

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Atlantic Medical & Diagnostic PC  
(Applicant)

- and -

Allstate Insurance Company  
(Respondent)

AAA Case No. 17-24-1334-7103

Applicant's File No. M23-741629

Insurer's Claim File No. 0719772633

NAIC No. 29688

**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 04/14/2025  
Declared closed by the arbitrator on 04/14/2025

James Errera, Esq. from Shapiro & Associates, P.C. participated virtually for the  
**Applicant**

Angela Venetsanos, Esq. from Law Offices of John Trop participated virtually for the  
**Respondent**

2. The amount claimed in the Arbitration Request, **\$2,475.15**, was AMENDED and permitted by the arbitrator at the oral hearing.

The amount claimed was amended by the applicant to \$1,770.42 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 29 year old EIP reported involvement in a motor vehicle accident on June 29, 2023; claimed related injury and underwent an office visit on July 12, 2023 and an office visit and trigger point injection with guidance provided by the applicant on July 26, 2023.

The applicant submitted a claim for these medical services, payment of which was denied for the following reasons:

The respondent contends that the bill for date of service July 12, 2023 was not received.

Payment of the bill for date of service July 26, 2023 was delayed pending verification requests for documents and information.

The verification requested included information regarding this claim and the business practices of the applicant.

The respondent also asserted a fee schedule defense.

**The issues to be determined at this hearing are:**

**Whether the applicant sustained its burden to establish a *prima facie* case of entitlement to no-fault benefits for date of service July 12, 2023.**

**Whether the respondent established that the claim for date of service July 26, 2023 is premature.**

**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.

Applicant's *prima facie* entitlement to no fault benefits for date of service July 12, 2023

It is well settled that an applicant establishes its *prima facie* entitlement to no-fault benefits by submitting evidentiary proof that the prescribed statutory billing forms had been mailed, received by the respondent 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 (2d Dept. 2004.)

The applicant has met its initial burden to establish that the "prescribed statutory billing forms had been mailed and received by the respondent" by submitting a certificate of mailing from the U.S. Post Office to establish that the bill for date of service July 12, 2023 was timely mailed on July 21, 2023.

The respondent did not submit an affidavit or other evidence to establish non-receipt of the bill for services rendered on July 12, 2023.

Based on the foregoing, the applicant has established its *prima facie* entitlement to no fault benefits for date of service July 12, 2023.

Since there was no denial of the claim for services rendered on July 12, 2023, the applicant is entitled to interest from August 26, 2023.

**Therefore, the applicant is awarded \$114.10 for services rendered on July 12, 2023 with interest calculated from August 26, 2023.**

Outstanding verification for services rendered on July 26, 2023

If an insurer requires any additional information to evaluate the proof of claim, such request for verification must be made within 15 business days of the receipt of the bill in order to toll the 30 day period to pay or deny the claim. See 11 NYCRR 65-3.5(b); See also New York Hosp. Med. Ctr. of Queens v. Allstate Ins. Co., 2014 NY Slip Op 00640 (2d Dept. 2014.)

Where there is a timely original request for verification, but no response to the original request for verification is received within 30 days, or the response to the verification request is incomplete, then the insurer, within 10 calendar days after the expiration of that 30 day period, must follow up with a second request for verification. Id.

If there is no response to the second or follow up request for verification, the time in which the insurer must decide whether to pay or deny the claim is indefinitely tolled. Id.

Therefore, when a no-fault medical service provider fails to respond to the requests for verification the claim is premature and should be denied without prejudice.

In the instant matter, the respondent sent timely verification requests to which the applicant did not submit a response.

In order to establish its defense, based on the applicable case law, the respondent was required to provide proof of mailing of the verification requests and an affidavit or other sufficient evidence to confirm that no response was received.

