

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Serene Acupuncture PLLC
(Applicant)

- and -

State Farm Mutual Automobile Insurance
Company
(Respondent)

AAA Case No. 17-23-1321-7308

Applicant's File No. FL23-62323

Insurer's Claim File No. 32-40N7-42Q

NAIC No. 25178

ARBITRATION AWARD

I, Corinne Pascariu, 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 08/01/2024
Declared closed by the arbitrator on 08/01/2024

Nancy Orlowski, Esq. from Field Law Group, P.C. participated virtually for the Applicant

Daniel Schlosser from Sarah C. Varghese & Associates f/k/a James F. Butler & Associates participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$445.94**, 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

Background

Assignor is a female who was 34-years-old when she was injured as the result of a motor vehicle accident on October 13, 2022. Assignor presented to Applicant October 20, 2022 - March 30, 2022, for chiropractic treatment. Respondent either denied or reduced reimbursement on the ground that the amount billed by Applicant exceeded the reimbursable rate under the New York State Worker's Compensation Fee Schedule.

Issue

The issue is whether Respondent can establish that the amount billed by Applicant exceeded the reimbursable rate under the New York State Worker's Compensation Fee Schedule.

4. Findings, Conclusions, and Basis Therefor

The case was decided on the submissions of the parties as contained in the ADR Center maintained by the American Arbitration Association and the oral arguments of the parties' representatives. There were no witnesses. I reviewed the documents contained in the file for both parties and make my decision in reliance thereon.

Upon reviewing the evidence submitted by the Applicant, I find the Applicant submitted sufficient credible evidence to establish a prima facie case with the respect to the services that are the subject of this arbitration. See, Mary Immaculate Hospital v. Allstate Insurance Co., 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004); Amaze Medical Supply Inc. v. Eagle Ins. Co., 2 Misc 3d 128[A], 2003 NY Slip Op 51701 (U) (App Term, 2d and 11th Jud Dists 2003).

Once Applicant has made out a prima facie case, the burden shifts to Respondent to timely request additional verification, deny, or pay the claim. Hospital for Joint Diseases v. Travelers Prop. Cas. Ins. Co., 9 NY3d 312 (2007).

The denials were timely.

18-unit, 15-unit and 12-unit Rule

Applicant seeks additional compensation for treatment rendered. Respondent made partial payment for specified dates of service, asserting the 18-unit, 15-unit or 12-unit rule. In applying this defense for these dates of service Respondent's denial asserted,

When performing a consultation or initial evaluation including multiple procedures and/or modalities on the same day, the maximum number of relative value units is limited to 18.0 or the amount billed, whichever is less for all providers combined. (New York Workers' Compensation Medical Fee, Physical Medicine Ground Rule 8; Chiropractic Fee Schedule, Evaluation & Management Ground 1B, Physical Medicine Ground Rule 2; Acupuncture Fee Schedule, Medicine Ground Rule 1A; Physical Therapy and Occupational Therapy Fee Schedule, Physical Medicine Ground Rule 2) NOTE: When a patient receives physical medicine procedures, acupuncture and/or chiropractic modalities from more than one provider, the patient may not receive more than 18.0 RVUs per day per accident or illness from all providers combined.

When multiple procedures and/or modalities are performed on the same day, the maximum number of relative value units is limited to 12.0 or the amount billed, whichever is less for all providers combined. (New York Workers' Compensation Medical Fee Schedule, Ground Rule 11; Chiropractic Fee Schedule, Physical Medicine Ground Rule 3; Acupuncture Fee Schedule, Medicine Ground Rule 1B; Physical Therapy and Occupational Therapy Fee Schedule, Physical Medicine Ground Rule 3). NOTE: When a patient receives physical medicine procedures, acupuncture and/or chiropractic modalities from more than one provider, the patient may not receive more than 12.0 RVUs per day per accident or illness from all providers combined.

When performing a re-evaluation including multiple procedures and/or modalities on the same day, the maximum number of relative value units is limited to 15.0 or the amount billed, whichever is less for all providers combined. (New York Workers' Compensation Medical Physical Medicine Fee Schedule Ground Rule 8, Chiropractic Physical Medicine Ground Rule 2, Acupuncture Medicine Fee Schedule Ground Rule 1A, Physical Therapy and Occupational Therapy Fee Schedule Ground Rule 2). NOTE: When a patient receives physical medicine procedures, acupuncture and/or chiropractic modalities from more than one provider, the patient may not receive more than Respondent essentially asserted that a provider was paid some or all of the 15/12 units of physical medicine, such that Applicant would not be reimbursed for all 15/12 units billed for treatment.

Respondent submitted sufficient proof for the 15/12-unit rule defense. Applicant did not offer a defense. Nothing further is due for the treatment rendered by Applicant.

