American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Health Nexus Inc. (Applicant)	AAA Case No.	17-22-1263-9626
	Applicant's File No.	GM22-421780, GM22-427785
- and -	Insurer's Claim File No.	0680902730000001
Geico Insurance Company (Respondent)	NAIC No.	35882

ARBITRATION AWARD

I, Charles Blattberg, 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: Eligible injured person

1. Hearing(s) held on 05/17/2023
   Declared closed by the arbitrator on 05/25/2023

   Jay Koo, Esq. from Law Offices of Gabriel & Moroff, P.C. participated virtually for the Applicant

   Christa Varone from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$2,668.38**, was AMENDED and permitted by the arbitrator at the oral hearing.

   Applicant reduced the total amount in dispute to $2,518.38 after eliminating the set up costs.

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

3. Summary of Issues in Dispute

The claimant was the 24 year-old male restrained driver of a motor vehicle that was involved in an accident on 12/9/21. Following the accident the claimant suffered injuries which resulted in the claimant seeking treatment. At issue is the 1/14/22-2/10/22 rental of a Vascutherm unit with cervical and lumbar wraps provided by Applicant.

4. Findings, Conclusions, and Basis Therefor

Based on a review of the documentary evidence, this claim is decided as follows:

Applicant establishes a prima facie case of entitlement to reimbursement of its claim by the submission of a completed NF-3 form or similar document documenting the facts and amounts of the losses sustained and by submitting evidentiary proof that the prescribed statutory billing forms [setting forth the fact and the amount of the loss sustained] had been mailed and received and that payment of no-fault benefits were overdue. See, *Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). I find that Applicant established a prima facie case for reimbursement.

The claimant was the 24 year-old male restrained driver of a motor vehicle that was involved in an accident on 12/9/21. The claimant reportedly injured his neck, upper back, and lower back. There was no reported loss of consciousness. There were no reported lacerations or fractures. Following the accident the claimant was transported to Long Island Community Hospital where he was evaluated, treated, and released. On 12/23/21 the claimant presented toSonia Sikand, PA-C of Macintosh Medical, P.C. with complaints of cervical pain rated 5/10, thoracic pain rated 5/10, and lumbar pain rated 6/10. Cervical examination revealed it was stiff and tender to palpation. Range of motion was restricted: anterior flexion 40/50°, extension 50/60°, bilateral lateral rotation 60/80° and bilateral lateral flexion 30/45°. Palpable trigger points were noted in the muscles of the head and neck. Thoracic examination revealed tenderness noted at paraspinal muscles. Range of motion of the thoracic spine was normal with both flexion and extension without pain. There was evidence of crepitation, laxity or instability noted in the thoracic spine. Hyperextension of thoracic spine caused increased pain. Lumbar examination revealed pain on palpation bilaterally L4-L5 and over the lumbar intervertebral spaces (discs). Range of motion: anterior flexion 60/60°, extension of 10/25° and bilateral lateral flexion 15/25°. Coordination and manual muscle strength were within normal limits. Straight leg raise was positive bilaterally at 45°. The claimant was recommended for physical therapy, chiropractic treatment, acupuncture, ultrasonically guided trigger point injections, EMG/NCV testing, range of motion testing, functional capacity testing, and MRIs (cervical spine, thoracic spine, and lumbar spine). PA Sikand supervised Outcome Assessment Testing.PA Sikand performed trigger point injections under ultrasonic guidance, 4 sites. PA Sikand prescribed Lidocaine 5% ointment x250g, 3% Diclofenac Sodium gel x100g, and Baclofen 20mg x30. PA Sikand prescribed durable medical equipment consisting of a cervical collar, cervical pillow, lumbar sacral support, lumbar cushion, bed board, eggcrate mattress, orthopedic car seat, EMS/TENS unit with belt, infrared heat lamp, and massager. PA

