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One Office, Two Locations: NYSI Opens Second Location in Buffalo, NY

The American Arbitration Association is happy to announce that the New York State Insurance (NYSI) Case Management Center in Buffalo, New York, is now open. The new center is a second location for NYSI and works in partnership with the New York City office. Overseen by Assistant Vice President Kate Stillman, the Buffalo center is located at 250 Delaware Avenue and is staffed with experts from the surrounding community. The Center currently is focusing on the intake and indexing functions with plans to add other supplementary services in 2018.

The addition of the Buffalo Center will expand the NYSI's mission to partner as well as collaborate with the New York Department of Financial Services (NYDFS) and other clients to provide high-caliber, professional ADR services and business intelligence.

For any conciliation and/or arbitration inquiries, please continue to contact your respective conciliation and arbitrator support team members.

Join the ECF Trend!

The AAA offers a free, fast, and easy way to submit no-fault case filings through its Electronic Case Filing (ECF) option. This service allows for submissions to be received electronically by emailing: nyicmc.filing submissions@adr.org. Immediately upon receiving your emailed submission, a confirmation receipt is generated and emailed to you.

Cases are uploaded to the case management platform daily and routed to a processing queue for assignment to staff. Cases also undergo a sufficiency review to ensure compliance standards are met. On matters where the review identifies areas requiring further verification or an amendment, a case filing specialist will contact the filer and/or the cases will be rejected.

While we continue to accept paper submissions, we encourage you to use our electronic case submission services. In order to be in compliance with the regulation and avoid a delay of initiation, please have your filing fees available. A draw-down account is required for all parties who wish to file electronically. Funds may be added to your draw-down account by submitting a credit card payment, wire transfer, or check.

For more information on filing cases via email, please refer to the [Email Filing Registration Form, Rules and Procedures](#).

ADR Center's Redacted Award Search

The Redacted Award Search on ADR Center is a vast library of knowledge that, if correctly utilized, can drastically aid parties with the preparation of their cases. The Award Search can be found at <https://aaa-nynf.modria.com/loadAwardSearchFilter>. It is not required to have log-in credentials in ADR Center to use the Award Search, as the awards generated always are redacted and do not display the injured party's name.

To best leverage the results, it's important to understand how to effectively utilize the search criteria. In contrast to other systems that may require complex Boolean language for searches, ADR Center removes the need for users to use discrete logic or any unfamiliar syntax. There are several fields that can be used to look up either a specific case or a variety of cases based on the information entered. It's best to combine search fields to help you condense the results of your search and reduce irrelevant awards.

The first thing to consider is your date ranges. If omitted, ADR Center's award search will assume that you want to search through every award issued since 2014. While this may be the case for some, others may want to narrow down their search to cases awarded within the past year, six months, or other time frames.



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Next, review the “Case Issue” field to hone in on specifically what you’re looking for. This box will have an expansive list of common case issues. For example, if you were looking for decisions regarding fee interpretation for a particular piece of durable medical equipment, you would check off the boxes for “Fees not in accordance with fee schedule” and “Medical Supplies.” It’s important to note that while the awards generated by this search may have other issues involved, the issues you selected will be included in the arbitrators’ decisions.

Other options to narrow your search are:

- The “Full Text Search” and “Without the Words” fields at the bottom of the page will allow you to search for specific words or phrases that may be crucial to your research.
- Simply by selecting the “All Words” radio button, your search will include awards that contain every word in the phrase you entered, similar to an “And” operator. Using this feature along with a search that included “Green, IME and Acupuncture” would generate awards that include all three terms in the body of the award.
- The “Any Word” radio button will act as an “Or” operator and will generate awards that contain at least one of the words you entered into the search field. This may be beneficial if you aren’t sure what terms to enter and need to view awards that contain some of the search criteria. The “Exact Phrase” option will generate awards that contain the words you entered in the order that you entered without performing any other type of compound-search function.

All lower awards and master awards issued within the last year utilize Optical Character Recognition (OCR). This means that once your results are generated and you select an award to review, you can press ctrl+F within the PDF document to perform a word search. This search will bring you to the passage within the award that is specific to your search. This time-saving feature can help you determine if the award is suitable to your research without having to read through the entire document.

For further assistance with ADR Center’s Award Search, you may contact ADR Center Customer Support by phone at 646-663-3488 or by email at NYSInsurance@adr.org. You may also access additional information regarding ADR Center online at <http://info.adr.org/nofaulthelp>.

The Process of Scheduling Hearings

Each year, the number of requests for no-fault arbitration that the AAA’s New York Insurance Case Management Center (NYICMC) receives exceeds the previous year’s tally. One of the Center’s primary goals is scheduling hearings as quickly and efficiently as possible to achieve practical and reasonable timing for the parties and arbitrators. Despite these efforts, our most recent survey elicited concern about the setting of hearing dates.

In response to our most recent survey, one participant noted that “The time to set a hearing from the initiation notice to the actual hearing date scheduled can exceed 6+ months on some cases. It is not fair to the insurance carrier to sustain the interest should the case be decided for the applicant just because AAA does not have enough staffing in a certain area.” Another survey participant noted that “The hearing schedule is not satisfactory. ”

There are many variables that must be considered in setting hearing dates.

