

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Atlantic Medical & Diagnostic PC
(Applicant)

- and -

State Farm Fire & Casualty Company
(Respondent)

AAA Case No. 17-24-1353-0439

Applicant's File No. ACT24-182219

Insurer's Claim File No. 3259Q688D

NAIC No. 25143

ARBITRATION AWARD

I, Charles Blattberg, 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: Eligible injured person

1. Hearing(s) held on 01/08/2025
Declared closed by the arbitrator on 01/13/2025

Jared Mallimo, Esq. from The Licatesi Law Group, LLP participated virtually for the Applicant

Ryan Waxon, Esq. from Sarah C. Varghese & Associates participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,932.47**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant reduced the amount at issue to \$1,645.10 pursuant to fee schedule as described below.

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

3. Summary of Issues in Dispute

The claimant [VP] was a 31-year-old male who was injured in or by a motor vehicle on 11/17/23. Following the accident, the claimant sought treatment. After the amendment of the amount claimed at issue is whether Applicant was properly reimbursed for ultrasonic guidance and injectable materials provided on 4/23/24.

4. Findings, Conclusions, and Basis Therefor

Based on a review of the documentary evidence, this claim is decided as follows:

An applicant establishes a prima facie case of entitlement to reimbursement of its claim by the submission of a completed NF-3 form or similar document documenting the facts and amounts of the losses sustained and by submitting evidentiary proof that the prescribed statutory billing forms [setting forth the fact and the amount of the loss sustained] had been mailed and received and that payment of no-fault benefits were overdue. See, *Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004).

The claimant [VP] was a 31-year-old male who was injured in or by a motor vehicle on 11/17/23. There are no medical reports in evidence for the period 11/17/23-1/15/24. The 1/16/24 lumbar spine CT produced an impression of intact lumbar vertebral bodies and posterior elements; no fracture; subluxation at the L3/4 and L4/5 levels related to facet joint hypertrophy; Schmorl's nodules at the L2/3 and L3/4 levels. Bulging of the L5/S1 discs with focal central and left lateral herniation impingement of nerve roots as noted above. Bulges of the annulus fibrosis of the L3/4 and L4/5 discs, with prominence of ligamentum flavum and subluxation contributing to central stenosis at both levels. Normal contour of the L1/2 and L2/3 discs. There are no medical reports in evidence for the period 1/17/24-2/10/24. On 2/11/24 Joseph Jimenez, M.D. (surgeon) and Robert Robenov, PA-C (surgical assistant) performed L4-L5 and L5-S1 lumbar percutaneous discectomy, nucleus pulposus ablation, annuloplasty and disc injection and radiographic interpretation. There are no medical reports in evidence for the period 2/12/24-4/22/24. On 4/23/24 the claimant presented to Idy Liang, N.P. of Atlantic Medical & Diagnostic PC (Applicant) for a follow-up examination with complaints of cervical spine pain rated 8/10, right wrist pain rated 0/10, bilateral knee pain rated 7/10, thoracic spine pain rated 0/10, lumbar spine pain rated 8/10 and left shoulder pain rated 8/10. Nurse Liang supervised Outcome Assessment Testing. Nurse Liang conducted Ultrasound examination of the lumbar spine using Butterfly IQ+ transducer. Muscle patterns of lumbar spine are consistent with diffuse and focal echogenic deflections at paraspinal musculature. This pattern is highly suggestive of muscle spasms of musculature at bilateral L4-L5 and L5-S1. Nurse Liang performed lumbar trigger point injections under ultrasonic guidance, 6 sites. The 4/23/24 office visit and the 4/23/24 lumbar trigger point injections under ultrasonic guidance were at issue here. After the amendment of the amount claimed at issue is whether Applicant was properly reimbursed for ultrasonic guidance and injectable materials provided on 4/23/24.

