American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Motion Medical Diagnostics, PC (Applicant)	AAA Case No.	17-20-1188-5756
	Applicant's File No.	20-010962
- and -	Insurer's Claim File No.	0458070910000001
	NAIC No.	35882
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Deepak Sohi, 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 05/04/2022
   Declared closed by the arbitrator on 05/04/2022

   Jeanine Oberster from The Licatesi Law Group, LLP participated in person for the Applicant

   Jaime Orlando from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$779.23**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The amount claimed was amended to $60.07 to reflect previous payment. As a result, the remaining amount claimed represents the balance of manual muscle testing.

   Stipulations WERE made by the parties regarding the issues to be determined.

   The parties stipulated that Applicant established a prima facie case of entitlement to No-Fault compensation with respect to its bill. The parties also stipulated that Respondent's NF-10 denial of claim form wastimely issued.

3. Summary of Issues in Dispute

This arbitration arises out of range of motion and manual muscle testing (ROM/MMT) provided to the EIP, a66-year-old male, who was involved in a motor vehicle accident as a driver on12/16/2019. Applicant is seeking reimbursement for the ROM/MMT provided to the EIP on date of service 9/15/2020. The bill for ROM/MMT was partially reimbursed and partially denied reimbursement based on the New York State Worker's Compensation Board Medical Fee Schedule.

4. Findings, Conclusions, and Basis Therefor

This case was decided on the submissions of the parties as contained in the Electronic Case Folder (ECF) maintained by the American Arbitration Association and the oral arguments of the parties' representatives at the hearing. No witnesses testified at the hearing. I reviewed the documents contained in the ECF for both parties and make my decision in reliance thereon.

FEE SCHEDULE

ROM/MMT

DATE OF SERVICE 9/15/2020

An insurance carrier's timely asserted defense that the bills submitted were not properly No-Fault rated or that the fees charged were in excess of the Workers' Compensation fee schedule is sufficient, if proven, to justify a reduction in payment or denial of a claim. See New York Hosp. Med. Ctr. of Queens v. Country-Wide Ins. Co., 295 A.D.2d 583, 586 (2002); East Coast Acupuncture, P.C. v. New York Cent. Mut. Ins., 2008 NY Slip Op 50344(U) (App. Term 2d Dep't., Feb. 21, 2008); A.B. Med. Servs., PLLC v. American Tr. Ins. Co., 15 Misc.3d 132(A), 2007 NY Slip Op 50680(U) (App. Term, 2nd & 11th Jud Dists. 2007); Rigid Medical of Flatbush, P.C. v. New York Cent. Mut. Fire Ins. Co., 11 Misc.3d 139(A), 816 N.Y.S.2d 700, 2006 NY Op 50582 (U) (App. Term 2nd & 11th Jud Dists. 2006);

Ultra Diagnostics Imaging v. Liberty Mut. Ins. Co., 9 Misc.3d 97, 98, 804 N.Y.S.2d 532, 2005 N.Y. Slip Op. 25402 (App Term, 2d Dep't.); Capio Med., P.C. v Progressive Cas. Ins. Co., 7 Misc 3d 129[A], 2005 NY Slip Op 50526 (U) (2005); Triboro Chiropractic & Acupuncture, PLLC v New York Cent. Mut. Fire Ins. Co., 6 Misc.3d 132 (A), 2005 NY Slip Op 50110 (U) (App Term, 2nd & 11th Jud Dists 2005).

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).

For date of service 9/15/2020, Applicant billed for ROM/MMT in the total amount of $985.00. Applicant billed twelve (12) units of CPT code 95851 (ROM), at a rate of $45.75 per unit for a total of $549.00. Applicant billed ten (10) units of CPT code 95831 (MMT), at a rate of $43.60 per unit for a total of $436.00. Respondent reimbursed the Applicant $91.44 for twelve (12) units of CPT code 95851 and $114.33 for ten (10) units of CPT code 95831.

In support of its fee schedule defense, Respondent submits an affidavit from Mr. Cleone Victor, a certified professional coder. Mr. Victor concludes that the services herein were reimbursed in full by the Respondent. Respondent argues that it properly reimbursed Applicant pursuant to the WCFS and denied the balance as over-charges. Applicant's counsel argues that this was an arbitrary reduction and should not be allowed. However, 11 NYCRR 65-3.8 does not allow payment for "medical service fees that exceed the charges permissible pursuant to Insurance Law sections 5108(a) and (b) and the regulations promulgated thereunder for services rendered by medical providers."

