American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

999 Coney Island Enterprises Inc. (Applicant)	AAA Case No.	17-24-1352-0432
	Applicant's File No.	NA
- and -	Insurer's Claim File No.	193651-GP
	NAIC No.	23760
Nationwide General Insurance Company (Respondent)		

ARBITRATION AWARD

I, Eileen Hennessy, 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-G.W.

1. Hearing(s) held on 03/12/2025
   Declared closed by the arbitrator on 03/12/2025

   Marc Schwartz from Marc L. Schwartz P.C. participated virtually for the Applicant

   Michele Rita from Hollander Legal Group PC participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$3,393.60**, 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 record reveals that the Assignor-G.W., a 59-year-old male, claimed injuries as the result of a motor vehicle accident that occurred on 11/3/2023. Applicant seeks reimbursement for a back cushion, bed board, electric heat pad, lumbosacral orthosis, egg crate mattress, orthopedic positioning seat, and Triad 3LT infrared heat pad with LLLT provided on 12/4/2023. Respondent denied the claim based on the 120-day rule. The issue to be determined is whether Respondent properly denied Applicant's claim based upon the 120-Day Rule?

4. Findings, Conclusions, and Basis Therefor

Applicant seeks reimbursement fora back cushion, bed board, electric heat pad, lumbosacral orthosis, egg crate mattress, orthopedic positioning seat, and Triad 3LT infrared heat pad with LLLT. This hearing was conducted using the documents contained in the Electronic Case Folder (ECF) maintained by the American Arbitration Association. All documents contained in the ECF are made part of the record of this hearing and my decision was made after a review of all relevant documents found in the ECF as well as the arguments presented by the parties during the hearing held via Zoom.

In accordance with 11 NYCRR 65-4.5(o) (1), an arbitrator shall be the judge of the relevance and materiality of the evidence and strict conformity of the legal rules of evidence shall not be necessary. Further, the arbitrator may question or examine any witnesses and independently raise any issue that Arbitrator deems relevant to making an award that is consistent with the Insurance Law and the Department Regulations.

Legal Framework - Tolling of claims

The general rule regarding payment of claims is set forth in 11 NYCRR §65-3.8(c), which states that "within 30 calendar days after proof of claim is received, the insurer shall either pay or deny the claim in whole or in part." No-Fault benefits are overdue if not paid within 30 calendar days after the insurer receives proof of claim, which shall include verification of all of the relevant information requested pursuant to 11 NYCRR §65-3.5. 11 NYCRR §65-3.8(a). As such, a claim need not be paid or denied until all demanded verification is provided. *See* Nyack Hospital v. General Motors Acceptance Corp., 27 A.D.3d 96, 808 N.Y.S.2d 399 (2d Dept. 2005), *mod'd on other,* 8 N.Y.3d 294, 832 N.Y.S.2d 880 (2007).

OUTSTANDING VERIFICATION

Legal Standard

Once Applicant establishes its prima facie case, the burden of proof shifts to Respondent to come forward with admissible evidence demonstrating the existence of a material issue of fact. Amaze Medical Supply Inc. v. Eagle Ins. Co., 2 Misc.3d 128(A), 2003 N.Y. Slip Op. 51701(U)(App. Term, 2 Dept, 2 & 11 Jud Dists., 2003).

11 NYCRR §65-3.5(b), Claim procedure states: "Subsequent to the receipt of one or more of the completed verification forms, any additional verification required by the insurer to establish proof of claim shall be requested within 15 business days of receipt of the prescribed verification forms. Any requests by an insurer for additional verification need not be made on any prescribed or particular form."

11 NYCRR §65-3.6(b), Verification requests states:"At a minimum, if any requested verifications has not been supplied to the insurer 30 calendar days after the original request, the insurer shall, within 10 calendar days, follow up with the party from whom the verification was requested, either by telephone call, properly documented in the file,

or by mail. At the same time the insurer shall inform the applicant and such person's attorney of the reason(s) why the claim is delayed by identifying in writing the missing verification and the party from whom it was requested".

NYCRR §65-3.5(c) mandates that the insurer is entitled to receive all items necessary to verify the claim directly from the parties from whom such verification was requested. The insurer has 15 business days from the date it receives the prescribed verification forms to seek additional verification from an Applicant.

