

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Pinnacle DMX Imaging  
(Applicant)

- and -

Progressive Casualty Insurance Company  
(Respondent)

AAA Case No. 17-21-1229-1363

Applicant's File No. N/A

Insurer's Claim File No. 21-4025716

NAIC No. 24279

**ARBITRATION AWARD**

I, Michelle Murphy-Louden, 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 09/15/2022  
Declared closed by the arbitrator on 11/28/2022

Greg Vinal, Esq. from Vinal & Vinal, P.C. participated in person for the Applicant

Allison Silverstein, Esq. from Law Offices of Perry & Frankson participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,600.00**, was AMENDED and permitted by the arbitrator at the oral hearing.

Per stipulation of Applicant, the amount in dispute was amended to \$1,468.58 based upon Respondent's submission of a copy of the cashed check proving prior payment in the amount of \$131.42.

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

3. Summary of Issues in Dispute

Whether Applicant is entitled to additional reimbursement for a cervical digital motion x-ray (DMX) performed on June 22, 2021, as the result of an April 14, 2021, motor vehicle accident.

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

Applicant charged the total amount of \$1,600.00 for cervical DMX in dispute herein. Respondent previously reimbursed Applicant the amount of \$131.42.

In support of its defense that Applicant's fee was not in accordance with the Fee Schedule, Respondent submitted herein an Affidavit of Darlene Buttner, CPC, dated December 20, 2022, in which she calculated the allowable Fee Schedule amount as \$131.42, the amount previously paid by Respondent.

As an initial matter, Applicant argued that Ms. Buttner's Affidavit should be precluded because it was "written in the future". However, I agree with Respondent that the year on the Affidavit, 2022, was a typographical error since it was uploaded into the ADR Center electronic case file on January 27, 2022, and January 28, 2022. Therefore, Ms. Buttner's Affidavit will not be precluded.

In addition, also to be addressed initially is Applicant's argument that in a prior arbitration I awarded it \$1,200.00 for a cervical DMX, reducing the award only by the provisions of Radiology Ground Rule 3. However, in that matter the Respondent did not submit either the testimony or Affidavit of a fee coding expert in support of its Fee Schedule defense which is not the case herein. Therefore, I will not find Applicant entitled to \$1,200.00 for the disputed cervical DMX based upon that prior matter as Respondent herein has supported its Fee Schedule defense by submission of the Affidavit of a fee coding expert.

Turning now to the merits of this case:

In her Affidavit, Ms. Buttner attested in relevant part:

5. The Fee Schedule includes instructions and ground rules that explain the application of the procedure descriptors and relative value units. When greater explanation of an instruction or ground rule is needed, the Fee Schedule directs a coder to refer to the Current Procedural Terminology book ("CPT book"), which is written by the AMA. The Fee Schedule does not direct a coder to any other authority than the CPT book.
6. The CPT book is a listing of descriptive terms and identifying codes for reporting medical services and procedures provided to patients. The CPT book provides further explanation of descriptive terms and identifying codes. It provides clinical examples, procedural descriptions, and illustration to explain the practical application of a CPT code. When more clarification is needed, the CPT book directs a coder to the Current Procedural Terminology Assistant ("CPT Assistant"), which is also authored by the AMA.

7. The CPT Assistant provides even greater clarity than the CPT book on specific coding issues.
8. For date of service **June 22, 2021**, Progressive received billing for the following services;
  - a. **76499 Mod 22**; Unlisted diagnostic radiographic procedure.
  - b. **76496**; Unlisted fluoroscopic procedure (eg, diagnostic, interventional).
9. In order to determine the payment amount according to the Fee Schedule. The Provider's zip code must be determined which is 13027. According to the Fee Schedule, zip code 13027 is listed in region I. The Conversion Factor for Radiology in region I is \$46.77.
10. In order to determine the allowable fee according to the Fee Schedule we multiply the conversion factor with the relative value (relative value listed below).
11. **76499**; this code is listed with a BR (by report) value in the fee schedule.
12. As noted, the provider billed 76499 with a -22 modifier. The definition of this modifier according to the fee schedule is, "Increased Procedure Services - When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code... ". The fee schedule does not indicate that the use of this modifier increases the allowable fee for the service in any way.
13. The fee schedule indicates in **Ground Rule #3 of the Introduction and General Guidelines Section** regarding By Report codes, "*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 ground rule also states, "*Fees for such procedures need to be justified 'by report'.*"
14. Progressive's reimbursement of 76499 is based on the procedure(s) performed as outlined by the provider: "Ligament Laxity Analysis, a digitalized radiograph".
15. The procedural information stated above is as described in the provider's description of procedure/ service(s) provided.
16. A letter from the provider explains that to calculate a fee for the BR code billed, the provider compared the procedures performed to RVU total of 22.45 each for BR codes 76499 and 76496. The letter is not clear on exactly how the provider calculated this RVU.

