American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Stand Up MRI of Brooklyn, PC (Applicant)	AAA Case No.	17-23-1287-3009
	Applicant's File No.	SullivanAn
- and -	Insurer's Claim File No.	685675
	NAIC No.	Self-Insured
MVAIC (Respondent)		

ARBITRATION AWARD

I, Neal S Dobshinsky, 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: J Doe

1. Hearing(s) held on 10/04/2023
   Declared closed by the arbitrator on 10/04/2023

   Michael Tomforde from Dash Law Firm, P.C. participated virtually for the Applicant

   Tracy Bader Pollak from Marshall & Marshall, Esqs. participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$1,728.97**, 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

   On 10/11/22, Applicant performed cervical and lumbar MRIs on J Doe. Applicant contends that it initially timely submitted its claims for payment to State Farm Insurance Company. When Applicant later found out that State Farm was not the proper insurer-more than 45 days after the MRIs were performed-Applicant submitted its claims to MVAIC for payment.

   MVAIC received Applicant's claims and rejected Applicant's justification for the late submission. MVAIC denied the claims based on Applicant's violation of the 45-day rule.

Was Applicant's justification for the late submission to MVAIC reasonable?

4. Findings, Conclusions, and Basis Therefor

I have read and considered the materials in the AAA's ADR Center case file. I have heard and considered the arguments of counsel. I find as follows:

Background

It is claimed that on 8/30/22, J Doe, then 56 years old, was injured in a motor vehicle. Doe sought care and treatment. Respondent MVAIC afforded no-fault coverage for Doe for this accident.

On referral from Gautam Khakhat, MD, on 10/11/22, applicant Stand Up MRI of Brooklyn performed cervical and lumbar MRIs on Doe.

Applicant's Claims and Respondent's Denials

Applicant, as Doe's assignee, contends that on 11/3/22, it timely submitted its claims for payment to State Farm by electronic submission. Applicant's arbitration submission shows that on 11/4/22, State Farm acknowledged receipt to the claims.

Applicant billed $725.77 for the cervical MRI, CPT code 72141, and $1,003.20 for the lumbar MRI, code 72148.

Applicant shows that it received a letter dated 12/23/22 from Doe's attorney who advised Applicant that no-fault claims should be submitted to respondent MVAIC.

On 12/30/22, Applicant wrote to MVAIC. Applicant explained that the claims were originally timely submitted to State Farm on 11/3 and that on 12/23/22 Applicant was notified by Doe's attorney that MVAIC is the correct no-fault carrier. Applicant sent evidence of its submission of the claim to State Farm and it requested that MVAIC review and process the claims.

MVAIC received Applicant's claims (re)dated 12/30/22 on 1/6/23. On 1/23/23, Applicant timely denied payment due to an untimely submission MVAIC wrote that "[a]s the medical bill was submitted more than 45 days following the date of service. The late submission will be excused where applicant can provide reasonable justification for its late submission."

The only issue argued and submitted for determination was whether Applicant's justification for the late submissions to MVAIC was reasonable. All other issues were waived.

The 45-day Rule and MVAIC's Denial of Claims

Section 11 NYCRR 65-2.4 (c) of the Regulations, as made applicable by section 65-3.3 (a), provides in relevant part:

> "Proof of Claim; Medical, Work Loss, and Other Necessary Expenses. In the case of a claim for health service expenses, the eligible injured person or that person's assignee or legal representative shall submit written proof of claim to the self-insurer, including full particulars of the nature and extent of the injuries and treatment received and contemplated, as soon as reasonably practicable but, in no event later than 45 days after the date services are rendered. . . . " However, "[t]he foregoing time limitations for the submission of proof of claim shall apply unless the eligible injured person submits written proof providing clear and reasonable justification for the failure to comply with such time limitation."

