American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

John T. Mather Memorial Hospital (Applicant)	AAA Case No.	17-23-1318-0503
	Applicant's File No.	RFA23-321852
- and -	Insurer's Claim File No.	32-28R7-32P
	NAIC No.	25178
State Farm Mutual Automobile 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 11/18/2024
   Declared closed by the arbitrator on 11/18/2024

   Philip Kim, Esq. from Horn Wright, LLP participated virtually for the Applicant

   Joseph Licata, Esq. from Rossillo & Licata LLP participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$4,653.97**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The amount claimed was amended by the applicant to $522.45 to conform to the appropriate fee schedule.

   Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

   The 60 year old EIP reported involvement in a motor vehicle accident on December 23, 2021; claimed related injury and underwent hospital treatment provided at the applicant's facility on May 14, 2022.

The applicant submitted a claim for these facility services, payment of which was delayed pending verification requests and then denied after 120 days from the initial date of the request for verification.

The verification requested was for documents and information related to this claim and to the corporate structure and business practices of the applicant.

A witness on behalf of the applicant was available to testify at the hearing.

The issues to be determined at the hearing are:

Whether the applicant provided timely relevant documentation which was the basis for the testimony of its witness.

Whether the respondent established its 120 day defense.

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.

120 day defense

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.

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 verification request 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 verification request, the insurer must act affirmatively once it receives a response to its verification request. Media Neurology, P.C. v. Countrywide Ins. Co., 21 Misc.3d 1101 (N.Y. City Civ. Ct. 2005.)

In this matter, the respondent issued timely requests for verification, which it contends was necessary to verify this claim.

In Island Life Chiropractic, PC v Travelers Ins.Co, 64 Misc. 3d 143(A), 117 N.Y.S.3d 428 (App Term 2d Dept. 2019) the court held that "Where a no-fault insurer is relying on the defense that an action is premature because verification is outstanding, it is the defendant insurer's prima facie burden at trial to demonstrate (1) that verification requests were timely mailed and that the defendant did not receive the requested verification. (see 11 NYCRR 65-3.8[a]; Right Aid Medical Supply Corp. v State Farm Mut. Auto Ins. Co., 58 Misc 3d 140(A), 94 N.Y.S.3d 540 NY Slip OP 51875[U] (App Term 2d Dept, 2d, 11th & 13th Jud Dists (2017.)

In the instant matter, the respondent submitted proof of mailing of the verification requests and an affidavit from someone with personal knowledge to attest to the fact that a response was not received from the applicant.

The applicant did not submit a response to the verification requests. However, the submissions contain a letter from the applicant dated July 14, 2022 which is marked "APPEAL" and which acknowledges the verification request for a letter of medical necessity and states that it "cannot determine medical necessity for emergency department visits." It also states that "Medical records are already on file with your office" without identifying what records were submitted.

Witness Testimony

At the hearing, a witness on behalf of the applicant was prepared to testify to the mailing of the appeal letter. However, the documents upon which this witness was prepared to testify were submitted on the day before and the day of the hearing.

The respondent objected to the late submissions and I agreed to not consider the late submissions.

In any event, after a discussion with the parties it was obvious that the letter dated July 14, 2022 that the applicant's witness was prepared to testify was not a response to the verification requests related to this claim. The letter referred to services rendered on May 15, 2022 with total charges of $398.00. The amount in dispute in this matter was $4,653.97, which was amended at the hearing to $522.45. This is the amount which a fee coder retained by the respondent determined was the correct reimbursable amount for the services at issue. The two bills at issue here were in the amount of $4,492.00 and $160.97.

The "appeal" letter referenced a letter from the respondent requesting a letter of medical necessity and medical records. The appeal stated that the applicant cannot determine medical necessity for emergency department visits and that the respondent had already received medical records.

Based on the submissions the respondent has established that the applicant failed to provide a response that was arguably responsive to the verification request. Therefore, the claim was denied on the grounds that the applicant failed to comply with the additional verification requested within 120 days of the original request.

Under these circumstances, 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.

11/21/2024
(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:
c498591b02a7e663764b986cb688001a

Electronically Signed

Your name: Anne Malone
Signed on: 11/21/2024