American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

MZY Acupuncture PC (Applicant)	AAA Case No.	17-20-1182-2415
	Applicant's File No.	3100753
- and -	Insurer's Claim File No.	0669129510000001
	NAIC No.	22055
Geico 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 10/04/2021
   Declared closed by the arbitrator on 10/04/2021

   Elvira Messina, Esq. from Law Offices of Andrew J. Costella Jr., Esq. participated in person for the Applicant

   Cindy Covelli, Esq. from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 4,120.55**, 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 32-year old male (R.C.) who was injured on October 6, 2019 when the motor vehicle he was driving was involved in an accident. The evidence also shows following the accident the injured party (IP) sought treatment and received acupuncture with cupping and infrared treatment from the applicant from October 14, 2019 - March 3, 2020. The evidence further shows upon receipt of the disputed bills the respondent either issued partial payments and denied the balances based on a fee schedule defense.

The issues presented is 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 fee schedule defense.

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 the applicant has submitted sufficient evidence to make out their prima facie case and shift 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)).

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).

The evidence shows the applicant received reimbursement at the chiropractic rate for the acupuncture treatment billed under CPT codes 97810, 97811, 97813 and/or 97814, which is the proper rate (See Great Wall Acupuncture, P.C. v. GEICO Ins. Co., 26 Misc.3d 23 (App. Term 2d Dept. 2009).

The applicant, however, argues the recent decision of the Appellate Division, First Judicial Department in Global Liberty Ins. Co. of N.Y. v. Acupuncture Now, P.C., 2019 NY Slip Op 08942 (App. Div. 1st Dept. 2019) states the chiropractic fee schedule rate is not necessarily the proper rate to reimburse a licensed acupuncturist.

In Global Liberty v. Acupuncture, the insurer sought a declaration that the chiropractic fee schedule is the proper rate of reimbursement for a licensed acupuncturist as a matter of law. The Appellate Division, however, refused to grant such a declaration, stating:

> Plaintiffs did not proffer admissible evidence sufficient to make a prima facie showing of entitlement to judgment on the issue as a matter of law (*see Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985]). Plaintiffs rely on a 2004 informal opinion letter of the former Insurance Department, but that letter did not resolve the issue. It allows insurers to pay "the rates established for doctors and chiropractors," instead of a higher "prevailing fee in the geographic location of the provider," so long as there is a review "for consistency with [the] charges permissible for similar procedures" under either fee schedule (Ops Gen Counsel NY Ins Dept No. 04-10-03; *see* 11 NYCRR 68.5 [b]). The opinion letter "did not give any guidance as to which particular fee schedule should be applied to a licensed acupuncturist in any particular instance, although the Department was aware" that "the fee schedules for acupuncture services performed by chiropractors are lower than the fee schedules for such services performed by physicians" (*Great Wall Acupuncture v GEICO Gen. Ins. Co.*, 16 Misc 3d 23, 28 [App Term, 2d Dept, 2d & 11th Jud Dists 2007]; *see Andryeyeva v New York Health Care, Inc.*, 33 NY3d 152, 174 [2019] [requiring judicial deference to an "agency's rational interpretation of its own regulations"]). While courts have held that "an insurer *may* use the workers' compensation fee schedule for acupuncture services performed by chiropractors to determine the amount which a licensed acupuncturist is entitled to receive" (*Great Wall Acupuncture, P.C. v Geico Ins. Co.*, 26 Misc 3d 23, 24 [App Term, 2d Dept, 2d, 11th & 13th Jud Dists 2009] [emphasis added]; *see also Akita Med. Acupuncture, P.C. v Clarendon Ins. Co.*, 41 Misc 3d 134[A], 2013 NY Slip Op 51860[U] [App Term, 1st Dept 2013]), such holdings do not foreclose the use of the physician fee schedule in all cases (*see e.g. Okslen Acupuncture P.C. v Travco Ins. Co.*, 44 Misc 3d 135[A], 2014 NY Slip Op 51209[U], *1 [App Term, 1st Dept 2014]; *Raz Acupuncture, P.C. v AIG Indem. Ins. Co.*, 28 Misc 3d 127[A], 2010 NY Slip Op 51177[U], *2 [App Term, 2d Dept, 2d, 11th & 13th Jud Dists 2010]).

