American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Dr Offenbacher Medical Imaging PLLC (Applicant)	AAA Case No.	17-22-1273-3545
	Applicant's File No.	115471
- and -	Insurer's Claim File No.	108384201
	NAIC No.	16616
American Transit Insurance Company (Respondent)		

ARBITRATION AWARD

I, Ann Lorraine Russo, 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: patient

1. Hearing(s) held on 12/04/2023
   Declared closed by the arbitrator on 12/04/2023

   Naomi Cohn, Esq. from Ursulova Law Offices P.C. participated virtually for the Applicant

   Erisa Ahmedi, Esq. from American Transit Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$2,751.34**, 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 dispute in this case is the nonpayment by the respondent for MRI testing services provided by the applicant from 5/28/2020 through 6/11/2020 for the twenty-three-year-old male patient as a result of injuries sustained in a motor vehicle accident on 5/10/2020. The respondent did not issue a denial in this case. The respondent provided verification remains open and outstanding.

4. Findings, Conclusions, and Basis Therefor

I have reviewed the documents contained in the electronic case folder as of the date of the hearing and oral arguments of counsel for the respective parties. No witness testimony was presented at the hearing.

The dispute in this case is the nonpayment by the respondent for MRI testing services provided by the applicant from 5/28/2020 through 6/11/2020 for the twenty-three-year-old male patient as a result of injuries sustained in a motor vehicle accident on 5/10/2020. The respondent did not issue a denial in this case. The respondent provided verification remains open and outstanding. It was noted that the applicant responded to the respondent's verification request. The respondent provided the examination under oath and a letter of medical necessity remain outstanding. However, the respondent did not submit the examination under oath notices to establish the timely tolling of the bills in this case. It was noted that the respondent did not submit a verification request forwarded to the treating medical provider for the letter of medical necessity. However, the respondent's submission contains a letter of medical necessity dated 7/23/2022 by Apex Medical PC, the patient's treating medical provider that was received by the respondent on 8/10/2020. The respondent did not submit verification requests forwarded to the applicant based upon the patient's pending examination under oath. The respondent's verification requests provide that the applicant's bills are pending an examination under oath of the respondent. As a result, the respondent has not submitted the supporting documentation to establish the respondent's position based upon outstanding verification in this case. Consequently, the respondent's position based upon the outstanding verification is defective and a denial and/or payment was due and owing for the bill in this case. The respondent did not establish the timely tolling of the applicant's bill or that verification remains outstanding in this case. The amount in dispute is $2,751.34 for the MRI testing services provided to the patient by the applicant in this case.

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 the submission of completed NF-3 forms documenting the facts and amounts of the losses sustained (Amaze Medical Supply v. Eagle Ins. Co., 2 Misc. 3d 128A, 784NYS 2d 918, 2003 NY Slip Op.517014 [App Term, 2d & 11th Jud. Dusts.]) and by submitting evidentiary proof that the prescribed statutory billing forms [setting forth the fact and the amount of the loss sustained] had been mailed and received and that payment of no-fault benefits were overdue." Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). Also, in this case, Respondent's own denials demonstrate that it received Applicant's claim forms. Therefore, I find Applicant established a prima facie case. Once an applicant establishes a prima facie case, the burden then shifts to the insurer to prove its defense. (See Citywide Social Work & Psy. Serv. P.L.L.C v. Travelers Indemnity Co., 3 Misc. 3d 608, 2004 NY Slip Op 24034 [Civ. Ct., Kings County 2004]).

However, even before determining whether Respondent met its burden of proof, it must first be determined whether Respondent's defense survives preclusion. In a no-fault action, a defense, other than one based upon a lack of coverage, survives preclusion only if raised in a denial that is (1) timely, Presbyterian Hosp. in the City of New York v.

