

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

True Health Pharmacy Inc.
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No.	17-20-1161-1703
Applicant's File No.	301613
Insurer's Claim File No.	0514405530101013
NAIC No.	35882

ARBITRATION AWARD

I, Alison Berdnik, 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: Claimant

1. Hearing(s) held on 06/02/2021, 09/22/2021
Declared closed by the arbitrator on 09/22/2021

Neil Menashe, Esq. from Neil Menashe Attorney At Law P.C. participated for the Applicant

Nicole Jeffares, Esq. from Geico Insurance Company participated for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 6,728.00**, 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

The Claimant, AG, a 28-year-old male, was a bicyclist struck by a motor vehicle on August 27, 2018. At issue in this case is \$6,728.00 for Naproxen and Cyclobenzaprine dispensed to the Claimant on October 4, 2018, together with lidocaine 5% ointment and diclofenac sodium 3% gel dispensed to the Claimant on October 17, 2018, November 1, 2018, November 19, 2018, and November 30, 2018.

Respondent timely denied Applicant's claim for services rendered October 4, 2018 based upon Applicant's failure to submit the bill within 45 days from the date on which the service was rendered.

Respondent timely denied Applicant's claims for services rendered October 17, 2018, November 1, 2018, and November 19, 2018 based upon peer review reports by Harry Jackson, M.D. dated November 28, 2018, December 19, 2018, and January 14, 2019.

With respect to Applicant's claim for services rendered November 30, 2018, Respondent has issued two different denials. With respect to the claim for lidocaine ointment in the amount of \$620.00, Respondent contends that prescription of the medical was not medically necessary, and offers a peer review report by Harry Jackson, M.D. in support of its defense. However, with respect to the claim for diclofenac gel in the amount of \$905.00, Respondent offers a denial asserting that Applicant failed to submit the claim within 45 days from the date on which services were rendered.

Respondent also contends that Applicant's charges exceed those permitted under the New York State Workers' Compensation Fee Schedule (the "Fee Schedule").

The issues presented for determination are:

- 1) Whether Applicant timely submitted its claims for prescription medications dispensed to the Claimant on October 4, 2018, together with the diclofenac 3% sodium gel dispensed November 30, 2018 to Respondent for reimbursement;
- 2) Whether the medications dispensed to the Claimant on October 17, 2018, November 1, 2018, and November 19, 2018, together with the lidocaine 3% ointment dispensed November 30, 2018 were medically necessary; and
- 3) Whether the disputed charges exceed those permitted under the governing fee schedule.

4. Findings, Conclusions, and Basis Therefor

This case was decided based upon the submissions of the parties as contained in the electronic file maintained by the American Arbitration Association, and the oral arguments of the parties' representatives. There were no witnesses present to testify during the hearing. I have reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

Applicant establishes its *prima facie* entitlement to reimbursement with proof that it submitted a proper claim, setting forth the fact and the amount charged for the services rendered and that payment of no-fault benefits was overdue. *See Insurance Law §5106(a)*; *Viviane Etienne Med. Care v. Country-Wide Ins. Co.*, 25 N.Y.3d 498, 501 (2015); *Mary Immaculate Hosp. v. Allstate Ins. Co.*, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept., 2004).

45 Day Rule

In the instant matter, Respondent asserts that Applicant has failed to establish its entitlement to reimbursement due to Applicant's failure to submit its bill for the Naproxen and Cyclobenzaprine dispensed to the Claimant on October 4, 2018, as well as its bill for the diclofenac 3% sodium gel dispensed to the Claimant on November 30, 2018 in accordance with the No-Fault Regulations.

The No-Fault Regulations Mandatory Personal Injury Protection Endorsement states:

Proof of Claim; Medical, Work Loss, and Other Necessary Expenses.
In the case of a claim for health service expenses, the eligible injured person or that person's assignee or representative shall submit written proof of claim to the Company, including full particulars of the nature and extent of the injuries and treatment received and contemplated, as soon as reasonably practicable but, in no event later than 45 days after the date services are rendered....

