American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Kings Chiropractic Wellness PC (Applicant)	AAA Case No.	17-19-1143-1154
	Applicant's File No.	127.344
- and -	Insurer's Claim File No.	191220514
	NAIC No.	11851
Progressive Casualty Insurance Company (Respondent)		

ARBITRATION AWARD

I, Josh Youngman, 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: IP

1. Hearing(s) held on 08/30/2021
   Declared closed by the arbitrator on 09/29/2021

   Douglas Mace, Esq. from Tsirelman Law Firm PLLC participated in person for the Applicant

   Jean Schabhuttl, Esq. from Progressive Casualty Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 1,589.21**, 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 evidence shows this arbitration to recover allegedly overdue PIP benefits involves a 23-year old female (N.J.) who was injured on March 31, 2019 when the motor vehicle she was driving was involved in an accident. The evidence also shows following the accident the injured party (IP) sought treatment and underwent a neuromuscular diagnostic procedure and received localized intensive neurostimulation treatment from the applicant on May 16, 2019.

The evidence appears to show upon receipt of the applicant's bill seeking reimbursement in the amount of $1,589.21 the respondent issued a partial payment of $201.14 and denied the balance based on a fee schedule defense. The applicant, however, did not acknowledge the respondent's payment in the amount of $201.14.

I thus requested the applicant to submit a statement whether they received that payment as a post-hearing submission.

The issues to be decided are whether the applicant submitted sufficient evidence to make out a prima facie case, and if so, whether the respondent submitted sufficient evidence to sustain their partial payment and/or fee schedule defenses.

4. Findings, Conclusions, and Basis Therefor

This Award is rendered after diligent review and consideration of the parties' evidence submitted to and maintained by the American Arbitration Association's electronic case filing system, "MODRIA," as well as the parties' oral arguments and any testimony presented at this matter's hearing. Evidence that was submitted after this matter's "closing" and without this Arbitrator's authorization was not considered.

An 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 § 5106a; Viviane Etienne Med. Care v. Country-Wide Ins. Co., 25 N.Y.3d 498 (2015); Mary Immaculate Hosp. v. Allstate Ins. *Co.*, 5 A.D. 3d 742 (App. Div. 2d 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 claim(s), and to submit evidence to sustain the basis of its denial(s).

I find that the applicant has submitted sufficient evidence to establish their prima facie case for the claim at issue, thus shifting the burden to the respondent. Further, the respondent may proceed with their fee schedule defense regardless of the presence of a timely denial (see 11 NYCRR § 65-3.8(g)(1)(ii).

As stated above, the applicant failed to acknowledge the respondent's alleged payment in the amount of $201.14 that is reflected on the respondent's Explanation of Benefits form and on a cashed check made out to the applicant for treatment rendered to the IP. The applicant, however, did not deny receipt of the respondent's payment and failed to submit any position, either in writing or verbally at the hearing, regarding the payment.

Thus, I directed the applicant to submit a written position regarding said payment via a post-hearing submission. My post-hearing directive to the applicant stated "The applicant to state whether they received the partial payment in the amount of $201.14 that is reflected on the respondent's Explanation of Benefits and cashed check. Further, a negative inference shall be taken if the applicant fails to make any such statement."

The applicant failed to submit any written position regarding whether they received the aforementioned payments.

I find the respondent's submission of Explanation of Benefit forms showing payment was made, as well as the cashed check, to be sufficient to give rise to a rebuttable presumption and shift the burden to the applicant to refute receipt of said payment. Thus, I deem the applicant's failure to submit any evidence or even an affirmative statement regarding the respondent's alleged payments to be insufficient to rebut the presumption afforded to the respondent. This is particularly true in light of the aforementioned post-hearing directives.

Thus, I find the respondent's unrebutted evidence to be sufficient to show the payment reflected on their Explanation of Benefits form in the amount of $201.14 was made.

The remaining issue is whether the respondent submitted sufficient evidence to sustain their fee schedule defense.

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."

The respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 2006 NY Slip 26240 (Civil Ct. Kings Co. 2006). If the insurer fails to demonstrate by competent evidentiary proof that an applicant's claims were billed in excess of the appropriate fee schedules, the defense of noncompliance with the fee schedule cannot be sustained. See, Continental Medical PC v. Travelers Indemnity Co., 11 Misc.3d 145A (App. Term 1st Dept. per curiam, 2006).

In the instant matter, the evidence shows the applicant billed under CPT codes 95999 and 99199, both of which are "by-report" codes. New York Workers Compensation Fee Schedule General Ground Rule 3 states:

> **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 services, the time, the skill, and equipment necessary, etc., is to be furnished. A detailed clinical records 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 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" relative value units to ensure that the relativity consistency is maintained. The general conditions and requirements of the General Ground Rules apply to all "BR" items.

