

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Advanced Medical Supplies Inc.
(Applicant)

- and -

Geico Insurance Company
(Respondent)

| | |
|--------------------------|------------------|
| AAA Case No. | 17-23-1288-9365 |
| Applicant's File No. | STLG23-62514 |
| Insurer's Claim File No. | 0462822820101075 |
| NAIC No. | 22063 |

ARBITRATION AWARD

I, Maryann Mirabelli, 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: Assignor

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

John Faris, Esq, from Law Office Of Stephen A. Strauss, PC 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, **\$1,309.27**, 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 arbitration arises out of a motor vehicle accident which took place on 11/7/22 whereby the Assignor (NW) a then 39-year-old female was allegedly injured in the accident and sought treatment with the provider. Applicant is seeking reimbursement in the amount of \$1309.27 for a lumbar brace and cervical traction unit provided to the Assignor on 12/28/22, along with interest and counsel fees, under the No-Fault Regulations in connection with injuries sustained in the motor vehicle accident.

The threshold issue presented at the hearing is whether Respondent's 120-day verification defense can be sustained. Respondent has also raised a fee schedule defense with respect to the lumbar brace.

4. Findings, Conclusions, and Basis Therefor

The hearing proceeded by ZOOM.

This decision is based upon the written submissions of counsel for the respective parties as well as oral argument. I have reviewed the documents contained in the Record as of the date of the hearing.

Upon reviewing the evidence submitted by the Applicant, I find the Applicant submitted sufficient credible evidence to establish a prima facie case with the respect to the services that are the subject of this arbitration. See, Mary Immaculate Hospital v. Allstate Insurance Co., 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004) Once Applicant has made out a prima facie case, the burden shifts to Respondent to timely request additional verification, deny, or pay the claim. Hospital for Joint Diseases v. Travelers Prop. Cas. Ins. Co., 9 NY3d 312 (2007).

At issue are a Lumbar brace (Code L0631) and a Cervical Traction (E0855). Although Respondent raised issue regarding the fees charged, the respondent failed to submit a fee audit in support of its fee schedule defense and thus failed to establish prima facie that the DME was not billed in accordance with the fee schedule. See, Cornell Medical, PC v. Mercury Casualty Co., 24 Misc.3d 58, 884 NYS2d 558 (App. Term 2d, 11 & 13 th Dists. 2009).

Additionally, Respondent's denial of claim form maintains the provider failed to comply with verification within 120 days of the date of the initial request and therefore is not entitled to reimbursement. Specifically, Respondent maintains the initial verification requests of 01/30/2023 and 01/31/2023 were not complied with.

A no-fault claim must be paid or denied within thirty (30) days after proof of claim is received or it is "overdue". See, N.Y. Ins. Law § 5106[a]; 11 NYCRR 65-3.8(a)(1); Presbyterian Hospital v. Maryland Cas. Co., 90 N.Y.2d 274 (1997). An insurer may toll the 30-day claim period for the purpose of obtaining verification. "[W]ithin 15 business days of receipt of the prescribed verification forms", an insurer may seek additional verification of claim. See, 11 NYCRR 65-3.5(b). "[I]f any requested verification 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". See, 11 NYCRR 65-3.6(b).

Once the insurer proves that it timely mailed its request and follow-up request for verification to the health care provider, if the latter does not demonstrate that it provided

the insurer with the requested verification prior to the commencement of litigation, the litigation is premature inasmuch as the 30-day period within which the insurer was required to pay or deny the claim did not commence to run. Proscan Imaging, P.C. v. Travelers Indemnity Co., 28 Misc.3d 127(A), 2010 N.Y. Slip Op. 51176(U), 2010 WL 2681691 (App. Term 2d, 11th & 13th Dists. July 7, 2010).

