

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Metropolitan Medical and Surgical, P.C.
(Applicant)

- and -

Allstate Fire & Casualty Insurance Company
(Respondent)

AAA Case No. 17-19-1130-0694

Applicant's File No. 00039151

Insurer's Claim File No. 0468539788
2CC

NAIC No. 29688

ARBITRATION AWARD

I, Evelina Miller, 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: ER

1. Hearing(s) held on 11/03/2020
Declared closed by the arbitrator on 11/03/2020

Mikhail Guseynov Esq from Drachman Katz, LLP participated by telephone for the Applicant

Peter Graziosi Esq from Law Offices Of Karen L. Lawrence participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 939.39**, was AMENDED and permitted by the arbitrator at the oral hearing.

At the time of the hearing Applicant amended amount in dispute to \$644.50. Respondent conceded that this amount is proper pursuant to the New York Workers' Compensation Fee Schedule.

Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

The dispute arises from the underlying automobile accident on July 23, 2017, in which the Assignor (ER), a 27-year-old-male was involved. Thereafter, Assignor sought private medical attention and was eventually evaluated with complaints of neck pain,

lower back pain, bilateral wrist pain, and left knee pain. Eventually patient was recommended to undergo injections. The bill in dispute is for an office visit performed on 1/22/19, and trigger point injections performed on the patient on 3/4/19. Respondent denied Applicant's bill based on the IME of Dr. D'Ambrosio performed on 11/8/18. All no-fault benefits were terminated on 11/23/17.

The first issue presented at the hearing is whether Respondent made out a prima facie case of lack of medical necessity, and if so, whether Applicant rebutted it.

The second issue presented at the hearing is whether collateral estoppel applies.

4. Findings, Conclusions, and Basis Therefor

I have reviewed the submissions contained in MODRIA which are maintained by the American Arbitration Association. These submissions are the record in this case. My decision is based on my review of that file, as well as the arguments of the parties at the hearing.

Initially I find that Applicant establishes its prima facie showing of entitlement to recover first-party no-fault benefits by submitting evidentiary proof that the prescribed statutory billing forms, setting forth the fact and amount of the loss sustained, had been mailed and received and that payment of no-fault benefits were overdue. See *Mary Immaculate Hospital v. Allstate Insurance Co.*, 5 A.D.3d 742, (2d Dept., 2004). Once an applicant establishes a prima facie case, the burden then shifts to the insurer to prove its defense. See *Citywide Social Work & Psy. Serv. P.L.L.C v. Travelers Indemnity Co.*, 3 Misc. 3d 608, 2004, NY Slip Op 24034 [Civ. Ct., Kings County 2004]).

Medical Necessity:

A denial premised on a lack of medical necessity must be supported by competent evidence such as an independent medical examination, a peer review or other proof which sets forth a factual basis and a medical rationale for denying the claim. *Healing Hands Chiropractic, P.C., v. Nationwide Assur. Co.*, 5 Misc., 3d 975, 787 N.Y.S. 2d 645 (Civ.Ct., New York County, 2004); *King's Med. Supply Inc. v. Country Wide Ins. Co.*, 5 Misc. 3d 767, 783 N.Y.S. 2d 448.

Once Respondent submits an IME report or peer review that has a sufficient factual basis and medical rationale, then the courts have routinely found that Respondent has established its prima facie defense that the disputed medical service is medically unnecessary. *A Khodadadi Radiology, P.C. v. NY Cent. Mut. Fire Ins. Co.*, 16 Misc.3d 131(A), 841 N.Y.S.2d 824 (Table, Text in WESTLAW), Unreported Disposition, 2007 WL 1989432, 2007 N.Y. Slip Op. 51342(U) (N.Y. Sup. App. Term Jul 03, 2007). See

also, Amaze Medical Supply Inc. v. Eagle Insurance Company, 2003NY Slip Op 51701 (U), 2 Misc.3d. 128 (App. Term 2d & 11 Dist.-2003).

IME by Dr. Philip D'Ambrosio M.D.

On 11/8/17, Assignor was examined by Dr. Philip D'Ambrosio M.D. in an orthopedic evaluation. Dr. D'Ambrosio reviewed the patient's medical history as well as performed an evaluation of the Assignor. Based on the medical records presented and the results of the evaluation, Dr. D'Ambrosio concluded that claimant has reached maximum improvement and medical treatment was no longer necessary.

