American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Far Rockaway Medical PC (Applicant)	AAA Case No.	17-23-1324-2538
	Applicant's File No.	807.655
- and -	Insurer's Claim File No.	3248G950Q
	NAIC No.	25178
State Farm Mutual Automobile Insurance Company (Respondent)		

ARBITRATION AWARD

I, Matthew J. Cavalier, 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 11/15/2024
   Declared closed by the arbitrator on 11/15/2024

   Allen Tsirelman, Esq from Tsirelman Law Firm PLLC participated virtually for the Applicant

   Jenna Pettograsso, Esq from Rivkin & Radler LLP participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$534.94**, was NOT AMENDED at the oral hearing.
   Stipulations WERE made by the parties regarding the issues to be determined.

   The Parties stipulated at the hearing that the date interest accrues if the Applicant prevails is November 7, 2023.

3. Summary of Issues in Dispute

   Whether the Assignor, a 34-year-old male ("MG") on the date of the accident ("DOA") who is the Eligible Injured Party ("EIP") injured in motor vehicle accident ("MVA") on April 14, 2023, and received PM&R medical services on dates of service ("DOS") July

12 and August 30, 2023, were correctly billed in the sum of $534.94, and timely submitted by the Applicant to the Respondent, with a sum in disputed on the AR-1 of $534.94,

Whether the Respondent can maintain its defense of the Applicant's premature filing of this arbitration for the Applicant has failed to respond in full to requests for additional verification ("RAVs") within 120 days of the initial letter dated February 7, 2022, and subsequent letters dated March 15, June 20, 2022, May 9 & 31, June 14, July 5 & 19, August 2, 8 & 9, and September 8, 2023, and the Respondent has not issued a denial based upon the Applicant's failure to respond within 120-days of the initial written request for additional verification?

4. Findings, Conclusions, and Basis Therefor

I have reviewed the documents contained in the ADR Center Case Folder as of the date of the hearing and this Award is based upon my review of the Record and the arguments made by the representatives of the parties at the Hearing. The Arbitrator shall be the judge of the relevance and materiality of the evidence offered, and strict conformity to legal rules of evidence shall not be necessary. The Arbitrator may question any witness or party and independently raise any issue that the Arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department Regulations. 11 NYCRR 65-4.5(o)(1) (Regulation 68-D

The Applicant is seeking to be reimbursed the sum of $534.94 for DOSApril 19, May 17, and June 14, 2023, for the disputed PM&R medical services. The Applicant timely billed the Respondent, and the Respondent sent the initial post-EUO of January 28, 2022, written request for additional verification with aletter dated February 7, 2022, and subsequent timely requests made on March 15, June 20, 2022, May 9 & 31, June 14, July 5 & 19, August 2, 8 & 9, and September 8, 2023, and did not issue a 120-day denial based upon the Applicant's failure to respondent completely respond to the initial request for additional verification dated February 9, 2022, and after the Applicant's June 6, 2022, acknowledged Response, stating there still is verification outstanding and this arbitration was filed prematurely.

Fee Schedule

The Parties requested at the Hearing that I take judicial Notice of the NYSWC Fee Schedule and its Associated Rules. Upon my review of the submitted records and the arguments of the Parties at the Hearing, I find the Applicant correctly billed for the disputed medical services upon their initial submissions, therefore, if the Applicant prevails, they will be awarded $534.94.

Prima facie Case

Upon reviewing the evidence submitted by the Applicant, I find the Applicant submitted sufficient credible evidence to establish a *prima facie* case with the respect to the services that are the subject of this arbitration. See**, Mary Immaculate Hospital v.**

Allstate Insurance Co., 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004); **Amaze Medical Supply Inc. v. Eagle Ins. Co.**, 2 Misc 3d 128[A], 2003 NY Slip Op 51701 (U) (App Term, 2d and 11th Jud Dists 2003).

Once Applicant has made out a *prima facie* case, the burden shifts to Respondent to timely request additional verification, deny, or pay the claim. **Hospital for Joint Diseases v. Travelers Prop. Cas. Ins. Co.**, 9 NY3d 312 (2007).

