American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

AAAMG Leasing Corp. (Applicant)	AAA Case No.	17-17-1057-3486
	Applicant's File No.	N/A
- and -	Insurer's Claim File No.	2016300131-3160001470
New York Central Mutual Fire Insurance Company (Respondent)	NAIC No.	14834

ARBITRATION AWARD

I, Phyllis Saxe, 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(PL)

1. Hearing(s) held on 05/10/2018
   Declared closed by the arbitrator on 05/10/2018

   Mark Scopinich,Esq. from Hanford, Cooke & Associates, P.C. participated in person for the Applicant

   James Mulhern from Dodge & Monroy P.C. participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 3,592.40**, 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

   The dispute before me arises from an automobile accident that occurred January 15,2016. The applicant AAAMG Leasing Corp. Rented to Pl a continuous passive motion exercise device for his shoulder for 56 days, and a cervical traction unit for 14 days. to the Assignor (PL) from 3/18/16 - 4/14/16. and applicant charged a total of $3592.40 for the rental period.

   Respondent, New York Central Mutual Fire Insurance Co. issued two NF -10s denials that indicated that the denial was due to a policy violation, and that the treatment rendered to the assignor (Pl) was not necessary. The reason of the denial was the accident was considered a staged loss and not an accident. The fraud provisions of the

insurance policy and the No-fault law therefore were applied to render this policy void. In addition, the denial asserted fee schedule defense.The issue in dispute is whether the respondent has met its burden of proof to support the defense of fraud, whether principles of collateral etoppel apply and if not, whether the fee schedule defenses should be sustained, and if so how much of an award is applicant entitled.

4. Findings, Conclusions, and Basis Therefor
This Award is rendered after my thorough review and consideration of the documentary evidence submitted by the Parties to the American Arbitration Association and maintained in the MODRIA electronic case filing system, and the oral arguments presented by the parties' representatives during the hearing.

Pursuant to 11 NYCRR 65-4.5 (o) (1) (regulation 68-D), the arbitrator shall be the judge of the relevance and materiality of the evidence offered and strict conformity to legal rules of evidence shall not be necessary. The arbitrator may question any witness or party and independently raise any issue that the arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department Regulations.

Background of this Claim and Linked Awards by Me and by Arbitrator Mandiberg

There are multiple previous awards related to this accident that were issued by Arbitrator Mandiberg in them all, respondent claimed that the injured party, allegedly in this car when the accident occurred had staged the accident. In each of these awards, he car and allegedly award some of which are as follows: In AAA# 17-16-1044-2978 Arbitrator Manidberg after considering the evidence submitted by Respondent, concluded that the same injured party here, PL had staged the accident. Based on the evidence submitted to the Arbitrator, she denied payment after concluding that there was fraud in the claim. I note that there are 14 other linked claims arising out of the same accident and invilon three people who were in the vehicle. This Assignor PL was one of them, Jean Dorismond, was another passenger in the car who was allegedly injured and Relus Gentilhome was another. (AAA Case # 17-16-1042-3098).

In my award of AAA# 17-17-1057-1013 I found that respondent sustained its burden of proof in denying payment because the injured party (PL) staged the collision:

Below are the pertinent parts of My prior award and Arbitrator Madiberg's prior award in AAA#17-16-1044-2978 as follows:

"Respondent denied reimbursement for the instant billing asserting, among other things, that: "The entire no-fault claim for [The Claimant herein] is denied based upon the investigation completed by NYCM insurance, which revealed that the loss of 1/15/2016 was a "staged" loss, an intentional act, not an accident as defined by the policy of insurance, did not occur as alleged and was not a covered event.

