

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

CPM Medical Supply Inc
(Applicant)

- and -

State Farm Mutual Automobile Insurance
Company
(Respondent)

AAA Case No. 17-18-1109-2080

Applicant's File No. NA

Insurer's Claim File No. 32-1990-L23

NAIC No. 25178

ARBITRATION AWARD

I, Victor Moritz, 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: IP

1. Hearing(s) held on 10/31/2019
Declared closed by the arbitrator on 10/31/2019

Marc Schwartz, Esq. from Marc L. Schwartz P.C. participated in person for the Applicant

Tara Gutman, Esq. from Goldberg, Miller and Rubin, P.C. participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 4,269.86**, 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

Was the applicant entitled to reimbursement for the rental cost of the continuous passive motion (CPM) machine and cold-water circulating unit (CTU) provided to the IP (S.A. 46 year old male) for use from February 7 through March 20, 2018, relative to an October 10, 2017 motor vehicle accident? The respondent denied this claim based on the purported failure of the applicant to provide responses to verification. The respondent also alleged a fee schedule defense, which is related to the outstanding verification items. Accordingly, this matter is determined after reviewing the submissions and presentations of both sides. I have reviewed the documents contained in the electronic case folder as of the closing of the file.

4. Findings, Conclusions, and Basis Therefor

I find for the applicant and I award the sum of \$4,269.86 for the rental cost of the CPU and CTU items at issue.

It is well settled that an applicant established its prima facie entitlement to payment by proving it submitted a claim set forth the facts and the amount of the loss sustained and that payment of no fault benefits were overdue (see Insurance Law § 5106[a]; Viviane Etienne Med. Care v Country-Wide Ins. Co., 25 NY3d 498, 501 (2015); Countrywide Ins. Co. v. 563 Grand Medical PC 50 A.D. 3d. 313 (1st Dep't, 2008); Sunshine Imaging Assoc./WNY MRI v. Geico. Ins. Co., 66 A.D. 3d. 1419 (4th Dep't, 2009). A facially valid claim is presented when it sets forth the name of the patient; date of accident; date of the services; description of services rendered and the charges for those services. See Vinings Spinal Diagnostic PC v. Liberty Mutual Insurance Company, 186 Misc. 2d 287 (1st Dist. Ct. Nass. Co.1996). The applicant has met its prima facie burden.

Legal Principles

11 NYCRR 65-3.8(c) states the defendant was required either to pay or deny the plaintiff's claims within 30 calendar days after proof of claim was received. An insurer which fails to properly deny a claim within 30 days as required by these statutory provisions may be precluded from interposing a defense to the claim. Presbyterian Hospital v. Aetna Cas. & Sur. Co., 233 A.D.2d 431, 432 (2nd Dept 1996) *lv. to app. den'd*, 90 N.Y.2d 802 (1997); Pradip Das/N.Y. Medical Rehab. P.C. v. Allstate Insurance Company, 746 N.Y.S.2d 262 (2nd Dept. 2002), Hosp. for Joint Diseases v. Travelers Prop. Cas. Ins. Co. 9 NY 3d. 312, 317 (2007).

Notwithstanding the above, 11 NYCRR 65-3.5 (c) states "The insurer is entitled to receive all items necessary to verify the claim directly from the parties from whom such verification was requested." See also, Nyack Hospital v. State Farm Mutual Automobile Ins. Co., 19 A.D.3d 569, (2d Dept. 2005), an insurer is not obligated to pay or deny a claim until it has received verification of all relevant information requested.

11 NYCRR 65-3.5 (b) states subsequent to the receipt of one or more of the completed verification form, any additional verification required by the insurer to establish proof of claim shall be requested within 15 business days of receipt of the prescribed verification forms. Further, the follow-up provisions of 11 NYCRR 65-3.6 (b) states at a minimum, if any requested verification has not been supplied to the insurer 30 calendar days after the original request, the insurer shall, within ten calendar days, follow-up with the party from whom the verification was originally requested, either by a telephone call, properly documented in the file, or by mail. At the same time the insurer shall inform the applicant and such person's attorney of the reason(s) why the claim is delayed by identifying in writing the missing verification and the party from whom it was requested.

Further, concerning claims for medical services rendered on or after April 1, 2013, 11 NYCRR § 65- 3.5 (o) provides that:

An applicant from whom verification is requested shall, within 120 calendar days from the date of the initial request for verification, submit all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply. The insurer shall advise the applicant in the verification request that the insurer may deny the claim if the applicant does not provide within 120 calendar days from the date of the initial request either all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply.

