

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Birch Medical & Diagnostic, PC
(Applicant)

- and -

American Transit Insurance Company
(Respondent)

AAA Case No. 17-19-1140-5054

Applicant's File No. 19-005250

Insurer's Claim File No. 1057465-01

NAIC No. 16616

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-W.C.

1. Hearing(s) held on 07/26/2021, 07/27/2021
Declared closed by the arbitrator on 07/26/2021

Jeanine Oberster from The Licatesi Law Group, LLP participated in person for the Applicant

Helen Cohen from American Transit Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 1,837.92**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant amended the amount in dispute from the original amount of \$1,837.92 to \$1,283.43.

Stipulations WERE made by the parties regarding the issues to be determined.

The parties stipulated and agreed that the amounts claimed do not exceed the maximum permissible charges under the fee schedule applicable to the disputed services.

3. Summary of Issues in Dispute

The record reveals that the Assignor-W.C., a 55-year-old male, claimed injuries as the driver of a motor vehicle involved in an accident that occurred on 5/5/2019. Applicant seeks reimbursement for an office visit, outcome assessment testing, bilateral lumbar trigger point injections (TPI) under ultrasound, and injectable medication conducted on 6/20/2019, which were denied based on the claimant was in the course of his employment at the time of the accident and Worker's Compensation benefits are primary. The issues to be determined are 1) whether Respondent may issue verification requests subsequent to issuance of a valid NF-10 and, if so, 2) whether the claim is premature based on outstanding verification?

4. Findings, Conclusions, and Basis Therefor

Applicant seeks reimbursement for an office visit, outcome assessment testing, bilateral lumbar TPI under ultrasound, and injectable medication. This hearing was conducted using the documents contained in the Electronic Case Folder (ECF) for the case 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, which was held via Zoom.

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".

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.

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)...

EUO NO-SHOW

Respondent denied the claims based on the Assignor's failure to appear for two duly scheduled EUOs. Under 11 NYCRR § 65-1.1 which prescribes the No-Fault Mandatory Personal Injury Protection (PIP) Endorsement, which must be included in all owners' policies of motor vehicle liability insurance issued in New York, the "Conditions" section of the endorsement contains a "Proof of Claim" provision, which states that:

...Upon request by the Company, the eligible injured person or that person's assignee or representative shall: ...(b) as may reasonably be required submit to examinations under oath by any person named by the Company and subscribe the same...

11 NYCRR § 65-1.1 (Conditions) states "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 appearance of a claimant at an EUO is a condition precedent to the insurer's liability on the policy. Stephen Fogel Psychological PC v. Progressive Insurance Company, 35, A.D.3d 720; 827 N.Y.S.2d 217 (App. Div. 2ndDept. 2006); Crotona Heights Medical, P.C. v. Farm Family Casualty Ins. Co., 27 Misc.3d 134(A), 910 N.Y.S.2d 404 (Table), 2010 N.Y. Slip Op. 50716(U), 2010 WL 1632086 (App. Term 2d, 11th &13th Dists. Apr. 16, 2010). To establish their defense an insurer must present proof that the EUO scheduling letters were mailed and that the Assignor failed to appear. See Fogel, *supra*.

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).

To establish the failure of the party to appear for duly scheduled EUOs, it is incumbent upon the insurer to submit proof by someone with personal knowledge of the non-appearance. Alrof, Inc. v. Safeco Natl. Ins. Co., 39 Misc.3d 130(A), 2013 N.Y. Slip Op. 50458(U)(App Term, 2 , 11 and 13 Jud. Dists., 2013).

Pursuant to NYCRR §65-3.5, however, it is additionally incumbent upon Respondent to have a good faith basis to request an EUO of a provider with "specific objective justification" to support the use of such examination. See Gegerson v. State Farm Insurance Co., 27 Misc.3d 1207(A), Slip Copy, 2010 WL 1428050 (Table) N.Y. Dist. Ct., 2010, wherein the court held that before an EUO default may be found, the insurer must establish its "specific objective justification supporting the use of such examination." The court in Gegerson cited two other cases in support of its holding: Progressive Northeastern Insurance Co. v. Arguelles Med. P.C., 2009 N.Y. Slip Op 32353 (Sup Ct. N.Y. Co.); and Westchester Medical Center v. GEICO, 2009 N.Y. Slip Op 30914 (Sup Ct. Nassau Co.)

