American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Brooklyn Medical Practice, PC (Applicant)	AAA Case No.	17-24-1348-0231
	Applicant's File No.	AR24-24092
- and -	Insurer's Claim File No.	1044626-01
	NAIC No.	16616
American Transit Insurance Company (Respondent)		

ARBITRATION AWARD

I, Perry Criscitelli, 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: EIP

1. Hearing(s) held on 09/16/2024
   Declared closed by the arbitrator on 09/16/2024

   Alek Beynenson, Esq. from The Beynenson Law Firm, PC participated by written submission for the Applicant

   Janna El Jamal, Esq. from American Transit Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$453.82**, 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

   Did the Respondent properly deny Applicant's claim in that Workers Compensation should be primary?

   Was the Applicant's proof of claim properly denied by Respondent for failure to submit written proof of claim within 45 days?

4. Findings, Conclusions, and Basis Therefor

I have reviewed all of the documents in the Electronic Case Folder which is maintained by the American Arbitration Association. This decision is based upon the documents reviewed as well as the argument made by the Respondent's representatives at the arbitration hearing.

This case involves an EIP involved in an accident on November 20, 2018. He thereafter was treated for injuries by various providers. The claims submitted were denied by Respondent based upon the determination that the EIP was within the course of his employment and Workers Compensation was primary.

Where the Respondent raises a defense that the EIP was injured in the course of employment, primary jurisdiction over the claim lies with the Workers Compensation Board. ("WCB") Arvatz v. Empire Mutual Ins. Co., 171 A.D.2d 262 (1st Dept. 1991). Primary jurisdiction with respect to determinations as to the applicability of the Workers' Compensation Law has been vested in the Workers' Compensation Board and it is therefore inappropriate for the courts to express views with respect thereto pending determination by the board; thus, where there are factual questions as to the EIP's status as an independent contractor or an employee, resolution is best suited for determination by the board, and the court should refer the matter to the board for a hearing and determination as to whether the injured person is relegated to benefits under the Workers' Compensation Law. Dunn v. American Transit Ins. Co., 71 A.D.3d 629 (2d Dept. 2010). Where the evidence is sufficient to raise a question of fact as to whether the EIP was acting as an employee at the time of the accident, the issue must be resolved by the Workers' Compensation Board. A.B. Medical Services, PLLC v. American Transit Ins. Co., 24 Misc.3d 75 (App. Term 9th & 10th Dists. June 18, 2009); Response Equipment, Inc. v. American Transit Ins. Co., 15 Misc.3d 145(A), 2007 N.Y. Slip Op. 51176(U) (App. Term 2d & 11th Dists. June 8, 2007). The mere allegation by the Respondent that an individual was injured in the course of employment does not suffice. The Respondent must proffer competent evidence in admissible form of the alleged facts giving rise to its contention that Workers' Compensation benefits are available. WestchesterMedical Centerv. American Transit Ins. Co., 60 A.D.3d 848 (2d Dept. 2009). The trier of fact need only find that there exists an issue of fact and/or law as to whether the injury took place in the course of employment. The Respondent does not bear the burden of proving that indeed the injured person was in the course of employment.

The Worker's Compensation defense asserted by the Respondent has been previously addressed in an award by Arbitrator Felber, AAA case number 17-20-1168-0146 following a hearing on March 15, 2021. In that award, the Worker's Compensation defense was disallowed predicated on the fact that on December 6, 2018 the Worker's Compensation board issued a decision disallowing the Worker's Compensation claim.

Accordingly, in this case, I find in favor of the Applicant.

45 DAY DEFENSE

Respondent's evidence established that the claims for dates of service December 1, 2020 and March 5, 2020 were timely denied based upon the Applicant's failure to submit written proof of claim within 45 days after the date services were rendered.

The No-Fault Regulations Mandatory Personal Injury Protection Endorsement states:

Proof of Claim; Medical, Work Loss, and Other Necessary Expenses. In the case of a claim for health service expenses, the eligible injured person or that person's assignee or representative shall submit written proof of claim to the Company, including full particulars of the nature and extent of the injuries and treatment received and contemplated, as soon as reasonably practicable but, in no event later than 45 days after the date services are rendered. The eligible injured person or that person's representative shall submit written proof of claim for work loss benefits and for other necessary expenses to the Company as soon as reasonably practicable but, in no event, later than 90 days after the work loss is incurred or the other necessary services are rendered. The foregoing time limitations for the submission of proof of claim shall apply unless the eligible injured person or that person's representative submits written proof providing clear and reasonable justification for the failure to comply with such time limitation.

