American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Medaid Radiology LLC (Applicant)	AAA Case No.	17-22-1270-6339
	Applicant's File No.	RFA22-311460
- and -	Insurer's Claim File No.	0437463530101025
	NAIC No.	35882
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Alison Berdnik, 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: Claimant

1. Hearing(s) held on 12/13/2023
   Declared closed by the arbitrator on 12/13/2023

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

   Jenna Pettograsso, Esq. from Rivkin & Radler LLP participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$133.83**, was AMENDED and permitted by the arbitrator at the oral hearing.

   At the commencement of the hearing, Applicant amended the amount in dispute to $78.86 to bring the charges into compliance with the governing fee schedule.

   Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

   The Claimant, AV, a 47-year-old female, was a passenger in a motor vehicle involved in an accident on June 30, 2021. At issue in this case is $78.86, as amended, for a skull

x-ray performed September 15, 2021. Respondent denied the claims on the grounds that Applicant failed to respond to verification requests within 120 days from the date of the initial request.

The issue presented for determination is whether Respondent has established Applicant's failure to respond to verification requests within 120 days under 11 NYCRR 65-3.8(b)(3).

4. Findings, Conclusions, and Basis Therefor

This case was decided based upon the submissions of the parties as contained in the electronic file maintained by the American Arbitration Association, and the oral arguments of the parties' representatives. Witnesses were not present to testify during the hearing. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

An Applicant establishes its *prima facie* showing of an entitlement to judgment as a matter of law by submitting evidentiary proof that the prescribed statutory billing forms had been mailed, received by the Respondent and that payment of no-fault benefits is overdue. *Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.2d 742, 774 N.Y.S.2d 564 (2nd Dept. 2005). A facially valid claim has been defined as one that sets forth the name of the patient, date of accident, date of service, description of services rendered and the charges for those services. *See, Vinings Spinal Diagnostic P.C. v. Liberty Mutual Insurance Company*, 186 Misc. 2d 128(A), 784 N.Y.S.2d 918 (2003).

At issue in this case is $78.86, as amended, for a skull x-ray performed September 15, 2021. Respondent denied the claims on the grounds that Applicant failed to respond to verification requests within 120 days from the date of the initial request.

The submission of Respondent's Denial of Claim Form ("NF-10") establishes that Respondent received Applicant's claim and that Respondent has not paid the claim. *Lopes v. Liberty Mutual Ins. Co.*, 24 Misc.3d 127(A), 2009 N.Y. Slip Op. 51279(U), 2009 WL 1799812 (App. Term 2nd, 11th & 13th Dists. Jan. 26, 2009. Thus, the submission of Respondent's NF-10 in this proceeding is sufficient to satisfy Applicant's burden in this instance.

No issue has been raised surrounding the timeliness of Respondent's verification requests. Rather, Applicant contends that it substantially complied with the requests and, to the extent information has not been provided, Applicant contends that Respondent is not entitled to the information requested.

Pursuant to 11 NYCRR 65-3.8(1), no-fault benefits are overdue if not paid within 30 calendar days after the insurer receives proof of claim, which shall include verification of all of the relevant information requested pursuant to section 65-3.5 of the Regulations.

According to 11 NYCRR 65-3.5:

> (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.

Additionally, 11 NYCRR 65-3.6 provides as follows:

> (b) Verification requests. 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 reasons(s) why the claim is delayed by identifying in writing the missing verification and the party from whom it was requested.

With respect to medical services rendered on or after April 1, 2013, 11 NYCRR 65-3.5(o) sets forth the following:

> 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 the verification request that the insurer may deny the claim if the applicant does not provide within 120 calendar days from the date of the original request either all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply.

11 NYCRR 65-3.8(b)(3) further provides:

> An insurer may issue a denial if, more than 120 calendar days after the initial request for verification, the applicant has not submitted all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply, provided that the verification request so advised the applicant as required in section 65-3.5(o) of this Subpart.

Where the insurer establishes that it timely mailed its verification request and follow-up request to the claimant, and the claimant fails to prove that it provided the requested verification prior to the commencement of the action, the action is premature, and should be dismissed without prejudice as the 30-day period within which the insurer was required to pay or deny the claim has not yet expired. *Triangle R. Inc v. GEICO Ins. Co*., 27 Misc. 3d 137(A), 922 N.Y.S.2d 696 (Table) 2010 N.Y. Slip Op. 50885(U), 2010 WL 2010158 (App. Term 2nd, 11th & 13th Jud. Dists. May 13, 2010.

