American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

New Age Medical PC (Applicant)	AAA Case No.	17-20-1187-4459
	Applicant's File No.	ZJ161668075
- and -	Insurer's Claim File No.	668481-02
	NAIC No.	16616
American Transit Insurance Company (Respondent)		

ARBITRATION AWARD

I, Evelina Miller, 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: MH

1. Hearing(s) held on 07/26/2022
   Declared closed by the arbitrator on 07/26/2022

   Ilya Murafa Esq from Law Offices of Zara Javakov, Esq. P.C. participated for the Applicant

   Helen Cohen Esq from American Transit Insurance Company participated for the Respondent

2. The amount claimed in the Arbitration Request, **$1,790.67**, 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 dispute arises from the underlying automobile accident of June 19, 2016, in which the Assignor (MH), a 41-year-old-male was involved. Thereafter, Assignor sought private medical attention and was eventually evaluated by Applicant with complaints of pain in the wrist, lower back, left hip and the left knee. Eventually patient was recommended to undergo MRI of the lumbar spine and the left hip which were performed on 11/8/18 and 11/15/18 respectively. Upon receipt of Applicant's bills Respondent issued verification request. Respondent contends that Applicant failed to respond to Respondent's requests and the claim remains outstanding.

The issue presented at the hearing is whether Applicant substantially complied with Respondent's verification requests.

4. Findings, Conclusions, and Basis Therefor

This award is rendered after a careful review and consideration of the parties' evidence submitted and maintained in MODRIA which is maintained by the American Arbitration Association. These submissions are the record in this case. My decision is based on my review of that file, as well as the arguments of the parties at the hearing. This hearing took place via ZOOM.

I find that Applicant establishes its prima facie showing of entitlement to recover first-party no-fault benefits by submitting evidentiary proof that the prescribed statutory billing forms, setting forth the fact and amount of the loss sustained, had been mailed and received and that payment of no-fault benefits were overdue. See *Mary Immaculate Hospital v. Allstate Insurance Co*.,5 A.D.3d 742, (2d Dept., 2004). Once an applicant establishes a prima facie case, the burden then shifts to the insurer to prove its defense. See *Citywide Social Work & Psy. Serv. P.L.L.C v. Travelers Indemnity Co., 3 Misc. 3d 608, 2004, NY Slip Op 24034 [Civ. Ct., Kings County 2004])*.

Upon receipt of Applicant's bill Respondent issued verification requests on 12/22/18, 1/28/19, 2/1/19 seeking the following:

1. *Proof that provider is a certified Workers' Compensation health Provider*

2. *The request was issued to the claimant-*
    a. *submit the names of Base or Car Service at the time of accident.*
    b. *Confirmation the named Base paid into Livery Fund*
    c. *If claimant worked during period of treatment, please submit an affidavit of the date returned to work.*

3. *MRI films of the hip*

4. *Letter of medical necessity signed and dated by the treating provider*

5. *All other diagnostic testing/MRI films performed on the claimant by your company or all other companies that are affiliated with your corporation. A letter summarizing these services must be forwarded with the reports/treatment plan. Please include reports and a letter of necessity from the referring/treating physician to show causal relationship to the accident of record.*

Respondent also issued verification requests to the Assignor on 8/5/16 and 9/9/16 seeking the following:

"*1. We are in receipt of your claim for benefits, be advised this claim maybe subject to the independent livery fund. In order to obtain this coverage please provide relevant information regarding your eligibility for such coverage.*
Forward the name of the Car Service or Base from which the call was dispatched, proof the vehicle involved in the accident of record and the Base have paid into the fund.
Please not if the claim is provided for under the Independent Livery Fund which allows for No-Fault benefits, the claim will be subject to WC rules and regulations regarding loss of income and regarding but not limited to loss of income, pre-authorization of medical treatment and procedures. If you continue to work during the period of treatment, you must state the date you started to work."

Applicant contends that on 1/22/19 it responded to Respondent's request and submitted the following:

- MRI films
- Patient's affidavit
- Proof that provider is a certified WC health provider
- Letter of medical necessity
- Copy of the Narrative report from the referring physician

Applicant contends that it has substantially complied with Respondent's request. Applicant further argued that there is no indication that the Assignor was in the course of his employment, as such Respondent was not entitled to information regarding Livery Fund and Car Service base.

Applicant refers to Assignor's affidavit which states the following:

"*I, (MH), confirm that on June 19, 2016 at about 16:00 PM, I was involved in an automobile accident on Grand Central Pkway and Clearview Expway, Queens, NY.*

I further state that at the time of the accident I was not in the course of employment."

"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 (*seeInsurance Law § 5106[a]; 11 NYCRR 65-3.8[c]; see also11 NYCRR 65-3.5)." Infinity Health Products, Ltd. v. Eveready Ins. Co., 67 A.D.3d 862, 864, 890 N.Y.S.2d 545, 547 (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-[business] 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 with or 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*).

11 NYCRR § 65-3.8 (b)(3) then provides that:

"…..An insurer may issue a denial if, more than 120 calendar days after the initial request for verification, the applicant has not submitted all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply, provided that the verification request so advised the applicant as required in section 65-3.5(o) of this Subpart."

11 NYCRR § 65- 3.5 (o) provides that:

"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."

"Pursuant to 11NYCRR 65-3.8 (b) New York State Insurance Regulation 68-C an insurer may issue a denial if, more than 120 calendar days after the initial request for verification, the applicant has not submitted all such verification under the **applicant's control or possession** or written proof providing reasonable justification for the failure to comply."