Response to the Request for Additional Verification

The Respondent contends that reimbursement of Applicant's claim was properly delayed for verification, which was never fully complied with. Respondent subsequently denied Applicant's claim predicated on the reasoning that Applicant failed to submit the verification documentation requested within the prescribed 120-day period.

11 NYCRR Section 65-3.8 (b) provides that 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. (120-day rule).

The verification requests concerns testimony elicited from an examination under oath (EUO) of Dr. Jean-Pierre Barakat, the Applicant's owner, on January 28, 2022. Although the EUO did not involve claims regarding this Assignor, Respondent subsequently sent verification requests regarding the disputed bills stemming from the EUO. The subject verification requests did not request any information directly involving the treatment rendered to this Assignor, but instead requested leases, financial documentation, payroll information, agreements, bank records, and literature Dr. Barakat reviewed regarding the clinical efficacy of certain durable medical equipment.

The Respondent contends that Applicant did not substantially comply with the verification requests and denied the claim based on Applicant's failure to comply with initial verification requests within 120 calendar days of such request or provide written proof providing reasonable justification for failure to comply with the verification request.

The Applicant previously responded to these identical verification requests on June 6, 2022 where they rendered a general objection that the requests are irrelevant and unduly burdensome. Notwithstanding the general objection, the response did include subleases, copies of checks, bank information, bank statements, 1099s, Dr. Barakat's curriculum vitiate, and a billing and collection services agreement with invoices. The response further advised Respondent that tax returns were not yet filed. Based on these responses, Applicant's counsel argues that Applicant substantially complied with all reasonable verification requested and the denial of this claim is improper, and Respondent cannot sustain the 120-day rule defense.

Respondent's counsel counters that Respondent sent a letter on June 20, 2022 to Applicant addressing Applicant's June 6, 2022 responses and detailed to Applicant the shortcomings of their responses. Specifically, Respondent's counsel argues that Applicant's owner Dr. Barakat did not provide a lease for one of the locations (Boston Road) that Applicant is utilizing and appears to be operating at the location under a lease agreement in the name of another professional corporation; that the bank statements are incomplete as monies deposited in Applicant's accounts are swiftly electronically transferred into another account without any explanation as to this unusual and concerning practice; and that Dr. Barakat and Applicant are evading their obligations under the no-fault laws and regulations by using the name of Far Rockaway and conducting all of their operations through the bank accounts, tax documents, and/or agreements maintained by a number of Dr. Barakat's many professional corporations (PCs).

Therefore, the crux of the dispute is whether Respondent's verification requests were reasonable, and if so, did Applicant's response comply with the reasonably requested verification.

Respondent has submitted an affidavit from Brian McCausland, an SIU investigator employed by Respondent's Special Investigative Unit ("SIU") and the EUO transcript of Dr. Barakat in support of the reasonableness and basis for requesting the post-EUO verification.

Mr. McCausland swears that the Respondent commenced an investigation into the Applicant based on an evaluation of their claims identifying various facts and circumstances that call into question Applicant's eligibility to collect no-fault benefits. Specifically, to determine if the services being provided to Respondent's insureds were provided on a non-individualized basis, designed to maximize profit without regard to patient care and is Applicant directly or indirectly provided financial or other consideration in exchange for patient referrals.

Mr. McCausland then swears that Applicant is a transient provider rendering services in clinics that have been investigated by Respondent for questionable financial arrangements which resulted in predetermined treatment and billing protocols as well as questions regarding lay person control at these clinic locations. Mr. McCausland contends that Dr. Barakat has been investigated in the past by Respondent for identical concerns regarding another PC he purportedly owns. Mr. McCausland then notes that Respondent has serious concerns about the source of Applicant's patient referrals at its locations as one of the locations is the subject of a criminal action regarding a massive criminal healthcare fraud conspiracy.

Mr. McCausland further asserts that the outcome assessment tests that are routinely billed by Applicant are not incorporated into the treatment plans and care for their insureds. Mr. McCausland then surmised Dr. Barakat's testimony and contends the additional verification was necessary based upon that testimony in order to confirm the testimony and/or resolve any questions that Dr. Barakat was unable and/or refused to answer.

