

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Advanced Spinal Care Rehabilitation PA
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No.	17-18-1100-1801
Applicant's File No.	DK18-44783
Insurer's Claim File No.	0321255800101018
NAIC No.	22055

ARBITRATION AWARD

I, Rebecca Novak, 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 ["EB"]

1. Hearing(s) held on 01/23/2020
Declared closed by the arbitrator on 01/23/2020

Henry Guindi Esq. from Korsunskiy Legal Group P.C. participated by telephone for the Applicant

Kathleen Durante, Esq. from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 2,900.62**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant amended the amount in dispute to \$1,576.40 to conform to fee schedule.

Stipulations WERE made by the parties regarding the issues to be determined.

The parties stipulated that Applicant established a prima facie case of entitlement to No-Fault compensation with respect to its bills. They stipulated that Applicant's fees as amended were correct. Additionally, they stipulated that should Applicant prevail, interest would accrue as of the date when the American Arbitration Association received Applicant's arbitration request.

3. Summary of Issues in Dispute

Whether Applicant established entitlement to No-Fault insurance compensation for manipulation under anesthesia (MUA) performed to treat Assignor, a 31-year-old male, on February 10, 2018, subsequent to being injured in a motor vehicle accident on October 8, 2017.

Whether Respondent properly denied Applicant's claims based upon outstanding verification not provided within 120 days after requesting same in initial verification requests.

4. Findings, Conclusions, and Basis Therefor

In this No-Fault insurance arbitration, Applicant is seeking as compensation \$1,576.40, for manipulation under anesthesia (MUA) performed to treat Assignor, a 31-year-old male, on February 10, 2018, who was a restrained driver injured in a motor vehicle accident on October 8, 2017. This amount sought by Applicant reflects a reduction from the original amount sought when the arbitration was commenced. Respondent denied the bills based upon failure to provide verification requested more than 120 days from the initial requests.

Both parties appeared at the hearing by counsel (Applicant via telephone), 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. This case was one of two linked cases involving services provided to Assignor. The two cases are AAA Case # 17-18-1098-8887 and AAA Case # 17-18-1100-1801. The record in this case is also deemed to include the record in the other case.

Stipulations were entered into at the hearing, amongst which were that Applicant established a prima facie case of entitlement to No-Fault compensation for the amount it sought and that Applicant's fees as amended were correct.

When an insurer receives a No-Fault claim form from a medical provider, it must timely request additional verification, deny, or pay the claim. Hospital for Joint Diseases v. Travelers Prop. Cas. Ins. Co., 9 NY3d 312 (2007).

Pursuant to 11 NYCRR 65-3.5(c), an insurer is entitled to receive all items necessary to verify the claim directly from the parties from whom such verification was requested. Thereafter, at a minimum, if any requested verification has not been supplied to the insurer 30 calendar days after the original request, the insurer shall, within 10 calendar days, follow up with the party from whom the verification was requested, either by telephone call, properly documented in the file, or by mail. See 11 NYCRR 65-3.6 (b). Once the insurer proves that it timely mailed its request and follow-up request for

verification to the health care provider, if the latter does not demonstrate that it provided the insurer with the requested verification prior to the commencement of litigation, the litigation is premature inasmuch as the 30-day period within which the insurer was required to pay or deny the claim did not commence to run. Proscan Imaging, P.C. v. Travelers Indemnity Co., 28 Misc.3d 127(A), 2010 N.Y. Slip Op. 51176(U), 2010 WL 2681691 (App. Term 2d, 11th & 13th Dists. July 7, 2010).

Furthermore, 11 NYCRR 65-3.8(b)(3) provides, "However, an insurer may issue a denial if, more than 120 calendar days after the initial request for verification, the applicant has not submitted all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply, provided that the verification request so advised the applicant as required in section 65-3.5(o) of this Subpart."

Respondent received two bills from Applicant related to MUA performed on Assignor on February 10, 2018. Both bills were received on February 19, 2018. At the hearing, Respondent acknowledged Applicants' bills in this matter as the record showed that such bills were received and EUO and verification requests were mailed by Respondent. In support of its lack of verification defense, Respondent submitted the EUO transcript of Peter Albis, D.C., the owner of Applicant, the verification request letters, the denials, and the affidavit of Peggy Fischer of Respondent's SIU as well as a brief that addresses the reason for the requested EUO verification.

