

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Bypass Orthotic & Prosthetic Corp
(Applicant)

- and -

Allstate Insurance Company
(Respondent)

AAA Case No.	17-24-1366-8507
Applicant's File No.	202409166912794
Insurer's Claim File No.	0725305940
NAIC No.	29688

ARBITRATION AWARD

I, Anne Malone, 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 02/18/2025
Declared closed by the arbitrator on 03/26/2025

George Lewis, Esq. from Law Offices of George T. Lewis, Jr., PC participated virtually for the Applicant

Olga Gromyko, Esq. from Law Offices of John Trop participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,495.00**, 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

The 66 year old EIP reported involvement in a motor vehicle accident on August 11, 2023; claimed related injury and received miscellaneous durable medical equipment on May 3, 2023 and a pad for water circulating heat unit on June 28, 2024.

The applicant submitted a claim for this durable medical equipment (DME), payment of which was timely denied by the respondent based upon a peer review by Stuart Springer, M.D dated August 19, 2024.

The respondent also asserted a fee schedule defense.

The issues to be determined at the hearing are:

Whether the respondent established that the DME provided by the applicant was not medically necessary.

Whether the respondent established its fee schedule defense.

4. Findings, Conclusions, and Basis Therefor

This hearing was held on Zoom and the decision is based upon the documents reviewed from the Modria File as well as the arguments made by counsel and/or representative at the arbitration hearing. Only the arguments presented at the hearing are preserved in this decision; all other arguments not presented at the hearing are considered waived.

Medical Necessity

The respondent denied payment for the aforementioned durable medical equipment for a lack of 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 [or examining physician's] determination that there was a lack of medical necessity for the services rendered." Provvedere, Inc. v. Republic Western Ins. Co., 2014 NY Slip Op 50219(U) (App. Term2d, 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 Bronx Expert Radiology, P.C. v. Travelers Ins. Co., 2006 NY Slip Op 52116 (App. Term 1st Dept. 2006.)

The Civil Courts have held that a defendant's peer review or report of medical examination must set forth more than just a basic recitation of the expert's opinion. The trial courts have held that a peer review or medical examination 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 specifics as to the claim at issue, is conclusory or vague. See Nir v. Allstate, 7 Misc.3d 544 (N.Y. City Civ. Ct. 2005.)

To support its contention that the durable medical equipment provided by the applicant was not medically necessary, respondent relies upon the peer review by Dr. Springer, who reviewed the medical records of the EIP, noted the injuries claimed and the treatment rendered to her. Dr. Springer considered possible

arguments and justification for the need for the durable medical equipment at issue and determined that it was not warranted under these circumstances.

According to the peer review Dr. Springer reviewed 29 medical records of treatment for the EIP from August 15, 2023 to June 10, 2024 related to the August 11, 2024 accident.

He submitted a comprehensive report in which he discussed specific DME provided to the EIP and the standard of care for the injury sustained by the EIP, which included a course of conservative care for a month and if this was unable to increase strength and range of motion after more than a month surgery should be considered.

Right knee arthroscopic surgery was performed on May 3, 2024 and the cold compression therapy unit and circulating heat pad was provided for post-operative use.

Dr. Springer stated that the EIP was not evaluated from the date of the subject accident, August 11, 2023 to December 18, 2023 for more than 4 months post-accident. However, the list of records reviewed indicates orthopedic treatment on August 15, 2023, September 8, 2023, October 13, 2023.

However, the submissions from the respondent did not include copies of all of the medical records listed in the peer review.

The applicant's submissions specifically demand that the respondent provide all records reviewed by the peer doctor.

Since only some of the records were submitted, the respondent has failed to establish that the right shoulder arthroscopy and related services included the DME at issue were not medically necessary.

Therefore, an award will be submitted in favor of the applicant pursuant to the appropriate fee schedule.

Fee Schedule

This claim was initially denied by the respondent based on a lack of medical necessity. I have already determined that the respondent did not establish this defense.

At the hearing on February 18, 2025, I requested post-hearing briefs to allow both parties to submit coder affidavits or other evidence to support their positions regarding the fee schedule issue.

To prevail in its fee schedule defense, the respondent must demonstrate by competent evidentiary proof that the applicant's claims are in excess of the appropriate fee schedule. If the respondent fails to do so, its defense of

noncompliance with the New York Workers' Compensation Medical Fee Schedule cannot be sustained. See Continental Medical, P.C. v Travelers Indemnity Co., 11 Misc. 3d 145A (App. Term 1st Dept. 2006.)

An insurer fails to raise a triable issue of fact with respect to a defense that the fees charged were not in conformity with the Workers' Compensation fee schedule when it does not specify the actual reimbursement rates which formed the basis for its determination that the claimant billed in excess of the maximum amount permitted. See St. Vincent Medical Services, P.C. v. GEICO Ins. Co., 29 Misc.3d 141(A), 907 N.Y.S.2d 441 (App. Term 2d, Dec. 8, 2010.)

The applicant billed \$1,400.00 under code E1399 for miscellaneous medical equipment and \$95.00 under CPT code E0249 for a pad for water circulating heat unit. The respondent asserted a fee schedule defense based on the 2024 New York Workers' Compensation Durable Medical Equipment Fee Schedule.

