American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Bayside Equipment Inc (Applicant)	AAA Case No.	17-24-1362-1905
	Applicant's File No.	FDNY24-75435
- and -	Insurer's Claim File No.	0747030658-01
	NAIC No.	17230
Allstate Property and Casualty Insurance Company (Respondent)		

ARBITRATION AWARD

I, Rhonda Barry, 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: EIP

1. Hearing(s) held on 03/07/2025
   Declared closed by the arbitrator on 03/07/2025

   Melissa Pirillo, Esq. from Fass & D'Agostino, P.C. participated virtually for the Applicant

   Linda Smith, Esq. from Law Offices of John Trop participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$5,839.31**, was NOT AMENDED at the oral hearing.
   Stipulations WERE made by the parties regarding the issues to be determined.

   The parties stipulated that the denials are timely. If applicable, interest accrues in accordance with 11 NYCRR§65-3.9.

3. Summary of Issues in Dispute

   The EIP, "PD" is a 60 year old male injured as a driver in a motor vehicle accident on 2/24/24. Applicant seeks $5839.31 for DME dispensed to the EIP for DOS 3/11/24-4/21/24. Respondent denied applicant's claim based upon lack of medical necessity according to the 8/5/24 peer review of Ayman Hadhoud, MD, PMR. Applicant

submits a rebuttal from Clifton Burt, MD. Relying on a fee schedule affidavit by Amanda Dix, CPC, respondent further opines that applicant billed excessively.

4. Findings, Conclusions, and Basis Therefor

I have completely reviewed all timely submitted documents contained in the ADR Center record maintained by the American Arbitration Association and considered all oral arguments. No additional documents were submitted by either party at hearing. No witnesses testified at hearing.

ANALYSIS

Applicant has established its prima facie entitlement to reimbursement for no fault benefits based upon the submission of a properly completed claim form setting forth the amount of the loss sustained, and that payment is overdue. Mary Immaculate Hospital v. Allstate Insurance Company, 5 AD3d 742, (2nd Dept. 2004). Westchester Medical Center v. Lincoln General Ins. Co, 60 AD3d 1045 (2nd Dept. 2009).

The burden now shifts to respondent to establish a lack of medical necessity with competent medical evidence which sets forth a clear factual basis (specifics of the claim) and medical rationale for denying the claim. Citywide Social Work and Psych Services, PLLC v. Allstate, 8 Misc. 3d 1025A (2005); Healing Hands Chiropractic v. Nationwide Assurance Co., 5 Misc. 3d 975 (2004). Respondent must offer sufficient and credible medical evidence that addresses the standards in the applicable medical community for the services and treatment in issue; explains when such services and treatment would be medically appropriate, preferably with understandable objective criteria; and why it was not medically necessary in the instance at issue.

The insurer must establish a factual basis and medical rationale for its asserted lack of medical necessity, which is supported by evidence of the generally accepted medical/professional practices. Beal Medea Products Inc. v. Geico, 27 Misc. 3d 1218 (A), 910 NYS 2d 760 (Civ. Ct. Kings County 2010). Respondent's submission was due on 9/30/24. The only peer review included was referable to a car seat.

Regulation 68-D, 11 NYCRR 65- 4 provides that the Respondent has 30 days to provide documents in support of its position once it is advised that applicant requests arbitration. (Commonly referred to as the "Rocket Docket") The respondent may request an additional 30 days (in writing) to respond. 11 NYCRR 65-4.2(3)(ii). "The written record shall be closed upon receipt of the Respondent's submission or the expiration of the period for receipt of the Respondent's submission. 11 NYCRR 65-4.2(3)(iii). Once the record is closed, any additional written submission can be made only at the request of or approval of the arbitrator.

Respondent does not offer any reasonable justification for not providing the proper documents. Respondent cannot sustain its defense based upon lack of medical necessity. Applicant's claim is awarded.

DME not supplied- Pneumatic Compression Device

Relying on the EUO transcript of the EIP respondent argues that the pneumatic compression device was never delivered.

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Q. Did they give you any machine at home, like, for home-use that, you know when you go to a doctor and they take your blood pressure and you put that little cuff on and it fills with air and it compresses, so it's a machine that does that same sort of thing, except instead of it being a blood pressure cuff, it is a sleeve on your arm or -

A. No, no.

Q. -- your leg or wherever you were injured, and it will fill with air so you feel that compression and release?

A. No. I didn't get that.

At hearing, applicant argued that the question raised was confusing as it described a blood pressure machine and not the Game Ready pneumatic compression device. Based upon the physician's prescription this device was rented for 28 days for the cervical and thoracic spine. There is a delivery receipt with the EIP signature. The device was not prescribed for use for his arm or his leg. It is not a blood pressure machine. As the burden of proof rests with respondent I am compelled to agree with applicant. The question was confusing and did not adequately describe the DME at issue. Applicant's claim is awarded.

