American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Rockwell Medical Care PC (Applicant)	AAA Case No.	17-24-1337-5224
- and -	Applicant's File No.	RMPC 335.01, 02, 03, 04
	Insurer's Claim File No.	1129512-02
American Transit Insurance Company (Respondent)	NAIC No.	16616

ARBITRATION AWARD

I, Mitchell Lustig, 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 08/12/2024, 09/23/2024
   Declared closed by the arbitrator on 09/23/2024

   Michael Lamond, Esq. from Michael J. Lamond PC participated virtually for the Applicant

   Adam Waknine, Esq. from American Transit Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$4,312.23**, was AMENDED and permitted by the arbitrator at the oral hearing.

   At the hearing , the claim was amendeded to the sum of $3,700.48. The Applicant's file contains a bill in the sum of $611.75 from MDRX Solutions LLC. Since MDRX Solutions is not a named party to this arbitration and I did not give permission to add MDRX Solutions as a party, the bill from MDRX Solutions in the sum of $611.75 is dimissed without prejudice.

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

3. Summary of Issues in Dispute

In dispute is Applicant Rockwell Medical Care PC's claim as the assignee of a 27-year-old female injured in a motor vehicle accident on May 6, 2023 for reimbursement in the revised sum of $3,700.48 for autonomic nervous system testing, extracorporeal shock wave testing ("ESWT") performed to the cervical spine and right shoulder and percutaneous electrical nerve stimulation (PENS) testing or a Biowave procedure performed by Dr. Jeremie Rachunow on June 20, 2023.

The Respondent denied that portion of the claim in the sum of $2,093.84 for the autonomic nervous system testing and the ESWT performed to the cervical spine and right shoulder on June 20, 2023 based upon a peer review report by Dr. Stuart Springer dated August 4, 2023 concluding that the latter services were not medically necessary.

4. Findings, Conclusions, and Basis Therefor

At the outset, the Applicant's counsel asserted that the Respondent's denials for that portion of the claim in the sum of $2,093.84 are late and that therefore the Respondent is precluded from asserting its defense that the autonomic nervous system testing and the extracorporeal shock wave testing were not medically necessary. Specifically, the Applicant's counsel noted that the Respondent 's NF-10s indicate that the Respondent received the Applicant's bills on July 14, 2023 and July 19, 2023 but that the Respondent did not deny the bills until **83 and 78 days** later on October 5, 2023.

Nor, did the Respondent extend its time to pay or deny the latter bills by requesting additional verification. (While the Respondent's file contains requests for additional verification, these verification requests do **not** pertain to the bills in the sum of $2,093.84 for the autonomic nervous system testing and the extracorporeal shock wave therapy testing).

Thus, the Applicant's counsel contended that the Respondent failed to properly toll its time to pay or deny the bills and that the Respondent is precluded from asserting its lack of medical necessity defense with regard to that portion of the claim in the sum of $2,093.84 for the autonomic nervous system testing and the ESWT performed on June 20, 2023. I agree with the Applicant's counsel.

Pursuant to Section 5106(a) of the Insurance Law and 11 NYCRR Section 65-3.8(a), an insurer is required pay or deny the claim with 30 calendar days after proof of claim is received.

The "substantial consequences" of "an insurer's failure to pay or deny a claim within 30 days" renders the benefits overdue, and commences the accrual of interest and attorney's fees. Hospital for Joint Diseases v. Travelers Prop. Cas. Ins.Co. 9 N.Y. 3d 312, 317 (2007); Presbyterian Hospital v. Maryland Cas. Co., 90 N.Y.2d 274, 600 N.Y.S.2d 536 (1997).

Even, {m|ore importantly, a carrier that fails to deny a claim within the 30-day period is generally precluded from asserting a defense against payment of the claim." Hospital for Joint Diseases v. Travelers Prop. Cas. Ins. Co., 9 N.Y.3d 312, 318 (2007). Referring to Central Gen. Hospital v. Chubb Group of Ins. Cos., 90 N.Y.2d 195 (1997), the Court of Appeals in Hospital for Joint Diseases "cautioned that the only exception to this preclusion remedy was a 'narrow' one for those 'situations where the insurance company raises a defense of lack of coverage."

