

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Macintosh Medical, P.C.
(Applicant)

- and -

State Farm Mutual Automobile Insurance
Company
(Respondent)

AAA Case No. 17-21-1229-9231

Applicant's File No. JL21-130817

Insurer's Claim File No. 52-21F3-83F

NAIC No. 25178

ARBITRATION AWARD

I, Thomas Awad, 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: EV

1. Hearing(s) held on 01/03/2023
Declared closed by the arbitrator on 01/03/2023

Robert Bott from The Licatesi Law Group, LLP participated in person for the Applicant

Joseph Licata from Rossillo & Licata LLP participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,668.16**, was AMENDED and permitted by the arbitrator at the oral hearing.

The amount at issue is hereby amended to \$1,015.82. The amount includes the fees under the following CPT codes:

76942 \$650.70

99358 \$280.12

J1094 \$85.00

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

3. Summary of Issues in Dispute

The Assignor, EV, was involved in a motor vehicle accident on 6/21/21. At issue in this case is \$1,015.82 for an office visit, Trigger Point Injections (TPI) and ultrasonic guidance for needle placement performed on 9/7/21. The issue presented is whether the Applicant's claims charge fees within the limits set by the New York State Workers' Compensation Fee Schedule adopted by the Superintendent of Insurance (Department of Financial Services).

4. Findings, Conclusions, and Basis Therefor

This case was decided based upon the submissions of the parties as contained in the electronic file maintained by the American Arbitration Association, and the oral arguments of the parties' representatives. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

The Assignor, EV, was involved in a motor vehicle accident on 6/21/21. At issue in this case is \$1,015.82 for an office visit, Trigger Point Injections (TPI) and ultrasonic guidance for needle placement performed on 9/7/21. Respondent claims that the fee charged by the Applicant is in excess of the allowable charge under the fee schedule.

An insurer has the burden of showing as a matter of law that said claims reflect the incorrect amount for services provided. *Jamil M. Abraham, M.D., P.C. v. Country Wide Ins. Co.*, 3 Misc. 3d 130[A], 787 N.Y.S.2d 678 (App Term 2d & 11th Jud. Dist. 2007); *New Era Massage Therapy, P.C. v. Progressive Cas. Ins. Co.*, 2009 N.Y. Misc. Lexis 2554, 242 N.Y.L.J. 2 (Sup Ct. Queens Co. June 26, 2009).

I have taken judicial notice of the New York State Workers' Compensation fee schedule. *Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co.*, 61 A.D.3d 13, 20 (2nd Dept., 2009).

The Applicant originally submitted a bill in the amount of \$2,173.37. Respondent paid \$505.21. Applicant amended the claim so that after taking the partial payment into account the Applicant asserts that \$1,015.82 is due. This amount includes fees under the following CPT codes:

76942 \$650.12

99358 \$280.12

J1094 \$85.00

CPT Code 76942

At the hearing, the amount at issue was amended to \$650.70. The claim includes one unit of CPT Code 76942 in the amount of \$289.20 and three units at 75 percent of \$289.20 per Radiology Ground Rule 3(c). The Respondent paid for one unit at \$289.20. This results in the amended claim under code 76942 of \$650.70 ($289.20 \times .75 = \216.90×3).

Respondent asserts that CPT code 76942 should be reimbursed only once per procedure.

In support of its position, the Respondent submits the fee audit of certified professional coder Stephanie Brown who attests that the proper fee is one unit of code 76942 in the amount of \$289.20.

In support of its defense, Respondent offers the FAQ section of the December 2017 CPT Assistant newsletter as it pertains to the administration of ultrasonic guidance in conjunction with trigger point injections, which reads as follows:

Question: When reporting ultrasound guidance for trigger-point injections (20551, 20552), is it appropriate to report multiple units of code 76942 based on the number of injections?

Answer: No, code 76942, Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation, may only be reported once, irrespective of the number of trigger-point injections performed.

