

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Diagnostic Assessment Chiropractic P.C  
(Applicant)

- and -

Geico Insurance Company  
(Respondent)

AAA Case No. 17-24-1337-1756

Applicant's File No. OS-81547

Insurer's Claim File No. 0666991200000001

NAIC No. 35882

**ARBITRATION AWARD**

I, Richard Martino, 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/patient.

1. Hearing(s) held on 07/30/2024  
Declared closed by the arbitrator on 07/30/2024

John Faris Esq. from Law Office of Olga Sklyut P.C. participated virtually for the Applicant

Heather Pliczak Esq. from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$894.36**, 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 studies performed on 11/28/23 following an 8/13/23 automobile accident.**

**The Assignor, a 49-year-old male, was involved in an automobile accident that occurred on 8/13/23.**

**The respondent issued a timely denial of the bill submitted based upon a fee schedule defense.**

**The issue is whether respondent's non-reimbursement of the applicant's bill was proper.**

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

**I have reviewed the documents contained in the Electronic Case Folder as of the date of the hearing.**

**This case involves a claim for diagnostic ultrasound studies performed on 11/28/23 following an 8/13/23 automobile accident.**

**The Assignor/injured party, a 49-year-old male, was involved in an automobile accident that occurred on 8/13/23.**

**The respondent issued a timely denial of the bill submitted based upon a fee schedule defense.**

**The issue is whether respondent's non-reimbursement of the applicant's bill was proper.**

**Respondent's NF-10 states that Applicant is not entitled to any reimbursement for the services at issue pursuant to the fee schedule. Respondent did not reimburse the applicant any amount for the billed services.**

**Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. See, Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 2006 NY Slip 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006). See also, Power Acupuncture PC v. State Farm Mutual Automobile Ins. Co., 11 Misc.3d 1065A, 816 N.Y.S.2d 700, 2006 NY Slip Op 50393U, 2006 N.Y. Misc. LEXIS 514 (Civil Ct, Kings Co. 2006). 11 NYCRR 65-3.8(g)(1), in effect as of April 1, 2013, provides that 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 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.**

**As such Respondent is not required to establish that it preserves a fee schedule defense in a timely denial of claim.**

**It is now well-settled that an insurer may reimburse a licensed acupuncturist pursuant to the workers' compensation fee schedule for acupuncture services**

rendered by a chiropractor. See *Z.M.S. & Y. Acupuncture, P.C. v. GEICO General Ins. Co.*, 58 Misc.3d 143(A), (2017 NY Slip Op 51891(U) (App Term 2d, 11th & 13th Dists. Dec. Page 5/11 22, 2017); *Easy Care Acupuncture, P.C. v. MVAIC*, 2016 NY Slip Op 51556(U) (App Term 1st Dept. Oct. 26, 2016); *Urban Well Acupuncture, P.C. v. Erie Ins. Co.*, 2016 NY Slip Op 51300(U) (App Term 1st Dept. Sept. 19, 2016); *GBI Acupuncture, P.C. v. State Farm Mut. Auto Ins. Co.*, 2016 NY Slip Op 50329(U) (App Term 2d, 11th & 13th Jud Dists. March 15, 2016). Judicial notice of the New York State Worker's Compensation Medical and Chiropractic Fee Schedules is taken. 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), 2011 NY Slip Op 51721(U) (App Term 2d, 11th & 13th Jud Dists. 2011); *Natural Acupuncture Health, P.C. v. Praetorian Ins. Co.*, 30 Misc.3d 132(A), 2011 NY Slip Op 50040(U) (App Term, 1st Dept. 2011).

I find that when the calculation of the proper fee for a particular service or procedure is clearly set forth in the schedule, an interpretation of the schedule by a qualified professional is not required. However, when there is more than one reasonable interpretation of the proper fee for a particular service rendered, an interpretation by a qualified professional is required. Applicant billed CPT code 76999 for the diagnostic ultrasound studies at issue.

Respondent argues that pursuant to General Ground Rule 10 of the Chiropractic Fee Schedule Applicant may not bill for CPT codes that are not contained in the Chiropractic Fee Schedule. On December 11, 2018, the New York State Workers' Compensation Board promulgated new fee schedules, which became effective April 1, 2019. With the exception of certain ground rules, the 34 Amendment to Regulation 83 delayed the implementation of the new fee schedules to October 1, 2020. The implementation of certain ground rules were not delayed and became effective for all services rendered April 1, 2019, and thereafter.

