American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

One Touch Health Supply Inc. (Applicant)	AAA Case No.	17-22-1272-8174
	Applicant's File No.	LIP-22002
- and -	Insurer's Claim File No.	0341353140101110
	NAIC No.	22055
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Eileen Hennessy, 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-C.B.

1. Hearing(s) held on 11/17/2023
   Declared closed by the arbitrator on 11/17/2023

   Lee-Ann Trupia from Law Offices of Ilya E Parnas P.C. participated virtually for the Applicant

   Maria Greenman from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$970.00**, was NOT AMENDED at the oral hearing.
   Stipulations WERE made by the parties regarding the issues to be determined.

   The parties stipulated and agreed that (i) Applicant has met its prima facie burden by submitting evidence that payment of no-fault benefits is overdue, and proof of its claim was mailed to and received by Respondent and (ii) Respondent's denial of the subject claim was timely issued.

3. Summary of Issues in Dispute

   The record reveals that the Assignor-C.B., a 38-year-old male, claimed injuries as the driver of a motor vehicle involved in an accident that occurred on 4/15/2022. Applicant seeks reimbursement for the rental of a Sustained Acoustic Medicine (SAM) Unit

provided from 6/3/2022 through 6/16/2022 and the purchase of coupling patches. Respondent denied the claim based on lack of medical necessity as determined by the peer review report of Harry E. Jackson, M.D., dated 7/28/2022. The issues to be determined are 1) whether the supplies billed were medically necessary and, if so, 2) whether the supplies were billed in accordance with the applicable fee schedule.

4. Findings, Conclusions, and Basis Therefor

Applicant seeks reimbursement for the rental of a SAM Unit and the purchase of coupling patches. 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. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

11 NYCRR 65-4.5 (o) (1) (Regulation 68-D), reads as follows: The arbitrator shall be the judge of the relevance and materiality of the evidence offered and strict conformity to legal rules of evidence shall not be necessary. The arbitrator may question any witness or party and independently raise any issue that the arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department Regulations.

Legal Standards for Determining Medical Necessity

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). The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment, Kingsbrook Jewish Medical Center v. Allstate Ins. Co., 61 A.D.3d 13, 871 N.Y.S.2d 680 (2d Dept. 2009), such as by a qualified expert performing an independent medical examination or conducting a peer review of the injured person's treatment. *See* Rockaway Boulevard Medical P.C. v. Travelers Property Casualty Corp., 2003 N.Y. Slip Op. 50842(U), 2003 WL 21049583 (App. Term 2d & 11th Dists. Apr. 1, 2003). The appellate courts have not clearly defined what satisfies the insurer's evidentiary standard except to the extent that "bald assertions" are insufficient. Amherst Medical Supply, LLC v. A Central Ins. Co., 41 Misc.3d 133(A), 981 N.Y.S.2d 633 (Table), 2013 NY Slip Op 51800(U), 2013 WL 5861523 (App. Term 1st Dept. Oct. 30, 2013). However, there are myriad civil court decisions tackling the issue of what constitutes a "factual basis and medical rationale" sufficient to establish a lack of medical necessity. 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 generally* 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 NY Slip Op 50137(U) (N.Y. City Civ. Ct. 2012).

Where a Respondent meets its burden, it becomes incumbent on the claimant to rebut the peer review. Be Well Medical Supply, Inc. v. New York Cent. Mut. Fire Ins. Co., 18 Misc.3d 139(A), 2008 WL 506180 (App. Term 2d & 11 Dists. Feb. 21, 2008); A Khodadadi Radiology, P.C. v. NY Central Mutual Fire Ins. Co., 16 Misc.3d 131(A), 2007 WL 1989432 (App. Term 2d & 11 Dists July 3, 2007. "[T]he insured/provider bears the burden of persuasion on the question of medical necessity. Specifically, once the insurer makes a sufficient showing to carry its burden of coming forward with evidence of lack of medical necessity, 'plaintiff must rebut it or succumb." Bedford Park Medical Practice, P.C. v. American Transit Ins. Co., 8 Misc.3d 1025(A), 2005 WL 1936346 at 3 (Civ. Ct. Kings Co., Jack M. Battaglia, J., Aug. 12, 2005). "Where the defendant insurer presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden shifts to the plaintiff which must then present its own evidence of medical necessity (*see* Prince, Richardson on Evidence §§ 3-104, 3-202 [Farrell 11 ed])." West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc.3d 131(A), 2006 N.Y. Slip. Op. 5187(U) at 2, 2006 WL 2829826 (App. Term 2d & 11 Dists. Sept. 29, 2006).