The Regulations require the Respondent to have a good faith basis, but the Regulations do not require the Respondent to share that with the claimant. 11 NYCRR 65-3.5(e); Ins. Dept. Opinion Letters (10/15/02 and 10/22/06).

Analysis

Applicant billed for an office visit, outcome assessment testing, bilateral lumbar TPI under ultrasound, and injectable medication (\$1,283.43) provided on 6/20/2019. Respondent indicates that the claim is premature and should be dismissed without prejudice as Applicant filed for arbitration during the pendency of the Respondent's verification requests.

Respondent originally denied the claim for date of service 6/20/2019, stating, "Claimant is eligible for Worker's Comp, as Claimant was in the course of employment. As a result this claim must be submitted to the Employer's Worker's Compensation Carrier" and "Fees not in accordance with Fee Schedule".

In the linked case of *YBD Universal Corp. v. ATIC*, AAA Case No.: 17-19-1143-2998, involving Assignor-W.C., Respondent withdrew their Worker's Compensation defense premised on the decision they submitted to the record. Specifically, in *State of New York - Workers' Compensation Board In regard to [Assignor-W.C.]*, WCB Case #G247 8025, the Board determined "At the Workers' Compensation hearing held on 09/06/2019 involving the claim of [Assignor-W.C.] at the Manhattan hearing location, Judge Barry Hermelee made the following decision, findings and directions: DECISION: Claim is disallowed. Form(s) C-8.1 which raised issues relating to treatment and/or related medical bills are resolved in favor of the carrier. The claimant was not involved in a

'covered service' & was not within the scope and/or course of his employment at the time of the subject accident. The case is closed". Respondent submitted a copy of that decision to the ECF in this case.

In this case, following receipt of the WCB decision on 9/16/2019, Respondent issued a verification request to Applicant, dated 10/3/2019, and scheduled the claimant's Examination under Oath ("EUO") for 12/4/2019, via correspondence, dated 10/3/2019. The verification request stated, in pertinent part:

We received your bill. The following additional verification is required in order to properly respond to your bill pursuant to 11NYCRR 65:15(d). Please Provide this in writing.

- 1 Please be advised the entire claim is delayed pending an examination under oath of the claimant, scheduled to verify the claim.
- 2 Please submit all other diagnostic test performed by your facility that are related to the accident of record, please include reports, copies of any recorded images and letter of medical necessity from the referring/treating physician to show causal relationship to the accident of record.
- 3 Please submit the letter of necessity for trigger point injections that the claimant has been referred for, and the number of times the claimant should continue to receiving treatment in order to reach the maximum benefit, and to show the causal relation to the accident of record.

The letters were carbon copied (CC'd) to the Assignor and his attorney, Law Office of Evans D. Prieston, P.C., as confirmed by the Letter of Representation in the record, dated 5/8/2019.

On each verification request Respondent advised Applicant of the following: As per Regulation 68 Section 65-3.5(o), the insurer may deny a claim if an applicant does not provide within 120 calendar days from the date of the initial request all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply. This 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.

Respondent submits the affidavit of Jinye Zhu, Respondent's claim examiner, dated 10/17/2019, which outlined the Respondent's office procedure for issuing verification requests and denials. Respondent also submits the affidavit of Luis Campbell, Respondent's mail room supervisor, dated 10/17/2019, which provides the Respondent's mailing procedure for verification requests and denials and attests that the mailing procedure was followed in this case. Ms. Zhu states, in pertinent part:

1. On 07/12/2019, American Transit received a claim in the amount of \$1,837.92 for services the applicant allegedly provided to the claimant 06/20/2019. The claim was timely denied on 07/23/2019 based on the claimant's eligibility for Workers' Compensation and based on fees not in accordance with fee schedules.

