American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Altai Corp. DBA Get Ready Medical Supply (Applicant)	AAA Case No.	17-21-1228-6522
	Applicant's File No.	BT21-148996
- and -	Insurer's Claim File No.	0426424180000001
	NAIC No.	
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Joseph Endzweig, 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 06/07/2023
   Declared closed by the arbitrator on 06/07/2023

   Sabine Sciarrotto, Esq. from The Tadchiev Law Firm, P.C. participated virtually for the Applicant

   Tara Hardinger, Esq. from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$3,076.04**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The amount was amended to $2,576.04 to reflect withdrawal of two bills.

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

3. Summary of Issues in Dispute

   This arbitration arises out of treatment of a 47 year old male for injuries sustained in a motor vehicle accident occurring on 11/24/20. Applicant seeks reimbursement for rental of a VascuTherm 5 device for cold/hot contrast and compression provided to the patient on 3/25/21. The rental was for 28 days and was billed at $2,520.00. Applicant further

seeks reimbursement for an upper body wrap provided on 3/25/21 and billed at $56.04. Applicant further seeks reimbursement for the technician set up of equipment, billed at $250.00 and a delivery fee billed at $250.00. These two bills in the total amount of $500.00 were withdrawn. The claim was accordingly amended to $2,576.04. Respondent denied reimbursement based on the Peer Review report of Dr. Harry Jackson.

4. Findings, Conclusions, and Basis Therefor

I have reviewed the documents contained in the Electronic Case Folder as of the date of the hearing and this Award is based upon my review of the Record and the arguments made by the representatives of the parties at the hearing.

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According to the records submitted by the parties, the claimant was a restrained driver of a motor vehicle involved in an accident. After the accident, he went to urgent care for an evaluation and treatment. During a 12/03/2020 evaluation with Dr. Bannerman, the claimant presented with neck pain and lower back pain. Clinical impression at that time included cervicalgia and lumbosacral radiculopathy. According to follow-up examination report dated 2/19/2021 by Christian Bannerman, M.D., the claimant presented with complaints of pain in the neck and lower back. Physical examination of the cervical spine revealed moderate muscle spasm. Range of motion was decreased with pain. Lumbar spine examination revealed moderate paraspinal muscle tenderness and spasm on palpation. Range of motion was decreased with pain. Neurological examination revealed Deep Tendon Reflexes was 2+. Muscle strength was normal. Sensation was intact. Clinical impression was of cervicalgia, cervical radiculopathy, LBP low back pain, lumbar radiculopathy, unspecified sprain unspecified shoulder, and pain at unspecified shoulder. The claimant was recommended physical therapy, referred orthopedic, chiropractic, acupuncture, and pain management consultations, and follow-up was indicated. He was prescribed Lidocaine 5% ointment. On 02/27/2021, the he was prescribed upper body wrap, and VascuTherm 5 device for cold/hot contrast and compression therapy (28 days) by Dr. Bannerman. On 03/25/2021, the claimant was provided with the above medical equipment.

Respondent submits a Peer Review report from Dr. Harry Jackson. Dr. Jackson concludes that the disputed devices were not medically necessary. He states that the

records show that the claimant sustained soft tissue injury and standard of care in this case is physical therapy and analgesic agents. He asserts that the supplied prescription deviated from the standard of care. He notes that Vascutherm device with accessories is an intermittent thermal compression and cold therapy system. He states that Claimant could have received the same therapy the unit provides while attending physical therapy sessions. Thus, he maintains that the exact same therapy at home is redundant and unnecessary. He further states that there is no clinical evidence that this device is beneficial for sprain/strain type injuries. Dr. Jackson notes that in "Cold and compression in the management of musculoskeletal injuries and orthopedic operative procedures: a narrative review" by Jon E Block; Open Access J Sports Med. 2010; 1: 105-113.; the author concluded that until there is a definitive trial of the clinical effects of a defined cryotherapy method and a defined compression modality, the real benefit and therefore the clinical application of generic cold compression therapy will remain unclear and evidence-based decisions about its use poorly guided." Dr. Jackson states that a bag of ice or hot water is sufficient for topical application of cold or heat. He argues that there are no extraordinary circumstances here that require anything more complicated than heat or cold 15 minutes 3-4 times per day as needed for swelling and pain relief. He states that evidence is limited that cryotherapy hastens return to participation. He notes that despite the general acceptance of cryotherapy as an effective intervention, evidence on which to base these conclusions is limited (Ref: Bleakley C, McDonough S, MacAuley D.