11 NYCRR § 65-3.8 (b)(3) then provides that:

An insurer may issue a denial if, more than 120 calendar days after the initial request for verification, the applicant has not submitted all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply, provided that the verification request so advised the applicant as required in section 65-3.5(o) of this Subpart.

Underlying Facts

The record reflects that the IP was prescribed for rental use the CPM machine for injuries related to the shoulder. The rental used was at the rate of \$85.00 a day from February 7, 2018 through March 20, 2018. Further, the IP was also provided rental use of a CTU. The rental period for this item was from February 7, 2018 through February 20, 2018, at the rate of \$49.99 per day.

In this instance, the respondent's denials were based upon the purported failure of the applicant to respond to requests for verification. The respondent received a bill for the rental use of the CPM machine and CTU from February 7 through February 27, 2018 on March 2, 2018. On March 16, 2018 the respondent sent to the applicant a verification request seeking an invoice for the items at issue. I note a follow up requested dated April 19, 2018.

Concerning the second date of use of the CPM machine from February 28 through March 20, 2018, the respondent received the bill on March 20, 2018. On April 6, 2018, the respondent sent to the applicant a verification request seeking an invoice for the items at issue. I note a follow up requested dated May 17, 2018.

The respondent issued denials for both bills on August 9, 2018 based on a violation of 11 NYCRR § 65- 3.5 (o) for failing to provide requested verification within 120 calendar under the applicant's control or possession or written proof providing reasonable justification for the failure to comply.

It is uncontested that the sole item at issue concerns an invoice request for the items that were prescribed for use by the IP.

At the time of the hearing, applicants counsel noted that on numerous occasions (April 5, April 16, May 4, and June 5, 2018) the applicant provided responses to this demand, noting that no invoice was needed as the items listed are not in the New York State Medicaid fee schedule, and is typically purchased by a patient for reimbursement pursuant to Regulation 83, Part F, DME Section B, NYS Medicaid Fee Schedule 4.3. In addition, any reference to a rental rate refers to the DME equipment designated with the Code RR, the CPM is not designated as an RR and therefore, rental rate cannot be calculated by using an invoice. Further, there's no need for your request as any additional information requested by you is impossible to be provided by this cost company and as such, is in violation of 11 NYCRR 65-3.2.

The response further notes that if the carrier believes that the statutes and regulations require a further response be submitted, then the applicant requests that statutory evidence. The provider further noted that their understanding was an invoice is required only when medical equipment is sold and not rented, as in this case.

The response goes on noting that a CPM device provided medical benefits, described it as accelerating recovery time by decreasing soft and joint tissue stiffness and reducing adhesions by allowing a proper movement in the passive range of motion for the patient. The letter also indicates the basis for the CTU following a procedure noting that it helps reduce inflammation, pain and swelling.

Analysis

In this instance the applicant on four occasions provided responses to the verification demand, notifying the respondent the items sought are not relevant.

At a minimum, I believe it was incumbent upon the respondent to provide some additional acknowledgment and further provide a reasonable basis for the request for this invoice.

The No-Fault regulations envision "communication, not inaction" from both parties with respect to requests for additional verification. (See, Westchester County Med. Ctr. v. New York Cent. Mut. Fire Ins. Co., 262 AD2d 553, [2d Dept 1999]; Urban Radiology, P.C. v. Tri-State Consumer Ins. Co., 2010 NY Slip Op 50987[U] [App Term 2d Dept 2010]; Dilon Medical Supply Corp. v. Travelers Ins. Co., 7 Misc.3d 927 [2005]; Mary Immaculate Hosp. v. New York Cent. Mut. Fire Ins. Co., 2008 NY Slip Op 52046[U] [App Term 2d Dept].)

In Media Neurology PC v. Countrywide Insurance Co., 21 Misc. 3rd 1101 A (Civ. Ct., Kings Co., September 15, 2008, J.C.C. Ash) the court noted that neither party may ignore communications from the other without risking their chances to prevail on the matter." citing All Health Medical Care PC v Geico Ins. Co. 2 Misc. 3d. 907 (Civ. Ct., Queens Co., January 16, 2004, J.C.C. Agate).

Based on the foregoing, the applicant's claim is awarded.