Respondent timely partially paid for these services, raising fee schedule defenses as to the remainder. Respondent has the burden of coming forward with "competent evidentiary proof" supporting its fee schedule defenses. See, *Continental Med., P.C. v. Travelers Indem. Co.*, 11 Misc.3d 145a (2006). An insurer fails to establish the existence of an issue of fact with respect to a defense that fees charged were excessive and not in accordance with the Workers' Compensation fee schedule in the absence of proof establishing the defense. *St. Vincent Medical Care, P.C. v. Country Wide Ins. Co.*, 26 Misc.3d 146(A), 907 N.Y.S.2d 441 (Table), 2010 N.Y. Slip Op.50488(U), 2010 WL 1063914 (App. Term 2d, 11th & 13th Dists. Mar. 19, 2010). If Respondent fails to demonstrate by competent evidentiary proof that an applicant's claims were in excess of the appropriate fee schedules, Respondent's defense of noncompliance with the appropriate fee schedules cannot be sustained. See, *Continental Medical PC v. Travelers Indemnity Co.*, 11 Misc.3d 145A, 819 N.Y.S.2d 847, 2006 NY Slip Op 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Term, 1st Dep't, per curiam, 2006).

At the hearing, the amount at issue was amended to \$1,645.10. Applicant seeks the unpaid balance for the J codes billed (J1100, J0665 and J3490) totaling \$777.50. Applicant also seeks reimbursement for five units of CPT code 76942 at \$173.52 each [75 percent of \$231.36 per Radiology Ground Rule 3(c)]. Respondent paid for one unit of CPT code 76942 asserting that CPT code 76942 should be reimbursed only once per procedure. In support of its position Respondent uploaded the affidavit of Jeffrey Futoran, CPC. Essentially, Mr. Futoran contends that since Applicant is only entitled to reimbursement for one unit for CPT code 20553, which is a fact not disputed by Applicant, similarly, Applicant is only entitled to reimbursement of one unit of ultrasonic guidance. Mr. Futoran relies on the FAQ section of the December 2017 (Volume 27, Issue 12), CPT Assistant newsletter which reads as follows: "*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?*" The answer was: "*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.*" Mr. Futoran also relied in part on the "CPT Knowledge Base: Response for Electronic Inquiry #14680" dated December 28, 2023, which confirmed that the US guidance can only be reported once per session and that this provision includes CPT code 20553. Applicant's counsel noted that the "CPT Knowledge Base: Response for Electronic Inquiry #14680" is unsigned, contains disclaimers, and further that Radiology Ground Rule "3C" does not include CPT code 20553. I find that this resource is not discredited by how it is signed or by the disclaimers reflected therein. "CPT Knowledge Base: Response for Electronic Inquiry #14680" states: "*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 ...*" It states further that this rationale also applies to many other procedures, including injections, and that this provision is intended to include billing of CPT code 20553.

Applicant uploaded an affidavit by Michael Miscoe, CPC. As noted by Respondent's counsel Mr. Futoran's affidavit was based on a review of the specific billing at issue unlike Mr. Miscoe's general affidavit. Essentially, Mr. Miscoe asserts that there is no prohibition or restriction to the number of units billed under CPT code 76942. He states that any reliance upon the FAQ section of CPT Assistant is misplaced as this FAQ pertains to CPT code 20552 (injection one or two muscles) where CPT code 20553, the code utilized by Applicant, represents three or more injected muscles. He states that the determining factor in the number of units of CPT code 76942 that may be billed is the number of muscles injected rather than the number of injections. Mr. Miscoe also contends that when it comes to secondary sources, e.g., the CPT Assistant (and more specifically the FAQ Section of the CPT Assistant), the CPT Assistant newsletter is a rather expensive subscription publication that few outside the community of professional coders subscribe to. Ultimately, he opines that the CPT Assistant newsletter, especially the conclusions offered in the FAQ section, at best, offers merely persuasive opinion guidance relative to the appropriate coding of physician services in New York Workers' Compensation cases. He contends that these opinions are only relevant as a persuasive resource where the published opinion does not conflict with the guidance of the CPT Editorial Panel.

