Better Health Med. PLLC v Empire/allcity Ins. Co.

2006 NY Slip Op 50571(U)

Decided on March 31, 2006

Civil Court Of The City Of New York, New York County

Thomas, J.

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Decided on March 31, 2006

Civil Court of the City of New York, New York County

Better Health Medical PLLC a/a/o WAHEED ALI MOHAMMAD, Petitioner,

against

Empire/allcity Insurance Company, Respondent(s),

119841/05

Delores J. Thomas, J.

The above captioned matter is before this Court on petitioner's petition to vacate a No-Fault Master Arbitration Award pursuant to CPLR § 7511. Respondent submitted a Reply to Petition but the respondent was not present at oral argument therefore the reply was not considered and the decision herein is rendered on default.

Petitioner, a provider of medical services, seeks to recover first party no-fault benefits for medical services provided to its assignor. Petitioner submitted bills

totaling $1,764.62 and partial payments were made in the amount of $849.84. When petitioner's assignor did not receive reimbursement from respondent for the balance of the bill(s) which totaled $914.78 for the medical services provided, petitioner filed a Request for Arbitration. An arbitrator designated by the American Arbitration Association ("AAA") issued a decision dated May 31, 2004 where the arbitrator found that:

> "the applicant has no status to present this claim, as it no longer is a Corporation registered with the New York State Department, Division of Corporation. An unlicensed facility may not present a claim for no-fault benefits. The denial by the respondent is sustained. The claim is denied in its entirety." [*2]

Petitioner requested a review by a Master Arbitrator who in a decision dated September 23, 2004 rendered a Master Arbitration Award upholding the lower Arbitration Award. The Master Arbitration Award was mailed to Petitioner on or about September 27, 2004 and less than ninety days have elapsed since Petitioner's receipt of the Master Arbitration Award.

The issue before this court is whether the Master Arbitrator's decision was arbitrary and capricious, irrational or having no plausible basis or whether the arbitrator's award was unsupported by the evidence in his holding that the petitioner could not present a claim for no-fault benefits.

Judicial review of an arbitration award is limited by statute, specifically, CPLR § 7511 *(Matter of Petrofsky v. Allstate Ins Co*, 54 NY2d 207 [1981]; *Matter of Bamoun v. Nationwide Mut. Ins. Co.*, 75 AD2d 812 [2nd Dept 1980]; *aff'd* 52 NY2d 957 [1981]). However, in the case of compulsory arbitration, the award may be vacated where the arbitrator's determination is without rational basis (*Caso v. Coffy*, 41 NY2d 153, 158 [1976] the decision is arbitrary and capricious (*Id; see generally Petrofsky v Allstate, supra*); or if the determination disregards applicable law or is based on an error of law (*Brunner v. Allstate Ins. Co.*, 79 AD2d 491 [4th Dept 1981]).

Courts have held that the Master Arbitrator's authority to review the award of the lower arbitration is derived from Section 675 of the Insurance Law (*Petrofsky v. Allstate, supra at*

208). A Master Arbitrator therefore in addition to the grounds set forth in CPLR Article 75 is also authorized to review the award on the grounds set forth in11 N.Y.C.R.R. 65.17 as promulgated by the Superintendent of Insurance.

The role of the Master Arbitrator is to review the determination of the lower arbitrator to assure that the arbitrator reached his decision in a rational manner; and, that the decision was not arbitrary and capricious, or incorrect as a matter of law *(Petrofsky v. Allstate Insurance Co., supra)*. The Master Arbitrator while possessing broader powers of review than the Court, is however like the courts precluded from reviewing factual or procedural errors *((Petrofsky v. Allstate, supra)*.

In the instant case, the Master Arbitrator found that:

> Although the rule stated by the lower arbitrator is overbroad and would not apply to a corporation dissolved for legitimate personal or business reasons, I conclude that it applies in the circumstances of these cases." The Master Arbitrator went on to say that: respondent alleged that the dissolution resulted from governmental action or pressure predicated on applicant's fraudulent, unethical and improper practices. Applicant's principal refused to comply with directives that he testify and the arbitrator was within his power in drawing adverse inference because of such refusal. I find that it would be contrary to public policy to award benefits to an entity dissolved and unlicensed as a result of its fraudulent and improper practices in presenting claims for services. [*3]

Petitioner argues that it is entitled to payment as it submitted a proper proof of claim(s) and that the respondent's denial of the claim was untimely. In addition, petitioner argues that the lower arbitrator allowed respondent to raise issues at the hearing which were irrelevant to the claim and such issues were precluded because they were not raised in a timely denial. Petitioner further argues that the subsequent status of a corporation has no bearing on such corporation's ability to collect payment for services which were rendered while such corporation was active.

Defendant argues that the insurance company was entitled to withhold payment for medical services provided by a fraudulently incorporated medical corporation and cites to *State Farm Mut. Auto Ins. Co., v. Mallela*, 4 NY3d 313 [2005](*"Mallela III*") where the Court of Appeals held:

> "The Superintendent's regulation allowing carriers to withhold reimbursement from fraudulently licensed medical corporations governs this case. We hold that on the strength of this regulation, carriers may look beyond the face of licensing documents to identify willful and material failure to abide by state and local law.

Defendant further argues it submitted sufficient evidence to support the arbitrator's denial by presenting a certificate from the New York State Department of State, Division of Corporations showing that petitioner was dissolved; that the corporation was dissolved as part of a plea in a criminal matter; and, that the doctor who was served with a subpoena and was to testify as to the relationship between petitioner and a management group refused to appear upon the advice of his attorney.