Application of Legal Standards

In support of its contention that the SAM Unit rental providedfrom 6/3/2022 through 6/16/2022 was not medically necessary, Respondent relies upon the peer review of Harry E. Jackson, M.D., dated 7/28/2022. A formal rebuttal was not submitted.

Respondent has met its evidentiary burden. The peer review authored by Harry E. Jackson, M.D., dated 7/28/2022, adequately sets forth the factual basis and medical rationale to support the conclusion that the prescribed SAM Unit was not medically necessary. That being so, the burden shifts to the Applicant to counter Respondent's showing.

In this matter, I am faced with conflicting opinions concerning the medical necessity for the disputed SAM Unit rental herein. There are no legal issues to resolve. This dispute involves solely an issue of fact, that is, whether the SAM Unit rental was medically necessary. Resolution of that fact is determined by which opinion is accepted by the trier of fact.

Having carefully reviewed the evidence, including the letter of medical necessity by Gamil Kostandy Saad, M.D., which relies on his examination report, dated 4/25/2022, the prescription, dated 4/25/2022, the delivery receipt, and all the medical records incorporated into the electronic file, I find, as a matter of fact, that the SAM Unit rental in dispute was medically necessary. The examination report sets forth clinical findings and explains the significance of those findings in relation to the SAM Unit rental that

was provided. I find the report sufficiently establishes the medical necessity of the prescribed SAM Unit thereby rebutting the arguments that were raised in the peer review. Having carefully considered the entire record, I find that the more credible and persuasive proof resides with the Applicant. Applicant's claim for the SAM Unit rental is granted and the issue to be determined is the proper reimbursement.

FEE SCHEDULE

It is Respondent's burden 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., 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 N.Y. Misc. LEXIS 514 (Civil Ct, Kings Co. 2006). If Respondent fails to demonstrate by competent evidentiary proof that a plaintiff's claims were in excess of 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 N.Y. Misc. LEXIS 1109 (App. Term, 1 Dep't, per curiam, 2006). A respondent may interpose a defense in a timely denial that the claim exceeds the fees permitted by the Workers' Compensation schedules, but respondent must, at minimum, establish, by evidentiary proof, that the charges exceeded that permitted by law. Abraham v. Country-Wide Ins. Co., 3 Misc.3d 130A, 787 N.Y.S.2d 678, 2004 N.Y. Misc. LEXIS 544 (App. Term, 2d Dept. 2004).

An insurer's unilateral decision to re-code or change a medical provider's billed CPT codes, to reimburse disputed medical services at a reduced rate, or to deny a 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, fee reductions and denials. *See* Amaze Medical Supply v. Eagle Insurance Company, 2 Misc. 3d 128A (App Term 2d and 11th Jud Dist 2003). A lay person is not qualified to evaluate the CPT codes or to change if the code is used by a health provider in its bills. *See* Abraham v. Country-Wide Ins. Co., 3 Misc. 3d. 130A (App. Term 2d. Dept. 2004). Once the insurer establishes a prima facie showing that the amounts charged by a provider were in excess of the fee schedule, the burden shifts to the provider to show that the charges involved a different interpretation of such schedule or an inadvertent miscalculation or error. Cornell Medical, P.C. v. Mercury Casualty Co., 24 Misc. 3d 58, 884 N.Y.S.3d 558 (App. Term 2d, 11th &13th Dists. 2009).

Furthermore, I take judicial notice of the New York State Workers' Compensation fee schedule. *See*, Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co., 61 A.D.3d 13, 20 (2d Dept. 2009); LVOV Acupuncture, P.C. v. Geico Ins. Co., 32 Misc.3d 144(A) (App Term 2d, 11th & 13th Jud Dists. 2011); Natural Acupuncture Health, P.C. v. Praetorian Ins. Co., 30 Misc.3d 132(A) (App Term, 1st Dept. 2011).

Analysis

Applicant requested payment for a rental period for the SAM Unit from 6/3/2022 through 6/16/2022 ($970.00), totaling fourteen days, billed under HCPCS code E1399

($60.00 per date of service) and coupling patches billed under HCPCS code E1399 ($130.00).

In *The Official New York Workers' Compensation Durable Medical Equipment Fee Schedule*["*WC DME FS*"], Effective 4/4/2022, Code E1399, described as, "Durable medical equipment, miscellaneous" has no assignedpurchase orrental fee.