Further, 11 NYCRR §65-3.8(l) states:

> For the purposes of counting the 30 calendar days after proof of claim, wherein the claim becomes overdue pursuant to section 5106 of the Insurance Law, with the exception of section 65-3.6 of this subpart, any deviation from the rules set out in this section shall reduce the 30 calendar days allowed.

Thus, a request for additional verification pursuant to 11 NYCRR §65-3.5(b) that is sent beyond the 15 business days is still valid so long as it is issued within 30 days from receipt of the claim; such a deviation will simply reduce the insurer's time to pay or deny by the same number of days. 11 NYCRR §65-3.8(l). *See* Nyack Hosp. v. General Motors Acceptance Corp., 8 NY3d 294, 2007 NY Slip Op 02439 (Court of Appeals, 2007).

The obligation to pay or deny a claim is not triggered until the insurer has received all of the relevant information that was requested. Hospital for Joint Diseases v. State Farm Mut. Auto. Ins. Co., 8 AD3d 533, 2004 NY Slip Op 05413 (App. Div., 2 Dept., 2004).

In addition to the above, the Fourth Amendment to 11 NYCRR 65-3, which is applicable to claims for medical services rendered on or after April 1, 2013, introduced a provision ([§65-3.5(o)] that sets a time frame for an applicant to respond to an insurer's verification request(s). In pertinent part, the provision states the following:

> An Applicant from whom verification is requested shall, within 120 calendar days from the date of the initial request for verification, submit all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply. The insurer shall advise the applicant in the verification request that the insurer may deny the claim if the applicant does not provide within 120 calendar days from the date of the initial request either all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply. 11 NYCRR §65-3.5(o).

In relation to this new provision, 11 NYCRR §65-3.8(b)(3) was amended so as to confer upon the insurer the right to deny a claim for non-compliance with §65-3.5(o). In pertinent part, the amendment to §65-3.8(b)(3) states the following:

> [A]n 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)…

Analysis

Applicant seeks reimbursement fora back cushion, bed board, electric heat pad, lumbosacral orthosis, egg crate mattress, and orthopedic positioning seat ($1,543.60) and Triad 3LT infrared heat pad with LLLT($1,850.00). Respondent denied the claim pursuant to 11 NYCRR §65-3.8(b)(3) and asserted that Applicant neither complied with Respondent's verification requests nor provided reasonable justification for the failure to comply.

Respondent relies on its initial and follow-up verification requests, issued to Applicant for the above referenced bills, which stated in pertinent part, "We are currently investigating this matter to determine whether the alleged injuries arose out of the use and operation of our insured vehicle and whether the injured party is an eligible injured party entitled to No-Fault benefits under the above mentioned policy. As a result we have requested an EUO of the claimant and/or their assignee. 1. Copies of the wholesale invoices showing the Make, Model # and amount paid for the Durable Medical Equipment Provided. 2. Proof of payment to wholesaler for supplies 3. Copies of Canceled checks, front and back and/or Credit Card Information used for Payments issued to your wholesaler".

On each verification request Respondent advised Applicant of the following: As per Regulation 68 Section 65-3.5(o), the insurer may deny a claim if an applicant does not provide within 120 calendar days from the date of the initial request all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply. This shall not apply to a prescribed form (NF-Form) as set forth in Appendix 13 of this Title, medical examination request, or examination under oath request.

Applicant submits a copy of their response, dated 3/25/2024, to the record which references the claimant's name, date of loss, date of service, and Applicant's name. The response is signed by 999 Coney Island Enterprises, Inc. There is no letterhead or individual's name, address, phone number, or fax number listed on the response. The response states in pertinent part:

> Please see the attached copies of the requested invoices and delivery receipts. If you have any further questions please contact me.

Attached to the response was three copies of Respondent's initial and follow-up verification requests, dated 1/17/2024 and 2/19/2024, copies of three invoices 1) from Smart Recovery Technologies, LLC, dated 9/4/2023, for a Triad 3LT, 2) from Global Provider Services, Inc., dated 9/14/2023, for a Triple Play Pro Facility Direct, and 3)

from City Ortho Trading, Inc., dated 9/12/2023, for a BPC Machine (Ballistic pressure compressor), and three delivery receipts from Applicant, dated 12/4/2023, for the 1) back cushion, bed board, electric heat pad, lumbosacral orthosis, egg crate mattress, and orthopedic positioning seat, 2) Triad 3LT infrared heat pad with LLLT, and 3) cold compression therapy system, lumbar compression wraps, and delivery. Applicant submits a copy of a facsimile cover sheet, which indicates the response was successfully faxed to (877) 590-8188 on 3/26/2024.

