

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Ultracare Supply Corp (Applicant)	AAA Case No.	17-23-1326-4632
- and -	Applicant's File No.	165649
	Insurer's Claim File No.	0703595388 2SG
Allstate Fire & Casualty Insurance Company (Respondent)	NAIC No.	29688

ARBITRATION AWARD

I, Kihyun Kim, 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: the Assignor

1. Hearing(s) held on 06/28/2024
Declared closed by the arbitrator on 06/28/2024

John Gallagher, Esq. from The Law Offices of John Gallagher, PLLC participated virtually for the Applicant

Brian Korman, Esq. from Law Offices of John Trop participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$8,577.98**, was NOT AMENDED at the oral hearing.
Stipulations WERE NOT made by the parties regarding the issues to be determined.
3. Summary of Issues in Dispute

The issues presented are (1) whether Respondent's denial for duplicate billing may be upheld, and (2) whether certain prescribed DME was medically necessary.

The Assignor (RSJ) was a 41-year-old male who was a passenger in an automobile that was involved in an accident on November 9, 2022. Applicant seeks reimbursement in the aggregate amount of \$8,577.98 for an ultrasound therapy device and a cold compression unit for the knee provided to the Assignor on July 25, 2023. Reimbursement for the cold compression unit was denied based on the peer review by Howard Kiernan, M.D., dated September 25, 2023.

4. Findings, Conclusions, and Basis Therefor

This arbitration was conducted using the documentary submissions of the parties contained in the ADR Center, maintained by the American Arbitration Association. I have reviewed the documents contained therein as of the close of the hearing and such documents are hereby incorporated into the record of this hearing. The hearing was held by Zoom video conference. Both parties appeared at the hearing by counsel, who presented oral argument and relied upon their documentary submissions.

The Assignor was a 41-year-old male who was injured in an automobile accident on November 9, 2022. Following the accident, the Assignor sought treatment, testing and supplies for his injuries from various providers, including Applicant.

On July 7, 2023, the Assignor underwent an arthroscopy of the right knee conducted by Robert Drazic, D.O., and assisted by Shmuel Kaufman, P.A., at facility in Bronx, New York. On July 25, 2023, apparently as part of the Assignor's post-operative rehabilitation, Applicant provided the Assignor with a cold compression unit for the knee and an ultrasound therapy device prescribed Dr. Drazic. Applicant billed Respondent for the DME, and Respondent timely denied Applicant's claims for the cold compression unit based on the peer review, dated September 25, 2023, by Howard Kiernan, M.D., who found the DME to be medically unnecessary. The ultrasound therapy device was denied based on duplicate billing.

Applicant now seeks reimbursement in the aggregate amount of \$8,577.98 for an ultrasound therapy device and a cold compression unit for the knee provided to the Assignor on July 25, 2023.

Analysis - Duplicate Billing - DOS 7/25/23 - Ultrasound device

In the present case, Applicant billed Respondent in the amount of \$4,137.99 under CPT code E1399 for the ultrasound therapy device provided to the Assignor on July 25, 2023. The bill was received on September 6, 2023, and on September 20, 2023, Respondent timely denied Applicant's claims in full based on duplicate billing, stating in the denial/EOB, in pertinent part, that:

The CPT/HCPCS procedure code or NDC billed is a duplicate service billed previously.

Respondent failed to upload any evidence to the record to support its defense, and Respondent's counsel conceded at the hearing that denial was issued in error and that it had no substantive defense for the bill in dispute.

Accordingly, Applicant is awarded that reimbursement in the amount of **\$4,137.99** for the ultrasound therapy device provided to the Assignor on July 25, 2023.

Legal Framework - Medical Necessity - Peer review

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 [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).

