American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Molnar Medical Services PC (Applicant)	AAA Case No.	17-19-1134-1372
	Applicant's File No.	AF19-107901
- and -	Insurer's Claim File No.	0462379530101053
	NAIC No.	22055
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Debbie Thomas, 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

1. Hearing(s) held on 03/02/2021
   Declared closed by the arbitrator on 03/02/2021

   Cliff Ryan from Abrams, Fensterman, Fensterman, Eisman, Formato, Ferrara, Wolf & Carone LLP participated in person for the Applicant

   Naela Hasan from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 445.70**, was AMENDED and permitted by the arbitrator at the oral hearing.

   Counsel for Applicant amended the amount claimed to $200.68, withdrawing the bills for date of service 2/28/19.

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

3. Summary of Issues in Dispute

   Applicant seeks reimbursement in the amended amount of $200.68 for Activity Limitation Measurement and Training ("ALMT") performed on March 7, 2019 on Assignor, D.S., a 32-year-old male who was the driver of a motor vehicle involved in an accident on January 5, 2019. Respondent partially paid the claim and denied the balance,

alleging that Applicant had billed in excess of the applicable fee schedule. The issue presented is whether Respondent properly reimbursed Applicant for the testing performed.

4. Findings, Conclusions, and Basis Therefor

The within award is based upon this arbitrator's review of the record as well as oral argument at the time of the hearing of this matter.

Under Sec. 5102 of the New York Insurance Law (McKinney 1985), No-Fault first party benefits are reimbursement for all medically necessary expenses on account of personal injuries arising out of the use or operation of a motor vehicle.

It is well settled that a healthcare provider establishes its *prima facie* entitlement to No-Fault benefits as a matter of law by submitting evidentiary proof that the prescribed statutory billing forms had been mailed and received and that payment of No-Fault benefits were overdue. *Westchester Medical Center v. Lincoln General Insurance Company*, 60 A.D.3d 1045, 877 N.Y.S.2d 340 (2 Dept. 2009); *see also Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). Respondent's denial indicating receipt of the proof of claim shows that Applicant mailed the proof of claim forms to the Respondent (*see, Ultra Diagnostic Imaging v. Liberty Mutual Insurance Co*., 9 Misc.3d 97). The evidence is sufficient to make out a *prima facie* case of entitlement to recovery of Applicant's bill.

Once Applicant has made out a *prima facie* case, the burden shifts to Respondent to timely request additional verification, deny, or pay the claim. *Hospital for Joint Diseases v. Travelers Prop. Cas. Ins. Co*., 9 NY3d 312 (2007). Respondent maintains the charges in dispute are in excess of or not in accordance with the applicable fee schedule.

Applicant billed $475.00 under CPT Code 97799 for Activity Limitation Measurement performed on March 7, 2019. Respondent changed Applicant's BR Code of 97799 to 97750 for Physical Performance Testing ("PPT") which is billed in units of time, and reimbursed Applicant for 6 units of testing in the amount of $274.32, leaving an unpaid balance of $200.68. Respondent did not submit a fee audit or an affidavit by a certified professional coder in support of its defense.

Arbitrator Mereyem Toksoy addressed the same fee schedule defense in AAA Case No. 17-18-1100-3464. Arbitrator Toksoy's award states in relevant part:

> Applicant seeks to be reimbursed for "Activity Limitation Measurement and Training" that was performed on 07-24-17. The record reflects that this service was billed in the amount of $475.00 under CPT 97799.

It also shows that Respondent issued partial payment in the amount of $249.96, thereby leaving a balance of $225.04.

CPT 97799 is a By Report (BR) code which is listed in the Physical Medicine section of the Medical Fee Schedule. It is described as:

> Unlisted physical medicine/rehabilitation service or procedure.

By Report (BR) codes do not have assigned Relative Value Units (RVUs). A provider who intends to submit a claim for an unlisted service must:

Submit records that adequately explain the service; and
Assign a value that is relatively consistent with other codes listed in the fee schedule(s).

These two requirements are set forth under the General Ground Rule for By Report (BR) items:

> Procedures Listed Without Specific 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 [chiropractor] shall establish a relative value unit consistent in relativity with other value units shown in the schedule. The insurer shall review all submitted "BR" unit values to ensure that relativity consistency is maintained. The general conditions and requirements of the General Ground Rules apply to all "BR" items.
> - See NY Workers' Compensation Medical Fee Schedule, Introduction & General Guidelines, General Ground Rule 3;
> - See NY Workers' Compensation Chiropractic Fee Schedule, Introduction & General Guidelines, General Ground Rule 2.

Respondent asserts that the appropriate code to use for the claimed service is CPT 97750.

