

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.	17-24-1348-0900
Applicant's File No.	445-PKT24-127419
Insurer's Claim File No.	364430
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 01/31/2025
Declared closed by the arbitrator on 01/31/2025

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, **\$4,946.39**, was AMENDED and permitted by the arbitrator at the oral hearing.

The amount claimed was amended by the applicant to \$2,530.20 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 32 year old EIP reported involvement in a motor vehicle accident on June 12, 2023, 2023; claimed related injury and underwent trigger point injections with guidance and office visits provided by the applicant on June 21, 2023 and July 26, 2023 and an office visit provided on August 30, 2023.

The applicant submitted a claim for these medical services. The claim for the office visit provided on August 30, 2023 was withdrawn with prejudice at the hearing. The respondent made partial payment of the remaining bills for June 21, 2023 and July 26, 2023 pursuant to its 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 \$4,946.39 for the services at issue, for which the respondent made partial payment of \$1,025.08. At the hearing, the applicant amended the amount in dispute to \$2,530.20 to reflect the payments made by the respondent with deductions for services provided by a PA. The respondent contends that the claim was paid in full pursuant to the applicable fee schedule.

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 multiple times.

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 1st 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, with the affidavit of Pamela Quigley, a National Certified Billing & Coding Specialist, who submitted a comprehensive analysis of the issues in this claim and determined that the correct reimbursable amount for the services at issue, performed by a PA is \$438.10.

Ms. Quigley determined that, pursuant to the Radiology Section of the New York Workers' Compensation Medical Fee Schedule and the NCCI only one unit is allowed for CPT code 76942 regardless of the number of needle placement performed. The NCCI states in pertinent part: "the unit of service for these codes is the patient encounter, not number of lesions, number of aspirations, number of biopsies, number of injections, or number of localizations.

Also, based on the relevant portions regarding reimbursement of Physician Assistants, of the New York State Workers' Compensation Medical Fee Schedule and the CPT Assistant, a PA can only be reimbursed 80% of the charges for a physician.

According to Ms. Quigley, the appropriate fee schedule includes no payment for code J094 which she determined should have been billed under CPT code 99070 pursuant to New York Workers Compensation Medical Fee Schedule which states: "[s]upplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided.)

Since this information was not provided by the applicant, it was Ms. Quigley's determination was that it was not reimbursable as billed.

In response to the fee coder affidavit by Ms. Quigley regarding the correct reimbursement for CPT code 76942 as it relates to CPT code 20553, the applicant submitted the affidavit of Michael Miscoe, Senior Forensic Coding and Compliance Auditor/Expert, 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 citation from the CPT Assistant Mr. Miscoe relies upon includes a question and answer related to diagnostic radiology specifically with regard to reporting ultrasound guidance for trigger-point injections (20051, 20052.)

Mr. Miscoe also included further documentation from the CPT Assistant regarding CPT code 76942 which allows for ultrasonic guidance twice for breast lesions, which is not relevant to the issue here.

The applicant included a copy of an unreported disposition of the District Court of Suffolk County, Third District, Decided on December 12, 2023 which determined that pursuant to a plain reading of the Radiology Section of the New York Workers' Compensation Fee Schedule allows for multiple units of CPT code 76942 when it is billed in conjunction with trigger point injections under CPT code 20553.

There is no mention of the CPT Assistant and its reference to this issue as it relates specifically to trigger point injections with ultrasonic guidance (CPT code 20553/76942 and CPT code 76942.)

After a review of all the evidence submitted an issue of fact remains as to the correct reimbursable amount for the services at issue. Conflicting opinions have been presented in the affidavit of Pamela Quigley, Certified Billing & Coding Specialist and the affidavit of Michael Miscoe, Senior Forensic Coding and Compliance Auditor/Expert, who submitted an affidavit on behalf of the applicant. I find that the submission of Ms. Quigley was more persuasive in this instance.

I am aware that there are numerous arbitration awards which support the arguments of this applicant and various defendants. However, based on the evidence submitted including reports from fee coder experts and the appropriate New York Workers' Compensation Medical Fee Schedule and CPT Assistant, I have determined that CPT code may only be reimbursed once regardless of the number of trigger point needle placements are performed.

Based on the foregoing, I find that the respondent has established its fee schedule defense.

Accordingly, this claim is dismissed with prejudice.

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 claim is DENIED in its entirety

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.

02/09/2025

(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:
54b4df7235499827ffb6776f82df9b06

Electronically Signed

Your name: Anne Malone
Signed on: 02/09/2025