

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Atlantic Medical & Diagnostic PC  
(Applicant)

- and -

Country-Wide Insurance Company  
(Respondent)

AAA Case No. 17-24-1348-0934

Applicant's File No. 44524-568643

Insurer's Claim File No. 365913001

NAIC No. 10839

**ARBITRATION AWARD**

I, Anne Malone, 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 12/09/2024  
Declared closed by the arbitrator on 12/09/2024

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

Ellen Maisto, Esq. from Jaffe & Velazquez, LLP participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$4,810.90**, was AMENDED and permitted by the arbitrator at the oral hearing.

The amount claimed was amended by the applicant to \$3,450.90 to conform to the appropriate fee schedule. The respondent did not agree to this amended amount.

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

3. Summary of Issues in Dispute

The 43 year old EIP reported involvement in a motor vehicle accident on October 21, 2023; claimed related injury and underwent trigger point injection with guidance and office visit provided by the applicant on January 4, 2024 and February 15, 2024.

The applicant submitted a claim for these medical services, for which partial payment was made pursuant to the respondent's calculation of the correct reimbursable amount pursuant to the New York Workers' Compensation Medical Fee Schedule.

**The issue to be determined at the hearing is whether the respondent established its fee schedule defense.**

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

This hearing was held on Zoom and the decision is based upon the documents reviewed in the Modria File as well as the arguments made by counsel and/or representative at the arbitration hearing. Only the arguments presented at the hearing are preserved in this decision; all other arguments not presented at the hearing are considered waived.

The applicant billed a total of \$5,623.72 for the services at issue, for which the respondent made partial payment of \$812.82 pursuant to its calculation of the appropriate PA fee schedule, leaving a balance of \$4,810.90. At the hearing the applicant amended the amount in dispute to \$3,450.90 based on the PA fee schedule for the procedures at issue. The respondent contends that the correct reimbursable amount for this claim is an additional \$1,117.50.

The outstanding issue is the billing of multiple charges for CPT code 76942. The respondent contends that this code can only be billed once regardless of the number of trigger points performed. The applicant contends that when ultrasound guidance for needle placement is performed with respect to trigger point injections it may be reported

To prevail in a fee schedule defense, the respondent must demonstrate by competent evidentiary proof that applicant's claims were in excess of the appropriate fee schedules, or 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 145(A) (App. Term 1<sup>st</sup> Dept. 2006.)

An insurer fails to raise a triable issue of fact with respect to a defense that the fees charged were not in conformity with the Workers' Compensation fee schedule when it does not specify the actual reimbursement rates which formed the basis for its determination that the claimant billed in excess of the maximum

amount permitted. See St. Vincent Medical Services, P.C. v. GEICO Ins. Co., 29 Misc.3d 141(A), 907 N.Y.S.2d 441 (App. Term 2d, Dec. 8, 2010.)

A fee schedule defense does not always require expert proof. There are two fee schedule scenarios. The first involves the basic application of the fee codes and simple arithmetic. The second scenario involves interpretation of the codes and often requires testimony and evidence beyond that of a lay individual.

The respondent supported its fee schedule defense, based on the relevant portions of the New York State Workers' Compensation Medical Fee Schedule and the CPT Assistant. The fee schedule states that a PA can be reimbursed 80% of the charges for a physician and the CPT Assistant states that code 76942 "may only be report once, irrespective of the number of trigger point injections performed.."

Regarding the correct reimbursement for CPT code 76942, the applicant submitted the affidavit of Michael Miscoe, CPC, a certified professional fee coder who submitted a comprehensive report in which he discussed payment for the services at issue. In his affidavit, Mr. Miscoe acknowledges that reliance on the CPT Assistant is proper. He states in pertinent part: "[b]y 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 A.D.3d 60, 63-64, 4 N.Y.S.3d 267 [2d Dept. 2015], affd 27 N.Y.3d 22, 29 N.Y.S.3d 242, 49 N.E.3d 711 [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] ). Glob. Liberty Ins. Co. v. McMahon, 99 N.Y.S.3d 310, 311-12 (N.Y. App. Div. 1st Dept. 2019.)

The CPT Assistant includes a question and answer related to diagnostic radiology specifically with regard to reporting ultrasound guidance for trigger-point injections (20051, 20052.)

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: Code 96942 may only be reported once, irrespective of the number of trigger-point injections performed.

Although the respondent did not submit an affidavit from a certified professional fee coder, medical professional or other expert, I have taken judicial notice of the New York Workers' Compensation Medical Fee Schedule and the CPT Assistant.

An issue of fact remains as to the correct reimbursable amount for the ultrasound guidance for trigger point injections at issue. Conflicting opinions have been presented by both parties.

After a review of all the evidence submitted, I find that the respondent has established its fee schedule defense.

**Accordingly, the applicant is awarded \$1,117.50 in disposition of this claim.**

Any further issues submitted in the record are held to be moot and/or waived insofar as they were not raised at the time of this hearing. This decision is in full disposition of all claims for no-fault benefits presently before this Arbitrator.

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	01/04/24 - 01/04/24	\$2,405.45	\$1,725.45	Awarded: \$585.75
	Atlantic Medical & Diagnostic PC	02/15/24 - 02/15/24	\$2,405.45	\$1,725.45	Awarded: \$585.75
Total			\$4,810.90		Awarded: \$1,171.50

B. The insurer shall also compute and pay the applicant interest set forth below. 05/16/2024 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." See 11 NYCRR §64-3.9(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. Where a claim is untimely denied, or not denied or paid, interest shall accrue as of the 30<sup>th</sup> day following the date the claim is presented by the claimant to the insurer for payment. Where a claim is timely denied, interest shall accrue as of the date an action is commenced or an arbitration requested, unless an action is commenced or an arbitration requested within 30 days after receipt of the denial, in which event interest shall begin to accrue as of the date the denial is received by the claimant. 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 was timely. LMK Psychological Servs. P.C. v. State Farm Mut. Auto. Ins. Co., 12 NY3d 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. For cases filed after February 4, 2015 the attorney's fee shall be calculated as follows: 20% of the amount of first-party benefits awarded, plus interest thereon subject to no minimum fee and a maximum of \$1,360.00. See 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 CT

SS :

County of Fairfield

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

01/08/2025  
(Dated)

Anne Malone

### **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:**  
eaf12a07c848a9e97e5a3963de638529

### Electronically Signed

Your name: Anne Malone  
Signed on: 01/08/2025