American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Kazu Chiropractic, PC (Applicant)	AAA Case No.	17-19-1141-0571
	Applicant's File No.	LOD-0183
- and -	Insurer's Claim File No.	194623033
	NAIC No.	24279
Progressive Casualty Insurance Company (Respondent)		

ARBITRATION AWARD

I, Eileen Hennessy, 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-T.B.

1. Hearing(s) held on 03/03/2021
   Declared closed by the arbitrator on 03/16/2021

   Gill S. Schapira from The Law Office of Gill S. Schapira, P.C participated in person for the Applicant

   Jean Schabhutti from Progressive Casualty Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 2,428.99**, was NOT AMENDED at the oral hearing.
   Stipulations WERE made by the parties regarding the issues to be determined.

   The parties stipulated and agreed that (i) Applicant has met its prima facie burden by submitting evidence that payment of no-fault benefits is overdue, and proof of its claims were mailed to and received by Respondent and (ii) Respondent's denials of the subject claims were timely issued.

3. Summary of Issues in Dispute

   The record reveals that the Assignor-T.B., a 29-year-old male, claimed injuries as the passenger of a motor vehicle involved in an accident that occurred on 3/31/2019. Applicant billed for an office visit and EMG/NCV testing of the upper and lower

extremities performed on 4/29/2019. Respondent denied this claim based on the Assignor's failure to attend two Independent Medical Examinations (IME). The issues for determination are 1) whether the Respondent's denials premised upon the IME no-show properly apprised the claimant of the basis of the defense and, if so, 2) whether Respondent's denials based upon the Assignor's failure to attend IMEs can be sustained?

4. Findings, Conclusions, and Basis Therefor

Applicant seeks reimbursement for an office visit and EMG/NCV testing of the upper and lower extremities This hearing was conducted using the documents contained in the Electronic Case Folder (ECF) maintained by the American Arbitration Association. All documents contained in the ECF are made part of the record of this hearing and my decision was made after a review of all relevant documents found in the ECF as well as the arguments presented by the parties during the hearing.

In accordance with 11 NYCRR 65-4.5(o) (1), an arbitrator shall be the judge of the relevance and materiality of the evidence and strict conformity of the legal rules of evidence shall not be necessary. Further, the arbitrator may question or examine any witnesses and independently raise any issue that Arbitrator deems relevant to making an award that is consistent with the Insurance Law and the Department Regulations.

Legal Framework - Tolling of claims

The general rule regarding payment of claims is set forth in 11 NYCRR §65-3.8(c), which states that "within 30 calendar days after proof of claim is received, the insurer shall either pay or deny the claim in whole or in part." No-Fault benefits are overdue if not paid within 30 calendar days after the insurer receives proof of claim, which shall include verification of all of the relevant information requested pursuant to 11 NYCRR §65-3.5. 11 NYCRR §65-3.8(a). As such, a claim need not be paid or denied until all demanded verification is provided. *See* Nyack Hospital v. General Motors Acceptance Corp., 27 A.D.3d 96, 808 N.Y.S.2d 399 (2d Dept. 2005), *mod'd on other*, 8 N.Y.3d 294, 832 N.Y.S.2d 880 (2007).

OUTSTANDING VERIFICATION

Legal Standard

Once Applicant establishes its prima facie case, the burden of proof shifts to Respondent to come forward with admissible evidence demonstrating the existence of a material issue of fact. Amaze Medical Supply Inc. v. Eagle Ins. Co., 2 Misc.3d 128(A), 2003 N.Y. Slip Op. 51701(U)(App. Term, 2 Dept, 2 & 11 Jud Dists., 2003).

11 NYCRR §65-3.5 (b), Claim procedure states: "Subsequent to the receipt of one or more of the completed verification forms, any additional verification required by the

insurer to establish proof of claim shall be requested within 15 business days of receipt of the prescribed verification forms. Any requests by an insurer for additional verification need not be made on any prescribed or particular form."

11 NYCRR §65-3.6 (b), Verification requests states:"At a minimum, if any requested verifications 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".

11 NYCRR §65-3.5 (c) mandates that the insurer is entitled to receive all items necessary to verify the claim directly from the parties from whom such verification was requested. The insurer has 15 business days from the date it receives the prescribed verification forms to seek additional verification from an Applicant.