When a claim passes the conciliation phase, the claim generally is “escalated” or transmitted to a hearing where the parties may appear before an arbitrator. The date when the scheduler completes this task is known as the “escalated to arbitration” date. The Center tries to schedule cases in the order they are received, slating the oldest pending cases first (adopting the “first-in, first-out” or “FIFO” method of inventory). However, this is not always feasible.



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While New York No-Fault Regulation 68 states arbitration hearings should be scheduled at least fifteen (15) calendar days in advance, the Center generally provides hearing notices thirty (30) days in advance whenever possible. In instances where a previously scheduled hearing slot becomes available due to a settlement or withdrawal, the Center may “back-fill” that slot provided it can do so with fifteen (15) days’ notice. Each hearing is slotted for fifteen (15) minutes unless the parties request additional time. For example, parties may require additional time to allow testimony by witnesses.

Scheduling an arbitration hearing date is contingent on the availability of the parties and arbitrators, escalation date, and any “scheduling flags” associated with a claim. Among the most important criteria for our scheduling team is the geographical region where the case is filed, as this impacts a respondent/carrier’s ability to appear for a hearing, particularly in northern New York regions.

In order to best accommodate the parties, the Center groups cases by “linking” and “batching” cases, allowing parties to appear before one arbitrator for multiple cases on the same day. In addition, linking brings together cases with common elements of proof and cases arising out of the same motor vehicle and date of accident. Cases filed at a later date may be scheduled for hearings before different arbitrators, although the claim may have stemmed from the same event. As an added convenience for the parties, the Center batches cases involving the same applicant attorney and same insurance carrier notwithstanding different injured persons and accidents.

The Center may also schedule hearings by the type of claim. For instance, an “express” case should be scheduled as early as possible. A case may qualify for the express track only if it meets specific criteria defined within the no-fault regulation. Non-assignee cases also follow this procedure subject to the assigned arbitrator’s preferences for hearing such cases. Express cases are cases that may be designated for rescheduling because the originally scheduled hearing was postponed or continued, and they may have a defined duration and/or time slot based on the arbitrator’s specific directives for the parties. Cases involving multiple providers and/or multiple insurers will be scheduled for additional time based on the additional number of parties beyond the applicant and respondent and also will be treated as express cases.

To manage a caseload of this size, it’s important to appoint an arbitrator in a timely manner. Arbitrators conduct hearings once a week on their pre-determined “primary” days for three (3) consecutive weeks. Every fourth week, arbitrators will hear cases on their chosen “alternate” days. The scheduling team aims to preserve a balance of hearing assignments so parties’ respective caseloads are fairly and evenly distributed across the arbitrator panel to the extent possible.

Other considerations for the scheduling team include available resources for each particular party. The Center reviews the number of representatives that reportedly can appear on behalf of a party to avoid “overbooking” the party on any given day. In a related manner, the team also reviews the parties’ accommodations requests to prevent a scheduling conflict where the party previously indicated it cannot appear on a particular date and/or in a specific county.



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DEVELOPMENTS IN NEW YORK NO-FAULT & SUM ARBITRATION:

Recent Arbitration Awards

The intent of this section is to provide a cross section of recent, well-reasoned arbitration awards that address commonly raised issues in no-fault and SUM arbitrations. The awards were objectively selected by an editorial board consisting of no-fault and SUM arbitrators with a view toward promoting discussion and analysis of relevant issues.

List of Arbitrator Abstracts

DME & Verification Request for Wholesale Invoice

- *Medical Records Retrieval/DBA Kamara Supplies & State Farm Mut. Automobile Ins. Co.*, AAA Case no. 17-17-1053-1592 (9/14/17) (Pamela Hirschhorn, Arb.).
- *Genesis Ortho Supply Corp. & Fiduciary Ins. Co. of America*, AAA Case no. 17-15-1010-8344 (2/28/16) (Henry Sawits, Arb.).
- *Medical Records Retrieval/DBA Kamara Supplies & State Farm Mut. Automobile Ins. Co.*, AAA Case no. 17-16-1034-1497 (10/10/17) (Walter Higgins, Arb.).
- *Medical Records Retrieval/DBA Kamara Supplies & State Farm Mut. Automobile Ins. Co.*, AAA Case no. 17-15-1025-6308 (3/3/17) (Teresa Girolomo, Arb.).

Death Benefit Claims

- *L.B. & Allstate Ins. Co.*, AAA Case no. 17-16-1029-2012 (6/22/17) (Debbie Kotin Insdorf, Arb.) See, also, AAA Case no. 99-16-1029-2012 (8/31/17) (Richard B. Ancowitz, Master Arb.).

Fraudulent Procurement of the Policy

- *M.G. & State Farm Fire & Cas. Co.*, AAA Case no. 17-15-1021-8978 (4/15/16) (Gary Peters, Arb.).
- *Isurply, LLC & State Farm Mut. Automobile Ins. Co.*, AAA Case no. 17-16-1026-4904 (12/9/16) (Jeffrey Silber, Arb.).
- *Jacobson Chiropractic, PC & National Liability & Fire Ins. Co.*, AAA Case no. 17-16-1026-5243 (2/9/17) (Lucille S. DiGirolomo, Arb.).
- *New York Community Hospital & Utica National Ins. Co.*, AAA Case no. 17-15-1016-6707 (4/21/16) (Rhonda Barry, Arb.).