17. As noted above, the CPT Assistant provides even greater clarity than the CPT book on specific coding issues. Based on this information, Progressive referred to a **CPT Assistant from April 2004**. "Would it be appropriate to report code 76499, *Unlisted diagnostic radiographic procedure*, for a digital motion X-ray study procedure? AMA Comment: From a CPT coding perspective, it would be appropriate to report code 76120, *Cineradiography/videoradiography*, except where specifically included, for the digital motion X-ray study procedure. Therefore, this code may be reported instead of the unlisted procedure code 76499."
18. Based on the information in CPT (CPT Assistant) of the proper code to use for the procedure(s) performed, is 76120 and would be allowed based on the radiology ground rules. Therefore, 76499 has been reviewed as 76120.
19. **76496**; Based on the documentation submitted the provider billed CPT Code 76496 for a Digital Motion X-Ray, or video Fluoroscopy of Cervical Flexion, Extension, Neutral, Bending, and Rotation. Per CPT Assistant, September 2000, "Additional codes should not be used for additional views of the same anatomic area, as additional views for one area are inclusive components of the videofluorography/cineradiographic procedure performed." Therefore 76496 is not separately reimbursable.
20. The following chart outlines the allowable fees with ground rules applied;

Procedure Code	Conversion Factor	RVU	NY Fee Schedule	Total Allowable
76499/76120	\$46.77	2.81	\$131.42	\$131.42
76496/76120	SEE	#19	ABOVE	\$0
<b>Total</b>				<b>\$131.42</b>

21. The total allowable fee based on the Provider's documents, provider's billing, CPT Assistant(s) and the Fee Schedule, is \$131.42.
22. Progressive previously issued payment in the amount of \$131.42 therefore, it is Progressive's position no additional payment would be allowed.

In support of its charge for the cervical DMX, Applicant submitted "Special Reports" stating that it had established an RVU of 22.45 for both CPT code 76499 and 76496, as well as an undated, unsigned letter which states as follows in relevant part:

Per the American Academy of Professional Coders (AAPC), the unlisted code 76496, "unlisted fluoroscopic procedure", is indeed the correct CPT code that should be utilized for the digital motion x- ray that we are performing. There is no comparable code, as 76120 and 76125 are described as cineradiography/ video radiography, which is different than the equipment that we utilize for our testing. You will also find conclusion that the CPT Assistant September 2000 is correct on the following website:

<http://www.aapc.com/discuss/thread/digita-motion-x-ray-dmx.8606/>.

...2. THE FDA, subsequent to the AMA publication in 2000, has determined that video fluorography/cineradiography and video fluoroscopy devices are substantially different, and the diagnostic purpose ( in terms of anatomic structures evaluated and conditions that can be diagnosed\_ of each is also substantially different. These differences are evidence by the fact that the FDA has established separate 510(5) device classifications for each. Video fluoroscopic devices are classified at 21 C.F.R 892.1650 ( image intensified fluoroscopic x- ray system) while cineradiography and video fluorography devices are classified as 21 C.F.R 892.1620( cine or spot fluorographic x-ray camera). While this, in itself, is not determinative, it is persuasive that these devices are not the same...

