

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Refua Rx Inc. (Applicant)	AAA Case No.	17-24-1363-0721
- and -	Applicant's File No.	GM23-717307, GM23-720736, GM23-720831
State Farm Mutual Automobile Insurance Company (Respondent)	Insurer's Claim File No.	32-49M7-18D
	NAIC No.	25178

**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 01/31/2025  
Declared closed by the arbitrator on 01/31/2025

John Fagan, Esq. from Law Offices of Gabriel & Moroff, P.C. participated virtually for the Applicant

Katherine Lalor, Esq. from Rivkin & Radler LLP participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$869.90**, 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 51 year old EIP reported involvement in a motor vehicle accident on May 9, 2023; claimed related injury and received various oral medications provided by the applicant from October 18, 2023 to December 1, 2023.

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 further documents and information related to claims for pharmaceuticals and/or 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." Thus, Respondent's request for post-EUO verification and its denial based upon the 120-day rule.

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.)

In the instant case, respondent issued requests for a witness on behalf of the applicant to appear at an EUO. The applicant complied and a witness on its behalf attended. Following the EUO of applicant, respondent issued timely requests for post-EUO information/documents.

There have been numerous hearings related to the same post-EUO documents/information requested by this respondent from this applicant involving other EIPs. Many of these other determinations have relied upon the findings by Arbitrator Andreotta (AAA case no. 17-23-1310-5036) in which she wrote:

Notably, there are thousands of pages of submissions from both

sides including multiple late supplemental submissions. Reviewing

this documentation and deciphering the arguments of the parties

was quite arduous and burdensome.

The Respondent contends that the following information has not been supplied and remains outstanding:

1. All Documents relating to the income and expenses of Refua Rx, including, but not limited to, bank statements, canceled checks (front and back), deposit records, electronic transfer records, and general ledgers, for the time period of August 2022 to the present;
2. Quarterly payroll tax returns (IRS Form 941 and NYS Form 45), including all attachments and schedules, for the time period of August 2022 to the present;
3. Identify the number of Lidocaine 5% Ointment prescriptions dispensed by Refua Rx each month from August 2022 to the present to patients with (i) Medicare/Medicaid; (ii) private medical insurance, and (iii) workers' compensation insurance.

The Applicant argued that the information provided constituted compliance with the Applicant's requests and that the remaining information that was objected to was not reasonable and the requests are not proper.

I find that in this matter, based on the EUO transcript and SIU affidavit, that the request for tax returns, bank records, income information, documents regarding topical Lidocaine ointment (which is not relevant to the claim at issue) and other inquires which are unnecessary to verify this particular claim are contrary to the regulations in 11 NYCRR 65-3.2.

Based on the foregoing, I find that the respondent has substantially complied with the verification requests with documents and information that is "arguably responsive" to the verification requests.

After a review of the submissions in the instant matter, I find that, although the prior awards related to the instant matter are not *res judicata* to the claim at issue, there is no new or different evidence in the record in the case at issue which would lead to a contrary finding and conclusion.

Based on the foregoing, I find that the respondent has established its 120 day defense and its denial is 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.

02/01/2025

(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:**  
8a3034b430949bdb53821e6b1d89258c

### **Electronically Signed**

Your name: Anne Malone  
Signed on: 02/01/2025