

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

JTK Chiropractic Care PC
(Applicant)

- and -

State Farm Mutual Automobile Insurance
Company
(Respondent)

AAA Case No.	17-22-1241-0384
Applicant's File No.	GTLJTK021522-003
Insurer's Claim File No.	32-24Q3-39D
NAIC No.	25178

ARBITRATION AWARD

I, Ioannis Gloumis, 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 12/12/2022, 02/28/2023
Declared closed by the arbitrator on 02/28/2023

George Lewis, Esq. from Law Offices of George T. Lewis, Jr., PC participated virtually for the Applicant

Jon DePasquale, Esq. from James F. Butler & Associates participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$798.59**, was NOT AMENDED at the oral hearing.
Stipulations WERE NOT made by the parties regarding the issues to be determined.
3. Summary of Issues in Dispute

Applicant seeks reimbursement of charges for diagnostic ultrasound testing that was performed upon the EIP on September 29, 2021, following a September 10, 2021 motor vehicle accident. Applicant billed Respondent in the total amount of \$885.00 for diagnostic ultrasound testing of the lumbar spine and the sacroiliac joints. Respondent issued payment in the amount of \$87.11 and denied the balance of \$798.59 based upon the defense that Applicant's charges are not in accordance with the fee schedule.

4. Findings, Conclusions, and Basis Therefor

I have reviewed the submissions contained in the American Arbitration Association's Electronic Case Folder in MODRIA, said submissions constituting the record in this case. This award is based upon the arguments that were presented by the parties during the arbitration hearing and the documentary evidence submitted by the parties. Bruce Jacobson, D.C. of Applicant appeared and testified during the arbitration hearing.

SUMMARY OF FACTS

The EIP, then a 59-year-old female restrained driver, was injured in a motor vehicle accident on September 10, 2021. Following the accident, the EIP sought private medical attention for pain in the thoracic spine and lumbar spine. The EIP came under the care of Macintosh Medical PC. Bruce Jacobson, D.C. of Applicant performed diagnostic ultrasound testing upon the EIP's lumbar spine and sacroiliac joints on September 29, 2021.

Applicant billed Respondent in the total amount of \$885.00 for the diagnostic ultrasound testing services that were performed on September 29, 2021. Applicant billed Respondent as follows: CPT code 76999 (\$590.00) and CPT Code 76999 59 (\$295.00). Respondent received Applicant's bill for the claim in dispute on November 12, 2021.

LEGAL STANDARDS FOR PRIMA FACIE CASE

To establish a prima facie case, a claimant is required to submit proof that it timely sent its claim for no-fault benefits to the insurer, that the insurer received the claim and that the insurer failed to pay or deny the claim within 30 days. See *Amaze Med. Supply Inc. v. Allstate Ins. Co.*, 3 Misc.3d 133(A) (App Term, 2d & 11th Jud Dists 2004); *King's Med. Supply Inc. v. Country-Wide Ins. Co.*, 5 Misc.3d 767 (Civ Ct, NY County 2004).

An insurer's denial of claim form indicating the date on which it was received adequately establishes that the claimant sent, and that the insurer received the claim. *Ultra Diagnostics Imaging v. Liberty Mutual Ins. Co.*, 9 Misc.3d 97 (App. Term 9th & 10th Dists. 2005).

APPLICATION OF LEGAL STANDARDS TO THE CLAIM

Since Respondent's evidence shows that Respondent received Applicant's bill for the claim in dispute on November 12, 2021, Applicant has established its prima facie case.

Furthermore, Respondent issued payment in the amount of \$87.11 and denied the balance of \$798.59 on December 21, 2021 based upon the defense that Applicant's charges are not in accordance with the fee schedule.

DEFENSE - APPLICANT'S CHARGES ARE NOT IN ACCORDANCE WITH THE FEE SCHEDULE

Applicant billed Respondent for diagnostic ultrasound testing of the EIP's lumbar spine and sacroiliac joints, which was performed by Dr. Jacobson on September 29, 2021. Applicant billed Respondent for the services as follows: CPT code 76999 (\$590.00) and CPT Code 76999 59 (\$295.00). The services were performed in zip code 11203. Respondent's specific denial provides the following explanations for the denial of the claim:

"...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..."

and

"...For two contiguous parts, the charge shall be the greater fee plus 50% of the lesser fee. (New York Workers' Compensation Medical Fee Schedule/Chiropractic Fee Schedule radiology multiple diagnostic procedures ground rule(s))..."

