American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Atlantic Medical & Diagnostic PC (Applicant)	AAA Case No.	17-23-1302-8728
	Applicant's File No.	M23-725159
- and -	Insurer's Claim File No.	3244D171R
	NAIC No.	25178
State Farm Mutual Automobile Insurance Company (Respondent)		

ARBITRATION AWARD

I, Nancy S. Linden, 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: YC

1. Hearing(s) held on 07/09/2024
   Declared closed by the arbitrator on 07/09/2024

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

   Matthew Kelly, Esq. from Sarah C. Varghese & Associates f/k/a James F. Butler & Associates participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$4,818.98**, was AMENDED and permitted by the arbitrator at the oral hearing.

   Applicant reduced its demand to $867.60, with its withdrawal with prejudice of its claims for CPT codes 99204, 20553, J1094, and the first instance of CPT code 76942 for date of service January 4, 2023, and its withdrawal with prejudice of its claims for CPT codes 99213, 20553, J1094, and the first instance of CPT code 76942 for date of service February 8, 2023.

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

3. Summary of Issues in Dispute

The Assignor, YC, a 43-year-old female, was involved in a motor vehicle accident on January 1, 2023. Following the accident, YC sought and received treatment including an initial office visit with ultrasound-guided trigger point injections (TPIs) of the cervical spine, trapezius & rhomboid musculature performed on January 4, 2023, and a follow-up office visit with ultrasound-guided TPIs of the cervical spine, trapezius & rhomboid musculature performed on February 8, 2023. Applicant billed Respondent for charges related to the afore-mentioned services. Thereafter, Respondent paid $1,475.08 of Applicant's bill for $2,467.47 for date of service January 4, 2023, denying the balance of $992.39 based upon the New York Workers' Compensation Fee Schedule, and Respondent paid $1,093.11 of Applicant's bill for $2,351.51 for date of service February 8, 2023, denying the balance of $1,258.40 based upon the fee schedule. At the hearing, Applicant reduced its demand to $867.60, seeking only reimbursement for the 5 denied instances of CPT code 76942. The issue presented is whether Respondent properly denied Applicant's billing based upon the fee schedule.

4. Findings, Conclusions, and Basis Therefor

The case was decided based upon the submissions of the parties contained in the electronic file maintained by the American Arbitration Association, and the oral arguments of the parties' representatives made at the arbitration hearing. There were no witnesses.

Applicant established its prima facie entitlement to reimbursement for no fault benefits based upon the submission of a properly completed claim form setting forth the amount of the loss sustained and that payment is overdue. Mary Immaculate Hospital v. Allstate Ins. Co, 5 AD 3d 742, (2d Dept. 2004). Westchester Medical Center v. Lincoln General Ins. Co, 60 AD 3d 1045 (2d Dept. 2009). Therefore, the burden now shifts to Respondent to prove its defense.

Respondent must demonstrate by competent evidentiary proof that Applicant's claims were in excess of the appropriate fee schedules, 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.145A (App. Term 1st Dept. 2006).

In the present case, for date of service January 4, 2023, Respondent paid one unit of CPT code 76942 at $231.36, the rate for a nurse practitioner, paid 2 units of CPT code 76942 in full at $289.20 each, and denied 3 units of CPT code 76942 billed at $289.20 of the six billed for the ultra-sound guided TPIs. For date of service February 8, 2023, Respondent paid one unit of CPT code 76942 at $231.36, paid 1 unit of CPT code 76942 in full, and denied 4 units of CPT code 76942 billed at $289.20 of the six billed for the ultrasound-guided TPIs. The balances were denied based upon the assertion that "it is inappropriate to bill this CPT code in multiple units".

In support of its defense, Respondent submits the affidavit of certified professional coder Jodie Cole who asserts that Applicant is only entitled to $231.36 for the 6 units of

CPT code 76942 billed on each date of service at issue. She relies on "CPT Assistant December 2017" which sets forth:

> **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, injections, localization device), imaging supervision and interpretation, may only be reported once, irrespective of the number of trigger-point injections performed.