SUM Awards: Causation

- *A.S. v. Geico Ins. Co.*, AAA Case no. 01-16-0004-8797 (Jodi Zagoory, Arb.).
- *E.B. v. Liberty Mut. Ins. Co.*, AAA Case no. 01-16-0003-3284 (Philip DeBellis, Arb.).

30-Day Notice of Accident and Late Receipt of NF-2

- *L.R. & Geico Ins. Co.*, AAA Case no. 17-16-1033-3215 (11/27/17) (Gillian Brown, Arb.).

Additional Verification Requested After a Denial on a Workers' Compensation Defense

- *Isurply LLC & American Transit Ins. Co.*, AAA Case no. 17-16-1043-0833 (9/28/17) (Yael Aspir, Arb.).



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Arbitrator Abstracts

DME & Verification Request for Wholesale Invoice

Medical Records Retrieval/DBA Kamara Supplies & State Farm Mut. Automobile Ins. Co., AAA Case No.17-17-1053-1592
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(9/14/17) (Pamela Hirschhorn, Arb.) Arbitrator Hirschhorn addressed whether the respondent's request for the supplier's invoices while processing a claim for a water-circulating unit was proper. The arbitrator determined that within the time limits prescribed by the regulations under 11 NYCRR 65-3.5 (b) and 11 NYCRR 65-3.6 (b), the respondent sought the supplier's invoice for the unit. The applicant objected, noting that the item was rented and thus, the invoice was not necessary to process the claim. The applicant noted that "12 NYCRR 442.2 (b) sets limits on the maximum permissible monthly rental charge for equipment, supplies, and services provided on a rental basis. The amount billed shall not exceed the lower of the monthly rental charge to the public or the price determined by the New York State Department of Health area office. The total accumulated monthly rental charges shall not exceed the fee amount allowed under the Medicaid fee schedule." Thus, the applicant argued that the purchase price of the unit was irrelevant for calculating its rental price. The respondent acknowledged that the equipment was rented but reiterated their request for the invoice. The claim was ultimately denied based on the applicant's failure to provide requested verification within 120 calendar days from the date of the initial verification request. See, 11 NYCRR65-3.8 (b)(3). Arbitrator Hirschhorn determined that the respondent's request was reasonable and necessary as required by 11 NYCRR65-3.2 (c), as the record did not reflect the make or model number of this item and this documentation would allow the insurer to ascertain the charge to the general public as required under 12 NYCRR442.2 (b).

Genesis Ortho Supply Corp. & Fiduciary Ins. Co. of America, AAA 17-15-1010-8344
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(2/28/16) (Henry Sawits, Arb.) Arbitrator Sawits addressed whether the respondent's verification request for various items including wholesale invoices for the rental cost of a CPM machine and CTU unit prescribed to an injured person following a right knee arthroscopic surgical procedure was proper. The respondent alleged that due to the outstanding verification requests, the claim was not ready for arbitration. In response to the insurer's verification request seeking the wholesale invoices for the CPM and CTU items, the applicant informed the respondent that since the injured person was only renting these items, the invoices were not material or necessary to the respondent's processing of this claim. Arbitrator Sawits agreed that the invoices were irrelevant since the items were rented. In light of the fact that applicant had provided proper responses to the other items requested and the respondent had failed to notify the applicant concerning their objections to any of the verification responses, the claim was awarded.

Medical Records Retrieval/DBA Kamara Supplies & State Farm Mut. Automobile Ins. Co., AAA Case No.17-16-1034-1497
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(10/10/17) (Walter Higgins, Arb.) Arbitrator Higgins found that respondent's verification requests, which included a request for wholesale invoices relative to a CPM machine and CTU unit prescribed following a right knee arthroscopic surgical procedure, were not proper. The respondent had not paid or denied the claim because of the outstanding verification requests. Arbitrator Higgins noted that the respondent sought the name of the manufacturer and model number for the equipment, the purchase invoice and the number of days the item had been rented since its acquisition. The applicant forwarded a letter to the respondent noting that the items were not sold and referenced 12 NYCRR 442.2 (b) which states "the maximum permissible monthly rental charge for equipment, supplies and services provided on a rental basis, shall not exceed the lower of the monthly rental charge to the public or the price determined by the New York State Department of Health area office. The total accumulated monthly rental



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charges should not exceed the fee amount allowed under the Medicaid fee schedule." Applicant further advised that since these items do not have a Medicaid fee schedule nor has the price been determined by the New York State Department of Health area office, the proper fee is the monthly rental charge to the general public. The purchase price is not relevant in calculating the rental price and thus is not required to verify this claim. Based upon this response, the applicant requested that the respondent provide a written detailed explanation if they still sought the wholesale invoice. Arbitrator Higgins agreed with the applicant's position and found that the respondent failed to provide a reasonable basis for the verification request for the manufacturer's name and model number, the invoice and days the DME had been rented since these requests fail to provide any information regarding the usual and customary price charged to the general public.

