American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

BibiMed, Inc (Applicant)	AAA Case No.	17-23-1326-2717
	Applicant's File No.	RB-57-386472
- and -	Insurer's Claim File No.	768532AA
	NAIC No.	23469
American Modern Home 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-J.C.

1. Hearing(s) held on 03/12/2025
   Declared closed by the arbitrator on 03/12/2025

   Alex A. Samaroo from Baker & Narkolayeva Law P.C. participated virtually for the Applicant

   Catey Berry from American Modern Home Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$3,507.28**, was AMENDED and permitted by the arbitrator at the oral hearing.

   Applicant amended the amount in dispute from the original amount of $3,507.28 to $784.00 ($700.00 for code E1399 and $84.00 for code A9999).

   Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

   The record reveals that the Assignor-J.C., a 73-year-old male, claimed injuries as the driver of a motor vehicle involved in an accident that occurred on 2/12/2022. Applicant seeks reimbursement for the rental of a Sustained Acoustic Medicine (SAM) Unit provided from 10/5/2022 through 11/1/2022 and the purchase of coupling patches.

Respondent partially denied the claim based on the applicable fee schedule. The issues to be determined are 1)whether the coupling patches are covered expenses eligible for reimbursement under Insurance Law § 5102, 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.

DME

The New York State Medicaid Program Procedure Codes and Coverage Guidelines (https://www.emedny.org/providermanuals/dme/pdfs/dme_procedure_codes.pdf) defines durable medical equipment (DME) as:

Other than prosthetic or orthotic appliances, which have been ordered by a practitioner in the treatment of a specific medical condition and which have all of the following characteristics:

(i) can withstand repeated use for a protracted period of time;
(ii) are primarily and customarily used for medical purposes;
(iii) are generally not useful to a person in the absence of an illness or injury; and
(iv) are usually not fitted, designed or fashioned for a particular individual's use.

Where equipment is intended for use by only one person, it may be either custom-made or customized.

Insurance Law § 5102 determines whether a particular service or product purchased is a covered expense eligible for reimbursement under the No-Fault Law. The statute reads as follows:

(a)Basic economic loss" means up to fifty thousand dollars per person of the following combined items, subject to the limitations of section five thousand one hundred eight of this article.:

(1) All necessary expenses incurred for:

(i) medical, hospital (including services rendered in compliance with Article 41 of the public Health Law, whether or not such services are rendered directly by a hospital), surgical, nursing, dental, ambulance, X-ray, prescription drug and prosthetic services;

(ii)psychiatric, physical therapy (provided that treatment is rendered pursuant to a referral) and occupational therapy and rehabilitation;

(iii)Any non-medical remedial care and treatment rendered in accordance with a religious method of healing recognized by the laws of New York; and

(iv)-Any other professional health services.

Under the terms of the statute only health care services, "prescription drugs and prosthetic services" are reimbursable. Over time the phrase "prescription drugs and prosthetic services" was expanded to include "necessary durable medical equipment". *See*, NYS Ins. Dept. Opinion Number 03-08-06: No-Fault Assignments for Durable Medical Equipment (April 1, 2003). The exact genesis of this expansion is unknown. Nevertheless, items of personal comfort like cervical pillow, car seats, and personal massagers, which are purchased by consumers without prescriptions from local retail outlets, are not DME and are not reimbursable first-party medical benefits.

PROOF OF CLAIM

11 NYCRR 65-1.1 provides: Proof of Claim; Medical, Work Loss, and Other Necessary Expenses. In the case of a claim for health service expenses, the eligible injured person or that person's assignee or representative shall submit written proof of claim to the Company, including full particulars of the nature and extent of the injuries and treatment received and contemplated, as soon as reasonably practicable but, in no event later than 45 days after the date services are rendered.

11 NYCRR § 65-3.8Provides: Payment or denial of claim (30-day rule).

(g)(1) 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.

In an action for first-party no-fault benefits, to establish a prima facie case, a plaintiff must submit proof of a properly completed claim submitted to defendant in a timely manner, a validly signed assignment of benefits form from the patient/assignor giving standing to the plaintiff, and proof that defendant received the claim and it failed to pay or deny the claim in 30 days. *See*: Viviane Etienne Medical Care, PC v. Countrywide Insurance Company, 2015 NY Slip Op 04787, (NY Court of Appeals, 6/10/15); Amaze Medical Supply, Inc. v. Eagle Insurance Co., 2 Misc 3d 128 (App Term 2d and 11th Jud. Dists, 2003). A facially valid claim has been defined as one that sets forth the name of

the patient, date of accident, date of service, description of services rendered and the charges for those services. *See*, Vinings Spinal Diagnostic P.C. v. Liberty Mutual Insurance Company, 186 Misc.2d 128(A), 784 N.Y.S.2d 918 (2003).

