

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Titan Diagnostic Imaging Services, Inc
(Applicant)

- and -

State Farm Mutual Automobile Insurance
Company
(Respondent)

AAA Case No. 17-22-1269-4666

Applicant's File No. 56236

Insurer's Claim File No. 3222B093G

NAIC No. 25178

ARBITRATION AWARD

I, Tracy Morgan, 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: injured person-assignor

1. Hearing(s) held on 11/22/2023
Declared closed by the arbitrator on 11/22/2023

Aleksey Selipanov, Esq. from The Law Offices of John Gallagher, PLLC participated virtually for the Applicant

Stuart Flamen, Esq. from McDonnell Adels & Klestzick, PLLC participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$2,430.45**, 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 Applicant is the assignee of no-fault benefits from injured person-assignor (YA), a 39 year old male who reported he was involved in a motor vehicle accident as a passenger on April 15, 2022. Following the accident, the injured person-assignor sought medical treatment and underwent various ultrasound studies, duplex scan of the arteries and complete study of the aorta on May 13, 2022. Applicant seeks reimbursement for the technical component of the studies. Respondent issued verification letters to Applicant and ultimately denied the claims maintaining that verification remained outstanding 120 days from the initial requests for verification.

The issue presented on this arbitration is whether Respondent properly denied Applicant's claims on the basis of outstanding verification?

4. Findings, Conclusions, and Basis Therefor

This hearing was conducted using documents contained in ADR Center. Any documents contained in the folder are hereby incorporated into this hearing. I have reviewed the relevant exhibits contained in the electronic file maintained by the American Arbitration Association and have considered all of the stipulations and arguments presented by both parties at the hearing of this matter. No witnesses appeared or testified.

Applicant's prima facie has been established. Respondent's letters, acknowledging receipt of the Applicant's bills, establish that Applicant sent, and that Respondent received the claims herein *A.B. Medical Services PLLC v Prudential Property & Casualty Insurance Co.*, 7 Misc3d 14 (App Term 2d & 11th Dists. Jan 20, 2005); *A.B. Medical Services v New York Cent. Mut. Fire Ins. Co.*, 3 Misc 3d 136(A), (App Term, 2d & 11th Jud Dists 2004).

11 NYCRR Section 65-3.8(a)(1) provides that no fault benefits are overdue if not paid within thirty (30) calendar days after the insurer received proof of claim, which shall include verification of all the relevant requested items pursuant to 11 NYCRR Section 65-3.5.

If an insurer requires any additional information to evaluate the proof of claim, such request for verification must be made within 15 business days of the receipt of the bill in order to toll the 30-day period to pay or deny the claim. *See generally*, 11 NYCRR 65-3.5(b); *See also*, *New York Hosp. Med. Ctr. of Queens v. Allstate Ins. Co.*, 2014 NY Slip Op 00640 (2d Dept. 2014).

In addition, 11 NYCRR 65-3.6 (b) of the no-fault regulations states that at a minimum, if any requested verifications has not been supplied to the insurer 30 calendar days after the original request, the insurer shall, within 10 calendar days, follow up with the party from whom the verification was requested, either by telephone call, properly documented in the file, or by mail. At the same time the insurer shall inform the Applicant and such person's attorney of the reason(s) why the claim is delayed by identifying in writing the missing verification and the party from whom it was requested.

If there is no response to the second or follow-up request for verification, the time in which the insurer must decide whether to pay or deny the claim is indefinitely tolled. *Id.* Therefore, when a no-fault medical service provider fails to respond to the requests for verification the claim is premature and should be denied without prejudice.

Effective April 1, 2013 11 NYCRR 65-3.5(o) was amended so 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 a 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... This subdivision shall apply, with respect to claims for medical services, to any treatment or service rendered on or after April 1, 2013."

11 NYCRR 65 - 3.8 (b) provides that, "[A]n insurer may issue a denial if, more than 120 days after the initial request for verification, the applicant has not submitted on such verification under the applicant control possession or written proof providing reasonable justification for the failure to comply, provided that the verification requested so advised the applicant as required in section 65 -3.5 (o) of this subpart.

New York State Regulation 68A, §65-1.1, Conditions, Proof of Claim, states in relevant part, that "Upon request by the Company, the eligible injured person, that person's assignee or that person's representative shall: (A) Execute a written proof of claim under oath; (B) as may reasonably be required submit to examinations under oath by any person named by the Company and subscribe the same...; and (C) Provide any other pertinent information that may assist the company in determining the amount due and payable".

Upon receipt of Applicant's claims, Respondent issued letters to Applicant advising that the claims in dispute were delayed and sought verification including Applicant's bank statements, general ledger, tax returns, copies of imaging for tests performed, scheduling records, 1099s, W-2s and individual invoices in connection with the purchase of ultrasound machines pursuant to the testimony of the Applicant's owner Anthony Palmieri. The initial requests regarding these bills were issued July 6, 2022 and July 18, 2022. Follow up requests were sent identical to the first requests dated August 9, 2022 and August 18, 2022. The claims were denied on November 8, 2022 and November 16, 2022 contending that verification remained outstanding 120 days following the initial requests for verification.

No issues concerning the timing of Respondent's letters or tolling of the claims were raised. I find that Respondent properly tolled the claims and timely denied them.

To support its denials, Respondent submitted the certified Examination Under Oath transcript of Anthony Palmieri's testimony dated August 12, 2021, verification requests noted above with corresponding certificates of mailing, Affidavit of Respondent's investigator, Christopher Howard, the Affidavit of Julius Bland, attesting to the mailing of the verification requests and the Affidavit of Jesse Martz, attesting to the regular mailing procedures in place. Respondent also submitted the report of David Preston, M.D., neurologist who reviewed a sample of Applicant's bills and patient records and found that none of the studies billed were medically necessary and that the studies were performed excessively upon individual patients. Dr. Preston concluded that the studies were fraudulently performed.

Mr. Howard attested that at his Examination Under Oath, Mr. Palmeri was unable to answer various questions concerning his business operation and financing that an owner would be expected to answer. The testimony and Respondent's investigation raised further suspicions that Applicant's services were not provided by employees of Applicant, the services were not medically necessary, the services were provided pursuant to arrangements with others and that the ownership, control and operation of Applicant's facility failed to comply with NY State licensing laws. In response to the requests for post-EUO information and documentation, Applicant merely provided the 1099 for an individual performing services for Applicant which is inconsistent with Mr. Palmieri's testimony that this individual receives a W-2 and is in contravention of NY State laws.

After a review of the documents submitted on this Record, I find that Respondent's requests for verification were reasonable and properly mailed to the Applicant.

The Record fails to establish that Applicant substantially complied with Respondent's requests for verification.

It is clear that the testimony raised issues of whether the services were provided in contravention of NY State licensing laws and Applicant failed to provide the verification requested.

"[W]hen a claimant submits bills to an insurer for payment, the claimant, who stands in the shoes of his assignor, must deal in good faith and cooperate with the insurer if it wants to get paid *Dilon Medical Supply Corp. v. Travelers Insurance Co.*, 7 Misc3d 927, 930 (Civ. Ct. Kings Co. 2005).

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 Misc3d 1228(A), 2010 NY Slip Op 50950(U) (Civ. Ct. Kings Co., Sylvia G. Ash, J., May 25, 2010).

Based on the foregoing, Applicant's claim is denied. Any further issues raised in the 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, Tracy Morgan, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

12/12/2023
(Dated)

Tracy Morgan

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:
bf90f05a806548ae528090bb572ea378

Electronically Signed

Your name: Tracy Morgan
Signed on: 12/12/2023