

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Andrew J. Dowd M.D.  
(Applicant)

- and -

Allstate Fire & Casualty Insurance Company  
(Respondent)

AAA Case No.	17-17-1064-5446
Applicant's File No.	TM-17-3137
Insurer's Claim File No.	418787271
NAIC No.	29688

### ARBITRATION AWARD

I, Paul Weidenbaum, 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: IP

1. Hearing(s) held on 08/30/2018  
Declared closed by the arbitrator on 08/30/2018

Naomie Jean-Philippe from Abrams, Fensterman, Fensterman, Eisman, Formato, Ferrara, Wolf & Carone LLP participated in person for the Applicant

Lindbergh Hmung from Smith & Brink, PC participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 6,854.97**, 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

This arbitration arises out of medical services provided to the injured person, a 38 year old male, who was involved in a motor vehicle accident which occurred on 6/16/16.

Whether the Respondent appropriately delayed for verification?

4. Findings, Conclusions, and Basis Therefor

This arbitration involves a claim for reimbursement for medical services provided to the injured person on dates of service between 7/20/16 and 7/28/16. The injured person, a 38 year old male, was involved in a motor vehicle accident which occurred on 6/16/16. The Applicant seeks reimbursement in the sum of \$6,854.97. Respondent has not issued a denial of the claim. Rather, the carrier has delayed for verification, seeking a number of documents and records enumerated in a verification request letter of 9/1/16 and a follow-up second request letter of 10/11/16. The case was decided after consideration of the arguments of counsel and following a thorough review of the submissions and documents contained in the Electronic Case File maintained by the American Arbitration Association, which are incorporated by reference herein.

Pursuant to 11 NYCRR 65-4 (Regulation 68-D), Section 65-4.5, an Arbitrator shall be the judge of the relevance and materiality of the evidence offered...The Arbitrator may question any witness or party and independently raise any issue that the Arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department Regulations. In addition, Master Arbitrator Peter J. Merani, in the case of *Sports Medicine & Orthopedic Rehabilitation a/a/o "I.B" v. Countrywide Insurance Co.*, AAA Case No. 17-R-991-14272-3, stated, in relevant part, that "the Arbitrator below is the trier of facts and must evaluate and weigh the evidence presented at the hearing in arriving at [his/her] decision. The Arbitrator, in weighing the evidence, has broad powers and discretion in determining what evidence is relevant and material. The Arbitrator is in the best position to evaluate the evidence and decide on the credibility of the submitted documents."

It is well-settled that a health care provider establishes its prima facie entitlement to reimbursement as a matter of law by proof that it submitted a claim, setting forth the fact and the amount of the loss sustained, and that payment of No-Fault benefits was overdue. *Damadian MRI in Canarsie, P.C. a/a/o Tyrone Harley v. General Assurance Co.*, 2006 NY Slip Op 51048U, Supreme Court of NY, App. Term 2d Dept., June 2, 2006; See Insurance Law Section 5106a, *Mary Immaculate Hosp. v. Allstate Ins. Co.*, 5 AD 3d 742, 774 N.Y.S. 2d 564 (2004); *Amaze Med. Supply v. Eagle Ins. Co.*, 2 Misc. 3d 128A, 784 N.Y.S. 2d 918 [2003 NY Slip Op 51701U (App. Term 2d & 11<sup>th</sup> Jud. Dists.)]. See also 11 NYCRR Section 65-1.1 *Vista Surgical Supplies, Inc. v. Metropolitan Property and Casualty Ins. Co.*, 2005-1328 KC, 2006 NY Slip Op 51047U, June 2, 2006.

Respondent contends that the billing in dispute was the subject of verification requests which remain unanswered. The general rule is set forth in 11 NYCRR Section 65-3.8(c), which states that "within 30 calendar days after proof of claim is received, the insurer shall either pay or deny the claim in whole or in part". This 30-day time period commences when the application for No-Fault benefits is complete, unless this time is extended by way of a demand for further verification of a claim, per 11 NYCRR Section 65-3.5. As such, a claim need not be paid or denied until all demanded verification is provided. *Nyack Hospital v. General Motors Acceptance Corp.*, 27 A.D. 3d 96, 808 N.Y.S. 2d 3999 (2d Dept. 2005), modified on other grounds, 8 N.Y. 3 294, 832 N.Y.S.