Applicant submits a rebuttal from Dr. David Gamburg. Dr. Gamburg asserts that the prescribed cold compression unit provides numerous benefits due to its unique combination of cold therapy and compression therapy. "Compression alone is shown to be effective in reducing swelling and edema. Active compression, which compresses intermittently, pushes that swelling out of the injured site and to the body's core so it can be disposed of through the lymphatic system. This type of compression also aids in enhancing the body's blood flow, which helps deliver more oxygen to the injured area. […] Cold therapy has also been proven to reduce pain and swelling, making your recovery faster and more comfortable. […] Studies find that when active compression is coupled with cold therapy, it results in increased blood flow, and decreased swelling, edema, and muscle spasms. […] [A cold compression unit] combines the benefits of a cold therapy machine (or cold therapy unit) and a compression machine to deliver intermittent compression therapy […] These benefits of cold compression therapy amount to a faster and more pleasant recovery. This therapy can be applied to those suffering from minor joint pain, to major surgery rehabilitation (such as ACL surgery recovery) and anything in between." Cold compression therapy . PowerPlay. (2017, March 1). https://powerplay.us/cold-compression-therapy/. He notes, similarly, "Cold and compression are routinely applied immediately after acute injury or following surgery to alleviate pain, reduce swelling and speed functional recovery." Block JE. Cold and compression in the management of musculoskeletal injuries and orthopedic operative procedures: a narrative review. Open access journal of sports medicine. 2010;1:105. Dr. Gamburg asserts that the cold compression device was prescribed to reduce pain and edema while increasing recovery speed following the aforementioned injuries sustained from the MVA. He notes that "Almost without exception, the use of cold compression therapy following either acute musculoskeletal injury or orthopedic surgery results in improved clinical outcomes compared to no treatment." Block JE.

Cold and compression in the management of musculoskeletal injuries and orthopedic operative procedures: a narrative review. Open Access J Sports Med. 2010;1:105-113. Published 2010 Jul 7. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3781860/. He notes that cold compression therapy is useful for many different post-traumatic conditions. Hee maintains that in accordance with the literature, the patient was prescribed the cold compression device to treat the patient's pain and tenderness that arose due to sudden trauma from a car accident. Dr. Gamburg further points out that the cold compression device is incomparable to an ice pack/wrap as the device is specifically designed to provide modality to a particular area with the facility to increase or lower the temperature. Unlike standard cryotherapy (e.g. ice packs), medical devices that employ compression cryotherapy allow for temperature adjustments based on clinician and patient preference. This function helps to avoid tissue damage and offers deeper, precise, and more consistent cooling without the pain and discomfort associated with ice packs. Dr. Gamburg further notes that the patient was diagnosed with radiculopathy ""In nearly all cases of cervical radiculopathy, the key pathophysiologic feature is inflammation." He notes that "As evidenced by the literature, the application of a cold compression unit was appropriate to address the inflammation that was causing symptomatic compression of spinal nerve roots in this patient." Dr. Gamburg concludes that the cold compression unit was medically necessary.

It is Applicant's prima facie burden to establish its entitlement to payment for the subject medical devices.

