

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

JTK Chiropractic Care PC  
(Applicant)

- and -

Geico Insurance Company  
(Respondent)

AAA Case No. 17-24-1350-7842  
Applicant's File No. GTLJTK071723.008  
Insurer's Claim File No. 8760070190000005  
NAIC No. 35882

### ARBITRATION AWARD

I, Camille Nieves, 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: Eligible Injured Person (CV)

1. Hearing(s) held on 10/02/2024  
Declared closed by the arbitrator on 10/02/2024

George Lewis from Law Offices of George T. Lewis, Jr., PC participated virtually for the Applicant

Jesse Brush from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,252.25**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant corrected the amount in dispute and amended to \$852.65 based on a duplicate bill.

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

3. Summary of Issues in Dispute

Applicant seeks reimbursement for spinal ultrasounds including the SI joints performed on 7/17/23 following a motor vehicle accident on 6/30/23. The charges were denied based on the fee schedule.

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

Applicant seeks reimbursement for spinal ultrasounds including the SI joints performed on 7/17/23 following a motor vehicle accident on 6/30/23. The charges were denied based on the fee schedule.

Applicant's coder states the correct code 76999, a by report code, was billed. The coder states the RVU for code 76800 for Ultrasound, spinal canal and contents, should not be used because the spinal canal and contents is not specifically identifiable or a precise description for multiple spinal regions and the code descriptor terminates between L1 and L2 so it does not cover the structure at issue here - the spine and spinal region.

As a result, the codes that should be used are found in the Radiology section and consist of many different codes and many different RVUs covering the cervical, thoracic and lumbar/SI joints including but not limited to the \$221.40 usually awarded in these circumstances.

I find the applicant's methodology as set forth in a 33 page dissertation on this subject flawed and inconsistent with the fee schedule.

The calculation for each section of the spine consists of three (3) different codes and RVUs and four (4) for the SI joints which results in overbilling for an ultrasound.

The applicant's coder's methodology is a form of unbundling and inconsistent with the fee schedule by report rules. Code 76999 - Unlisted Ultrasound Procedure - is more appropriately billed using the RVU for code 76800 which while not identical to the service provided is closest in relativity to the service provided considering time, skill and equipment utilized.

Respondent relies on the analysis of Crystal Russo, CPC, who states applicant, a chiropractor, billed code 76999 for ultrasounds of the cervical and thoracic spine which is a by report code with no assigned RVU. Ground rule 2 provides the criteria which should be provided to establish an RVU.

Ms. Russo further states the codes which should be used for ultrasounds of the spine are 76800, 76536, 76604, 76705, 76881 and 76882 which best represent the services. None

of these codes are listed in the chiropractic fee schedule which prohibits a chiropractor from billing codes not contained in the chiropractic fee schedule (See, ground rule 10). The code billed - 76999 - is addressed in the CPT Assistant as a code which is appropriate for reporting ultrasound of the spinal canal and contents but it is inappropriate to report the code for each area of the spine as it includes the entire spinal canal.

Chiropractic Radiology ground rule 5(c) allows a chiropractor to perform diagnostic ultrasounds under CPT code 76999 (unlisted ultrasound procedure) but only if a comparison code is not available. This is not the case here according to Ms. Russo where there are many codes in existence, albeit, not in the chiropractic fee schedule. Ms. Russo opines "These are not services for which a code does not exist - these were simply not adopted by the NYS Workers' Compensation Board when it prepared the contents of the chiropractic fee schedule. Thus, they are unavailable to applicant for billing."

Furthermore, "the intent of ground rule 5(c) is to provide reimbursement for truly unlisted procedures, not to allow a provider to bill for a procedure that already exists." The fact that the amendments specifically eliminated the codes discussed above and prohibited this specialty from billing outside its own fee schedule indicates a clear intention to prevent chiropractors from billing for these services.

I disagree with this interpretation as a code is included in the chiropractic fee schedule for ultrasound of the spine albeit a by report code which applicant billed.

In my previous decisions on this issue, I determined that the RVU for an ultrasound of the spine found in the Medicine Fee Schedule - 5.56 - should be used to establish a fee for an ultrasound performed by a chiropractor. The code billed (76999) is appropriate for a chiropractor but because it is a by report code an RVU must be established. This may be accomplished by referring to the RVUs of similar procedures such as code 76800 (ultrasound of spinal canal and contents). Thus, applicant is being reimbursed for a code that is in fact listed in his own fee schedule (76999) but using an RVU for a similar service (76800) and the conversion rate for a chiropractor. This is completely consistent with the fee schedule rules.

While the Applicant may not bill codes that are found outside of his fee schedule, there is no bar, when billing for a BR code in applicant's fee schedule and when there are no similar services in the chiropractor's fee schedule, to view the relative value units of

services found in the Medical Fee Schedule for all ultrasound studies in order to establish a relative value unit consistent with the service he has provided. The service was performed on the spine and performed for the same purpose - to evaluate the extent of the soft tissue spinal injuries of the assignor.

I therefore find that the code billed is appropriate and the RVU for ultrasound of the entire spinal canal and its contents which is found in the Medicine Fee Schedule is also appropriate as it is most similar and one of the highest relative value units for any ultrasound study found in the entire Medicine Fee Schedule. Applicant chiropractor billed approximately 23.28 relative value units for performing ultrasound of the entire spinal regions. There is no radiological service found in the entire chiropractor's fee schedule allowing such a relative value unit for any service, nor is there any ultrasound service found in the entire Medicine Fee Schedule that has assigned such a relative value unit for any ultrasound service.

I find that applicant may bill a relative value unit of 5.56 to evaluate the spine and its regions to determine the extent of the assignor's soft tissue injuries to the spine. I find that the maximum allowable charge for ultrasound procedure of the spine and all its regions is \$221.40 (CF 39.82 X RVU 5.56 = \$221.40).

Award for applicant.

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>JTK Chiropractic Care PC</b>	<b>07/17/23 - 07/17/23</b>	<b>\$1,252.25</b>		<b>Awarded: \$221.40</b>
<b>Total</b>			<b>\$1,252.25</b>		<b>Awarded: \$221.40</b>

B. The insurer shall also compute and pay the applicant interest set forth below. 06/05/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest shall be computed from the date of filing at a rate of 2% per month, simple, 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

Pursuant to 11 NYCRR 65-4.6, 20% of the amount of first party benefits, plus interest thereon, subject to a maximum of \$1360.00.

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 FL

SS :

County of Osceola

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

10/04/2024  
(Dated)

Camille Nieves

**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:**  
fde8b6879ee56349b81f8857ba11bf15

**Electronically Signed**

Your name: Camille Nieves  
Signed on: 10/04/2024