American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

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| New York Spine Specialists (Applicant) | AAA Case No. | 17-18-1100-5462 |
| | Applicant's File No. | 2117469 |
| - and - | Insurer's Claim File No. | 272 PP H7G0092 R |
| Travelers Commercial Insurance Company (Respondent) | NAIC No. | 36137 |

**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 11/14/2019
   Declared closed by the arbitrator on 11/14/2019

   Gary Pustel from Israel, Israel & Purdy, LLP (Great Neck) participated in person for the Applicant

   Shana Kleinman from Law Office Of Aloy O. Ibuzor participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 55.71**, 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 72 year old male, was injured in a collision on 3/10/18. This claim is for an initial consultation on 5/3/18, billed under CPT code 99244 at $236.94. The Respondent paid $181.23, based upon a fee audit wherein it was determined that the documentation did not support CPT code 99244. Respondent paid the Applicant pursuant to CPT code 99243.

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.**

**Applicant's submission:**

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

The Applicant billing indicates that the consultation was of moderate complexity.

**On 5/3/18, the EIP had an evaluation at the Applicant.** He was seen by Demetrios Mikelis, MD. This report indicates that the EIP was referred to the Applicant from Dr. Krishna.

He reported being involved in an MVA on 3/10/18. He presented with complaints of low back pain and neck pain.

The EIP works as a barber. He had no significant history of neck or back pain. He was currently working. He has had physical therapy, a TENS unit, brace, hot pack, ice pack, exercise and massage. He is getting physical therapy at the rate of 3 times per week.

He complained of low back pain, neck pain and arm pain with radiation into both the bilateral upper extremities and the bilateral lower extremities accompanied by numbness, tingling and dysesthesias.

The back pain was rated at 9/10; the neck pain was also rated 9/10. The pain was described as a dull/aching, numbness/tingling, constant and sharp shooting. The pain was aggravated by lifting, carrying, bending and moving around, standing up, sitting, lying on side and lying down.

The PX of the cervical spine found tenderness and spasm to percussion. Cervical flexion was measured at 45/70; extension was 35/45; right and left turning was 55/80.

As the lumbar spine, inspection to percussion and palpation found tenderness and spasm. Flexion was measured at 65/90; extension was 20/40; left and right turning was 35/60.

The motor examination in the upper extremities found motor strength was 4/5 in the bilateral deltoid and the left wrist extensor/flexor.

Sensation was altered in the bilateral C4, C5, C6 and C7 dermatomes. DTRs in the upper extremities were abnormal, but not quantified.

As to the lower extremity examination, strength was 4/5 in the right hip flexor and right hamstring. Sensation was altered in the right L4, L5 and S1 dermatomes. DTRs were abnormal in the lower extremities, but not quantified.

The results of the MRIs for the cervical spine and the lumbar spine are reported.

**The Diagnosis was:** herniated cervical intervertebral disc; herniated lumbar intervertebral disc; bilateral lumbosacral nerve root lesions.

**The Plan** indicates that various treatment options were discuss with the patient including both surgical and nonsurgical modalities, including chiropractic, physical therapy and spinal injections. The patient has elected to proceed with chiropractic care as well as physical therapy and for cervical and lumbar spine epidural injections.

The patient was directed to refrain from activities that exacerbated his symptoms.

The Applicant has also provided copies of the MRI report for the lumbosacral spine and the MRI report for the cervical spine.

**Respondent's submission:**

The Respondent's position is that the Applicant's claim was paid at the proper fee schedule rate based upon the assertion that the documentation did not support the CPT code billed.

**I note that the Respondent issued its NF-10 on 5/23/18. In that NF-10, the Respondent reimbursed the Applicant at $181.23 against billing in the amount of $236.94.** The basis for the reduced payment was that the reimbursement was made pursuant to CPT code 99243. The definition for CPT code 99244 is provided on the EOB.

The Respondent's original submission contains a copy of the EIP's NF-2 and the Applicant's billing.

Also provided was a copy of the narrative report for the 5/3/18 office visit at the Applicant.

**The Respondent has submitted a fee audit from Amy C. Kaczmarek, CPC, which was sworn to on 11/7/2018.**

In her affidavit, Ms. Kaczmarek lists her credentials and notes that she has been a CPC since 2008. She has also been certified in Evaluation and Management Specialty (CEMC) since 2014.

She has reviewed the Applicant's billing and the CPT codes.

CPT code 99244 is in office consultation that has 3 components: 1) a comprehensive history; 2) a comprehensive examination and 3) medical decision-making of moderate complexity. "Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with patient and/or family."

She then notes that in the instant case, reimbursement was made pursuant to CPT code 99243. The basis was that the notes submitted did not reflect the criteria for CPT code 99244.

Ms. Kaczmarek notes that the review of symptoms was needed to meet a comprehensive history. This portion of the E/M visit is when the patient goes over any problems related, or not related, to the chief complaint. This can be done on a checklist form or by the physician asking the patient such things as do you have blurry vision, do you have trouble hearing, cough, sore throat, etc..or simply by the patient telling the doctor the problems he/she is having (bloodied nose, chest pain, swelling, bruises, shortness of breath, etc.). The Applicant's report documented 2 systems, the musculoskeletal and the neurological, not the 10 or more which is needed for a complete review of systems.

In addition, past history, family history and social history must all be documented to meet a comprehensive history. The report at issue only documented a social history.

Because the ROS was not complete and because the family and past history was not documented, "the history portion of the visit is DETAILED."

Since the history was not "comprehensive," billing under CPT code 99245, 99244, 99205 or 99204 was not available, regardless of the examination and medical decision-making.

She then discusses "Moderate" decision-making and notes that the report issue does not reflect this level. As a result, she opines that reimbursement under CPT code 99243 is the appropriate amount.

**At the hearing:**

Applicant relied upon its billing and the initial office visit report.

Respondent relied upon the affidavit of Ms. Kaczmarek.

**FINDINGS:**

The Applicant has established its prima facie case.

This claim is for an initial consultation on 5/3/18, billed under CPT code 99244 at $236.94.

**On 5/23/18, Respondent issued an NF-10 to the Applicant re billing in the amount of $236.94.** Respondent paid $181.23, leaving amounted disputed $55.71. As per the EOB, the basis for the reduced payment was that the Respondent calculated that the proper reimbursement rate would be under CPT code 99243 and is reimbursed the Applicant accordingly.

The Respondent has submitted an affidavit from Amy C. Kaczmarek, CPC, who opines that the correct reimbursement for the services provided by the Applicant was pursuant to CPT code 99243 at $181.23.

In this case, the fee audit details reasons as to why the Respondent reimbursed under CPT code 99243, as opposed to CPT code 99244.

The Applicant has not challenged the reasoning set forth by Ms. Kazcmarek in her fee audit.

I do note that the affidavit of Ms. Kazcmarek was dated 5 months after the Respondent issued its NF-10, but that does not mean that people at the Respondent did not confer with her or another CPC as to the propriety of the Applicant's billing at or about the time that the NF-10 was issued.

The claim is denied.

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 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.

11/15/2019
(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:**
b8a3c719f10771a3cb7536c1de692363

**Electronically Signed**

Your name: James Hogan
Signed on: 11/15/2019