American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

RX For You Corp. (Applicant)	AAA Case No.	17-17-1079-3265
	Applicant's File No.	
- and -	Insurer's Claim File No.	20-0210-1B0
	NAIC No.	25178
State Farm Mutual Automobile Insurance Company (Respondent)		

ARBITRATION AWARD

I, Eva Gaspari, 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: E.I.P and/or J.T.

1. Hearing(s) held on 06/05/2019
   Declared closed by the arbitrator on 06/05/2019

   Rima Nayberg, Esq. from Law Offices of Rima Nayberg P.C participated in person for the Applicant

   Lauren Tucker, Esq. from Richard T. Lau & Associates participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 978.93**, 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 dispute arises from a November 17, 2016 motor vehicle accident in which the Assignor (J.T.) was a 28 year old male driver. Following the accident, the assignor was prescribed a continuous passive motion device (CPM). The Applicant has submitted this claim to arbitration for the prescription of the CPM and synthetic pad for date of service May 16, 2017, for which it seeks the amount of $978.93. Respondent has denied this claim based on a 120 day denial which states: "previously you were requested to provide additional verification on two occasions: June 7, 2017 and July 14,

2017. Your claim for No-Fault benefits is denied, in its entirety, as pursuant to Regulation 68, Section 65-3.5 (o): 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." The question presented is whether the services at issue have been properly denied pursuant to the 120 day rule.

4. Findings, Conclusions, and Basis Therefor

This arbitration dispute arises from a November 17, 2016 motor vehicle accident in which the Assignor (J.T.) was a 28 year old male driver. Following the accident, the assignor was prescribed a continuous passive motion device (CPM). The Applicant has submitted this claim to arbitration for the prescription of the CPM and synthetic pad for date of service May 16, 2017, for which it seeks the amount of $978.93. Respondent has denied this claim based on a 120 day denial which states: "previously you were requested to provide additional verification on two occasions: June 7, 2017 and July 14, 2017. Your claim for No-Fault benefits is denied, in its entirety, as pursuant to Regulation 68, Section 65-3.5 (o): 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." The question presented is whether the services at issue have been properly denied pursuant to the 120 day rule.

FINDINGS

This matter was decided based upon the submissions of the parties as contained in the electronic file maintained by the American Arbitration Association, as well as upon the oral arguments of the parties at the time of the hearing. All documents contained in the ADR folder are hereby incorporated into this hearing and in reaching my findings I have reviewed all relevant exhibits contained in the ADR Center. Only submissions which were uploaded into the ADR Center at the time of the hearing date were considered in making the instant determination. All matters raised on oral argument at the time of the hearing have been addressed herein. Any further issues raised in the hearing record are held to be moot and/or waived insofar as not specifically raised at the time of the hearing.

As an initial matter I find that Applicant has demonstrated its prima facie case for the medical equipment dispute. (a medical provider establishes a prima facie showing of their entitlement to judgment as a matter of law by submitting evidentiary proof that the prescribed statutory billing forms had been mailed and received and that payment of no fault benefits was overdue.) *See,* Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept.2004); *See also*: Viviane Etienne Med. Care v Country-Wide Ins. Co. 2015 NY Slip Op 04787 (proof of mailing is satisfied by an insurer's admission of receipt of bills.)

ADDITIONAL VERIFICATION

In this matter, the respondent denied the billing for date of service based on an allegation that the applicant failed to provide the verification that was requested within 120 days of the initial request per 11 NYCRR 65-3.5(o). If an insurer requires any additional information to evaluate the proof of claim, such request for verification must be made within 15 business days of the receipt of the bill in order to toll the 30-day period to pay or deny the claim. See generally, *11 NYCRR 65-3.5(b)*; See also, New York Hosp. Med. Ctr. of Queens v. Allstate Ins. Co., 2014 NY SLIP OP 00640 (2 Dept. 2014). Where there is a timely original request for verification, but no response to the request for verification is received within 30 calendar days thereafter, or the response to the original request for verification is incomplete, then the insurer, within 10 calendar days after the expiration of that 30-day period, must follow up with a second request for verification. If there is no response to the second follow-up request for verification, the time in which the insurer must decide whether to pay or deny the claim is indefinitely tolled. Therefore, when a no-fault medical service provider fails to respond to the requests for verification the claim is premature and should be denied without prejudice. In the alternative, pursuant to 11 NYCRR 65-3.5(o), an insurer may elect to deny the claim after 120 days of the request, based upon the failure to provide the requested verification.