Respondent has a duty to communicate with the applicant and vice versa. The purpose of the no-fault regulations is to ensure prompt resolution of claims submitted by parties injured in motor vehicle accidents. 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 Misc.3d 927, 796 N.Y.S.2d 872 (Civ. Ct. Kings Co. 2005; *Westchester County Medical Center v. N.Y. Central Mutual Life Ins. Co.*, 262 A.D.2d 553, 692 N.Y.S.2d 665 (2nd Dept. 1999). "When 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 Ins. Co.*, 7 Misc.3d 927, 930, 796 N.Y.S.2d 872, 875 (Civ. Ct. Kings Co. 2005).

The response to a verification request that is "arguably responsive" places the burden to take further action upon the respondent. *All Health Medical Care, P.C. v. GEICO,* 2 Misc.3d 907 (N.Y. City Civ. Ct. 2004). Moreover, as long as applicant's documentation is "arguably responsive" to an insurer's verification request, the insurer must act affirmatively once it receives a response to its verification request. *Media Neurology, P.C. v. Countrywide Ins. Co.,* 21 Misc.3d 1101 (N.Y. City Civ. Ct. 2005). "If the provider objects to the request for verification, then the issue of whether the requested verification material and the objection were proper are preserved and become questions of fact for the trier of fact." *Victory Medical Diagnostics, PC v. Nationwide Property and Cas. Ins. Co.*, 36 Misc.3d 568, 576, 949 N.Y.S.2d 855 (Dist. Ct. Nass. Co. 2012).

In *Medaid Radiology, LLC and GEICO*, AAA case no. 17-21-1199-9692, I was asked to consider the same issues presented in this case, namely, whether Respondent properly denied Applicant's claim on the grounds that Applicant failed to fully comply with its verification requests. In finding in favor of Respondent, I reasoned as follows:

> By way of background, Respondent received Applicant's claims on September 21, 2020. However, on August 27, 2020, at Respondent's

request, Applicant appeared to give testimony at an Examination Under Oath. Based on the testimony provided, Respondent issued post EUO verification requests which sought the following list of documents and information with regard to issues raised at the EUO:

1. Sign in sheets and referrals from other healthcare providers;

2. Documents evidencing ownership of the applicant at the time of treatment for which you seek payment;

3. A list of the individuals who provide the healthcare services on behalf of the applicant, licensing documents for those individuals, and documents identifying the relationship between each individual and the Provider (i.e., W-2s, 1099s, and/or K-1s);

4. Documents, contracts, and agreements (including proofs of payment thereunder) between the applicant and any entity or individual that leases space and/or equipment to or from the Provider, including 481 North 13th Street, Newark, NJ;

5. Documents, contracts, and agreements (including proofs of payment thereunder) between the applicant and any entity or individual that provides management, consulting, administrative, billing or collection services to the Provider, including agreements with Star Solutions;

6. Documents, contracts, and agreements (including proofs of payment thereunder) between the applicant and any entity or individual that provides or facilitates travel of assignors to treatment locations of the applicant, including MDMN Transportation;

7. Documents relating to the income and expenses of the applicant, including but not limited to payroll tax returns and corporate tax returns from inception to present;

8. Copies of bank statements, account opening documents, opening/signatory authorization, canceled checks (copies of the front and back of checks) in connection with any bank account held in the name of Medaid Radiology from inception to the present;

9. Copies of (i) Dr. Alkies Lapas (Dr. Lapas) medical degrees and licensing documents, including a curriculum vitae; (ii) all agreements and/or contracts, including proof of payments made thereunder, between Medaid Radiology and Dr. Lapas; and (iii) all invoices received from Dr. Lapas, or any entity owned by Dr. Lapas, including proof of payments made thereunder;

10. Copies of the following documents: (i) the job descriptions for the personnel employed by Medaid Radiology; (ii) the staff orientation plan; (iii) the staff education plan; (iv) the policy and procedure manual for Medaid Radiology, including the date of the last review;

