American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

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| Miklos F Losonczy MD<br>(Applicant) | AAA Case No. | 17-21-1230-0986 |
| | Applicant's File No. | MKPC 385.01 |
| - and - | Insurer's Claim File No. | 3219D888X |
| | NAIC No. | 25178 |
| State Farm Mutual Automobile Insurance Company<br>(Respondent) | | |

## ARBITRATION AWARD

I, Paul Weidenbaum, 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 07/19/2022
   Declared closed by the arbitrator on 07/19/2022

   Michael J. Lamond from Akiva Ofshtein PC participated in person for the Applicant

   Nicole McErlean from Freiberg, Peck & Kang, LLP participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$1,399.95**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The amount claimed in No-Fault benefits was amended during the arbitration hearing from $1,399.96 to $699.98 in order to acknowledge a prior payment in the sum of $699.98 made by the Respondent, and the amendment was permitted by this arbitrator.

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

3. Summary of Issues in Dispute

This arbitration arises out of the medical treatment provided to the injured person, an 18 year old female, who was involved in a motor vehicle accident which occurred on 4/29/21.

Whether the Respondent's reduction/denial of the Applicant's claim for reimbursement of No-Fault benefits based on fee schedule can be sustained?

4. Findings, Conclusions, and Basis Therefor

I have reviewed all of the documents contained in the Electronic Case Folder [ECF] maintained by the American Arbitration Association [AAA] as of the date of the arbitration hearing.

This arbitration arises out of the medical treatment provided to the injured person, an 18 year old female, who was involved in a motor vehicle accident which occurred on 4/29/21. Applicant initially sought reimbursement for services provided on 8/5/21 in the sum of $1,399.96. However, during the arbitration hearing, Applicant's counsel amended the amount claimed in No-Fault benefits to $699.98, or 50% of the AR-1 amount in dispute, in order to acknowledge a prior payment in the sum of $699.98 made by the Respondent.

The Respondent has submitted a fee audit prepared by James Lee, C.P.C. dated 2/14/22, in which he concludes that no additional reimbursement is due for the services provided to the claimant on 8/5/21 as those services were appropriately reimbursed by the Respondent when it previously paid the sum of $699.98. Mr. Lee attests as follows in his 2/14/22 fee audit affidavit:

***1. I, James S. Lee, DC, CPC, have personal knowledge of the facts at issue, being a Certified Professional Coder, credentialed with the American Academy of Professional Coders ("AAPC"). In order to become credentialed with the AAPC, I was required to take classes in coding, billing, and compliance, and to successfully complete a comprehensive examination administered by the AAPC. I must adhere to ongoing continuing education requirements in order to maintain my credentialing. I am a member of the Jamaica, New York and Cliffside Park, New Jersey AAPC chapters. I possess eleven years of billing and coding experience.***

***2. As a licensed Chiropractor in the State of New York and the State of New Jersey with eleven years of professional experience, I possess knowledge of the medical terminology described within in the relevant records. I am currently engaged in private practice.***

***3. I have been requested to conduct a review of the following claim(s) in order to determine whether the correct American Medical Association's (AMA) Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes were applied and billed correctly.***

***4. The following records were reviewed:***

***a. Arbitration request form***

***b. Claim from Miklos F. Losonczy MD totaling $2,099.94***

***c. Corresponding NF-10 denial and explanation of review***

***d. 8/5/21 records for extracorporeal shockwave therapy***

***Per 11 NYCRR $ 68 and section 5108 of the Insurance Law, the New York State Workers' Compensation Medical Fee Schedule applies to the claims herein.***

***The Workers Compensation fee schedule was updated effective 4/1/2019, with it being applicable for no-fault providers from 10/1/20.***

***In general, the correct fee for a particular procedure is calculated by multiplying the Relative Value Units (RVU) assigned to the procedure's CPT code with the applicable Conversion Factor (CF), subject to ground rules.***

***The records indicate that this provider has a mailing address in Brooklyn, NY I1209. The place of service is listed as Ozone Park, NY 11416. Both locations fall within Region IV for determining Conversion Factor.***

***The applicable Conversion Factors are as follows: (a). Surgery codes: $251.94***

***Surgery Ground Rule 5 states: "When multiple procedures, unrelated to the major procedure and adding significant time or complexity, are provided at the same operative session, payment is for the procedure with the highest allowance plus half of the lesser procedures." Add-on and modifier 5l exempt codes are exempt from this reduction rule.***