11 NYCRR §65-3.5 (d) states: If the additional verification required by the insurer is a medical examination, the insurer shall schedule the examination to be held within 30 calendar days from the date of receipt of the prescribed verification forms.

Further, 11 NYCRR §65-3.8(l) states:

> For the purposes of counting the 30 calendar days after proof of claim, wherein the claim becomes overdue pursuant to section 5106 of the Insurance Law, with the exception of section 65-3.6 of this subpart, any deviation from the rules set out in this section shall reduce the 30 calendar days allowed.

Thus, a request for additional verification pursuant to 11 NYCRR §65-3.5(b) that is sent beyond the 15 business days is still valid so long as it is issued within 30 days from receipt of the claim; such a deviation will simply reduce the insurer's time to pay or deny by the same number of days. 11 NYCRR §65-3.8(l). *See* Nyack Hosp. v. General Motors Acceptance Corp., 8 NY3d 294, 2007 NY Slip Op 02439 (Court of Appeals, 2007).

The obligation to pay or deny a claim is not triggered until the insurer has received all of the relevant information that was requested. Hospital for Joint Diseases v. State Farm Mut. Auto. Ins. Co., 8 AD3d 533, 2004 NY Slip Op 05413 (App. Div., 2 Dept., 2004).

In addition to the above, the Fourth Amendment to 11 NYCRR 65-3, which is applicable to claims for medical services rendered on or after April 1, 2013, introduced a provision ([§65-3.5(o)] that sets a time frame for an applicant to respond to an insurer's verification request(s). In pertinent part, the provision states the following:

> 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. 11 NYCRR §65-3.5(o).

In relation to this new provision, 11 NYCRR §65-3.8(b)(3) was amended so as to confer upon the insurer the right to deny a claim for non-compliance with §65-3.5(o). In pertinent part, the amendment to §65-3.8(b)(3) states the following:

> [A]n 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)…

IME NO-SHOW

Legal Standards

The mandatory No-Fault endorsement in motor vehicle liability insurance policies provides:

> No action shall lie against the Company unless, as a condition precedent thereto, there shall have been full compliance with the terms of this coverage." The same endorsement provides also: "The eligible injured person shall submit to medical examination by physicians selected by, or acceptable to, the Company, when, and as often as, the Company may reasonably require." 11 NYCRR 65-1.1(d) ("Conditions"). "Under New York's no-fault automobile insurance scheme, an insurer can deny an insured's claim for medical treatment if the treatment is not medically necessary.

"To verify a treatment's medical necessity, an insurer may require the claimant to submit to medical examination by physicians selected by, or acceptable to, the [insurer], when, and as often as, the [insurer] may reasonably require. These examinations are referred to as independent medical examinations (IMEs)." Sky Medical Supply Inc. v. SCS Support Claims Services, Inc., 17 F.Supp.3d 207, 214-215 (E.D.N.Y. 2014) (internal quotation marks omitted). While Insurance Department Regulations [11 NYCRR 65-3.5(e)] state that a No-Fault insurer must base its request for an examination under oath upon "the application of objective standards so that there is specific objective justification supporting the use of such examination," it does not impose such a standard on a request for an IME. All County, LLC v. Unitrin Advantage Ins. Co., 31 Misc.3d 134(A), 927 N.Y.S.2d 814 (Table), 2011 N.Y. Slip Op. 50621(U), 2011 WL 1448124 (App. Term 9th & 10th Dists. Apr. 6, 2011).

The purpose of an IME is to permit the insurer to verify the person's injuries, to determine the injured party's condition and to determine if the injured party needs any additional treatment or testing for those conditions and injuries. [citation omitted] In no-fault cases, the purpose of the IME is to assist the carrier in determining the extent of the injured party's disability and that person's need for additional and continued benefits." Boulevard Multispec. Medical, P.C. v. Tri-State Consumer Ins. Co., 43 Misc.3d 802, 805, 982 N.Y.S.2d 864, 867 (Dist. Ct. Nassau Co. 2014). A defense that an assignor failed to appear at an IME requires proof of such. *E.g.*, Careplus Medical Supply, Inc. v. AutoOne Ins. Co., 24 Misc.3d 132(A), 890 N.Y.S.2d 368 (Table), 2009 N.Y. Slip Op. 51372(U), 2009 WL 1926843 (App. Term 9th & 10th Dists. June 29, 2009); Daras v. GEICO Ins. Co., 22 Misc.3d 141(A), 881 N.Y.S.2d 362 (Table), 2009 N.Y. Slip Op. 50438(U), 2009 WL 679491 (App. Term 2d, 11th & 13th Dists. Mar. 10, 2009).