...4. In 2004, yet another opinion was published in the Q/A portion of the CPT

Assistant in response to the exact same question that you posit above. American Medical Association, CPT Assistant, Radiology, 76499 (Q&A, p. 15 (April 2004) the AMA response is not persuasive and ultimately inaccurate for a variety of reasons as followed;

a. First, the question does not reveal the fluoroscopic nature of the service. The question describes the service at issue only as a "digital motion X-ray study procedure." Since the question does not reveal either the nature of the service, or the issue relevant to the proper analysis and determination, it cannot be 'assumed that CPT IS understood what service the DMX device performed and it is therefore not surprising that the results rendered were inaccurate.

b. Second, the question asked whether CPT 76499 was the appropriate code, not 76496. The question creates a Hobson's choice. By avoiding the correct code, the AMA CPT IS employee answering the question, was forced to choose between two incorrect codes.

c. Third, the answer states that "[f]rom a CPT coding perspective, it would be appropriate to report 76120". The answer continues with the statement that this code "MAY BE reported instead of the unlisted procedure code 76499..." based on the instructions for use of CPT cited above, there can only be one correct method of reporting a service. The suggestion that CPT 76120 is an "appropriate" choice, and that it "may" be reported instead of another suggested choice, implies that either code could be used. This is obviously incorrect rendering this reference completely unpersuasive in resolving this issue.

d. Finally, while the answer states that a "CPT coding perspective" was applied, as noted from the analysis above, the conclusion rendered by CPT IS deviates from the CPT code selections standards published by the CPT Editorial Panel in CPT-4. As such, the CT IS conclusion is clearly inaccurate and therefore further invalidates this reference as providing any

persuasive guidance as the proper coding for diagnostic fluoroscopy performed with the DMX device.

In conclusion, there is only one correct code choice where the method of selection is limited to the instructions and content of the CPT Manual. Where CPT conventions are objectively applied, the only correct code for diagnostic Video Fluoroscopy is CPT 76496. The CPT Assistant reference, which provided persuasive authority at best, are not determinative of this or any issue generally, with respect to the specific issue in this case, are unpersuasive given that the conclusion rendered is not supported by the CPT code selection standards published by COP Editorial panel in CPT-4.

...As far as the no fault fee schedule, it lists 76496 as "by report" and the fee should reflect the complexity associated with the procedure. Our facility provides you with a 8-10 page complex report detailing multiple levels of the spine.

### **ANALYSIS**

In order to render a determination in this matter the undersigned requested evaluation by an independent fee coder through AAA.

In a report prepared by Julia Nabiullina, CPC, CPCO, CPMA, CRC, dated October 3, 2022, Ms. Nabiullina determined that the allowable Fee Schedule amount for the cervical DMX in dispute is \$280.62, \$149.20 more than the amount previously paid by Respondent. Ms. Nabiullina's analysis is as follows in relevant part:

**Evaluation:** Based on the review of the medical records provided along with the applicant's explanation of the procedure, it was noted that the provider has provided the same procedure report/notes for two CPT codes billed (CPT 76499 and 76496), indicating different time spent in each. However, based on the nature of the service, it is clear that only one procedure has been performed. The applicant heavily relies on the explanation provided by Michael Miscoe, ESQ, advisory board member of the American Academy of Professional Coders (AAPC), where the latter explains why the DMX procedure in question cannot be coded with CPT code 76120. I agree with my colleague, Mr. Miscoe, that the guidance provided by AMA assistant in 2000 is not only outdated, revisited and rephrased along the way (starting in 2002 and 2004), but also describing two procedures that cannot be compared for CODING purposes. The coding for the procedure is agreed to remain 76496, however not both CPT codes billed.

The main concern lies on the actuarial part for the procedure, which is the rate calculation. CPT code 76499 is not listed in the NY Workers' Compensation Chiropractic Fee Schedule. Understanding that this is not a commonly accepted service, the references are very limited.

... (2) If the service is stand-alone in nature and was performed as a medically necessary procedure for the patient, per New York Workers' Compensation fee schedule General Rule #3 titled "Procedures Without Specified Unit Values", for any procedure where the unit value is listed in the schedule as "BR", the physician shall establish a unit value consistent in relativity with other unit values shown in the schedule. The ground rules also state that the insurer shall review all submitted "BR" unit values to ensure that the relativity consistency is maintained. The amount allowed is based on documented time, skill, and equipment.

In that case, the payment calculation will fall under the actuarial formula as prescribed in Federal Registrar and communicated by the Centers for Medicare and Medicaid Services (CMS):

**Payment Amount = Total RVU \* Conversion Factor, where the Total RVU = [(wRVU \* Work GPCI) + (PE RVU \* PE GPCI) + (OPPS MP RVU \* MP GPCI)]**

GPCI = Geographic Practice Cost Index

wRVUs= Work RVUs

PE RVUs = Practice Expense Relative Value Units

MRVUs = Malpractice Relative Value Units

In other words, the rate is set based on the compilation of the main factors: work associated, practice expense (overhead) and malpractice risks/cost for the procedure, tuned by the geographic location. The conversion factor set by the

Workers Comp (NY region 01 \$46.77) does include calculation for the latter component.