In support of its 120-day defense the Respondent has set forth the affidavit of Marty Brodell which is dated January 17, 2018. Brodell states that he is employed as a claims representative for the respondent insurer and works out of the Ballston Spa, New York office, and has since June 5, 2012. He states that he is personally familiar with the

standard business practices for the receipt of mail, handling of claims, and with generating documents which are associated with claims decisions. He adds that he has reviewed the subject claims file and has personal knowledge of the claim based upon his review. Brodell sets forth the procedure for creation and receipt of documents and indicates that all mail for New York PIP claims are printed and mailed through the Ballston Spa office regardless of the office which is indicated on the document. With concern to the receipt of documents, he states that all information associated with NY PIP Benefits which are received through the US Postal Service, or by other means, are date stamped, scanned into the ECS System and placed into the file associated with the claim number on the document which allows claim files to be accessed by authorized State Farm employees including those at Ballston Spa. Once a bill is received if additional information is necessary a request and necessary forms are mailed in accordance with regular business practices for handling of PIP claims. He has personally reviewed the file and computer records and conducted a diligent search of the file and based upon that review attests that the verification was requested and that upon a search of the claims file, has determined that the files do not contain a response to the verification which was requested.

Based upon the record before me I find as a matter of fact that the Respondent has demonstrated that it timely requested additional verification of the Applicant and s imilarly, I find that the Respondent has proffered denials which preserve its defenses. Specifically, a review of the evidence indicates that the Applicant submitted its claim to the Respondent on May 30, 2017 and the claim was received by the Respondent on June 5, 2017. Thereafter on June 7, 2017 the Respondent issued a request for additional verification and a follow up request was made on July 14, 2017. The requests both contain a Georgia return address, along with the name and phone number of the handling claims representative, and set forth the following:

> As part of the verification process in connection with the review and analysis of the treatment for which you have billed, we will require the submission of the following verification items from you and/or we are advising you of the following verification items that are outstanding. Pertinent information concerning the time, skill, and equipment necessary must be furnished to us according to the "by report" Ground Rules of the Workers' Compensation fee schedule. Since documentation is required for reimbursement, please submit dictated notes, with a detailed description of the services and any pertinent supply/medication wholesale invoice, if applicable. Please provide a current invoice for E0935. In order to expedite this request, please include this letter with your

> submission. We will be unable to consider your bill until we receive the requested verification. Emily Gilchrist Claim Specialist (844) 292-8615 Ext. 5188845513

Thereafter on October 10, 2017, the claim was denied in full based upon the following: "previously you were requested to provide additional verification on two occasions: June 7, 2017 and July 14, 2017. Your claim for No-Fault benefits is denied, in its entirety, as pursuant to Regulation 68, Section 65-3.5 (o): 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."

An applicant in a no-fault matter that receives a request for additional verification is required to respond to the verification request even if such request pertains to information not within its possession. See D & R Medical Supply, Inc. v. American Transit Ins. Co., 2011 NY Slip Op 51727 (App Term 2d Dept. 2011).

As part and parcel of its arbitration submission the Applicant sets forth a fax transmission dated August 3, 2017. This transmission indicates that a facsimile was transmitted to "State Farm" and contained 9 pages which were successfully transmitted to the number "1-844-218-1140". This fax transmission report is affixed to the June 7, 2017 correspondence from State Farm and the 9 pages consist of the June 7, 2017 request for additional verification, an April 25, 2017 examination report from Cohen & Kramer, M.D., P,.C., a May 16, 2017 prescription for the DME at issue on the letter head of Cohen & Kramer, M.D., P,.C., a medical supply invoice order form dated February 8, 2017 on the letter head of Source Ortho on which "Optiflex K-1 Knee CPM-STD Pendant" is circled, and a delivery slip for the CPM Pad and CPM Machine which is dated May 16, 2017.

In reviewing the competing proofs, wherein the Applicant alleges that it responded to the request for additional verification, and the Respondent maintains that it has not received the response, I find as a matter of fact that the Applicant has set forth evidence which demonstrates that it has responded to the demand for additional verification. Notably, 11 NYCRR 65-3.5(k) mandates that: "every insurer, which writes more than

1,000 motor vehicle liability policies in this state, shall establish procedures for the receipt of all claims, notices and verification, subject to this Part, by facsimile and/or electronic data transmittal." Applicant's submission provides evidence that its response to verification was sent by facsimile to the Respondent, and that the transmission was completed. Accordingly, tt is incumbent upon the Respondent to prove that it did not receive the response. In this case the Applicant submitted its proof of fax transmission as part and parcel of its initial submission for arbitration of the dispute, which includes the fax transmission number to which the documents were submitted.

