

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

BV Physical Therapy PC  
(Applicant)

- and -

Progressive Casualty Insurance Company  
(Respondent)

AAA Case No. 17-21-1189-8654

Applicant's File No. DK21-126612

Insurer's Claim File No. 20-3766243

NAIC No. 24279

**ARBITRATION AWARD**

I, Aaron Maslow, 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: Assignor ["NL"]

1. Hearing(s) held on 07/11/2022  
Declared closed by the arbitrator on 07/11/2022

Korsunskiy Legal Group P.C. from Korsunskiy Legal Group P.C. participated by written submission for the Applicant

Progressive Casualty Insurance Company from Progressive Casualty Insurance Company participated by written submission for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,025.60**, 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

Applicant commenced this New York No-Fault insurance arbitration, seeking as compensation \$1,025.60 remaining unpaid from that which it billed for performing range of motion testing, muscle testing, and activity limitation measurement testing on Assignor, a 27-year-old female who was injured in a motor vehicle accident on June 19, 2020. Four bills are at issue, and the dates of service were July 15, 2020 and Sept. 22, 2020. Respondent made partial payment toward each bill, asserting fee defenses, including that fees were not in accordance with fee schedule.

- Whether Applicant established entitlement to additional No-Fault insurance compensation for range of motion testing, muscle testing, and activity limitation measurement testing performed on Assignor, beyond the amount paid by Respondent.
- Whether to sustain reimbursement for activity limitation measurement testing at four units.
- Whether CPT Codes 95851-95852 for range of motion testing should be reported once for each extremity and/or trunk section, and not for each muscle or motion tested.
- Whether CPT Codes 95831-95834 for muscle testing should be reported once for each extremity and/or once for the anatomical body part described in the code descriptor, and not for each muscle or motion tested.
- Whether fees were not in accordance with fee schedule.

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

##### Appearances

For Applicant:

Korsunskiy Legal Group P.C.  
3237 Long Beach Road  
Suite 110  
Oceanside, NY 11572

For Respondent:

Progressive Casualty Insurance Company  
725 Broadway  
Albany, NY 12207

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This arbitration was organized by the American Arbitration Association, which has been designated by the New York State Department of Financial Services

to coordinate the mandatory arbitration provisions of Insurance Law § 5106(b), which provides:

Every insurer shall provide a claimant with the option of submitting any dispute involving the insurer's liability to pay first party ["No-Fault insurance"] benefits, or additional first party benefits, the amount thereof or any other matter which may arise pursuant to subsection (a) of this section to arbitration pursuant to simplified procedures to be promulgated or approved by the superintendent.

This arbitration was scheduled for a hearing to take place on July 11, 2022. Rule a of the Rules for Arbitration of No-Fault Disputes in the State of New York, promulgated by the American Arbitration Association (AAA), and 11 NYCRR 65-4.5(a) in the New York No-Fault Regulations both provide: "At the arbitrator's discretion, if the dispute involves an amount less than \$2,000, the parties shall be notified that the dispute shall be resolved on the basis of written submissions of the parties." On May 21, 2022 the undersigned arbitrator entered a determination in this case's Electronic Case Folder that the instant dispute would be resolved on the basis of the written submissions of the parties. This was subsequently conveyed to the parties by AAA, who informed them that no live hearing would be conducted.

I have reviewed the submissions' documents contained in the American Arbitration Association's ADR Center as of July 11, 2022, said submissions constituting the record in this case. This is pursuant to 11 NYCRR 65-4.2(b)(3)(iv), which vests discretion in the arbitrator to determine whether documents which otherwise would be excluded from the record due to lateness by virtue of 11 NYCRR 65-4.2(b)(3)(i)-(iii) should be considered.

It is noted that on May 21, 2022, I instructed the parties to submit a fee coder affidavit concerning the fee issues. Respondent did submit one; Applicant did not.