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 W. Ins. Co.*, 42 Misc 3d 141(A), 2014 NY Slip Op 50219(U) (App. Term 2d, 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.*, 13 Misc 3d 136(A), 2006 NY Slip Op 52116 (App Term 1st Dept. 2006). The Appellate Courts have not clearly defined what satisfies this standard except to the extent that "bald assertions" are insufficient. *Amherst Med. Supply, LLC v. A. Cent. Ins. Co.*, 41 Misc 3d 133(A), 2013 NY Slip Op 51800(U) (App. Term 1st Dept. 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 civil courts have held that a defendant's peer review or medical evidence must set forth more than just a basic recitation of the expert's opinion. 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 (Civ. Ct. Kings Co. 2005). "Generally accepted practice is that range of practice that the profession will follow in the diagnosis and treatment of patients in light of the standards and values that define its calling." *Id.*, at 547 (*citing City Wide Social Work & Psychological Servs. v. Travelers Indem. Co.*, 3 Misc. 3d 608, 612 [Civ. Ct., Kings County 2004]).

To meet the burden of persuasion regarding medical necessity - in the absence of factually contradictory records - the applicant must submit a rebuttal which meaningfully refers to and rebuts the assertions set forth in the peer review report. *See generally, Pan Chiropractic, P.C. v Mercury Ins. Co.*, 24 Misc 3d 136[A], 2009 NY Slip Op 51495[U] (App Term, 2d, 11th & 13th Jud Dists 2009).

Peer Review - Howard Kiernan, M.D., dated September 25, 2023

Respondent relies upon the peer review report of Howard Kiernan, M.D., dated September 25, 2023, in asserting lack of medical necessity for the cold compression unit for the knee provided to the Assignor on July 25, 2023. At the outset, the peer report lists the various medical records which Dr. Kiernan reviewed and provides a brief medical history of the accident and the treatment that the Assignor received. Dr. Kiernan

opined that based on the review of the submitted medical records, the post-operative DME viz., Cold and Compression Therapy Unit, provided to the Assignor on July 25, 2023, by Applicant, was not medically necessary

Dr. Kiernan noted that the Assignor was a 41-year-old male who was involved in a motor vehicle accident on November 9, 2022, and on July 7, 2023, the Assignor underwent right knee arthroscopy. He further noted that:

The claimant was provided a cold therapy unit; however, this DME was not medically necessary. 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 the topical application of heat or cold.

Dr. Kiernan cited medical authority that stated that "[u]ntil 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." He asserted that until further research can support these claims, it is impossible to determine accurately how effective cryotherapy is as a treatment.

Dr. Kiernan maintained that the standard of care was post-operative conservative treatment including physical therapy sessions to help the claimant to return to activities of daily living. He indicated that an early mobilization program based on supervised exercises seems safe and feasible, improves functional capacity and prevents any complications.

Analysis - Medical Necessity - Cold compression - DOS 7/25/23

After reviewing all of the submissions and taking into account the oral arguments of the parties, I find that Dr. Kiernan's peer review fails to set forth a factual basis and medical rationale for his determination that the the cold compression unit for the knee provided to the Assignor on July 25, 2023, was medically unnecessary. I find the peer report to be conclusory and unpersuasive. While Dr. Kiernan did reference a general standard of care of post-operative conservative treatment including physical therapy sessions to help the claimant to return to activities of daily living, the peer review says little about any accepted medical standard for the prescription of a cold compression therapy unit specifically, and how or why the prescription of the unit deviated from any specific standard of care in this case. Simply questioning the proven effectiveness of a device, or the superiority, cost-effectiveness or the efficacy of a device as compared to an alternative, without sufficient context, detail or explanation is insufficient to meet Respondent burden. In fact, Dr. Kiernan's suggestion that a heating pad or a bag of ice is sufficient for the topical application of heat or cold, arguably suggests that there may be a benefit for post-operative cold compression therapy. At most, I perceive a difference of opinion, rather than a demonstration of deviation from generally accepted practice in the treating surgeon's decision to prescribe the post-operative supplies. Dr. Kiernan fails to provide any adequate explanation or any meaningful discussion, with reference and application of the specific facts and findings from the Assignor's medical record, of how

or why the DME deviated from any generally accepted standard of care. Based on the totality of the evidence in the record, I find Dr. Kiernan's peer review to be lacking and insufficient to meet Respondent's burden of proof as to the lack of medical necessity. As Respondent has failed to meet its initial burden of production. I need not review the evidence submitted by Applicant to rebut Respondent's position. I find that presumption of medical necessity attached to Applicant's prima facie case stands.

