

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Atlantic Medical & Diagnostic PC (Applicant)	AAA Case No.	17-22-1266-8518
- and -	Applicant's File No.	M22-703498
	Insurer's Claim File No.	0647724129 2NA
Allstate Fire & Casualty Insurance Company (Respondent)	NAIC No.	29688

**ARBITRATION AWARD**

I, Lester Hill, 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 06/09/2023  
Declared closed by the arbitrator on 06/09/2023

James Errera from Shapiro & Associates, P.C. participated virtually for the Applicant

Linda Smith from Law Offices of John Trop participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,365.49**, 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

Were the office evaluation and trigger point injections with ultrasound guidance provided to the EIP on July 12, 2022 medically unnecessary based upon the IME conducted by Dr. Stuart Hersch on January 25, 2022? The 44 year-old EIP was involved in a motor vehicle accident on October 30, 2021 and received treatment for injuries to the neck, low back, hips and right knee.

4. Findings, Conclusions, and Basis Therefor

At issue is whether the office evaluation and trigger point injections with ultrasound guidance provided to the EIP on July 12, 2022 were medically unnecessary.

The basis of the respondent's timely denial is the IME conducted by Dr. Stuart Hershon on January 25, 2022.

I have reviewed the documents contained in the electronic case folder as of June 9, 2023. This decision is rendered based upon those documents and the parties arguments at the hearing conducted on June 9, 2023.

An Applicant establishes a prima facie showing of its entitlement to No-Fault benefits as a matter of law by submitting evidentiary proof that the prescribed statutory billing forms had been mailed and received and the payment of No-Fault benefits were overdue. *Westchester Medical Center v. Lincoln General Ins. Co.*, 60 A.D. 3d 1045, 877 N.Y.S.2d 340 (2d Dept. 2009); *Westchester Medical Center v. Clarendon National Ins. Co.*, 57 A.D. 3d 659, 868 N.Y.S. 2d 759 (2d Dept. 2008); *New York and Presbyterian Hosp. v. Allstate Ins. Co.*, 31 A.D. 3d 512, 818 N.Y.S. 2d 583 (2d Dept. 2006); *LMK Psychological Services, P.C. v. Liberty Mut. Ins. Co.*, 30 A.D. 3d 727, 816 N.Y.S. 2d 587 (3d Dept. 2006); *Nyack Hospital v. Metropolitan Property & Casualty Insurance Co.*, 16 A.D.3d 564, 791 N.Y.S. 2d 658 (2d Dept. 2005). The submission of Respondent's NF-10 denial of claim form established that the insurer received the claim referenced therein as having been submitted by the provider and that the insured did not pay the claim. *Lopes v. Liberty Mutual Ins. Co.*, 24 Misc.3d 127 (A), 2009 N.Y. Slip Op. 51279(U), 2009 WL 1799812 (App. Term 2d, 11th & 13th Dists. Jan. 26, 2009).

New York's Comprehensive Motor Vehicle Insurance Reparation Act requires an insurance carrier to reimburse an injured party (or his or her assignee) for all "reasonable and necessary expenses" and "medical expenses" arising from the use and operation of the insured vehicle.

Lack of medical necessity is a valid defense to an action to recover No-Fault benefits. *Countrywide Ins. Co v. 563 Grand Med.*, P.C. 50 A.D. 3d 313 (1st Dept. 2008); *A.B. Med. Servs., PLLC v. Liberty Mut. Ins Co.*, 39 A.D. 3d 779 (2d Dept. 2007), if raised in a denial that is (1) timely, *Presbyterian Hosp. in the City of New York v. Maryland Casualty Ins. Co.*, 226 A.D. 2d 613 (2d Dept. 1996), (2) includes the information called for in the prescribed denial of claim form, 11 NYCRR Section 65-3.4 (11); *Nyack Hosp. v. Metropolitan Prop. & Cas. Ins. Co.*, 16 A.D. 3d 564 (2d Dept. 2005); *Nyack Hosp. v. State Farm Mut. Auto Ins. Co.*, 2004 WL 2394038, 2004 NY Slip Op 07663 (2d Dept. Oct. 25 2004), and (3) promptly apprises the Applicant with a high degree of specificity of the ground or grounds on which the disclaimer is predicated, *General Accident Ins. Group v. Cirucci*, 46 N.Y. 2d 862, 414 N.Y.S. 2d 512 (1979); *New York University Hosp. Rusk Ins.. Hartford Acc. & Indem. Co.*, 32 A.D. 3d 458, 2006 NY Slip Op 06223 (2d Dept. 2006).

