

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Ambulatory Surgical Center of Englewood
(Applicant)

- and -

Integon National Insurance Company
(Respondent)

AAA Case No. 17-21-1202-0336

Applicant's File No. n/a

Insurer's Claim File No. 9TINY09129-02

NAIC No. 29742

ARBITRATION AWARD

I, Teresa Girolamo, Esq., 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: S.L.

1. Hearing(s) held on 07/14/2022
Declared closed by the arbitrator on 07/14/2022

Dino DiRenzo, Esq. from Dino R. DiRienzo Esq. participated in person for the Applicant

Joseph J. Licata III, Esq. from Rossillo & Licata LLP participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$8,553.42**, 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 Respondent is able to establish that there was a policy violation, as such, no coverage is afforded as Respondent issued a Global Denial of Benefits, that S.L. failed to appear for Independent Medical Examinations as such all claims are denied effective 7/31/2020 which is the date of loss. Therefore, Respondent relies on the its policy terms and the decision of *Unitrin Advantage Ins. Co. v. Bayshore Physical Therapy, P.L.L. C.* 82 A.D. 3d 559, in support of its defense, that no coverage shall be afforded, due to a policy violation.

Whether Respondent is also able to establish its affirmative defense of lack of medical necessity based upon a peer report of Dorothy Scarpinato, M.D. ?

Whether the proper fee schedule is \$3,026.24 based upon a fee audit by Carolyn Mallory, CPC?

4. Findings, Conclusions, and Basis Therefor

I have reviewed the documents contained in the Electronic Case Folder as of the date of the hearing.

Both Applicant and Respondent each submitted evidence in support of their contentions. This decision is based on my review of that file, as well as the arguments of the parties at the hearing. Each party appeared via ZOOM.

This is the second of two cases that came before me on 7/14/2022 involving the same date of service. The first case was AAA 17-20-1172-8848 *Englewood Orthopedics Group / S.L. v. Integon*. In that case, as in this case the services related to a left knee surgery performed on 11/14/19 at Applicant's facility. In both cases, Respondent issues a Denial of Benefits based upon an IME no show defense and a peer report of Dorothy Scarpinato, M.D.

In the case now before me, this bill was received on 12/9/2019, verification was issued with the final one on 12/20/19 and the date indicated of 1/16/2020 was the date that the MRI was received. As such, this bill was denied on 2/12/2020. In this case the reasons are the same as in the linked award, a policy violation wherein the injured party failed to appear for IMEs and a peer report of Dorothy Scarpinato.

Legal Analysis:

The case relied upon by Respondent at the hearing was *Unitrin Advantage Ins. Co. v. Bayshore Physical Therapy, PLLC*, 2011 NY Slip Op 01948, 82 AD3d 559 (1st Dep't 2011) in that the failure to appear for an Examination Under Oath, like the failure to appear for an IME, may be viewed as a breach of a condition precedent to coverage which would void the policy *ab initio*.

Thus, Respondent contends that the failure of Applicant to appear for scheduled Independent Medical Examinations is a breach of a condition precedent to coverage under the no-fault policy, and therefore fits squarely within the exception to the preclusion doctrine, as set forth in *Central Gen. Hosp. v Chubb Group of Ins. Cos.*

(90 NY2d195 [1997]). A denial premised on breach of a condition precedent to coverage voids the policy *ab initio* and, in such case, the insurer cannot be precluded from asserting a defense premised on no coverage (*see Chubb*, 90 NY2d at 199).

In order for Respondent to prevail based upon the *Unitrin* decision, a carrier must show that it satisfied its *prima facie* burden on summary judgment of establishing that it requested Independent Medical examinations and that the requests were in accordance with the procedures and time frames set forth in the no-fault implementing regulations, and that S.L. failed to appear in this case.

In the linked case I found as follows:

Facts:

On 9/5/2019 S.L. was a then 22-year-old male who was the driver of a vehicle involved in a motor vehicle accident. According to the police report there were no injuries observed or reported. Neither vehicle was towed from the scene of the accident. The address for S.L. as per the police report is 428 Bedford Avenue, Mount Vernon, NY 10553.

According to S.L.'s No Fault Application dated 10/4/19, injuries are listed as "multiple injuries". No hospital treatment is listed. For treating providers, S.L. lists, "medical office". The address listed on the NF-2 is 164 S. Fulton Avenue, Mount Vernon, NY 10553.