MVAIC's submission includes an internal memo dated 1/20/23 that explains its reasoning. "The provider submitted their internal system notes showing initial submission to State Farm. The provider also supplied a letter sent to them from the claimant attorney on 12/23/22 indicating MVAIC is primary." "No POM to MVAIC was supplied. No bill denial was rcvd showing MVAIC rcvd the bill timely, after it was denied by State Farm. If State Farm didn't address the bill timely, why didn't the provider file Arbitration or Suit against State Farm?. Submitting bills and then following up to pursue payment or denial is the responsibility of the provider. No proof was submitted by the provider to indicate anything like that was done in the time frame of them submitting their bills to State Farm & then submitting them to MVAIC."

MVAIC's analysis makes no sense in this context. Proof of timely mailing (POM) to MVAIC is not at issue. Applicant does not contend that the claims were initially submitted to MVAIC. Applicant does not contend that the bill was denied by State Farm, but merely that it submitted the claim to MVAIC within a reasonable time after it was informed that MVAIC was the correct carrier. MVAIC criticizes Applicant for not filing for arbitration or commencing suit against State Farm if State Farm had not addressed the bills timely. MVAIC's suggestion that Applicant did not act promptly is not supported by the evidence.

Applicant performed the MRIs on 10/11/22. Applicant had 45 days, that is until 11/25/22 to submit its claim(s) for payment. Applicant's evidence, which was submitted to MVAIC, shows that it submitted its claim(s) to State Farm electronically on 11/3/22, which was well within 45 days.

An insurer has 30 days to pay or deny a claim. That would mean that State Farm, assuming it were the proper insurer, would have had until 12/5/22 (12/3/22 was a Saturday, so the time to pay or deny is extended to the next business day) to pay or deny the claim(s). There is no evidence that State Farm responded to Applicant's submission. Nevertheless, on 12/23/22, Doe's attorney notified Applicant that MVAIC was the correct carrier. From the date that State Farm should have paid or denied the claim according to the regulations to 12/23/22 was only 20 days.

Given that insurers generally mail payments and denials, it is not unreasonable for applicants to wait some number of days after the 30 days that an insurer has to pay or deny a claim to take further steps. Here, within 20 days, Applicant learned that it should submit its claim to MVAIC. I take judicial notice that the end of December is a holiday season and sometimes claims processing is delayed. Applicant contends that it submitted its bill dated 12/30/23 to MVAIC. MVAIC received Applicant's submission on 1/6/23, 42 days late.

The evidence shows that Applicant acted with a reasonable sense of urgency to submit the bills to MVAIC once it was aware that the State Fund was not the correct carrier. In the first instance, an applicant is required to act promptly to demonstrate reasonable justification why it did not timely submit its claim to the correct insurer. Here, Applicant did that. *Jacob Nir, MD v MVAIC, 2007*, 17 Misc3d 134[A], 2007 NY Slip Op 52124[U] (App. Term 2nd & 11th Jud. Dists).

Conclusion

Applicant's justification for its late submission of the claims to MVAIC was reasonable. MVAIC did not overcome that showing.

Based on the parties' submissions, their arguments, the law, the regulations, and the weight of the credible evidence, I conclude that Applicant is entitled to payment.

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
	Stand Up MRI of Brooklyn, PC	**10/11/22 - 10/11/22**	**$725.77**	**Awarded: $725.77**
	Stand Up MRI of Brooklyn, PC	**10/11/22 - 10/11/22**	**$1,003.20**	**Awarded: $1,003.20**
Total			**$1,728.97**	**Awarded: $1,728.97**

B. The insurer shall also compute and pay the applicant interest set forth below. 02/17/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Respondent shall compute and pay interest from the accrual date noted above-the date on which Applicant requested arbitration by filing with the AAA-at a rate of 2% per month, simple interest, calculated on a pro-rata basis using a 30-day month and ending with the date of payment subject to the provisions of 11 NYCRR 65-3.9.

C. Attorney's Fees

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

Respondent shall pay Applicant's attorney a fee in an amount equal to 20% of the total amount of the benefits plus the interest awarded in this arbitration, subject to the provisions of 11 NYCRR 65-4.6.

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 NJ
SS :
County of Monmouth

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

10/31/2023
(Dated)

Neal S Dobshinsky

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:
f1fbb1d2925bcc4bd10afdc2890f6331

Electronically Signed

Your name: Neal S Dobshinsky
Signed on: 10/31/2023