Medical Records Retrieval/DBA Kamara Supplies & State Farm Mut. Automobile Ins. Co., AAA Case No.17-15-1025-6308
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(3/3/17) (Teresa Girolamo, Arb.) Arbitrator Girolamo addressed whether the respondent's request for the manufacturer's invoices for a CPM machine and a pump for a water circulating pad provided to the injured person for injuries sustained to the left shoulder were proper. The timeliness of the verification was not in dispute. Arbitrator Girolamo discussed the specific requests noting that the respondent sought "the manufacture and model name/number for the equipment item, detailed purchase invoice demonstrating your cost for the particular equipment dispensed, and the number of days the particular equipment item had been rented for this patient since its acquisition." The verification requests also noted that "per Regulation Section 65-3.5 (o), the insurer may deny the claim if the applicant did not provide within 120 calendar days from the date of the initial verification request all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply." The applicant stated that they provided responses to the demands however conceding they did not provide the invoices, noting "per 12NYCRR 442.2 (b) the maximum permissible monthly rental charge for equipment, supplies and services provided on a rental basis, shall not exceed the lower of the monthly rental charge to the public or the price determined by the New York State Department of Health area office. The total accumulated monthly rental charges should not exceed the fee amount allowed under the Medicaid fee schedule." The applicant argued that the purchase price is therefore unnecessary to verify this claim since it is irrelevant for the purposes of calculating the rental price. The respondent ultimately denied the claim based upon the failure of the applicant to provide the requested verification within 120 days from the initial verification request. Arbitrator Girolamo upheld the respondent's denial finding the request for the wholesale invoice was reasonable.

Death Benefit Claims

L.B. & Allstate Ins. Co., AAA Case no. 17-16-1029-2012
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(6/22/17) (Debbi Kotin Insdorf, Arb.) Arbitrator Insdorf addressed whether respondent was required to pay medical expenses, funeral expenses and a death benefit claim. The deceased applicant's daughter (N.L.B.) commenced an arbitration proceeding for medical expenses, funeral expenses and a death benefit. The deceased applicant's daughter qualified as a Voluntary Administrator of the decedent's estate on December 2, 2014 in New York Surrogate's Court. Applicant was a pedestrian when she was struck by a vehicle insured by respondent. After being discharged from the hospital, she went to Bay Park Nursing Home where she later died. Arbitrator Insdorf found that applicant had no standing to bring the claim for medical expenses as the deceased had executed an assignment of benefits and therefore any claims must be brought by the providers. Thus, arbitrator Insdorf dismissed the claim for medical benefits without prejudice. Arbitrator Insdorf noted that "Basic Economic Loss" is defined in relevant part as ... "Medical expenses, work loss, other expenses and when death occurs, a death benefit as herein provided." Thus, arbitrator Insdorf concluded that "other expenses" does not include funeral expenses when a death occurs and the claim for funeral expenses was denied. However, arbitrator Insdorf found that the no-fault regulations expressly provide for a death benefit. A copy of the death certificate was mailed to the respondent. Respondent argued that there was a lack of causation between the motor vehicle



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accident and the applicant's death. Arbitrator Insdorf rejected respondent's lack of causation defense citing to relevant case law, which holds that the insurer has the burden to come forward with proof in admissible form to establish the fact or the evidentiary foundation for its belief that the patient's treated condition was unrelated to his or her automobile accident. See, *Mount Sinai Hosp. v. Triboro Coach Inc.*, 263 AD2d 11 (2d Dept. 1999). Moreover, unlike negligence actions where plaintiffs must prove causation, plaintiffs seeking to recover first-party no-fault payments bear no such initial burden as causation is presumed. See, *Kingsbrook Jewish Medical Center v. Allstate Ins. Co.*, 61 AD3d 13 (2d Dept. 2009). Accordingly, arbitrator Insdorf issued an award of \$2,000.00 representing payment of said death benefit. Master arbitrator Richard B. Ancowitz found that the lower arbitrator's award was not arbitrary, capricious or incorrect as a matter of law. See, *L.B. & Allstate Ins. Co.*, AAA Case no. 99-16-1029-2012 (8/31/17) (Richard B. Ancowitz, Master Arb.).