The applicant proposed the total RVU of 22.45 for the procedure, whereas the respondent's coder offered 2.81.

If we dissect the formula above even further, the main components for calculating the value will be Work RVU + Practice Expense RVU + Malpractice RVU. Let's review other radiology RVUs for CY 2021, provided by the American College of Radiology, to compare these:

1. CPT code 72126 (CT scan cervical spine with contrast material) Total RVU: 5.36; professional (reading) component: 1.71 (the rest is TC for facility cost)
2. CPT code 72131 (CT scan lumbar spine with contrast material) total RVU = 4.08; professional (reading) component: 1.41 (the rest is TC for facility cost)
3. CPT code 77469 (Intraoperative radiation treatment management) RVU = 12.79; professional (reading) component: 1.38 (the rest is TC for facility cost)
4. CPT code 78804 (radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring 2 or more days imaging) total RVUs 19.42; professional (reading) component: 1.38 (the rest is TC for facility cost)

Based on the statement provided it is observed that the applicant's valued RVU calculation is not evidence based and is overstated.

As seen above in radiology comparison, for Professional (reading) component, the RVU will vary between 1.38 to 1.71. For another comparison, a clinical visit with any other MD/DO for a critical patient with the risk for life, demonstrating high Medical Decision Making, estimated as 40-54 minutes in duration and coded with CPT code 99215 measures 4.11 RVUs.

If the service was performed as stand-alone in the applicant's facility (not ASC or other facility during another significant procedure), the total RVUs will be taken into consideration. In the last example with the highest RVUs, yet lower than billed by the applicant, the three components mentioned above (work, practice expense, malpractice) clearly outweigh the risks and costs of the DMX in question. In the examples (1) and (2), the cost of the machine, ancillary support and malpractice are relatively closer to the procedure in discussion. Therefore, based on the comparison above, our firm recommends the total value of no more than **6 RVUs**.

**The calculation** will be as follows:  $6 \times 46.77 = \$280.62$



It is to be noted that a copy of Ms. Nabiullina's complete report was provided to the parties prior to the issuance of the within Award. Applicant did not object or otherwise respond to Ms. Nabiullina's report. However, Respondent responded by letter submitted November 15, 2022, which stated as follows:

Respondent notes that in a related matter with the same provider and same services, a separate IHC report found that the CPT Assistant was still valid and applicable to this matter regarding the use of CPT 76120. That IHC report found that Respondent's Coder Affidavit, which is exactly similar to that in this matter, was correct in its findings regarding the appropriate rate of reimbursement. This again was a discussion regarding the same services from the same provider but relating to a different patient. A copy of the IHC report and supporting documentation for that opinion is attached hereto.

The IHC report from Julia Nabiullina in this matter finds that the CPT Assistant relied upon by Respondent was outdated, yet there was no reference to any particular subsequent or related authority that would support this conclusion. There was no authority cited to show that the CPT Assistant guidance no longer applied. This was a conclusory finding by Julia Nabiullina that was unsupported and which conflicts with the findings of another independent coder who came to a different conclusion with the same materials and who attached the support for same.

Respondent relies upon the attached IHC report and documentation as well as prior submissions and argument at hearing, in support of its position that nothing further is owed to the Applicant in this matter.

On the same day as the within matter was heard I also heard the matter of Pinnacle MRI DMX and Progressive Casualty Insurance Company, AAA Case No. 17-21-1210-8234. This case also involved Applicant's claim for additional reimbursement for a cervical DMX which had been previously paid by Respondent in the amount of \$931.42.

As in the instant matter, in AAA Case No. 17-21-1210-8234 I requested evaluation by an independent fee coder through AAA in order to render a determination.

In a report prepared by Susan Montana, COC, CPMA, CHTS-TR, dated September 29, 2022, Ms. Montana determined that the allowable Fee Schedule amount for the cervical DMX in dispute was \$131.42. Ms. Montana's analysis was as follows in relevant part:

We are not persuaded that 76120 *Cineradiography/videoradiography, except where specifically included* is not the appropriate CPT code to report the services performed.

