American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Lidas Medical Supply, Inc (Applicant)	AAA Case No.	17-16-1035-2839
	Applicant's File No.	130679
- and -	Insurer's Claim File No.	HOK2843
	NAIC No.	36145
St. Paul Travelers Insurance Co. (Respondent)		

ARBITRATION AWARD

I, Bernadette Connor, 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 04/06/2017
   Declared closed by the arbitrator on 04/06/2017

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

   Michael Rappaport, Esq. from Law Office of Aloy O. Ibuzor participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 1,585.27**, 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

   Whether Applicant is entitled to reimbursement for medical services provided to the Assignor herein as a result of injuries sustained in a motor vehicle accident that occurred on December 6, 2015.

4. Findings, Conclusions, and Basis Therefor

I have carefully reviewed the submissions contained in the Modria ADR Center maintained by the American Arbitration Association. I have also considered the oral arguments of the parties presented at the hearing of this matter.

An arbitrator "shall be the judge of the relevance and the materiality of the evidence offered, strict conformity to the rules of evidence shall not be necessary. The arbitrator may question or examine any witness or party and independently raise any issue that arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department regulations." 11 N.Y.C.R.R. 65-45 (o) (1). Additionally, as the trier of the facts and the law, an Arbitrator is authorized to review and take judicial notice of any rule, law, medical document or periodical or any other document which may impact and aid in making a decision, as long as it conforms with the Insurance laws and the New York State Insurance Department Regulations. *Matter of Medical Society v. Serio,* 100 NY2d 854, 768 NYS2d 423 (2003).

Applicant seeks reimbursement for the following medical supplies provided to the Assignor, a 63 year-old female, who sustained injuries to the neck and back in a motor vehicle accident on December 6, 2015: Cervical collar; foam mattress; dry pressure pad for mattress; general use cushion; infrared heat lam; deep tissue massager; TENS unit.

Respondent did not issue a denial of Applicant's claim, arguing that the matter is not ripe for arbitration as Applicant has failed to fully comply with requests for additional verification. In support of its contention, Respondent submitted into evidence correspondence sent to Applicant, dated February 24, 2016 and March 30, 2016, requesting, *an NF-3 with the provider's actual signature; documentation describing the equipment that was provided to the above-referenced patient, as well at the name of the original manufacturer, make and model and the instruction manual; initial report/evaluation from treating/referring Dr. Radha Gara where the need for infrared lamp, general use cushion, lumbar sacral support, personal massager, knee support, bed board, egg rate mattress, cane, Philadelphia collar, cervical pillow impacts the injured parties treatment plan; detailed and completed letter of medical necessity, including prescribed usage, date of onset, frequency of use, prescribed setting of use, indications for use, areas to be treated, and duration of treatment use with referring doctor's original signature.*

Respondent also submitted into evidence a letter it sent to Applicant, dated April 8, 2016, acknowledging receiving "a portion of the verification previously requested." However, Respondent advised Applicant that the following documents were still outstanding: *initial report/evaluation from treating/referring Dr. Radha Gara where the need for infrared lamp, general use cushion, lumbar sacral support, personal massager, knee support, bed board, egg rate mattress, cane, Philadelphia collar, cervical pillow was documented or indicated...All follow up reports/evaluations from treating /referring Dr. Radha Gara documenting how the need for the infrared lamp, general use cushion, lumbar sacral support, personal massager, knee support, bed board, egg crate mattress, cane, Philadelphia collar, cervical pillow imacts the injured parties treatment plan.*

Respondent advised Applicant that it was unable to process the claim until Applicant submitted the items.

Decision:

Under Section 5102 of the New York Insurance Law, No-Fault first party benefits are reimbursable for all medically necessary expenses due to personal injuries arising out of the use or operation of a motor vehicle. Applicant establishes a prima facie entitlement to judgment as a matter of law by proof that he submitted a claim, setting forth the fact and amount of the loss sustained, and that the payment of No-Fault benefits was overdue. See Insurance Law Section 5106a; *Damadian MRI in Canarsie, P.C.* v. *General Assurance Company*, 2006 NY Slip Op 51048U, 2006 NYS Misc. Lexis 1363 (Decided June 2, 2006 Appellate Term, 2d Department); *Amaze Medical Supply, Inc. v. Eagle Insurance Company*, 2 Misc. 3rd 128, 784 N.Y.S. 2d 918 (2003).

A No-Fault claim must be paid or denied within thirty days or it is "overdue." The insurer may lengthen the time limitations by requesting additional verification. Pursuant to 11 NYCRR 65-3.5(b), the insurer has 15 (fifteen) business days after receiving proof of claim to request additional verification. If an insurer fails to timely deny a claim, the insurer is precluded from raising a number of defenses.

Further, section 65-3.6 (b) states: "At a minimum, if any requested verification has not been supplied to the insurer 30 calendar days after the original request, the insurer shall, within 10 calendar days, follow up with the party from whom the verification was requested, either by telephone call, properly documented in the file, or by mail. At the same time the insurer shall inform the applicant and such person's attorney of the reason(s) why the claim is delayed by identifying in writing the missing verification and the party from whom it was requested."

Applicant cannot simply ignore Respondent's request for additional verification and Respondent cannot ignore Applicant's response to a verification request. In *Westchester Co. Med. Ctr. v. New York Central Mut. Fire Ins. Co.,* 262 A.D.2d 553, 692 N.Y.S.2d 664 (2d Dept.199), the plaintiff failed to respond to the insurer's request for additional verification. The Court held that, "Any confusion on the part of the plaintiff as to what was being sought should have been addressed by further communication, not inaction." In *Canarsie Chiropractic, P.C. v. State Farm Mut. Auto Ins. Co.,* 27 Misc. 3d 1228 (A), 911 N.Y.S.2d 691 (Civ. Ct. Kings County 2010, the Court, citing *Westchester Co. Med. Ctr. v. New York Central Mut. Fire Ins. Co.,* supra, the Court held that by failing to respond to the insurer's request for additional verification, the plaintiff had waived its defense and could not argue that the additional verification requests were defective. Even when a claimant believes it need not comply with a verification request, the claimant still has the duty to communicate with the insurer regarding the request.

After carefully reviewing the evidence presented, I find that Respondent properly requested additional verification and that Applicant has not fully complied. Therefore, this matter is not ripe for arbitration as additional verification is still outstanding.

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 DISMISSED without prejudice

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of New York
SS :
County of New York

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

05/09/2017
(Dated)

Bernadette Connor

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:
5a32024901d86e7b013cd534be3d59bb

Electronically Signed

Your name: Bernadette Connor
Signed on: 05/09/2017