

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Orthocare Surgical  
(Applicant)

- and -

Liberty Mutual Fire Insurance Company  
(Respondent)

AAA Case No.	17-18-1095-7153
Applicant's File No.	NF 25863
Insurer's Claim File No.	LA000-036132057-01
NAIC No.	23035

**ARBITRATION AWARD**

I, Gregory Watford, 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: Assignor (GR)

1. Hearing(s) held on 03/12/2019  
Declared closed by the arbitrator on 03/12/2019

Michael Manfredi, Esq. from Law Office of Thomas Tona P.C participated in person for the Applicant

Herman Buchanan, Hearing Spec. from Liberty Mutual Fire Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 2,275.00**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant's counsel amended the amount in dispute to \$1,986.98.

Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

Whether Applicant established entitlement to No-Fault compensation for durable medical equipment provided to Assignor;

Whether Respondent made out a prima facie case of lack of medical necessity and, if so, whether Applicant rebutted it.

Whether Respondent established that Applicant billed in excess of the NY Fee schedule.

#### 4. Findings, Conclusions, and Basis Therefor

Applicant was represented by Michael Manfredi, Esq., who presented oral arguments and relied upon documentary submissions at the hearing. Respondent appeared by Herman Buchanan, Hearing Spec., who presented oral arguments and relied upon documentary submissions. I have reviewed the submissions and documents contained in the American Arbitration Association's ADR Center Electronic Case File (ECF). These submissions constitute the record in this case.

The dispute arises from the underlying automobile accident of September 3, 2017, in which the Assignor, a 43 year old male, was a driver. As a result of the impact he was transported to Mount Sinai Hospital where he complained of pain to the back. He was evaluated, given pain medication and released. He subsequently sought private medical attention where he complained of injuries to the head, neck, back, right shoulder and right knee. He was recommended to begin conservative care treatments including, chiropractic treatments, acupuncture, pain management and diagnostic testing. He was prescribed durable medical equipment.

On October 22, 2017, Assignor underwent an MRI scan of the right knee which revealed tear of posterior root attachment of the medial meniscus with a 1.5 cm septated parameniscal cyst, complex tear of anterior body and anterior horn of the lateral meniscus, anterior subcutaneous soft tissue swelling and edema consistent with recent trauma or bursitis.

On December 6, 2017, he had an orthopedic consultation with Dr. Randall Ehrlich where he complained of right knee pain. He was examined and diagnosed with right knee symptomatic traumatic internal derangement resulting from a motor vehicle accident. He was recommended for right knee arthroscopy.

On January 9, 2018, Assignor underwent an independent medical examination (IME) conducted by Dr. Richard Weiss where he was diagnosed with right knee sprain/strain which was resolving and he was recommended to continue with physical therapy treatments for the next six (6) weeks.

On January 18, 2018, Assignor underwent right knee surgery performed by Dr. Ehrlich. The post operative diagnoses were right knee medial and lateral meniscal tears, chondral injury of trochlea, patella, lateral femoral condyle, and medial femoral condyle, impinging osteophytosis inferior and superior patella, anterior interval contracture with suprapatellar adhesion formation, multiple chondral loose bodies in all three compartments and tricompartmental reactive synovitis. On that date, Dr.

Ehrlich prescribed Assignor durable medical equipment in the form of a CPM unit (E0935) for the right knee for 21 days and pneumatic compression device (DVT) unit (E0676) for 14 days.

Applicant submitted the bills to Respondent in the amended amount of \$1,986.98 under CPT codes E0676 (\$1,820.00) and E0660 (\$166.98). At the hearing Applicant withdrew the claim for \$130.00 under CPT code A9901. Respondent denied the claims based upon the peer review of Dr. Jules Hip Flores.

After reviewing the records, I find that Applicant established its prima facie case of entitlement to No-Fault compensation. See Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D.3d 742, 774 N.Y.S.2d 564 (N.Y. App. Div 2<sup>nd</sup> Dept. 2004). Therefore, the burden now shifts to the Respondent to demonstrate lack of medical necessity. See Alvarez v. Prospect Hosp., 68 N.Y.S.2d 320, 501 N.E.2d 572, 508 N.Y.S.2d [1986]; A.B. Medical Services v. Geico Ins. Co., 2 Misc 3d 26 [N.Y. App. Term 2<sup>nd</sup> and 11<sup>th</sup> Jud. Dists. 2003]).

If an insurer asserts that the medical test, treatment, supply or other service was medically unnecessary, the burden is on the insurer to prove that assertion with competent evidence such as an independent medical examination, a peer review or other proof that sets forth a factual basis and a medical rationale for denying the claim. (See A.B. Medical Services, PLLC v. Geico Insurance Co., 2 Misc. 3d 26 [N.Y. App. Term, 2<sup>nd</sup> & 11<sup>th</sup> Jud. Dists 2003]; Kings Medical Supply Inc. v. Country Wide Insurance Company, 783 N.Y.S. 2d at 448 & 452; Amaze Medical Supply, Inc. v. Eagle Insurance Company, 2 Misc. 3d 128 [N.Y. App. Term, 2<sup>nd</sup> and 11<sup>th</sup> Jud Dists 2003]). The courts have held that a peer review 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 medical practice as a medical rationale for his findings; and 3) the peer review report fails to provide specifics as to the claim at issue, is conclusory or vague. See, Jacob Nir, M.D. v. Allstate Insurance Co., 7 Misc. 3d 544 (N.Y. City Civ. Ct. 2005).