At the time of the examination patient presented with complaints of pain in the neck pain, lower back pain, bilateral wrist pan, and left knee pain. Dr. D'Ambrosio examined the patient's cervical, and thoracolumbar spine, as well as bilateral wrists, and the left knee. Examination of the cervical spine revealed a decrease in extension. The remainder of the examination revealed no positive objective findings.

In order for an applicant to prove that the disputed expenses were medically necessary, it must meaningfully refer to, or rebut, the conclusions set forth in the IME reports.

Ortho-Med Surgical Supply, Inc. v. Progressive Cas. Ins. Co., 2012 NY Slip Op 50149(U) (App Term 2d, 11th & 13th Jud Dists Jan. 24, 2012); Yklik, Inc. v. Geico Ins. Co., 2010 NY Slip Op. 51336(U) (App Term 2d, 11th & 13th Dists. July 22, 2010); High Quality Medical, P.C. v. Mercury Ins. Co., 2010 N.Y. Slip Op. 50447(U) (App Term 2d, 11th & 13th Dists. Mar. 10, 2010); Pan Chiropractic, P.C. v. Mercury Ins. Co., 24 Misc.3d 136(A), 2009 N.Y. Slip Op. 51495(U) (App Term 2d, 11th & 13th Dists. July 9, 2009).

A letter of medical necessity sworn to by a provider who had examined assignor, along with other medical documentation, may be sufficient to rebut the IME and establish the medical necessity of the services rendered. See *Quality Psychological Servs., P.C. v. Mercury Ins. Group, 2010 NY Slip Op 50601(U) (App Term 2d Dept., April 2, 2010)*. See also *Neomy Med., P.C. v. Geico Ins. Co., 2012 NY Slip Op 50145(U) (App Term 2d, 11th & 13th Jud Dists Jan. 24, 2012); Vinings Spinal Diagnostic, P.C. v. Geico Gen. Ins. Co., 2010 NY Slip Op 51897(U) (App Term 2d Dept., Nov. 8, 2010)* (an affidavit from a chiropractor "meaningfully referred to" the peer and "sufficiently rebutted the conclusions set forth therein"); *Park Slope Med. & Surgical Supply, Inc. v. New York Cent. Mut. Fire Ins. Co., 22 Misc.3d 141(A), 2009 NY Slip Op 50441(U) (App Term 2d, 11th & 13th Jud Dists 2009)*.

Likewise, an affirmation from the provider's assignor's treating doctor who stated that he had examined assignor around the time of the IME and whose findings contradicted the findings of the IME doctors is sufficient to raise an issue of fact as to the medical necessity of the disputed services. *Triumph Assocs. Physical v. New York Cent. Mut.*

Fire Ins. Co., 43 Misc. 3d 143(A), 2014 NY Slip Op 50875(U) (App Term 2d Dept. 2014)

The issue of medical necessity of services denied based on the IME report by Dr. D'Ambrosio has been previously decided by Arbitrator Richard Martino in *Cosmopolitan Physical Therapy PC v. Allstate Fire & Casualty Insurance Company*, AAA Case No. 17-18-1101-1464. In that case Arbitrator Martino did not find Respondent's position persuasive since Dr. D'Ambrosio M.D. examined the patient after the MRIs of the cervical and lumbar spine were conducted on 9/5/17. The MRI's of the spine clearly contradicts the conclusions of the respondent's medical examiner, as the MRI's revealed multiple disc herniations. Therefore, Arbitrator Martino held that Respondent has not met its burden of proving that the therapy treatments in dispute were not medically necessary for the subject patient. I have determined medical necessity of services performed on this patient denied based on the IME of Dr. D'Ambrosio in AAA Case 17-19-1128-7876 *M & D Elite Pharmacy LLC v. Allstate Insurance Company* as well as in AAA Case # 17-18-1102-9327 *Excell Clinical Lab v. Allstate Fire & Casualty Insurance Company*. In those cases I agreed with Arbitrator Martino and found that Applicant submitted sufficient evidence to rebut the findings of the IME doctor. Reimbursement was granted to Applicant in those cases.