2d 880 (2007). Furthermore, 11 NYCRR Section 65-3.5(c) provides that "the insurer is entitled to receive all items necessary to verify the claim directly from the parties from whom such verification was requested."

The Section of Mandatory Personal Injury Protection Endorsement, Section 1 of 11 NYCRR Section 65-1.1 (Regulation 68-A), regarding "conditions" sets forth the following:

*" 'Action Against Company'. No action shall lie against the Company unless, as a condition precedent thereto, there shall have been full compliance with the terms of this coverage."*

In the instant matter, the timing and substance of the various documents exchanged between the parties was discussed at length with counsel at the time of the Hearing. Respondent also generated follow-up requests for such additional verification and sought compliance from Applicant's counsel.

Specifically, the documents and information requested are as follows:

- *Name and license of all persons that provided and/or supervised each service/test to the above patient, including the treating health care providers, and technicians or assistants.*
- *Place of service and address where each of the billed for services were provided*
- *W-2 and/or 1099 or other verifiable proof concerning the employment status of each of the individuals performing the billed for services*
- *The complete medical file, including but not limited to any medical reports, medical records, studies, notes, test results, medical, surgical (pre and post-operative) and anesthesiology records and reports relating to any procedures, patient history, diagnosis and evaluation relating to the billed for services prepared by applicant*
- *Any medical reports, narratives, letters of medical necessity relating to any referrals made by any health care provider to the applicant that resulted in the performance of the billed for services, surgery and/or any procedure*
- *Any correspondence and medical reports to any referring health care provider relating to any services, surgery and/or procedure performed on the patient that is the subject of the billed for services*
- *Any and all documents related to any prescriptions provided to the above patient for pharmaceuticals and/or durable medical equipment*
- *Any correspondence and/or referrals to any health care provider relating to the dispensing of pharmaceuticals or the provision of durable medical equipment*

***· Examination Under Oath of the eligible injured person (to be conducted by Smith & Brink)***

A second request was sent to the Applicant on 10/11/16.

On 10/17/16, Applicant sent correspondence to the Respondent, which stated the following, in relevant part:

***"The names of the persons that provided services for this claim are Andrew J. Dowd, M.D. and Robert Riselvato, RPA-C. Please see attached copies of their licenses and the W-2 for the employee Robert Riselvato.***

***Any anesthesiology records and reports can be requested from the facility where the procedure was performed:***

***Queens Surgi-Center***

***83-40 Woodhaven Blvd.***

***Glendale, N.Y. 11385***

***Please see the attached medical reports, narratives, and letter of medical necessity."***

Thereafter, on 11/10/16, counsel for the Respondent sent a letter to Applicant acknowledging receipt of the Applicant's 10/17/16 correspondence and document production in response to the initial verification request, as follows:

***"...Please accept this correspondence acknowledging receipt of the following in response to Allstate's requests for additional verification:***

- 1) Correspondence from Christine Lee, Billing Representative for Andrew Dowd, M.D. to Allstate dated October 17, 2016;***
- 2) Andrew Dowd, M.D.'s letter of medical necessity dated 10/7/16;***
- 3) Andrew Dowd, M.D.'s patient evaluation report dated 7/20/16;***
- 4) Queens Surgi-Center Record of Operation Report;***
- 5) Andrew Dowd, M.D.'s patient evaluation report dated 8/10/16;***
- 6) The University of the State of New York, Education Department, Office of the Professions, Registration Certificate for Robert Anthony Riselvato;***
- 7) The University of the State of New York, Education Department, Office of the Professions, Registration Certificate for Andrew J. Dowd;***

8) *Form W-2 Wage and Tax Statement for Robert A. Riselvato;*

9) *Astoria Medical Imaging MRI of the Right Knee without contrast report.*

*To the extent your bill includes claims for any medical treatment or services rendered on or after April 1, 2013...please be advised that your claim may be denied if you fail to provide within 120 calendar days from the date of this initial request for additional verification either all such verification requested herein that is under your control or possession, or written proof providing reasonable justification for your failure to comply. 11 NYCRR Section 65-3.5(o). Please provide the following:*

