American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:	
	AAA Case No. AAA Assessment No. Applicant's File No.
- and -	
Progressive Insurance Company (Respondent)	Insurer's Claim File No.

ARBITRATION AWARD

I, Aaron D. Maslow, Esq., 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: Assignor ["KB"]

1. Hearing(s) held on
☒11/19/12
and declared closed by the arbitrator on 11/19/12.

Naomi Cohn, Esq., participated in person for the Applicant.
Dana Koos, Esq., participated in person for the Respondent.

2. The amount claimed in the Arbitration Request, **$3,121.10**, 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

- Whether Applicant established entitlement to No-Fault compensation for facility services for manipulation under anesthesia performed on Assignor

- Whether Respondent timely and properly pended Applicant's bill in seeking additional verification

4. Findings, Conclusions, and Basis Therefor

Appearances

For Applicant:

Gene Sigalov, Esq.
P.O. Box 230456
Brooklyn, NY 11223
Of counsel: Naomi Cohn, Esq.

For Respondent:

McCormack & Mattei, P.C.
1035 Stewart Avenue
2nd floor
Garden City, NY 11530
By: Dana Koos, Esq.

Applicant commenced this No-Fault arbitration, seeking as compensation $3,121.10, which it billed for providing facility services for manipulation under anesthesia ("MUA") performed on Dec. 15, 2011, on Assignor, a 26-year-old male who was injured in a motor vehicle accident on Oct. 3, 2011. Respondent denied payment on two grounds: lack of medical necessity and fees not being in accordance with fee schedule.

Both parties appeared at the hearing by counsel, who presented oral argument and relied upon documentary submissions. I have reviewed the submissions' documents contained in the American Arbitration Association's Electronic Case Folder as of the date of the hearing as well as those in the linked cases, said submissions constituting the record in this case. Additionally, two witnesses testified on behalf of Respondent: Dr. Christopher Burrei, D.O., who authored the peer review relied upon by Respondent in asserting lack of medical necessity; and Karen Waldenmaier, a coding specialist employed by Respondent.

This case was one of four which were linked by the American Arbitration Association. Three cases were commenced by Applicant, York Comprehensive Medical, PLLC, seeking facility service fees for the MUA, and the fourth was commenced by Complex Care Anesthesia, PLLC, seeking compensation for the anesthesia administered during the MUA. The four cases are: 412012086642, 412012086587, 412012086597, and 412012086537. The documents in all four cases are deemed to constitute the record for each case. The witness' testimony applied to the four cases (except that Ms. Waldenmaier's testimony did not relate to the anesthesia case).

MUA was performed on three dates on Assignor: Dec. 13, 14, and 15, 2011, by Drs. Alex Khait, D.C., and Avi Weinberger, D.C., working for Actual Chiropractic, P.C. (whose billing was not before me). Applicant herein, York Comprehensive Medical, PLLC, served as the ambulatory surgery facility, and the anesthesia was provided by Complex Care Anesthesia, PLLC.

At the hearing, Applicant argued that since Respondent did not deny its bill within the requisite 30-day period mandated by Insurance Law §5106(a) and 11 NYCRR 65-3.8(a)(1),

and since Respondent did not timely and properly toll the 30-day deadline, it presented a prima facie case of entitlement to compensation and Respondent was precluded from raising its asserted defenses of lack of medical necessity and fees not being in accordance with fee schedule.

The facts concerning this argument are as follows. Respondent received Applicant's bill on Dec. 28, 2011. On Jan. 9, 2012, Respondent sent Applicant a letter denoted a "Verification Request," confirming receipt of the subject bill and stating that "We require the following items before consideration of this bill: • All benefits remain delayed pending the cooperation of the injured party in the investigation of this claim, including, but not limited to a recorded statement."

On Jan. 31, 2012, Respondent sent a letter to Assignor c/o Naimark & Tannenbaum, presumably a law firm, stating in pertinent part that it had "unsuccessfully attempted to obtain a recorded statement from you regarding your accident and injury claim," and that "We are hereby requesting a recorded statement over the telephone relating to your accident and injuries." The letter stated the date of Feb. 7, 2012; the time of 10:00 a.m.; and the telephone number when and where Assignor would be called for him to provide the recorded statement. This letter was not copied to Assignor.

On Feb. 8, 2012, Morrison & Wagner, a law firm, sent a letter to Respondent stating that it had been retained by Assignor for injuries sustained in the motor vehicle accident.

