

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Atlantic Medical & Diagnostic PC
(Applicant)

- and -

Progressive Casualty Insurance Company
(Respondent)

AAA Case No.	17-23-1327-7828
Applicant's File No.	445-PKT23-124091
Insurer's Claim File No.	23-2260807
NAIC No.	14800

ARBITRATION AWARD

I, Josh Youngman, 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: IP

1. Hearing(s) held on 09/06/2024
Declared closed by the arbitrator on 09/06/2024

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

Jennifer Kilfolye, Esq. from Progressive Casualty Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$3,118.39**, was AMENDED and permitted by the arbitrator at the oral hearing.

The applicant amended the amount in dispute to \$1,735.20 based on the applicant's interpretation of the proper amount per the fee schedule.

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

3. Summary of Issues in Dispute

This dispute involves a claim for PIP benefits brought by the applicant as an assignee of a 32-year old male (M.M.) who was injured on July 13, 2023 when the motor vehicle he

was a passenger in was involved in an accident. The evidence further shows following the accident the injured party (IP) sought treatment and had an office visit and received a trigger point injection with guidance on July 13, 2023 and on August 24, 2023.

The evidence further shows upon receipt of the applicant's bills seeking reimbursement for said treatment, the respondent made partial payments and denied the balances based on fee schedule defenses.

The applicant now seeks an award in the amount of \$867.60 per date of service for the unpaid units of the guidance code (CPT code 76942). The applicant further withdraws the portion of the claims seeking reimbursement for CPT codes 99204 and 20553, and the first (1st) unit of CPT code 76942 per date of service.

The issues to be decided are whether the applicant submitted sufficient evidence to make out a prima facie case for the disputed claim, and if so, whether the respondent submitted sufficient evidence to sustain their fee schedule defense.

4. Findings, Conclusions, and Basis Therefor

This Award is rendered after diligent review and consideration of the parties' evidence submitted to and maintained by the American Arbitration Association's electronic case filing system, "MODRIA," as well as the parties' oral arguments and any testimony presented at this matter's hearing. Evidence that was submitted after this matter's "closing" and without this Arbitrator's authorization was not considered.

An applicant establishes its prima facie entitlement to reimbursement with proof that it submitted a proper claim, setting forth the fact and the amount charged for the services rendered and that payment of no-fault benefits was overdue. See Insurance Law § 5106a; Viviane Etienne Med. Care v. Country-Wide Ins. Co., 25 N.Y.3d 498 (2015); Mary Immaculate Hosp. v. Allstate Ins. Co., 5 A.D. 3d 742 (App. Div. 2d Dept. 2004). Once an applicant has established its prima facie case, the burden shifts to the insurer to establish that it timely and properly denied the claim(s), and to submit evidence to sustain the basis of its denial(s).

I find that the applicant has submitted sufficient evidence to establish its prima facie case for the claims at issue. Further, the respondent may proceed with their fee schedule defenses regardless of whether the claims were timely denied (see 11 NYCRR § 65-3.8(g)(1)(ii)).

Insurance Law § 5102(a)(1) defines "basic economic loss" as including "all necessary expenses incurred for...professional health services" subject to the limitations of Insurance Law § 5108. Insurance Law § 5108 limits the amounts to be charged by providers of health services, and states that charges for services specified in Insurance Law § 5102(a)(1) "shall not exceed the charges permissible under the schedules prepared and established by the chairman for the workers' compensation board...except where the insurer...determines that unusual procedures or unique circumstances justify

the excess charge." 11 NYCRR § 65-3.16(a) provides that "[p]ayment for medical expenses shall be in accordance with fee schedules promulgated under section 5108 of the Insurance Law and contained in Part 68 of this Title (Regulation 83)." 11 NYCRR § 68.1 provides that the "existing fee schedules prepared and established by the chairman of the Workers' Compensation Board...are hereby adopted by the Superintendent of Insurance with appropriate modifications so as to adapt such schedules for use pursuant to section 5108 of the Insurance Law."

The respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 2006 NY Slip 26240 (Civil Ct. Kings Co. 2006). If the insurer fails to demonstrate by competent evidentiary proof that an applicant's claims were billed in excess of the appropriate fee schedules, the defense of noncompliance with the fee schedule cannot be sustained. See, Continental Medical PC v. Travelers Indemnity Co., 11 Misc.3d 145A (App. Term 1st Dept. per curiam, 2006).

