American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

New Century Pharmacy, Inc. (Applicant)	AAA Case No.	17-18-1104-2042
	Applicant's File No.	N/A
- and -	Insurer's Claim File No.	0527271140101032
	NAIC No.	35882
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Lisa Abrams, 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 01/23/2020
   Declared closed by the arbitrator on 01/23/2020

   Rajesh Barua, Esq. from The Law Offices of Hillary Blumenthal P.C. participated in person for the Applicant

   Crystal Russo from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 195.38**, 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 treatment for the IP (SS), a 25-year-old female driver, related to injuries the IP sustained in a motor vehicle accident that occurred on April 1, 2017. Following the accident, the IP sought private medical attention. Applicant seeks reimbursement for durable medical equipment (DME) and, in particular, a knee brace supplied on May 2, 2017 and a lumbar sacral orthosis (LSO) supplied on May 10, 2017. According to Applicant, Respondent sought verification after an examination under oath (EUO) occurred on July 27, 2017, and argues that Respondent's denial is untimely because Respondent's time to either pay or deny Applicant's claim was not tolled. According to Respondent, it sought additional verification based on the testimony at the EUO, but Applicant failed to provide the requested information. Respondent claims that it denied payment for the DME based on the fact that verification was not

received within 120 days of the claimed additional verification requests. The issues in dispute are whether Respondent timely denied Applicant's claim and, if so, whether Applicant to responded to the verification requests. Respondent also raised a fee schedule defense.

4. Findings, Conclusions, and Basis Therefor

This case was decided based upon the submissions of the parties as contained in the electronic case 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.

It is well settled that "New York's no-fault automobile insurance system is designed 'to ensure prompt compensation for losses incurred by accident victims without regard to fault or negligence, to reduce the burden on the courts and to provide substantial premium savings to New York motorists.'" *Fair Price Med. Supply Corp. v Travelers Indem. Co.*, 10 N.Y.3d 556, 562-63 (2008) citing *Hospital for Joint Diseases v. Travelers Prop. Cas. Ins. Co*., 9 N.Y.3d 312 (2007). In furtherance of these goals, the Superintendent of Insurance has adopted regulations implementing the No-Fault Law (Insurance Law art 51), including circumscribed time frames for claim procedures. The Court of Appeals described the basic no-fault regime as follows:

> The[] regulations require an accident victim to submit a notice of claim to the establish insurer as soon as practicable and no later than 30 days after an accident (*see* 11 NYCRR 65-1.1, 65-2.4[b]). Next, the injured party or the assignee ... must submit proof of claim for medical treatment no later than 45 days after services are rendered (*see* 11 NYCRR 65-1.1, 65-2.4[c]). Upon receipt of one or more of the prescribed verification forms used to proof of claim, ... an insurer has 15 business days within which to request 'any additional verification required by the insurer to establish proof of claim' (11 NYCRR 65-3.5[b]). An insurer may also request 'the original assignment or authorization to pay benefits form to establish proof of claim' within this time frame (11 NYCRR 65-3.11[c]). Significantly, an insurance company must pay or deny the claim within 30 calendar days after receipt of the proof of claim (*see* Insurance Law § 5106 [a]; 11 NYCRR 65-3.8[c]). If an insurer seeks additional verification, however, the 30-day window is tolled until it receives the relevant information requested (*see* 11 NYCRR 65-3.8[a][1])" (*Hospital for Joint Diseases*, 9 N.Y.3d at 317, 849 N.Y.S.2d 473, 879 N.E.2d 1291 [footnotes omitted]).
> Finally, we reviewed the "substantial consequences" of "[a]n insurer's failure to pay or deny a claim within 30 days" (*id.*). First,

> "[b]y statute, overdue payments earn monthly interest at a rate of two percent and entitle a claimant to reasonable attorneys' fees incurred in securing payment of a valid claim (*see* Insurance Law § 5106[a])" (*Hospital for Joint Diseases,* 9 N.Y.3d at 317-318, 849 N.Y.S.2d 473, 879 N.E.2d 1291). Citing *Presbyterian,* we emphasized that even "[m]ore importantly, a carrier that fails to deny a claim within the 30-day period is generally precluded from asserting a defense against payment of the claim" (*id.* at 318, 849 N.Y.S.2d 473, 879 N.E.2d 1291). Referring to *Central Gen. Hosp. v. Chubb Group of Ins. Cos.,*90 N.Y.2d 195, 659 N.Y.S.2d 246, 681 N.E.2d 413 (1997), we cautioned that the only exception to this preclusion remedy was a "narrow" one for those "situations where an insurance company raises a defense of lack of coverage" (*Hospital for Joint Diseases,* 9 N.Y.3d at 318, 849 N.Y.S.2d 473, 879 N.E.2d 1291).
>
> In such cases, an insurer who fails to issue a timely disclaimer is not prohibited from later raising the defense because the insurance policy does not contemplate coverage in the first instance, and requiring payment of aclaimupon failure to timely disclaim would create coverage where it never existed.