ANALYSIS

Applicant requested payment for a rental period for the SAM Unit from 10/5/2022 through 11/1/2022 ($2,940.00), totaling twenty-eight days, billed under HCPCS code E1399 ($105.00 per date of service) and fifty-six units of coupling patches billed under HCPCS code A9999 ($567.28 or $10.13 per unit amended to $252.00 or $4.50 per unit). Regarding the coupling patches, Respondent paid $168.00 and denied the balance stating, "allowed fee is based on invoice/proof of cost" and "Patches - $120.00/40 patches + $48.00 for 16 additional + $168.00". Applicant seeks the amended balance of $84.00 for the coupling patches.

The prescription by Sunil Kukreja, M.D., dated 10/3/2022, is for the rental of a PA Home Care Low Level Laser Therapy (LLLT) for 28 days and an ultrasound therapy system for 28-days for the left shoulder. There are no supporting medical records submitted to the record.

While not raised by either party I note that there is no prescription in the record for coupling patches or any indication in the record that the ultrasound therapy system prescribed required coupling patches. The first invoice provided for the sam Professional unit indicates that each unit includes the items needed to operate the device including a, "sam Professional, dual applicator, 120 bandages and armband device". Furthermore, there is no indication that the second invoice submitted is related to the coupling patches billed. Specifically, Applicant billed, "sam Couplimg Patches-NU" and the invoice is for forty, "Patch 1 pack (40 patches)", with no reference to the sam professional unit or coupling patches.

The issues to be determined are 1) whether the coupling patches are covered expenses eligible for reimbursement under Insurance Law § 5102 as the coupling patches were not prescribed as billed and 2) whether the coupling patches are included with the same Professional Unit billed.

There is no prescription for the coupling patches in the record. I also note there are no delivery receipts establishing that either supply was provided to the claimant as billed.

Insurance Law § 5102 determines whether a particular service or product purchased is a covered expense eligible for reimbursement under the No-Fault Law. The statute reads as follows:

(a)Basic economic loss" means up to fifty thousand dollars per person of the following combined items, subject to the limitations of section five thousand one hundred eight of this article.:

(1) All necessary expenses incurred for:

(i) medical, hospital (including services rendered in compliance with Article 41 of the public Health Law, whether or not such services are rendered directly by a hospital), surgical, nursing, dental, ambulance, X-ray, prescription drug and prosthetic services;

(ii) psychiatric, physical therapy (provided that treatment is rendered pursuant to a referral) and occupational therapy and rehabilitation;

(iii) Any non-medical remedial care and treatment rendered in accordance with a religious method of healing recognized by the laws of New York; and

(iv) Any other professional health services.

As noted by the informal opinion issued by the Office of General Counsel on June 11, 2001:

> Whether a particular service rendered or product purchased is a covered expense eligible for reimbursement under No-Fault is governed by Section 5102(a)(1) as follows:
> All necessary expense incurred for (1) medical, hospital (including services rendered in compliance with article forty-one of the public health law, whether or not such services are rendered directly by a hospital), surgical, nursing, dental, ambulance, x-ray, prescription drug and prosthetic services; (ii) psychiatric, physical and occupational therapy and rehabilitation; (iii) and non-medical remedial care and treatment rendered in accordance with a religious method of healing recognized by the laws of this state; and (iv) any other professional health services. For the purpose of determining basis economic loss, the expenses incurred under this paragraph shall be in accordance with the limitations of section five thousand one hundred eight of this article.
> The category of "any other professional health services" covered under Section
> 5102(a)(1)(iv) is implemented under Regulation 68, 11 NYCRR 65.15(o)(vi) as follows:
> The term any other professional health services, as used in section 5102(a)(1)(iv) of the Insurance Law, this Part and approved endorsements, shall be limited to those services that are required or would be required to be licensed by the State of New York if performed within the State of New York. Such professional health services should be necessary for the treatment of the injuries sustained and within the lawful scope of the licensee's practice. Charges for the services shall be covered pursuant to schedules promulgated under section 5108 of the Insurance Law and Part 68 of this Title (Regulation 83). The services need not be initiated through referral by a treating or practicing physician.
> In order for a service rendered to constitute a reimbursable health service, it must be a covered expense under either (A) or (B) below:
> A) It falls under one of the enumerated categories included as expenses incurred pursuant to Section 5102(a)(i)(ii) and (iii), specifically including medical, hospital, surgical, nursing, dental, ambulance, x-ray, prescription drug and prosthetic services; psychiatric, physical and occupational therapy and rehabilitation; or

