

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Atlantic Medical & Diagnostic PC
(Applicant)

- and -

The Standard Fire Insurance Company
(Respondent)

AAA Case No. 17-24-1355-0126

Applicant's File No. JL24-135501

Insurer's Claim File No. 272 PP
IWN7432 002

NAIC No. 19070

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 03/31/2025
Declared closed by the arbitrator on 03/31/2025

Andrew Leahy, Esq. from The Licatesi Law Group, LLP participated virtually for the Applicant

Liz Souza, Esq. from Law Offices of Tina Newsome-Lee participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$5,575.44**, was AMENDED and permitted by the arbitrator at the oral hearing.

The amount claimed was amended by the applicant to \$4,199.60 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 59 year old EIP reported involvement in a motor vehicle accident on December 17, 2023; claimed related injury and underwent office visits and trigger point injections with guidance provided by the applicant on March 5, 2024 and April 16, 2024.

The applicant submitted a claim for these medical services, payment of which was denied by the respondent on the grounds that there was no coverage for this claim because the applicant was not properly licensed.

The respondent also asserted a fee schedule issue.

The issues to be determined at the hearing are:

Whether the respondent established its coverage defense.

Whether the respondent established its fee schedule defense.

4. Findings, Conclusions, and Basis Therefor

This 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.

Coverage

The claim at issue was denied on the grounds that there was no coverage for this claim because the applicant was not properly licensed.

The NF-10 states in pertinent part:

CLAIM IS DENIED BASED ON INFORMATION AND
BELIEF THAT THE APPLICANT-PROVIDER IS NOT
PROPERLY LICENSED IN ACCORDANCE WITH
APPLICABLE NEW YORK STATE OR LOCAL LAW
LICENSING REQUIREMENT NECESSARY TO PERFORM
SUCH SERVICE IN NEW YORK AND, THEREFORE,
IS INELIGIBLE FOR REIMBURSEMENT OF NO-FAULT
BENEFITS UNDER THE NO-FAULT AND IMPLEMENTING
REGULATIONS (SEE SECTION 65-3.16 (12); ARTICLE 15 OF
THE BCL); THAT THE BILLED FOR

SERVICES WERE NOT PROVIDED AS BILLED; THAT THE BILLED FOR

SERVICES WERE PROVIDED IN SUCH A WAY THAT WAS NOT IN ACCORDANCE WITH THE APPLICABLE STANDARD OF CARE AND THEREFORE WAS NOT PROVIDED AS BILLED; THE SERVICES WERE PROVIDED WERE THE RESULT OF AN IMPROPER REFERRAL UNDER

SECTION 238-A, ET AL., OF THE PUBLIC HEALTH LAW.

In this matter, the respondent failed to provide any documentation to support this defense.

Therefore, the respondent failed to establish its coverage defense.

Fee Schedule

In this matter, the respondent denied payment for the services at issue based on its coverage defense. I have already determined that the respondent has failed to establish its defense of a lack of medical necessity. The only remaining issue is the appropriate reimbursable amount for these services pursuant to the New York Workers' Compensation Chiropractic 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.

The respondent contends that the correct reimbursable amount for the services at issue is \$876.20 (\$438.10 for each date of service.)

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.

Other fee schedule issues include billing for CPT code 99358 and reimbursement for J codes.

The respondent supported its fee schedule defense, with the affidavit of Erin Hale, CPC, a certified professional fee coder who submitted a comprehensive analysis and determined that the correct reimbursable amount for the services at issue, performed by a PA is \$438.10 for each date of service for a total of \$876.20.

Ms. Hale 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 placements 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's Assistants, of the New York State Workers' Compensation Medical Fee Schedule and the CPT Assistant, a PA or NP can only be reimbursed 80% of the charges for a physician.

Ms. Hale's calculations included reimbursement for services rendered by a PA of \$101.93 for the office visit billed under CPT code 99214; trigger point injection billed under CPT code 20553 \$104.81; ultrasonic guidance billed under CPT code 76942 \$231.36 - allowed only once regardless of the number of trigger points billed for a total of \$438.10 for each date of service.

Ms. Hale noted that the applicant did not charge for CPT code 99358 for date of service on March 5, 2024 and listed this code on the bill for date of service April 16, 2024 with a charge of \$0.00. Therefore, she indicated \$0.00 reimbursement for this code.

Finally, Ms. Hale stated that since no invoice was attached for the 3 J codes she was unable to recommend any reimbursement.

However, the respondent did not request any invoices for these charges and therefore it did not establish a fee schedule defense for the charges for J1100, J0665 and J3490. Therefore, it is appropriate to award \$794.10 for the injections billed for each date of service for a total of \$1,588.20.

Based on the foregoing, the applicant would be entitled to a total of \$2,464.40 for the claim for services rendered on March 5, 2024 and April 16, 2024.

In response to the fee coder affidavit by Erin Hale, 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. 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 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 codes 20553, 76942 and CPT code 76942.)

Mr. Miscoe discussed the rules related to the pharmaceuticals that were provided in this claim and identified CPT code 99070 referenced in Surgery Ground Rule 1B.

Mr. Miscoe did not discuss the fact that the services at issue were provided by a PA and that these charges are reimbursable at 80% of the physician's charges and did not provide any total amount of reimbursement allowed for the medical services and pharmaceuticals billed by the applicant.

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 Erin Hale, CPC 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 Erin Hale, CPC, 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, the applicant is awarded \$2,464.40 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	03/05/24 - 03/05/24	\$2,787.72	\$2,099.80	Awarded: \$1,232.20
	Atlantic Medical & Diagnostic PC	04/16/24 - 04/16/24	\$2,787.72	\$2,099.80	Awarded: \$1,232.20
Total			\$5,575.44		Awarded: \$2,464.40

- B. The insurer shall also compute and pay the applicant interest set forth below. 07/05/2024 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 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.)

- 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.

04/29/2025
(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:
bce1743823624be1322456dfa4618eb

Electronically Signed

Your name: Anne Malone
Signed on: 04/29/2025