11 NYCRR 65-3.8(b)(3) allows an insurer to issue a denial if after 120 days, the Applicant has not submitted all verification under its control or written proof of a reasonable justification for the failure to provide the requested items. Respondent's verification requests stem from examinations under oath of Applicant's representative, held on October 11, 2017 and Applicant's owner, Fatima Elkhettab held on February 7, 2018. Respondent has repeatedly issued verification requests seeking the same information sought herein. Applicant has repeatedly responded to the verification requests providing some information sought post-EUO and objecting to the remaining information not provided.

Applicant asserted that it substantially complied with the Respondent's post-EUO verification requests providing most of the requested documentation and objecting to the other items as unreasonable and/or unnecessary. Respondent countered that the Applicant's claim should be denied because Applicant failed to provide full responses to the verification requests. Specifically, with respect to this claim, Respondent received the bill on 1/3/23 and sent an initial verification letter on 1/30/23 followed by a 3/3/23 request. I note the two of the three documents requested in the verification letters deal with fitness kits which are not at issue in this arbitration and therefore do not apply in this specific arbitration as the claims are for a lumbar brace and cervical traction unit. Therefore, the only documentation requested which is applicable in this case is the third request for the following:

"Documents relating to the income and expenses of Advanced, including but not limited to corporate tax returns, payroll tax returns, financial statements, bank statements, cancelled checks, and general ledgers, from January 2014 to present."

Respondent asserts Applicant objected to the requested material, though failed to substantially respond to requests for additional verification. I note objection letters submitted by the Applicant dated 1/16/23, 2/7/23 and 3/13/23. With respect to the third request regarding tax returns in the 1/16/23 verification response, Applicant referenced that at the time of the EUO of the provider on February 7, 2018, the applicant's owner, Fatima Elkhettab, testified extensively regarding the applicant's corporate matters including but not limited to the applicant's ownership, employee salaries, persons with access to the applicant's bank accounts, preparation of corporate taxes as well as knowledge and management of the applicant's month to month finances.

Notwithstanding the aforementioned testimony regarding the financial matters of the applicant, at the time of the EUO on February 7, 2018, as well as in subsequent written correspondence sent to the respondent and its counsel, the applicant and its counsel

objected, multiple times, to the reasonableness of GEICO's request for the financial records in order to process the applicant's no-fault claims. Applicant asserted that the respondent failed to submit evidence of reasonableness and necessity to substantiate its requests.

In support of its defense, Respondent submitted an affidavit from Theresa Sarlo, an investigator employed by Respondent in its Special Investigative Unit, who indicated that Respondent commenced an investigation, based on various facts and circumstances, which called into question Applicant's eligibility to receive no-fault reimbursement giving rise to Respondent's EUO request(s). Included in the affidavit is the claim that the verification requested was necessary to verify whether Applicant is engaged in fraudulent billing patterns designed to overcharge Respondent; engaged in a pattern of billing Respondent for goods and services not actually provided; and whether the "charges are the byproduct of bona fide arms-length transactions."

Both sides submitted arbitration decisions in their favor. In these cases, my colleagues considered substantially the same documentary verification requests and response by Applicant. Having reviewed the documents submitted including the briefs of the parties, the pertinent parts of the EUO testimony and the affidavit of Ms. Sarlo, and the many communications between the parties regarding the requests and exchange of documents under the facts as presented herein, I agree with those of my colleagues that find in favor of the Applicant.

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. *Vista Surgical Services v. Utica Mutual Insurance Company*, 22 Misc. 3d 142(A) (App. Term 2nd, 11th, and 13th Dists. 2009). Arbitrator Lester Hill in his well-reasoned analysis of the issue in, *AAA Case No. 17-21-1224-8436* (10/16/22) having reviewed similar proof presented herein reached a conclusion that the Respondent has not demonstrated the "special circumstances" to warrant the applicant to produce financial records, specifically, tax returns, bank records, and financial statements. He highlights the arguments made by Ms. Sarlo, and the memorandum of law produced by counsel for the Applicant. Arbitrator Hill goes on to say,

