American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

334 Grand Concourse Medical PC (Applicant)	AAA Case No.	17-21-1221-5817
	Applicant's File No.	AF21-123286
- and -	Insurer's Claim File No.	0633011950000002
	NAIC No.	22055
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Thomas Eck, 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

1. Hearing(s) held on 07/25/2022
   Declared closed by the arbitrator on 07/26/2022

   Joshua Mak from Abrams Fensterman, LLP participated in person for the Applicant

   Kelly Armstrong from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$2,101.17**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The amount in dispute has been amended to $1400.78 by the Applicant to reflect payments made and fee schedule rates.

   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 bills. The parties also stipulated that Respondent's NF-10 denial of claim forms were timely issued.

The parties have stipulated that the sole issue to be decided is the amount due pursuant to the Workers' Compensation Fee Schedule.

3. Summary of Issues in Dispute

This arbitration arises out of medical treatment for the Assignor, a 45-year-old male, who was involved in a motor vehicle accident on 3/20/2021. The Assignor came under the care of the Applicant who is now seeking reimbursement for shockwave therapy services provided to the Assignor for dates of service 7/22/2021-7/22/2021. Respondent denied payment based on an Independent Medical Examination.

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

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. 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).

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. If Respondent fails to demonstrate by competent evidentiary proof that an Applicant's claims were in excess of the appropriate fee schedules, Respondent'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 curium, 2006).

I take judicial notice of the New York State Workers' Compensation Board Medical Fee Schedule ("Fee Schedule") because it is of sufficient authenticity and reliability. See, Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co., 61 A.D.3d 13, 871 N.Y.S.2d 680 (2d Dept. 2009); LVOV Acupuncture, P.C. v. Geico Ins. Co., 32 Misc.3d 144(A), 939 N.Y.S.2d 741(Table) (App Term 2d, 11th & 13th Jud Dists. 2011).

The parties have stipulated that the sole issue to be decided is the amount due pursuant to the Workers' Compensation Fee Schedule as the Respondent is unable to establish its defense based on an Independent Medical Examination.

CPT Code 0101T

Applicant submitted bills for shockwave therapy services performed under CPT code 0101T (Unlisted modality (Extracorporeal shock wave involving musculoskeletal system, not otherwise specified, high energy) in the amount of $700.39. Respondent argues that the services billed are to be reimbursed only once per date of service and Applicant is due 1 unit in the amount of $700.39 (251.94 x 2.78). Respondent has submitted an affidavit from Crystal Russo, Certified Professional Coder. Applicant argues the code remains 0101T and are due $700.39 (251.94 x 2.78) for the 1st unit and $350.20 (251.94 x 2.78 x .5) for each additional unit and has submitted an affidavit from Akeisha Sinanan, Certified Professional Coder.

After careful review of the evidence and arguments made by the parties at the hearing, I find the Applicant is only due 1 unit per date of service. As stated by the Respondent's coder:

> The CPT code descriptor for both CPT code 0019T and 0101T is "Extracorporeal shock wave involving musculoskeletal system, not otherwise specified, high energy." The description does not designate the services as an anatomic specific region or as "each area or section." Therefore, the services billed covers the *entire* musculoskeletal system and is to be reimbursed only once per day. CPT code 0102T has a description of "Extracorporeal shock wave, high energy, performed by a physician, requiring anesthesia other than local, *involving lateral humeral epicondyle."* Clearly outlined, CPT code 0102T is for a specific anatomic region unlike CPT code

0019T and 0101T which is for the *entire* musculoskeletal system. Accordingly, the Applicant provider is only entitled to one unit of extracorporeal shock wave therapy per day.

I also note the recent decision by Arbitrator Natia Pavel in Sooraj Poonawala, MD v Liberty Mutual Insurance Company - 17-21-1230-3019 where the Arbitrator states:

> Provider billed code 0101T. Per NYS Fee Schedule, code 0101T is defined as: Extracorporeal shock wave involving musculoskeletal system, not otherwise specified; high energy The 2018 NYS fee schedule effective 10/1/2020 includes code 0101T with an RVU value of 2.78. Also, according to said fee schedule under section 9 Category III Codes (page 381) that code 0101T is subject to the conversion factor from the "Surgery" section. Region IV (4) surgery conversion factor is $251.94 x 2.78 = $700.39.
>
> It is also noted that the provider billed code 0101T at 3 units per date of service. This is incorrect billing. Per AMA CPT lay description for 0101T it states: High-energy extracorporeal shock wave delivery involves the application of pressure waves that travel through fluid and soft tissue, with effects of the shock wave occurring at sites where there is a change in impedance, such as the bone-soft tissue interface. Extracorporeal shock wave therapy is used to treat common orthopaedic conditions (i.e., plantar calcaneal spurs, epicondylopathic humeri radialis) because of the therapy's stimulatory effect on bone formation. Other potential uses of extracorporeal shock wave therapy include treating bone marrow hypoxia and subperiosteal hemorrhage, increasing regional blood flow, and activating osteogenic factors such as bone morphogenic protein, direct cellular effects, and mechanical effects as a result of strain gradients.
>
> According to the rules of the "Medically Unlikely Edits" (MUE) for code 0101T, only one (1) unit of service per day is allowed. (see attached) An MUE for a HCPCS / CPT code is the maximum units of service that a provider would report under most circumstances for a person on a single date of service. The MUE Adjudication Indicator (MAI) indicates the type of MUE and its basis. The MAI unit assigned to HCPCS/CPT codes will determine - 2 - how your claim will process and/or deny. Note, Medically Unlikely Edits (MUE) for codes with a MAI of "3" are date of service edits. These are "per day edits based on clinical benchmarks". Again, according to the rules of

the "Medically Unlikely Edits" (MUE) for code 0101T, only one (1) unit of service per day is allowed. A MUE for a HCPCS / CPT code is the maximum units of service that a provider would report under most circumstances for a person on a single date of service.

The medical records validate that the provider is doing shockwave treatment to the cervical, lumbar and left knee areas. Code 0101T is not defined by the AMA CPT as a 'per anatomic site' treatment but instead, for high energy extracorporeal shockwaves involving the musculoskeletal (MS) system. The MS system includes multiple muscles and ligaments in the body. Based on the above code 0101T definition and the MUE edit that validates a once per day procedure, code 0101T paid x 1 unit only.

I find the Respondent has established that the services provided are only to be billed 1 unit per day. A review of the medical records indicates that the services were performed on the cervical, thoracic, and lumbar spine. I find the Respondent's coder, decision by Arbitrator Pavel, and plain reading of the fee schedule establishes that the services performed are only to be billed once per day. Code 0101T is not defined by the AMA CPT as a 'per anatomic site' treatment but instead, for high energy extracorporeal shockwaves involving the musculoskeletal (MS) system. The MS system includes multiple muscles and ligaments in the body. Therefore, based on a preponderance of the evidence, Applicant is due **$700.39**.

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
	334 Grand Concourse Medical PC	**07/22/21 - 07/22/21**	**$2,101.17**	**$1,400.78**	**Awarded: $700.39**
Total			**$2,101.17**		**Awarded: $700.39**

B. The insurer shall also compute and pay the applicant interest set forth below. 10/25/2021 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest shall accrue from the initiation 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 Suffolk

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

08/24/2022
(Dated)

Thomas Eck

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:
6fdc26e207d75d9efc83af7db4571249

Electronically Signed

Your name: Thomas Eck
Signed on: 08/24/2022