American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Medaid Radiology LLC (Applicant)	AAA Case No.	17-21-1207-3125
	Applicant's File No.	RFA21-298099
- and -	Insurer's Claim File No.	0682064600000002
	NAIC No.	35882
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Ben Feder, 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: IP or assignor

1. Hearing(s) held on 05/30/2023
   Declared closed by the arbitrator on 05/30/2023

   Sheetal Paul from Russell Friedman & Associates LLP participated virtually for the Applicant

   Chris Mango from Rivkin & Radler LLP participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$828.31**, 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

   This arbitration arises out of medical treatment for the IP, an 18 year old male, related to injuries sustained in a motor vehicle accident that occurred on 10/11/20. Applicant seeks reimbursement for a left shoulder MRI provided to the IP on 11/2/20. Respondent timely denied payment of the services based upon 11 NYCRR Section 65-3.8(b) (3), otherwise known as the "120 day rule". Applicant asserts that it fully complied with Respondent's verification requests.

   Whether Respondent's denial, based on the 120 day rule, can be upheld?

4. Findings, Conclusions, and Basis Therefor

Applicant has established its prima facie case with proof that it submitted a proper claim, setting forth the fact and the amount charged for the services rendered and that payment of no-fault benefits was overdue (see Insurance Law § 5106 a; Mary Immaculate Hosp. v. Allstate Ins. Co., 5 AD 3d 742, 774 N.Y.S. 2d 564 [2004]; Amaze Med. Supply v. Eagle Ins. Co., 2 Misc. 3d 128A, 784 N.Y.S. 2d 918, 2003 NY Slip Op 51701U [App Term, 2nd and 11th Judicial Districts). The burden shifts to the insurer to prove that the services were not medically necessary.

The Respondent denied the claim 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." Respondent's denial asserts that Applicant failed to comply with the verification requests within 120 days.

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. Geico, 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 Services., PC v Travelers Ins. Co., 9 Misc. 3d 137(A), 2005 NY Slip Op. 51735(U) (2005).

The record is clear in this matter. Respondent sought further verification post-examination under oath of the principal of Applicant. Applicant responded by providing certain information and objecting to the remainder as inappropriate. It is significant to note that the verification sought has been an ongoing dispute between the parties. There are numerous awards submitted by both sides regarding the specific verification at issue herein. The relevant record reveals that the remaining verification sought are as follows:

1. Documents, contracts, and agreements (including proofs of payment thereunder) between the Provider and any entity or individual that leases space and/or equipment to or from the Provider, including 481 North 13th Street, Newark, NJ;

2. Documents, contracts, and agreements (including proofs of payment thereunder) between the Provider and any entity or individual that provides management, consulting, administrative, billing or collection services to the Provider, including agreements with Star Solutions;

3. Copies of bank statements, account opening documents, opening/signatory authorization, canceled checks (copies of the front and back of checks) in connection with any bank account held in the name of "Medaid Radiology" from inception to the present;

4. Copies of (i) Dr. Alkies Lapas' ("Dr. Lapas") medical degrees, including a curriculum vitae; and (ii) all agreements and/or contracts, including proof of payments made thereunder, between Medaid Radiology and Dr. Lapas;

5. Copies of the following documents: (i) the job descriptions for the personnel employed by Medaid Radiology; (ii) the staff orientation plan; (iii) the staff education plan; (iv) the policy and procedure manual for Medaid Radiology, including the date of the last review; (v) the patient care policies and procedures for Medaid Radiology; (vi) the quality assurance program for patient care implemented by Medaid Radiology; (vii) the policies and procedures implemented regarding infection control at Medaid Radiology; and (viii) the policies and procedures regarding emergency kits at Medaid Radiology;

6. A list of the members of the following committees, including a description of each member's relationship to Medaid Radiology: (i) the patient care policy committee; (ii) the quality assurance committee; and (iii) the Infection Control Committee;

7. Copies of minutes from the last three (3) meetings of the Patient Care Policy Committee for Medaid Radiology;

8. Documents, contracts, and agreements (including proofs of payment thereunder) relating to the opening and use of Post Office Box 829971, Philadelphia, PA 19182; and

9. Copies of the service agreement for the online scheduling program utilized by Medaid Radiology and testified to at the EUO by Mr. Alon, including all invoices and proofs of payment made thereunder.

The issue before me requires a balancing between the Respondent's right to request verification pursuant to 11 NYCRR § 65.15 (g) (1) (I); 2 (iii), and Applicant's rights under the Claims Practice Principles pursuant to 11 NYCRR 65-3.2. For the case at bar, the latter right infers an abuse of process utilizing the verification process by treating Applicant unfairly and intentionally delaying

payment. Applicant's counsel argues that the Respondent has turned the verification process into an investigatory opportunity for delay and recalcitrance. I agree.

