American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

eMed Pharmacy Corp. (Applicant)	AAA Case No.	17-24-1336-2103
	Applicant's File No.	RFA23-323133
- and -	Insurer's Claim File No.	0330460460101025
	NAIC No.	35882
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Thomas Eck, 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 08/26/2024
   Declared closed by the arbitrator on 08/26/2024

   Alex Mun from Horn Wright, LLP participated virtually for the Applicant

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

2. The amount claimed in the Arbitration Request, **$1,206.72**, was NOT AMENDED at the oral hearing.
   Stipulations WERE made by the parties regarding the issues to be determined.

   The parties stipulated that Applicant established a prima facie case of entitlement to No-Fault compensation with respect to its bills. The parties further stipulated that Respondent's NF-10 denial of claim forms were timely issued.

3. Summary of Issues in Dispute

   This arbitration arises out of medical treatment for the 20-year-old Assignor (PI) related to injuries sustained in a motor vehicle accident that occurred on 2/13/2023. Applicant seeks reimbursement for prescription medication

provided on 4/15/2023-5/16/2023. Respondent denied these services based on 120-Day Rule.

4. Findings, Conclusions, and Basis Therefor

This case was decided on the submissions of the parties as contained in the Electronic Case Folder (ECF) maintained by the American Arbitration Association and the oral arguments of the parties' representatives at the hearing. No witnesses testified at the hearing. I reviewed the documents contained in the ECF for both parties and make this decision in reliance thereon.

120 DAY - VERIFICATION REQUESTS

To receive payment of a claim, Applicant "need only file a 'proof of claim' (11 NYCRR 65.11(k)(3)), and the insurers are obliged to honor it promptly or suffer the statutory penalties." Dermatossian v. New York City Transit Authority, 67 N.Y.2d 219, 224, 501 N.Y.S.2d 784, 787 (1986). Furthermore, the No-Fault law requires a carrier to either pay or deny a claim for No-Fault benefits within thirty (30) days from the date an applicant supplies proof of claim. See, Insurance Law §5106 (a) and 11 NYCRR 65-3.8.

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. Any requests by an insurer for additional verification need not be made on any prescribed or particular form. If a claim is received by an insurer at an address other than the proper claims processing office, the 15 business day period for requesting additional verification shall commence on the date the claim is received at the proper claims processing office. In such event, the date deemed to constitute receipt of claim at the proper claim processing office shall not exceed 10 business days after receipt at the incorrect office. See 11 NYCRR §65-3.5(b).

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. See 11 § 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. Amaze Medical Supply Inc. v. Allstate Insurance Co., 3 Misc3d at 133. Hospital for Joint Diseases v. State Farm Mut. Auto. Ins. Co., 8 AD3d 533, 2004 NY Slip Op 05413 (App. Div., 2 Dept., 2004).

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 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 not apply to a prescribed form (NF-Form) as set forth in Appendix 13 of this Title, medical examination request, or examination under oath request. 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. NYCRR §65-3.5(o).

With respect to a verification request and notice, an insurer's non-substantive technical or immaterial defect or omission, as well as an insurer's failure to comply with a prescribed time frame, shall not negate an applicant's obligation to comply with the request or notice. This subdivision shall apply to medical services rendered, and to lost earnings and other reasonable and necessary expenses incurred, on or after April 1, 2013. NYCRR §65-3.5(p).

The issue between these two parties has been ongoing for quite some time. There are numerous awards issued in both parties' favor. Both parties referred to arbitration awards in their favor. I am persuaded by and adopt Arbitrator Phylis Saxe's detailed analysis of Applicant's response in the

linked case of eMed Pharmacy Corp. and Geico Insurance Company, AAA Case No.: Arbitrator Hennessy's decision, in part, is as follows:

Summary of Issues in Dispute

This no-fault arbitration arises from an automobile accident dated 8/10/22. The Assignor AR was involved in the accident and sustained injuries, resulting in him seeking medical treatment. On 10/12/22, AR was supplied with pain medication from E-Med Pharmacy. This bill seeks $ 361.99 as payment for the medication. The Insurer issued a timely denial based on a 120-day defense. It claims that following an Examination Under Oath ("EUO") of Applicant, Respondent sought additional verification and then denied payment, alleging that Applicant did not respond to the verification requests within 120 days of Respondent's initial request. The applicant contends that it substantially complied with the Respondent's verification requests.

