American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Pinnacle DMX Imaging (Applicant) - and - State Farm Mutual Automobile Insurance Company (Respondent)	AAA Case No. Applicant's File No. Insurer's Claim File No. NAIC No.	17-23-1306-4722 NA 52-32D1-15L 25178

ARBITRATION AWARD

I, Mary Anne Theiss, 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: Claimant

1. Hearing(s) held on 12/15/2023
   Declared closed by the arbitrator on 12/15/2023

   Gregory Vinal, Esq. from Vinal & Vinal, P.C. participated virtually for the Applicant

   Mohammad Rubbani, Esq. from James F. Butler & Associates participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$1,468.58**, 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

   The Claimant was in an automobile accident on March 29, 2022.

   The Applicant, Pinnacle DMX Imaging is seeking $1,468.58 for the date of service July 27, 2022.

   The issue is the fee schedule.

4. Findings, Conclusions, and Basis Therefor

The Claimant was in an automobile accident on March 29, 2022.

The Applicant, Pinnacle DMX Imaging is seeking $1,468.58 for the date of service July 27, 2022.

The issue is the fee schedule.

Under New York State No-Fault Law an Applicant can make a prima facie showing of medical necessity by submitting "…a properly completed claim form, which suffices on its face to establish the "particulars of the nature and extent of the injuries and [health benefits] received and contemplated" (11 NYCRR 65-1.1), and the "proof of the fact and the amount of loss sustained." (Insurance Law section 5102 [a]) See Amaze Medical Supply Inc. a/a/o Johnny Bermudez v. Eagle Insurance Company 784 N.Y.S.2d 918 and Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004).

The Carrier submitted an affidavit from Matthew Kenyon, CPC, CPMA. He noted that the Applicant billed $1,600.00, the Carrier paid $131.42 which Mr. Kenyon indicates was an overpayment.

Code 76499 22 was billed for $800.00 which is an unlisted diagnostic radiographic procedure of the cervical spine. Code 76496 was billed $800.00 which is an unlisted fluoroscopic procedure and $0 was paid. Mr. Kenyon indicated that the Provider incorrectly billed CPT code 76499 for computerized radiographic measurement analysis (CRMA).

Mr. Kenyon indicated that the report submitted is consistent with reports of the very same nature that are in support of the use of software (digital media) to enhance radiographic films. He went on to indicate that based on the report submitted the CRMA of the cervical spine was performed which uses software to enhance radiographic films to diagnose ligament laxity. Under the Worker's Compensation Fee Schedule Radiology Ground Rule #2 the use of digital or photographic media and/or imaging is not reported separately but is considered to be a component of the basic procedure and shall not merit any additional payment. The use of the software to enhance radiographic films is not something that would merit additional payment. Therefore, the reimbursement was $0.

Mr. Kenyon indicated that CPT code 76496 (unlisted fluoroscopic procedure). He noted that fluoroscopy is an X-ray where the X-ray image appears on a fluorescent screen, or television monitor to view body structures while performing the procedure. He stated that the Provider was not performing any treatment or procedure in which any unlisted or unspecified fluoroscopic procedures, diagnostic, or interventional is being performed. He noted that according to the Worker's Compensation Medical Fee Schedule Ground Rule #3 procedures listed without specified unit values, By Report (BR) in the Relative Value column represent services that are too variable in nature of their performance to permit assignment of unit values. Fees for each procedure need to be justified. Pertinent information concerning the nature, extent, and need for the procedure or service, the time, the skill, and the equipment necessary is to be furnished. In any procedure where the unit value is listed as By Report the physician shall establish a unit value consistent in relativity with other unit values shown in the schedule. Mr. Kenyon stated that there were no documents submitted that would establish a unit value consistent in relativity with other unit values shown in the schedule to justify an $800.00 charge for CPT code 76499. He went on to indicate that codes 76120 should be allowed for studies of the

cervical spine and that this was Region I, the Relative Value is 2.81, $46.77 was used for the conversation factor and $131.42 would be appropriate. That amount was paid.