Fair Price Med. Supply Corp. v Travelers Indem. Co., 10 N.Y.3d at 562-63.

It is also well settled that an insurer is not obligated to pay or deny a claim until it has received verification of all relevant information requested. *Mount Sinai Hosp. v. Chubb Grp. of Ins. Companies*, 43 A.D.3d 889, 843 N.Y.S.2d 634 (2nd Dept. 2007) (); *Hosp. for Joint Diseases v. New York Cent. Mut. Fire Ins. Co.,* 44 A.D.3d 903, 844 N.Y.S.2d 371 (2nd Dept. 2007); *New York & Presbyterian Hosp. v. Progressive Cas. Ins. Co*., 5 A.D.3d 568, 569, 774 N.Y.S.2d 72 (2nd Dept. 2004). Furthermore, no-fault regulations do not specifically define or limit the information or documentation an insurer may request through verification. In fact, the regulations provide that an insurer can request "... all items necessary to verify the claim directly from the parties from whom such verification was requested." 11 NYCRR 65-3.5(c). As long as a medical provider's documentation is arguably responsive to an insurer's verification request, the insurer must act within 30 days of the medical provider's response, or it will be precluded from presenting any non-coverage defenses; an insurer must affirmatively act once it receives a response to its verification request. *All Health Medical Care, P.C. v. Government Employees Ins. Co.*, 2 Misc.3d 907, 771 N.Y.S.2d 832 (Civ. Ct. Queens Co. 2004).

In addition, 11 NYCRR 65-3.6 (b) of the no-fault regulations states that 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. At the same time the insurer shall inform the Applicant and such person's attorney of the reason(s) why the claim is delayed by identifying in writing the missing verification and the party from whom it was

requested. The ten (10) day follow-up requirement regarding the request for verification is strictly construed, and an insurer who fails to follow-up for verification fails to act diligently in the processing of a claim. *Presbyt. Hosp. v. Aetna Cas. & Sur. Co.*, 233 A.D.2d 431 (2nd Dept. 1996).

Additionally, an EUO cannot be used to toll the timeliness of late denial. In fact, the No Fault regulations at 11 NYCRR 65-3.5(o) states: "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 insurer shall advise the applicant in the verification request that the insurer may deny the claim if the applicant does not provide within 120 calendar days from the date of the initial request either all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply. This subdivision shall not apply to a prescribed form (NF-Form) as set forth in Appendix 13 of this Title, medical examination request, or examination under oath request. This subdivision shall apply, with respect to claims for medical services, to any treatment or service rendered on or after April 1, 2013 and with respect to claims for lost earnings and reasonable and necessary expenses, to any accident occurring on or after April 1, 2013."

Respondent acknowledges that it received both of Applicant's bills on May 30, 2017. Respondent requested an EUO on June 13, 2017 and July 6, 2017, which EUO occurred on July 27, 2017. The purpose of the June 13, 2017 EUO scheduling letter was to question Applicant concerning the pattern and frequency of the pharmaceutical procedures, arrangements between the provider and the physicians and locations where the prescriptions are generated, compounding practices, billing and coding practices, compliance with licensing laws, handling and production of pharmaceutical products. The EUO scheduling letters stated that for purposes of the EUO Respondent was "requesting the Provider produce and provide all documents relating to the services the provider had rendered to the patient" and listed various documents which included a wide range of documents. Respondent's own words identify these documents as for the purpose of the EUO only.

After conducting the July 27, 2017 EUO, on August 9, 2017 and September 12, 2017, Respondent made requests for verification. It stated that as a "follow up" to the EUO of Applicant, it is seeking additional documentation, and in particular:

> 1. Copies of all purchase invoices, wholesale receipts, or related documentation evidencing the purchase of all pharmaceutical products, including any pharmaceutical products used in any compounded drugs, dispensed to the eligible injured persons listed on (See attachment) New Century Pharmacy [20170614-0013];
> 2. The complete lease agreement (including any appendices, exhibits, schedules or other attachments) between New Century Pharmacy, Inc. and 63-108th Street Realty, LLC, and proof of payments made thereunder for the last six months;

3. All W-2 forms from New Century Pharmacy, Inc. and any documentation regarding the employment status or relationship between New Century Pharmacy, Inc. and any person employed by New Century Pharmacy, Inc. including, but not limited to, Robert Yakutilov, Renita Nal, Irina Korneyeva, Barno Kushmakova, Diane Sierra, Katrin Matatov and Eduard Aranov;
4. Copies of licenses and certifications for all pharmacists employed by New Century Pharmacy, Inc. including, but not limited to, Robert Yakutilov and Renita Nal;
5. All employment agreements and contracts (including any appendices, exhibits, schedules or other attachments) between New Century Pharmacy, Inc. and any person employed by New Century Pharmacy, Inc. including, but not limited to, Robert Yakutilov, Renita Nal, Irina Korneyeva, Barno Kushmakova and Diane Sierra; and
6. Proof of filing of any documents with the NYS Board of Pharmacy advising that Renita Nal is the supervising pharmacist of New Century Pharmacy, Inc.