Additionally, I note, Regulation § 65-3.5(c) provides that an insurer is entitled to *receive all items necessary to verify the claim directly from the parties from whom such verification is requested.* This latter section does not confine or require the insurer to seek information solely from the provider but rather contemplates that verification information may be sought from any source." *Westchester Medical Center v. One Beacon Ins. Co.,* 22 Misc.3d 1102(A), 880 N.Y.S.2d 228 (Table), 2008 N.Y. Slip Op.

52580(U) at 2, 2008 WL 5431381 (Sup Ct. Nassau Co., Daniel R. Palmieri, J., Dec. 1, 2008).

Applicant "cannot simply rest on its laurels and ignore a verification request . . . Since the [Applicant] desires to be paid the onus is on it to insure that the [Respondent] has all of the required information to verify and pay the claim." D*&R Medical Supply, Inc. v. Clarendon Nat. Ins. Co., 22 Misc. 3d 1127(a), 881 N.Y.S.2d 362, 2009 Slip Op 50306(U) (Civ. Ct. Kings Co., Feb. 6, 2009).* "Any confusion on the part of [an applicant] as to what was being sought should [be] addressed by further communication, not inaction." *Westchester County Medical Center v. New York Central Mut. Ins. Co., 262 A.D. 553, 692 N.Y.S.2d 665 (2d Dept. 1999).* "Even when a claimant believes it need not comply with a verification request, the claimant still has a duty to communicate with the insurer regarding the request. . . The [insurer] should not be put in a position to second guess the reason or reasons why the [claimant] has failed to respond to the request." *Canarsie Chiropractic, P.C. v. State Farm Mut. Auto. Ins. Co., 27 Misc. 3d 1228(A), 911 N.Y.S.2d 691 (Civ. Ct. Kings Co. 2010).* A failure to raise an objection to the request will even result in a waiver of the defense the notices were defective and unreasonable. *Canarsie Chiropractic, P.C. v. State Farm Mut. Auto. Ins. Co., 27 Misc. 3d 1228(A), 911 N.Y.S.2d 691 (Civ. Ct. Kings Co. 2010).*

The purpose of the No-Fault statute is to ensure prompt resolution of claims by accident victims. The parties' obligations are centered on good faith and common sense. Any questions concerning a communication should be addressed by further communication, not inaction. *Dilon Medical Supply Corp. v. Travelers Ins. Co., 7 Misc.3d 927 (Civ. Ct. Kings Co. 2005)*. The response to a verification request that is "arguably responsive" places the burden to take further action upon the carrier. *All Health Medical Care, P.C. v. GEICO, 2 Misc.3d 907 (NY City Civ Ct. 2004)*. Moreover, as long as applicant's documentation is arguably responsive to an insurer's verification request, the insurer must act affirmatively once it receives a response to its verification request. *Media Neurology P.C. v. Countrywide, Ins. Co., 21 Misc.3d 1101 (NY City Civ. Ct. 2005).*

Based on the above, I find that Applicant has substantially complied with Respondent's request for verification pursuant to **11 NYCRR § 65- 3.5 (o)** by providing the documents under the applicant's control or possession. The information sought was sought from the Assignor and not from Applicant. Furthermore, I agree with Applicant and find that since Respondent was notified by the Assignor in the form of a notarized Affidavit that he was not in the course of his employment at the time of the accident. Without further evidence from the Respondent indicating that there is a question of fact for Workers' Compensation Board, I do not find that the information requested regarding Livery Fund was necessary for processing the claim. The response to a verification request that is "arguably responsive" places the burden to take further action upon the carrier. *All Health Medical Care, P.C. v. GEICO, 2 Misc.3d 907 (NY City Civ Ct. 2004)*.

Accordingly, Applicant's claim for reimbursement 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**
	New Age Medical PC	**11/08/18 - 11/08/18**	**$912.00**	**Awarded: $912.00**
	New Age Medical PC	**11/15/18 - 11/15/18**	**$878.67**	**Awarded: $878.67**
Total			**$1,790.67**	**Awarded: $1,790.67**

B. The insurer shall also compute and pay the applicant interest set forth below. 12/09/2020 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

   Since the motor vehicle accident occurred after April 5, 2002, interest shall be calculated at the rate of two percent per month, simple, calculated on a pro rata basis using a 30-day month. 11 NYCRR 65-3.9(a). In accordance with 11 NYCRR 65-3.9c, interest shall be paid on the claims totaling $1,790.67 from the date the arbitration was commenced.

C. Attorney's Fees

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

Respondent shall pay Applicant an attorney's fee upon the amount awarded plus the interest, as calculated in section "B" above, and in accordance with 11 NYCRR 65-4.6(e), i.e., 20 percent of the amount of first party benefits, plus interest thereon. The minimum attorney's fee payable shall be in accordance with 11 NYCRR 65-4.6c. For cases filed after February 4, 2015, there is no minimum attorney's fee but there is a maximum fee of $1,360.00. However, if the benefits and interest awarded thereon is equal to or less than the respondent's written offer during the conciliation process, then the attorney's 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 Kings

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

08/26/2022
(Dated)

Evelina Miller

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:
821a36c2e8c560c00eca35a0e8639624

Electronically Signed

Your name: Evelina Miller
Signed on: 08/26/2022