After careful reflection and consideration of the facts presented in this matter, I find that the Applicant has set forth evidence which credibly indicates that it responded to the request for additional verification, and that the Respondent has not persuasively supported its defense that verification was not received within 120 days of its request. In reviewing the Brodell affidavit, it does not address the established procedures for receipt of verification by facsimile or electronic data transmittal, nor does it contest the legitimacy of the number to which the documents were transmitted. Per 11 NYCRR 65-4.5[o][1], the arbitrator shall be the judge of the relevance and materiality of the evidence offered. Moreover, the arbitrator may determine what evidence to accept or reject and what inferences should be drawn based on the evidence. See Mott v State Farm, 55 NY2d 224 (1982). On a review of the evidence I find that Brodell's omission of standard business practices for receipt of documents by facsimile, along with the failure to address the fax transmission sheet which was part and parcel of the Applicant's arbitration submission, adversely affects the weight and credibility of Respondent's defense.

Finally, to the extent that Respondent may argue that the response is not complete, it must be noted that although a "partial" response is insufficient to verify the claim, the insurer has a duty to communicate with the applicant and vice versa. The purpose of the No-Fault statute is to ensure prompt resolution of claims by accident victims. The parties' obligations are centered on good faith and common sense. Any questions concerning a communication should be addressed by further communication, not inaction. Dilon Medical Supply Corp. v. Travelers Ins. Co., 7 Misc.3d 927 (Civ. Ct. Kings Co. 2005). The response to a verification request that is "arguably responsive" places the burden to take further action upon the carrier. All Health Medical Care, P.C. v. GEICO, 2 Misc.3d 907 (NY City Civ Ct. 2004). Moreover, as long as applicant's

documentation is arguably responsive to an insurer's verification request, the insurer must act affirmatively once it receives a response to its verification request. Media Neurology P.C. v. Countrywide, Ins. Co., 21 Misc.3d 1101 (NY City Civ. Ct. 2005).

FEE SCHEDULE

As provided in 11 NYCRR §65-3.8(g)(1)(ii), and recently affirmed by the court in Precious Acupuncture Care, P.C. v Hereford Ins. Co., 2018 NY Slip Op 50042(U), 58 Misc 3d 147(A) (Appellate Term, Second Dept. 2018), a fee schedule defense need not be preserved in a timely denial. Though it is a defense that can be raised at any time, it is still a defense, upon which the insurer bears the burden of proof. To that extent, where an insurer sets forth a defense based upon fee schedule they are required to come forward with competent evidentiary proof to support its fee schedule defenses. Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 2006 NY Slip 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006). When an insurer fails to demonstrate by competent evidentiary proof that a medical provider's claims were in excess of the appropriate fee schedules, their defense of noncompliance with the appropriate fee schedules cannot be sustained. Continental Medical PC v. Travelers Indemnity Co., 11 Misc.3d 145A, 819 N.Y.S.2d 847, 2006 NY Slip Op 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Tm, 1st Dep't, per curiam, 2006). Per Respondent's January 10, 2018 brief, fee schedule is not in dispute and "the sole issue is that the applicant failed to respond to verification requested to verify the claim." Moreover, on a search of the record, there is no evidence proffered by the respondent in support of its fee schedule defenses. As the respondent has not set forth evidence in support of its defense relating to its fee schedule defenses it has not sustained the merits of its defense.

HOLDING

After careful review and consideration of the aforementioned, I find that the Respondent's has not set forth competent evidence to support its defense to this claim. Accordingly, Applicant's claim is granted.

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**
	RX For You Corp.	**05/16/17 - 05/16/17**	**$978.93**	**Awarded: $978.93**
Total			**$978.93**	**Awarded: $978.93**

B. The insurer shall also compute and pay the applicant interest set forth below. 11/12/2017 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

In the instant matter Applicant is awarded interest pursuant to the no-fault regulations. 11 NYCRR 65-3.9 (a) provides that Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30 day month." Pursuant to 11 NYCRR 65-3.9 (c) provides that "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." In the matter of LMK Psychological Servs. PC v. State Farm Mut. Auto. Ins. Co., 12 NY 3d. 217 (2009), the court addressed the issue of interest and found that pursuant to 11

NYCRR §65-3.9(c) interest shall be tolled upon the issuance of a denial whether it is timely or not when an applicant does not request arbitration or institute a lawsuit within thirty days after receipt of a denial form or payment of benefits calculated pursuant to Insurance Department regulations. It appears the intent of 65-3.9(c) was to start interest on the date of the request.

Therefore, pursuant to N.Y. Comp. Codes R. & Regs. tit. 11, § 65-3.9 (2002), "Interest on overdue
payments," the Respondent shall pay interest to the Applicant on the awarded overdue PIP benefit at a rate of two percent (2%) per month calculated on a pro rata basis using a thirty (30) day month, starting 11/12/17.

C. Attorney's Fees

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

As this matter was filed after February 4, 2015, this case is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant the attorney's fee, in accordance with the newly promulgated 11 NYCRR 65-4.6(d).

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

06/13/2019
(Dated)

Eva Gaspari

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:
cd06f0a2d28874e99688de3a907ecff7

Electronically Signed

Your name: Eva Gaspari
Signed on: 06/13/2019