

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Supportive Products, Corp.
(Applicant)

- and -

American Transit Insurance Company
(Respondent)

AAA Case No. 17-20-1172-8090

Applicant's File No. 149453

Insurer's Claim File No. 1072363-02

NAIC No. 16616

ARBITRATION AWARD

I, Aaron Maslow, 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 ["AV"]

1. Hearing(s) held on 04/12/2021
Declared closed by the arbitrator on 04/12/2021

John Gallagher, Esq., from The Law Offices of John Gallagher, PLLC participated for the Applicant

Tina Lin, Esq., from Law Offices of Daniel J. Tucker, P.C. participated for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 6,411.39**, 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

- Whether Applicant established entitlement to No-Fault insurance compensation for supplies provided to Assignor.
- Whether Applicant established a prima facie case of entitlement to No-Fault compensation.
- Whether arbitration is premature due to additional verification sought by Respondent which was not provided by Applicant.

4. Findings, Conclusions, and Basis Therefor

Appearances

For Applicant:

The Law Offices of John Gallagher, PLLC
Address: 9707 3rd Avenue
2nd Floor, Suite A
Brooklyn, NY 11209
By: John Gallagher, Esq.

For Respondent:

Law Offices of Daniel J. Tucker, P.C.
One Metro Tech Center
7th floor
Brooklyn, NY 11201
By: Tina Lin, Esq.

Applicant commenced this New York No-Fault insurance arbitration, seeking as compensation \$6,411.39 which it billed for dispensing supplies on three dates in 2019 to Assignor, a 20-year-old female who allegedly was injured in a motor vehicle accident on Oct. 23, 2019. Respondent neither paid nor denied the three bills at issue. Rather, it maintains that it pended them for additional verification and that this arbitration is premature due to Applicant's failure to provide that which was requested in the requests. The following are the details concerning what was billed by Applicant:

Date of Service Nov. 7, 2019 (\$1,709.90 charged)*

- Billed HCPCS Code E0215, described as "Electrical Heat Pad"; E0215 defined in HCPCS system as "Electric heat pad, moist"; charged \$20.93.
- Billed HCPCS Code E0272, described as "Mattress Foam Rubber"; E0272 defined in HCPCS system as "Mattress, foam rubber"; charged \$155.52.
- Billed HCPCS Code E2621, described as "Lumbar Cushion"; E2621 defined in HCPCS system as "Positioning wheelchair back cushion, planar back with lateral supports, width 22 inches or greater, any height, including any type mounting hardware"; charged \$519.64.
- Billed HCPCS Code E0190, described as "Cervical Pillow"; E0190 defined in HCPCS system as "Positioning cushion/pillow/wedge, any shape or size, includes all components and accessories"; charged \$22.04.

- Billed HCPCS Code E0274, described as "Bed Board"; E0274 defined in HCPCS system as "Over-bed table"; charged \$101.85.
- Billed HCPCS Code L0634, described as "LSO"; L0634 defined in HCPCS system as "Lumbar-sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to t-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, custom fabricated"; charged \$759.92.
- Billed HCPCS Code L0174, described as "Cervical Collar (soft)"; L0174 defined in HCPCS system as "Cervical, collar, semi-rigid, thermoplastic foam, two piece with thoracic extension, prefabricated, off-the-shelf"; charged \$130.00.

Date of Service Dec. 5, 2019 (\$3,048.86 charged)*

- Billed HCPCS Code E0691, described as "Ultraviolet Therapy System"; E0691 defined in HCPCS system as "Ultraviolet light therapy system, includes bulbs/lamps, timer and eye protection; treatment area 2 square feet or less"; charged \$673.94.
- Billed HCPCS Code E0762, described as "Tens Unit System"; E0762 defined in HCPCS system as "Transcutaneous electrical joint stimulation device system, includes all accessories"; charged \$535.26.
- Billed HCPCS Code E0944, described as "TENS Belt"; E0944 defined in HCPCS system as "Pelvic belt/harness/boot"; charged \$40.90.
- Billed HCPCS Code E1310, described as "Whirlpool"; E1310 defined in HCPCS system as "Whirlpool, non-portable (built-in type)"; charged \$1,610.55.
- Billed HCPCS Code E1399, described as "massager"; E1399 defined in HCPCS system as "Durable medical equipment, miscellaneous"; charged \$188.21.