Prior to a review of the evidence, I note my recent award in the matter of Atlantic Medical & Diagnostic PC v. State Farm Mutual Automobile Ins. Co., AAA Case No.: 17-23-1330-5012 (2024). In that matter, I dealt with the same fee schedule issue that is in dispute herein. Further, after my review of the evidence in that matter, I stated:

In the instant matter, the applicant concedes the office visit, the trigger point injection and the first (1st) unit of CPT code 76942 were properly paid for each date of service. The applicant, however, seeks reimbursement for the 2nd, 3rd, 4th and 5th units of CPT code 76942 that were billed per date of service (at 75% of the fee schedule amount).

The respondent, however, argues that the applicant is not entitled to reimbursement for the additional units of CPT code 76942 that were billed per date of service.

In support of their position, the respondent submits an affidavit executed by Jeffrey Futoran, CPC. I have previously found the respondent's position to be persuasive based on a review of similar evidence that is submitted herein (see Eastern Medical Practice, P.C. v. Geico Ins. Co., AAA Case No.: 17-19-1149-7611 (2021)).

In addition, the respondent herein argues that there are "new developments" that support the respondent's position that the applicant is entitled to reimbursement for only one (1) unit of CPT code 76942 per date of service.

I note I have previously reviewed the Q&A from the CPT Assistant from 2017 referenced by the respondent, which stated:

Question: When reporting ultrasound guidance for trigger point injections (20551, 20552), is it appropriate to report multiple units of code 97942 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.

In the instant matter, the respondent argues Mr. Futoran subsequently made an "electronic inquiry" in 2023 to clarify whether the answer that CPT code 76942 should be billed once per date of service applied to a trigger point injection billed under CPT code 20553 (and not just with CPT codes 20551 and 20552).

The respondent further submits a printout from the AMA CPT Knowledge Base that 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.

The respondent further argued the answer from the AMA CPT Knowledge Base referenced above was incorporated into a CPT Assistant article in May 2024. The respondent submits the May 2024 CPT Assistant article which contains the same language from the AMA CPT Knowledge Base stated above.

The respondent also argues Arbitrator Dimitrios Stathopoulos and Arbitrator Nancy S. Linden both recently altered their position on this issue based on the "new developments" referenced above.

In the matter of Atlantic Medical & Diagnostic PC v. State Farm Mutual Automobile Ins. Co., AAA Case No.: 17-23-1316-7782 (2024), Arbitrator Dimitrios Stathopoulos dealt with this issue and stated:

In the past I addressed this issue on numerous occasions and found that the ultrasound guidance for needle placement for multiple trigger point injections may be reported in multiple units, irrespective of the fact that Applicant is only limited to reimbursement for one trigger point injection. I would consistently reject Respondent's reliance on a CPT Assistant, December 2017, question and answer series that found when reporting ultrasound guidance for trigger point injections (20551, 20552) CPT code 76942 may only be reported once, irrespective of the number of trigger point injections performed. The basis of my rejection of the 2017 CPT Assistant answer is that multiple trigger point injections (more than 3) are billed under CPT code 20553, and not CPT code 20551 or 20552 as referenced in the question the 2017 CPT assistant answered. I reasoned since the question specifically carves out trigger point injections under CPT code 20551 and 20552, I was reluctant to extrapolate from the answer that CPT code 76942 is also limited to one unit when 3 or more

multiple trigger point injections are billed under CPT code 20553. However, subsequent inquiries to the AMA CPT knowledge base about whether appropriate it would be appropriate to report multiple units of code 76942, if 3 or more trigger point injections (20553) are performed yielded an answer that it would be appropriate to report code 76942 once per operative session regardless of the number of injections performed. This question and answer were subsequently codified in the May 2024 CPT Assistant. While Respondent's counsel presents a plethora of arguments that the CPT Assistant should not be considered authoritative in no-fault matters, I find the arguments without merit. The CPT Assistant is incorporated by reference into the New York State Workers' Compensation Medical Fee Schedule and any award without consideration to the CPT Assistant is incorrect as a matter of law. See, *Matter of Global Liberty Ins. Co. v. McMahon*, 172 A.D. 3d 500 (1 Dept. 2019). Therefore, Respondent's fee schedule defenses regarding the multiple reporting of 76942 is sustained. As such Applicant is only entitled to the 1 unit of the ultrasound guidance in the sum of \$231.36 which is what the Respondent paid. Applicant is not entitled to any further reimbursement for the additional units of ultrasound guidance. Accordingly, Applicant's claim is denied in its entirety.

