American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Marco Equipment Inc.
(Applicant)

- and -

Progressive Casualty Insurance Company
(Respondent)

AAA Case No.	17-24-1380-1738
Applicant's File No.	M24-772259
Insurer's Claim File No.	24-5992711184
NAIC No.	32786

ARBITRATION AWARD

I, Daniel Felber, 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: MC

1. Hearing(s) held on 03/05/2026
   Declared closed by the arbitrator on 03/21/2026

   James Errera, Esq. from Shapiro & Associates, P.C. participated virtually for the Applicant

   Christian Guayasamin, Claims Representative from Progressive Casualty Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$4,249.97**, was AMENDED and permitted by the arbitrator at the oral hearing.

   Applicant amended the total amount in dispute to $3,199.99 to comport with the with the terms of the parties' Preferred Provider Organization agreement ("PPO Agreement").

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

3. Summary of Issues in Dispute

   Assignor MC, a 27-year-old male, was the driver of a motor vehicle involved in an accident on August 3, 2024. Assignor suffered injuries for which he received treatment. In dispute is Applicant's amended claim for a low-frequency ultrasound diathermy

device and patch kit (durable medical equipment or "the DME") provided to Assignor on October 7, 2024. Respondent delayed the case for additional verification subsequently denied the claim after 120 days from its first verification request, claiming that Applicant failed to fully verify the claim ("120-day defense"). The issue to be determined in this arbitration is whether Respondent sustained its 120-day defense.

4. Findings, Conclusions, and Basis Therefor

This case was decided based upon 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 MODRIA for both parties and make my decision in reliance thereon.

Applicant established its *prima facie* entitlement to reimbursement with proof that it submitted a proper claim, setting forth the fact and the amount charged for the services rendered and that payment of no-fault benefits was overdue. See Insurance Law § 5106 a; *Viviane Etienne Med. Care v. Country-Wide Ins. Co.*, 25 N.Y.3d 498, 501 (2015).

120 DAY DEFENSE

A. <u>Legal Framework</u>

If an insurer asserts that the claim is not fully verified, 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, 2nd, 11th, and 13th Jud. Dists. 2015). 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 (2nd Dept. 2004).

Pursuant to the Fourth Amendment to 11 NYCRR § 65-3, effective April 1, 2013, "[a]n applicant from whom verification is requested shall, within 120 calendar days from the

date of the initial request for verification, submit all verification under the applicant's control or possession or written proof providing reasonable justification for failure to comply." 11 NYCRR § 65-3.5(o). 11 NYCRR § 65-3.8 (b)(3) states that "the 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 failure to comply, provided that the verification request so advised the applicant as required in section 65-3.5(o) of this Subpart." Respondent's verification requests quoted the pertinent portions of 11 NYCRR § 65-3.5(o) and 11 NYCRR § 65-3.8(b)(3), so I determine that it reserved its right to deny the claim for applicant's failure to comply with the verification requests.

B. The Record

Respondent timely issued requests for additional verification on October 22, 2024 and November 22, 2024 seeking invoices from the wholesale supplier or manufacturer, including the complete product description, make and model. The record contains a verification response from Applicant, dated November 21, 2024, purporting to attach an "invoice", but no invoice appears in the record. The record includes a copy of the parties' PPO Agreement [1] which, in relevant part, requires Applicant accept the lesser of the PPO Agreement's reimbursement rate in the total amount of $3,199.99 or 90% of the usual and customary rates for the unlisted DME. The record also contains a manufacturers' suggested retail price list ("MSRP") for the DME in the mount of $5,690 .00. Respondent denied the claim on February 26, 2025 alleging that Applicant failed to submit the requested verification within 120 days of the initial request.

C. The Parties' Contentions

Applicant argues that Respondent's 120-day defense cannot be sustained because Respondent was in possession of all information needed to fully verify the claim.

Applicant argues that the reimbursement terms set forth in the PPO Agreement, together with the MSRP, is sufficient to establish the proper reimbursement for the subject DME

obviating the need for the wholesale invoice in order to fully verify the claim. Specifically, Applicant contends that these documents fully establish that the PPO Agreement's reimbursement rate ($3,199.99) is less than 90% of the usual and customary rates as reflected by the MSRP for the unlisted DME ($5,690.00"), entitling Applicant to reimbursement in the amount of the amended claim.

Respondent contends that it had a reasonable, good faith, factual basis for requesting the manufacturer's invoice documenting the cost of the DME to establish the usual and customary rates needed in order to determine the proper reimbursement in accordance with the terms of the PPO Agreement.

D. Findings

It is well-settled that an insurer has the right to verify the identity of the wholesaler, the nature and authenticity of the wholesale invoice, and the actual cost of the equipment. *Custom Orthotics Limited V. Government Employees Insurance Company*, 25 Misc. 3d 545 (Civil Ct. Queens County 2009). *See, also, CPM Med Supply Inc. v. State Farm Fire and Casualty Insurance Company*, 63 Misc. 3d 140 (A) (App Term 2d Dept. 2019) (where a provider neither provides the requested invoices, nor asserts that it is not in possession of the invoices, the claim is not fully verified).

Here, Applicant simply argues that the invoices were not needed based upon its bald assertion that the MSRP constitutes the usual and customary rates for the DME, sufficient to determine the proper rate of reimbursement pursuant to the terms of the PPO Agreement.

I find that Applicant's position does not constitute a sufficient response or a reasonable justification for its failure to comply with a verification request (11 NYCRR 65 - 3.8 [b] [3]), *Village Med Supply Inc. v. Travelers Property Casualty Insurance Company*, 61 Misc 3d 126 (App. Term 1st Dept. 2018). Respondent's request for a copy of the wholesale invoice was reasonable and directly relevant to determine the usual and customary rates for the prescribed DME..

Accordingly, based on a fair preponderance of the credible evidence, Respondent's 120-day defense is sustained.

Applicant's amended claim is denied.

Any further issues raised in the hearing record are held to be moot and/or waived as far as not raised at the time of the hearing.

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[1] The record contains copies of contracts between Respondent and Coventry, a network agreement between Coventry and MagnaCare, and an agreement between MagnaCare and Applicant setting forth reimbursement rates for the DME. Based upon the foregoing evidence, I find that Respondent was in privity of contract with Applicant sufficient to establish that the terms of the PPO Agreement apply herein.

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 NY
SS :
County of Westchester

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

03/21/2026
(Dated)

Daniel Felber

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:
17c8f6f2e8200b019d45163b6d2ccf0a

Electronically Signed

Your name: Daniel Felber
Signed on: 03/21/2026