Applicant offers a one page "report", dated 10/23/19, with the handwritten notes as follows, "initial", "L knee arthroscopy", "no clearance."

Due to said accident, L.S. sustained injuries to his neck, lower back and left knee .

On 9/13/2019 L.S. presented to Future Chiropractic Care and also for an acupuncture initial evaluations. On 10/4/19 L.S. underwent an MRI of the left knee that provided as Impression number 5, : intrameniscal tear in the posterior horn of the medial meniscus".

On 10/24/19 L.S. presented for an initial physical therapy evaluation as well as an Initial evaluation by James Gutierrez, M.D. with Englewood Orthopedics Group.

On 11/14/19 L.S. underwent left knee arthroscopic surgery performed by Frances Rispoli, D.O.

On 7/23/2020 Applicant filed for Arbitration seeking recovery of \$6,758.55 for date of service of 11/14/19. According to the health claim form Applicant billed as follows:

CPT Code 29881 LT \$3,531.15

CPT Code 29875 LT \$1,351.02

CPT Code 29876 LT \$1,792.29

CPT Code 20610 LT \$84.09

The charges were related to a left knee surgery performed on 11/1/19 by Frances Rispoli, D.O. the preoperative diagnosis was 'left knee possible posterior horn medial meniscal tear'. The post operative diagnosis was, 'left knee posterior lateral meniscal tear, synovitis, pathologic medial plicial band'. (The surgical report is dictated but not proofread, nor signed).

Respondent received the bill on 12/9/2019 and sought verification. The bill states that final verification was requested on 12/20/19; and received on 1/16/2020. The bill was denied on 2/12/2020. According to the reason for the denial, Respondent advises as follows:

Policy condition(s) precedent to coverage and requirements outlined in Amended Regulation 68 violated. All NO Fault benefits (health services, other necessary expenses and loss of earnings) are denied in their entirety based on the injured person's failure to attend the Chiropractic/ Acupuncture physical exams of 12/09/19 and 1/13/20.

Per an independent peer review of billing and records amount in dispute denied based on lack of necessity and/or etiology. Please see attached a copy of the peer review report for further details.

In reviewing the records, it was the MRI report that was received on 1/16/2020. (pg 4/225)

On 1/15/2020 Respondent issued a Global Denial of Benefits based upon the policy violation of the no shows for IMEs on 12/9/2020 and 1/13/2020.

IME no Show Defense

Respondent, by Media Referral Incl., issued a scheduling letter on 11/20/19 for an IME of 12/9/19 with Ji Hoon Kim, D.C., L.Ac. for a Chiropractic/Acupuncture IME. Respondent was advised of the non appearance and as such same was re-scheduled for 1/13/2020 at 1:15 pm. The second scheduling letter is dated 12/12/19. Respondent was once again advised of the non-appearance.

At page 36/255 Respondent offers proof of mailing to S.L. at 164 S. Fulton Avenue, Mount Vernon, NY 10553 and 428 Bedford Avenue, Mount Vernon, NY 10553.

Proof of mailing for the second IME letters are at page 44-45/225.

Respondent offers a notarized statement from Ji Hoon Kim, dated 12/9/19, that on said date, he was present in the office, and S.L. failed to appear for the IME on that date. (pg. 59/225). Respondent offers a second statement by Ji HOon Kim, dated 1/13/2020 regarding the non-appearance for the IME of 1/13/2020.

Applicant argues that the matter was tolled pending a receipt of the MRI which was not asked for from Applicant. As such, Applicant argues that the delay in processing this claim was improper.

In reviewing the request, dated 12/9/19 Applicant is correct. The second box, which would have addressed the IME requirement was not checked off. Respondent was not required to send copies of the IME notices or the EUO notices to Applicant. Nor was it required to notify Applicant. I do so on the authority of Clinton Place Medical, P.C. v. New York Central Mutual Fire Ins. Co., 42 Misc.3d 150(A), 2014 N.Y. Slip Op. 50413(U) (App. Term 2d, 11th & 13th Dists. Mar. 11, 2014)

The only box checked off was "other", which specifically stated, that Respondent was looking for the MRI from Westchester Radiology & Imaging.