"[A] plaintiff demonstrates prima facie entitlement to summary judgment by submitting evidence that payment of no-fault benefits are overdue, and proof of its claim, using the statutory billing form, was mailed to and received by the defendant insurer." Viviane Etienne Medical Care, P.C. v. Country-Wide Ins. Co., 25 N.Y.3d 498, 501 (2015). "The court may, in its discretion, rely on defendant's documentary submissions establishing defendant's receipt of plaintiff's claims [citation omitted]." Lenox Hill Radiology MIA, P.C. v. American Transit Ins. Co., 19 Misc.3d 358, 363 (Civ. Ct. New York Co. 2008). An insurer's denial of claim form indicating the date on which it was received adequately establishes that the claimant sent, and that the defendant received, the claim. Ultra Diagnostics Imaging v. Liberty Mutual Ins. Co., 9 Misc.3d 97 (App. Term 9th & 10th Dists. 2005). Respondent's NF-10 denial of claim forms acknowledged receipt of Applicant's proofs of claim and proved partial payment of the bills embodied therein. Hence, I find that Applicant established a prima facie case of entitlement to No-Fault compensation.

Respondent's denials were timely issued, i.e., within the 30-day deadline prescribed by Insurance Law §5106(a) and 11 NYCRR 65-3.8(a)(1). As such, all

defenses in the denials may be considered. In any event, fee issues may be considered regardless of whether a denial of claim is timely issued. E.g., Jing Luo Acupuncture, P.C. v. NY City Transit Authority, 60 Misc.3d 136(A), 2018 N.Y. Slip Op. 51083(U) (App. Term 2d, 11th & 13th Dists. July 6, 2018); Surgicare Surgical Associates v. National Interstate Ins. Co., 50 Misc.3d 85 (App. Term 1st Dept. 2015), aff'g, 46 Misc.3d 736 (Civ. Ct. Bronx Co. 2014) (New Jersey); USAA General Indemnity Co. v. New York Chiropractic & Physical Therapy, PLLC, 60 Misc.3d 254 (Civ. Ct. Richmond Co., Lisa Grey, J., May 1, 2018).

#### Activity Limitation Measurement Testing

Applicant billed \$475.00 for activity limitation measurement testing in two bills, one for date of service July 15, 2020 and one for date of service Sept. 22, 2020. In each instance, Respondent paid \$166.64, leaving \$308.36 in dispute. Besides asserting that fees were not in accordance with fee schedule, Respondent's denial of claim contained the following:

Based on your documentation, we disagree with your opinion of the proper Relative Value Unit (RVU) for this procedure. Per NY Workers' Compensation Ground Rules, the insurer shall review all submitted "BR" relative value units to ensure that the relativity consistency is maintained. Based on the documentation submitted, reimbursement is being made equivalent to 4 units of code 97750.

I note that the activity limitation measurement testing was billed under CPT Code 97799. CPT Code 97799 is defined in the Workers' Compensation Medical Fee Schedule as "Unlisted physical medicine/rehabilitation service or procedure." It is a "by report" code. The Ground Rules in the Workers' Compensation fee schedules apply to No-Fault unless they require reports specific to Workers' Compensation. 11 NYCRR 68.1(b)(1). Ground Rule 3 to Chapter 1 (Introduction and General Guidelines) of the Workers' Compensation Medical Fee Schedule sets forth reporting requirements for services billed with CPT codes which are "by report":

"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 service, the time, the skill, and equipment necessary, etc., is to be furnished. A detailed clinical record 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 No-Fault Regulations, at 11 NYCRR 65-3.8(g) prohibit compensation in excess of the fee schedule.

Respondent's fee coder affidavit explained how Applicant submitted a report with which Respondent disagreed. In this report, Applicant compared activity limitation measurement testing to CPT Codes 97750 physical performance testing, 97545 work hardening and conditioning, and 97800 functional capacity evaluations. In each instance, it was explained by Respondent's coder how the comparisons were inapropos.

I have reviewed Applicant's report, entitled "'Activity Limitation Measurement and Training Report (billed as 97799)." The report lacks Assignor's name. Therefore it is not particularized to Assignor. The contents of the report are identical to those submitted in other cases. It is general in nature as to the procedure.

Applicant's report described the testing as follows:

Activity limitations are difficulties an individual may have in the performance of daily activities - both at work and domestically. Such limitations must be actually observable, and are rated regardless of capacity or aptitude. Several additions and qualifiers to activity limitations are: activity limitations involve the integrated use of body functions at the individual level; activity limitations involve qualitative or quantitative alterations in the way an activity is performed in relation to reduce or eliminate an activity limitation, though an underlying impairment (of body function or structure) if applicable.

