American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:		
Montefiore/Moses Division / **Applicant_ 1** (Applicant)	AAA Case No.	412010021655
	AAA Assessment No.	17 991 15542 10
- and -	Applicant's File No.	
Country-Wide Insurance Company (Respondent)	Insurer's Claim File No.	1000510001

ARBITRATION AWARD

I, Glen A. Wiener, 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

1. Hearing(s) held on
☒08/10/10
and declared closed by the arbitrator on 8/10/10.

Ayssa Domashitsky, Esq. participated in person for the Applicant.
Jason Moussourakis, Esq. participated in person for the Respondent.

2. The amount claimed in the Arbitration Request, **$9,634.00**, 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

After sitting silent, can Respondent now claim deficiencies in Applicant's response to its requests for additional verification?

4. Findings, Conclusions, and Basis Therefor

The decision below is based on the documents on file in the Electronic Case Folder maintained by the American Arbitration Association as of the date of this hearing and on oral arguments of the parties. No witness testimony was produced at the hearing.

Assignor AB was involved in an automobile accident on October 7, 2009. Applicant, Montefiore/Moses Division, as assignee of AB, seeks $9,634 reimbursement, with interest and counsel fees, under the No-Fault Regulations, for emergency room services provided to Assignor

on October 7, 2009. Respondent, **Country-Wide Insurance Company**, insured the motor vehicle involved in the automobile accident. Under New York's Comprehensive Motor Vehicle Insurance Reparation Act (the "No-Fault Law"), New York Ins. Law §§ 5101 et seq., Respondent was obligated to reimburse the injured individual (or its assignee) for all reasonable and necessary medical expenses arising from the use and operation of the insured vehicle. However, Respondent, failed to pay or deny the claim alleging Applicant failed to completely comply with its requests for additional verification.

THE LAW

A No-Fault claim must be paid or denied within thirty days or it is "overdue." commencing the accrual of interest and attorney fees. *See*, N.Y. Ins. Law § 5106[a] (McKinney 2000); 11 NYCRR § 65[g][3]; *Presbyterian Hospital v. Maryland Cas. Co*., 90 N.Y.2d 274, 660 N.Y.S.2d 536 (1997).

There is an exception to the 30-day rule. 11 NYCRR § 65-3.5 (b) provides that, "within 15 business days of receipt of the prescribed verification forms" an insurer may seek additional verification of a claim. "If any requested verifications has not been supplied to the insurer 30 calendar days after the original request, the insurer shall, within 10 calendar days, follow up with the party from whom the verification was requested. . . At the same time the insurer shall inform the applicant and such person's attorney of the reason(s) why the claim is delayed by identifying in writing the missing verification and the party from whom it was requested." 11 NYCRR § 65-3.6 (b). Under 11 NYCRR § 65-3.8(a)(1) No-Fault benefits are overdue if not paid within 30 calendar after the insurer receives proof of claim, which shall include verification of all the relevant information requested pursuant to 65-3.5".

An insurer is not obligated to pay or deny a claim until it has received verification of all relevant information requested (*see* 11 NYCRR 11 NYCRR 65-3.8 (b) (3)]; *St. Vincent's Hospital Richmond v. American Transit Insurance Company*, 299 A.D.2d 338 (2nd Dept. 2002); *New York Hosp. Med. Ctr. of Queens v Country-Wide Ins. Co.*, 295 A.D.2d 583, 744 N.Y.S.2d 201 (2nd Dept 2002). "Just as the insurer has a duty to speedily process claims, the claimant for benefits has a duty of cooperation in supplying information reasonably requested by the insurer to process the claim." *Dilon Medical Supply Corp. v. Travelers Ins. Co*., 2005 Slip Op 25113, 7 Misc.3d 927, 796 N.Y.S.2d 872 (Civ. Ct. Kings Co., Arlene Bluth, J., March 24, 2005) Applicant "cannot simply rest on its laurels and ignore a verification request . . . Since the [Applicant] desires to be paid the onus is on it to insure that the [Respondent] has all of the required information to verify and pay the claim." *D&R Medical Supply, Inc. v. Clarendon Nat. Ins. Co.*, 22 Misc.3d 1127(a), 881 N.Y.S.2d 362, 2009 Slip Op 50306(U)(Civ. Ct. Kings Co., Gennie Edwards, J. Feb. 6, 2009). "Any confusion on the part of [an applicant] as to what was being sought should [be] addressed by further communication, not inaction." *Westchester County Medical Center v. New York Central Mut. Ins. Co*., 262 A.D. 553, 692 N.Y.S.2d 665 (2d Dept 1999). "Even when a claimant believes it need not comply with a verification request, the claimant still has a duty to communicate with the insurer regarding the request. . . The [insurer] should not be put in a position to second guess the reason or reasons why the [claimant] has failed to respond to the request." *Canarsie Chiropractic, P.C. v. State Farm Mut. Auto. Ins. Co*., 2010 Slip Op 50950U (Civ. Ct. Kings Co. Silvia Ash, J. May 25, 2010). A failure to raise an objection to the request will even result in a waiver of the defense the notices were defective and unreasonable. *Canarsie Chiropractic, P.C. v. State Farm Mut. Auto. Ins. Co*., 2010 Slip Op 50950U (Civ. Ct. Kings Co. Silvia Ash, J. May 25, 2010).