To begin with, I am not of the opinion that all requests for further verification are unrestrained. Other areas of the regulations and decisions by both the courts and arbitrators discuss the need for good cause or a reasonable basis to be shown to obtain further verification. The courts have held that the carrier is not permitted to use the verification process to obtain information concerning corporate structure or finances regarding the provider. See Dynamic Medical Imaging P.C. a/a/o v. State Farm Mut. Auto. Ins. Co., 29 Misc. 2d. 278, 2010 NY Slip Op. 20285 (Dist. Ct., Nassau Co., J. Hirsh, July 15, 2010). I note recent decision where the court noted materials relating to a Mallela defense (discussed below) cannot be obtained as verification of the claim; an EUO cannot be scheduled for the purpose of inquiring into the corporate structure of the provider. Concourse Chiropractic, PLLC v. State Farm Mutual Ins. Co., 35 Misc.3d 1213(A), 2012 N.Y. Slip Op. 50676(U), (Dist. Ct. Nassau Co., Fred J. Hirsh, J., Apr. 16, 2012). I believe Applicant is correct in that at the very least, Respondent must demonstrate a fact or founded belief that the Applicant is a fraudulent corporation to allow a special circumstance to exist and thus entitle the Respondent to the Applicant's financial documents including corporate tax returns. Midborough Acupuncture P.C. v. State Farm Ins. Co. 21 Misc. 3d. 10, 12 (App. Term, 2d. Dept. 2008).

Additionally, permitting an insurer to obtain written documents such as tax returns, incorporation agreements or leases, regarding a potential fraudulent incorporation Mallela defense (see State Farm Mutual Automobile Insurance Co. v. Mallela, 2005 NY Slip Op 02416 [4 NY3d 313]) as part of the verification process defeats the stated policy and purpose of the No-fault law and carries with it the potential for abuse (Island Chiropractic Testing, P.C. v Nationwide Ins. Co., 35 Misc. 3d 1235, NY District Ct, 2012).

The record does not contain a basis for requesting the aforementioned financial, banking and contractual records. Respondent has submitted an affidavit by Navindrachand Gopi, a member of Respondent's Special Investigative Unit (SIU) in support of their position.

I find the affidavit to be accusatory and without any detailed factual information that reveals wrongdoings and/or fraud on the part of Applicant. The affidavit makes allegations and relies upon Applicant's transcript testimony as being suspect of fraudulent and/or inappropriate business activity. The primary premise of the affidavit speaks about layperson control and predetermined medical protocols. Respondent argues that they have "strong concerns" regarding Applicant's business practices and relationships. However,

Respondent does not have strong evidence to substantiate the accusations. I find that the affidavit relies on guilt by association. If Respondent actually believes that Applicant engages in fraudulent activity, then it behooves Respondent to file a declaratory judgment and litigate the elements of the suspected wrongdoings/fraud in a more appropriate forum.

I find that I am most persuaded by the analysis and findings of Justice Consuelo Mallafre Melendez in Arthur Ave. Med. Servs., PC v GEICO Ins. Co., 2021 NY Slip Op 21108, decided on April 20, 2021. Justice Mallafre Melendez found:

"Both the Mallela and Carothers [see Andrew Carothers, M.D., P.C. v. Progressive Insurance Company, 2019 NY Slip Op 04643] courts stressed principles of expediency and good cause in investigations of fraudulent licensing and improper fee sharing and acknowledged that abuse of the verification process may exist. At no time did the Court of Appeals state that carriers have unfettered authority in the extent of these investigations."

Respondent would have best been served in seeking a declaratory judgment to stay Applicant's claims, or if it felt that it had enough evidence, to pursue a case based on fraud and/or improper practices, and issued denials based on those grounds. It is the undersigned Arbitrator's position that the verification sought goes beyond the purview of the No-fault reimbursement system. I find that Respondent was not entitled to the financial and business records requested. There is nothing in the record that indicates fraud on the part of the Applicant to warrant requesting business, income and/or its corporate structure records.

Notwithstanding the aforementioned analysis, the record reflects that Applicant provided responses regarding the verification sought for specific injured parties. In addition, Applicant provided financial, business and tax records that the undersigned Arbitrator would have deemed non-discoverable and inappropriate under the circumstances. Most importantly, I find that Applicant submitted persuasive evidence that it appropriately complied with Respondent's verification requests.

Accordingly, I find that Respondent was not entitled to the financial/business records requested. In addition, I find that Applicant complied with Respondent's requests. Essentially, I find that the Respondent violated the Claims Practice Principles by treating the Applicant as an adversary and by not seeking to resolve the claim amicably or promptly.

Therefore, Applicant is entitled to reimbursement in the amount requested. This decision is in full disposition of all claims for No-fault benefits presently before this Arbitrator.

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**
	Medaid Radiology LLC	**11/02/20 - 11/02/20**	**$828.31**	**Awarded: $828.31**
Total			**$828.31**	**Awarded: $828.31**

B. The insurer shall also compute and pay the applicant interest set forth below. 06/10/2021 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

   Interest runs from the filing date for this case until the date that payment is made at two percent per month, simple interest, on a pro rata basis using a thirty day month.

C. Attorney's Fees

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

After calculating the sum total of the first-party benefits awarded in this arbitration plus the interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20% of that sum total, subject to no minimum and a maximum of $1360.00.

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 Nassau

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

06/05/2023
(Dated)

Ben Feder

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:
34679bbac4ba9af3f927e43ada739df8

Electronically Signed

Your name: Ben Feder
Signed on: 06/05/2023