Where a respondent contends that it did not receive the bill in question within the required timeframe under the no-fault regulations, it is incumbent upon the applicant to come forward with some proof that it submitted the claim timely. If an applicant makes such a submission, it will carry a presumption that the submitted claim was received by the respondent. It is then incumbent upon the respondent to come forward with some affirmative proof that it did not receive the claim in question.

DOS October 4, 2018

Here, Respondent contends that it did not receive Applicant's claim for services rendered October 4, 2018 until January 7, 2019, and, as such, Respondent denied Applicant's claim based upon its failure to submit the bill within 45 days from the date on which the service was rendered. Applicant has not submitted any evidence demonstrating timely submission of its bill, nor does Applicant offer any reasonable justification for the failure to timely submit the bill. Consequently, Respondent's denial predicated upon the 45-Day Rule violation is sustained.

Accordingly, Applicant's claim in the amount of \$256.00 for the Naproxen and Cyclobenzaprine dispensed to the Claimant October 4, 2018 is denied in its entirety.

DOS November 30, 2018

According to the NF-10 contained in evidence in the record below, Respondent did not receive Applicant's bill in the amount of \$905.00 for the diclofenac sodium 3% gel until April 3, 2020. However, a copy of Applicant's bill for diclofenac sodium 3% gel in the amount of \$905.00 is included in Respondent's own submission and is date stamped received December 26, 2018. It also does not go unnoticed that Respondent's evidence also includes a peer review report by Harry Jackson, M.D. dated January 15, 2019 wherein he addresses Applicant's claim for the diclofenac gel dispensed to the Claimant

on November 30, 2018. However, to Respondent's detriment, it has failed to offer any evidence that it ever issued a denial of Applicant's claim based upon a lack of medical necessity. The only NF-10 in evidence denying Applicant's claim for the diclofenac gel dispensed November 30, 2018 in the amount of \$905.00 is predicated upon Applicant's purported failure to submit the claim within 45 days from the date on which the service was rendered. While Applicant has not offered proof of mailing of the bill, Respondent's own arbitration submission confirms that Applicant did, in fact, submit the claim within 45 days. Thus, Respondent's defense is unsupported by the evidence, and, as such, cannot be sustained.

Respondent has not offered any evidence demonstrating that Applicant's charge exceeds that permitted under the governing fee schedule. Accordingly, Applicant is awarded \$905.00 for its claim for the diclofenac 3% sodium gel dispensed to the Claimant on November 30, 2018.

Medical Necessity

All remaining claims at issue in this proceeding, namely lidocaine 5% ointment and diclofenac 3% sodium gel dispensed to the Claimant October 17, 2018, November 1, 2018, and November 19, 2018 have been denied by Respondent based upon various peer review reports by Harry Jackson, M.D., all of which assert that the prescription medication at issue was not medically necessary.

As such, the burden now shifts to the Respondent to prove that the services were not medically necessary. *Amaze Medical Supply v. Eagle Insurance*, 2 Misc.3d 128(A) (2003). Once the Respondent makes a sufficient showing to carry its burden of coming forth with evidence of lack of medical necessity, the Applicant must rebut it. *A. Khodadadi Radiology, P.C. v. NY Central Mutual Fire Insurance*, 16 Misc.3d 131(A), 841 N.Y.S.2d 824 (2007).

It is well-settled that 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). 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 [App. Term 2nd & 11th 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 [App. Term 2nd & 11th Jud. Dists. 2003].)

The trial 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, Nir v. Allstate Ins. Co.*, 7 Misc.3d 544, 547, 796 N.Y.S.2d 857, 860 (Civ. Ct. Kings Co. 2005); *see also, All Boro Psychological Servs. P.C. v. GEICO*, 2012 N.Y. Slip Op. 50137(U) (Civ. Ct. Kings Co. 2012).

