American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

AMC Psychology PC (Applicant)	AAA Case No.	17-18-1103-4697
	Applicant's File No.	N/A
- and -	Insurer's Claim File No.	0481690527
	NAIC No.	19232
Allstate Property and Casualty Insurance Company (Respondent)		

ARBITRATION AWARD

I, Tracy Morgan, 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: injured person-assignor

1. Hearing(s) held on 03/25/2020
   Declared closed by the arbitrator on 03/25/2020

   Roman Kulik, Esq. from Kulik Law Firm, PC participated by telephone for the Applicant

   Kevin Davis, Esq. from Law Offices of John Trop participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **$ 1,117.70**, 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 Applicant is the assignee of no-fault benefits from injured person-assignor (FG), a 56 year old male who was involved in a motor vehicle accident on November 8, 2017. Following the accident, the injured person-assignor underwent a psychological diagnostic interview and psychological testing performed by Applicant on November 16, 2017. Respondent contends that it sought verification and maintains that verification remains outstanding.

   The issue presented is whether Respondent established that it properly tolled the instant claims and established that verification was not provided?

4. Findings, Conclusions, and Basis Therefor

This hearing was conducted using documents contained in ADR Center. Any documents contained in the folder are hereby incorporated into this hearing. I have reviewed the relevant exhibits contained in the electronic file maintained by the American Arbitration Association and have considered all of the stipulations and arguments presented by both parties at the hearing of this matter. No witnesses appeared or testified.

A health care provider establishes its prima facie entitlement to no-fault benefits by submitting evidentiary proof that the prescribed statutory billing forms were mailed to and received by the insurer and that payment of no-fault benefits is overdue *See Insurance Law § 5106 [a]; 11 NYCRR 65.15 [g]; Viviane Etienne Medical Care, P.C. v Country-Wide Ins. Co.*, 25 NY3d 498 (2015).

I find that Applicant established its prima facie entitlement to No-fault benefits as proofs of claim were mailed to and received by the insurer and payment of No-Fault benefits is overdue.

11 NYCRR Section 65-3.8(a)(1) provides that no fault benefits are overdue if not paid within thirty (30) calendar days after the insurer received proof of claim, which shall include verification of all the relevant requested items pursuant to 11 NYCRR Section 65-3.5.

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 (2d Dept. 2014).

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.

If there is no response to the second or follow-up request for verification, the time in which the insurer must decide whether to pay or deny the claim is indefinitely tolled. *Id.* 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.

Respondent contends that Applicant's bills were timely delayed pursuant to verification requests that were never responded to. Respondent submitted copies of letters addressed to the Applicant dated January 24, 2018 and follow up letters dated March 1, 2018 seeking among other items, treatment and session notes, evaluation reports, letter of medical necessity, sign in sheets, intake sheets, name and license of psychologist performing or supervising the services billed, identify those with whom Applicant has contracted with for administrative services, management services, accounting, billing and collection services and copies of checks for such services.

No further proof was submitted to support Respondent's contention that the verification letters were properly mailed and that verification remains outstanding. The dates of mailing for these verification requests remain unknown. There is no actual proof of mailing for the verification letters. There is no affidavit detailing Respondent's daily business practice of receiving bills and processing verification requests, payment or denials. There is no Affidavit detailing the mailing procedures for the verification letters and there is no affidavit stating what if any responses were received by Applicant pertaining to the requested verification or that no response was received.

Here, Applicant does not acknowledge receipt of the verification requests. There is no evidence of a response or objection from Applicant or Applicant's counsel.

Generally, proof that an item was properly mailed gives rise to a rebuttable presumption that the item was received by the addressee. The presumption may be created by either proof of actual mailing or proof of a standard office practice or procedure designed to ensure that items are properly addressed and mailed *See New York & Presbyt. Hosp. v Allstate Ins. Co*., 29A.D.3d 547, 2006 NY Slip Op 03558 (2d Dept. 2006).

Here, Respondent did not submit any proof of actual mailing of the verification request letters and did not submit proof of a standard office practice or procedure addressing the mailing of the verification requests herein.

While the rules of evidence are necessarily relaxed at arbitration, the credibility of the documents submitted must be given careful consideration. The respondent is still obliged to offer evidence that adequately and reliably sustains its burden of proof. It is not outside the bounds of rationality to require proof of mailing under such circumstances where the seminal issue hinges upon the propriety of statutorily distinctive correspondence.

"The law is well-settled that for an insurer's verification request to toll the 30 day rule, the insurer must prove that it mailed the request and follow-up request within the statutorily prescribed period. *See, S&M Supply Inc. v. Geico Insurance*, 2003 NY Slip Op 51192 (U) (App. Term 2d & 11 Jud. Dist. 2003); *Ocean Diagnostic Imaging, PC v. Lancer Insurance Company*, 6 Misc. 3d 62 (App. Term 2d & 11 Jud. Dist. 2004). (Emphasis added).

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, PC v. Travelers Indemnity Company*, 28 Misc. 3d 127 (A), 2010 NY Slip Op 51176 (U) (App. Term 2d, 11 and 13 Dists. 2010). (Emphasis added). As Arbitrator Maher noted (AAA# 4120130710), "… merely providing a copy of the verification request, without some form of proof of mailing, does not meet the insurer's burden of demonstrating that the verification was timely mailed and whom it was actually mailed."

I find that Respondent did not establish that the verification requests were properly or timely mailed to the Applicant. There is no presumption of receipt by the Applicant that need be rebutted. Although the verification letters contained the correct address for the Applicant, I note that the verification letters Respondent submitted were not signed and as such, together with the circumstances presented herein, I find them insufficient to establish proper proof of mailing. As such, Respondent failed to establish its defense that these claims were properly tolled. Respondent's verification letters indicated that the claims were received on January 2, 2018 and as such, these claims became overdue on February 1, 2018. Any further issues raised in the record are held to be moot 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.

		Claim	

Medical		From/To	Amount	Status
	AMC Psychology PC	**11/16/17 - 11/16/17**	**$194.50**	**Awarded: $194.50**
	AMC Psychology PC	**11/16/17 - 11/16/17**	**$553.92**	**Awarded: $553.92**
	AMC Psychology PC	**11/16/17 - 11/16/17**	**$369.28**	**Awarded: $369.28**
Total			**$1,117.70**	**Awarded: $1,117.70**

B. The insurer shall also compute and pay the applicant interest set forth below. 02/01/2018 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. Interest shall be 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(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. However, the regulations toll the accrual of interest when 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 Insurance Department regulations." See, 11 NYCRR 65-3.9(c). The Superintendent and the New York Court of Appeals has interpreted this provision to apply regardless of whether the particular denial at issue was timely*LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co.*, 12 NY3d 217 (2009).

As determined above, these claims became overdue 30 days after Respondent received them, February 1, 2018.

C. Attorney's Fees

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

As this matter was filed on or 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 an attorney's fee, in accordance with newly promulgated 11 NYCRR 65-4.6(d) For claims that fall under the Sixth Amendment to the regulation, the following shall apply: "If the claim is resolved by the designated organization at any

time prior to transmittal to an arbitrator and it was initially denied by the insurer or overdue, the payment of the applicant's attorney's fee by the insurer shall be limited to 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon, for each applicant with whom the respective parties have agreed and resolved dispute, subject to 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, Tracy Morgan, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

04/07/2020
(Dated)

Tracy Morgan

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:
70992f6627b6a26eb6df7ca92292bcaa

Electronically Signed

Your name: Tracy Morgan
Signed on: 04/07/2020