

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

CitiMed Complete Medical Care PC
(Applicant)

- and -

Progressive Casualty Insurance Company
(Respondent)

AAA Case No. 17-24-1338-7737

Applicant's File No. RB-204-400355

Insurer's Claim File No. 23-5353869

NAIC No. 32786

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 04/25/2025
Declared closed by the arbitrator on 04/25/2025

Elyse Ulino, Esq. from Baker & Narkolayeva Law P.C. participated virtually for the Applicant

Alice Downing from Progressive Casualty Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$2,051.48**, was AMENDED and permitted by the arbitrator at the oral hearing.

The amount claimed was amended by the applicant to \$1,650.01 to conform to the appropriate fee schedule. The respondent did not agree to this amended amount.

Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

The 46 year old EIP reported involvement in a motor vehicle accident on January 16, 2023; claimed related injury and underwent office visits and psychological evaluation and testing, provided by the applicant from April 3, 2023 to May 15, 2023.

The applicant also billed for physical therapy treatment provided to the EIP on dates of service April 3, 2023 to April 19, 2023 and May 10, 2023 to May 15, 2023 and chiropractic treatment provided on May 10, 2023. The charges for chiropractic treatment provided on May 10, 2023 and physical therapy provided from May 10, 2023 to May 15, 2023 were paid in full, pursuant to the appropriate fee schedule and were withdrawn at the hearing.

The respondent made partial payment for the physical therapy treatment provided from April 3, 2023 to April 19, 2023 and office visits/consultations provided on April 3, 2023, April 12, 2023 and May 15, 2023 based on its calculation of the correct reimbursable amount pursuant to the New York Workers' Medical Fee Schedule.

Payment of the bill for psychological evaluation and testing was delayed pending verification requests and then denied after 120 days from the initial date of the request for verification.

The verification requested was for the time billed for the services at issue.

The applicant contends that the respondent did not provide proof of mailing of the initial verification request.

The issues to be determined at the hearing are:

Whether the respondent established its fee schedule defense for dates of service April 3, 2023, April 12, 2023 and May 15, 2023.

Whether the respondent established its 120 day 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.

Fee Schedule

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.)

Office visit for dates of service April 3, 2023, April 12, 2023 and May 15, 2023

The applicant billed a total of \$579.49 for the three office visits/consultation for which the respondent made partial payment of \$303.01 leaving a balance of \$276.48.

This claim includes office visits provided on three separate occasions. Follow-up psychiatric evaluations by Dr. Levinson, billed under CPT code 99214 were provided on April 3, 2023 and May 15, 2023 and were down-coded by the respondent to CPT code 99213.

An initial podiatry consultation by Dr. Shah billed under CPT code 99244 was provided on April 12, 2023 and was down-coded by the respondent to CPT code 99214.

The respondent did not request any verification of the actual time spent by Dr. Levinson on either date of follow-up evaluations.

The respondent did not an affidavit from a certified professional fee coder, medical professional or other expert to support its fee schedule defense.

Based on the foregoing, the respondent failed to establish its fee schedule defense for dates of service April 3, 2023, April 12, 2023 and May 15, 2023.

Therefore, the applicant is awarded \$276.48 for the office visits/consultation provided from April 3, 2023 to May 15, 2023.

Physical therapy provided from April 3, 2023 to April 19, 2023

The applicant billed \$194.79, which was amended at the hearing to \$177.54 for physical therapy treatment provided on these dates of service for which the respondent made partial payment of \$125.85, leaving a balance of \$51.69.

The applicant contends that the respondent made payment of \$57.30 for chiropractic treatment provided on April 19, 2023 and therefore, no further reimbursement for this date of service is due to the applicant.

The respondent submitted a copy of an Explanation of Benefits for chiropractic treatment provided on April 19, 2023 and cancelled check for \$57.30 dated May 5, 2023.

Based on the foregoing, the respondent has established its fee schedule defense for physical therapy treatment provided on April 19, 2023 and no further payment is due.

Therefore, the claim for physical therapy services provided on April 19, 2023 is dismissed with prejudice.

120 day denial

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.

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.)

In this matter, the respondent issued timely requests for verification.

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.)

After a review of the submissions, I find that the respondent provided proof of mailing of the verification requests which was sufficient to establish timely mailing of both requests for verification.

In response to the verification requests, the applicant submitted a copy of a letter dated October 19, 2023. However, the response was not provided within 120 days of the initial request and did not provide the time for performance of the psychological services at issue which was requested by the respondent.

Based on the foregoing, the respondent has established its 120 day defense.

Therefore, the claim for psychological services is dismissed with prejudice.

Accordingly, the applicant is awarded \$276.48 and the remainder of 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 applicant is AWARDED the following:

A.

| Medical | | From/To | Claim Amount | Amount Amended | Status |
|---------|---|----------------------------|-------------------|-----------------|--------------------------|
| | CitiMed Complete Medical Care PC | 04/03/23 - 04/03/23 | \$39.60 | \$39.60 | Awarded: \$39.60 |
| | CitiMed Complete Medical Care PC | 04/03/23 - 04/19/23 | \$68.94 | \$51.69 | Denied |
| | CitiMed Complete Medical Care PC | 04/12/23 - 04/12/23 | \$197.28 | \$197.28 | Awarded: \$197.28 |
| | CitiMed Complete Medical Care PC | 04/19/23 - 04/19/23 | \$1,321.84 | | Denied |
| | CitiMed Complete Medical Care PC | 05/10/23 - 05/10/23 | \$57.30 | | Denied |
| | | | | | |

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|--------------|---|--------------------------------|-------------------|-----------------|------------------------------|
| | CitiMed Complete Medical Care PC | 05/10/23 - 05/15/23 | \$239.12 | \$166.25 | Denied |
| | CitiMed Complete Medical Care PC | 05/15/23 - 05/15/23 | \$127.40 | \$39.60 | Awarded: \$39.60 |
| Total | | | \$2,051.48 | | Awarded: \$276.48 |

- B. The insurer shall also compute and pay the applicant interest set forth below. 03/04/2024 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.

05/10/2025
(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:
ff0a51ecfd6633772d65c8cd45e870db

Electronically Signed

Your name: Anne Malone
Signed on: 05/10/2025