

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Hector Melgar PT PC (Applicant)	AAA Case No.	17-19-1144-7200
- and -	Applicant's File No.	2318408
	Insurer's Claim File No.	0512156514 2BE
Allstate Fire & Casualty Insurance Company (Respondent)	NAIC No.	29688

ARBITRATION AWARD

I, Neal S. Dobshinsky, 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: J Doe

1. Hearing(s) held on 01/20/2021
Declared closed by the arbitrator on 01/20/2021

Gary Pustel from Israel, Israel & Purdy, LLP (Great Neck) participated by telephone for the Applicant

Inna Vilig from Law Offices Of Karen L. Lawrence participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, \$ **2,307.96**, 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

A physical therapist with Applicant initially evaluated Doe on 8/9/18. Doe was treated on that date and many dates thereafter up to and including 12/5/18. The period at issue in this case is 10/8 through 12/5/18. Applicant sought payment of its fees for the services.

Insurer contends that it timely requested additional verification of Applicant's claims, and that it timely followed-up on those requests. Applicant contends that it substantially responded to the requests and there is no reason for Insurer to have not paid the claims. Insurer contends that Applicant's responses were incomplete and not

substantial. Insurer denied payment on Applicant's claims for violation of the 120-day rule-that is Applicant failed to provide all of the requested verification within 120 days from the date of the initial request or written proof of a reasonable justification for failure to comply.

At the oral hearing and in its supplemental submission, Applicant argued that Insurer's defense is barred on collateral estoppel grounds.

Did Applicant substantially respond? Is Insurer's defense barred by collateral estoppel?

4. Findings, Conclusions, and Basis Therefor

I have read and considered the materials in the American Arbitration Association's ADR Center case file and heard and considered the parties' arguments. I find as follows:

Background

On 8/4/18, J Doe, a male, then 38 years old, was the driver of a motor vehicle, stopped at the side of the road, when it was in an accident. Doe claims that he was injured. He then sought care from a number of health care providers among them physical therapists affiliated with applicant Hector Melgar PT PC.

On 8/9/18, Doe saw one of the physical therapists for an initial evaluation. Doe was examined. The therapist recommended treatments 3 to 5 times per week for 4 to 5 weeks. Doe started treatment.

On 10/8/18, Hector Melgar, PT, performed lower extremity EMG/NCV testing on Doe. Doe was re-evaluated on 10/11 and 11/4. During the period from 10/8 to 12/5/18, Doe continued to get therapy.

Applicant's Claims and Insurer's Responses/Denials

Applicant, as Doe's assignee, timely submitted five bills for services rendered during the period from 10/8 to 12/5/18.

Insurer concedes it received all of the claims. It contends that for each claim it sent a timely letter to Applicant in which it acknowledged receipt of one or more bills and it requested additional verification. The items requested included W-2 and 1099 forms concerning the employment status of various identified individuals; records regarding transportation service providers; bank records; other agreements and records; and an examination under oath of Doe. Except for the reference to the date the bill(s) was (were) received, the date(s) of service and the amount(s), all of the letters requested the same items. The list of items sought has little, if anything, to do with the actual services provided to Doe. Insurer followed-up with timely second letters to Applicant.

All of the letters included the warning language required by the Regulations (11 NYCRR 65-3.5 (o)). That is, Insurer notified Applicant that if the requested documents were not provided within 120 calendar days the claim(s) may be denied.

Insurer contends that it issued timely denials for all of the claims. Each denial is worded more or less in the same way: "The no-fault claim is denied as the applicant did not provide within 120 days of the initial request . . . either all such verification under the applicant's control or possession, or written proof providing reasonable justification for the failure to comply."

Applicant argued that it had substantially responded to Insurer's requests. It contends that Insurer's defense that it violated the 120-day rule is barred on collateral estoppel grounds.

The only issues argued and submitted for decision at the oral hearing were: (i) Did Applicant substantially respond to Insurer's request(s) for additional verification? (ii) Is Insurer's 120-day rule defense barred by collateral estoppel? All other issues were waived.

Claim Processing and Requests for Additional Verification; the 120-day Rule

The No-Fault regulations provide that "[w]ithin 30 calendar days after proof of claim is received, the insurer shall either pay or deny the claim in whole or in part." 11 NYCRR 65-3.8(c). The 30-day period may be extended by the insurer's timely demand for further verification of the claim. 11 NYCRR 65-3.5(b); 65-3.6(b). Such demand must be made within 15 business days of receipt of the prescribed verification forms. 11 NYCRR 65-3.5(b). If the demanded verification is not received within 30 days, the insurer must issue a follow-up request within 10 days of the insured's failure to respond. 11 NYCRR 65-3.6(b). A claim need not be paid or denied until all demanded verification is provided. 11 NYCRR 65-3.8(b)(3). No-fault benefits are overdue if not paid within 30 calendar days after the insurer receives proof of claim, which includes verification of all of the relevant information requested pursuant to 11 NYCRR 65-3.5.