> It falls under the category of "other professional health services" under Regulation 65, 11 NYCRR 65.15(o)(vi). To be covered under this category, the service rendered must be:
> A health service licensed under New York law or, when performed out-of-state, required to be licensed under New York law; and
> When performed, such health service must fall within the lawful scope of the provider's license.
> With respect to reimbursement for services which provide health-related products, such items are limited solely to prescription drugs and prosthetic devices which are enumerated under Section 5102(a)(1)(i).
> When a health service or product is eligible for reimbursement under any of these categories, only those services and products determined to be medically necessary to treat those injuries arising out of the motor vehicle accident may, in fact, be reimbursed in accordance with Section 5108 and Regulation 83.

The Office of General Counsel issued an opinion on 6/16/2004, representing the position of the New York State Insurance Department, which stated in pertinent part:

> N.Y. Ins. Law § 5102(a)(1) mandates that "basic economic loss", which means up to $50,000 in reimbursement for No-Fault expenses, subject to the fee schedule limitations of Section 5108, shall include: "(1) All necessary expenses incurred for: (I) medical, hospital surgical, nursing, dental, ambulance, x-ray, prescription drug and prosthetic services;". Included under the category of prosthetic services is durable medical equipment and supplies (DME) provided by a licensed health provider or medical equipment supplier.

An arbitrator is not bound by principles of substantive law or rules of evidence and may do justice and apply his or her own sense of law and equity to the facts as he or she finds them to be. Matter of Chin v. State Farm Ins. Co., 73 A.D.3d 918, 919, 900 N.Y.S.2d 738, 740 (2d Dept. 2010).

The coupling patches billed by Applicant were not prescribed and therefore are not reimbursable. *See* Amaze Medical Supply Inc. v. Eagle Ins. Co., 2 Misc.3d 128A, 784 N.Y.S.2d 918 (App. Term 2d & 11th Dists. 2003)(dicta noting that un-prescribed medical equipment is not recoverable.) Vista Surgical Supplies, Inc. v. State Farm Mutual Ins. Co., 12 Misc.3d 134(A), 820 N.Y.S.2d 846 (App. Term 2d & 11th Dists. 2006). (Where a piece of DME is not listed on the prescribing doctor's prescription, there is a lack of a prima facie case of entitlement to compensation for dispensing it.)

In this matter, I find that Respondent has met its burden of proof that the coupling patches were not prescribed as billed. Applicant's own evidence indicates that the billed coupling patches were not prescribed and are included as part of the sam professional unit rental billed. Moreover, a prescription for the coupling patches is not contained in the record. Respondent has shifted the burden to Applicant to establish that the coupling patches were prescribed as billed, which Applicant failed to rebut. As the coupling patches were not prescribed they are not reimbursable.

Coupling Patches Included with SAM Professional Unit

In addition to not being prescribed, the invoice for the sam Professional unit clearly indicates that the dual applicator and bandages are included with the purchase price for the device and therefore are not separately reimbursable. Furthermore, the Centers for Medicare & Medicaid Services (CMS) has determined thatt the sam device and its coupling patches are an integral part of the procedure, meaning they are not separate billable items, and payment for the service includes payment for the device and patches.

The Introduction to the New York Worker's Compensation DME Fee Schedule states in pertinent part: "'The Official New York Workers' Compensation Durable Medical Equipment (DME) Fee Schedule lists the DME that may be supplied to an injured worker when medically necessary and in accordance with the applicable medical treatment guidelines. The items on the DME Fee Schedule are described by using applicable Healthcare Common Procedure Coding System (HCPCS) codes and terminology."

In June 2017, a code application was made to the Center for Medicare & Medicaid Services (CMS), Healthcare Common Procedure Coding System (HCPCS) Workgroup, by SAM Unit Manufacturer, ZetrOZ Systems, LLC. Specifically, according to the public meeting agenda, held on 6/7/2017, APPLICATION# 17.090, Agenda Item #8, stated: "Request to establish two new Level II HCPCS to identify: 1) a multi-hour long-duration therapeutic ultrasound device; and 2) a supply of single-use coupling patches. Trade names: Sustained Acoustic Medicine (SAM), SAM Sport, SAM Professional. Applicant did not suggest coding language."