It is well settled that a health care provider establishes its prima facie entitlement to payment as a matter of law by 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; Mary Immaculate Hosp. v. Allstate Ins. Co., 5 AD 3d 742, 774N.Y.S. 2d 564 [2004]; Amaze Med. Supply v. Eagle Ins. Co., 2 Misc. 3d 128A, 784 N.Y.S. 2d918, 2003 NY Slip Op 51701U [App Term, 2d & 11th Jud Dists]).*

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 and 11thJud Dists 2003]).

Since Applicant submitted a timely and proper claim the burden is on the respondent to prove that the disputed medical devices were not medically necessary.

In the event an insurer relies on a peer review report to demonstrate that a particular service was medically unnecessary the peer reviewer's opinion must be supported by sufficient factual evidence or proof and cannot simply be conclusory or may be supported by evidence of generally accepted medical/professional practice or standards. See *Nir v. Allstate Insurance Company,* 2005 NY Slip Op 25090; 7 Misc.3d 544; 796

N.Y.S.2d 857; 2005 N.Y.Misc. LEXIS 419 and *Citywide Social Work & Psy. Serv.P.L.L.C. v. Travelers Indemnity Co.*, 3 Misc. 3d 608; 777 N.Y.S.2d 241; 2004 NY Slip Op 24034.

When an insurer interposes a timely denial of claim that sets forth a sufficiently detailed factual basis and adequate medical rationale for a claim's rejection, the presumption of medical necessity attached to the applicant's properly completed claim is rebutted and the burden shifts back to the claimant to refute the peer review and prove the necessity of the disputed services. Id. See, e.g., CPT Med. Servs., P.C. v. New York Cent. Mut. Fire Ins. Co., 2007 NY Slip Op 27526, 18 Misc.3d 87 (App. Term 1st Dept.); Eden Med., P.C. v. Progressive Cas. Ins. Co., 2008 NY Slip Op 51098(U), 19 Misc.3d 143(A) (App Term 2d & 11th Jud Dists., 2008); Bath Med. Supply, Inc. v. New York Cent. Mut. Fire Ins. Co., 2008 NY Slip Op 50347(U) (App. Term 2d Dept., Feb. 26, 2008) (since the provider failed to rebut the peer review's showing of a lack of medical necessity, defendant was entitled to dismissal of complaint). Where Respondent has set forth a medical rationale and factual basis in support of its contention that the treatment was not medically necessary, the burden then shifts to Applicant, who bears the ultimate burden of persuasion.

Upon consideration of the arguments of counsel and after a thorough review of all submissions I find that Respondent has submitted sufficient evidence to meet its burden of demonstrating that the disputed medical devices were not medically necessary so as to require the applicant to come forward with additional evidence in support of the need for the services. Respondent sets forth a factual basis and a medical rationale for denying the claim. I find that Applicant has submitted sufficient evidence, through the rebuttal of Dr. Gamburg, to satisfy its burden of refuting the findings of the peer review and demonstrating the medical necessity of the disputed devices. Dr. Gamburg sufficiently addresses the issues raised by the peer and adequately explains the necessity for the services. I find the Applicant's proof in this case to be more credible and more persuasive than Respondent's proof. In addition, in this case I must defer to the recommendation of the treating physician who bears the ultimate responsibility for properly caring for his patient.

Respondent further raises a fee schedule defense.

Applicant requested payment in the amount of $2,520.00 under CPT code E1399 for a 28 day rental period for the CCU device and $56.04 for the upper body wrap. Respondent argues that 12 NYCRR 442.2(b) states that 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 area office. Pursuant to the New York State Department of Health area office, the maximum monthly rental fee is calculated at 1/10 of the equipment provider's acquisition cost. Pursuant to the Policy Guidelines of the New York State Medicaid DME Fee Schedule, the monthly rental fee is calculated at 1/10 of the equipment provider's acquisition cost for the DME items that have not been assigned a Maximum Reimbursement Amount (MRA) in New York State Medicaid Program DME Fee schedule."

There are numerous prior arbitration decisions involving this issue. I agree with the decision of Arbitrator Eileen Hennessy, in E.M.A. Medical Equipment v. State Farm Mutual Automobile Insurance Company, AAA Case No. 17-17-1069-5450, and base my decision in large part on that decision.

