

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Welcome Acupuncture PC
(Applicant)

- and -

Allstate Fire & Casualty Insurance Company
(Respondent)

AAA Case No. 17-24-1379-4029

Applicant's File No. 415391

Insurer's Claim File No. 0684351018
2YC

NAIC No. 29688

ARBITRATION AWARD

I, Amanda R. Kronin, 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: BW

1. Hearing(s) held on 06/23/2025
Declared closed by the arbitrator on 06/23/2025

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

Marisa Alis, Esq from Law Offices of John Trop participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$8,272.93**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant submitted its claim in the amended amount of \$4251.93:
\$3500.22 denied on the 120 day rule and \$751.71 denied on the IME

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

3. Summary of Issues in Dispute

The Assignor, BW, a 30 year old male, who was the passenger of a motor vehicle involved in a motor vehicle accident on 9/11/22. Following the accident, BW sought and received treatment by the above provider from 9/12/22 through 7/13/23. Thereafter, the

Assignor appeared for an IME with John Iozzio, DC, LAc on 5/10/23 and benefits were terminated as of 6/05/23. The question presented is whether further treatment from 6/05/23 through 7/13/23 was medically necessary. Further, the pre-IME bills were denied based on the 120-day rule. Accordingly, the issue to be determined is whether Respondent's 120-day defense can be sustained.

4. Findings, Conclusions, and Basis Therefor

The case was decided on the submissions of the Parties as contained in the electronic file maintained by the American Arbitration Association and the oral arguments of the parties' representatives. There were no witnesses. I reviewed the documents contained in the electronic file for both parties and make my decision in reliance thereon.

A review of the competent evidence in the record reveals that Applicant established a prima facie case of entitlement to reimbursement of its claim in the amended amount of \$4251.93, by submitting evidence that the prescribed statutory billing form was mailed and received, and that the Respondent failed to either pay or deny the claim within the requisite 30-day period. Mary Immaculate Hospital v. Allstate Insurance Co., 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004).

Outstanding Verification

Pursuant to Insurance Law §5106(a) and 11 NYCRR §65-3.8, No-Fault benefits are overdue if not paid or denied within 30 calendar days after the insurer receives proof of claim, which shall include verification of all of the relevant information requested. An Applicant establishes a prima facie showing of entitlement to No-Fault benefits under Article 51 of the Insurance Law by "submitting evidence that payment of no-fault benefits are overdue, and proof of its claim, using the statutory billing form, was mailed to and received by the defendant insurer." Viviane Etienne Med. Care, P.C. v. Country-Wide Ins. Co., 25 N.Y.3d 498, 14 N.Y.S. 3d 283 (Court of Appeals, 2015).

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). If an insurer asserts that the claim(s) are premature due to outstanding verification, the insurer must demonstrate that the verification request and follow-up verification request were timely issued, and that no response was received. Compas Med., P.C. v. Praetorian, 49 Misc 3d 129(A), 2015 NY Slip Op 51403(U)(App Term, 2 , 11 and 13 Jud. nd th th Dists. 2015). As required by 11 NYCRR §65-3.5(b), the initial request for verification is to be made within 15 business days of receipt of the claim. A request 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).

On the other hand, if the initial request for verification is made beyond 30 days from receipt of the claim, the request will be deemed a nullity and the time to pay or deny will have expired. Compas Med., P.C. v. Farm Family Cas. Ins. Co., 2015 NY Slip Op 51631(U) (App. Term 2 , 11 and 13 Jud. Dists. 2015). nd th th Page 3/8 Additionally, after 30 calendar days from the original request, the insurer has a regulatory duty to issue a second verification request within the following 10 calendar days. 11 NYCRR §65-3.6(b). 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 this case, I find that Applicant has established its prima facie case, thereby shifting the burden to Respondent. As required by 11 NYCRR §65-3.5(b), the initial request for verification is to be made within 15 business days of receipt of the claim. A request 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). On the other hand, if the initial request for verification is made beyond 30 days from receipt of the claim, the request

will be deemed a nullity and the time to pay or deny will have expired. Compas Med., P.C. v. Farm Family Cas. Ins. Co., 2015 NY Slip Op 51631(U) (App. Term 2 , 11 and 13 Jud. Dists. 2015).

Additionally, after 30 calendar days from the original request, the insurer has a regulatory duty to issue a second verification request within the following 10 calendar days. 11 NYCRR §65-3.6(b). 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). If the insurer can demonstrate that the initial verification request and follow-up verification request were timely issued, and that no response was received, the matter will be deemed premature and not ripe for adjudication. See Mount Sinai Hosp. v. Chubb Group of Ins. Co., 43 AD3d 889, 2007 NY Slip Op 06650 (App. Div., 2 Dept., nd 2007). Furthermore, pursuant to 11 NYCRR §65-3.8(b)(3), "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..."

