American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Metro Healthcare Partners (Applicant)	AAA Case No.	17-24-1347-4805
	Applicant's File No.	3242460
- and -	Insurer's Claim File No.	0720581800
	NAIC No.	29688
Allstate 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 11/25/2024
   Declared closed by the arbitrator on 11/25/2024

   Ryan Berry, Esq. from Israel Purdy, LLP participated virtually for the Applicant

   Shanna Nelson, Esq. from Law Offices of John Trop participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$1,544.97**, 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 8 year old EIP reported involvement in a motor vehicle accident on June 13, 2023; claimed related injury and underwent physical therapy treatment, x-rays and office visits provided by the applicant from June 26, 2023 to October 20, 2023.

   The applicant submitted a claim for these medical services, payment of which was delayed pending verification requests for documents and information.

   The verification requested includes medical treatment related to this claim and the business practices of the applicant.

The EIP was 8 years old at the time of the accident. There is an issue as to whether a proper assignment of benefits was submitted and whether the applicant has standing to bring this claim.

The issues to be determined at the hearing are:

Whether there is an assignment of benefits which confers standing to the applicant to bring this claim.

The issue to be determined at the hearing is whether the respondent established that the claim is premature.

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.

Standing

The first issue, which must be determined, is whether there is an assignment of benefits which confers standing to the applicant to bring this claim.

CPLR §1209 provides in pertinent part:

> A claim or controversy involving an infant, person judicially declared to be incompetent or conservatee shall not be submitted to arbitration except pursuant to a court order made upon application of the representative of such infant, incompetent or conservatee; provided, however that a claim brought on behalf of an infant pursuant to paragraph one or two of subdivision (f) of section three thousand four hundred twenty of the insurance law may be submitted arbitration without a court order.

Further, CPLR §1209 "like other provisions of CPLR 1209 is primarily designed to ensure that courts 'safeguard the rights and interests of infants' whom the

courts are bound to protect.'" Cutway v S.T.A.R. Programs, Inc., 75 A.D.3d 811, 812-813, 904 N.Y.S.2d 806 (3d Dept. 2010.)

In addition, an assignment of benefits is a necessary component of complete proof of claim. See A.B.Medical Services PLLC v. Progressive Insurance, 2003 WL 21005006 (N.Y. Supp. App. Term 2003.)

The issue here is whether there is a proper assignment of benefits which confers standing to the assignee to bring this claim. It has been determined that a parent may assign all of his/her own rights to a medical provider with respect to no-fault benefits. See Coastal Commercial Corp. v. Kosoff & Sons, 10 A.D.2d 372, which held that "an assignment at law contemplates a completed transfer of the entire interest of the assignor in the particular subject of assignment, whereby the assignor is divested of all control over the thing assigned."

In this case, the assignee was an infant, years old at the time of the subject accident. Based on the submissions, it appears that the Assignment of Benefits was signed by the infant assignor. There is no indication that it was signed by a parent or guardian.

However, recent case law has held that CPLR§ 1209 "only appears where [an] infant [is] a party" to an arbitration proceeding. See Matter of Fast Care Med. Diagnostics, PLLC/PV v Government Employees Insurance Co., 2018 NY Slip OP 03831, 161 Ad3d 1149 (2d Dept. 2018) citing Goldenberg v Goldenberg, 25 A.D.2d 670 (1966.)

The court noted that the infant patient is not a party to the arbitration, rather the applicant, as the infant's assignee is the part that brought the arbitration. See 11 65-3.11[a].) Fast Case, *supra.*

According to the relevant case law an arbitrator's award finding a lack of standing in a no-fault arbitration is irrational and in conflict with CPLR§ 1209, which applies "only where an infant is a party" to an arbitration hearing.

Based on the foregoing, I find that the applicant has standing to bring the claim at issue.

Outstanding verification

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.

