

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)

- and -

Allstate Fire & Casualty Insurance Company
(Respondent)

AAA Case No.	17-22-1235-7808
Applicant's File No.	RFA21-304025
Insurer's Claim File No.	0621309961
NAIC No.	29688

ARBITRATION AWARD

I, Phyllis Saxe, 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: Assignor(JR)

1. Hearing(s) held on 07/06/2023
Declared closed by the arbitrator on 07/06/2023

Ryan Woodworth, Esq from Russell Friedman & Associates LLP participated virtually for the Applicant

Frank Gissaro, Esq. from Law Office Of Lawrence & Lawrence participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,933.08**, 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 no-fault arbitration arises from an automobile accident that occurred on 4/4/21. The Assignor (JR) a 51-year-old male, was involved in the accident. LC did not seek emergency medical attention on the accident date but presented for clinical evaluations on 4/5/21 and 4/8/21, complaining of neck, low back, right shoulder, and foot pain. On 6/9/21 and 7/1/21 LS had MRIs taken by Nexray Medical Imaging. The bills were submitted to Allstate and in response, Allstate issued additional verification request.

As a threshold matter, the parties discussed the legal implications of the global denials dated 10/5/21 in which it alleged that the Assignor failed to Appear at EUOs on 7/28/21

and 9/16/21. The Insurer admitted that it never interposed a specific denial so the bill in dispute in which it raised the EUO -no-show defense.

The Insurer's reliance on a global denial does not preserve the policy conditions defense. In Westchester Medical Center v. Lincoln Ins. Co., 60 A.D.3d 1045, 1046-47, 877 N.Y.S.2d 340, 342 (2d Dept. 2009) and the Fourth Department in Med., Nationwide Affinity Ins. Co. of Am. v Jamaica Wellness P.C., 167 AD3d 192, 197 [4th Dept. 2018]. have held: "[w]here, as here, the defendant's denial of liability also was based upon an alleged breach of a policy condition, to wit, the failure of the plaintiff's assignor to appear at an examination under oath, such an alleged breach does not serve to vitiate the medical provider's right to recover no fault benefits or to toll the 30-day statutory period. Rather, such denial was subject to the preclusion remedy (citations omitted)."

The unexcused failure to appear at a medical examination or examination under oath constitutes a breach of a policy condition, is distinguishable from a lack of coverage in the first instance. Accordingly, the respondent must demonstrate that it has timely issued its denial in order to proceed with its defense. See generally, Central General Hosp. v.Chubb, AD31045 [2d Dept., 2009]. As such, it is insufficient to show that this EIP failed to appear for two IMEs or EUOs.

The issue is whether the specific denials which referenced a 120-day defense can be sustained.

4. Findings, Conclusions, and Basis Therefor

The decision below is based on documentary evidence maintained in electronic form and oral arguments presented by both parties' representatives during the hearing. The hearings were conducted via Zoom. Pursuant to 11 NYCRR 65-4.5 (o) (1) (regulation 68D), the arbitrator shall be the judge of the relevance and materiality of the evidence offered and strict conformity to legal rules of evidence shall not be necessary.

120-Day Defense

As stated above, the Respondent issued a denial claim and raised the defense that the Applicant failed to comply with its additional verification request within 120 days of its initial requests.

With respect to claims for medical services rendered on or after April 1, 2013,:

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.

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.

For DOS 7/1/21 and 7/12/21, the Respondent issued additional verification requests in a timely manner. Allstate issued additional verification requests on 7/29/21 and 9/21/21. The Respondent requested additional verification from the Applicant seeking eight items of information related to the MRIs.

The Insurer issued denials to the two bills and claimed that the applicant did not provide responses 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.

In response, the Applicant pointed to a 9/8/21 letter from Nexray Medical Imaging, which advised that it was responding to the requests. It provides the invoiced MRI, the technician's name, and the IRS filing on the issue of w-2 or 1099s. It advised that it did not have referrals or reports, but it provided the name of its accountant, the sublease agreement, certificates of incorporation, and agreements for the diagnostic imaging equipment.

Based on the regulation cited above, the additional verification was issued in a timely manner. However, the Applicant showed evidence that it responded to the additional verification requests on 9/8/21. It supplied a meaningful response. Thereafter the respondent did not acknowledge the response but rather denied the claim. This was in error as the respondent was obligated to consider the response and, if it was deficient, send an additional request for further clarification. The respondent failed to do so.

The Applicant is awarded \$1933.08 in full satisfaction of this claim.

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 d/b/a Soul Radiology	07/01/21 - 07/01/21	\$966.54	Awarded: \$966.54
	Nexray Medical Imaging PC d/b/a Soul Radiology	07/12/21 - 07/12/21	\$966.54	Awarded: \$966.54
Total			\$1,933.08	Awarded: \$1,933.08

- B. The insurer shall also compute and pay the applicant interest set forth below. 04/29/2022 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 regulations. See generally, 11 NYCRR §65-3.9. Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30 day month." 11 NYCRR §65-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. However, the regulations toll the accrual of interest when an applicant "does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations." See, 11 NYCRR 65-3.9(c). The Superintendent and the New York Court of Appeals have interpreted this provision to apply regardless of whether the particular denial at issue was timely. *LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co.*, 12 N.Y.3d 217 (2009).

C. Attorney's Fees

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

1. Since this case was filed on or after February 4, 2015, this case is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant an attorney's fee, in accordance with newly promulgated 11 NYCRR 65-4.6(d). For claims that fall under the Sixth Amendment to the regulation, the following shall apply: "If the claim is resolved by the designated organization at any time prior to transmittal to an arbitrator and it was initially denied by the insurer or overdue, the payment of the applicant's attorney's fee by the insurer shall be limited to 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon, for each applicant with whom the respective parties have agreed and resolved dispute, subject to a maximum fee of \$1,360."

- 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 Suffolk

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

08/02/2023
(Dated)

Phyllis Saxe

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:
e85e132a77c815efaf7ccc486ab81212

Electronically Signed

Your name: Phyllis Saxe
Signed on: 08/02/2023