American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Nexray Medical Imaging PC d/b/a Soul Radiology (Applicant)	AAA Case No.	17-21-1232-2994
	Applicant's File No.	RFA21-303581
- and -	Insurer's Claim File No.	1097175-01
	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: DM

1. Hearing(s) held on 02/28/2023
   Declared closed by the arbitrator on 02/28/2023

   Mohamed Anwar Esq from Russell Friedman & Associates LLP participated virtually for the Applicant

   John Gilroy Esq from American Transit Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$2,695.51**, 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 April 29, 2021, in which the Assignor (DM), a 31-year-old-male was involved. Thereafter, Assignor sought private medical attention and was eventually evaluated at Graham Wellness Medical P.C. with complaints of neck pain, lower back pain and bilateral shoulder pain. Eventually patient was recommended to undergo MRIS of the Cervical and Lumbar spine as well as the MRI of the right shoulder. Upon receipt of Applicant's bill Respondent issued verification requests to Applicant seeking information to verify the claim. Respondent contends that the claim is premature since Applicant failed to comply with the outstanding verification to date.

The issue presented at the hearing is whether Respondent properly tolled its regulatory time to pay or deny the bill by issuing verification requests from Applicant

The second issue presented at the hearing is whether Applicant substantially complied with verification requests sought by the Respondent

4. Findings, Conclusions, and Basis Therefor

I have reviewed the submissions contained in MODRIA which are 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. All parties at this hearing appeared 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 for date of service of 5/12/21 Respondent issued verification requests on 6/25/21 and thereafter on 7/30/21, seeking the following:

> *"1. Medical records (hospital/ ER/ Ambulance and/or any Medical Records) from the date of service of accident to show injuries sustained at the time of accident to verify injuries and the necessity of treatment thereafter.*
> *2. Submit the MRI film of the right shoulder*
> *3. Submit an independent letter of medical necessity signed and dated by the treating/referring physician indicating in detail how each of the diagnostic testing is causally related to the accident of record.*
> *4. Initial report from referring physician."*

Upon receipt of Applicant's bill for date of service of 6/2/21 Respondent issued verification requests on 7/20/21 and thereafter 8/25/21 seeking the following:

> *"1. Medical records (hospital/ ER/ Ambulance and/or any Medical Records) from the date of service of accident to show injuries sustained at the time of accident to verify injuries and the necessity of treatment thereafter.*
> *2. Submit the MRI film of the cervical and lumbar spine.*

3. Submit an independent letter of medical necessity signed and dated by the treating/referring physician indicating in detail how each of the diagnostic testing is causally related to the accident of record.
4. Initial report from referring physician."

It is the Respondent's burden initially to prove that it timely mailed its request and follow-up request for verification to the health care provider. See, e.g., *Proscan Imaging, P.C. v. Travelers Indemnity Co., 28 Misc.3d 127(A), 2010 N.Y. Slip Op. 51176(U), 2010 WL 2681691 (App. Term 2d, 11th &13th Dists. July 7, 2010).*

In this case, it was uncontested that the Respondent mailed timely requests for verification requesting the items listed above. The verification requests contain the correct address as well as proper language. I find the verification requests to be timely issued and proper.

"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 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, 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 or with 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 § 65-3.6 (b) of the No-Fault Regulation states:

"Verification requests. 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."

Even if an insurance company's initial request for verification is sent more than 15 business days after receipt of the claim, it is not "a nullity" so long as it is made before the 30-day claim denial window has expired. See *11 NYCRR 65-3.8 (j); Hospital for Joint Diseases v. Travelers Prop. Cas. Ins. Co., 9 N.Y.3d 312, 320 (2007); Nyack Hosp. v. General Motors Acceptance Corp., 8 N.Y.3d 294, 300 (2007). Compare O & M Medical, P.C. v. Travelers Indemnity Ins. Co., 2015 NY Slip Op 50476(U) (App Term 2d, 11th & 13th Jud Dists. March 26, 2015).*

An insurer is not obligated to pay or deny a claim until it has received verification of all relevant information requested. *11 NYCRR § 65.15(g)(1)(I); 2(iii). See Hosp. for Joint Diseases v. New York Cent. Mut. Fire Ins. Co., 2007 NY Slip Op 08038 (App. Div. 2d Dept.); Mount Sinai Hosp. v. Chubb Group of Ins. Cos., 2007 NY Slip Op 06650 (App. Div. 2d Dept.); New York & Presbyterian Hosp. v. Progressive Cas. Ins. Co., 2004 NY Slip Op 01750 (2d Dept. May 26, 2004); Eagle Surgical Supply, Inc. v. Travelers Indem. Co., 2010 NY Slip Op 51775(U) (App Term 2d Dept. Oct. 5, 2010); Beta Supply, Inc. v. Government Empls. Ins. Co., 2008 NY Slip Op 51406(U) (App Term 1st Dept., July 16, 2008); Bronx Expert Radiology P.C. v. Travelers Ins. Co., 2006 NY Slip Op 51227(U) (App Term 1st Dept, June 29, 2006); Elite Chiropractic Servs., PC v Travelers Ins. Co., 9 Misc 3d 137(A), 2005 NY Slip Op. 51735(U) (2005).*

