

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

CitiMed Surgery Center, LLC  
(Applicant)

- and -

Allstate Insurance Company  
(Respondent)

AAA Case No. 17-22-1257-4977

Applicant's File No. RB-215-292095

Insurer's Claim File No. 0648351443

NAIC No. 19232

**ARBITRATION AWARD**

I, Deepak Sohi, 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 11/22/2023  
Declared closed by the arbitrator on 11/22/2023

Elyse Ulino from Baker & Narkolayeva Law P.C. participated virtually for the Applicant

Rosemary Krupp from Law Office Of Lawrence & Lawrence participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$2,929.14**, 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 cervical and lumbar epidural steroid injections under fluoroscopic guidance (injections) provided to the EIP, a 68-year-old male, who was involved in a motor vehicle accident on 11/28/2021. Applicant is seeking reimbursement for the facility fee for the injections provided to the EIP on dates of service 1/14/2022, 3/4/2022, and 3/11/2022. Respondent denied reimbursement for the facility fee for the injections provided to the EIP on date of service 1/14/2022 based on the Applicant's failure to respond to Respondent's request for additional verification within 120 days of the initial request. Respondent denied reimbursement for the

facility fee for the injections provided to the EIP on dates of service 3/4/2022 and 3/11/2022 based on the EIP's failure to appear for two scheduled Independent Medical Examination (IME) appointments.

#### 4. Findings, Conclusions, and Basis Therefor

This case was decided on the submissions of the parties as contained in the Electronic Case Folder (ECF) maintained by the American Arbitration Association and the oral arguments of the parties' representatives at the hearing. No witnesses testified at the hearing. I reviewed the documents contained in the ECF for both parties and make my decision in reliance thereon.

### **120-DAY RULE**

### **OUTSTANDING VERIFICATION**

### **INJECTIONS**

### **DATE OF SERVICE 1/14/2022**

The Respondent denied the claims herein 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 specifically stated as follows:

Per New York State Regulation 68-C, section 65-3.5; 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 medical bill is denied as you have failed to provide 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.

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).

11 NYCRR § 65-3.5 Claim Procedure, states:

(a) Within 10 business days after receipt of the completed application for motor vehicle no-fault benefits (NYS form N-F 2) or other substantially equivalent written notice, the insurer shall forward, to the parties required to complete them, those prescribed verification forms it will require prior to payment of the initial claim. (b) 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-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.

In this case, a review of the competent evidence submitted to the ECF reveals Applicant submitted a bill for a cervical epidural steroid injection under fluoroscopic guidance provided to the EIP on date of service 1/14/2022 in the amount of \$976.38. Respondent received the Applicant's bill on 2/10/2022. Respondent issued its initial request for additional verification on 2/22/2022. Respondent issued its follow-up request for additional verification on 3/30/2022. Respondent requested information and various medical records. Subsequently, on 6/28/2022, the Respondent issued a denial based on the Applicant's failure to respond to Respondent's request for additional verification within 120 days of the initial request.

There is no response in the ECF from the Applicant to these requests for additional verification. The evidence herein or lack thereof demonstrates that the Applicant neither provided the requested verification nor did it make contemporaneous objections to the Respondent's requests. Applicant does not contest the timeliness of the subject verification requests. It is indisputable that this claim was timely denied on the basis of the 120-day rule.

The legislative intent of the no-fault regulation "demonstrates an interest in prompt resolution of reimbursement claims, a desire to avoid litigation, and statutory consequences on an insurer to incentivize it to seek verification of a claim, deny it, or pay. No-fault reform was enacted to provide prompt uncontested, first-party insurance benefits. That is part of the price paid to eliminate common-law contested lawsuits. . . .The tradeoff of the no-fault reform still allows carriers to contest ill-founded, illegitimate and fraudulent claims, but within a strict, short-leashed contestable period and process designed to avoid prejudice and red-tape dilatory practices." See, Viviane Etienne Medical Care, P.C. v. Country Wide Ins. Co., 25 NY3d 498 (2015), citing to, Presbyterian Hospital in the City of N.Y. v. Maryland Cas. Co., 90 NY2d 274 (1997).

Indeed, prior to the amendment the "prompt resolution" of claims was often frustrated by the open-ended nature of the verification procedures, which resulted in Applicant's failing to respond to verification requests leaving claims in limbo for months and even years. The verification procedures were slowed further by dilatory correspondence and gamesmanship from both sides resulting in ultra-technical arguments, which were never

intended by the drafters of the regulation. Ultimately, the intent of the regulation has always been for both sides to communicate with one another in order to verify and resolve the claim.

Applicant has a duty to communicate with the Respondent and vice versa. The parties' obligations are centered on good faith and common sense. Any questions concerning a communication should be addressed by further communication, not inaction. Dilon Medical Supply Corp. v. Travelers Ins. Co., 7 Misc3d 927, 796 N.Y.S.2d 872 (Civ. Ct. Kings Co. 2005).

In the within matter, Respondent issued timely verification requests and included the proper 120-day language. The information was neither provided by the Applicant, prior to the Respondent's denial, nor was any good excuse for failing to do so offered by the Applicant. Since the Applicant did not respond to the Respondent's initial request for verification within 120 calendar days, I find that the Respondent properly denied the Applicant's claims for its failure to respond to Respondent's request for additional verification within 120 days of the initial request.

