

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Long Island Jewish Medical Center (NSUH) (Applicant)	AAA Case No.	17-22-1250-8764
	Applicant's File No.	RFA22-307394
- and -	Insurer's Claim File No.	662113
MVAIC (Respondent)	NAIC No.	Self-Insured

ARBITRATION AWARD

I, Camille Nieves, 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: Eligible Injured Person (AJ)

1. Hearing(s) held on 12/06/2023
Declared closed by the arbitrator on 12/06/2023

Helen Feingersh from The Russell Friedman Law Group LLP participated virtually for the Applicant

Jeffrey Kadushin from Marshall & Marshall, Esqs. participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$33,016.97**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant amended the amount in dispute to \$13,685.92 based on the fee schedule and respondent's coder's calculations.

Stipulations WERE made by the parties regarding the issues to be determined.

The parties stipulated to the amended amount in dispute.

3. Summary of Issues in Dispute
4. Findings, Conclusions, and Basis Therefor

Applicant seeks reimbursement for treatment of a 4 year old male pedestrian hit by a car on 8/26/21 while playing. He was brought to the ER and treated from 8/26/21 to 8/27/21 including multiple radiologic studies for loss of consciousness from 8/26/21 to 8/27/21. The charges were timely denied based on failure to submit the bill within 45 days.

The bill was received by MVAIC on 11/15/21, having been mailed on 11/9/21. Respondent timely denied based on failure to submit within 45 days.

Respondent submits an affidavit by Lawrence Pak, claims representative, dated 12/1/23, attesting to non-receipt of any reasonable justification for the untimely submission.

This constitutes a prima facie case of a defense based on 45 days. The burden shifts to applicant.

Applicant agrees that the first time the claim was sent to respondent was on 11/9/21 which is 74 days after the date of service.

Applicant submits the log showing applicant's efforts to learn to carrier information and produced a witness today (D. Ghert) who testified about applicant's efforts to appeal and provide reasonable justification for the late submission to which respondent failed to respond.

The witness testified to faxes and telephone calls to respondent's claims representative. Respondent argues the faxes were not sent to MVAICs fax number. The log entries were testified to by the witnesses who identified line numbers for the notations.

On 1/7/22, applicant's log shows that reasonable justification appeal was sent to respondent by letter dated 1/7/22 which was faxed to respondent's adjuster S. Ojha at fax no. 646 205-7841 which respondent denied receiving (line 62).

The 1/7/22 letter indicates late proof of claim was provided to the applicant by the patient who is a minor pedestrian. His mother did not have any information when he was brought to the hospital except to provide the private health carrier Infinity Medicaid. Eight days later on 9/3/21 applicant asked the mother for the police report which she did not have but she indicated she would provide attorney information. On 9/30/21 attorney information was obtained and Rosenberg & Gluck was called and applicant was advised the case was under investigation. Applicant called back on 10/7/21 and 10/8/21 and left messages and on 10/13/21 Affinity was billed. On 11/4/21 it was learned that MVAIC was the insurer and the bill and records were mailed on 11/9/21 and admittedly received on 11/15/21 and timely denied on 11/28/21.

On 1/21/22 applicant then called the adjuster at 646 205-7841 and left a message (line 68) regarding the status of the appeal. On 2/18/22 the appeal letter was re-faxed to respondent for a third time (line 79) and again on 3/3/22 the adjuster was called and a voicemail was left (line 84). On 3/18/22 and 4/1/22 the adjuster was called again (lines 93 and 97) and the appeal was faxed again (line 98).

The unanswered telephone calls and messages indicate the call goes right to voicemail

I find applicant has demonstrate sufficient evidence which amounts to reasonable justification to learn the correct carrier's identity under circumstances which render it impossible to know that information at the outset. The patient's mother would not know the carrier as her son was a pedestrian and applicant then undertook best efforts to find out calling the mother and the attorneys. At the earliest possible moment when it was learned that MVAIC was the insurer, the claim was immediately sent to MVAIC. Just before learning about MVAIC, the claim was sent to Affinity but after 45 days.

Applicant then undertook to file an appeal/reconsideration based on reasonable justification to which respondent was obligated to respond. Respondent's claims representative does not address the multiple calls that were made inquiring about the appeal and which were unanswered.

Respondent's contentions that it did not receive the fax and email is noted but applicant has demonstrated sufficient documentation and testimony that such communications were sent to the phone number and adjuster listed on the NF10 and that there was no response whatsoever.