2. On 09/16/2019, American Transit received a Notice of Decision from the Workers' Compensation board stating that the claim is disallowed. Within 15 business days of the worker's compensation decision, on 10/03/2019, I sent a request for additional verification to the applicant, claimant, and claimant's attorney advising and requesting the following: Please be advised the entire claim is delayed pending an examination under oath of the claimant, scheduled to verify the claim. Please submit all other diagnostic tests performed by your facility that are related to the accident of record; please include reports, copies of any recorded images and letter of medical necessity from the referring/treating physician to show causal relationship to the accident of record. Please submit the letter of medical necessity for trigger point injections that the claimant has been referred for, and the number of times the claimant should continue to receive treatment in order to reach the maximum benefit, and to show the causal relation to the accident of record.
3. Please be advised, an Examination Under Oath appointment letter was sent to the claimant and the claimant's attorney on 10/03/2019, scheduling the appointment for 12/04/2019. To date, the requested verification remains outstanding, and therefore, the arbitration matter is premature.

Respondent argues that Applicant prematurely filed the instant arbitration claim on 9/5/2019, prior to Respondent's receipt of the WCB decision and issuance of Respondent's verification request, dated 10/3/2019. There is no indication in the record of whether Applicant responded to the verification request or whether the claimant appeared for the EUO, as the information was not available at the time of the American Arbitration Association's ("AAA") deadline for Respondent's defense position for this arbitration.

There is no dispute that the no-fault law applies to this case based on the determination by the WCB, i.e., *State of New York - Workers' Compensation Board In regard to [Assignor-W.C.]*, WCB Case #G247 8025, that the claimant is not eligible for WC.

Untimely Verification Request

The No-Fault law requires a carrier to either pay or deny a claim for No-Fault benefits within thirty (30) days from the date an applicant supplies proof of claim. *See*, Insurance Law §5106 (a) and 11 NYCRR 65-3.8. The 30-day period in which to either pay or deny a claim is extended where the insurer makes a request for additional verification within the requisite 15-[business] daytime period (*see Montefiore Med. Ctr. v Government Empls. Ins. Co.*, 34 AD3d 771; *New York & Presbyt. Hosp. v. Allstate Ins. Co.*, 31 AD3d 512). *Kingsbrook Jewish Medical Center v. Allstate Insurance Co.*, 61 A.D.3d 13, 17-18, 871 N.Y.S.2d 680, 683 (2d Dept. 2009). "If the requested verification is not

received within 30 days, the insurer must send a follow-up letter within 10 days thereafter (see 11 NYCRR 65.15[e][2])." New York & Presbyterian Hospital v. American Transit Insurance Co., 287 A.D.2d 699, 700, 733 N.Y.S.2d 80, 81-82 (2d Dept. 2001).

Arbitrator Giovanna Tuttolomondo addressed this issue in a well-reasoned decision, *Concourse Chiropractic and ATIC*, AAA Case No.: 17-20-1164-5954, heard on 6/17/2021. I concur with the decision, which stated in pertinent part:

Respondent initially issued NF-10s, confidently asserting that the Assignor was eligible for Workers' Compensation. Respondent proffers no statute or case law in support of its assertion that it can reinvent the claims process and issue a request for verification after denying the claim.

As the Court held in All-County Medical & Diagnostic P.C. v. Progressive Cas. Ins. Co., [Dist. Ct. Nassau 2005], an insurer is "limited to the defenses that were specifically raised in the NF-10. The four corners of the Denial of Claim form, the NF-10, and defenses there stated with a high degree of specificity."

