

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Aris Diagnostic Medical PLLC
(Applicant)

- and -

Allstate Fire & Casualty Insurance Company
(Respondent)

AAA Case No. 17-20-1188-6179

Applicant's File No. 2411170

Insurer's Claim File No. 0572240224
2LR

NAIC No. 29688

ARBITRATION AWARD

I, Sandra Adelson, 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: the patient

1. Hearing(s) held on 07/28/2022
Declared closed by the arbitrator on 07/28/2022

Ryan Berry, Esq. from Israel, Israel & Purdy, LLP (Great Neck) participated in person for the Applicant

Meghan McDonough, Esq. from Law Offices of John Trop participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$3,109.46**, 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 patient was 48-year-old-female driver, who was involved in a motor vehicle accident on 12/18/19. Her vehicle was T-boned by another vehicle. Airbags did deploy. The patient sustained injuries to the neck, lower back, shoulders, and bilateral knees. Following the accident, she was taken to the emergency room of Glen Cove Hospital by ambulance. The patient was prescribed MRI scans of the knees and cervical and lumbar spine. The applicant seeks payment for the performance of an MRI scan of the left and right knee performed on 1/22/20 and cervical spine and lumbar spine MRI scans performed on 2/17/20.

Respondent issued denials which stated "Per New York State Regulation 68-C, section 65-3.5; 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 medical bill is denied as you have failed to provide within 120 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."

Respondent raised no issues as to Fee Schedule at the time of the hearing.

4. Findings, Conclusions, and Basis Therefor

The record consisted of claimant's submission, respondent's submission, as well as documents not enumerated within this decision, but which are contained in the case file maintained by the American Arbitration Association. **THE ARBITRATOR SHALL BE THE JUDGE OF THE RELEVANCE AND MATERIALITY OF THE EVIDENCE OFFERED** pursuant to 11 NYCRR 65-4.5 (o) (1) (Regulation 68-D). The arbitrator may question any witness or party and independently raise any issue that the arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department Regulations. Based on a review of the documentary evidence, this claim is decided as follows

It is now well-settled that a medical provider establishes a prima facie case of entitlement to payment of no-fault benefits upon the submission of a proper claim form setting forth the fact and amount of the losses sustained as well as the additional fact that that the payment of no-fault benefits was then overdue. Insurance Law 5106(a); *Mary Immaculate Hospital v. Allstate Insurance Co.*, 5 A.D.3d 742; *Amaze Medical Supply, Inc. v. Eagle Insurance Co.*, 2 Misc 3d 128(A).

A presumption of medical necessity attaches to a timely submitted no fault claim. *All County Open MRI & Diagnostic Radiology. P.C. v. Travelers Ins. Co.*, 11 Misc. 3d 131[A], 815 N.Y.S.2d 493 (App.Term 9th & 10th Jud. Dists. 2006). The burden then shifts to the defendant to rebut the presumption of medical necessity. *A.B. Medical Services PLLC v. Utica Mut. Ins. Co.*, 10 Misc 3d 50, 809 N.Y.S.2d 765 (App.Term 2nd & 11th Jud. Dists. 2005); and *A Plus Medical, P.C. v. Government Employees Ins. Co.*, 21 Misc 3d 799, 870 N.Y.S.2d 858 (Civil Ct. Kings Co. 2008).

The respondent issued additional verification requests dated 3/24/20 and 4/28/20 with regard to MRI scans performed on 1/22/20 and additional verification requests dated 4/16/20 and 5/26/20 with regard to MRI scans performed on 2/17/20. The respondent asserts that additional EUO verification is pending. Each additional verification request [noted herein] sought the identical information which included requests for licensing

information, W2/1099s, medical reports, technician name, financial agreements, subleases, marketing materials, management agreements, billing and consulting agreements, ownership documents, other financial and management records.