We include the Coders' Desk Reference lay description of the procedure for reference:

76120 Cineradiography uses **high speed x-ray films** to take a series of images of an organ or system in motion such as the vocal cords or heart. These images taken in exposure ranges of **nanoseconds to milliseconds** are like the individual frames of a motion picture. This allows the movement to be frozen and tracked very minutely to gather information about time-varying characteristics.  
**[emphasis added]**

The To whom it may concern document references a "conclusion that the CPT Assistant September 2000 is correct on the following website: <http://www.aapc.com/discuss/thread/digita-motion-x-ray-dmx.8606/>". When we try to access this page we receive a 404 Error (meaning the page does not exist).

We reference 3 CPT Assistant articles (copies attached) that support the use of 76120 for the procedure performed on 9/24/2020. For each reference we note **[emphasis added]**

CPT Assistant September 2000 states: *The term videofluoroscopy is **synonymous** with videofluorography.*

Applicant states that the two terms aren't the same and if they were the same they wouldn't be referenced differently. This is inaccurate, as there are many examples in medical terminology and procedures where there are interchangeable terms. For some very common and familiar examples we note EKG vs. ECG; or cerebrovascular accident vs. cerebral infarction (also known as a stroke); are synonymous terms. In fact,

Applicant appears to use synonymous terms to describe the services performed within their own supporting documentation - Digital Motion X-ray vs. video fluoroscopy.

Just because the devices used are different doesn't mean that the AMA CPT coding must also be different. There are many examples where there are different tools, modalities, approaches, etc. that are used to perform a particular procedure that supports the same CPT code. In fact, the CPT description for 76120 indicates there are different terms and tools/equipment used to support the use of that code.

That same CPT Assistant article also states:

- the code is used for "**recording motion at fluoroscopy**".
- "the **unlisted code 76499 should not be used** to identify a cineradiography or videofluorography procedure".

CPT Assistant April 2004:

Question: "Would it be appropriate to report code 76499, Unlisted diagnostic radiographic procedure, for a **digital motion X-ray** study procedure?"

Answer: "From a CPT coding perspective, it would be **appropriate to report code 76120**, Cineradiography/videoradiography, except where specifically included, for the **digital motion X-ray** study procedure. Therefore, this code may be reported **instead of the unlisted procedure code 76499**"

CPT Assistant April 2011 again clarified:

Question: "How is **digital motion fluoroscopy** reported? Is it appropriate to report the videoradiography code 76120?"

Answer: "Yes, digital motion fluoroscopy should be reported **using CPT code 76120**".

Therefore, the allowable fee schedule amount for the billed services is calculated as follows:

CPT	NYS WC RVU	Conversion Factor Region I	Fee Schedule Amount (RVU x conversion factor)
76120	2.81	46.77	\$131.42

As an added observation, the Applicant has assigned a total of 45 RVUs for this procedure. A review of the NYS Workers' Compensation Medical Fee Schedule identifies only a couple much more complex procedures that come close to 45 RVUs:

- Brain MRI performed during an open intracranial procedure
- Aortal angiography
- Mechanical removal of a central catheter device obstruction
- Certain complex radiation therapies

Having obtained two different opinions, I reviewed both carefully and I have determined that Ms. Montana's analysis is more persuasive than that of Ms. Nabiullina's and as such I adopt Ms. Montana's conclusion that the allowable Fee Schedule amount for the cervical DMX in dispute is \$131.32, the amount previously paid by Respondent.

Ms. Nabiullina's analysis is based upon her rejection of CPT code 76120 as the correct reimbursement code because the guidance provided by the 2000 CPT Assistant was "outdated, revised, and rephrased" in 2002 and 2004, and because it describes two procedures that cannot be compared for coding purposes. However, Ms. Nabiullina failed to recognize the most recent CPT Assistant of 2011, cited by Ms. Montana, which specifically clarifies that digital motion fluoroscopy should be reported using CPT code 76120. This failure renders Ms. Nabiullina's analysis unpersuasive and insufficient to find that Applicant is entitled to additional reimbursement in this matter.

ACCORDINGLY, APPLICANT'S CLAIM IS DENIED IN ITS ENTIRETY.

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 Saratoga

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

11/29/2022  
(Dated)

Michelle Murphy-Louden

**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:**  
12395e0fc63882555c7f29663cb861f9

### **Electronically Signed**

Your name: Michelle Murphy-Louden  
Signed on: 11/29/2022