The appearance at an IME is a condition precedent to the insured's liability on the policy, and an insurer may deny a claim retroactively to the date of loss for a claimant's failure to attend IMEs, "when, and as often as, the [insurer] may reasonably require." Stephen Fogel Psychological, P.C. v. Progressive Casualty 4. Ins. Co., 35 A.D.3d 720, 827 N.Y.S.2d 217 (App. Div, 2 Dept, 2006) (citing to 11 NYCRR §65-1.1 wherein it states: "The eligible injured person shall submit to medical examination by physicians selected by, or acceptable to, the Company when, and as often as, the Company may reasonably require."). An insurer may deny a claim on the basis that the injured person-assignor failed to attend IMEs even if the IMEs were in a different medical specialty from that which underlies the claim. Id. *See also* Unitrin Advantage Ins. Co. v. Bayshore Physical Therapy, PLLC, 82 A.D.3d 559, 918 N.Y.S.2d 473 (1st Dept. 2011).

Appearance at an IME is required whether the insurance company demands it before a claim form is submitted or after the claim form is submitted. An assignee of all the rights, privileges, and remedies to which a motor vehicle accident victim is entitled under the No-Fault Law stands in the shoes of the victim and acquires no greater rights than he had. New York and Presbyterian Hospital v. Country Wide Ins. Co., 17 N.Y.3d 586, 592, 934 N.Y.S.2d 54, 59 (2011). Hence, the failure by an assignor-injured person to attend scheduled IMEs inures to the detriment of a medical provider who has taken an assignment of benefits from the assignor-injured person.

To establish the defense, an insurer must demonstrate that two separate requests for the IME were properly mailed to the assignor, and that the assignor failed to appear for the examination on either of the scheduled dates. Apollo Chiropractic Care, PC v. Praetorian Ins. Co., 27 Misc 3d 139(A), 2010 NY Slip Op 50911(App. Term, 1 Dept., 2010).

The affirmations and affidavits of the medical professionals who were to perform the IMEs can establish that a health care provider's assignor failed to appear for said IMEs. *E.g.*, Tri-Mount Acupuncture, P.C. v. NY Central Mutual Fire Ins. Co., 30 Misc.3d 144(A), 924 N.Y.S.2d 312 (Table), 2011 N.Y. Slip Op. 50335(U), 2011 WL 830762 (App. Term 2d, 11th & 13th Dists. Mar. 2, 2011); Radiology Today, P.C. v. GEICO Ins. Co., 25 Misc.3d 133(A), 901 N.Y.S.2d 910 (Table), 2009 N.Y. Slip Op. 52208(U), 2009 WL 3645541 (App. Term 2d, 11th & 13th Dists. Oct. 23, 2009). Alleviation Med.

Servs., P.C. v. Hertz Co., 2016 NY Slip Op 50399(U) (App Term, 2 Dept., 2nd, 11th, & 13th, Jud. Dists, Mar. 23, 2016). As the rules of evidence do not apply to No-Fault arbitrations, 11 NYCRR 65-4.5(o)(1), a signed statement rather than an affirmation or affidavit from the doctor who was to perform the IME also suffices, and there are other ways of proving an IME no-show.

SUFFICIENCY OF IME NO-SHOW DENIALS

Applicant's counsel argued at the hearing for the first time that the denials premised upon the IME no-show are defective and insufficient to apprise the Applicant of the basis of the defense as the IME no show dates are not listed on the claim specific denials or the global denial. Applicant cited to General Accident Insurance Group v. Cirucci, et. al and Aetna Life & Casualty Company, 414 N.Y.S.2d 512 (1979). Respondent counter-argued that the denials are sufficient to apprise the claimant of the basis of the defense and requested an opportunity to respond to Applicant's argument with a post hearing brief and supporting caselaw. Applicant strongly objected to Respondent's request to submit a post hearing brief arguing that Respondent's denials are clearly defective on their face and that there is no caselaw which could arguably support their position. Moreover, Applicant argued Respondent should have been aware of Applicant's argument and submitted a brief in support of their defense prior to the hearing as the argument has been raised before in other unrelated arbitrations.

