

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Atlantic Medical & Diagnostic PC  
(Applicant)

- and -

Allstate Insurance Company  
(Respondent)

AAA Case No. 17-23-1319-8755

Applicant's File No. M23-733226

Insurer's Claim File No. 0664509833

NAIC No. 29688

**ARBITRATION AWARD**

I, Lori Ehrlich, 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: Claimant

1. Hearing(s) held on 07/02/2024  
Declared closed by the arbitrator on 07/02/2024

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

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

2. The amount claimed in the Arbitration Request, **\$2,391.12**, was AMENDED and permitted by the arbitrator at the oral hearing.

Amended to \$1,703.20

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

3. Summary of Issues in Dispute

In dispute is Applicant's claim in the sum of \$1,703.20 for an evaluation, trigger point injections, medication, and ultrasound guidance. The services at issue were rendered to Applicant's assignor, S.A., said claim arising from an automobile accident on September 9, 2022.

Respondent has denied the claim at issue maintaining that verification requests remain outstanding, and the issue presented is whether the within claim is ripe for arbitration. Respondent also raises a fee schedule defense.

The parties appeared via Zoom.

I have reviewed the documents entered into the ADR by July 2, 2024.

#### 4. Findings, Conclusions, and Basis Therefor

The services at issue were provided to the Applicant on May 5, 2023. Applicant has set forth a prima facie case for each of the claims at issue by the submission of a completed health claim form documenting the fact and amount of the loss sustained (*Amaze Medical Supply v. Eagle Ins. Co.*, 2 misc. 3d 128A, 784NYS 2d 918, 2003 NY Slip Op.517014 [App Term, 2d & 11 Jud. Dusts.]).

As an initial matter, I note that Respondent filed a declaratory judgement action entitled *Allstate Insurance Company et al v. Landow, M.D. et al*, Case # 1:24-cv-02010 in the United States District Court for the Eastern District of New York, in which Applicant is a named defendant. The Summons and Complaint was filed on March 19, 2024 and Applicant appeared on April 4, 2024, there has been no stay of pending arbitrations claims, and therefore Respondent's request for a continuance or an adjournment is denied.

Respondent maintains that the Applicant is precluded from recovery based on the failure to attend two scheduled examinations under oath. Respondent's evidence consists of an EUO scheduling letter dated June 29, 2022, scheduling Applicant's EUO for July 19, 2022. The Respondent also submits a letter dated July 27, 2022, rescheduling the Applicant's EUO for September 20, 2022. Respondent has submitted proof of mailing of the scheduling letters and transcripts documenting Applicant's failure to appear.

Applicant's Counsel contends that Respondent's denial based on Claimant's failure to appear for an EUO is not properly sustained as the EUO letters do not include the requisite statutory language advising the Applicant of its right to reimbursement as mandated by 11 NYCRR Section 65-3.5(e) which provides as follows: "The insurer shall inform the applicant at the time the examination is scheduled that the applicant will be reimbursed for any loss earnings and reasonable transportation expenses incurred in complying with the request." As the letters do not contain the required language, the letters are defective.

Applicant further contends that the EUO for September 20, 2022, was not timely scheduled. Counsel contends that the follow up letter dated July 27, 2022, was not mailed until August 3, 2022, more than 10 days after the date that Applicant failed to appear for the first EUO. Therefore, Counsel asserts that the follow up request does not comply with 11NYCRR 65-3.6 (b) which provides: "*Verification requests. At a minimum, if any requested verifications has not been supplied to the insurer 30 calendar days after the original request, the insurer shall, within 10 calendar days, follow up with the party from whom the verification was requested, either by telephone call, properly documented in the file, or by mail. At the same time the insurer shall inform the applicant and such person's attorney of the reason(s) why the claim is delayed by identifying in writing the missing verification and the party from whom it was requested*."

