

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Hudson Pain Medicine PC
(Applicant)

- and -

MVAIC
(Respondent)

AAA Case No. 17-24-1362-9084

Applicant's File No. 3135076

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, **\$1,660.00**, 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 an EMG/NCV on December 12, 2023 and office visits provided by the applicant on December 12, 2023 and March 5, 2024.

The applicant submitted a claim for these medical services, payment of which was delayed pending responses to verification requests.

The verification requested was for hospital records, including ER records, admission, discharge, any applicable radiology reports related to treatment related to the subject accident.

The respondent also asserted a fee schedule defense.

The issues to be determined at the hearing are:

Whether the claim was premature.

Whether the respondent established its fee schedule 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.

Outstanding verification

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 December 12, 2023 and March 5, 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 December 12, 2023 and March 5, 2024.

Ms. Story attested to the fact that the bill for services rendered on 12/12/23 was received by MVAIC on 2/14/24. Within 15 business days, on 2/22/24 MVAIC issued and mailed timely verification requests to the applicant. When a response was not received within 30 days of the initial request, on 3/23/24 the respondent sent a second request which was timely mailed to the applicant.

Ms. Story also attested to the fact that the bill for services rendered on 3/5/24 was received by MVAIC on 4/1/24. Within 15 business days, on 4/11/24 MVAIC issued and mailed timely verification requests to the applicant. When a response was not received within 30 days of the initial request, on 5/11/24 the respondent sent a second request which was timely mailed to the applicant.

Ms. Story also attested to the fact that each request contained a statement indicating that the claim may be denied if requested information isn't provided within 120 calendar days from the initial request unless the applicant provides written reasonable justification for its failure to comply.

In response to the contention of timely mailing of verification requests by the respondent, the applicant submitted an affidavit by Abel Mendez, the custodian of records and biller for the applicant who 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 respondent did not 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 is more persuasive.

Under these circumstances, I find that the respondent has established that the verification requested by the respondent remains outstanding and the time to pay or deny this claim is tolled.

Therefore, the fee schedule issue need not be determined at this time.

Accordingly, the claim for dates of service December 12, 2023 and March 5, 2024 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 claim is DISMISSED without prejudice

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:
90ede6d0021a17a8a1707aed75cc1a3a

Electronically Signed

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