The purpose for the testing is threefold, according to the report. It will identify functional weakness and strength deficits, allowing for proper treatment and rehabilitation, aid in establishing an impartial and objective measurement of the patient's capabilities, and provide the patient with quantifiable limitations he or she faces as a result of the injury.

The report continues by stating that "Depending on the level of patient's compliance, the examination takes 40-55 minutes." It is also claimed that the patient received training as to how to deal with limitations.

As for the fee, this report maintains that Code 97799 is appropriate. It compared the activity limitation measurement testing to three services "[i]n order to consider a proper amount to be billed." The three services are as follows:

97750 - Physical Performance Testing - each 15 minutes - 5.41 RVUs

97545 - Work hardening/conditioning - 28.00 RVUs

97800 - Functional capacity evaluation - \$500

According to this report, "After taking in[to] consideration both value of Functional Capacity evaluation and other similar codes, and the prevailing rate charged by the providers in our geographic area, we determined that the proper amount to bill for this procedure is \$475."

I find this report insufficient for a by report code. First, the above cited Ground Rule requires "[p]ertinent information concerning the nature, extent, and need for the procedure or service, [and] the time." This report contained no pertinent information specific to Assignor which would explain why this testing was performed. The specific time was not documented for Assignor. A general statement that it takes 40-55 minutes is insufficient.

The Ground Rule emphasizes that original records will be given far greater weight than reports formulated later on. The only original record is a set of computer-generated data; it lacks any recordation of specific, tailor-made instructions for Assignor based on the particular injuries. The skill of the person performing the service was also not documented although the Ground Rule requires it.

Finally, while "a relative value unit consistent in relativity with other relative value units shown in the schedule" must be established by the physician, that did not take place here. In fact, if one were to work backwards arithmetically, and take the flat fee of \$475.00 and divide it by the Region IV conversion factor of \$7.70 for physical therapists, the relative value units would be 61.68. Assuming that 40-55 minutes were spent (although the exact amount of time for Assignor is not set forth), assigning 61.68 relative value units is grossly disproportionate to the 28.00 units assigned for four hours of Code 97545 work hardening.

Applicant charged about the same as the prescribed fee for a functional capacity evaluation. There are many requirements for the latter such as that it should not be performed prior to three months post-injury unless there is significant documented change in condition, that the testing be performed in connection with work obligations, and that there be a narrative cover sheet with recommendations. These conditions were not met in the instant case, so charging \$475.00, which is close to the Region IV \$495.00 fee for a Code 97800 functional capacity evaluation, is inappropriate.

In light of the foregoing, I find that the report submitted by Applicant fails to comply with the requirements of Ground Rule 3 to Chapter 1 (Introduction and General Guidelines) of the Workers' Compensation Medical Fee Schedule.

As a means of containing the cost of No-Fault automobile liability insurance, the Legislature provided for the establishment of schedules of maximum permissible charges for medical, hospital, and other professional health services payable under

No-Fault insurance benefits. Tucciarone v. Progressive Ins. Co., 204 A.D.2d 864 (3d Dept. 1994). In order to contain the cost of providing medical services to patients treated under New York's No-Fault law, the state legislature set limits on the fees health care providers may charge patients who sustain injuries by incorporating into the No-Fault scheme the fee schedules established by the Worker's Compensation Board for industrial accidents. John Giugliano, DC, P.C. v. Merchants Mutual Ins. Co., 29 Misc.3d 367 (Civ. Ct. Kings Co. 2010). Other court decisions have also recognized that one of the purposes for enacting the No-Fault system for motor vehicle accidents in the first instance was to save on the cost of insurance premiums. E.g., Matter of Medical Society v. Serio, 100 N.Y.2d 854, 860 (2003); Goldberg v. Corcoran, 153 A.D.2d 113, 118 (2d Dept. 1989); Palmer v. Allstate Ins. Co., 101 A.D.2d 127, 132-133 (2d Dept. 1984).

Most medical services provided for in the Workers' Compensation fees schedules have specific relative values which, when multiplied by the appropriate conversion factor, yield maximum permissible charges. There are some services, however, which lack specific relative values. They could be billed under the miscellaneous by report codes and they will be compensated for under the No-Fault system. However, the fees must be justified by the health service providers who perform them. That requirement is consistent with the aforecited legislative history. Allowing health service providers to bill for unspecified procedures at flat rates where the information provided fails to comply with the requirements to individually particularize how those rates were arrived at would contravene the legislative intent in enacting the No-Fault system in the 1970s. Applicant here has not provided sufficient information to justify its flat rate of \$475.00.