Respondent indicates that they have not received the documents requested in their verification demands, apart from the invoice for the Triad 3LT, to date. Respondent submits a response, dated 4/3/2024, to Applicant's verification response for the bills in dispute in this claim and other claims received from Applicant, issued to Applicant's attorney at the address listed on the bills' cover letters, dated 12/25/2023, which Respondent argues was non-responsive to the requests. Specifically, Respondent's response states in pertinent part:

> RE: 999 Coney Island Enterprises Inc.
>
> DOS 12/4/24, Lumbar Compression Wraps and Cold Compression Therapy System:
>
> Full Verification has net been received and the following requested documents remain outstanding:
>
> 1. Proof of payment towholesaler.
> 2. Copies cf Canceled check, front and back, and/cr Credit Card Informatica used fer payments to your wholesaler. Once the requested information is received and the coverage finalized, this matter will be reviewed.
>
> You have not provided a copy of the invoice for the Lumbar
>
> Compression Wraps
>
> DOS 12/4/24: Triad 3LT Infrared Heat Pad
>
> Full Verification has net been received and the following requested documents remain outstanding:
>
> 1. Proof of payment towholesaler.
> 2. Copies cf Canceled check, front and back, and/cr Credit Card Informatica used fer payments to your wholesaler. Once the requested information is received and the coverage finalized, this matter will be reviewed.
>
> DOS 12/4/24, Multiple Supples billed:
> You have not provided any response, bill remains delayed for full verification
> 1. Copies of the wholesale invoices showing the Make, Model # and amount paid for the Durable Medical Equipment Provided .

2. Proof of payment towholesaler.
3. Copies cf Canceled check, front and back, and/cr Credit Card Information used fer payments to your wholesaler.:

In addition, In response to our verification request, you have submitted a City Ortho Trading Inc. Invoice for a BPC Machine. Upon review of your submitted bills, this supply nor device has been billed to Nationwide Insurance. Please provide a clarification of what this invoice correlates to as far as bills submitted to Nationwide.

In support of the creation and mailing of Respondent's verification requests and denials, receipt of Applicant's response, and response to Applicant's verification response, Respondent submits the affidavits of Claims Manager Maureen Tyo, dated 8/1/2024, and Claims Specialist II Stephen Klimek, dated 7/29/2024, and affirmation of Associate Operations Manager of CCC Intelligent Solutions, Inc., Matthew McClendon.

There was no response from Applicant to Respondent's 4/3/2024 response in the record.

Respondent thereafter denied the claims stating, "Pursuant to 11 NYCRR 65-3.8(b) New York State Insurance Regulation 68-C 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. Nationwide is denying your claim for failure to provide the requested verification or written proof providing reasonable justification for the failure to comply within 120 calendar days after our initial request on 1/17/2024".

Applicant argued at the hearing of this matter that Respondent's defense should fail as it replied to Respondent's requests within 120 days. Furthermore, Applicant argued that Respondent's request for wholesale invoices for supplies billed that are listed with a maximum reimbursement rental and purchase fee in the NYS Durable Medical Equipment Fee Schedule, including codes E2611, E0215, L0642, E0272, and T5001, is unnecessary and unreasonable as the maximum allowable rental and purchase reimbursement for the codes billed is controlled by the fee schedule. Moreover, Applicant argued that Respondent's 4/3/2024 response was insufficient as it was addressed and mailed to Applicant's attorney rather than Applicant directly.

Respondent argues that contrary to Applicant's assertion that the requested documentation was not provided in response to Respondent's requests, including copies of the wholesale invoices showing the Make, Model# and amount paid for the Durable Medical Equipment Provided, apart from the wholesale invoice for the Triad 3LT, proof of payment to wholesaler for supplies, and copies of Canceled checks, front and back and/or Credit Card Information used for Payments issued to your wholesaler. The invoices provided were not related to the supplies billed in this case, apart from the Triad 3LT. Furthermore, Applicant was required to respond to Respondent's requests and advise of any objections, regardless of whether Applicant deemed the request unreasonable Moreover, Applicant's verification response was not on any letterhead. It was signed, "999 Coney Island Enterprises" but did not list an individual's name, address, phone number, or fax number where responses to their correspondence should

be forwarded to. Respondent addressed and mailed their 4/3/2024 response to Applicant's attorney at the address listed on the cover letters submitted with the bills, dated 12/25/2023, which stated in pertinent part, "Please be advised a copy of any and all other correspondence relating to this claim should be forwarded to this office". Applicant's cover letter further noted that failure to do so would result in prejudice to his client and objections to such documents being proper at arbitration or litigation.