An insurance carrier must establish a detailed factual basis and a sufficient medical rationale for its position that the medical service was not medically necessary. *Vladimir Zlatnick, M.D. P.C. v. Travelers Indem. Co.*, 2006 NY Slip Op 50963(U) (App Term 1st Dept. 2006).

The EIP was involved in a motor vehicle accident on October 30, 2021. The EIP was treated at the emergency room of Nassau University Hospital on the day of the accident. The EIP presented to Macintosh Medical On November 2, 2021 with complaints of pain in the neck, mid back, low back, both hips and the right knee. The examination reported reduced range of motion of the cervical and lumbar spine with tenderness and spasms and positive straight leg raising, positive orthopedic testing for the hips bilaterally, and tenderness and normal range of motion with pain in the right knee. The EIP was placed in a course of conservative treatment and administered trigger point injections to the lumbar musculature. The EIP underwent MRIs of the cervical and lumbar spine on November 8, 2021 which reported a disc herniation at L4-L5 and disc bulges at L3-L4, L5-S1, and C5 through C7. The EIP underwent an MRI of the thoracic spine on November 9, 2021 which reported a disc herniation at T7-T8. The EIP presented to Pain Physicians on November 16, 2021 with complaints of pain in the neck and low back. The examination reported tenderness and spasms in the cervical and lumbar musculature, reduce range of motion of the cervical and lumbar spine, positive straight leg raising, and reduced sensation in the cervical dermatomes. The EIP was administered trigger point injections and lumbar epidural steroid injections on November 23, 2021. The EIP underwent an MRI of the right knee on December 2, 2021 which reported bursitis and a small Baker's cyst. The EIP was administered lumbar trigger point injections on December 7, 2021. The EIP presented to Macintosh Medical on January 11, 2022 with complaints of pain in the lumbar spine. The examination reported reduced range of motion of the lumbar spine with spasms and trigger points and positive straight leg raising.

Dr. Hershon conducted the orthopedic IME on January 25, 2022 at which time the EIP complained of pain in the lumbar spine. The examination reported normal range of motion of the cervical and lumbar spine with negative orthopedic testing and normal neurological findings, normal range of motion and negative orthopedic findings for the bilateral shoulders, elbows, wrists, hips, knees and ankles. The conclusion was that the EIP needed no further orthopedic treatment.

No-Fault benefits were terminated effective February 18, 2022.

The EIP presented to Macintosh Medical on March 1, 2022 with complaints of pain in the lumbar spine. The examination reported normal findings for the right knee hips and cervical spine, spasms, trigger points and reduced range of motion in the lumbar spine with positive straight leg raising. The EIP was prescribed diclofenac, baclofen and 5% lidocaine ointment, which was provided to the EIP on March 12, 2022. The EIP presented to the applicant on July 12, 2022, at which time the applicant conducted an office evaluation and administered trigger point injections to form muscles utilizing ultrasound guidance.

I find the respondent has not demonstrated by sufficient factual basis and medical rationale that the treatment subsequent to the IME cutoff was medically unnecessary. The credible IME report shifts the burden to the applicant to demonstrate medical necessity. I find the reports of Macintosh Medical and Pain Physicians, both prior to and subsequent to the IME cut off, To be credible, sufficiently detailed and consistent with the objective evidence which reported a disc herniation in the lumbar spine and multiple disc bulges in the lumbar spine. The reports of Macintosh Medical demonstrate decreasing symptomology in evaluation conducted subsequent to the IME cut off, which I find to be evidence attesting to the efficacy of the post IME treatment. The reports of Macintosh Medical on March 1, 2022 site normal findings for the right knee, bilateral hips and the cervical spine and the only positive symptomology is the complaints and objective findings relative to the lumbar spine. Based upon the totality of the credible evidence, I find the applicant has demonstrated that the treatment subsequent to the IME cutoff was medically necessary.

The respondent raised a fee schedule defense.

The respondent submitted the affidavit of Carolyn Mallory, a certified bill coder. She states that the applicant is entitled to reimbursement for CPT code 20553 injections (three or more muscles) as four muscles were injected. She states that since only one unit of CPT code 20553 can be reported per session, the applicant is entitled to only one unit of ultrasound guidance under CPT code 76942 in the amount of \$289.20 and one unit of the injectate material under CPT code J1094 (injectate) in the amount of \$1.14 as the ultrasound guidance and injectate material were used in association with the one unit of trigger point injections and reimbursement for the office evaluation. She cites CPT Assistant, December 2017 that: "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." She states that the applicant is entitled to only one unit of CPT code 76942.

