American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Atlantic Medical & Diagnostic PC (Applicant)	AAA Case No.	17-24-1353-6959
	Applicant's File No.	ACT24-182471
- and -	Insurer's Claim File No.	3266M367N
	NAIC No.	25143
State Farm Mutual Automobile Insurance Company (Respondent)		

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 02/10/2025
   Declared closed by the arbitrator on 02/10/2025

   Andrew Leahy, Esq. from The Licatesi Law Group, LLP 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, **$2,020.97**, was NOT AMENDED at the oral hearing.
   Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

   The 73 year old EIP reported involvement in a motor vehicle accident on April 23, 2024; claimed related injury and underwent trigger point injections with guidance and an office visit provided by the applicant on May 2, 2024 and May 4, 2024.

   The applicant submitted a claim for these medical services provided by a PA. The respondent contends that the claim is premature and was not ripe for arbitration at the time it was submitted.

The respondent denied this claim based on the applicant's failure to respond to verification requests within 120 days from the date of the initial request.

Nevertheless, the respondent made partial payment of this claim with interest pursuant to its calculation of the correct reimbursable amount pursuant to the New York Workers' Compensation Medical Fee Schedule for services at issue.

The respondent asserted a fee schedule defense.

The issues to be determined at the hearing are:

Whether the claim is premature.

Whether the respondent established its 120 day defense.

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.

<u>Premature submission of claim</u>

This claim involves medical services rendered on May 2, 2024 and May 5, 2024. It is the respondent's burden to prove that the claim at issue was properly denied.

The respondent timely submitted verification requests for an invoice for one of codes billed. The claim was received by the respondent on May 14, 2024 and the requests were dated June 5, 2024 and July 3, 2024.

The applicant filed this claim for arbitration on June 26, 2024 before responding to the verification requests.

Based on the foregoing, the claim was not ripe for arbitration while the verification requests were pending.

Although the applicant submitted a response to the verification requests on September 14, 2024, this claim should be denied without prejudice since it was not ripe for arbitration while the verification requests were still pending when the applicant filed for arbitration.

The parties acknowledged that the respondent made payment of $574.06 for this claim on January 21, 2025 based on its calculation of the correct reimbursable amount for the services provided based on the applicable fee schedule for services provided by an NP, and included interest for late payment of the claim.

The only remaining issue is whether the respondent established its fee schedule defense. After discussion of these issues at the hearing, I have decided to resolve the remaining fee schedule issue at this time.

Fee Schedule

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. I find that the claim at issue is analogous to the second scenario and requires expert testimony.

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.

The respondent supported its fee schedule defense, with the affidavit of Jeffrey Futoran, CPC, a certified professional fee coder who submitted a comprehensive analysis which included his opinion that CPT code 76942 is only reimbursable once in connection with trigger point injection billed under CPT code 20553. Mr. Futoran also analyzed payment for the office visit billed under CPT code 99204 and the three J codes which were reimbursable for a total of $2.62. Mr. Futoran did not include payment for the J codes in his determination of the total reimbursable amount since these charges were included in the denial of this claim based on a 120 day defense. Mr. Futoran determined that the correct

reimbursable amount for the services at issue, performed by a PA is $499.18. The respondent made payment of $574.06 which was the total amount for these charges with interest.

Payment for the J codes remains outstanding. The applicant billed $529.40 for these codes. Mr. Futoran determined that the total reimbursable amount for these codes, based on the Red Book AWP is $2.62.

In response to the affidavit by Mr. Futoran, regarding the correct reimbursement for payment for the services of an NP, CPT code 76942 as it relates to CPT code 20553 and the J codes billed, 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].)

Included in the affidavits is the question and answer from the CPT Assistant that refers specifically to the number of times that ultrasonic guidance (CPT code 76942) can be billed with trigger point injections (CPT code 20553) The answer to the question reported in the CPT Assistant is that CPT code 76942 can only be reported once regardless of the number of trigger point performed. Mr. Miscoe does not acknowledge that this is the correct reimbursable amount related to the claim at issue.

Mr. Miscoe mentions that services performed by an NP should be billed at 80% of the physician rate but does not provide the total amount that should be billed in this instance and does not discuss the correct reimbursable amount for the J codes included in this claim.

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 Jeffrey Futoran, CPC and by Michael Miscoe, Senior Forensic Coding and Compliance Auditor/Expert, who submitted an affidavit on behalf of the applicant. I find that the submission of Mr. Futoran 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, the appropriate New York Workers' Compensation Medical Fee Schedule and CPT Assistant, I have determined that CPT code 76942may only be reimbursed once regardless of the number of trigger point needle placements are performed.

Under these circumstances, I find that the respondent has established its fee schedule defense.

Based on the foregoing, the applicant is entitled to payment of $2.62 for the J codes, $114.81 in attorneys' fees and $40 filing fee.

Accordingly, the applicant is awarded $2.62 with interest and attorneys' fees as noted above.

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	Status
	Atlantic Medical & Diagnostic PC	**05/02/24 - 05/04/24**	**$2,020.97**	**Awarded: $2.62**
Total			**$2,020.97**	**Awarded: $2.62**

B. The insurer shall also compute and pay the applicant interest set forth below. 01/21/2025 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 30th 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.)

Applicant is awarded $114.81 in attorneys' fees.

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.

02/13/2025
(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:
e4077edef4b768febb9663084f9d73e5

Electronically Signed

Your name: Anne Malone
Signed on: 02/13/2025