(v) the patient care policies and procedures for Medaid Radiology; (vi) the quality assurance program for patient care implemented by Medaid Radiology; (vii) the policies and procedures implemented regarding infection control at Medaid Radiology; and (viii) the policies and procedures regarding emergency kits at Medaid Radiology;

11. A list of the members of the following committees, including a description of each members relationship to Medaid Radiology: (i) the patient care policy committee; (ii) the quality assurance committee; and (iii) the Infection Control Committee;

12. Copies of minutes from the last three (3) meetings of the Patient Care Policy Committee for Medaid Radiology;

13. Documents, contracts, and agreements (including proofs of payment thereunder) relating to the opening and use of Post Office Box 829971, Philadelphia, PA 19182;

14. Copies of the service agreement for the online scheduling program utilized by Medaid Radiology and testified to at the EUO by Mr. Alon, including all invoices and proofs of payment made thereunder;

15. Copies of the service agreement between the applicant and Megatech, as testified to at the EUO by Mr. Alon, including all invoices and proofs of payment made thereunder;

16. All MRI films for enumerated EIPs.

Parenthetically, following receipt of Applicant's claims at issue in this proceeding, Respondent issued verification requests specific to each claims in question, reiterating its demands outlined in its initial post-EUO demand.

On December 30, 2020, the Applicant, by its counsel provided an extensive response to the request for verification. However, Applicant unequivocally stated that it was not providing several of the records requested, including payroll tax returns, bank statements, account opening documents, opening/signatory authorization, and cancelled checks, asserting that the information requested is beyond the scope of the EUO, not relevant to the verification of the subject claims, and is overly broad and palpably improper.

By correspondence dated January 11, 2021, the Respondent acknowledged receipt of the Applicant's response, and informed Applicant that it failed to fully comply with its verification requests, asserting that the following remained outstanding:

1. Documents, contracts, and agreements (including proofs of payment thereunder) between the applicant and any entity or

individual that leases space and/or equipment to or from the applicant, including 481 North 13th Street, Newark, NJ;

2. Documents, contracts, and agreements (including proofs of payment thereunder) between the applicant and any entity or individual that provides management, consulting, administrative, billing or collection services to the applicant, including agreements with Star Solutions;

3. Copies of bank statements, account opening documents, opening/signatory authorization, canceled checks (copies of the front and back of checks) in connection with any bank account held in the name of "Medaid Radiology" from inception to the present;

4. Copies of (i) Dr. Alkies Lapas' ("Dr. Lapas") medical degrees, including a curriculum vitae; and (ii) all agreements and/or contracts, including proof of payments made thereunder, between Medaid Radiology and Dr. Lapas;

5. Copies of the following documents: (i) the job descriptions for the personnel employed by Medaid Radiology; (ii) the staff orientation plan; (iii) the staff education plan; (iv) the policy and procedure manual for Medaid Radiology, including the date of the last review; (v) the patient care policies and procedures for Medaid Radiology; (vi) the quality assurance program for patient care implemented by Medaid Radiology; (vii) the policies and procedures implemented regarding infection control at Medaid Radiology; and (viii) the policies and procedures regarding emergency kits at Medaid Radiology;

6. A list of the members of the following committees, including a description of each member's relationship to Medaid Radiology: (i) the patient care policy committee; (ii) the quality assurance committee; and (iii) the Infection Control Committee;

7. Copies of minutes from the last three (3) meetings of the Patient Care Policy Committee for Medaid Radiology;

8. Documents, contracts, and agreements (including proofs of payment thereunder) relating to the opening and use of Post Office Box 829971, Philadelphia, PA 19182;

9. Copies of the service agreement for the online scheduling program utilized by Medaid Radiology and testified to at the EUO by Mr. Alon, including all invoices and proofs of payment made thereunder.

Respondent has provided an affidavit from its SIU investigator, namely, Navindrachand Gopi, which provides a detailed analysis of the basis upon which the decision was made to conduct an EUO of Applicant as well as the issues and concerns that arose out of that

EUO testimony. In my view, the affidavit provides more than sufficient support as to why the post EUO verification requests were issued.