In Bronx Acupuncture Therapy, P.C. v. Hereford Ins. Co., 175 A.D.3d 455 (2d Dept. 2019), it was held that a denial of claim concerning a by report service which is predicated upon a defense that the provider failed to provide pertinent information concerning the nature, extent, and need for the service, or the time, the skill and the equipment necessary -- matters required to be set forth in the requisite report - is without merit as a matter of law since the insurer could have sought the information in a verification request; in essence, such a denial is based on the lack of sufficient information. In the case at bar, however, Respondent did not deny payment on the basis of by report information not being provided. A report was sent by Applicant along with the claim form and Respondent did make partial payment instead of completely denying the bill. An insurer need not adhere to a health service provider's report concerning the amount charged but may consider it and determine that the service is compensable at a reduced amount. See 11 NYCRR 68.5(a). Hence Bronx Acupuncture Therapy, P.C. is not applicable although a by report code was billed.

By failing to substantiate its fee of \$475.00 in its report which accompanied the claim form, Applicant charged an excessive fee in contravention of 11 NYCRR 65-3.8(g). I sustain denial of compensation beyond what was paid. No further compensation is awarded for the activity limitation measurement testing. Applicant's prima facie case of entitlement to No-Fault compensation was overcome by the defense that fees were not in accordance with fee schedule.

### Range of Motion & Muscle Testing

Applicant charged \$416.60 for range of motion testing on July 15, 2020, and \$278.11 for muscle testing on that date. Respondent paid \$166.64 for the range of motion testing and \$119.19 for the muscle testing, leaving \$249.96 and \$158.92 respectively in dispute.

When the No-Fault Law was first enacted by New York's State Legislature there were no limitations on fees charged by medical providers. Laws 1973, ch. 13. However, when the Legislature revised the No-Fault Law in 1977, it added a provision limiting fees for medical services to "the charges permissible under the schedules prepared and established by the chairman of the workmen's compensation board for industrial accidents. . . ." Laws 1977, Ch. 892, § 15, adding Insurance Law § 678. Section 3 of the newly added § 678 provided: "No provider of health services specified in paragraph (a) of subdivision one of section six hundred seventy-one of this article may demand or request any payment in addition to the charges authorized in subdivisions one and two of this section." The memorandum of the State Executive Department stated, "The application of the workmen's compensation fee schedule to injuries covered by no-fault is expected to significantly reduce the amount paid by insurers for medical services, and thereby help contain the no-fault premium." McKinney's Sessions Laws 1977, p. 2449. The adoption of the workmen's compensation fee schedules was a response to "various abuses, including health-care charges for auto accident victims which are significantly higher than they would be for a person not suffering an auto injury. As a form of legislatively mandated social insurance providing benefits to accident victims, no-fault is most analogous to workmen's compensation, and application of the workmen's compensation fee schedules to no-fault cases would be entirely appropriate." *Id.*, p. 2450.

In the 1984 recodification of the Insurance Law (Laws 1984, Ch. 367), the prior § 678's provisions were recodified to § 5108:

- (a) The charges for services specified in paragraph one of subsection (a) of section five thousand one hundred two of this article and any further health service charges which are incurred as a result of the injury and which are in excess of basic economic loss, shall not exceed the charges permissible under the schedules prepared and established by the chairman of the workers' compensation board for industrial accidents, except where the insurer or arbitrator determines that unusual procedures or unique circumstances justify the excess charge.
- (b) The superintendent, after consulting with the chairman of the workers' compensation board and the commissioner of health, shall



promulgate rules and regulations implementing and coordinating the provisions of this article and the workers' compensation law with respect to charges for the professional health services specified in paragraph one of subsection (a) of section five thousand one hundred two of this article, including the establishment of schedules for all such services for which schedules have not been prepared and established by the chairman of the workers' compensation board.

(c) No provider of health services specified in paragraph one of subsection (a) of section five thousand one hundred two of this article may demand or request any payment in addition to the charges authorized pursuant to this section. Every insurer shall report to the commissioner of health any patterns of overcharging, excessive treatment or other improper actions by a health provider within thirty days after such insurer has knowledge of such pattern.