Findings, Conclusions, and Basis Therefor

The Post EUO Additional Verification Requests

This case involves a dispute between Applicant and Respondent regarding post-EUO verification requests. Upon receipt of each of the bill in dispute, verification requests were made of Applicant which were partially responded to. Benjamin Pinhasov ("Pinhasov"), a principal owner of Applicant, subsequently appeared for an EUO on November 15, 2022, and thereafter, Respondent determined that additional verification was necessary to determine, among other things, whether Applicant is entitled to reimbursement for No-Fault benefits.

The post EUO verification sought on the bill is at issue here. For each bill at issue, Respondent sent Applicant timely initial and follow-up requests for post-EUO verification. The verification sought various items, including an updated NYS license, tax returns, and W-2 and 1099 forms. Copies of the delay letters and verification requests were submitted into the record by Respondent and Applicant did not offer any argument opposing the timeliness of the verification requests.

There were communications between the parties as some documents were provided and some not. Respondent did acknowledge receipt of

a response from Applicant dated March 22, 2023, wherein Applicant responded to several of the items requested and objected to others. Applicant also requested more time "to produce 2022 W-2s, 1099s and K-1s as they are not yet available." It also requested more time "to produce 2022 payroll and tax returns as they are not yet available."

On March 31, 2023, Respondent, through its attorneys, responded to Applicant's response letter. This March 31 letter followed several other letters sent in January and February 2023 regarding the verification which Respondent asserted remained outstanding, - there were no responses to these letters from Applicant. Respondent's counsel advised Applicant and its attorneys that while Applicant had requested in its March 22, 2023 "partial response" more time to respond, Applicant had failed to provide a reasonable justification as to why the requested verification was not forthcoming or available within the proper time limits of the No-Fault regulations.

After acknowledging receipt of some of the items it requested, in its March 31, 2023 letter Respondent listed all of the outstanding documents it considered "necessary to thoroughly evaluate the claims at issue." This included W-2, 1099, K-1 forms, and employment agreements (where applicable) for all persons who have performed work for or on behalf of Applicant; Application documents, registration forms, and any accompanying documents evidencing ownership submitted by or on behalf of Applicant to the New Jersey and New York Boards of Pharmacy in connection with any request for registration or licensure and/or the transfer of any registration or license; All payroll and tax returns filed from January 1, 2021 to the present by or on behalf of Applicant; copies of specified bank statements and licenses and certifications for all pharmacists and pharmacy technicians; specified lease agreements; purchase invoices, wholesale receipts, and related documentation; and copies of any written agreements/contracts and proofs of payment thereunder between Applicant and any pharmaceutical wholesalers utilized by Applicant from 2021 to the present. Respondent added a notation to several of the requests, explaining what was lacking from a previous response and why some of the requested items were specifically needed.

Respondent asserts that it never received all of the requested verification and, therefore, timely denied the bill on 4/6/23 on the basis of Applicant's failure to provide the requested verification or written proof of reasonable justification for its failure to provide the requested verification within 120 calendar days from the date of the initial request for verification.Pursuant to 11 NYCRR 65-3.5(c), an insurer is entitled to receive all items necessary to verify the claim directly from the parties from whom such verification was requested. Thereafter, at a minimum, if 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, either by telephone call, properly documented in the file, or by mail. 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).

Furthermore, 11 NYCRR 65-3.8(b)(3) provides, "However, 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."

After considering the arguments raised by both parties and reading the EUO testimony, documents, and correspondence between these parties, I find the Respondent's position more compelling. I cite Arbitrator Rebecca Novak's comprehensive award in AAA # 17-23-1307-5325, in which she detailed the basis for sustaining the 120-day denial.

The Applicant raised several arguments in its submission and at the hearing. It first asserted that numerous responses included in over

700 pages of documentation had been previously provided. It also argued that as the "120-day Rule" does not apply to EUO requests, it cannot possibly apply to document demands stemming from EUOs -

"Based on the foregoing, your citation to 11 NYCRR 3.5 (o) is improper as a matter of law and is being disregarded as such." I disagree with Applicant. To begin with, the no-fault regulations do not place an explicit limit on the respondent's ability to request verification of a no-fault claim. I find that, light of the facts surrounding the operation of Applicant's business and Respondent's investigation, the requests were proper and Respondent adequately explained why it sought the requested verification. By way of example, its justification for requesting invoices is entirely justified because an insurer has the right to confirm that what was Applicant has failed to establish in dispensed was indeed billed properly. I also find that why common documents, such as W-2's and tax returns were not available for production during the initial 120 day period. The No-Fault program "stresses the justifying of claims." Nyack Hosp. v. General , 8 N.Y.3d 294, 300 (2007). Information sought as additional Motors Acceptance Corp. verification is not necessarily that which can be found on the prescribed verification forms "but any information that the carrier finds necessary to properly review and process the claim." Westchester Medical Center v. Travelers Property & Casualty Ins. , 2001 N.Y. Slip Op. 50082(U) at 3 (Sup. Ct. Nassau Co., Ralph P. Franco, J., Oct. Co. 10, 2001).

