

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Progressive Medical Care, PC
(Applicant)

- and -

State Farm Fire & Casualty Company
(Respondent)

AAA Case No. 17-19-1136-7107

Applicant's File No. CF13006889

Insurer's Claim File No. 32-7505-R67

NAIC No. 25143

ARBITRATION AWARD

I, Mitchell Lustig, 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 03/24/2021
Declared closed by the arbitrator on 03/24/2021

Tinamarie Franzoni, Esq. from Choudhry & Franzoni, PLLC participated in person for the Applicant

Joe Licata, Esq. from Rossillo & Licata LLP participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 4,301.36**, 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 properly reduced the Applicant's bills in accordance with the fee schedule?

4. Findings, Conclusions, and Basis Therefor

In dispute is Applicant Progressive Medical Care, PC's claim as the assignee of a 28-year-old male injured in a motor vehicle accident on January 19, 2019, for

reimbursement in the sum of \$4,301.36 for trigger point impedance imaging (TPII) and localized intensive neurostimulation treatments (LINT) performed by Dr. Allan Hausknecht on May 7, 2019 and May 24, 2019.

The amount in dispute represents the difference between the amount billed by the Applicant (\$4,910.00) and the amount reimbursed by the Respondent (\$608.64).

The Respondent denied the claim based upon the grounds that the Applicant's bills were in excess of the Workers' Compensation Fee Schedule.

I have reviewed the documents contained in the ADR Center. This decision is based upon the submission of the parties and the arguments made by the parties at the hearing.

It is well settled that a health care 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 (2nd Dept. 2009); Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). I find that the Applicant has established a prima facie case.

WHETHER THE INSURER HAS PROVEN THAT THE BILLING FOR THE DISPUTED SERVICES WAS IN EXCESS OF THE FEE SCHEDULE

An insurance carrier's timely asserted defense that the bills submitted were not properly no-fault rated or that the fees charged were in excess of the Workers' Compensation Fee Schedule is sufficient, if proven, to justify a reduction in payment or denial of claim. New York Hosp. Med. Ctr. Of Queens v. Country-Wide Insurance Company, 295 A.D.2d 583, 744 N.Y.S.2d 201 (2nd Dept. 2002); East Coast Acupuncture, P.C. v. New York Central Mutual Insurance, 18 Misc.3d 139(A), 2008 N.Y. Slip Op. 50344(U) (App. Term 2nd and 11th Jud. Dists. 2008); A.B. Medical Services, PLLC v. American Transit Insurance Company, 15 Misc.3d 132(A), 2007 N.Y. Slip Op. 50680(U) (App. Term 2nd and 11th Jud. Dists. 2007).

The insurer has the burden of coming forward with "competent evidentiary proof" to support its fee schedule reduction or denial. See, e.g., Robert Physical Therapy, P.C. v. State Farm Mutual Automobile Insurance Company, 13 Misc.3d 172, 3006 N.Y. Slip Op. 26240 (N.Y. Civ. Ct. Kings Co. 2006).

In the absence of such proof, a defense of noncompliance with the appropriate fee schedule cannot be sustained. Continental Medical, P.C. v. Travelers Indemnity Company, 11Misc,3d 145(A), 2006 N.Y. Slip Op. 50841(U) (App. Term 1st Dept. 2006).

The defense of fees not being in accordance with the fee schedule must be rejected where the insurer fails to address how the amount charged by the provider was in excess of the fee schedule. See e.g., Jesa Medical Supply, Inc. v. Geico Ins. Co., 25 Misc.3d 1098, 2009 N.Y. Slip Op. 29386 (N.Y. Civ. Ct. 2009).

In support of its contention that the Applicant billed in excess of the fee schedule, the Respondent submitted a fee Affidavit from its Certified Fee Coder, Matthew Kenyon. In his Affidavit, sworn to on February 19, 2020, Ms. Kenyon stated that the Applicant was entitled to the sum of \$41.40 for each date of service for a total amount of \$82.80.

Specifically, the Applicant billed CPT Code 995999 and 99199 for each date of service.

In his Affidavit, Mr. Kenyon noted as follows:

"The provider has reported CPT codes 95999 and 99199. None of these CPT codes have RVUs assigned. The provider did however include an affidavit by Lorena Villalobos CMC Dated 12/20/2018.

In the affidavit Lorena Villalobos CMC explains the provider's evaluation of the unlisted procedure. The basis for an evaluation however makes no mention at all to the Official New York State Workers' Compensation Medical Fee Schedule which must be applied here for reimbursement as a matter of law. Lorena Villalobos CMC states that 34.8 RVUs are to be paid for the "Impedance Imaging" and references as a comparable to "Thoracic and Lumbar MRIS" as the basis for relative RVUs.

Per NY WC Medical Fee Schedule, General Ground Rules #3: "for any procedure where the unit value is listed in the schedule as 'BR', the physician shall establish a unit value consistent in relativity with other unit values shown in the schedule." Lorena Villalobos CMC has not established a unit value consistent in relativity with other unit values shown in the schedule. Lorena Villalobos CMC states that 37.71 RVUs are to be paid for the "Neurostimulation Treatment" and references comparable to 70% anesthesia and 30% treatment. Once again, Per NY WC Medical Fee Schedule, General Ground Rules #3: "for any procedure where the unit value is listed in the schedule as "BR", the physician shall establish a unit value consistent in relativity with other unit values shown in the schedule." Lorena Villalobos CMC has not established a unit value consistent in relativity with other unit values shown in the schedule.

Furthermore, when the RVUs provided by Lorena Villalobos CMC are divided by the billed amounts, the result should establish the conversion factor applied for the geographical location of the services rendered in accordance with the NY WC Medical Fee Schedule.