I further find guidance in the Decision of my colleague, Arbitrator Yael Aspir, who decided a similar issue as that presented herein. In AAA Case Number 17-16-1043-0833, Arbitrator Aspir stated, in most pertinent part:

"In dispute are the Applicant's claims for \$3,186.44, for medical supplies provided to the EIP on 09/22/15 through 10/22/15. Respondent timely denied the claim based on the EIP's eligibility for Workers' Comp. Thereafter, when the WC claim was denied, Respondent issued Verification Requests for the bills in dispute. The issue to be determined is whether Respondent is entitled to issue Verification Requests subsequent to issuance of a valid NF-10."

-and-

"This claim presents an issue of first impression. Specifically, after issuing a timely NF-10 based on a referral to Workers' Comp, does the ultimate denial by the WC Board "re-start Respondent's clock" to pay or deny the claim?"

At the hearing, counsel for Respondent presented arguments that the initial NF-10 was essentially invalidated by the WC Board's decision, affording Respondent the opportunity to start the claims process anew. He argues that on 03/11/16, when Respondent received notice that WC had denied the claim, it triggered a new time clock, affording Respondent the opportunity to request verification, pay or deny the claim. As verification requests were timely issued on 04/07/16 and 05/12/16, and the requested information has not yet been received, Respondent's position is that the claim is not ripe for arbitration and should be dismissed without prejudice.

Conversely, Applicant argues that a valid and timely denial was issued, and that the law does not allow for respondent to "rescind" their NF-10 in exchange for another bite of the apple. Therefore, the verification requests issued were untimely, and he argues that the claim is due and owing.

Respondent, upon receipt of the first bill submission, made a choice to deny the claim based on the EIP's eligibility for Workers' Comp benefits. That is their chosen defense, and therefore, they "stand or fall" upon it. They cannot now change the basis of their denial, and choose to go down the path of verification requests instead, due to an unfavorable outcome."

I agree with find, for the reasons expressed above, that Respondent is bound by its initial NF-10s. The basis for the initial NF-10 [Workers' Compensation] ultimately proved to be improper and/or unsubstantiated; Respondent had no basis in fact or law to issue a second NF-10. In turn, a defense based on a policy violation, since it was not raised in a timely NF-10, cannot stand.

In *CPM Medical Supply Inc and American Transit Insurance Company*, AAA Case No.: 17-19-1138-5819, heard on 5/11/2021, Arbitrator Gregory Watford stated in pertinent part:

A review of the ECF revealed that Respondent provided a copy of the 6/11/19 verification request which stated that the bill was delayed pending the EUO of Assignor based upon the correspondence received from the WCB. It should be noted that there are also EUO scheduling letters dated 6/7/19 for an EUO scheduled for 8/5/19, 7/22/19 for an EUO scheduled for 10/16/19 and a 7/23/19 letter for an EUO scheduled for 9/16/19.

It should further be noted that there are no documents in the ECF identifying the additional verification information that was received on 6/13/19. Moreover, as per the EUO scheduling letters, it is clear that the EUO did not occur on 6/13/19.

Moreover, it appears that after receipt of the WCB Notice of Decision, Respondent abandoned its initial theory of defense and now asserted the defense of medical necessity. Respondent did not provide any authority in the form of reference to a provision in the no-fault regulations, awards or caselaw to support the change of defense under these facts.

I find that Respondent's second denial asserting the defense of medical necessity is untimely. Full Spine Chiropractic of N.Y. v. American Transit, 17-17-1058-2829, Arbitrator Nada Saxon, dated 6/6/18; Haar Orthopedics & Sports Medicine v. American Transit, 17-16-1037-8930 Arbitrator Corrine Pascariu, dated 11/3/17; Action Open MRI v. American Transit, 17-17-1054-1057, Arbitrator Pauline Molesso, dated 5/2/18.