I agree. This code is located in the Physical Medicine section of the Medical and Chiropractic Fee Schedules. It is defined as:

Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes.

My decision accounts for the following:

The procedure report for the testing performed on 07-24-17. On the first page of the report, it states:

> NIOSH Static Strength Testing
> The examinee was tested using the JTECH computerized static strength evaluation system and standard lift evaluation protocols outlined by NIOSH in the Work Practices Guide for Manual Lifting, 1981. The examinee's NIOSH population percentile is determined by comparing lift strength results with published norms with the 50th percentile indicating the average for the patient's gender. NIOSH has determined a minimum of the 25th percentile should be demonstrated for the worker to safely perform that type of lift on the job.

The description clearly indicates that Applicant performed computerized muscle strength testing on the assignor. It also shows that Applicant carried out this service according to protocols outlined in a guide published by the National Institute for Occupational Safety and Health (NIOSH). The remainder of the report displays the assignor's muscle strength in different anatomic regions.

In the following CPT Assistant article, the American Medical Association advises that computerized muscle testing should be reported under code 97750:

> *Physical Performance Test or Measurement (97750):*
> Code 97750, Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes, describes tests and measurements performed by a physician or other qualified health care professional. Testing may be manual and/or performed using equipment. Examples include isokinetic testing, functional capacity testing, timed up and go test, dynamic gait index, and computerized muscle testing. Standardized testing batteries may be incorporated into a physical performance test. Elements involved in physical performance tests or measurements, as reported by code 97750, include the test or measurement procedure itself, as well as time required to analyze and interpret the resulting data while the patient is present. Code 97750 is time based. Documentation of the following time elements will assist in supporting the number of units billed for this procedure.

Total time spent with the patient in providing the test and measurement, including the time spent preparing the patient for the test and measurement procedure.

The time spent performing the selected protocol.

The time spent with the patient in providing any post-testing instructions.

The descriptor for code 97750 may be reported on the same date of service as an E/M service or a physical therapy and occupational therapy evaluation/re-evaluation. Documentation should support the need for the physical performance test or measurement to be done on the same date of service as physical or occupational therapy evaluation/re-evaluation, as well as a separate written report stating the findings, as described above.

The article also includes a section where the AMA responds to inquiries:

Commonly Asked Questions:
Question:
When is it appropriate to report code 97750, Physical performance test or measurement, manual muscle testing (95831-95834), and/or range of motion testing (95851-95852)?

Answer:
If the intent of the physician or qualified health care provider is to perform a range of motion and/or manual muscle test (eg, to compare the right and left sides) as a separate procedure, it would be appropriate for the provider to choose the appropriate codes from the 95831-95852 series. For example, a patient with a lower motor neuron disease (eg, post-polio syndrome or Guillain-Barre syndrome) presents with weakness of isolated muscle groups. The provider will want to identify any restrictions in passive and active range of motion as well as specific muscles that are weak. The provider will use this information to establish a treatment plan that will positively impact identified impairments. If the provider instead determines that it is appropriate to measure and test the patient's physical performance during specific activities, then code 97750 is the appropriate service to report.
Question:
What are the appropriate components of documentation that will support the use of code 97750?
Answer:
When reporting code 97750, the physician or other qualified health care professional is required to have a separate written report noting the findings. The provider should include the reason for performing the test or measurement, identification of any protocol or standardized test that was used, data that were collected, direct contact time spent with the patient, and analysis of the findings.
Question:
Can manual muscle testing (95831-95834), range of motion testing (95851-95852), and physical performance test and measurement (97750) be performed on the same date of service?
Answer:
No. Codes 95851, Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine), and 95831, Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk, are designated in the code

descriptors as separate procedures. Codes designated as separate procedures should not be reported in addition to the code for the total procedure or service for which they are considered an integral component. In this case, because range of motion testing (95851) and manual muscle testing (95831) may be performed as part of a physical performance test or measurement (eg, musculoskeletal or functional capacity), only code 97750 should be reported. Codes 95851 and 95831 should not be reported separately because both services are designated as separate procedures and, as such, would be considered integral components of a physical performance test.

Question:

How is computerized muscle testing reported?

Answer:

Computerized muscle testing should be reported using code 97750. A separate written report is required. Only direct patient contact time is reported.

This article can be found in:

CPT Assistant, Manual Muscle Testing, Range of Motion Testing, and Physical Test or Measurement, May 2008; Volume 18: Issue 5.

I note that CPT Assistant is a source which must be considered when evaluating a claim for No-Fault benefits. See Matter of Global Liberty Ins. Co. v. McMahon , 172 A.D.3d 500, 99 N.Y.S.3d 310, 2019 NY Slip Op 03692 (App. Div., First Dept., May 9, 2019).

