

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

A to Z Physical Therapy PC
(Applicant)

- and -

MVAIC
(Respondent)

AAA Case No. 17-24-1355-8049

Applicant's File No. 3133707

Insurer's Claim File No. 707871

NAIC No. Self-Insured

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 06/09/2025
Declared closed by the arbitrator on 06/09/2025

Melissa Scotti, Esq. from Law Offices of Andrew J. Costella Jr., Esq. participated virtually for the Applicant

Craig Marshall, Esq. from Marshall & Marshall, Esqs. participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,748.29**, 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 42 year old EIP was involved in a motor vehicle accident on October 18, 2023; claimed related injury and underwent physical therapy treatment provided by the applicant from October 20, 2023 to January 11, 2024.

The applicant submitted a claim for these medical services. Payment of the bills for dates of service October 30, 2023 to December 4, 2023 was timely denied by the respondent because the they were not submitted within 45 days of the dates of service.

Payment of the bills for dates of service January 4, 2024, January 8, 2024 and January 11, 2024 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 a complete W9 including taxpayer identification number and certification.

The respondent also asserted a fee schedule defense.

The issues to be determined at the hearing are:

Whether the applicant established its *prima facie* entitlement to no fault benefits for dates of service October 30, 2023 to December 4, 2023.

Whether the whether the respondent established its 120 day defense for dates of service January 4, 2024, January 8, 2024 and January 11, 2024.

Whether the respondent established its fee schedule defense for the claim at issue.

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.

Applicant's *prima facie* case of entitlement to no-fault benefits

It is well settled that an applicant establishes its *prima facie* showing of entitlement to No-Fault benefits by submitting evidentiary proof that the prescribed statutory billing forms had been mailed, received by the respondent and that payment of no fault benefits were overdue. Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D. 3d 742, 774 N.Y.S.2d 564 (2d Dept. 2004.)

An insurer in a no-fault matter will be precluded as a matter of law from asserting a defense based upon the untimely submission of the bill/bills at issue if such defense is not raised in a timely denial. See New York and Presbyterian Hospital v. Empire Ins. Co., 286 A.D.2d 322 (2d Dept.2001.)

If respondent has preserved such defense in a timely denial, respondent will still be precluded from proffering such defense as a matter of law unless respondent advised applicant that late submission of the bill/bills will be excused where the applicant can provide a reasonable justification of the failure to timely submit the

bill/bills. 11 NYCRR 65-3.3(e). See also Radiology Today, P.C. v. Citiwide Auto Leasing, Inc., 2007 NY Slip Op 27111 (App. Term 2nd and 11th Jud. Dists. 2007.)

The respondent contends that it did not receive the bills for dates of service October 30, 2023 to December 4, 2023.

The applicant submitted an affirmation by Abel Mendez who stated that he was the custodian of records and medical biller for the applicant. He further attested to the fact that he personally mailed the bills for dates of service October 30, 2023 to December 4, 2023 to the respondent at 110 Williams Street, New York, N Y 10038.

However, based on the submissions, the bills were sent to an incorrect address. The correct address for MVAIC at the time of this claim is 100 William Street, New York, NY 10038.

Based on the foregoing, the applicant did not establish timely mailing of the bills at issue to the respondent.

Under these circumstances, the respondent has established that the bills for dates of service were submitted more than 45 days after the date of service and the applicant has not established its *prima facie* entitlement for no fault benefits for the claim at issue.

Therefore, the claim for dates of service October 30, 2023 to December 4, 2023 is dismissed with prejudice.

Respondent 120 day defense for dates of service January 4, 2024, January 8, 2024 and January 11, 2024.

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 for dates of service January 4, 2024, January 8, 2024 and January 11, 2024.

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 submitted the affidavit of Cheryl Story, a claims representative employed by the EIP who affirmed her personal knowledge of the usual and customary office procedures which are followed by MVAIC in the regular and customary course of business.

Ms. Story discussed in detail the general office procedures related to all incoming mail received by the respondent. She also discussed the specific bills for dates of service January 4, 8 and 11, 2024.

Ms. Story attested to the fact that the three bills for services rendered in January, 2024 were received by the respondent on 2/1/24. Within 15 business, on 2/12/24 MVAIC issued and mailed timely verification requests to the applicant. When a response was not received within 30 days of the initial request, on 3/13/24 the respondent sent a second request which was timely mailed to the applicant.

Each request was for a complete W9, taxpayer identification number and certification. The requests also contained a statement that the claim may be denied if the requested information wasn't provided within 120 calendar days from the initial request without reasonable justification for the failure to comply.

When no response was received, on 6/20/24 and 6/25/24 MVAIC issued and mailed a denial to the applicant.

Ms. Story specifically stated that as of the date of her affirmation, May 2, 2025 MVAIC has not received the documents requested.

The in his affidavit on behalf of the applicant, Abel Mendez stated that "our physical therapy office never received any of the Respondent's alleged verification requests for this particular EIP prior to the filing of this arbitration." He also stated that the respondent failed to provide any proof of mailing of the subject verification requests.

Mr. Mendez stated that the respondent failed to proffer either USPS date-stamped proof of mailing or USPS certified mailing receipts. He therefore concluded that I should draw a negative inference, against the respondent for failing to provide any of the proofs of mailing that he determined were necessary to establish that the verification requests were timely mailed.

This statement is in direct contradiction of the comprehensive affidavit from Ms. Story on behalf of the respondent, which was sufficient to establish timely mailing of the verification requests.

After a review of all the evidence submitted an issue of fact remains as to whether the respondent provided sufficient evidence of timely mailing of the verification requests at issue. Conflicting opinions have been presented in the affirmations of Ms. Story, on behalf of the respondent and Mr. Mendez on behalf of the applicant.

Based on the totality of the evidence in this matter, I find that the affirmation of Ms. Story, on behalf of the respondent is more persuasive.

Under these circumstances, I find that the respondent has established its 120 day defense.

Based on the foregoing, the fee schedule issue is moot.

Therefore, the claim for dates of service January 4, 2024, January 8, 2024 and January 11, 2024 is dismissed with prejudice.

Accordingly, the entire 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 claim is DENIED in its entirety

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.

07/01/2025
(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:

f65b4e94f03dc0dcebc3f08e8c1fa7e1

Electronically Signed

Your name: Anne Malone
Signed on: 07/01/2025