OFFICE OF THE INSURANCE COMMISSIONER
MARYLAND INSURANCE ADMINISTRATION

S.M.,[1]	*	
Plaintiff,	*	
v.	*	**Case No. 27-1001-23-00018**
STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY	*	
	*	
Defendant.	*	

* * * * * * * * * * * * * *

DECISION

S.M. ("Plaintiff") initiated this proceeding under § 27-1001 of the Insurance Article, Md. Code Ann., Ins. § 27-1001 (2017 Repl. Vol.),[2] alleging that State Farm Mutual Automobile Insurance Company ("Defendant") breached its contractual obligations to Plaintiff by failing to fully pay his first-party claim for damages in connection with an automobile accident that occurred in Montgomery County, Maryland on June 15, 2020 (the "Claim").

For the reasons set forth below, the Maryland Insurance Administration (the "Administration") concludes that Plaintiff has not demonstrated that Defendant breached its duty of coverage by not paying the full amount of damages claimed by Plaintiff.

I. STANDARD OF REVIEW

Section 3-1701, Md. Code Ann, Cts. & Jud. Proc. § 3-1701 (2020 Repl. Vol.), authorizes the award of special damages to an insured in a civil coverage or breach of contract action if the insured demonstrates that the insurer failed to act in good faith in denying, in whole or in part, a

[1] The Maryland Insurance Administration (MIA) uses initials to protect the plaintiff's privacy.
[2] Unless otherwise noted, all statutory citations are to the Insurance Article of the Annotated Code of Maryland.

first-party property insurance or disability insurance claim. However, before the insured may file an action seeking special damages pursuant to § 3-1701, the insured must first submit a complaint to the Administration under § 27-1001. Within ninety (90) days of the receipt of such a complaint, the Administration must render a decision on the complaint that determines:

1. Whether the insurer is required under the applicable policy to cover the underlying claim;

2. The amount the insured was entitled to receive from the insurer;

3. Whether the insurer breached its obligation to cover and pay the claim;

4. Whether an insurer that breached its obligation failed to act in good faith; and

5. If there was a breach and the insurer did not act in good faith, the amount of damages, expenses, litigation costs and interest.

"Good faith" is defined in §27-1001 as "an informed judgment based on honesty and diligence supported by evidence the insurer knew or should have known at the time the insured made the claim."

An insurer may not be found to have failed to act in good faith under § 27-1001 "solely on the basis of delay in determining coverage or the extent of payment to which the insured is entitled if the insurer acted within the time period specified by statute or regulation for investigation of a claim by an insurer." § 27-1001(e)(3).

Plaintiff has the burden of proof and must meet this burden by a preponderance of the evidence. *See* Md. Code Ann., State Gov't § 10-217 (2014 Repl. Vol.); *Md. Bd. Of Physicians v. Elliott,* 170 Md. App. 369, 435, *cert denied,* 396 Md. 12 (2006).

II. PROCEDURAL BACKGROUND

On March 6, 2023, the Administration received Complaint No. 27-1001-23-00018 (the "Complaint") stating a cause of action in accordance with § 27-1001. In the Complaint, Plaintiff

alleges that following the June 15, 2020 motor vehicle accident, Plaintiff suffered from a traumatic brain injury which caused Plaintiff to experience severe headaches, bouts of vertigo, loss of consciousness and other related neurological issues. Plaintiff alleges that he was treated at the Suburban Hospital Emergency Department immediately following the accident, and then began receiving treatment for his traumatic brain injury on June 17, 2020, as a result of the accident. While Plaintiff asserts that Defendant received records pertaining to the discovery, diagnosis and monitoring of Plaintiff's injuries, including records pertaining to Plaintiff's pre-existing benign brain tumor, Plaintiff alleges that Defendant failed to justify their unsubstantiated and "obviously low and unsupported offer" to settle the Claim. Further, Plaintiff alleges that Defendant made no attempt to access Plaintiff's previous medical records until September 2022. Lastly, as the basis for Plaintiff's claim under 27-1001, Plaintiff asserts that Defendant never performed their own independent medical examination of the Plaintiff's injuries.

