

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Tim Canty M.D. PLLC
(Applicant)

- and -

American Transit Insurance Company
(Respondent)

AAA Case No. 17-16-1031-3162

Applicant's File No. M0403

Insurer's Claim File No. 65894404

NAIC No. 16616

ARBITRATION AWARD

I, Aaron Maslow, 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 ["JC"]

1. Hearing(s) held on 09/25/2017
Declared closed by the arbitrator on 09/25/2017

Andrew Bruskin, Esq., from Munawar & Andrews-Santillo LLP participated in person for the Applicant

Ariana Pabalon, Esq., from American Transit Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 6,801.34**, 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 Tim Canty M.D., PLLC established entitlement to No-Fault insurance compensation for various medical services provided to the EIP
- Whether, in the absence of an assignment of benefits in the record made out to Applicant from the EIP, Applicant possesses standing to pursue this arbitration claim for No-Fault compensation

4. Findings, Conclusions, and Basis Therefor

Appearances

For Applicant:

Munawar & Andrews-Santillo LLP
420 Lexington Avenue
Suite 2601
New York, NY 10170
By: Andrew Bruskin, Esq.

For Respondent:

Daniel J. Tucker, P.C.
One Metro Tech Center
7th floor
Brooklyn, NY 11201
By: Ariana Pabalon, Esq.

Applicant Tim Canty M.D., PLLC commenced this New York No-Fault insurance arbitration, seeking as compensation \$6,801.34 which it billed for performing various medical services from Feb. 25, 2015 to Sept. 2, 2015, to treat the EIP, a male individual who was injured in a motor vehicle accident on Jan. 18, 2015. The services included various therapeutic injections and physical therapy. Respondent denied payment of some of Applicant's seven bills on the ground of lack of medical necessity, citing a peer review by Dr. Joseph Cole. Other bills were denied based upon an IME cutoff, the EIP having been examined by Dr. Alan Wolf. Fee related defenses were also asserted in connection with the bills.

This arbitration was conducted under the auspices of the American Arbitration Association, which has been designated by the New York State Department of Financial Services to administer the mandatory arbitration provisions of Insurance Law § 5106(b), which provides:

Every insurer shall provide a claimant with the option of submitting any dispute involving the insurer's liability to pay first party ["No-Fault insurance"] benefits, or additional first party benefits, the amount thereof or any other matter which may arise pursuant to subsection (a) of this section to arbitration pursuant to simplified procedures to be promulgated or approved by the superintendent.

Both parties appeared at the hearing by counsel, who presented oral argument and relied upon documentary submissions. I have reviewed the submissions' documents contained in the American Arbitration Association's ADR Center as of the date of the hearing, said submissions constituting the record in this case.

At the hearing, I raised an issue: There was no assignment of benefits in the record from the EIP to Applicant, Tim Canty M.D., PLLC.* The only assignment submitted into the record was from the EIP to NY Ambulatory and Anesthesia, PC.

I note the holding of the court in Lopes v. Liberty Mutual Ins. Co., 24 Misc.3d 127(A), 890 N.Y.S.2d 369 (Table), 2009 N.Y. Slip Op. 51279(U), 2009 WL 1799812 (App. Term 2d, 11th & 13th Dists. Jan. 26, 2009), that in the absence of an assignment, a claim submitted by a health care provider must be deemed to have been submitted on behalf of the individual who has the right to be paid under the No-Fault regulations. Ergo, a health care provider who claims to have standing to pursue payment on his own behalf in litigation must show a signed assignment. If there is no assignment, then only the injured person possesses standing.

I am concluding as a matter of law that a health care provider must submit an actual signed assignment of benefits made out to it in order to possess standing to arbitrate a dispute over No-Fault benefits and obtain compensation for itself.

Unlike in court, " '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' [citations omitted]." Matter of Chin v. State Farm Ins. Co., 73 A.D.3d 918, 919, 900 N.Y.S.2d 738, 739-740 (2d Dept. 2010). Requiring an actual signed assignment of benefits in order for a health service entity to be able to argue in support of a claim for compensation to be paid to it is not clearly violative of a strong public policy, is not totally or completely irrational, and does not manifestly exceed a specific, enumerated limitation on an arbitrator's power. See Matter of Chin, *supra*. It is quite rational and equitable to require that those who wish to stand in the shoes of the eligible injured person and pursue a claim for money in his place prove that he authorized it to do so.

It is not a secret that there has been some fraud in the No-Fault system, witness the convictions obtained by law enforcement authorities over the last decade. Doctors have been convicted and sentenced for falsifying No-Fault forms. Non-doctors have been convicted for operating massive schemes to defraud insurance companies. The Court of Appeals recognized this in Serio, 100 N.Y.2d at 861, 768 N.Y.S.2d at 426 (2003):

Between 1992 and 2001, reports of suspected automobile insurance fraud increased by 275%, the bulk of the increase occurring in no-fault insurance fraud. Reports of no-fault fraud rose from 489 cases in 1992 to 9,191 in 2000, a rise of more than 1700%. No-fault fraud accounted for three quarters of the 16,902 reports of automobile-related fraud received by the Insurance Department's Frauds Bureau in 2000, and more than 55% of the 22,247 reports involving all types of insurance fraud. In 1999, the Superintendent established a No-Fault Unit within the Frauds Bureau to focus specifically on no-fault fraud and abuse. By one estimate, the combined effect of no-fault insurance fraud has been an increase of

over \$100 per year in annual insurance premium costs for the average New York motorist.

