American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Wellness Physical Therapy Rehabilitation PLLC (Applicant)	AAA Case No.	17-19-1151-2327
	Applicant's File No.	57547
- and -	Insurer's Claim File No.	0545275125 2AP
Allstate Fire & Casualty Insurance Company (Respondent)	NAIC No.	29688

ARBITRATION AWARD

I, Glen Cacchioli, 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 05/11/2021
   Declared closed by the arbitrator on 05/11/2021

   Melinia Cardis, Esq. from Law Offices of Zara Javakov, Esq. P.C. participated for the Applicant

   James McNamara, Esq. from Law Offices Of Karen L. Lawrence participated for the Respondent

2. The amount claimed in the Arbitration Request, **$ 676.33**, 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 Assignor was involved in a motor vehicle accident on May 13, 2019. Following the accident Assignor underwent activity limitation measurement testing, range of motion testing, and muscle testing. Applicant billed Respondent for the testing. Respondent partially reimbursed Applicant contending applicant billed in excess of the fee schedule. As such the issue presented for this hearing is fee schedule.

4. Findings, Conclusions, and Basis Therefor

The case was decided on the documents contained in the ADR Center and the oral arguments of counsel. There were no witnesses.

On May 13, 2019 Assignor was involved in a motor vehicle accident. Subsequently Assignor came under the care and treatment of applicant's PC.

Applicant billed respondent for treatment rendered on May 22, 2019 and June 3, 2019 as follows: $357.57 for 9 units of manual muscle testing ($39.73 per unit) under code 95831 and $499.92 for 12 units of range of motion testing under code 95851 ($41.66 per unit); $475.00 for ALT under code 97799.

Respondent reimbursed Applicant $291.62 (7 units for range of motion testing at $41.66 per unit) contending reimbursement is limited to 7 units. The amount in dispute is $208.30.

Respondent reimbursed Applicant $114.58 for manual muscle testing changing the CPT Code to 95834. The amount in dispute is $242.99.

Respondent reimbursed Applicant $249.96 for ALT changing the CPT code to 97750. The amount in dispute is $225.04.

FEE DISPUTE

Effective April 1, 2013 11 NYCRR 65-3.8(g)(1) has been amended so that the application of the New York State Worker's Compensation fee schedule is no longer a precludable defense and no payment is due on those claims in excess of the fee schedule. Nonetheless, the insurer has the burden of proving that the fees charged were excessive and not in accordance with the Worker's Compensation fee schedule. *St. Vincent Medical Care PC v. Countrywide Insurance Company*, 26 Misc. 3d 146 (A), 907 NYS 2d 441 (App. Term 2d, 11th and 13th Dists. 2010). If an insurer fails to demonstrate by competent evidentiary proof that a medical provider billed in excess

of the appropriate fee schedule, its fee schedule defense cannot be sustained. *Continental Medical PC v. Travelers Indemnity Co.*, 11 Misc.3d 145A(App. Term, 1st Dept 2006); *Robert Physical Therapy, P.C. v. State Farm Mut. Auto. Ins. Co.*, 13 Misc. 3d 172 (Civ Ct Kings Co 2006).

Respondent has the burden of coming forward with competent evidentiary proof to support itsfee schedule defenses. See, Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 2006 NY Slip 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006). See also, Power Acupuncture PC v. State Farm Mutual Automobile Ins. Co., 11 Misc.3d 1065A, 816 N.Y.S.2d 700, 2006 NY Slip Op 50393U, 2006 N.Y. Misc. LEXIS 514 (Civil Ct, Kings Co. 2006). If Respondent fails to demonstrate by competent evidentiary proof that a plaintiff's claims were in

excess of the appropriate fee schedules, defendant's defense of noncompliance with the appropriate fee schedules cannot be sustained. See, Continental Medical PC v. Travelers Indemnity Co., 11 Misc.3d 145A, 819 N.Y.S.2d 847, 2006 NY Slip Op 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Term, 1st Dep't, per curiam, 2006).

Also see St. Vincent Medical Care, P.C. v. Country Wide Ins. Co., 2010 N.Y. Slip Op. 50488(U), 2010 WL 1063914 (App. Term 2d, 11th & 13th Dists. Mar. 19, 2010) where the Court held an insurer fails to establish the existence of an issue of fact with respect to a defense that fees charged were excessive and not in accordance with the Workers Compensation fee schedule in the absence of proof establishing the defense.