As outlined by Arbitrator Glen Wiener in *Surgut Leasing Corp and Geico Insurance Company*, AAA Case No.: 17-23-1284-3966 [10/25/2023]:

> **Legal Framework**
>
> Pursuant to the authority granted in Insurance Law § 5108, the fee schedules prepared and established by the chair of the Workers' Compensation Board ["Chair"] are adopted by the Superintendent of Financial Services ["Superintendent"] for use in calculating no-fault reimbursement. 11 NYCRR § 68.1.
>
> For Workers' Compensation Claims, the rental of durable medical equipment ["DME"] prior to April 4, 2022, was governed by 12 NYCRR 442.2(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 June 2021, and effective on April 4, 2022, the Chair adopted, via regulation, *The WC DME FS*. As part of the process 12 NYCRR 442.2 was amended as follows:

(a) (1) 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 Official New York Workers' Compensation Durable Medical Equipment Fee Schedule, third edition, January 19, 2022, prepared and published by the Board, which is hereby incorporated by reference, available for viewing free of charge on the Board's website.

> *(2) The maximum permissible monthly charge for the rental of durable medical equipment shall be the rental price listed in the Official New York Workers' Compensation Durable Medical Equipment Fee Schedule multiplied by the total number of months or weeks respectively for which the durable medical equipment is needed. In the event the total rental charge exceeds the purchase price, the maximum permissible charge for the durable medical equipment shall be the purchase price listed in the Official New York Workers' Compensation Durable Medical Equipment Fee Schedule, whether or not the claimant keeps the durable medical equipment or returns it when no longer needed.*

(b) (1) Prior authorization in accordance with section 442.4 must be obtained when indicated on the Official New York State Workers' Compensation Durable Medical Equipment Fee Schedule for any durable medical equipment prior to prescribing or supplying.

(2) When a medical provider recommends durable medical equipment that is not listed in the Official New York Workers' Compensation Durable Medical Equipment Fee Schedule, prior authorization, including a proposed purchase price or rental price for such equipment, must be obtained and provided within the prior authorization request prior to prescribing or supplying such durable medical equipment.

> The Superintendent did not want the prior authorization requirement for unlisted DME to apply to No-Fault. However, without a stated fee listed in the *WC DME FS*or the need for prior authorization there was no cost containment provision or mechanism.
>
> Prior to April 4, 2022, the total accumulated monthly rental charge limited to the fee allowed under the Medicaid fee schedule.
> Therefore, the Superintendent deemed it necessary to adopt an emergency amendment to 11 NYCRR 68 (Insurance Regulation 83) to cap the purchase price and the total accumulated rental fee of DME supplies for which either no price has been established in the *WC DME FS*or for supplies not even listed in the *WC DME FS*.
>
> The first emergency regulation became effective on April 4, 2022, as noticed in the April 20, 2022, NYS State Register and was slated to expire on July 2, 2022. It stated:
>
> *Part E. Durable medical equipment fee schedule.*
>
> *(a) This Part shall apply to durable medical equipment not listed in the Official New York Workers' Compensation Durable Medical Equipment Fee Schedule and to durable medical equipment listed in the Official New York Workers' Compensation Durable Medical Equipment Fee Schedule for which no fee has been assigned because the durable medical equipment requires prior authorization.*
>
> *(b) The maximum permissible purchase charge or the total accumulated rental charge for such durable medical equipment shall be the lesser of the:*
>
> *(1) acquisition cost (i.e., 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%; or*
>
> *(2) usual and customary price charged by durable medical equipment providers to the general public.*

Arbitrator Glen Wiener further noted:

Subsequent Emergency Regulations became effective on June 30, 2022 (Second Emergency Regulation), September 27, 2022 (Third Emergency Regulation), and on December 23, 2022 (Fourth Emergency Regulation).

It is important to note that The Emergency Regulations only limited the total accumulated amount a provider couldcharge for the rental of DME. Daily, weekly, and monthly rental fees were not capped in the Emergency Regulations.

The regulation was adopted on a permanent basis effective February 15, 2023. Substantive changes in the permanent regulation regarding the maximum accumulated rental charge and the adoption of a new maximum permissible monthly rental charge only became effective on June 1, 2023.

As of June 1, 2023, the maximum permissible monthly rental charge for such durable medical equipment shall be one-tenth of the acquisition cost to the provider. Rental charges for less than one month shall be calculated on a pro-rata basis using a 30-day month.
Under the permanent regulation effective on June 1, 2023, the total accumulated rental charge for such durable medical equipment was limited to the lessor of the:

(i) acquisition cost plus 50%;

(ii) usual and customary price charged by durable medical equipment providers to the general public; or

(iii) purchase fee for such durable medical equipment established in the Official New York Workers' Compensation Durable Medical Equipment Fee Schedule.