The final coding decision issued by CMS HCPCS Workgroup, Application Summaries for DME and Accessories; O&P; Supplies and Other, dated 6/7/2017, stated as follows:

> Centers for Medicare & Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) Application Summaries for DME and Accessories; O & P; Supplies and Other
> June 7, 2017
> This HCPCS Code Application Summary document includes a summary of each HCPCS code application discussed at the June 7, 2017 HCPCS Public Meeting for DME and Accessories; O & P; Supplies and Others HCPCS code applications are presented within the summary document in the same sequence as the Agenda for this Public Meeting. Each individual summary includes: the application number, topic; background/discussion of the applicant's request; CMS' published preliminary HCPCS coding recommendation; CMS' published preliminary Medicare payment recommendation; a summary of comments offered on behalf of each applicant at CMS' HCPCS public meeting in response to our preliminary recommendations; and CMS' final HCPCS coding decision. We publish a separate HCPCS Code

Application Summary document for each HCPCS Public Meeting held. This is one of a series of five HCPCS Code Application Summaries for CMS' 2017-2018 HCPCS coding cycle.
Introduction and Overview
Approximately 69 people attended.
The agenda included 17 items.
Cindy Hake, Director, CMS National Level II HCPCS Coding Program and Deputy Director, Division of DMEPOS Policy, provided an overview of the HCPCS public meeting procedures as it relates to the overall HCPCS coding process.
Joel Kaiser, the Director of the Division of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Policy, presented an overview of the methods used for setting the payment amount for DME, prosthetics, orthotics and supplies and when the different payment categories are used. The overview was also provided as a written document along with the agenda for today's meeting. For additional information, the DME payment rules are located at Section 1834(a) of the Social Security Act. The Medicare fee schedule for DME, Prosthetics, Orthotics and Supplies, and background information can be accessed and downloaded free of charge at: http:www.cms.gov/DMEPOSFeeSched/.
Prior to the Public Meetings, over the course of several months, the CMS HCPCS Workgroup convene, discuss, and establish preliminary coding recommendations on all HCPCS code applications and make preliminary coding recommendations. At the same time, CMS assigns preliminary recommendations regarding the applicable Medicare payment category and methodology that will be used to set a payment amount for the items on the agenda. The preliminary coding and payment recommendations are posted on the CMS HCPCS web site, specifically at www.cms.gov/medhcpcsgeninfo/08_HCPCSPublicMeetings.asp#TopOfPage, as part of the HCPCS public meeting agendas.
Information provided at the CMS HCPCS Public Meetings is considered by the CMS HCPCS Coding Workgroup at a subsequent workgroup meeting. The Workgroup reconvenes after the public meetings and reconsiders its preliminary coding recommendations in light of any new information provided and formulates its final coding decisions.
CMS maintains the permanent HCPCS Level II codes and reserves final decision-making authority concerning requests for permanent HCPCS codes. Final decisions regarding Medicare payment are made by CMS and must comply with the Statute and Regulations. Payment determinations for non-Medicare insurers, (e.g., state Medicaid Agencies or Private Insurers) are made by the individual state or insurer.
…
June 7, 2017
Agenda Item # 8
Application# 17.090
TOPIC
Request to establish two new Level II HCPCS to identify: 1) a multi-hour long-duration therapeutic ultrasound device; and 2) a supply of single-use