Further, in the matter of Atlantic Medical & Diagnostic PC v. State Farm Mutual Automobile Ins. Co., AAA Case No.: 17-23-1305-7804 (2024), Arbitrator Nancy S. Linden dealt with this issue and stated:

Notably, Applicant has also submitted a statement speaking to the Knowledge Base Q & A submitted by Mr. Futoran. 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 its (sic) response that refers the requester to other payer types,

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.

In response to Mr. Miscoe's affidavit, Ms. Seidman points out in her affidavit that Mr. Miscoe is relying on an April 2005 CPT Assistant, yet the most recent volume pertaining to 76942 is from 2017, as of the writing of her affidavit, and, as advised by Respondent's counsel, is now from 2024.

Based on the foregoing, I find the arguments of Respondent's coder and counsel more compelling than that of Applicant's coder and counsel.

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 established its defense on this record. Applicant's claim is, therefore, denied.

As stated above, I have previously found the respondent's position to be persuasive based on a review of similar evidence that is submitted herein (see Eastern Medical Practice, P.C. v. Geico Ins. Co., AAA Case No.: 17-19-1149-7611 (2021)). I also note the "new developments" referenced by the respondent offer further support for the respondent's position.

Thus, I find the evidence submitted herein to be sufficient to sustain the respondent's position and to shift the burden to the applicant.

In the instant matter, the applicant submits an affidavit from Michael Miscoe, the "President and senior forensic coding and compliance auditor/expert of Practice Masters, Inc." Mr. Miscoe also asserts trigger point injections are properly billed per muscle(s) and not per injection(s).

I have previously reviewed Mr. Miscoe's affidavit and have found Mr. Miscoe persuasively addressed and rebutted the respondent's position regarding the use of CPT code 76942 per muscle and not per injection (see Macintosh Medical, P.C. v. Progressive Casualty Ins. Co., AAA Case No.: 17-21-1190-7381 (2022)).

I now alter my position, however, and find the portion of the AMA CPT Knowledge Base as well as the CPT Assistant article from May 2024 to be directly on point. I also find said sources to be authoritative on resolving previously unresolved fee schedule issues such as the one in dispute herein.

Further, I have previously reviewed the award of Macintosh Medical, P.C. v. Progressive Casualty Ins. Co., AAA Case No.: 17-21-1227-1715 (2022). In that matter, Arbitrator Michelle Murphy-Louden dealt with an almost identical dispute and requested an Independent Health Consultant (IHC) review the billing and submit an opinion regarding the proper rate of reimbursement.

The award makes reference to a report prepared by Joyce Ehrlich, CPC. Ms. Ehrlich stated the applicant was entitled to only one (1) unit of CPT code 76942. The award also makes reference to a response to Ms. Ehrlich's report from Mr. Miscoe. The award further makes reference to a response from Ms. Ehrlich that states:

Therefore, my question to Miscoe is why rely on a guidance that is not specific to the services provided by the Applicant, when one specific to the services exists. I maintain that CPT Assistant December 2017 is the appropriate guidance to use in determining the correct billing of these CPT codes. We are evaluating whether it is appropriate to report multiple units of code 76942 based on the number of trigger point injections. CPT Assistant December 2017 specifically answers that question ("76942 may only be reported once irrespective of the number of trigger point injections performed").

The applicant argues Ground Rule 3 from the 2018 New York Workers Compensation Radiology Fee Schedule proves the respondent's position is incorrect. The ground rule states:

Multiple Diagnostic Procedures

The following adjustments apply to all diagnostic services (70010-76499, 76506-76999, 77002-77003, and 78012-78999):

- 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.

Thus, the applicant argues the inclusion of a range of CPT codes that includes CPT code 76942 in the above-referenced ground rule supports the applicant's position that CPT code 76942 can be billed multiple times per date of service.