As required by § 27-1001(d)(3), the Administration forwarded the Complaint and accompanying documents to Defendant on March 9, 2023. On April 18, 2023, Defendant filed a response to the Complaint and accompanying documents as required by §27-1001(d)(4).[3]

III. FINDINGS

Based on a complete and thorough review of the written materials submitted by the Parties, the Administration finds that Plaintiff has not established by a preponderance of the

[3] On June 5, 2023, the Undersigned notified the parties that the Decision would not be issued in this matter by the 90-day deadline for the Maryland Insurance Administration to issue its decision under by §27-1001(e)(1)(i). The Undersigned requested consent from the parties to an extension of the 90-day deadline until June 19, 2023. While Plaintiff declined to consent to an extension of the deadline, citing the need to file a civil case in the Circuit Court for Montgomery County, MD by June 14, 2023, the Undersigned notified the parties that the Decision would be issued by June 12, 2023.

evidence that he is entitled to additional coverage for the Claim under the Policy or that Defendant failed to act in good faith in its handling of the Claim.

On June 15, 2020, Plaintiff was involved in an automobile accident on Route 355 and Pooks Hill Road, in Montgomery County, MD. While Plaintiff was driving northbound on Route 355, and turning onto Pooks Hill Road, Plaintiff's vehicle was struck by another vehicle operated by J.P. At the time of the accident, J.P. was headed southbound on Route 355, ran a red light, and struck Plaintiff's vehicle. ("Accident") Immediately following the Accident, Plaintiff was transported to the Suburban Hospital emergency department by ambulance from the scene of the Accident. At the emergency department, Plaintiff received an MRI procedure. The result of the MRI showed that Plaintiff had, "no acute intracranial process," and that there was no change to Plaintiff's previously diagnosed brain tumor. Plaintiff was treated and released from the Suburban Hospital emergency department on the same date.

At the time of the Accident, Plaintiff was insured under an automobile insurance policy issued by Defendant providing Uninsured and Underinsured Motorist ("UM/UIM") coverage with a policy limit of $25,000 for each person/$500,000 for each accident ("Policy")

At the time of the Accident, J.P. was insured under an automobile insurance policy issued by Geico.

On June 16, 2020, Plaintiff contacted Defendant to report the Accident. Then, on June 17, 2020, Anthony Washington ("Adjuster Washington") contacted Plaintiff and J.P. to obtain the facts concerning the Claim. Based on Adjuster Washington's investigation of the Claim, Defendant determined that J.P. was liable for the Accident. On June 17, 2020, Defendant issued a letter to J.P. stating,

> We have carefully considered the facts of this accident. Based on our investigation we do not believe our insured was legally liable for your damages.

> Failure to Obey Traffic Controlled Device
>
> In the absence of legal liability, we would not be justified in making settlement. Therefore, we must deny payment of this claim.
>
> ….

On June 17, 2020, Plaintiff was treated at Multi-Specialty Healthcare for headaches and dizziness. Based on the assessment prepared by Gavin Morgan, P.A. at the time of treatment, Plaintiff's injuries included a bilateral shoulder sprain/strain, left wrist sprain/strain, lumbosacral sprain/strain, and posttraumatic headaches, and post-concussion syndrome.

On June 24, 2020, Plaintiff was treated by Dr. Jacob Gordon of Multi-Specialty Healthcare. In Dr. Gordon's report, with respect to Plaintiff's past medical history, Dr. Gordon reported that Plaintiff had a history of benign tumor in third ventricle, which was discovered three years prior to the date of treatment. Dr. Gordon's report also indicates that, "[h]is care is overseen by a neurosurgeon at John Hopkins where he gets a yearly MRI through Kaiser every February." Plaintiff was also treated by Dr. Matthew Menet of Multi-Specialty Healthcare on July 22, 2020 for pain to his shoulder, wrist and back. At the time Plaintiff was treated by Dr. Menet, Plaintiff denied feeling dizziness. Approximately three weeks later, on July 7, 2020, Plaintiff was examined by Dr. Jacob Gordon and underwent another MRI scan.

