American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Vital Points Acupuncture PC (Applicant)	AAA Case No.	17-18-1108-5595
	Applicant's File No.	None
- and -	Insurer's Claim File No.	60134
	NAIC No.	24309
Hereford Insurance Company (Respondent)		

ARBITRATION AWARD

I, Eva Gaspari, 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: E.I.P and/or J.R.

1. Hearing(s) held on 02/27/2020, 03/25/2021
   Declared closed by the arbitrator on 03/25/2021

   Roman Kulik from Kulik Law Firm, PC participated in person for the Applicant

   Joseph Kuroly from Law Offices of Rubin & Nazarian participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 628.66**, 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 dispute arises from an automobile accident which occurred on April 11, 2016 in which the Assignor (J.R.), a 60-year-old male, was a driver. Following the accident, the Applicant submitted claims for acupuncture totaling $628.66 for dates of service September 27, 2016 through October 17, 2016. At the hearing Respondent interposed the defense that there are outstanding requests for additional verification for Applicant's claims for services. The issue presented for these claims is whether they are ripe for arbitration.

4. Findings, Conclusions, and Basis Therefor

This matter was decided based upon the submissions of the parties as contained in the electronic file maintained by the American Arbitration Association, as well as upon the oral arguments of the parties at the time of the hearing. All documents contained in the ADR folder are hereby incorporated into this hearing and in reaching my findings I have reviewed all relevant exhibits contained in the ADR Center. Only submissions which were uploaded into the ADR Center at the time of the hearing were considered in making the instant determination. As a matter of procedure, this matter was originally scheduled for a hearing on February 27, 2020. At the time of the hearing the matter was continued with the following directives:

> Per the evidence presented at the hearing, Respondent requested a completed NF-9, Denial from the Workers Compensation Board and trip sheets for the claims at issue. On December 22, 2016, February 7, 2017 and March 23, 2017 the Applicant responded stating that they were not in possession of a completed NF-9 or a Denial from the Workers Compensation Board. On November 9, 2016 the Respondent issued a payment to Vital Points Acupuncture for this EIP for earlier dates of service August 23, 2016 through September 2, 2016. This earlier bill had been received by the Respondent on September 20, 2016 and was denied on fee schedule grounds on November 9, 2016. As the partial payment is potentially inconsistent with a position that there was a bona fide coverage issue which required additional verification, but as there are linked awards which directly pertain to this Assignor and Assignee which uphold requests for additional verification, at the arbitrator's discretion, post-hearing evidence is requested in this matter pursuant to 11 NYCRR 4.5(o)(1) and (2) to clarify the issue of whether the Respondent had a bona fide basis for its demands, or if in the alternative Respondent it had determined that No Fault Coverage was available as of the aforementioned November 9, 2016 payment which was made under this policy.
> Respondent is directed to produce an affidavit by a claims supervisor which details the processing of the claim for this EIP in detail which is sufficient to identify the following: 1. The date that the initial notice of claim was received (example NF-2) 2. The date of each request for workers' compensation verification which was made relating to this EIP and to whom each request was made. 3. The responses which were received, including the dates of each response and content of each response. 4. If responsive documents were provided, the Respondent is directed to upload these documents into the record. To that extent, if the Respondent is in possession of a completed questionnaire, NF-9 or letter from the workers' compensation board, they are directed to upload these

> documents into the record. 5. A list of all payments, with dates, of payments which have been made under this claim which relate to this assignor and date of loss.

In response to these directives the Respondent uploaded the affidavit by Carl Periana, which is dated May 27, 2020 and a PIP ledger indicating that payments totaling $8,687.83 have been made under this policy. At oral argument the Respondent argued that the evidence demonstrated outstanding requests for the NF-9 and the Denial from the Workers' Compensation Board. Applicant responds that the Respondent has failed to demonstrate a bona-fide basis for the demands, that the Applicant has responded to the request for additional verification by advising the Respondent that they were not in receipt of the requested items, and that the prior payments demonstrates that there is not a good faith basis for stating that these items are required to process the claim. Finally, citing to A.B. Medical Services, PLLC v. American Transit Insurance Company, 8 Misc.3d 127(A), 2005 N.Y. Slip Op. 50959(U) (App. Term 2nd,11th and 13th Jud.Dists. 2005), Applicant argues that the Respondent has not demonstrated potential merit to its position that the EIP was in the course of his employment. All matters raised on oral argument at the time of the February 27, 2020 hearing as well as the March 25, 2021 hearing have been addressed herein. Any further issues raised in the hearing record are held to be moot and/or waived insofar as not specifically raised at the time of the hearing.