The applicant's position asserted that there has been substantial compliance with the respondent's requests. In support of their position the applicant has submitted a response to respondent's post EUO additional verification requests dated 4/16/20, 5/26/20, 4/28/20 and 3/24/20. The applicant submitted a response dated 7/22/20 along with exhibits containing documents and information provided to respondent as well objections and stated reasons for objecting to certain requests. (Proof of mailing of the 7/22/20 letter from applicant was included within applicant's submission). In fact, it is necessary to copy and paste the detailed responses, objections and identification of documents provided to respondent:

"We are in receipt of numerous and substantially identical requests your office has made with regard to the above referenced provider's request for payment for services provided to your insureds. These request demand the production of information and documents that far exceed what could be reasonably required to identify the amounts due and owing in any particular claim. The requests also improperly request information that was previously provided. The voluminous nature of your requests, as well as you repeatedly demand the production of information already provided, make it difficult to respond in a timely manner.

There is a regulatory framework within which insurers must operate with regard to the payment of No-Fault claims. Specifically, insurers are required to assist the applicant in the processing of a claim and may not treat the applicant as an adversary.

Furthermore, insurers are prohibited from demanding verification of facts unless there are good reasons to do so, and when verification of facts is necessary, it should be done as expeditiously as possible. See 11 NYCRR 65-3.2(b). Additionally, there are restrictions on the scope of any inquiry into licensure status. Specifically, such inquiry regarding licensure status is not permitted unless the insurer can demonstrate "behavior tantamount to fraud." *State Farm Mutual Automobile Insurance Co. v. Mallela*, 4 N.Y.3d 313 (2005).

As the regulatory framework provides the sole basis for insurers' authority to take any action, demands that do not comply with the regulatory framework are without legal support. In the absence of evidence demonstrating behavior tantamount to fraud, insurers may not conduct an unregulated, self-serving, unending investigation into licensure status. The requests propounded fail to comply with the above referenced limitations.

Furthermore, the requests appear to be motivated, not by any desire to verify pending claims, but rather to delay the payment of claims and to impose upon the applicant the

unnecessary expense associated with the production of documentation about information that is both readily available to the general public and not truly needed to evaluate any pending claim. Additionally, even though you received notice that our office represented the applicant with regard to this specific claim and we have requested that any request for additional verification be sent to our office, you have disregarded these requests and instead choose to send the requests directly to the applicant.

Notwithstanding the forgoing, and preserving any objections to same, applicant has dedicated substantial resources to provide the following response to the following requests:

We respectfully ask you immediately note your records to reflect receipt of the attached documents and the information provided herein as it is not reasonable to continually request the production of documents that have already been provided. See *Brownsville Advance Med., P.C. v Country-Wide Ins., Co.* 33 Misc.3d 1236(A) (insurer's repetitive verification demands are contrary to "11 NYCRR 65-3.2(b) that provides an applicant or claimant should not be treated as an adversary and verification of facts should not be requested unless the insurer has a good reason for doing so.) Much of the information requested by the demands was already in your possession. For example, the corporation organizational documents and Filing Receipt had been previously provided to Allstate several hundred times between June 2013 and November 2014. On numerous occasions, including on October 21, 2013, Allstate's SIU department acknowledging receipt of "Aris Diagnostic Medical, PLLC's articles of organization, EIN and corporate filing receipt." These documents as well as a response to all of the requests related to the business operation of the applicant's medical practice were also provided on April 13, 2018, May 22, 2018 and again on June 13, 2018.

To the extent that your request references a demand for an Examination Under Oath of

the applicant or the patient, please note the objection that such a demand is unreasonable and not authorized by the applicable regulations. Your office cannot demonstrate that the applicant is engaged in behavior tantamount to fraud, and as such you may not withhold or delay payment of No-Fault while you conduct an investigation into licensure status.

Request: License of person supervising service and was such person and supervision 'Direct and On Site' during performance of the billed for service

Response: This compound question is difficult to understand and respond to as phrased. The only licensed person(s) that provided service to this patient was the physician(s) identified on the NF-3 and the report(s) provided with the initial billing. Dr. Simon Ryoo (and any other physician identified on the NF-3 and report) is/are licensed by the

State of New York to practice medicine and board certified in the field of radiology. Copies of licenses are attached. Information regarding licensure status is readily available on the website of the office of the professions <http://www.op.nysed.gov/opsearches.htm> and there should be no need for the applicant to have to continually provided copies of document that have already been provided.