Respondent presented the affidavit of Mercy Acuna, RN, BSN, CPC, wherein Coder Acuna attested to the following, in relevant part:

"...The provider is a chiropractor. The location of service is in region IV (zip of service = 11203) The conversion factor for Radiology = \$39.82...The new conversion factor became effective 10/1/2020 for No -Fault... The provider billed CPT code 76999 x 2. · CPT code 76999 is "Unlisted ultrasound procedure (eg, diagnostic, interventional)" and has a "BR" under the RVU column. · Per NY WC Chiropractic Fee Schedule, General Ground Rules #2: Procedures listed without Specified Unit Values, By report (BR) items: "BR" in the relative value column represents services that are too variable in the nature of their performance to permit assignment of unit values. Fees for each procedure need to be justified "by report." Pertinent information concerning 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 unit value is listed in the schedule as "BR", the chiropractor shall establish a unit value consistent in relativity with other unit values shown in the schedule. The insurer shall review all submitted "BR" unit value to ensure that the relativity consistency is maintained..." · The provider billed the amount of \$885.00 but did not indicate as to the comparable services or codes already in the Chiropractic fee schedule that is consistent in relativity. · Based on the radiology report, the ultrasound on 9/29/2021 was performed on the soft tissues of the lumbar spine and SI joints...Based on the documentation submitted, the appropriate reference code that would be consistent in relativity for each of the area is CPT code 76882. Per the CPT Book Guidelines and CPT Assistant Sept. 2016: Code 76882 refers to an examination of an extremity that would be **performed primarily for evaluation of muscles, tendons, joints, and/or soft tissues**. This is a limited examination of the extremity where a specific anatomic structure such as a tendon or muscle is assessed. In addition, the code would be used to evaluate a soft-tissue mass that may be present in an extremity where knowledge of its cystic or solid characteristics is needed. **NOTE:** CPT code 76882 is not listed in the Chiropractic Fee Schedule. To maintain the relative consistency as per the "By Report" rule, a code in the chiropractic fee schedule with the same relative value as 1.28 (RVU for 76882) should be used. The code that would be consistent in relativity is CPT code 72020 (radiologic examination of the spine). Per the Chiropractic Radiology Ground Rules # 2. Multiple Diagnostic Procedures A) For two contiguous parts, the charge shall be the greater fee plus 50 percent of the lesser fee. B) For two remote parts, the charge shall be the greater fee plus 75 percent of the lesser fee. Bilateral procedures are considered remote parts. NOTE: The lumbar spine and the SI joints are contiguous parts. · The reference code for the ultrasound of the lumbar area is CPT code 72020 (RVU = 1.28 x \$39.82) = \$50.97 · The reference code for the ultrasound of the SI joint area is CPT code 72020 (RVU = 1.28 x \$39.82) = \$50.97 at 50% = \$25.49 The allowable amount per the fee schedule = \$76.46 NOTE: CPT code 76882 is not listed in the Chiropractic fee schedule. · Per NY WC Chiropractic Fee Schedule, General Ground Rules #2: Procedures listed without Specified Unit Values, By report (BR) items: "BR" in the relative value column represents services that are too variable in the nature of their performance to permit assignment of unit values. Fees for each procedure need to be justified "by report." Pertinent information concerning 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 unit value is listed in the schedule as "BR", the chiropractor shall establish a unit value consistent in relativity with other unit values shown in the schedule. The insurer shall review all submitted "BR" unit value to ensure that the relativity consistency is maintained..."

Coder Acuna further attested to the following:

"...Per the 34th amendment of Regulation 83, the below rules went into effect 4/1/2019. (a) General Ground Rule 10 in the Workers' Compensation Chiropractic Fee Schedule set forth in 12 NYCRR 348; The rule states: A chiropractor may only use CPT codes contained in the Chiropractic fee schedule for billing of treatment. A chiropractor may not use codes that do not appear in the Chiropractic Fee Schedule. (b) General Ground Rule 19 in the Workers' Compensation Medical Fee Schedule set forth in 12 NYCRR 329; The rule states: There are separate and distinct fee schedules for use by podiatrists (Podiatry Fee Schedule). Chiropractors (Chiropractic Fee Schedule), and Psychologists (Behavioral Medicine Fee Schedule). A podiatrist, chiropractor, or psychologist may not use the CPT coding guidelines contained in this medical Fee Schedule. Podiatrists, Chiropractors and Psychologists should consult the applicable fee schedule relevant for his or her scope of practice when submitting bills for treatment. · Based on the above, the only relative value that would be consistent that is in the chiropractic fee schedule is 1.28 (which is the RVU for 76882). In this case, the code listed in the Chiropractic Fee Schedule that has the same RVU of 1.28 is CPT code 72020...The total allowable amount per the fee schedule = \$76.46. The provider was previously paid \$86.41. No additional reimbursement due..."