Fee schedule

The insurer has the burden of proving that the fees charged were excessive and not in accordance with the Worker's Compensation fee schedule. St. Vincent Medical Care PC v. Countrywide Insurance Company, 26 Misc. 3d 146 (A), 907 NYS 2d 441 (App. Term 2d, 11th and 13th Dists. 2010). If the insurer fails to demonstrate, by competent evidentiary proof, that the claims were in excess of the appropriate fee schedule, the defense of noncompliance cannot be sustained. See, Continental Medical PC v Travelers Indemnity Company, 11 Misc.3d 145(a), 819 NYS 2d 847 (App. Term 1st Dept. 2006).

I am permitted to take judicial notice of the NY Workers Compensation fee schedules Kingsbrook Jewish Medical Center v. Allstate Insurance Company, 61 AD3d 13 (2d Dept. 2009); LVOV Acupuncture PC v. Geico Insurance

Company, 32 Misc. 3d 144 (A) (App. Term 2d, 11th and 13th Jud. Dists. 2011). Natural Acupuncture Health PC v. Praetorian Insurance Company, 30 Misc. 3d 132 (A), 2011 N Y slip op 50040 (U), (App. Term 1st Dept. 2011). I also take judicial notice of the 2008 and 2013 CPT Assistant. The official New York Workers Compensation Medical Fee Schedule, promulgated by the chair of the Workers Compensation Board, directs users to "refer to the CPT book for explanation of coding rules and regulations not listed in the schedule," and the CPT book, in turn, expressly refers to the CPT Assistant newsletter; thus, the CPT Assistant newsletter must be considered in rendering an arbitration award when the insurer states it is relying on it in making partial payment. Matter of Global Liberty Insurance Company v. McMahon, 2019 NY Slip Op 03692 (1st Dept., 5/9/19).

The no-fault regulatory scheme is designed to promote the prompt payment of legitimate claims. Nyack Hospital v. General Motors Acceptance Corp., 8 NY 3d 294 (2007). The New York State Insurance Law §5108 (a) limits the charges by providers of health services to those permissible under the schedules prepared an established by the chairman of the Worker's Compensation Board for industrial accidents. The purpose of the Worker's Compensation medical fee schedule is to prevent "excessive billing" by each individual provider. Nyack, supra. In furtherance of this determination, the no fault system adopts the NYS Medicaid Program Fee Schedule for DME billing and reimbursement. See Opinion of General Counsel no. 09-02-06, 2/20/09. Specifically, and in accordance with 12 NYCRR§ 442.2 (*prior to 4/4/22*):

(a) the maximum permissible charge for the purchase of durable medical equipment, medical/surgical supplies, orthotic and prosthetic appliances the fee payable for such equipment and supplies under the New York State Medicaid program at the time such equipment and supplies provided… If the New York State Medicaid program does not establish a fee payable for a specific item, then the fee payable in accordance with Medicaid rules 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 coarser any sales-tax) to the provider +50% or

(2) the usual and customary charge to the general public.

(b) The maximum permissible monthly rental charge for (durable medical equipment) 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 Gur Medical Supplies v. Geico, AAA # 17 - 22 - 1253 - 9431 (4/28/23), Arbitrator Wiener determined as follows:

In June 2021, the WCB made significant changes to the regulation pertaining to reimbursement for DME. One of the changes with the creation of a New York Worker's Compensation DME fee schedule. These changes became effective on April 4, 2022. As part of the changes the WCB eliminated the lesser of acquisition cost +50% or usual and customary fee calculation for unlisted DME. Under the new regulation, prior authorization is required for DME listed in the DME fee schedule for which no reimbursement amount is assigned and for DME that is not listed in the DME fee schedule. The WCB also capped the total accumulated rental charge for DME supplies listed in the DME fee schedule to the purchase price of those supplies. In adopting the new WCB regulation, DFS eliminated the need for prior authorization, thereby eliminating any cost control provision for the rental of DME for which I the no price has been established in the DME fee schedule office supplies not listed in the DME fee schedule.

To correct this problem, DFS issued emergency regulation amending 11 NYCRR 68 (Insurance Regulation 83) by adding a new part E to Appendix 17 - C, capping the amounts billed for the purchase or rental of DME, for which no price has been established in the DME fee schedule or is not listed in the DME fee schedule. The emergency regulation became effective as of 4/4/22 and was published in the New York State register on 4/20/22.