According to the No-Fault Regulations, at 11 NYCRR 65-4.5(o)(iii)(2), I determined whether the parties provided and exchanged documents in accordance with the requirements of the "Rocket Docket" rule (11 NYCRR 65-4.2(b)(3)), which requires that an Applicant submit and serve its evidentiary documents upon submitting and serving the arbitration request form, and that a Respondent submit and file its evidentiary documents within 30 days of being advised by the designated arbitration association of the Applicant's submission. Applicant filed this arbitration on 9/6/2019. Respondent's response was due on 10/21/2019 and was timely uploaded on 10/8/2019, seventeen months prior to the hearing on 3/3/2021. Applicant had an opportunity to review the record and submit a memorandum of law in support of their argument regarding the defectiveness of Respondent's denials prior to the hearing thereby allowing Respondent an opportunity to review and respond to their argument prior to the hearing but chose not to. Contrary to Applicant's argument, Respondent is under no duty to point out potential flaws in their defense prior to it being raised by Applicant. I find it would be prejudicial to Respondent to deny them an opportunity to respond to Applicant's arguments raised for the first time at the hearing.

In accordance with 11 NYCRR 65-4.5(o) (1), an arbitrator shall be the judge of the relevance and materiality of the evidence and strict conformity of the legal rules of evidence shall not be necessary. Further, the arbitrator may question or examine any witnesses and independently raise any issue that Arbitrator deems relevant to making an award that is consistent with the Insurance Law and the Department Regulations.

Therefore, I issued the following post hearing directive for Respondent. Applicant declined an opportunity to submit a post hearing brief with caselaw in support of their argument.

Brief due from Respondent by 03/05/2021:

Respondent may submit a post hearing brief by 3/5/2021 with a memorandum of law in support of their position that their denials are valid despite not listing the IME no show dates. Applicant declined an opportunity to respond to Respondent's post-hearing brief.

The global denial premised upon the Assignor's failure to appear for IMEs, dated 7/15/2019, which was mailed to Applicant and Applicant's attorney, states:

> Under the terms of the above referenced policy issued to our policy holder, in the section titled, 'YOUR DUTIES', 'A person claiming coverage must: cooperate with us in any matter concerning a claim or lawsuit; submit to medical examinations at our expense by doctors we select as often as we may reasonably require'.
> In addition, pursuant to NYS Regulation 68-A, Section 65-1.1, Conditions, Proof of Claim, 'The eligible injured person shall "submit to medical examination by physicians selected by, or acceptable to, the Company, when, and as often as, the Company may reasonably require'.
> By refusing to submit to our multiple requests for medical examinations, the applicant for benefits has failed to cooperate with our investigation and comply with the guidelines set forth under our policy and NYS Regulation 68A. All No-Fault benefits are therefore denied.
> Pursuant to Regulation 68, Section 65-1.1, no action shall lie against the Company unless, as a condition precedent thereto, there shall have been full compliance with the terms of this coverage."

The claim specific denial states: "Failure to submit to multiple requests for Medical Examinations is a violation of both this policy's contractual Duties and Conditions under Proof of Claim that precede coverage under Reg. 68, Section 65-1. No Fault benefits under this policy are denied".

After reviewing the evidence in the ECF and the Respondent's post-hearing brief, I reject Applicant's argument and find that in the instant case, the denials herein did inform the Applicant with the requisite degree of specificity as to why the claim was being denied, i.e., the Assignor's failure to appear for multiple requested IMEs. Applicant was provided with the requisite specificity required as to why the claim was denied. I agree with the reasoning set forth by Arbitrator Kramer-Avalone in *Pain Medical, PLLC v. Progressive Insurance Company*, AAA Case No.: 17-14- 9051-6707:

> *In Cirucci, the denial stated "We have disclaimed liability by reason of the facts of insured's failure to report this accident to us and failed to cooperate since we were notified of the accident by you." The court in Cirucci stated: "Although an insurer may disclaim coverage for a valid reason (Insurance Law, § 167, subd 8) the notice of disclaimer must promptly apprise the claimant with a high degree of specificity of the ground or grounds on which the disclaimer is predicated. Absent such*

specific notice, a claimant might have difficulty assessing whether the insurer will be able to disclaim successfully. This uncertainty could prejudice the claimant's ability to ultimately obtain recovery. In addition, the insurer's responsibility to furnish notice of the specific ground on which the disclaimer is based is not unduly burdensome, the insurer being highly experienced and sophisticated in such matters." [Emphasis added.]