On July 10, 2020, Defendant determined that Plaintiff's vehicle was a total loss. Defendant sent a letter to Plaintiff offering to pay $107,954.40, as the actual cash value for Plaintiff's vehicle, plus taxes and title transfer fees in settlement of this portion of the Claim. Thereafter, a check in the amount of $107,954.40 was issued to the lienholder of Plaintiff's vehicle. Defendant also issued payments exhausting the Personal Injury Protection (PIP) coverage for the Claim.

On August 5, 2020, Plaintiff was again treated by Dr. Gordon. At this visit, Dr. Gordon noted the following with respect to Plaintiff's condition, "No apparent significant physical distress. Pleasant and cooperative. Head normocephalic and atraumatic." Notwithstanding this finding, Dr. Gordon diagnosed Plaintiff with a traumatic brain injury without loss of consciousness, sequela. On August 19, 2020, Plaintiff was treated by Gavin Morgan of Multi-Specialty Healthcare. Based on his examination of Plaintiff's head, neck, back, shoulders, wrist, and lumbosacral spine, Plaintiff's condition remained unchanged. Further, on August 25, 2020, Plaintiff was again treated by Dr. Steven Millmond of Multi-Specialty Healthcare for a follow-up visit and received an MRI scan of his spine. No changes to Plaintiff's condition were reported during that visit. On October 28, 2020, Plaintiff was again treated by Dr. Menet of Multi-Specialty Healthcare. In Dr. Menet's medical report for this visit, Plaintiff reported "no new complaints" and that "his symptoms are manageable." From February 8, 2021 through April 2, 2021, Plaintiff received physical therapy treatment from Arso Neuro Rehab and Orthopedic Center, LLC for dizziness, giddiness, and concussion with loss of consciousness. On April 2, 2021, Plaintiff reported that, "his overall dizziness on a day-to-day basis has decreased significantly."

Less than one month later, notwithstanding Plaintiff's prior medical records demonstrating improvement of his symptoms, Plaintiff was again treated by Dr. Gordon on April 28, 2021. For this visit, Dr. Gordon reported that Plaintiff experienced, "current severe headache, severe sleep disturbance, moderate dizziness." Plaintiff also reported that his headache frequency was 6 out of 7 days. Dr. Gordon also stated in his April 28, 2021 treatment report that, "[Plaintiff] has an underlying neurosurgical condition that was present prior to the date of the crash. It is clear, however, that his function in multiple neurological domains

worsened suddenly because of the injuries sustained on that day." No further documents or records demonstrating any further or ongoing treatment were submitted to Defendant.

Three months later, on July 22, 2021, Plaintiff's attorney sent correspondence to Defendant seeking consent to settle the Plaintiff's liability claim with GEICO for the policy limit in the amount of $50,000, pursuant to §19-511. Defendant assigned Claim Specialist Aroni Ferrarini ("Adjuster Ferrarini") to handle the UM/UIM portion of Plaintiff's Claim. Plaintiff's attorney also sent correspondence to Defendant demanding $200,000, due to Plaintiff's traumatic brain injury resulting from the Accident. On August 11, 2021, Plaintiff's attorney requested a response to the demand package within 15 days, or he threatened to file a lawsuit. Adjuster Ferrarini responded to the request on August 16, 2021 stating,

> This will acknowledge your demand letter of August 11, 2021 received on August 11, 2021 … I understand that this demand is a copy of the demand you sent to GEICO. You sent this copy for us to review along with your request for consent for your client to settle with GEICO. I will await your actual demand and not consider this demand as an actual time limit demand for State Farm.
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> ….