The Applicant submitted a document from Pinnacle DMX which stated the following:

> 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 preforming. There is no comparable code, as 76120 and 76125 are described as cineradiology/ video radiography, which is different than the equipment that we utilize for our testing. Digital motion x-ray is an x-ray machine that takes 30 x-rays in one second minimizing the amount of radiation to about one-one thousandth of the normal radiation. But with that, we are able to see the entire spine through motion as opposed to a regular x-ray, which is static, and in only one position. The movement allows me to see flexibility, ligament instability, and/ or ligament laxity in the neck, torso and lower back, (ligaments ae not visible in the x-ray, however; we can see the effects of ligament damage). According to the fee schedule, CPT 76496 and 76499 are a "by report code" and should be recognized as such.
>
> We have sent the report to you, which is a muiti-page detailed report outlining every level of spine that we are studying on the above-mentioned patient. The work that is involved in the reporting is very extensive and time consuming. Every plane of motion is tested. For example, in this case of the cervical spine, flexion, extension, oblique flexion and extension, rotation with open and closed mouth, and later flexion with open and closed mouth are preformed, in order to assess all ligaments stressed in every single plane of motion. The relative value is calculated by using three stand means: the work, the practice expenses, and the malpractice expense. You should be able to determine the reimbursement by the extensive detailed report that has been sent to you.
>
> Following the guidelines set forth in the NYS Medical Fee Schedule, based upon the zip code for 13027, we are considered region 1. Which radiology codes have the conversion factor or 46.77. Based upon our calculations for the following CPT codes, which are both listed by report codes in the fee schedule, we have calculated the RVU's as followed: CPT 74696, charged amount $800.00, we have established RVU of 22.45. CPT 76499, charged amount $800.00, we have established RVU of 22.45.
>
> Comprehensive interpretation of the Diagnostic Fluoroscopic procedure which has a registered trademark product name of: Digital Motion X-ray (DMX). Medical Necessity: A professional interpretation of the images captured is necessary during Diagnostic Fluoroscopic imaging procedure to fully understand the extent of the patient's injuries and conditions and to provide a definitive diagnosis. The full interpretation of the images captured during a diagnostic fluoroscopic imaging procedure is determined by several factors:
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> • A full interpretation is @ 45 minutes, i.e. A typical cervical spine study is made up to 7 different arcs/pianes of motion with each one evaluating different

anatomical structures. Extraction of the key images for the nodding, lateral flexion and extension, right oblique flexion and extension, left oblique flexion and extension, A-P cervical right and left lateral bending, A-P rotation right and left and A-P open mouth right and left lateral bending to be imported into the narrative report for a total of at least 14 images.

• Mensuration techniques to measure the degrees and translation for each one the key images. These measurements are necessary for the clinician to determine and pinpoint the areas of injury. Following the guidelines set forth in the NYS Medical Fee Schedule, based upon the zip code for 13027, we are considered region 1. Which radiology codes have the conversion factor or 46.77. Based upon our calculations for the follow CPT.codes, which are both listed by report codes in the fee schedule, we have calculated the RVU's as followed: CPT 76499, charged amount $800.00, we have established RVU of 22.45.

Definition of Test (Professional C om ponent): Diagnostic fluoroscopic procedure which has a registered trademark product of Digital Motion X-ray (DMX), this diagnostic fluoroscopic procedure is used to diagnose ligaments and osseous injuries, and is designed to image the skeletal structures of the body in motion. Medical Necessity: Refer to prescription/ medical necessity page attached. The referring/treating doctor is the determining factor for prescribing the Diagnostic fluoroscopic procedure based upon his evaluation of the patient. 1) Pain provoked by specific spine or joint motion 2) Failure to respond to conservative treatment 3) Symptomatology such as headache, posterior neck pain, increased pain with movement. Time/Effort: The full evaluation using the diagnostic fluoroscopic imaging procedures is determined by several factors: A full study is @ 45 minutes, i.e. A typical cervical spine study is made up to 7 different arcs/planes of motion with each one evaluating different anatomical structures. Each with the minimum of 3 repetitions per plane of m option which include nodding, lateral flexion and extension, right oblique flexion and extension, left oblique flexion and extension, A-P cervical right and left lateral bending, A-P rotation right and left and A-P open mouth right and left lateral bending- these allow the doctor to diagnose the twenty -two major ligaments that stabilize the cervical spine (right and left alar ligaments, right and left accessory ligaments, transverse ligament, anterior longitudinal ligament, posterior longitudinal ligament, five capsular ligaments on the right, five capsular ligaments on the left and five interspinous ligaments.) following the diagnostic fluoroscopic procedure, the doctor/technician reviews the study with the patient. The diagnostic fluoroscopic procedure enables the doctor to evaluate every joint in the body as well as the spine. These include, but are not limited to the cervical, lumbar, wrist, shoulder, knee, hip, elbow, ankle, & TMJ. According to the requirements of State law, a physician or certified x-ray technician can only perform the D M X procedure. Special Equipment: Fluoroscopy is an imaging technology commonly used by physicians to obtain real-time images of the internal structures of a patient through a fluoroscope. A fluoroscope consists of an x-ray source and a fluorescent screen between which the patient is positioned. The fluorescent screen is electronically and optically coupled to an Image intensification system and television camera, allowing the images to be seen on a monitor, recorded, and stored.