A decision for applicant should be awarded where respondent fails "to proffer sufficient evidence to establish as a matter of law the amounts charged for said claims were in excess of the amounts permitted by the fee schedule." Jesa Med. Supply Inc. v. GEICO Ins. Co., 25 Misc.3d 1098; 887 N.Y.S. 482 (Civ. Ct. Kings Co. 2009); Kingsbrook Jewish Medical Ctr. v. Allstate Ins. Co., AD3d, 2009 NY Slip Op 00351 (2d Dept. 2009).

Once the insurer makes a prima facie showing that the amounts charged by a provider were inexcess 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).*

I am permitted to take judicial notice of the Worker's Compensation fee schedule. Kingsbrook Jewish Medical Center the Allstate Insurance Company, 61 AD 3d 13 (2d Dept. 2009); LVOV Acupuncture PC v. Geico Insurance Company, 32 Misc. 3d 144 (A) (App. Term 2d, 11th and 13th Jud. Dists. 2011). Natural Acupuncture Health PC v. Praetorian Insurance Company, 30 Misc. 3d 132 (A), 2011 N Y slip op 50040 (U), (App. Term 1st Dept. 2011).

MANUAL MUSCLE TESTING AND RANGE OF MOTION TESTING

Respondent maintains the provider billed in excess of the New York Workers' Compensation Fee schedule with respect to CPT code 95831 and 95851.

MANUAL MUSCLE TESTING

According to the American Medical Association's CPT Assistant and the fee schedule, "The series of codes 95831-95834, Muscle testing, manual, are intended to report

manual test of muscles or muscle groups for strength based on grading scales. Codes 95831-95834 should be reported once for each extremity and/or once for the anatomical body part described within the code descriptor. It is not intended to be used for each muscle tested."

CPT 95831 provides for muscle testing manual (separate procedure) with report; extremity (excluding hand) or trunk. Applicant billed $39.73 under CPT 95831 for each muscle tested (9).

Respondent reimbursed Applicant $114.58 under CPT code 95834 contending "Payment has been adjusted to reflect allowance for total evaluation of a body including hands (95834)."

According to the American Medical Association's CPT Assistant and the fee schedule, "The series of codes 95831-95834, Muscle testing, manual, are intended to report manual test of muscles or muscle groups for strength based on grading scales. Codes 95831-95834 should be reported once for each extremity and/or once for the anatomical body part described within the code descriptor. It is not intended to be used for each muscle tested."

Where a fee code exists, encompassing MMT of the entire body (95833/95834), health care providers should not be entitled to obtain greater compensation than the amount permitted by simply billing for the same testing rendered to "multiple" parts of the body. Here, Applicant billed for 9 units at $39.73 (2 for the neck, 1 for the trunk, 6 for the shoulder). Respondent reimbursed Applicant 3 units in the amount of $114.58. Therefore, since Applicant billed in excess of the fee schedule by billing for each muscle tested as opposed to each extremity further reimbursement is not appropriate. Accordingly, this part of Applicant's claim is denied.

RANGE OF MOTION TESTING

*CPT 95851*provides for range of motion measurements and report (separate procedure); each extremity (excluding hand) of each trunk section (spine).

Applicant billed $41.66 under CPT 95851 for each muscle tested (12).

Respondent reimbursed applicant $291.62 for 7 units contending according to the New York State Worker's Compensation fee schedule, billing under code 95851 is limited to one unit for each extremity or each trunk section. Respondent offered no further explanation.

According to the American Medical Association's CPT Assistant and the fee schedule CPT 95851 allows for range of motion testing for each body part, not each muscle. Code 95851for each extremity (excluding hand) or each trunk section (spine) may be reported for each extremity (excluding hand) measured or for each trunk section measured (eg, cervical, thoracic, or lumbar).

Here, Applicant billed for 12 units therefore I find the provider did improperly bill for the treatment. CPT code 95851 allows for range of motion testing for each body part, not each muscle. As such applicant was entitled to bill and be reimbursed up to 7 units (7 times $41.66 = $291.62). Since respondent reimbursed applicant the correct amount Applicant is not entitled to additional reimbursement for range of motion testing. Accordingly, this part of Applicant's claim is denied.