Fee Schedule

Amended Regulations section 65-3.8(g)(1) states proof of the fact, and amount of loss sustained pursuant to Insurance Law section 5106(a) shall not be deemed supplied by an applicant to an insurer and no payment shall be due for such claimed medical services under any circumstances: (i) when the claimed medical services were not provided to an injured party; or (ii) for those claimed medical service fees that exceed the charges permissible pursuant to Insurance Law sections 5108(a) and (b) and the regulations promulgated thereunder for services rendered by medical providers. (2) This subdivision shall apply to medical services rendered on or after April 1, 2013.

Thus, the applicant's bill may not be in violation of the abovementioned regulation.

Notwithstanding this fact, the defendant has the burden to come forward with competent evidentiary proof to support its fee schedule defenses. Robert Physical Therapy, P.C. v. State Farm Mut. Auto. Ins. Co., 13 Misc. 3d. 172(Civ. Ct. Kings Co. 2006). When a defendant fails to demonstrate by competent evidentiary proof that a plaintiff's claim was in excess of the appropriate fee schedules, defendant's defense of noncompliance with the appropriate fee schedule cannot be sustained. Continental Medical, P.C. v. Travels Indemnity Co., 11 Misc. 3d.145A (App. Term 1st Dept. 2006).

Respondent reiterated the point that the applicant may not bill above fee schedule.

While respondent is correct in noting the applicant may not bill above fee schedule, do not believe the amended regulations were put into effect to shift the burden from the respondent to establish that a charge submitted by the applicant was above fee schedule. To do so would be to erode the holding in Viviane Etienne Med. Care v Country-Wide Ins. Co. cited above and to de facto require the applicant to establish the fee schedule for the service provided as an element of their prima facie case. I believe the regulations were put into effect to prevent an applicant from receiving reimbursement for a service provided at a rate clearly in excess of the fee schedule where the respondent issued an untimely or even failed to issue any denial for the service.

Therefore I believe the regulations require that a charge is reduced or even dismissed when on its face, the charges exceed the permissible rates established by the New York State Worker's Compensation Fee Schedule. As an example, a bill for a service listed in the code or that can be easily deciphered by utilizing the relative value unit (RVU), and the conversion factor (CF) for the service provided are examples of when a bill must be reduced regardless of whether the respondent issued a fee schedule defense. For services however, that require more of an extensive expert analysis, the burden remains of the carrier to establish the services were billed above fee schedule.

12 NYCRR 442.2 (b) provides in relevant part "the maximum permissible monthly rental charge for equipment, supplies, and services provided on a rental basis shall not exceed the lower of the monthly rental charge to the general public or the price

determined by the New York State Department of Health (DOH) area office. The total accumulated monthly rental charges shall not exceed the amount allowed under the Medicaid fee schedule. In this instance, the DOH area office has not determined the rental price nor is the specific item at issue CPM machine listed in the Medicaid fee schedule. Thus, the applicant's permissible monthly rental charges are rental charged to the general public.

The respondent's position was since the applicant never submitted the invoice; the amount owed could not be calculated.

I note a June 8, 2016, the DOH by Joanne Criscione, Senior Attorney, Bureau of Health Insurance Programs, Division of Legal Affairs in responding to a letter sent from an attorney representing an applicant stated that the DOH did not establish the reimbursement rate applicable to workers' compensation claims for durable medical equipment, which have not been assigned maximum reimbursable amounts. Ms. Criscione reiterated that the DOH has no authority to make such a proclamation. The letter that the parties previously had been alluding to (dated July 3, 2014) stated Medicaid reimbursement policy as set forth by the Medicaid Provider Manuals for durable medical equipment.

I find instructive the analysis set forth by *Arbitrator Andrew Horn Medical Records Retrieval dba Kamara Supplies v. Liberty Mutual Insurance Company AAA Case 17â15â1025â3727* (January 20, 2017):

Although the New York State Medicaid Program Durable Medical Equipment Manual Policy Guidelines pertinently provide that, "(f)or DME items that do not have a MRA, the rental fee is calculated at 10% of the equipment provider's acquisition cost" with the added proviso that the "total accumulated monthly rental charges may not exceed the actual purchase price of the item," the "Medicaid provider manual and the policy guidance for durable medical equipment are not included as part of the durable medical equipment fee schedule used in workers' compensation cases...." 12 NYCRR 442.2 (g).

Accordingly, durable medical equipment that has not has its price determined by the Department of Health or that is not included in the Medicaid fee schedule is compensable pursuant to 11 NYCRR 68.5. See High Quality Med. Supplies, Inc. v. Mercury Ins. Group, 53 Misc.3d 136(A), 2016 NY Slip Op 51444(U) (App Term 2d, 11th & 13th Jud Dists. Oct. 5, 2016).