The general rule is that in order to prevail in its fee schedule defense, the respondent must demonstrate by competent evidentiary proof that the applicant's claims are in excess of the appropriate fee schedule. If the respondent fails to do so, its defense of noncompliance with the New York Workers' Compensation Medical Fee Schedule cannot be sustained. See Continental Medical, P.C. v Travelers Indemnity Co., 11 Misc. 3d 145A (App. Term 1st Dept. 2006.)

However, it is the respondent's contention that in this instance it is questionable whether the applicant established its *prima facie* case of entitlement to no-fault benefits for the miscellaneous DME because it did not establish the correct reimbursement rate it. This item of DME was billed under a CPT code which is a "miscellaneous" code listed in the fee schedule without a fee amount.

To support this assertion the respondent relies upon 11 NYCRR 65-3(g)(1) which provides:

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:

(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.

The respondent argued that the legislative purpose underlying Insurance Law §5108 has always been to "significantly reduce the amount paid by insurers for medical services and thereby help contain the no-fault premium." See Surgicare Surgical Associates v National Interstate Ins. Co., 50 Misc.3d 85 (App. Term 1st Dept. 2015) (citing Donald D. Goldberg, M.D., et.al. v James P. Corcoran, 153 A.D.2d 113 (2d Dept 1989).

After a review of these decisions, I have determined that they can be distinguished from the issue in the instant matter in several respects and are not relevant to this claim.

The respondent argued correctly that pursuant to 12 NYCRR §442.2(a) for codes where, either there is no maximum charge listed, such as code E1399 for non-rental items, the correct reimbursable amount is 150% of the acquisition cost or the usual and customary price charged to the general public, whichever is less.

Both parties were given an opportunity to provide affidavits from certified medical professional, medical professional or other expert evidence to support their positions on the fee schedule issue in this matter.

Neither the respondent nor the applicant provided an affidavit/affirmation from a certified professional fee coder, medical professional or other expert to establish the correct reimbursable amount for the miscellaneous DME billed under code E1399.

The respondent submitted a comprehensive brief outlining its position regarding the appropriate fee schedule and a copy of the 2024 DME fee schedule.

The original submissions by the applicant included an invoice, which does not appear to be related to this claim, which identified an item of durable medical equipment as a CTU described as "Breg Polarcare Cube" and listed code E0236 with a price of \$262.00. The 2024 DME fee schedule lists E0236 as a pump for water circulating pad and a fee of \$325.08.

Included in the same invoice is a charge for a multi-use cold therapy pad listed with code E0249 with a price of \$63.00. This is listed in the 2024 DME fee schedule as a pad with circulating water heat unit, for replacement only and does not list any fee.

Assuming that the submitted invoice represents the applicant's evidence of the correct reimbursable amount for both items of DME, the applicant would be entitled to \$393.00 (150% of the acquisition cost based on the invoice submitted by the applicant) for code E0236 and no reimbursement for code E0249 since it is not listed as a replacement.

Since this is the only explanation by either party of the correct reimbursable amount for the pad for water circulating heat unit, the applicant has established entitlement to reimbursement for this DME.

Therefore, the applicant is awarded \$393.00 for the pad for water circulating heat unit.

Accordingly, the applicant is awarded a total of \$393.00 and the remainder of the claim is dismissed with prejudice.

Any further issues submitted in the record are held to be moot and/or waived insofar as they were not raised at the time of this hearing. This decision is in full disposition of all claims for no-fault benefits presently before 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 applicant is AWARDED the following:

A.

Medical		From/To	Claim Amount	Status
	Bypass Orthotic & Prosthetic Corp	05/03/24 - 06/28/24	\$1,495.00	Awarded: \$393.00
Total			\$1,495.00	Awarded: \$393.00

- B. The insurer shall also compute and pay the applicant interest set forth below. 09/26/2022 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant is awarded interest pursuant to the no-fault regulations. See generally, 11 NYCRR §65-3.9. Interest shall be calculated "at a rate of two percent per month, calculated on a *pro rata* basis using a 30 day month." See 11 NYCRR §64-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. However, the regulations toll the accrual of interest when 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 Insurance Department regulations. Where a claim is untimely denied, or not denied or paid, interest shall accrue as of the 30th day following the date the claim is presented by the claimant to the insurer for payment. Where a claim is timely denied, interest shall accrue as of the date an action is commenced or an arbitration requested, unless an action is commenced or an arbitration requested within 30 days after receipt of the denial, in which event interest shall begin to accrue as of the date the denial is received by the claimant. See, 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 was timely. LMK Psychological Servs. P.C. v. State Farm Mut. Auto. Ins. Co., 12 NY3d 217 (2009.)

C. Attorney's Fees

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

Applicant is awarded statutory attorney's fees pursuant to the no fault regulations. For cases filed after February 4, 2015 the attorney's fee shall be calculated as follows: 20% of the amount of first-party benefits awarded, plus interest thereon subject to no minimum fee and a maximum of \$1,360.00. See 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 CT

SS :

County of Fairfield

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

04/09/2025

(Dated)

Anne Malone

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:
4098c879b3c13968201aeb5cb135875d

Electronically Signed

Your name: Anne Malone
Signed on: 04/09/2025