

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

OrthoMotion Rehab DME Inc., LLC (Applicant)	AAA Case No.	17-23-1298-0695
- and -	Applicant's File No.	GM23-584769, GM23-587147, GM23-590622, GM23-593729
Geico Insurance Company (Respondent)	Insurer's Claim File No.	0442751310101055
	NAIC No.	35882

ARBITRATION AWARD

I, Cathryn Ann Cohen, the undersigned arbitrator, designated by the American Arbitration Association pursuant to the Rules for New York State No-Fault Arbitration, adopted pursuant to regulations promulgated by the Superintendent of Insurance, having been duly sworn, and having heard the proofs and allegations of the parties make the following **AWARD**:

Injured Person(s) hereinafter referred to as: Assignor

1. Hearing(s) held on 11/22/2023
Declared closed by the arbitrator on 11/22/2023

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

Crystal Russo, Esq. from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$4,820.00**, 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

Applicant seeks \$4,820.00 reimbursement of charges for a Vascutherm back wrap (\$135.00) and consumable patches (\$555.00) provided on January 26, 2023 plus the rental of a Vascutherm device under code E1399 from January 26, 2023 through February 22, 2023 (28 days at \$80.00 per day) as well as the rental of a SAM unit under code E1399 from January 26, 2023 through February 24, 2023 (30 days at \$63.00 per day) per prescription to Assignor a 51-year-old male driver involved in a motor vehicle accident on December 15, 2022.

Respondent timely denied reimbursement based on a peer review by Howard Kiernan, M.D. dated March 2, 2023, opining the DME was not medically necessary.

By checking box 18, the denials also raise the defense that the billing is not in accordance with the fee schedule. As further explanation of its fee schedule defense, at the hearing, counsel for Respondent argued that for medical equipment and supplies billed using code E1399 the maximum permissible charge is 10% of the acquisition cost.

4. Findings, Conclusions, and Basis Therefor

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I have reviewed the documents in the ADR Center record of the case maintained by the AAA as of the date of the hearing.

It is well settled that a health care provider establishes a prima facie case of entitlement to recover first-party no-fault benefits by submitting 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 was overdue. (*see Insurance Law Sec. 5106[a]; Mary Immaculate Hosp v. Allstate Ins. Co.*, 5 AD3d 742 [2004]. Respondent's denial(s) indicating receipt of the proof of claim shows that Applicant mailed the proof of claim form(s) to the Respondent (*see Ultra Diagnostic Imaging v. Liberty Mutual Insurance Co.*, 9 Misc3d 97). The evidence is sufficient to make out a prima facie case of entitlement to recovery of Applicant's bills.

Lack of Medical Necessity Defense

Once Applicant has established a prima facie case the burden shifts to the insurer to prove that the medical treatment was not medically necessary (*see Citywide Social*

Work & Psychological Services v Allstate Ins. Co., 8 Misc3d 1025A; *A.B. Medical Services, v Geico Ins. Co.*, 2 Misc3d 26). Neither the Insurance Law nor the Regulations define "medical necessity." A review of case law reveals that most courts have evaluated medical necessity based on whether or not services provided were in accord with the generally accepted medical practices. Therefore, to prove that the services were not medically necessary, at a minimum, lack of necessity must be supported by competent evidence such as an IME or peer review or other proof which sets forth a factual basis and medical rationale for denying the claim. A peer review report's medical rationale is insufficient if it is unsupported by or controverted by evidence of medical standards (*see Nir v. Allstate Insurance Company* 7 Misc3d 544).

Upon a showing of lack of medical necessity through a peer review, an Applicant is required to rebut same (*see A Khodadadi Radiology, P.C. v. NY Central Mutual Fire Ins. Co.*, 16 Misc.3d 131(A)).

The peer notes that Assignor was a restrained driver of a vehicle struck on the front on December 15, 2022, sustaining multiple injuries including injuries to the neck, mid- back and lower back. On January 9, 2023, Assignor presented to Amira Nasser, PA/Hiram Emmanuel Luigi-Martinez, M.D., at Atlantic Medical & Diagnostic, P.C. with complaints of pain in the neck, mid-back and lower back. Physical examination of the cervical spine revealed tenderness to palpation upon the cervical facet and decreased range of motion. Examination of the thoracic spine was normal. Examination of the lumbar spine revealed decreased range of motion, trigger point tenderness and positive SLR. Assignor was recommended for conservative treatment. MRIs, prescribed medications and DME.

Assignor was provided with the Vascutherm with back wrap and SAM unit and patches.

As regards the SAM unit and patches, Assignor sustained soft tissue injuries which would be expected to respond to conservative treatment, such as analgesics and a course of physical therapy. The peer asserts that Assignor was appropriately prescribed physical therapy but prescribing DME for home use while receiving physical therapy was redundant and excessive further noting that, "Many people use home DME as comfort items." The peer asserts that there is no relevant literature available in support of such DME for home use in acute musculoskeletal injuries. If ultrasound was desired, it could have been provided as part of the conservative program. Providing the SAM unit while the claimant was receiving physical therapy was redundant and excessive. The peer points to an article indicating that when patients failed to respond to physical therapy, SAM proved to be a useful adjunct to facilitate healing. Here, Assignor did not start a course of physical therapy. The peer also states the effectiveness of ultrasound is not proven and that more investigation is needed.

