

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Trinity Health Chiropractic PC
(Applicant)

- and -

State Farm Mutual Automobile Insurance
Company
(Respondent)

AAA Case No. 17-22-1244-0894

Applicant's File No. AR21-14523

Insurer's Claim File No. 32-09F3-36C

NAIC No. 25178

ARBITRATION AWARD

I, Kihyun Kim, 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: the Assignor

1. Hearing(s) held on 12/30/2022
Declared closed by the arbitrator on 12/30/2022

Alek Beynenson, Esq. from The Beynenson Law Firm, PC participated for the Applicant

Nicole McErlean, Esq. from Freiberg, Peck & Kang, LLP participated for the Respondent

2. The amount claimed in the Arbitration Request, **\$798.47**, was NOT AMENDED at the oral hearing.
Stipulations WERE made by the parties regarding the issues to be determined.

The parties stipulated to Applicant's prima facie case and to Respondent's timely denials.

3. Summary of Issues in Dispute

The issue presented is whether Applicant's claims were properly billed and paid pursuant to fee schedule.

The Assignor (JG-T) was a 44-year-old male who was the driver of an automobile that was involved in an accident on July 18, 2020. Applicant seeks reimbursement in the

aggregate amount of \$536.13 for the balance of the charges that were partially paid by Respondent for two office evaluations of the Assignor and thirty-one dates of chiropractic services provided to the Assignor from March 29, 2021 to June 9, 2021.

4. Findings, Conclusions, and Basis Therefor

This arbitration was conducted using the documentary submissions of the parties contained in the ADR Center, maintained by the American Arbitration Association. I have reviewed the documents contained therein as of the close of the hearing and such documents are hereby incorporated into the record of this hearing. Both parties appeared at the hearing by counsel, who presented oral argument and relied upon their documentary submissions. There were no witnesses.

At the hearing, Respondent acknowledged receipt of the bills in question and the parties stipulated to Applicant's prima facie case and to Respondent's timely denials.

The Assignor was a 44-year-old male who was injured in an automobile accident on July 18, 2020. Following the accident, the Assignor sought treatment and testing for his injuries from various providers, including Applicant.

From March 29, 2021 to June 9, 2021, Applicant conducted two office evaluations of the Assignor and provided thirty-one dates of chiropractic services to the Assignor. Applicant billed Respondent for its services, and Respondent partially paid Applicant's claims but timely denied the remainder based on a fee schedule dispute.

Applicant now seeks reimbursement in the aggregate amount of \$536.13 for the balance of the charges that were partially paid by Respondent for two office evaluations of the Assignor and thirty-one dates of chiropractic services provided to the Assignor from March 29, 2021 to June 9, 2021.

Legal Framework - Fee Schedule - Generally

It is well established that a healthcare provider must limit its charges according to the applicable fee schedule. *Goldberg v. Corcoran*, 153 AD2d 113, 117-18 (App Div, 2d Dept 1989). Amended Regulations section 65-3.8(g)(1) states proof of the fact, and amount of loss sustained pursuant to Insurance Law section 5106(a) shall not be deemed supplied by an applicant to an insurer and no payment shall be due for such claimed medical services under any circumstances: (i) when the claimed medical services were not provided to an injured party; or (ii) for those claimed medical service fees that exceed the charges permissible pursuant to Insurance Law sections 5108(a) and (b) and the regulations promulgated thereunder for services rendered by medical providers. This subdivision applies to medical services rendered on or after April 1, 2013.

Notwithstanding the foregoing, the insurer has the burden to come forward with competent evidentiary proof to support its fee schedule defenses. *Robert Physical Therapy, P.C. v. State Farm Mut. Auto. Ins. Co.*, 13 Misc. 3d. 172 (Civ. Ct. Kings Co. 2006). In the absence of such proof, a defense of noncompliance with the appropriate fee schedule cannot be sustained. *Continental Medical, P.C. v. Travelers Indemnity*

Company, 11 Misc. 3d 145(A), 2006 N.Y. Slip Op. 50841(U) (App. Term 1st Dept. 2006). A lay person is not qualified to evaluate the CPT codes or to change if the code is used by a health provider in its bills. See *Abraham v. Country-Wide Ins. Co.*, 3 Misc. 3d. 130A (App. Term 2d. Dept. 2004). Once the insurer makes a prima facie showing that the amounts charged by a provider were in excess of the fee schedule, the burden shifts to the provider to show that the charges involved a different interpretation of such schedule or an inadvertent miscalculation or error. *Cornell Medical, P.C. v. Mercury Casualty Co.*, 24 Misc. 3d 58, 884 N.Y.S.3d 558 (App. Term 2d, 11th & 13th Dists. 2009).