Sikand prescribed the use of a Vascutherm unit with cervical and lumbar wraps and a sustained acoustic medicine (SAM) device. On 12/23/21 the claimant presented to Glenn H. Whitney, D.C. of Glenridge Chiropractic, P.C. and was initiated on chiropractic treatment. On 12/28/21, on referral fromPA Sikand, the claimant presented to Concierge Diagnostics, Inc. for musculoskeletal ultrasound studies of the cervical spine, thoracic spine, and lumbar spine. Cervical and thoracic studies revealed "no sonographic evidence of focal bony or ligaments abnormalities." Lumbar study revealed "mild degree of strain/sprain with no evidence of post-traumatic changes like edema, scarring or extensive myofascitis or myositis." On referral from PA Sikand on12/28/21 the claimant underwent Extracorporeal Shockwave Therapy (ESWT) to the right shoulder. On 1/4/22 Joseph A. Raia, M.D. conducted a neurological examination preliminary to upper extremities and lower extremities EMG/NCV testing performed the same day that suggested evidence consistent with normal studies. The 1/6/22 cervical spine MRI produced an impression of C4-C5 disc bulging impinges upon the anterior thecal sac, C5-C6 disc bulging impinges upon the anterior thecal sac, C6-C7 posterior disc space narrowing with disc bulging impinges upon the anterior thecal sac and narrows the neural foramina bilaterally. The 1/6/22 thoracic spine MRI produced an impression of T8-9 left disc herniation impinges upon the anterior thecal sac. On 1/10/22 Dr. Whitney prescribed a cervical traction unit with pump and a custom fitted TLSO. On 1/11/22 the claimant underwent ESWT to the cervical spine, thoracic spine, and lumbar spine. The 1/13/22 lumbar spine MRI produced an impression of L3-L4 disc bulging mildly narrows the neural foramina bilaterally and L5-S1 left neural foraminal disc herniation impinges upon its nerve root. On 1/20/22PA Sikand conducted a follow-up examination that was substantially similar to that of 12/23/21, supervised Outcome Assessment Testing, and performed trigger point injections under ultrasonic guidance, 4 sites. PA Sikand prescribed Lidocaine 5% ointment x250g, 3% Diclofenac Sodium gel x100g, and Baclofen 20mg x30. On 1/25/22 the claimant underwent ESWT to the cervical spine, thoracic spine, and lumbar spine. On 1/27/22 the claimant underwent ESWT to the cervical spine, thoracic spine, and lumbar spine. On 2/7/22 the claimant underwent ESWT to the cervical spine, thoracic spine, and lumbar spine. At issue is the 1/14/22-2/10/22 rental of the Vascutherm unit with cervical and lumbar wraps provided by Health Nexus, Inc. (Applicant).

DOS 1/14/22-1/27/22

The burden has shifted to the Respondent as they have raised a medical necessity defense. In order to support a lack of medical necessity defense Respondent must "set forth a factual basis and medical rationale for the peer reviewer's determination that there was a lack of medical necessity for the services rendered." See, *Provvedere, Inc. v. Republic Western Ins. Co.*, 2014 NY Slip Op. 50219(U) (App. Term 2nd, 11th and 13th Jud. Dists. 2014). Respondent bears the burden of production in support of its lack of medical necessity defense, which if established shifts the burden of persuasion to Applicant. See generally, *Bronx Expert Radiology, P.C. v. Travelers Ins. Co.*, 2006 NY Slip Op. 52116 (App. Term 1st Dept. 2006). As a general rule, reliance on rebuttal documentation will be weighed in light of the documentary proofs and the arguments presented at the arbitration. Moreover, the case law is clear that a provider must rebut the conclusions and determinations of the IME/peer doctor with his own facts. *Park Slope Medical and Surgical Supply, Inc. v. Travelers*, 37 Misc.3d 19 (2012).

