

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

S & M Pharmacy
(Applicant)

- and -

Allstate Insurance Company
(Respondent)

AAA Case No. 17-24-1356-9695

Applicant's File No. 404237

Insurer's Claim File No. 0748312113

NAIC No. 29688

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 03/19/2025
Declared closed by the arbitrator on 03/19/2025

Neil Menashe, Esq. from Neil Menashe Attorney at Law P.C. participated virtually for the Applicant

David Kelly, Esq. from Law Offices of James F. Sullivan, PC participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,431.52**, 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 37 year old EIP reported involvement in a motor vehicle accident on March 13, 2024; claimed related injury and received a Lidocaine pad and Cyclobenzaprine prescription medication provided by the applicant on May 7, 2024 and June 5, 2024.

The applicant submitted a claim for this topical and oral prescription medication, payment of which was delayed pending a response to verification requests.

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

The respondent also asserted a fee schedule defense.

The issues to be determined at the hearing are:

Whether the respondent established the claim is premature.

Whether the respondent established its fee schedule 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.

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.

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.)

The respondent issued timely requests for verification. However, 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 did not submit proof of mailing of the verification requests and did not submit evidence from someone with personal knowledge that a response was not received from the applicant.

Under these circumstances, the respondent failed to establish that the claim is premature and therefore, the time to pay or deny this bill is not tolled.

Therefore, an award will be issued in favor of the applicant pursuant to the appropriate fee schedule.

Fee Schedule

The applicant billed a total of \$1,431.52 for the prescription oral and topical medication at issue, for which payment was delayed by the respondent due to outstanding verification requests. I have already determined that the claim is not premature and the time to pay it was not tolled. However, the respondent also asserted a fee schedule defense.

To prevail in its fee schedule defense, the respondent must demonstrate by competent evidentiary proof that the applicant's claims are in excess of the appropriate fee schedule. If the respondent fails to do so, its defense of noncompliance with the New York Workers' Compensation Medical Fee Schedule cannot be sustained. See Continental Medical, P.C. v Travelers Indemnity Co., 11 Misc. 3d 145A (App. Term 1st Dept. 2006.)

An insurer fails to raise a triable issue of fact with respect to a defense that the fees charged were not in conformity with the Workers' Compensation fee schedule when it does not specify the actual reimbursement rates which formed

the basis for its determination that the claimant billed in excess of the maximum amount permitted. See St. Vincent Medical Services, P.C. v. GEICO Ins. Co., 29 Misc.3d 141(A), 907 N.Y.S.2d 441 (App. Term 2d, Dec. 8, 2010.)

The respondent supported its fee schedule defense, with the affidavit of Jeffrey Futoran, CPC a certified professional coder who submitted a comprehensive review and analysis and determined, based on the applicable New York Workers' Compensation Fee Schedule that the correct reimbursable amount for the prescription medication at issue is \$760.24.

The applicant did not submit an affidavit from a certified professional fee coder, medical professional or other expert to refute the findings of the respondent's expert.

Based on the foregoing, the respondent has established its fee schedule defense.

Accordingly, the applicant is awarded \$760.24 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
	S & M Pharmacy	05/07/24 - 06/05/24	\$1,431.52	Awarded: \$760.24
Total			\$1,431.52	Awarded: \$760.24

- B. The insurer shall also compute and pay the applicant interest set forth below. 07/18/2024 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.

03/21/2025

(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:
e630c63d2d18d5f9f485af53127909b3

Electronically Signed

Your name: Anne Malone
Signed on: 03/21/2025