You are respectfully referred to *Brownsville Advance Med., P.C. v Country-Wide Ins., Co.* 33 Misc.3d 1236(A) where the court found that repetitive verification demands for items that have already been provided are contrary to 11 NYCRR 65-3.2(b) that provides an applicant or claimant should not be treated as an adversary and verification of facts should not be requested unless the insurer has a good reason for doing so. Dr. Ryoo and Dr. Josef Aronov are both members of the corporation and both provide onsite and offsite supervision of the practice and the services provided by the practice. Onsite and direct supervision by a physician is neither required nor provided for every patient and it would be unreasonably burdensome to retrospectively correlate the physicians' schedule to the time and date of this test to determine and report the irrelevant fact as to whether the supervision provided was onsite or remote.

Request: W-2 and/or 1099 along with other verifiable proof (including IRS Report 941 and NYS 45) concerning the employment status of the individuals performing the billed for services

Response: Redacted documents are attached hereto. These documents verify the status of the individuals and should be more than sufficient for the purposes of claim verification. Unredacted, these documents contain personal sensitive information.

Unrestricted disclosure of sensitive information threatens the privacy and personal security of the underlying individuals. It also may subject the applicant to civil liability. If the redacted information is necessary to verify the subject claim please provide the specific information needed; the justification for the request; an agreement that the insurer and its agents, employees and attorneys will agree to hold the information in confidence, to not disclose it in any manner; and a binding assurance that the aforementioned will hold the individual and the applicant harmless from any injury related the disclosure of this information.

Request: Any prescriptions, medical reports, narratives, letters of medical necessity relating to any referrals made by any health care provider to the Aris Diagnostic Medical, PLLC that resulted in the performance of the billed for services;

Response: As you are aware the prescription for each prescribed service were provided with the initial billing and as such are already in your possession. Any additional required documents are attached. All responsive items have been provided.

Request: Interpretive medical records reflecting findings, reports and diagnoses relating to the billed for services

Response: Some of the aforementioned documents were provided with the initial billing and as such are already in your possession. Any additional required documents are attached.

Request: Any and all patient intake forms completed by the patient

Response: Attached

Request: Name of technician who performed billed for test as well as any certifications and/or licensing related to his or her credentials and authorization to perform such tests.

Response: The technologists are identified on the attached list. Also attached is documentation of certification.

Request: Names and addresses of all individuals and entities with whom the applicant has entered into agreements for the purchase, lease, sub-lease, licensing or rental of office or clinical space;

Response: This request is patently improper. It is also overbroad, vague and unduly burdensome. It requests information completely unrelated in time and substance from the underlying demand for payment. All requests for additional verification must be supported by "good reasons" and be done expeditiously. See 11 NYCRR 65-3.2.

Similarly, the regulations require that such requests must be "necessary" to verify the particular claim. Furthermore, investigations into licensure compliance are limited to those circumstances where the carrier can demonstrate behavior tantamount to fraud. *State Farm Mutual Automobile Insurance Co. v. Mallela*, 4 N.Y.3d 313 (2005). There is no good reason for such a request and there has been no behavior even remotely tantamount to fraud. Finally, the Insurance Department, in an opinion letter dated September 15, 1995, indicated that "the department does not believe that lease agreement is relevant to making a determination on whether to pay or deny a [no-fault] claim." Despite the fact that the request is improper, meritless and unauthorized applicant, reserving all objections, a copy of the current lease is attached.

Request: Copies of all agreements that the applicant has entered into with any individuals and entities for the purchase, lease, sub-lease, licensing or rental of office or clinical space;

Response: See the objections above.

Request: Names and addresses of all individuals and entities with whom the applicant has entered into agreements for the provision of advertising, marketing, or public relations services

Response: This request is patently improper. It is also overbroad, vague and unduly burdensome. It requests information completely unrelated in time and substance from the underlying demand for payment. All requests for additional verification must be supported by "good reasons" and be done expeditiously. See 11 NYCRR 65-3.2.