Fraudulent Procurement of the Policy

M.G. & State Farm Fire & Cas. Co., AAA Case no. 17-15-1021-8978

<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(4/15/16) (Gary Peters, Arb.) Arbitrator Peters addressed whether respondent established its defense based upon fraudulent procurement of the policy. Respondent submitted an affidavit from an employee of State Farm Mutual Insurance Company in the Underwriting Department, which referenced that although applicant's vehicle was insured at a residence in Yonkers, New York, an investigation revealed that applicant was not residing in Yonkers, New York, and that the vehicle was principally garaged in the Bronx. The affidavit further referenced that had State Farm been aware of this, they would not have issued the subject policy. The applicant/injured person provided testimony at the hearing before arbitrator Peters. The applicant/injured person testified that at the time of accident, he resided in Yonkers, New York, and was the operator of a motor vehicle that was registered to his wife at the Yonkers address. The applicant/injured person also testified that he resided in the Bronx "off and on" due to marital difficulties. The applicant/injured person testified that he never misrepresented the location of where the vehicle was garaged in order to obtain cheaper rates. However, due to marital difficulties, his wife moved out of the marital residence in Yonkers, New York, to live with her sister in Mayopac, New York and took the vehicle with her. Arbitrator Peters reviewed the EUO transcript of testimony taken of the applicant/injured person in which he testified that in November, 2014, the policy was changed to the Mayopac, New York address. Despite marital problems, he stayed at the Mayopac address on and off. Arbitrator Peters found that although the applicant/injured person had "multiple residences" wherein he lived in the Bronx, Yonkers and Mayopac for different periods of time, the applicant/injured person believed that the vehicle was garaged primarily in Mayopac, New York, and he was only utilizing the car a few days per week. Arbitrator Peters noted that Insurance Law Sec. 3105 governs material misrepresentation and fraudulent procurement of insurance contracts and that there was no intentional false misrepresentation in this case, since the applicant/injured person did in fact reside at three (3) different locations and his wife principally used the vehicle to care for his children's needs.

Isurply, LLC & State Farm Mut. Automobile Ins. Co., AAA Case no. 17-16-1026-4904

<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(12/9/16) (Jeffrey Silber, Arb.) Arbitrator Silber addressed whether respondent established its defense based upon fraudulent procurement of the policy. Arbitrator Silber noted that although VTL Sec. 313 does not permit an insurer to cancel an automobile insurance policy retroactively on the grounds of fraud or misrepresentation, an insurer is entitled to raise the affirmative defense of fraudulent procurement of the policy in an action to recover benefits thereunder. Arbitrator Silber cited to relevant case law that referenced that misrepresenting residency status for the purpose of rate evasion, if proven, constitutes a material misrepresentation that precludes recovery under the policy. The injured person provided testimony at an examination under oath (EUO), and respondent "outlined" a list of eighteen (18) discrepancies, which the respondent argued established that the injured person actually resided in Brooklyn and not Port Jervis, and thus the injured person made intentional and material misrepresentations



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in the application for his insurance policy. Arbitrator Silber considered all of the evidence and found that respondent failed to establish its defense based upon fraudulent procurement of the policy. Arbitrator Silber noted that the injured person worked in Brooklyn, where the accident occurred and lived in Port Jervis. Although the injured person testified that she travelled for one and a half hours every day to work, arbitrator Silber found that this did not constitute a misrepresentation, as many people travel that amount of time to work. The injured person testified that her grandmother lives in Brooklyn and that she stayed there the night before the accident. The injured person also testified that her children attend school in Brooklyn and that she was treated at a Brooklyn medical facility. However, the injured person was registered to vote in Port Jervis, and all her mail was delivered to the policy address. Thus, respondent's defense was not established.

Jacobson Chiropractic, PC & National Liability & Fire Ins. Co., AAA Case no. 17-16-1026-5243
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(2/9/17) (Lucille S. DiGirolomo, Arb.) Arbitrator DiGirolomo addressed whether respondent established its defense based upon fraudulent procurement of the policy. Respondent argued that the assignor used a Saranac Lake, New York, address to procure the policy of insurance when he never lived there. Respondent submitted an SIU report wherein the investigator advised that he went to the Saranac Lake address and spoke to various occupants who had no knowledge of applicant residing at the premises. Moreover, the SIU investigator was advised that the apartment allegedly rented by the assignor was occupied by a different individual, who was a pilot at the local airport and had resided there since February, 2015. Respondent submitted an EUO transcript of testimony in which the assignor testified that although he planned on moving to Saranac Lake for school and would start in September, he never lived in Saranac Lake. Arbitrator DiGirolomo cited to relevant case law that referenced that the standard for determining residency for purposes of insurance coverage requires something more than temporary or physical presence and requires at least some degree of permanence and intention to remain. Arbitrator DiGirolomo found that the mere intention to reside at certain premises is not sufficient. Accordingly, arbitrator DiGirolomo found that respondent's defense was established.

New York Community Hospital & Utica National Ins. Co., AAA Case no. 17-15-1016-6707
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(4/21/16) (Rhonda Barry, Arb.) Arbitrator Barry addressed whether respondent established its defense based upon fraudulent procurement of the policy. Arbitrator Barry noted that although pursuant to VTL Sec. 313, a policy may not be canceled retroactively, the insurance carrier may assert the fraudulent procurement of the policy by the assignor in an action by a health care provider assignee for no-fault benefits. To sustain its defense, the insurer must provide that the subject insurance policy was procured through material misrepresentation. See, Insurance Law Sec. 3105. Arbitrator Barry cited to relevant case law noting that a misrepresentation is material only if the insurer would not have issued the policy had it known the facts misrepresented. Arbitrator Barry reviewed the available record, which included the EUO transcript of testimony taken of the injured person. The injured person testified that he lived in Rochester from January, 2014 through the date of accident in November, 2014. However, the injured person had no bills, receipts or cancelled checks documenting that he resided at that location. The injured person testified that he paid rent to his friend in Rochester for the last six months of 2013 in cash and traveled back and forth between Rochester and Brooklyn. The injured person was unable to testify regarding the amount of time spent at either location and could not adequately describe his residence in Rochester. Arbitrator Barry noted that the no-fault application provided a Brooklyn address and the injured person had a New York State commercial driver's license that provided a Brooklyn address. Respondent also submitted an investigative report that referenced that the investigator spoke with the landlord of the premises in Rochester where the injured person purportedly resided and the landlord did not know the injured person. Respondent provided the affidavit of its underwriter who averred that the injured person listed a Rochester, New York, address as his place of residence and the location where the insured vehicle would be garaged when in fact he resided in Brooklyn. This was done to save on policy premiums, as the cost of the policy premiums for a vehicle to be listed as principally garaged in Rochester, New York, as opposed to Brooklyn, New York, is significantly less. Respondent maintained that it would not have issued the policy to the injured person at the same



