

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Electrodiagnostic & Physical Med PC
(Applicant)

- and -

New York City Transit Authority
(Respondent)

AAA Case No. 17-17-1054-8519

Applicant's File No. 1933308

Insurer's Claim File No. BU201301070027001

NAIC No. Self-Insured

ARBITRATION AWARD

I, Patricia Daugherty, 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 10/26/2018
Declared closed by the arbitrator on 10/26/2018

Helen Mann Ruzhy from Israel, Israel & Purdy, LLP participated in person for the Applicant

Laura Weiss from Foley, Smit, O'Boyle & Weisman participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 5,103.15**, 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 Assignor, "HP" is an 81-year-old female who was a passenger on a bus that was involved in a motor vehicle accident on January 7, 2013. At issue in this case are multiple bills for physical therapy treatments and office visits from January 11, 2013 through September 30, 2016 in the combined amount of \$5,103.15. Respondent argues that all claims that were submitted for reimbursement prior to February 4, 2014 (\$4,473.90) are time-barred pursuant to a 3-year statute of limitations. Respondent asserts that the remaining twelve claims (\$629.25) were denied pursuant to independent medical examination (IME). The issues to be determined are: 1.) whether Applicant's claims that were submitted prior to February 4, 2014 are time-barred; 2.) whether

Applicant established its prima facie case; 3.) whether Respondent preserved its lack of medical necessity defense in timely denials; and if so 4.) whether the claims were medically necessary.

4. Findings, Conclusions, and Basis Therefor

This case was decided based upon the submissions of the parties as contained in the electronic file maintained by the American Arbitration Association, and the oral arguments of the parties' representatives. There were no witnesses. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

Statute of Limitations

Respondent argues that it is a self-insured entity that is subject to a three-year statute of limitations pursuant to CPLR 214(2). Respondent relies on the Court of Appeals holding in Contact Chiropractic, P.C. v. New York City Transit Authority, 2018 NY Slip Op 03093 (2018) which settled a longstanding divide between lower appellate courts in finding that the three-year statute of limitations set forth in CPLR 214(2) applies to no-fault claims against a self-insurer.

Applicant argues that the holding in Contact Chiropractic, P.C. was not the law when this arbitration was filed, therefore Respondent should be subject to the six-year statute of limitations set forth in CPLR 213(2) for this matter.

Respondent counters that the law has not changed, just the interpretation of the law. The fact that courts previously misinterpreted the then-existing law is unfortunate for self-insurers like Respondent, but it does not create additional liabilities with a longer statute of limitations.

I agree with Respondent. The Contact Chiropractic, P.C. decision did not create a new statute of limitations for self-insurers. The statute of limitations for self-insurers has always been three years and now the Court of Appeals has confirmed it.

Applicant filed its demand for arbitration on February 3, 2017. As such, all causes of action that accrued prior to February 4, 2014 are denied as time barred.

While Applicant maintained its position that a six-year statute of limitations applies herein, both parties agreed that if I found that a three-year statute of limitation applies to Respondent, the remaining causes of action subject to Respondent's lack of medical necessity defense must have accrued after February 4, 2014. The parties agreed that there are twelve bills that were filed within the three-year statute of limitations. These bills are for dates of service February 4, 2014 through September 30, 2015 and are addressed below.

Prima Facie

It is well settled that an applicant established its prima facie entitlement to payment by proving it submitted a claim setting forth the facts and the amount of the loss sustained, and that payment of no fault benefits were overdue (see Insurance Law § 5106[a]; Viviane Etienne Med. Care v Country-Wide Ins. Co., 25 NY3d 498, 501 (2015); Mary Immaculate Hosp. v. Allstate Ins. Co., 5 A.D. 3d 742, 774 N.Y.S. 2d 564 (2nd Dept., 2004).

