

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Titan Diagnostic Imaging Services, Inc  
(Applicant)

- and -

LM General Insurance Company  
(Respondent)

AAA Case No. 17-21-1202-4973

Applicant's File No. n/a

Insurer's Claim File No. 0428600510004

NAIC No. 36447

**ARBITRATION AWARD**

I, James Hogan, 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: EIP

1. Hearing(s) held on 02/17/2022  
Declared closed by the arbitrator on 02/17/2022

Roman Kulik from Kulik Law Firm, PC participated in person for the Applicant

Sheena Faublas from LM General Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$850.00**, was AMENDED and permitted by the arbitrator at the oral hearing.

At the hearing, the Applicant amended the amount in controversy to \$813.94.

Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

The EIP a 35 year old man, was injured in a collision on 6/16/2020. This claim is for an ultrasound paraspinal examination administered to the EIP on 9/14/2020 and billed at \$850.00. Respondent denied the claim stating that as per the American College of Radiology this procedure has no clinical utility as a screening, diagnostic or adjunctive imaging tool. In addition, CPT code 76999 was not listed in the fee schedule that was in effect on the date of service. In addition, Respondent has provided a fee audit which

indicates that should the claim be awarded, the amount of the award should be \$203.75. Applicant has submitted a fee audit indicating that should the claim be awarded the reimbursement to the Applicant should be \$813.94.

#### 4. Findings, Conclusions, and Basis Therefor

**This decision is based upon my review of the electronic file maintained by the American Arbitration Association, and the arguments of the parties set forth in the hearing.**

**Applicant's submission:**

Applicant is billing for an ultrasound paraspinal examination billed under CPT code 76999-TC at \$850.00 for DOS 9/14/2020.

**In a Supplemental Submission and uploaded on 2/4/22**, the Applicant has provided a report from Ralph Dauito, MD, the interpreting physician.

The date of service is indicated as 9/14/2020.

The report is entitled **"MSK of the Cervical & Lumbar vertebral joints with Bilateral W/ Trapezius Muscle & SI Joints."**

As per this report, the patient presented with continued evidence of aberrant spinal biomechanics, including changes in normal spinal segment of movement and potential aberrations in the tissues which support articular function. Ultrasonography of the cervical spine, including adjacent ligaments and muscular structures was performed to demonstrate the presence or absence of certain graphically demonstrable abnormalities in these vertebral and paravertebral tissues, and to rule out the presence of any pathological masses. Multiple sonographic images were obtained of the cervical vertebral tissues transversely from C1 through C7 and bilateral trapezius muscles.

The examination of C1 through C7 levels demonstrated no evidence of cystic or solid soft tissue mass. Abnormal acoustic dropout is seen at the posterior spinous processes.

As to the paraspinal muscles, an abnormal acoustic pattern was seen in the patient's paraspinal musculature. The musculature and fascial planes are preserved. The right trapezius muscle is visualized and appears abnormally hypoechoic. Marked swelling and hypoechogenicity is visualized bilaterally.

As to the facet joints, no facet hypertrophy noted bilaterally. Joint capsule appears hyperechoic and not enlarged. Mild to moderate inflammatory responses visualized in the joints.

The patient presented with back pain and tightness post MVA. The patient presented with evidence of aberrant spinal biomechanics including changes in normal spinal

segmental movement and potential aberrations in the tissues which support articular function. Ultrasonography of the lumbar vertebrae was performed to demonstrate the presence or absence of any inflammation in these articular tissues.

Technique: utilizing a 5-10-MHZ variable transducer, static transverse images were obtained from the L5-S1 with patient in a prone position.

Findings: L1 through L5, S1 are of abnormal appearance. Bilateral SI joint is of abnormal sonographic appearance with moderate inflammation noted in L1-L5. Abnormal hypoechogenicity of the bilateral lumbar musculature. SI joint presents an inflammatory response.

The Impression was sonographic imaging of the lumbar vertebrae revealed evidence of articular and/or soft tissue inflammatory changes consistent with nerve irritation. Bilateral moderate swelling of the lumbar paraspinal muscle consistent with significant muscle spasm. Findings are consistent with bulging and herniation of the intervertebral discs.

An abnormal acoustic pattern is visualized in the bilateral paraspinal musculature, which in conjunction with the appropriate clinical findings is compatible with right paraspinal muscle with spasm. Moderate swelling of the right and ..... consistent with the moderate muscle spasm.

Mild-moderate inflammatory..... auma noted C1-C7 & L1-L5, MRI correlation is strongly advised.

The blank spaces are the result of the signature of Dr. Dauito being placed over part of the text.

**In a supplemental submission uploaded on 2/3/22, the Applicant has provided an affidavit from Frank Keane, CPC.**

Mr. Keane has reviewed the Applicant's billing for the diagnostic testing billed under CPT code 76999- TC indicating the technical component for the Ultrasounds of the Cervical and Lumbar Spine and for the Bilateral Ultrasounds of Extremity, the Bilateral Trapezius Muscles and the Bilateral Sacroiliac Joints. Billing was presented utilizing CPT code 76999, an unlisted ultrasound procedure.