On Feb. 13, 2012, Respondent sent Applicant a letter denoted a "Verification Request: Follow-up Notice," again confirming receipt of the subject bill and stating that "We require the following items before consideration of this bill: • All benefits remain delayed pending the cooperation of the injured party in the investigation of this claim, including, but not limited to a recorded statement."

On Mar. 6, 2012, Respondent sent Assignor a letter c/o Morrison & Wagner, stating in pertinent part that it had "unsuccessfully attempted to obtain a recorded statement from you regarding your accident and injury claim," and that "We are hereby requesting a recorded statement over the telephone relating to your accident and injuries." The letter stated the date of Mar. 19, 2012; the time of 10:00 a.m.; and the telephone number when and where Assignor would be called for him to provide the recorded statement. This letter was copied to Assignor.

On Mar. 19, 2012, Morrison & Wagner sent a fax to Respondent stating that it no longer represented Assignor.

On Apr. 27, 2012, Respondent sent Assignor a letter stating in pertinent part that it had "unsuccessfully attempted to obtain a recorded statement from you regarding your accident and injury claim," and that "We are hereby requesting a recorded statement over the telephone relating to your accident and injuries." The letter stated the date of May 9, 2012; the time of 10:00 a.m.; and the telephone number when and where Assignor would be called for him to provide the recorded statement.

On May 9, 2112, Respondent obtained the recorded statement from Assignor. Thereafter, on June 6, 2012, it issued its denial appurtenant to the subject bill in dispute.

"A no-fault provider establishes its prima facie entitlement to summary judgment by proof of the submission to the defendant of a claim form, proof of the fact and the amount of the loss sustained, and proof either that the defendant failed to pay or deny the claim within the requisite 30-day period, or that the defendant issued a timely denial of claim that was conclusory, vague or without merit as a matter of law [citations omitted]." The New York Hospital Medical Center of Queens v. Statewide Ins. Co., 33 Misc.3d 130(A), 941 N.Y.S.2d 539 (Table), 2011 N.Y. Slip Op. 51863(U) at 1, 2011 WL 4952962 (App. Term 9th & 10th Dists. Oct. 14, 2011). Here, Applicant proved that it submitted its bill to Respondent and that the denial was issued more than 30 days after the bill was received. The bill was received on Dec. 28, 2011, and the denial was issued on June 6, 2012. Thus, Applicant established its prima facie case of entitlement to No-Fault compensation.

"Pursuant to Insurance Law § 5106(a) and the Insurance regulations, an insurer must either pay or deny a claim for motor vehicle no-fault benefits, in whole or in part, within 30 days after an applicant's proof of claim is received (*see* Insurance Law § 5106[a]; 11 NYCRR former 65.15[g][3], now 11 NYCRR 65-3.8[c]; *see also* 11 NYCRR 65-3.5)." Infinity Health Products, Ltd. v. Eveready Ins. Co., 67 A.D.3d 862, 864, 890 N.Y.S.2d 545, 547 (2d Dept. 2009). "The 30-day period in which to either pay or deny a claim is extended where the insurer makes a request for additional verification within the requisite 15-[business] day time period (*see Montefiore Med. Ctr. v Government Empls. Ins. Co.*, 34 AD3d 771; *New York & Presbyt. Hosp. v. Allstate Ins. Co.*, 31 AD3d 512)." Kingsbrook Jewish Medical Center v. Allstate Insurance Co., 61 A.D.3d 13, 17-18, 871 N.Y.S.2d 680, 683 (2d Dept. 2009). "If the requested verification is not received within 30 days, the insurer must send a follow-up letter within 10 days thereafter (see 11 NYCRR 65.15[e][2])." New York & Presbyterian Hospital v. American Transit Insurance Co., 287 A.D.2d 699, 700, 733 N.Y.S.2d 80, 81-82 (2d Dept. 2001). "Thus, a timely additional verification request tolls the insurer's time within which to pay or deny a claim (*see Fair Price Med. Supply Corp. v Travelers Indem. Co.*, 10 NY3d at 563; *New York & Presbyt. Hosp. v. Countrywide Ins. Co.*, 44 AD3d 729, 730)." Kingsbrook Jewish Medical Center v. Allstate Insurance Co., supra at 18, 871 N.Y.S.2d at 683 (2d Dept. 2009).