Other courts have also commented on fraud in the No-Fault system. "[I]t is appropriate . . . to take judicial notice of the fact that '[t]he impact of fraud on this State's no-fault system is notorious' (*Fair Price Med. Supply Corp. v Travelers Indem. Co.*, 10 NY3d 556, 567 [Smith, J., dissenting]; see *Consolidated Edison Co. of N.Y. v Public Serv. Commn. of State of N.Y.*, 47 NY2d 94, 110; *Appelbaum v Deutsch*, 111 AD2d 21, 22, *affd* 66 NY2d 975; *Dougherty v 425 Dev. Assoc.*, 93 AD2d 438, 447; see also *Prince, Richardson on Evidence* §§ 2-202, 2-203 [Farrell 2008]). Despite efforts to prosecute deceptive health care providers and medical mills, '[t]he number of suspected no-fault fraud reports received by the Department [of Financial Services] increased by 16 percent from 2011 to 2012' (Submission Letter from Benjamin M. Lawskey, Superintendent of the Department of Financial Services, dated March 15, 2013 [Cover Letter for 2012 Annual Report on the Activities of the Department to Investigate and Combat Health Insurance Fraud]). In 2012, '[r]eports of no-fault fraud totaled 90 percent of health insurance fraud reports, up from 85 percent in 2011, and more than half of reports of fraud of all types, making no-fault fraud again the biggest single fraud issue [in 2012]' (*id.*)."
Viviane Etienne Medical Care, P.C. v. Country-Wide Ins. Co., 114 A.D.3d 33, 49-50, 977 N.Y.S.2d 292, 306 (2d Dept. 2013) (Miller, J., dissent).

"[I]t is becoming apparent to the courts, law enforcement agencies and the media that many people are engaged in fraudulent criminal activity so as to obtain money to which they are not entitled for treatment which was never rendered and that such activity adds to the costs borne by law abiding citizens [citations omitted]. . . ." *Stephen Fogel Psychological, P.C. v. Progressive Casualty Ins. Co.*, 7 Misc.3d 18, 27, 793 N.Y.S.2d 661, 668 (App. Term 2d & 11th Dists. 2004) (Golia, J., dissent), rev'd on other grounds, 35 A.D.3d 720, 827 N.Y.S.2d 217 (2d Dept. 2006). Due to an unexpected and exponential rise in no-fault fraud since the system's inception, that flood has now grown into a tsunami of fraudulent activity." *St. Vincent Medical Care, P.C. v. Country-Wide Ins. Co.*, 26 Misc.3d 58, 64, 894 N.Y.S.2d 811, 816 (App. Term 2d, 11th & 13th Dists. May 8, 2009) (Golia, J., dissent), rev'd on other grounds, 80 A.D.3d 599, 914 N.Y.S.2d 293 (2d Dept. 2011).

Eight years after it decided *Serio*, the Court of Appeals still acknowledged the existence of fraud in the No-Fault system. "No-fault abuse still abounds today. In 2010, no-fault accounted for 53% of all fraud reports received by the Insurance Department (Annual Report to the Governor and the Legislature of the State of New York on the Operations of the Insurance Frauds Prevention Act at 23)." *Perl v. Meher*, 18 N.Y.3d 208, 214, 936 N.Y.S.2d 655, 657 (2011).

Requiring a signed assignment of benefits from a person injured in a motor vehicle accident in order to establish that his or her rights are transferred promotes the deterrence of fraud. I simply cannot conceive of permitting a professional medical business entity to obtain compensation in another's place without that other

person signing over that right. Where there is a total lack of an assignment of benefits to the medical professional seeking compensation, as is the situation here, the health care provider does not have standing to pursue the claim.

I note that Master Arbitrator Peter J. Merani affirmed Arbitrator Donna Ferrara, in Matter of Arbitration of South Nassau Community Hospital a/a/o "AJ" v. GEICO Ins. Co., AAA Case No. 99-13-9045-9467, where Arbitrator Ferrara held similarly. Master Arbitrator Merani wrote:

The issue in this case does not concern itself with the validity of an assignment but instead the issue is whether the provider is entitled to recover no fault payments without first establishing that there is a properly executed assignment of benefits. The lower arbitrator decided that the Applicant provider was not entitled to payment without first establishing that it actually obtained a legal right belonging to the eligible injured person in order to proceed to the arbitration. A valid assignment is a necessary precondition for the Applicant to seek no fault payments for services rendered to the eligible injured person. With regard to the assignment of benefits the lower arbitrator found that without an assignment of benefits the Applicant had no standing to bring the claim. The arbitrator's decision was reached after reviewing the documents and oral arguments presented at the arbitration hearing. The arbitrator below did not act in an arbitrary and capricious manner in finding that Applicant provider had no standing or claim for reimbursement.

In the instant case, inasmuch as Applicant lacked a signed assignment of benefits from the EIP, I conclude that it lacks standing to maintain the instant arbitration.

Accordingly, the within arbitration claim is dismissed without prejudice.

* "The arbitrator may . . . independently raise any issue that the arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department regulations." 11 NYCRR 65-4.5(o)(1). This regulatory provision was validly enacted. Matter of Medical Society v. Serio, 100 N.Y.2d 854, 768 N.Y.S.2d 423 (2003). Insurance Law § 5106(b), requiring only that claimants be provided the option of arbitration, does not preclude an arbitrator from inquiring into issues deemed relevant. Id. at 872, 768 N.Y.S.2d at 434. The provision of 11 NYCRR 65-4.5(o)(1) to the effect that an arbitrator may independently raise any issue that he deems relevant to making an award does not violate the Due Process clause of the United States and New York State Constitutions. 563 Grand Medical, P.C. v. New York State Ins. Dept., 24 A.D.3d 413, 805 N.Y.S.2d 643 (2d Dept. 2005).

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

10/14/2017
(Dated)

Aaron Maslow

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:

3cc7dc08bc6c6d140dbc2f48caa80f8c

Electronically Signed

Your name: Aaron Maslow
Signed on: 10/14/2017