
	LN Medical Diagnostic PC	**08/30/16 - 08/30/16**	**$3,700.00**	**$3,487.06**	**Awarded: $212.94**

Total	**$3,700.00**		**Awarded: $212.94**

B. The insurer shall also compute and pay the applicant interest set forth below. 12/20/2017 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

The above described filing date is inapplicable to the calculation of interest to be paid to the applicant. If a no-fault claim was neither paid nor denied within 30 days after it was presented to the insurer, interest must be calculated commencing 30 days after the claim was presented to the insurer for payment until the date the claim is paid, Hempstead General Hospital v. Insurance Co. of North America, 208 A.D.2d 501 (2d Dept. 1994). As such, interest is due from 30 days after this claim was presented to the insurer for payment up until the date the claim is paid.

C. Attorney's Fees

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

If this matter was filed prior to February 4, 2015, the insurer shall pay the applicant an attorney's fee in accordance with 11 NYCRR 65-4.6 (e). If this matter was filed on or after February 4, 2015, the insurer shall pay the applicant an attorney's fee in accordance with 11 NYCRR 65-4.6(d); and in such same event, if the benefits and interest awarded thereon are equal to or less than the respondent's written offer during the conciliation process, then the attorney's fee shall be based upon the provisions of 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 Nassau

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

07/09/2019
(Dated)

Paul Israelson

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:
e55225abb5ff5a1ea0caaf212e8d30ad

Electronically Signed

Your name: Paul Israelson
Signed on: 07/09/2019