Similarly, the regulations require that such requests must be "necessary" to verify the particular claim. Furthermore, investigations into licensure compliance are limited to those circumstances where the carrier can demonstrate behavior tantamount to fraud. *State Farm Mutual Automobile Insurance Co. v. Mallela*, 4 N.Y.3d 313 (2005). There is no good reason for such a request and there has been no behavior even remotely tantamount to fraud. The Insurance Department, in an opinion letter dated September 15, 1995, indicated that "the department does not believe that lease agreement is relevant to making a determination on whether to pay or deny a [no-fault] claim." As the terms of any such agreement cannot constitute a defense to a no-fault action, there is no reason the applicant should be required to identify "names and addresses of all individuals and entities with whom the applicant has entered into agreements for the provision of advertising, marketing, or public relations services. See: *In re Allstate Property and Cas Ins Co v New Way Massage Therapy PC*, 19 N.Y.S.3d 897 (Ap Div, 1st Dept, 2015). Despite the fact that the request is improper, meritless and unauthorized applicant, reserving all objections, attached is a copy of Public Relations Agreement.

Request Copies of all agreements that the applicant has entered into with any individuals and entities for the provision of advertising, marketing, or public relations services

Response: You are directed to the objections above.

Request: Copies of all invoices, receipts, and proofs of payment related to any advertising, marketing, or public relations services provided to the applicant by any individuals and entities

Response: In addition to the observations and objections noted in the response to Request 11 above, compliance with this request would be unreasonably difficult, time consuming and expensive. It would not yield any information that would be instrumental in adjusting the underlying claim and, as such, is an unreasonable demand.

Request: Names and addresses of all individuals and entities with whom the applicant has entered into agreements for the provision of management or consulting services;

Response: This request is improper for same reasons noted in the above objections. The applicant does not utilize the services of a practice management company or service.

Request: Copies of all agreements that the applicant has entered into with any individuals and entities for the provision of management or consulting services;

Response: This request is improper for same reasons noted in above.

Request: Copies of all invoices, receipts, and proofs of payment related to any

management or consulting services provided to the applicant by any individuals and entities

Response: This request is improper for same reasons noted above. The applicant does not utilize the services of a practice management company or service.

Request: Names and addresses of all individuals and entities with whom the applicant has entered into agreements for the provision of accounting and/or billing/collection services.

Response: This request is improper for same reasons noted above. Additionally, you have no authority to review examine or scrutinize the applicant's relationship with providers of professional accounting or legal services.

Request. Copies of all agreements that the applicant has entered into with any individuals and entities for the provision of accounting and/or billing/collection services.

Response: This request is improper for same reasons noted above. Additionally, you have no authority to review examine or scrutinize the applicant's relationship with providers of professional accounting or legal services.

Request: Copies of all invoices, receipts, and proofs of payment related to any accounting and/or billing/collection services provided to the applicant by any individuals and entities;

Response: This request is improper for same reasons noted above. Additionally, you have no authority to review examine or scrutinize the applicant's relationship with providers of professional accounting or legal services.

Request: Copies of all fair market value opinions or valuation reports obtained by the applicant in connection with any agreement disclosed in your response to Request No. 10-16 above.

Response: No agreements requested in Request 10-16 were disclosed and as such the request as phrased does not request an additional response. Notwithstanding this fact, you may not withhold payment pending the production of items that do not exist.

Additionally, this request is improper for same reasons noted above.

No-fault reform was enacted to provide prompt uncontested, first-party insurance benefits (see, *Montgomery v Daniels*, 38 N.Y.2d 41). As you should be aware, there is

a regulatory framework within which you must operate with regard to the payment of No-Fault claims. Specifically, you are required to assist the applicant in the processing of a claim. You may not treat the applicant as an adversary. Furthermore you are prohibited from demanding verification of facts unless there are good reasons to do so, and when verification of facts is necessary, it should be done as expeditiously as possible.

Responding to a request for verification of facts, should not require the assistance of someone with clairvoyance or a post doctorate degree.

Simply stated, you are not permitted to do what you are doing. You are ignoring information that was previously provided and interposing unnecessarily complex overly broad demands, disregarding the regulatory framework and improperly delaying payment of the claim that should have been addressed within 30 days. To the extent that you are hiding behind a facade of conducting an inquiry into compliance with state or local licensing laws, such inquiry is not permitted unless you can show behavior tantamount to fraud. Your entire demand is unlawful, improper, and abusive.

Should you have any reasonable demands specifically tailored to address any factually grounded reasonable concern, we would welcome the opportunity to provide reasonable relevant information to address those concerns.