As an initial matter, I find that Applicant has submitted credible evidence to establish a prima facie case of medical necessity. (a medical provider establishes a prima facie showing of their entitlement to judgment as a matter of law by submitting evidentiary proof that the prescribed statutory billing forms had been mailed and received and that payment of no fault benefits was overdue.) *See*, Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept.2004). Particularly, the evidence indicates that the Respondent received the Applicant's claims for services. *See*, Viviane Etienne Med. Care v Country-Wide Ins. Co. 2015 NY Slip Op 04787 (2015). In this matter there are no denials for the subject claims and Respondent has interposed the defense that the claim is not ripe for arbitration because there are outstanding requests for additional verification. Additionally, the defense of fee schedule remains preserved, and accordingly, has been reviewed sua sponte.

FEE SCHEDULE

As part and parcel of the intent of the No Fault Law, services are subject to limitation of charges. In particular, *Insurance Law § 5108 (a)* provides that expenses "shall not exceed the charges permissible under the schedules prepared and established by the chairman of the workers' compensation board..." With respect to charges that are not fixed by the Workers Compensation Fee Schedule, the Superintendent of Insurance is vested with the authority to promulgate rules and regulations with respect to charges for services "including the establishment of schedules for all such services for which schedules have not been prepared and established by the chairman of the workers' compensation board." *See*, Insurance Law § 5108 (b). In the event that there is no fee schedule for a professional health service, then "the permissible charge for such service shall be the prevailing fee in the geographic location of the provider subject to review by the insurer for consistency with charges permissible for similar procedures under schedules already adopted or established by the superintendent." 11 NYCRR §68.5 (b).

In the case of this provider, an acupuncturist, there is no fee schedule which has been adopted or established for services performed by licensed acupuncturists. Therefore, the amount an acupuncturist can charge is governed by 11 NYCRR §68.5 (b). The effect of this regulation, with regard to the issue of acupuncture reimbursement, was clarified with The Office of General Counsel issued the following opinion on January 5, 2004, representing the position of the New York State Insurance Department:

> Since acupuncture services rendered by a licensed acupuncturist are not included under the Worker's Compensation fee schedules and the Superintendent has not adopted an applicable fee schedule for licensed acupuncturists, N.Y. Codes R. & Regs. tit. 11, § 68.5(b) (2003) (Regulation 83) provides:
>
> (b) if the superintendent has not adopted or established a fee schedule applicable to the provider, then the permissible charge for such service shall be the prevailing fee in the geographic location of the provider subject to review by the insurer for consistency with charges permissible for similar procedures under schedules already adopted or established by the superintendent.

The matter of the interplay involved between the prevailing geographic rate and insurer review for similar procedures under already adopted schedules was addressed in the case of Great Wall Acupuncture, PC v. Geico, 16 Misc.3d 23, 2007 NY Slip Op 27164 (App. Term 2nd & 11th Jud. Dists. 2007), in which a licensed acupuncturist billed at the usual and customary rate, and the insurer reimbursed the provider at a rate that was consistent with similar services contained in the chiropractic fee schedule. The insurer maintained