Seven views are performed during a Cervical Diagnostic Fluoroscopic procedure: 1) Neutral lateral Projection: The integrity of the cervical lordosis and overall condition of the cervical spine is evaluated. The loss of the cervical lordosis may be a result of damage to the posterior longitudinal, capsular or interspinous ligaments. 2) lateral Nodding Projection: This view examines the integrity of the transverse ligament which is responsible for preventing the anterior movement of C l on C2. An increase of the Atlanta-Dens interspace (ADI) indicates damage to the transverse ligament 3) Motion in the Neutral lateral Projection to Full Flexion; This view examines the integrity of the posterior longitudinal ligament demonstrated by a forward (anterior) movement of one vertebrae over the vertebrae below or by the posterior widening of the intervertebral disc space (increased disc angle). Motion in the Neutral lateral Projection to Full Extension: This view examines the integrity of the anterior longitudinal ligament demonstrated by a backward (posterior) movement of one vertebrae over the vertebrae below or by the posterior widening of the intervertebral disc space (increased disc angle), A) Motion in the Oblique Flexion Projection: This view examines the integrity of the capsular ligaments by observing gapping of the facet joints, located on the posterior cervical spine (C2-C7), there are five capsular ligaments on the right and left. Motion in the Oblique Extension Projection: This view examines the integrity of the capsular ligaments by encroachment into the intervertebral foramen, located on the posterior cervical spine (C2-C7), there are five capsular ligaments on the right and left. 5) Motion In the A-P Projection lateral Bending; This view allows us to evaluate coupled motion of the spinous processes which examines facet Joint integrity. 6) Motion in the A-P Rotation Prolection: This view allows us to examine the rotational range of motion between Occiput Ci-C2. Increased motion indicates damage to the alar and accessory ligaments. 7) Motion in the A-P Open Mouth lateral Bending Projection: This view examines the integrity of the alar and accessory ligaments either by the lateral overhang of C l on C2 or by the changes in the para-odontoid spaces.

Following the guidelines set forth in the NYS Medical Fee Schedule, based upon the zip code for 13027, we are considered region 1. Which radiology codes have the conversion factor or 46.77. Based upon our calculations for the following CPT codes, which are both listed by report codes in the fee schedule, we have calculated the RVU's as followed: CPT 74696, charged amount $800.00, we have established RVU of 22.45.

I find the Applicant successfully rebutted the arguments set forth by the Carrier.

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**
	Pinnacle DMX Imaging	**07/27/22 - 07/27/22**	**$1,468.58**	**Awarded: $1,468.58**
Total			**$1,468.58**	**Awarded: $1,468.58**

B. The insurer shall also compute and pay the applicant interest set forth below. 07/06/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

   The insurer shall compute and pay the applicant the amount of interest from the filing date of the request for arbitration, at a rate of two percent (2%) per month, simple interest (i.e., not compounded), using a 30-day month and ending with the date of payment of the award, subject to the provisions of 11 NYCRR §65-3.9(c). The filing date, pursuant to the American Arbitration Association records, is as noted above interest is paid from the date of filing.

C. Attorney's Fees

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

   The insurer shall pay the applicant an attorney's fee in accordance with 11 NYCRR 65-4.6(d). As this matter was filed after February 4, 2015, this case is subject to the provisions promulgated by the Department of Financial Services in the Sixth

Amendment to 11NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant an attorney's fee in accordance with 11 NYCRR 65-4.6(d). Subject to a maximum fee of $1,360.00.

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 NY

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

12/20/2023
(Dated)

Mary Anne Theiss

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:
5b0a63c72b6e0529c4701774a12319d7

Electronically Signed

Your name: Mary Anne Theiss
Signed on: 12/20/2023