American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Kayal Orthopaedic Center, PC (Applicant)	AAA Case No.	17-24-1361-1479
	Applicant's File No.	3134863
- and -	Insurer's Claim File No.	0534431030101031
	NAIC No.	22055
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Eileen Hennessy, 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-M.R.

1. Hearing(s) held on 06/04/2025
   Declared closed by the arbitrator on 06/04/2025

   Melissa Scotti from Law Offices of Andrew J. Costella Jr., Esq. participated virtually for the Applicant

   Maria Greenman from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$6,552.00**, was NOT AMENDED at the oral hearing.
   Stipulations WERE made by the parties regarding the issues to be determined.

   The parties stipulated and agreed that (i) Applicant has met its prima facie burden by submitting evidence that payment of no-fault benefits is overdue, and proof of its claims were mailed to and received by Respondent and (ii) Respondent's denials of the subject claims were timely issued.

3. Summary of Issues in Dispute

   The record reveals that the Assignor-M.R., a 43-year-old female, claimed injuries as the driver of a motor vehicle involved in an accident that occurred on 2/15/2023. Applicant seeks reimbursement for an office visit, physical therapy, acupuncture treatment, a bursa

joint injection, and injectable medication conducted from 3/6/2024 through 5/1/2024, denied based on the Assignor's failure to attend two duly scheduled Independent Medical Examinations (IME). The issues to be determined are 1) whether Applicant's claim is precluded by the doctrine of collateral estoppel, and if not, 2) whether the Respondent properly denied the claim based on the Assignor's failure to appear for two IMEs?

4. Findings, Conclusions, and Basis Therefor

Applicant seeks reimbursement foran office visit, physical therapy, acupuncture treatment, a bursa joint injection, and injectable medication This hearing was conducted using the documents contained in the Electronic Case Folder (ECF) maintained by the American Arbitration Association. All documents contained in the ECF are made part of the record of this hearing and my decision was made after a review of all relevant documents found in the ECF as well as the arguments presented by the parties during the hearing held via Zoom.

In accordance with 11 NYCRR 65-4.5(o) (1), an arbitrator shall be the judge of the relevance and materiality of the evidence and strict conformity of the legal rules of evidence shall not be necessary. Further, the arbitrator may question or examine any witnesses and independently raise any issue that Arbitrator deems relevant to making an award that is consistent with the Insurance Law and the Department Regulations.

COLLATERAL ESTOPPEL

The doctrines of res judicata and collateral estoppel are fully applicable to arbitration proceedings. *See* American Ins. Co., v. Messinger, 43 N.Y.2d 184, 401 N.Y.S.2d 36 (1977). Collateral estoppel is a rule of justice and fairness which mandates that issues once tried should not be re-litigated by a party in a subsequent proceeding who had been afforded a full and fair opportunity to contest the issues raised in a prior proceeding. Commissioners of State Ins. Fund v. Low, 3 N.Y.2d 590, 595, 170 N.Y.S.2d 795, 800 (1958). One of the primary purposes of the doctrine of res judicata is grounded in public policy concerns intended to insure finality, prevent vexatious litigation and promote judicial economy. Matter of Hodes v. Axelrod, 70 N.Y.2d 364 (1987); Matter of Reilly v. Reid, 45 N.Y.2d 24 (1978). 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 party 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*, Gilberg v. Barbieri, *supra.*). 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). Under New York's transactional approach, as a general rule, "once a claim is brought to a final conclusion, all other claims arising out of the same transaction or series of transactions are barred, even if based upon different

theories or if seeking a different remedy." Parker v. Blauvelt Volunteer Fire Co., Inc., 93 N.Y.2d 343, 347 (1999) *citing* O'Brien v. City of Syracuse, 54 N.Y.2d 353, 357 (1981). The policies underlying the application of res judicata and collateral estoppel are avoiding relitigation of a decided issue and the possibility of an inconsistent result. Notably, the preclusive effect, if any, to be afforded to an earlier decision in a subsequent arbitration proceeding is for the arbitrator of the second proceeding to determine. City School Dist. v. Tonawanda Education Assoc., 63 N.Y.2d 846, 482 N.Y.S.2d 258 (1984).

Legal Framework - Tolling of claims

The general rule regarding payment of claims is set forth in 11 NYCRR §65-3.8(c), which states that "within 30 calendar days after proof of claim is received, the insurer shall either pay or deny the claim in whole or in part." No-Fault benefits are overdue if not paid within 30 calendar days after the insurer receives proof of claim, which shall include verification of all of the relevant information requested pursuant to 11 NYCRR §65-3.5. 11 NYCRR §65-3.8(a). As such, a claim need not be paid or denied until all demanded verification is provided. *See* Nyack Hospital v. General Motors Acceptance Corp., 27 A.D.3d 96, 808 N.Y.S.2d 399 (2d Dept. 2005), *mod'd on other*, 8 N.Y.3d 294, 832 N.Y.S.2d 880 (2007).