"[A]n insurer may issue a denial if, more than 120 calendar days after the initial request for verification, the applicant has not submitted all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply, provided that the verification request so advised the applicant as required in section 65-3.5(o) of this Subpart." 11 NYCRR 65-3.8 (b) (3)

Applicant's Substantial Compliance

The overwhelming evidence shows that Insurer repeatedly requests that Applicant provide the same documents in response to many claims not just those where J Doe is the injured person, assignor. In this case, Applicant's initial filing was 959 pages and its supplemental filing was another 270 pages. But, it's not the sheer volume that is important; it is what the evidence credibly and persuasively shows that it important.

The evidence shows that Applicant has substantially complied with the requests. Indeed, there a copy of a letter from Applicant's counsel dated January 29, 2018 to Insurer's Special Investigation Unit that references scores of claims and responds to these same verification requests. There is a second such letter dated March 29, 2018, to Insurer's counsel, a third letter to Insurer's counsel dated May 1, 2018, and a fourth responsive letter dated January 14, 2019.

There is a letter from Insurer's counsel dated January 25, 2019, to Applicant's counsel acknowledging receipt of the January 14, 2019 letter. Insurer's counsel states that three items remain outstanding, including the examination under oath of the injured person. But, Insurer's own submission includes a transcript of Doe's EUO that was conducted on December 5, 2018, so that could not have been outstanding.

There is yet another letter from Applicant's counsel dated February 6, 2019, to Insurer's counsel with additional materials (additional fair market value opinions or valuation reports obtained by the applicant in connection with any agreement disclosed in response to prior verification requests) supplementing it prior responses. And still another letter from Applicant's counsel dated March 14, 2019, to Insurer's counsel with additional bank records.

It cannot be disputed that Applicant provided substantial responses, reams of responsive documents, to Insurer's requests many times over.

Insurer's 120-day Rule Violation Defense and Collateral Estoppel

Notwithstanding the mountain of evidence to the contrary, Insurer argues that Applicant's responses to the requests for additional verification are not complete and not substantial enough.

While Applicant argued that it had substantially responded to Insurer's requests, it further contends that Insurer's defense that it violated the 120-day rule has been determined against Insurer at many prior arbitrations by other arbitrators and by me, and that the awards in those matters should be given collateral estoppel effect to bar Insurer's defense here.

For example, in *Matter of Hector Melgar PT PC and Allstate Insurance Company*, AAA Case No. 17-19-1144-7202, [12/27/2020, Arbitrator Dobshinsky] (same applicant, same insurer, services provided during the same time period as here, materially the same requests for additional verification, substantially the same responses from Applicant), Applicant sought payment of its fees for physical therapy, a re-evaluation, and EMG/NCV testing. Insurer denied payment of Applicant's fees on the ground that Applicant had not provided the additional verification it sought.

In that award I concluded that the evidence showed that Applicant substantially complied with the same requests as here. I also noted that the decisions of other arbitrators rejecting Insurer's defense were additional persuasive reasons to reject the 120-day rule violation defense.

The doctrine of collateral estoppel applies in arbitration proceedings, including disputes over no-fault benefits, and bars re-litigation of the same claim or issue in a subsequent proceeding. See, *Martin v. Geico Direct Insurance*, 31 AD3d 505, 506 [2d Dept. 2006].

Collateral estoppel, or issue preclusion, bars a party from re-litigating in a subsequent action or proceeding, an issue raised in a prior action or proceeding and decided against that party or those in privity. The policies underlying collateral estoppel are to avoid re-litigation of a decided issue and the possibility of inconsistent results. *Buechel v. Bain*, 97 NY2d 295, 303 [2001]; *Comprehensive Med. Care of N.Y., PC v. Hausknecht*, 55 AD3d 777 [2d Dept 2008].

Application of collateral estoppel depends upon two factors: (i) "an identity of issue which has necessarily been decided in the prior action and is decisive of the present action;" and (ii) "a full and fair opportunity to contest the decision now said to be controlling." The burden of establishing the first of these factors is upon the party seeking to impose collateral estoppel; the second is to be disproven by the opponent. *Forcino v Miele*, 122 AD2d 191, 193 [2d Dept 1986]; *Triboro Quality Med. Supply, Inc. v State Farm Mut. Auto Ins. Co.*, 36 Misc 3d 131[A], 2012 NY Slip Op 51289[U] [App Term, 2d Dept, 2d, 11th & 13th Jud Dists 2012].