Numerous items were sought by Respondent post-EUO in its verification requests, which were in the nature of corporate, financial, and bank records. This included lease agreements, billing agreements, W-2s for employees, corporate bank statements, and a funding agreement with Geko Corporation. Respondent denied Applicant's claims on the basis of Applicant's failure to provide the requested verification or written proof of reasonable justification for its failure to provide the requested verification within 120 calendar days from the date of the initial requests for verification.

At the hearing, Applicant's counsel did not object to the timeliness of the verification requests or the denials. Applicant only asserts that Respondent's demands with respect to the outstanding verification were unreasonable and were not necessary to verify Applicant's claims. Respondent asserted that to date Applicant has not fully replied to the verification requests. It was conceded that the verification which Respondent claims is still outstanding is the funding agreement with Geko Corporation.

Respondent's verification requests stem from an investigation into the billing by and practices of Applicant, as the former suspected that Applicant may not be truly owned and controlled by Dr. Peter Albis, its owner of record. Applicant also had concerns that improper fee splitting took place, that Applicant's treatment of patients followed a predetermined protocol, and that billed services were not performed. However, it appears from Respondent's documentation that its main concern was that Applicant might not actually be controlled by Dr. Albis, but by non-licensed persons. This is in the nature of a "Mallela issue." In State Farm Mutual Automobile Ins. Co. v. Mallela, 4 N.Y.3d 313, 794 N.Y.S.2d 700 (2005), it was held that insurance companies may withhold No-Fault payments for medical services provided by fraudulently incorporated

enterprises to which patients have assigned their claims even if the actual care received by the patients was within the scope of the license of those who treated them. More recently, the Court of Appeals clarified that the issue is not even whether there was fraudulent incorporation but whether laypersons are controlling a professional medical entity. See Andrew Carothers, M.D., P.C. v. Progressive Ins. Co., 33 N.Y.3d 389 (2019). The Court held that A plaintiff is ineligible to seek No-Fault reimbursement under 11 NYCRR 65-3.16(a)(12), when it is a material breach of the foundational rule for professional corporation licensure, which is that it be controlled by licensed professionals.

In Matter of Arbitration of 3Y Acupuncture P.C. a/a/o "DA" v. GEICO Ins. Co., AAA Case No. 17-15-1014-3042 (Aaron Maslow, Arb., Dec. 8, 2015), there appears a salient discussion of the propriety of obtaining financial and corporate records when an insurer maintains a belief that the respective medical provider is not controlled by its owner of record but by unlicensed laypersons:

"If the provider objects to the request for verification, then the issue of whether the requested verification material and the objection were proper are preserved and become questions of fact for the trier of fact. If the insurer can establish it had a reasonable, good faith, factual basis for requesting the verification, then the failure of the claimant provider to furnish the material will result in the dismissal of the action. If the insurer cannot establish a reasonable, good faith, factual basis for requesting the verification, then the insurer will be required to pay the claim."

Victory Medical Diagnostics, P.C. v. Nationwide Property and Casualty Ins. Co., 36 Misc.3d 568, 576, 949 N.Y.S.2d 855, 862 (Dist. Ct. Nassau Co. 2012).

The No-Fault program "stresses the justifying of claims." Nyack Hosp. v. General Motors Acceptance Corp., 8 N.Y.3d 294, 300, 832 N.Y.S.2d 880, 884 (2007).

Information sought as additional verification is not necessarily that which can be found on the prescribed verification forms "but any information that the carrier finds necessary to properly review and process the claim." Westchester Medical Center v. Travelers Property & Casualty Ins. Co., 2001 N.Y. Slip Op. 50082(U) at 3, 2001 WL 1682931 (Sup. Ct. Nassau Co., Ralph P. Franco, J., Oct. 10, 2001). A claimant "cannot simply rest on its laurels and ignore a verification request. . . .

Since the plaintiff desires to be paid, the onus is on it to ensure that the defendant has all of the required information to verify and pay the claim." 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).

The insurer bears a burden of proving that its verification request was valid. A.B. Medical Services P.L.L.C. v. Highlands Ins. Co., N.Y.L.J., May 27, 2003, p. 21, col. 3 (Civ. Ct. New York Co., Lucy Billings, J.).