Maryland Casualty Ins. Co., 226 A.D.2d 613 (2nd Dept. 1996); Central Gen. Hosp. v. Chubb Group of Ins. Co., 90 N.Y.2d 195 (1997), (2) includes the information called for in the prescribed denial of claim form, 11 NYCRR § 65-3.4 (c) (11); 3 Nyack Hosp. v. Metropolitan Prop. & Cas. Ins. Co., 16 A.D.3d 564 (2d Dept. 2005); Nyack Hosp. v. State Farm Mut. Auto. Ins. Co., 2004 WL 2394038, 2004 NY Slip Op 07663 (2d Dept. Oct. 25, 2004); Summit Psychological, P.C. v. General Assur. Co., 9 Misc.3d 8, 801 N.Y.S. 2d. 117, 2005 N.Y. Slip OP. 25263, (App Term 2nd Dept., 2005); Shtarkman v. Allstate Ins. Co., 8 Misc.3d 129(A), 2005 NY Slip Op 51028(U) (App Term 2d & 11th Jud Dists.), or is not fatally defective, and (3) "promptly apprise(s) the claimant with a high degree of specificity of the ground or grounds on which the disclaimer is predicated", General Accident Ins. Group v. Cirucci, 46 N.Y.2d 862, 864, 414 N.Y.S.2d 512, 387 N.E.2d 223 (1979); New York University Hosp. Rusk Ins. v. Hartford Acc. & Indem. Co., 32 A.D.3d 458, 2006 NY Slip Op 06223 (2d Dept. 2006). The respondent did not issue a denial in this case. The respondent provided that verification remains outstanding and due in this case.

The respondent did not submit verification requests forwarded to the applicant based upon the patient's pending examination under oath. The respondent's verification requests provide that the applicant's bills are pending an examination under oath of the patient. As a result, the respondent has not submitted the supporting documentation upon which the bill was tolled and is based in this case. The verification requests submitted in this case provide that the applicant's bill is pending the examination under oath of the patient. However, the respondent did not submit a copy of any verification requests to toll the respondent's time frame to deny or pay the applicant's claim based upon the pending examinations under oath of the patient in this case. The respondent has not submitted the verification requests based upon an outstanding examination under oath for review and in support of the verification requested, and timeliness of the tolling of the applicant's bills in this case. The respondent has not submitted the verification in support of the timeliness of the denials and the denials are therefore cannot sustain the bill was timely tolled in this case. In the case at hand, the respondent did not submit the supporting documentation to establish the applicant's bill was timely tolled in this case. The respondent did not issue a timely denial or payment for the bill in this case. See 11 NYCRR Section 65-3.8. As a result, the applicant's claim is granted.

The respondent has not submitted the examination under oath letters to the patient in this case to establish the timely tolling of the applicant's bill. The respondent has not established that the examination under oath was requested within the required 30 calendar day time frame from the receipt of the bill in this case. See 11 NYCRR Section 65-3.5(d) and American Transit Insurance Company v. Longevity Medical Supply, 131 A.D.3d 841, 17 N.Y.S.3d 1 (1st Dept. 2015) where the Court found that to meet its prima facie burden, an insurer must establish that it requested IMEs in accordance with the procedures and time frames set forth in the No-Fault regulations. See also American Transit Insurance Company v. Clark, 131 A.D.3d 840, (1st Dept. 2015); Acupuncture Approach P.C. v. Allstate Insurance Company, 46 Misc.3d 151(A), 2015 N.Y. Slip Op. 50318(U) (App. Term 1st Dept. 2015).

Furthermore, in W.H.O. Acupuncture, PC v. Travelers Home and Marine Ins. Co., 36 Misc.3d 152(A), 2012 N.Y. Slip Op. 51707(U) (App. Term 2, 11 and 13 Jud. Dists.

2012) the Court found that Respondent has an obligation to schedule the IME within 30 days of receipt of a bill, in accordance with Insurance Department Regulation 11 NYCRR § 65-3.5 (d). See also Irina Acupuncture, P.C. v. Nationwide Affinity Insurance Company, 2017 Ny Slip Op 51461 (U) [57 Misc. 3d 146 (A)] (App. Term 2, 11 and 13 Jud. Dists. 2012). Neptune Medical Care, P.C. v Ameriprise Auto & Home Ins., supra., though discussing the procedures concerning the scheduling of an EUO, is applicable for IMEs that require even more stringent scheduling requirements per 11 NYCRRR 65-3.5 (d). The Court notes "(e)ven if (the insurer) had tolled the 30-day period … by timely requesting verification pursuant to 11 NYCRR § 65-3.8 (a), … the Regulations do not provide that such a toll grants an insurer additional opportunities to make requests for verification that would otherwise be untimely." Since the Respondent cannot establish that the first examination was within 30 days of its receipt of the bills, in this case, it cannot sustain its position that verification remains outstanding in this case.

