American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

New York Recovery PT PC (Applicant)	AAA Case No.	17-22-1257-2842
	Applicant's File No.	OS-57991
- and -	Insurer's Claim File No.	0647560242
	NAIC No.	19232
Allstate Insurance Company (Respondent)		

ARBITRATION AWARD

I, Yael Aspir, 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: EIP

1. Hearing(s) held on 05/18/2023
   Declared closed by the arbitrator on 05/18/2023

   Olga Sklyut from Law Office of Olga Sklyut P.C. participated virtually for the Applicant

   Marissa Allis from Law Offices of John Trop participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$4,075.45**, 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 EIP, XH, a 32 year old female driver, was injured by a motor vehicle involved in an accident on 10/28/21. In dispute is the Applicant's claim for $4,075.45 for treatment provided to the EIP on 11/02/21 through 03/22/22.

   Respondent denied the claim based on the 120 day rule. No fee schedule issues were raised at the hearing and no fee audits were provided for review.

   The issue to be determined is whether Respondent's defense can be sustained.

4. Findings, Conclusions, and Basis Therefor

The case was decided on the submissions of the Parties as contained in the electronic file maintained by the American Arbitration Association and the oral arguments of the parties' representatives. There were no witnesses. I reviewed the documents contained in the electronic file for both parties and make my decision in reliance thereon.

A review of the competent evidence in the record reveals that Applicant established a prima facie case of entitlement to reimbursement of its claim, by submitting evidence that the prescribed statutory billing form was mailed and received, and that the Respondent failed to either pay or deny the claim within the requisite 30-day period. Mary Immaculate Hospital v. Allstate Insurance Co., 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). Once Applicant has made out a prima facie case, the burden shifts to Respondent to timely request additional verification, deny, or pay the claim. Hospital for Joint Diseases v. Travelers Prop. Cas. Ins, Co., 9 N.Y.3d 312 (2007).

11 NYCRR 65-3.5(c) indicates that the insurer is entitled to receive all items necessary to verify the claim directly from the parties from whom such verification was requested. Thereafter, at a minimum, if any requested verification 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. See 11 NYCRR 65-3.6 (b). Once the insurer proves that it timely mailed its request and follow-up request for verification to the health care provider, if the latter does not demonstrate that it provided the insurer with the requested verification prior to the commencement of litigation, the litigation is premature inasmuch as the 30-day period within which the insurer was required to pay or deny the claim did not commence to run. 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).

Respondent denied the claims in reliance on 11 NYCRR Section 65- 3.8(b)(3) which 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 verification under the Applicant's control or possession or written proof providing reasonable justification for the failure to comply."

The record reflects that Applicant seeks reimbursement for treatment provided to the EIP on 11/02/21 through 03/22/22. Following receipt of the claim, Respondent sought further verification, and ultimately denied the claim based on the 120 day rule.

In support of its claim, Applicant submitted a response to verification with an affidavit of mailing to Respondent at 4 Metrotech Center, Ste 2001, Brooklyn, NY 11201 and/or PO Box 2874, Clinton, IA 52733. However, Respondent argued that the verification requests mailed to Applicant specifically stated as follows:

Please remit all your responses to the address below: Allstate Verifications PO Box 660328 Dallas TX 75266-0328.

A similar issue was previously addressed by Arbitrator Eck in *New York Recovery PT PC v. Allstate Insurance Company*, 17-21-1224-3619. In that case, the Arbitrator concluded that Applicant's response to an incorrect address was not a valid response to verification. In the above-referenced case, Arbitrator Eck stated as follows:

> *Subsequent to the receipt of one or more of the completed verification forms, 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. Any requests by an insurer for additional verification need not be made on any prescribed or particular form. If a claim is received by an insurer at an address other than the proper claims processing office, the 15 business day period for requesting additional verification shall commence on the date the claim is received at the proper claims processing office. In such event, the date deemed to constitute receipt of claim at the proper claim processing office shall not exceed 10 business days after receipt at the incorrect office. See 11 NYCRR §65-3.5(b).*
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> *The obligation to pay or deny a claim is not triggered until the insurer has received all of the relevant information that was requested. Amaze Medical Supply Inc. v. Allstate Insurance Co., 3 Misc3d at 133. Hospital for Joint Diseases v. State Farm Mut. Auto. Ins. Co., 8 AD3d 533, 2004 NY Slip Op 05413 (App. Div., 2 Dept., 2004).*
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> *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. NYCRR §65-3.5(o).*
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> *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. This subdivision shall apply to medical services rendered, and to lost earnings and other reasonable and necessary expenses incurred, on or after April 1, 2013. NYCRR §65-3.5(p).

In the instant matter, Respondent requested additional verification from the Applicant for bill with dates of service 12/29/2020-6/24/2021 for physical therapy services.

A review of the letters show they do have the prescribed statutory language advising the Applicant that their claim may be denied if the verification sought is not provided within 120 days from the initial request.

Applicant argues they responded by letter dated 4/22/2021. Respondent argues that the responses were sent to the wrong address. Applicant sent the responses to 4 Metrotech Center, suite 2001, Brooklyn, NY 11201.

Respondent argues this address is no longer valid and also points to the request letters which state: "Please remit all responses to the address below: Allstate Verification, PO Box 660328, Dallas TX 75266-0328.

Respondent submitted an award by Arbitrator Greta Vilar in support of its argument that the responses were sent to the wrong address. See Motion Medical Diagnostics, PC v Allstate Fire & Casualty Insurance Company - 17-21-1217-0323. Arbitrator Vilar stated:

The respondent argues that it did not receive the applicant's verification response and points out that the address and fax number to which the verification response was sent were incorrect. The respondent points out that its verification request letters specifically direct that responses are to be submitted to a Texas PO Box address. A phone number for additional questions is provided, but there is no fax number listed on the verification request for service of responses via fax. The respondent argued that the address used by the applicant was in Brooklyn, NY, and not the Texas address indicated in the verification requests. In addition, the fax number listed on the applicant's letter does not appear to correspond to any valid fax number for verification responses. I was unable to find any record of the fax number utilized by the applicant in sending its verification responses in any of the evidence before me.

Having thoroughly reviewed the records before me, I am persuaded by the respondent on the issue of verification. The verification requests clearly indicate the address to be used when responding to verification. The applicant inexplicably used a different address. In addition, I find that the evidence before

me is insufficient to show that the fax number utilized by the applicant is in fact a valid fax number for verification responses. I find that this is insufficient, and the applicant's claim is dismissed.

After reviewing the ECF, I find the Respondent timely and properly requested Additional verification from the Applicant. Applicant has not submitted any evidence to establish that they responded to the requests for verification at the proper address. I agree with Arbitrator Vilar that the address in which the verification is to be sent to is clearly stated on each request letter. It is unclear why they were not sent to the address listed. Therefore, based on the preponderance of the evidence, Applicant's claim is hereby dismissed without prejudice.

In the instant case, I find that Respondent timely sought verification in accordance with 11 NYCRR 65-3.5 and 65-3.6 and that the verification was not received within 120 days. I am persuaded by Arbitrator Eck's and Arbitrator Vilar's rationale discussed above and adopted herein.

Therefore, for the reasons noted above, I find that Applicant failed to establish that it properly responded to the requested verification and I find that Respondent properly denied Applicant's claim.

Accordingly, Applicant's claim is denied in its entirety.

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

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

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

Accordingly, the claim is DENIED in its entirety

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

State of NY
SS :
County of Nassau

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

06/02/2023
(Dated)

Yael Aspir

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:
8cb8209836b8e8020070765e0d432583

Electronically Signed

Your name: Yael Aspir
Signed on: 06/02/2023