In order to prevail, respondent's peer review must address all of the pertinent objective findings contained in applicant's medical evidence. It must then clearly explain why, notwithstanding those findings, the disputed service was inconsistent with generally accepted medical or professional practices. *Amaze Medical Supply Inc. v. Eagle Insurance Co.*, *supra*, 2 Misc.3d 128(A); *Citywide Social Work, et al, v. Travelers Indemnity Company*, 3 Misc.3d 608, 777 N.Y.S.2d 241 (Civ. Ct. Kings Co. 2004). Where other reports in the insurer's papers contradict the conclusion of its peer review, or that the service was not medically necessary, it has failed to make out a prima facie case in support of the defense of lack of medical necessity. *Hillcrest Radiology Associates v. State Farm Mutual Automobile Insurance Company*, 28 Misc.3d 138(A), 200 N.Y. Slip Op. 51467(U) 2010 WL 3258144 (App Term 2nd, 11th, and 13th Dists. 2010).

DOS October 17, 2018

Respondent timely denied Applicant's claim for lidocaine 5% ointment and diclofenac 3% sodium gel dispensed to the Claimant October 17, 2018 based upon two different peer review reports by Harry Jackson, M.D. dated November 28, 2018.

Dr. Jackson considered various records in conjunction with his peer review. He notes the Claimant's involvement in the underlying accident on August 27, 2018, and that he did not seek any emergency medical care immediately following the accident. The Claimant was evaluated by Michael Patin, M.D. on September 5, 2018 for complaints of pain in the neck, low back, and bilateral knees. Following examination, clinical impression was of cervicgia, pain in the left knee, low back pain, and muscle spasm. The plan consisted of physical therapy, physical capacity testing, chiropractic treatment, acupuncture, consultations with a neurologist and orthopedist, x-rays of the left knee and lower leg, and MRI of the left knee with follow-up. Dr. Jackson notes that the Claimant was prescribed diclofenac sodium 3% gel and lidocaine 5% ointment on October 17, 2018, both of which was dispensed to the Claimant the same day. Upon completion of his review of the records, Dr. Jackson concluded that prescription of lidocaine and diclofenac sodium gel was medically unnecessary.

Dr. Jackson maintains that the Claimant had soft tissue injuries requiring analgesic treatment. According to Dr. Jackson, there is no evidence based scientific proof that topical agents, such as lidocaine ointment or diclofenac sodium gel, are effective or superior to other available oral alternatives. He maintains that there is no evidence that the Claimant was unable to use oral medications. Finally, Dr. Jackson states that the role of topical presentations, when compared to traditional routes, has not yet been fully explored.

Overall, I find the peer review of Dr. Jackson to be facially insufficient to sustain Respondent's *prima facie* burden of establishing a lack of medical necessity for the prescription medication. Dr. Jackson fails to proffer any standard of care for the treatment of this particular Claimant's injuries, and how, in this instance, prescription of either lidocaine ointment or diclofenac sodium gel deviated from any such standard. A peer report must demonstrate that the services rendered were not in agreement with generally accepted medical or professional standards. Without evidence of accepted medical practice, a peer reviewer's opinion is simply a different professional judgment which, in and of itself, does not establish that the disputed services were not medically necessary. Moreover, suggesting an alternative or citing to an inconclusive study is not the equivalent of demonstrating a deviation from acceptable standards of care as propounded under *Nir v. Allstate Ins. Co.*, 7 Misc.3d 544, 796 N.Y.S.2d 857 (Civ. Ct. Kings Co. 2005). It is not enough for an expert to simply reiterate medical records, cite to medical literature for a limited premise, and then summarily conclude that a service is unnecessary. Thus, Dr. Jackson's report in no way comports with any of the standards enumerated in *Nir, supra*, and, as such, Respondent's defense predicated upon a lack of medical necessity cannot be sustained.

DOS November 1, 2018

Respondent timely denied Applicant's claim for lidocaine 5% ointment and diclofenac 3% sodium gel dispensed to the Claimant November 1, 2018 based upon a peer review report by Harry Jackson, M.D. dated December 19, 2018.

