American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Massapequa Diagnostic Imaging PC (Applicant)	AAA Case No.	17-20-1163-9948
	Applicant's File No.	n/a
- and -	Insurer's Claim File No.	808675-GH
	NAIC No.	23760
Nationwide Insurance Company (Respondent)		

ARBITRATION AWARD

I, Preeti Priya, 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: Assignor [NT]

1. Hearing(s) held on 09/23/2020
   Declared closed by the arbitrator on 09/23/2020

   Anna Goldman, Esq., from Law Office of Anna Goldman P.C. participated by telephone for the Applicant

   Ivy Cherian, Esq., from The Law Office Of Kevin J. Philbin participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **$ 674.47**, 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 Applicant established entitlement to No-Fault compensation for fees associated with ultrasound tests performed upon Assignor;

   Whether Respondent established that Applicant billed in excess of the New York Workers' Compensation Chiropractic fee schedule.

4. Findings, Conclusions, and Basis Therefor

Applicant was represented by Anna Goldman, Esq., who presented oral arguments and relied upon documentary submissions. Ivy Cherian, Esq., represented Respondent and presented oral arguments and relied upon documentary submissions. I have reviewed the submissions contained in the American Arbitration Association's ADR Center. These submissions are the record in this case.

The dispute arises from the underlying automobile accident of April 1, 2019, in which the Assignor, a 62 year old male, was a driver. Thereafter, Assignor was evaluated by John Milone, DC. On June 12, 2019 ultrasound tests were performed. Applicant submitted the claims for ultrasound testing performed on July 12, 2019 to Respondent. Respondent partially paid and denied the remainder of the claims.

After reviewing the records, I find that Applicant established its prima facie case of entitlement to No-Fault compensation. See Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004).

The rates charged by Applicant must be in accordance with Insurance Law § 5108. The services in dispute were performed subsequent to the effective date, April 1, 2013, of the Fourth Amendment to Regulation 68-C. Sub division (g) (1) of No-Fault Regulation 65-3 now states that proof of fact that the amount of loss sustained pursuant to Insurance Law section 5106(a) shall not be deemed supplied by an applicant to an insurer and no payment shall be due for claimed medical services under any circumstances: (i) when the claimed medical services were not provided to an injured party; or (ii) for those claimed medical services that exceed the charges permissible pursuant to Insurance Law sections 5108(a) and (b) and the regulations promulgated thereunder for services rendered by medical providers.

I take judicial notice of the New York Workers' Compensation fee schedule. See Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co., 61 A.D.3d 13, 20 (2d Dept. 2009); LVOV Acupuncture, P.C. v. Geico Ins. Co., 32 Misc.3d 144(A), 2011 NY Slip Op 51721(U) (App Term 2d, 11th & 13th Jud Dists. 2011); Natural Acupuncture Health, P.C. v. Praetorian Ins. Co., 30 Misc.3d 132(A), 2011 NY Slip Op 50040(U) (App Term, 1st Dept. 2011).

Applicant billed using CPT codes 76536, 76856 and 76881. CPT code 76856 is defined as ultrasound, pelvic (nonobstetric), CPT code 76536 defined g ultrasound soft tissue of head and neck (e.g. thyroid, parathyroid, parotid), and code 76881 defined as nonvascular extremity ultrasound real time with image documentation.

Respondent submitted an Affidavit by Russell Arnold, CPC-P designation, (Certified Professional Coder). Mr. Arnold stated he has "reviewed Applicant's AR-1 submission and billing received relative to the above matter, and same was improperly billed to NATIONWIDE."

He stated "Applicant billed CPT Code 76881-TC-RT for services allegedly rendered on June 12, 2019 in the amount of $235.94. Applicant improperly billed this service. Based on the 34th Amendment to Regulation 83 (11NYCRR 68) section 68.1(a)(2)(ii)(a), General Ground Rule 10 in the Workers' Compensation Chiropractic Fee Schedule set

forth in 12NYCRR 34 8 shall apply to all charges for health services performed on or after…. The ground rule states "a Chiropractor may only use CPT codes contained in the Chiropractic Fee Schedule for billing treatment." CPT Code 76881-TC is not a listed code within the Chiropractic Fee Schedule. As such, Applicant is not entitled to reimbursement for this service as it is not covered under New York No-Fault." He noted "" CPT Code 76856-TC is not a listed code within the Chiropractic Fee Schedule. As such, Applicant is not entitled to reimbursement for this service as it is not covered under New York No-Fault. The use of modifier -59 does not negate this rule." He discussed all of the codes used by Applicant.

He opined "That based on my review of Applicant's invoice totaling $674.47, NATIONWIDE was overbilled. The aforementioned bill should have totaled $0.00 as outlined above." Respondent met its burden to come forward with competent evidentiary proof to support its fee schedule defense Robert Physical Therapy, P.C. v. State Farm Mut. Ins. Co., 13 Misc 3d 172 (Civ.Ct. Kings Co.2006).

Once the insurer makes a prima facie showing that the amounts charged by a provider were in excess of the fee schedule, the burden shifts to the provider to show that the charges involved a different interpretation of such schedule or an inadvertent miscalculation or error. Cornell Medical, P.C. v. Mercury Casualty Co., 24 Misc.3d 58, 884 N.Y.S.2d 558 (App. Term 2d, 11th & 13th Dists. 2009).