OUTSTANDING VERIFICATION

Legal Standard

Once Applicant establishes its prima facie case, the burden of proof shifts to Respondent to come forward with admissible evidence demonstrating the existence of a material issue of fact. Amaze Medical Supply Inc. v. Eagle Ins. Co., 2 Misc.3d 128(A), 2003 N.Y. Slip Op. 51701(U)(App. Term, 2 Dept, 2 & 11 Jud Dists., 2003).

11 NYCRR §65-3.5(b), Claim procedure states: "Subsequent to the receipt of one or more of the completed verification forms, any additional verification required by the insurer to establish proof of claim shall be requested within 15 business days of receipt of the prescribed verification forms. Any requests by an insurer for additional verification need not be made on any prescribed or particular form."

11 NYCRR §65-3.6(b), Verification requests states:"At a minimum, if any requested verifications has not been supplied to the insurer 30 calendar days after the original request, the insurer shall, within 10 calendar days, follow up with the party from whom the verification was requested, either by telephone call, properly documented in the file, or by mail. At the same time the insurer shall inform the applicant and such person's attorney of the reason(s) why the claim is delayed by identifying in writing the missing verification and the party from whom it was requested".

NYCRR §65-3.5(c) mandates that the insurer is entitled to receive all items necessary to verify the claim directly from the parties from whom such verification was requested. The insurer has 15 business days from the date it receives the prescribed verification forms to seek additional verification from an Applicant.

Further, 11 NYCRR §65-3.8(l) states:

> For the purposes of counting the 30 calendar days after proof of claim, wherein the claim becomes overdue pursuant to section 5106 of the Insurance Law, with the exception of section 65-3.6 of this subpart, any deviation from the rules set out in this section shall reduce the 30 calendar days allowed.

Thus, a request for additional verification pursuant to 11 NYCRR §65-3.5(b) that is sent beyond the 15 business days is still valid so long as it is issued within 30 days from receipt of the claim; such a deviation will simply reduce the insurer's time to pay or deny by the same number of days. 11 NYCRR §65-3.8(l). *See* Nyack Hosp. v. General Motors Acceptance Corp., 8 NY3d 294, 2007 NY Slip Op 02439 (Court of Appeals, 2007).

The obligation to pay or deny a claim is not triggered until the insurer has received all of the relevant information that was requested. Hospital for Joint Diseases v. State Farm Mut. Auto. Ins. Co., 8 AD3d 533, 2004 NY Slip Op 05413 (App. Div., 2 Dept., 2004).

In addition to the above, the Fourth Amendment to 11 NYCRR 65-3, which is applicable to claims for medical services rendered on or after April 1, 2013, introduced a provision ([§65-3.5(o)] that sets a time frame for an applicant to respond to an insurer's verification request(s). In pertinent part, the provision states the following:

> An Applicant from whom verification is requested shall, within 120 calendar days from the date of the initial request for verification, submit all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply. The insurer shall advise the applicant in the verification request that the insurer may deny the claim if the applicant does not provide within 120 calendar days from the date 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. 11 NYCRR §65-3.5(o).

In relation to this new provision, 11 NYCRR §65-3.8(b)(3) was amended so as to confer upon the insurer the right to deny a claim for non-compliance with §65-3.5(o). In pertinent part, the amendment to §65-3.8(b)(3) states the following:

> [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)…

IME NO-SHOW

Legal Standards

The mandatory No-Fault endorsement in motor vehicle liability insurance policies provides:

> No action shall lie against the Company unless, as a condition precedent thereto, there shall have been full compliance with the terms of this coverage." The same endorsement provides also: "The eligible injured person shall submit to medical examination by physicians selected by, or acceptable to, the Company, when, and as often as, the Company may reasonably require." 11 NYCRR 65-1.1(d) ("Conditions"). "Under New York's no-fault automobile insurance scheme, an insurer can deny an insured's claim for medical treatment if the treatment is not medically necessary.