The Superintendent of Insurance adopted regulations implementing the statutory provisions governing fees for No-Fault insurance, in Regulation 83. Specifically, in 11 NYCRR 68.1(a), the Superintendent adopted the "fee schedules prepared and established by the chairman of the Workers' Compensation Board for industrial accidents." In 11 NYCRR 68.1(b)(1), the Superintendent provided: "The charges for services specified in paragraph one of subsection (a) of section 5102 of the Insurance Law and any further health service charges which are incurred as a result of the injury and which are in excess of basic economic loss, shall not exceed the charges permissible under the schedules prepared and established by the chair of the Workers' Compensation Board for industrial accidents." So that it was clear, the Superintendent provided in 11 NYCRR 68.0(f): "Providers of health services are prohibited from demanding or requesting any payment for services in excess of permissible charges, and the law requires insurers to report to the Commissioner of Health patterns of overcharging, excessive treatment or other improper actions by a health provider."

In 12 NYCRR 329-1.3(a), the chair of the Workers' Compensation Board enacted the following provision: "The medical fee schedule for medical, physical therapy and occupational therapy services shall be the Official New York Workers' Compensation Medical Fee Schedule, updated June 1, 2012, prepared by the Board and published by OptumInsight, which is herein incorporated by reference." This Workers' Compensation Medical Fee Schedule therefore governs all No-Fault claims for medical expenses, as per the above statutory and regulatory provisions.

Thus, through statute and regulation, the Workers' Compensation Medical Fee Schedule governs the range of motion and muscle testing performed on Assignor. The Workers' Compensation Medical Fee Schedule provides that CPT Code 95851 range of motion testing is to be billed by extremity or trunk section, and that CPT Code 95831 muscle testing is to be billed by extremity or the trunk. The following are the official provisions regarding these two codes in the said Fee Schedule:

95851 Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)

95831 Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk

Additionally, said Fee Schedule contains provisions with respect to CPT Code 95833:

95833 Muscle testing, manual (separate procedure) with report; total evaluation of body, excluding hands

The Region IV conversion factor for physical therapists is \$7.70. When it is multiplied by the 5.41 RVUs assigned by the Workers' Compensation Medical Fee Schedule to Code 95851 range of motion testing, the resulting maximum permissible charge is \$41.66. Applicant billed \$41.66 per line entry.

The Region IV conversion factor for physical therapists is \$7.70. When it is multiplied by the 5.16 RVUs assigned by the Workers' Compensation Medical Fee Schedule to Code 95831 muscle testing, the resulting maximum permissible charge is \$39.73. Applicant billed \$39.73 per line entry.

Moreover, CPT Code 95833, defined as muscle testing of the entire body excluding hands, is assigned 13.53 RVUs. When multiplied by the \$7.70 Region IV conversion factor for physical therapists, the resulting product is \$104.18. Applicant's bill for muscle testing exceeded the \$104.18 one could be compensated for testing the entire body. It could never have been the intention of the Legislature, in limiting No-Fault fees, to allow this to occur. The Workers' Compensation Board, in creating its Fee Schedule, could never have intended to allow one to receive compensation for testing less than the entire body than it could for testing the entire body. Obviously Applicant overcharged in its billing for muscle testing by billing more than \$104.18 for testing not the entire body excluding hands, but merely parts of the body.

To properly determine the amount of No-Fault insurance compensation for the subject testing and whether to sustain Respondent's fee defenses, each bill must be recalculated. My calculations follow.

#### July 15, 2020: Range of Motion Testing

Applicant's billing and Respondent's appurtenant denial of claim were as follows:

Billed \$416.60; Paid \$166.64; Dispute \$249.96

95851 range of motion testing - cervical flexion - \$41.66

95851 range of motion testing - cervical extension - \$41.66  
95851 range of motion testing - cervical lateral right - \$41.66  
95851 range of motion testing - cervical lateral left - \$41.66  
95851 range of motion testing - lumbar flexion - \$41.66  
95851 range of motion testing - lumbar extension - \$41.66  
95851 range of motion testing - lumbar lateral right - \$41.66  
95851 range of motion testing - lumbar lateral left - \$41.66  
95851 range of motion testing - knee flexion right - \$41.66  
95851 range of motion testing - knee flexion left - \$41.66

Respondent's denial of claim appurtenant to the bill for range of motion testing asserted, "Codes 95851-95852 should be reported once for each extremity and/or trunk section. It is not to be used for each muscle or motion tested and is therefore denied." The denial also asserted that fees were not in accordance with fee schedule.