After reviewing the record and hearing the arguments of the parties I find that Applicant has established its prima facie case for eleven of the twelve bills (Dates of service 2/4/14, 4/22/14, 6/17/14, 9/16/14, 9/24/14, 12/2/14, 3/10/15, 6/26/15, 9/22/15, 1/29/16 and 5/31/16). In support of its prima facie case, Applicant uploaded the affidavit of mailing of Daisy Alcantara, who is employed as the head of the billing department for Applicant who attests to the mailing of the bills. She identifies the dates of service, the amounts of the bills and the dates they were mailed to the carrier. She describes the business procedure used in mailing the bills and supplied copies of the cover letters that accompanied the bills in the mailings. In regard to date of service September 30, 2016, Ms. Alcantara states that the bill that was mailed was in the amount of \$50.22, when the subject bill in dispute for September 30, 2016 is in the amount of \$35.28. It is not clear as to whether Ms. Alcantara was referencing a different bill for this date of service or whether her affidavit identified the wrong amount of the bill. While I find that Applicant has not established its prima case for its claim for September 30, 2016 in the amount of \$35.28, I do not find this to discredit the remaining contentions of Ms. Alcantara's affidavit.

Timeliness of the Denials of Claims

It is also well settled than an insurer must pay or deny a claim within thirty days of receiving proof of claim. Insurance Law § 5106 [a]; 11 NYCRR 65-3.8(a). Presbyterian Hosp. in City of N.Y. v Maryland Cas. Co., 90 NY2d 274 (1997). An insurer may extend the thirty-day period through the verification procedures set forth in 11 NYCRR 65-3.5. Failure to comply with or extend the thirty-day period results in the preclusion of most defenses, including medical necessity. Presbyterian Hosp. in City of N.Y. v Maryland Cas. Co.; Vista Surgical Supplies v. State Farm Mut. Ins. Co., 14 Misc. 3d 135(A) (App Term, 2nd and 11th Jud. Dists. 2007). The narrow exceptions to the preclusion rule apply to lack of coverage and fraud defenses. See Central Gen. Hosp. v Chubb Group of Ins. Cos., 90 NY2d 195(1997); Matter of Metro Med. Diagnostics v Eagle Ins. Co., 293 AD2d 751 (2002).

Respondent has not submitted any denials of claim for dates of service 2/4/14, 4/22/14, 6/17/14, 9/24/14 or 12/2/14.

Respondent submitted a denial of claim for services rendered on 9/16/14 where the bottom of the first page is cut off, so it cannot be determined if it was issued timely.

Respondent submitted a denial of claim for services rendered on 3/10/15 where the top of the first page is cut off, so it cannot be determined if this denial was timely issued to the Applicant provider.

Respondent submitted a denial of claim for services rendered on 6/26/15 where the bottom of the first page is cut off, so it cannot be determined if it was issued timely.

Respondent submitted a denial of claim for services rendered on 9/22/15 dated January 26, 2016, more than 30 days after its receipt of the claim on October 7, 2015.

Respondent submitted a denial of claim for services rendered on 1/29/16 dated October 18, 2016, more than 30 days after its receipt of the claim on May 27, 2016.

Respondent submitted a denial of claim for services rendered on 5/31/16 dated October 18, 2016, more than 30 days after its receipt of the claim on August 24, 2016.

A review of the evidence presented reveals that Respondent has not established that it preserved its lack of medical necessity defense by issuing timely denials for any of the bills in dispute.

Based on the foregoing, Applicant is awarded \$593.97 for the services rendered on 2/4/14, 4/22/14, 6/17/14, 9/16/14, 9/24/14, 12/2/14, 3/10/15, 6/26/15, 9/22/15, 1/29/16 and 5/31/16.

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
	Electrodiagnostic & Physical Med PC	01/11/13 - 09/30/16	\$5,103.15	Awarded: \$593.97
Total			\$5,103.15	Awarded: \$593.97

- B. The insurer shall also compute and pay the applicant interest set forth below. 03/14/2014 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant is awarded interest pursuant to the no-fault regulations. See generally, 11 NYCRR §65-3.9. A claim is overdue when it is not paid within 30 days after an insurer receives proof of claim. (Insurance Law §5106[a]; 11 NYCRR 65-3.8(a)(1). All overdue benefits shall bear interest calculated at a rate of two percent per month, calculated on a pro rata basis using a 30-day month. 11 NYCRR 65-3.9(c). If an applicant does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Department of Financial Services regulations, interest shall not accumulate on the disputed claim or element of claim until such action is taken.

Interest accrued as follows:

DOS: 2/4/14. PRINCIPAL:\$50.22. Bill was mailed on 2/6/14. Allowing five days for mailing pursuant to CPLR 2103(b)(2), Respondent received the claim on 2/11/14. Interest began to accrue when the claim became overdue on 3/14/14.