I have also considered the following explanation offered by the Applicant to justify its use of CPT 97799 for the claimed services:

Activity Limitation Measurement and Training Report (billed as 97799)

Activity limitations are difficulties an individual may have in the performance of daily activities - both at work and domestically. Such limitations must be actually observable, and are rated regardless of capacity or aptitude. Several additions and qualifiers to activity limitations are: activity limitations involve the integrated use of body functions at the individual level; activity limitations involve qualitative or quantitative alterations in the way an activity is performed in relation to reduce or eliminate an activity limitation, through an underlying impairment (of body function or structure) if applicable.

Purpose of activity limitation test is to accurately determine individual's ability to perform meaningful tasks safely and dependably. It is based on objective performance measurements that are analyzed and recorded by state of the art computer technology. It is not an observation or subjective determination of an individual's self-report of abilities.

Results of the test will serve three valuable purposes:

Test will identify functional weakness and strength deficits, allowing for proper treatment and rehabilitation.

Test aids in establishing an impartial and objective measurement of the patient's capabilities, daily activities and work limitations, necessary for judicial resolution, disability determination and treatment progress determination.

Test provides the patient with objective and quantifiable limitations he/she faces as a result of the injury. Establishing safe activity limits and training are aimed at determination of limitation and outlining the precautions to be taken not to aggravate the injury.

The patient was tested using JTech computerized evaluation system. Coefficient of Variation and difference between successive reps of 14% or less indicates validity, reproducibility and consistency of effort.

Depending on the level of patient's compliance, the examination takes 40-55 minutes.

In addition to testing, patient received a comprehensive training as to how to deal with the limitation in both work and home environments. Patient received written and verbal instructions as to how to avoid aggravating the injury and what steps need to be taken outside of a formal medical setting in order to facilitate recovery.

After extensive review of the Workers' Compensation Fee Schedule, the only proper CPT code to be used for the procedure is 97799. Activity Limitation Measurement and Training is a combination of both testing patient's physical abilities and limitations, but also it integrates a training component which provides the patient with necessary tools to deal with the said limitations and to prevent aggravation of the injury. There is no code in the fee schedule which would reflect the abovementioned components.

To determine the value of a "BR" code, one must review the instructions for unlisted codes under General Ground Rule 2 and 3. In order to consider a proper amount to be billed, we considered the following codes that do have specific RVU listed in the Fee Schedule.

97750 - Physical Performance Testing - each 15 minutes - 5.41 [RVUs]
97545 - Work hardening/conditioning - 28.00 [RVUs]
97800 - Functional Capacity Evaluation - $500

In comparing the codes, activity limitation measurement and training is most similar to Functional Capacity Evaluation. However, it may not be billed under 97800 since ALM&T has a wider purpose and application than Functional Capacity Evaluation. FCE only evaluates patients limitation as they apply in determination of work limitations and ALM&T also includes evaluation of any restrictions patient may have in day to day activities. In addition, FCE does not have the training component, present in ALM&T. Presence of training component is not simply an addition of unrelated procedure. Training is an extension of the testing and is an integral and necessary part of ALM&T evaluation. Therefore, ALM&T should have a greater RVU value than Functional Capacity Evaluation.

In addition to looking at the RVU of similar codes, we also looked at the amounts charged for this procedure by other medical professionals in our geographic area. According to review of recent American Arbitration

Association awards and NY Civil Court decisions, we determined that the overwhelming majority of the providers are charging $475 for performing ALM&T.
After taking in consideration both value of Functional Capacity Evaluation and other similar codes, and the prevailing rate charged by the providers in our geographic area, we determined that the proper amount to bill for this procedure is $475.

I do not find this explanation to be credible.

The services reported under By Report code 97799 are neither similar to a Functional Capacity Evaluation nor are they more comprehensive.

I note that Ground Rule 14 of the Physical Medicine section of the Medical Fee Schedule pertains to Functional Capacity Evaluations. A provider who intends to report this service must satisfy the numerous requirements listed in the ground rule.
The provision states:
Functional Capacity Evaluations:

Indications:

The FCE is utilized for the following purposes:

- To determine the level of safe maximal function at the time of maximal medical improvement.
- To provide a prevocational baseline of functional capabilities to assist in the vocational rehabilitation process.
- To objectively set restrictions and guidelines for return to work.
- To determine whether specific job tasks can be safely performed by modification of technique, equipment, or by further training.
- To determine whether additional treatment or referral to a work hardening program is indicated.
- To assess outcome at the conclusion of a work hardening program.

