American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Comprehensive MRI of New York, PC (Applicant)	AAA Case No.	17-25-1380-7252
	Applicant's File No.	BautistaJC
- and -	Insurer's Claim File No.	1125365-01
	NAIC No.	16616
American Transit Insurance Company (Respondent)		

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 05/15/2025
   Declared closed by the arbitrator on 05/15/2025

   Michael Tomforde, Esq. from Dash Law Firm, PC participated virtually for the Applicant

   Jeff Siegel, Esq. from American Transit Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$3,813.34**, 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 June 27, 2024; claimed related injury and underwent lumbar, cervical and left knee MRI studies on September 3, 2024 and bilateral shoulder MRI studies provided by the applicant on September 5, 2024.

   The applicant submitted a claim for these medical services. A denial on the grounds that Workers' Compensation benefits were primary was issued by the respondent for services in the amount of $1,590.51 for services rendered on September 3, 2024 was late on its face. The bills for dates of service September 3, 2024 in the amount of $666.85 and September 5, 2023 in the amount of

$1,555.98 were delayed pending responses from the applicant for verification requests for documents/information requested by the applicant.

The verification requested was for letters of medical necessity and reports from the referring physician and MRI films of the lumbar spine and right shoulder.

The issues to be determined at the hearing are:

Whether respondent established that the bill for date of service September 3, 2023 in the amount of $1,590.51 was properly and timely denied.

Whether respondent established that the bills for dates of service September 3, 2023 in the amount of $666.85 and September 5, 2023 in the amount of $1,555.98 were premature.

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.

Timeliness of the denial for services in the amount of $1,590.51 rendered on September 3, 2024

According to the NF-10 submitted by the respondent, the bill in the amount of $1,590.51 for date of service September 3, 2024 was dated September 18, 2024 and received by the respondent on September 19, 2024. The global denial is dated November 9, 2024 and the specific denial is dated November 25, 2024.

The respondent did not provide any explanation for the late denial of this bill.

The penalty for an insurer's failure to issue a timely and proper denial of claim is that it will be precluded from objecting to the claim. In Viviane Etienne Med. Care, P.C. v Country-Wide Ins. Co., 114 A.D.3d 33 (2d Dept. 2013) the Appellate Division held that:

Challenges and objections regarding whether the services were

in fact rendered, were causally related to a covered accident or

were medically necessary are not available to the defendant insurer

after the onset of litigation unless the insurer proffered a timely and

proper denial of claim within the prescribed time frame.

Under these circumstances, since the respondent did not issue a proper and timely denial within the prescribed time frame of 30 days from receipt of the bill in question therefore, it has not preserved any defense, except for fee schedule, if applicable.

There was no fee schedule defense for this claim.

Based on the foregoing, the respondent has not established timely mailing of the denial for services rendered on September 3, 2024.

Therefore, the applicant is awarded $1,590.51 for services provided on September 3, 2024.

Outstanding Verification - dates of service September 3, 2024 ($666.85) and September 5, 2024 ($1,555.98)

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.

In the instant matter, the respondent sent timely verification requests to which the applicant did not submit a response.

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 the instant matter, the applicant did not respond to the verification requested.

Under these circumstances, the respondent established that this claim is premature.

Therefore, the claim for the bills fordates of service September 3, 2024 ($666.85) and September 5, 2024 ($1,555.98)is dismissed without prejudice.

Accordingly, the applicant is awarded $1,590.51 and the remainder of the claim is dismissed without 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	Status
	Comprehensive MRI of New York, PC	**09/03/24 - 09/03/24**	**$1,590.51**	**Awarded: $1,590.51**
	Comprehensive MRI of New York, PC	**09/03/24 - 09/03/24**	**$666.85**	**Dismissed without prejudice**
	Comprehensive MRI of New York, PC	**09/05/24 - 09/05/24**	**$1,555.98**	**Dismissed without prejudice**
Total			**$3,813.34**	**Awarded: $1,590.51**

B. The insurer shall also compute and pay the applicant interest set forth below. 01/06/2025 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.

06/03/2025
(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:
dbbf13ec832e3fed9e1b1d74b8c68a90

Electronically Signed

Your name: Anne Malone
Signed on: 06/03/2025