An action by a medical provider seeking No-Fault benefits is premature where the record establishes that the provider did not fully respond to the insurer's requests for additional verification. Orthoplus Products, Inc. v. Global Liberty Ins. Co. , 64 Misc.3d "[128(A), 2019 N.Y. Slip Op. 51003(U) (App. Term 1st Dept. June 19, 2019).

"[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 Ins. Co. , 7 Misc.3d 927, 930 (Civ. Ct. Kings Co. 2005) (any verification which may be sought from an eligible injured person may be sought from his assignee-medical supply provider).

Based on the foregoing case law, and having reviewed the evidence presented in this case and hearing the arguments of counsel, I find that Respondent met its burden of all of the initial verification and has not provided proving that Applicant did not provide any of the requested additional verification, as well as failed to offer a reasonable justification for its non-compliance. Applicant's own evidence establishes that at most there was partial compliance.

In addition, Arbitrator O Grady sustained the denial of the claim and provided a comprehensive analysis of the facts. I agree with his analysis and incorporate parts of this award (AAA # 17-23-1306-8158). In support of the 120-day defense, Arbitrator O'Grady noted that:

Respondent supports the necessity of the verification requested with the affidavit of Lynnette Stone, employed by it as an investigator in its Special Investigations Unit (SIU). She explains that:

1. Geico's concerns about the applicant include, but are not limited to: (a) the pattern in the nature and frequency of the pharmaceutical products prescribed and dispensed, including whether they are medically necessary or prescribed pursuant to fraudulent treatment protocols; (b) the arrangements between eMed and the physicians and locations where the prescriptions are generated, including whether the prescriptions dispensed and billed by eMed are the product of illegal kickback and/or referral arrangements; (c) the billing and coding practices associated with the claim submissions that have been made to GEICO; (d) the procedures surrounding the receipt of scripts from prescribing doctors as well as the dispensing and delivery practices utilized by eMed; (e) whether eMed is in compliance with material licensing laws and, therefore, eligible for reimbursement under 11 N.Y.C.R.R. §65-3.16 (a)(12), with respect to, among other things, the acquisition, handling, production, and dispensation of the pharmaceutical products.

2. GEICO's investigation included, but was not limited to, a review and analysis of eMed's claims for reimbursement submitted to GEICO, statements by GEICO Insureds, public records, site inspections, and investigations into related healthcare providers, including related pharmacy providers and healthcare providers that

purportedly authorize prescriptions that are filled by eMed and submitted to GEICO. The investigation only confirmed GEICO's original concerns in that GEICO identified various circumstances which indicate that: • The pharmaceutical products billed and dispensed through eMed do not appear to be medically necessary, but rather, are prescribed pursuant to pre¬ determined treatment protocols designed to maximize profits without any genuine regard for patient care, health, or safety; • Emed's charges are the byproducts of unlawful, collusive or otherwise suspect referral arrangements in which licensed healthcare providers and/or clinic administrative staff generate prescriptions for pharmaceuticals and divert them to eMed Pharmacy in exchange for kickbacks or other financial incentives. • eMed engaged in questionable billing and coding practices; • eMed may be improperly dispensing prescriptions, including controlled substances to New York based Insureds; and • eMed may not be in compliance with material state and federal licensing laws respect to, among other things, the operation of the pharmacy and the acquisition, handling, production, and dispensing of pharmaceutical products and, therefore, may not be eligible for reimbursement of No-Fault benefits.