The evidence shows the respondent reimbursed the applicant $201.14 for the treatment billed under CPT code 95999 and denied the treatment billed under CPT code 99199. The respondent's explanation of benefits states the treatment billed under CPT code 99199 was denied due to the fact the applicant billed under a CPT code that is not found in the 2018 New York Workers Compensation Chiropractic Fee Schedule.

It is undisputed that the ground rules of the 2018 New York Workers Compensation Fee Schedule referenced above took effect for services rendered on or after April 1, 2019.

General Ground Rule 19 from the 2018 New York Workers Compensation Fee Schedule states:

> **19. Use of Medical Fee Schedule Codes**
>
> There are separate and distinct fee schedules for use by Podiatrists (Podiatry Fee Schedule), Chiropractors (Chiropractic Fee Schedule), and Psychologists (Behavioral Medicine Fee Schedule). A Podiatrist, Chiropractor, or Psychologist may not use the CPT coding guidelines contained in this Medical Fee Schedule. Podiatrists, Chiropractors, and Psychologists should consult the applicable fee schedule relevant for his or her scope of practice when submitting bills for treatment.

In addition, Chiropractic Ground Rule 10 from the 2018 New York Workers Compensation Fee Schedule states:

> **10. Codes in the Chiropractic Fee Schedule**
>
> 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.

I find these ground rules to be unambiguous and to clearly state a chiropractor cannot bill for CPT codes that are found outside the Chiropractic section of the 2018 New York Workers Compensation Fee Schedule.

CPT code 99199 is found in the 2012 and 2018 New York Workers Compensation Medical Fee Schedules and is not found in any of the sections of the 2012 or 2018 New York Workers Compensation Chiropractic Fee Schedule.

Thus, I find the evidence to be sufficient to show the applicant, a chiropractor, improperly billed under CPT codes not found in the Chiropractic section of the 2018 New York Workers Compensation Fee Schedule. In addition, the applicant does not submit any evidence that shows they are entitled to reimbursement for treatment billed under CPT code 99199 or that show the above-referenced ground rules are either inapplicable or are being misapplied.

Further, under the circumstances presented herein, I do not find the respondent must request verification in order to assert a defense based on the aforementioned Ground Rules.

Thus, the claim submitted under CPT code 99199 is denied.

In addition, for the treatment billed under CPT code 95999, the evidence shows the respondent reimbursed the applicant $201.14 and denied the balance.

In support of their defense for CPT code 95999, the respondent submits evidence to show they requested verification from the applicant in the form of the relative value the applicant assigned to the treatment billed under CPT code 95999. The respondent further submits what appears to be the applicant's response to the verification requests, which provides a summary of how the applicant applied a relative value of 34.8 to the treatment billed under CPT code 95999.

Further, the respondent's explanation of benefits states "you have indicated the RVU for this procedure is 34.8 RVU's. We have reimbursed you this value based on the regional conversion factor for your specialty."

The applicable chiropractic conversion factor is 5.78. Thus, the evidence shows the respondent calculated the amount they paid by taking 34.8 * 5.78, which equals $201.14.

Since CPT code 95999 appears in the 2012 New York Workers Compensation Medical Fee Schedule, it appears as though the respondent's application of a conversion factor of 5.78 is proper.

The evidence, however, appears to show the applicant assigned a radiology conversion factor to their billing that was submitted under CPT code 95999. As stated above, however, CPT code 95999 is found in the 2018 New York Workers Compensation Chiropractic Medicine Fee Schedule (and the 2012 New York Workers Compensation Medical Fee Schedule).

Thus, it is unclear why a radiology conversion factor, and not a chiropractic medicine conversion factor, would apply.

In addition, I find the applicant fails to submit sufficient persuasive evidence to support the use of a radiology conversion factor. The affidavit of Lorena Villalobos, CPC might be sufficient to support the use of a relative value of 34.8 for the disputed treatment, but Ms. Villalobos does not persuasively explain why a radiology conversion factor is applicable.

Further, I have reviewed the arbitration awards submitted by both parties and agree with the reasoning of the awards submitted by the respondent.

Thus, the evidence shows the respondent reimbursed the applicant at the proper rate and the claim is denied.

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, Josh Youngman, 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)

Josh Youngman

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:
e0b8e280aa20a275ab2955c5af1acb14

Electronically Signed

Your name: Josh Youngman
Signed on: 10/06/2021