Respondent claimed at the hearing that it timely and properly tolled the 30-day deadline, thus pending the bill. It argued that the Jan. 9. 2012 letter to Applicant was issued within 15 business days after receiving the bill on Dec. 28, 2011, and that when 30 days had elapsed, the Feb. 13, 2012 letter sent to Applicant constituted the required follow-up verification request. While there is no documentation in the record of attempts to obtain the recorded statement from Assignor prior to the Jan. 31, 2012 letter to Assignor c/o Naimark & Tannenbaum, Respondent argued that obviously such attempts were made because the letter refers to unsuccessful attempts.

Applicant argued at the hearing that the Jan. 9, 2012 and Feb. 13, 2012 letters were mere delay letters which did not constitute true verification requests. If the Jan. 31, 2012

letter was a verification request it was issued 24 business days after Dec. 28, 2011, leaving only six days to deny the bill once verification was received. The recorded statement took place on May 9, 2012, so the denial had to be issued by May 15, 2012. It being issued on June 6, 2012, it was untimely. In any event, the Jan. 31, 2012 letter did not constitute a verification requests, argued Applicant, because it was not sent to Assignor and there was no proof that Naimark & Tannenbaum was retained by Assignor as his attorneys at the time.

There is case law concerning what the courts have denoted as "delay letters." A letter which states that the claimant's records have been received but that payment was being delayed pending completion of the insurance company's investigation does not toll the 30-day statutory period for paying or denying the claim. Nyack Hospital v. Encompass Insurance Co., 23 A.D.3d 535, 806 N.Y.S.2d 643 (2d Dept. 2005). A letter informing a health service provider that the insurer was investigating the claim and was in the process of obtaining verification, which included examinations under oath, is insufficient to toll the 30-day statutory time period within which a claim must be paid or denied. Parsons Medical Supply, Inc. v. Progressive Northeastern Ins. Co., 36 Misc.3d 148(A), ___ N.Y.S.2d ___ (Table), 2012 N.Y. Slip Op. 51649(U), 2012 WL 3734399 (App. Term 2d, 11th & 13th Dists. Aug. 23, 2012). Letters to a health care provider merely stating that the insurer was waiting for the results of an investigation by its special investigation unit as well as the scheduling of an EUO are delay letters not constituting verification requests, and they do not toll the statutory time period within which a claim must be paid or denied. Points of Health Acupuncture, P.C. v. Lancer Ins. Co., 28 Misc.3d 133(A), 2010 N.Y. Slip Op. 51338(U), 2010 WL 2990138 (App. Term 2d, 11th & 13th Dists. July 22, 2010). A letter which merely informs a claimant that a decision on the claim is delayed pending an investigation and which does not specify a particular form of verification and the person or entity from whom the verification is sought, may not be relied upon to toll the 30-day claim determination period. Ocean Diagnostic Imaging P.C. v. Commerce Insurance Co., 7 Misc. 3d 133(A), 801 N.Y.S.2d 237 (Table), 2005 N.Y. Slip Op. 50642(U), 2005 WL 1021859 (App. Term 2d & 11th Dists. Apr. 29, 2005).

Had the Jan. 9, 2012 and Feb. 13, 2012 letters from Respondent to Applicant merely stated that benefits were delayed pending an investigation, that would be insufficient to pend the bill and toll the 30-day deadline. Had the letters stated that benefits were delayed pending an investigation and a recorded statement, that too would be insufficient inasmuch as the identity of the person from whom the statement was sought was not identified. This is all per the cited case law. Here, however, a specific item sought and the identity of the person from whom it was sought -- the injured party -- were stated. Thus, the Jan. 9, 2012 and Feb. 13, 2012 letters from Respondent to Applicant were not merely delay letters but verification requests. However, that does not end the analysis.

In seeking additional verification, an insurer is not limited to seeking it from the applicant. Doshi Diagnostic Imaging Services v. State Farm Ins. Co., 16 Misc.3d 42, 842 N.Y.S.2d 153 (App. Term 9th & 10th Dists. 2007). Thus, Respondent was within its rights to seek a recorded statement from the Assignor. Respondent's sending letters to Applicant concerning its need to obtain a recorded statement from Assignor did not alone complete the effort to obtain additional verification. The additional verification which is sought had to be