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rate had the insured provided truthful information. Based on the foregoing, arbitrator Barry found that respondent's defense based upon fraudulent procurement was established.

Sum Awards: Causation

A.S. v Geico Ins. Co., AAA Case no. 01-16-0004-8797

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(7/13/17) (Jodi Zagoory, Arb.) Claimant, age 58, was injured on February 19, 2015 when she was struck by an underinsured vehicle. She was standing at the rear of her parked car and was about to put groceries into the trunk when a car struck the front of her car, causing her car to hit her and resulting in her falling backwards under the car. Claimant went home following the accident and began to feel pain in her neck and back and experienced headaches and nausea. She went to Lutheran Medical Center, where she was diagnosed with an unspecified head injury and lumbar sprain. Claimant was discharged with a prescription for Ibuprofen and was instructed to seek follow-up medical attention. Claimant subsequently sought treatment with a neurologist, who prescribed physical therapy, prescription medications and diagnostic testing that included electro diagnostic testing and MRI studies. Claimant also received chiropractic treatment from March 25, 2016 until June 29, 2016. Claimant underwent a cervical spine MRI, which revealed a right lateral disc herniation at C4-C5 that extended into and narrowed the right neural foramen with right facet hypertrophy; a posterior disc bulge at C5-C6 with surrounding bony ridge formation that impressed on the ventral thecal sac with peripheral disc bulging that encroached toward the foramina with uncovertebral joint hypertrophy and dorsal ligamentous impression on the thecal sac. An MRI study of claimant's lumbar spine reported a bulging disc with a midline annular tear at L3-L4 with flattening of the dural sac and medial foraminal encroachment bilaterally; a bulging disc at L4-L5 with left foraminal annular tear and shallow broad-based left foraminal disc herniation that encroached the left neural foramen; and a large central disc herniation that deformed the dural sac with central spinal canal stenosis at L5-S1. The MRI studies were reviewed on behalf of the respondent by a radiologist who reported multilevel degenerative disc disease, most pronounced at C5-C6, mild degenerative spondylosis, posterior spondylitic changes at C5-C6 without evidence of cord compression, bilateral foraminal narrowing at C5-C6 and right-sided foraminal narrowing at C4-C5 due to uncovertebral joint hypertrophy. The radiologist stated that these findings were not causally related to the subject accident. With respect to the lumbar spine study, respondent's radiologist found that the study showed multilevel degenerative disc disease, smooth annular disc bulges at L3-L4 and L4-L5 with a left foraminal annular fissure at the L4-L5 level, a focal midline disc herniation at L5-S1 that deformed the thecal sac and resulted in a mild degree of central lumbar canal stenosis, and degenerative lower lumbar facet arthropathy. Respondent's radiologist opined that the L3-L4 and L4-L5 findings were degenerative in nature and unrelated to the subject accident. However, respondent's radiologist did not offer an opinion regarding the herniated disc he found at L5-S1. The arbitrator concluded as follows: "I presume his omission of causation of the L5-S1 herniated disc was intentional, and therefore, I understand it to mean that the L5-S1 herniated disc was not a degenerative finding, but rather, a traumatically caused condition, causally related to the subject accident." On April 15, 2015, claimant consulted with a pain management specialist who administered a cervical transforaminal epidural steroid injection on the right at C6-C7. Claimant also underwent EMG/NCV studies which revealed evidence of right C6-C7 radiculopathy. The doctor administered cervical transforaminal epidural steroid injections on two subsequent occasions Claimant was also seen by a psychotherapist for post-traumatic stress disorder, anxiety, and depression due to her physical difficulties, which included difficulty getting out of bed because of leg pain. The arbitrator found that the accident was 100% attributable to the negligence of the underinsured vehicle. With respect to damages, the arbitrator concluded that the accident caused claimant to sustain a herniated disc in her lumbar spine, as well as cervical radiculopathy for which she underwent three (3) cervical epidural steroid injections and also sustained some psychological harm, all of which continued to cause her pain and some disability. Claimant was awarded the maximum available SUM coverage of \$100,000. After applying \$25,000, representing payment from the tortfeasor's carrier, the net award was \$75,000.