Both 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 the instant case, it is undisputed that respondent issued timely verification requests for documents and/or information to the applicant. Regulation §65-3.5(c) provides that "an insurer is entitled to receive all items necessary to verify the claim directly from the parties from whom such verification is requested." This right should not be construed to require a provider to supply material over which it has no control. See MVAIC v. Stand-Up MRI of Manhattan, P.C., 32 Misc.3d 1205(A), 2011 N.Y. Slip Op. 51187(U) (Sup. Ct. Queens Co. 2011.)

The applicant submitted responses that were "arguably responsive" to the and substantially complied with the verification requests.

Under these circumstances, the respondent did not establish that the claim is premature and the time to pay or deny the claim was not tolled.

Accordingly, the applicant is awarded $1,544.97 in disposition of this claim.

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 applicant is AWARDED the following:

A.

Medical	**From/To**	**Claim Amount**	**Status**

	Metro Healthcare Partners	**06/26/23 - 06/26/23**	**$137.91**	**Awarded: $137.91**
	Metro Healthcare Partners	**06/26/23 - 06/26/23**	**$203.76**	**Awarded: $203.76**
	Metro Healthcare Partners	**06/27/23 - 06/27/23**	**$171.90**	**Awarded: $171.90**
	Metro Healthcare Partners	**07/05/23 - 07/05/23**	**$114.60**	**Awarded: $114.60**
	Metro Healthcare Partners	**07/14/23 - 07/14/23**	**$114.60**	**Awarded: $114.60**
	Metro Healthcare Partners	**07/13/23 - 07/13/23**	**$114.60**	**Awarded: $114.60**
	Metro Healthcare Partners	**07/18/23 - 07/18/23**	**$114.60**	**Awarded: $114.60**
	Metro Healthcare Partners	**07/21/23 - 07/21/23**	**$114.60**	**Awarded: $114.60**
	Metro Healthcare Partners	**07/25/23 - 07/25/23**	**$114.60**	**Awarded: $114.60**
	Metro Healthcare Partners	**07/28/23 - 07/28/23**	**$114.60**	**Awarded: $114.60**
	Metro Healthcare Partners	**10/17/23 - 10/17/23**	**$114.60**	**Awarded: $114.60**
	Metro Healthcare Partners	**10/20/23 - 10/20/23**	**$114.60**	**Awarded: $114.60**

Total	**$1,544.97**	**Awarded: $1,544.97**

B. The insurer shall also compute and pay the applicant interest set forth below. 05/10/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant is awarded interest pursuant to the no-fault regulations. See generally, 11 NYCRR §65-3.9. Interest shall be calculated "at a rate of two percent per month, calculated on a *pro rata* basis using a 30 day month." See 11 NYCRR §64-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. However, the regulations toll the accrual of interest when an applicant "does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits" calculated pursuant to Insurance Department regulations. Where a claim is untimely denied, or not denied or paid, interest shall accrue as of the 30th day following the date the claim is presented by the claimant to the insurer for payment. Where a claim is timely denied, interest shall accrue as of the date an action is commenced or an arbitration requested, unless an action is commenced or an arbitration requested within 30 days after receipt of the denial, in which event interest shall begin to accrue as of the date the denial is received by the claimant. See, 11 NYCRR §65-3.9(c.) The Superintendent and the New York Court of Appeals has interpreted this provision to apply regardless of whether the particular denial was timely. LMK Psychological Servs. P.C. v. State Farm Mut. Auto. Ins. Co., 12 NY3d 217 (2009.)

C. Attorney's Fees

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

Applicant is awarded statutory attorney's fees pursuant to the no fault regulations. For cases filed after February 4, 2015 the attorney's fee shall be calculated as follows: 20% of the amount of first-party benefits awarded, plus interest thereon subject to no minimum fee and a maximum of $1,360.00. See 11 NYCRR §65-4.6(d.)

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 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.

11/26/2024
(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:
be3502d2b1c7de96f7616eb723845bd8

Electronically Signed

Your name: Anne Malone
Signed on: 11/26/2024