Taking judicial notice of the Fee Schedule is permissible. See, Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co., 61 A.D.3d 13, 871 N.Y.S.2d 680 (2d Dept. 2009).

In accordance with 11 NYCRR 68.1 (a), the New York State Worker's Compensation Fee Schedule ("fee schedule") has been adopted by the New York State Department of Financial Services to determine the appropriate amount to be paid for no-fault benefits. With specific regard to the payment of no-fault benefits for either the sale or rental of durable medical equipment devices, the New York State Workers Compensation Board has adopted the New York State Medicaid program fee schedule. Where the New York State Medicaid program fee schedule does not set forth a fee amount for a particular durable medical equipment device, pursuant to 12 NYCCR 442.2, in the event the durable medical equipment device is sold, no-fault benefit payments shall not exceed the acquisition cost plus fifty percent, and in the event the durable medical equipment device is rented, no-fault benefits shall not exceed the lesser of the usual and customary price charged to the general public or the price determined by the New York State Department of Health area office.

In this regard, 12 NYCCR 442.2 states in pertinent part:

> (a) The maximum permissible charge for the purchase of durable medical equipment, medical/surgical supplies, and orthotic and prosthetic appliances shall be the fee payable for such equipment or supplies under the New York State Medicaid program at the time such equipment and supplies are provided, except that the fee for bone growth stimulators (HCPCS codes E0747, E0748 and E0760) shall be paid in one payment and not split. For orthopedic footwear or if the New York State Medicaid program has not established a fee payable for the specific item, then the fee payable, shall be the lesser of:
>
> (1) the acquisition cost (i.e. the line item cost from a manufacturer or wholesaler net of any rebates, discounts or other valuable considerations, mailing, shipping, handling, insurance costs or any sales tax) to the provider plus 50 percent; or (2) the usual and customary price charged to the general public.
>
> (b) The maximum permissible monthly rental charge for such 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 area office. The total accumulated monthly rental charges shall not exceed the fee amount allowed under the Medicaid fee schedule.

In the within matter, the applicant's claim is for the rental of the CCU device. Therefore, pursuant to 12 NYCCR 442.2 (b), the applicant shall be paid the lesser of either, (1) the amount set forth in the New York State Medicaid program for the subject device, or (2) the lesser of the usual and customary price charged to the general public for the rental of these durable medical equipment devices or the price determined by the New York State Department of Health area office.

The subject device was billed by the applicant under CPT code E1399 (i.e. durable medical equipment, misc.). The New York State Medicaid program lists CPT code E1399, however, it does not set forth any fee amount for a durable medical device billed under that CPT code. Under these same circumstances where a durable medical equipment device is billed under a CPT code listed in the New York State Medicaid program, and no fee amount is set forth in the New York State Medicaid program for that CPT code, it has been argued that the Appellate Division, First Department in Matter of Glob. Liberty Ins. Co. v. ISurply, LLC, 2018 NY Slip Op 04961 (1st Dept. 2018) has indicated (in dicta) that the one-sixth/one-tenth rule set forth in the New York State Medicaid Program Durable Medical Equipment Manual Policy Guidelines applies to calculate the fee payable for such device (as the subject CCU device).

In MiiSupply, LLC v. State Farm Mutual Automobile Insurance Company, AAA Case No.: 17-17-1056-3652, Arbitrator Paul Isrealson held:

> "Specifically, in this regard, the Appellate Division, First Department in Matter of Glob. Liberty Ins. Co. v. ISurply, LLC, 2018 NY Slip Op 04961 (1st. Dept. 2018) issued a decision on 7/3/2018, which stated: "It is true that the Medicaid DME fee schedule, which listed certain codes for DMEs, some of which had a MRA and [*3] some of which did not, established that for those that did not have a MRA, the monthly rate of 1/6th of the equipment provider's acquisition cost would apply. And it is also true that, pursuant to 12 NYCRR § 442.2(b), "the total accumulated monthly charges shall not exceed the fee amount allowed under the Medicaid fee schedule."

