American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Supplies Made Easy Inc (Applicant)	AAA Case No.	17-26-1440-7586
	Applicant's File No.	N/A
- and -	Insurer's Claim File No.	04009605-2025
	NAIC No.	Self-Insured
Repwest Insurance Company (Respondent)		

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 07/27/2026
   Declared closed by the arbitrator on 07/27/2026

   Ian Besso, Esq. from The Sigalov Firm PLLC participated virtually for the Applicant

   Jennifer Jordan, Esq. from Husch Blackwell LLP participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$2,847.65**, 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 42 year old EIP reported involvement in a motor vehicle accident on July 7, 2025; claimed related injury and received an EMS device unit, infrared heating lamp with stand, massager (percussor) electric and water circulating heat pad with pump provided by the applicant on September 3, 2025.

   The applicant submitted a claim for this durable medical equipment (DME), partial payment of which was timely made by the respondent based upon its determination of the correct reimbursable amount pursuant to the New York Workers' Compensation Medical Fee Schedule.

The issue to be determined at the hearing is 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 in 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.

The applicant billed a total of $4,154.56 for the DME at issue, for which the respondent made partial payment of $1,306.91 based on its calculation of the correct reimbursable amount pursuant to the appropriate fee schedule, leaving a balance of $2,847.65.

To prevail in a fee schedule defense, the respondent must demonstrate by competent evidentiary proof that applicant's claims were in excess of the appropriate fee schedules, or otherwise respondent's defense of noncompliance with the appropriate fee schedule cannot be sustained. Continental Medical, P.C. v. Travelers Indemnity Co., 11 Misc.3d 145(A) (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.)

A fee schedule defense does not always require expert proof. There are two fee schedule scenarios. The first involves the basic application of the fee codes and simple arithmetic. The second scenario involves interpretation of the codes and often requires testimony and evidence beyond that of a lay individual. I find that the fee schedule issue presented in this case is analogous to the latter scenario and requires an expert opinion.

The respondent supported its fee schedule defense with the affidavit of Chelsea Burst, CPC who submitted a comprehensive report which included a determination of the correct reimbursable amount according to the DME fee schedule for the heat lamp with stand billed under CPT code E0245 was correctly reported for an infrared heating lamp. Although this code is listed in the DME fee schedule listed. She calculated the average purchase price to the general public as $70.40, which was the amount paid by the respondent.

Ms. Burst also determined that the water circulating heat pad with pump billed under CPT code Eo217 is listed in the DME fee schedule for $412.03 and recommended reimbursement at that price.

Ms. Burst determined that the DME which the applicant described as an EMS unit was incorrectly billed under CPT code E0747, which is described in the DME fee schedule asOsteogenesis stimulator, electrical, noninvasive, other than spinal applications. She recommended payment for the EMS unit four lead under CPT code E1399 and calculated the correct reimbursable amount based on the price to the general public for an EMS unit is $50.64, which was the amount paid by the respondent.

Ms. Burst also determined that the DME billed under CPT code E0480 is described in the fee code as a "pneumatic or electric percussor, which is considered an airway clearance device for patients with medical conditions causing accumulation of pulmonary secretions. It is a handheld device used in chest physiotherapy to loosen thick mucus and phlegm from the lungs."

She noted that the prescribed device is documented in the DME fee code as a "massager, a device which provides deep tissue stimulation that aids in muscle recovery and reduces soreness, improved range of motion, enhanced circulation, reduced muscle stiffness and pain relief." She corrected the fee code to CPT code E1399 and determined that the average price to the general public for a handheld massager is $95.74 and that is the correct reimbursable amount for this DME.

Based on these calculations, the respondent's expert fee coder determined that the correct total reimbursable amount for the DME at issue is $628.81.

The applicant acknowledged payment of $1,206.91, which is in excess of the fee coder's calculation.

In response to the affidavit of Chelsea Burst, CPC, the applicant did not submit an affidavit from a certified professional fee coder, medical professional or other expert to refute the findings of the respondent's expert.

Based on the foregoing, the respondent has established its fee schedule defense.

Accordingly, 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 claim is DENIED in its entirety

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.

08/16/2026
(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:
a6d1964fc59ade80f3a31995d90257fe

Electronically Signed

Your name: Anne Malone
Signed on: 08/16/2026