In addition, a multitude of telephone calls were made and there was no response thereto either.

Applicant submits the log showing applicant's efforts to learn to carrier information and produced a witness today (D. Ghert) who testified about applicant's efforts to learn the status of the appeal.

The witness testified to telephone calls to the claims representative. Respondent argues the faxes were not sent to MVAICs fax number.

Applicant also contends there were multiple telephone calls and messages left. The witness D. Ghert testified to a timeline.

Basically on 1/7/22 a reconsideration letter was faxed to respondent.

There are no log notes prior to 11/5/21 and the notes submitted are from the billing company - not the hospital. Respondent argues the first bill sent to Affinity - the patient's private health insurer - was sent after 45 days on 10/31/21. This should be enough to sustain the denial. I find that it is not dispositive of the issue whether there is reasonable justification.

The regulation in question was

11 NYCRR 65-1.1 states under Proof of Claim as follows: "In the case of a claim for health service expenses, The [EIP] or that person's assignee... shall submit written proof of claim to the company ... as soon as reasonably practicable but in no event later than 45 days after the date of services are rendered. ... The foregoing time limitations for the

submission of proof of claim shall apply unless the [EIP] ... submits written proof providing clear and reasonable justification for the failure to comply with such time limitation." However, an insurer will be precluded from asserting a defense based upon the ground that plaintiff untimely submitted its claim if such defense is not raised in a timely denial. *New York and Presbyterian Hospital v. Empire Ins. Co.*, 286 A.D.2d 322 (2nd Dept. 2001). Even if such a defense is timely preserved, respondent will still be precluded from this defense if respondent failed to advise the applicant that "late notice will be excused where the applicant can provide reasonable justification of the failure to give timely notice." 11 N.Y.C.R.R. 65-3.3.

In the instant case, Respondent issued a timely denial based upon Applicant's failure to submit written proof of claim within 45 days after the date the services were rendered. The denial contained the requisite language as per the insurance regulation.

Late notice will be excused where applicant can show reasonable justification for the failure to submit the bill within 45 days.

The question is whether applicant has made such a showing. I find it has.

As set forth in applicant's brief:

"The Courts and Arbitrators have consistently held that a carrier's failure to demonstrate (1) that it has established procedures to ensure due consideration of denial of claims based upon late filings and (2) that it gave appropriate consideration to the medical provider's explanation for failing to send the bill within the statutory time frame, must result in a finding that the carrier failed to properly deny the claim, thereby entitling the provider to reimbursement. See, *Bronx Expert Radiology a/a/o Manuel Castillo v. Clarendon Nat. Ins. Co.*, 23 Misc. 3d 133(A)(App. Term, 1st Dept. 2009) (the court denied the Carrier's motion for summary judgment as the record did "not indicate whether defendant gave any consideration to plaintiff's explanation for its tardy submissions as required by the regulations"); *Bronx Expert Radiology, O.C. a/a/o Robert Fontecchio v. NYCT*, 32 Misc. 3d 140(A), 936 N.Y.S.2d 57 (App. Term. 1st Dept. 2011)."

Applicant described best efforts to learn the correct insurer in a timely fashion but was provided with no assistance until after the 45 days period expired. A witness D. Ghert testified to letters of reconsideration and telephone calls to respondent. The letters and calls are documented by date in the record but there was no response to any of them.

The regulation was not intended to avoid payment of claims but to avoid prejudice to the carrier by the submission of late claims. Allowing this claim will not run contrary to those goals especially where applicant has demonstrated its efforts to identify the correct carrier and then to file an appeal for reconsideration which respondent was obligated to consider.

I find there is reasonable justification demonstrated by the evidence and that the appeal should have been considered and a response provided.

The charges are awarded.

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	Amount Amended	Status
	Long Island Jewish Medical Center (NSUH)	08/26/21 - 08/27/21	\$33,016.97		Awarded: \$13,685.92
Total			\$33,016.97		Awarded: \$13,685.92

- B. The insurer shall also compute and pay the applicant interest set forth below. 05/19/2022 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest shall be computed from the date of filing at a rate of 2% per month, simple, ending with the date of payment of the award.

C. Attorney's Fees

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

Pursuant to 11 NYCRR 65-4.6, 20% of the amount of first party benefits, plus interest thereon, subject to 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 FL

SS :

County of Osceola

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

12/07/2023
(Dated)

Camille Nieves

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:
6edc8900b4f6085a8c125535ec5e4e0c

Electronically Signed

Your name: Camille Nieves
Signed on: 12/07/2023