Applicant charged multiple line entries for range of motion testing of the cervical and lumbar spines. This constituted overcharging. The Workers' Compensation Medical Fee Schedule definition for CPT Code 95851 clearly provides for compensation once for each part of the trunk and once for each extremity.

Billing should have been as follows:

95851 range of motion testing - cervical - \$41.66  
95851 range of motion testing - lumbar - \$41.66  
95851 range of motion testing - right knee - \$41.66  
95851 range of motion testing - left knee - \$41.66  
Total - \$166.64

I sustain Respondent's defense that fees were not in accordance with fee schedule (Box 18). I sustain Respondent's defense that range of motion testing compensation is limited to once per extremity or trunk section, and not for each muscle or motion tested. Respondent paid \$166.64, which is exactly the correct amount. Applicant is not entitled to further compensation.

#### July 15, 2020: Muscle Testing

Applicant's billing and Respondent's appurtenant denial of claim were as follows:

Billed \$278.11; Paid \$119.19; Dispute \$158.92

95831 muscle testing - neck flexion - \$39.73  
95831 muscle testing - neck extension - \$39.73  
95831 muscle testing - neck rotation right - \$39.73  
95831 muscle testing - neck rotation left - \$39.73

95831 muscle testing - trunk flexion - \$39.73  
95831 muscle testing - knee extension right - \$39.73  
95831 muscle testing - knee extension left - \$39.73

Respondent's denial of claim appurtenant to the bill for muscle testing asserted, "Codes 95831-95834 should be reported once for each extremity and/or once for the anatomical body part described within the code descriptor. It is not to be used for each muscle or motion tested and is therefore denied." The denial also asserted that fees were not in accordance with fee schedule.

Applicant charged multiple line entries for muscle testing of the neck. This constituted overcharging. Applicant billed the neck separately from the trunk, of which it is a part. This constituted overcharging. The Workers' Compensation Medical Fee Schedule definition for CPT Code 95851 clearly provides for compensation once for the trunk and once for each extremity. Moreover, there is a limit on the fee for muscle testing of the entire body. In exceeding it, Applicant overcharged.

Billing should have been as follows:  
95833 muscle testing - entire body (excluding hands) - \$104.18

I sustain Respondent's defense that fees were not in accordance with fee schedule (Box 18). I sustain Respondent's defense that muscle testing compensation is limited to once for each extremity and/or once for the anatomical body part described within the code descriptor, and not for each muscle or motion tested. Respondent paid \$119.19. It doing so it overpaid. Applicant is not entitled to further compensation. Respondent has not made a claim for restitution of the overpayment and there is a question as to whether it can be directed.

### Conclusion

The fee defenses which are sustained overcome Applicant's prima facie case of entitlement to No-Fault compensation. Accordingly, the within arbitration claim is denied in its entirety.

This arbitrator has not made a determination that benefits provided for under Article 51 (the No-Fault statute) of the Insurance Law are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of Assignor. As such and in accordance with the provisions of the prescribed NYS Form NF-AOB (the assignment of benefits), Applicant health provider shall not pursue payment directly from Assignor for services which were the subject of this arbitration, notwithstanding any other agreement to the contrary.

Imposition of Costs: 11 NYCRR 65-4.5(t)(1) in the No-Fault Regulations provides: "Effective with arbitrations filed on and after March 1, 2002, the arbitrator

may impose all administrative costs of arbitration to the applicant or apportion the administrative costs of arbitration between the parties if the arbitrator concludes that the applicant's arbitration request was frivolous, was without factual or legal merit, or was filed for the purpose of harassing the respondent. Cases in which arbitrators impose all administrative costs to the applicant shall be excluded from the assessment calculation contained in subdivision (aa) of this section."