Applicant first offers the affidavit of Priti Kumar, CPC in support of its contention that it is entitled to reimbursement for multiple units of CPT code 76942. Ms. Kumar maintains that Applicant is entitled to reimbursement for multiple units billed at the Fee Schedule rate after applying the multiple diagnostic procedure reduction per Ground Rule 3(c) of the Radiology section of the Fee Schedule. Ms. Kumar further maintains that any reliance on the FAQ section of the CPT Assistant is misguided since external data, such as the CPT Assistant, "is not part of New York Workers' Compensation Fee Schedule and, therefore, cannot be used to determine fees for New York claims."

The debate over the use of the CPT Assistant in No-Fault claims was clarified in *Matter of Global Liberty Ins. Co., v. McMahon*, Dec. May 9, 2019, 2019 NY SLIP Op 03692, Appellate Division, 1 Dept.

"The Official New York Workers' Compensation Medical Fee Schedule, promulgated by the chair of the Workers' Compensation Board, directs users to "refer to the CPT book for an explanation of coding rules and regulations not listed in this schedule." The CPT book, in turn, expressly makes reference to CPT Assistant. By both statute and regulation, the fee schedules established by the

chair of the Workers' Compensation Board are expressly made applicable to claims under the No-Fault Law (see Insurance Law § 5108; 11 NYCRR 68.0, 68.1[a][1]; see generally *Government Empls. Ins. Co. v Avanguard Med. Group, PLLC*, 127 AD3d 60, 63-64 [2d Dept 2015], *affd* 27 NY3d 22 [2016]). Accordingly, because CPT Assistant is incorporated by reference into the CPT book, which is incorporated by reference into the Official New York Workers' Compensation Medical Fee Schedule applicable to this claim under the No-Fault Law, the award rendered without consideration of CPT Assistant [*2] is incorrect as a matter of law (see 11 NYCRR 65-4.10[a][4]). We therefore grant the petition to vacate the award and remand the matter to the lower arbitrator for a new arbitral proceeding, at which relevant portions of CPT Assistant shall be given due consideration."

In following the *Global Liberty* case, the CPT Assistant is indeed to be utilized for determining the proper Fee Schedule amount under New York No-Fault claims.

Applicant also offers a lengthy affidavit by Michael Miscoe, CPC. Essentially, Mr. Miscoe asserts that there is no prohibition or restriction to the number of units billed under CPT code 76942. He states that any reliance upon the FAQ section of CPT Assistant is misplaced as this FAQ pertains to CPT code 20552 (injection one or two muscles) where CPT code 20553, the code utilized by Applicant, represents three or more injected muscles. He states that the determining factor in the number of units of CPT code 76942 that may be billed is the number of muscles injected rather than the number of injections. Mr. Miscoe also contends that when it comes to secondary sources, e.g., the CPT Assistant (and more specifically the FAQ Section of the CPT Assistant), the CPT Assistant newsletter is a rather expensive subscription publication that few outside the community of professional coders subscribe to. Ultimately, he opines that the CPT Assistant newsletter, especially the conclusions offered in the FAQ section, at best, offers merely persuasive opinion guidance relative to the appropriate coding of physician services in NY Workers' Compensation cases. He contends that these opinions are only relevant as a persuasive resource where the published opinion does not conflict with the guidance of the CPT Editorial Panel.

I concur with Arbitrator Chow's analysis in AAA case # 17-21-1212-8163.

Applicant coder's contention that the CPT Assistant only applies when there are conflict/confusion with regard to application of the fee schedule directly conflicts with the above court ruling. Moreover, the 5th paragraph of the Introduction and General Guidelines section of the fee schedule specifically directs the reader to "refer to the CPT book for an explanation of coding rule and regulations not listed in this schedule." As such, it is

apparent that coding rules contained in the CPT book and CPT Assistant are necessary components to render an accurate fee schedule analysis. As such, although the Applicant's coder contends that Radiology Ground Rule 3(c) supports billing multiple units for this code, this does not preclude the application of coding rules and regulations found in the CPT book and CPT Assistant that may contain exceptions to this ground rule.