With respect to a verification request and notice, 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. 11 NYCRR 65-3.5(p).

An insurer is not obligated to pay or deny a claim until it has received verification of all relevant information requested; any action begun before such verification has been provided is premature inasmuch as the period for the insurer to respond to the claim has not begun to run. *Nyack Hospital v. State Farm Mutual Automobile Ins. Co., 19 A.D.3d 569, 796 N.Y.S.2d 538 (2d Dept. 2005).*

"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 (see, *Dilon Medical Supply Corp. v. Travelers Insurance Co.*, 7 Misc 3d 927). It is well established that 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. (see, *Dilon Medical Supply Corp. v. Travelers Insurance Co*, supra). If a Plaintiff deems a Verification Request to be defective and or unreasonable, it is incumbent on that Plaintiff to convey that information to the Defendant and to state the reasons thereof, thereby giving the Defendant the opportunity to respond accordingly. The Defendant should not be put in a position to second guess the reason or reasons why the Plaintiff has failed to respond to the request." *Canarsie Chiropractic, P.C. v. State Farm Mutual Automobile Ins. Co., 27 Misc.3d 1228(A), 911 N.Y.S.2d 691 (Table), 2010 N.Y. Slip Op. 50950(U) at 2, 2010 WL 2105860 (Civ. Ct. Kings Co., Sylvia G. Ash, J., May 25, 2010).*

A claimant "cannot simply rest on its laurels and ignore a verification request. . . . Since the plaintiff desires to be paid, the onus is on it to ensure that the defendant has all of the required information to verify and pay the claim. Plaintiff completely ignored its burden and commenced this action prematurely." *D & R Medical Supply, Inc. v. Clarendon Nat. Ins. Co., 22 Misc.3d 1127(A), 881 N.Y.S.2d 362 (Table), 2009 N.Y. Slip Op. 50306(U), 2009 WL 485262 (Civ. Ct. Kings Co., Genine D. Edwards, J., Feb. 26, 2009).*

Applicant contends that on 7/23/21, it submitted a response to the Respondent's verification requests. Applicant stated the following:

"We received your request dated 6/25/21. As per your request, please find the following documents:

- *DVD of MRI film*
- *Invoice for requested MRI film*
- *Copy of your request."*

Thereafter, on 8/27/21 Applicant issued a second response to the Respondent's verification request stating the following:

"We received your request dated 7/30/21. As per your request, please find the following documents:

- *Narrative Report*
- *Letter of Medical Necessity*
- *Copy of your request."*

On 9/27/21 Respondent issued a letter to Applicant acknowledging Applicant's responses to the outstanding verification. In this letter Respondent noted that bills were still delayed pending the following:

Medical records (HOSPITAL / ER / AMBULANCE and/or any MEDICAL RECORDS) from the date of accident to show injuries sustained at the time of accident to verify injuries and the necessity of treatment thereafter.

On 11/26/21 Respondent issued a letter to Applicant acknowledging Applicant's responses to the outstanding verification. In this letter Respondent noted that bills were still delayed pending the following:

"Please be advised that the entire claim is delayed pending an examination under oath of the claimant, Scheduled to verify the claim

Medical records (HOSPITAL / ER / AMBULANCE and/or any MEDICAL RECORDS) from the date of accident to show injuries sustained at the time of accident to verify injuries and the necessity of treatment thereafter."

Respondent contends that Applicant has failed to substantially comply with the outstanding verification as the items requested in the last letter dated 11/26/21 have not been submitted.

Applicant argued that it has substantially complied with the outstanding verification by submitting all the evidence in its responses dated 7/23/21 and 8/27/21.

Applicant further argued that Respondent's request for an EUO in the letter dated 11/26/21 is untimely and therefore insufficient.