In *Bay Plaza Chiropractic v. State Farm Mutual Automobile Insurance Co.*, 21 Misc.3d 1102 (Civ. Ct. Richmond County 2008), the court determined that the insurer must show "good cause" by demonstrating behavior that is tantamount to fraud when requesting verification in accordance with *Malella*. In *Nexray Medical Imaging PC v. Allstate Insurance Co.*, 39 Misc.3d 1237 (District Ct. Nassau County 2013), the court held that *Malella* discovery requests must be supported by "case specific allegations". In *Pomona Medical Diagnostics PC v. Adirondack Ins. Co.*, 2012 NY Slip Op 51165 (App. Term 1st Dept.), the court held that insurers cannot engage in a mere fishing expedition for *Malella* evidence. The court has held that to obtain bank statements and tax returns, which is highly intrusive, the respondent must show special circumstances to warrant verification of this type. *See, Vista Surgical Services v. Utica Mutual Ins. Co.*, 22 Misc.3d 142(A) (App. Term 2nd, 11th, and 13th Dists. 2009).

Comparing the relevant evidence submitted by the parties, and upon consideration of the arguments presented by counsel during the hearing, I find that the Respondent is entitled to the verification requested. While an insurer does not have an unrestricted right to seek "*Mallela* type" verification in each claim presented, based on the facts presented herein I find that there was a reasonable basis for further verification. I find, as a matter of fact, that there was good cause shown for requesting the various items in the verification requests issued post EUO and that Applicant has failed to substantially comply with Respondent's verification request. The testimony raised significant concerns. Respondent's affidavit by Navindrachand Gopi provides a detailed analysis of what led to the EUO request and what concerns were raised during the EUO that prompted the post EUO verification requests. The concerns focused on whether Applicant was eligible to collect no-fault benefits as being in violation of New York and/or New Jersey law. The investigation as well as the testimony taken at the EUO more than adequately supports Respondent's position that the verification requested was reasonable and necessary in order to determine Applicant's eligibility to collect no-fault benefits. The affidavit further provides a detailed list of what was not provided.

The doctrine of collateral estoppel precludes a party from re-litigating in a subsequent action or proceeding, an issue that was raised in a prior action or proceeding and decided against that party, whether or not the tribunals or causes of action are the same. *See, Ryan v. New York Telephone*, 62 N.Y.2d 494, 478 N.Y.2d 823. To invoke the doctrine

of collateral estoppel, there must be an identity of issues which has been decided in the prior action (and which is decisive in the present action) and there must have been a full and fair opportunity to contest the decision now said to be controlling. *See, Gilberg v. Barbieri*, 441 N.Y.S.2d 49; *Schwartz v. Public Administrator of County of Bronx*, 24 N.Y.2d.65, 68, 298 N.Y.S.2d 955, 958 (1969). The doctrines of *res judicata* and collateral estoppel are fully applicable to arbitration proceedings. *American Ins. Co., v. Messinger*, 43 N.Y.2d 184, 401 N.Y.S.2d 36 (1977); *Clemens v. Apple*; 65 N.Y.2d 746, 492 N.Y.S.2d 20 (1985); *County of Rockland v. Aetna Casualty & Surety Co.*, 129 A.D.2d 606, 514 N.Y.S.2d 102 (2nd Dept. 1987); *Protocom Devices, Inc. v. Figueroa*, 173 A.D.2d 177, 569 N.Y.S.2d 80 (1st Dept. 1991); *Hilowitz v. Hilowitz*, 85 A.D.2d 621, 445 N.Y.S.2d 22 (2nd Dept. 1981).

No issue has been raised surrounding the timeliness of Respondent's denial and my consideration of the same evidence in the prior related matter involves the same parties, together with the same defense advanced by Respondent in this proceeding. Applicant was aptly represented by counsel in the prior proceeding before me and had a full and fair opportunity to litigate the issues. Therefore, I must conclude that the doctrine of collateral estoppel should be applied in this matter and, pursuant thereto, find in favor of Respondent.

That being said, I adopt and incorporate by reference my reasoning and ultimate determination in the prior related matter and, pursuant thereto, sustain Respondent's denial relative to the bill at issue in this proceeding. Applicant has not offered any additional evidence in these proceedings to persuade me otherwise. For example, I am not persuaded by Applicant's counsel that the "Stipulation of Dismissal Without Prejudice" of an underlying federal court action involving a business partner of Applicant's principal requires a different outcome. The litigation pending in federal court was merely tangential to Respondent's investigation into Applicant's business practices and its underlying reason for requesting the Applicant's attendance at an EUO, together with the subsequent post-EUO demands in the first instance. Nevertheless, I find the disposition of federal litigation involving one of Applicant's alleged business partners, which, notably, was not decided on the merits of the evidence, of no consequence to this proceeding.

