

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Far Rockaway Medical PC
(Applicant)

- and -

State Farm Mutual Automobile Insurance
Company
(Respondent)

AAA Case No. 17-23-1316-8831

Applicant's File No. 804.682

Insurer's Claim File No. 3246R638V

NAIC No. 25178

ARBITRATION AWARD

I, Rhonda Barry, 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 12/24/2024
Declared closed by the arbitrator on 12/24/2024

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

Andre Oge, Esq. from Rivkin & Radler LLP participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$891.41**, was NOT AMENDED at the oral hearing.
Stipulations WERE made by the parties regarding the issues to be determined.

The parties stipulated that if applicable, interest accrues in accordance with 11 NYCRR§65-3.9.

3. Summary of Issues in Dispute

The EIP, "JM" is a 59 year old female injured as a driver in a motor vehicle accident on 3/11/23. Applicant seeks \$891.41 for office visits and OATs on DOS 3/15/23 and 4/12/23. Upon receipt of applicant's claim respondent requested additional verification. When no response was forthcoming respondent mailed a follow- up request. No response was forthcoming. In accordance with 11 NYCRR 65-3.8(b)(3), applicant was

properly advised that it had 120 days to respond to verification or provide written reasonable justification for the failure to comply. When applicant failed to do so, respondent denied the claims.

4. Findings, Conclusions, and Basis Therefor

I have completely reviewed all timely submitted documents contained in the ADR Center record maintained by the American Arbitration Association and considered all oral arguments. No additional documents were submitted by either party at hearing. No witnesses testified at hearing.

ANALYSIS

A prima facie case of entitlement to no-fault compensation is made out by submitting evidence that the prescribed statutory billing form has been mailed and received, and that the defendant failed to either pay or deny the claim within the requisite 30-day period. Westchester Medical Center v. Lincoln General Insurance Company, 60 AD 3d 1045, 877 NYS 2d 340 (2d Dept. 2009); Westchester Medical Center v. Clarendon National Insurance Company, 57 A.D. 3d 659, 816 NYS 2d 759 (2d Dept. 2008). Respondent's verification requests effectively acknowledge receipt of applicant's claims. Further, the date stamped bills are included in respondent's submission.

Once the applicant submits its claim, respondent has 30 days within which to pay or deny the claim. Ins Law 5106(a); 11 NYCRR §65-3.8(a)(1). "The purpose for demanding verification is to extend or toll the carrier's time to pay or deny the claim so the carrier can obtain information regarding the claim." Dynamic Medical Imaging, PC v. State Farm Mutual Automobile Ins. Co., 9 Misc. 3d 278 (Dist. Ct Nas. Cty 2010). 11 NYCRR §65-3.5(b) provides that "subsequent to receipt of one or more completed verification, any additional verification required by the insurer to establish proof of the claim shall be requested within 15 business days of receipt of the prescribed verification forms." 11 NYCRR § 65-3.6 (b) provides that, "...if any requested verification has not been supplied to the insurer 30 calendar days after the original quest, the insurer shall, within 10 calendar days follow-up with the party from the verification was requested..." The time for an insurer to pay or deny a claim does not begin to run where the provider fails to respond to a verification request. Nyack Hospital v. Progressive Casualty Co., 296 AD 2d 482 (2d Dept. 2002).

Applicant's claims were received on 4/24/23 and 5/22/23. On 5/9/23 and 6/7/23, respectively, respondent requested additional verification including lease agreements, income and expenses, tax returns, bank records, invoices, transportation agreements and other documents relative to corporate structure. When no response was forthcoming, follow-up letters were generated and mailed on 6/14/23 and 7/13/23. Respondent provides proof of actual mailing from the USPS. There was no response from applicant.

Based upon information gleaned from the parties' submissions, there is an extensive history between applicant and respondent. Respondent opines that applicant's claim was received as a part of an ongoing investigation conducted by Brian McCausland, SIU investigator. Specifically, respondent believe that applicant may have been rendering services on a non-individualized basis designed to maximize profit without regard to patient care and may be directly or indirectly providing financial or other consideration in exchange for patient referrals.

