American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Five Star Rx. Inc. (Applicant)	AAA Case No.	17-23-1308-4406
	Applicant's File No.	154.751
- and -	Insurer's Claim File No.	0683185840000001
	NAIC No.	22063
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Anne Malone, 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 10/04/2024
   Declared closed by the arbitrator on 10/04/2024

   Vincent Ku, Esq. from Tsirelman Law Firm PLLC participated virtually for the Applicant

   Samantha Bibbo, Esq. from Rivkin & Radler LLP participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$2,852.20**, 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 72 year old EIP reported involvement in a motor vehicle accident on July 8, 2021; claimed related injury and received Lidocaine ointment, Ibuprofen and Cyclobenzaprine provided by the applicant on November 2, 2021.

   The applicant submitted a claim for this prescription medication, payment of which was delayed pending the EUO of the applicant and requests for documents and information submitted after the EUO of the applicant was completed and then timely denied after 120 days from the date of the original request.

The post-EUO requests were for documents and information related to the corporate structure and business practices of the applicant.

The issue to be determined at the hearing is whether the respondent's 120 day denial is proper.

4. Findings, Conclusions, and Basis Therefor

This hearing was held on Zoom and the decision is based upon the documents reviewed in the Modria File as well as the arguments made by counsel and/or representative at the arbitration hearing. Only the arguments presented at the hearing are preserved in this decision; all other arguments not presented at the hearing are considered waived.

If an insurer requires any additional information to evaluate the proof of claim, such request for verification must be made within 15 business days of the receipt of the bill in order to toll the 30 day period to pay or deny the claim. See 11 NYCRR 65-3.5(b); See also New York Hosp. Med. Ctr. of Queens v. Allstate Ins. Co., 2014 NY Slip Op 00640 (2d Dept. 2014.)

Where there is a timely original request for verification, but no response to the original request for verification is received within 30 days, or the response to the verification request is incomplete, then the insurer, within 10 calendar days after the expiration of that 30 day period, must follow up with a second request for verification. Id.

If there is no response to the second or follow up request for verification, the time in which the insurer must decide whether to pay or deny the claim is indefinitely tolled. Id.

Therefore, when a no-fault medical service provider fails to respond to the requests for verification the claim is premature and should be denied without prejudice.

However, pursuant to 11 NYCRR §65-3.5(o) 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 applicant's control or possession or written proof providing reasonable justification for the failure to comply.

11 NYCRR 65-3.5(o) specifically excludes EUOs from its purview. The document requests at issue were in response to the testimony by the witness on behalf of the applicant at the EUO and therefore fall outside of the 120-day rule.

In any event, the Court in Neptune Med. Care, P.C. v. Ameriprise Auto & Home Ins., 48 Misc. 3d 139A (2015), Appellate Term, 2d Department, found that "even if defendant had tolled the 30-day period within which it was required to pay or deny the bills at issue, by timely requesting verification pursuant to 11 NYCRR 65-3.8(a)…the Regulations do not provide that such a toll grants an insurer additional opportunities to make requests for verification that would otherwise be untimely."

However, in this instance the EUO was timely requested in correspondence that included requests for various documents/information necessary to verify the subject claim to be provided at the EUO of a witness on behalf of the applicant.

The applicant initially argued that although the second request for the EUO and documents/information requested in the initial correspondence did not specifically enumerate each of the documents/information requested the post-EUO requests were untimely.

According to the submissions, the EUO was rescheduled on several occasions and was held on March 31, 2022 and that it included not only the instant claim, but also more than 100 related claims involving the same applicant and respondent. On April 11, 2022 the respondent timely sent the first of several post-EUO requests for documents/information which had been timely submitted at the time that the EUO was first requested.

The parties have a duty to communicate with each other. The purpose of the No-Fault statute 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.)

The response to a post-EUO request for documents/information 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 post-EUO request, the insurer must act affirmatively once it receives this response. Media Neurology, P.C. v. Countrywide Ins. Co., 21 Misc.3d 1101 (N.Y. City Civ. Ct. 2005.)

According to the applicant's submissions, on July 28, 2022 it first sent a response to the pre and post EUO requests with documents/information and/objections. The respondent acknowledged the responses on August 8, 2022 and requested complete responses for documents/information for which incomplete responses.

When no further response was received the respondent denied this claim for applicant's failure to respond to outstanding requests necessary to verify the subject claim for more than 120 days from the date of the first verification request.

The courts have consistently held that an insurer does not have to pay or deny a claim until it has received verification of all of the relevant information requested. See Montefiore Med Ctr. v Gov't Empls. Ins. Co., 34 AD 3d 771(2nd Dept. 2006.)

In the instant matter, the evidence submitted indicates that the first response to the pre and post EUO requests was not provided by the applicant until July 28, 2022, which is in excess of the statutory 120-day time frame in 11 NYCRR Section 65-3.5(o)

At the hearing, the applicant relied upon the holding in Burke Physical Therapy, P.C. v. State Farm Mutual Auto Ins. Co., 2024 NY Slip Op 23111 (App Term 2d Dept 2024) which precludes the insurer from making "additional" verification requests based upon the EUO.

However, a review of the submissions in this matter established that the initial requests for documents/information to verify this claim were timely sent within the statutory time frame. In addition, the respondent acknowledged the late response and provided its reasons for requesting further complete responses. The applicant did not reply to the request.

There have been many arbitration decisions regarding the issues involved with this applicant and respondent and the same verification issues.

I agree with Arbitrator Kleinman's prior award (AAA 17-24-1336-6769) in which he stated: "I note that in Burke, the court did not address whether there were requests for verification made prior to the EUO that were not complied with, whether the requests issued after the EUO contained the same requests for information as the requests issued prior to the EUO, nor did the court address whether the request for an EUO in that case asked for documents to be produced at the EUO by the testifying party. The court in Burke also did not address whether a request made during an EUO that was not complied with at the EUO constituted an "original request for additional verification."

In addition, he noted that "[t]he information requested by the insurer post-EUO comports with the information that was requested during, and prior to, the EUO. I find that the post-EUO verification requests are requests for additional information that "has not been supplied" to complete the EUO verification process, and that the application of Burke does not mean that the insurer's request were untimely. Therefore, I find that the verification requests issued post-EUO were proper and there was an obligation for a further response to be submitted. The Respondent was within its rights to issue its denial for failure to respond to

the verification requests within the proscribed time period after 120 days had passed."

I find that the claim at issue was properly denied on the grounds that the applicant failed to comply with additional documents/information requested within 120 days of the pre and post-EUO requests.

Based on the foregoing, the respondent has established that the denial was proper.

Accordingly, the claim is dismissed with prejudice.

Any further issues submitted in the record are held to be moot and/or waived insofar as they were not raised at the time of this hearing. 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 CT
SS :
County of Fairfield

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

10/24/2024
(Dated)

Anne Malone

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:
8265fbaa3cf84b29c3d07ed152354619

Electronically Signed

Your name: Anne Malone
Signed on: 10/24/2024