This same dicta in Matter of Glob. Liberty Ins. Co. v. ISurply, LLC, 2018 NY Slip Op 04961 (1st. Dept. 2018) is an express direction to apply the one-sixth/one-tenth rule set forth in the New York State Medicaid Program Durable Medical Equipment Manual Policy Guidelines to calculate the fee for those particular durable medical equipment devices which are listed in the New York State Medicaid program, where no fee amount is set forth in the New York State Medicaid program for such device, such as the subject device.

It appears that the weight of legal authority indicates that the one-sixth fee limitation set forth in the 2013 version (April 20, 2013) of the New York State Medicaid Program Durable Medical Equipment Manual Policy Guidelines and the one/tenth fee limitation

set forth in the 2016 version (July 1, 2016) of the New York State Medicaid Program Durable Medical Equipment Manual Policy Guidelines apply to a no-fault fee calculation of the rental of the CCU device.

The 2016 version (July 1, 2016) of the New York State Medicaid Program Durable Medical Equipment Manual Policy Guidelines expressly provide the following with regard to reimbursement for the rental of durable medical equipment devices:

> The monthly rental charge includes: all necessary equipment; delivery; maintenance and repair costs; parts, supplies and services for equipment set up; and replacement of worn essential accessories or parts (tubes, mouthpieces, hoses, etc.)
>
> 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 an MRA, the rental fee is calculated at 10% of the equipment provider's acquisition cost.

I further note that in GEICO v. MIISUPPLY LLC, (Index No. 616953/18, Supreme Court, Nassau County, Decided 12/2/19), Justice Thomas Feinman held:

> Pursuant to the Policy Guidelines, for DME items that do not have a maximum reimbursement amount listed, as is the case with the SAM device rented by the defendant here, "the rental fee is calculated at 10% of the equipment provider's acquisition cost. Further, Code El399 is included for billing of "Durable Medical Equipment, Misc." in the list of Codes approved by NYS Medicaid DMEFS. Accordingly, the total monthly rental charges for the SAM device at issue may not exceed 10% of the equipment provider's acquisition cost of $3,400.00. As 10% of that figure is $340.00, plaintiffs have demonstrated that they correctly calculated the maximum allowable daily rate over a thirty-day month at $11.33. The plaintiffs have therefore met their burden for summary judgment (see Zuckerman, supra).

Therefore, according to the facts of this case the rental period for the subject device, billed under code E1399, a code listed in the DME fee schedule, was in 2021, and therefore, the one-tenth fee limitation set forth in the 2016 version (7/1/2016) of the New York State Medicaid Program Durable Medical Equipment Manual Policy Guidelines applies to a no-fault fee calculation for these same devices.

The acquisition cost of the unit was $2,499.00. It was rented for 28 days. In accordance with the above formula. ($2,499 X .1 = $249.90 divided by 30 = $8.33/day X 28 days)

the amount that Applicant is entitled to for the rental is $233.24. The bill for the wrap was $56.04. Applicant is therefore entitled to the sum of $289.28 ($233.24 + $56.04).

Accordingly, I award the sum of $289.28.

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**
	Altai Corp. DBA Get Ready Medical Supply	**03/25/21 - 03/25/21**	**$3,076.04**	**$2,576.04**	**Awarded: $289.28**
Total			**$3,076.04**		**Awarded: $289.28**

B. The insurer shall also compute and pay the applicant interest set forth below. 11/28/2021 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest shall run from the date the request for arbitration was received by the AAA.

C. Attorney's Fees

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

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 NY
SS :
County of Westchester

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

06/08/2023
(Dated)

Joseph Endzweig

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:
c87d7f3ff56a3e25b297b33bc51b6fab

Electronically Signed

Your name: Joseph Endzweig
Signed on: 06/08/2023