It is noted that this is a By Report code, and as such is subject to the provisions of Ground Rule #3 of the fee schedule.

He then discusses the criteria for billing a BR code.

He opined that the Applicant properly billed this code in accordance with the aforementioned Ground Rule.

In determining the proper reimbursement for a BR code we must look to other codes in the fee schedule that list specific values for comparable services. He then notes that CPT

code 76800 is for ultrasound of the spinal canal and contents. It carries 5.56 RVUs. Utilizing a conversion factor of 52.90, in Region IV, the reimbursement rate for that CPT code would be \$294.12. That reimbursement rate has a split with the professional component taking 45% and the technical component taking 55%. Therefore, the technical component of CPT code 76800 would amount to \$161.77.

Mr. Keane notes that ultrasound of the soft tissues of both the cervical and lumbar sections of the spine were performed, therefore, the provider would be entitled to 2 units of the reimbursement.

He then refers to CPT code 76881, ultrasound, extremity, noninvasive, real-time with imaging documentation.

This CPT code has said RVU of 4.46. Utilizing the same conversion factor, the reimbursement rate would be \$235.93.

Ultrasounds were taken of the bilateral trapezius and the bilateral SI joints. The diagnostic testing provided is therefore due reimbursement of 4 units of the above code as the testing was provided on 4 extremities.

That code has split of 25/75 with 75% being for the technical component. 75% of \$235.93 is \$176.95.

Mr. Keane opines that Applicant billed CPT code 76999-TC which is an Unlisted Ultrasound Procedure. This is a proper description of the billing for the ultrasound procedures performed. Since it is a BR code, reimbursement must be consistent with similar charges for similar procedures. Since CPT codes 76800 and 76881 are the most similar codes listed with a specific RVU, the provider should be reimbursed at the rate of those codes.

He then opines that the Applicant is entitled to \$283.10 for the ultrasounds of the cervical and lumbar sections of the spine, relying upon his previous noted calculation.

He also says that based upon his previously noted calculation, the Applicant is entitled to 4 units of CPT code 76881 which totals \$530.84.

In sum, Mr. Keane opines that the reimbursement to the Applicant should be \$813.94.

**Respondent's submission:**

Respondent contends that the Applicant is billing for an ultrasound of the spine and that the documentation submitted indicates that the provider has billed an inaccurate CPT code. In addition, the service rendered was the paraspinal ultrasound and pursuant to the American College of Radiology, there was no proof of the clinical utility of this procedure.

I see that the Respondent argues that the CPT code utilized by the Applicant, 76999-TC is a CPT code which is not listed in the fee schedule that was in effect on the date of service, 9/14/2020.

Respondent issued an NF-10 on 9/30/2020 denying the Applicant's claim.

**Respondent has submitted a document from Melissa Simon, RN, BSN, CPC, who is in the employ of the Respondent.**

It is noted that the Applicant billed utilizing CPT code 76999-TC.

It was also noted that the conversion factor for the location of the Applicant would be \$52.90.

The Applicant billed an unlisted ultrasound procedure. The report indicates that ultrasonography was performed to the cervical vertebral tissue, C1 through C7 and the bilateral trapezius muscles. Additionally, images were performed to the lumbar and sacral spine regions from L1 through L5 and S1. Dr. Dauito is listed as the interpreting physician.

The Applicant is billing for the technical component for the service.

The referring doctor was Melanie Walcott, DC. Ms. Simon says that the EIP's bill history did not validate that a bill was submitted with the Modifier 26 by another provider to include Dr. Walcott for this same DOS.

Ms. Simon also says that CPT code 76999 is a BR code and is subject to Ground Rule #2. The RVU charged must be consistent with like services from the same section of the fee schedule in terms of time, skill and equipment.

She opines that this CPT code is similar to CPT code 76882 which is defined as ultrasound, limited, joint or other nonvascular extremity structure(s) (eg, joint space, peri-articular tendon(s), muscle(s), nerve(s), other soft tissue structure(s), or soft tissue mass(es)), real-time with imaging documentation.

The Respondent agrees in part that CPT code 76882 for the bilateral trapezius muscles is reimbursable as follows: an RVU of  $1.28 \times \$52.96 \times 31\%$  (modifier TC)  $\times 2$  anatomical sites = \$41.98.

In addition, the carrier recommends reimbursement for ultrasound imaging of the cervical, lumbar and sacral spinal regions under CPT code 76800. That calculation is  $5.56 \text{ RVUs} \times \$52.90 \times 55\%$  (modifier TC) = \$161.77.

The total amount eligible would be \$203.75.

These amounts were pursuant to the medical fee schedule that was effective on 6/1/2012.

**At the Hearing:**

Each of the parties relied upon their respective coder's affidavit.

**Findings:**

Applicant has established this prima facie case.

This claim is for an ultrasound paraspinal examination administered to the EIP on 9/14/2020 and billed at \$850.00.

The amount at issue was amended to \$813.94.

Respondent denied the claim stating that as per the American College of Radiology this procedure has no clinical utility as a screening, diagnostic or adjunctive imaging tool. In addition, CPT code 76999 was not listed in the fee schedule that was in effect on the date of service.