sought within the 15-business day deadline from a person who had the information or can reasonably obtain it from someone else. Thus, the court in D & R Medical Supply, Inc. v. Clarendon Nat. Ins. Co., 22 Misc.3d 1127(A), 881 N.Y.S.2d 362 (Table), 2009 N.Y. Slip Op. 50306(U), 2009 WL 485262 (Civ. Ct. Kings Co., Genine D. Edwards, J., Feb. 26, 2009), held that whether the claimant possesses the verification requested or it is in the hands of the referring physician, it cannot shift its obligation to verify a claim to the insurer. However, Applicant here was in no position to provide a recorded statement from Assignor. (This is unlike medical records from a referring physician, conceivably which Applicant could obtain from him.) Only Assignor -- not Applicant -- could provide the recorded statement.) Thus it behooved Respondent to notify Assignor within 15 business days that it wanted a recorded statement from him. This is analogous to the situation in D & R Medical Supply v. Progressive Ins. Co., 24 Misc.3d 521, 876 N.Y.S.2d 628 (Civ. Ct. Kings Co. 2009), wherein the court held that a claim by a medical supply provider is not effectively tolled by the insurer with additional verification requests where the provider informs the insurer that it is not in possession of the documentation sought, but rather it should be requested from the prescribing doctor, and the insurer fails to so request it.

Did Respondent timely seek the recorded statement in its letters to Assignor? I find that it did not. There is no documentation of any communication from Respondent to Assignor prior to the Jan.31, 2012 letter. And that letter was sent to Assignor care of a law firm concerning whom there is no documentation that it was Assignor's attorneys of record. Because of that, I find that the Jan. 31, 2012 letter did not constitute a verification request to Assignor. The Mar. 6, 2012 letter -- sent to Morrison & Wagner, from whom Respondent obtained a letter of representation which is in the record, and copied to Assignor -- is actually the first effective letter sent by Respondent to Assignor seeking from the latter a recorded statement. This is 69 days after receipt of Applicant's bill. A verification request sent to a claimant 66 days after receipt of the claim is untimely. Executive MRI Imaging, P.C. v. New York Central Mutual Fire Insurance Co., 13 Misc.3d 140(A), 831 N.Y.S.2d 359 (Table), 2006 N.Y. Slip Op. 52250(U), 2006 WL 3437501 (App. Term 2d & 11th Dists. Nov. 13, 2006). A verification request issued after the expiration of the 30-day period for paying or denying No-Fault claims does not toll the payment due date. Boulevard Multispec Medical, P.C. v. MVAIC, 19 Misc.3d 138(A), 866 N.Y.S.2d 90 (Table), 2008 N.Y. Slip Op. 50872(U), 2008 WL 1886375 (App. Term 2d & 11th Dists. Apr. 14, 2008).

To summarize my findings of fact and conclusions of law: While the Jan. 9, 2012 and Feb. 13, 2012 letters from Respondent to Applicant constituted verification requests they alone did not suffice to pend the bill and toll the 30-day deadline. A request for a recorded statement from Assignor had to be directed to Assignor himself in order to properly pend the bill and toll the 30-day deadline. The first such proper and effective request to Assignor was the Mar 6, 2012 letter. However, inasmuch as that letter was issued more than 30 days after the bill was received -- in fact it was issued 69 days later -- the letter constituted an untimely verification request. Inasmuch as the recorded statement was not sought in a timely manner, Respondent never legally pended the bill and tolled the 30-day deadline. The late issuance of its denial cannot be excused, per Presbyterian Hospital v. Maryland Casualty Company, 90 N.Y.2d 274, 660 N.Y.S.2d 536, 683 N.E.2d 1 (1997), and the asserted defenses of lack of medical necessity and fees not being in accordance with fee schedule are precluded. See

Country-Wide Insurance Co. v. Zablozki, 257 A.D.2d 506, 684 N.Y.S.2d 229 (1st Dept. 1999) (defense of excessive testing is precluded where insurer failed to deny No-Fault claim within 30 days); Mercury Casualty Co. v. Encare, Inc., 90A.D.3d 475, 934 N.Y.S.2d 390 (1st Dept. 2011) (excessive fees do not fit within lack of coverage exception to rule that No-Fault insurer which issues a denial of claim in an untimely or otherwise defective manner is prohibited from challenging the claim).

Applicant is correct that it proved that since Respondent did not deny its bill within the requisite 30-day period mandated by Insurance Law §5106(a) and 11 NYCRR 65-3.8(a)(1) and since Respondent did not timely and properly toll the 30-day deadline, it presented a prima facie case of entitlement to compensation and Respondent was precluded from raising its asserted defenses.