General Ground Rule 10 of the Worker's Compensation Chiropractic Fee Schedule is one of these excepted ground rules that became effective April 1, 2019. General Ground Rule 10 of the Chiropractic Fee Schedule 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.

CPT 76999 is a "by-report" code that is contained in the 2012 and 2020 Chiropractic Fee Schedules. General Ground Rule 3 discusses "by-report" codes and states: 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 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 documentation. The original official record, such as operative report and hospital chart, will be given far greater weight than supplementary reports formulated and submitted at later dates.

Respondent argues that CPT 76999 is not the proper code for the services rendered; rather CPT 76800, 76536, and/or 76705 would be the proper codes for the services performed, none of which appear in the Chiropractic Fee schedules, therefore Applicant would not be entitled to reimbursement for the services.

In support of its fee schedule defense Respondent submitted an affidavit from Crystal Russo, a Hearing Specialist for Respondent and a certified professional coder. Ms. Russo states that CPT 76999 is a "by report" code and pursuant to Ground Rule 2 "the report should contain pertinent information concerning the nature, extent and need for the procedure or service, the time, the skill and the equipment necessary to perform the service. Ms. Russo used the CPT book and the CPT Assistant and determined that based upon the time, skill and equipment utilized to provide the service, CPT codes 76800, 76536, 76604, 76705, 76881 and 76882 best represent the services performed and none of these CPT codes are contained in the 2012 or 2020 Chiropractic Fee Schedules, therefore Applicant is not eligible for reimbursement for the services.

I am not persuaded by the affidavit of Ms. Russo as I find it to be a general conclusory opinion regarding what she believes the appropriate fee for the diagnostic ultrasound should be. Ms. Russo attests that "based upon the time, skill and equipment utilized to provide the service, CPT codes 76800, 76536, 76604, 76705, 76881 and 76882 best represent the services performed," however Ms. Russo does not attest to having reviewed the Assignor's medical records to determine the extent, nature, location or length of time of the service actually provided to Assignor and, as such, I find her affidavit lacks credibility for the purpose of this claim.

Due to the foregoing reasons , I find that the respondent has failed to establish its fee schedule defense for the diagnostic ultrasound studies at issue.

It is well settled that an applicant for no-fault benefits establishes its prima facie entitlement to payment by proving that it submitted a claim, set forth the fact and the amount of the loss sustained, and proof that the defendant had failed to pay or deny the claim within the requisite 30 day period, or that the defendant had issued a timely denial of the claim that was conclusory, vague, or without merit as a matter of law (see Insurance Law §5106[a]; Ave T MPC Corp v. Auto One Insurance Co., 32 Misc.3d 128 (A), 934 N.Y.S.2d 32; 2011 N.Y. Slip Op 51292 [U], 2011 WL 2712964 (App Term 2d & 11<sup>th</sup> and 13<sup>th</sup> Jud Dists. July 5, 2011). A "facially valid claim," is presented where it sets forth the name of the patient; date of accident; date of services; description of services rendered and the charges for those services. See, Vinings Spinal Diagnostic P.C. v. Liberty Mutual Insurance Company, 186 Misc.2d 287; 717 NYS2d 466 (1<sup>st</sup> Dist. Ct. Nass. Co.)

**Applicant has presented a facially valid claim for the services in dispute.**

**Therefore, the claim is granted.**

**Applicant is awarded \$894.36.**

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
	Diagnostic Assessment Chiropractic P.C	11/28/23 - 11/28/23	\$894.36	Awarded: \$894.36
Total			\$894.36	Awarded: \$894.36

- B. The insurer shall also compute and pay the applicant interest set forth below. 02/20/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Since the claim arose from an accident that occurred on or after April 5, 2002, interest shall be paid, at the rate of 2% per month, simple, from the arbitration filing date, and ending with the date of payment of the award.

C. Attorney's Fees

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

Respondent shall pay the applicant an attorney fee, in accordance with 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 Nassau

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

07/31/2024  
(Dated)

Richard Martino

**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:**  
f41d1c6084e92aeb86bc10ae02b03b56

### Electronically Signed

Your name: Richard Martino  
Signed on: 07/31/2024