***CPT code 0101T is a category III code for "extracorporeal shock wave involving musculoskeletal system, not otherwise specified, high energy" with a Relative Value of 2.78. The fee schedule indicates that the surgery conversion factor applies. The second and third units of CPT code 0101T are not separately reimbursable. The code description does not indicate an allowance for multiple units as it is not a time-based code and it does not allow per body region. The NCCI's Medically Unlikely Edits confirms that only one unit of this code is allowable per date of service. As such, the first unit is reimbursable at l00oh as billed at $699.98. The additional units are not reimbursable. Conclusion: The claim totaling $2,099.94 exceeds the permissible fee schedule. The correct allowable amount is $699.98. The carrier issued prior payment of $699.98. No additional payment is due. See applicable sections of the fee schedule and other reference materials annexed to this affidavit.***

However, on 7/19/22, the date of the hearing, Applicant's counsel, for the purpose of impeaching the credibility of the Respondent's fee coding expert, uploaded to the

Electronic Case Folder [ECF] a prior fee audit affidavit dated 7/6/21 prepared by Mr. Lee in connection with billing under the same Code 0101T, in which Mr. Lee reached a different conclusion, as follows:

***I, James S. Lee, DC, CPC, have personal knowledge of the facts at issue, being a Certified Professional Coder, credentialed with the American Academy of Professional Coders ("AAPC"). In order to become credentialed with the AAPC, I was required to take classes in coding, billing, and compliance, and to successfully complete a comprehensive examination administered by the AAPC. I must adhere to ongoing continuing education requirements in order to maintain my credentialing. I am a member of the Jamaica, New York and Cliffside Park, New Jersey AAPC chapters. I possess ten years of billing and coding experience.***

***As a licensed Chiropractor in the State of New York and the State of New Jersey with ten years of professional experience, I possess knowledge of the medical terminology described within in the relevant records. I am currently engaged in private practice.***

***I have been requested to conduct a review of the following claim(s) in order to determine whether the correct American Medical Association's (AMA) Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes were applied and billed correctly***

***The following records were reviewed:***

***a. Claim from East Coast Medical Care PC totaling $2,197.74***

***b. Corresponding NF-10 denial and explanation of benefits***

***c. Shockwave therapy records and exam reports Per 11 NYCRR $ 68 and section 5108 of the Insurance Law, the New York State Workers' Compensation Medical Fee Schedule applies to the claims herein. The Workers Compensation fee schedule was updated effective 4/1/2019,with it being applicable for no-fault providers from 10/1/2020. In general, the correct fee for a particular procedure is calculated by multiplying the Relative Value Units (RVU) assigned to the procedure's CPT code with the applicable Conversion Factor (CF), subject to ground rules. The records indicate that this provider has a mailing address in Brooklyn, Ny 11209. The place of service is listed as Bronx, NY 10465. Both locations fall within Region IV for determining Conversion Factor. The applicable Conversion Factors for Region IV are as follows:(a). E/M codes: $15.06 (b). Surgery codes: $251.94***

***General Ground Rule 3 states: "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 conceming the nature, extent, and need for the procedure or service, the time, the skill, and equipment necessary, etc., is to be furnished. For any procedure where the relative value 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.***

***Surgery Ground Rule 5 states: "when multiple procedures, unrelated to the major procedure and adding significant time or complexity, are provided at the same operative session, payment is for the procedure with the highest allowance plus half of the lesser procedures. The same rule applies for bilateral procedures when such are not specifically identified in the schedule." Add-on and modifier 51 exempt codes are exempt from this reduction rule.***

***CPT code 99201is an E/M code for an office or other outpatient visit for the evaluation and management of a new patient with a Relative Value of 5.83. Modifier 25 should have been appended to indicate a significant and separately identifiable E/M service. It is reimbursable once for the first exam.***

***CPT code 0101T is a category III code for "extracorporeal shock wave involving musculoskeletal system, not otherwise specified, high energy" with a Relative Value of 2.78. The fee schedule indicates that the surgery conversion factor applies. As such, the surgery multiple procedure rule also applies. The first unit per date of service is reimbursable at 100% as billed at $699.98. The additional units per date of service are reimbursable at 50%: Conversion Factor $251.94 x RVU 2.78=$700.39 x 50%= $350.20.***

***Conclusion: The claim totaling $2,187.74 exceeds the permissible fee schedule. The correct allowable amount is $ 1,488.18. The carrier issued prior payment of $787.78. If all other issues are set aside, an additional $700.40 is due. See applicable sections of the fee schedule and other refbrence materials annexed to this affidavit.***