Notice

11 NYCRR 65-3.3 (e) Notice states:

When an insurer denies a claim based upon a failure to provided timely written notice of claim or timely submission of proof of claim by the applicant, such denial must advise the applicant that late notice will be excused where the applicant can provide reasonable justification of the failure to give timely notice. (Emphasis added).

As to the bills for date of service March 5, 2020, and December 1, 2020 through December 29, 2020, the Respondent raises the 45 day defense. Relative to the bill for March 5, 2020 in the amount of $64.65, the subject bill was received on May 15, 2020 in excess of 45 days from the date of service. Accordingly, as to that bill, I sustain the denial. As to the second bill for date of service December 1, 2020 through December 29, 2020, as to that portion of the bill relative to December 1, 2020, the bill was received on January 19, 2021 in excess of 45 days. Accordingly, Applicant is denied payment of $27.88, and $5.76, $93.65, and $27.46.

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**
	Brooklyn Medical Practice, PC	**02/25/20 - 02/25/20**	**$64.65**	**Awarded: $64.65**
	Brooklyn Medical Practice, PC	**03/05/20 - 03/05/20**	**$64.65**	**Denied**
	Brooklyn Medical Practice, PC	**09/16/20 - 09/16/20**	**$136.13**	**Awarded: $136.13**
	Brooklyn Medical Practice, PC	**12/01/20 - 12/29/20**	**$188.39**	**Awarded: $33.46**
Total			**$453.82**	**Awarded: $234.24**

B. The insurer shall also compute and pay the applicant interest set forth below. 05/21/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Pursuant to Insurance Law § 5106 (a), interest accrues on overdue no-fault insurance claims at a rate of 2% per month. A claim is overdue when it is not paid within 30 days after a proper demand is made for its payment (Insurance Law § 5106 [a]; 11 NYCRR 65.15 [g]). The Superintendent's regulation tolls the accumulation of interest if the claimant "does not request arbitration or institute a lawsuit within 30 days after receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance

Department regulations" (11 NYCRR 65-3.9 [c]). The Superintendent has interpreted this provision to mandate that the accrual of interest is tolled, regardless of whether the particular denial at issue was timely. That interpretation was upheld by the Court of Appeals in LMK Psychological Servs, P.C. v. State Farm Mut. Auto. Ins. Co., 2009 NY Slip Op 02481 (April 2, 2009). Where no denial of claim is issued in response to a proper demand for payment, the insurer does not benefit from the tolling provision and interest will accrue from the date 30 days after the proper demand for payment is made. Interest that accrues when a denial of claim is not issued within 30 days after the proper demand for payment is made will be tolled upon the issuance of a denial of claim, although such denial is untimely, and the failure to request arbitration or institute a lawsuit within 30 days after receipt of that denial of claim form.

C. Attorney's Fees

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

11 NYCRR 65-4.6 establishes a minimum attorneys' fee and further provides that:

For cases filed on or before February 4, 2015, the "attorney's fee shall be limited as follows: 20 percent of the amount of first-party benefits, plus interest thereon, awarded by the . . . court, subject to a maximum of $850" (11 NYCRR 65-4.6 [e]). The October 8, 2003, opinion letter of the Superintendent interpreted that regulation and stated that the minimum amount of attorneys' fees awarded to an assignee health care provider pursuant to Insurance Law § 5106 is "based upon the aggregate amount of payment required to be reimbursed based upon the amount awarded for each bill which had been submitted and denied. The minimum attorney fee . . . is not due and owing for each bill submitted as part of the total amount of the disputed claim sought in the court action" (Ops Gen Counsel NY Ins Dept No. 03-10-04 [Oct. 2003]). For purposes of calculating attorneys' fees, the Superintendent has interpreted a claim to be the total medical expenses claimed in a cause of action pertaining to a single insured, and not each separate medical bill submitted by the provider. The Insurance Department's interpretation of its own regulation was upheld by the Court of Appeals in LMK Psychological Servs, P.C. v. State Farm Mut. Auto. Ins. Co., 2009 NY Slip Op 02481 (April 2, 2009). Attorneys' fees are therefore to be calculated based on the aggregate of all bills for each insured; and

For cases filed after February 4, 2015, the attorney's fee is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D). The attorney's fee shall be limited as follows: 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon, for each applicant per arbitration or court proceeding, subject to a maximum fee of $1,360. If the nature of the dispute results in an attorney's fee that could be computed in accordance with the limitations prescribed in both subdivision (c) and this subdivision, the higher attorney's fee shall be payable.

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

09/17/2024
(Dated)

Perry Criscitelli

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:
9bebf7960c212eda4f9c46313fc09cbc

Electronically Signed

Your name: Perry Criscitelli
Signed on: 09/17/2024