The issue in this case should be governed by Collateral Estoppel. Two requirements must be met before collateral estoppel can be invoked. There must be an identity of issue which has necessarily been decided in the prior action and is decisive of 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*, 53 N.Y. 2d 285, 291 [1981]). The litigant seeking the benefit of collateral estoppel must demonstrate that the decisive issue was necessarily decided in the prior action against a party, or one in privity with a party (see, *id.*). The party to be precluded from re-litigating the issue bears the burden of demonstrating the absence of a full and fair opportunity to contest the prior determination. *Buechel v. Bain*, 97 N.Y. 2d 295, 303 (2001).

"The estoppel inquiry is whether an issue involved here was disposed of there, and whether the parties sought to be bound with it here was a party there, had a fair chance to have the issue determined in her favor there, and failed." *Zabriskie v. Zoloto*, 257 NY. NYS2d 965 (1st Dep't. 1965).

It is clear that the issue in both these arbitrations is identical. The claims at issue in both cases are services performed on the patient as a result of the MVA which occurred on 7/23/17. In both cases Applicant's bills were denied based on the IME of Dr. D'Ambrosio performed on 11/8/18. It is also clear that the Respondent in each case was identical, the same insurance company. The Applicants in this case is not the same as the Applicant in the case before Arbitrator Martino.

If the party to be estopped in the second action was not a party to the first action, she must at least be shown to be in "strict privity" with the party who lost in the first action. *People v. Lo Cicero*, 14 NY2d 374 (1964). Privity as used in this sense means a relationship of a kind that enables the court to be perfectly comfortable in visiting the consequences of the first action on the party to the second action. *See Restatement 2d, Judgments, §41; as to assignors and assignees, § 55.*

Applicant derives its interests entirely from the assignment from the assignor and is bound by the assignor's actions. The assignor, through the application of the applicant/assignee, had a full opportunity to be heard on this issue and won.

Conclusion:

Since the matter at hand is denied based on the same IME report by Dr. D'Ambrosio performed on 11/8/17, as in AAA Case #17-18-1101-1464, 17-19-1128-7876 as well as in AAA Case # 17-18-1102-9327 I find that collateral estoppel applies. As stated above, Arbitrator Martino previously held in that case that Respondent has not met the burden of persuasion, as such the burden does not shift to applicant to establish medical necessity. I agree with Arbitrator Martino's well-reasoned award and find that the IME by Dr. D'Amborsio is insufficient to establish the burden of persuasion. However, Applicant does submit MRI findings performed on 9/15/17 which revealed positive findings of disc herniations.

Accordingly, Applicant's claim for reimbursement is granted 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 applicant is AWARDED the following:

A.

Medical		From/To	Claim Amount	Amount Amended	Status
	Metropolit an Medical and Surgical, P.C.	01/22/19 - 01/22/19	\$64.07	\$64.07	Awarded: \$64.07
	Metropolit an Medical and Surgical, P.C.	03/04/19 - 03/04/19	\$875.32	\$580.43	Awarded: \$580.43
Total			\$939.39		Awarded: \$644.50

B. The insurer shall also compute and pay the applicant interest set forth below. 05/30/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Since the motor vehicle accident occurred after April 5, 2002, interest shall be calculated at the rate of two percent per month, simple, calculated on a pro rata basis using a 30 day month. 11 NYCRR 65-3.9(a). In accordance with 11 NYCRR 65-3.9c, interest shall be paid on the claims totaling \$644.50 from the date the arbitration was commenced.

C. Attorney's Fees

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

Respondent shall pay Applicant an attorney's fee upon the amount awarded plus the interest, as calculated in section "B" above, and in accordance with 11 NYCRR 65-4.6(e), i.e., 20 percent of the amount of first party benefits, plus interest thereon. The minimum attorney's fee payable shall be in accordance with 11 NYCRR 65-4.6c. For cases filed after February 4, 2015, there is no minimum attorney's fee but there is a maximum fee of \$1,360.00. However, if the benefits and interest awarded thereon is equal to or less than the respondent's written offer during the conciliation process, then the attorney's fee shall be based upon the provisions of 11 NYCRR 65-4.6(b)."

- D. The respondent shall also pay the applicant forty dollars (\$40) to reimburse the applicant for the fee paid to the Designated Organization, unless the fee was previously returned pursuant to an earlier award.

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

State of New York
SS :
County of Nassau

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

12/03/2020
(Dated)

Evelina Miller

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:
11f1f9d239dcd40b2a4ebff831605d8

Electronically Signed

Your name: Evelina Miller
Signed on: 12/03/2020