coupling patches. Trade Names: Sustained Acoustic Medicine (SAM), SAM Sport, SAM Professional.
Applicant did not suggest coding language.
BACKGROUND
ZetrOZ Systems, LLC submitted a request to establish two new Level II HCPCS codes, one each to identify the Sustained Acoustic Medicine (SAM) and the coupling patches used with the device. According to the applicant, the SAM device is a wearable, low-intensity, long-duration ultrasound diathermy device used to aid in soft-tissue recovery and treat pain from conditions such as arthritis. It is indicated for the treatment of pain, muscle spasms, joint contracture, and to increase local circulation.
The SAM device is applied to the skin over the treatment site on a daily basis by the patient and is completely non-invasive. The ultrasound energy produced by the device penetrates approximately 5 cm into the musculoskeletal tissue, thereby reaching deep tissues of the body.
The SAM device is powered by a rechargeable battery and applied with an ultrasonic coupling patch that contains an adhesive bandage, plastic connector ring, and integrated coupling media. The device delivers continuous ultrasound energy at 3 MHz, 0.132 watts per square centimeter, and 1.3. watts for a total of 18,720 joules of energy per 4-hour treatment.
The applicant comments that the existing codes for low-intensity ultrasound bone stimulators do not adequately describe the SAM device. The device and the patches are currently being billed using existing code E1399 "Durable medical equipment, miscellaneous" and existing code A9901 " DME delivery, set up, and/or dispensing service component of another HCPCS code" is used to bill for the shipping costs.
PRELIMINARY HCPCS CODING RECOMMENDATION
This request to establish two new Level II HCPCS codes to separately identify the SAM multi-hour long-duration therapeutic ultrasound device and a supply of single-use coupling patches has not been approved. These products are an integral part of a procedure and payments for that service includes payment for the ultrasound device and coupling patches if used. The reporting and use of additional codes could be considered duplicative.
PRELIMINARY MEDICARE PAYMENT RECOMMENDATION
No separate Medicare payment.
SUMMARY OF PRIMARY SPEAKER COMMENTS AT THE PUBLIC MEETING
The applicant submitted written comments disagreeing with the preliminary recommendation that the SAM device is applied daily in the home by the patient, and not in the medical setting. Therefore, HCPCS coding and billing is appropriate for reporting the home use of the SAM device for medical treatment.
FINAL DECISION
This request to establish two new Level II HCPCS codes to separately identify the SAM multi-hour long-duration therapeutic ultrasound device and a supply of single-use coupling patches has not been approved. This

> device is FDA cleared for use only when administered and monitored by a healthcare practitioner. The products that are the subject of this application are an integral part of a procedure and payment for that service includes payment for the ultrasound device and coupling patches if used. Reporting using additional codes could be considered duplicative and inappropriate.

The subject patches were billed by Applicant under HCPCS code A9999 in addition to the SAM Unit, which was billed under HCPCS code E1399. This code is a miscellaneous code listed in the fee schedule with no corresponding purchase or rental fee.

According to the manufacturer's warning listed in the SAM Unit directions on the manufacturer's website, samrecover.com, the SAM Unit cannot be operated safely without the use of the coupling patches. Specifically, the warning stated: "ALWAYS administer treatment using a new sam Ultrasound Coupling Patch. Use one sam Ultrasound Coupling Patch per applicator. Use of the sam Ultrasound Applicator without a new sam Ultrasound Coupling Patch MAY RESULT IN BURN and/or REPEATED SHUTOFF of the sam Applicator" and "DO NOT administer treatment if the applicator is not connected to a sam Ultrasound Coupling Patch". Under section 4.4. sam ULTRASOUND COUPLING Patches, the instruction book states "The sam Device utilizes ultrasound coupling Patches which are manufactured with ultrasound coupling media sealed inside. The ultrasound coupling Patches ARE REQUIRED to secure the sam Applicators to the body". *See Sam: Directions for Use*, Model sam-271, issued by ZetrOZ Systems.

Therefore, according to the manufacturer of the product, coupling patches are an integral component of the SAM Unit, which cannot be safely operated without them. This supply should have been billed under HCPCS code A9900, which is described as, "Miscellaneous dme supply, accessory, and/or service component of another hcpcs code", which more closely matches the description of the supplies billed. Moreover, CMS HCPCS Workgroup, which is responsible for drafting and instituting HCPCS codes, which are included in the NYS DME Medicaid Fee Schedule, states "The products that are the subject of this application are an integral part of a procedure and payment for that service includes payment for the ultrasound device and coupling patches if used. Reporting using additional codes could be considered duplicative and inappropriate". CMS declined to add additional HCPCS codes for the SAM Unit and coupling patches to be billed separately. Furthermore, as stated in the manufacturer's directions and CMS, the SAM Unit device is only cleared for use by the FDA when administered and monitored by a healthcare practitioner. Therefore, the SAM device is not FDA approved to be administered by patients directly, as billed by this Applicant.

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 amended $252.00 charge is denied since it is inclusive of the DME fee. *See also* AAA Case No.: 412013147255.

Based on the totality of the evidence, I find that the Applicant has not established a prima facie entitlement to reimbursement for the coupling patches as they were not prescribed and are inclusive to the sam Professional device billed. Accordingly, Applicant's claim for the coupling patches provided from 10/5/2022 through 11/1/2022 ($84.00) is denied.

