American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Brooklyn Medical Practice, PC (Applicant)	AAA Case No.	17-25-1433-0270
	Applicant's File No.	AR25-29608
- and -	Insurer's Claim File No.	1061744-1
	NAIC No.	16616
American Transit Insurance Company (Respondent)		

ARBITRATION AWARD

I, Eva Gaspari, 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: E.I.P and/or R.T.C.

1. Hearing(s) held on 06/30/2026
   Declared closed by the arbitrator on 06/30/2026

   Jeffrey Kramer from Law Office of Jeffrey M. Kramer participated virtually for the Applicant

   Megan Harris from American Transit Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$1,516.85**, 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

   This arbitration dispute arises from an automobile accident which occurred on June 17, 2019 in which the Assignor (R.T.C.), a 46-year-old male, was a bicyclist. At issue in this arbitration are claims for medical services provided from July 20, 2022 through July 16, 2024. The Respondent has denied services based on the findings of an IME by Dr. J. Serge Parisien, M.D., with an effective cut-off date of January 13, 2020 and September 21, 2020. The issue presented is whether the Respondent properly denied continued treatment based on the findings of Dr. Parisien's examination. Additionally, the

Respondent has denied services based on the defense that written proof of claim was not received within 45 days after the services were rendered. The question presented is whether the respondent properly denied the services based on late notice of claim.

4. Findings, Conclusions, and Basis Therefor

This matter was decided based upon the submissions of the parties as contained in the electronic file maintained by the American Arbitration Association, as well as upon the oral arguments of the parties at the time of the hearing. All documents contained in the ADR folder are hereby incorporated into this hearing and in reaching my findings I have reviewed all relevant exhibits contained in the ADR Center. Only submissions which were uploaded into the ADR Center prior to the hearing were considered in making the instant determination. All matters raised on oral argument at the time of the hearing have been addressed herein. Any further issues raised in the hearing record are held to be moot and/or waived insofar as not specifically raised at the time of the hearing.

A medical provider establishes a prima facie showing of their entitlement to judgment as a matter of law by submitting evidentiary proof that the prescribed statutory billing forms had been mailed and received and that payment of no fault benefits was overdue. See, Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept.2004). The Respondent, by its denials, has admitted receipt of the subject bills. Accordingly, I find that the Applicant has established its prima facie case concerning all claims in dispute. Applicant having established its prima facie case, the burden shifts to the Respondent to demonstrate its articulated defenses.

LATE NOTICE OF CLAIM (45 DAY DENIAL)

Pursuant to the Insurance Department Regulations 11 NYCRR § 65 - 1.1 "the eligible injured person or that person's assignee . . . shall submit written proof of claim to the Company . . . in no event later than 45 days after the date services are rendered"

To the extent that the Respondent has denied services based on the defense that written proof of claim was not received within 45 days after the services were rendered, I hold that this defense is unsubstantiated, as the claims were received within 45 days of treatment.

MEDICAL NECESSITY

The Respondent has denied services based on the findings of an IME by Dr. J. Serge Parisien, M.D., with an effective cut-off date of January 13, 2020 and September 21, 2020. The issue presented is whether the Respondent properly denied continued treatment based on the findings of Dr. Parisien's examination. Respondent bears the burden of production in support of a medical necessity defense, which if established shifts the burden of persuasion to applicant. See generally, Bronx Expert Radiology, P.C. v. Travelers Ins. Co., 2006 NY Slip Op 52116 (App. Term 1 Dept. 2006).

These IMEs by Dr. Parisien, as well as rebuttal evidence, was previously considered in the linked Matter of the Arbitration between: Brooklyn Medical Practice, PC and American Transit Insurance Company, AAA Case No. 17-22-1259-7653 (Abrams, 03/19/2023). In this holding, which involved identical parties and an identical defense, the following findings were reached:

> The contemporaneous examination revealed objective and subjective findings, the IP exhibited pain and was symptomatic on the same day as the IME. Respondent failed to sufficiently rebut Applicant's records with evidence that the services were not medically necessary.

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). In order for the doctrine to apply, however, it must be first shown that 1) the party against whom collateral estoppel is sought 2) had a full and fair opportunity to contest the determination said to be dispositive of the instant controversy. Moreover, 3) the issue in the prior action must be identical, and thus decisive, to the issue in the action for which application of the doctrine is sought. See, Gilberg v. Barbieri, 53 N.Y. 2d 285, 441 N.Y.S. 2d 49 (1981); Schwartz v. Public Administrator of County of Bronx, 24 N.Y.2d.65, 68, 298 N.Y.S.2d 955, 958 (1969).

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). The principles of res judicata require that "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". O'Brien v. City of Syracuse, 54 N.Y.2d 353 (1981).