In Island Life Chiropractic, PC v Travelers Ins.Co., 64 Misc. 3d 143(A), 117 N.Y.S.3d 428 (App Term 2d Dept. 2019) the court held that "Where a no-fault insurer is relying on the defense that an action is premature because verification is outstanding, it is the defendant insurer's *prima facie* burden at trial to demonstrate (1) that verification requests were timely mailed and that the defendant did not receive the requested verification. (See 11 NYCRR 65-3.8[a]; Right Aid Medical Supply Corp. v State Farm Mut. Auto Ins. Co., 58 Misc 3d

140(A), 94 N.Y.S.3d 540 NY Slip OP 51875[U] (App Term 2d Dept, 2d, 11<sup>th</sup> & 13<sup>th</sup> Jud Dists (2017.)

In the instant matter, the respondent did not submit proof of mailing of the verification requests and did not submit evidence from someone with personal knowledge that a response was not received from the applicant.

Under these circumstances, the respondent failed to establish that the claim is premature and therefore, the time to pay or deny this bill at issue is not tolled.

**Therefore, an award will be issued in favor of the applicant pursuant to the applicable fee schedule.**

The applicant billed a total of \$2,475.15 which included charges for 2 office visits (\$114.10 July 7, 2023 and (\$55.06 July 26, 2023) and charges on July 26, 2023 for a trigger point injection (\$104.81), ultrasonic guidance (\$231.36 for first charge and \$338.00 - \$67.60 x 5 for the other charges) and \$397.50 for code J1094.

At the hearing, the amount in dispute was amended to \$1,770.42 to reflect a deduction for services provided by a PA.

The respondent contends that there should be no charge for the July 21, 2023 office visit since the bill was not received. I have already determined that the respondent has not established this defense.

The respondent contends that the correct reimbursable amount for the all the services, including the J code provided on July 26, 2023 is \$545.89, pursuant to the New York Workers' Compensation Medical Fee Schedule.

The outstanding issues are the correct reimbursable amount for the J Code and the billing of multiple charges for CPT code 76942 for ultrasonic guidance related to the performance of trigger point injections billed under CPT code 20553. 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 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. I find that the fee schedule issue presented in this case is analogous to the latter scenario and requires an expert's opinion.

The respondent supported its fee schedule defense, with a generic affidavit of Carolyn Mallory, CPC, a certified professional fee coder who submitted a comprehensive analysis and determined that the total correct reimbursable amount for the services at issue is \$545.89. This includes the reimbursable amount for a trigger point injection with ultrasonic guidance performed by a PA is \$505.33 and code J1094 billed under CPT code 99070 is \$40.56.

This affidavit, while not directly related to the claim at issue in this matter, involves the same billing for these services performed by a PA and includes the Redbook product details related to the drugs injected in this case.

In relation to billing multiple units of ultrasonic guidance with trigger point injections, Ms. Mallory refers specifically to the CPT Assistant and this question and answer:

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: "No, code 96742, 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."

According to Ms. Mallory, the same response to this question was given on 10/30/2023 regarding code 20553 because it was not included in the 2017. CPT 76942 can only be billed once regardless of the number of trigger point injections administered.

Regarding the J code, Ms. Mallory relied upon Ground Rule 16 in the surgery section of the New York Workers' Compensation fee schedule which allows for supplies and materials provided "over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies or materials provided)." "Payment shall not exceed the invoice cost of the item..." These can be reported separately using CPT code 99070.

Ms. Mallory used the Redbook as a source to determine the correct reimbursement of 99070 and determined that it is \$40.56.

In response to the fee coder affidavit by Carolyn Mallory, CPC 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. McMahan, 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 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 Carolyn Mallory, CPC on behalf of the respondent 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 the respondent's expert 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.

**Therefore, the applicant is awarded \$545.89 for services rendered on July 26, 2023.**

**Accordingly, the applicant is awarded a total of \$659.99 in disposition of this claim with additional interest for date of service July 21, 2023 as indicated 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	Amount Amended	Status
	Atlantic Medical & Diagnostic PC	07/12/23 - 07/26/23	\$2,475.15	\$1,770.42	Awarded: \$659.99
Total			\$2,475.15		Awarded: \$659.99

- B. The insurer shall also compute and pay the applicant interest set forth below. 01/31/2024 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.

04/15/2025  
(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:**  
a7bb5a3edcdb196f22e3f38b8c2de65a

### **Electronically Signed**

Your name: Anne Malone  
Signed on: 04/15/2025