Insurer's defenses in the earlier arbitration and this one are based on the same requests for additional verification. The items requested have little, if anything, to do with the services provided a particular injured person, rather they have to do with Applicant's business operations and relationships. Accordingly, Applicant has established the identity of issue factor.

The burden is on Insurer to show that it did not have a full and fair opportunity to contest the issue now said to be controlling. "A determination whether the first action or proceeding genuinely provided a full and fair opportunity requires consideration of "the `realities of the [prior] litigation', including the context and other circumstances which * * * may have had the practical effect of discouraging or deterring a party from fully litigating the determination which is now asserted against him." Among the specific factors to be considered are the nature of the forum and the importance of the claim in the prior litigation, the incentive and initiative to litigate and the actual extent of litigation, the competence and expertise of counsel, the availability of new evidence, the differences in the applicable law and the foreseeability of future litigation." *Ryan v. New York Tel. Co.*, 62 N.Y.2d 494, 501 [1984].

The forum is the same. The applicant and insurer are the same. The additional verification requested by Insurer is the same. Insurer's defense is the same. Applicant's responses are substantially the same. Insurer's interests in resisting Applicant's claims is the same. The prior arbitration was for a significant amount. There is no contention that Insurer did not have a full and fair opportunity to present evidence in support of its 120-day rule violation defense. There is no evidence that Insurer was not aware that there were likely other claims, such as this one, where a determination in Applicant's favor in the earlier arbitrations could (would) be used against it. The prior matter was vigorously argued and defended. Insurer's counsel, a member of its staff of attorneys,

was highly experienced with no-fault matters. Insurer does not contend that the applicable law has changed since the earlier arbitration or that there is any new, previously unavailable evidence, which would show that the earlier determination was incorrect.

Applicant has established the factor necessary to show that collateral estoppel effect should be given to the earlier determination. Insurer has not offered anything to show that it should not. Applying these principles, the prior arbitration decision that determined that Insurer had not established 120-day rule violation defense, precludes the re-litigation of that issue here.

I am not persuaded by the arbitration award submitted by Insurer where it appears that the evidence showed that applicant did not specifically respond to the requests in that matter.

Furthermore, whether based on collateral estoppel principles or consideration of the evidence in support of 120-day rule violation defense anew-which I have done-the conclusion remains the same. Insurer has failed to sustain the defense.

This award is consistent with the awards in other cases involving the same material facts (Applicant, Insurer, requests for additional verification, and responses) and issue heard and decided by me on the same day: *Matter of Hector Melgar PT PC and Allstate Fire & Casualty Insurance Company*, AAA Case nos. 17-19-1144-5781, 17-19-1144-5796, 17-19-1144-6008, 17-19-1144-6089, 17-19-1144-7289.

Conclusion

Based on the parties' submissions, their arguments, the law, the regulations, and the weight of the credible evidence, I conclude that Insurer failed to establish a defense to payment on the claims at issue. Applicant is entitled to payment on its claims.

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	Status
	Hector Melgar PT PC	10/08/18 - 10/08/18	\$1,276.16	Awarded: \$1,276.16
	Hector Melgar PT PC	10/11/18 - 10/25/18	\$392.70	Awarded: \$392.70
	Hector Melgar PT PC	10/31/18 - 11/08/18	\$246.40	Awarded: \$246.40
	Hector Melgar PT PC	11/14/18 - 11/19/18	\$146.30	Awarded: \$146.30
	Hector Melgar PT PC	11/27/18 - 12/05/18	\$246.40	Awarded: \$246.40
Total			\$2,307.96	Awarded: \$2,307.96

B. The insurer shall also compute and pay the applicant interest set forth below. 10/12/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Insurer shall compute and pay interest from the accrual date noted above-the date Applicant requested arbitration by filing with the AAA-at a rate of 2% per month, simple interest, calculated on a pro-rata basis using a 30-day month and ending with the date of payment subject to the provisions of 11 NYCRR 65-3.9.

C. Attorney's Fees

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

Insurer shall pay Applicant's attorney a fee in an amount equal to 20% of the total amount of the benefits plus interest awarded in this arbitration, subject to the provisions of 11 NYCRR §65-4.6.

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

02/08/2021
(Dated)

Neal S. Dobshinsky

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:
c49b69025e90f1391796af039386db7f

Electronically Signed

Your name: Neal S. Dobshinsky
Signed on: 02/08/2021