

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Pelle Supply Inc
(Applicant)

- and -

United Farm Family Insurance Company
(Respondent)

AAA Case No. 17-24-1369-5344

Applicant's File No. 190461

Insurer's Claim File No. -

NAIC No. Self-Insured

ARBITRATION AWARD

I, Corinne Pascariu, 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

1. Hearing(s) held on 07/31/2025
Declared closed by the arbitrator on 07/31/2025

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

Cliff Ryan, Esq. from Scahill Law Group PC participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$8,400.00**, 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

Background

Assignor is a male who was 52-years-old when he was injured as the passenger in a motor vehicle involved in an accident on July 21, 2024. On July 27, 2024, Applicant provided assignor with an ultrasound therapy device and a cervical wearable electromagnetic therapy device, collectively durable medical equipment (DME).

Issue

The issue is whether Respondent can establish that following basis that it asserted for denying the claim:

Pursuant to Regulation 68 claims must be presented within a specified period of time from the date of service.

This CPT/HCPCS code is a "non-specific code." As noted in CPT/HCPCS a description of this procedure must accompany the bill for proper consideration of payment and for verification of proper coding.

The diagnosis reported by the provider may represent a condition occurring as a result of the motor vehicle accident or an unrelated condition.

The Item billed is a valid code but has no established fee in the New York Workers' Compensation DME Fee Schedule. Therefore, the invoice is required in accordance with the New York No Fault Regulation 83, Section 68.1, Part E of Appendix 17-C.

4. Findings, Conclusions, and Basis Therefor

The case was decided on the submissions of the Parties as contained in the ADR Center maintained by the American Arbitration Association and the oral arguments of the parties' representatives. There were no witnesses. I reviewed the documents contained in the file for both parties and make my decision in reliance thereon.

To receive payment of a claim, Applicant "need only file a 'proof of claim' (11 NYCRR 65.11(k)(3)), and the insurers are obliged to honor it promptly or suffer the statutory penalties." Dermatossian v. New York City Transit Authority, 67 N.Y.2d 219, 224, 501 N.Y.S.2d 784, 787 (1986). Furthermore, the No-Fault law requires a carrier to either pay or deny a claim for No-Fault benefits within thirty (30) days from the date an applicant supplies proof of claim. See, Insurance Law §5106 (a) and 11 NYCRR 65-3.8. As will be explained below, I find that Applicant established a prima facie case of entitlement to reimbursement of its claim, by submitting evidence that the prescribed statutory billing form was mailed and received, and that the Respondent failed to either pay or deny the claim within the requisite 30-day period. Viviane Etienne Medical Care, P.C. v. Country-Wide Ins. Co., 25 N.Y.3d 498, 14 N.Y.S.3d 283 (2015); Mary Immaculate Hospital v. Allstate Insurance Co., 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004).

Bill not received by Respondent within 45 days

Respondent asserts that Applicant failed to submit the bill within 45 days. Applicant provided the items on July 27, 2024, and Respondent's denial indicates that it received the bill on September 12, 2024.

The Mandatory Personal Injury Protection Endorsement set forth in 11 NYCRR 65-1.1 (d) states:

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.

The burden of proving that written proof of the claim was timely submitted to the carrier is upon the Applicant. This is part of the Applicant's prima facie case. see Mary Immaculate Hosp. v Allstate Ins. Co., 5 A.D.3d 742 [2004]; Amaze Med. Supply v Eagle Ins. Co., 2 Misc. 3d 128(A), 2003 NY Slip Op 51701(U) (Sup.Ct. App T. 2d Dep't 2003).

To establish that the Applicant mailed the billing to the Respondent, it must conclusively show it submitted its claim form to the Respondent. See A.B. Med. Servs. v State Farm Mut. Auto. Ins. Co., 3 Misc. 3d 130(A), 2004 NY Slip Op 50387(U), (App Term, 2d & 11th Jud Dists).

Generally, "proof that an item was properly mailed gives rise to a rebuttal presumption that the item was received by the addressee" Matter of Rodriquez v. Wing, 251 A.D.2d 335, 336, 673 N.Y.S.2d 734). The presumption may be created by either proof of actual mailing or proof of a standard office practice or procedure designed to ensure that items are properly addressed and mailed". Residential Holding Corp. v. Scottsdale Ins. Co., 286 A.D.2d 679, 680, 729 N.Y.S.2d 776 (2d Dep't 2001).

Applicant provided the bill at issue and the corresponding proof of mailing which was stamped by the USPS on August 5, 2024. I find that this evidence establishes that Applicant submitted the bill to Respondent within 45 days of providing assignor with the DME.