Relying on the court's ruling in *Island Life Chiropractic, P.C. v Travelers Ins. Co.*, 2019 NY Slip Op 51273(U) (App. Term 2nd, 11th and 13th Jud. Dist. August 2, 2019), Applicant further contends that Respondent's failure to offer an affidavit identifying the outstanding information and documentation is fatal to its defense. I respectfully disagree. First, Applicant objected to various demands and, therefore, is well aware of the information not provided. Second, Respondent's January 11, 2021, April 15, 2021, June 15, 2021, and August 12, 2021 correspondence clearly delineate the information outstanding.

Finally, to the extent Respondent relies upon arbitration decisions wherein the arbitrator determined, generally, that post-EUO demands are improper, I respectfully disagree. I also respectfully disagree with my colleagues who have determined that the Applicant in

this proceeding substantially complied with Respondent's verification requests. Respondent's SIU affidavit provides a detailed analysis of the basis upon which the decision was made to conduct Applicant's EUO, and, similarly, provides sufficient justification to support Respondent's post-EUO demands. In fact, I note that my determination is consistent with the determinations by several additional colleagues (*see*, AAA case no. 17-21-1196-1257, Arb. Lester Hill; AAA case no. 17-21-1100-9664, Arb. Drew Gewuerz; AAA case no. 17-21-1199-9578, Arb. Debbie Thomas; AAA case no. 17-21-1199-9660, Arb. Brett Hausthor; AAA case no. 17-21-1196-1170, Arb. Victor Moritz; AAA case no. 17-21-1201-4388, Arb. Karen Fisher-Isaacs; AAA case no. 17-21-1199-9694, Arb. Evelina Miller; AAA case no. 17-21-1196-1271, Arb. Stephen Czuchman; AAA case no. 17-21-1196-1269, Arb. Ellen Weisman; and AAA case no. 17-21-1196-1168, Arb. Anthony Bianchino; AAA case no. 17-21-1196-1176, Arb. John O'Grady; AAA case no. 17-21-1196-1174, Arb. Giovanna Tuttolomondo; AAA case no. 17-22-1270-6171, Arb. Eva Gaspari; AAA case no. 17-21-1228-6935, Arb. Eileen Hennessey, AAA case no. 17-22-1257-3502, Arb. Mitchell Kleinman; AAA case no. 17-22-1257-3537, Arb. Kent Benziger; AAA case no. 17-22-1257-3613, Arb. Thomas Eck; AAA case no. 17- 21-1196-1192, Arb. Deepak Sohi; AAA case no. 17-22-1257-4023, Arb. Linda Filosa; AAA case no. 17-22-1270-5682, Arb. Maria Schuchmann; AAA case no. 17-22-1270-6325, Arb. Kevin Glynn; AAA case no. 17-21-1270-6068, Arb. Tali Philipson; AAA case no. 17-22-1270-6098 Arb. Jan Chow; AAA case no. 17-21-1212-7632, Arb. Teresa Girolamo; and AAA case no. 17-22-1257-3588, Arb. Neil Dobshinsky.)

Additionally, several Master Arbitrators have affirmed lower arbitrator decisions and sustained Respondent's 120-day defense as it pertains to this Applicant. *See, Medaid Radiology LLC and GEICO Ins. Co.*, AAA Case No. 99-21-1199-9660 (Master Arbitrator Weisman 7/26/22); *Medaid Radiology LLC and GEICO Ins. Co.*, AAA Case No. 99-21-1196-1170 (Master Arbitrator Grob 7/21/22); *Medaid Radiology LLC and GEICO Ins. Co.*, AAA Case No. 99-21-1196-1121 (Master Arbitrator Trestman 7/14/22).

Accordingly, for the reasons noted above, including the reasons cited in my prior decision, Applicant's claim at issue in this proceeding is denied.

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 Suffolk

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

12/15/2023
(Dated)

Alison Berdnik

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:
219213c6f9c7b513f7542a941187e455

Electronically Signed

Your name: Alison Berdnik
Signed on: 12/15/2023