The applicant submitted the report of Michael Miscoe, a certified bill coder, whose report was limited to the issue of multiple units of CPT code 76942. He asserts that there is no prohibition or restriction to the number of units billed under CPT code 76942. He states that the determining factor in the amount of units of CPT code 76942 that may be billed is the amount of muscles injected, not the number of injections. He states regarding the billing of multiple units of CPT code 76942, he cites CPT Assistant, April, 2005 the following Q & A: "Would it be appropriate to report code 76942, Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation, twice when there is more than one lesion in the breast? A: From a CPT coding perspective, code 76942 should be reported per distinct lesion that requires separate needle placement. Therefore, if several passes are made into two separate lesions in the same organ (i.e., two lesions in same breast), then code 76942 would be reported twice where there was more than one lesion in the breast of the

patient and ultrasound guidance was utilized two times based upon reimbursement for each lesion which is examined". He further states that CPT Assistant, December, 2017 could be interpreted as restricting the use of multiple units of CPT code 76942 based upon the number of injections administered. He states based upon the CPT Assistant article from April, 2005, the controlling principle is the number of lesions, not the number of injections. He states that CPT guidelines attempt to place relative value units cognizant of the cost of equipment, skill, and time. He further states that there are many procedures in which the guidance costs extensively more than the procedure itself. Certainly, that is the case in trigger point injections where the cost of the equipment utilized in the trigger point injections, a needle and a small amount of anesthetic, is minimal compared to the cost for the ultrasound equipment. The report of the applicant demonstrates that four muscles were injected during the procedure.

I find the respondent has not demonstrated by a sufficient factual basis that the applicant billed in excess of the fee schedule by billing multiple units of CPT code 76942. I am still troubled by the unambiguous National Correct Coding Initiative for the Centers of Medicare and Medicaid which as of January 1, 2022 unambiguously state, in section G .3 of the Radiological services section, that CPT code 76942 may only be billed once per patient encounter regardless of the number of needle placements performed. However, I recognize that the Centers of Medicare and Medicaid are not controlling with respect to no-fault reimbursement. Further, I find the April, 2005 CPT Assistant article cited by Mr. Miscoe to be of little import due to the fact that comparing breast biopsy to trigger point injections fails. The difference between trigger point injection codes and breast biopsy codes is that the biopsy codes specifically state that the codes can be billed for individual lesions with an accompanying code for 76942. That is not the case with trigger point injections. However, I still find the December, 2017 CPT Assistant FAQ ambiguous on the issue of whether muscles or injections are being utilized to determine whether multiple units of ultrasound can be appropriately billed. Is this a distinction without a difference? I think not. Certainly, one can imagine the circumstance where there are two trigger points injected in one muscle and one trigger point in each of two muscles. Are they treated the same based upon the respondent's analysis of the 2017 CPT Assistant article? I would think that it is clear that in the first example of two trigger point injections in one muscle, the applicant will be entitled to only one unit of ultrasound guidance. I still find the 2017 CPT Assistant article ambiguous and unclear of whether a provider can bill for multiple units of ultrasound guidance when multiple muscles are injected. The applicant billed for four units under CPT code 76942 (ultrasound guidance). I do not find that the respondent has overcome their burden to demonstrate that the multiple units of CPT code 76942 and J1094 are not entitled to reimbursement. Additionally, Radiological Ground Rule 3 applies to the additional units of CPT code 76942 for reimbursement at 75% per unit. Additionally, the respondent submitted no convincing evidence that the applicant is entitled to only one unit for the injectate material billed under CPT code J1094 in the amount of \$1.14.

Therefore, applicant is awarded \$231.36 for the initial claim for CPT code 76942, \$520.56 for the additional three units of CPT code 76942 at 75%, \$104.81 for the injection therapy under CPT code 20553, \$74.24 for the office evaluation and \$4.56 for

the injectate material (I find the report of Ms. Malory correct that one milligram was administered at each of the four injection sites and that the proper reimbursement is \$1.14 for one milligram of material).

Accordingly, applicant is awarded \$935.53.

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	Status
	Atlantic Medical & Diagnostic PC	07/12/22 - 07/12/22	\$1,365.49	Awarded: \$935.53
Total			\$1,365.49	Awarded: \$935.53

- B. The insurer shall also compute and pay the applicant interest set forth below. 09/19/2022 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest is awarded from the date of the filing of the AR1 at a rate of 2% per month, simple, ending with the payment of the claim.

C. Attorney's Fees

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

Attorney fees are awarded pursuant to 11 NYCRR 65 - 4.6(e) at a rate of 20% of the awarded claim, including interest, to a maximum of \$1360.00.

- 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 NY

SS :

County of Nassau

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

06/12/2023  
(Dated)

Lester Hill

**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:**  
c60a7b395e7837397be81c9ed591b95c

### **Electronically Signed**

Your name: Lester Hill  
Signed on: 06/12/2023