DOS: 4/22/14. PRINCIPAL:\$50.22. Bill was mailed on 4/24/14. Allowing five days for mailing pursuant to CPLR 2103(b)(2), Respondent received the claim on 4/29/14. Interest began to accrue when the claim became overdue on 5/30/14.

DOS: 6/17/14. PRINCIPAL:\$64.07 . Bill was mailed on 6/18/14. Allowing five days for mailing pursuant to CPLR 2103(b)(2), Respondent received the claim on 6/23/14. Interest began to accrue when the claim became overdue on 7/24/14.

DOS: 9/16/14. PRINCIPAL:\$50.22 . Bill was mailed 9/19/14. The date Respondent received the claim is illegible from the NF-10. Therefore, allowing five days for mailing pursuant to CPLR 2103(b)(2), it is presumed Respondent received the claim on 9/24/14.

Interest began to accrue when the claim became overdue on 10/25/14. There is no evidence as to when the denial was issued, therefore interest on this bill was not effectively tolled.

DOS: 9/24/14. PRINCIPAL:\$64.07. Bill was mailed on 9/30/14. Allowing five days for mailing pursuant to CPLR 2103(b)(2), Respondent received the claim on 10/5/14. Interest began to accrue when the claim became overdue on 11/5/14.

DOS: 12/2/14. PRINCIPAL:\$50.22 . Bill was mailed on 12/9/14. Allowing five days for mailing pursuant to CPLR 2103(b)(2), Respondent received the claim on 12/14/14. Interest began to accrue when the claim became overdue on 1/14/15.

DOS: 3/10/15. PRINCIPAL:\$50.22. Bill was mailed on 3/13/15. Allowing five days for mailing pursuant to CPLR 2103(b)(2), Respondent received the claim on 3/18/15. Interest began to accrue when the claim became overdue on 4/19/15.

DOS: 6/26/15. PRINCIPAL:\$50.22. Bill was mailed 6/30/15. The date Respondent received the claim is illegible from the NF-10. Therefore, allowing five days for mailing pursuant to CPLR 2103(b)(2), it is presumed Respondent received the claim on 7/5/15. Interest began to accrue when the claim became overdue on 8/5/15. There is no evidence as to when the denial was issued, therefore interest on this bill was not effectively tolled.

DOS: 9/22/15. PRINCIPAL:\$64.07. Respondent received the claim on 10/7/15. Interest began to accrue when the claim became overdue on 11/7/15. Interest accrued from 11/7/15 through 1/25/16. The NF-10 dated 1/26/16 tolled the interest until the AR-1 was filed. Interest began to accrue again on 2/3/17.

DOS: 1/29/16. PRINCIPAL:\$50.22. Bill was mailed on 1/30/16. Allowing five days for mailing pursuant to CPLR 2103(b)(2), Respondent received the claim on 2/4/16. Interest began to accrue when the claim became overdue on 3/6/16. Interest accrued from 3/6/16 through 10/17/16. The NF-10 dated 10/18/16 tolled the interest until the AR-1 was filed. Interest began to accrue again on 2/3/17.

DOS: 5/31/16. PRINCIPAL:\$50.22 . Bill was mailed on 6/3/16. Allowing five days for mailing pursuant to CPLR 2103(b)(2), Respondent received the claim on 6/8/16. Interest began to accrue when the claim became overdue on 7/9/16. Interest accrued from 7/9/16 through 10/17/16. The NF-10 dated 10/18/16 tolled the interest until the AR-1 was filed. Interest began to accrue again on 2/3/17.

C. Attorney's Fees

The insurer shall also pay the applicant for attorney's fees as set forth below

Respondent shall pay Applicant an attorney's fee, in accordance with 11 NYCRR §65-4.6(e). Therefore, the insurer shall pay the applicant an attorney's fee of 20% of benefits plus interest, with no minimum fee and a maximum fee of \$1,360. However, if the benefits and interest awarded thereon is equal to or less than the respondent's written offer during the conciliation process, then the attorney's fee shall be based upon the provisions of 11 NYCRR 65-4.6(b).

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

10/27/2018
(Dated)

Patricia Daugherty

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:
f512ec61e43447d958e8c4790b92777d

Electronically Signed

Your name: Patricia Daugherty
Signed on: 10/27/2018