In this case, the CPT Assistant December 2017 publication specified the following:

Question: When reporting ultrasound guidance for trigger-point injections (20551, 20552), is it appropriate to report multiple units of code 76942 based on the number of injections?

Answer: No, code 76942, Ultrasonic guidance for needle placement (eg. Biopsy, aspiration, injection, localization device), imaging supervision and interpretation, may only be reported once, irrespective of the number of trigger-point injections performed.

Although Applicant's coder contends that this excerpt does not address the distinction between the general number of injections versus the number of muscles receiving the injections, I find this very lack of distinction speaks volumes to the irrelevancy of the number of muscle sites injected. The question specifically referenced CPT 20552, a code that involves injections to 1-2 muscle sites. If the number of muscle sites were relevant in determining the number of billable units for CPT 76942, the answer would have addressed this since the question included this issue via its reference to CPT 20552. Instead, the answer made it clear that only one unit is reportable with trigger point injection codes regardless of the number of injections or muscles injected.

Lastly, even though the April 2005 CPT Assistant stated that CPT 76942 should be reported per distinct lesion, the December 2017 CPT Assistant is clearly the more recent publication. Moreover, with CPT 76942 being applicable to other types of needle placements such as biopsy, aspirations and localization, the application of the April 2005 CPT excerpt is broad, while the December 2017 CPT excerpt is specific to trigger point injections, the disputed services at hand. As such, I find the December 2017 CPT Assistant to be more relevant in this matter.

I note that there is an ongoing dispute whether the use of CPT code 76942 can be billed multiple times in conjunction with injections. There is a split among arbitrators as to how to apply the code at issue. I find Respondent's fee schedule analysis persuasive. Respondent is correct, code 76942 can only be reimbursed once.

The Respondent previously paid for one unit of 76942 in the amount of \$289.20. I find that the Respondent has established its fee schedule defense and the claim under CPT code 76942 is denied.

99358

The Applicant asserts that it is due \$280.12 under CPT code 99358 for a "Prolonged evaluation and management service before and/or after direct patient care; first hour." The Respondent's EOB states that the fee was denied on the following basis, "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 New York Workers' Compensation Medical Fee Schedule. (Surgical Ground Rule 1)." Respondent's coder refers to the CPT Assistant and concludes that the services are inclusive in another code billed and paid by the carrier on the same date of service.

The Respondent's coder simply states that according to the CPT Assistant these services are inclusive "to the Evaluation and Management Service billed by this provider and paid by the carrier on the same date of service.

Neither the EOB nor the affidavit of Ms. Brown adequately explains the denial of the code. There is no reference to which code 99358 is included in and how much was paid. As a result, I find that the Respondent has failed to sustain its burden of proof on this code. The Applicant is awarded \$280.12.

CPT Code J1094

Under code J1094 the claim is \$85.00. Respondent's coder states that nothing is due under this code. However, the Respondent's denial indicates that \$85.00 was paid under that code.

Accordingly, the 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 applicant is AWARDED the following:

A.

Medical		From/To	Claim Amount	Amount Amended	Status
	Macintosh Medical, P.C.	09/07/21 - 09/07/21	\$1,668.16	\$1,015.82	Awarded: \$280.12
Total			\$1,668.16		Awarded: \$280.12

B. The insurer shall also compute and pay the applicant interest set forth below. 12/07/2021 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

The Respondent shall compute and pay the Applicant the amount of interest computed from the date the AR-1 was deemed filed with the American Arbitration Association, at the rate of 2% per month, simple, and ending with the date of payment of the award, subject to the provisions of 11 NYCRR 65-3.9(c).

C. Attorney's Fees

The insurer shall also pay the applicant for attorney's fees as set forth below

The Applicant's attorney is entitled to one attorney fee in accordance with 11 NYCRR 65-4.6 (d).

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 New York

SS :

County of Nassau

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

01/16/2023
(Dated)

Thomas Awad

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:
a31ff6622e0005eca5d24a5eebfcf2c3

Electronically Signed

Your name: Thomas Awad
Signed on: 01/16/2023