It is well-established that the insurer is not obligated to pay a claim until it has received verification of all relevant information requested. The regulations further permit the insurer to deny a claim if the requested verification is not provided within 120 calendar days of the initial request for verification. The verification provisions promulgated by the no-fault regulations confer upon the Respondent the right to obtain verification of a claim. However, "If the provider objects to the request for verification, then the issue of whether the requested verification material and the objection were proper are preserved and become questions of fact for the trier of fact. If the insurer can establish it had a reasonable, good faith, factual basis for requesting the verification, then the failure of the claimant provider to furnish the material will result in the dismissal of the action. If the insurer cannot establish a reasonable, good faith, factual basis for requesting the verification, then the insurer will be required to pay the claim." **Victory Medical Diagnostics, P.C. v. Nationwide Property and Casualty Ins. Co.**, 36 Misc.3d 568, 576, 949 N.Y.S.2d 855, 862 (Dist. Ct. Nassau Co. 2012).

Accordingly, based on a review the evidence submitted and the arguments of the Parties, I find that Applicant has substantially complied with Respondent's reasonable verification requests, and that Respondent has failed to establish a good faith factual basis for requesting the remaining purported outstanding verification.

Dr. Barakat appeared for an EUO and provided extensive testimony regarding this Applicant. Dr. Barakat answered questions on his background and why he formed this Applicant PC; the services the Applicant renders which are primarily evaluations and outcome assessment testing and explained how Applicant bills for the services; Applicant's leasing arrangements at the locations Applicant operates and how he found the locations; that he does all the banking for the Applicant himself; does not interact with the other providers at Applicant's locations; that while he prescribed medications and durable medical equipment (DME) Applicant did not receive any compensation from DME companies or pharmacies in exchange for the prescriptions; answered questions regarding certain patient charts; and testified regarding expenses of more than $1000 a month, which were essentially expenses to the billing company and rent. It should be noted that the Applicant's Attorney objected to many of the questions that involved Dr. Barakat's other PC as being beyond the scope of the EUO of this Applicant.

I do not find the objections unreasonable as Respondent fails to show how questions related to Dr. Barakat's other PCs are necessary to verify the claims of this Applicant. In addition, and of import, the generalized accusations of treatment designed to maximize profit without regard to patient care and that Applicant indirectly provided financial or other consideration in exchange for patient referrals, are accusations that are not supported with any meaningful evidence to establish the reasonableness of the verification requested. Moreover, Respondent fails to show how the request for essentially financial documentation would assist in determining whether Applicant's services were designed to maximize profit without regard to patient care without any evidence from a medical expert that reviewed these claims to potentially establish the reasonableness of these requests for that purpose.

In addition, there is no evidence, circumstantial or otherwise, to suspect that Applicant/Dr. Barakat is engaged directly or indirectly in a financial arrangement for the exchange of patient referrals. In addition, the criminal action involving one of the locations Applicant renders services does not involve the Applicant, nor Dr. Barakat. Respondent essentially offers speculation and conjecture, and without any plausible proof, Respondent is merely engaging in a fishing expedition and thus fails to set forth a good faith factual basis for requesting the purported outstanding requested verification.

Therefore, the 120-day denials cannot stand. Accordingly, Applicant's amended claim is granted in its entirety.

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**
	Far Rockaway Medical PC	**08/30/23 - 08/30/23**	**$127.41**	**Awarded: $127.41**
	Far Rockaway Medical PC	**07/12/23 - 07/12/23**	**$407.53**	**Awarded: $407.53**
Total			**$534.94**	**Awarded: $534.94**

B. The insurer shall also compute and pay the applicant interest set forth below. 11/07/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

The Respondent shall compute and pay the Applicant the amount of interest computed from the date the AR-1 was deemed filed with the American Arbitration Association, at the rate of 2% per month, simple, and ending with the date of payment of the award, subject to the provisions of 11 NYCRR 65-3.9(c).

C. Attorney's Fees

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

The Applicant's attorney is entitled to one attorney fee in accordance with 11 NYCRR 65-4.6.

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 Suffolk

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

12/14/2024
(Dated)

Matthew J. Cavalier

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:
541f478a41f857f7cef98934252f4c8c

Electronically Signed

Your name: Matthew J. Cavalier
Signed on: 12/14/2024