"Impedance Imaging" and references as a comparable to "Thoracic and Lumbar MRIS"

$$1915/34.8 = 55.0287356$$

This result (conversion factor 55.0287356) is not indicative of any conversion factor listed in the NY WC Medical Fee Schedule.

"Neurostimulation Treatment" and references comparable to 70% anesthesia and 30% treatment. $37.71 @ 70\% = 26.397$

$$540 @ 70\% = 378$$

$$378/26.397 = 14.31$$

After analyzing the valuation made by Lorena Villalobos CMC, I strongly disagree and stand firm by my valuation for the services rendered.

Regarding CPT code 99199 (Unlisted special service, procedure or report)

Based on the medical documentation and research performed, the provider is performing TENS (Transcutaneous electrical nerve stimulation) to the patient using the Nervomatrix Soleve Noninvasive Target Stimulation device for 30 minutes per session.

Research was done to determine what the Nervomatrix Soleve Noninvasive Target Stimulation device is used for when treating the patient in order to make a determination what the correct CPT code should be.

Based on the Pain in Motion International Research Group randomized controlled trial for the electrical stimulation therapy of trigger points (www.painphysicianjournal.com), the Nervomatrix Soleve Noninvasive Target Stimulation device is used to locate trigger points through skin resistance and provide transcutaneous electrical nerve stimulation TENS to lower back muscles (trigger points).

Further, more the FDA Approval K100668 for Nervomatrix Ltd. NeMa-st device, model v1.0.2 is for TENS for pain relief. (See attached)

The provider has incorrectly reported CPT code 99199.

Based on the medical documentation and research performed, the correct CPT code to report is CPT code 97039 BR "By Report Code" (Unlisted modality (specify type and time if constant attendance))

Per NY WC Medical Fee Schedule, General Ground Rule's #3: Procedures listed without Specified Unit Values, 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 unit values. Fees for each procedure 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... for any procedure where the unit value is listed in the schedule as "BR", the physician shall establish a unit value consistent in relativity with other unit values shown in the schedule. The insurer shall review all submitted "BR" unit value to ensure that the relativity consistency is maintained..."

Based on the above research, and medical documentation, the RVU value that would be consistent in relativity with the services rendered would be for CPT code 97032 (Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes)

Formula: 2.45 (RVUs for CPT code 97032) X \$8.45 (Physician Region 4 Physical Medicine Conversion Factor) = \$20.70 X 2 Units (30 minutes of treatment) = 41.40.

Regarding CPT code 95999 (Unlisted neurological or neuromuscular diagnostic procedure)

Based on the medical documentation and research performed, the Nervomatrix Soleve Noninvasive Target Stimulation device first performed a diagnostic study to identify the locations of trigger points on the lower back documented as "Trigger point Impedance Imaging".

Further, more the FDA Approval K100668 for Nervomatrix Ltd. NeMa-st device, model v1.0.2 is for TENS for pain relief. (See attached)

Based on the Pain in Motion International Research Group randomized controlled trial for the electrical stimulation therapy of trigger points (www.painphysicianjournal.com), the Nervomatrix Soleve Noninvasive Target Stimulation device does not perform any actual imaging as all. The device mechanically uses its probes to assess "skin resistance" (as the probes of the device touch the skin's surface) to determine the location to apply TENS treatment. No actual imaging is being generated through any radiological instrumentation. The device probes are only touching the surface of the skin. Based on the "skin resistance", the device then applies TENS to those locations on the back.

Based on the above research, and medical documentation, the Official New York Workers' Compensation Medical Fee Schedule does not include CPT code(s) that would provide appropriate Relative Value Units to reimburse a Trigger Point Impedance Imaging through "skin resistance".

Typically, as part of the preservice associated with the application of TENS to a patient, the qualified health care provider would perform a pre-service assessment in order to determine the location of trigger points and apply TENS based on the outcome of that assessment. No additional reimbursing is warranted for this preservice as any preservice would be considered included in the TENS therapy.

Therefore, reimbursement for services performed using the Nervomatrix Soleve Noninvasive Target Stimulation device for 30 minutes of treatment is \$41.40"

In opposition, Applicant submitted a Letter dated December 20, 2018 from Lorena Villalobos, CPC. She states based upon comparable charges of other healthcare providers in the geographical area for TPII and numerous payments for TPII by other insurance companies, the appropriate amount billed is \$2,455.00 for medical doctors. The closest comparison, she argued, with regard to TPII is the "sum of the Thoracic and Lumbar MRIs visual anatomy," whose relative value units would "not add up to the diagnostic part of NVX." Nonetheless, in order to arrive at a CPT code closest in relativity, this comparison was used. Consequently, an RV of 34.8 was chosen. LINT, she explained, would most closely compare with trigger point injections, therefore an RV of 37.71 was chosen, which includes 70% anesthesia (RV 15.91) and treatment 30% (RV 21.8).

In addition, the Applicant submitted an "Independent Review and Opinion Summary from Health City dated December 27, 2018 asserting that Ms. Villalobos' letter dated December 20, 2018" appears to be in line with the services provided."

After careful consideration of the evidence, I find that Mr. Kenyon's fee Affidavit is more credible and persuasive than the Applicant's rebuttal evidence. Accordingly, the

Respondent's denials based upon the grounds that the Applicant billed in excess of the fee schedule are upheld. Since the Respondent already reimbursed the Applicant in the sum of \$608.67, which is more than allowed under Mr. Kenyon's fee Affidavit, I find that the Applicant is not entitled to any additional reimbursement.

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

03/26/2021
(Dated)

Mitchell Lustig

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:
c64af6d2a07e42429d0004506fc36060

Electronically Signed

Your name: Mitchell Lustig
Signed on: 03/26/2021