Inasmuch as Respondent herein neither paid or denied the Applicant's bills for the autonomic nervous system testing and ESWT within the 30-day statutory period after it received the Applicant's bills and did not prove that it timely extended its time to pay or deny the claim, the Respondent is precluded from raising any non-coverage defenses, including the defense of lack of medical necessity.

However, I find that the Applicant billed in excess of the fee schedule for the ESWT testing of the cervical spine and right shoulder.

The Applicant billed for the extracorporeal shock wave testing utilizing CPT Code 0101T. The Applicant billed in the sum of $700.39 for the ESWT of the cervical spine and $350.00 for the ESWT of the right shoulder performed on June 20, 2023. Since the ESWT was performed on the same date of service, I find that the Applicant is only entitled to the sum of $700.39 for the ESWT performed on June 20, 2023.

The CPT code descriptor for CPT Code 0101T is "Extracorporeal shock wave involving the musculoskeletal system, not otherwise specific, high energy." The description does not designate the services as an anatomic region or as "each area or section." Therefore, the services billed covers the **entire** musculoskeletal system and is reimbursed only once per day.

I note that the relative value for CPT Code 0101T is 2.78. When this is multiplied by the surgery factor of $251.94, the Applicant in only entitled to the sum of $700.39 for each date of service (2.78 x $251.94 = $700.39). In addition, I find that the Applicant is entitled to the sum of $248.34 for the office visit billed pursuant to CPT Code 99243,

Thus, I find that the Applicant is entitled to the sum of $1,743.64 for the autonomic nervous system testing and the ESWT performed on June 20, 2023 ($794.91 + $948.73 = $1,743.64).

The Respondent did not pay or deny that portion of the claim in the sum of $1,606.64 for the biowave procedure performed on June 20, 2023 but rather maintained that this portion of the claim was premature because the Applicant did not respond to its request for additional verification.

WHETHER THE CLAIM IS PREMATURE

Pursuant to Section 5106(a) of the Insurance Law and 11 NYCRR Section 65-3.8(a), an insurer is required pay or deny the claim with 30 calendar days after proof of claim is received.

The 30-day statutory period may be extended by a request by the insurance company for additional verification of the claim, 11 NYCRR Section 65-3.8(a)(1), so long as the request is made within 15 business days of the receipt of the claim. 11 NYCRR Section 65-3.5(b). Mount Sinai Hospital v. Triboro Coach, 263 A.D.2d 11, 699 N.Y. S.2d 77 (2nd Dept. 1999).

The insurance regulations also impose upon the insurer, when an initial verification request is not honored within 30 days, the duty to follow up with a second request either by a phone call documented in the file or by mail within 10 days. 11 NYCRR Section 65-3.6(b). See New York Hosp. Med. Ctr. of Queens v. Country-Wide Ins. Co., 295 A.D. 2d 583, 584-585 (2nd Dept. 2002).

Until such time as the applicant responds to all outstanding verification requests, the 30-day period in which to pay or deny the claim does not begin to run, and any claim for payment is premature. Central Suffolk Hospital v. New York Central Mutual Fire Insurance Company, 24 A.D.3d 492, 807 N.Y.S.2d 382 (2nd Dept. 2005); New York & Presbyterian Hospital v. Progressive Casualty Insurance Company, 5 A.D.3d 568, 774 N.Y.S.2d 72 (2nd Dept. 2004); Triangle R, Inc. v. Geico Insurance Company, 27 Misc.3d 137(A), 2010 N.Y. Slip Op. 50885(U) (App. Term 2nd, 11th and 13th Jud. Dists. 2010).

The record in the within matter indicates the Respondent received the Applicant's bill in the sum of $1,606.64 for the Biowave procedure on September 11, 2023. (See Paragraph 18 of the Affidavit of Cheryl Glaze contained in the Respondent's submission).

The Respondent sent letters to the Applicant provider on October 5, 2023 and November 8, 2023 advising the Applicant that the claim was being delayed pending the EUO of the claimant.