The No-Fault law requires a carrier to either pay or deny a claim for No-Fault benefits within thirty (30) days from the date an applicant supplies proof of claim. See, Insurance Law §5106 (a) and 11 NYCRR 65-3.8.

Respondent denied the bill on October 2, 2024, which is more than thirty days later and is therefore late. "When an insurance company fails to comply with its duty to act expeditiously in processing no-fault claims, it will be precluded from raising most defenses. see, e.g., Presbyterian Hospital in City of N.Y. v. Maryland Casualty Co., 226 A.D.2d 613, 641 N.Y.S.2d 395.

While many defenses are precludable, its defenses predicated on causation, and the rate of reimbursement are not. Respondent may assert these defenses at any time. Therefore, I will consider these defenses.

Causation

Respondent asserted that "the diagnosis reported by the provider may represent a condition occurring as a result of the motor vehicle accident or an unrelated condition."

Respondent did not provide any evidence in support of this argument. Therefore, it fails to establish this defense.

Invoice

It is unclear whether Respondent had Applicant's invoice. The denial indicates that Respondent did not have it, but it is referenced by Respondent's fee coder, Kathryn Salvo, CPC. If Respondent did not have it but wanted it Respondent should have sent a request for verification and not simply denied reimbursement. Gaba Medical, P.C. v. Progressive Specialty Ins. Co., 36 Misc.3d 139(A), 957 N.Y.S.2d 264 (Table), 2012 N.Y. Slip Op. 51448(U), 2012 WL 3139780 (App. Term 2d, 11th & 13th Dists. July 25, 2012). Denying reimbursement without seeking verification, simply is arbitrary.

Rate of Reimbursement

Applicant billed \$4,350 under CPT code E1399 for the ultrasound therapy device

and \$4,050 under CPT code E1399 for the cervical wearable electromagnetic therapy device.

Respondent relying on an affidavit by Kathryn Salvo, CPC, asserts that Applicant is only entitled to \$2495 and \$149.95, respectively, for these items.

When an insurer intends to contest and reduce a medical provider's fees, it has the burden of coming forward with competent evidentiary proof to support its fee schedule reduction or denial. Roberts Physical Therapy, P.C. v. State Farm Mutual Automobile Insurance Company, 13 Misc.3d 172, 3006 N.Y. Slip Op. 26240 (N.Y. Civ. Ct. Kings Co. 2006). In the absence of such proof, the defense of noncompliance with the appropriate fee schedule cannot be sustained. Continental Medical P.C. v. Travelers Indemnity Company, 11 Misc.3d 145(A), 2006 N.Y. Slip Op. 29386 (N.Y. Civ. Ct. 2009). A claims examiner may not unilaterally reduce a bill to which a doctor has affixed his name. "An insurer fails to establish the existence of an issue of fact with respect to a defense that fees charged were excessive and not in accordance with the Workers' Compensation fee schedule in the absence of proof establishing the defense." St. Vincent Medical Care, P.C. v. Country Wide Ins. Co., 26 Misc.3d 146(A), 907 N.Y.S.2d 441 (Table), 2010 N.Y. Slip Op. 50488(U), 2010 WL 1063914 (App. Term 2d, 11th & 13th Dists. Mar. 19, 2010).

Kathryn Salvo, CPC

Ms. Salvo provides a comprehensive analysis of the codes billed. She states that reimbursement was calculated based on The Official New York State Workers' Compensation Medical Fee Schedule, The Durable Medical Equipment Fee Schedule which went into effect on April 4, 2022.

The 36 Amendment to 11 NYCRR 68 which added a new Part E of Appendix 17-C to read follows

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 for purchase, rental, or both has been assigned.

(b) As used in this Part, acquisition cost means the line-item cost to the provider from a manufacturer or wholesaler net of any rebates, discounts or valuable consideration, mailing, shipping, handling, insurance costs or sales tax.

(c) The maximum permissible purchase charge for such durable medical equipment shall be the lesser of the:

(1) acquisition cost plus 50%; or

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

(d)(1) On and after 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.

(2) The total accumulated rental charge for such durable medical equipment shall be the least of the:

(i) acquisition cost plus 50%;

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

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

Ms. Salvo explains that the code billed, E1399 is listed in the NY WC DME Fee Schedule, however it does not have a listed MRA. When there is no listed fee schedule amount, price is to be determined by either manufacture's invoice (acquisition cost) OR usual and customary cost to the general public.

To determine the rate of reimbursement Ms. Salvo compares the rate of the acquisition cost plus 50% to the usual and customary price charged by durable medical equipment providers to the general public.