Respondent's brief correctly notes that "there is no rental price listed in the rental column for this code so, in that regard, the rental value for this device is unlisted."
Respondent also accurately acknowledges that the Superintendent [DFS] adopted regulations to cap the total accumulated rental fees for supplies notlisted in the*WC DME FS*to safeguard against the depletion of patient's $50,000.00 no-fault insurance benefits.
The DME at issue was provided from 6/3/2022 through 6/16/2022 and is only subject to the limitations set forth in the first emergency regulation which became effective on 4/4/2022. Under the First Emergency Regulation the total accumulated rental charge was limited to the lessor of 150% of the acquisition cost or the usual and customary price charged by durable medical equipment providers to the general public.

There is no evidence establishing Applicant's acquisition cost or the usual and customary price charged to the general public.

I find that in cases where the DME billed by Applicant is billed under a code with no fee listed in the fee schedule and there is no proof of the acquisition cost in the record the initial burden is on the Applicant to establish that the amount billed is commensurate with the fees charged to the general publicbefore the Respondent's calculations can be

considered. I agree with Arbitrator Teresa Giroloma's well-reasoned analysis of this issue in *Pro Recovery Services Inc and Geico Insurance Company*, AAA Case No.: 17-21-1228-1092 heard on 6/28/2022, which stated in pertinent part:

> *1. Summary of Issues in Dispute*
>
> *Whether Applicant has established its prima facie case?*
>
> *Whether Applicant is entitled to any recovery as Respondent contends that Applicant filed to establish its burden of proof regarding fee schedule for a miscellaneous code?*
>
> *Whether Respondent is able to establish its affirmative defense of lack of medical necessity?*
>
> *2. Findings, Conclusions, and Basis Therefor*
>
> *I have reviewed the documents contained in the Electronic Case Folder as of the date of the hearing. This decision is based on my review of that file, as well as the arguments of the parties at the hearing. Each of the parties appeared via ZOOM.*
>
> *In this case, on 11/22/2021 Applicant filed for Arbitration. Applicant lists two bills on the AR-1. Both bills are for dates of service of 2/11/2021 - 2/24/2021. The first bill is in the amount of $1,129.94 with the second bill in the amount of $979.30.*
>
> *According to the NF-3's Applicant billed for an Intermittent Pneumatic Compression Device under CPT Code E0676 RR Qty 14, in the amount of $1,129.94. This bill was received by Respondent on 3/6/2021 and timely denied on 3/23/2021 based upon fee schedule and a peer report by Shruti Patel, M.D.*
>
> *For the second bill of service for 2/11/2021 - 2/24/2021, Applicant billed under CPT Code E1399 for SAM Ultrasound Unit with 28 Gel Capture Patches under CPT Code 1399 RR Qty 14 for the total of $979.30. This bill was also received on 3/6/2021; denied on 3/23/2021 and also based upon a peer report by Shruti Patel, M.D.*
>
> *No pricing information to the general public was provided by Applicant for either device.*
>
> *This is the second of two cases that came before me on 6/28/2022 involving Applicant, the injured party K.M. and Respondent.*

In the first case of AAA 17-21-1202-3129 Pro Recovery Services/ M.K. v. GEICO, as in this case Respondent argues that Applicant failed to establish its prima facie case of entitlement, as it was argued that Applicant bears the burden when billing the CPT Code E1399. As such, without same, Respondent argues that the issue of medical necessity is not reached.

In the linked award I noted and held as follows:

> *At the time of the Arbitration, I advised the parties that I have in the past recently held that the burden of fee schedule for a code such as E1399 does rest on Applicant.*
>
> *By example, in the case of AAA 17-21-1203-0601 Breaks N Braces/ D.M. v. State Farm, came before me on 2/2/2022. In that case the issue of fee schedule for CPT Code E1399 was at issue.*
>
> *In that case as in the case herein, Respondent paid at the 10% rule. Respondent at the hearing, on 5/27/2022 argues that when an Applicant bills under E1399 that the established rate is what is afforded to the general public.*

In the case of AAA 17-21-1203-0601 Breaks N Braces/ D.M. v. State Farm I noted as follows:

> *Having researched this issue extensively since this hearing, I find that the proper fee schedule is the rate to the general public and that it is Applicant's burden to provide this information. …*
>
> *In the case of AAA 17-21-1204-2357 Trinity Bracing v GEICO, Arbitrator Maslow, referenced, the Workers' Compensation Board chair has promulgated a Durable Medical Goods Fee Schedule. At 12 NYCRR 442.2(a), it provides:*
>
> *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

Arbitrator Maslow, next references:

At 12 NYCRR 442.2(b), it provides:

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.