Applicant claims that the denial is late because Respondent did not properly toll the claim because verification was not sought within 15 business days of the receipt of the prescribed verification forms.

Respondent had 30 days from May 30, 2017, to either pay or deny Applicant's claim. Rather, Respondent denied Applicant's claims on January 2, 2018 based on the following reason: "Payment is denied. You have failed to comply with our verification request of 08/09/17 within 120 calendars days of such request or provide us with written proof providing reasonable justification for your failure to comply with the verification request." I find that Respondent's requests were untimely because the denial is based solely on the initial request for additional verification on August 9, 2017 and not on the EUO. See, *Todaro v. Geico Gen. Ins. Co.*, 46 A.D.3d 1086 (3rd Dept. 2007) (a no-fault insurer is bound by the "four corners of the denial" and "must stand or fall upon the defense upon which it is based its refusal to pay.")

In *Neptune Medical Care, P.C. v. Ameriprise Auto & Home Insurance*, 48 Misc.3d 139(A), 2015 N.Y. Slip Op. 51220 (U) (App. Term 2nd, 11th and 13th Jud. Dists. 2015), the Court stated that "(e)ven if (the insurer) had tolled the 30-day period…by timely requesting verification pursuant to 11 NYCRR Section 65-3.8 (a)… the Regulations do not provide that such a toll grants an insurer additional opportunities to make requests for verification that would otherwise be untimely." *Id.*

Respondent has failed to show that it complied with the governing regulations with respect to denying Applicant's claim. Respondent's denial was outside the 30-calendar day time frame for issuing a denial, and I find that the Respondent failed to establish that it was entitled to deny Applicant's bills because the claim was not tolled by requesting the additional verification requests after the EUO.

A review of the competent evidence in the record reveals that Respondent failed to toll the time to pay or deny the claim. Consequently, the verification requests are nullities with respect to the bill at issue. I therefore find that the denial is late and that Applicant is entitled to reimbursement.

The Fee Schedule Defense

The insurer has the burden of proving that the fees charged were excessive and not in accordance with the Workers' Compensation fee schedule. *See, St. Vincent Med. Care, P.C. v. Country Wide Ins. Co.*, 26 Misc. 3d 146(A), 907 N.Y.S.2d 441 (App. Term 2010). If the insurer fails to demonstrate, by competent evidentiary proof, that the claims were excess of the appropriate fee schedule, the defense of noncompliance cannot be sustained. *See, Cont'l Med., P.C. v. Travelers Indem. Co.*, 11 Misc. 3d 145(A), 819 N.Y.S.2d 847 (App. Term 2006).

Regarding date of service May 2, 2017, the disputed knee brace was billed by Applicant utilizing CPT code L1820 billed in the amount of $110.00, and for date of service May 10, 2017, the disputed LSO was billed in the amount of $83.38 by Applicant utilizing CPT code L0628. At the hearing, Respondent asserted that based upon a plain reading of the NYS Medicaid DME fee schedule guidelines, Applicant is only entitled to $110.00 for the knee brace and $65.92 for the LSO.

I take judicial notice of the NYS Medicaid DME fee schedule in this matter. *See, Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co*., 61 A.D.3d 13, (2nd Dept. 2009); *LVOV Acupuncture, P.C. v. Geico Ins. Co.*, 32 Misc.3d 144(A), 2011 NY Slip Op 51721(U) (App Term 2d, 11th & 13th Jud Dists. 2011); *Natural Acupuncture Health, P.C. v. Praetorian Ins.* Co., 30 Misc.3d 132(A), 2011 NY Slip Op 50040(U) (App Term, 1st Dept. 2011).

Having taken judicial notice of the NYS Medicaid DME fee schedule in this matter I find that Respondent is correct. Having reviewed the submissions of the parties and considered the oral arguments of their respective representatives, I conclude that Applicant is due reimbursement in the amount of $175.92. Applicant's claim is granted in that amount.

This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator. Any further issues raised in the hearing record are held to be moot, without merit, and/or waived insofar as not raised at the time of the hearing.

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**
	New Century Pharmacy, Inc.	**05/02/17 - 05/02/17**	**$112.00**	**Awarded: $110.00**
	New Century Pharmacy, Inc.	**05/10/17 - 05/10/17**	**$83.38**	**Awarded: $65.92**
Total			**$195.38**	**Awarded: $175.92**

B. The insurer shall also compute and pay the applicant interest set forth below. 08/30/2018 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

   Interest runs from the initiation date for this case until the date that payment is 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 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 65-4.6 (c) and (e). However, if the benefits and interest awarded thereon is equal to or

less than the Respondent's written offer during the conciliation process, the attorney's fee shall be based upon the provisions of 11 NYCRR 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, Lisa Abrams, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

02/10/2020
(Dated)

Lisa Abrams

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:
400f5503f39f02d2ee57a1f11ad1e427

Electronically Signed

Your name: Lisa Abrams
Signed on: 02/10/2020