Dr. Jacobson testified during the hearing that he disagreed with Coder Acuna's use of the RVUs from CPT Code 76882 and the description of a limited study because the services did not consist of a limited study and involved examinations of the lumbar spine and paraspinal musculature bilaterally and the sacroiliac joints bilaterally. Dr. Jacobson described a complete examination of structures, surrounding tissue, ligaments, muscles, vertebrae, canal with contents, and outside musculature. Dr. Jacobson further testified that Coder Acuna mischaracterized the code applied and does not explain why the code's RVUs are to be applied from a medical point of view, and she just stated that it is the code that applies. Dr. Jacobson further testified that the services performed are much more comprehensive services than the limited study described by Coder Acuna. Lastly, Dr. Jacobson testified that he agrees with the report of Maureen Norman, Registered Medical Coder, from AAA Case Number 17-21-1218-5188. According to the arbitration awarded from AAA Case Number 17-21-1218-5188, Ms. Norman stated "...*There are no ultrasound codes in the chiropractic fee schedule that specifically define the Lumbar Spine, the 2 complete SI Joints, and the structures surrounding (outside of) the spinal canal (musculature, nerve roots) all necessary for appropriate diagnosis, other than the unlisted ultrasound code 76999. Ground Rules guidelines specify analyzing similar CPT*

codes for cross-walking in determination of work value. Therefore, the unlisted code is used. This is in accordance with NY Work Comp Ground Rules..."

Arguments By The Parties During The Arbitration Hearing

While Respondent stipulated to Dr. Jacobson's license as a chiropractor in the State of New York and credentials, Respondent argued that Dr. Jacobson is not a certified professional coder. Respondent also presented the IHC report from Susan Montana, COC, CPMA, CHTS-TR dated September 16, 2022 from AAA *Case Number 17-21-1218-5188* which held that the diagnostic ultrasound services performed by Dr. Jacobson are not reimbursable.

Applicant presented a copy of the affidavit of Crystal Russo, CPC in rebuttal to the IHC report from AAA *Case Number 17-21-1218-5188* and in rebuttal to the affidavit of Coder Acuna. In her affidavit, Coder Russo allowed for reimbursement of CPT Code 76999 using the 3.83 RVUs from CPT Code 76705 for ultrasound of the lower back and sacroiliac joints.

LEGAL STANDARDS FOR FEE SCHEDULE DEFENSES

It is Respondent's burden to come forward with competent evidentiary proof to support its fee schedule defenses. See *Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co.*, 13 Misc.3d 172, 822 N.Y.S.2d 378 (Civil Ct, Kings Co. 2006). See also, *Power Acupuncture PC v. State Farm Mutual Automobile Ins. Co.*, 11 Misc.3d 1065A (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 (App. Term, 1st Dep't, per curiam, 2006).

A 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 (App. Term, 2d Dept. 2004).

Furthermore, I take judicial notice of the New York State Workers' Compensation Fee Schedule. See, *Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co.*, 61 A.D.3d 13, 20 (2d Dept. 2009); *LVOV Acupuncture, P.C. v. Geico Ins. Co.*, 32 Misc.3d 144(A) (App Term 2d, 11th & 13th Jud Dists. 2011); *Natural Acupuncture Health, P.C. v. Praetorian Ins. Co.*, 30 Misc.3d 132(A) (App Term, 1st Dept. 2011).

DECISION

I have reviewed the Chiropractic Fee Schedule of the New York State Workers' Compensation Fee Schedule that is effective for the date of service in dispute and find that the proper CPT code for the services in dispute is CPT Code 76999, which is listed in the Radiology Section of the Chiropractic Fee Schedule and defined as follows: Unlisted ultrasound procedure (eg, diagnostic, interventional). I am not persuaded by the IHC report of IHC Montana from AAA *Case Number 17-21-1218-5188*. IHC Montana held that the services are not reimbursable because CPT Code 76705 is not listed in the Chiropractic Fee Schedule, Chiropractic Fee Schedule Ground Rule 10 provides that a chiropractor may only use CPT codes contained in the Chiropractic Fee Schedule for billing of treatment, and a chiropractor may not use codes that do not appear in the Chiropractic Fee Schedule.