The doctrines of res judicata and collateral estoppel are fully applicable to arbitration proceedings. *See, generally*, American Ins. Co., v. Messinger, 43 N.Y.2d 184, 401 N.Y.S.2d 36 (1977) (holding: the doctrines of claim preclusion and issue preclusion between the same parties apply as well to awards in arbitration as they do to adjudications in judicial proceedings citing: Rembrandt Inds. v Hodges Int.,38 N.Y.2d 502; New York Lbr. & Wood Working Co v Schneider, 119 N.Y. 475; Wiberly v Matthews, 91 N.Y. 648; 23 Carmody-Wait 2d, NY Prac, Arbitration, § 141:151, p 80). In the arbitration forum, 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); Board of Education v. Patchogue-Medford Congress of Teachers, 48 N.Y.2d 812, 424 N.Y.S.2d 122 91979); Matter of Springs Cotton Mills [Buster Boy Suit Co.], 275 App. Div. 196, 88 N.Y.S.2d 295 (App. Div., 1st Dept - 1949) affd. without opinion. 300 N.Y. 586, 89 N.E.2d 877 (1949); Melendez v. Budget Rent-A-Car, 7 Misc. 3d 585, 588, 794 N.Y.S.2d 830 (2005).

Upon a review of the matter before me I find that defense offered in this arbitration is identical to that which has been previously ruled upon in the prior proceeding. Additionally, I note that the Respondent in the two actions are identical and the record makes clear that a full and fair opportunity to be heard was extended in the prior proceeding. Accordingly, I find that the doctrine of collateral estoppel is appropriately applied in this proceeding and that the issues which are presented in this hearing have already been fully adjudicated and that the prior decision is binding on this matter.

Having reviewed this determination as well as the underlying treatment records, I concur with the findings of Arbitrator Abrams and find in favor of the Applicant.

FEE SCHEDULE

Where an insurer sets forth a defense based upon fee schedule they are required to come forward with competent evidentiary proof to support its fee schedule defenses. Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 2006 NY Slip 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co.

2006). When an insurer fails to demonstrate by competent evidentiary proof that a medical provider's claims were in excess of the appropriate fee schedules, their defense of noncompliance with the appropriate fee schedules cannot be sustained. Continental Medical PC v. Travelers Indemnity Co., 11 Misc.3d 145A, 819 N.Y.S.2d 847, 2006 NY Slip Op 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Tm, 1st Dep't, per curiam, 2006). After carefully reviewing the evidence which has been presented on the Respondent's fee schedule defense, I find, as a matter of fact, that the Respondent has not presented a sufficient evidentiary showing to satisfy its initial burden of proof for its fee schedule defense. Notably, in the case before me, the Respondent has not submitted evidence such as that by a certified medical coder or other reliable evidence which show that the charges exceed those authorized under the fee schedule. I find that the Respondent has failed to sustain its defense through competent evidence.
Accordingly, this claim is granted.

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
	Brooklyn Medical Practice, PC	**07/20/22 - 07/16/24**	**$1,516.85**	**Awarded: $1,516.85**
Total			**$1,516.85**	**Awarded: $1,516.85**

B. The insurer shall also compute and pay the applicant interest set forth below. 12/11/2025 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

In the instant matter Applicant is awarded interest pursuant to the no-fault regulations. 11 NYCRR 65-3.9 (a) provides that Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30 day month." Pursuant to 11 NYCRR 65-3.9 (c) provides that "if an applicant does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Department of Financial Services regulations, interest shall not accumulate on the disputed claim or element of claim until such action is taken." In the matter of LMK Psychological Servs. PC v. State Farm Mut. Auto. Ins. Co., 12 NY 3d. 217 (2009), the court addressed the issue of interest and found that pursuant to 11 NYCRR §65-3.9(c) interest shall be tolled upon the issuance of a denial whether it is timely or not when an applicant does not request arbitration or institute a lawsuit within thirty days after receipt of a denial form or payment of benefits calculated pursuant to Insurance Department regulations. It appears the intent of 65-3.9(c) was to start interest on the date of the request. Therefore, pursuant to N.Y. Comp. Codes R. & Regs. tit. 11, § 65-3.9 (2002), "Interest on overdue payments," the Respondent shall pay interest to the Applicant on the awarded overdue PIP benefit at a rate of two percent (2%) per month calculated on a pro rata basis using a thirty (30) day month, starting12/11/25.

C. Attorney's Fees

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

As this matter was filed after February 4, 2015, this case is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant the attorney's fee, in accordance with the newly promulgated 11 NYCRR 65-4.6(d).

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

07/15/2026
(Dated)

Eva Gaspari

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:
1e1e023399d1470db850b8ba5300a1fa

Electronically Signed

Your name: Eva Gaspari
Signed on: 07/15/2026