Respondent timely denied the 1/14/22-1/27/22 DME rental at issue based on the 6/28/22 peer review byHoward A. Kiernan, M.D. It is noted that the medical records in evidence and the medical reports listed by Dr. Kiernan as reviewed do not reference any surgery or arthroscopy. After reviewing the claimant's history, treatment, and medical records, Dr. Kiernan opines "based on the review of the submitted medical records, I have come to the conclusion that the DME provided to the claimant was not medically necessary. Records indicate that the claimant is a 25-year-old male who was involved in a motor vehicle accident on 12/9/2021. This device was intended to provide cryotherapy. This DME was not indicated in this case. The claimant was referred for conservative modality sessions and hot/cold therapy can be administered in those sessions itself. If additional cryotherapy was needed then simple ice/hot packs could be used. There was no need to provide a specialized DME for a case of simple soft tissue sprain strain injuries." Dr. Kiernan continues "cold therapy systems are a superficial cold modality providing continuous Cryotherapy for a variety of indications. Routine **post-operative** care for a **non-complicated surgical**procedure does not require the use of this device. A heating pad or a bag of ice is sufficient for topical application of heat or cold. There are no extraordinary circumstances here that require anything more complicated than topical ice or cold 15 minutes 3-4 times per day as needed for swelling and pain relief. Additionally, Evidence is limited that cryotherapy hastens to return to participation. The **operative procedure performed** was a **routine arthroscopic surgery** and a simple ice therapy would suffice the need for cold therapy and thus, there was no requirement for a complicated device. The effectiveness of this method of pain relief is still doubtful. There is not enough scientific evidence supporting the use of this device. Further, the claimant would also be sent for conservative treatment for rehabilitation **after the surgery**. That program would include oral medications for pain control. Those medications would be far more effective in quelling the pain as compared to the prescribed DME." Dr. Kiernan asserts "Many more high-quality trials are needed to provide evidence-based guidelines in the treatment of acute soft-tissue injuries" [*Citation omitted*]. "Until further research can support these claims, however, it is impossible to determine accurately how effective cryotherapy is as a treatment" [*Citation omitted*]. "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" [*Citation omitted*]. The clinical application of the cold compression is not clear. The evidence-based decision is not well guided regarding the beneficial use of cold compression **post-operatively**. Hence, it was not medically necessary [*Citation omitted*]. Dr. Kiernan concludes "in this case, the standard of care was to try the claimant with conservative modalities such as physical therapy for rehabilitation instead of prescribing DME for home use.

Applicant submitted a 1/27/23 peer rebuttal by Arun K. Agrawal, M.D. This rebuttal employs quotations from the 6/28/22 peer review by Dr. Kiernan. As this appears verbatim above such quotations are omitted below. After reviewing the claimant's history, treatment, and medical records, and after reciting the stock pre-printed "ThermoTek VascuTherm therapy system" reasons for prescription from the preprinted prescription form; Dr. Agrawal notes "the facts of peer review are not correct. In this case, DME is not prescribed post-operatively. In fact, it is given for cervical and lumbar