Date of Service Dec. 13, 2019 (\$1,652.63 charged)*

- Billed HCPCS Code E0855, described as "Cervical Traction"; E0855 defined in HCPCS system as "Cervical traction equipment not requiring additional stand or frame"; charged \$502.63.
- Billed HCPCS Code L0632, described as "LSO Appl Control Custom Fitte [sic]"; L0632 defined in HCPCS system as "Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to t-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated"; charged \$1,150.00.

This arbitration was organized by the American Arbitration Association, which has been designated by the New York State Department of Financial Services to coordinate the mandatory arbitration provisions of Insurance Law § 5106(b), which provides:

Every insurer shall provide a claimant with the option of submitting any dispute involving the insurer's liability to pay first party ["No-Fault insurance"] benefits, or additional first party benefits, the amount thereof or any other matter which may arise pursuant to subsection (a) of this section to arbitration pursuant to simplified procedures to be promulgated or approved by the superintendent.

Both parties appeared at the videoconference hearing by counsel, 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.

"[A] plaintiff demonstrates prima facie entitlement to summary judgment by submitting evidence that payment of no-fault benefits are overdue, and proof of its claim, using the statutory billing form, was mailed to and received by the defendant insurer." Viviane Etienne Medical Care, P.C. v. Country-Wide Ins. Co., 25 N.Y.3d 498, 501 (2015). "[A] medical provider seeking reimbursement from a no-fault insurer demonstrates its entitlement to reimbursement of overdue benefits when it proves that it submitted a *completed* claim form to the insurer." *Id.* at 507 (emphasis added). "The court may, in its discretion, rely on defendant's documentary submissions establishing defendant's receipt of plaintiff's claims [citation omitted]." Lenox Hill Radiology MIA, P.C. v. American Transit Ins. Co., 19 Misc.3d 358, 363 (Civ. Ct. New York Co. 2008). An insurer's denial of claim form indicating the date on which it was received adequately establishes that the claimant sent, and that the defendant received, the claim. Ultra Diagnostics Imaging v. Liberty Mutual Ins. Co., 9 Misc.3d 97 (App. Term 9th & 10th Dists. 2005).

A medical supply provider fails to submit a properly completed claim form when neither its medical reports nor its prescription mention an item for which compensation is sought. Adam's Medical Supplies, Inc. v. Windsor Group Ins. Co., 3 Misc.3d 126(A), 2004 N.Y. Slip Op. 50310 (2d & 11th Dists. Apr. 14, 2004). Where a piece of medical equipment is not listed on the prescribing doctor's prescription, there is a lack of a prima facie case of entitlement to compensation for dispensing it. Vista Surgical Supplies, Inc. v. State Farm Mutual Ins. Co., 12 Misc.3d 134(A), 2006 N.Y. Slip Op. 51189(U) (App. Term 2d & 11th Dists. June 15, 2006). The cost of unprescribed medical equipment is not a recoverable No-Fault benefit, even where the insurer's denial is precluded. Amaze Medical Supply Inc. v. Eagle Ins. Co., 2 Misc.3d 128(A), 2003 N.Y. Slip Op. 51701(U) (App. Term 2d & 11th Dists. Dec. 24, 2003); Amaze Medical Supply Inc. v. Allstate Ins. Co., 3 Misc.3d 43 (App. Term 2d & 11th Dists. 2004).

I find that Applicant failed to establish a prima facie case of entitlement to No-Fault compensation with respect to the following supplies dispensed to Assignor inasmuch as what was dispensed did not conform to what was prescribed:

