**A M E R I C A N A R B I T R A T I O N A S S O C I A T I O N**
**NO-FAULT/ACCIDENT CLAIMS**

In the Matter of the Arbitration between

(Claimant)

v.

PRUDENTIAL INSURANCE COMPANY
(Respondent)

**AAA CASE NO.: 18 Z 600 05251 03**
**INS. CO. CLAIMS NO.: 33W12072D07062**
**DRP NAME: Barry E. Moscowitz**
**NATURE OF DISPUTE: Application of and Adherence to Fee Schedules**

## AWARD OF DISPUTE RESOLUTION PROFESSIONAL

**I, THE UNDERSIGNED DISPUTE RESOLUTION PROFESSIONAL (DRP),** designated by the American Arbitration Association under the Rules for the Arbitration of No-Fault Disputes in the State of New Jersey, adopted pursuant to the 1998 New Jersey "Automobile Insurance Cost Reduction Act" as governed by *N.J.S.A. 39:6A-5, et. seq*., and, I have been duly sworn and have considered such proofs and allegations as were submitted by the Parties. The Award is **DETERMINED** as follows:

Injured Person(s) hereinafter referred to as: EM.

1. ORAL HEARING held on July 21, 2003.

2. ALL PARTIES APPEARED at the oral hearing(s) .

NO ONE appeared telephonically.

3. Claims in the Demand for Arbitration were AMENDED and permitted by the DRP at the oral hearing (Amendments, if any, set forth below). STIPULATIONS were not made by the parties regarding the issues to be determined (Stipulations, if any, set forth below).

Claims in the Demand for Arbitration were amended from $1,753.40 to $1,405.61.

4. FINDINGS OF FACTS AND CONCLUSIONS OF LAW:

This matter concerns a dispute regarding the recovery of medical expense benefits under personal injury protection coverage arising out of an automobile accident that occurred on May 13, 2002. It was submitted to me on the initiative of claimant by way of Demand for Arbitration dated March 24, 2003.

More specifically, this dispute involving medical expense benefits concerns application of and adherence to fee schedules promulgatged by the Commissioner of Banking and Insurance.

FINDINGS OF FACT:

Claimant submitted:

Demand for Arbitation dated March 24, 2003;
Arbitration Statement submitted at the hearing;
Affidavit of Services dated June 21, 2003.

Respondent submitted a letter dated June 19, 2003.

On May 13, 2002, EM was injured in an automobile accident. As a result of her injuries, EM went to claimant for treatment. From May 21 through September 9, 2002, claimant treated EM.

Claimant submitted the bills for this treatment to respondent for payment. Respondent paid some of the bills but not all of them. As a result, claimant filed this Demand for Arbitration.

The issues presented are many: (1) whether or not respondent properly denied payment for ROM testing under CPT code 95851; (2) whether or not respondent properly denied payment for the office visits under CPT code 99215;

Regarding the first issue, claimant argues that respondent improperly denied payment for ROM testing under CPT code 95851. In support of its argument, claimant relies upon the fee schedule. According to the fee schedule, the charge for ROM testing is $30.50 for manual or computer generated measurements.

Respondent, on the other hand, argues that it properly denied payment for ROM testing under CPT code 95851. In support of its argument, respondent relies upon the National Correct Coding Guide. It is attached to respondent's submission as Exhibit D. According to respondent, ROM testing under CPT code 95851 is a component part of the office visit under CPT code 99205.

Regarding the second issue, claimant argues that respondent improperly denied payment for the office visits under CPT code 99215. In support of its argument, respondent relies upon N.J.A.C. 11:3-29.4(o). Under that regulation, follow-up evaluations and management services for the re-examination of an established patient shall be reimbursed in addition to physical medicine and rehabilitation procedures twice within any 30-day period. One of the following four circumstances, however, must exist: (1) There is a definite measurable change in the patient's condition requiring significant change in the treatment plan; (2) The patient fails to respond to treatment, requiring a change in the

treatment plan; (3) The patient's condition becomes permanent and stationary, or the patient is ready for discharge; or (4) It is medically necessary to provide the evaluation services over and above those normally provided during the therapeutic services. Claimant argues that EM there was a definite measurable change in EM's condition requiring significant change in the treatment plan because EM was referred to an orthopedist. Claimant also argues that this constitutes a discharge.

Respondent, on the other hand, argues that it properly denied payment for the office visits under CPT code 99215.

Regarding the third issue, claimant argues that respondent improperly denied payment for the NCV testing under CPT code 95900. In support of its argument, claimant relies upon the statement of the American Association of Electrodiagnostic Medicine. According to that association, "motor NCSs are billed using CPT codes 95900 and 95903" and "study of the sensory, motor, and mixed nerve fibers of a given nerve constitutes 3 separate and distinct services and should be billed and reimbursed accordingly." And according to claimant, of the six motor nerves tested, 4 were tested under 95900 w/o F-wave and 2 were tested under 95903 w/F-wave for comparison.

Respondent, on the other hand, argues that it properly denied payment for the NCV testing under CPT code 95900. In support of its argument, respondent relies upon the American Medical Association CPT Companion. According to the CPT Companion, "any single motor nerve conduction study should be reported using 95900 (if no single F-waves are studied) or 95903 (if F-waves are studied), and any single sensory or mixed nerve conduction study should be reported as 95904." And according to respondent, since F-waves were studied, the testing should have been billed under 95903.