Applicant submitted an Affidavit by John Milone, DC, in support of the billing. It is his "personal knowledge that to contain the cost of providing medical services to patients treated under NY No-Fault law, the legislature set limits on the fees health care providers may charge patients who sustain injuries by incorporating into the no-fault scheme the fee schedule established by the Worker's Compensation Board. The fee schedule is divided into sections; each section lists a variety of medical procedures and assigns to each procedure a number known as a "CPT code". When the procedure billed are not listed under the applicable fee schedule, I shall establish a fee consistent with other fees for comparable procedures shown in such schedule."

He reviewed the NF-10 and disagreed "with carrier's reimbursement of the bills." He explained "According to NYS Workers Compensation Fee Schedule Radiology Section, Region IV CPT Code 76536, 76881, 76856, 76881 with TC component should be billed as is follows….that most radiology codes, including ultrasounds. x-rays, CT scans, magnetic angiography and MRI's may be billed with modifier 26 or TC meaning they can be billed separately. Additionally, they may be billed with no modifier at all, indicating that the provider performed both the professional and technical services."

Respondent's Counsel argued that that the disputed ultrasound services billed under CPT codes 76536, 76881, and 76856 are not reimbursable because these codes are not listed in the Chiropractic Fee Schedule. She maintained that Respondent properly denied reimbursement of Applicant's claims based on New York Workers' Compensation Chiropractic Fee Schedule Ground Rule#10 which went into effect on April 1, 2019.

Ground Rule 10 states "A chiropractor may only use CPT codes contained in the Chiropractic Fee Schedule for billing of treatment. A chiropractor may not use codes that do not appear in the Chiropractic Fee Schedule."

Applicant's counsel countered that Chiropractic Ground Rule 10 does not apply in this case because a chiropractor is authorized to perform ultrasound services. She explained that the Chiropractic Fee Schedule lists CPT code 76999 that can be used for billing of ultrasound services. She contended that in this case where the Applicant billed improperly, the Applicant should be paid under CPT code 7699. She stated that the Respondent did not deny the claim for lack of medical necessity of the ultrasounds and that a chiropractor is licensed to perform ultrasounds. She argued that the billed CPT codes should be paid under CPT code 76999.

Applicant's counsel also relied upon two awards by Arbitrator Heidi Obiajulu with AAA case numbers 17-20-1159-3940 and 17-20-1159-3745. In both cases, Applicant's counsel presented similar arguments to Arbitrator Obiajulu as she did before me. Arbitrator Obiajulu found "that the purpose of Chiropractic Ground Rule#10 is to prevent a chiropractor from billing for a service that he or she is not authorized to perform. It's undisputed that the applicant would have been reimbursed for ultrasounds if it billed under CPT code 76999." She was "persuaded that the proper approach, in this case, is to crosswalk the billed CPT codes to CPT code 76999 and assign RVUs." She also found "e sole evidence in the record regarding the assignment of RVUs is the fee audit by Matthew D. Kenyon, CPC. A review of his fee audit reveals that he determined that regarding the spinal ultrasounds, the RVU of 76800 should be used and that the technical component would be $110.70 [arrived at by multiplying 5.56 times $36.20 (the radiology conversion factor), which equals $201.27 at 55%]…." She held "in favor of the applicant in the amount of $153.74."

In the case before me, Mr. Arnold does not present an amount to be paid nor does he reference CPT code 76999. This important fact is distinguishable from the decisions rendered by Arbitrator Obiajulu. Further, I have consistently held that any codes billed with the "by report" designation, as here, must meet the requirements listed in the Fee Schedule.

Under New York State Workers' Compensation Chiropractic, Fee Schedule General Ground Rules, 2, 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 chiropractor 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" unit values to ensure that the relativity consistency is maintained. The general conditions and requirements of the General Ground Rules apply to all "BR" items."

A "by report" claim requires Respondent to assess the claim in accordance with the "report" that is submitted with the bill. Applicant did not comply with the requirements of the Fee Schedule. Since the Applicant failed to substantiate the time spent, the skill and equipment used, and the amount that it had billed with the report.

Even if I were to "crosswalk the billed CPT codes to CPT code 76999", I would not be able to award an amount as Mr. Arnold and Respondent have not listed an amount. Further, Dr. Milone's Affidavit discusses using CPT codes found outside of the Chiropractic Fee Schedule. He knows that "the legislature set limits on the fees health care providers may charge" and still he charges outside of the Chiropractic Fee Schedule using CPT codes that are for MD designation. Applicant did not meet its burden "to show that the charges involved a different interpretation of such schedule or an inadvertent miscalculation or error". See Cornell Medical, P.C. v. Mercury Casualty Co., *ID*. Dr. Milone did not calculate the amounts using the Chiropractic Fee Schedule. Further his Affidavit is conclusory. I find the evidence weighs in favor of Respondent.

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 New York

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

09/24/2020
(Dated)

Preeti Priya

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:
2e19987be0e1470bc9f5862af430ba90

Electronically Signed

Your name: Preeti Priya
Signed on: 09/24/2020