ACTIVITY LIMITATION MEASUREMENT TEST

Applicant billed Respondent $475.00 under CPT Code 97799 (by report code/Activity Limitation Measurement Test) for date of service May 22, 2019. Respondent changed the code to CPT Code 97750 (physical performance test or measurement with written report, each 15 minutes) and reimbursed Applicant $249.96. The amount in dispute is $225.04.

Respondent fails to demonstrate by competent evidentiary proof that a plaintiff's claims were in excess of the appropriate fee schedules, defendant's defense of noncompliance with the appropriate fee schedules cannot be sustained. See, Continental Medical PC v. Travelers Indemnity Co., 11 Misc.3d 145A, 819 N.Y.S.2d 847, 2006 NY Slip Op 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Term, 1st Dep't, per curiam, 2006).

The definition of CPT codes requiring a determination of which CPT codes are appropriate under which circumstances must be made by a medical professional. A layperson is not qualified to evaluate or change the CPT codes when used by a health provider in its bills. See Abraham v. Country-Wide Ins. Co., 3 Misc.3d 130A (App. Term 2d dept. 2004. See also Summit Medical Services v. American International Ins. Co., NYLJ June 7, 2005, p.20 col.1, where the courts held that a claim's representative speculative conclusions as to the proper medical codes that should be used to describe a medical provider's services were insufficient for denial of a claim. See also Ying E. Acupuncture v. Global Liberty Ins. Co., 2008 NY Slip Op 51863 (U), where the court held that a person with relevant training and/or educational background was necessary to competently assess a medical procedure.

Respondent reimbursed Applicant under CPT Code 97750 contending "since range of motion testing (95851) and manual muscle testing (95831) are performed as part of a physical performance test or measurement (eg, musculoskeletal, functional capacity), only code 97750 should be reported. Codes 95851 and 95831 should not be separately reported, as both services are designated as separate procedures and, as such, are considered to be integral components of the physical capacity test (97750)."

In reviewing all the evidence, I find that respondent has failed by a preponderance of the evidence to establish that the applicant billed in excess of the applicable fee schedule. When the respondent intends to reduce the medical provider's fee, it needs to base that reduction on a proper peer review or affidavit by a person having sufficient expertise to establish their grounds for the fee schedule defense providing an explanation as to why the charges are best described by other billing codes. A claim examiner may not unilaterally change a CPT code and subsequently reduce or deny a claim without proper support. First Aid Occupational Therapy, PLLC v. Country-Wide Ins. Co., 26 Misc3d 135(A), 2010 N.Y. Slip Op. 50149(U) (App. Term 2d, 11 and 13 Jud. Dists. 2010). Here, since respondent did not submit any evidence by such expert, I find it failed to meet its burden of proof in establishing its defense. Accordingly, this part of applicant's claim is granted in the amount of $225.04.

CONCLUSION: Applicant is awarded $491.74 for all claims brought in this arbitration.

DECISION: PARTIAL AWARD IN FAVOR OF THE APPLICANT

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	Status
	Wellness Physical Therapy Rehabilitation PLLC	**05/22/19 - 05/22/19**	**$225.04**	**Awarded: $225.04**
	Wellness Physical Therapy Rehabilitation PLLC	**06/03/19 - 06/03/19**	**$208.30**	**Denied**
	Wellness Physical Therapy Rehabilitation PLLC	**06/03/19 - 06/03/19**	**$242.99**	**Denied**
Total			**$676.33**	**Awarded: $225.04**

B. The insurer shall also compute and pay the applicant interest set forth below. 12/23/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest is to be calculated from the date of filing of the AR-1 (12/23/19). The end for the calculation of the period of interest shall be excluded from the calculation. In calculating interest, the date of accrual shall be excluded from the calculation (General

Construction Law Section 20). Where a motor vehicle accident occurs after April 5, 2002, interest shall be calculated at the rate of two percent per month, simple interest, calculated on a pro rate basis using a 30 day month. 11 NYCRR 65-3.9(a).

C. Attorney's Fees

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

After calculating the sum total of the first-party benefits awarded in this arbitration plus the interest thereon, Respondent shall pay the applicant an attorney's fee equal to 20% of that total sum, subject to a maximum of $1,360.00. See 11 NYCRR 65-4.6(d).

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

05/17/2021
(Dated)

Glen Cacchioli

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:
0bd95eb748943cccb4c7285f1b6ece0d

Electronically Signed

Your name: Glen Cacchioli
Signed on: 05/17/2021