

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

EZ Triboro Services Inc  
(Applicant)

- and -

Global Liberty Insurance Company of New  
York  
(Respondent)

AAA Case No. 17-20-1171-7342  
Applicant's File No. SBG-11566-2523593  
Insurer's Claim File No. 201341  
NAIC No. 11092

**ARBITRATION AWARD**

I, Frank Marotta, 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-RR

1. Hearing(s) held on 09/23/2021  
Declared closed by the arbitrator on 09/23/2021

Raymond Mak, Esq. from Sanders Grossman Aronova PLLC participated in person for the Applicant

Roman Kravchenko, Esq. from Law Office of Jason Tenenbaum, PC participated in person for the Respondent

2. The amount claimed in the Arbitration Request, \$ **2,240.00**, 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

The record reveals that the Assignor-RR, a 75-year-old-female, sustained injuries in a motor vehicle accident on 1/11/20.

The Applicant filed arbitration seeking reimbursement for providing the Assignor with a pneumatic compression device between 2/14/20 and 2/27/20 & 2/28/20 and 3/12/20 prescribed by Suresh Paulus, DO.

The Respondent has not paid or denied the claims but asserts that the Applicant filed for arbitration premature because of outstanding verification.

The issue for determination is whether the claim should be dismissed without prejudice.

#### 4. Findings, Conclusions, and Basis Therefor

The Applicant filed this arbitration in the amount of \$2,240.00 for disputed fees in connection with a pneumatic compression device provided to the Assignor between 2/14/20 and 2/27/20 & 2/28/20 and 3/12/20.

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.

There is no issue that the Respondent received the bills in issue. Not only were they upload as part of their submission to AAA, but Respondent also provides verification letters from Atlas Financial Holding (Hereinafter "Atlas") to the Applicant for additional information needed to verify the claims. Verification request letters are sufficient to establish that a bill was submitted to and received by an insurer for the purposes of establishing health care providers prima facie entitled to reimbursement of assigned benefits. Spine America Medical, P.C. v. State Farm Mutual Automobile Insurance Company, 13 Misc.3d 135(A), N.Y. Slip Op. 52035(U) (App. Term 9th and 10th - October 5, 2006).

Once an applicant establishes the submission and receipt of a bill, the burden shifts to Respondent who may present evidence that the claim was either timely and properly paid or if not precluded, denied based on competent medical evidence sufficient to establish the service provided was medically unnecessary, Insurance Law §5106(a); 11NYCRR §65- 3.8(a) (1); 11NYCRR §65- 3.8(c), Presbyterian Hosp. v Maryland Cas. Co., 90 NY 2d 274, 660 NYS 2d 536 (1997); or that there is no coverage for the claim in question regardless of the timeliness of the denial. Kingsbrook Jewish Medical Center v. Allstate Ins. Co., 61 A.D.3d 13, 21, 871 N.Y.S.2d 680, 686 (2d Dept. 2009); Mount Sinai v. Triboro Coach, 263 A.D. 2d. 11, 699 N.Y.S. 2d 77 (2d Dept. 1999); Central General Hospital v. Chubb Group of Ins. Cos., 90 N.Y.2d 195 at 199, 659 N.Y.S.2d 246 (1997).

An insurer is required to pay or deny a claim for no-fault benefits within 30 days. Insurance Law §5106(a); 11NYCRR 65- 3.8(a) (1); 11 NYCRR 65-3.8(c) and the failure

to do so will precluded the insurer from raising most defenses against payment. Presbyterian Hosp. v Maryland Cas. Co., 90 NY 2d 274, 660 NYS 2d 536 (2d Dept. 1997); Central General Hospital v. Chubb, 90 NY 2d 195, 659 NYS 2d 246 (1997).

After a review of the documents contained in the ECF and in consideration of the arguments made by the parties at the hearing, I find for Applicant.

Although not signed Respondent provided an affidavit of Regina Abbatiello, No-Fault Adjuster for Atlas which is the parent company of American County Insurance Company (hereinafter ACIC). Ms. Abbatiello notes in paragraph four that when mail is received at any of the offices by ACIC the mail is indexed and electronically scanned into their computer system. The computer will electronically stamp the mail with the date it is received. The bills submitted by Respondent indicate that the bill for services between 2/14/20 and 2/27/20 was received on 3/3/20 and the bill for services between 2/28/20 and 3/12/20 was received on 3/18/20. Respondent provided copies of verification letters dated 4/10/20 and 8/17/20 regarding the bill for services between 2/14/20 and 2/27/20. The Respondent also provided verification letters dated 4/24/20 and 8/17/20 regarding the bill for services between 2/28/20 and 3/12/20.