In light of this determination, the testimony of Dr. Christopher Burrei, D.O., and Karen Waldenmaier are academic. (For purposes of a complete decision, I note that Dr. Burrei testified consistently with his peer review, in which he cited to guidelines of New York State applicable to Workers' Compensation and of the International Chiropractic Association, which hold that chiropractic performed under general anesthesia for musculoskeletal injuries is not medically necessary. Ms. Waldenmaier testified that the proper fee for the facility services provided for MUA would be calculated by applying the highest fee a hospital in New York City could receive under PAS No. 34, per the Workers' Compensation Products of Ambulatory Surgery Fee Schedule, inasmuch as Applicant was not certified by Workers' Compensation but was accredited by a certifying agency. The appropriate fee would be $1,248.44 for date of service. I did find both witnesses credible but that is moot since I have precluded the defenses of lack of medical necessity and fees not being in accordance with fee schedule.)

Accordingly, the within arbitration claim is granted in its entirety.

Interest: "Pursuant to Insurance Law §5106(a), interest accrues on overdue no-fault insurance claims at a rate of 2% per month. A claim is overdue when it is not paid within 30 days after a proper demand is made for its payment [citations omitted]." LMK Psychological Services, P.C. v. State Farm Mut. Auto. Ins. Co.,12 N.Y.3d 217, 879 N.Y.S.2d 14 (2009). "If 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, interest shall not accumulate on the disputed claim or element of claim until such action is taken." 11 NYCRR 65-3.9(c). This provision of the No-Fault regulations applies to untimely-issued denials as well as to timely ones, and results in interest being tolled until arbitration is requested. LMK Psychological Services, P.C. v. State Farm Mut. Auto. Ins. Co., supra; see also East Acupuncture, P.C. v. Allstate Ins. Co., 61 A.D.3d 202, 873 N.Y.S.2d 335 (2d Dept. 2009). In the case at bar, Applicant did not request arbitration within 30 days after receipt of Respondent's denial; the denial was issued on June 6, 2012, and Applicant presumptively received it a few days afterwards, more than 30 days before it commenced arbitration, which was July 27, 2012, according to the American Arbitration Association. Hence, there are actually two periods of interest, the first of which commences 30 days from when the insurer received proof of claim and ends on the date it issued its

denial, and the second of which commences on the date arbitration was commenced and ends on the date of payment of the claim. State Farm Mut. Auto Ins. Co. v. Pfeiffer, 95 A.D.2d 806, 463 N.Y.S.2d 527 (2d Dept. 1983). In calculating interest, the date of accrual in both periods shall be excluded from the calculation. General Construction Law § 20 ("The day from which any specified period of time is reckoned shall be excluded in making the reckoning.") Where a motor vehicle accident occurs after Apr. 5, 2002, interest shall be calculated at the rate of two percent per month, simple, calculated on a pro rata basis using a 30-day month. 11 NYCRR 65-3.9(a); Gokey v. Blue Ridge Ins. Co., 22 Misc.3d 1129(A), 881 N.Y.S.2d 363 (Table), 2009 N.Y. Slip Op. 50361(U), 2009 WL 562755 (Sup. Ct. Ulster Co., Henry F. Zwack, J., Jan. 21, 2009).

Attorney's Fee: Applicant is entitled to an attorney's fee pursuant to Insurance Law §5106(a) and 11 NYCRR 65-4.6(e).

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.

Accordingly, the applicant is AWARDED the following:

A.

Benefits	Amount Claimed	Amount Awarded
Health Service Benefits	3,121.10	3121.10
Totals:	$3,121.10	$3,121.10

B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 07/27/2012, which is a relevant date only to the extent set forth below.)

The interest rate shall be two percent per month, simple (i.e., not compounded), on a pro rata basis using a 30-day month. With respect to the within claim, Respondent shall pay Applicant interest computed from Jan. 27, 2012 to June 6, 2012, but excluding Jan. 27, 2012 from being counted within the period of interest; and from July 27, 2012 to the date of payment of the award, but excluding July 27, 2012 from being counted within the period of interest.

C. Attorney’s Fees

The insurer shall also pay the applicant for attorney's fees as set forth below.

After calculating the sum total of the first-party benefits awarded in this arbitration plus interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20 percent of that sum total, subject to the minimum and maximum amounts provided for in 11 NYCRR 65-4.6. Since the within arbitration request was filed on or after Apr. 5, 2002, if the sum total of the benefits and interest awarded thereon is equal to or less than Respondent's written offer during the conciliation process, then the attorney's fee shall be based upon the provisions of 11 NYCRR 65-4.6(b).

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 New York
SS :
County of Kings.

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

11/21/12
(Dated)

(Aaron D. Maslow, Esq.)

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.