Insurance companies may withhold No-Fault payments for medical services provided by fraudulently incorporated enterprises to which patients have assigned their claims even if the actual care received by the patients was within the scope of the license of those who treated them. State Farm Mutual Automobile Ins. Co. v. Mallela, 4 N.Y.3d 313, 794 N.Y.S.2d 700 (2005). "State law mandates that professional service corporations be owned *and controlled* only by licensed professionals (*see* Business Corporation Law §§ 1503[a]; 1507, 1508), and that

licensed professionals render the services provided by such corporations (*see* Business Corporation Law § 1504[a])." One Beacon Insurance Group, LLC v. Midland Medical Care, P.C., 54 A.D.3d 738, 740, 863 N.Y.S.2d 728, 730 (2d Dept. 2008) (emphasis added). If a professional corporation is under the control of an unlicensed individual, an insurer may deny No-Fault reimbursement; it is irrelevant whether or not the corporation was fraudulently incorporated, i.e., formed by a licensed professional who intended to turn control of the corporation over to an unlicensed party. AIU Ins. Co. v. Deajess Medical Imaging, P.C., 24 Misc.3d 161, 882 N.Y.S.2d 812 (Sup. Ct. Nassau Co. 2009).

Business Corporation Law §§ 1503(a), 1507, and 1508 mandate that professional service corporations be owned and controlled only by individuals authorized by law (licensed) to practice the profession which the corporation is authorized to practice and that licensed professionals render the services provided by the corporations. Allstate Ins. Co. v. Plainview Professional Medical, P.C., 2009 N.Y. Slip Op. 32341(U) at 2, 2009 WL 3344825 (Sup. Ct. Nassau Co., Stephen A. Bucaria, J., Sept. 24, 2009). "However, the pivotal issue of fact in *Mallela* was whether the defendant medical corporations were owned or controlled by non-physicians. The Court clearly held that if the plaintiff ultimately demonstrated that the defendant medical corporations were owned or controlled by non-physicians, in violation of BCL §§ 1507 and 1508, they would not be eligible for reimbursement pursuant to 11 NYCRR 65-3.16[a][12]. Nowhere did the Court state or suggest that plaintiff had to demonstrate anything more. Thus, to the extent that *Mallela* stands for the proposition that a carrier has the burden of demonstrating a willful and material violation of a state or local licensing requirement that amounts to fraud in order to trigger 11 NYCRR 65-3.16[a][12], it also stands for the proposition that a carrier can meet this burden by demonstrating that a medical corporation is owned or controlled by non-physicians." Andrew Carothers, M.D., P.C. v. Insurance Companies Represented by Bruno, Gerbino & Soriano, LLP and Frieberg & Peck, LLP, 26 Misc.3d 448, 458-459, 888 N.Y.S.2d 372, 380 (Civ. Ct. Kings Co. 2009).

"The primary reason for seeking verification of the licensing status of a provider and/or the professional corporation making application for payment of no-fault benefits is to determine if the provider and/or the professional corporation is eligible to obtain payment of no-fault benefits." Brownsville Advance Medical, P.C. v. Country-Wide Ins. Co., 33 Misc.3d 1236(A), 941 N.Y.S.2d 536 (Table), 2011 N.Y. Slip Op. 52255(U) at 3, 2011 WL 6355291 (Dist. Ct. Nassau Co., Fred J. Hirsh, J., Dec. 10, 2011). This decision is in accord with Applicant's hearing position which is that the demand for information relating to a *Mallela* defense is not obtainable through verification. However I do not accept this holding. I am of the opinion that it is contrary to the other case law I have cited. I do not find the holding persuasive.

An insurer's investigation of a health service provider for improper management and billing operations substantiates the need for an EUO. *E.g.*, LK Health Care Products Inc. v. GEICO General Ins. Co., 39 Misc.3d 1230(A), ___ N.Y.S.2d ___ (Table), 2013 N.Y. Slip Op. 50810(U) at 3, 2013 WL 2249170 (Civ. Ct. Kings Co., Katherine A. Levine, J., May 9, 2013). Likewise, a verification request may be utilized when there is reasonable suspicion of improper billing and management.