Dr. Jackson considered various records in conjunction with his peer review. He notes the Claimant's involvement in the underlying accident on August 27, 2018, and that he did not seek any emergency medical care immediately following the accident. The Claimant was evaluated by Michael Patin, M.D. on September 5, 2018 for complaints of pain in the neck, low back, and bilateral knees. Following examination, clinical impression was of cervicgia, pain in the left knee, low back pain, and muscle spasm. The plan consisted of physical therapy, physical capacity testing, chiropractic treatment, acupuncture, consultations with a neurologist and orthopedist, x-rays of the left knee and lower leg, and MRI of the left knee with follow-up. On October 3, 2018, the Claimant presented to Dr. Patin with complaints of pain in the neck, lower back, and bilateral knees. The Claimant was recommended for MRI/x-ray of the left knee and to continue physical therapy. Dr. Jackson notes that the Claimant was prescribed diclofenac sodium 3% gel and lidocaine 5% ointment on October 17, 2018, both of which was dispensed to the Claimant on November 1, 2018. Upon completion of his review of the records, Dr. Jackson concluded that prescription of lidocaine and diclofenac sodium gel was medically unnecessary.

Dr. Jackson maintains that the Claimant had soft tissue injuries requiring analgesic treatment. According to Dr. Jackson, there is no evidence based scientific proof that topical agents, such as lidocaine ointment or diclofenac sodium gel, are effective or superior to other available oral alternatives. He maintains that there is no evidence that

the Claimant was unable to use oral medications. Finally, Dr. Jackson states that the role of topical presentations, when compared to traditional routes, has not yet been fully explored.

Overall, I find the peer review of Dr. Jackson to be facially insufficient to sustain Respondent's *prima facie* burden of establishing a lack of medical necessity for the prescription medication. Dr. Jackson fails to proffer any standard of care for the treatment of this particular Claimant's injuries, and how, in this instance, prescription of either lidocaine ointment or diclofenac sodium gel deviated from any such standard. A peer report must demonstrate that the services rendered were not in agreement with generally accepted medical or professional standards. Without evidence of accepted medical practice, a peer reviewer's opinion is simply a different professional judgment which, in and of itself, does not establish that the disputed services were not medically necessary. Moreover, suggesting an alternative or citing to an inconclusive study is not the equivalent of demonstrating a deviation from acceptable standards of care as propounded under *Nir v. Allstate Ins. Co.*, 7 Misc.3d 544, 796 N.Y.S.2d 857 (Civ. Ct. Kings Co. 2005). It is not enough for an expert to simply reiterate medical records, cite to medical literature for a limited premise, and then summarily conclude that a service is unnecessary. Thus, Dr. Jackson's report in no way comports with any of the standards enumerated in *Nir, supra*, and, as such, Respondent's defense predicated upon a lack of medical necessity cannot be sustained.

DOS November 19, 2018

Respondent timely denied Applicant's claim for lidocaine 5% ointment and diclofenac 3% sodium gel dispensed to the Claimant November 19, 2018 based upon two different peer review reports by Harry Jackson, M.D. dated January 14, 2019 (lidocaine ointment) and January 15, 2019 (diclofenac gel). For the same reasons cited in his prior reports, Dr. Jackson concludes that prescription of the lidocaine ointment and diclofenac gel dispensed to the Claimant November 19, 2018 was medically unnecessary. Dr. Jackson maintains that the Claimant had soft tissue injuries requiring analgesic treatment. According to Dr. Jackson, there is no evidence based scientific proof that topical agents, such as lidocaine ointment or diclofenac sodium gel, are effective or superior to other available oral alternatives. He maintains that there is no evidence that the Claimant was unable to use oral medications. Finally, Dr. Jackson states that the role of topical presentations, when compared to traditional routes, has not yet been fully explored.