Based on the proof provided the Respondent failed to timely toll their time to pay or deny the claims in question. An insurer may extend the 30-day period in which it has to pay or deny a claim by making a request for additional verification of the claim within, "*15 business days of receipt of the prescribed verification forms*" 11 NYCRR §65-3.5(b). If the verification has not been supplied to the insurer 30 days after the original request the insurer shall, "*at a minimum... within 10 calendar days, follow with the party from whom the verification was requested, either by telephone call properly documented in the file or by mail.*" 11 NYCRR §65-3.6(b).

With regards to both bills the initial verification requests were made more than 30 days after receipt of the bills. An initial request for verification made beyond 30 days from receipt of the claim is a nullity and the time to pay or deny will have expired. Compas Med., P.C. v. Farm Family Cas. Ins. Co., 2015 NY Slip Op 51631(U) (App. Term 2nd, 11th and 13 Jud. Dists. 2015). Even if could be said that the initial verification requests were timely, the follow-up letters are in violation of 11 NYCRR §65-3.6(b). The Appellate Courts have been consistent in holding that the failure to issue a second timely verification request results in the abandonment of the requested verification. In such an instance, no benefit of tolling occurs, and the No-Fault carrier will be precluded from asserting most defenses due to the untimeliness of any resultant denial. Kings Med Supply Inc. v. Allstate Ins. Co., 2005 NY Slip Op 50451(U) (App Term, 2nd Dept - 2005); Kings Med Supply Inc v. Kemper Auto & Home Ins. Co., 2005 NY Slip Op 50450(U) (App Term, 2nd Dept - 2005); Ocean Diagnostic Imaging P.C. v. Allstate Ins. Co., 2006 NY Slip Op 50140(U) (App Term, 2nd Dept - 2006).

I find for the Applicant in the amount billed as Respondent has not provided any evidence that the billing is in excess of the applicable fee schedule, First Aid Occupational Therapy, PLLC v. Country-Wide Ins. Co., 26 Misc.3d 135(A), 907 N.Y.S.2d 100 (Table), 2010 N.Y. Slip Op. 50149 (U), 2010 WL 376835 (App. Term 2d, 11th & 13th Dists. Jan. 29, 2010); Continental Medical PC v. Travelers Indemnity Co.,

11 Misc.3d 145A, 819 N.Y.S.2d 847, 2006 NY Slip Op 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Term, 1st Dept, per curiam, 2006), which is their burden. St. Vincent Medical Care PC v. Countrywide Insurance Company, 26 Misc. 3d 146 (A), 907 NYS 2d 441 (App. Term 2d, 11th and 13th Dists. 2010); Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 2006 NY Slip 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006).

Applicant further argues that since Respondent has not provided evidence of payment or denial interest runs from the 31st day after the claim was presented to the carrier for payment. In this case April 3, 2020, for bill for services between 2/14/20 and 2/27/20 and 4/18/20 for the services between 2/28/20 and 3/12/20.

For the reasons noted above the Applicant is awarded \$2,240.00 with interest from the thirty first day after the claim was presented to them.

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
	<b>EZ Triboro Services Inc</b>	<b>02/14/20 - 03/12/20</b>	<b>\$2,240.00</b>	<b>Awarded: \$2,240.00</b>
<b>Total</b>			<b>\$2,240.00</b>	<b>Awarded: \$2,240.00</b>

- B. The insurer shall also compute and pay the applicant interest set forth below. 04/03/2020 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest is governed by 11 NYCRR §65-3.9. Where a motor vehicle accident occurs after April 5, 2002, 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 (c) indicates that "*If an applicant does not request arbitration ... with 30-days after the receipt of a denial of claim or payment of benefits ... interest shall not accumulate ... until such action is taken.*" 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). Where no denial has been issued and no payment has been made, it is clear from the statute that the claim is overdue, and interest runs from the thirty first day after the claim was presented to the carrier for payment. New York Presbyterian Hospital v. Allstate Insurance Company, 30 A.D.3d 492, 819 N.Y.S.2d 268, 2006 N.Y. Slip Op. 04815 (2nd Dept 2006). Hempstead General Hospital v. Insurance Company of North America, 208 A.D.2d 501, 617 N.Y.S.2d 478 (2nd Dept 1994).

C. Attorney's Fees

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

The Respondent shall also pay the Applicant an attorney fee in accordance with 11 NYCRR §65-4.6 (e). If, however, the benefits and interest awarded thereon is equal to or less than the Respondent's written offer during the conciliation period, then the attorney fee shall be based upon the provisions of 11 NYCRR §65-4.6 (b).

- 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 Suffolk

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

09/24/2021  
(Dated)

Frank Marotta

**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:**  
50859da25ac79a0904bd9a1c4945b652

### **Electronically Signed**

Your name: Frank Marotta  
Signed on: 09/24/2021