I do find that the denial in this case meets the test articulated in Cirucci: the claim was denied based upon the grounds of lack of medical necessity after a medical examination, and the denial clearly apprises the Applicant that the insurance carrier denied the claim asserting that, the fees were in excess of the fee schedule. I do not find that the language of the denial "could prejudice the claimant's ability to ultimately obtain recovery."

Respondent also "checked off" boxes 18, 19, 21 and 22 on the denial of claim form, indicating that the fees were in excess of the fee schedule; Excessive treatment, service or hospitalization; Unnecessary treatment service or hospitalization from 03/28/2012 through 03/28/2012; See other explained below. I deem the denial sufficient and find that the Respondent has preserved its defenses.

Respondent cited to Quality Psychological Services PC v. Avis Rent-A-Car Systems, LLC, 47 Misc.3d 129(A) (App Term, 2d Dept, 2015) in support of its argument that a denial need not identify the dates of an IME no-show to be valid. Specifically, the Court stated:

In this action by a provider to recover assigned first-party no-fault benefits, defendant moved for summary judgment dismissing the complaint and plaintiff cross-moved for summary judgment. The Civil Court denied defendant's motion, finding that defendant's denial of claim form was defective and that it was not attached in full to defendant's motion papers. The court also denied plaintiff's cross motion, finding that plaintiff had failed to attach the denial of claim form to its motion papers and, therefore, had failed to establish that the denial was "vague, conclusory or factually insufficient." Plaintiff appeals from so much of the order as denied its cross motion for summary judgment.

A no-fault plaintiff is only entitled to summary judgment where it demonstrates that defendant failed to timely pay or deny a claim (see Insurance Law § 5106 [a]; Viviane Etienne Med. Care, P.C. v Country-Wide Ins. Co., 114 AD3d 33 [2013]), or that the denial is conclusory, vague or without merit as a matter of law (see Westchester Med. Ctr. v Nationwide Mut. Ins. Co., 78 AD3d 1168 [2010]). Here, plaintiff has not alleged that it did not receive a denial of claim from defendant. Moreover, the denial of claim form attached to defendant's motion papers, which plaintiff argues is fatally defective, states that the claim was being denied because plaintiff's assignor had failed to appear for two properly scheduled examinations under oath. Contrary to plaintiff's argument, the failure to set forth the dates of the scheduled examinations in the denial of claim form did not render the denial conclusory, vague, or without merit as a matter of law (cf. A.B. Med.

Servs., PLLC v Liberty Mut. Ins. Co., 39 AD3d 779 [2007]). Plaintiff's argument that it was entitled to summary judgment because defendant attached an incomplete copy of the denial to its motion papers lacks merit. Consequently, plaintiff's cross motion for summary judgment was properly denied.

Accordingly, the order, insofar as appealed from, is affirmed.

See also Actual Chiropractic, P.C. against Mercury Casualty Company, 2016 NY Slip Op 51435 (U) [53 Misc 3d 135 (A)], Supreme Court, Appellate Term, 2nd Dept., 2d, 11th and 13th Judicial Districts, 9/27/2016, wherein the Court held in pertinent part:

*The proof submitted by defendant established that it had timely mailed both the EUO scheduling letters and the denial of claim forms at issue (see St. Vincent's Hosp. of Richmond v Government Empls. Ins. Co., 50 AD3d 1123[2008]), and that plaintiff's assignor had failed to appear for the duly scheduled EUOs (see Stephen Fogel Psychological, P.C. v Progressive Cas. Ins. Co., 35 AD3d 720[2006]; Ortho Prods. & Equip., Inc. v Interboro Ins. Co., 41 Misc 3d 143[A], 2013 NY Slip Op 52054[U] [App Term, 2d Dept, 2d, 11th & 13th Jud Dists 2013]). We note that, contrary to the conclusion of the Civil Court, "the failure to set forth the dates of the scheduled examinations in the denial of claim form[s] did not render the denial[s] conclusory, vague, or without merit as a matter of law" (Quality Psychological Servs., P.C. v Avis Rent-A-Car Sys., LLC, 47 Misc 3d 129[A], 2015 NY Slip Op 50378[U], *1 [App Term, 2d Dept, 2d, 11th & 13th Jud Dists 2015]).*