Initially I find the response issued by the Applicant to be sufficient. Applicant submitted *DVD of MRI film, Invoice for requested MRI film, Narrative Report, and letter of medical necessity.* Respondent's requests states that Applicant is to provide HOSPITAL / ER / AMBULANCE and/or any MEDICAL RECORDS. Respondent submitted a narrative report dated 5/4/21, just 5 days post date of accident. Furthermore, there are discharge papers from Wykoff hospital which indicate that the patient had undergone an x-ray of the lumbar spine. Patient also received a prescription for Ibuprofen, lidocaine 5%, and naproxen.

"If the provider objects to the request for verification, then the issue of whether the requested verification material and the objection were proper are preserved and become questions of fact for the trier of fact." *Victory Medical Diagnostics, PC v. Nationwide Property and Cas. Ins. Co., 36 Misc.3d 568, 576, 949 N.Y.S.2d 855 (Dist. Ct. Nass. Co. 2012).*

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).*

"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. Nationwide is denying your claim for failure to provide the requested verification or written proof providing reasonable justification for the failure to comply within 120 calendar days after our initial request on 5/22/15."

Here, Applicant did respond to Respondent's verification requests providing the information in its possession which consists of *DVD of MRI film, Invoice for requested MRI film, Narrative Report, and letter of medical necessity.* Thus, I find that Applicant has substantially complied with Respondent's verification requests.

Regarding the timeliness of the EUO requests I find that Respondent does not properly toll its time to issue additional verification requests.

"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 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, 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 or with 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).

Respondent is under a regulatory obligation pursuant to 11 NYCRR 65-3.8[c] to either pay or deny the bill, or toll its regulatory time constraint by issuing a verification request pursuant to 11 NYCRR 65.3.5(b), and 65-3.6 (b).

Insurance Regulation 68-C Section 65-3.5 (b) of the No-Fault Regulations states:

> *"Subsequent to the receipt of one or more of the completed verification fo rms, 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."*

Section 65-3.6 (b) of the No-Fault Regulation states:

> *"Verification requests. 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*

In order to toll the 30-day deadline, an initial EUO request must be sent within 30 days after receipt of the bill. *Tsatskis v. State Farm Fire and Casualty Co., 36 Misc.3d 129(A) (App. Term 9 & 10 Dist. June 27, 2012*. Further, although the EUO need not be scheduled within a 30-day period, the actual request for the EUO must be issued within 15 days of receipt of the claim to toll the period. *The New York Hospital Medical v. Allstate Ins. Co., 2012 N.Y. Slip Op. 30418(U) at 4, 2012 WL 683158 (Sup. Ct. Nassau Co., Anthony L. Parga, J., Feb. 7, 2012*).

While an insurer may request further verification in the form of an EUO after receipt of additional verification, see, e.g., *Neptune Med. Care, P.C. v. Ameriprise Auto & Home, 2015 NY Slip Op 51220(U) (App Term 1st Dept., Ins. Aug. 5, 2015); Quality Psychological Servs., P.C. v. Utica Mut. Ins. Co., 38 Misc.3d 136(A), 2013 NY Slip Op 50148(U) (App Term 1st Dept., Feb. 1, 2013)* (EUO of provider requested after EUO completed of the provider's assignor), the insurance carrier has an "initial burden of establishing, prima facie, that it requested (examinations) in accordance with the procedures and time frames set forth in the no-fault implementing regulations'", *Acupuncture Approach, P.C., v. Allstate Ins. Co., 2015 NY Slip Op 50318(U) (App Term 1st Dept., March 16, 2015) (quoting Unitrin Advantage Ins. Co. v. Bayshore Physical Therapy, PLLC, 82 A.D.3d 559, 560 (1st Dept. 2011*), and an EUO request made well beyond the requisite 15-day time period for additional verification, outside the 30-day claims determination period, is ineffective to extend the 30-day period within which an insurer is required to pay or deny a claim, see *O & M Medical, P.C. v. Travelers Indemnity Ins. Co., 2015 NY Slip Op 50476(U) (App Term 2d, 11th & 13th Jud Dists. March 26, 2015)* (request sent nearly three months after receipt of claim is "a nullity");

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 are 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). See also *William Jones, M.D. and Ameriprise Auto Home Ins. Co., AAA Case No. 412013081313, AAA Assessment No. 17 991 60360 13 (arb. Andrew M. Horn, April 14, 2014), aff'd 17 991 R 38783 14 (Master Arb. Norman H. Dachs, Aug. 26, 2014).* (T)he Regulations do not provide that such a toll grants an insurer additional opportunities to make requests for verification that would otherwise be untimely." *Neptune Med. Care, P.C. v. Ameriprise Auto & Home Ins. U, 2015 NY Slip Op 51220 (App Term 1st Dept., Aug. 5, 2015).*

Applicant contends that the EUOs in this case were scheduled late. Specifically, Applicant points out that Respondent issued verification requests for dates of service of 5/12/21 on 6/25/21, and for date of service of 6/2/21 on 7/20/21. However, Respondent issued its initial request for an EUO (*in Respondent submission)* on 12/1/21, 5 months later - past the 30-day period.