Moreover, the fraud provisions of the policy of insurance were violated per the Personal Automobile Insurance Policy, "Mandatory Personal Injury Protection" The company will pay first-party benefits to reimburse for basic economic loss sustained by an eligible injured person on account of personal injuries caused by an accident arising out of the use or operation of a motor vehicle or a motorcycle during the policy period and within the United States of America, its territories or possessions, or Canada,

Please refer to the no-fault application for motor vehicle no-fault benefits that was signed and dated by you which states, "Any person who knowingly and with intent to defraud any insurance company or other person files an application for commercial insurance or a statement of claim for any commercial or personal insurance benefits containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who, in connection with such application or claim, knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or stated claim for each violation".

No-fault insurance policies only cover vehicular accidents. An accident is by definition, unintentional; a deliberate collision is not an accident. Therefore, damages resulting from a deliberate collision are not covered by no-fault insurance.

Arbitrator Mandiberg reviewed the evidence submitted in the claim before her. The evidence submitted to her is the same evidence that is submitted in this claim before me and is as follows:

*The original inception date of the policy was 12/11/2015 and the loss occurred 35 days later on 01/15/2016.

*The policy was cancelled on 3/15/2016 at the insured's request.

* The insured, [HA] was not in the insured vehicle at the time of the loss.

* During the underwriting interview of [HA] on 12/30/2015, he denied there were other drivers of his vehicle.

* The insured vehicle driver, [JD], was not listed on the policy.

* [HA] has a long history of accidents dating back to 1997 as the insured and passenger relating to numerous insurance companies.

* [JD] had a GEICO loss on 10/23/11 and this loss are the only one discovered.

* [PL] Has a long history of accidents dating back to 1993 as the insured and passenger relating to numerous. insurance companies contained in the SIU data file.

* [The Claimant herein] - Only this claim discovered.

* [IT] - A GEICO loss on 2/2/16 (a month after this loss) and a few losses dating back to 1997.

* Adverse VIN - This loss and another on 11/29/10 with the previous owner.

* The special investigations unit scheduled signed statements and EUO's were scheduled by Dodge & Monroy attorney's office for [HA] and [JD] and they failed to appear for them.

* Examinations under oath were conducted for [PL] and [The Claimant herein].

* As a result of the EUO's: There was inconsistent testimony between [PL] and [The Claimant herein] concerning this matter. The most significant inconsistency concerned the relationship between all three claimants and the insured. [PL] testified that they were "all friends", He also testified that [The Claimant herein] was friends with the insured, [HA] and the claimant, [JD]. However, this is contradicted by [The Claimant herein]. According to [The Claimant herein], he is only friends with Mr. [L]. Although, he knows the insured, [HA], he does not consider him a friend and he has not seen or heard of him since the accident. He only sees him at a local barber shop. He does not socialize with him outside the barber shop. As for Mr. [D], the [Claimant herein] testified that he first met him on the date of the occurrence. He does not consider him a friend and he has not seen him since the accident." Respondent further asserted that its insured [HA] "has a new NYCM loss on 12/03/2016 with a very similar accident description as this loss." In sum, Respondent concluded that "Due to our investigation and the aforementioned, your claim is hereby denied in its entirety effective 1/15/2016."

I note that the same evidence was presented to me as was presented before Arbitrator Mandiberg. The law applied to evaluating the evidence of staged accident was artfully included in the Arbitrator Mandiberg's award. She noted that with respect to Respondent's defense herein, notice is taken of the case of V.S. Medical Services, P.C. v. Allstate Ins. Co., 11 Misc.3d 334, 811 N.Y.S. 2d 886 (Civ. Ct. Kings Co. 2006), aff'd. 25 Misc.3d 39, 889 N.Y.S.2d 360 (App. Term 2d, 11th & 13th Dists.2009). This case held that when denying a claim premised upon an alleged lack of coverage, an insurer need only to prove this defense by a preponderance of the evidence, rather than by the more stringent standard of clear and convincing evidence. The case therefore interpreted the case of Fair Price Med. Supply Corp. v. Travelers Indem. Co., 42 A.D.3d 277, 284, 837 N.Y.S.2d 350 (2007), aff'd 10 N.Y.3d 556, 890 N.E.2d 233, 860 N.Y.S.2d 471 (2008), wherein the Court held that it was appropriate to apply the "preponderance of the evidence" standard when determining if a collision was a covered event. The court

further held that "what excuses the insurer's compliance with the 30-day rule in a staged-accident case is not the egregiousness of the fraud; rather, it is the absence of coverage for something that is not an accident".