1. *To the extent not already provided, the complete medical file, including but not limited to any medical reports, medical records, studies, notes, test results, medical, surgical [pre or post-operative] and anesthesiology records and reports relating to any procedures, patient history, diagnosis and evaluation relating to the billed for services prepared by applicant.*
2. *Any correspondence and medical reports to any referring health care provider relating to any services, surgery and/or procedure performed on the patient that is the subject of the billed for services.*
3. *Any and all documents related to any prescriptions provided to the above patient for pharmaceuticals and/or durable medical equipment.*
4. *Any correspondence and/or referrals to any health care provider related to the dispensing of pharmaceuticals or the provision of durable medical equipment."*

Applicant, by letter dated 12/6/16, responded to the 11/10/16 correspondence from the Respondent, as follows:

*"We object to your continued requests as it is our position that we have already responded to your requests via correspondence dated October 17, 2016 and have sent all the documents available to us. As such, we consider verification closed."*

Each of these enumerated items-together with Respondent's reasonable basis for requesting each such item-was discussed at length at the time of the Arbitration Hearing. It is undisputed that the Applicant provided the records and documents which the Respondent acknowledged having received in its letter of 11/10/16. As to the remaining requests for records and documents contained in the Respondent's initial verification request, the Applicant, in its 10/17/16 correspondence addressed those by asserting that such were not in Applicant's control or possession, and informed Respondent that same could be obtained directly from the Queens Surgi-Center facility.

Respondent's denial was based upon Section 65-3.5(o), which took effect as of April 1, 2013. The denial set forth that Applicant's claim for No-Fault benefits was denied in its entirety pursuant to Regulation 68, Section 65-3.5(o). More specifically, this Regulation provides that an Applicant from whom verification is requested shall, within 120

calendar days from the date of the initial request for verification, submit ***all such verification under the Applicant's control or possession***, or written proof providing reasonable justification for the failure to comply. I find that the relevant documents which were the subject of the Respondent's requests for verification were provided, and with respect to those not so provided, Applicant set forth reasonable justification for the failure to comply; to wit, that such documents and records are not within the Applicant's control or possession.

Accordingly, I find that the Applicant substantially complied with the Respondent's requests for verification, and the Respondent's delay for verification beyond the time of its receipt of the Applicant's 10/17/16 correspondence herein was inappropriate.

Based upon the foregoing, and after careful consideration of the totality of the credible evidence, I find that Respondent herein did not appropriately delay for verification, and the Applicant's claim for No-Fault benefits is granted. Reimbursement as requested is due and owing. 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 applicant is AWARDED the following:

A.

Medical		From/To	Claim Amount	Status
	<b>Andrew J. Dowd M.D.</b>	<b>07/20/16 - 07/28/16</b>	<b>\$6,854.97</b>	<b>Awarded: \$6,854.97</b>

<b>Total</b>	<b>\$6,854.97</b>	<b>Awarded: \$6,854.97</b>
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- B. The insurer shall also compute and pay the applicant interest set forth below. 05/31/2017 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest runs from the filing date for this case, 5/31/17, until payment has been 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

After calculating the sum total of the first party benefits awarded in this arbitration plus the interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20% of that sum total, subject to a minimum of \$60 and a maximum of \$850. See, 11 NYCRR Section 65-4.6(c) and (e). However, if the benefits and interest awarded thereon are less than or equal to the Respondent's written offer during the conciliation process, the attorney's fee shall be based upon the provisions of 11 NYCRR Section 65-4.6(b). For cases filed after February 4, 2015 there is no minimum fee and a maximum fee of \$1,360.00.

- 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 New York  
 SS :  
 County of NASSAU

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

08/31/2018  
 (Dated)

Paul Weidenbaum

## **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:**  
9789cada8cc63daf5df453911e17433f

**Electronically Signed**

Your name: Paul Weidenbaum  
Signed on: 08/31/2018