Finally, I note in closing that responding to the request required many hours and involved the production of hundreds of pages of documents that are nearly universally

unrelated to the underlying claims. I hope that you will accept this submission as a complete response and you will pay the underlying claims. In the event that you are insisting upon the production of further documents, please articulate the specific justification for such request including how your request comports with 11 NYCRR 65-3.2 so we can respond in a considered and appropriate manner."

Respondent's additional verification requests:

With regard to the additional verification request which sought information for licensing information, W2/1099s, medical reports, technician name, financial agreements, subleases, marketing materials, management agreements, billing and consulting agreements, ownership documents, other financial and management records, I find that the aforementioned requests for information had nothing to do with the issue as to the payment of the MRI scans. Respondent's proof failed to establish a credible basis suggesting fraud which would justify respondent requesting the additional verification in issue. The No Fault Regulations state that

"65-3.2 Claim practice principles to be followed by all insurers.

(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..."

Due to the fact that this claim was for MRI scans, respondent's requests for non-specific information having nothing to do with this claim establishes that respondent was requesting verification which had nothing to do with this claim and without good reason. Additionally, respondent's actions further suggest that respondent was treating applicant as an adversary. Applicant has established that respondent had requested information which had already been received by respondent. Respondent also failed to show that it had good reasons to request the information objected to by applicant.

Request for an EUO cannot delay a claim:

Furthermore, the additional requests seeking an EUO cannot toll respondent's time to issue a denial or issue verifications requests. The No-Fault regulations specifically stated at 65-3.5(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."

Therefore, the additional verification requests for the EUO could not be considered as valid additional verification requests which would toll this claim. Respondent's proof did not include EUO scheduling letters with proofs of mailing to sustain a defense for failure to appear. Further, the reference to an EUO in each additional verification request does not identify who respondent seeks to question under oath. Therefore this request is vague and overbroad.

Reference should also be made to the Master Award of Hon. Alfred J. Weiner in AAA Case No. 99-16-1027-6556, Daniel Cohen Psychology, P.C. and American Transit Insurance Company which affirmed the Arbitration Award of Arbitrator Alana Baran in AAA Case No. 17-16-1027-6556, Daniel Cohen Psychology, P.C. and American Transit Insurance Company. Master Arbitrator Weiner held the following:

"Regarding the IMEs, the No-Fault regulations provide that if the additional verification requested by the insurer is a medical examination, the insurer shall schedule the examination to be held within 30 calendar days from the date of receipt of the prescribed verification forms. See, 11 NYCRR 65-3.5 (d). The no-fault arbitrator held, "Based on the foregoing, this arbitrator finds that, where the bill was received August 21, 2015, and the IME was scheduled for September 21, 2015, respondent failed to establish prima facie its defense based upon a failure to appear for IMEs as respondent failed to show that the scheduling of IMEs complied with the Insurance Department Regulations." Respondent failed to show that the EUO examinations were scheduled with the patient or provider within 30 days from the date of receipt of the prescribed verification forms.

Additionally, the claim could not be tolled based on the EUO request which is prohibited by the Fourth Amendment to the Regulations: "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." (emphasis added).

No response from respondent to applicant's 7/22/20 response letter:

Respondent's submission did not include respondent's reply to applicant's 7/22/20 letter. The Respondent did not include any correspondence or reply to the applicant's document submission and applicant's objections to the post EUO verification requests. It is also notable that respondent's counsel at the hearing, did not state respondent was not in possession of applicant's responses to verification.

It is notable however, that respondent did not respond to applicant's verification response of 7/22/20. Therefore, Lenox Hill Radiology v. Globally Liberty Insurance Co. of N.Y., 2017 Misc. Lex 2911, 56 Misc. 3d 12 13(A) is controlling. The held in Lenox Hill Radiology, supra. the following:

"No-fault regulations mandate that a claim for health services expenses be submitted by written proof of claim to the insurer, no later than 45 days after the date that health services were rendered (see 11 NYCRR §65-2.4[c]). After receipt of the written proof of claim, a no-fault claim is overdue if not paid or denied by the insurer within 30 calendar days (see Insurance Law §5106[a]; 11 NYCRR §65-3.8[a][1],[c]).