Thereafter, in order to rehabilitate the credibility of its fee coding expert, the Respondent submitted the below 6/13/22 affidavit of James Lee, in which he states the following:

***I previously conducted fee reviews of claims where multiple units of CPT code 0101T were billed. In a few early instances of reviewing such claims, I permitted reimbursement for the multiple units of this code with the application of the surgery multiple procedure rule. However, after further consideration and analysis, I revised my position to permit reimbursement for just one unit per day.***

***CPT Code 0101T is a surgery type Category III code for "Extracorporeal Shockwave involving musculoskeletal system, otherwise specified, high energy".***

***The NCCI's Medically Unlikely Edits (MUEs) indicates that only one unit of this code is allowable per date of service. MUEs limit the number of times a service or procedure can be reported by a physician on the same date of service to an individual patient. The edits are based on anatomic considerations, HCPCS/CPT code descriptors, CPT coding instruction, and nature of service or procedure. Further, code***

***description does not indicate any language that would allow for multiple units, such as a per-time clause, per-region clause, per-unit clause, etc. Instead, it is written to apply to the "musculoskeletal system".***

***Based on the above, I affirm my current position that only one unit of CPT Code 0101T is reimbursable per day regardless of the body region on which they are performed.***

Respondent argues that the fees charged by Applicant for the services at issue were in excess of those permitted under the Workers' Compensation Fee Schedule. 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). If Respondent fails to demonstrate by competent evidentiary proof that a plaintiff's claims were in excess of the appropriate fee schedules, defendant's defense of noncompliance with the appropriate fee schedules cannot be sustained. See, Continental Medical PC v. Travelers Indemnity Co., 11 Misc.3d 145A, 819 N.Y.S.2d 847, 2006 NY Slip Op 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Term, 1st Dep't, per curiam, 2006).

Respondent may interpose a defense in a timely denial that the claim exceeds the fees permitted by the Workers' Compensation schedules, but Respondent must, at minimum, establish, by evidentiary proof, that the charges exceeded that permitted by law. Abraham v. Country-Wide Ins. Co., 3 Misc.3d 130A, 787 N.Y.S.2d 678, 2004 NY Slip Op 50388U, 2004 N.Y. Misc. LEXIS 544 (App. Term, 2d Dept. 2004).

I credit that Mr. Lee has, by the terms of his 6/13/22 affidavit set forth above, renounced his previously held position with respect to the appropriateness of billing more than one unit per date of service of CPT Code 0101T. Mr. Lee's 6/13/22 affidavit offers a clear and concise rationale for the basis upon which he changed his view of the ability of a physician to bill multiple units of CPT Code 0101T on a single date of service for an individual patient, and, therefore, his 2/14/22 affidavit prepared by Mr. Lee and submitted on behalf of the Respondent to support its fee schedule defense in the instant matter is credible and persuasive.

I find the 2/14/22 affidavit of James Lee, C.P.C., the Respondent's fee coding expert, to be determinative on the question of the allowable rate of reimbursement for services provided and billed under Code 0101T. Accordingly, it is my determination that the Applicant is not entitled to any further reimbursement for date of service 8/5/21, and the Applicant's claim for the amended sum of $699.98 is hereby denied in its entirety.

This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator.

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

   I do NOT impose the administrative costs of arbitration to the applicant, in the amount established for the current calendar year by the Designated Organization.

6. **I find as follows with regard to the policy issues before me:**
   - ☐ The policy was not in force on the date of the accident
   - ☐ The applicant was excluded under policy conditions or exclusions
   - ☐ The applicant violated policy conditions, resulting in exclusion from coverage
   - ☐ The applicant was not an "eligible injured person"
   - ☐ The conditions for MVAIC eligibility were not met
   - ☐ The injured person was not a "qualified person" (under the MVAIC)
   - ☐ The applicant's injuries didn't arise out of the "use or operation" of a motor vehicle
   - ☐ The respondent is not subject to the jurisdiction of the New York No-Fault arbitration forum

Accordingly, the claim is DENIED in its entirety

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of New York
SS :
County of NASSAU

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

07/19/2022
(Dated)

Paul Weidenbaum

**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:**
0307db40b853cdedc7b54c0c68848e78

**Electronically Signed**

Your name: Paul Weidenbaum
Signed on: 07/19/2022