> Further, plaintiffs did not "proffer sufficient evidence to establish as a matter of law that the claims were improperly billed or were in excess of the amount permitted by the fee schedule" (*Easy Care Acupuncture, P.C. v A. Cent. Ins. Co.*, 48 Misc 3d 129[A], 2015 NY Slip Op 50973[U], *1 [App Term, 1st Dept 2015]).
>
> In any event, defendants raised an issue of fact as to whether the physician fee schedule should apply. They rely on the former Insurance Department's regulatory impact statement accompanying its proposed 2010 rule amendment, by which it sought to clarify "inconsistent" court rulings, that "acupuncture treatments are the primary service performed and billed by licensed acupuncturists" and "such treatments merit reimbursement at the same rate that medical doctors receive for comparable services" (NY Reg, July 21, 2010 at 12-13). They also proffered, among other things, an affidavit from a licensed acupuncturist who averred that he was consistently reimbursed by workers' compensation insurers at the physician rates, for over 15 years, which plaintiffs did not rebut.

I find it logical and proper to continue to hold the proper rate of reimbursement for a licensed acupuncturist is set by the New York Workers Compensation Chiropractic Fee Schedule. Further, even if I were to hold the chiropractic rate is not the proper rate for the acupuncture performed by a licensed acupuncturist as a matter of law, the applicant fails to submit any evidence to show their services are more akin to those provided by a physician than those provided by a chiropractor, or that another rate is proper.

Further, I do not read the Appellate Division's decision in Global Liberty v. Acupuncture to state the chiropractic rate is not proper, just that it is not proper "as a matter of law". In the instant matter, however, there is no evidence submitted that would lead to a finding that any other fee schedule, or rate of reimbursement, is applicable. I also find the burden of proving an alleged entitlement to a rate of reimbursement higher than the chiropractic fee schedule rate logically falls on the applicant, who fails to submit sufficient evidence to sustain that burden.

Thus, I find the evidence shows the applicant received the proper rate of reimbursement for the claims under CPT codes 97810, 97811, 97813 and 97814.

For some of the infrared treatment billed under CPT code 97026, the respondent has asserted a defense based on Physical Medicine Ground Rule 11 and/or Chiropractic Physical Medicine Ground Rule 3. The pertinent rules state as follows:

> Ground Rule 11 of the Physical Medicine Section of the New York State Workers' Compensation Medical Fee Schedule: When multiple physical medicine procedures and/or modalities are performed on the same day, reimbursement is limited to 8.0 RVUs or the amount billed, whichever is less. The following codes represent the physical medicine procedures and modalities subject to this rule: 97010 97012 97014 97016 97018 97022 97024 97026 97028 97032 97033 97034 97035 97036 97039 97110 97112 97113 97116 97124 97139 97140 97150 97530 97535 97537 97542 97760 97761 97762.

> Ground Rule 3 of the Physical Medicine Section of the New York State Workers' Compensation Chiropractic Fee Schedule: When multiple physical medicine procedures and/or modalities are performed on the same day, reimbursement is limited to 8.0 RVUs or the amount billed, whichever is less. The following codes represent the physical medicine procedures and modalities subject to this rule: 97010 97012 97014 97024 97026 97028 97032 97033 97034 97035 97036 97039 97110 97112 97113 97116 97124 97139 97140 97530 98940 98941 98942.

The respondent alleges that the applicant billed in excess of the amount of physical medicine that is reimbursable per date of service. The respondent further alleges they paid the applicant the maximum permissible amounts, or distributed the maximum permissible amount to the applicant and another provider of physical medicine, and properly denied the balances.

The applicant now seeks the unpaid balances while the respondent defends its payments as proper pursuant to the "8 unit rule".

The respondent, however, fails to submit any evidence to show another provider was reimbursed for physical medicine performed on any of the dates of service where the respondent asserted an 8-unit defense.

CPT code 97026 has a relative value of 2.54 and is thus properly reimbursed at $14.68. Thus, the applicant is entitled to an award in the amount of $14.68 for the infrared treatment billed on March 3, 2020.

Further, the evidence shows the applicant billed for an October 14, 2019 office visit under CPT code 99202. The evidence further shows the respondent denied the bill based on an Explanation of Benefits that stated "There is no allowance for this procedure in the New York State Workers Compensation Fee Schedule under the provider's specialty." The respondent does not provide any support for this defense or any evidence showing an acupuncturist cannot bill under CPT code 99202.