Date of Service Nov. 7, 2019

- Billed HCPCS Code E0272, described as "Mattress Foam Rubber"; E0272 defined in HCPCS system as "Mattress, foam rubber"; charged \$155.52. Nowhere in Dr. Maria Ciechorska's Nov. 7, 2019 prescription -- submitted by Applicant -- is a foam rubber mattress mentioned.
- Billed HCPCS Code E2621, described as "Lumbar Cushion"; E2621 defined in HCPCS system as "Positioning wheelchair back cushion, planar back with lateral supports, width 22 inches or greater, any height, including any type mounting hardware"; charged \$519.64. Nowhere in Dr. Maria Ciechorska's Nov. 7, 2019 prescription -- submitted by Applicant -- is a positioning wheelchair back cushion mentioned.
- Billed HCPCS Code E0190, described as "Cervical Pillow"; E0190 defined in HCPCS system as "Positioning cushion/pillow/wedge, any shape or size, includes all components and accessories"; charged \$22.04. Dr. Maria Ciechorska's Nov. 7, 2019 prescription -- submitted by Applicant -- called for an orthopedic pillow but a Code E0190 supply is merely for positioning, not for orthopedic relief.
- Billed HCPCS Code E0274, described as "Bed Board"; E0274 defined in HCPCS system as "Over-bed table"; charged \$101.85. Dr. Maria Ciechorska's Nov. 7, 2019 prescription -- submitted by Applicant -- did not mention an over-bed table.
- Billed HCPCS Code L0634, described as "LSO"; L0634 defined in HCPCS system as "Lumbar-sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to t-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, custom fabricated"; charged \$759.92. Dr. Maria Ciechorska's Nov. 7, 2019 prescription -- submitted by Applicant -- called for a "Lumbosacral Orthosi [sic]." Nowhere was there prescribed a lumbar-sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to t-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, custom fabricated. There are numerous lumbo-sacral orthoses and if Applicant was uncertain as to which should be dispensed it should have contacted the prescribing doctor for further written instructions.
- Billed HCPCS Code L0174, described as "Cervical Collar (soft)"; L0174 defined in HCPCS system as "Cervical, collar, semi-rigid, thermoplastic foam, two piece

with thoracic extension, prefabricated, off-the-shelf"; charged \$130.00. Dr. Maria Ciechorska's Nov. 7, 2019 prescription -- submitted by Applicant -- called for a "Cervical collar soft." Nowhere was there prescribed a cervical collar which was semi-rigid with thermoplastic foam, two piece with thoracic extension, prefabricated, off-the-shelf. There are numerous cervical collars and if Applicant was uncertain as to which should be dispensed it should have contacted the prescribing doctor for further written instructions. Moreover, dispensing a semi-rigid cervical collar is also contrary to a prescription for a soft one.

Date of Service Dec. 5, 2019

- Billed HCPCS Code E0691, described as "Ultraviolet Therapy System"; E0691 defined in HCPCS system as "Ultraviolet light therapy system, includes bulbs/lamps, timer and eye protection; treatment area 2 square feet or less"; charged \$673.94. The Dec. 5, 2019 prescription of Dr. Maria Ciechorska -- submitted by Applicant -- lacked any mention of an ultraviolet light therapy system.
- Billed HCPCS Code E0762, described as "Tens Unit System"; E0762 defined in HCPCS system as "Transcutaneous electrical joint stimulation device system, includes all accessories"; charged \$535.26. The Dec. 5, 2019 prescription of Dr. Maria Ciechorska -- submitted by Applicant -- lacked any mention of a TENS unit.
- Billed HCPCS Code E0944, described as "TENS Belt"; E0944 defined in HCPCS system as "Pelvic belt/harness/boot"; charged \$40.90. The Dec. 5, 2019 prescription of Dr. Maria Ciechorska -- submitted by Applicant -- lacked any mention of a TENS belt or a pelvic belt/harness/boot.
- Billed HCPCS Code E1310, described as "Whirlpool"; E1310 defined in HCPCS system as "Whirlpool, non-portable (built-in type)"; charged \$1,610.55. The Dec. 5, 2019 prescription of Dr. Maria Ciechorska -- submitted by Applicant -- called for a "Hydrotherapy whirlpool." It did not call for a built-in whirlpool. In fact, there are different types of whirlpools in the HCPCS system, such as an overtub type, a built-in type, and a portable walk-in one. If Applicant was uncertain as to which one Dr. Ciechorska wanted it should have obtained written clarification. Moreover, nothing in the record establishes that Assignor's bathroom was modified so that the whirlpool could be built in.
- Billed HCPCS Code E1399, described as "massager"; E1399 defined in HCPCS system as "Durable medical equipment, miscellaneous"; charged \$188.21. The Dec. 5, 2019 prescription of Dr. Maria Ciechorska -- submitted by Applicant -- called for an electric massager. Applicant's bill did not indicate that such was dispensed.