"To verify a treatment's medical necessity, an insurer may require the claimant to submit to medical examination by physicians selected by, or acceptable to, the [insurer], when, and as often as, the [insurer] may reasonably require. These examinations are referred to as independent medical examinations (IMEs)." Sky Medical Supply Inc. v. SCS Support Claims Services, Inc., 17 F.Supp.3d 207, 214-215 (E.D.N.Y. 2014) (internal quotation marks omitted). While Insurance Department Regulations [11 NYCRR 65-3.5(e)] state that a No-Fault insurer must base its request for an examination under oath upon "the application of objective standards so that there is specific objective justification supporting the use of such examination," it does not impose such a standard on a request for an IME. All County, LLC v. Unitrin Advantage Ins. Co., 31 Misc.3d 134(A), 927 N.Y.S.2d 814 (Table), 2011 N.Y. Slip Op. 50621(U), 2011 WL 1448124 (App. Term 9th & 10th Dists. Apr. 6, 2011).

The purpose of an IME is to permit the insurer to verify the person's injuries, to determine the injured party's condition and to determine if the injured party needs any additional treatment or testing for those conditions and injuries. [citation omitted] In no-fault cases, the purpose of the IME is to assist the carrier in determining the extent of the injured party's disability and that person's need for additional and continued benefits." Boulevard Multispec. Medical, P.C. v. Tri-State Consumer Ins. Co., 43 Misc.3d 802, 805, 982 N.Y.S.2d 864, 867 (Dist. Ct. Nassau Co. 2014). A defense that an assignor failed to appear at an IME requires proof of such. *E.g.*, Careplus Medical Supply, Inc. v. AutoOne Ins. Co., 24 Misc.3d 132(A), 890 N.Y.S.2d 368 (Table), 2009 N.Y. Slip Op. 51372(U), 2009 WL 1926843 (App. Term 9th & 10th Dists. June 29, 2009); Daras v. GEICO Ins. Co., 22 Misc.3d 141(A), 881 N.Y.S.2d 362 (Table), 2009 N.Y. Slip Op. 50438(U), 2009 WL 679491 (App. Term 2d, 11th & 13th Dists. Mar. 10, 2009).

The appearance at an IME is a condition precedent to the insured's liability on the policy, and an insurer may deny a claim retroactively to the date of loss for a claimant's failure to attend IMEs, "when, and as often as, the [insurer] may reasonably require." Stephen Fogel Psychological, P.C. v. Progressive Casualty 4. Ins. Co., 35 A.D.3d 720, 827 N.Y.S.2d 217 (App. Div, 2 Dept, 2006) (citing to 11 NYCRR §65-1.1 wherein it states: "The eligible injured person shall submit to medical examination by physicians

selected by, or acceptable to, the Company when, and as often as, the Company may reasonably require."). An insurer may deny a claim on the basis that the injured person-assignor failed to attend IMEs even if the IMEs were in a different medical specialty from that which underlies the claim. Id. *See also* Unitrin Advantage Ins. Co. v. Bayshore Physical Therapy, PLLC, 82 A.D.3d 559, 918 N.Y.S.2d 473 (1st Dept. 2011).

Appearance at an IME is required whether the insurance company demands it before a claim form is submitted or after the claim form is submitted. An assignee of all the rights, privileges, and remedies to which a motor vehicle accident victim is entitled under the No-Fault Law stands in the shoes of the victim and acquires no greater rights than he had. New York and Presbyterian Hospital v. Country Wide Ins. Co., 17 N.Y.3d 586, 592, 934 N.Y.S.2d 54, 59 (2011). Hence, the failure by an assignor-injured person to attend scheduled IMEs inures to the detriment of a medical provider who has taken an assignment of benefits from the assignor-injured person.

To establish the defense, an insurer must demonstrate that two separate requests for the IME were properly mailed to the assignor, and that the assignor failed to appear for the examination on either of the scheduled dates. Apollo Chiropractic Care, PC v. Praetorian Ins. Co., 27 Misc 3d 139(A), 2010 NY Slip Op 50911(App. Term, 1 Dept., 2010).

The affirmations and affidavits of the medical professionals who were to perform the IMEs can establish that a health care provider's assignor failed to appear for said IMEs. *E.g.*, Tri-Mount Acupuncture, P.C. v. NY Central Mutual Fire Ins. Co., 30 Misc.3d 144(A), 924 N.Y.S.2d 312 (Table), 2011 N.Y. Slip Op. 50335(U), 2011 WL 830762 (App. Term 2d, 11th & 13th Dists. Mar. 2, 2011); Radiology Today, P.C. v. GEICO Ins. Co., 25 Misc.3d 133(A), 901 N.Y.S.2d 910 (Table), 2009 N.Y. Slip Op. 52208(U), 2009 WL 3645541 (App. Term 2d, 11th & 13th Dists. Oct. 23, 2009). Alleviation Med. Servs., P.C. v. Hertz Co., 2016 NY Slip Op 50399(U) (App Term, 2 Dept., 2nd, 11th, & 13th, Jud. Dists, Mar. 23, 2016). As the rules of evidence do not apply to No-Fault arbitrations, 11 NYCRR 65-4.5(o)(1), a signed statement rather than an affirmation or affidavit from the doctor who was to perform the IME also suffices, and there are other ways of proving an IME no-show.