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 10/5/2022 through 11/1/2022 ($2,940.00), totaling twenty-eight days, billed under HCPCS code E1399 ($105.00 per date of service). Respondent paid $2,240.00 and denied the balance stating, "allowed fee is based on invoice/proof of cost" and "SAM Sport- $4800.00 % 60 days = $80.00/day. $80.00/day x 28 days rented = $2240.00". Applicant seeks the balance of $700.00.

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", and Code A9999, described as, "Miscellaneous DME supply or accessory, not otherwise specified", have no assignedpurchase orrental fee.

Prior to 4/4/2022, in accordance with 11 NYCRR 68.1 (a), the New York State Worker's Compensation Fee Schedule ("fee schedule") had been adopted by the New York State Department of Financial Services to determine the appropriate amount to be paid for no-fault benefits. With specific regard to the payment of no-fault benefits for either the sale or rental of DME devices, the New York State Workers Compensation Board has adopted the New York State Medicaid program fee schedule. Where the New York State Medicaid program fee schedule does not set forth a fee amount for a particular DME device, pursuant to 12 NYCCR 442.2, in the event the DME device was sold, no-fault benefit payments shall not exceed the acquisition cost plus fifty percent, and in the event the DME device was rented, no-fault benefits shall not exceed the lesser of the usual and customary price charged to the general public or the price determined by the New York State Department of Health area office.

In this regard, 12 NYCCR 442.2 stated in pertinent part:

> (a) 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.
>
> (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.

and

(g) The Medicaid provider manual and the policy guidelines 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.

Arbitrator Glen Wiener in *Surgut Leasing Corp and Geico Insurance Company*, AAA Case No.: 17-23-1284-3966 [10/25/2023], outlined the amendments that took place effective 4/4/2022 and thereafter, wherein he stated in pertinent part:

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 DMEFS*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 totalaccumulated amount a provider could charge 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.

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 10/5/2022 through 11/1/2022 and is only subject to the limitations set forth in the third emergency regulation, which became effective on 9/27/2022. Under the third 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. In this case, Respondent submitted an invoice from Applicant, for ten "sam Professional, dual applicator, 120 bandages and armband device", which were priced at $4,800.00 each unit for a total of $48,000.00 minus a $14,000.00 discount for a total price of $34,000.00 (excluding the $110.00 delivery charge to Applicant, which Respondent is not responsible for) for a total unit price of $3,400.00. Therefore, in accordance with the third emergency regulation, effective 9/27/2022, Applicant would be limited to the total accumulated rental charge of $5,100.00 ($3,400.00 x 150%) for the sam Professional device billed under code E1399 if Applicant billed for more than one month of charges. However, the Emergency Regulations did not address the daily, weekly, or monthly rental charges for codes not listed in the fee schedule.

Therefore, the issue to be determined is whether Applicant billed in accordance with the applicable fee schedule for the daily rental charge of $105.00 per day. There is no evidence establishing the usual and customary price charged to the general public.

The Workers Compensation DME Fee Schedule became effective 4/4/2022 in Workers' Compensation cases but was not adopted by the NYS Department of Financial Services ("DFS") until 6/1/2023 in no fault cases.

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 usual and customary price charged to the general public 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 Professional Unit, is listed in the fee schedule, but has no MRA listed. As such, for HCPCS code E1399, 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. Therefore, Applicant must prove the usual and customary price charged to the general public. Applicant relies on the affidavit of Certified Professional Coder (CPC), Priti Kumar, dated 2/20/2025, wherein Ms. Kumar notes in pertinent part, "For DOS from 10/05/2022- 11/01/2022 (28 DOS) the Applicant billed **rental of:** SAM Pro System under 28 units of code El399 at $2,940.00, that is, **$105.00 per unit** ($2,940.00 / 28); which are the usual and customary rental charge payable by the general public, and therefore Applicant is entitled to reimbursement for this code at the billed rate". However, I do not find Applicant's affidavit persuasive. While Applicant's affidavit repeatedly indicates that the supply was billed in accordance with the usual and customary fee charged to the general public,

there is no evidence submitted to establish how they arrived at the rate of $105.00 per day. 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 $105.00 per date of service for the sam Professional 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 Professional Unit for dates of service 10/5/2022 through 11/1/2022 is denied.

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.

04/10/2025
(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:
0cbd8241cd52c8041db045f81e99e830

Electronically Signed

Your name: Eileen Hennessy
Signed on: 04/10/2025