American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

The Center for Musculoskeletal Disorders (Applicant)	AAA Case No.	17-24-1350-2939
	Applicant's File No.	00134309
- and -	Insurer's Claim File No.	0694884347 KFR
Allstate Fire & Casualty Insurance Company (Respondent)	NAIC No.	29688

ARBITRATION AWARD

I, Ben Feder, 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: IP or assignor

1. Hearing(s) held on 02/04/2025
   Declared closed by the arbitrator on 02/04/2025

   Mikhail Guseynov from Drachman Katz, LLP participated virtually for the Applicant

   Meghan McDonough from Law Offices of John Trop participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$170,574.00**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The claim was amended to $4152.79.

   Stipulations WERE made by the parties regarding the issues to be determined.

   With the amendment of the claim, the parties stipulate that no fee schedule dispute exists.

3. Summary of Issues in Dispute

   This arbitration claim, and two other claims heard the same hearing date, arise out of medical treatment for the IP (RS), a 50 year old female, related to injuries sustained in a motor vehicle accident that occurred on 12/7/22. In this claim,

Applicant seeks reimbursement for a right knee arthroscopy, performed on 3/12/24. Respondent's denial is timely based upon a peer review by Dr. Hillsman dated 4/16/24. Applicant issued a rebuttal by Dr. Winiarsky dated 9/10/24. In addition, Applicant asserts that the claim should be awarded based on the doctrine of collateral estoppel.

Whether the right knee arthroscopy, performed on 3/12/24, was medically necessary in light of Respondent's peer review?

Whether the claim should be awarded based on the doctrine of collateral estoppel?

4. Findings, Conclusions, and Basis Therefor

Applicant has established its prima facie case with proof that it submitted a proper claim, setting forth the fact and the amount charged for the services rendered and that payment of no-fault benefits was overdue (see Insurance Law § 5106 a; Mary Immaculate Hosp. v. Allstate Ins. Co., 5 AD 3d 742, 774 N.Y.S. 2d 564 [2004]; Amaze Med. Supply v. Eagle Ins. Co., 2 Misc. 3d 128A, 784 N.Y.S. 2d 918, 2003 NY Slip Op 51701U [App Term, 2nd and 11th Judicial Districts). The burden shifts to the insurer to prove that the services were not medically necessary.

If an insurer asserts that the medical test, treatment, supply or other service was medically unnecessary, the burden is on the insurer to prove that assertion with competent evidence such as an independent medical examination, a peer review or other proof that sets forth a factual basis and a medical rationale for denying the claim. (See A.B. Medical Services, PLLC v. Geico Insurance Co., 2 Misc. 3d 26 [App Term, 2nd and 11th Judicial Districts 2003]; Kings Medical Supply Inc. v. Country Wide Insurance Company, 783 N.Y.S. 2d at 448 & 452; Amaze Medical Supply, Inc. v. Eagle Insurance Company, 2 Misc. 3d 128 [App Term, 2nd and 11th Judicial Districts, 2003]).

When an insurer relies upon a peer review report to demonstrate that a particular service was not medically necessary, the peer reviewer's opinion must be supported by sufficient factual evidence or proof and cannot simply be conclusory. As per the holding in Jacob Nir, M.D. v. Allstate Insurance Co., 7 Misc.3d 544 (2005), the peer reviewer must establish a factual basis and medical rationale to support the finding that the services were not medically necessary, including setting forth generally accepted standards in the medical community. The opinion of the insurer's expert, standing alone, is insufficient to

carry the insurer's burden to prove that the services were not medically necessary. CityWide Social Work & Psychological Services, PLLC v. Travelers Indemnity Co., 3 Misc.3d 608, 777 N.Y.S.2d 241 (N.Y. Civ. Ct. Kings Co. 2004).

Initially, Applicant argues that the doctrine of collateral estoppel applies to this claim, and subject thereto, this basis of denial should not be sustained, and Applicant should be awarded the claim.

It is within the Arbitrator's authority to determine the preclusive effect of a prior arbitration. Matter of Falzone v. New York Central Mutual Fire Ins. Co., 15 N.Y.3d 530, 914 N.Y.S.2d 67 (2010), aff'd, 64 A.D.3d 1149, 881 N.Y.S.2d 769 (4th Dept. 2009).

Under the doctrine of collateral estoppel, a party is precluded from relitigating an issue which has been previously decided against it in a prior proceeding where it had a full and fair opportunity to litigate the issue (see D'Arata v. New York Cent. Mut. Fire Ins. Co., 76 N.Y.2d 659 [1990]). The two elements that must be satisfied to invoke the doctrine of estoppel are that (1) the identical issue was decided in the prior action and is decisive in the present action, and (2) the party to be precluded from relitigating the issue had a full and fair opportunity to contest the prior issue (see Kaufman v. Lilly Co. [65 N.Y.2d 449, 455 (1985)]) (Luscher v. Arrua, 21 AD3d 1005, 1007 [2005]). The burden is on the party attempting to defeat the application of collateral estoppel to establish the absence of a full and fair opportunity to litigate (D'Arata, 76 N.Y.2d at 664; see also Kaufman, 65 N.Y.2d at 456).

Under AAA case # 17-24-1350-2752, the undersigned Arbitrator determined that the surgery in dispute was medically necessary as it related to the facility fee for the subject surgery. Under AAA case # 17-24-1350-2752, I found that "the IP's medical records, coupled with the rebuttal, successfully rebutted the peer review report, exhibited a sound medical rationale and justified the need for the procedure in question." AAA case # 17-24-1350-2752 involved the same parties, related services, basis of denial, and the same evidence. Respondent had a full and fair opportunity to contest the determination said to be dispositive of this instant controversy. The seminal issues presented herein are identical to the issues considered by the undersigned Arbitrator under AAA Case # 17-24-1350-2752. I must conclude that the doctrine of collateral estoppel must be applied in this matter and pursuant thereto; I find that Respondent cannot maintain their basis of denial.

Accordingly, Applicant is entitled to reimbursement, as amended. This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator.

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**
	The Center for Musculoskeletal Disorders	**03/12/24 - 03/12/24**	**$170,574.00**	**$4,152.79**	**Awarded: $4,152.79**
Total			**$170,574.00**		**Awarded: $4,152.79**

B. The insurer shall also compute and pay the applicant interest set forth below. 05/31/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest runs from the filing date for this case until the date that payment is made at two percent per month, simple interest, on a pro rata basis using a thirty day month.

C. Attorney's Fees

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

After calculating the sum total of the first-party benefits awarded in this arbitration plus the interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20% of that sum total, subject to no minimum and a maximum of $1360.00.

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 NY
SS :
County of NASSAU

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

02/10/2025
(Dated)

Ben Feder

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:
1fe71e7b7c449ba5cf273e87baa14901

Electronically Signed

Your name: Ben Feder
Signed on: 02/10/2025