The thirty days may be extended where an insurer requests additional verification within 15 days of receipt of the claim (see 11 NYCRR 65-3.5[b]). If the insurer has not received a verification from the plaintiff within 30 days of the initial request, an insurer must send a follow-up verification request by phone call or mail within 10 days to the requested party (see 11 NYCRR §65-3.6[b]). This tolls the insurer's obligation to pay or deny the claim until it receives the additional information requested (see 11 NYCRR 65-3.8[a][1]; Hospital For Joint Diseases v Traveler's Property Casualty Ins. Co., 9 N.Y.3d 312, 879 N.E.2d 1291, 849 N.Y.S.2d 473 [2007]).

Where a requested verification is not provided an insurer is not required to pay or deny the claim (see 11 NYCRR §65-3.8[a][3]; NY & Presbyt. Hosp. v Progressive Cas. Ins. Co., 5 AD3d 568, 570, 774 N.Y.S.2d 72 [2nd Dept 2004]). However, an insurer may deny the claim after 120 calendar days if plaintiff does not provide all of the requested verification under its control or possession, or written proof providing reasonable justification for its failure to comply (see 11 NYCRR §65-3.5[o], for all claims submitted after 4/1/13). Also, an insurer's "non-substantive, technical or immaterial defect or omission, as well as an insurer's failure to comply with a prescribed time frame" shall not "negate an applicant's obligation to comply with the request or notice" (see 11 NYCRR §65-3.5[p], for all claims submitted after 4/1/13).

Though an insurer is entitled to request and receive information necessary to the processing and verifying of the provider's claim (see 11 NYCRR §65-3.5[c]), the scope of the requested materials are not unlimited (see generally 11 NYCRR 65-3.6[b]). Insurance regulations require the existence of "good reasons" to demand verification

(see 11 NYCRR 65-3.2[c]; *Doshi Diagnostic Imaging Servs. v State Farm Ins. Co.*, 16 Misc 3d 42, 842 N.Y.S.2d 153 [2nd Dept 2007])....

Here, the Court determines that defendant has failed to demonstrate a prima facie entitlement to summary judgment for dismissal with proof in admissible form sufficient to establish there are no material issues of fact (see *Alvarez v Prospect Hospital*, supra; *Stephen Fogel Psychological, P.C. v Progressive Ins. Co.*, 35 AD3d 720, 721, 827 N.Y.S.2d 217 [2nd Dept 2006]; *Prime Psychological Services P.C. v Nationwide Prop. & Cas. Ins. Co.*, 24 Misc 3d 230, 232, 882 N.Y.S.2d 844 [Civ Ct. Richmond Cty. 2009]).

The Court notes that the affidavit of Regina Abbatiello, No-Fault Claims Adjuster, demonstrates she was personally familiar with the standard office policy and operating procedures for the processing of no-fault claims in litigation or arbitration, including payments and denials of benefits. She states her affidavit was given after a detailed review "of all document/ correspondence and computer records maintained by Global in accordance with its standard operating procedures that are recorded/document and maintained under claim no. NF15930301."

She further states she generated the verification requests, and follow-up additional verification requests with carbon copies, to the plaintiff assignor at the address shown on the NF-3 claim forms, seeking information, including MRI films, and the referring doctor's report on the need for multiple MRI studies. Defendant's records show that a verification request was sent out on 11/18/15 for each claim which had been received on 11/09/15.

Upon not receiving a response, a second verification request was sent out on 12/18/15. No response with the requested information was provided.

The Court finds the stated procedure in the instant matter is conclusory and lacking in relevant specifics to set forth the standard office practice or procedure used to ensure that items were properly addressed and mailed (see *Delta Diagnostic Radiology, P.C. v Chubb Group of Ins.*, 17 Misc 3d 16, 847 N.Y.S.2d 322 [App.Term 2nd Dept 2007]). The proof establishes that verification requests are placed by the adjusters in the outgoing mail bin. However, the proof fails to sufficiently demonstrate what happens to the verification requests after placement in the mail bin. It appears that mixed mail for defendant's office is placed in the mail bin, not just mail being sent for verification requests.