Applicant's prima facie case and the timeliness of the Respondent's verification requests were not disputed by the parties at the hearing.

The issue presented here is whether Applicant has established that they responded to Respondent's requests?

I find that Respondent's requests constitute reasonable verification requests to which Respondent is entitled. The evidence shows that a proper verification request and follow-up have been made for the bills and that to date, same has never been returned. Applicant chose not to provide the requested documentation in response to the verification requests within 120 days and risked dismissal in the event Respondent denied the claim. The bills were properly denied by Respondent after 120 days in accordance with 11 NYCRR §65-3.5(o). There are no specific responses to Respondent's requests in the record. Apart from the invoice for the Triad 3LT, and the delivery receipts for the supplies in dispute, which were not requested by Respondent in the verification requests, several of the documents provided to Respondent were unrelated to the claim in dispute. The regulations and case law are clear. Applicant is required to respond to Respondent's request for additional verification. In Dilon Medical Supply Corp v. Travelers Insurance Company, 7 Misc.3d 927, 796 N.Y.S.2d 872 (Civ. Ct. Kings County 2005) the Court stated, "[j]ust as the insurer has a duty to speedily process claims, the claimant for benefits has a duty to cooperate in supplying information reasonably requested by the insurer to process the claim." The Court continued that "even if the claimant believes it cannot or need not comply with the insurer's request, the claimant still has a duty to communicate with the insurer regarding the request". In Westchester County Medical Center v. N.Y. Central Mutual Fire Ins. Co., 262 A.D.2d 553, 692 N.Y.S.2d 665 (2 Dept. 1999), the Court admonished a plaintiff who failed to respond to a defendant's verification request because it deemed the request to be "unintelligible." The Court found that whether or not the request was confusing, it was clearly a verification request that plaintiff could not ignore without placing itself in peril. The Court held that "Any confusion on the part of the plaintiff as to what was being sought should have been addressed by further communication, not inaction." In Canarsie Chiropractic, P.C. v. State Farm Mut. Auto Ins. Co., 27 Misc. 3d 1228 (A), 911 N.Y.S.2d 691 (Civ. Ct. Kings County 2010, the Court, citing Westchester Co. Med. Ctr. v. New York Central Mut. Fire Ins. Co., supra, the Court held that by failing to respond to the insurer's request for additional verification, the plaintiff had waived its defense and could not argue that the additional verification requests were defective.

Furthermore, I find that Respondent properly addressed their response to Applicant's attorney at the address listed on the bills' cover letters, especially considering Applicant's response was not provided on Applicant's letterhead and did not list an individual's name, address, phone number, or fax number where responses should be

forwarded to. Applicant did not indicate the requested information was not in their control or possession, provide reasonable justification for the failure to provide the requested documentation, or provide proof that Applicant requested Respondent to reconsider the denials based upon a reasonable justification. The Appellate Term, Second Department has repeatedly held that failure to respond to verification requests shall result in a determination that the claim is premature (in claims prior to the April 1, 2013, amendment to the Regulations) or result in dismissal of the claims premised on the 120-day rule. *See* SK Prime Medical Supply, Inc. v. Citiwide Auto Leasing, Inc., 2018 N.Y. Slip. Op 50734 (U), Appellate Term, 2nd Dept., May 18, 2018. *See also* City Care AcupLT, uncture, P.C. v Allstate Prop. & Cas. Ins. Co., 2017 NY Slip Op 51839(U)(App. Term 2d Dept. 2017).

The verification requests contain the requisite language from 11 NYCRR §65-3.5(o), advising the Applicant that the claim may be denied "if the applicant does not provide within 120 calendar days from the date of the initial request either all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply".

Considering the above, Respondent's asserted defense premised on the 120-day rule is sustained and the claim for the bills for date of service 12/4/2023 ($3,393.60) is denied.

CONCLUSION

Accordingly, Applicant's claim is denied. This award is in full disposition of all No-Fault benefit claims submitted to 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 NY
SS :
County of Nassau

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

04/10/2025
(Dated)

Eileen Hennessy

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
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Electronically Signed

Your name: Eileen Hennessy
Signed on: 04/10/2025