It would be irrational to not to impose similar requirements on an insurer. As noted by Justice Agate:

> *While an insurance company may not issue a denial while its verification request remains outstanding, once it receives information from a claimant in response to its request, the ball is now in the insurance company's court to act on the response. That action could be to pay the claim, deny the claim, or request further verification, if it finds the provided response insufficient.* ***The verification however, does not remain outstanding simply because defendant only received some of the material it requested.***
> *All Health Medical Care, P.C. v. GEICO,* 2 Misc. 3d 907, 771 N.Y.S.2d 832 (Civ. Ct. Queens Co., Augustus C. Agate, J., January 16, 2004)(emphasis added)

THE FACTS OF THE CASE

Respondent received Applicant's bill on November 9, 2009. On November 13, 2009 Respondent requested the following additional verification:

> *Completed and signed NF-2 and NF-4*
> *Complete copies of any x-rays*
> *Signed assignment of benefits*
> *Police Report*
> *The complete hospital record*

December 14, 2009 Respondent properly sent a follow-up demand to Applicant requesting the same material as noted in its prior letter. On February 4, 2010, Applicant sent a letter to Respondent stating, "In response to your letter date 12/14/2009 regarding [AB] please see attached." [A copy of this letter was submitted at the hearing.] It is not known what was attached to this letter. However, it is undisputed that if all the material requested was not provided, Respondent failed to react to Applicant's response by requesting any missing documentation.

THE ANALYSIS

"Neither party may ignore communications from the other without risking its chance to prevail in the matter*" Media Neurology, P.C. v. Countrywide Ins. Co.*, 873 N.Y.S.2d 235, 2008 N.Y. Misc. Lexis 5512 (Civ. Ct. Kings Co. Silvia Ash, J. Sept 15, 2008). Herein, after receiving Applicant's letter dated February 4, 2010, Respondent failed to notify Applicant whether any additional materials were still outstanding. "As [Respondent] took no steps to preserve its defenses to [Applicant's claim], this [tribunal] finds that [Respondent] failed to comply with the No-Fault Law by failing to either pay or deny the claim within 30 days from the date of receipt of [Applicant's] response." *Media Neurology, P.C. v. Countrywide Ins. Co.*, Accordingly, Applicant's request seeking $9,634 reimbursement for the emergency room services provided to Assignor on October 7, 2009 is granted.

This award is in full disposition of all No-Fault benefit claims submitted to 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.

Accordingly, the applicant is AWARDED the following:

A.

Benefits	Amount Claimed	Amount Awarded
Health Service Benefits	9,634.00	9634
Totals:	$9,634.00	$9,634.00

B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 05/07/2010, which is a relevant date only to the extent set forth below.)

Since the motor vehicle accident occurred 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).

In accordance with 11 NYCRR 65-3.9(a), since no denial was issued, interest shall accure as of December 12, 2009, the 30th day after the claim was fully presented by the claimant, [which is the date the claim should have been paid or denied by Respondent] and ends on the date the claim is paid.

C. Attorney's Fees

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

In accordance with 11 NYCRR 65-4.6(e), the insurer shall pay Applicant an attorney's fee equal to 20% of the total amount awarded in this proceeding plus interest, with the minumun fee set at $60 and the maximun fee capped

at $850.

Given that the within arbitration request was filed on or after Apr. 5, 2002, if 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 New York.

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

8/18/10
(Dated)

(Glen A. Wiener)

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.