In addition, Respondent has provided a fee audit which indicates that should the claim be awarded, the amount of the award should be \$203.75.

Applicant has submitted a fee audit indicating that should the claim be awarded the reimbursement to the Applicant should be \$813.94.

As to the contention that the Applicant billed on the rate CPT code that was not in effect at the time of the services, the Respondent should have sent the request for verification to the Applicant instead of simply denying the claim.

In Gaba Medical, P.C. v. Progressive Specialty Ins. Co., 36 Misc.3d 139(A), 2012 N.Y. Slip Op. 51448(U), (App. Term 2d, 11th & 13th Dists. July 25, 2012). CPT Code 97750 is a time-based code -- a maximum permissible charge of \$41.66 applies to self-employed physical therapists in the New York City region for each 15 minutes -- and there is no rational basis for Respondent's unilateral assumption that 60 minutes was spent on the service, an assumption which led Respondent to make partial payment of \$83.31. Respondent did not seek additional verification as to the time spent on these dates, so the unilateral partial payment cannot be sustained on the stated ground that CPT Code 97750 applied. This asserted defense of Respondent does not defeat Applicant's prima facie case.

The intent of the court in Gaba Medical was that a Respondent should not simply take unilateral action when there is a question. The Respondent should contact the Applicant to try to determine any questions that might be raised. This is done utilizing a request for additional verification. In the instant case, the Respondent should have sent the verification request to the Applicant asking the basis for the CPT code that was utilized since that CPT code was not in effect on the date of service.

Respondent is reminded of Insurance Regulation 65-3.2 (b) Assist the Applicant in the processing of a claim. Do not treat the Applicant as an adversary.

(d) hasten the processing of a claim through the use of a telephone whenever it is possible to do so.

Therefore, since the Respondent has not demonstrated that it took any action to try to clarify the CPT code utilized by the Respondent, I find that the services provided are compensable.

As to the amount of reimbursement, in this case we have the battle of the coders.

Each of the coders agree that the reimbursement rate is \$52.90 for Region IV.

As to the fee audit by Mr. Keane, CPT code 76800 has a conversion factor 5.56. The calculation totals \$294.12. The technical component is 55% which he computes to be \$161.77.

Mr. Keane opines that since the imaging was of the cervical and lumbar section of the spine, 2 units of reimbursement were allowed. Ms. Simon disagrees.

The definition of CPT code 76800 is "Ultrasound, spinal canal and contents."

I take this definition to mean all imaging of the spinal canal. I disagree with Mr. Keane's interpretation and agree with that of Ms. Simon.

**This portion of the claim is awarded in the amount of \$161.77.**

**As to the extremities**, Mr. Keane relies upon CPT code 76881 which is defined as "Ultrasound, extremity, non-vascular, real-time with image documentation, complete." He takes the position that since 4 extremities were examined the Applicant is entitled to 4 units of reimbursement.

This CPT code carries 4.46 RVUs,  $\times 52.90 = \$235.93$ . Utilizing the PC/TC split of 25/75, the reimbursement rate for the technical component should be \$176.95. Since the bilateral trapezius muscles were scanned as well as the muscles in the bilateral lumbar spine were scanned, Mr. Keane opines that the Applicant is entitled to reimbursement for 4 separate scans each at 75% of \$176.95 for a total of \$530.84.

Ms. Simon utilizes CPT code 76882, which carries 1.28 RVUs and has a split of 69/31. She computes the reimbursement for 2 anatomical sites at \$41.98.

After reviewing each of the fee audits, as well as the definition for each CPT code as listed in the Radiology Section of the Medical Fee Schedule, I agree with the interpretation proffered by Mr. Keane. **Therefore, this portion of the claim is awarded in the amount of \$530.84.**

**The claim is awarded in the amount of \$692.61.**

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	Amount Amended	Status
	<b>Titan Diag. Imaging Inc</b>	<b>09/14/20 - 09/14/20</b>	<b>\$850.00</b>	<b>\$813.94</b>	<b>Awarded: \$692.61</b>
<b>Total</b>			<b>\$850.00</b>		<b>Awarded: \$692.61</b>

- B. The insurer shall also compute and pay the applicant interest set forth below. 04/30/2021 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

I find that the date for interest to accrue is the date of the filing of the arbitration, 4/30/21 as this is the date when the Applicant's filing was processed and notice of the arbitration sent to the Respondent. As per Insurance Regulation 65-3.9, interest is due until such amount is paid, and without demand therefor.



C. Attorney's Fees

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

The insurer shall pay the Applicant's attorney as per 11 NYCRR 65-4.6 (e). However, if the award and interest is equal to, or less than, Respondent's written offer during the conciliation process, then the attorney's fee shall be based upon 11 NYCRR 65-4.6 (b).

- 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 Suffolk

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

02/17/2022  
(Dated)

James Hogan

**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:**  
dd206ea4432877a41290598780de42fc

### Electronically Signed

Your name: James Hogan  
Signed on: 02/17/2022