American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Isurply LLC (Applicant)	AAA Case No.	17-17-1056-2931
	Applicant's File No.	none
- and -	Insurer's Claim File No.	LA000-032110830-04
	NAIC No.	23035
Liberty Mutual Fire Insurance Company (Respondent)		

ARBITRATION AWARD

I, Victor Moritz, 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: EIP

1. Hearing(s) held on 12/07/2017
   Declared closed by the arbitrator on 12/07/2017

   Michael Tomforde, Esq. from Dash Law Firm, P.C. participated in person for the Applicant

   Denise Perugini, Claims Representative, from Liberty Mutual Fire Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 2,874.50**, 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

   Was the applicant entitled to reimbursement for the costs associated with a continuous passive motion (CPM) machine and pneumatic compression device prescribed to the EIP (I.W. 53 year old female) resulting from a June 2, 2015 motor vehicle accident? The respondent denied this claim based on a lack of medical necessity per the results of a peer review by Dr. Igor Rubinshteyn. Further at the time of the hearing respondent's representative indicated the policy limits had been exhausted. Accordingly, this matter is determined after reviewing the submissions and presentations of both sides. I have reviewed the documents contained in the electronic case folder as of the closing of the file.

4. Findings, Conclusions, and Basis Therefor

I find for the respondent and deny the claim in its entirety.

Submissions

In this instance the respondent issued denials for the CPM machine and pneumatic compression device based upon the results of peer reviews submitted by Dr. Igor Rubinshteyn.

Further, respondent at the time the action was initiated noted that over $42,000.00 of the subject policy had been reimbursed as of March 16, 2017. As such, they noted the policy might exhaust before a determination of this claim.

The respondent has also submitted copies of the pertinent portions of the insurance policy identifying the PIP coverage limits.

On December 6, 2017, the respondent submitted a copy of a payment ledger which establishes the respondent had reimbursed $47,029.42 for medical expenses under the underlying policy. Further, the respondent had reimbursed the sum of $2,376.46 for lost wages. As such, they had paid out $49,405.88. Notwithstanding this fact, the total policy limits herein have been exhausted.

Policy Exhaustion

I note that Insurance Law § 5102(a) defines basic economic losses reimbursement up to $50,000.00 per person for all necessary expenses arising from a motor vehicle accident as covered under New York Insurance Law § 5102. When an insurer has paid full monetary limits set forth in the policy, however, its duties under the contract of insurance cease. See New York State Department of Insurance general counsel opinion letter dated July 30, 2008.

11 NYCRR 65â3.15 states as follows: "When claims aggregate to more than $50,000.00, payments for basic economic loss shall be made to the applicant and/or assignee in the order in which each service was rendered, or each expense was incurred, provided claims therefore were made to the insurer prior to the exhaustion of the $50,000.00. If the insurer pays the $50,000.00 before receiving claims for services rendered prior in time to those which were paid, the insurer will not be liable to pay such late claims. If the insurer receives claims of a number of providers of other services, at the same time, the payment should be made in the order of rendition of services."

Once the contractual policy limits have been exhausted the carrier is under no further obligation under the contract of insurance. When an insurer has paid the full monetary

limits set forth in the policy, its duties under the contract that the insurance cease citing the Hospital for Joint Diseases v. State Farm Mutual Automobile Insurance Co. 8 A.D.3d. 533 (2d Dept. 2004); See also Hospital for Joint Diseases v. Hertz Corp. 22A.D. 2d 3d 724 (2d Dept. 2005). See also, Mount Sinai Hosp. v. Zurich American Ins. Co. 15 A.D. 3d. 55 (2d. Dep't 2005).

Accordingly, since no duty is owed to the assignor to reimburse for further services; there is no duty owed to the applicant as the assignee stands in the shoes of the assignor citing Long Island Radiology v. Allstate 36Ad 3d 763 2d Dept. (2007).

I note an opinion letter from ***the Office of General Counsel of the New York State Insurance Department of July 30, 2008***, noting as follows: "Upon exhausting the amount of noâfault benefits available the assignor the assignment is no longer effective. At that point the patient must rely on any other available insurance coverage and the provider's ability to bill the patient directly will depend on the contractual arrangement that the provider has with the patient's subsequent insurer, if in fact there is other insurance coverage. If the patient has no other form of insurance, the provider may bill the patient directly once the noâfault benefits are exhausted as the patient is now an uninsured person."

In Nyack Hospital v. General Motors Acceptance Corp., 8 NY 3d 294 (2007) I note that Judge Kaye indicated that after the insurer had received the "verified claim" by Nyack the insurer should have paid the hospital ahead of other unpaid verified claims for services rendered or expenses incurred later than the services billed by Nyack up to its policy limits.

In pertinent part citing to Nyack Hospital, where the court takes note of the regulations stating as follows:

> when claims aggregate to more than $50,000.00, payments for basic economic loss shall be made to the applicant and/or an assignee in the order in which each service was rendered or each expense was incurred, provided claims therefore were made to the insurer prior to the exhaustion of the $50,000.00. If the insurer pays the $50,000.00 before receiving claims for services rendered prior in time to those which were paid, the insurer will not be liable to pay such late claims. If the insurer receives claims of a number of providers of services, at the same, the payments shall be made in the order of the rendition of services.