The respondent's counsel noted that 11 NYCRR Section 65-1.1. provides that "Action against Company. No action shall lie against the Company unless, as a condition precedent thereto, there shall have been full compliance with the terms of coverage." This section then goes on to state, "the eligible injured person shall submit to medical examinations by physicians selected by or acceptable to the Company when and as often as the Company may reasonably require.". However, certain pre-requisites must be satisfied in order to effectuate a proper denial based upon the failure of an injured party to appear for independent medical examinations, especially since the severe penalty of breach of contract and violation of a policy condition negating coverage from the inception can be asserted for the alleged non-appearance at the independent medical examinations. The statutory pre-requisites must be completely satisfied by the insurer prior to the insurer issuing a denial based upon the injured party's failure to appear for the independent medical examinations.

The no fault regulations must be strictly interpreted and followed, especially in the event of the patient's failure to appear for independent medical examinations can be considered a breach of a policy condition and impact the patient's rights and obligations pursuant to the insurance policy. Clearly, strict compliance with the statutory regulations is required, especially in the event that such a drastic determination and penalty of breach of contract and a violation of a policy condition can be asserted for the alleged non-appearance at the independent medical examinations.

Respondent relies on Unitrin Advantage Ins. Co. v. Bayshore Physical Therapy, 82 AD3d 559 (2011), Stephen Fogel Psychological, P.C. v Progressive Cas. Ins. Co., See 2006 NY Slip Op 09604 [35 AD3d 720], in support of its position that Respondent is not precluded from raising its IME no-show defense regardless of the timeliness of the denials. As a result, Respondent had a right to deny this claim retroactive to the date of loss. This defense vitiates coverage retroactive to the date of loss. The appearance of an insured at an IME is a condition precedent to coverage, the breach of which voids the policy ab initio. See, Fogel, supra. Furthermore, an insurer may deny a claim retroactively to the date of loss on the basis of a failure to submit to an IME, regardless of whether its defense is raised in a timely and/or claim-specific denial". See, Unitrin Advantage Ins. Co. v. Bayshore Physical Therapy, 82 AD3d 559 (2011). However, these cases do not obviate the scheduling requirements set forth in 11 NYCRR 65-3.5(d).

The Appellate Division, First Department and Appellate Term, Second Department agree that in order for Respondent to make prima facie showing of its entitlement to a dismissal of this matter based on the Assignor's failure to appear at the scheduled IMEs, Respondent must demonstrate that its initial and follow-up requests for the IMEs were issued timely in accordance with 11 NYCRR Section 65-3.5(d). See American Transit Insurance Company v. Longevity Medical Supply, 131 A.D.3d 841, 17 N.Y.S.3d 1 (1st Dept. 2015) and Irina Acupuncture, P.C. v. Nationwide Affinity Insurance Company, 2017 Ny Slip Op 51461 (U) [57 Misc. 3d 146 (A)] (App. Term 2, 11 and 13 Jud. Dists. 2012). Accordingly, I also find Respondent's examination requests untimely as to these bills. Therefore, Respondent's defense premised upon examination under oath pending verification cannot be sustained for the bills in this case and these claims are reimbursable.

Based upon the evidence presented in this case, it is the opinion of this Arbitrator that the applicant has established that the respondent did not issue timely and proper verification requests for the testing services in a proper and timely manner in this case.

Accordingly, the applicant's claim is granted.

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
	Dr Offenbacher Medical Imaging PLLC	**05/28/20 - 05/28/20**	**$879.73**	**Awarded: $879.73**
	Dr Offenbacher Medical Imaging PLLC	**06/04/20 - 06/04/20**	**$912.00**	**Awarded: $912.00**
	Dr Offenbacher Medical Imaging PLLC	**06/11/20 - 06/11/20**	**$959.61**	**Awarded: $959.61**
Total			**$2,751.34**	**Awarded: $2,751.34**

B. The insurer shall also compute and pay the applicant interest set forth below. 11/04/2022 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

The respondent shall pay the applicant interest from the date of the arbitration filing on 11/4/2022.

C. Attorney's Fees

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

The respondent shall pay the applicant attorney fees pursuant to 11 NYCRR Section 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 NY
SS :
County of Nassau

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

12/06/2023
(Dated)

Ann Lorraine Russo

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:
e10d1568c14aabcf9355a200cf37be90

Electronically Signed

Your name: Ann Lorraine Russo
Signed on: 12/06/2023