that this was reasonable and appropriate "based upon a comparison of the training and experience of licensed acupuncturists, physicians and chiropractors who perform acupuncture services…" Id. *16 Misc.3d at 28*. The Appellate Term held that the insurer appropriately utilized the chiropractic fee schedule, an existing schedule, in reviewing the charge of services. In so holding the Court not only clarified an insurer's rights when reviewing billing for a service that does not have an existing schedule, but also implicitly held that acupuncturists may bill for services despite the fact that acupuncturists do not have an established fee schedule. I have reviewed the charges in dispute and note that the Respondent has not presented evidence, such as that by a certified fee coder, or other competent evidence, that the charges at issue exceed those authorized by the New York State Workers Compensation Fee Schedule. Nor have they demonstrated that the charges are not in alignment with the holding in Great Wall Acupuncture, PC v. Geico, 16 Misc.3d 23, 842 NYS2d 131 (App. Term 2nd & 11th Jud. Dists. 2007); Great Wall Acupuncture, PC v. Geico, 25 Misc. 3d 138A, 906 NYS2d 772 (App. Term 2d Dept 2009).

ADDITIONAL VERIFICATION

Pursuant to the No-Fault Regulations, 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 claim, 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 (2 Dept. 2014). Pursuant to 11 NYCRR 65-3.5 (p) the insurer's failure to comply with a prescribed time frame does not negate the applicant's obligation to comply with the request. Per 11 NYCRR 65-3.8(l), any deviation in the time for the initial request will reduce the insurer's time to deny to the claim in accordance with the deviation. Where the verification is not complied with within 30 days of the initial request, an insurer must follow up within 10 calendar days after the expiration of that 30-day period. See, 11 NYCRR 65-3.6(b). If there is no response to the second follow-up request for verification, the time in which the insurer must decide whether to pay or deny the claim is indefinitely tolled or in the alternative they may deny the claim based on the failure to respond within 120 days of the initial request pursuant to 11 NYCRR §65-3.5(o).

As to the claim which forms the basis of this arbitration, the record indicates that this claim was received by the Respondent on November 1, 2016. On November 29, 2016,

the Respondent issued a request for additional verification which indicated that the assignor may have been in the course of their employment and requested an NF-9 and denial from Workers Compensation. An applicant in a no-fault matter that receives a request for additional verification is required to respond to the verification request even if such request pertain to information not within its possession. See D & R Medical Supply, Inc. v. American Transit Ins. Co., 2011 NY Slip Op 51727 (App Term 2d Dept. 2011). On December 2, 2016, the Applicant responded, stating that they were not in possession of the requested items, and directed the Respondent to the assignor for these items. On January 4, 2017, the Respondent issued a requested additional verification request to the Applicant, which requested the same items as the November 29, 2016 request. On January 31, 2017, the Respondent wrote to Applicant, acknowledging receipt of their correspondence, and stating that the claim remains delayed for requested verification. The January 31, 2017 correspondence further advised the Applicant that the assignor and his attorney had been notified to submit an NF9, trip sheets and Workers Compensation Board denial. There were ongoing communications between the parties, all of which indicates that the Applicant was not in possession of the requested documents; the Respondent was aware that the Applicant was not in possession of the requested documents; and which indicate that Respondent had requested the outstanding verification directly from the assignor.

Although a "partial" response is insufficient to verify the claim, the insurer has a duty to communicate with the applicant and vice versa. The purpose of the No-Fault statute is to ensure prompt resolution of claims by accident victims. The parties' obligations are centered on good faith and common sense. Any questions concerning a communication should be addressed by further communication, not inaction. Dilon Medical Supply Corp. v. Travelers Ins. Co., 7 Misc.3d 927 (Civ. Ct. Kings Co. 2005). The response to a verification request that is "arguably responsive" places the burden to take further action upon the carrier. All Health Medical Care, P.C. v. GEICO, 2 Misc.3d 907 (NY City Civ Ct. 2004). Moreover, as long as the applicant's documentation is arguably responsive to an insurer's verification request, the insurer must act affirmatively once it receives a response to its verification request. Media Neurology P.C. v. Countrywide, Ins. Co., 21 Misc.3d 1101 (NY City Civ. Ct. 2005).

In reviewing the requests for additional verification which were made regarding this claim, it is evident that the verification requests were made for the specific purpose of assessing whether the assignor was entitled to No-Fault benefits. In fact, the only logical

basis for the demands for a denial from the Workers Compensation Board, NF-9 and trip sheets is to verify whether benefits were properly subject to the jurisdiction of the Workers Compensation Board. Moreover, the correspondences between the parties demonstrate that the Applicant communicated that they were not in the possession of the requested information, placing the onus on the Respondent of seeking the requested information from the assignor.

