

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

TBFW Services Inc.  
(Applicant)

- and -

Geico Insurance Company  
(Respondent)

AAA Case No.	17-22-1251-1294
Applicant's File No.	DK22-260543
Insurer's Claim File No.	328015340101034
NAIC No.	22063

**ARBITRATION AWARD**

I, John Langell, 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 10/03/2023  
Declared closed by the arbitrator on 10/03/2023

Robin Grumet, Esq. from Korsunskiy Legal Group P.C. participated virtually for the Applicant

Jaime Orlando, Esq. from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$4,169.28**, was AMENDED and permitted by the arbitrator at the oral hearing.

The total amount in controversy has been amended to 558.71 in accordance with the Applicant's interpretation of the fee schedule.

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

3. Summary of Issues in Dispute

The Assignor is a then 42 year old male who was injured in an automobile accident on 10/22/21. Assignor underwent electrodiagnostic testing on 11/18/21. Reimbursement for

that testing was partially paid and partially denied by the Respondent based solely on fee schedule considerations. The issue for resolution at this hearing is whether the Respondent's partial payment was appropriate.

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

This hearing was conducted using documents contained in the ECF, and the oral arguments presented by the parties' representatives. Any documents contained in the folder are hereby incorporated into this hearing. I have reviewed all relevant exhibits contained in the ECF maintained by the American Arbitration Association.

Based on the materials submitted for my review, I find that Applicant's claims were submitted to and received by Respondent, and therefore that Applicant has demonstrated a prima facie case of entitlement to the disputed no fault benefits. See, Viviane Etienne Med. Care, P.C. v. Country Wide Ins. Co., 2013 NY Slip Op. 08430 (2nd Dept. 2013). Respondent has the 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).

The Applicant originally billed a total of 4,264.03, for two codes, 95905 and 95907. The Applicant billed for 16 units of code 95905, and one unit of code 95907. Code 95905 refers to motor and/or sensory nerve conduction studies. Code 95907 refers to nerve conduction studies of 1 or 2 nerves. The Applicant now acknowledges that its original bill was incorrect, in that it should only have billed for a single unit of code 95913, which refers to 13 or more nerve conduction studies. Applicant acknowledges that code 95905 is limited by the plain language of the fee schedule to one unit for each limb tested, and that codes 95905 and 95907 should not in any event be billed together. I note that the Respondent's denial correctly avers that code 95905 may only be reported once per limb, and also that code 95905 may not be reported in conjunction with codes 95885, 95886, and 95907-95913. Accordingly, the Respondent paid the Applicant the sum of 94.75, the amount billed by the Applicant for one unit of code 95907, while denying any payment for code 95905. It is notable, however, that the Respondent has agreed that the Applicant actually tested more than 13 individual nerves, a fact which is further confirmed by the underlying records of treatment.

I note that 11 NYCRR 65-3.2 sets forth specific claims practice principles to be followed by all insurers, and that among the principles listed are "Assist the applicant in the processing of a claim", and "Do not treat the applicant as an adversary." In that connection, I have previously found, in Case No. 17-17-1069-8777, that "even an acknowledged coding error or mistake is [not] a valid basis, in and of itself, for the denial of payment of claims for PIP benefits." I referred approvingly in that case to the reasoning of Arbitrator Gewuerz, who, in Case No. 17-16-1052-3177, opined that an applicant's coding error, mistake, or misuse of a CPT code or coding convention is not a valid basis for denial of payment. Arbitrator Gewuerz appropriately emphasized that such a denial would run afoul of the duties imposed on insurers by the No Fault regulations referred to hereinabove. I continue to agree with the reasoning expressed in

the cited cases, as I also agree with Arbitrator Moritz, who, in Case No. 17-18-1090-7297, stated that "Even if the applicant entered the wrong code, the record is clear that the respondent understood the service that was performed. At a minimum, the respondent could have sought further verification, via 11 NYCRR 65-3.5 if they were unsure about the procedure provided to the IP."

In the present case, I note that the actual service provided by the Applicant in terms of the number of nerves tested is undisputed by the Respondent. I also note that the Respondent never sought an appropriate adjustment of the Applicant's bill, or requested any additional verification with respect to that bill, before limiting payment to the amount 94.75 in compensation for testing 1-2 nerves, as opposed to the more than 13 nerves that were actually tested. It is also notable, however, that the Applicant has itself miscalculated the amount due in compensation for its services. The Applicant has suggested that it is due the sum of 558.71, acknowledging receipt of Respondent's payment of 94.75, while reasoning that the original bill should have included the sum of 653.46 for the testing of 13 or more nerves. Applicant's calculation fails to take account of the apparent fact that the presently disputed bill pertains only to the technical component of the services rendered. I note that, in a related case that was heard and considered together with the present case, 17-22-1259-8449, a different Applicant billed for the professional component of the same 11/18/21 testing at issue in the present case. I note as well that the Applicant in that case was represented by the same attorney representing the Applicant in the present case. I note that the technical component of coder 95913, which refers to the testing of 13 or more nerves, is 38%, which, when applied to the sum of 653.46, which would otherwise be the correct fee schedule amount for code 95913, results in a final fee schedule amount of 248.31. In view of the entirety of the within discussion, I find that Applicant's original bill was compensable in that amount. I also find that, since payment has already been issued by the Respondent in the amount of 94.75, the Applicant is currently owed the amount of 153.56.

Any additional issues not referred to hereinabove are held to be moot and/or waived insofar as not specifically raised at the time of the hearing.

Accordingly, the Applicant's claim is upheld in the amount of 153.56.

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
	<b>TBFW Services Inc.</b>	<b>11/18/21 - 11/18/21</b>	<b>\$4,169.28</b>	<b>\$558.71</b>	<b>Awarded: \$153.56</b>
<b>Total</b>			<b>\$4,169.28</b>		<b>Awarded: \$153.56</b>

- B. The insurer shall also compute and pay the applicant interest set forth below. 05/21/2022 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Consistent with applicable regulations of the New York State Insurance Department, including 11 NYCRR 65-3.9 (c) and 11 NYCRR 65-4.2 (b), I find that Arbitration was requested on 5/21/22, and so find that interest shall accumulate from that date at the simple rate of 2 percent per month, calculated on a pro rata basis using a 30 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 the interest thereon, Respondent shall pay the applicant an attorney's fee equal to 20% of that total sum, subject to a maximum of \$1,360.00. See 11 NYCRR 65-4.6(d).

- 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 New York

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

10/11/2023  
(Dated)

John Langell

### **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:**  
027bcba12d10893b8e43f0b93b43b3ca

### Electronically Signed

Your name: John Langell  
Signed on: 10/11/2023