An insurer's unilateral decision to re-code or change a medical provider's billed CPT codes, to reimburse disputed medical services at a reduced rate, or to deny a claim in its entirety, is ineffectual when unsupported by a peer review report or by other proof setting forth a sufficiently detailed factual

basis and medical rationale for the code changes, fee reductions and denials. See Amaze Medical Supply v. Eagle Insurance Company, 2 Misc. 3d 128A (App Term 2d & 11th Jud. Dist. 2003).

The fee schedule clearly sets forth that manual muscle testing is billable per extremity or trunk and range of motion testing is billable per extremity or trunk section. Applicant not only billed more than once per extremity for muscle testing and more than once per trunk section for range of motion testing it also billed for multiple body parts per extremity, such as the neck which is a part of the trunk. Applicant charged for each procedure performed to each extremity and trunk section which is clearly not allowed under the WCFS. A fee schedule defense can be raised at any time, as the Applicant is not entitled "under any circumstance" to payment that exceeds the WCFS.

The WCFS describes CPT code 95831 as "Muscle testing, manual (separate procedure); extremity (excluding hand) or trunk with report". CPT code 95851 is described as "Range of motion measurement and report (separate procedure); each extremity (excluding hands) or each trunk section (spine)". It is clear that the codes are for testing for each extremity and not for each procedure or movement performed to each extremity and only for each trunk section with regard to ROM and is not so for MMT in which the trunk is not broken down by section (cervical, thoracic, and lumbar spine sections).

For date of service 9/15/2020, Applicant billed twelve (12) units of ROM testing (95851), in the amount of $549.00. However, according to the Applicant's bill, the maximum number of units the Applicant could be reimbursed for is two (2) units, (two (2) trunk sections, cervical and lumbar), at $45.71 each. This amounts to $91.44. Respondent reimbursed the Applicant $91.44 for the ROM testing herein. Clearly, Respondent reimbursed the Applicant in full for the ROM testing provided for herein and no further amount is due.

For date of service 9/15/2020, Applicant billed ten (10) units of MMT (95831), in the amount of $436.00. However, Mr. Victor argues that once Applicant bills five (5) or more units of CPT code 95831 this constitutes MMT of the entire body as there are only four (4) extremities and the trunk,

which is properly reimbursed as CPT code 95833. CPT code 95833 is described in the WCFS as "Muscle testing, manual (separate procedure); total evaluation of the body, excluding hands". Respondent argues Applicant unbundled the MMT herein which is not permitted under the WCFS.

The proper calculation, in this instance, for reimbursement of CPT code 95833 is RVU 13.53 x RCF 8.45. This amounts to $114.33, which is the amount the Respondent reimbursed the Applicant for the MMT provided herein. However, while I find that Respondent supports this re-code from CPT code 95831 to CPT code 95833 with an affidavit from a certified professional coder, the parties agreed that hands were included in the manual muscle testing and therefore the correct CPT code to be billed was 95834 which is defined in the WCFS as "Muscle testing, manual (separate procedure); total evaluation of the body, including hands". The proper calculation for CPT code 95834 is RVU 14.88 x RCF 8.45, this amounts to $125.74. Respondent already reimbursed the Applicant $114.33 for the manual muscle testing herein. I find that Applicant is owed the difference of $11.41.

Accordingly, in light of the foregoing, based on the arguments of counsel, and after thorough review and consideration of all submissions, I find in favor of the Applicant. Consequently, the Applicant's claim is granted in the amount of $11.41 for the balance of manual muscle testing provided for on date of service 9/15/2020.

This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator. Any further issues raised in the hearing record are held to be moot and/or waived insofar as not raised at the time of the hearing.

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**
	Motion Medical Diagnostics, PC	**09/15/20 - 09/15/20**	**$779.23**	**$60.07**	**Awarded: $11.41**
Total			**$779.23**		**Awarded: $11.41**

B. The insurer shall also compute and pay the applicant interest set forth below. 12/18/2020 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest runs from the filing date for this case until the date that payment is made at two percent per month, simple interest, on a pro rata basis using a thirty-day month.

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 interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20 percent of that sum total, as provided for in 11 NYCRR 65-4.6(d), subject to a maximum fee of $1,360.00.

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

05/05/2022
(Dated)

Deepak Sohi

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:
8828a7befcc2d9f1ea7243723ef0b72d

Electronically Signed

Your name: Deepak Sohi
Signed on: 05/05/2022