

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Dinesh Verma Medical P.C.  
(Applicant)

- and -

State Farm Mutual Automobile Insurance  
Company  
(Respondent)

AAA Case No. 17-20-1158-7147

Applicant's File No. CF13009898

Insurer's Claim File No. 32-B296-1X7

NAIC No. 25178

**ARBITRATION AWARD**

I, Shawn Kelleher, 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: BC

1. Hearing(s) held on 09/23/2021  
Declared closed by the arbitrator on 09/23/2021

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

Ann Hellegers from James F. Butler & Associates participated for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 4,948.77**, 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, BC, a 31-year-old female, was involved in a motor vehicle accident on 9/3/19. At issue in this case is \$4,948.77 for trigger points impedance mapping and localized intensive neurostimulation treatment performed on 10/2/19 and 10/17/19. Respondent timely denied the claim based upon application of the fee schedule. The issue presented is what is the proper reimbursement under the New York State Workers' Compensation fee schedule.

4. Findings, Conclusions, and Basis Therefor

This case was decided based upon the submissions of the parties as contained in the electronic file maintained by the American Arbitration Association, and the oral arguments of the parties' representatives. There were no witnesses. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

Applicant establishes its prima facie entitlement to reimbursement with proof that it submitted a proper claim, setting forth the fact and the amount charged for the services rendered and that payment of no-fault benefits was overdue. See Insurance Law § 5106 a; Viviane Etienne Med. Care v. Country-Wide Ins. Co., 25 N.Y.3d 498, 501 (2015); Mary Immaculate Hosp. v. Allstate Ins. Co., 5 A.D. 3d 742, 774 N.Y.S. 2d 564 (2<sup>nd</sup> Dept., 2004). Once an Applicant has established its prima facie case, the burden shifts to the insurer to establish that it timely and properly denied the claims, and the basis of its denial.

Based upon a review of the parties' submissions, I find that Applicant established its prima facie entitlement to reimbursement. I also find that Respondent timely denied the subject bills.

Insurance Law § 5102(a)(1) defines "basic economic loss" as including "all necessary expenses incurred for...professional health services" subject to the limitations of Insurance Law § 5108. Insurance Law § 5108 limits the amounts to be charged by providers of health services, and states that charges for services specified in Insurance Law § 5102(a)(1) "shall not exceed the charges permissible under the schedules prepared and established by the chairman for the workers' compensation board...except where the insurer...determines that unusual procedures or unique circumstances justify the excess charge." 11 NYCRR § 65-3.16(a) provides that "[p]ayment for medical expenses shall be in accordance with fee schedules promulgated under section 5108 of the Insurance Law and contained in Part 68 of this Title (Regulation 83)." 11 NYCRR § 68.1 provides that the "existing fee schedules prepared and established by the chairman of the Workers' Compensation Board...are hereby adopted by the Superintendent of Insurance with appropriate modifications so as to adapt such schedules for use pursuant to section 5108 of the Insurance Law."

Respondent has the burden of coming forward with competent evidentiary proof to support its fee 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).

Applicant billed \$2,455.00 under CPT codes 9599 and 99199 for three treatments. Respondent submits a coder report from Becky Lynn Neve CPC to support its reduction.

She states that each service should be paid at \$262.91 for CPT code 95999 and \$20.70 for CPT code 97032. Specifically, she notes:

- CPT<sup>®</sup> code 95999 - Located in the New York Workers' Compensation Medicine Fee Schedule in the Medicine section, with an assigned Relative Value of "BR" under the RVU column.

- o Per the Official New York Workers' Compensation Medical Fee Schedule, General Ground Rule #3: Procedures Listed Without Specified 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 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. . . .For any procedure where the relative value unit is listed in the schedule as "BR", the physician shall establish a relative value unit consistent in relativity with other unit values shown in the schedule." (hereinto, See Exhibit F)

The provider has not related this service to others with specified relative value units, and has provided no documentation as to how they arrived at the fee for the procedure performed.

According to the clinical documentation reviewed, the provider is reporting this code for Trigger Points Impedance Imaging (TPII). As per documented in the medical report (hereinto, See Exhibit G), they are "Utilizing an array of miniature probes, Nervomatrix automated, computer-controlled unit performs complete impedance scanning of the entire doctor predesignated back region (maximum scanned area size 20x30 cm<sup>2</sup>) which is combine with smart computer-generated algorithms. Computerized analysis of the two- dimensional data is based on the measured electrical properties of each finite pixel within the scanned region by using image processing software and smart algorithms. This allows precise identification and localization of active and clinically relevant trigger points."