"I find the respondent has not presented the "special circumstances" to warrant the intrusion into the applicant's finances. I am often confronted with this issue and the argument that investigation of the applicant's finances is necessary to address issues of ownership and financial control and kickbacks. I sincerely doubt that an investigation into the applicant's finances (or for that matter any applicant suspected of kickbacks) would find checks made out to the alleged recipient of kickbacks (and marked "kickback" in the memorandum portion of the check) or a check to an undisclosed partner. Putting aside this tongue-in-cheek comment, I am at a loss of how an investigation of the applicant's finances are relevant to the verification of this claim. In instances where there is a genuine issue of ownership of a medical provider that requires a medical professional to be the owner, financial and tax records may be of some significance. That is not

the instance here since there is no requirement for a medical professional to be the owner of the supplier of durable medical goods. The applicant produced volumes of invoices for the durable medical goods it provides. The respondent alleges that the applicant mislabels and mischaracterizes the durable medical goods which it purchases when the applicant bills for the durable medical goods. How any investigation into the applicant's finances would provide any relevant information regarding this issue is dubious.

I find the applicant's claim verified and find the respondent's denial based upon 11 NYCRR 65-3.6 (o) to be without merit."

I agree with the above cited decision and find that the Affidavit of Ms. Sarlo does not provide a sufficient basis to establish the Respondent's right to the financial information sought in its verification requests. It is significant that a portion of Ms. Sarlo's argument as to why GEICO is entitled to corporate tax returns, payroll tax returns, financial statements, bank statements, cancelled checks, and general ledgers, from January 2014 to present hinges on statements regarding DME providers in general. Ms. Sarlo's affidavit was not supported by meaningful evidence to warrant the production of the financial documentation requested. See, also, AAA Case no. 17-23-1287-1237 (Josh Youngman, Arb.); AAA Case no. 17-23-1288-9125 (Steven Celauro, Arb.).

Therefore, no other issue needs to be addressed. Based on the proof provided I find Respondent's 120-day denial to be without merit.

Pursuant to 11 NYCRR 65-4 (Regulation 68-D), §65-4.5, an Arbitrator shall be the judge of the relevance and materiality of the evidence offered...The Arbitrator may question any witness or party and independently raise any issue that the Arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department Regulations. Master Arbitrator Peter J. Merani, in the case of Sports Medicine & Orthopedic Rehabilitation a/a/o "I.B." v. Country-Wide Insurance Co., AAA Case No. 17-R-991-14272-3, stated, in relevant part, that "*the Arbitrator below is the trier of facts and must evaluate and weigh the evidence presented at the hearing in arrive at [his/her] decision. The Arbitrator, in weighing the evidence, has broad powers and discretion in determining what evidence is relevant and material. The Arbitrator is in the best position to evaluate the evidence and decide on the credibility of the submitted documents*".

Applicant is awarded \$1309.27, plus interest, an attorney's fee and the arbitration filing fee, as outlined below in Sections A through D below.

This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator.

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 |
|---------|--------------------------------|---------------------|--------------|---------------------|
| | Advanced Medical Supplies Inc. | 12/28/22 - 12/28/22 | \$1,309.27 | Awarded: \$1,309.27 |
| Total | | | \$1,309.27 | Awarded: \$1,309.27 |

- B. The insurer shall also compute and pay the applicant interest set forth below. 03/02/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest on the above-awarded amount shall be computed and paid at a rate of 2% per month, simple, commencing on the date the claim was filed in arbitration and 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

An attorney's fee of 20% shall be paid on the sum total of the awarded claim plus interest, subject to a maximum of \$1,360.

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

12/18/2023

(Dated)

Maryann Mirabelli

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:
58e32f94208e731a78b827fed450eb82

Electronically Signed

Your name: Maryann Mirabelli
Signed on: 12/18/2023