I agree with the reasoning set forth by Arbitrator Samiya Mir in *Jamaica Supplies and Progressive Casualty Insurance Company*, AAA Case No.: 17-19-1149-5732:

11 NYCRR § 65-3.8 (h) states, "With respect to a denial of claim (NYS Form NF-10), an insurer's non-substantive technical or immaterial defect or omission shall not affect the validity of a denial of claim. This subdivision shall apply to medical services rendered, and to lost earnings and other reasonable and necessary expenses incurred, on or after April 1, 2013." Id. The Appellate Term in the 2d, 11th, and 13th Districts has held that omission of the no-show dates does not invalidate a denial of claim. The court held such in Quality Psychological Services, P.C. v. Avis Rent-A-Car Systems, LLC, 47 Misc.3d 129(A), 2015 N.Y. Slip Op. 50378(U) (App. Term 2d, 11th & 13th Dists. Mar. 12, 2015), a case in which the denial had stated that the claim was being denied because the assignor had failed to appear for two properly scheduled examinations. See id. The court held that, "the failure to set forth the dates of the scheduled examinations in the denial of claim form did not render the denial conclusory, vague or without merit as a matter of law." Id. See also JYW Medical, P.C. v. IDS Property Ins. Co., 58 Misc.3d 134(A), 2017 N.Y. Slip Op. 51800(U) (App. Term 2d, 11th & 13th Dists. Dec. 19, 2017); AB Med Servs PLLC v. Liberty Mut. Ins. Co., 39 A.D.3d 779 (2007).

Arbitrator Weisman discussed a similar issue in AAA Case No.: 17-17-1055-5998 (affirmed by Master Arbitrator Powers July 25, 2018).

> *Arbitrator Weisman held, "I find that the denial herein meets Respondent's burden as enunciated in Cirucci, Id., as it contains a "high degree of specificity" of the ground on which the disclaimer is predicated. . . In this case, the denial properly informs Applicant that the disclaimer is predicated on its failure to respond to multiple requests for additional verification by failing to appear for an EUO to provide pertinent information that would assist in determining the amounts due and payable." See AAA Case No. 17-17-1055-5998 (Arb. Weisman) (affirmed by Master Arbitrator Powers on July 25, 2018). See also AAA Case No. 17-19-1127-9236.*
> *I agree with Respondent. In the instant case the denial clearly stated that the Assignor failed to appear for 'multiple requests' for medical examinations, which is consistent with the regulations requiring the insurer to provide at least two opportunities for a provider to appear for an IME. I find that, in this case, Applicant was properly informed of the basis for the disclaimer of coverage, and the failure to include the dates of the IMEs was not a material defect. See also Actual Chiropractic v. Mercury Casualty Co., 2016 NY Slip Op, 51435 (U), 2016 WL (App. Term 2d, 11 and 13 Dists, Sept. 27, 2016).*
> *I find that the submissions demonstrate that Respondent properly notified the Assignor of the requests to appear for IMEs and that the Assignor failed to appear. Therefore, having carefully considered the submissions of the parties, the relevant caselaw, Applicant's claim is denied.*

Unitrin Advantage Ins. Co. v All of NY, Inc., 158 AD3d 449 [1st Dept 2018]), is distinguishable from the case at bar. The Appellate Division, First Department states:

> *Although the EUO scheduling letters for the third and fourth dates of medical services, both of which reflected services rendered on May 31, 2013, were timely, the reasons for denial on the NF-10 denial of claim form were stated solely as a failure to appear for an EUO scheduled on July 29, 2013. The second examination date, August 12, 2013, is not mentioned, and therefore did not sufficiently apprise the provider as to the reason for denial (see Nyack Hosp. v State Farm Mut. Auto. Ins. Co., 11 AD3d 664, 664-665 [2d Dept 2004]).*

