American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Atlantic Medical & Diagnostic PC (Applicant)	AAA Case No.	17-25-1403-8147
	Applicant's File No.	ACT25-218604
- and -	Insurer's Claim File No.	700879214212
	NAIC No.	34339
Farmers 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 06/08/2026
   Declared closed by the arbitrator on 06/08/2026

   Rachel Stein, Esq. from The Licatesi Law Group, LLP participated virtually for the Applicant

   Lisa Annibale, Esq. from Law Offices of Rothenberg & Romanek participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$2,020.97**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The amount claimed was amended by the applicant to $1,549.14 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 34 year old EIP, reported involvement in a motor vehicle accident on March 24, 2025; claimed related injury and underwent trigger point injection with guidance provided by the applicant on April 3, 2025.

The applicant submitted a claim for these medical services, payment of which was timely denied by the respondent based upon a peer review by Samuel Carli, M.D. dated June 26, 2025. In response, the applicant submitted a rebuttal dated December 29, 2025 by Viviane Etienne, M.D. who was one of the EIP's treating medical providers.

The respondent also asserted a fee schedule defense.

The issues to be determined at the hearing are:

Whether the respondent established that the medical services at issue were not medically necessary.

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 from 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.

Medical Necessity

The respondent denied payment for the aforementioned services for a lack of medical necessity.

In order to support a lack of medical necessity defense respondent must "set forth a factual basis and medical rationale for the peer reviewer's [or examining physician's] determination that there was a lack of medical necessity for the services rendered."

Provvedere, Inc. v. Republic Western Ins. Co., 2014 NY Slip Op 50219(U) (App. Term2d, 11th and 13th Jud. Dists. 2014.) Respondent bears the burden of production in support of its lack of medical necessity defense, which if established shifts the burden of persuasion to applicant. See Bronx Expert Radiology, P.C. v. Travelers Ins. Co., 2006 NY Slip Op 52116 (App. Term 1st Dept. 2006.)

The Civil Courts have held that a defendant's peer review or report of medical examination must set forth more than just a basic recitation of the expert's opinion. The trial courts have held that a peer review or medical examination report's medical rationale will be insufficient to meet respondent's burden of proof if: 1) the medical rationale of its expert witness is not supported by

evidence of a deviation from "generally accepted medical" standards; 2) the expert fails to cite to medical authority, standard, or generally accepted specifics as to the claim at issue, is conclusory or vague. See Nir v. Allstate, 7 Misc.3d 544 (N.Y. City Civ. Ct. 2005.)

In support of its contention that the medical services provided by the applicant were not medically necessary, respondent relies upon the report of the peer review by Dr. Carli, who reviewed the medical records of the EIP and noted the injuries claimed and the treatment rendered to him. Dr. Carli considered possible arguments and justification for the need for the medical services at issue and determined that they were not warranted under the circumstances presented.

Dr. Carli discussed the medical standard of care for the injuries sustained by the EIP and determined that the trigger point injection at issue did not meet these criteria. It was his opinion that the efficiency of trigger point injection is debatable.

Dr. Carli determined that the documentation provided by the applicant is insufficient to support distinct trigger points and the clinical examination of the EIP was not indicative of trigger points and therefore, the injections were not medically necessary.

He supported, with relevant medical literature, his opinion that the medical services provided to the EIP were not medically necessary.

Respondent has factually demonstrated that the services at issue were not medically necessary. Accordingly, the burden now shifts to the applicant, who bears the ultimate burden of persuasion, pursuant to Bronx Expert Radiology, P.C., *supra.*

In opposition to the peer review, the applicant presented a rebuttal by Dr. Etienne, who had examined the EIP on April 3, 2025 and noted various areas of pain with tenderness to palpation, reduced range of motion and positive objective testing.

Dr. Etienne stated that a diagnosis of trigger points is not subjective and that in this case they were confirmed by physical examination and ultrasound.

After a review of all the evidence submitted an issue of fact remains as to whether the services rendered are medically necessary. Conflicting opinions have been presented in the peer review by Dr. Carli and the report of Dr. Etienne who submitted a rebuttal on behalf of the applicant.

I find that the applicant submitted a rebuttal which meaningfully refers to and rebuts the findings of Dr. Carli. In addition, the medical reports submitted contradict the assertions made by him and are sufficient to overcome the burden of production established by the respondent.

Based on the foregoing, I find that the respondent has failed to establish that the medical services at issue were not medically necessary.

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

Fee Schedule

The respondent denied payment of this claim based on a lack of medical necessity. I have already determined that the respondent did not establish this defense. The remaining issue is the correct reimbursable amount based on the New York Worker's Compensation Medical Fee Schedule.

According to the AR-1 the applicant billed a total of $2,020.97 for the services at issue, for which the respondent made partial payment of $163.01 for services provided by a PA.

At the hearing, the applicant amended the amount in dispute to $1,549.14 to conform to the appropriate fee schedule deduction for services provided by a PA.

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 Katie Van Camp, 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 $738.58. This includes payment in full for the J codes billed by the applicant.

She 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 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.

In response to the fee coder affidavit by Katie Van Camp, 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 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 , 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 Katie Van Camp, 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 $738.58 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	**04/03/25 - 04/07/25**	**$2,020.97**	**$1,549.14**	**Awarded: $738.58**
Total			**$2,020.97**		**Awarded: $738.58**

B. The insurer shall also compute and pay the applicant interest set forth below. 06/11/2025 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.)

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.

06/30/2026
(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:
93721ed5e3b32bff0fd9e3482b371066

Electronically Signed

Your name: Anne Malone
Signed on: 06/30/2026