Moreover, a copy of defendant's actual letters of requests for further verification are attached as an exhibit to the moving papers. However, there is no admissible statement from any person having knowledge of the facts which would sufficiently link the standard office practices and procedures for the generating and mailing of these verifications. Nor is there any sworn statement from a person with knowledge, for admitting these letters as business records (see CPLR 4518[a]). The only connecting statement is made by the affirmations of defendant's counsel, which have no evidentiary value, as an attorney's affirmation not based upon personal knowledge is without probative value or evidentiary significance (see *Warrington v Ryder Truck Rental, Inc.*, 35 AD3d 455, 456, 826 N.Y.S.2d 152 [2nd Dept 2006]; see also *Wesh v Laidlaw*, 59

AD3d 534, 873 N.Y.S.2d 180 [2nd Dept 2009]). Also, defendant's attorneys have not provided a proper foundation for an opinion (see *People v Goldstein*, 6 NY3d 119, 843 N.E.2d 727, 810 N.Y.S.2d 100 [2005]). In addition, an attorney's opinion which is not based [*8] upon personal knowledge "is without evidentiary value and thus unavailing" (see *Zuckerman v City of New York*, supra at 563).

The Court further finds that defendant has failed to establish an objective, reasonable basis for the contents of the verification demands alleged to have been mailed to plaintiff (see 11 NYCRR 65-3.2[c]; *Doshi Diagnostic Imaging Servs. v State Farm Ins. Co.*, 16 Misc 3d 42, 842 N.Y.S.2d 153 [2nd Dept 2007]).

The evidence shows that verification requests were responded to by plaintiff's attorneys, by 7 cover letters each dated 12/18/15, for the respective claim amounts of: \$878.67, \$878.67, \$878.67, \$878.67, \$912.00, \$959.61 and \$879.73. In each letter, plaintiff's attorneys stated:

"Enclosed please find a further response to your verification request"(emphasis added) concerning the above-referenced claim. These documents constitute all available documentation provided by the above-referenced provider. Accordingly, kindly remit payment. Failure to do so may result in litigation being commenced"

Attached to each letter was a copy of a pertinent medical report showing the results of an: MRI left wrist without contrast, MRI left hip without contrast, MRI left foot without contrast, MRI left shoulder without contrast, MRI lumbar spine without contrast, MRI thoracic spine without contrast, and MRI cervical spine without contrast.

Plaintiff has demonstrated it satisfied its duty to timely communicate with defendant, providing a statement of reasonable justification why it could not provide what further verification sought, as it had provided all of the available documents (see 11 NYCRR §65-3.5[o]; see also *Dilon Med. Supply Corp. v Travelers Ins. Co.*, 7 Misc 3d 927, 931-932, 796 N.Y.S.2d 872 [NY City Civ. Ct. 2005]), and it would be unable to fully satisfy the insurer's request (see *Westchester County Med. Ctr. v New York Cent. Mut. Fire Ins. Co.*, 262 Ad2d 553, 692 N.Y.S.2d 665 [2nd Dept 1999]). A defendant also has a duty to act, by payment or denial of the claim or request for further verification, upon receipt of plaintiff's response to defendant's verification request, so long as plaintiff's documentation is arguably responsive to defendant's verification request (see ***All Health Med. Care v Government Employees Ins. Co.*, 2 Misc 3d 907, 771 N.Y.S.2d 832 [NY City Civ Ct. 2004]**).

Here, defendant remained silent in the face of plaintiff's verification responses, and failed to demonstrate "good reason" to support its continued verification requests, as required by 11 NYCRR 65-3.2[c]).

Moreover, there is no sworn statement from anyone with knowledge, which provides a reasonable basis for the verification demands. The affidavit of Regina Abbatiello (No-Fault Examiner) states that upon receipt of the claim with billing, "the following represent the bills that were delayed pending the receipt of additional verification." She further states: "the additional verification requests and follow-up additional verification

requests were sent to Plaintiff Assignee with appropriate carbon copies in accordance with the regulations." She then relates what was sought: "The information that was sought included: copies of mri films; referring doctors report on the need for multiple mri studies." However, the foregoing statements are conclusory, and no reason is stated for the verification requests. Nor is any recognition or credit acknowledged in her affidavit for the 7 letters of 12/18/15 with MRI medical reports supplied by plaintiff in response to the verification demands.

