American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Atlantic Medical & Diagnostic PC (Applicant)	AAA Case No.	17-23-1314-0980
	Applicant's File No.	44522-390092
- and -	Insurer's Claim File No.	32-34J6-41Q
	NAIC No.	25143
State Farm Fire & Casualty Company (Respondent)		

ARBITRATION AWARD

I, Keith Tola, 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 07/08/2024
   Declared closed by the arbitrator on 07/08/2024

   Joaquin Lopez, Esq. from Barshay, Rizzo & Lopez, PLLC. participated virtually for the Applicant

   John Rossillo, Esq. from Rossillo & Licata LLP participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$939.08**, was AMENDED and permitted by the arbitrator at the oral hearing.

   At the hearing, the amount in dispute was amended to $765.56. Respondent continued to take issue with applicant's charges.

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

3. Summary of Issues in Dispute

   This case stems form a New York motor vehicle accident which occurred on May 22, 2022, wherein the EIP allegedly sustained injuries. On June 28, 2022, applicant administered trigger point injections under ultrasound guidance for needle placement, and billed for same along with the injectable, Dexamethasone. Respondent issued partial

payment and denied the balance based on fee schedule. Applicant seeks to recover the balance, as amended.

4. Findings, Conclusions, and Basis Therefor

This Award was issued upon consideration of the parties' arguments and upon review of the relevant evidence contained within the ADR Center files.

In support of its partial payment and fee schedule defenses, respondent submitted the analysis of its expert, Antionette Perrie, D.C., L.Ac., CPC. Dr. Perrie indicated:

Re: Dexamethasone (J1094)

"Provider billed HCPCS code J1094 in the amount of $265.00. This code is significant for *Injection, dexamethasone acetate, 1 mg.* Records indicate that 4 units were used by the provider for this date of service. According to General Ground Rule #4, all pharmaceuticals are correctly billed using CPT code 99070 and are paid at the invoice price. The provider was paid in the amount [$20] for a medication that costs $1.60. There is no justification for the amount billed. General Ground Rule #4 is as follows:

> "For pharmaceuticals administered by the medical provider in a medical office setting, payment shall not exceed he invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070."

Attached is a medication invoice. The drug in question is purchased on 5/19/22.

The provider purchased 8 cases of the medication at the cost of $2392.00. Therefore, each case of the medication is $299.00.

Each case contains 25 vials of the medication. Therefore, each vial is $11.96.

Each vial of the medication contains 30 units of the drug. Therefore, each unit is $0.40. The price for 4 units is $1.60. Keep in mind that this is not a single use vial. The provider received reimbursement in the amount of $20.00 which is more than the cost of an entire vial of the medication."

Re: Ultrasound Guidance (76942(59)

"Provider billed codes 76942 - PA and 76942 - 59 - PA, each in the amount of $231.36. The code represents Ultrasonic guidance for needle placement (eg. Biopsy, aspiration, injection, localization device), imaging supervision and interpretation. The service is found in the Radiology Fee Schedule. In this case the provider has billed this service 4 times, once per injection. The "59" modifier has been improperly appended. Although the "59" modifier is used to identify separate procedures, in this case one may not report

multiple units of the code, when the guidance procedure itself is related to a single injection procedure represented by a single dedicated code, irrespective of the number of injections or number of muscles injected, 3 or more. The code is properly used ont time per underlying procedure code (in this case, the only underlying procedure code is the trigger point injection code itself, CPT 20553, which is properly reported once). The RV is 4.97. The radiology conversion factor is $58.19.