On September 30, 2021, Plaintiff's attorney sent Adjuster Ferrarini a settlement demand, including an itemized list of medical bills in the amount of $26,258.80. Adjuster Ferrarini responded the following day requesting documentation concerning Plaintiff's traumatic brain injury. In response, Plaintiff's attorney directed Adjuster Ferrarini to the medical report included in the demand. Specifically, Plaintiff's attorney informed Adjuster Ferrarini that the condition was diagnosed by Dr. Jacob Gordon.

Upon review of the settlement demand submitted by Plaintiff's attorney in November 2021, Defendant determined that medical causation had not been established based on the documentation provided. Thereafter, Adjuster Ferrarini requested the Plaintiff's prior medical

reports from before the Accident. On December 17, 2021, Adjuster Ferrarini sent a letter to Plaintiff's attorney offering $5,000 in settlement of the UM/UIM portion of the Claim. Thereafter, on January 9, 2022 and April 7, 2022, Adjuster Ferrarini sent requests to Plaintiff's attorney seeking Plaintiff's medical records from prior to the Accident. In June 2022, Plaintiff's attorney authorized Defendant to request reports of Plaintiff's medical treatment from before the Accident.

In August 2022, Adjuster Ferrarini requested Plaintiff's prior medical records from Kaiser Permanente, however, the records were incomplete with respect to the diagnosis of the tumor. Adjuster Ferrarini again contacted Plaintiff's attorney seeking medical records from Plaintiff's medical condition and treatment prior to the Accident.

On October 20, 2022, Adjuster Ferrarini sent a letter to Plaintiff's attorney offering to settle the UM/UIM in the amount of $21,755. Defendant also sent a second letter enclosing a payment of $5,000. Specifically, Defendant stated, "This payment should be considered an advance without prejudicing your client's right to receive a higher amount in the future through continued negotiations."

On December 10, 2022, Defendant sent additional correspondence to Kaiser Permanente, stating, "Please provide the prior medical records that pertain to the brain tumor that was treated in 2017, and any follow up treatment or treatment plan through June 15, 2020."

On January 19, 2023, Adjuster Ferrarini contacted Plaintiff's attorney and explained that Plaintiff was diagnosed with a benign brain tumor of the left ventricle on August 22, 2015, and that Plaintiff switched his plan to Kaiser Permanente in January 2018. Plaintiff's attorney also stated that after the initial diagnosis of the tumor, Plaintiff was examined yearly during two or three MRI procedures. Plaintiff's attorney also stated that after the Accident, Plaintiff suffered

from vertigo, nausea, and falls. On February 22, 2023, Adjuster Ferrarini sent a letter to Plaintiff's attorney increasing the settlement offer to $28,855.12. However, Defendant received no further correspondence from Plaintiff's attorney until the filing of the 27-1001 Complaint.

IV. DISCUSSION

While Plaintiff asserts that Defendant received records pertaining to the discovery, diagnosis and monitoring of Plaintiff's injuries, including records pertaining to Plaintiff's pre-existing benign brain tumor, Plaintiff alleges that Defendant failed to justify their offers to settle the Claim. Further, Plaintiff alleges that Defendant made no attempt to access Plaintiff's previous medical records until September 2022. Lastly, as the basis for Plaintiff's claim under 27-1001, Plaintiff asserts that Defendant never performed their own independent medical examination of the Plaintiff's injuries. As Geico paid $50,000 to the Plaintiff in satisfaction of the liability claim, Plaintiff asserts that he is entitled to an additional $200,000, as the policy limit, for the UM/UIM Claim.

I find, however, that Plaintiff did not prove that he is entitled to additional damages under the Policy, as Plaintiff has produced insufficient evidence in support of his demand for an additional $200,000 to satisfy the Claim. As an initial matter, the evidence demonstrates that Defendant acted promptly to investigate Plaintiff's Claim. Specifically, the evidence demonstrates that Plaintiff first reported the Claim on June 16, 2020. The following day, on June 17, 2020, Adjuster Washington contacted Plaintiff and J.P. to investigate the Accident. On the same day, Defendant determined that J.P. was at fault for the Accident.