Although I have previously found that argument to be persuasive, as stated above I now find the portion of the AMA CPT Knowledge Base and the CPT Assistant article from May 2024 to be directly on point and authoritative.

I also agree with the respondent's position that the ground rule referenced above discusses the proper methodology to use when calculating the rate of reimbursement for a large range of codes. The ground rule does not specifically address the issue of whether CPT code 76942 can be billed more than once when used to provide guidance for a trigger point injection.

That issue, however, was specifically addressed in the AMA CPT Knowledge Base and the CPT Assistant article from May 2024.

Further, the applicant argues the language of the fee schedule is clear and there is no ambiguity on the issue of whether CPT code 76942 can be billed more than once per operative session. Thus, the applicant argues it is improper to look to the AMA CPT Knowledge Base or the CPT Assistant.

I disagree and find the willingness to not only answer the direct question at issue but to incorporate said answer into a CPT Assistant article proves that issue is not resolved by a plain reading of the fee schedule. I also find it would be unreasonable to simply ignore the AMA CPT Knowledge Base and the CPT Assistant article from May 2024 referenced above.

Thus, for the reasons stated above, the claims are denied.

In the instant matter, the respondent submits a fee schedule review from Leona Bender, CPC. Ms. Bender makes assertions similar to those referenced above.

Further, in the matter of Atlantic Medical & Diagnostic PC v. State Farm Mutual Automobile Ins. Co., AAA Case No.: 17-24-1332-6635 (2024), I stated:

In addition, the respondent submits a question from Ms. Mallory to the CPT Knowledge Base made in October 2023 and a response dated October 30, 2023. The response states:

This is in response to your Electronic Inquiry (EI) # 14566 dated October 29, 2023. From a CPT coding perspective and based upon the limited information provided in your inquiry, code 76942, Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation, may be reported only once regardless of the number of trigger point injections administered. The intent of code 76942 is for reporting per procedure (eg, biopsy, aspiration, injection). Essentially, the trigger point injection (20553) does not bundle imaging guidance, therefore, this may be separately reported, when performed.

You may also wish to contact your local third-party payers, as they may have additional information and requirements for reporting these codes.

The applicant argued the inclusion of "You may also wish to contact your local third-party payers, as they may have additional information and requirements for reporting these codes" proves that there is no definitive rule that CPT code 76942 can only be billed once per date of service when used for guidance for a trigger point injection.

I disagree. The applicant does not submit any evidence to show that the respondent has any "additional information and requirements for reporting these codes". The applicant further fails to submit sufficient persuasive evidence to support an argument that the fact some third party payers may have "additional information and requirements for reporting these codes" rebuts the clear language of the AMA CPT Knowledge Base, the May 2024 CPT Assistant article or the substance of the response to Ms. Mallory's inquiry.

I have reviewed the evidence submitted herein and see no reason to disturb my prior determination that only one (1) unit of CPT code 76942 is reimbursable per date of service when billed for guidance performed with a trigger point injection.

I have reviewed the evidence submitted herein and see no reason to disturb my prior determination.

Thus, the disputed claims are denied.

Further, as stated by the Supreme Court of the State of New York, County of New York in the matter of Country-Wide Ins. Co. v. Sayed Physical Therapy, P.C., 2022 NY Slip Op 31874(U) (Sup. Ct. NY County 2022):

It is not the duty of the arbiter, be it an arbitrator or Court, to parse [through] hundreds of pages of exhibits to make a out a claim or defense for a party (*see e.g. Barsella v. City of New York*, 82 A.D.2d 747, 748 [1st Dept 1981]); such duty belongs to counsel, as advocate. Failing to elucidate evidence in support of a party's claim is not error of the arbitrator but is rather error of counsel, and such failure does not render an arbitrator's award arbitrary and capricious (*see Stephen Fogel Psychological, P.C. v. Progressive Cas. Ins. Co.*, 35 A.D.3d 720, 721 [2d 2006]).

Thus, any issues not referenced above are held to be moot and/or waived insofar as they were not sufficiently raised at the time of the hearing.

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 CA
SS :
County of San Diego

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

09/11/2024
(Dated)

Josh Youngman

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:
a8d98525af2391029e47906ec5771364

Electronically Signed

Your name: Josh Youngman
Signed on: 09/11/2024