Under the new part E:

(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 …to the provider +50%; or

(2) the usual and customary price charged by durable medical equipment provided to the general public.

A cap on the monthly rental fee was added to the permanent regulation that became effective on 2/15/23. This provision states that: (d) (1) on and after 6/1/23, the maximum permissible monthly rental charge for such durable medical equipment shall be 1/10th of the acquisition cost of the provider. Rental charges for less than one month shall be calculated on a pro rata basis using the 30 day month."

As noted in Ms. Dix's affidavit, Applicant billed E0221, E1399- RR, E1399-NU and E0675 - RR.

E0221 for the PEFM Infra Mat was purchased. E1399 was used for the SAM unit and coupling patches. The unit is a rental whereas the coupling patches are purchased. E0675 was reported for the purchase of the pneumatic compression device. Ms. Dix changed the code to E1399 as it was prescribed for neck pain and not arterial insufficiency. Ms. Dix noted that no manufacturers' invoice was provided.

Therefore, Ms. Dix conducted online research for the purchase price of generic items to figure out the supplier cost to the general public. She lists various items as the result of a search. Ms. Dix does not detail the nature of the research or the parameters of the search. It is unknown how many models are available and whether the model chosen is in fact the one dispensed to the EIP. There are no market surveys or other arbitration awards to support his conclusion. There is no evidence that the cited rates would apply to the geographic location of this provider. "Reference to a single company offering a particular item at a given rental rate is not sufficient evidence of rental costs to the public, particularly in New York." Triboro Orthopedics, PC v. Allstate, AAA # 17 - 18 - 1105 - 4350 (Arbitrator Langell, 7/9/19); "Cherry picking the supposedly cheapest rate for generic CPM does not constitute the rate available to the general public." All Body Healing Supplies, LLC v. State Farm Mutual Automobile Insurance Company, AAA # 17 - 18 - 1108- 8313 (Arbitrator Parson, 7/4/19); "It is unclear and unsubstantiated how the Medcom applies in the geographic region for this provider. First there are several units, different prices on the Medcom website so it is difficult to determine which one matches the device provided to the IP. Second, the Medcom Group is in Colorado or not the geographic area or of the applicant." Ortho Care Tech Inc. v. State Farm Fire and Casualty Company, AAA # 17 - 17 - 1068- 5833 (Arbitrator Feder, 2/15/19). There is no indication that any search was done with respect to prevailing rates in the State of New York.

If respondent needed further documentation or additional information for services billed, the insurer needs to request additional verification in accordance with 11 NYCRR§ 65 - 3.5 (b). Bronx Acupuncture Therapy v. Hereford Insurance Company, 2017 NY Slip Op 50101 (U) (App. Term 2d Dept., 1/20/17), *aff'd*, 2019 NY Slip op 06059, 175 AD 3d 455 (2d Dept. 8/7/19).

Ms. Dixon's affidavit is insufficient to sustain respondent's burden of proof. Applicant's claims are awarded as billed.

Interest: Applicant is awarded interest in accordance with 11 NYCRR§65 - 3.9 (a)-(f). Accordingly, interest is calculated at a rate of 2% per month, calculated on a pro rata basis using a 30 day month. A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. If an applicant does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form, or payment of benefits calculated pursuant to Department of Financial Services Regulations, interest shall not accumulate on the disputed claim or element of claim until such action is taken. 11 NYCRR §65 - 3.9 (c). The Superintendent and the New York Court of Appeals has interpreted this provision to apply regardless of whether the particular denial at issue was timely. LMK Psychological Services PC v. State Farm Mutual Automobile Insurance Company, 12 NY 3d 217 (2009).

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**
	Bayside Equipment Inc	**03/11/24 - 04/21/24**	**$5,839.31**	**Awarded: $5,839.31**
Total			**$5,839.31**	**Awarded: $5,839.31**

B. The insurer shall also compute and pay the applicant interest set forth below. 08/23/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

   Based on the submission of a timely denial, interest shall be paid from 8/23/24, the date of filing, on the amount awarded of $5839.31 at a rate of 2% per month, simple, and ending with the date of payment of the award subject to the provisions of 11 NYCRR 65 - 3.9 (e).

C. Attorney's Fees

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

   This case is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4.6(d) (Insurance Regulation 68-D).

Accordingly, the insurer shall pay the applicant an attorney's fee, in accordance with newly promulgated 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 Nassau

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

03/10/2025
(Dated)

Rhonda Barry

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:
68dfe95cac82d8af47c9a00f4302f157

Electronically Signed

Your name: Rhonda Barry
Signed on: 03/10/2025