American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Eastern Medical Practice PC (Applicant)	AAA Case No.	17-19-1152-5197
	Applicant's File No.	JL19-104869
- and -	Insurer's Claim File No.	0557897542 2ST
	NAIC No.	29688
Allstate Fire & Casualty Insurance Company (Respondent)		

ARBITRATION AWARD

I, John O'Grady, 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 08/17/2021
   Declared closed by the arbitrator on 08/17/2021

   Michael Licatesi Esq. from The Licatesi Law Group, LLP participated by telephone for the Applicant

   James McNamara Esq. from Law Offices Of Karen L. Lawrence participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **$ 1,443.41**, was NOT AMENDED at the oral hearing.
   Stipulations WERE made by the parties regarding the issues to be determined.

   Unless otherwise indicated in Section 3 below, in which case the dispute between the parties will be addressed in this Award, the parties stipulated and agreed that (i) Applicant has met its prima facie burden by submitting evidence that payment of no-fault benefits are overdue, and proof of its claim was mailed to and received by Respondent; (ii) Respondent's denial of the subject claim was timely issued; and (iii) the amount claimed does not exceed the maximum permissible charges under the fee schedule applicable to the disputed services.

3. Summary of Issues in Dispute

   CASE SUMMARY

Applicant, as assignee of an eligible injured person, a 45-year-old female, seeks reimbursement of the following charge(s) following a motor vehicle accident on August 5, 2019: trigger point injections with ultrasound guidance and examinations all performed on November 19, 2019.

Respondent timely denied the claim(s), paying them in part and denying them in part, contending that it made appropriate payment pursuant to the Workers Compensation Fee Schedule, as further detailed below.

ISSUE(S)

Whether respondent paid the claims for trigger point injections and related services consistent with the Workers Compensation Fee Schedule.

4. Findings, Conclusions, and Basis Therefor

Applicant made the following claims:

1. Injection, single or multiple trigger point, 3 or more muscles; 4 units; CPT Code 20553; $476.40;

2. Sono (ultrasound) guidance; 4 units; CPT Code 76942; $1051.64;

3. Office visit (follow-up); 1 unit; CPT Code 99214; $92.97;

4. Outcome Assessment Testing; 1 unit; CPT Code 99358; $204.41; and

5. Methylprednisolone, 40 mg injections; 1 unit; Code J1030; $12.50.

Respondent paid the claims as follows:

1. Injection, single or multiple trigger point, 3 or more muscles; 4 units; CPT Code 20553: $119.10, paying one unit and denying three units;

2. Sono (ultrasound) guidance; 4 units; CPT Code 76942: $262.91, paying one unit and denying three units;

4. Outcome Assessment Testing; 1 unit; CPT Code 99358: $0.00, denying the claim in full;

and

5. Office visit (follow-up); 1 unit; CPT Code 99214: $0.00, denying the claim in full.

Respondent paid the claims for in the amount billed, Methylprednisolone, 40 mg injections; 1 unit; Code J1030; in the amount billed, $12.50.

1. In paying just one unit for the claim for injections pursuant to CPT Code 20553, respondent's Denials of Claim indicate that "These units have been separated from the original line item" and that "The procedure codes referenced by the provider was used more than what is normally expected per visit." It was acknowledged at the hearing that the injections were to four sites in the lumbar spine on each date. The description in the Surgery Section of the Fee Schedule for CPT Code 20553 is "injections, single tendon sheath, or ligament, aponeurosis, single or multiple trigger points, 3 or more muscles."

It is noted that the Relative value is different and least for a single tendon, origin/insertion (CPT Code 20551), more for a single or multiple trigger point, 1 or two muscles (CPT Code 20553), and still more for this CPT Code. It is also clear that one unit of CPT Code 20553 is the maximum that may be billed for the service, as it considers any amount of muscles. Applicant's proof includes an affidavit by the Certified Professional Coder, Priti Kumar, but that does not address this Code. The claim for the difference between the amount claimed for these injections in the amount paid is denied.

2. In paying just one unit for the claim for ultrasound guidance pursuant to CPT Code 76942, respondent's Denials of Claim again indicate that "These units have been separated from the original line item" and that "The procedure codes referenced by the provider was used more than what is normally expected per visit."

Respondent relies on the AMA CPT Assistant from 2017, Issue 12 (December) in which CPT Code 76942 was addressed and where the CPT Assistant dictates that it "may only be reported once, irrespective of the number of trigger point injections performed."

Applicant relies on the affidavits of Ms. Kumar. She contends that sonography or ultrasound is a radiology service and that where it is billed more than one time it should be treated as multiple radiological services performed on the same date and the total amount billed adjusted accordingly. She also discusses the CPT Editorial Panel. She says that the CPT Assistant Frequently Asked Question section from which the language relied upon by the respondent is contained is not intended to be authoritative because it is not subject to a rigorous editorial

process. She discusses anatomy and physiology and ultrasonography but makes no cogent explanation for why it is necessary to have multiple uses of the sonography, or that more than one ultrasound service was provided.

I find that the CPT Assistant properly guides the resolution here. In **Matter of Global Liberty Ins. Co. v. McMahon, 172 AD3d 500 (1st Dept. 2019),** the Appellate Division held that the New York Workers' Compensation Medical Fee Schedule, which applies to No-Fault, directs users to "refer to the CPT book for an explanation of coding rules and regulations not listed in this schedule," and the CPT book, in turn, expressly makes reference to the CPT Assistant newsletter. Accordingly, the claim for the difference between the amount claimed and amount paid is denied.

3. In denying payment for CPT Codes 99358 (Outcome Assessment Testing), and 99214 (follow-up office visit) respondent contends that "this procedure/service is considered to be part of the global surgical package which includes all normal follow-up care for the period indicated in the" Fee Schedule (Surgical Ground Rule 1).

The trigger point injections were billed under CPT code 20553, a code which is located within the Surgery section of the Medical Fee Schedule. This service qualifies as a surgical procedure as per the aforementioned Ground Rules. CPT code 20553 has a FUD of 0, which means that office visits and evaluations could not be performed on the same day as this procedure. The code descriptors and surgical ground rules are sufficient to render a determination that CPT codes 99358 and 99214 were in fact part of the surgical package regardless of whether it was pre-operative or postoperative relative to the trigger point injections. Since the above charges were performed on the same date as this surgical procedure, they are not separately reimbursable. Applicant fails to establish that these charges fall under one of the exceptions that are described under paragraph (A) of Ground Rule 6. The rule clearly contemplates uncommon or unusual complications, recurrence, or the presence of other diseases or injuries requiring significant additional services and notes that additional charges must be substantiated by report. I note that the affidavit of Ms. Kumar that I previously referenced in my decision is silent as to these charges. Accordingly, I find respondent's argument persuasive that additional reimbursement for the office visit and outcome assessment testing is not warranted, and this portion of applicant's claim is denied.

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 New York
SS :
County of Nassau

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

08/18/2021
(Dated)

John O'Grady

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:
a3cd81893ba8f13767c732360fe4b92f

Electronically Signed

Your name: John O'Grady
Signed on: 08/18/2021