Code Not in Fee Schedule - CPT code 99202

In the instant matter, Applicant, a professional acupuncture entity, utilized CPT code 99202 to bill for an evaluation.

Respondent denied reimbursement as follows:

The procedure/service code billed is not listed in the Acupuncture fee schedule for the provider specialty. There is a separate and distinct fee schedules for use by Acupuncturists (Acupuncture Fee Schedule set forth in 12 NYCRR 329). An Acupuncturist may not use CPT codes that do not appear in the applicable fee schedule relevant to the provider's scope of practice. (Pursuant to the New York Workers' Compensation Acupuncture Fee Schedule, General Ground Rule 7 set forth in 12 NYCRR 32.)

Applicant argued that Respondent should have cross walked the code to one that is reimbursable instead of denying it.

Finding

The New York State Workers' Compensation Fee Schedule has separate and distinct fee schedules for the various specialties. For example, the fee schedule for use by Chiropractors is within the Chiropractic Fee Schedule set forth in 12 NYCRR 348, Podiatrists use the Podiatry Fee Schedule set forth in 12 NYCRR 343 and Psychologists use the Behavioral Fee Schedule set forth in 12 NYCRR 333. Pursuant to the New York Workers' Compensation Medical Fee Schedule, General Ground Rule 19 set forth in 12 NYCRR 329, revised April 1, 2019, a provider such as a Chiropractor, Podiatrist or Psychologist may not use CPT codes that do not appear in the applicable fee schedule relevant to the provider's scope of practice.

In the instant matter, Applicant is a professional acupuncturist. CPT code 99202 is not contained within the separate and distinct Acupuncture Fee Schedule. Therefore, Applicant's use of CPT code 99202 was improper.

I reject Applicant's assertion that Respondent should have cross walked the code to one that is reimbursable. Applicant has the responsibility to bill the correct code and should have done so instead of relying on Respondent to cross walk it for them.

Therefore, I sustain Respondent's denial and deny reimbursement of the code.

CPT Code 97810

On October 17 and 19, 2022, Applicant billed CPT code 97810.

Respondent denied reimbursement of code 97810 on the ground that is included in CPT code 97813 billed the same day.

CPT code 97811

On October 26, 2022, Applicant billed code 97811. Respondent denied reimbursement of CPT code 97811 for the following reasons:

- The procedure code used by the provider requires a prerequisite code to be used.
- The provider is using modifier -59 to indicate under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier -59 will identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician.
- NY Acu 97811 Included In 97814

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). If Respondent fails to demonstrate by competent evidentiary proof that a plaintiff's claims were in excess of the appropriate fee schedules, Respondent's defense of noncompliance with the appropriate fee schedules cannot be sustained. See, Continental Medical PC v. Travelers Indemnity Co., 11 Misc.3d 145A, 819 N.Y.S.2d 847, 2006 NY Slip Op 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Term, 1st Dep't, per curiam, 2006).

At the hearing counsel for Applicant argued that Respondent did not meet the burden of persuasion because they did not submit a coder affidavit in support of its defense. I agree.

An arbitrator may take judicial notice of the fee schedule when it involves a plain reading of it. That is not the case in this instance as such I decline to do so.

Respondent failed to submit any evidence in support of its defense. Therefore, I find in favor of Applicant for these three codes and award \$76.75 in satisfaction of the claim.

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
	Serene Acupuncture PLLC	10/17/22 - 10/26/22	\$164.38	Awarded: \$76.75
	Serene Acupuncture PLLC	10/31/22 - 11/28/22	\$98.17	Denied
	Serene Acupuncture PLLC	12/29/22 - 01/16/23	\$84.32	Denied
	Serene Acupuncture PLLC	01/24/23 - 02/22/23	\$54.05	Denied
	Serene Acupuncture PLLC	02/27/23 - 03/14/23	\$29.66	Denied
	Serene Acupuncture PLLC	03/28/23 - 03/28/23	\$15.36	Denied
Total			\$445.94	Awarded: \$76.75

- B. The insurer shall also compute and pay the applicant interest set forth below. 10/19/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest shall be calculated from the date listed above, until the date that payment is made at two percent per month, simple interest on a pro rata basis using a thirty-day month.

C. Attorney's Fees

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

Attorney's Fees shall be calculated pursuant to the amended terms, as follows: 20 percent of the amount of first-party benefits, plus interest thereon, subject to a maximum fee of \$1,360. [11 NYCRR §65-4.6(d)]. There is no minimum fee.

- 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 NJ

SS :

County of Bergen

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

08/01/2024

(Dated)

Corinne Pascariu

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:
ebd3eebb06f4a6d176435cd017f44012

Electronically Signed

Your name: Corinne Pascariu
Signed on: 08/01/2024