Decision:

"Pursuant to Insurance Law § 5106(a) and the Insurance regulations, an insurer must either pay or deny a claim for motor vehicle no-fault benefits, in whole or in part, within 30 days after an applicant's proof of claim is received (see Insurance Law § 5106[a]; 11 NYCRR former 65.15[g][3], now 11 NYCRR 65-3.8[c]; see also 11 NYCRR 65-3.5)." Infinity Health Products, Ltd. v. Eveready Ins. Co., 67 A.D.3d 862, 864, 890 N.Y.S.2d 545, ___ (2d Dept. 2009). "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-day time 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). "Thus, a timely additional verification request tolls the insurer's time within which to pay or deny a claim (see Fair Price Med. Supply Corp. v Travelers Indem. Co., 10 NY3d at 563; New York & Presbyt. Hosp. v. Countrywide Ins. Co., 44 AD3d 729, 730)." Kingsbrook Jewish Medical Center v. Allstate Insurance Co., supra at 18, 871 N.Y.S.2d at 683 (2d Dept. 2009).

As a complete proof of claim is a prerequisite to receiving no fault benefits, a claim need not be paid or denied until all demanded verification is provided (see, 11 NYCRR 65- 3.5[c]; Montefiore Med. Ctr . NY Central Mutual Fire Ins. Co., 9 A.D.3d 354, 780 N.Y.S.2d 161 (2nd Dep't 2004); NY & Presbyterian Hosp. v. American Transit Ins. Co., 287 A.D.2d 699, 733 N.Y.S.2d 80 (2nd Dep't 2001); Hosp. for Joint Diseases v. Elrac, Inc. , 11 A.D.3d 432, 783 N.Y.S.2d 612 (2nd Dep't 2004).

When verification has properly been requested on a claim, a follow up request has been issued and verification has not been received, any action or arbitration to collect that claim is premature. Metroscan Medical Diagnostics PC v. Progressive Cas. Ins. Co., 15 Misc.3d 126A, 836 N.Y.S.2d 500, 2007 NY Slip Op 50500U, 2007 N.Y. Misc. LEXIS 903 (App. Tm, 2nd Dep't 2007); Doshi Diagnostic Imaging Servs. v. State Farm Ins. Co., 16 Misc.3d 42, 842 N.Y.S.2d 153, 2007 NY Slip Op 27193, 2007 Misc. LEXIS 3524 (App. Tm, 2nd Dep't 2007); Elmont Open MRI & Diagnostic Radiology P.C. d/b/a/ All County Open MRI & Diagnostic Radiology v. State Farm Ins. Co., 15 Misc.3d 139A, 841 N.Y.S.2d 819, 2007 NY Slip Op 50988U, 2007 N.Y. Misc. LEXIS 3526 (App. Term, 2d Dept 2007).

Having reviewed the letter the issue, I conclude that the letter was specific enough to constitute a proper and effective delay letter/ additional verification

request. I further conclude that the letter sent by Respondent to Applicant effectively tolled the claim as it was quite specific from whom/ what entity the MRI was requested from.

As such, based upon the arguments presented and the evidence herein I find that Respondent timely issued its Denial of Benefits based upon the grounds of an IME no show policy defense as well as lack of medical necessity.

The issue of medical necessity becomes moot, as the services were also denied based upon the policy violation. Therefore Applicant's claim is denied.

The identical letter/ verifications were issued in this case, as such, in this case therefore I also find that same were proper to toll the time to pay or deny this claim. I further conclude herein as in the linked case that Respondent established its affirmative defense of a policy violation. Therefore Applicant's claim is denied, rendering the issue of medical necessity and fee schedule moot.

5. Optional imposition of administrative costs on Applicant.
Applicable for arbitration requests filed on and after March 1, 2002.

I do NOT impose the administrative costs of arbitration to the applicant, in the amount established for the current calendar year by the Designated Organization.

6. I find as follows with regard to the policy issues before me:

- ☐ The policy was not in force on the date of the accident
- ☐ The applicant was excluded under policy conditions or exclusions
- ☐ The applicant violated policy conditions, resulting in exclusion from coverage
- ☐ The applicant was not an "eligible injured person"
- ☐ The conditions for MVAIC eligibility were not met
- ☐ The injured person was not a "qualified person" (under the MVAIC)
- ☐ The applicant's injuries didn't arise out of the "use or operation" of a motor vehicle
- ☐ The respondent is not subject to the jurisdiction of the New York No-Fault arbitration forum

Accordingly, the claim is DENIED in its entirety

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

State of New York
SS :
County of Nassau

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

07/14/2022
(Dated)

Teresa Girolamo, Esq.

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:
f4c831eee5b6359b75f73d60ca92b89f

Electronically Signed

Your name: Teresa Girolamo, Esq.
Signed on: 07/14/2022