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E.B. v. Liberty Mutual Insurance Company, AAA Case no. 01-16-0003-3284

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(3/16/17) (Philip DeBellis Arb.) The underinsured motorist claim arose out of a two-car collision that occurred on March 20, 2014 when a vehicle operated by claimant (age 58) was struck in the rear while slowing down in heavy traffic. One week after the accident, claimant sought treatment for neck, back and bilateral shoulder complaints at a facility in Valley Stream where she underwent a course of treatment consisting of acupuncture, chiropractic and various modes of physiotherapy, twice weekly over a six-month period. Claimant underwent a MRI of the left shoulder, which revealed tears of the supraspinatus tendon and biceps tendon. A right shoulder MRI reported a tear of the supraspinatus tendon. A cervical spine MRI noted disc herniation at C2-C3 without indicia of stenosis and disc bulges at C3-C4 and C4-C5. A lumbar spine MRI indicated disc bulges at L4-L5 and L5-S1. The MRI studies were reviewed on behalf of respondent by a radiologist who stated that the left and right shoulder MRI films showed degenerative changes consistent with degenerative joint disease as well as tears "of indeterminate age and etiology." On May 2, 2014, claimant was seen by an orthopedist who recommended arthroscopic surgery for both shoulders, but claimant declined due to fear of surgery. Claimant was employed at Creedmoor Psychiatric Center and missed two days from work as a result of the accident. Claimant testified that as a result of her injuries sustained in the accident, she needed assistance with certain tasks. Claimant testified regarding continuing complaints regarding her neck, back and bilateral (left greater than right) shoulders. These continuing complaints limited her ability to perform activities of daily living such as washing her hair, showering, getting dressed, housework, grocery shopping and exercise. Claimant also testified that her sleep was disturbed due to pain. On cross-examination, the claimant acknowledged that she injured her left shoulder in a prior vehicular accident in 2004 and underwent a course of medical treatment, which included a left shoulder MRI study, and that she recovered on a personal injury claim arising out of that prior accident. However, claimant denied any injury, complaints or treatment to the neck or back as a result of the 2004 accident. Claimant also stated that the injuries sustained in the prior accident were completely resolved within the period of active treatment and well before the occurrence of the subject accident. On March 16, 2016, claimant was examined by a physician who had previously treated claimant. The doctor noted positive physical examination findings that included paraspinal muscle spasms and significant limitations in ranges of motion of the cervical spine, lumbar spine and both shoulders. An orthopedic examination performed on behalf of the respondent noted "subjective limitation of motion and voluntary guarding.... with subjective complaints of discomfort; however, there were no objective findings noted." The arbitrator noted that claimant's submissions did not include any report or record from the principal treating facility. Instead, there was a report of a solitary consultative visit with an orthopedist conducted forty-three (43) days post-accident, which the arbitrator found was too early to substantiate the persistence of functional limitations over a significant period and an initial examination of the patient by a physician performed two years post-accident (and after a year and one-half gap in treatment). The report contained boilerplate language that the arbitrator found was likely fashioned with a greater emphasis on meeting the perceived litigation needs of the patient than on presenting sound medical assessment. The arbitrator also found that the medical submissions were flawed in that the physicians' reports (including the report from respondent's examining orthopedist) failed to reflect that they were informed of the history of left shoulder injuries sustained in the prior 2004 motor vehicle accident. The arbitrator found that such omission rendered meaningless their opinions on the critical issue of causation, as there appeared to be no rational basis to distinguish between what may have been residual from the prior accident and that which was assignable to the accident on which the instant claim is predicated. The arbitrator also found that claimant's own testimony lacked credibility, as her deposition testimony regarding her duties and responsibilities at work conflicted with her testimony at arbitration. Since the arbitrator determined that claimant had failed to demonstrate that the injuries claimed had a value in excess of the \$25,000 already recovered from the tortfeasor's carrier, the underinsured motorist claim was denied.



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30-Day Notice of Accident and Late Receipt of NF-2