A plain reading of the New York State Workers' Compensation Chiropractic Fee Schedule shows that the description for CPT 76999 applies to the diagnostic ultrasound services that were performed by Applicant. Moreover, Applicant applied modifier 59 to the second charge of CPT Code 76999.

Radiology Ground Rule 5(C) of the Chiropractic Fee Schedule provides the following:

"Miscellaneous...C) For diagnostic ultrasound procedures, use code 76999 and submit the required report."

Ground Rule 2 of the Introduction and General Guidelines of the Chiropractic Fee Schedule provides the following:

"Procedures Listed Without Specified Relative Value Units

By report (BR) items; "BR" in the relative value column represent 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 concerning the nature, extent, and need for the procedure or service, the time, the skill, and equipment necessary, etc., is to be furnished. A detailed clinical record is not necessary, but sufficient information shall be submitted to permit a sound evaluation. It must be emphasized that reviews are based on records; hence the importance of the documentation. The original official record, such as operative report in hospital chart, will be given far greater weight than supplementary reports formulated and submitted at later dates. For any procedure where the relative value unit is listed in the schedule as "BR," the chiropractor 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" unit values to ensure that the relativity consistency is maintained. The general conditions and requirements of the general ground rules apply to all "BR" items."

Respondent has failed to present sufficient competent evidentiary proof that establishes that Applicant's claim was in excess of the Chiropractic Fee Schedule's allowance. CPT Code 76999 is specifically listed in the Radiology Section of the Chiropractic Fee Schedule and is defined as "Unlisted ultrasound procedure (eg, diagnostic, interventional)." Therefore, a chiropractor is allowed to bill for diagnostic ultrasound procedures under the Radiology Section of the Chiropractic Fee Schedule. Coder Acuna opined that 1.28 RVUs from CPT 76882 are the only RVUs that are relative in consistency with the services that were performed. Dr. Jacobson testified that this is incorrect as he did not perform a limited study. While Coder Russo's affidavit is not specific to the claim in dispute, Coder Russo opined that the 3.83 RVUs from CPT Code 76705 for ultrasound of the lower back and sacroiliac joints are the RVUs that are relative in consistency with the services that were performed. Based upon the difference in opinion from two certified professional coders as to the applicable RVUs, and following the testimony by Dr. Jacobson during the hearing, I find that Respondent has failed to establish its fee schedule defenses in this case. Furthermore, I am not persuaded by the IHC report from AAA *Case Number 17-21-1218-5188* because the New York State Workers' Compensation Chiropractic Fee Schedule allows for reimbursement of diagnostic ultrasound services under CPT 76999, as the code and the description are listed in the Radiology Section of the Chiropractic Fee Schedule.

Respondent has failed to establish that the RVUs billed by Applicant are not consistent in relativity with the actual services that were performed. I am not persuaded that Applicant is precluded from billing for diagnostic ultrasound testing under CPT Code 76999 because the applicable RVUs that are relative in consistency from other CPT codes are not contained in the Chiropractic Fee Schedule effective October 1, 2020. Therefore, Respondent's defense should not be upheld.

Accordingly, Applicant's claim is hereby granted in the amount of \$798.59.

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	Status
	JTK Chiropractic Care PC	09/29/21 - 09/29/21	\$798.59	Awarded: \$798.59
Total			\$798.59	Awarded: \$798.59

- B. The insurer shall also compute and pay the applicant interest set forth below. 03/04/2022 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Since the claim(s) in question arose from an accident that occurred on or after April 5, 2002, the insurer shall compute and pay Applicant the amount of interest computed from

the date of filing, at the rate of 2% per month, simple, and ending with the date of payment of the award, subject to the provisions of *11 NYCRR 65-3.9(c)* (stay of interest).

C. Attorney's Fees

The insurer shall also pay the applicant for attorney's fees as set forth below

Respondent shall also pay Applicant an attorney's fee in accordance with *11 NYCRR 4.6*.

- 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 NY

SS :

County of Nassau

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

03/30/2023

(Dated)

Ioannis Gloumis

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
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Electronically Signed

Your name: Ioannis Gloumis
Signed on: 03/30/2023