spine pain." Dr. Agrawal continues "although conventional intermittent application of ice packs and wraps may have a positive effect on the healing process but they are not necessarily the best solution when cryotherapy is prescribed. Whereas, an ice machine (Cold water circulating unit in this case) provides better results in the following ways: It penetrates deeper and lasts longer when it is delivered with ice packs; This DME uses wraps that get more coverage than ice packs; One cannot control the temperature of ice packs like a water circulating pump; The adjustable wraps of this device can be used for almost any injured area including, knees, shoulders, wrists, groins, ankles, and backs. Therefore, this denial will not sustain." Dr. Agrawal asserts "I would also state that examples of an acute injury include sprains, strains, and contusions. A soft tissue injury (STI) is the damage of muscles, ligaments and tendons throughout the body. These injuries hurt and take long to heal because damaged tissue causes the release of various chemicals, which perpetuate the problem. After an acute injury occurs, one of the best immediate treatments that continue to be recommended is the R.I.C.E. protocol. R.I.C.E. stands for Rest (to avoid further injury and pain); Ice (to diminish inflammation and pain). Compression (swelling reduction and injury support) and elevation (raise injury above the heart to reduce swelling). The Vascutherm therapy system delivers a totally unique and proprietary thermal compression therapy solution in one easily transportable device. Thermoelectric technology eliminates the need for ice, offers precise temperature control for preventing thermal tissue damage, and delivers exceptional reliability. This system is designed to provide fluid heating, cooling and compression as specified by the physician according to the type of injury sustained. It helps to reduce the edema associated with soft tissue injuries such as burns, postoperative edema and ligament sprains. There is thus a medical utility to the use of these devices and the fact that there is no single accepted and global treatment protocol with respect to soft tissue injuries lends itself to further deference to the treating provider [*Citation omitted*]. The results indicated that the application of thermo-therapy and cryotherapy accompanied with a pharmacologic treatment could relieve pain in the patients with acute low back pain. The findings of this study indicated that thermotherapy and cryotherapy caused low back pain to be relieved. Since these methods predictably have fewer side-effects and are economical and accessible, they could be used, alongside pharmacologic treatments, as supplementary ones for reducing pain in the patients with low back pain." Dr. Agrawal then goes into a lengthy explanation of the Vascutherm therapy system that is omitted as it does not address the medical necessity of this "unique and proprietary" device for this particular claimant at the time it was prescribed. Dr. Agrawal concludes "moreover, the DME are beneficial in conjunction with conservative care including physical therapy, conservative chiropractic spinal manipulative treatment and acupuncture treatment; in order that the patient should be able to derive maximum benefit from the therapy it was necessary that her pain levels be reduced. I would further state that when a person is met with an MVA, the recovery process can be difficult and long and the use of DME can benefit in such times. They help in making the conservative care more effective. They also make healing process faster as well as make the recovery process at home more comfortable. As the patient gets aquatinted to these DME over time, the frequency of the in-office sessions can be reduced and this is the time when such DME proves very useful. Also, as the patient progresses towards the normal lifestyle following any trauma, they may yet experience pain at times. The use of such DME is again beneficial at such times because these DME will already be available with the patient. At that point, there won't be any need to consume expensive pills or to

immediately schedule an appointment of physical therapy sessions. The use of medical supplies for home use is supplemental to in-office treatment. Thus, they are quite useful for patients, such as this one, who benefit from their use on those days and at those times when the patient is not receiving in-office treatment. The home unit would provide continuous therapy so as to significantly reduce pain and increase strength. Therefore, the DME at issue were appropriately recommended and provided. There are no specific guidelines delineating the absolute structured path for treatment to be universally prescribed to all patients. Great deference should be given to the treating provider charged with the responsibility to examine, diagnose and treat a patient who presents with symptoms and positive clinical findings. Based upon a review of the aforementioned documents, taking into consideration the patient's the history of the injury, the patient's complaints, clinical findings and in accordance with the generally accepted standards of care in the relevant medical community, [*the*] Vascutherm device provided from 01/14/2022 to 01/27/2022 was causally related to the subject accident and medically necessary."

Dr. Kiernan's peer review is not only factually flawed, but unpersuasive. Dr. Kiernan's opinion is based almost entirely on the prescription of a Vascutherm unit following a routine or non-complicated arthroscopic surgery when there was no such surgery performed. As such, the peer review fails to set forth a sufficient factual basis or medical rationale to support the conclusion that the prescription of the equipment in dispute was not medically necessary. Dr. Kiernan does not state any generally accepted medical standards from which the treating physician here deviated when prescribing the equipment in dispute. Applicant is entitled to reimbursement.

DOS 1/28/22-2/10/22

The insurer has the burden of coming forward with "competent evidentiary proof" to support its fee schedule reduction or denial. See, e.g., *Roberts Physical Therapy, P.C. v. State Farm Mutual Automobile Insurance Company*, 13 Misc.3d 172, 3006 N.Y. Slip Op. 26240 (N.Y. Civ. Ct. Kings Co. 2006). In the absence of such proof, a defense of noncompliance with the appropriate fee schedule cannot be sustained. *Continental Medical, P.C. v. Travelers Indemnity Company*, 11Misc,3d 145(A), 2006 N.Y. Slip Op. 50841(U) (App. Term 1st Dept. 2006).