Given that Respondent's letter rescheduling is dated more than 10 days after the missed EUO on November 28, 2022, I agree with Applicant's contention that the follow up letter was untimely, and therefore the denial based on EUO no show is not properly sustained. See, Restoration Chiropractic, P.C. v 21st Century Ins. Co., 2019 NY Slip Op 51961(U) [65 Misc 3d 157(A)] wherein the Appellate Term Second Department held, "The record establishes that defendant's follow-up scheduling letter was mailed more than 10 days after plaintiff's assignor had failed to appear for the first scheduled EUO. As a result, this follow-up scheduling letter was untimely (*see* 11 NYCRR 65-3.5 [b]). Consequently, defendant's motion should have been denied (*see Parisien v 21st Century Ins. Co.*, 62 Misc 3d 150[A], 2019 NY Slip Op 50275[U] [App Term, 2d Dept, 2d, 11th & 13th Jud Dists 2019]) See also, Acupuncture Health Plaza 1, P.C. v. Allstate Insurance Company, 2017 NY Slip Op 50939(U) [56 Misc 3d 133(A)].

Respondent raises a fee schedule defense. When raising a fee schedule defense, Respondent has the burden to come forward with competent evidentiary proof to support its fee schedule defenses. Robert Physical Therapy, P.C. v. State Farm Mut. Auto. Ins. Co., 13 Misc. 3d. 172(Civ. Ct. Kings Co. 2006). When a Respondent fails to demonstrate by competent evidentiary proof that an Applicant's claim was in excess of the appropriate fee schedule. Respondent's defense of noncompliance with the appropriate fee schedule cannot be sustained. Continental Medical, P.C. v. Travels Indemnity Co., 11 Misc. 3<sup>rd</sup> 145A (App. Term 1<sup>st</sup> Dept. 2006).

Applicant billed Respondent for 6 units of ultrasound guidance pursuant to CPT code 76942. Applicant amended the amount in dispute at the commencement of the hearing to be consistent with the fee schedule for nurse practitioners, including one unit of ultrasound at 100%, 75% of the billed amount for each of the five remaining units, the initial evaluation and trigger point injections. Respondent contends that Applicant is only entitled to the initial unit of ultrasound, not the additional five units. Also at issue is the fee for medication billed pursuant to J1094 and the initial evaluation.

Respondent submits the affidavit of Jeffrey Futoran, C.P.C., (submitted on the day of the hearing), in support of its contention that a provider may only report ultrasound once irrespective of the number of trigger-point injections performed. Mr. Futoran further maintains that the evaluation billed pursuant to CPT 99214 is a follow up examination, not an initial consultation or initial and therefore may not be separately reported or billed from surgery code 20553, pursuant to Surgery Ground Rule 2. Additionally, Mr. Futoran asserts that the medication billed pursuant to J1094 should be reimbursed at \$66.25 as Applicant's claim form documents \$397.50 for 6 units (\$66.25 per 1mg unit) and the procedure note documents that only 1mg of dexamethasone acetate was injected.

Applicant contends that where the plain reading of the fee schedule, in this case of Radiology Ground Rule 3, is clear and unambiguous, it supersedes the CPT

Assistant and supports Applicant's entitlement to reimbursement for the units billed for ultrasound guidance. Applicant submits the affidavit of Michael D. Miscoe in support of its contention that reimbursement is owed for all 6 units of CPT code 76942 billed. Mr. Miscoe states that the evaluation was properly reported with modifier 25 pursuant to General Ground Rule 15 as a "Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service". He notes that different diagnoses are not required for reporting of the E/M services on the same date.

In Atlantic Medical & Diagnostic PC and Allstate Insurance Company, (17-23-1289-0320), a case involving the same parties, I considered the identical issue and concluded that Applicant was entitled to reimbursement for the number of units of ultrasound billed. In that case, Applicant submitted Mr. Miscoe's affidavit and Respondent submitted an affidavit from Carolyn Mallory, CPC. While Ms. Mallory relied on a CPT Assistant article from December 2017 in support of her opinion, Mr. Futoran's affidavit relies on an inquiry which he submitted to the AMACPT Network, and his affidavit quotes from the inquiry as follows:

Is it appropriate to report multiple units 76942 if three or more trigger-point injections (20553) are performed?