In this case, I find that Applicant has established its prima facie case, thereby shifting the burden to Respondent. In order to sustain its defense that the claim is premature, Respondent must show that it mailed the verification letters to Applicant. Respondent contends that it mailed verification requests. However, Respondent "did not meet this burden in that it failed to establish that the 30-day period was tolled by the verification requests it allegedly mailed to plaintiff since it failed to submit, in admissible form, any proof of mailing of said requests or an affidavit from one with personal knowledge that the requests were sent to plaintiff. Nor did it create a presumption of mailing by submission of an affidavit describing the standard operating procedures it uses to ensure that its verification requests are mailed." S & M Supply Inc. v. GEICO Ins., 2003 NY Slip Op 51192(U) (N.Y. App. Term July 9, 2003).

While the rules of evidence are relaxed at an arbitration hearing, that does not mean they are to be completely ignored. There was no evidence submitted by Respondent to demonstrate that the verification requests were actually mailed. A mere copy of the letters themselves is not sufficient

proof that the same were mailed, nor was there any evidence that the requested items remained outstanding. Accordingly, Respondent's defense cannot be sustained, and Applicant is entitled to an award for this claim. As such, Applicant is awarded \$3500.22 for the pre-IME treatment denied on the 120 day rule. Any further issues raised in the hearing record are held to be moot and/or waived insofar as not raised at the time of the hearing.

IME with John Iozzio, DC, LAc on 5/10/23 and benefits were terminated as of 6/05/23

John Iozzio's report of 5/10/23 revealed an objectively negative and unremarkable examination. The Assignor's physical exam was completely normal and negative, from a chiropractic and acupuncture standpoint. Dr. Iozzio's report is very detailed and coherent. Dr. Iozzio concluded that the Assignor's cervical, thoracic, lumbar spine, sprain/strains were resolved. The examination report presents a cogent medical rationale in support of respondent's lack of medical necessity defense and meets the burden of production. Respondent has factually demonstrated the services rendered were not medically necessary.

However, in the case at bar, the IME report was not persuasive and it was apparent from the contemporaneous medical reports by the treating physician that the patient was not fully recovered, had restricted range of motion and that further medical treatment was needed. I find the evidence submitted by Applicant more credible on the necessity of further treatment for the Assignor's injuries, including the acupuncture and chiropractic treatment disputed herein.

On 5/01/23 and 5/31/23, the Assignor presented to the treating acupuncturist, these evaluations revealed that the Assignor's condition was improving with treatment but that he required additional treatment in order to attain pre-accident status.

Further, the Applicant has submitted numerous treatment notes which demonstrate that the Assignor's condition had not completely resolved at the time of the IME. In totality, I do not find it credible that an Assignor who underwent very consistent treatment; each time relating complaints regarding his neck and back, could present a completely negative IME as

Dr. Iozzio represents. In addition, I note, that as the court held in Amato v. State Farm Ins. Co., 30 Misc.3d 238, 910 N.Y.S.2d 637, "an IME is a snapshot of the injured party's medical condition as of the date of the IME. The opinion of the doctor conducting an IME and issuing a report that no further treatment or testing is needed is nothing more than an expert's opinion that at the time the examination was conducted the claimant did not need any further treatment or testing."

After careful review of the records submitted by the parties on the ADR Center and consideration of the oral arguments of counsel at the hearing, I determine that applicant's medical records are sufficient to refute respondent's prima facie showing of a lack of medical necessity for further chiropractic treatment of the patient based on Dr. Iozzio's negative IME and establish, by a fair preponderance of the credible evidence, that the patient's causally related injuries were unresolved on the date of the IME, and that the health services at issue were medically necessary.

Accordingly, after a careful review of the records and consideration of the parties' oral arguments, I find for the Applicant. Reimbursement as requested is due and owing herein. Therefore, applicant is entitled to recover \$751.71 for treatment rendered post IME. 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
	Welcome Acupuncture PC	09/12/22 - 07/13/23	\$8,272.93	\$4,251.93	Awarded: \$4,251.93
Total			\$8,272.93		Awarded: \$4,251.93

B. The insurer shall also compute and pay the applicant interest set forth below. 12/23/2024 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." 11 NYCRR §65-3.9(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." 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 at issue was timely. LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 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 fees pursuant to the no-fault regulations. See, 11 NYCRR §65-4.5(s)(2). The award of attorney fees shall be paid by the insurer. 11 NYCRR §65-4.5(e). For claims that fall under the Sixth Amendment to the regulation the following shall apply: "If the claim is resolved by the designated organization at any time prior to transmittal to an arbitrator and it was initially denied by the insurer or overdue, the payment of the applicant's attorney's fee by the insurer shall be limited to 20 percent of the total amount of first-party benefits and any additional first- party

benefits, plus interest thereon, for each applicant with whom the respective parties have agreed and resolved disputes, subject to a maximum fee of \$1,360." 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 NY

SS :

County of Suffolk

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

06/27/2025

(Dated)

Amanda R. Kronin

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:
76e2ab1f93daffa1d86d74f41b2652e3

Electronically Signed

Your name: Amanda R. Kronin
Signed on: 06/27/2025