ELECTROMAGNETIC THERAPY EMTT

She searched internet for the usual and customary price charged by durable medical equipment providers to the general public and determines that the rate or reimbursement is as follows:

Based on the research via the web from EBAY.com, the average price of 3 similar items for rent for ELECTROMAGNETIC THERAPY EMTT devices is \$2,575.66

Formula of averaged prices: \$2,575.66

She also calculates the rate of reimbursement using supplied invoice from provider:

Based on an invoice addressed to the provider for HCPCS code E1399-

ELECTROMANETIC UNIT lists the acquisition cost to the provider as \$2899.00.

Formula for purchase: Acquisition Cost \$2,899.00 @ 150% = \$4,348.50

Based on above, general public pricing of \$2,575.66 is supported.

ULTRASOUND THERAPY UNIT

Ms. Salvo used the same strategy to determine the cost of the ultrasound therapy unit. Her search online revealed the following:

Per the result of the research, PROHEALTHCARE PRODUCTS has pricing available to the general public for an ULTRASOUND THERAPY UNIT. Pricing is based on the model device supplied which is priced at \$149.95 for purchase.

Calculations for the correct reimbursement are based on the price model that cost the general public.

Formula: \$149.95

She also calculates the rate of reimbursement using supplied invoice from provider:

Based on an invoice addressed to the provider for HCPCS code E1399-ULTRASOUND THERAPY UNIT lists the acquisition cost to the provider as \$2,758.00.

Formula for purchase: Acquisition Cost \$2,758.00 @ 150% = \$4,137.00

Based on above, general public pricing of \$149.95 is supported.

In both instances Ms. Salvo concludes that the lower cost is based on the usual and customary price charged by durable medical equipment providers to the general public and recommends reimbursement based on this rate.

Applicant's Argument

Applicant seeks reimbursement based on its acquisition cost plus 50%. In support, it provided its invoice which supports the amount billed.

At the hearing Applicant's representative argued that Respondent failed to establish the usual and customary price charged by durable medical equipment providers to the general public. He questioned the reliability of Ms. Salvo's research and resulting calculation. He argued that she does not adequately explain what search she conducted, what she considered and, ultimately, how she determined the cost to the general public. Moreover, it is unclear whether she considered assignor's invoice in making this determination.

Reimbursement should have been based on the invoice. If Respondent did not have access to it and needed it for the calculation, it should have been requested.

Finding

After careful consideration of Ms. Salvo's affidavit and the arguments set forth by both parties, I find for the Applicant.

Ms. Salvo fails to establish the usual and customary price charged to the public at the time the items were dispensed to assignor.

Regarding the **electromagnetic therapy EMTT device**, Ms. Salvo relies on the result on an eBay searched conducted on March 3, 2023, more than one year before the items were dispensed.

As for the **ultrasound therapy unit complete**, she provides only the cost of one comparable item. She does not indicate when the search was conducted, how many items she considered or even if the item she relied upon is the same as the one dispensed.

For these reasons, the internet search she conducted to determine the price is inadequate for several reasons.

1. Limited Sources: The search relied on only one website, which does not provide a broad or representative view of the available prices. Without consulting a wider range of sources, the results are incomplete and may not reflect the usual and customary price charged to the public.

2. Small Number of Comparable Items: The search produced only a few similar items to compare. With such limited data, it is difficult to draw accurate and reliable conclusions about the item's price.

3. Outdated Information (Over One Year Old): The pricing information found is over a year old. Because prices can change significantly relying on outdated data does not give an accurate picture of price at the time assignor was provided with the items.

Applicant substantiated the amount it billed. Respondent failed to establish the usual and customary price charged to the public at the time the items were dispensed to assignor. Accordingly, I find in favor of Applicant and award \$8400 in satisfaction of the claim.

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
	Pelle Supply Inc	07/27/24 - 07/27/24	\$4,350.00	Awarded: \$4,350.00

	Pelle Supply Inc	07/27/24 - 07/27/24	\$4,050.00	Awarded: \$4,050.00
Total			\$8,400.00	Awarded: \$8,400.00

B. The insurer shall also compute and pay the applicant interest set forth below. 10/13/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest shall be calculated from the date listed above, until the date that payment is made at two percent per month, simple interest on a pro rata basis using a thirty-day month.

C. Attorney's Fees

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

Attorney's Fees shall be calculated pursuant to the amended terms, as follows: 20 percent of the amount of first-party benefits, plus interest thereon, subject to a maximum fee of \$1,360. [11 NYCRR §65-4.6(d)]. There is no minimum fee.

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 NJ
 SS :
 County of Bergen

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

08/04/2025
 (Dated)

Corinne Pascariu

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:
98cb9ae3b8f40ecb74c0e0a26080b037

Electronically Signed

Your name: Corinne Pascariu
Signed on: 08/04/2025