Applicant's principal, Jean-Pierre - Barakat, MD testified at an EUO on 1/28/22. Thereafter, respondent requested post EUO verification including identical documents to that which were requested with regard to the specific claim. Applicant partially responded by letter dated 6/6/22 and objected to other requests.

Respondent argues that applicant did not respond or object to the 12/19/22 or 1/20/23 verification requests. "Even when the claimant believes it need not comply with a verification request, the claimant still has a duty to communicate with the insurer regarding the request (see, Dilon Medical Supply Corp. v. Travelers Insurance Company, 7 Misc. 3d 927).

That being said, the purpose of the no-fault law "is not served when an insurer repeatedly request the same verification from the same provider, especially in situations where the material demanded has been previously provided. Brownsville Advanced Medical, PC v. Countrywide Insurance Company, 33 Misc. 3D 1236 (A), 941 NYS 2d 536 (District Ct. Nassau County 2011).

Respondent argues that the information sought was necessary to establish its "Mallela" defense. In State Farm v. Mallela, 4 NY 3d 313, 794 NYS 2d 700(2005), the court held that insurance companies may withhold No-fault payments for medical services provided by fraudulently incorporated enterprises to which patients have assigned their claims even if the actual care received by patients was within the scope of the license of those who treated them.

Relying on the court's holding in Burke Physical Therapy PC v. State Farm, 2024 NY Slip Op 24111 (App. Term 2d Dept., 3/15/24), applicant opines that while respondent may have properly tolled the claim pursuant to the initial request for request for, the toll expired on 1/28/22 when the EUO was completed and proof of claim became complete. The court specifically held that, "*in the case of an examination under oath or medical examination, the verification is deemed to have been received by the insurer on the date the examination was performed.... In any event, defendant's argument misconstrues both 11 NYCRR 65 - 3.8 (a) the regulatory basis for tolling, and 11 NYCRR 65 - 3.5 (b) which permits an insurer to request additional verification within 15 business days of the prescribed verification form. It was defendant's time to pay or deny plaintiff's claim that was told pursuant to 11 NYCRR 65 - 3.8 (A) by the time the EUO scheduling letters - not defendant's time to request additional verification under 11 NYCRR 65 - 3.5 (B) any request for additional verification must be made within 15 business days of receipt of the prescribed verification form...*"

The holding in Burke, supra is inapplicable to the facts of this matter. Respondent did not request an EUO of the applicant for this claim. Upon receipt of this claim, respondent timely requested additional verification. While the verification was essentially the same as that previously requested, as noted, supra, respondent opines that each applicant's response was insufficient.

Applicant also argues that, after an insurer receives a substantial response to a verification demand its conduct in repeatedly sending out the same verification request is not consistent with the no-fault laws objective to provide a tightly timed process claim, disputation, and payment. American Transit Insurance Company v. New York Presbyterian Hospital, 2020 NY Slip Op 34150 (Supreme Ct. New York County 2020).

Respondent, however, argues that applicant's claim of substantial compliance with the verification request is incorrect as a matter of law (see, American Transit Insurance Company v. PDA New York, 2023 NYLJ LEXIS 2380, 9/11/23, Sup. Ct. Kings County, J Maslow).

Under either theory, the salient question is whether or not there was a reasonable basis for the verification, ab initio.

Respondent acknowledges that there was a partial responses from applicant; applicant also objected. As indicated in applicant's response to post EUO verification many of the items that respondent requested simply did not exist or were not in applicant's possession.

"If the provider objects to the request for verification, then the issue of whether the requested verification material and the objection were proper is preserved and become questions of fact for the trier of fact. If the insurer can establish it had 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 Diagnostic, PC v. Nationwide Property and Casualty Insurance Company, 36 Misc. 3d 568, 949 NYS 2d 855 (District Ct. Nassau County 2012).

Therefore, the next question is whether or not there was a reasonable basis for the verification requests.

