American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Ryan D Tichauer DC (Applicant)	AAA Case No.	17-25-1396-4555
	Applicant's File No.	OS-103757
- and -	Insurer's Claim File No.	0778559401
	NAIC No.	29688
Allstate Fire & Casualty Insurance Company (Respondent)		

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 08/03/2026
   Declared closed by the arbitrator on 08/03/2026

   Olga Sklyut, Esq. from Law office of Olga Sklyut, PC participated virtually for the Applicant

   Caroline Glover, Esq. from Law Offices Of Richard Schoenberg 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 61 year old EIP reported involvement in a motor vehicle accident on December 14, 2024; claimed related injury and underwent diagnostic ultrasound provided by the applicant on February 19, 2025.

   The applicant submitted a claim for these medical services, partial payment of which was timely made by the respondent based on its calculation of the correct reimbursable amount pursuant to the New York Workers' Compensation Chiropractic 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 from 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 $761.06 for the diagnostic ultrasound at issue for which the respondent made timely payment of $354.60 which was acknowledged in the AR-1.

According to the submissions, these services were provided by a chiropractor.

In order to prevail in a fee schedule defense, the respondent must demonstrate by competent evidentiary proof that applicant's claims were in excess of the appropriate fee schedules, or otherwise respondent's defense of noncompliance with the appropriate fee schedule cannot be sustained. Continental Medical, P.C. v. Travelers Indemnity Co., 11 Misc.3d 145(A) (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.)

Chiropractic Fee Schedule - effective 2020

The respondent supported its fee schedule defense by submitting sections of the chiropractic fee schedule concerning multiple procedures and various prior arbitration awards regarding the same issues as the ones in this matter.

This claim involves one bill for unspecified diagnostic ultrasound billed under CPT code 76999. According to the submissions, the ultrasound procedures at issue included the cervical, thoracic and lumbar spine and the charge for these procedures is $761.06. There is no breakdown of the charge for each individual procedure for the cervical, thoracic and lumbar spine.

The chiropractic fee schedule lists 76999 as a "By Report" (BR) code. This represents services that are too variable in nature of their performance to permit

assignment of relative value units and fees need to be justified "by report" as stated in Ground Rule 2.

CPT code 76800 is definedas "ultrasound, spinal canal," is listed in the chiropractic radiology fee schedule and includes cervical, thoracic and lumbar ultrasound.

However, this code is not found in the chiropractic fee schedule.

According to Ground Rule 10 in the Chiropractic Fee Schedule

A chiropractor may only use CPT code 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.

According to the EOB, which accompanied the denial, the respondent determinedthat the correct reimbursable amount for the services at issue is $354.60 based on "CPT codes 76880 and 76881 for ultrasound of the spinal and contents and ultrasound of complete joint, "as this best describes the services rendered."

Based on a plain reading of the radiology fee schedule and the calculations of the respondent in the EOB, the applicant would be entitled to $519.19 for the services at issue. The respondent made payment of $354.60 which was acknowledged in the AR-1.

However, since CPT code 76881 is not in the chiropractic fee schedule, no further reimbursement is required.

The applicant submitted the affidavit of Jennifer Nestoiter, CBCS, a certified billing and coding specialist who submitted a comprehensive review and analysis. She noted that the chiropractic radiology fee schedule has 78 codes, including 76999. Seventy seven of those codes are listed as "radiologic examination" which she determined means "x-rays." In addition, it was her opinion that diagnostic ultrasound and x-rays are different and that using $221.40 RVUs from any of the 77 chiropractic radiology codes to establish an RVU in relativity would be incorrect.

It was Ms. Nestoiter opinion that "the plaintiff must look at the Radiology Section of the Medical Fee Schedule in order to establish an appropriate RVU for Diagnostic Ultrasound."

Based on the foregoing, Ms. Nestoiter determined that the applicant is entitled to $761.06 as reimbursement for this claim based on charges for CPT codes 76800 -

$221.40 (*ultrasound,*): 76881 - $133.20 (*ultrasound, complete joint [i.e. joint space and peri-articular soft tissue structures] real time with image documentation);* 76604 - $152.31 *(ultrasound, chest [includes mediastinum] real time with image documentation);* 76536 - $120.95 (*ultrasound, soft tissues of head and neck [e.g. thyroid, parathyroid, parotid,] real time with image documentation) and* 76856 *(ultrasound, pelvic [nonobstertric], real time with image documentation; complete.)*

(descriptions from Radiology Fee Schedule added.)

The affidavit submitted by Ms. Nestoiter does not provide an explanation for all of the CPT codes cited in her analysis of the diagnostic ultrasound that was provided to this EIP.

In this instance the applicant complied with the first part of Ground Rule 10 for the procedure at issue by billing "BR" code 76999, which is included in the Chiropractic Radiology Fee Schedule.

However, neither the applicant nor the respondent complied with the second part which specifically prohibits the use by a chiropractor of billing codes that do not appear in the Chiropractic Fee Schedule.

This does not mean that the treatment rendered to this EIP is not reimbursable, only that it is not reimbursable if it is performed by a chiropractor.

Based on the foregoing, I find that no further reimbursement is due on this claim.

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.

08/23/2026
(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:
b5e7ffa38139624bc9b3beb974673683

Electronically Signed

Your name: Anne Malone
Signed on: 08/23/2026