3. During the course of its investigation into pharmaceutical providers such as eMed, insurers have discovered an alarming increase in the amount of prescription drug products prescribed to No-Fault patients suffering from seemingly minor injuries sustained in fender-bender type automobile accidents. Specifically, many pharmaceutical providers appear to systematically provide, without regard for medical necessity, pharmaceutical products to a multitude of No-Fault patients who are treating at various "No-Fault Clinics" known to operate as profit-driven "medical mills." These No-Fault Clinics purport to provide their patients with an abundant amount of questionable healthcare goods and services, including pharmaceutical products, without regard to patients' individual symptoms, conditions or accident circumstances, for the sole purpose of submitting inflated, fraudulent billing to insurance carriers. With respect to the prescription of pharmaceuticals, GEICO's investigation revealed patterns in which physicians operating from No-Fault Clinics appear to repeatedly and systematically prescribe the same medically unnecessary pharmaceuticals, including costly topical pain medications, to an alarming number of patients as a matter of course

and regardless of the patients' symptoms and conditions. Many of these pharmaceuticals appear to be dispensed and billed pursuant to fraudulent prescriptions or collusive kickback schemes where, in exchange for unlawful cash kickbacks or other incentives, licensed physicians operating from No-Fault Clinics purport to prescribe pharmaceutical products to their patients without regard for genuine patient care. These prescriptions are then used by pharmaceutical providers such as eMed to justify fraudulent billing submitted to automobile insurance carriers.

4. Per public records, eMed is a retail pharmacy purportedly owned by Maya Podlesnaya ("Podlesnaya") and Vadim Dolsky ("Dolsky"). Though Podlesnaya and Dolsky appear to reside in New York and Puerto Rico, respectively, eMed is situated within Hudson Regional Hospital located at 55 Meadowlands Parkway, Secaucus, New Jersey 07094 ("Hudson Regional"). Hudson Regional was acquired by Yan Moshe ("Moshe") in January of 2018 and he currently sits as Chairman of the Hudson Regional Board. Moshe, Hudson Regional, and Dolsky have been subject to numerous GEICO investigations and lawsuits.

5. Dolsky has been the subject of prior investigations conducted by GEICO and other insurance companies. Recently, GEICO conducted an investigation into Dolsky and another pharmacy of which he has an ownership interest - AV Chemists LLC ("AV Chemists"). AV Chemists was originally formed and began operating in 2018. When Dolsky was added as a member, billing for AV Chemists increased drastically. Specifically, by 2018, AV Chemists billed GEICO less than a total of $5,000.00. However, once Dolsky became an owner of the pharmacy in 2019, the billing submitted to GEICO through AV Chemists increased dramatically with the pharmacy billing over $283,000.00 in 2019, over $542,000.00 in 2020, and over $312,000.00 in 2021 - mostly for Topical Pain Products in the form of Lidocaine 5% Ointment. Notably, Dolsky is the purportedly owner of at least 25 plus acupuncture corporations.

6. eMed began submitting bills to GEICO in 2017 and billed a total of $1,179.88 that year. Interestingly, similar to the pattern with AV Chemists, after Moshe came to acquire Hudson Regional in January 2018, eMed's billing increased exponentially with the pharmacy

billing $679,218.85 in 2020, and over $1 million in 2021. This drastic increase in billing and the receipt of such an alarming number of prescriptions in such a short period of time raised concerns regarding the veracity of the prescriptions including whether they were written and routed to eMed pursuant to illegal collusive arrangements with healthcare providers and laypersons associated with No-Fault Clinics.

7. Significantly, Moshe has been investigated by several no-fault insurers and named as a defendant in multiple lawsuits based on his alleged involvement in no-fault insurance fraud schemes. For example, GEICO previously sued Moshe and other associated medical providers in a federal insurance fraud action, Government Employees Insurance Co., et al. v. Yan Moshe a/k/a Yan Leviev, et al., E.D.N.Y. Case No. 1:20-cv-01098 (E.D.N.Y. 2020), for submitting billing for fraudulent services to providers in both New York and New Jersey. More specifically, it was alleged those defendants wrongfully obtained more than $25,000,000.00 from GEICO by submitting, and causing to be submitted, thousands of fraudulent no-fault insurance charges relating to medically unnecessary, illusory, and otherwise non-reimbursable healthcare services including purported examinations, diagnostic tests, pain management injections, surgical procedures, anesthesia services, drug screening, and the provision of surgical facility space. Id. Moreover, GEICO further alleged that the providers in that action secretly and unlawfully owned, controlled, and/or derived economic benefit from the defendant medical professional corporations. Id. See also State Farm Mutual Automobile Insurance Company v. CPT Medical Services, et al., E.D.N.Y. Docket No. 04-cv-5045; Travelers Indemnity Company v. Liberty Medical Imaging Associates, PC, et. al., E.D.N.Y. Docket No. 07-cv-2519; Government Employees Insurance Co., et al. v. New Hyde Park Imaging, P.C., et al., E.D.N.Y. Docket No. 11-cv-01166; Government Employees Insurance Co., et al. v. Mani Ushyarov, D.O., et al., E.D.N.Y. Docket No. 11-cv-3657; Liberty Mutual Insurance Company, et al. v. Nexray Medical Imaging, P.C., et al., E.D.N.Y. Docket No. 12-cv-5666.