Date of Service Dec. 13, 2019

- Billed HCPCS Code E0855, described as "Cervical Traction"; E0855 defined in HCPCS system as "Cervical traction equipment not requiring additional stand or frame"; charged \$502.63. The undated prescription of Dr. Maria Ciechorska -- submitted by Applicant -- specified a "C-Traction." not cervical traction equipment not requiring an additional stand or frame. In fact there are various cervical traction units, assigned HCPCS Codes E0840, E0849, E0855, E0856, and E0860. If Applicant was uncertain as to which cervical traction unit to dispense it should have contacted the prescription writer and obtained written clarification.
- Billed HCPCS Code L0632, described as "LSO Appl Control Custom Fitte [sic]"; L0632 defined in HCPCS system as "Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to t-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated"; charged \$1,150.00. Applicant submitted an undated prescription of Dr. Maria Ciechorska referring to an "LSO Custom." However, there is no prescription for a lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to t-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated. In fact, there are various custom LSOs and if Applicant was uncertain as to which custom LSO to dispense it should have contacted the prescription writer and obtained written clarification.

Therefore, with respect to the foregoing supplies, what Applicant dispensed was not in accordance with the respective prescriptions in evidence. This constitutes a failure to submit a properly completed claim form. A party's own contradictory evidence deprives it of a prima facie case in support of its burden of coming forward. See Shur v. Unitrin Advantage Ins. Co., 56 Misc.3d 136(A), 2017 N.Y. Slip Op. 51011(U) (App. Term 9th & 10th Dists. Aug. 10, 2017); Hillcrest Radiology Associates v. State Farm Mutual Automobile Ins. Co., 28 Misc.3d 138(A), 2010 N.Y. Slip Op. 51467(U) (App. Term 2d, 11th & 13th Dists. Aug. 13, 2010). Applicant's own evidence denudes it of a prima facie case of entitlement to No-Fault compensation per the cited case law.

I find that Applicant otherwise established a prima facie case of entitlement to No-Fault compensation. Respondent's appurtenant verification requests acknowledged receipt of Applicant's bill and concededly nothing was paid. Hence, there is a prima facie case of entitlement to No-Fault compensation for the following supply:

Date of Service Nov. 7, 2019

- Billed HCPCS Code E0215, described as "Electrical Heat Pad"; E0215 defined in HCPCS system as "Electric heat pad, moist"; charged \$20.93.

Respondent argued that its verification requests of Jan. 14, 2020; Feb. 18, 2020; and Feb. 27, 2020 appurtenant to the bill for date of service Nov. 7, 2019 were not complied with. To the extent that all these verification requests sought the identical items, they were:

- Detailed statement describing events surrounding accident and vehicles involved
- Name, address, and telephone Numbers of any Witness
- Explanation as to why claimant is not listed on the police report
- Any proof that claimant was in our insured vehicle at time of accident (taxi receipt, ambulance report, etc.)
- Amended Police report
- Letter of referral / letter of Medical necessity from referring physician to show causal relationship to accident on record. LETTER OF MEDICAL NECESSITY FOR EACH ITEM SOLD, AND IF CUSTOM FITTINGS, DOCTOR MUST STATE WHY CUSTOM MADE FITTINGS ARE NEEDED.
- Manufacture invoice
- Report of the referring doctor for the date referral/prescription was done

At the hearing, Applicant acknowledged receipt of the verification requests. It highlighted the fact that a letter dated Jan. 22, 2020 responded to them. This letter is in the record. In pertinent part it states:

This letter is in response to your verification request dated January 14, 2020 requesting additional verification:

Manufacturer's Invoice:

Pursuant to the No Fault regulations, a Dealer in Products for the Disabled is not obligated to provide a manufacture' s invoice when billing under the Medicaid and Medicare fee schedule. Supportive Products, Corp. is a Dealer in Products for the Disabled and bills under the Medicaid and Medicare fee schedule. As such, Supportive Products, Corp. reserves the right to object to an Insurance company's request for the manufacturer's invoice because an Insurance company is not entitled to one. Therefore, Supportive Products, Corp. is

objecting to the request for the manufacturer's invoice because an Insurance Company is not entitled to one under the No Fault regulations.