As to the 1/28/22-2/10/22 DME rental at issue Respondent timely reimbursed $116.62 and denied the $989.38 remainder advising "*[f]or Medical equipment and supplies billed under E1399, the maximum 1 permissible charge is 10% of the acquisition cost*."

Respondent's representative argued that the New York State Medicaid Durable Medical Equipment fee schedule mandates that for equipment that does not have an assigned Maximum Reimbursement Amount ("MRA"), the monthly rental fee is calculated at 10% of the equipment provider's acquisition cost. Applicant's counsel argued that neither the New York State Department of Health (DOH) nor the New York State Medicaid Fee Schedule contains a monthly rental rate for this item. As such, the only method to determine the monthly rental charge is the monthly rental charge to the general public. 12 NYCRR 442.2(b) specifically denotes the NYS Medicaid Fee Schedule as the document to rely on to determine the maximum rental charge allowed,

not the Medicaid DME Policy Guidelines. These documents are not interchangeable. 12 NYCRR 442.2(g) specifically emphasizes this point - 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 except to the extent such documents contain the Medicaid durable medical equipment fee schedule. Therefore, Applicant argues that as such, an insurance carrier's calculation based on the 1/10th rule (or 10%) is incorrect.

There is no dispute that CPT code E1399, billed by Applicant, has no reimbursement amount listed in the durable medical equipment fee schedule. Specifically: 12 NYCRR 442.2(b) reads as follows:

"*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*."

12 NYCRR 442.2(g) reads as follows:

"*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 Worker's Compensation cases except to the extent such documents contain the Medicaid durable medical equipment fee schedule*."

Accordingly, I find that this argument that monthly rate shall not exceed one-tenth the acquisition cost was an incorrect interpretation. I find Applicant is entitled to reimbursement based on the monthly rental charge to the general public; I further find the formula in the Medicaid DME Policy Guidelines does not apply to No-Fault reimbursement. Respondent would have the burden of establishing the monthly rental charge to the general public.

In addition, reference must be made to case law. In *Global Liberty Insurance Co. v. Isurply, LLC*, Index No. 28577/2016, the Court held that the proper calculation is the rate charged to the general public. Specifically, in the *Global Liberty* decision, the Court discussed the 2016 opinion letter from Joanne Criscione, Esq. which indicates that the DOH had not made a prior determination on the DMEs. Ms. Criscione's June 8, 2016 letter specifically referenced 12 NYCRR Part 442.2 (g) when she said, "*My letter [July 3, 2014] merely states the Medicaid reimbursement policy as that policy is set forth in the Medicaid Provider Manual for DME*." 12 NYCRR Part 442.2 (g) states: The Medicaid provider manual and the policy guidelines for durable medical equipment are not included as part of the durable medical equipment fee schedule used in workers' compensation cases except to the extent such documents contain the Medicaid durable medical equipment fee schedule. *Thus, it is clear: the rental fee for durable medical equipment which do not have a maximum reimbursement amount (MRA) is the usual and customary fee charged to the general public*.

Additionally, in the Supreme Court, Bronx County decision of *Maidstone Ins. Co. v. Medical Records Retrieval, Inc.*, 2018 N.Y. Misc. LEXIS 1318, 2018 NY Slip Op. 50556(U), 59 Misc. 3d 1215(A) decided on 4/4/18, the Court held that the fees regarding a CPM and water circulating unit were "*DME items [which] are not listed at all on the Medicaid fee schedule, the Department of Health has not determined a monthly rental charge. Under these circumstances, the applicable monthly rental charge will be the rate charged to the general public (12 NYCRR §442.2[b])*." To the extent Respondent relies upon the decision by Justice Thomas Feinman in *Government Employees Insurance Company v. MiiSupply, Inc.* dated October 13, 2019, Index No. 616953/18, in which Justice Feinman declares that the rental of a SAM unit should be calculated at 1/10th of the provider's acquisition cost, it does not go unnoticed that Justice Feinman ignores the language of 12 NYCRR 442.2(g), which specifically excludes the Policy Guidelines in determining the applicable fee for equipment rental. Respondent has failed to meet its burden regarding its 1/10th rule defense.