The Court in this case did not specifically address whether the EUO dates are required to be listed on the denial. Rather the Court determined that Respondent failed to sustain their defense of failure to appear for EUOs as a matter of law as the denial does not state that the claimant failed to appear for two EUOs. To sustain the defense of a breach of a condition precedent, to wit, the failure to appear for an EUO, the insurer must demonstrate as a matter of law that it twice duly demanded an EUO, that the party twice failed to appear, and that the insurer issued a timely denial. Interboro Ins. Co. v. Clennon, 113 A.D.3d 596, 979 N.Y.S.2d 83 (App. Div., 2 Dept, 2014). The denial in the referenced case is premised upon the failure to appear for a single EUO and the insurer therefore failed to demonstrate that the claimant was given two opportunities to attend as

required to establish the defense of EUO no-show as a matter of law, while in this case Respondent's denial indicates that multiple IMEs were scheduled, and the claimant failed to appear.

Respondent has properly preserved its IME no-show defense. The remaining issue is whether the Respondent has established its defense.

Application of Legal Standards

Respondent has come forward with sufficient evidence to demonstrate the mailing of the IME letters and the Assignor's failure to appear for the scheduled IMEs. Specifically, Respondent has submitted IME notices, scheduled for 6/10/2019 and 7/8/2019 with Pierce Ferriter, M.D., properly addressed to the Assignor at the addresses listed on the NF-2 and Assignment of Benefits (AOB) and addressed to the Assignor's attorney. An affidavit of Georgianna Michios, Litigation Manager of Exam Works, Inc., the Respondent's IME scheduling vendor, established mailing of the IME scheduling letters. A presumption of receipt by Assignor of the IME notices exists by virtue of the notices having been properly mailed to the Assignor at his address. An affidavit from Pierce Ferriter, M.D. attested to the failure of Assignor to appear for the IMEs. Respondent's 7/15/2019 general denial and claim specific denials asserted the failure of Assignor to attend multiple IMEs. Respondent argues that all claims are denied retroactively to the date of loss. Applicant did not submit any evidence tending to show that Assignor did not receive the IME notices. Neither did it submit any evidence to show that Assignor did attend the IMEs or that there was a valid reason for not attending the IMEs.

Applicant did not raise any arguments at the hearing regarding the timeliness of the IME scheduling letters. The parties stipulated as to the timeliness of the denials.

The defense of IME no-show is sustained as Respondent's burden of proof has been met. As stated by the court in Unitrin Advantage Insurance Co., v. Bayshore Physical Therapy, P.L.L.C., 82 A.D.3d 559, 918 N.Y.S.2d 473, (1 Dept., 2011), the Assignor's failure to appear for an IME as requested by the insurer "when, and as often as [it] may reasonably require" [*See*, 11 NYCRR Sec. 65-1.1] constitutes a breach of a condition precedent to coverage under the patient's No-Fault policy and therefore fits squarely within the exception to the preclusion rule set forth by the Court of Appeals in Central Gen. Hosp. v. Chubb Group of Ins. Cos., 90 N.Y.2d 195 (1997). As a result, Respondent had a right to deny this claim retroactive to the date of loss. This defense vitiates coverage retroactive to the date of loss. The appearance of an insured at an IME is a condition precedent to coverage, the breach of which voids the policy ab initio. *See*, Fogel, *supra*. Furthermore, an insurer may deny a claim retroactively to the date of loss on the basis of a failure to submit to an IME, regardless of whether its defense is raised in a timely and/or claim-specific denial. *See*, Unitrin Advantage Ins. Co. v. Bayshore Physical Therapy, 82 AD3d 559 (2011).

Based upon the proof presented, I find that Respondent has established by a preponderance of the evidence the failure of the Assignor to appear at two properly

scheduled IMEs and has therefore sustained its defense. The burden has shifted to the Applicant and has not been rebutted. Therefore, I find in favor of the Respondent and the claim is denied.

CONCLUSION

Applicant's claim is denied in its entirety. This decision is in full disposition of all claims for No-Fault benefits presently before this arbitrator.

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

04/13/2021
(Dated)

Eileen Hennessy

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:
39545082c57709b68fa36c285e4bc5bc

Electronically Signed

Your name: Eileen Hennessy
Signed on: 04/13/2021