With concern to the requests which were made to the assignor, the evidence indicates that the Respondent first received notice of this claim on April 18, 2016, at which time it received the assignor's NF-2 application for No-Fault Benefits. The evidence demonstrates that 44 days later, on June 1, 2016, the Respondent issued a request directly to the assignor for a completed NF-9, denial from the Workers Compensation Board, and for a Driver Questionnaire. On June 24, 2016, the assignor's attorney, Mitchell Klafter, advised Respondent that they were representing the assignor. On July 6, 2016, a second request for the NF-9 and Questionnaire was issued directly to the assignor, without a carbon copy to his attorney. On August 30, 2016 the first claim for PIP benefits was paid under the policy. A second payment was made for PIP benefits on September 16, 2016 with additional PIP benefits having been paid on November 7, 2016, November 11, 2016, November 14, 2016. The record further demonstrates that PIP payments were made under this policy on April 18, 2017, October 30, 2017, November 2, 2017, November 10, 2017, November 27, 2017, December 5, 2017; on January 24, 2018, March 12, 2018, May 8, 2018, May 16, 2018, May 31, 2018, June 6, 2018, June 27, 2018, July 17, 2018, July 19, 2018, July 20, 2018, July 27, 2018, August 17, 2018, August 21, 2018, August 29, 2018, August 31, 2018, September 4, 2018, September 11, 2018, September 26, 2018, October 3, 2018, October 11, 2018, October 22, 2018, November 14, 2018, November 15, 2018, November 27, 2018, November 28, 2018, January 22, 2019, December 5, 2018, December 14, 2018, December 19, 2018; January 24, 2019, January 25, 2019, February 4, 2019, February 27, 2019, March 18, 2019, March 20, 2019, March 29, 2019, December 11, 2019; and most recently on March 11, 2020.

Respondent has demonstrated that it requested this information from the assignor, however the first request for this information was not made until 44 days after receipt of the completed NF-2. The No-Fault Regulations provide for the following claim procedure: 11 NYCRR 65-3.5 (a) "within 10 business days after receipt of the completed application for motor vehicle no- fault benefits (NYS form NF-2) or other

substantially equivalent written notice, the insurer shall forward, to the parties required to complete them, those prescribed verification forms it will require prior to payment of the initial claim." It further provides, in relevant part (b) "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." Accordingly, the requests for additional verification were not timely requested of the Applicant.

In the case of this arbitration, the Respondent has not demonstrated that it had a bona fide basis for the requested verification, as they have not produced evidence of a reasonable basis for their demand despite being provided additional time post-hearing to do so. Nor have they show that there was good reason to continue to withhold payment to this Applicant. See, A.B. Medical Services, PLLC v. American Transit Insurance Company, 8 Misc.3d 127(A), 2005 N.Y. Slip Op. 50959(U) (App. Term 2nd,11th and 13th Jud.Dists. 2005) (If the insurer's contention that the Assignor acted in the course of his employment at the time of the accident is "mere speculation" that fails to establish that the defense's "potential merit" the issue need not be resolved by the Board.)

The only rational basis for a claim that verification is outstanding is that the information was necessary to verify whether no-fault coverage was primary. However, in the case of this claim, shortly after requesting information for the purposes of confirming coverage, the Respondent began voluntarily paying No-Fault benefits under the policy. The evidence demonstrates that these payments were continually made to various medical providers throughout the years 2016 through 2020. Notably, the last correspondence that was made directly to the assignor which requested verification relating to potential workers compensation coverage was made on July 6, 2016. Shortly thereafter, on August 30, 2016, the first claim for PIP benefits was voluntarily made under the policy. These payments were continually made to various medical providers who were treating the assignor. Moreover, the evidence presented includes a denial of benefits and explanation of benefits which was made to this applicant for other claims relating to this assignor. This NF-10 denial of claim form indicates that a portion of health service benefits has been paid, and a portion denied based exclusively on a fee schedule defense.