Finally, although Respondent did not submit a fee audit or any expert proof in support of its contention that Applicant billed in excess of the fee schedule, Respondent did submit on 3/10/23 (one week before the hearing) a position statement in which it asserted that it is the Applicant's prima facie burden to demonstrate the proper fee for the miscellaneous and/or unlisted DME at issue here billed under CPT code E1399. Since Applicant did not meet its prima facie burden, Respondent asserts that it is not entitled to any reimbursement. It is noted that this position is wholly inconsistent with the 1/10th rule set forth in Respondent's denial. Specifically, Respondent relies upon 11 NYCRR Section 65-3.8(g) (1), which is applicable to services or supplies provided after April 1, 2013. However, the exact same argument made by Respondent here was soundly rejected by Arbitrator Michael Rosenberger in a well-reasoned and cogent decision which held that the latter regulation does not shift the prima facie burden to the Applicant. See *ABV Medical Supplies Inc. v. Geico Insurance Company*, AAA Case No.: 17-21-1228-2841 (Arbitrator Michael Rosenberger, 11/28/22). In his decision, Arbitrator Rosenberger held that the prima facie burden remains at all times with the Respondent to prove that the Applicant billed in excess of the fee schedule. As specifically noted by Arbitrator Rosenberger:

"*In support of this contention respondent relies upon several arbitration awards, but such awards are unpersuasive in light of the bevy of appellate and legislative authority on the issue including the New York Court of Appeals. Applicant, as set forth in its own memorandum of law, asserts that the law is well settled as to applicant's prima facie case and that providing such proof is not part of its burden. To the contrary, any issues regarding fee schedule are affirmative defenses to which respondent must support with a coder affidavit if such billing is open to interpretation. For the reasons set forth below, applicant is not required to establish its fee schedule is proper as part of its prima facie case.*

The law is well settled in no-fault regarding applicant's prima facie case. Indeed, for nearly a decade applicant's prima facie case has been one of the few clear and consistent tenets of the law: submission of the bill and overdue. Previously there were many years of contentious litigation over applicant's prima facie case riddled with novel

arguments but the issue was resolved by the New York Court of Appeals in Viviane Etienne Med. Care, P.C. v. CountryWide Ins. Co., 25 NY3d 491 (2015). The New York Court of Appeals held that "a plaintiff demonstrates prima facie entitlement to summary judgment by submitting evidence that payment of no-fault benefits are overdue, and proof of its claim, using the statutory billing form, was mailed to and received by the defendant insurer."

Respondent is seeking to expand applicant's prima facie case to include something not contemplated by the New York Court of Appeals - fee schedule. Fee schedule has always been an affirmative defense falling upon respondent to establish the burden of production in the first instance. Prior attempts to shift the initial burden of proof regarding fee schedule to applicant's have been rejected by the Appellate Courts. The most analogous to the instant fact pattern pertains to by-report billing and to a certain degree the use of time-based codes. Respondent argues the burden should fall upon applicant. However, these arguments have been rejected and the courts have held the onus falls upon respondent to seek verification to determine the proper fee schedule and prove their affirmative defense. This is not a prima facie burden. See, Bronx Acupuncture Therapy, P.C. v Hereford Ins. Co., 2019 NY Slip Op 06059 (2d Dept. 2019); See also, Bronx Acupuncture Therapy, PC v. Hereford Ins. Co., 54 Misc3d 135(A) (App Term 1 Dept. 2017).