Twelve Unit Rule

Under the new/amended Chiropractic Fee Schedule, the "12 Unit Rule" of the Workers Compensation Fee Schedule limits payment for certain physical medicine services to a total of twelve units per day. Ground Rule 3 of the Physical Medicine Section of the Workers Compensation Chiropractic Fee Schedule provides, in pertinent part, that:

Multiple Physical Medicine Procedures and Modalities When multiple physical medicine procedures and/or modalities are performed on the same day, reimbursement is limited to 12.0 RVUs per patient per day per accident or illness or the amount billed, whichever is less. **Note:** When a patient receives physical medicine procedures, acupuncture and/or chiropractic modalities from more than one provider, the patient may not receive more than 12.0 RVUs per day per accident or illness from all providers combined.

The following codes represent the physical medicine procedures and modalities subject to Ground Rule 3:

97010 97012 97014 97024 97026 97028 97032 97033 97034 97035
97036 97039 97110 97112 97113 97116 97124 97139 97140 97530
98940 98941 98942

In addition, Ground Rule 2 of the Physical Medicine Section of the Workers Compensation Chiropractic Fee Schedule provides, in pertinent part, that: "The maximum number of relative value units (including treatment) per patient per day when billing for an initial evaluation shall be limited to 18.0 RVUs. The maximum number of relative value units (including treatment) per patient per day when billing for a re-evaluation shall be limited to 15.0 RVUs."

Analysis - Fee Schedule/12 unit rule - Office/Chiro - DOS 3/29/21-6/9/21

In the present case, Applicant billed Respondent in the amount of \$57.15/day under CPT code 98941 for thirty-one dates of chiropractic services provided to the Assignor from March 29, 2021 to June 9, 2021. On one of these dates of service (5/20/20), Applicant also billed Respondent in the amount of \$68.20 under CPT code 99212 for a re-evaluation of the Assignor. In addition, on a separate date of service (4/18/20), Applicant again billed Respondent in the amount of \$68.20 under CPT code 99212 for a re-evaluation of the Assignor.

On the date of service where only an office re-evaluation was performed (DOS:4/18/20), Respondent partially paid Applicant's claims in the amount of \$36.19 and denied the remainder (\$32.01) based on a fee schedule dispute. The EOB/denial stated, in pertinent part, that:

In accordance to New York No-Fault Law, Regulation 68, this base fee was calculated according to the New York Workers' Compensation Board Schedule of Fees, pursuant to Regulation 83 and/or Appendix 17-C of 11 NYCRR

With respect to the Respondent's fee reductions, Respondent admittedly did not upload a fee schedule/coder affidavit. However, Respondent's denials provided adequate explanation of the its fee reductions, and I note that I am permitted to take judicial notice of the Workers' Compensation Fee Schedule. *See Kingsbrook Jewish Medical Center v. Allstate Insurance Company*, 61 A.D.3d 13, 20 (2nd Dept. 2009); 32 Misc.3d 144(A), 2011, *LVOV Acupuncture, P.C. v. Geico Ins. Co.*, N.Y. Slip Op. 51721(U) (App. Term 2nd, 11th and 13th Jud.Dists. 2011); *Natural Acupuncture Health, P.C. v. Praetorian Ins. Co.*, 30 Misc.3d 132(A), 2011 N.Y. Slip Op. 50040(U) (App. Term 1 Dept. 2011).

Accordingly, on the date of service where only an office re-evaluation was performed (DOS:4/18/20), I find Respondent properly reduced Applicant's charges based on a plain reading of the fee schedule and a simple mathematical calculation. The E/M services were performed by a chiropractor in Region IV which has a conversion factor of 7.92 under the fee schedule. Applying the applicable chiropractor conversion factor to the assigned RVU for CPT code 99212, Applicant was entitled to reimbursement in the amount of \$36.19 [4.57 RVU x 7.92], which is exactly what Respondent paid Applicant for such code on the date of service billed.

On the date of service where an office re-evaluation and chiropractic services were both performed (DOS:5/20/20), Respondent partially paid Applicant's claims in the aggregate amount of \$32.79 and denied the remainder (\$92.56) based on a fee schedule dispute. The EOB/denial stated, in pertinent part, that:

In accordance to New York No-Fault Law, Regulation 68, this base fee was calculated according to the New York Workers' Compensation Board Schedule of Fees, pursuant to Regulation 83 and/or Appendix 17-C of 11 NYCRR

When performing a re-evaluation including multiple procedures and/or modalities on the same day, the maximum number of relative value units is limited to 15.0 or the amount billed, whichever is less for all providers combined. (New York Workers' Compensation Medical Physical Medicine Fee Schedule Ground Rule 8, Chiropractic Physical Medicine Ground Rule 2, Acupuncture Medicine Fee Schedule Ground Rule 1A, Physical Therapy and Occupational Therapy Fee Schedule Ground Rule 2). NOTE: When a patient receives physical medicine procedures, acupuncture and/or chiropractic modalities from more than one provider, the patient may not receive more than 15.0 RVUs per day per accident or illness from all providers combined.