CPT Code 76942. To report the use of ultrasound guidance to guide injections or aspirations, the suggested code is 76942 - Ultrasound guidance for needle placement (e.g. biopsy, aspiration, injection, localization device), imaging supervision and interpretation. Report 76942 in addition to the code for the underlying procedure. See attached from AAPC, CPT Assistant, June 2017, and SuperCoder, November 2017 …

The only CPT code to which this guidance code can be applied is the trigger point injection codce of 20553. CPT 20553 is the underlying procedure. In regard to injection services, you may only apply the guidance code once to each procedure code. If your multiple trigger point injections contain 15 injections into 1 muscle or 1 injection into each of 15 muscles, you may not bill guidance 15 times. You may only bill it once. See the following from the AMA, the copyright owners and publishers of the CPT…

For this date of service, the records show that there were 4 injections. In explanation of the CPT Assistant, it is quite clear that regardless of the number of injections in a trigger point injection session, the guidance code is reported once. Whether you inject a single muscle 10 times or 4 muscles one time in each muscle, the fact remains that the guidance code is used once. It makes no sense from a logical point of view to be able to capture a guidance code payment 4 times for a single injection into each of 4 muscles when 10 injections into a single muscle can only be paid once even though there are 10 separate injections. Based on the assertion that multiple units of CPT 76942 may be billed per patient per encounter, you are left with the curious result that the underlying service, which is the trigger point injection code, is paid at $104.81 while the ultrasound guidance would be paid in the amount of $925.44. It defies logic and offends common sense…

Applying the above rules, reimbursement is in the amount of RV 4.97 x $58.19 conversion factor = $289.20. The service is performed by a PA; therefore, final payment is 80% of the medical fee. This equals $231.36.

In summary, correct reimbursement to the provider for date of service 6/28/2022 is in the amount of $439.70. The provider was paid in the amount of $458.10. No additional fee is due."

As noted, applicant has amended its claim from $939.08 (the amount billed minus the amount paid), to $765.56. By way of breakdown, applicant is seeking compensation under Code 76942 as follows: $231.36 x 75% = $173.52 x the remaining three charges = $520.56, Plus the balance of its charge for dexamethasone ($245.00) = $765.56.

Applicant has provided the affidavit of its fee schedule expert, Michael Miscoe, CPC. Mr. Miscoe has testified before me on this very issue in unrelated cases and his affidavit

submitted herein is consistent with this extensive testimony. Mr. Miscoe concluded an applicant provider may bill multiple times under Code 76942 per date of service. He indicated CPT Assistant, December 2017, could be interpreted as restricting the use of multipole units of CPT Code 76942 based upon the number of injections administered, but noted that based upon the CPT Assistant article from April 2005, the controlling principle is the number of lesions not the number of injections. According to Mr. Miscoe, the CPT guidelines attempt to place relative value units cognizant of the cost of equipment, skill and time. However, he noted there are many procedures were the guidance costs extensively more than the procedure itself. Certainly, that is the case in trigger point injections were 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.

Mr. Miscoe indicated that the CPT Assistant Editorial Panel is not considered authoritative, and that the FAQ section of the CPT Assistant is not incorporated within the CPT Assistant, and therefore, also not authoritative. He opined the FAQ section relied upon by the respondent's expert consists of questions and answers but it is unclear who posed the question. He advocated that the CPT Assistant contradicts a plain reading of the New York State Workers' Compensation Board Fee Schedule.

Mr. Miscoe indicated that the proper procedure in determining the applicable fee schedule amount would be to follow the Radiology Fee Schedule Ground Rule 3, and, if it was not sufficiently specific, then proceed to use an ancillary authority such as the CPT Assistant. In his opinion, Ground Rule 3C was sufficient to decide the proper rate of reimbursement and it was not necessary to use the CPT Assistant. However, if the fee schedule does not fully inform the user of the proper amount and calculations, then the CPT Assistant is used. For these types of injections, it is noted that they are made multiple times around a trigger point. According to Mr. Miscoe, the trigger point muscle being injected should be considered as if it were a different site or lesion. This would be consistent with other parts of the fee schedule that allow additional billing. Mr. Miscoe indicated the CPT Assistant that was quoted by the Respondent that indicated that the guidance could only be billed once regardless of the number of "injections" should be read as "injections or muscles injected" as it does for CPT codes 20552 and 20553, which would mean that for a different muscle or site, the guidance could be billed again.

