

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Manalapan Surgery Center
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No.	17-16-1037-2712
Applicant's File No.	FL15-6237
Insurer's Claim File No.	037539770-0101-022
NAIC No.	22055

ARBITRATION AWARD

I, Karen Fisher-Isaacs, 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 08/08/2017, 09/05/2017
Declared closed by the arbitrator on 09/05/2017

Melissa Field from Field Law Group, P.C. participated in person for the Applicant

Lisa Aquino from Law Office of Printz & Goldstein participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 26,733.42**, was AMENDED and permitted by the arbitrator at the oral hearing.
Applicant amended the amount of the claim to \$11,457.18

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

3. Summary of Issues in Dispute

In dispute is Applicant's billing for its facility fee for three dates when MUA was performed, February 21, February 22 and March 15, 2015, for Assignor, a 43-year old female, in connection with treating injuries allegedly sustained in a January 6, 2015 motor vehicle accident.

Whether Applicant's claim is ripe for arbitration.

4. Findings, Conclusions, and Basis Therefor

I have reviewed the documents contained in the American Arbitration Association's ADR Center as of the date of the hearing in this matter and have considered all pertinent documents contained therein for the purpose of rendering this award.

Applicant seeks reimbursement in the amended amount of \$11,457.18 for providing the facility associated with MUAs performed on February 21, 22 and March 15, 2015 for Assignor, a 43- year old female, in connection with treating injuries allegedly sustained in a motor vehicle accident on January 6, 2015. Respondent has neither paid nor denied Applicant's billing alleging that there is outstanding verification.

I find that Applicant has established its prima facie case as Applicant has met the requirements enunciated in *Ave T MPC Corp. v Auto One Ins. Co.*, 32 Misc 3d 128[A], 2011 NY Slip Op 51292[U] [App Term, 2d, 11th & 13th Jud Dists 2011]). The Court held that "A no-fault provider establishes its prima facie entitlement to summary judgment by proof of the submission to the defendant of a claim form, proof of the fact and the amount of the loss sustained, and proof that the defendant either failed to pay or deny the claim within the requisite 30-day period, or issued a timely denial of claim that was conclusory, vague or without merit as a matter of law (see Insurance Law § 5106 [a]; *Westchester Med. Ctr. v Nationwide Mut. Ins. Co.*, 78 AD3d 1168 [2010]; see also *New York & Presby Hosp v. Allstate* 31 AD3d 512 [2006])."

Assignor was the driver of a motor vehicle that was involved in an accident on January 6, 2015. She came under the care of Ryan Tichauer, D.C on January 29, 2015. After performing a physical examination, Dr. Tichauer recommended MUA.

Assignor underwent MUA procedures on February 21, 22 and March 15, 2015. It is undisputed that upon receiving each of Applicant's bills for its facility fee, Respondent timely sent out initial verification requests and then follow up verification requests. Respondent was seeking

- A brief written statement explaining why MUA deemed necessary on 1/29/15
- Who referred the injured party to Professional Chiropractic Care for MUA? Please submit a copy of the referral.

-Prior to the MUA procedures, what treatment did the injured party receive to the pelvis?
Please

submit documentation reflecting this treatment.

-Were any radiologic/diagnostic tests done on the pelvis prior to the MUA procedures?
If so, please provide the test results. If not please advise why these tests were not necessary prior to the MUA procedures.

Applicant argued that it is entitled to reimbursement because it responded by letters dated April 24, May 21 and May 28, 2015. Each letter stated, "Manalapan Surgery Center is an ambulatory surgery center which assists the doctor in performing the procedure and thus, may not process all of the medical records and documentation requested including written statement explain why MUA necessary, copy of the referral, documentation reflecting pelvis treatment, radiologic/diagnostic tests, medical clearance report. Please request these items and any such additional information directly from the treating provider." I do not find Applicant's response sufficient.

A claimant who receives an assignment from an injured party has a duty to respond to a request for additional verification even if it is not the treating medical provider, and cannot simply ignore it. *Dilon Medical Supply Corp. v. Travelers Ins.*, 7 Misc.3d 927, 796 N.Y.S.2d 872 (Civ. Ct. Kings Co. 2005) Co. (medical supply provider). In seeking additional verification, an insurer is not limited to seeking it from the applicant. *Doshi Diagnostic Imaging Services v. State Farm Ins. Co.*, 16 Misc.3d 42, 842 N.Y.S.2d 153 (App. Term 9th & 10th Dists. 2007).

Whether the claimant possesses the verification requested or it is in the hands of the referring physician, it cannot shift its obligation to verify a claim to the insurer. *D & R Medical Supply, Inc. v. Clarendon Nat. Ins. Co.*, 22 Misc.3d 1127(A), 881 N.Y.S.2d 362 (Table), 2009 N.Y. Slip Op. 50306(U), 2009 WL 485262 (Civ. Ct. Kings Co., Genine D. Edwards, J., Feb. 26, 2009).

"An insurer does not have to pay or deny a claim until it has received verification of all relevant information requested (see, 11 NYCRR 65.15[g][1][i],[2][iii])." *New York & Presbyterian Hospital v. American Transit Ins.*, 287 A.D.2d 699, 700, 733 N.Y.S.2d 80, 82 (2d Dept. 2001). Co. An insurer is not obligated to pay or deny a claim until it has received verification of all relevant

information requested; any action begun before such verification has been provided is premature inasmuch as the period for the insurer to respond to the claim has not begun to run. *Nyack Hospital v. State Farm Mutual Automobile Ins. Co.*, 19 A.D.3d 569, 796 N.Y.S.2d 538 (2d Dept. 2005).

Excel Surgery Ctr., L.L.C. v Fiduciary Ins. Co. of America (2017 NY Slip Op 50408 (U)) is directly on point. There, the Appellate Term held that when an assignor failed to adequately respond to a carrier's request for verification, the carrier's 30-day period it

had to deny or pay the claim did not begin to run. Although *Excel* was decided after the claim was presented here, it did not break new ground. It drew on existing and established precedent. See *Gurnee v. Aetna Life & Casualty Co.*, 55 N.Y.2d 184 (1982). Consequently, I must apply its reasoning here.

Inasmuch as there is outstanding verification, Applicant's prima facie case of entitlement to No-Fault compensation has been overcome by Respondent. The within arbitration claim is dismissed without prejudice.

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 Kings

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

10/03/2017
(Dated)

Karen Fisher-Isaacs

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:
e0d57a78b1c02f75026f72dba535f82f

Electronically Signed

Your name: Karen Fisher-Isaacs
Signed on: 10/03/2017