L.R. & Geico Ins. Co., AAA Case no. 17-16-1033-3215
<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(11/27/17) (Gillian Brown, Arb.) Arbitrator Brown addressed whether the insurer received notice of accident within 30 days after the accident despite the receipt of a late NF-2. Therein, the injured person sought reimbursement of lost wages and the claim was denied based on respondent's contention that the policy's Mandatory Personal Injury Protection Endorsement requiring written notice of the accident no more than 30 days after the date of accident, had not been complied with. The injured person testified at the hearing of this matter regarding the injuries sustained, her hospital treatment immediately following the accident, as well as her treatment with other medical providers thereafter. The injured person testified that she was unable to return to her part-time position as a salesperson for a department store as a result of her injuries. With regard to notice of accident, the injured person testified that she spoke by telephone with respondent's adjuster on several occasions and that during one of those conversations the adjuster informed her that he had mailed her "a form," presumably an NF-2, which had not been returned. The injured person testified that she told the adjuster that she had not received the form in question and asked him to forward another one. According to the injured person's testimony, upon receipt of the form, she completed it and sent it via facsimile to the insurer. The injured person also testified that she sent a copy of the police accident report to the insurer via facsimile. Under cross-examination, the injured person testified that she had searched her records but was unable to find any confirmation sheets for those facsimile transmissions. Arbitrator Brown noted that the respondent received notice of the accident in question on December 10, 2015, which was the day after the accident. Arbitrator Brown also found that the submission contained a signed no-fault application from the injured person dated January 25, 2016 and that respondent's denial dated February 3, 2016 was issued to eleven (11) different providers, including the hospital where the injured person initially sought treatment. The insurer argued that its denial should be upheld due to late receipt of the NF-2 on January 27, 2016. Applicant argued that pursuant to a New York State Insurance Department Circular Letter issued in 2009 as well as relevant case law, the notice that respondent received in this case was sufficient. Arbitrator Brown reviewed the aforesaid Circular letter issued by the New York State Insurance Department in 2009, which set forth in pertinent part that Regulation 68 does not establish a required time frame in which a claimant must return an NF-2 form to an insurer. Pursuant to 11 NYCRR 65-3.3 (e) an insurer may issue a denial for failure to provide timely written notice of claim within 30 days of the accident, however, as noted in the June 2, 2008 Opinion of the Department's Office of General Counsel, neither the Insurance Law nor the regulations promulgated thereunder authorize an insurer to issue a denial on the ground that the claimant failed to return a completed NF-2 to the insurer when the claimant has otherwise submitted timely written notice within 30 days of the accident in accordance with 11 NYCRR 65-1.1. The Circular letter further advised that 11 NYCRR 65-3.3 (d) allows for satisfaction of the written notice requirement through the insurer's receipt of an NF-2 or completed hospital facility form (NYS Form NF-5), and that the written notice requirement may be satisfied in other ways, including receipt by an insurer of a Department of Motor Vehicles Accident Report 104 (MV-104) or other accident report indicating injuries to the eligible injured person pursuant to 11 NYCRR 65-3.3 (c), or pursuant to a completed hospital facility form (NYS Form NF-5) submitted on behalf of a provider of health services in lieu of a prescribed NF-2. Arbitrator Brown concluded as follows: "In the instant matter, it appears quite likely that respondent did in fact receive an NF-5, as its denial was addressed to Sister's Hospital, the facility which treated the EIP after the accident. Further, based on the EIP's testimony, and the phone logs submitted by respondent itself, it appears clear that respondent had actual and sufficient notice of the accident, the injuries and the hospital treatment." Since the arbitrator found that respondent had sufficient actual notice of the accident and the injuries notwithstanding the late receipt of the signed NF-2, applicant was awarded reimbursement for lost wages sustained.



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Additional Verification Requested After a Denial Based on a Workers' Compensation Defense*Isurply LLC & American Transit Ins. Co.*, AAA Case no. 17-16-1043-0833<https://aaa-nynf.modria.com/loadAwardSearchFilter>

(9/28/17) (Yael Aspir, Arb.) Arbitrator Aspir addressed the issue of whether the respondent may seek further verification of a claim after initially denying the claim based on a defense the claimant was in the course of employment at the time of the accident and thus eligible for workers' compensation. After the denial was issued, on March 11, 2016, the respondent received notice from the Workers' Compensation Board that the claim was disallowed. On April 8, 2016, the respondent forwarded a letter to the applicant titled "Additional Verification Needed-First Request" seeking MRI films and photos of the surgical procedure. A second request was forwarded to the applicant on May 13, 2016. The applicant provided a partial response on May 20, 2016 and provided the name of the imaging company who could provide further responses. On May 26, 2016, the respondent provided another letter to the applicant, noting they had received their partial response and the claim remained pending. The issue as addressed by the arbitrator was "does the ultimate denial by the Workers' Compensation Board 'restart Respondent's clock' to pay or deny the claim?" At the hearing, respondent argued that the Workers' Compensation Board's decision allowed the carrier to restart the claims process, including the opportunity to seek further verification. Thus the requests for verification were proper, and since the information remained outstanding, the claim was not ripe for determination. The applicant argued that since a denial was already issued by the respondent, they were not permitted to "rescind" that denial and renew the claims process by seeking further verification. Arbitrator Aspir noted the carrier is bound by the "four corners of the denial" *Todaro v Geico General Ins. Co.* 46 A.D.3d. 1086, 848 N.Y.S.2d. 393 (3rd Dept. 2007) and in this case chose to deny the claim based on the Workers' Compensation defense. The respondent cannot now choose another defense and seek further verification of the claim in hopes of achieving a more favorable result. Arbitrator Aspir noted that the respondent could have chosen to issue an NF-9 form to the applicant prior to issuing their denial. Arbitrator Aspir noted that an NF-9 form is an agreement between the applicant and the insurer stating that in the event the Workers' Compensation or N.Y.S. Disability carrier denied liability for payment of benefits, the insurer agrees to process the applicant's no-fault claim without deducting Workers' Compensation or disability benefits on the applicant's execution of this form. This "shall obligate the applicant to diligently pursue the claim and to repay first-party benefits equal to the withheld amounts in the event such amounts are eventually paid to the applicant." Arbitrator Aspir mentioned other specific requirements, including that the completed agreement is sent to the local district office of the Workers' Compensation Board. The Board will then notify the no-fault carrier of the applicant's hearing to allow the carrier to attend and submit evidence, including specific questions to the parties. A failure of the applicant to execute this agreement would allow the no-fault carrier to avoid payment of attorney's fees and interest and to the extent any reimbursement due the no-fault carrier is not made by the applicant, the insurer may deduct future first-party benefits due on the claim. Thus, since this remedy was available to the respondent, arbitrator Aspir determined that the verification requests were not proper.