EUO scheduling letters issued more than 15 business days after receipt of a bill, and also more than 30 calendar days after its receipt are nullities. The ability to toll the 30-day deadline within which an insurer is required to pay or deny a bill through the issuance of a verification request pursuant to 11 NYCRR 65-3.8(a) does not grant an insurer an additional opportunity to make requests for verification that would otherwise be untimely. *Neptune Medical Care, P.C. v. Ameriprise Auto & Home Ins., 48 Misc.3d 139(A), N.Y.S.3d (Table), 2015 N.Y. Slip Op. 51220(U), 2015 WL 4939009 (App. Term 2d, 11th & 13th Dists. Aug. 5, 2015*) (EUO scheduled in addition to requesting additional verification did not toll subject bill).

The EUO in this case was scheduled late, not within 30 days of receipt of the bill. Pursuant to the holding in *Neptune Medical Care* The ability to toll the 30-day deadline within which an insurer is required to pay or deny a bill through the issuance of a verification request pursuant to 11 NYCRR 65-3.8(a) does not grant an insurer an additional opportunity to make requests for verification that would otherwise be untimely.

Upon review of the evidence before me and the arguments presented at the hearing, I find that Applicant had substantially complied with Respondent's verification requests on 8/27/21.

Additionally, as discussed above, pursuant to the holding in *Neptune Medical Care* the ability to toll the 30-day deadline within which an insurer is required to pay or deny a bill through the issuance of a verification request pursuant to 11 NYCRR 65-3.8(a) does not grant an insurer an additional opportunity to make requests for verification that would otherwise be untimely. As such, Respondent's requests for an EUO were issued late and not within its regulatory time.

As such, I find that the claim for dates of service of 5/12/21 and 6/2/21 became due on 10/1/21 (Applicant submitted its final response on 8/27/21. Allowing 5 days for mailing, puts the response in Respondent's hands on 9/1/21. The claim became fully verified on 9/1/21), 30 days after Respondent received response to the verification requests from Applicant.

Accordingly, Applicant's claim for reimbursement is granted for dates of service of 5/12/21 and 6/2/21.

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**
	Nexray Medical Imaging PC	**05/12/21 -**	**$966.54**	**Awarded:**

	d/b/a Soul Radiology	**05/12/21**		**$966.54**
	Nexray Medical Imaging PC d/b/a Soul Radiology	**06/02/21 - 06/02/21**	**$1,728.97**	**Awarded: $1,728.97**
Total			**$2,695.51**	**Awarded: $2,695.51**

B. The insurer shall also compute and pay the applicant interest set forth below. 10/01/2021 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 regulation. See generally, 11 NYCRR 65-3.9.

With respect to the interest accrual date, see specifically 11 NYCRR 65-3.9(c), and 65-4.5(s)(3). "All overdue mandatory and additional personal injury protection benefits due an applicant or assignee shall bear interest at a rate of two percent per month, calculated on a pro-rata basis using a 30-day month. . . .

Thus, where an insurer fails to pay or deny a claim within the requisite 30-day period, the claim becomes overdue and interest begins to accrue at that point. Interest continues to accrue on an overdue claim until the claimant receives payment or a denial of claim form."

Applicant mailed final response to the verification requests on 8/27/21. Allowing 5 days for mailing puts the bills in Respondent's hands on 9/1/21.

Affording 30 days for processing, the claim became overdue on 10/1/21.

Interest continues to accrue on an overdue claim until the claimant receives payment or a denial of claim form is issued. As such, Applicant is entitled to interest from the date the bill became due not counting the date of accrual. (General Construction Law 20).

In calculating interest, the date of accrual shall be excluded from the calculation. General Construction Law § 20 ("The day from which any specified period of time is reckoned shall be excluded in making the reckoning.") Where a motor vehicle accident occurs after Apr. 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); *Gokey v. Blue Ridge Ins. Co., 2009 NY Slip Op 50361(U), 881 N.Y.S.2d 363 (Table), 2009 WL 562755 (Sup. Ct. Ulster Co., Henry F. Zwack, J., Jan. 21, 2009).*

As such, interest shall commence on 10/1/21, the date the claim became due.

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 NY
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.

04/11/2023
(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:
84049befb681d461d56aea3b1099f96a

Electronically Signed

Your name: Evelina Miller
Signed on: 04/11/2023