In the case of V.S. Medical Services, infra, the court held that the defendant therein could "properly premise its defense upon a lack of coverage and could establish this defense by a preponderance of the evidence; defendant was not required to establish that the subject collision was the product of fraud, which would require proof of all the elements of fraud, including scienter (See : Apollo H.V.A.C. Corp. v. Halpern Constr., Inc., 55 AD3d 855, 867 N.Y.S.2d 115 (2008), by clear and convincing evidence (See: Simcuski v. Saeli, 44 NY2d442, 377 N.E.2d 713, 406 N.Y.S.2d 259 (1978); Hutt v. Lumbermen's Mut. Cas. Co., 95 A.D.2d 255, 466 N.Y.S.2d 28 (1983)." The court noted that evidence establishing proof of a "staged accident" is often circumstantial since it is the rare occasion when a participant in such an event actually admits that the collision was intentional. The Court stated that circumstantial evidence of a staged accident submitted by the Respondent is sufficient "if a party's conduct may be reasonably inferred based upon logical inferences to be drawn from the evidence". In addition to the foregoing, an allegation by defendant that the accident at issue was the result of a staged loss or material misrepresentation must be supported by more than just unsubstantiated hypothesis and supposition. See: A.B. Medical Services, P.C. v. Eagle Ins. Co., 3 Misc.3d 8 (App. Term 2nd Dept. 2003); Great Wall Acupuncture v. Utica Mutual Ins. Co., 14 Misc.3d 144(A) (App. Term 2nd and 11th Jud. Dists. 2007); Comprehensive Mental v. Allstate Ins. Co., 14 Misc.3d 130(A) (App. Term 9th and 10th Jud. Dists. 2007). See also: A.B. Medical Services, P.C. v. Utica Mutual Ins. Co., 10 Misc.3d 50 (App. Term 2nd Dept. 2005); Webster Diagnostic Medicine, P.C. v. State Farm Ins. Co. N.Y. Slip. Op. 27134 (App. Term 2nd Dept. 2007); Comprehensive Mental Assessment & Med. Care, P.C. v. State Farm Mut. Auto Ins. Co., 2007 N.Y. Slip. Op. 50691(U).

Respondent denied the claim based upon the investigation conducted, which Respondent asserts revealed that the subject loss was an intentional act. Respondent further asserts that there were misrepresentations in the presentation of the claim, as demonstrated by the inconsistent testimony of the Claimant herein and another occupant of the vehicle at the time of the incident, which together demonstrate its "founded belief" that this was a staged loss. Thus, the issue to be decided is whether the Respondent established that the loss of 1/15/16 was an intentional act which would preclude recovery under the subject policy of insurance.

In support of this contention, Arbitrator Mandiberg noted that Respondent submitted the relevant EUO transcripts as well as a detailed affidavit generated by its Special Investigator for this claim. I too find the EU transcript and affidavits credible and persuasive. It is the Respondent's burden to come forward with admissible evidence of the foundation for its belief that there is no coverage for a particular loss. See: Mount Sinai Hospital v. Triboro Coach Inc., 699 N.Y.S.2d 77, 84 (2d Dept. 1999). However, "The burden of persuasion stays with the plaintiff, and if the insurer carries its burden of coming forward, 'plaintiff must rebut it or succumb.' (See: Baumann v Long Is. R.R.,110 A.D.2d 739, 741 [2d Dept. 1985].)". A.B. Medical, supra.

Based on evidence presented, I find (as did Arbitrator Mandiberg) that Respondent has met its evidentiary burden of its "founded belief" that the underlying accident was a "staged loss." Based upon the foregoing, and after careful consideration of the totality of the credible evidence, I find Respondent appropriately denied the instant billing. Accordingly, this claim is denied in its entirety.

