American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Olga Gibbons d/b/a Astro Medical Services (Applicant)	AAA Case No.	17-20-1156-3336
	Applicant's File No.	ASCF302.06,07
- and -	Insurer's Claim File No.	84636
	NAIC No.	24309
Hereford Insurance Company (Respondent)		

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 ["PO"]

1. Hearing(s) held on 04/30/2021
   Declared closed by the arbitrator on 04/30/2021

   Michael Lamond, Esq., from Akiva Ofshtein P.C. participated for the Applicant

   Rosemary Repetto, Esq., from Law Offices of Rubin & Nazarian participated for the Respondent

2. The amount claimed in the Arbitration Request, **$ 3,364.02**, 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 manipulation under anesthesia (MUA) performed on Assignor.
   - Whether this arbitration is premature due to unprovided verification.

4. Findings, Conclusions, and Basis Therefor

   Appearances

For Applicant:

Akiva Ofshtein P.C.
P.O. Box 090382
Brooklyn, NY 11209
By: Michael Lamond, Esq.

For Respondent:

Law Offices of Rubin & Nazarian
36-01 43rd Avenue
Long Island City, NY 11101
By: Rosemary Repetto, Esq.

Applicant commenced this New York No-Fault insurance arbitration, seeking as compensation $3,364.02 for medical services provided on July 26, 2019, to Assignor, a 28-year-old male who was injured in a motor vehicle accident on June 1, 2019. In dispute are two bills for manipulation under anesthesia (MUA) in the amounts of $2,691.22 and $672.80. Respondent neither denied the bills nor made payment. Rather, Respondent contends that this arbitration is premature due to unprovided additional verification which it requested.

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). "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). Respondent's verification requests acknowledged

receipt of Applicant's proofs of claim; Respondent conceded that the bills were not paid. Hence, I find that Applicant established a prima facie case of entitlement to No-Fault compensation.

"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 requests and follow-up requests for verification to Applicant; Applicant conceded such. Respondent's additional verification requests were dated Oct. 2, 2019 and Nov. 6, 2019. Applicant responded by faxes dated Oct. 15, 2019; Oct. 30, 2019; and Dec. 23, 2019.

Respondent sought:

- Please submit a fully executed procedural consent form.
- Please submit a fully executed anesthesia consent form.
- Please submit all treatment notes documenting the claimant progress with conservative treatment.
- Please provide the MRI report of left shoulder, pelvis and left hip.
- Please provide the MRI film/CD of cervical, lumbar spine, left shoulder, pelvis and left hip.
- Please note CPT code 27194 is described as "closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation with manipulation, requiring more than local anesthesia" according to NYS Worker's Compensation. Please all documentation including radiographic images showing any fractures(s) or dislocation(s) of the pelvic ring.
- Please submit licensing, credentials and certification of the physicians to perform services.
- Based on Ground rule 12C of the NYS Worker's Compensation Fee Schedule for two Surgeons - Please provide a copy of your prorated agreement.
- Further pending Trip Sheets, and Worker's Compensation Board denial/determination on coverage from claimant/attorney as our findings reveals the claimant may have been working on the date of loss.

Following Applicant's responses, Respondent sent it a letter dated Jan. 10, 2020, listing what it claimed remained outstanding. Per Respondent's last letter, the following remained outstanding:

·A fully executed anesthesia consent form.

·Treatment notes documenting the claimant's progress with conservative treatment.

·MRI report of left shoulder, Pelvis, and hip.

· MRI CD of Cervical, lumbar spine, Left shoulder, pelvis and left hip.

· CPT code 27194 is described as "closed treatment of Pelvic ring fracture, dislocation, diastasis or subluxation with manipulation, requiring more than local anesthesia" according to NYS Worker's Compensation, provide all documents including radiographic images showing any fracture(s) or dislocation(s) of the pelvic ring.

· A copy of prorated agreement.

· Trip sheets and Workers' Comp board denial/determination on coverage.