Overall, I find the peer review of Dr. Jackson to be facially insufficient to sustain Respondent's *prima facie* burden of establishing a lack of medical necessity for the prescription medication. Dr. Jackson fails to proffer any standard of care for the treatment of this particular Claimant's injuries, and how, in this instance, prescription of either lidocaine ointment or diclofenac sodium gel deviated from any such standard. A peer report must demonstrate that the services rendered were not in agreement with generally accepted medical or professional standards. Without evidence of accepted medical practice, a peer reviewer's opinion is simply a different professional judgment which, in and of itself, does not establish that the disputed services were not medically necessary. Moreover, suggesting an alternative or citing to an inconclusive study is not

the equivalent of demonstrating a deviation from acceptable standards of care as propounded under *Nir v. Allstate Ins. Co.*, 7 Misc.3d 544, 796 N.Y.S.2d 857 (Civ. Ct. Kings Co. 2005). It is not enough for an expert to simply reiterate medical records, cite to medical literature for a limited premise, and then summarily conclude that a service is unnecessary. Thus, Dr. Jackson's report in no way comports with any of the standards enumerated in *Nir, supra*, and, as such, Respondent's defense predicated upon a lack of medical necessity cannot be sustained.

Fee Schedule

Respondent also contends, however, that Applicant's claims for the prescription medication exceed those permitted under the governing fee schedule. Specifically, Respondent contends that the appropriate rate of reimbursement for the lidocaine 5% ointment dispensed October 17, 2018, November 1, 2018, November 19, 2018, and November 30, 2018 is appropriately reimbursed at \$613.80. Respondent further contends that the diclofenac gel dispensed to the Claimant on October 17, 2018 is appropriately reimbursed at \$905.00.

The rates charged by Applicant must be in accordance with Insurance Law §5108. The services in dispute were performed subsequent to the effective date of the Fourth Amendment to Regulation 68-C (April 1, 2013). 11 NYCRR 65-3.8(g)(1) now states that proof of fact that the amount of loss sustained pursuant to Insurance Law 5106(a) shall not be deemed supplied by an applicant to an insurer and no payment shall be due for 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 services that exceed the charges permissible pursuant to Insurance Law 5108(a) and (b) and the regulations promulgated thereunder for services rendered by medical providers.

The language of 11 NYCRR §65-3.8(g)(1) does not place any additional requirement on a medical provider to substantiate the calculation of its fees as part of its *prima facie* case; the burden of asserting a defense that a provider billed in excess of the fee schedule remains on the insurer, who need not pay the bill if it determines that the bill contravenes the fee schedule. *East Coast Acupuncture, PC v. Hereford Insurance Company*, 51 Misc.3d 441, 26 N.Y.S.3d 441 (Civil Ct. Kings Co. 2016). If respondent needed further documentation or additional information for services billed when there is no specific code in the Workers' Compensation fee schedule the insurer needs to request additional verification in accordance with 11 NYCRR 65-3.5(b). *Bronx Acupuncture Therapy v. Hereford Insurance Company*, 2017 NY Slip Op. 50101(U) (App. Term 2nd Dept. 2017), *aff'd* ___ A.D.3d ___, 2019 N.Y. Slip Op. 06059 (2nd Dept. Aug. 7, 2019).

However, the burden remains with Respondent to come forward with competent evidentiary proof to support its fee schedule defenses. *See, Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co.*, 2006 NY Slip 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct. Kings Co. 2006). *See also, Power Acupuncture PC v. State Farm Mutual Automobile Ins. Co.*, 11 Misc.3d 1065A, 816 N.Y.S.2d 700, 2006 NY Slip Op 50393U, 2006 N.Y. Misc. LEXIS 514 (Civil Ct.

Kings Co. 2006). An insurer who raises a fee schedule defense, "will prevail if it demonstrates that it was correct in its reading of the fee schedules." *Jesa Medical Supply, Inc. v. Geico Ins. Co.*, 2009 N.Y. Slip Op. 29386, 25 Misc.3d 1098, 887 N.Y.S.2d 482 (Civ. Ct. Kings Co. 2009). If Respondent fails to demonstrate by competent evidentiary proof that a plaintiff's claims were more than the appropriate fee schedules, defendant's defense of noncompliance with the appropriate fee schedules cannot be sustained. *See, Continental Medical PC v. Travelers Indemnity Co.*, 11 Misc.3d 145A, 819 N.Y.S.2d 847, 2006 NY Slip Op 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Term 1st Dept. *per curiam*, 2006).