As stated above I issued a prior Award which involved the issues that are raised by Respondent in this matter. It invovled medical devices supplied by AAAMG leasing to PL , the same insured and the same insurer. Therefore, I find that the doctrine of collateral estoppel is applicable to the billing presently in dispute. According to Black's Law Dictionary, Sixth ed., 1990, the doctrine of collateral estoppel is defined as follows: "Prior judgment between the same parties on different cause of action is an estoppel as to those matters in issue or points controverted, on determination of which finding or verdict was rendered". (Citation omitted). Furthermore, the doctrine of collateral estoppel precludes a party from re-litigating in a subsequent action or proceeding, an issue that was raised in a prior action or proceeding and decided against that party, whether or not the tribunals or causes of action are the same. See: Ryan v. New York Telephone, 62 N.Y.2d 494, 478 N.Y.2d 823. To invoke the doctrine of collateral estoppel, there must be an identity of issues which has been decided in the prior action (and which is decisive in the present action) and there must have been a full and fair opportunity to contest the decision now said to be controlling. See: Gilberg v. Barbieri, 441 N.Y.S.2d 49. In addition, the Court of Appeals has held that the doctrine of collateral estoppel "is applicable to issues resolved by earlier arbitration." Rembrandt Industries v. Hodges International, 38 N.Y.2d 592, 381 N.Y.S.2d 383. Furthermore, it is within the Arbitrator's authority to determine the preclusive effect of a prior arbitration. See: Matter of Falzone v. New York Central Mutual Fire Ins. Co., 64 A.D.3d 1149, 881 N.Y.S.2d 769 (4 Dept. 2009). In addition to the foregoing, it has been held that the doctrines of res judicata and collateral estoppel apply to Arbitration Awards, "including those rendered in disputes over no-fault benefits, and will bar re-litigation of the same claim or issue". Furthermore, the court held that "a judgment in one action is conclusive in a later one…when the two causes of action have such measure of identity that a different judgment in the second would destroy or impair rights or interests established by the first…" See: Matter of Ranni, 58 N.Y.2d 715, 458 N.Y.S.2d 910 (1982); Monroe v. Providence Washington Ins. Co., 126 A.D.2d 929, 511, N.Y.S.2d 449 (3d Dept. 1987).

As a final matter, I note that a denial based on a material misrepresentation by the insured is a "lack of coverage" defense and is, therefore, not waivable and is exempt from the thirty (30) day preclusion rule governing the denial of No-Fault claims, Therefore, there is no need to make a determination herein regarding either the existence or timeliness of denials. AB. Medical Services PLLC v. Commercial Mutual Ins. Co., 12 Misc. 3d 8, 820 N.Y.S.2d 378 (2"d Dept 2006). Quoting Harmony Anesthesiology/Applicant v. Liberty Mutual Ins. Co., AAA Case No. 412013090462.

Accordingly, this claim is denied in its entirety.

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.

6. **I find as follows with regard to the policy issues before me:**
   - ☐ The policy was not in force on the date of the accident
   - ■ The applicant was excluded under policy conditions or exclusions
   - ☐ The applicant violated policy conditions, resulting in exclusion from coverage
   - ■ The applicant was not an "eligible injured person"
   - ☐ The conditions for MVAIC eligibility were not met
   - ☐ The injured person was not a "qualified person" (under the MVAIC)
   - ☐ The applicant's injuries didn't arise out of the "use or operation" of a motor vehicle
   - ☐ The respondent is not subject to the jurisdiction of the New York No-Fault arbitration forum

Accordingly, the claim is DENIED in its entirety

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of New York
SS :
County of Nassau

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

06/07/2018
(Dated)

Phyllis Saxe

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.

ELECTRONIC SIGNATURE

Document Name: Final Award Form
Unique Modria Document ID:
38f4f41af72c564ddc949bba29d8595e

Electronically Signed

Your name: Phyllis Saxe
Signed on: 06/07/2018