General Requirements:

- The FCE may be prescribed only by a licensed physician in New York state, or may be requested by the carrier when indicated.
- The FCE does not require prior authorization by the carrier.
- The attending physician must justify the indication for each at the request of the carrier (see Eligibility Criteria).
- The FCE shall be performed by a physical or occupational therapist currently holding a valid license in New York state, or other licensed provider

qualified by scope of practice. Constant supervision by the licensed provider is required.

Specific Requirements:

The FCE, when medically necessary and indicated, may be performed only at the point of maximum medical improvement in the opinion of the attending physician.

The FCE should not be prescribed prior to three (3) months post-injury unless there is a significant documented change in the claimant's status which justifies earlier utilization.

At least one of the following eligibility criteria is required for all claimants:

Claimant is preparing to return to previous job.

Claimant has been offered a new job (verified).

Claimant is working with a rehabilitation provider and a vocational objective is established.

Claimant is expected to be classified with a non-schedule permanent partial disability.

Reports will include the following information:

Patient demographics including work history.

Indication for evaluation.

Type of evaluation performed.

Raw and tabulated data.

Normative data values.

Narrative cover sheet with recommendations.

The bill for services provided must be attached to the report to be processed by the carrier.

All evaluation tools must be standardized, and normative data and interpretative guidelines must be attached to the report.

Charges for psychometric testing performed as part of the FCE by providers other than psychologists or psychiatrists are inclusive and may not be billed separately.

Testing and/or treatment provided by licensed psychologists or psychiatrists must be performed in accordance with the Psychology or Medicine fee schedules, and should be billed separately.

If a provider satisfies these requirements, he/she is entitled to the fee schedule allowance for the respective region of the state where the service was performed. The rates are listed at the end of Ground Rule 14:

Region I: $378.00
Region II: $400.00
Region III: $455.00
Region IV: $495.00

In this case, Applicant has not offered any proof to demonstrate that the claimed services are similar to a Functional Capacity Evaluation.

There is also no evidence to support the argument that the claimed services must be reported under CPT 97799 because they have a "wider purpose and application."

The record simply shows that Applicant performed computerized muscle testing; and in view of the documents referenced above, reimbursement must be calculated according to CPT 97750.
CPT 97750 is a time-based code which has been assigned 5.41 Relative Value Units (RVUs).
Generally speaking, the rate of reimbursement for a service is calculated by multiplying the Relative Value Units (RVUs) by the applicable Conversion Factor. The Conversion Factor is based on the provider's licensing status (e.g., physical therapist, medical doctor) and the region where the service was performed.

With respect to the instant claim, the record reveals that Applicant is a physical therapist located in Region IV.

Applying the formula to the facts of this case results in a fee of $41.66 for one unit (15 minutes) of testing.

5.41 Relative Value Units x $7.70 Conversion Factor = $41.66

By Applicant's own admission, the time needed to perform the testing ranges from 40-55 minutes. See above, i.e., "Activity Limitation Measurement and Training Report (billed as 97799)."

Using the maximum length (55 minutes) and accounting for four (4) units, the total eligible fee equates to $166.64.

$41.66 x 4 units (1 hour of testing) = $166.64.

In this case, the evidence shows that Respondent paid $249.96 for the testing, which is the equivalent of six (6) units (90 minutes of testing).

Given the record and for the reasons stated here, I find that Applicant is not entitled to any further reimbursement.

I agree with the detailed and thorough award of Arbitrator Toksoy and find that the Activity Limitation Measurement and Testing performed here was properly reimbursed as Physical Performance Testing. Although Respondent did not submit a fee audit or fee coder affidavit in support of its defense, the ALMT report submitted by Applicant here is identical to the one submitted in the matter before Arbitrator Toksoy. This report indicates that the test takes 40-55 minutes, depending on the level of the patient's compliance.

While I have previously held that Respondent cannot change an Applicant's CPT code to a time-based code without asking the Applicant how much time it spent performing the test, the facts of this case differ in that Applicant states in its report that this test takes 40-55 minutes, which would account for a maximum of 4 units of 97750, one of the codes that Applicant, in its reports, indicates resembles the testing performed herein. Respondent reimbursed Applicant for 6 units, two units more than what Applicant admits it generally takes to perform this test. Therefore, I find that Respondent had a rational reason to apply CPT code 97750 and also to reimburse 6 units of that code. Accordingly, I find for Respondent. Applicant is not entitled to additional reimbursement for ALMT performed on March 7, 2019. *See also* AAA Case No. 17-17-1080-0191 (Arbitrator Phillipson) and AAA Case No. 17-19-1119-0312 (Arbitrator Vilar).

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 Nassau

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

03/08/2021
(Dated)

Debbie Thomas

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
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Your name: Debbie Thomas
Signed on: 03/08/2021