An insurer's unilateral decision to either change an Applicant's CPT codes, pay reduced fees for disputed medical services, or deny the claim in its entirety, is ineffectual when unsupported by a peer review report or by other proof setting forth a sufficiently detailed factual basis and medical rationale for the code changes, denials or reductions. *Amaze Medical Supply v. Eagle Insurance Company*, 2 Misc.3d 128(A) (App. Term 2nd and 11th Jud. Dists. 2003).

I am, however, also permitted to take judicial notice of the Workers' Compensation Fee Schedule. *Kingsbrook Jewish Medical Center the Allstate Insurance Company*, 61 A.D.3d 13 (2nd Dept. 2009); *LVOV Acupuncture PC v. Geico Insurance Company*, 32 Misc.3d 144(A) (App. Term 2nd, 11th & 13th Jud. Dists. 2011); *see also, Natural Acupuncture Health PC v. Praetorian Insurance Company*, 30 Misc.3d 132(A), 2011 N.Y. Slip Op. 50040(U) (App. Term 1st Dept. 2011).

Chapter V of Title 12 NYCRR, which was amended to add a new Subchapter M, Parts 440 and 442, and reads as follows:

M. Pharmacy and Durable Medical Goods Fee Schedules and Appendices Part 440.

Pharmacy Fee Schedule

Section 440.1 Applicability.

This pharmaceutical fee schedule is applicable to prescription drugs or medicines dispensed on or after the most recent effective date of section 440.5 of this part for medical care or treatment of an injured employee, regardless of the date of accident or date of disablement. The date that the prescription drug or medicine is dispensed shall be the applicable date for reimbursement in accordance with this fee schedule. Prescription drugs or medicines dispensed prior to July 11, 2007, shall be reimbursed at the usual and customary rate in the location where the claimant resides. Prescription drugs or medicines dispensed on or after July 11, 2007, but prior to the most recent effective date of section 440.5 of this part, shall be reimbursed pursuant to the fee schedule in section 440.5 of this part in effect on the date the prescription drug or medicine was dispensed.

Section 440.5 of the Pharmaceutical Fee Schedule sets forth the following:

The maximum reimbursement or payment for prescription drugs or medicines in uncontroverted cases, including all brand name and generic prescription drugs or medicines, shall be the Average Wholesale Price for the national drug code for the prescription drug or medicine on the day it was dispensed minus twelve percent of the Average Wholesale price plus a dispensing fee of four dollars for brand name drugs or medicines or minus twenty percent of the Average Wholesale Price plus a dispensing fee of five dollars for generic drugs or medicines.

Section 440.2(a) defines "Average Wholesale Price" or "AWP" as:

...the average wholesale price of a prescription drug as provided in the most current release of the Red Book published by Thomson Reuters or Medi-Span Master Drug Database by Wolters Kluwer Health or any successor publisher, on the day a prescription drug is dispensed, or other nationally recognized drug pricing index adopted by the Chair or Chair's designee.

It does not go unnoticed that Applicant billed \$1,132.00, together with an additional \$5.00 dispensing fee, for the diclofenac gel dispensed to the Claimant on October 17, 2018. However, Applicant billed \$900.00, together with an additional \$5.00 dispensing fee for the diclofenac gel dispensed to the Claimant on November 1, 2018, November 19, 2018, and November 30, 2018. According to the EOB prepared by SCS contained in evidence in the record below, the appropriate rate of reimbursement is \$905.00. The EOB cites 12 NYCRR; subchapter M; section 440.5 in support of its reimbursement rate. The last page of each EOB provides the NDC (national drug code) assigned to each prescription, together with the corresponding AWP (average wholesale price), namely 11.79, effective October 2017 through the "present" as provided by The Bridge (Medispan) and The Red Book databases, both of which maintain copyright dates of 2020 and, as such, were current and applicable to the dates of service at issue.