However, the Respondent did **not** submit any letters scheduling the examination under oath of the claimant.

The Applicant's attorney argued that the Respondent's letters dated October 5, 2023 and November 8, 2023 did not constitute proper requests for additional verification and did not toll the Respondent's time to pay or deny the claim because the letters merely stated that the bills were being delayed pending an EUO of the claimant. However, as further noted by the Applicant's counsel, the Respondent did **not** submit any letters scheduling the EUO of the claimant. I agree with the Applicant's counsel that the Respondent failed to toll its time to pay or deny the Applicant's claim. See PDG Psychological PC v. State Farm Mutual Automobile Insurance Co., 6 Misc.3d 1022(A), 2005 N.Y. Slip Op. 50150(U) (N.Y. Civ. Ct. Kings Co. 2005).

It is well settled that an insurer's general delay letters, which request no verification, are insufficient to toll the 30-day statutory time period within which a claim must be paid or denied. Westchester Medical Center v. Lincoln General Insurance Company, 60 A.D.3d 1045, 877 N.Y. S.2d 340 (2nd Dept. 2009); Nyack Hospital v. Encompass Insurance Company, 23 A.D.3d 535, 806 N.Y.S.2d 643 (2nd Dept. 2005); Colonia Medical, P.C. v. New York Cent. Mut. Fire Ins. Co., 40 Misc.3d 134(A), 2013 N.Y. Slip Op. 51266(U) (App. Term 2nd, 11th and 13th Jud. Dists. 2013); Parsons Medical Supply, Inc. v. Progressive Northeastern Ins. Co., 36 Misc.3d 148(A), 2012 N.Y. Slip Op. 51649(U) (App. Term 2nd, 11th and 13th Jud. Dists. 2012).

Thus, I find that the Applicant's bill for the Biowave procedure performed on June 20, 2023 is overdue.

However, at the hearing, the Respondent's attorney asserted that the Applicant billed in excess of the fee schedule for the Biowave procedure.

The Applicant billed the following CPT Codes for the biowave procedure performed on June 20, 2023:

99243 ($248.34) initial office visit

64999 ($1,078.30) biowave procedure

99070 ($280.00) biowave percutaneous electrode array.

In support of its fee schedule defense, the Respondent submitted a Fee Affidavit by its Certified Fee Coder, Carolyn Mallory, sworn to March 28, 2024. In her Fee Affidavit, Ms. Mallory asserted that the Applicant was only entitled to the sum of $524.22 for the biowave procedure, not the sum of $1,606.64 billed by the Applicant. Specifically, Ms. Mallory allowed $248.34 for the initial office visit, $275.88 for the biowave procedure billed pursuant to CPT Code 64999 and $0.00 allowance for CPT Code 99070 (supplies and materials) because the charges for the latter code are included in the relative value of CPT Code 64999.

However, I note that Ms. Mallory's Affidavit is not specific to the bill in dispute as it references a **different** Assignor and **different** date of service than is in dispute herein.

In opposition, the Respondent submitted an Affidavit from its certified fee coder, Roza Vinogradov. In her Affidavit, Ms. Vinoradov asserted that the Applicant is entitled to the sum of $1,078.30 for the biowave procedure billed pursuant to CPT Code 64999. As specifically noted by Ms. Vinogradov in her Fee Affidavit.

"The Applicant performed and billed Biowave PENS procedures under unlisted CPT code 64999 for DOS 06/20/2023. Code 64999 is listed in the New York Worker's Compensation Fee Schedule under the Surgery section as a "By Report" code. The

documentation has specifically mentioned that Biowave PENS procedures was the procedure reported under code 64999. Thus, the Applicant has complied with the requirement of billing this By Report Code.

As per Ground Rule 2, "Procedures Listed Without Specified Relative Value is justified by report." The provider is required to provide "pertinent information concerning the nature, extent, and need for the procedure or service, the time, the skill, and the equipment necessary." Most importantly, Ground Rule 2 clearly states that the provider **"shall establish a relative value unit consistent in relativity with other relative units shown in the schedule."**

Thus, in accordance with Ground Rule 2, Applicant established its RVU (4.28 x $251.94 =$1078.30) and has complied with the requirement of billing this By Report Code.