Thus, as Applicant's attorney persuasively argued, I find that the permissible charges for the disputed DME, in the absence of any prices determined by the New York State Department of Health or Medicaid, are the rental charges to the general public.

While some arbitrators have utilized the calculation set forth in Medicaid's DME policy guidelines, many others have rejected it and determined that the appropriate rate is the "rental charge to the general public." See, e.g., Advanced DME Recovery, Inc. and State Farm Mut. Ins. Co., AAA Case No. 17-15-1006-9333 (arb. Lester Hill July 12, 2016); Advanced DME Recovery, Inc. and American Transit Ins. Co., AAA Case No. 17-15-1019-6987 (arb. Michael Korshin June 12, 2016); Advanced Recovery Equipment

& Supplies and Liberty Mut. Ins. Co., AAA Case No. 17-15-1005-9362 (arb. Robyn McAllister Aug. 1, 2015); Horizon Ortho Supply Corp. and Liberty Mut. Fire Ins. Co., AAA Case No. 17-15-1014-5105 (arb. Maryann Mirabelli July 11, 2016); Medical Records Retrieval/DBA Kamara Supplies and Allstate Ins. Co., AAA Case No. 17-15-1024-7067 (arb. Stacey Erdheim Nov. 9, 2016); Medical Records Retrieval/DBA Kamara Supplies and Geico Ins. Co., AAA Case No. 17-15-1024-6130 (arb. Glen Cacchioli Sept. 30, 2016); Medical Records Retrieval/DBA Kamara Supplies and Geico Ins. Co., AAA Case No. 17-15-1025-4992 (arb. Walter Winning Nov. 25, 2016); Medical Records Retrieval/DBA Kamara Supplies and Liberty Mut. Ins. Co., AAA Case No. 17-15-1023-8731 (arb. Antonietta Russo Nov. 1, 2016); Medical Records Retrieval/DBA Kamara Supplies and Merchants Ins. Group, AAA Case No. 17-15-1023-1018 (arb. Bryan Miller Oct. 31, 2016); MK DME, Inc. and Liberty Mut. Ins. Co., AAA Case No. 17-15-1020-0304 (arb. Evelina Miller June 2, 2016).

In fact, master arbitrator Victor J. D'Ammora in US Tech Rehab, Inc. and Liberty Mut. Ins. Co., AAA Case No. 99-14-1001-2311 (Feb. 1, 2016), reversed a lower arbitrator's decision because the "proper charge for the CPU and CTU is the monthly rental charges to the general public" and "the lower arbitrator() erred by allowing the Respondent to use a legally prohibited fee schedule to reduce the claim." See also Isurply LLC and State Farm Auto. Ins. Co., AAA Case No. 99-15-1020-9938 (master arbitrator Robert Trestman Sept. 26, 2016).

In this instance, the applicant billed the rental rate of \$85.00 per day for the CPM machine and \$49.99 per day for the CTU. The applicant has submitted multiple awards, reimbursement checks from other insurers and portions of the Optum HCPCS fee analyzer to establish rental rates for these items available to the general public.

The record establishes the cost for the CPM machine (EO936) to the general public is \$85.00 in the national fiftieth percentile. The applicant facility located in Brooklyn, New York is entitled to reimbursement at \$85.00 per day (forty-two days) totaling \$3570.00.

Similarly, the cost of the CTU (EO218) to the general public is \$160.02 in the national fiftieth percentile. The applicant is entitled to the billed rate of \$49.99 per day (fourteen days) totaling \$699.86.

Therefore, the applicant is awarded the sum of \$4,269.86.

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	Total	Status
	CPM Medical Supply Inc	02/07/18 - 03/20/18	\$4,269.86	\$ 4,269.86	Awarded: \$4,269.86
Total			\$4,269.86	Awarded: \$4,269.86	

B. The insurer shall also compute and pay the applicant interest set forth below. 10/22/2018 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

The respondent shall pay interest at a rate of two percent per month, simple on a pro rata basis using a thirty day month. With respect to the claim herein, interest will run from October 22, 2018, the date of the filing of this claim through payment of the claim.

C. Attorney's Fees

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

As this matter was filed **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 newly promulgated 11 NYCRR 65-4.6(d).

With respect to this claim, the applicant is entitled to attorney's fees for the medical services provided to the EIP for which the applicant is awarded the sum of \$4269.86.

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

11/11/2019
(Dated)

Victor Moritz

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:
36b2b7bd897e2df349145624dce4a73e

Electronically Signed

Your name: Victor Moritz
Signed on: 11/11/2019