C2087 - E&M with 98941

Per Ground Rule 2 of the Physical Medicine Section of the Workers Compensation Chiropractic Fee Schedule the maximum number of relative value units (including treatment) per patient per day when billing for a re-evaluation shall be limited to 15.0 RVUs. As Applicant's billing did not exceed the 15.0 RVUs for such date of service, Respondent's denial, in effect, asserted a portion of the available 15.0 RVUs of physical medicine procedures and modalities were previously billed and paid to another provider for the same date of service at issue. A review of the uploaded records reveals that Respondent has provided sufficient proof of prior billing and payment to a physical therapist for 10.86 RVUs services covered by the twelve unit/fifteen unit rule for the same date of service at issue, leaving 4.14 RVUs of the 15.0 RVUs available to pay Applicant for its services. Applying the applicable chiropractor conversion factor for E/M services to the available RVUs, Applicant was entitled to reimbursement for CPT code 99212 in the amount of \$32.79 [4.14 RVUs x 7.92], which is exactly what Respondent paid Applicant for such code on the date of service.

On the remaining thirty dates of service where only chiropractic services were provided, Respondent paid Applicant's claims in full as billed for fifteen dates of service, partially paid Applicant's claims in the aggregate amount of \$10.89 for five dates of service, and partially paid Applicant's claims in the aggregate amount of \$12.89 for ten dates of service. Respondent denied the remainders (\$46.26 or \$44.26) based on a fee schedule dispute, stating in the EOBs/denials, in pertinent part, that:

In accordance to New York No-Fault Law, Regulation 68, this base fee was calculated according to the New York Workers' Compensation Board Schedule of Fees, pursuant to Regulation 83 and/or Appendix 17-C of 11 NYCRR

When multiple procedures and/or modalities are performed on the same day, the maximum number of relative value units is limited to 12.0 or the amount billed, whichever is less for all providers combined. (New York Workers' Compensation Medical Fee Schedule, Ground Rule 11; Chiropractic Fee Schedule, Physical Medicine Ground Rule 3; Acupuncture Fee Schedule, Medicine Ground Rule 1B; Physical Therapy and Occupational Therapy Fee Schedule, Physical Medicine Ground Rule 3). NOTE: When a patient receives physical medicine procedures, acupuncture and/or chiropractic modalities from more than one provider, the patient may not receive more than 12.0 RVUs per day per accident or illness from all providers combined.

As Applicant's billing did not exceed the relevant maximum 12 units per day, Respondent's denials, in effect, asserted a portion of the available 12.0 RVUs of physical medicine procedures and modalities were previously billed and paid to another provider for the same dates of service at issue. As Applicant's billing did not exceed the 15.0 RVUs for such date of service, Respondent's denial, in effect, asserted a portion of the available RVUs of physical medicine procedures and modalities were previously billed and paid to another provider for the same dates of service at issue. A review of the uploaded records reveals that Respondent has provided sufficient proof of prior billing and payment to an acupuncturist (10.65 RVUs) or a physical therapist (10.86 RVUs) for services covered by the twelve unit rule for the same dates of service at issue, and that Respondent properly reduced Applicant's charges for each date of service based upon the remaining RVUs available (1.35 RVUs or 1.14 RVUs) after such prior payments.

The chiropractic services were performed by a chiropractor in Region IV which has a physical medicine conversion factor of 9.55 under the fee schedule; thus, Respondent's payments of \$12.89 [1.35 x9.55] or \$10.89 [1.14 x9.55] on each of the relevant dates of service were appropriate.

Applicant did not upload a coder affidavit or put in any other evidence to support a different fee calculation or to otherwise rebut Respondent's fee reductions.

Based on the totality of the evidence in the record, Applicant's claims for additional reimbursement for the balance of the charges that were partially paid by Respondent for two office evaluations of the Assignor and thirty-one dates of chiropractic services provided to the Assignor from March 29, 2021 to June 9, 2021, are denied.

Conclusion

For the reasons set forth herein, Applicant's claims are denied in their entirety. This decision is in full disposition of all claims for no-fault benefits presently before this Arbitrator. Any further issues raised in the hearing record are held to be moot and/or waived insofar as not specifically raised at the time of the hearing.

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

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

6. **I find as follows with regard to the policy issues before me:**

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

Accordingly, the 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 Suffolk

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

01/28/2023
(Dated)

Kihyun Kim

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:
3326fd83ecbb293091ba3413de8e27de

Electronically Signed

Your name: Kihyun Kim
Signed on: 01/28/2023