Arbitrator Pascariu, when confronted with the issue whether Respondent can overturn a timely denial and later issue a new one on a new basis reasoned:

"Respondent now argues that their 30-day period to pay or deny the claim did not begin to run until Arbitrator Entin issued what they assert is a final disposition regarding the Workers' Compensation defense. I disagree. This argument is similar to one previously made by MVIAC. They argued that their time to pay or deny a claim did not begin to run until a person was deemed qualified. However, in New York Hospital Medical Center of Queens v. Motor Vehicle Accident Indemnification Corp., 12 A.D.3d 429, 784 (2d Dept. 2004), the second department disagreed with this line of reasoning and found that "The 30-day deadline for paying or denying a claim does not begin when MVAIC has "qualified" an injured party inasmuch as the 30-day deadline applies likewise to MVAIC as it does to any insurer subject to Insurance Law article 51." New York Hospital Medical Center of Queens v. Motor Vehicle Accident Indemnification Corp., 12 A.D.3d 429, 784 N.Y.S.2d 593 (2d Dept. 2004). This decision was echoed by the courts in A.B. Medical Services, PLLC v. Motor Vehicle Accident Indemnification Corp., 6 Misc.3d 131(A), 800 N.Y.S.2d 341 (Table), 2005 N.Y. Slip Op. 50088(U), 2005 WL 263757 (App. Term 2d & 11th Dists. Feb. 1, 2005), "30-day time requirement, applicable to Motor Vehicle Accident Indemnification Corp., begins to run after proof of claim is received and not after it has "qualified" an eligible insured" and in Daily Medical Equipment Distribution Center, Inc. v. MVAIC, 53 Misc.3d 148(A), 2016 N.Y. Slip Op. 51622(U) (App. Term 2d, 11th & 13th Dists. Nov. 1, 2016), "The 30-day claim determination period does not begin to run after MVAIC is satisfied that a claimant is a qualified person who is also a covered person; defenses which are subject to preclusion remain subject to the time frames set forth in the No-Fault Regulations." I extend this line of reasoning to the instant matter and find that the 30-day period to pay or deny a claim does not begin to run after Workers' Compensation Board issues their final determination. The determination by the Board neither extends Respondent's time to deny a claim nor does it allow a Respondent to retract a denial and assert a new one. Thus, Respondent's time to deny the claim expired 30 days after they received the proof of claim. The fact that they rescinded one denial based upon Arbitrator Entin's decision is irrelevant. (See AAA Case no. 17-16-1037-8930 Dated 11/3/17)"

Arbitrators Saxon and Molesso cited to Arbitrator Pascariu's award and reasoning when addressing a similar issue in their awards. I am persuaded by the awards and the reasoning of my fellow arbitrators on this issue and agree with Applicant's argument.

When an insurance company fails to comply with its duty to act expeditiously in processing no-fault claims, it will be precluded from raising

*most defenses. see, e.g., Presbyterian Hospital in City of N.Y. v. Maryland Casualty Co., 226 A.D.2d 613, 641 N.Y.S.2d 395. This is because the very purpose of the no-fault law was to ensure the "swift reimbursement of accident victims * * * who had serious injuries". Pavone v. Aetna Cas. & Sur. Co., 91 Misc.2d 658, 663, 398 N.Y.S.2d 630), with "as little litigation as possible". Matter of Furstenburg (Aetna Cas. & Sur. Co.), 67 A.D.2d 580, 583, 415 N.Y.S.2d 849, rev'd on other grounds 49 N.Y.2d 757, 426 N.Y.S.2d 465, 403 N.E.2d 170)." Presbyterian Hospital v. Aetna Casualty & Surety Co., 233 A.D.2d 431, 432, 650 N.Y.S.2d 255, 257 (2d Dept. 1996).*

I also find that Respondent should have preserved all defenses in its initial denial including medical necessity which is a precludable defense. However, it failed to do so. Consequently, the defense of medical necessity asserted in the untimely denial is precluded.

Accordingly, Applicant is entitled to be reimbursed as billed.

Master Arbitrator Victor Hershdorfer has held that it is not arbitrary or capricious for an arbitrator to rely upon a determination of the WC Board. *See*, AAA Case Number 99-15-1018-2414.