With that, Ms. Cole determines that Applicant should only have been paid one unit of CPT code 76942 per date of service.

In support of its fee schedule argument that "multiple units of 76942 (fluoroscopic guidance) are reimbursable within the same visit if performed on different sites on multiple muscles" Applicant has submitted an affidavit prepared by certified professional coder Michael Miscoe. Specifically, Mr. Miscoe points out that "the CPT Editorial Panel has created the following description of CPT 76942, which is incorporated by the Schedule: Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injections, localization device), imaging supervision and interpretation" and "as is clear from the CPT description, this code is reportable for a single needle placement associated with either a biopsy, aspiration, injection, localization device, etc.". Further, "the CPT Editorial Panel provides the following parenthetical instruction for Ultrasound Guidance Procedures (CPT 76932-76965): (*Do not report 76942 in conjunction with 10004, 10005, 10006, 10021, 10030, 19083, 19285, 20604, 20606, 20611, 27096, 32408, 32554, 32555, 32556, 32557, 37760, 37761, 43232, 43237, 43242, 45341, 45342, 46948, 55874, 64479, 64480, 64483, 64484, 64490, 64491, 64493, 64494, 64495, 76975, 0213T, 0214T, 0215T, 0216T, 0217T, 0218T, 0232T, 0481T, 0582T).* Mr. Miscoe continues "where CPT 76942 is performed in conjunction with a trigger point injection service (CPT 20552-20553), it is notable that neither CPT 20552 nor 20553 include ultrasound or other guidance in their respective code descriptions (see below) and that these codes are not within the list of codes included with the parenthetical instructions above" and "as noted above, trigger point injection services are reported using CPT 20552 or 20553 (depending on the number of muscles injected), which are described by the CPT Editorial Panel as follows: 20552- Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s), 20553- Injection(s); single or multiple trigger point(s), 3 or more muscle(s)". That said, "as noted in the code description for CPT 20552 and 20553, it is not the number of injections, but the number of muscles (that receive one (1) or more injections) that define the appropriate code to use". Mr. Miscoe addresses the CPT Assistant FAQ Article referenced by Ms. Cole, pointing out that "it is understood that some have alleged that another CPT Assistant FAQ Article (December 2017) exists that addresses the reporting of CPT 76942 and 20553; however, there is no reference to this article in the Professional Edition of CPT relative to CPT 20553". Thus, "based on the description of CPT 76942, this service is

technically reportable for the guidance of each 'needle insertion'" and "where separate ultrasound guidance was performed for separate needle insertions, the service can be reported in units consistent with the provisions of Radiology Ground Rule 3". Mr. Miscoe thus explains that "where ultrasound guidance is performed in conjunction with trigger point injection(s) to three or more separate muscles, consistent with Radiology Ground rule 3.C), the first claim line reporting CPT 76942 for the first muscle is charged at 100% of the Schedule allowance while the second, third and any additional claim lines reporting CPT 76942 with modifier 59 would be charged at 75% of the Schedule allowance for this code".

Notably, Respondent has submitted an additional Q&A from the AMA Knowledge Base dated 4/29/24 which addresses CPT code 20553 specifically. Indeed, it states:

> **Question:** Would it be appropriate to report multiple units of code 76942, if three or more trigger-point injections (20553) were performed?
>
> **Answer:** It would be appropriate to report code 76942, Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation, once per operative session, regardless of the number of injections performed (including bilateral procedures). To report code 76942, it is necessary to include a permanent record of the images and interpretation in the medical record.