For the foregoing reasons, the Court determines defendant has failed to establish a prima facie showing of entitlement to summary judgment dismissing the complaint as a matter of law.

Accordingly, the motion for summary judgment by defendant dismissing plaintiff's complaint pursuant to CPLR 3212, is denied."

Applicant's counsel's response letter dated 7/22/20 established substantial compliance with the additional verification requests. Within 30 days of 7/22/20, respondent was obligated to either issue a denial or provide a credible response to applicant's letter, objections and documents provided.

The Arbitration Award of Arbitrator Fred Lutzen in AAA Case No. 17-2-1172-7490 involving the same applicant and respondent-Aris Diagnostic Medical PLLC/different patient and Allstate Fire and Casualty Insurance Company. This arbitration award discussed a similar scenario to the facts before this arbitrator.

Arbitrator Lutzen held the following:

"On 7/10/19, Applicant submitted a more detailed response letter with numerous objections to the items requested and also enclosed copies of items that were previously received by Respondent on 9/13/18. Respondent's internal "Received" stamp appears on the financial records, lease documents, management records, and other items that were requested by Respondent. These records were provided a few months before the date of service at issue.

Since (1) Respondent had recently received the bulk of items requested on 9/13/18, (2) Applicant's initial claim submission included the medical reports, physician report, assignment, and bill, and (3) Applicant's response to the request for verification on 3/21/19 included the MRI films for both cervical and lumbar spine, I find that Applicant's response dated 3/21/19 was arguably responsive to Respondent's request.

However, on 4/17/19, Respondent re-issued the original request with the same language that did not acknowledge receipt of any of the numerous items already provided by Applicant and received by Respondent as of that date.

11 N.Y.C.R.R. §65-3.5 provides, in part, as follows:

§ 65-3.5 Claim procedure.

(c) The insurer is entitled to receive all items necessary to verify the claim directly from the parties from whom such verification was requested. (emphasis added).

Applicant's counsel argued that because Respondent did not acknowledge receipt of the items requested and did not communicate to Applicant which specific items Respondent believed were still outstanding, that the claims should be awarded.

Respondents are required to advise that Applicant's responses were insufficient. See, *Custom Orthotics, Ltd. v. Gov't Employees Ins. Co.*, 25 Misc. 3d 545, 549 (Civ. Ct., Queens Co., 2009). The Respondent did neither and instead chose to ignore the Applicant's response and reiterate its identical request for items already provided, which was improper.

11 N.Y.C.R.R. §65-3.2 provides, in part, as follows:

§ 65-3.2 Claim practice principles to be followed by all insurers

(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.

Conclusion

Based upon a preponderance of the credible evidence, I find that Applicant established its prima facie case and arguably responded to Respondent's requests for additional verification.

If Respondent believed that Applicant's response was insufficient, it should have explained in writing why it believed this."

I therefore find that applicant has demonstrated "substantial compliance" with Respondent's verification requests in good faith. Applicant has produced numerous documents which have been requested. I find that the Respondent has not sufficiently justified its need for any outstanding documentation. As such, Respondent's 120 rule denials cannot be sustained. Therefore, From a review of the documents submitted by each side and the arguments of the parties, I find that respondent's denials cannot be sustained.

The 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
	Aris Diagnostic Medical PLLC	01/22/20 - 01/22/20	\$1,537.67	Awarded: \$1,537.67
	Aris Diagnostic Medical PLLC	02/17/20 - 02/17/20	\$659.79	Awarded: \$659.79
	Aris Diagnostic Medical PLLC	02/17/20 - 02/17/20	\$912.00	Awarded: \$912.00
Total			\$3,109.46	Awarded: \$3,109.46

- B. The insurer shall also compute and pay the applicant interest set forth below. 07/22/2020 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest to run from 30 days after the presentment of the additional verification response and five days for mailing.

C. Attorney's Fees

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

Applicable attorney fees on the amount awarded in accordance with 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 Suffolk

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

08/10/2022
(Dated)

Sandra Adelson

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:
35e21081e2b5d068e0adbe87f16a12f1

Electronically Signed

Your name: Sandra Adelson
Signed on: 08/10/2022