Certainly, seeking a medical entity's bank statements is extremely intrusive. A showing of special circumstances is required to warrant production of income tax returns in a verification request. *E.g.*, Vista Surgical Supplies, Inc. v. Utica Mutual

Ins. Co., 22 Misc.3d 142(A), 880 N.Y.S.2d 876 (Table), 2009 N.Y. Slip Op. 50493(U), 2009 WL 754770 (App. Term 2d, 11th & 13th Dists. Mar. 17, 2009). But a request for the assignor's Social Security number is appropriate. Olympic Chiropractic, P.C. v. American Transit Ins. Co., 14 Misc.3d 129(A), 836 N.Y.S.2d 487 (Table), 2007 N.Y. Slip Op. 50011(U), 2007 WL 29051 (App. Term 2d & 11th Dists. Jan. 2, 2007).

Indeed, in Andrew Carothers, M.D., P.C. v. Progressive Ins. Co., 33 N.Y.3d 389 (2019), financial and corporate records placed into evidence by the defendants helped prove control by laypersons.

I note that in HKP Physical Therapy, P.C. v. Government Employees Ins. Co., ___ Misc.3d ___, 2019 N.Y. Slip Op. 29381 (Sup. Ct. New York Co., Dakota D. Ramseur, J., Dec. 2, 2019), the court held that an insurer may obtain documentary material relating to a potential *Mallela* or fraudulent corporation defense through a request for additional verification.

While Applicant has cited cases to the effect that it is inappropriate to seek leases and financial information as part of the EUO verification procedure, I am inclined to follow the holding in HKP Physical Therapy, P.C. v. Government Employees Ins. Co., and I adopt the analysis of Arbitrator Maslow, as quoted above. Of course, Respondent would still have to establish special circumstances warranting the verification requests by Respondent for Applicant's financial and corporate records.

I find that such special circumstances were established by Respondent. I do so based on the affidavit of Peggy Fischer, Respondent's SIU investigator, as follows:

4. GEICO initiated its investigation of Advanced Spinal because various facts and circumstances were identified that called into question the eligibility of Advanced Spinal to collect no-fault benefits including but not limited to (i) whether Advanced Spinal is truly owned and controlled by Peter Albis, D.C. or engages in the unlawful corporate practice of chiropractic medicine because it is actually owned and controlled by laypersons. . . .

...

6. According to public records, Advanced Spinal is owned by Peter Albis who has been the focus of other investigations conducted by GEICO. More specifically, *Albis has been named in a Federal RICO lawsuit filed in the Eastern District of New York along with Dr. Bruce Jacobson and Dr. Diana Beynin (among others)*. Advanced Spinal provides Manipulation Under Anesthesia (MUA) procedures utilizing questionable providers including Bruce Jacobson and Diana Beynin. Advanced Spinal is a New Jersey corporation and not registered in New York state. The MUAs are done on New York claimants involved in New York accidents at two locations in New Jersey; Dynamic Surgery Center, 321 Essex Street, Hackensack NJ and Health Plus Surgical Center, 190 Midland Avenue, Saddle Brook, NJ. [emphasis added]

I also do so based on the EUO testimony provided by Dr. Albis. Dr. Albis needed a written list of locations he travels to where he performs services in order to answer a question seeking the addresses. He also testified that he did not treat patients at these

locations. He paid rent to the doctors at them. Some of the arrangements were made through a marketing company. He entered into an agreement with Geko Corporation whereby he borrowed money from them and paid a 50% interest fee. Checks which Dr. Albis received from insurers were deposited into an escrow account specifically so that Geko Corporation could be repaid.

The fact that Dr. Albis is paying an entity a high interest rate and earmarks payments from insurers toward paying that high interest rate certainly raises legitimate questions as to whether funds are being siphoned by laypersons, who may be directing Dr. Albis in terms of where he visits the offices of doctors.

Prior to reaching my determination, I have reviewed multiple arbitration awards in favor of Applicant or Respondent. I respectfully disagree with those who found that seeking the financial and corporate records of Applicant was inappropriate. I agree with the determinations of those arbitrators who sustained the verification requests

I find that Respondent has a legitimate potential *Mallela* concern, which justified its verification requests, including seeking the funding agreement with Geko Corporation.

Applicant's prima facie case of entitlement to compensation has been overcome by Respondent proving that it properly and effectively tolled the 30-day deadline, and properly issued the subject 120-day rule denials of claim on the basis that Applicant did not provide all the requested verification.

Accordingly, the within arbitration claim is denied in its entirety.

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 DENIED in its entirety

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

01/27/2020

(Dated)

Rebecca Novak

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:

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Electronically Signed

Your name: Rebecca Novak
Signed on: 01/27/2020