11 NYCRR 65-3.8(g)(1), in the No-Fault Regulations, provides as follows:

Proof of the fact and amount of loss sustained pursuant to Insurance Law section 5106(a) shall not be deemed supplied by an applicant to an insurer and no payment shall be due for such claimed medical services under any circumstances: (i) when the claimed medical services were not provided to an injured party; or (ii) for those claimed medical service fees that exceed the charges permissible pursuant to Insurance Law sections 5108(a) and (b) and the regulations promulgated thereunder for services rendered by medical providers.

Moreover, in 11 NYCRR 65.5 (health services not set forth in schedules), it provides:

If a professional health service is performed which is reimbursable under section 5102(a)(1) of the Insurance Law, but is not set forth in fee schedules adopted or established by the superintendent, and:

(a) if the superintendent has adopted or established a fee schedule applicable to the provider, then the provider

shall establish a fee or unit value consistent with other fees or unit values for comparable procedures shown in such schedule, subject to review by the insurer; or

(b) if the superintendent has not adopted or established a fee schedule applicable to the provider, then the permissible charge for such service shall be the prevailing fee in the geographic location of the provider subject to review by the insurer for consistency with charges permissible for similar procedures under schedules already adopted or established by the superintendent.

With respect to which party bears the burden of fee schedule Arbitrator Maslow provided a well-reasoned analysis which is directly on point. In that case, Arbitrator Maslow, stated, The Workers' Compensation Durable Medical Goods Fee Schedule, quoted above, is applicable, as per Insurance Law § 5108(a). 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 is to be applied. However, the New York State Department of Health area office has not set a fee. That leaves the monthly rental charge to the general public. I construe that term to mean the monthly rental charge by the particular health service provider to the general public. The party with the best information on that would be Applicant. It is presumably aware of its monthly charge to the public at large, i.e., not just Workers' Compensation or No-Fault patients. Therefore, it is proper to impose the burden of proof on providing this information on Applicant -- not on Respondent. Burdens of proof are allocated to put them on the party more likely to have access to the proof. Oceanside Medical Healthcare, P.C. v. Progressive Ins., 2002 N.Y. Slip Op. 50188(U) at 9, 2002 WL 1013008 (Civ. Ct. Kings Co., Jack M. Battaglia, J., May 9, 2002).

This burden of proof concerning the rental of supplies where compensation would be in the amount charged to the general public is to be distinguished from situations where it is proper to place the burden of proof on the insurer, for example when the EAPG fee computation must be made in connection with ambulatory surgery centers. Here, Applicant has not provided any information as to how much it charges patients in general -- not just those who have Workers' Compensation or No-Fault coverage. Without having provided the necessary information regarding its charges to the general public, I am constrained to find that the charged fee was in excess of "the charges permissible pursuant to Insurance Law sections 5108(a) and (b)

and the regulations promulgated thereunder for services rendered by medical providers," as per 11 NYCRR 65-3.8(g)(1)(ii).

It is true, according to 11 NYCRR 65.5, that if a professional health service is performed which is reimbursable under section 5102(a)(1) of the Insurance Law but is not set forth in fee schedules adopted or established by the superintendent, the insurer may review a provider's fee consistent with other fees or unit values for comparable procedures shown in such schedule. Rental of a cold compression pump is not provided for specifically in the Workers' Compensation Durable Medical Goods Fee Schedule, but there is a process which is to be applied for determining the fee. As applied here, the process would entail Applicant providing information as to its monthly rental charge to the general public. Therefore, I find that the provisions of 11 NYCRR 65.5 do not provide sufficient guidance to the facts of this case.

Without Applicant providing its monthly rental charge to the general public, I cannot find that Respondent's denials of claim should be rejected. I do note that Respondent's calculations were based on 10% of the of the acquisition cost. No doubt Respondent engaged in a good faith effort to make partial payment toward a charge it deemed excessive. However, the 10% analysis is not the appropriate analysis to undertake. This is because it is based on the guidance in the New York Medicaid Durable Medical Equipment Fee Schedule: "For DME items that do not have a MRA, the rental fee is calculated at 10% of the equipment provider's acquisition cost." Case law has held that this 10% provision does not apply to No-Fault. E.g., Matter of Global Liberty Ins. Co. v. I Surply, LLC, 163 A.D.3d 418 (1st Dept. 2018); Maidstone Ins. Co. v. Medical Records Retrieval, Inc., 59 Misc.3d 1215(A), 2018 N.Y. Slip Op. 50556(U) (Sup. Ct. Bronx Co., Mary Ann Brigantti, J., April 4, 2018); Advanced Recovery Equipment & Supplies, LLC v. Maya Assurance Co., 58 Misc.3d 1209(A), 2018 N.Y. Slip Op. 50022(U) at 1 (Civ. Ct. Queens Co., Larry L. Love, J., Jan. 3, 2018). As the Workers' Compensation Durable Medical Goods Fee Schedule provides, at 12 NYCRR 442.2(g), "The Medicaid provider annual 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, I cannot sustain the amounts paid by Respondent, but I deem said amounts academic since Applicant failed to meet its