However, notice is taken of the holding 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], *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."

I concur with Arbitrator Jan Chow's detailed analysis in AAA Case No.: 17-21-1212-8163. There Arbitrator Chow determined:

"Although Applicant's coder contends that this excerpt does not address the distinction between the general number of injections versus the number of muscles receiving the injections, I find this very lack of distinction speaks volumes to the irrelevancy of the number of muscle sites injected. The question specifically referenced CPT 20552, a code that involves injections to 1-2 muscle sites. If the number of muscle sites were relevant

in determining the number of billable units for CPT 76942, the answer would have addressed this since the question included this issue via its reference to CPT 20552. Instead, the answer made it clear that only one unit is reportable with trigger point injection codes regardless of the number of injections or muscles injected.

Lastly, even though the April 2005 CPT Assistant stated that CPT 76942 should be reported per distinct lesion, the December 2017 CPT Assistant is clearly the more recent publication. Moreover, with CPT 76942 being applicable to other types of needle placements such as biopsy, aspirations and localization, the application of the April 2005 CPT excerpt is broad, while the December 2017 CPT excerpt is specific to trigger point injections, the disputed services at hand. As such, I find the December 2017 CPT Assistant to be more relevant in this matter."

Both parties uploaded copies of decisions from recent litigation arising from trials that were conducted on this issue in the Suffolk County District Court (favoring Applicant) and Bronx County Civil Court (favoring Respondent). See, *Atlantic Medical & Diagnostic, PC v. State Farm Mut. Auto. Ins. Co.*, District Court, Suffolk County, Second District, Lindenhurst, dated November 14, 2024 (Index No. CV-318-23/BA); *Atlantic Medical & Diagnostic, PC v. State Farm Mut. Auto. Ins. Co.*, District Court, Suffolk County, Second District, Huntington, dated December 12, 2024 (Index No. CV-6944-23/HU); *Macintosh Medical, PC v. State Farm Mut. Auto. Ins. Co.*, Civil Court of the City of New York, County of Bronx, dated January 8, 2025 (Index No. CV-723734-22/BX). The varying decisions have brought no clarity on this issue, just differing interpretations. These decisions lack precedential value and were based on testimony and evidence not presented here. I maintain my prior findings that only one unit of CPT code 76942 can be billed per date of service when also billing CPT code 20553. I agree with Respondent that it is appropriate to utilize extrinsic sources to analyze the issue here. While Applicant correctly noted that the individual code descriptors for CPT codes 76942 and 20553 are explicit, I find that it is the pairing of these two codes that raises an ambiguity warranting the use of an extrinsic source for clarification. Based on the above, I find that only one unit of CPT code 76942 is reimbursable.

As to the J codes billed (J1100, J0665 and J3490) Mr. Miscue argues that these medications were not "dispensed" by a pharmacy and should not be limited to the invoice or wholesale cost of the injected material. However, as noted by Mr. Futoran, Surgery Ground Rule 16 specifically states separately that "For pharmaceuticals administered by the medical provider in a medical office setting, payment shall not exceed the 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." Here, assignee submitted a purchase order with the invoice costs. Applicant's counsel argued that this purchase order was not current but it was received by Respondent on 4/10/24. Moreover, Applicant did not submit anything setting forth a different cost for these medications. Mr. Futoran concluded that the billed amounts were correctly paid based on the invoice costs. Here, the medications were administered and not dispensed, and it took place in an office setting at the provider's office. I find Mr. Futoran's analysis more persuasive with respect to the J codes.

Accordingly, the claim is denied in its entirety.

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

02/07/2025
(Dated)

Charles Blattberg

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:
828d9e4988e940987c125ff19bbd8e84

Electronically Signed

Your name: Charles Blattberg
Signed on: 02/07/2025