In Bronx Acupuncture Therapy, P.C. v Hereford Ins. Co., 2019 NY Slip Op 06059 (2d Dept. 2019), plaintiff billed for Code 97039, which is an unlisted modality. Defendant denied the claim on the ground that "the provider failed to provide pertinent information concerning the nature, extent, and need for the service, or the time, the skill and the equipment necessary." In finding for plaintiff, the Appellate Division held:

We agree with the Appellate Term's determination that the denial of the plaintiff's claim for services billed under CPT code 97039 was without merit as a matter of law. Although an unlisted modality must be justified by report, this requirement has no bearing on the insurer's burden of requesting additional verification in the first instance (see Hospital for Joint Diseases v Travelers Prop. Cas. Ins. Co., 9 NY3d at 319), which the defendant insurer did not do. Since there is no dispute that the defendant received the requisite claim form and that the denial of the claim was without merit as a matter of law, summary judgment on the cause of action to recover for services billed under CPT code 97039 (moxibustion) was properly awarded to the plaintiff. (Emphasis added.)

Similarly, here, respondent contends the burden should fall upon applicant to establish its billed amount is in accordance with the fee schedule ab initio as part of its prima facie case. There is no Appellate or legislative authority to support this position. Indeed, when the regulation was amended in 2013 to permit a fee schedule defense to be raised even in the absence of a timely denial the legislature did not choose to expand applicant's prima facie case.

Respondent also relies upon 11 N.Y.C.R.R. 65-3.8(g) to support its position. However, again, the intention behind this amendment was not to impact applicant's prima facie case. To the contrary, the purpose of the regulatory amendment was to effectively abrogate the ruling in Fair Price Med. Supply, Corp. v. Travelers Ins. Co., 10 NY3d 556

(2008), which required a defense premised upon overbilling or phantom billing to be preserved in a timely denial of claim form. The regulatory amendment permitted such defenses to be raised at any time. There was never any legislative intent to modify applicant's prima facie case. See generally, Regulatory Impact Statement for the Fourth Amendment to 11 NYCRR 65-3 (Insurance Regulation No. 68-C). Finally, and most importantly, the regulatory amendment being relied upon was effective April 1, 2013 - two years prior to the holding in Viviane Etienne, supra and six years prior to the Appellate Division ruling in Bronx Acupuncture. If the Appellate Division or New York Court of Appeals believed the regulatory amendment required an applicant to establish fee schedule as part of its prima facie case it would have done so. It did not."

I am persuaded by Arbitrator Rosenberger's decision. See also Comfort Care Services Inc. v. Geico Insurance Company, AAA Case No.: 17-21-1203-8953 (Arbitrator Meryem Toksoy, 8/15/22) and Triborough Orthopedics P.C. v. Geico Insurance Company, AAA Case No.: 17-21-1219-0299 (Arbitrator Andrew Horn 8/29/22). As I find that durable medical equipment that had not had its price determined by the Department of Health or that was not included in the Medicaid Fee Schedule is compensable pursuant to 11 NYCRR § 68.5 at the rate charged to the general public, and Respondent did not provide the acquisition cost or the customary price charged to the general public, I find that the Respondent has failed to demonstrate that Applicant billed in excess of fee schedule. Respondent also did not adequately demonstrate that the wraps are included with the rented item.

Accordingly, Applicant is awarded $2,518.38.

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
	Health Nexus Inc.	**01/14/22 - 01/27/22**	**$1,679.00**	**$1,529.00**	**Awarded: $1,529.00**
	Health Nexus Inc.	**01/28/22 - 02/10/22**	**$989.38**	**$989.38**	**Awarded: $989.38**
Total			**$2,668.38**		**Awarded: $2,518.38**

B. The insurer shall also compute and pay the applicant interest set forth below. 08/26/2022 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest runs from 8/26/22 (the date that arbitration was requested) until the date that payment is made at two percent per month, simple interest, on a pro rata basis using a thirty day month.

C. Attorney's Fees

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

Pursuant to 11 NYCRR §65-4.6 (d), ". . . the attorney's fee shall be limited as follows: 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon for each applicant for arbitration or court proceeding, 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 NY
SS :
County of Nassau

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

06/16/2023
(Dated)

Charles Blattberg

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:
0847b945f6da513d9ba1da3f175b0d13

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Your name: Charles Blattberg
Signed on: 06/16/2023