burden of proving what its monthly rental charge to the general public is for a cold compression pump.

Accordingly, the defense asserted in the denials of claim, fees not in accordance with fee schedule, is sustained. Said defense overcomes Applicant's prima facie case of entitlement to No-Fault compensation.

In the case now before me, the issue therefore is whether or not Applicant has met its burden of proving what its monthly rental charge is to the general public for the device billed under CPT Code E1399.

In this case at page 13/59 Applicant offers a Fee Schedule Affidavit, from the owner of Breaks N Braces, who describes what the VacuTherm 4 devise is and that it is most often prescribed to patients following arthroscopy surgery. According to this Affidavit, the rental cost to the general public is $5,995.95. When purchased in volume by a Medical supplier the price can be discounted to$1,999.95 by contract. I see nothing to support these calculations and find them merely self serving.

The monthly rental charge to the general public, is just that, what would it cost someone in the general public to rent this supply on a daily basis. I am simply unpersuaded by Applicant evidence which I find unsupported by independent evidence to corroborate the billing submitted herein. As such, having given this careful consideration, I find that the defense asserted in the denials of claim, fees not in accordance with fee schedule, is sustained. Said defense overcomes Applicant's prima facie case of entitlement to No-Fault compensation.

Applicant's claim is denied.

At the time of this hearing, I advised the parties that the above-mentioned case of AAA 17-21-1203-0601 Breaks N Braces/ D.M. v. State Farm was appealed and was affirmed by Master Arbitrator Burt Feilich, under AAA 99-21-1203-0601. In reviewing the matter, Arbitrator Burt Feilich, stated,

Arb. Girolamo noted that the NYS Department of Health has not established a price for the rental of the device at issue in this case. Consequently, she determined that respondent had not properly calculated the reimbursement rate for the device rented by applicant in this case.

However, Arb. Girolamo approvingly cited at great length from another arbitration award that she stated dealt with the exact

same issues as that presented herein, concerning the proper fee schedule valuation of an item billed by the provider using a miscellaneous DME CPT code, i.e. E 1399, and which party had the burden of proof on the issue of the fee schedule. That award was by Arb. Aaron Maslow in the case of Trinity Bracing Inc. v. Geico, AAA # 17-21-1204-2357.

Master Arbitrator Burt Feilich, also stated:

The arbitrator was entitled to exercise her discretion in determining whatever relevance, weight and/or credibility to accord to the evidence on the issue of the fee schedule under 11 NYCRR 65-4.5(o)(i).

Applicant vigorously contends that Arb. Girolamo incorrectly placed the burden of proof on applicant to establish its rental rate for the equipment provided to claimant, and that her reliance on the award by Arb. Maslow and its reasoning and conclusion were contrary to prevailing case law along with being arbitrary and capricious….

Arbitrator Burt Feilich, stated, in conclusion "The award under review is not contrary to the provisions of the regulations cited above as it placed the evidentiary burden of establishing a provider's monthly rental rate to the general public on applicant."

There is no question that the determination by Arb. Girolamo had a logical and rational basis. It is also beyond argument that she did not consider all of the evidence included in the case file concerning the issue of who bears the burden of proof on establishing a claim for supplies as well as who bears the burden of proof on the fee schedule question presented in this case. Furthermore, there appears to be no clear prevailing case law concerning which party has the evidentiary burden of proof for the monthly rate billed to the general public for an item of DME billed using a miscellaneous CPT code not included in the Medicaid DME fee schedule. Consequently, it cannot be said that the award was inconsistent with prevailing case law or that it was arbitrary or capricious.