The process described in the medical report documented above is similar to what is being done when performing ultrasonic guidance. Per the Coder's Desk Referecnes for Procedures, "Ultrasound is the process of bouncing sound waves far above the level of human perception through interior body structures. The sound waves pass through different densities of tissue and reflect back to a receiving unit at varying speeds. The unit converts the waves to electrical pulses that are immediately displayed in picture form on screen." CPT code 76942 (ultrasonic guidance for needle placement, imaging supervision and interpretation) represents this service, and has an established Relative Value of 4.97.

Reimbursement was calculated by the following formula: Conversion factor (CF) for Radiology times the Relative Value Units (RVU).

Calculation for 76942:  $\$52.90 \times 4.97 \text{ RVU} = \$262.91$

· CPT<sup>®</sup> code 99199 - Located in the New York Workers' Compensation Medical Fee Schedule in the Medicine section, with an assigned Relative Value of "BR" under the RVU column.

o Per the Official New York Worker's Compensation Medical Fee Schedule, General Ground Rules #3: Procedures Listed Without Specified 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 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. . . .For any procedure where the relative value unit is listed in the schedule as "BR", the physician shall establish a relative value unit consistent in relativity with other unit values shown in the schedule." (hereinto, See Exhibit F)

§ The provider has not related this service to others with specified relative value units, and has provided no documentation as to how they arrived at the fee for the procedure performed.

According to the clinical documentation reviewed, the provider is reporting this code for Localized Intense Hyperstimulation Analgesia (also referred to as Localized Intense Neurostimulation (LINT)) to the trigger points identified using TPII. As per documented in the report (hereinto, See Exhibit H) this procedure is performed using the Nervomatrix, utilizing pulse parameters, with a frequency range of 1-8 Hz, pulse width 50-800 microseconds with a current of 0.1-10 mA. "The applicator was positioned above the patient to bring the protruding end of the probes over the upper part of the area and the applicator joint was locked. The applicant was lowered until the tips of the probes were approximately 80 mm above the patient's back. The Patient Reference Electrode Module was attached to the patient during the treatment. The Reference Electrode interconnects the Electrical hardware and the Probes."

This device was submitted to the Food and Drug Administration (FDA) for approval, and the FDA website (hereinto, See Exhibit I) indicates this device is similar to the NeMa-st which is classified as "Stimulator, nerve, transcutaneous for pain relief". Information regarding the NeMa-st which is found on the FDA website and is from Nervomatrix. Based on this information, the Nervomatrix device provides the same treatment as the NeMa-st.

This device provides localized intense neurostimulation to trigger points utilizing probes.

Per the American Medical Association (AMA) Coding Consultation, dated June 1996, page 10:

Question: What is the appropriate code for trigger point therapy?

AMA Comment: Trigger point therapy is reported according to the technique used by the therapist. For example, if the therapy is performed by use of the therapist's finger(s) or hand(s), then report code 97250. If a point stimulator is used to perform the trigger point therapy, then report code 97032.

97032 (Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes), has an established Relative Value of 2.45. 97032 is reported based on total treatment time.

Reimbursement was calculated by the following formula: Conversion factor (CF) for E/M, Medicine, and Physical Medicine times the Relative Value Units (RVU), times the units. The treatment notes for this service do not include any documentation of total treatment time, therefore, 1 unit of 97032 would be supported. (hereinto, See Exhibit H).

Calculation for 97032:  $\$8.45 \times 2.45 \text{ RVU} \times 1 \text{ unit} = \$20.70$

She notes that Applicant was overpaid in this matter. I find that this affidavit provide a cogent and well explained fee for the CPT codes in dispute.

Applicant submits a coder report of Lorena Villalobos. Ms. Villalobos tries to explain the NVX machine. She states that the reimbursable amount would be \$2,455.00. She states that this should be billed 34.8 RVUS or the combined amount of an MRI of the cervical and lumbar spines. She then goes on to state an RVU of 37.71 was chosen for the LINT, which includes 70% anesthesia (RV 15.91) and treatment 30% (RV 21.8). Based upon a review of this affidavit, I find same is insufficient. The affidavit makes little sense. It is nothing more than a conclusory explanation. She does not explain where these numbers come from, why she chooses these numbers, or what CPT codes she is using. As such, this affidavit is patently insufficient.

As the affidavit provided by Applicant is not persuasive, the claim is denied. I have also reviewed the numerous awards from other arbitrations who have reached similar conclusions. See Arbitrators DiGirolomo and Silber, both using Carolyn Mallory's coder affidavit under AAA Case Nos. 17-19-1129-8368 and 17-19-1129-2850.

This is in full dispositive of the claims herein.

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

10/06/2021

(Dated)

Shawn Kelleher

**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:**  
d792e17a1db052ca49aa16448492e3f8

### **Electronically Signed**

Your name: Shawn Kelleher  
Signed on: 10/06/2021