Defendant subsequently determined that Plaintiff's vehicle was a total loss and issued a check in the amount of $107,954.40 to the lienholder of Plaintiff's vehicle. Moreover, based on Plaintiff's medical records and medical bills, $2,500 was paid to Plaintiff, as the limit of PIP

coverage under the Policy. Defendant received the first settlement demand for the policy limit from Plaintiff's attorney by electronic mail on July 28, 2021. Plaintiff has not submitted evidence in this case demonstrating lost wages associated with his injuries from the Accident.

While Plaintiff alleges that Defendant made no attempt to access Plaintiff's previous medical records until September 2022, I find that the evidence demonstrates numerous requests from Adjuster Ferrarini to Plaintiff's attorney for the documents demonstrating his prior diagnosis and treatment for the benign tumor. Moreover, while Dr. Gordon prepared a medical report on April 28, 2021 diagnosing Plaintiff with a traumatic brain injury resulting from the Accident, the documents do not demonstrate any evidence of medical treatment received by Plaintiff after that time. Furthermore, at a previous office visit earlier in the month of April 2021, in which Plaintiff received physical therapy from Arso Neuro Rehab and Orthopedic Center, LLC, Plaintiff reported that, "his overall dizziness on a day-to-day basis has decreased significantly." Finally, aside from medical bills in the amount of $23,943.00, Plaintiff has not submitted any documents demonstrating Plaintiff's lost wages resulting from the Accident.

While Plaintiff makes conclusory assertions that Defendant breached its obligations under the Policy, and that Plaintiff is entitled to the remaining $200,000 under the UM/IUM coverage of the Policy, Plaintiff has not satisfied his burden of demonstrating that Defendant breached its obligations under the Policy. Instead, based on the evidence in this case, the dispute between the Parties is based solely on Defendant's valuation of the Claim.

Accordingly, I find that Plaintiff has not demonstrated that Defendant breached its obligations under the Policy or failed to act in good faith in connection with the Claim.

V. CONCLUSIONS OF LAW

In accordance with § 27-1001, the Administration concludes:

1. Plaintiff established by a preponderance of the evidence that Defendant is obligated under the policy to cover the Claim.

2. Plaintiff did not establish by a preponderance of the evidence that Defendant failed to provide the coverage required under the Policy.

3. Plaintiff did not establish by a preponderance of the evidence that she is entitled to additional damages as a result of the Claim.

4. Plaintiff did not establish by a preponderance of the evidence that Defendant breached its obligation under the policy to cover and pay the Claim.

5. Since a breach is a necessary element of a failure to act in good faith, Plaintiff did not establish a failure by Defendant to act in good faith.

6. Since Plaintiff did not establish a breach or failure by Defendant to act in good faith, there is no basis for the Administration to address special damages.

VI. DECISION

Based on the foregoing findings and conclusions, it is the Administration's Decision on this 12th day of June, 2023, that Defendant did not violate Md. Code Ann., Ins. § 27-1001 (2017 Repl. Vol.).

This Decision shall take effect as a Final Decision if no administrative hearing is requested in accordance with § 27-1001(f)(1).

KATHLEEN A. BIRRANE
Insurance Commissioner

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ERICA J. BAILEY
Associate Commissioner, Hearings

APPEAL RIGHTS

If a party receives an adverse decision, the party shall have thirty (30) days after the date of service (the date the decision is mailed) of the Administration's decision to request a hearing, which will be referred to the Office of Administrative Hearings for a final decision, or to appeal the decision to the Circuit Court under Title 10, Subtitle 2 of the State Government Article of the Annotated Code of Maryland. MD. CODE ANN., INS. § 27-1001(f) and (g) (2017 Repl. Vol.).