Applicant has also submitted a statement speaking to this Knowledge Base Q & A. Counsel argues that

> With respect to the inquiry by Defendant's current putative witness to the 'CPT Knowledge Base' system, it is notable that the underlying inquiry conveniently failed to mention:
>
> · That a ground rule specifically contemplating multiple reimbursement of this exact code already exists (Ground Rule 3 specifically allows multiple reimbursement of code 76942),
>
> · That the context of the inquiry was based on a payer type that has a prescribed fee schedule that allows for multiple reimbursement of 76942. (The requester fails to mention the inquiry pertained to New York No Fault billing and reimbursement as evidenced by itys (sic) response that refers the requester to other payer types,

That said, Applicant's counsel provides the full response from Knowledge Base, that is

> This is written in response to your Electronic Inquiry (El)# 14680 dated December 26, 2023. From a CPT coding

> perspective, based upon the limited information provided in your inquiry, the CPT Assistant reference you cited lists codes 20551, 20552 in parentheses not as an exclusive or otherwise exhaustive list; the same rationale would also apply to many other procedures (especially injections), including code 20553. The general intent of ultrasound guidance code 76942 is that it be reported once per operative session, irrespective of the number of individual injections performed, including bilateral procedures. Code 76942 is intended to be reported once per session and in order to report this code, a permanent record including images and their interpretation must be saved in the medical record. While this reflects the intent of CPT, you may also wish to contact your local third-party payers, as they may have additional information and requirements for reporting these codes.

Counsel continues,

> The last paragraph is perhaps the most telling in that it proves the insufficiency in the context provided by Mr. Futoran in the underlying inquiry. The response specifically refers Mr. Futoran to 'local third-party payers, as they may have additional information and requirements for reporting these codes.' 1. Why would an entity proposed to be the authority on a billing matter need to disclaim its response? 2. Why would a response meant to be applied to No-Fault Insurance First-Party claims refer the person who inquired for the clarification to Third-Party Payers? No Fault, pursuant to 11 NYCRR §65 relates to 'First Party Benefit'" and payers. This is clearly meant for commercial or third-party claims, not No-Fault.

Based on the foregoing, I find Applicant's arguments more persuasive, and, thus, Applicant is entitled to reimbursement of the denied balances.

As such, upon a preponderance of the evidence in the electronic case file and following consideration of the arguments raised at the hearing, I find that Respondent has not established its defense on this record. Applicant's claim is, therefore, granted.

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**
	Atlantic Medical & Diagnostic PC	**01/04/23 - 02/08/23**	**$4,818.98**	**$867.60**	**Awarded: $867.60**
Total			**$4,818.98**		**Awarded: $867.60**

B. The insurer shall also compute and pay the applicant interest set forth below. 06/08/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant is awarded interest pursuant to the no-fault regulations. See generally, 11 NYCRR §65-3.9. Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30 day month." 11 NYCRR §65-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. However, the regulations toll the accrual of interest when an applicant "does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations." See, 11 NYCRR 65-3.9(c). The Superintendent and the New York Court of Appeals has interpreted this provision to apply regardless of whether the particular denial at issue was timely. LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 217 (2009).

C. Attorney's Fees

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

Applicant is awarded statutory attorney's fees pursuant to the no-fault regulations. See, 11 NYCRR §65-4.5(s)(2). The award of attorney fees shall be paid by the insurer. 11 NYCRR §65-4.5(e). Accordingly, "the attorney's fee shall be limited as follows: 20 percent of the amount of first-party benefits, plus interest thereon, awarded by the arbitrator or the court, subject to a maximum fee of $850." Id. The minimum attorney fee that shall be awarded is $60. 11 NYCRR §65-4.5(c). However, if the benefits and interest awarded thereon is equal to or less than the respondent's written offer during the conciliation process, then the attorney's fee shall be based upon the provisions of 11 NYCRR §65-4.6(i). For claims that fall under the Sixth Amendment to the regulation the following shall apply: "If the claim is resolved by the designated organization at any time prior to transmittal to an arbitrator and it was initially denied by the insurer or overdue, the payment of the applicant's attorney's fee by the insurer shall be limited to 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon, for each applicant with whom the respective parties have agreed and resolved disputes, subject to a maximum fee of $1,360." 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 NY
SS :
County of Suffolk

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

07/21/2024
(Dated)

Nancy S. Linden

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:
ac5c3e4a19ad91b8a5aa07b42010c552

Electronically Signed

Your name: Nancy S. Linden
Signed on: 07/21/2024