Police report/ MV-104 report:

Please see enclosed for the police report.

Please be advised, that all of the other information, that you requested is not in our control or possession.

The issue here is whether that portion of Applicant's arbitration claim relating to the HCPCS Code E0215 electric heat pad, moist, is premature for not having provided requested additional verification. No denial of claim was issued.

Applicant did not question the timeliness of Respondent's additional verification requests. It essentially argued that it provided what it could and that once the Jan. 22, 2020 letter was received by Respondent the latter had to pay or deny within 30 days per Insurance Law §5106(a) and 11 NYCRR 65-3.8(a)(1). I reject this argument.

"The Insurance Law and regulations promulgated thereunder provide that "[w]ithin 30 calendar days after proof of claim is received, the insurer shall either pay or deny the claim in whole or in part" (11 NYCRR 65-3.8(c); *see* Insurance Law § 5106[a]). This 30-day period may be extended by, *inter alia*, a timely demand by the insurance company for further verification of a claim (*see* 11 NYCRR 65-3.5(b); 65-3.6(b)). Such a demand must be made within [15 business] days of receipt of a completed application (*see* 11 NYCRR 65-3.5(b)). If the demanded verification is not received within 30 days, the insurance company must issue a follow-up request within 10 days of the insured's failure to respond (*see* 11 NYCRR 65-3.6(b))." New York & Presbyterian Hospital v. Progressive Casualty Ins. Co., 5 A.D.3d 568, 569-570 (2d Dept. 2004).

The Regulations provide further, at 11 NYCRR 65-3.5(o), in terms of the duty of a claimant to respond:

(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 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.

The rights of an insurer are amplified upon at 11 NYCRR 65-3.8(b)(3):

(3) Except as provided in subdivision (e) of this section, an insurer shall not issue a denial of claim form (NYS form N-F 10) prior to its receipt of verification of all of the relevant information requested pursuant to sections 65-3.5 and 65-3.6 of this Subpart (e.g., medical reports, wage verification, etc.). 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. 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 paragraph 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.

The No-Fault program "stresses the justifying of claims." Nyack Hosp. v. General Motors Acceptance Corp., 8 N.Y.3d 294, 300 (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 (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), 2009 N.Y. Slip Op. 50306(U) (Civ. Ct. Kings Co., Genine D. Edwards, J., Feb. 26, 2009). A medical supplier fails to provide requested verification when, in response to a request for an initial report and letter of medical necessity from the referring physician, it merely states that the supplies at issue had been provided pursuant to a doctor's prescription and does not advise the insurer of the doctor's name nor where he is located. D & R Medical Supply v. American Transit Ins. Co., 32 Misc.3d 144(A), 2011 N.Y. Slip Op. 51727(U) (App. Term 2d, 11th & 13th Dists. Sept. 19, 2011).

"A claim need not be paid or denied until all demanded verification is provided [citations omitted]." New York & Presbyterian Hospital v. Progressive Casualty Ins. Co., 5 A.D.3d 568, 570 (2d Dept. 2004). An insurer is not required to pay or deny a claim upon receipt of a partial response to a verification request. Orthoplus Products, Inc. v. Global Liberty Ins. Co., 64 Misc.3d 128(A), 2019 N.Y. Slip Op. 51003(U) (App. Term 1st Dept. June 19, 2019); New Horizon Surgical Center, LLC v. Travelers Ins. Co., 65 Misc.3d 139(A), 2019 N.Y. Slip Op. 51690(U) (App. Term, 2d, 11th & 13th Dists. Oct. 18, 2019); Compas Medical, P.C. v. Travelers Ins. Co., 53 Misc.3d 136(A), 2016 N.Y. Slip Op. 51441(U) (App. Term 2d, 11th & 13th Dists. Oct. 5, 2016).

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).

Here, Respondent proved that it timely mailed its request and follow-up request for verification to the health care provider; Applicant conceded such. The Jan. 22, 2020 letter purports to provide a police report; on its face it rejects providing any of the other requested items. I find that the letter fails to meet Applicant's burden of proof of having provided the requested items per Proscan Imaging, P.C. Applicant failed to submit an affidavit to support provision of the police report. The letter admits that nothing else will be provided. Moreover, even if the police report was provided, the rest was not and a partial response is insufficient. See Orthoplus Products, Inc. v. Global Liberty Ins. Co., *supra*; New Horizon Surgical Center, LLC v. Travelers Ins. Co., *supra*; Compas Medical, P.C. v. Travelers Ins. Co., *supra*.