This is written in response to your Electronic Inquiry (EI) # 14680 dated December 26, 2023. Is it appropriate to report multiple units 76942 if three or more trigger-point injections (20553) are performed? 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."

In Atlantic Medical & Diagnostic PC and State Farm Mutual Automobile Insurance, (17-23-1319-8765), Arbitrator Nancy Linden had the opportunity to review the inquiry submitted by Mr. Futoran, as well as Applicant's response and states:

*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,*

Arbitrator Linden's award included the text of the inquiry and response and further states:

*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.*

Arbitrator Linden concluded, and I agree, that Applicant is entitled to reimbursement the additional units of CPT 76942 billed. Mr. Futoran's inquiry does not convince me to deviate from my prior determinations. The inquiry is subject to interpretation, and does not contradict Mr. Miscoe's affidavit which states in pertinent part, "Radiology Ground Rule 3 (Multiple Diagnostic Procedures) establishes that where multiple diagnostic services are performed (70010-76499, 76505-76999, 77002-77003, and 7801278999) at the same encounter, the compensation for the procedures is based on the relative value of the diagnostic services and whether the images are taken on contiguous or noncontiguous body parts as follows: A) For two contiguous parts, the charge shall be the greater fee plus 50 percent of the lesser fee. B) For two remote parts, the charge shall be the greater fee plus 75 percent of the lesser fee. Bilateral procedures are considered remote parts. C) For three or more parts, whether contiguous or remote, the charge shall be the greatest fee plus 75 percent of the total of the lesser fees. This rule establishes, relative to CPT 76942, which is included in the code range addressed by the rule, that this code is reportable in multiple units. Because this Schedule Ground Rule squarely establishes that CPT 76942 may be reported in units, the General Ground rule cited above indicates that the CPT Editorial Panel guidance is not relevant to this issue."

I further find that Applicant's contention as to reimbursement for the follow up evaluation billed pursuant to CPT 99214-25 is more persuasive than that of Respondent. However, Applicant has not addressed the issue of medication reimbursement raised by Mr. Futoran, and therefore, the medication reimbursement is reduced to \$66.25, as determined by Mr. Futoran.

Based on the foregoing, I find that Applicant is entitled to 6 units of ultrasound as billed, one unit at 100% of the fee at the PA rate of \$231.36 for the initial unit of ultrasound and an additional \$173.52 for each of the remaining five units which is 75% of the PA rate. Applicant is also awarded \$101.93 for the evaluation and \$104.41 for the trigger point injections and \$66.25 for the medication, for a total award of \$1,407.58

The above award addresses all of the issues raised by the parties.

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	05/05/23 - 05/05/23	\$2,391.12	\$1,703.20	Awarded: \$1,407.58
					Awarded:

<b>Total</b>	<b>\$2,391.12</b>		<b>\$1,407.58</b>
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- B. The insurer shall also compute and pay the applicant interest set forth below. 10/06/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

The Insurer shall pay interest at the rate of 2% per month, simple (not compounded), on a pro rata basis using a 30-day month. Interest shall be computed from October 6, 2023 to the date of payment.

C. Attorney's Fees

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

This case is subject to the provisions as to attorney fee promulgated in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D): There is an attorney fee of 20% of benefits plus interest, with no minimum fee and a new maximum fee of \$1360.00. However, for all arbitration requests filed on or after April 5, 2002, 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(b).

- 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 Westchester

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

07/28/2024  
(Dated)

Lori Ehrlich

**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:**  
552fd4adcb801bf2e7858b26093201c1

### **Electronically Signed**

Your name: Lori Ehrlich  
Signed on: 07/28/2024