Regarding the fourth issue, claimant argues that respondent improperly denied payment for the disposable needles under CPT code 99070. In support of its argument, claimant relies upon the fee schedule. According to claimant, it provided a description of the code.

Respondent, on the other hand, argues that it properly denied payment for the disposable needles under CPT code 99070. In support of its argument, respondent relies upon the fee schedule as well. According to respondent, CPT code 99070 is a non-specific code and claimant never provided a description of the code.

Regarding the fifth issue, claimant argues that respondent improperly denied the professional component of the EMG testing under CPT codes 95861, 95869, 95900, 95904, and 95903. In support of its argument, claimant relies upon NJAC 11:3-29.4(l). According to claimant, the actual performance and/or interpretation of the diagnostic testing is not included in the follow-up evaluations and management services.

Respondent, on the other hand, argues that it properly denied the professional component of the EMG testing under CPT codes 95861, 95869, 95900, 95904, and 95903. In support of its argument, respondent relies upon the American Medical Association's Principles of CPT Coding. According to the association, "when technical and

professional components of the service are performed by the same provider, then it is not appropriate or necessary to report the components of the service separately." They are part of the global charge. And, according to respondent, that is the case here.

CONCLUSIONS OF LAW:

Regarding the first issue, I conclude that claimant has not proven by a preponderance of the evidence that respondent improperly denied payment for ROM testing under CPT code 95851. As respondent argues, ROM testing CPT code 95851 is a component part of the office visit under CPT code 99205. As a result, claimant shall not be reimbursed for the ROM testing under CPT code 95851.

Regarding the second issue, I conclude that claimant has proven by a preponderance of the evidence that respondent improperly denied payment for the office visits under CPT code 99215. I base this conclusion on N.J.A.C. 11:3-29.4(o). As a result, claimant shall be reimbursed for the office visits under 99215.

Regarding the third issue, I conclude that claimant has proven by a preponderance of the evidence that respondent improperly denied payment for the NCV testing under CPT code 95900. I base this conclusion on the CPT Companion and the fact that of the six motor nerves tested, 4 were tested under 95900 w/o F-wave and 2 were tested under 95903 w/F-wave for comparison. As a result, claimant shall be reimbursed for the NCV testing under CPT code 95900.

Regarding the fourth issue, I conclude that claimant has proven by a preponderance of the evidence that respondent improperly denied payment for the disposable needles under CPT code 99070. I base this conclusion on the fact that claimant did provide a description of the code. As a result, claimant shall be reimbursed for the disposable needles under CPT code 99070.

Regarding the fifth issue, I conclude that claimant has not proven by a preponderance of the evidence that respondent improperly denied the professional component of the EMG testing under CPT codes 95861, 95869, 95900, 95904, and 95903. I base this conclusion on American Medical Association's Principles of CPT Coding. As the association states, "when technical and professional components of the service are performed by the same provider, then it is not appropriate or necessary to report the components of the service separately." As a result, claimant shall not be reimbursed for the professional component of the EMG testing under CPT codes 95861, 95869, 95900, 95904, and 95903. They are part of the global charge.

Claimant shall be awarded the medical expense benefits it claims in the amount set forth in section 5 of this Award.

Finally, I award claimant attorney's fees. Under N.J.A.C. 11:3-5.6(d)(3), an award may include attorney's fees for a successful claimant in an amount consonant with the award and with Rule 1.5 of the Supreme Court's Rules of Professional Conduct. Rule 1.5 states

that a lawyer's fee shall be reasonable. The factors to be considered are, among others: the time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly; the fee customarily charged in the locality for similar legal services; the amount involved and the results obtained; and the experience, reputation, and ability of the lawyer or lawyers performing the services.

In this case, claimant was successful. As a result, I award claimant attorney's fees consonant with the amount of the award. The amount awarded considers the factors enumerated above as well as respondent's objection to claimant's hourly rate and time expended. The amount is set forth in secton 10 of this Award.

Claimant shall be awarded costs and attorney's fees in the amount set forth in section 10 of this Award.

5. MEDICAL EXPENSE BENEFITS:

Awarded

| Provider | Amount Claimed | Amount Awarded | Payable to |
|---|---|---|---|
| Rehabilitation Medicine Center | $1,405.61 | $424.92 | Provider |
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Explanations of the application of the medical fee schedule, deductibles, co-payments, or other particular calculations of Amounts Awarded, are set forth below.

The amount awarded shall be subject to all applicable fee schedules, deductibles, and/or co-payments consistent with this Award.

6. INCOME CONTINUATION BENEFITS: Not In Issue

7. ESSENTIAL SERVICES BENEFITS: Not In Issue

8. DEATH BENEFITS: Not In Issue

9. FUNERAL EXPENSE BENEFITS: Not In Issue

10. I find that the CLAIMANT did prevail, and I award the following COSTS/ATTORNEYS FEES under N.J.S.A. 39:6A-5.2 and INTEREST under N.J.S.A. 39:6A-5h.

(A) Other COSTS as follows: (payable to counsel of record for CLAIMANT unless otherwise indicated): $325 for filing fee

(B) ATTORNEYS FEES as follows: (payable to counsel of record for CLAIMANT unless otherwise indicated): $1,200

(C) INTEREST is as follows: waived per the Claimant. $ .

This Award is in **FULL SATISFACTION** of all Claims submitted to this arbitration.

August 20, 2003
Date

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**Barry E. Moscowitz**, Esq.