The dispute in this arbitration concerns whether what Applicant provided as responses discharged its obligations, triggering the 30-day period for Respondent to pay or deny. With respect the foregoing items Respondent claimed were not provided, Applicant's fax responses asserted as follows in sum and substance:

· A fully executed anesthesia consent form:

Attached are consent forms. We object to this request as an improper delay tactic. All documents relevant to the services rendered were sent with the initial bill submissions. We are providing all medical reports in our possession.

· Treatment notes documenting the claimant's progress with conservative treatment:

Attached are follow-up examination reports. We object to this request as an improper delay tactic. All documents relevant to the services rendered were sent with the initial bill submissions. We are providing all medical reports in our possession.

· MRI report of left shoulder, Pelvis, and hip:

Attached are MRI reports for the cervical spine and lumbar spine. We object to this request as an improper delay tactic. The requested reports must be requested directly from the facility where the MRI was performed.

· MRI CD of Cervical, lumbar spine, Left shoulder, pelvis and left hip:

Attached are MRI reports for the cervical spine and lumbar spine. We object to this request as an improper delay tactic. The requested reports must be requested directly from the facility where the MRI was performed.

· CPT code 27194 is described as "closed treatment of Pelvic ring fracture, dislocation, diastasis or subluxation with manipulation, requiring more than local anesthesia" according to NYS Worker's Compensation, provide all documents including radiographic images showing any fracture(s) or dislocation(s) of the pelvic ring:

We are not in possession. We provided relevant medical records. We object to this request as an improper delay tactic.

·A copy of prorated agreement:

Not mentioned in Applicant's fax responses.

·Trip sheets and Workers' Comp board denial/determination on coverage:

Not mentioned in Applicant's fax responses.

The Dec. 23, 2019 fax response contained the following additional paragraph: "The provider objects to this verification request as being abusive and nonspecific to the medical necessity to evaluate the claim. The adjuster is not medically qualified to request additional information for medical necessity. We challenge the handling of this claim as excessive and abused and in excess of quick resolution of claim."

I find that the fax responses fail to meet Applicant's burden of proof of having provided the requested items per Proscan Imaging, P.C. Based on cited case law, I find that the respective items in Respondent's verification requests were 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. If MUA of the pelvis is performed, an insurer is entitled to documents including radiographic images showing any fractures or dislocations of the pelvic ring. It is entitled to MRI reports of all body parts on which MUA was performed. MUA should not be performed unless prior treatment has not been successful; requesting treatment notes is eminently reasonable. In terms of items which Applicant did not possess, it did not advise the insurer of the name and address from whom to obtain them. D & R Medical Supply v. American Transit Ins. Co., supra. Applicant did not even refer to certain requested items in its fax responses.

I note further that Respondent did send copies of its correspondence to Assignor and other medical providers in an attempt to secure the requested items. It did not receive all that it sought from anyone. It is entitled to complete compliance with its requests per the case law cited above; a partial response is insufficient.

Applicant argued at the hearing, "It is not our obligation to go to others to obtain information." This position is inconsistent with "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). An insurer can seek the information either from the applicant or another entity. To expedite the processing of a bill, a medical provider should communicate the name and address of who can provide it,

assuming it is not in possession of it. D & R Medical Supply v. American Transit Ins. Co., supra. However, ultimately, if the insurer does not receive what it sought, it is not required to pay the claim; this is in accordance with the No-Fault Regulations; this is especially true where, as here, Respondent attempted to obtain the information from various sources. Respondent's requests were neither excessive nor abusive.

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 and must be dismissed without prejudice.

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.

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Please note that the Modria template for New York No-Fault arbitration awards contains an unalterable preprinted entry below for the State of New York, County of _____ as the location where the award was executed. This award was executed in the State of Florida, County of Palm Beach.

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 DISMISSED without prejudice

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of New York
SS :
County of State of Florida, County of Palm Beach

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.

05/02/2021
(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

Document Name: Final Award Form
Unique Modria Document ID:
4a9c11e744fc351757de658041d85ca5

Electronically Signed

Your name: Aaron Maslow
Signed on: 05/02/2021