American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

eMed Pharmacy Corp. (Applicant)	AAA Case No.	17-23-1307-5443
	Applicant's File No.	RFA23-318926
- and -	Insurer's Claim File No.	0533896320101064
	NAIC No.	35882
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Matthew Summa, 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 08/30/2024
   Declared closed by the arbitrator on 08/30/2024

   Helen Feingersh, Esq. from Horn Wright, LLP participated virtually for the Applicant

   Chris Mango, Esq. from Rivkin & Radler LLP participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$19.02**, 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 Assignor, JP, a 32-year-old female, was involved in a motor vehicle accident on 7/1/2022. At issue in this case is $19.02 for medication, which was provided on 11/7/2022. Respondent issued requests for additional verification and then denied the bill based upon Applicant's alleged failure to respond. The issue presented is whether Respondent properly denied the claim.

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. There were no witnesses. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

Pursuant to Insurance Law §5106(a) and 11 NYCRR §65-3.8, No-Fault benefits are overdue if not paid or denied within 30 calendar days after the insurer receives proof of claim, which shall include verification of all of the relevant information requested. As required by 11 NYCRR §65-3.5(b), the initial request for verification is to be made within 15 business days of receipt of the claim. A request that is sent beyond the 15 business days is still valid so long as it is issued within 30 days from receipt of the claim; such a deviation will simply reduce the insurer's time to pay or deny by the same number of days. 11 NYCRR §65-3.8(l). See Nyack Hosp. v. General Motors Acceptance Corp., 8 NY3d 294, 2007 NY Slip Op 02439 (Court of Appeals, 2007). On the other hand, if the initial request for verification is made beyond 30 days from receipt of the claim, the request will be deemed a nullity and the time to pay or deny will have expired. Compas Med., P.C. v. Farm Family Cas. Ins. Co., 2015 NY Slip Op 51631(U) (App. Term 2nd, 11th and 13th Jud. Dists. 2015). Additionally, after 30 calendar days from the original request, the insurer has a regulatory duty to issue a second verification request within the following 10 calendar days. 11 NYCRR §65-3.6(b).

The obligation to pay or deny a claim is not triggered until the insurer has received all of the relevant information that was requested. Hospital for Joint Diseases v. State Farm Mut. Auto. Ins. Co., 8 AD3d 533, 2004 NY Slip Op 05413 (App. Div., 2nd Dept., 2004). If the insurer can demonstrate that the initial verification request and follow-up verification request were timely issued, and that no response was received, the matter will be deemed premature and not ripe for adjudication. See Mount Sinai Hosp. v. Chubb Group of Ins. Co., 43 AD3d 889, 2007 NY Slip Op 06650 (App. Div., 2nd Dept., 2007).

Pursuant to 11 NYCRR §65-3.8(b)(3), "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… This subdivision shall apply, with respect to claims for medical services, to any treatment or service rendered on or after April 1, 2013 and with respect to claims for lost earnings and reasonable and necessary expenses, to any accident occurring on or after April 1, 2013."

The bill at issue was received on 11/8/2022. On 11/23/2022 Respondent issued requests for verification pertaining to documents Respondent maintains are necessary to verify the claim based upon the 11/15/2022 EUO testimony of Benjamin A. Pinhasov, one of the owners of Applicant. A second request was issued on 12/30/2022, requesting the same documentation.

Applicant responded to these requests, providing over eight hundred pages of documents on 3/22/2023. Applicant also requested an extension in order to provide additional documents. Respondent issued a denial for this bill on 4/7/20233, based upon Applicant's alleged failure to respond to the verification requests.

After a review of all the evidence submitted in this case, I find that Respondent has breached the tenets of 11 NYCRR 65.15(d)(1), which state that in obtaining all necessary items of verification, an insurer is obligated to act in good faith in connection with its claim practices as follows: (1) Have as your basic goal the prompt and fair payment to all automobile accident victims; (2) Assist the applicant in the processing of a claim. Do not treat the applicant as an adversary; (3) Do not demand verification of facts unless there are good reasons to do so. When verification of facts is necessary, it should be done as expeditiously as possible; and (4) Clearly inform the applicant of the insurer's position regarding any disputed matter. [See, 11 NYCRR 65.15].

The regulation is clear, Pursuant to 11 NYCRR §65-3.8(b)(3), "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**…" **[Emphasis added]**

Based upon the records submitted, it is clear that Applicant did not ignore Respondent's communications. Applicant provided over 800 pages of information, and informed Respondent that it would need more time to provide additional documents. This request was a reasonable justification for the failure to comply within the 120-day period.

Respondent argues that in the event I find its denial invalid, the claim should be dismissed without prejudice, as verification remains outstanding. This argument is without merit. An insurer must stand or fall upon the defense upon which it based its refusal to pay and cannot create new grounds. Todaro v. GEICO General Ins. Co., 46 A.D.3d 1086 (3d Dept. 2007); Matter of State Farm Ins. Co. v. Domotor, 266 A.D.2d 219, 220-221 (2d Dept. 1999). Once the insurer has issued a 120-day denial it is stuck with that defense. It cannot then claim verification is still outstanding. Respondent acts at its own peril when it issues improper denials.

As such, I find that Respondent's denial is improper, and an award shall be issued in favor of Applicant.

Any further issues raised in the hearing 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 applicant is AWARDED the following:

A.

Medical		**From/To**	**Claim Amount**	**Status**
	eMed Pharmacy Corp.	**11/07/22 - 11/07/22**	**$19.02**	**Awarded: $19.02**
Total			**$19.02**	**Awarded: $19.02**

B. The insurer shall also compute and pay the applicant interest set forth below. 07/18/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

   Pursuant to the no-fault regulations, Applicant is awarded interest running from the above-referenced date. Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30-day month." 11 NYCRR §65-3.9(a).

C. Attorney's Fees

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

The insurer shall pay the applicant an attorney's fee pursuant to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D). In accordance with newly promulgated 11 NYCRR 65-4.6(d). "If the claim is resolved by the designated organization at any time prior to transmittal to an arbitrator and it was initially denied by the insurer or overdue, the payment of the applicant's attorney's fee by the insurer shall be limited to 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon, for each applicant with whom the respective parties have agreed and resolved dispute, subject to a maximum fee 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 Queens

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

09/04/2024
(Dated)

Matthew Summa

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:
7914b39948c58597a2dae7f347aa62e0

Electronically Signed

Your name: Matthew Summa
Signed on: 09/04/2024