Dr. Hip-Flores reviewed documents including the hospital records, initial evaluation reports, medical records, follow-up evaluation reports, and diagnostic test results. He then outlined the treatment of the Assignor. Regarding the DME prescribed in this case Dr. Hip-Flores and stated *"pneumatic compression devices have been medically proven to be effective and are considered medically appropriate when used in the home for deep vein thrombosis prophylaxis after major surgery, including major orthopedic surgery, in patients when pharmacological prophylaxis is contraindicated."* He cited to medical literature to support his argument. According to the medical literature, major surgery includes *"total hip arthroplasty (THA), total knee arthroplasty (TKA), or hip fracture surgery (HFS)."*

Addressing the DME prescribed in this case, Dr. Hip-Flores opined: *"In this clinical setting, the available medical records suggest that the claimant had undergone right knee surgery on 01/18/2018. As per the above mentioned citation pneumatic*

*compression device is recommended after major surgeries which include total hip arthroplasty, total knee arthroplasty or hip fracture surgery and not the knee arthroscopy. In addition, there was no documentation which substantiates that there was a contraindication to pharmacological prophylactic treatment. Hence, based on above cited guideline and available medical records, pneumatic compression device provided to the claimant was not medically necessary." He further stated "In this clinical setting, pneumatic compression device was not medically necessary. Hence, DME delivery, set up, and/or dispensing service was also not medically necessary at that time."*

Every peer review requires individual scrutiny to determine whether the burden should be shifted back to the claimant to submit contrary expert proof. The conclusory opinions of the peer reviewer, standing alone and without support of medical authorities, will not be considered sufficient to establish the absence of medical necessity. (See, Amaze Medical Supply Inc. v. Eagle Ins. Co., 2 Misc.3d 128(A), 784 N.Y.S.2d 918 (Table), 2003 N.Y. Slip Op. 51701(U), 2003 WL 23310886 (N.Y. App. Term 2<sup>nd</sup> & 11<sup>th</sup> Dists. Dec. 24, 2003).

I find that the peer review of Dr. Hip-Flores has failed to set forth a prima facie case that the disputed DME prescribed in this case were not medically necessary. I find that the sole authority relied upon by Dr. Hip-Flores regarding the DME was the Excellus medical policy guidelines which, by itself is not persuasive medical authority to this arbitrator. Consequently, I find that the generally accepted medical standard of care for prescribing the DME in question was not sufficiently and persuasively established by Dr. Hip-Flores.

Based upon the foregoing I find that Respondent has not sufficiently established a prima facie defense that the durable medical equipment prescribed in this case was not medically necessary. Consequently, the burden does not shift to Applicant to rebut Respondent's proof.

### **Fee Schedule**

Since the denials were timely issued and Box 18 was checked, Respondent preserved its fee schedule defense. See Triboro Chiropractic and Acupuncture, PLLC v. New York Central Mutual Fire Insurance Co., 6 Misc.3d 132(A), N.Y. Slip Op. 50110(U), 2005 WL 265151 (N.Y. App. Term 2<sup>nd</sup> & 11<sup>th</sup> Dists. Feb. 2, 2005). Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. Continental Medical PC v. Travelers Indemnity Co., 11 Misc.3d 145A, 819 N.Y.S.2d 847, (N.Y. App. Term, 1<sup>st</sup> Dep't, 2006); Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 13 Misc.3d 172, 822 N.Y.S.2d 378, (Civil Ct, Kings Co. 2006).

The "burden remains on the insurer to assert a defense that a provider billed in excess of the fee schedule." East Coast Acupuncture, PC v. Hereford Insurance Company, 51 Misc. 3d 441, 26 N.Y.S. 3d 441, 443 (Civil Ct. Kings County 2016) (holding that the new regulation "does not place any additional requirements on the medical provider, such as a requirement, in the general case, to substantiate the calculation of its fees).

I take judicial notice of the Worker's Compensation fee schedule. See Kingsbrook Jewish Medical Center the Allstate Insurance Company, 61 AD 3d 13 (N.Y. App. Div. 2<sup>nd</sup> Dept. 2009); LVOV Acupuncture PC v. Geico Insurance Company, 32 Misc. 3d 144 (A) (N.Y. App. Term 2<sup>nd</sup>, 11<sup>th</sup> and 13<sup>th</sup> Jud. Dists. 2011). Natural Acupuncture Health PC v. Praetorian Insurance Company, 30 Misc. 3d 132 (A), 2011 N Y slip op 50040 (U), (N.Y. App. Term 1<sup>st</sup> Dept. 2011).