As per the ECF, Respondent received the bill in dispute on 7/12/2019 and denied the same on 7/23/2019 based upon the WCB defense and the fee schedule. After receiving the above-referenced Notice of Decision from the WCB, Respondent issued a verification request and EUO scheduling letter, both dated 10/3/2019, whereby it requested additional documents regarding the claim as well as the claimant's EUO. Similar to AAA Case No.:17-16-1043-0833, at the hearing, counsel for Respondent presented arguments that the initial NF-10 was essentially invalidated by the WCB's decision, affording Respondent the opportunity to start the claims process anew. On 9/16/2019, when Respondent received notice that the WCB had denied the claim, it triggered a new claims process, affording Respondent the opportunity to request verification, pay or deny the claim. As a verification request was timely issued on 10/3/2019, and the arbitration was filed prior to the issuance of the second request or receipt of the requested information, Respondent's position is that the claim is not ripe for arbitration and should be dismissed without prejudice.

Moreover, similar to AAA Case No.:17-16-1043-0833, Applicant argues that a valid and timely denial was issued, and that the law does not allow for Respondent to "rescind" their NF-10 in exchange for another bite of the apple. Therefore, the verification request issued was untimely, and the claim is due and owing.

Specifically, Applicant argued that the verification request is untimely in that, as per the denial, the bill was received by Respondent on 7/12/2019 and the verification request was not issued until 10/3/2019, after the claim was denied based on eligibility for WC on 7/23/2019. Applicant further argues they are not required to respond to verification requests after the carrier has advised that the claim is denied.

Furthermore, Applicant asserted that Respondent's premature defense cannot be sustained as the initial EUO was not scheduled within 30 days of receipt of the claim as required by 11 NYCRR Section 65-3.5(b).

It appears that after receipt of the WCB Notice of Decision, Respondent abandoned its initial theory of defense and now asserted the defense that the claim was premature as a verification request and EUO were pending.

I agree with Arbitrator Watford's analysis in AAA Case No.: 17-19-1138-5819 and find that Respondent's verification request is untimely. Full Spine Chiropractic of N.Y. v. American Transit, 17-17-1058-2829, Arbitrator Nada Saxon, dated 6/6/18; Haar Orthopedics & Sports Medicine v. American Transit, 17-16-1037-8930 Arbitrator Corrine Pascariu, dated 11/3/17; Action Open MRI v. American Transit, 17-17-1054-1057, Arbitrator Pauline Molesso, dated 5/2/18.

Furthermore, I find that the EUO scheduling letter was untimely and did not toll the Respondent's time to pay or deny the claim or seek further verification as the initial EUO was not requested within 15 days of receipt of the bill or within 30 days of the claim's determination period. Respondent received said claim on 7/12/2019 and did not issue the first scheduling letter until 10/3/2019, and that the Respondent's proof would be insufficient to sustain its defense of lack of coverage based on the Assignor's failure to appear for the scheduled EUO.

Although Respondent's attorney argued that processing of the bill had been properly tolled by the WCB while considering the Assignor's claim for WC and then by the verification request issued on 10/3/2019, in the form of a request for additional documents, "(e)ven if (the insurer) had tolled the 30-day period ... by timely requesting verification pursuant to 11 NYCRR § 65-3.8 (a), ... the Regulations do not provide that such a toll grants an insurer additional opportunities to make requests for verification that would otherwise be untimely." See Neptune Med. Care, P.C. v. Ameriprise Auto & Home Ins., 48 Misc.3d 139(A) (App Term 2d, 11th & 13th Dists. 2015). An initial EUO request made well beyond the requisite 15-day time period for additional verification, outside the 30-day claims determination period, is a "nullity". See O & M Medical, P.C. v. Travelers Indemnity Ins. Co., 47 Misc.3d 134(A), 2015 NY Slip Op 50476(U) (App Term 2d, 11th & 13th Jud Dists. March 26, 2015); Neptune Med. Care, P.C. v. Ameriprise Auto & Home Ins., 48 Misc.3d 139(A), 2015 NY Slip Op (App Term 2d, 11th & 13th Jud Dists. 2015) where the court held that "Even if the EUO scheduling letters were timely with respect to any other pending claims ..., they were untimely with respect to the bill(s) at issue." See also Okslen Acupuncture, P.C. v. Lancer Ins. Co., 2013 NY Slip Op. 50821(U) (App Term 1st Dept., May 21, 2013); Quality Psychological Servs., P.C. v. Utica Mut. Ins. Co., 2013 NY Slip Op 50148(U) (App Term 1st Dept., Feb. 1, 2013), Optimal Well-Being Chiropractic, P.C. v. Ameriprise Auto & Home, 40 Misc.3d 129(A), 2013 NY Slip Op 51106(U) (App Term 2d, 11th & 13th Jud Dists. 2013) (EUO letter sent more than 70 days after receipt of bills was untimely); Tsatskis v. State Farm Fire & Cas. Co., 2012 NY Slip Op 51268 (App Term 2d Dept., June 27, 2012) (EUO request sent more than 30 days after receipt of claim did not toll statutory period); St. Vincent Med. Care, P.C. v. Travelers Ins. Co., 26 Misc.3d 144(A), 2010 NY Slip Op 50446(U) (App Term 2d Dept.) (EUO letters mailed 52 days after receipt of bills were untimely).