In order to arrive at its established RVU, the provider was required to consider the type and extent of treatment, the level of skill, the amount of time involved, the customary charges billed for same or similar BR codes services, among other things.

The services are to be reimbursed depends on the skill of the provider, the nature, extent and the time involved. Since the procedure requires high skill whereby the patient does not experience any pain, or any other complications, and the procedure can take up to 15 minutes, the RVU 4.28 is reasonable.

It should be noted that comparing Biowave PENS to traditional PENS, electroacupuncture, or trigger point injections ("TPIs") would be inaccurate as Biowave PENS have an added time component, requiring the session to last no less than 15 minutes, therefore, to account for the added time, it should be reimbursed at a slightly higher rate at an RVU of 3.22 would be an accurate representation for Biowave PENS. Moreover, there is also no code that accurately describes the implantation of the single use array which should be reimbursed at a rate somewhere between CPT codes 64550 (Application of surface transcutaneous stimulator), with an RVU of 0.32, and 64553 (Percutaneous implantation of neurostimulator electrode array), with an RVU of 0.73. Further, the application of the patented electrode array requires the doctor to apply a downward pressure of 20 pounds per square inch in order for the grid array to fully puncture the skin, making this procedure more complex than the application of a simple surface electrode as in CPT Code 64550 and less complex than the surgical implantation of an electrode such as CPT Code 64553 and therefore an RVU of 0.53 per array would be and accurate representation of this procedure. Therefore, a total relative value per application of Boiwave is determined as: **0.53 + 0.53 +3.22 = $4.28** is fair and reasonable.

The available documentation indicate that the treatment was provided to thoracic spine region on 06/20/2023. Thus, the amount for CPT 64999 is determined as follows:

For one unit of CPT code 64999,

4.28x $251.94 = $1078.30

Therefore, the Applicant is entitled to re-imburse CPT codes 64999 as billed for DOS 06/20/2023."

In addition, the Applicant's coder asserted that the Applicant was entitled to the sum of $280.00 for CPT Code 99070.

After careful consideration of the evidence, I am persuaded by Ms. Viogradov's Fee Affidavit regardig the proper reimbursment for CPT Code 64999 and I find that it is more credible and persuasive than Ms. Mallory's Fee Affidavit.

Thus, I find that the Applicant is entitled to the sum of $1,078.30 for the biowave procedure billed pursuant to CPT Code 64999. In addition, I find that the Applicant is entitled to the sum of $248.34 for the office visit billed pursuant to 99243. However, I find that the Applicant is not entitled to any reimbursement for CPT Code 99070.

Thus, I find that the Applicant is entitled to the sum of $1,326.64 for the biowave procdure performed on June 20, 2023.

Based upon the foregoing, I find in favor of the Applicant in the sum of $3,070.28 ($1,743.64 + $1,326.64 = $3,070.28).

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
	Rockwell Medical Care PC	**06/20/23 - 06/20/23**	**$611.75**	**$0.00**	**Dismissed without prejudice**
	Rockwell Medical Care PC	**06/20/23 - 06/20/23**	**$794.91**	**$794.91**	**Awarded: $794.91**
	Rockwell Medical Care PC	**06/20/23 - 06/20/23**	**$1,606.64**	**$1,606.64**	**Awarded: $1,326.64**
	Rockwell Medical Care PC	**06/20/23 - 06/20/23**	**$1,298.93**	**$1,298.93**	**Awarded: $948.73**
Total			**$4,312.23**		**Awarded: $3,070.28**

B. The insurer shall also compute and pay the applicant interest set forth below. 02/22/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

The insurer shall pay interest from February 22, 2024, the date that arbitration was requested, to the date of payment.

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). However, if the benefits and interest awarded thereon is equal to or less than the Respondent's written offer during the conciliation process, the attorney's fee shall be based upon the provisions of 11 NYCRR Section 65-4.6(b).

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

09/25/2024
(Dated)

Mitchell Lustig

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:
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Electronically Signed

Your name: Mitchell Lustig
Signed on: 09/25/2024