Respondent submitted a fee audit by Robert Phillips, CPC, who discussed the amounts billed under CPT codes E0676, E0660 and A9901. As previously stated, Applicant withdrew the claim under CPT code A9901.

According to Mr. Phillips, CPT code E0660 under the DME fee schedule is reimbursed at \$166.98. I find that Mr. Phillips' assertion is correct. Applicant is awarded \$166.98 under CPT code E0660.

According to Mr. Phillips, he opined that did not have sufficient information to determine the rental rate for CPT code E0676.

*"The Workers' Compensation Board has adopted the NYS Medicaid durable medical equipment (DME) fee schedule. Per the New York State Medicaid program, the rental payment must not exceed the lower of the monthly rental charge to the general public or the price determined by the DOH. For DME items that have been assigned a Maximum Reimbursement Amount (MRA), the rental fee is 10% of the listed MRA. For DME items that do not have a MRA, the rental fee is calculated at 1/6th of the equipment provider's acquisition cost. Per the New York State Medicaid program, the reimbursement for purchase of DME must not exceed the lower of the price as shown in the fee schedule for durable medical equipment; or the usual and customary price charged to the general public. Reimbursement of DME with no price listed in the fee schedule must not exceed the lower of the acquisition cost (by invoice to provider) plus 50%; or the usual and customary price charged to the general public."*

*"Provider billed for equipment for which there is no established NYS Medicaid fee and has not submitted a manufacturer's invoice to support the acquisition cost. Based on the above and available information, reimbursement consideration cannot be determined for code E0676 rental in accordance with the codes/fees/ground rules of the NYS Fee Schedule."*

Applicant's counsel argued that Respondent could have requested additional verification in order to obtain the information to determine the amount that is reimbursable under CPT E0676.

Respondent has provided no support or authority for the fact that just because an item is not specifically listed in the DME fee schedule, that it is not reimbursable. The "burden remains on the insurer to assert a defense that a provider billed in excess of the fee schedule." East Coast Acupuncture, PC v. Hereford Insurance Company, 51 Misc. 3d 441, 26 N.Y.S. 3d 441, 443 (Civil Ct. Kings County 2016) (holding that the new regulation "does not place any additional requirements on the medical provider, such as

a requirement, in the general case, to substantiate the calculation of its fees). Moreover, Respondent could have requested verification from Applicant seeking information regarding the DME that is not included in the fee schedule in order to properly evaluate Applicant's claim. Bronx Acupuncture Therapy, Pc v. Hereford Ins. Co., 2017 NY Slip Op 50101 (N.Y. Appellate Term, 2<sup>nd</sup> Dept. 2017). However, Respondent chose not to do so.

Based upon the foregoing, Applicant is awarded \$1,820.00 under CPT Code E0676.

Therefore, Applicant is entitled to a total award of \$1,968.98.

This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator. Any further issues raised in the hearing record are held to be moot, without merit, and/or waived insofar as not raised at the time of the hearing.

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
	Orthocare Surgical	01/23/18 - 01/23/18	\$2,275.00	\$1,986.98	Awarded: \$1,986.98
Total			\$2,275.00		Awarded: \$1,986.98

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- B. The insurer shall also compute and pay the applicant interest set forth below. 05/18/2018 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant's award shall bear interest at a rate of two percent per month, calculated on a pro rata basis using a 30-day month from the date payment became overdue to the date of the payment of the award pursuant to 11 NYCRR 65-3.9. The end date for the calculation of the period of interest shall be the date of payment of the claim. General Construction Law § 20 ("The day from which any specified period of time is reckoned shall be excluded in making the reckoning.")

Where a claim is timely denied, interest shall begin to accrue as of the date arbitration is requested by the claimant unless arbitration is commenced within 30 days after receipt of the denial, in which event interest shall begin to accrue as of the 30th day after proof of claim was received by the insurer. 11 NYCRR 65-4.5(s)(3), 65-3.9(c); Canarsie Medical Health, P.C. v. National Grange Mut. Ins. Co., 21 Misc.3d 791, 797 (Sup. Ct. New York Co. 2008) ("The regulation provides that where the insurer timely denies, then the applicant is to seek redress within 30 days, after which interest will accrue.")

Applicant initiated the instant arbitration on 5/18/18 which is not within 30 days of the denial in this case.

C. Attorney's Fees

The insurer shall also pay the applicant for attorney's fees as set forth below

Respondent shall pay Applicant a separate attorney's fee, in accordance with 11 NYCRR 65-4.6(d). Since the within arbitration request was filed on or after February 4, 2015, this case is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant an attorney's fee, in accordance with 11 NYCRR 65-4.6(d) subject to a maximum fee of \$1,360.

- 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 New York  
SS :  
County of Nassau

I, Gregory Watford, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

04/11/2019  
(Dated)

Gregory Watford

### **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:**  
acb048123ff1a52bf9504c3361df9538

### **Electronically Signed**

Your name: Gregory Watford  
Signed on: 04/11/2019