8. Both Dolsky and Moshe were recently sued by Liberty Mutual Insurance Company ("Liberty") for billing Liberty and other New York automobile insurers for excessive and medically useless

fraudulent services. See Liberty Mutual Insurance Company et al v. Advanced Comp. Lab., L.L.C. D/b/a Toplab et al. Case No.: 1:22-cv-3541 (E.D.N.Y. 2022). Both Dolsky and Moshe are alleged to have perpetrated a fraudulent scheme using illegal referral and kickback arrangements to permit associated medical providers to access a steady stream of New York-based patients and/or patient names, in order to fraudulently bill Liberty Mutual and exploit New York's no-fault insurance system for financial gain without regard to genuine patient needs. Id.

9. Due to the various facts and circumstances, including the suspected relationship between Dolsky, Moshe and the above-mentioned providers, significant concerns arose regarding possible unlawful arrangements between eMed and the healthcare providers and clinic locations that are the source of its prescriptions, including whether the prescriptions dispensed and billed by eMed are the product of illegal kickback and referral practices.

10. The concern regarding whether eMed was receiving prescriptions based on collusive arrangements was heightened by the fact that a review of patient claim files revealed eMed, a pharmacy located within a hospital in Secaucus New Jersey, was inexplicably receiving scripts and delivering medications to New York-based insureds who reside in New York City and beyond. A patient address analysis revealed that the average driving distance, in miles from eMed to patient addresses is 30 miles.

11. GEICO also had concerns regarding eMed's coding and billing practices, and the manner in which it processed incoming prescriptions. For example, a review of the bills submitted to GEICO revealed significant discrepancies between the codes being billed and the pharmaceuticals actually dispensed to patients. A further review of the billing submitted by eMed revealed that nearly half the prescriptions dispensed and billed by eMed were purported telephone prescriptions and were submitted for reimbursement without any supporting documentation to confirm the veracity of the prescription.

12. Based upon GEICO's investigation, GEICO requested eMed appear for an EUO. On November 15, 2022, Benjamin Pinhasov ("Pinhasov"), the alleged co-owner of eMed, appeared for the EUO

and his testimony confirmed GEICO's basis for requesting an EUO and further necessitated GEICO's request for further documentation to verify eMed's claims. For example, Pinhasov gave the following testimony, reflected in the EUO transcript: • Pinhasov graduated college in a degree in Accounting and then worked at eMed as a pharmacy technician for four months before becoming its principal owner, despite public records that do not reflect his ownership interest and rather only identifies him as an office manager (p. 13: 1. 17; p. 20: 1. 10); • Pinhasov had no pharmacology experience before joining eMed (p. 13: 1. 17); • Yan Moshe is eMed's landlord (p. 28: 1. 25); • Pinhasov was unable to testify as to the formation of eMed in New Jersey (p. 30: 1. 7 p. 31: 1. 7); • eMed was hemorrhaging money when Pinhasov decided to become principal owner (p. 33: 1. 19); • Dolsky is physically at the pharmacy on an "as-needed basis" and is not physically there often (p. 57: p. 23); • Dolsky is a "equity partner" at eMed and has no involvement with eMed's day-to-day operations (p. 58: 1. 21); • eMed employs a marketing employee who earns $150,000 a year plus a productivity bonus, whose responsibilities include going to doctors' offices, maintaining a relationship, "educating physicians," and dropping off marketing pamphlets (p. 149: 1. 13; p. 187: 1. 15); and • Pinhasov did not find it strange that a Westbury, New York doctor was prescribing medication for a New York based patient to be filled at eMed located in New Jersey (p. 235: 1. 14).

13. Following the EUO, to confirm whether eMed complied with New York law, GEICO sought verification in the form of certain documents to address the above-referenced concerns. The request for additional verification was necessary to confirm Pinhasov's testimony.