As regards the Vascutherm device, Assignor sustained soft tissue injury of the lumbar spine which would be expected to respond to conservative treatment such as analgesics and a course of physical therapy. If cold/hot compression treatment was desired, it could have been provided as part of the prescribed conservative program, or with topical application of ice, or by simply taking a hot bath. There was no need to supplement the plan with DME. Moreover, a therapist's cold/hot treatment would be far superior compared to that of DME at home. In addition, the peer states that the clinical benefit of cold/hot compression therapy is doubtful. citing some articles. The peer also states that until there is a definitive trial of the clinical effects of a define cryotherapy method, the real benefit of cold compression therapy remains unclear. The effectiveness of this method of pain relief is still doubtful and there is not enough scientific evidence supporting the use of this device.

Respondent's evidence fails to set forth a factual basis and medical rationale to establish lack of medical necessity for the disputed DME provided to Assignor which it is Respondent's burden to establish. The peer review is merely the peer's opinion standing alone unsupported by evidence of medical standards. The peer fails to articulate with medical support that in providing these DME there was a departure from generally accepted standard of care. The peer's feeling that if ultrasound and cold compression was desired, these modalities could have been provided as part of the conservative treatment program and that topical application of ice is just as beneficial does not establish that these DME were medically unnecessary as experts differ on the best approach to facilitate healing. Lack of proven efficacy does not establish lack of medical necessity. The denials based on lack of medical necessity are not supported by substantial evidence. Moreover, Applicant submits a rebuttal from Drora Hirsch, M.D. which credibly refutes the peer's opinion on the medical necessity of the disputed DME provided to Assignor. Applicant is entitled to reimbursement for the rental of the Vascutherm device with back wrap and SAM unit with patches provided to Assignor.

As regards Respondent's fee schedule defense, the fee schedule allowances for Durable Medical Goods are found in 12 NYCRR §442. 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.

Applicant argues this item is not listed in the NYS Medicaid fee schedule but is reimbursable as durable medical equipment (DME) pursuant to no-fault regulations.

Based thereon, the only permissible charge under this section for this item of DME is the rental charges to the general public. Applicant argues the amount charged is reasonable for this item being provided in the New York Metropolitan Area.

Respondent contends that the NYS Department of Health relies upon the Medicaid DME, Orthotics, Prosthetics and Supplies Policy Guidelines (part of the DME provider Manual) to ascertain the monthly rental fee and that those guidelines indicate that the rental fee is calculated at 10% of the equipment provider's acquisition cost for DME items, such as this item in dispute, that have not been assigned a Maximum Reimbursement Amount (MRA) in the NYS Medicaid (DME) Fee Schedule.

In fact, Respondent has not submitted any determination by a Department of Health area office which establishes the applicable reimbursement rate. Additionally, pursuant to 12 NYCRR §442.2(g) "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."

I disagree with Respondent's position. Rather, concurring with Applicant, I find that the appropriate reimbursement rate for the rental of this item of DME pursuant to 12 NYCRR Section 442.2 is the monthly rental charge to the general public. The rental charge for this device is not unreasonable.

As there is no MRA under the Medicaid fee schedule and the New York State Department of Health area office has not determined a monthly rental charge for this item of DME at issue, the sole limiting factor is the monthly rental charge of said item to the general public.

Indeed, squarely on point is a recent Civil Court/Queens County case that held that where, as in this case, there was no MRA under the Medicaid fee schedule and the Department of Health did not determine a monthly rental charge for the DMEs at issue, the only limiting factor was the items' rental charge of said items to the general public (*see Advanced Recovery Equip. & Supplies v Maya Assurance Co.*, 58 Misc3d 1209(A)).

As such, defendant has failed to sustain its burden that the provider billed in excess of the fee schedule.

Accordingly, Applicant's request for reimbursement is granted.

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
	OrthoMotion Rehab DME Inc., LLC	01/26/23 - 02/06/23	\$2,406.00	Awarded: \$2,406.00
	OrthoMotion Rehab DME Inc., LLC	02/07/23 - 02/13/23	\$1,001.00	Awarded: \$1,001.00
	OrthoMotion Rehab DME Inc., LLC	02/14/23 - 02/20/23	\$1,001.00	Awarded: \$1,001.00
	OrthoMotion Rehab DME Inc., LLC	02/21/23 - 02/24/23	\$412.00	Awarded: \$412.00
Total			\$4,820.00	Awarded: \$4,820.00

- B. The insurer shall also compute and pay the applicant interest set forth below. 05/04/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

In accordance with 11 NYCRR 65-3.9(c) interest shall be paid on the claim awarded in the amount of \$4,820.00 from MAY 4, 2023 the date the arbitration request was received by the AAA.

C. Attorney's Fees

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

In accordance with 11 NYCRR 65-4.6(d) the insurer shall pay Applicant an attorney's fee on the claim awarded in the amount of \$4,820.00.

- 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 New York

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

12/15/2023
(Dated)

Cathryn Ann Cohen

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:
380ac966e0c9242b7536d7dffe7e18d4

Electronically Signed

Your name: Cathryn Ann Cohen
Signed on: 12/15/2023