Based on cited case law, I find that requested the respective items in its verification request was reasonable and within "any information that the carrier finds necessary to properly review and process the claim," mentioned in Westchester Medical Center v. Travelers Property & Casualty Ins. Co., *supra*. Additionally, a request for a "manufacturers invoice documenting the cost of the medical equipment or supplies" and "proof of payment for the medical equipment or supplies" is eminently reasonable. Custom Orthotics, Ltd. v. Government Employees Ins. Co., 25 Misc.3d 545 (Civ. Ct. Queens Co. 2009). A medical supply provider fails to raise a triable issue with its claim that the insurer had no "good reason" for its verification request for a manufacturer's invoice documenting the cost of the supplies provided to the assignor. Village Medical Supply, Inc. v. Travelers Property Casualty Ins. Co., 61 Misc.3d 126(A), 2018 N.Y. Slip Op. 51311(U) (App. Term 1st Dept. Sept. 17, 2018). A medical supply provider does not provide a sufficient response or reasonable justification for the failure to comply with a verification request seeking

an invoice when it answers with its opinion that such invoice was "not needed" based on its own interpretation of how the rate of reimbursement should be calculated, and it fails to state that it is not in possession or control of the invoice. CPM Med Supply, Inc. v. State Farm Fire and Casualty Ins. Co., 63 Misc.3d 140(A), 2019 N.Y. Slip Op. 50576(U) (App. Term 2d, 11th & 13th Dists. Apr. 12, 2019). A medical supply provider's letter stating that it was not providing wholesale invoices requested by the insurer in verification requests constitutes a failure to comply with the requests. Active Care Medical Supply Corp. v. Farmington Casualty Co., 64 Misc.3d 127(A), 2019 N.Y. Slip Op. 50987(U) (App. Term 2d, 11th & 13th Dists. June 14, 2019). Therefore, Applicant's refusal to provide the manufacturer's invoice for the HCPCS Code E0215 electric heat pad, moist, is unreasonable.

Respondent did not issue a 120-day denial, which is its prerogative not to do. It was entitled to wait until the requested verification was provided. "[A] suit cannot be for overdue no-fault billing unless and until an insurer receives the verification requested and thirty days has elapsed from the date of receipt of that verification." Westchester Medical Center v. Travelers Property & Casualty Ins. Co., *supra*. If the insurer demonstrates that it timely mailed its verification request and follow-up verification request, and that it did not receive all of the verification requested, and the claimant does not show that such verification was provided prior to commencement of litigation, the 30-day period within which the insurer must pay or deny the claim has not begun to run and the litigation is premature. Favorite Health Products, Inc. v. New York Central Mutual Fire Ins. Co., 43 Misc.3d 126(A), 2014 N.Y. Slip Op. 50467(U) (App. Term 2d, 11th & 13th Dists. Mar. 17, 2014).

Accordingly, the within arbitration claim is premature with respect to the HCPCS Code E0215 electric heat pad, moist, and that part relating is dismissed without prejudice (despite anything to the contrary in the "Accordingly" component of this award below). The remainder of the claim is denied inasmuch as Applicant failed to make out a prima facie case of entitlement to No-Fault compensation.

This arbitrator has not made a determination that benefits provided for under Article 51 (the No-Fault statute) of the Insurance Law are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of Assignor. As such and in accordance with the provisions of the prescribed NYS Form NF-AOB (the assignment of benefits), Applicant health provider shall not pursue payment directly from Assignor for services which were the subject of this arbitration, notwithstanding any other agreement to the contrary.

* The HCPCS system (Healthcare Common Procedure Coding System) was developed in the 1970s to provide a standardized coding system for describing the specific items and services provided in the delivery of health care. It insures that insurance claims are processed in an orderly and consistent manner. With the implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), use of the HCPCS for transactions involving health care information became mandatory.

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 Kings

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

04/12/2021
(Dated)

Aaron Maslow

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

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Electronically Signed

Your name: Aaron Maslow
Signed on: 04/12/2021