

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Wee's Physical Therapy & Wellness Clinic  
(Applicant)

- and -

State Farm Mutual Automobile Insurance  
Company  
(Respondent)

AAA Case No. 17-22-1257-0965

Applicant's File No. A33851

Insurer's Claim File No. 32-27C5-41T

NAIC No. 25178

**ARBITRATION AWARD**

I, Bryan Hiller, 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 02/01/2023  
Declared closed by the arbitrator on 02/01/2023

Amisha Dukarm, Esq. from Munawar & Hashmat LLP participated in person for the Applicant

John Rossillo, Esq. from Rossillo & Licata LLP participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$4,392.02**, was AMENDED and permitted by the arbitrator at the oral hearing.

The amount claimed in the Arbitration Request, \$4,392.02, was AMENDED at the oral hearing to \$1,920.00 based on partial payment leaving only code G0283 at issue.

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

3. Summary of Issues in Dispute

Whether Applicant validly denied payment for the physical therapy treatment provided to the Assignor between November 15, 2021 and February 26, 2022 based on the fee schedule?

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

Applicant seeks reimbursement, along with interest and counsel fees, under the No-Fault Regulations, for the costs associated with physical therapy treatment provided to the Assignor between November 15, 2021 and February 26, 2022 in connection with injuries sustained by Assignor in a motor vehicle accident on November 10, 2021. The services at issue were partially paid with the remainder being denied on the basis of the fee schedule. This decision is based upon the written submissions of counsel for the respective parties as well as oral arguments at the hearing conducted on February 1, 2023.

Assignor, a then 81 year old male restrained driver, was involved in a passenger side t-bone automobile accident on November 10, 2021. Following the accident, Assignor went to the local emergency room where he was evaluated, had x-rays taken, treated and discharged home. Due to continued symptomology, Assignor came under the care of multiple conservative treatment providers including Applicant Wee's Physical Therapy & Wellness Clinic. The physical therapy treatments at issue were provided by Applicant Wee's Physical Therapy & Wellness Clinic's facility between November 15, 2021 and February 26, 2022 and the notes related to that treatment are attached to the Record.

A health care provider establishes its prima facie entitlement to payment as a matter of law by proof that it submitted a proper claim, setting forth the fact and the amount charged for the services rendered and that payment of no-fault benefits was overdue (see Insurance Law § 5106 a; *Mary Immaculate Hosp. v. Allstate Ins. Co.*, 5 AD 3d 742, 774N.Y.S. 2d 564 [2004]). I find that Applicant established a prima facie case of entitlement to reimbursement of its claim by timely submitted valid bills for treatment at issue.

Since Respondent's denials were timely, it was within its rights to assert that further treatment was medically unnecessary or not paid pursuant to the fee schedule (see *Liberty Queens Medical, P.C. v. Liberty Mutual Insurance Co.*, 2002 NY Slip Op 40420(U), 2002 WL 31108069 (App. Term 2d & 11th Dists. June 27, 2002)). A treatment or service is medically necessary if it is "appropriate, suitable, proper and conducive to the end sought by the professional health service in consultation with the patient. It means more than merely convenient or useful treatment or services, but treatment or services that are reasonable in light of the patient's injury, subjective and objective evidence of the patient's complaints of pain, and the goals of evaluating and treating the patient" (see *Fifth Avenue Pain Control Center v. Allstate*, 196 Misc. 2d 801, 807-808 (Civ. Ct. Queens Cty. 2003)). Medically necessary treatment or services must be "consistent with the patient's condition, circumstances and best interest of the patient with regard to the type of treatment or services rendered, the amount of treatment or services rendered, and the duration of the treatment or services rendered" (*Id.*). Medical services are compensable where they serve a valid medical purpose (see *Sunrise Medical Imaging PC v. Lumbermans Mutual*, 2001 N.Y. Slip Op. 4009).

For the \$1,920.00 balance for chiropractic services between November 15, 2021 and February 26, 2022, the contested balance reflects chiropractic modalities that Applicant billed under CPT code G0283, which is not in the New York State Worker's Compensation chiropractic fee schedule. Respondent contends that this CPT code is not reimbursable and under the chiropractic ground rules chiropractors may not use CPT codes that do not appear in the applicable fee schedule.

Respondent's fee schedule defense has merit. The 35 amendment to regulation 83 th which is applicable to claims with a date of service occurring on or after October 1, 2020 introduced a chiropractic fee schedule that sets forth the relative value units, ground rules and CPT codes for billing chiropractic services. Ground Rule 10 of this fee schedule specifically limits chiropractors to the use of CPT codes contained in the chiropractic fee schedule for the billing of treatment and the chiropractor may not use CPT codes that do not appear in the chiropractic fee schedule.

In this instance the chiropractic modalities billed under CPT code G0283 do not appear in the chiropractic fee schedule and these modalities were rendered after the October 1, 2020 effective date.

Applicant's counsel does not dispute that the CPT code G0283 is not reimbursable under the revised fee schedule. Rather, Applicant's counsel argued that since it was not in the fee schedule it should be treated as a By Report code and, thus, Respondent should have requested verification if they needed additional information to provide proper payment for the code. Respondent's counsel counters that it is not Respondent's burden to adjust erroneously submitted CPT codes and Applicant is bound by their bill.

Although I appreciate Applicant's counsel's arguments that the service reflected under CPT code G0283 is the equivalent of a CPT code which is a service reimbursable under the New York chiropractic fee schedule, there was no indication that the Applicant communicated to the Respondent prior to the commencement of this action that Applicant erroneously billed the wrong CPT code, and that the bill should be readjusted and paid to reflect the correct New York CPT code. Instead, Applicant proceeded to commence this arbitration subjecting the Respondent to unnecessary interest and attorney's fees if I find the Respondent should have unilaterally adjusted the code and paid the Applicant pursuant to a CPT code that was not billed. I decline to do so. Respondent was in full compliance of their obligations. A bill was presented, and Respondent justifiably denied reimbursement based on a straight reading of the fee schedule that does not permit reimbursement of the CPT code billed by the Applicant. Applicant's claim is denied.

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

02/01/2023  
(Dated)

Bryan Hiller

#### **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:**  
ea4946593c50bf83af815fa38c0faab6

### **Electronically Signed**

Your name: Bryan Hiller  
Signed on: 02/01/2023