Applicant argues at the hearing, for the first time, that the Respondent has not furnished proof of mailing for its requests for additional verification, however, I find Applicant has not submitted sufficient evidence to rebut the presumption of mailing. Applicant has failed to submit an affidavit that details the Applicant's office practices and procedures with regard to its receipt of mail and correspondence from insurance carriers it regularly deals with, that supports its contention that the subject requests for additional verification were not received. I generally take communication between the parties during the claims process as a given unless one of the parties, at minimum, allege within its submission that a document or letter was not received giving enough time for the other party to support its mailing. I find mere oral argument at the hearing is insufficient to require proof of mailing for correspondence between the parties during the claims process. I find an affidavit of mailing is not necessary.

In the context of arbitration, 11 NYCRR §65-4.5(o)(1) advises that "[t]he arbitrator shall be the judge of the relevance and materiality of the evidence offered, and strict conformity to the rules of evidence is not necessary."

The regulations envision "communication, not inaction" from both parties in regards to requests for additional verification. See, e.g., Westchester County Med. Ctr. v. New York Cent. Mut. Fire Ins. Co., 262 A.D.2d 553, 262 A.D.2d 553, 692 N.Y.S.2d 665 (2d Dept. 1999); Mary Immaculate Hosp. v. New York Cent. Mut. Fire Ins. Co., 2008 NY Slip Op 52046(U), 21 Misc.3d 130(A) (App Term 2d Dept., Oct. 9, 2008); Custom Orthotics, Ltd. v. Geico, 25 Misc.3d 545, 883 N.Y.S.2d 884 (NY Civ. Ct. 2009); Media Neurology, PC v. Countrywide Ins. Co., 21 Misc.3d 1101(A), 873 N.Y.S.2d 235 (Table), (NY Civ. Ct. 2008); All Health Medical Care, PC v. Geico, 2 Misc.3d 907, 771 N.Y.S.2d 832 (NY Civ. Ct. 2004).

"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).

Accordingly, in light of the foregoing, based on the arguments of counsel, and after thorough review and consideration of all submissions, I find in favor of the Respondent. Consequently, the Applicant's claim for the cervical epidural steroid injection under fluoroscopic guidance provided for on date of service 1/14/2022 is hereby denied with prejudice.

**IME NO-SHOW**

**INJECTIONS**

### **DATES OF SERVICE 3/4/2022 & 3/11/2022**

Pursuant to 11 NYCRR 65-1.1, Conditions, "No action shall lie against the Company unless, as a condition precedent thereto, there shall have been full compliance with the terms of this coverage". Further, the Regulations state "the eligible injured person shall submit to medical examination by physicians selected by, or acceptable to, the Company when, and as often as, the Company may reasonably require." The appearance at an IME is a condition precedent to the insured liability on the policy, and an insurer may deny a claim retroactively to the date of loss for an [Assignor's] failure to attend IMEs, "when, and as often as, the [insurer] may reasonably require." Stephen Fogel Psychological, P.C., v. Progressive Cas. Ins. Co., 35 AD3d 720 (2nd Dept., 2006).

An insurer makes its prima facie showing of the defense by demonstrating that two separate requests for IMEs were mailed to the assignor and that the Assignor failed to appear for the examination on either scheduled date pursuant to the requests. Apollo Chiropractic Care, P.C. v. Praetorian Insurance Company, 27 Misc.3d 139(A), 2010 N.Y. Slip Op. 50911(U) (1<sup>st</sup> Dept. 2010).

Respondent's denials are based upon the EIP's failure to appear for two Independent Medical Examination (IME) appointments scheduled for 3/9/2022 and 3/23/2022. In support of this denial, Respondent submitted two IME scheduling letters, an affidavit from, Ms. Jean Rony Pressoir an administrator from Respondent's IME vendor, D&D Associates, attesting to the office practices and procedures with regard to the mailing of the IME letters herein, and affidavits from the medical doctors, Dr. Stuart Springer, MD, and Dr. Jay W. Eneman, MD, who were scheduled to perform the IMEs attesting to the EIP's non-appearance at the IME appointments on the scheduled dates and times.

It is uncontroverted that the EIP did not appear for the IME appointments as scheduled. Applicant does not allege that the EIP appeared at either of the scheduled IME appointments. Further, Applicant has not set forth any reason why the IME notices were not complied with, nor has Applicant set forth any evidence that the notices were untimely or not addressed properly. Accordingly, based upon the facts of this matter, I find, by a preponderance

of the evidence, the EIP failed to appear for the scheduled IMEs in violation of the policy conditions.

Accordingly, in light of the foregoing, based on the arguments of counsel, and after thorough review and consideration of all submissions, I find in favor of the Respondent. Consequently, the Applicant's claims for the cervical and lumbar epidural steroid injections under fluoroscopic guidance provided on dates of service 3/4/2022 and 3/11/2022 are denied with prejudice.

This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator. Any further issues raised in the hearing record are held to be moot and/or waived insofar as not raised at the time of the hearing.

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

11/24/2023  
(Dated)

Deepak Sohi

### **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:**  
e0e6205ba1287ea87a3cc52ee375bd96

### **Electronically Signed**

Your name: Deepak Sohi  
Signed on: 11/24/2023