Before the Court can decide on the whether to vacate the arbitrator and Master's Arbitration's award, this Court must first review the question as to whether section § 65-3.16 (a)(12) should be applied prospectively only or retroactively. In this case, the services were provided on January 19, 2000. The stated reasons for denial as listed in the June 20, 2000 NF-10 are:

> Diagnostic tests denied based upon AAEM recommendations regarding reasonable numbers of studies to arrive at diagnosis.
> Diagnostic tests have been over utilized & therefore were unnecessary & did not assist in rendering any diagnosis.
> Fees not in accordance to fee schedule. EMG supplies are included in charge of the EMG test.

It is well settled that an insurer must either pay or deny a claim for first party no fault benefits within 30 days after receiving proof of the claim (see, Insurance Law § 5106[a]; 11 NYCRR § 65.15[g][3] now 11 NYCRR § 65-3.5[a]). Failure to timely deny the claim renders the no-fault benefits overdue, and the insurer is precluded from

raising any defenses, other than lack of coverage *(see, Presbyterian Hosp. v. Maryland Cas. Co.*, 90 NY2d 274 [1997]). It is clear that the NF-10 on its face shows that the claim was not timely denied [FN1] and it does not list [*4]fraud of any kind as the reason for denial. It is also clear that the Court of Appeals said in its holding in *Mallela III*, that an insurer may deny payment to a fraudulently incorporated provider. The Court of Appeals in *Mallela III*, however, failed to address the issue of whether § 65-3.16(a)(12) should apply retroactively to payments not yet paid by the insurance carrier. [FN2] The lower courts have split in their decisions. Several courts have held that public policy concerns warrant denials of payment to fraudulent licensed medical providers and *Mallela III* should be applied retroactively (*see, A.T. Med.,P.C. v. State Farm Mut. Ins. Co.* 10 Misc 3d 568, 2005 NY Slip Op. 25461 [Civ. Ct, Queens Co., 2005]; *Multiquest, PLLC v. Allstate Ins. Co.,* 9 Misc 3d 1031, 2005 NY Slip Op. 25356 [Civ. Ct, Queens Co. 2005]; *Metroscan Imaging PC v. Geico Ins. Co.* 8 Misc 3d 829 [Civ. Ct, Queens Co. 2005]). Others courts have held that if the Court of Appeals wanted to apply the *Mallela III* decision retroactively, it would have said so. In addition, these courts have further held that unless the law or a review of the legislative history specifically state or indicate the law is retroactive in nature, the law is prospective only; therefore those courts have allowed fraudulently licensed providers to collect payments for services rendered prior to enactment of § 65-3.16(a)(12) (*see, Multiquest P.L.L.C. v Allstate Ins. Co*, 10 Misc 3d 1061[A], 2005 NY Slip Op. 52071[U] [Civ. Ct. Queens Co., 2005]); *Multiquest PLLC v. Allstate Ins. Co.*, 10 Misc 3d 877, 2005 NY Slip Op. 25512 [Civ. Ct., Queens Co, 2005]. There is much debate as to whether a fraudulently licensed medical provider who provided services before April 5, 2002, is entitled to payment and the lower court's have ruled inconsistently. The Court of Appeals has yet to rule on this issue. It is not *this* Court's function nor within this court's jurisdiction in the instant matter to settle this debate and rule one way or the other as any ruling from this court would simply be another

voice in the debate. The review, in this case, is limited to whether the arbitrator or Master Arbitrator's decisions was arbitrary or capricious or incorrect as a matter of law.

This Court finds that the determination by the arbitrator that fraud may be an issue in the processing of this claim does not constitute an arbitrary or capricious ruling nor is it incorrect as a matter of law. The decision is rationally reasoned based on the facts of this case.

In this case, the arbitrator took a negative inference from several facts that: (1) the applicant, despite the service of a subpoena, did not appear; (2) the corporation was no longer active; (3) such dissolution may have been the result of a plea bargain based upon fraudulent, criminal activity; and (4) the applicant's representative did not present any information that contradicted respondent's allegations.

A view of the arbitration award from both the lower and Master Arbitrator shows that there is no basis to vacate the award. Both arbitrators determined that the claim was rejected based upon an allegation of fraud. The issue regarding the relationship of the medical facility and its management group plus the negative inferences surrounding the applicant was a rational basis for denial of this claim. This holding and thus the arbitrator's award was based upon the resolution of factual and legal determinations reached after reviewing the evidence submitted; such a determination may not be set aside by this Court even were the Court to disagree with [*5]those findings. The Master Arbitrator's award therefore was neither arbitrary, capricious, irrational or without a substantial or plausible basis. Also, based upon the ruling in *Mallela III* and lower court cases, the decision is not incorrect as a matter of law.

Accordingly, petitioner's petition seeking to vacate the Arbitration Award is hereby dismissed. This decision is rendered on default.

This constitutes the decision and order of the Court.

DATED: March 31, 2006 Brooklyn,

New York

DELORES J. THOMAS

Judge Civil Court

Footnotes

Footnote 1: There is no allegation that defendant asked for addition verification of information pursuant to 11 NYCRR §65-3.5.

Footnote 2: The Court of Appeals in *State Farm Mut. Auto Ins. Co., v. Mallela,* 4 NY3d 313,322 [2005] did hold that no cause of action for fraud of unjust enrichment would lie for any payments made by the carriers before that regulation's effective date of April 4, 2002.