As explained above, the Workers' Compensation Medical Fee Schedule, which governs fees chargeable for medical services provided to persons injured in motor vehicle accidents, pursuant to Insurance Law § 5108(a), is explicitly clear in how fees are to be calculated for range of motion and muscle testing. Respondent paid exactly the correct amount for one bill. It overpaid for the other bill. Applicant overcharged in various ways: (1) It charged for multiple movements of a body part in range of motion testing. (2) It charged for multiple movements of a body part in muscle testing. (3) It charged for the neck separately from the trunk. (4) It charged more for muscle testing of certain body parts than it could have charged for muscle testing of the entire body. The amounts of Applicant's overcharges were excessive. The overcharging could not have been the product of miscalculation. I find Applicant's maintenance of these overcharging practices in this arbitration to have been frivolous. Upon receipt of Respondent's denials of claim appurtenant to these bills, it should have been apparent to Applicant that it overcharged. Counsel for Applicant should have noticed this prior to filing for arbitration. Yet Applicant continued to pursue compensation for the referenced bills in an attempt to enforce its overcharging. After the undersigned issued a directive that a fee coder affidavit be submitted, Applicant did not do so. Applicant's arbitration request was frivolous and without factual or legal merit with respect to the bills. I impose half of the administrative costs of this arbitration (reflecting the bills for range of motion and muscle testing) on Applicant. As per 11 NYCRR 65-4.5(t)(2), "The amount of such administrative costs per case shall be established for each calendar year by the designated organization. The administrative cost shall be based upon the actual administrative costs per case in the prior calendar year. Such costs shall be paid to the designated organization and the receipt of such costs shall be used to reduce the actual expenses of the designated organization for the administration of the arbitration forum."

5. Optional imposition of administrative costs on Applicant.  
Applicable for arbitration requests filed on and after March 1, 2002.

I apportion the administrative costs of arbitration to the applicant, in the amount established for the current calendar year by the Designated Organization.

I find that the applicant's arbitration request was frivolous, was without factual or legal merit or was filed for the purpose of harassing the respondent, pursuant to Section 65-4.5(t) of the Regulations of the Department of Financial Services. The basis of my determination is as follows:

Compensation Medical Fee Schedule, which governs fees chargeable for medical services provided to persons injured in motor vehicle accidents, pursuant to Insurance Law § 5108(a), is explicitly clear in how fees are to be calculated for range of motion and muscle testing. Respondent paid exactly the correct amount for one bill. It overpaid for the other bill. Applicant overcharged in various ways: (1) It charged for multiple movements of a body part in range of motion testing. (2) It charged for multiple movements of a body part in muscle testing. (3) It charged for the neck separately from the trunk. (4) It charged more for muscle testing of certain body parts than it could have charged for muscle testing of the entire body. The amounts of Applicant's overcharges were excessive. The overcharging could not have been the product of miscalculation. I find Applicant's maintenance of these overcharging practices in this arbitration to have been frivolous. Upon receipt of Respondent's denials of claim appurtenant to these bills, it should have been apparent to Applicant that it overcharged. Counsel for Applicant should have noticed this prior to filing for arbitration. Yet Applicant continued to pursue compensation for the referenced bills in an attempt to enforce its overcharging. After the undersigned issued a directive that a fee coder affidavit be submitted, Applicant did not do so. Applicant's arbitration request was frivolous and without factual or legal merit with respect to the bills. I impose half of the administrative costs of this arbitration (reflecting the bills for range of motion and muscle testing) on Applicant. As per 11 NYCRR 65-4.5(t)(2), "The amount of such administrative costs per case shall be established for each calendar year by the designated organization. The administrative cost shall be based upon the actual administrative costs per case in the prior calendar year. Such costs shall be paid to the designated organization and the receipt of such costs shall be used to reduce the actual expenses of the designated organization for the administration of the arbitration forum."

The specific findings upon which I impose or apportion such administrative costs to the applicant are as follows:

| <b>Claimant</b>        | <b>% of Admin Costs</b> |
|------------------------|-------------------------|
| BV Physical Therapy PC | 50.00%                  |
| <b>TOTAL</b>           | <b>50.00%</b>           |

**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 Kings

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

07/16/2022

(Dated)

Aaron Maslow

#### **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:**  
6ea8643e80a5e3364cf5bfb7740ca33

### **Electronically Signed**

Your name: Aaron Maslow  
Signed on: 07/16/2022