Determination

As a starting point, notice is taken of the case of *Matter of Global Liberty Ins. Co. v McMahon, 172 AD3d 500, 2019 NY Slip Op 03692 (1st Dept. 2019)*. In relevant part, the court held:

> "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], aff'd 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 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."

After careful review of the totality of the credible evidence, not to mention my own independent research on this issue, I find that Applicant can only be compensated for one unit under Code 76942. Consequently, I am persuaded by the position asserted by respondent and its expert, Ms. Perrie, and find it to be the more credible assessment. I therefore find that respondent's recommended payment of only one unit under Code 769452 should be sustained and that no further reimbursement would be due.

The affidavit of Mr. Miscoe with respect to the ultrasonic guidance is detailed and worthy of credibility - it is a credible opinion asserted by one expert on an issue for which expert opinions differ. That said, I do not find applicant's position persuasive as I do the Respondent's position. In particular, I do not agree with Mr. Miscoe that Ground Rule 3C is sufficient on its own to determine the correct value of the subject services. Therefore, I agree with the Respondent that the CPT Assistant should be considered as an authoritative source. The argument that the answer to the CPT Assistant FAQ that stated that CPT code 76942 can be reported irrespective of the "number of trigger-point injections performed" should read "number of muscles" or "number of sites" if that is indeed what was intended by the AMA is well-taken. However, after considering the question and answer, if the injection site is moved or a different muscle is being injected, it still requires additional injections. Since the answer to the FAQ relies on the number of trigger-point injections performed, I find that additional trigger point injections at a different site/muscle would still be covered under this statement, and therefore, CPT code 76942 would only be allowed to be billed for one time. *See AAA Case No. 17-21-12058-7990; AAA Case No. 17-21-1216-9964.*

In *Macintosh Medical, PC and Progressive Cas. Ins. Co., AAA case no. 17-21-1193-9781,* Arbitrator John O'Grady was asked to consider the merits of Dr. Miscoe's opinion surrounding billing for multiple units of ultrasonic guidance. In rejecting Dr. Miscoe's analysis, Arbitrator O'Grady reasoned as follows:

> "I conclude that applicant may only be reimbursed for one unit pursuant to CPT Code 76942. 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. The December 2017 CPT Assistant adequately answers the question of how many units may be reimbursed when guidance is provided for multiple injections. In doing so it does not replace the CPT Codebook, it clarifies it. Where it says that the code "may only be reported once, irrespective of the number of trigger point injections performed" that language, in the absence of qualifying language, is inclusive of multiple trigger point injections no matter where provided, including at multiple sites. Mr. Miscoe's testimony attempts to create an issue where one does not exist, attempting to add qualifying language to a clear explanation. Respondent's defense regarding this payment is therefore sustained and the claim for the difference between the amount claimed and amount paid is denied."

In *AAA Case No.: 17-21-1192-5195 (9/14/22),* Arbitrator Criscitelli heard what was presumably the same testimony from Dr. Miscoe on the issue of reimbursement for multiple units under Code 76942, and she noted, in relevant part:

> "… Having carefully considered the totality of the oral testimony, the Record in MODRIA and the zealous advocacy by counsel for both parties, as trier of fact, I find Respondent's position more persuasive. Mr. Miscoe was a pleasant witness and ardently presented his opinion. Although appreciated, however, I am not persuaded by his conclusion that Applicant is entitled to payment beyond 1 unit of guidance.
>
> As I have consistently found, directly, on point is Matter of Global Liberty Ins. Co., v. McMahon, 2019 NY SLIP Op 03692 (App. Div. 1 Dept. 2019), where the Court expressed in pertinent part:
>
> "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 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."