Based on the totality of the evidence in the record, Applicant is entitled to reimbursement in the amount of **\$2,451.00** for the cold compression unit for the knee provided to the Assignor on July 25, 2023.

[NOTE: In support of its fee schedule defenses, Respondent uploaded an amended fee schedule/coder affirmation, dated June 27, 2024, Carolyn Mallory CPC, who determined that the appropriate reimbursement for the DME at issue was limited to \$2,451.00. It is not disputed that Respondent has the initial burden to come forward with competent evidentiary proof to support its fee schedule defenses. *Robert Physical Therapy, P.C. v. State Farm Mut. Auto. Ins. Co.*, 13 Misc. 3d. 172 (Civ. Ct. Kings Co. 2006); see also *Maidstone Ins. Co. v Medical Records Retrieval, Inc.*, 2018 NY Slip Op 50556(U) (Sup. Ct., Bronx County, April 4, 2018); *Acuhealth Acupuncture, P.C. v Hereford Ins. Co.*, 58 Misc 3d 141[A], 2017 NY Slip Op 51871[U] (App Term 2017). Ms. Mallory explained that 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. She determined that the acquisition cost plus 50% yielded an allowable reimbursement amount of \$2,451.00 for the DME provided. I found Ms. Macy's affidavit along with Respondent's other supporting evidence was sufficient to make a prima facie showing that the amounts charged by Applicant were in excess of the fee schedule. The burden therefore shifted to Applicant to show that the charges involved a different interpretation of such schedule or an inadvertent miscalculation or error. *See 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). Applicant did not, however, upload its own coder affidavit or put in any other evidence to support a different fee calculation or to otherwise rebut Respondent's fee reductions. As Applicant has failed to meet its ultimate burden of persuasion, I find that the appropriate amount of reimbursement for the DME provided in this proceeding to be \$2,451.00.]

Conclusion

For the reasons set forth herein, Applicant is awarded reimbursement in the total amount of \$6,588.99, with attorney's fees, interest and the arbitration filing fee as set forth below. This decision is in full disposition of all claims for no-fault benefits presently before this Arbitrator. Any further issues raised in the hearing record are held to be moot and/or waived insofar as not specifically raised at the time of the hearing.

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
	Ultracare Supply Corp	07/25/23 - 07/25/23	\$4,439.99	Awarded: \$2,451.00
	Ultracare Supply Corp	07/25/23 - 07/25/23	\$4,137.99	Awarded: \$4,137.99
Total			\$8,577.98	Awarded: \$6,588.99

B. The insurer shall also compute and pay the applicant interest set forth below. 11/22/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest shall be computed from November 22, 2023, the AR-1 filing date, at the rate of 2% per month and ending with the date of payment of the award, subject to the provisions of 11 NYCRR 65-3.9 (c).

C. Attorney's Fees

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

Respondent shall pay the Applicant's attorney's fees, in accordance with 11 NYCRR 65-4.6(d).

- D. The respondent shall also pay the applicant forty dollars (\$40) to reimburse the applicant for the fee paid to the Designated Organization, unless the fee was previously returned pursuant to an earlier award.

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

State of NY
SS :
County of Suffolk

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

07/28/2024
(Dated)

Kihyun Kim

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:
fe0a2eb508bbd2b66a8bdee227796615

Electronically Signed

Your name: Kihyun Kim
Signed on: 07/28/2024