Accordingly, the award is affirmed in its entirety

At the time of the Arbitration Respondent advises that there are a number of Arbitrator's that follow this same reasoning. By example, there was a recent matter that came before Arbitrator Camille Nieves on 6/15/2022, in the case of AAA 17-21-1222-3170 Caresoft Leasing Corp v. GEICO, wherein that case Applicant billed under CPT Code

E1399 for a vascutherm and wrap. In that case Arbitrator Camille Nieves, states as follows:

> *It is not dispute that the two rates of reimbursement for DME rentals is the lower of either the monthly rental charge to the general public or the price determined by the NYS Dept. of Health.*
>
> *Also not in dispute is the fact that the code at issue - E1399 - is listed in the Medicaid fee schedule without a Maximum Reimbursement Amount versus codes which are not listed at all.*
>
> *In either scenario, there is no established rate of reimbursement and the provider must establish a monthly rental rate to the general public.*
>
> *Respondent contends the provider failed to establish a rate and therefore is entitled to no reimbursement.*
>
> *I am in agreement on this issue that the appropriate rate under these circumstances is the rate to the general public; however, neither side has demonstrated the rate to the general public.*

Arbitrator Camille Nieves, stated in that case "Applicant bills $79.00/day without any proof that this bears any relation to the rate to the general public and applicant argues that this should be awarded because respondent does not prove the rate to the general public. I disagree. What would be the result if applicant billed $2,000.00/day or more? Should it be reimbursed in that amount without proof and exhaust the policy for a claim for a massager or similar device? A vascutherm may be purchased through Amazon for $219.00. It is used for cold therapy. The price quoted by Amazon is more consistent with the 10% cost proposed by respondent. Respondent has already reimbursed well in excess of that amount - $1048.39. Applicant billed a total of $3298.65.the defense asserted in the denials of claim, fees not in accordance with fee schedule, is sustained. Said defense overcomes Applicant's prima facie case of entitlement to No-Fault compensation."

In that case Arbitrator Camille Nieves, therefore states:

> *I find applicant's method of failing to establish an appropriate fee based on the cost to the general public to be a failure to establish a prima facie case. I find that where there is an unlisted DME code or a listed code with no assigned MRA "the calculation is uniquely accessible to the provider" as stated by Arbitrator Haskel in 17-20-1177-7310 which also involved code E1399."*

Arbitrator Camille Nieves, states that she is persuaded by the arguments set forth by Respondent as set forth in its brief as follows:

> *"As such, Arbitrator Haskel joined Arbitrators Maslow, Casey, Girolamo, Jacob, Tola, and O'Grady, and shifted the burden of proof for unlisted and/or miscellaneous DME codes to the Applicant. Interestingly, Arbitrator Haskel went a step further and found that, "under the circumstances, Applicant has not made a prima facie showing of entitlement to payment for this item" and denied reimbursement for the massager billed under code E1399. See id. at 4.*
>
> *In placing the burden of production on the Applicant in cases involving unlisted and/or miscellaneous DME codes, whether rentals or not, substantive policy and the spirit of the no fault regulations are both served. To not place the burden on Applicant here would result in incentivizing medical providers to bill for unlisted or miscellaneous DME codes, select an exceedingly high billing rate, and hope that the insurer would be too inundated to seek verification, a task the insurer should not be required to do anyway with these types of codes. To ensure that the legislative purpose underlying Insurance Law § 5108 is fulfilled, that being "to significantly reduce the amount paid by insurers for medical services, and thereby help contain the no-fault premium", the burden should be on the Applicant to prove that the rate it seeks reimbursement at is appropriate. See Surgicare Surgical Associates v. National Interstate Ins. Co., 50 Misc.3d at 87."*
>
> *Here, respondent reimbursed at a different rate but applicant provided no evidence of the rate which applicant itself argues is the appropriate rate of reimbursement.*
>
> *This is inconsistent with the fee schedule and spirit of the no fault regulations to promote fair billing and reimbursement of all appropriate claims and to discourage excessive billing. To hold otherwise could conceivably exhaust a policy on a claim for DME simply because the insurer did not prove the cost to the general public.*
>
> *I find that in the absence of such proof, applicant was reimbursed by respondent at a different rate and that applicant has failed to demonstrate another amount consistent with the cost to the general public. No further monies are due and owing.*

Based upon the arguments presented in this case hereto, I find in accordance with the above case law, that Applicant has failed to

provide any evidence of the rate of appropriate reimbursement to the general public, as such Applicant is unable to establish its prima facie case. Therefore, Applicant's claim is for reimbursement under CPT Code E1399 in the amount $979.30 is denied.

With respect to the first bill for which Applicant billed under CPT Code E0676 same is not in the fee schedule.

