

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Active Life Chiropractic PC
(Applicant)

- and -

Nationwide Affinity Insurance Company Of
America
(Respondent)

AAA Case No. 17-23-1312-0188

Applicant's File No. OS-74984

Insurer's Claim File No. 779807-GN

NAIC No. 26093

ARBITRATION AWARD

I, Anne Malone, 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: EIP

1. Hearing(s) held on 02/03/2025
Declared closed by the arbitrator on 02/03/2025

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

Michele Rita, Esq. from Hollander Legal Group PC participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$406.46**, 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 36 year old EIP reported involvement in a motor vehicle accident on September 21, 2022; claimed related injury and underwent diagnostic ultrasound provided by the applicant on March 14, 2023.

The applicant submitted a claim for these medical services, partial payment of which was timely made by the respondent based upon its determination of the correct reimbursable amount pursuant to the New York Workers' Compensation Medical Fee Schedule.

The issue to be determined at the hearing is whether the respondent established its fee schedule defense.

4. Findings, Conclusions, and Basis Therefor

This hearing was held on Zoom and the decision is based upon the documents reviewed in the Modria File as well as the arguments made by counsel and/or representative at the arbitration hearing. Only the arguments presented at the hearing are preserved in this decision; all other arguments not presented at the hearing are considered waived.

The applicant billed a total of \$627.86 for the services at issue, for which the respondent made partial payment of \$221.40 pursuant to the appropriate fee schedule, leaving a balance of \$406.46.

To prevail in its fee schedule defense, the respondent must demonstrate by competent evidentiary proof that the applicant's claims are in excess of the appropriate fee schedule. If the respondent fails to do so, its defense of noncompliance with the New York Workers' Compensation Medical Fee Schedule cannot be sustained. See Continental Medical, P.C. v Travelers Indemnity Co., 11 Misc. 3d 145A (App. Term 1st Dept. 2006.)

An insurer fails to raise a triable issue of fact with respect to a defense that the fees charged were not in conformity with the Workers' Compensation fee schedule when it does not specify the actual reimbursement rates which formed the basis for its determination that the claimant billed in excess of the maximum amount permitted. See St. Vincent Medical Services, P.C. v. GEICO Ins. Co., 29 Misc.3d 141(A), 907 N.Y.S.2d 441 (App. Term 2d, Dec. 8, 2010.)

A fee schedule defense does not always require expert proof. There are two fee schedule scenarios. The first involves the basic application of the fee codes and simple arithmetic. The second scenario involves interpretation of the codes and often requires testimony and expertise beyond that of a lay individual. I find that the fee schedule issue presented in this case is analogous to the latter scenario and requires an expert's opinion.

Late denial

The denial of this claim was late on its face. However effective April 1, 2013, 11 NYCRR 65-3.8(g)(1) has been amended so that the application of the New York State Worker's Compensation fee schedule is no longer a precludable defense and no payment is due on those claims in excess of the fee schedule. Per 11 NYCRR 65-3.8(g), where the services were rendered after April 1, 2013, a defense of excessive fees is not subject to preclusion Surgicare Surgical Associates v. National Interstate Ins. Co., Misc.3d, N.Y.S.3d, 2015 N.Y. Slip Op. 25338 (App. Term 1st Dept. Oct. 8, 2015), 46 Misc.3d 736, 997 N.Y.S.2d

296 aff'g (Civ. Ct. Bronx Co. 2014) (New Jersey fee schedule.) The insurer is entitled to reduce the bills to the proper fee schedule amount.

The respondent supported its fee schedule defense, with the affidavit of Russell Arnold, CPC, a certified professional coder who submitted a comprehensive review and analysis and determined, based on the applicable New York fee schedule that the correct reimbursable amount for the services at issue is \$221.40. This is based on CPT code 76800 in the general radiology section of the New York Workers' Medical Fee Schedule which is for ultrasound of the spinal canal. The NF-3 includes only one CPT code 76999 and describes only "diagnostic ultrasound" without further explanation.

The description in the Diagnostic Sonogram Report submitted by the applicant describes the findings of the ultrasound of the spine as abnormal echogenicity of the bilateral paraspinal muscles of the lumbar, cervical and thoracic spine.

The applicant submitted the affidavits of Jennifer Nestoiter, CBCS, and Yelena Davydkina, CPC, both of whom provided analyses based on their reviews of the medical submission and determined that the correct reimbursable amount for the services at issue is \$627.86. This was calculated by combining 5 different codes from the general radiology section of the New York Workers' Compensation Medical Fee Schedule which includes CPT codes for ultrasound :76800 - spinal canal, 76881 - complete joint, 76604 - posterior chest, 76536 - neck and head and 76856 - pelvis. The total of these 5 different procedures is \$627.86.

The coders who submitted reports for the applicant did not provide any explanation of the reasons for including the five separate ultrasound procedures as being related to a spinal injury diagnosed by the EIP's treating medical provider. The report of Ms. Nestoiter states that according to the medical records provided, the ultrasound examination was of the spinal canal, posterior chest, neck and head and pelvis. However, she did not identify the specific report or section of the Diagnostic Sonogram Report for the March 14, 2023 which supports this statement.

It is significant to note that none of the fee coders relied upon any CPT codes which are contained in the Chiropractic Fee Schedule to describe the actual services provided to the EIP, although the applicable fee schedule clearly states that no reimbursement is allowable if the medical services at issue are not contained in the Chiropractic Fee Schedule.

After a review of all the evidence submitted an issue of fact remains as to the correct reimbursable amount for the services at issue. Conflicting opinions have been presented in the affidavit of Russell Arnold, CPC and the affidavits of Jennifer Nestoiter, CBCS and Yelena Davydkina, a biller and billing manager who submitted affidavits on behalf of the applicant. I find that the submission of Mr. Arnold was more persuasive in this instance.

Under these circumstances, the respondent established its fee schedule defense. The submissions include evidence of payment by the respondent of \$221.40, which is acknowledged in the AR-1. Therefore, no further payment is due.

Accordingly, the claim is dismissed with prejudice.

Any further issues submitted in the record are held to be moot and/or waived insofar as they were not raised at the time of this hearing. This decision is in full disposition of all claims for no-fault benefits presently before this Arbitrator.

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 claim is DENIED in its entirety

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of CT

SS :

County of Fairfield

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

02/11/2025
(Dated)

Anne Malone

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:
3268d9d80e3e230ca74846e7a29de42f

Electronically Signed

Your name: Anne Malone
Signed on: 02/11/2025