11 NYCRR § 65-3.2; Claim practice principles to be followed by all insurers:

- (a) Have as your basic goal prompt and fair payment to all automobile accident victims.
- (b) Assist the applicant in the processing of a claim. Do not treat the applicant as an adversary.

(c) Do not demand verification of facts unless there are good reasons to do so.

When verification of facts is necessary, it should be done as expeditiously as possible...

(e) Clearly inform the applicant of the insurer's position regarding any disputed matter.

The insurer bears the burden of proving that its verification request was valid. A.B. Medical Services PLLC v. Highlands Insurance Company, NYLJ May 27, 2003, page 21 column 3 (Civil Ct. New York, Billings J.).

In State Farm v. Burke Physical Therapy, 2022 NY slip op 30580 (U) (Supreme Court Nassau County 2022), Justice Prager determined, on the issue of an insurer's demand for Malella information:

In this Court's view, only one conclusion can be drawn-that on the precise question at issue here, the law is unsettled. To the extent that the Court finds one position more persuasive than the other, the Court is of the opinion that for purposes of the determination herein, it is of no import. What matters is the reasonableness of BURKE's justification for refusing to provide the documents sought. In the absence of a clear answer as to whether or not STATE FARM was entitled to obtain the numerous documents sought at the verification stage of the claims, the Court cannot find, as a matter of law, that BURKE's justification was unreasonable. Accordingly, the Court cannot find, as a matter of law, that BURKE failed to satisfy its obligation under 11 NYCRR 65-3.5(0) to offer, within 120 days, "written proof providing reasonable justification for the failure to comply." The Court thus finds that, on the record presented, STATE FARM has failed to meet its burden to establish a right to disclaim coverage. See TAM Medical Supply Corp. v Tri State Consumers Ins. Co., 57 Misc 3d 133(A) (App Term, 2d Dept., 2d, 11th & 13th Jud. Dists. 2017).

In State Farm v. Mallela, 4 NY 3d 313, 794 NYS 2d 700(2005), the court held that insurance companies may withhold No-fault payments for medical services provided by fraudulently incorporated enterprises to which patients have assigned their claims even if the actual care received by patients was within the scope of the license of those who treated them.

In Andrew Carothers, MD, PC v. Progressive Insurance Company, 33 NY 3d 389 (2019), the Court of Appeals clarified their findings in Malella, supra and held that "Malella does not require a finding of fraud for the insurer to withhold payments to a medical service corporation and properly controlled by nonphysicians."

"In New York, a professional service corporation may be owned and controlled only by licensed professionals (BCL § 1507). Moreover, licensed professionals are permitted to incorporate only if they are the sole organizers, owners and operators of the professional Corporation (BCL § 1503 [a], [b]; 1508). To incorporate, the license

individual must obtain a "certificate... Issued by the [New York State Department of Education] certifying that each of the proposed shareholders, directors and officers is authorized by law to practice the profession which the corporation is being organized to practice (BCL § 1503 [b] [ii]), and the Department of Education may not issue a certificate of authority to professional service Corporation unless it meets these qualifications (see Education Law §6507 [4] [c] [i]). Once the professional corporations formed, shareholders may not transfer the voting power to any person who is not a licensed professional in the field (BCL§ 1507 [a]); only shareholders a licensed professionals engaged in the practice may be directors and offices (BCL§ 1508 [a])." Andrew Carothers MD v. Progressive Insurance Company, 33 NY 3d 389 (2019), supra.