HCPCS CPT Code E0676 is a miscellaneous code with no set fee amount in the fee schedule. As such, Respondent argues that as with CPT Code E0767 like CPT Codes E1399 or A9999, the burden to establish the proper fee schedule amount is on Applicant. Based upon the above rationale, hereto Applicant's claim is denied. The issue of medical necessity is therefore moot as to each bill.

The issue before me remains whether Applicant has met its burden of proving what its monthly rental charge is to the general public for the device billed under HCPCS Code E1399? I agree with and adopt Arbitrator Giroloma's analysis in AAA Case No.: 17-21-1228-1092, along with Arbitrator Camille Nieves and Arbitrator Maslow's analysis of the burden of persuasion cited therein. As stated in AAA 17-21-1204-2357, *Trinity Bracing v GEICO*, by Arbitrator Maslow:

I construe that term to mean the monthly rental charge by the particular health service provider to the general public. The party with the best information on that would be Applicant. It is presumably aware of its monthly charge to the public at large, i.e., not just Workers' Compensation or No-Fault patients. Therefore, it is proper to impose the burden of proof on providing this information on Applicant -- not on Respondent. Burdens of proof are allocated to put them on the party more likely to have access to the proof. Oceanside Medical Healthcare, P.C. v. Progressive Ins., 2002 N.Y. Slip Op. 50188(U) at 9, 2002 WL 1013008 (Civ. Ct. Kings Co., Jack M. Battaglia, J., May 9, 2002).

This burden of proof concerning the rental of supplies where compensation would be in the amount charged to the general public is to be distinguished from situations where it is proper to place the burden of proof on the insurer, for example when the EAPG fee computation must be made in connection with ambulatory surgery centers. Here, Applicant has not provided any information as to how much it charges patients in general -- not just those who have Workers' Compensation or No-Fault coverage. Without having provided the necessary information regarding its charges to the general public, I am constrained to find that the charged fee was in excess of "the charges permissible pursuant to Insurance Law sections 5108(a) and (b) and the regulations promulgated thereunder for services

rendered by medical providers," as per 11 NYCRR 65-3.8(g)(1)(ii).

HCPCS code E1399, billed for the SAM Unit, is listed in the fee schedule, but has no MRA listed. As such, for HCPCS code E1399, without proof of the acquisition cost, the burden to establish the proper fee schedule amount is on Applicant as "the calculation is uniquely accessible to the provider" as stated by Arbitrator Haskel in 17-20-1177-7310. Applicant has not submitted proof of the net acquisition cost or competent proof of the amount charged to the general public for the code billed. Therefore, Applicant must prove the usual and customary price charged to the general public. I find that Applicant provided insufficient evidence of the usual and customary price charged to the general public for the SAM Unit. Therefore, the burden was not shifted to Respondent to support their fee schedule calculations. Based upon the arguments presented in this case hereto, I find in accordance with the above case law, that as Applicant has not provided evidence of how they arrived at the amount billed of $60.00 per date of service for the SAM Unit, Applicant has not established its prima facie case for reimbursement. Therefore, I find that the fees charged were not in accordance with the fee schedule and exceeded the charges permissible pursuant to Insurance Law sections 5108(a) and (b) and the regulations promulgated thereunder. Therefore, Applicant's claim for reimbursement for the rental of the SAM Unit for dates of service 6/3/2022 through 6/16/2022 is denied.

Regarding the charge for the coupling patches billed under HCPCS code E1399 ($130.00) I have previously determined in an unrelated claim, i.e. *ANMM, Inc. v. Geico Ins. Co.*, AAA Case No.: 17-23-1286-3074, that coupling patches are an integral part of the SAM Unit and are not separately reimbursable. Moreover, the General Guidelines section of the Medicaid DME Fee Schedule indicates the reimbursement amounts for DME, medical/surgical supplies, prosthetics, orthotics and orthopedic footwear includes delivery, set-up and all necessary fittings and adjustments. The rental charge section also states that 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. Based on 12 NYCRR 442.2 (c), Applicant's $130.00 charge, billed under HCPCS code E1399, is denied since it is inclusive of the DME fee. *See also* AAA Case No.: 412013147255.

To the extent that this decision may conflict with any of my prior arbitration awards, this decision is based on the binding legal authority discussed herein.

CONCLUSION

Accordingly, Applicant's claim is denied in its entirety. This award is in full disposition of all No-Fault benefit claims submitted to this Arbitrator.

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 claim is DENIED in its entirety

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of NY
SS :
County of Nassau

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

12/18/2023
(Dated)

Eileen Hennessy

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:
7cce70278d817b0519703169d6e47a3b

Electronically Signed

Your name: Eileen Hennessy
Signed on: 12/18/2023