Applicant \$760.00 for lidocaine 5% ointment dispensed to the Claimant on October 17, 2018 and billed \$620.00 for the lidocaine 5% ointment subsequently dispensed November 1, 2018, November 19, 2018 and November 30, 2018. Respondent contends, however, that the appropriate rate of reimbursement for the lidocaine ointment is \$613.80 and offers an EOB prepared by SCS in support of its defense. The EOB cites 12 NYCRR; subchapter M; section 440.5 in support of its reimbursement rate. The last page of each EOB provides the NDC code assigned to each prescription, together with the corresponding average wholesale price, namely 7.61, effective October 2017 through the "present" as provided by The Bridge (Medispan) and The Red Book databases, both of which maintain copyright dates of 2020 and, as such, were current and applicable to the dates of service at issue.

With respect to the lidocaine 5% ointment, I am persuaded by SCS that the appropriate rate of reimbursement is \$613.80. The average wholesale price assigned to the NDC number is 7.61. Applicant has billed for 100 units of lidocaine. Calculating $7.61 \times 100 = \$761.00$, and when 20% is deducted (see 12 NYCRR), the result is \$608.80. Adding the \$5.00 dispensing fee results in a rate of reimbursement in the amount of \$613.80 for each date of service at issue, namely October 17, 2018, November 1, 2018, November 19, 2018, and November 30, 2018.

Applicant has billed \$1,137.00 (inclusive of a \$5.00 dispensing fee) for its claim for diclofenac gel 3% dispensed to the Claimant on October 17, 2018. Applicant has submitted a charge for the diclofenac gel dispensed November 1, 2018 and November 19, 2018 in the amount of \$905.00 (inclusive of the \$5.00 dispensing fee.) No issue has been raised surrounding Applicant's charge for the diclofenac 3% sodium gel dispensed to the Claimant on November 1, 2018 and November 19, 2018. Rather, Applicant's only contention is that the appropriate rate of reimbursement for the diclofenac gel dispensed on October 17, 2018 is also \$905.00. The NDC included on each bill is identical. Respondent has not offered an EOB for the diclofenac gel dispensed on October 17, 2018. Nevertheless, Respondent's counsel contends that the appropriate rate of reimbursement is similar to Applicant's charges for the diclofenac gel dispensed November 1, 2018 and November 19, 2018, namely \$905.00. However, absent expert analysis by a fee coder, or, at the very least, a further written explanation by Respondent as to how it arrived at its conclusion that Applicant is entitled to reimbursement in the amount of \$905.00, I am constrained to find that Respondent has failed to meet its burden of establishing that Applicant's charge for the diclofenac gel dispensed October 17, 2018 exceeds that permitted under the fee schedule. I cannot presume that the medication dispensed to the Claimant on October 17, 2018 is identical to the medications subsequently dispensed on November 1, 2018 and November 19, 2018. Accordingly, Applicant is awarded \$1,132.00 for the diclofenac gel dispensed October 17, 2018, and \$905.00 as billed for the diclofenac gel dispensed on the three remaining dates of service at issue.

Conclusion

Applicant is awarded reimbursement in an aggregate sum of \$6,302.20 in full satisfaction of its claims for services rendered October 17, 2018, November 1, 2018, November 19, 2018, and November 30, 2018. As noted above, Applicant's claim for the medication dispensed on October 4, 2018 is denied.

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	Status
	True Health Pharmacy Inc.	10/04/18 - 11/30/18	\$6,728.00	Awarded: \$6,302.20
Total			\$6,728.00	Awarded: \$6,302.20

- B. The insurer shall also compute and pay the applicant interest set forth below. 04/01/2020 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant is awarded \$6,302.20, together with applicable interest computed from the date of the filing of the AR-1 until June 2, 2021, the date of the originally scheduled hearing in this proceeding, which was adjourned at Applicant's request. Applicant is, however, entitled to additional interest computed from September 22, 2021, the date on which the hearing in this proceeding was held, until such time as payment of the claim is made.

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 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 New York

SS :

County of Suffolk

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

09/29/2021

(Dated)

Alison Berdnik

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:
f4528f35ecaedb66f703aaa20d30eccc

Electronically Signed

Your name: Alison Berdnik
Signed on: 09/29/2021