The record here notes that while GEICO acknowledges receipt of some documents from eMed, the following documents remain outstanding: • All W-2, 1099, K-1 forms, and employment agreements (where applicable) for all persons who have performed work for or on behalf of eMed, including, but not limited Page 10/14to, any documentation regarding employee status or relationship of any eMed employee from January 1, 2021 to the present; • Application documents, registration forms, and any accompanying documents evidencing ownership submitted by or on

behalf of eMed to the New Jersey and New York Boards of Pharmacy in connection with any request for registration or licensure and/or the transfer of any registration or license; • All payroll and tax returns filed from January 1, 2021 to the present by or on behalf of eMed; • Copies of bank statements from January 1, 2021 to the present relating to eMed' s bank account(s), including copies of cancelled checks, from January 1, 2021 to the present; • Copies of licenses and certifications for all pharmacists and pharmacy technicians who have been employed by eMed from 2021 to the present; • All lease agreements for the locations where eMed operates, including those locations within Hudson Regional Hospital, including both the first and second floors, and any proofs of payment thereunder for use of said locations; • Copies of all purchase invoices, wholesale receipts, and related documentation, including copies of proofs of payment made thereunder, evidencing the purchase of all pharmaceutical products dispensed to the eligible injured persons listed on Exhibit "A;" • Copies of any written agreements/contracts and proofs of payment thereunder between eMed and any pharmaceutical wholesalers utilized by eMed from 2021 to the present;

I agree with Arbitrator O'Grady that based on the foregoing, GEICO concluded that it was both necessary and reasonable to request that eMed appear for an EUO and for GEICO to request post-EUO verification, to address concerns regarding, among other things: (a) the pattern in the nature and frequency of the pharmaceutical products prescribed and dispensed, including whether they are medically necessary or prescribed pursuant to fraudulent treatment protocols; (b) the arrangements between eMed and the physicians and locations where the prescriptions are generated, including whether the prescriptions dispensed and billed by eMed are the product of illegal kickback and/or referral arrangements;

(c) the billing and coding practices associated with the claim submissions that have been made to GEICO; (d) the procedures surrounding the receipt of scripts from prescribing doctors as well as the dispensing and delivery practices utilized by eMed; and (e) whether eMed is in compliance with material licensing laws and, therefore, eligible for reimbursement under 11 N.Y.C.R.R. §65-3.16 (a)(12), with respect to, among other things, the acquisition,

handling, production, and dispensation of the pharmaceutical products. Respondent establishes that the concerns raised by Mr. Pinhasov's testimony and its investigation are sufficient to establish the need for the requested verification. Respondent demonstrates the need for the information requested, and that applicant has not sufficiently complied with its request.

Based on the foregoing case law, and having reviewed the evidence presented in this case and hearing the arguments of counsel, I find that Respondent met its burden that all of the Post-EUO verification had not been provided and that the Applicant failed to offer a reasonable justification for its non-compliance. The applicant's own evidence establishes that, at most, there was partial compliance. Since Applicant did not establish complete compliance with the requests in this instance - reasonably sought - it is irrelevant as to when Respondent corresponded back.

The claim is denied.

I concur with and adopt Arbitrator Saxe's analysis and find that Respondent's requests constitute reasonable verification requests to which Respondent is entitled. The evidence shows that a proper verification request and follow-up have been made for the bill and same was never returned within the 120-day time period. Applicant chose not to provide the requested documentation in response to the verification requests within 120 days and risked dismissal in the event Respondent denied the claim. The bill was properly denied by Respondent after 120 days in accordance with 11 NYCRR §65-3.5(o). Applicant has not indicated that the requested verification was not in their control or possession, provided reasonable justification for the failure to provide the requested documentation, or provided proof that Applicant requested Respondent to reconsider the denial based upon a reasonable justification. The Appellate Term, Second Department has repeatedly held that failure to respond to verification requests shall result in a determination that the claim is premature (in claims prior to the April 1, 2013, amendment to the Regulations) or result in dismissal of the claims premised on the 120-day rule. See SK Prime Medical Supply, Inc. v. Citiwide Auto Leasing, Inc., 2018 N.Y. Slip. Op 50734 (U), Appellate Term, 2 Dept., May 18, 2018. nd See also City Care Acupuncture, P.C. v Allstate Prop. & Cas. Ins. Co., 2017 NY Slip Op 51839(U)(App. Term 2d Dept. 2017).

The verification requests contain the requisite language from 11 NYCRR §65-3.5(o), advising the Applicant that the claim may be denied "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".

Accordingly, I find Applicant failed to respond to Respondent's verification requests and Respondent's denial predicated upon the 120-day rule is sustained. Applicant's claim is denied in its entirety. 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 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 Queens

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

09/24/2024

(Dated) Thomas Eck

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:
5cb34be3b9b8ffae49a1112842c7111b

Electronically Signed

Your name: Thomas Eck
Signed on: 09/24/2024