I agree with my learned colleague Arbitrator Aspir in AAA Case Number 17-16-1043-0833, in a case directly on point, where he stated, "Respondent, upon receipt of the first bill submission, made a choice to deny the claim based on the EIP's eligibility for Workers' Comp benefits. That is their chosen defense, and therefore, they 'stand or fall' upon it. They cannot now change the basis of their denial and choose to go down the path of verification requests instead, due to an unfavorable outcome."

Therefore, in the instant case, I find that based upon the WCB determination that the accident is not covered by WC, Respondent's defense of eligibility for WC coverage fails, and Applicant prevails on this bill, which was denied solely based upon the claimant's eligibility for WC.

Accordingly, Applicant's claim is granted in its entirety. This award is in full disposition of all No-Fault benefit claims submitted to 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 applicant is AWARDED the following:

A.

Medical		From/To	Claim Amount	Amount Amended	Status
	Birch Medical & Diagnostic, PC	06/20/19 - 06/20/19	\$1,837.92	\$1,283.43	Awarded: \$1,283.43

Total	\$1,837.92	Awarded:	\$1,283.43
--------------	-------------------	-----------------	-------------------

- B. The insurer shall also compute and pay the applicant interest set forth below. 09/05/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant is awarded interest pursuant to the no-fault regulations. *See generally*, 11 NYCRR §65-3.9. Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30-day month." 11 NYCRR §65-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. However, the regulations toll the accrual of interest when an applicant "does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations." *See*, 11 NYCRR 65-3.9(c). The Superintendent and the New York Court of Appeals has interpreted this provision to apply regardless of whether the denial at issue was timely. LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 217 (2009). Based on the regulations, interest shall accrue from the date the applicant requested arbitration in this matter. *See*, 11 NYCRR 65-3.9(c).

- C. Attorney's Fees

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

Applicant is entitled to an attorney's fee pursuant to Insurance Law §5106(a). After calculating the sum total of the first-party (No-Fault) benefits awarded in this arbitration plus interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20 percent of that sum total, subject to the following limitations: In the event the above filing date was prior to Feb. 4, 2015, the attorney's fee is subject to a minimum of \$60.00 and a maximum of \$850.00, per 11 NYCRR 65-4.6(e). In the event the above filing date was on or after Feb. 4, 2015, the attorney's fee is subject to a maximum of \$1,360.00, per 11 NYCRR 65-4.6(d). In the event the above filing date was on or after Feb. 4, 2015 and first-party (No-Fault) benefits are awarded to more than one Applicant herein, the attorney's fee shall be calculated separately for each Applicant, each Applicant's attorney fee being subject to the \$1,360.00 maximum.

- 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, 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.

08/22/2021
(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:
9cde5d6cb2dc2eff1b297ea7add3d52a

Electronically Signed

Your name: Eileen Hennessy
Signed on: 08/22/2021