Further, as stated by Arbitrator Drew M. Gewuerz, Esq., CPC in Complete Spinal Physical Therapy & Chiropractic PLLC v. Geico Ins. Co., AAA Case No.: 17-17-1077-9678 (2019):

> Although the Chiropractic Fee Schedule does not contain the billed procedure, there is no prohibition from using or incorporating a CPT code or "Relative Value" from a different section of the Workers' Compensation Fee Schedule. The Fee Schedule is separated into sections for convenience only. As the Respondent does not dispute that the billed and performed procedure is outside the Applicant's licensed practice scope or the Applicant's amended claims' amounts, the Applicant is awarded...

The fee schedule states CPT code 99202 has a relative value of 7.27, which when multiplied by the applicable conversion factor of 5.78, is properly reimbursed at $42.02. Thus, the applicant is entitled to an award in the amount of $42.02 for the October 14, 2019 office visit.

Further, the evidence shows the respondent reimbursed the applicant the proper rate for the office visit billed under CPT code 99212 on December 3, 2019 (4.57 * 5.78 = $26.41).

The evidence further shows the applicant billed either $35.00 for the initial unit of cupping treatment and $32.48 for the 2nd unit per date of service or $25.00 for the initial unit and $24.48 for the 2nd unit per date of service, all under CPT codes 97039 and 97799, which is listed as "by-report" code.

Ground Rule 2 of the Introduction and Guidelines to the Chiropractic section of the Worker's Compensation Fee Schedule states:

> **2. Procedures Listed Without Specified 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 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 chiropractor shall establish a relative value unit consistent in relativity with other relative value units shown in the schedule. The insurer shall review all submitted "BY" unit values to ensure that the relativity is maintained. The general conditions and requirements of the General Ground Rules apply to all "BR" items.

Thus, as per the language above, a provider who chooses to bill under a by-report code should substantiate their billing with documentation that permits the recipient of the bill to perform a "sound evaluation". Further, the fee schedule makes it clear that the amount charged for treatment billed under a by-report code should be consistent with the relative values listed for similar treatment. These requirements are logical as a provider who bills under a by-report code does not have an explicit limitation on the amount they are permitted to bill.

The evidence further shows the respondent reimbursed the applicant $13.87 per unit of cupping and denied the balances based on a fee schedule defense.

In support of their fee schedule reductions, the respondent submits an affidavit from Steven Schram, L.Ac., D.c. Dr. Schram attests the proper relative value for cupping is 2.40 and the proper rate of reimbursement for cupping is $13.87 per unit. I have previously found $13.87 to be a proper rate of reimbursement for cupping treatment (see East Coast Acupuncture, P.C. v. Geico Ins. Co., AAA Case No.: 17-16-1043-6365 (2018)). Thus, I find the respondent has submitted sufficient evidence to show $13.87 is a proper rate of reimbursement for cupping treatment, shifting the burden to the applicant.

I have also reviewed the fee schedule audit submitted by the respondent by Habanero, Inc. in a linked matter involving the same IP. Although the audit pertains to a different claim, the substance of the audit was the proper rate of reimbursement for cupping treatment and thus the audit's conclusions are applicable herein.

The applicant fails to submit any evidence rebutting the evidence referenced above or in support of their billing. Thus, the applicant is entitled to an award in the amount of $56.70.

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**
	MZY Acupuncture	**10/14/19 -**	**$4,120.55**	**Awarded:**

	PC	**03/03/20**		**$56.70**
Total			**$4,120.55**	**Awarded: $56.70**

B. The insurer shall also compute and pay the applicant interest set forth below. 10/21/2020 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Pursuant to 11 NYCRR § 65-3.9, "Interest on overdue payments," the respondent shall pay interest to the applicant on the awarded overdue PIP benefit at a rate of two percent (2%) per month calculated on a pro rata basis using a thirty (30) day month. As applied to the claim(s) herein, interest accrues from the date the arbitration request was received through the date of payment of the awarded overdue PIP benefit (where arbitration was not initiated within 30 days after receipt of a denial(s) of claim(s)), or from the date that the claim(s) was(were) overdue where no denial was issued through the date of payment of the awarded overdue PIP benefits.

C. Attorney's Fees

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

As this arbitration was filed after February 4, 2015, it is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR § 65-4. Accordingly, the respondent shall pay the applicant an attorneys' fee according to § 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, 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.

10/13/2021

(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:
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Electronically Signed

Your name: Josh Youngman
Signed on: 10/13/2021