Based on these facts, I find that the Respondent has indicated a waiver of its jurisdictional defenses. To that extent, there has been no evidence presented which

supports a good faith basis for a claim that benefits should be pursued through the Workers' Compensation Board. Furthermore, these payments began shortly after the requests for verification were issued, and reasonably indicate that the Respondent had made a coverage determination. Absent a continuing need to verify coverage, the Respondent has not demonstrated that they had a valid basis for the requested verification. Under these circumstances it would be reasonable for the assignor to conclude that the insurer was no longer in need of verification pertaining to coverage. It would also be reasonable to conclude that the insurer had concluded their investigation and confirmed that benefits were available to the assignor under their personal injury protection policy. To that extent, the payment register indicates that these payments were made under the assignor's Personal Injury Protection policy. Simply stated, the evidence indicates that the Respondent requested verification from the Applicant for the basis of verifying whether no-fault or workers compensation was primary for coverage. Applicant responded to this demand, promptly notifying the Respondent that they were not in possession of the requested information. The Respondent requested the information directly from the assignor. A month later the Respondent began issuing payments under the PIP policy and thereafter, continually made payments under the PIP policy. The reasonable inference which can be drawn from these facts is that the Respondent verified that coverage was available under this no-fault policy.

It is notable that 11 NYCRR 65-3.2 provides for the "Claim practice principles to be followed by all insurers", which set forth the following: "(a) Have as your basic goal the prompt and fair payment to all automobile accident victims; (b) Assist the applicant in the processing of a claim. Do not treat the applicant as an adversary; (c) Do not demand verification of facts unless there are good reasons to do so. When verification of facts is necessary, it should be done as expeditiously as possible; (d) Hasten the processing of a claim through the use of a telephone whenever it is possible to do so; (e) Clearly inform the applicant of the insurer's position regarding any disputed matter; (f) Respond promptly, when a response is indicated, to all communications from insureds, applicants, attorneys and any other interested persons." In light of these "claim practice principles", and based on the facts presented, I find as a matter of fact that the Respondent has failed to demonstrate a bona fide basis for its defense that this claim is premature or that there are outstanding requests for additional verification. Accordingly, Applicant's claim is granted.

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**
	Vital Points Acupuncture PC	**09/27/16 - 10/17/16**	**$628.66**	**Awarded: $628.66**
Total			**$628.66**	**Awarded: $628.66**

B. The insurer shall also compute and pay the applicant interest set forth below. 10/19/2018 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

   In the instant matter Applicant is awarded interest pursuant to the no-fault regulations. 11 NYCRR 65-3.9 (a) provides that Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30 day month." Pursuant to 11 NYCRR 65-3.9 (c) provides that "if 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 Department of Financial Services regulations, interest shall not

accumulate on the disputed claim or element of claim until such action is taken." In the matter of LMK Psychological Servs. PC v. State Farm Mut. Auto. Ins. Co., 12 NY 3d. 217 (2009), the court addressed the issue of interest and found that pursuant to 11 NYCRR §65-3.9(c) interest shall be tolled upon the issuance of a denial whether it is timely or not when an applicant does not request arbitration or institute a lawsuit within thirty days after receipt of a denial form or payment of benefits calculated pursuant to Insurance Department regulations. It appears the intent of 65-3.9(c) was to start interest on the date of the request. Therefore, pursuant to N.Y. Comp. Codes R. & Regs. tit. 11, § 65-3.9 (2002), "Interest on overdue payments," the Respondent shall pay interest to the Applicant on the awarded overdue PIP benefit at a rate of two percent (2%) per month calculated on a pro rata basis using a thirty (30) day month, starting 10/19/18.

C. Attorney's Fees

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

As this matter was filed 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 the attorney's fee, in accordance with the newly promulgated 11 NYCRR 65-4.6(d).

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

04/15/2021
(Dated)

Eva Gaspari

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:
6f544eb83c47daf931b60afdee92833c

Electronically Signed

Your name: Eva Gaspari
Signed on: 04/15/2021