Application of Legal Standards

Notably, I decided in *Kayal Orthopaedic Center, P.C. v. Geico Ins. Co.*, AAA Case No.: 17-23-1330-5269, [5/23/2024], a case involving Assignor-M.R., that Respondent's denials were sufficient, and Respondent's defense of IME no-show defense was valid. Specifically, I held in pertinent part:

> *3. Summary of Issues in Dispute*
>
> *The record reveals that the Assignor-M.R., a 43-year-old female, claimed injuries as the driver of a motor vehicle involved in an accident that occurred on 2/15/2023. Applicant seeks reimbursement for physical therapy and acupuncture services conducted on 10/31/2023, denied based on the Assignor's failure to attend two duly scheduled Independent Medical Examinations (IME). The issue to be*

determined is whether the Respondent properly denied the claim based on the Assignor's failure to appear for two IMEs?

Findings, Conclusions, and Basis Therefor

Applicant seeks reimbursement for physical therapy and acupuncture services…

…

Application of Legal Standards

Respondent has come forward with sufficient evidence to demonstrate the mailing of the IME letters, the timeliness of its denial, and the Assignor's failure to appear for two scheduled IMEs. Specifically, Respondent has submitted IME notices scheduled for 5/18/2023 and 7/20/2023 with Gary Florio, M.D. properly addressed to the Assignor, along with proof of mailing in the form of an affidavits of Cassandra Manning and Jennifer Booth, employees of ISG, Respondent's IME vendor, and certificates of mailing postmarked by the United States Postal Service (USPS) and signed for as received by an employee of the USPS. A presumption of receipt by the Assignor of the IME notices exists by virtue of the notices having been properly mailed to the Assignor at her address. Affidavits from Gary Florio, M.D. attested to the failure of the Assignor to appear for the IMEs. Respondent's claim specific denials asserted the failure of the Assignor to attend IMEs.

Applicant did not raise any arguments at the hearing regarding the sufficiency or the timeliness of the IME scheduling letters.

Applicant did not submit any evidence tending to show that Assignor did not receive the IME notices. Neither did it submit any evidence to show that Assignor did attend the IMEs or that there was a valid reason for not attending the IMEs. Thus, I am convinced that this patient ignored these IME letters at her own peril as she failed to attend the IMEs on both dates. Having done so, she has negated her right to benefits under this policy.

The insurer is entitled to judgment where it proves that two separate requests for an IME were duly mailed to the Assignor and the latter failed to appear on either of the dates. Apollo Chiropractic Care, P.C. v. Praetorian Ins. Co., 27 Misc.3d 139(A), 932 N.Y.S.2d 420 (Table), 2010 N.Y. Slip Op. 50911(U), 2010 WL 2026636 (App. Term 1st Dept. May 24, 2010).

Based upon the proof presented, I find that Respondent has established by a preponderance of the evidence the failure of the Assignor to appear at two properly scheduled IMEs and has therefore

sustained its defense. The burden has shifted to the Applicant and has not been rebutted.

CONCLUSION

Accordingly, in light of the foregoing, based on the arguments of counsels, and after thorough review and consideration of all submissions, Applicant's claim is denied. The remaining issues are rendered moot. This award is in full disposition of all No-Fault benefit claims submitted to this Arbitrator.

The parties are identical, the parties were present at the hearings before me and had a full and fair opportunity to contest the Respondent's defense of IME no-show in this case, i.e., the failure of the Assignor to attend two duly scheduled IMEs on 5/18/2023 and 7/20/2023. I concur with my prior decision and find it is entitled to collateral estoppel effect. Respondent established its defense of IME no-show, which Applicant failed to rebut. Therefore, I find in favor of the Respondent.

The bills for dates of service 3/6/2024 through 5/1/2024 ($6,552.00), timely denied premised upon the failure of the claimant to appear for two duly scheduled IMEs, is denied.

CONCLUSION

Accordingly, in light of the foregoing, based on the arguments of counsels, and after thorough review and consideration of all submissions, Applicant's claim is denied. The remaining issues are rendered moot. This award is in full disposition of all No-Fault benefit claims submitted to 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 claim is DENIED in its entirety

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

State of NY
SS :
County of Nassau

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

07/07/2025
(Dated)

Eileen Hennessy

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:
32fd56a0d1da1f0633731f08e1c72cf0

Electronically Signed

Your name: Eileen Hennessy
Signed on: 07/07/2025