A suggestion that the FAQs in the CPT Assistant are not authoritative is contrary to the determination above. The CPT Assistant is considered in whole, and therefore, is authoritative in its entirety. Indeed, the FAQs provide depth and substance to the CPT

Assistant; it is irrelevant who posed the questions. The questions and answers were deemed reliable and relevant, which resulted in publication. Finally, I note that CPT Codes 20551 and 20552 are interchangeable with CPT Code 20553 for purposes of the FAQ. The only difference in the Codes is the number of injections administered (1, 2 and 3 injections, respectively), which is irrelevant because the controlling point in the FAQ is that Code 76942 is only billable once, irrespective of the number of injections or muscles treated. This statement could not be any clearer. I do not find that it is contextually inappropriate. Moreover, I do not find that a plain reading of the NYFS and its Ground Rules support a finding that Applicant may bill for more than 1 unit of guidance.

On the foregoing, I find that Respondent properly concluded only one unit is due as payment for the initial unit of ultrasound under Code 76942.

I note in closing that this issue has been extensively addressed in this Forum. For instance, Arbitrator Drew M. Gewuerz, Esq., CPC, in AAA Case Number 17-20-1161-7425, expressed in pertinent part:

> "As to the rate of payment, the Respondent contends that the Applicant's claim charges excessive fees and the Applicant's amendment to its claim's billed amounts still do not reflect the maximum legally permissible fees. The Respondent's contention is correct, and it proves by a preponderance of the credible evidence that the Applicant is constrained to a maximum legally permissible total of $262.91 [1 unit] for the claim."

Similarly, Arbitrator Yael Aspir, in AAA Case Number 17-21-1230-1514, determined in relevant part:

> "I am persuaded by Respondent's fee audit and multiple similar arbitration awards, that the CPT Assistant FAQ provides that CPT code 76942 may only be reimbursed once for TPI."

In alignment, Arbitrator Mitchell Kleinman, in *AAA Case Number 17-21-1213-4459*, determined in dispositive part:

> "The addendum affidavit from Kumar argues that the CPT Assistant Editorial Panel has no mandate that the FAQ section "is intended to be authoritative" and that the FAQs are "not subject to the rigorous editorial process conducted by the CPT Editorial Panel." The affidavit further contends that the FAQ is not applicable to CPT code 20553. I do not find Kumar's affidavit to be credible or persuasive with respect to the reliability of the FAQs published in the CPT Assistant. The addendum does not sufficiently support its contentions with respect to the reliability of the FAQs. The American Medical Association publishes the CPT Assistant and is clearly aware that an FAQ section exists in their own publication. The CPT Assistant is considered a reliable document by this forum and the courts. The assertion that the AMA takes great care to publish a document with widespread use that is frequently relied upon, but leaves in unreliable information that is not properly vetted is not credible. Whether or not

the FAQs are subject to the same rigorous process as the other parts of the CPT Assistant is not supported in the affidavit, but even if this were true, this would affect only the weight of the answer to the FAQ and not call for it to be completely disregarded. I find that the answer to the FAQ is applicable, credible and more persuasive than the arguments put forth by the rebuttal and addendum affidavits. Therefore, I find that the Respondent's affidavit from its coding expert to be more persuasive."

In view of the foregoing, and again, upon consideration of the relevant evidence presented in both pre-hearing briefs, affidavits and other evidentiary submissions, I acknowledge an apparent split amongst the panel, however, I am persuaded by respondent's position and find that applicant may only bill and be compensated for one unit under Code 76942.

Finally, applicant's expert did not address the analysis provided by Ms. Perrie, respondent's expert, as to the correct rate of reimbursement for the dexamethasone.

In summary, I find applicant is not entitled to any additional compensation. As such, this 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 NY
SS :
County of Nassau

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

07/31/2024
(Dated)

Keith Tola

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
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Electronically Signed

Your name: Keith Tola
Signed on: 07/31/2024