As noted in Mr. McCausland's affidavit, Dr. Barakat testified as follows:

- Barakat's other professional corporation, Bronx County Medical, is the main leaseholder at the Boston Road Location;
- Far Rockaway Medical replaced Bronx County Medical at the East 149th Street Location because State Farm "wasn't paying" Bronx County Medical.
- Barakat either refused to, or could not name, any of the other professional corporations or healthcare providers that operate from the same locations that Far Rockaway Medical operates from; • Barakat does not interact with the other healthcare providers at each location.
- Barakat was not aware of and could not explain why State Farm received billing from Far Rockaway Medical under two different tax identification numbers.
- Barakat did not know if there was an officer manager or management company at any of the locations from which Far Rockaway Medical operates.
- While Barakat prescribes pharmaceutical products to insureds, it is the clinic personnel at each location that chose the pharmacies where prescriptions would be sent.
- Despite writing prescriptions for DME, Barakat does not maintain relationships with any DME companies and, again, let the clinic personnel at each location choose the DME company to which the prescriptions would be sent.
- With respect to the Boston Road Location, Barakat could not recall the name of the transportation company utilized by the clinic to transport patients. Barakat did not know whether there was a transportation company at the other three locations from which Far Rockaway Medical operates.
- Barakat testified that sometimes he chooses which CPT codes to bill and other times, his billing company, Advanced Collections, chooses which CPT codes to bill.
- Despite having lease agreements at each location, Barakat has not paid rent consistently each month; and

- Far Rockaway Medical does not advertise or market its services, and apparently, receives all of its patients through word of mouth. 13. After the EUO, in order to confirm whether Far Rockaway Medical is in compliance with New York law, State Farm sought verification in the form of certain documents in order to address the above-referenced concerns.

According to Mr. McCausland, Far Rockaway medical is a transient provider that has rendered services at Several multidisciplinary clinics where medical providers were engaged in questionable financial arrangements which resulted in predetermined treatment and billing protocols. There is also a question of layperson control at these locations. Further, applicant is providing services on a non-individualized basis designed to maximize profit. Mr. McCausland questioned billing practices for initial office visits and outcome assessment tests.

At hearing, applicant questioned the efficacy of Mr. McCausland's affidavit as well as the affidavits of other SIU investigators in related matters. He notes that much of the language used in these affidavits is boilerplate and does not consider the specific services rendered. To the contrary, respondent explained that the testimony of applicant's principal created the need for additional documentation and the affidavits are in fact provider specific.

After careful consideration of the party submissions and the arguments at hearing I find that while there was a reasonable basis to conduct the EUO and request much of the post EUO verification, respondent has failed to establish a reasonable basis for the continued repetitive requests. Mr. McCausland's affidavit is unpersuasive and conclusory. There is no evidence, other than speculation, that the services were provided to a predetermined protocol order to maximize profit. There is no expert report or peer review to refute the medical necessity of the testing. There is no adequate reason, based upon Dr. Barakat's testimony to suggest that there were improper financial and referral arrangement to suggest the need for ongoing repetitive verification at the claims stage.

Applicant responded and objected to the verification. I agree with applicant's objections in respondent's denial based upon the 120 day rule is vacated.

Applicant's claims are awarded.

Interest: Applicant is awarded interest in accordance with 11 NYCRR§65 - 3.9 (a)-(f). Accordingly, interest is calculated at a rate of 2% per month, calculated on a pro rata basis using the 30 day month. A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. If 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 Department of Financial Services Regulations, interest shall not accumulate on the disputed claim or element of claim

until such action is taken. 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 at issue was timely. LMK Psychological Services PC v. State Farm Mutual Automobile Insurance Company, 12 NY 3d 217 (2009).

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	04/12/23 - 04/12/23	\$407.53	Awarded: \$407.53
	Far Rockaway Medical PC	03/15/23 - 03/15/23	\$483.88	Awarded: \$483.88
Total			\$891.41	Awarded: \$891.41

- B. The insurer shall also compute and pay the applicant interest set forth below. 09/18/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Based on stipulation, interest shall be paid from 9/18/23, the date of filing, on the amount awarded of \$891.41 at a 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 (e).

C. Attorney's Fees

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

This case is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4.6(d) (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant an attorney's fee, in accordance with newly promulgated 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 NY

SS :

County of Nassau

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

12/30/2024
(Dated)

Rhonda Barry

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:
345af8a923910bb38014e0a8790d3299

Electronically Signed

Your name: Rhonda Barry
Signed on: 12/30/2024