In addition I note the matter Manhasset Diagnostic Imaging P.C., et al. v. Government Employees Insurance Co., Civil Court City of New York County of Bronx, Index No. 001953/09 Bench Trial 5/10/12 (J.C.C. Jose Padilla, Jr.). In this case, respondent issued a denial for MRI studies based on medical necessity. Meanwhile, the respondent continued to pay other claims set forth and though there were sufficient proceeds in the policy to pay off the bill when received at the time of the bench trial the policy limits had been exhausted. At the time of trial, the defendant abandoned its medical necessity defense relying solely upon the policy limits exhaustion which clearly took place after the bill had been received. Judge Padilla ruled as follows: "It is beyond cavil that

defendant insurer cannot be held liable for benefits that exceed the $50,000.00 amounts contracted for in the instant policy see Hospital for Joint Diseases v. Hertz Corp., 22 A.D. 3d 724 (2d Dept. 2005); Countrywide Insurance Co. v. Sawh, 272 A.D. 2d 245 (First Dept, 2000), Allstate Insurance Co. v. DeMoura, 30 Misc. 3d 145(A) (App. Term 1st. Dept . 2011). In view of the undisputed facts the defendant already paid the full monetary amounts set forth in the policy, its duty under the contract of insurance ceased and it could not be held liable for benefits exceeding the policy citing Presbyterian Hospital v. Empire Insurance Co., 220 A.D. 2d 733, 734 (2d. Dept. 1995)."

Wage Set-Off

I note that the lost wage payout totaled $2376.46 for lost wages from June 2 through August 18, 2015, totaling $2,970.58.

Insurance Law section 5102 (a) (2), which deducts or offsets from the definition of lost earnings/basic economic loss disability payments provided by the injured person's employer, and in accordance with Insurance Law section 5102 (b) (1), which deducts or offsets from the definition of lost earnings/first party benefits 20% of the injured person's lost earnings.

In Normile v Allstate Ins. Co. 87 A.D.2d 721, (3rd Dept. 1982); affirmed 60 N.Y.2d 1003, (1983) the court stated: "A fair reading of the language, in our view, imports a statutory scheme whereby an injured person is entitled to receive first-party benefits equal to his basic economic loss up to $50,000 less the statutory deductions set forth in section 671 (subd. 2) of the Insurance Law. …. Plaintiff seeks to hold the insurance carrier liable for up to $50,000 in coverage without any deductions. In other words, the $50,000 limitation would apply to first-party benefits rather than basic economic loss. If the Legislature had so intended, they could have easily provided that first-party benefits mean payments for basic economic loss, less the deductions, with the benefits payable up to $50,000.

We conclude that by placing the limitation in the definition of basic economic loss, the Legislature clearly intended that the limitation apply to basic economic loss." Normile v Allstate Ins. Co., 87 A.D.2d at 721, 722.

Citing **Arbitrator Paul Israelson**in**Accelerated DME Recovery Inc. v State Farm Mutual Automobile Ins. Co., AAA 17-14-9050-9297 (February 8, 2016):**

…In Balanca v. Geico General Ins. Co. 13 Misc.3d 90, 827 N.Y.S.2d 408, (App. Term 2nd 11th Dist. 2006) the court stated: "Insurance Law § 5102(b) provides that payments for lost earnings are to be reduced by 20% as well as by the amount the eligible injured person receives from collateral sources such as state disability benefits. In Kurcsics v. Merchants Mut. Ins. Co., 49 N.Y.2d 451, 457, 426 N.Y.S.2d 454, 403 N.E.2d 159 [1980], the Court of Appeals explained that the 20% reduction applicable to claims for lost earnings was intended to avoid a windfall to the eligible injured person since payments for lost earnings would not be includable in income for the purposes of federal income taxation. Thus, the 20% reduction was to be applied to the actual gross lost earnings per month without regard to the maximum $2,000 recoverable as lost earnings per month.

*In addition, in light of the holdings in Heitner v. Government Employees Ins. Co., 64 N.Y.2d 834, 486 N.Y.S.2d 933, 476 N.E.2d 332 [1985], revg. 103 A.D.2d 111, 479 N.Y.S.2d 51 [1984] for reasons stated at 118 Misc.2d 752, 461 N.Y.S.2d 195 and Normile v. Allstate Ins. Co., 87 A.D.2d 721, 448 N.Y.S.2d 907 [1982], affd. 60 N.Y.2d 1003, 471 N.Y.S.2d 550, 459 N.E.2d 843 [1983] for reasons stated below, it is settled that to the extent payments received by the injured person from, among other things, state disability insurance reduce the amount of lost earnings payable under Insurance Law § 5102(a)(2), such reductions are credited to the insurer and are used to deplete the amount of coverage available to pay basic economic loss benefits. Consequently, an eligible injured person who has gross *92 lost earnings equal to or greater than $2,500 in a month would, after application of the 20% reduction (see Insurance Law § 5102[b]), be qualified to receive the full $2,000 monthly payment authorized by Insurance Law § 5102(a)(2) prior to a reduction, if any, for payments received from, among other things, state disability insurance. The Normile case unequivocally held that an insurer's obligation to pay lost earnings as basic economic loss can be satisfied notwithstanding the fact that the actual amount paid will be less than the amount of coverage for available basic economic loss." Balanca v. Geico General Ins. Co., 13 Misc.3d at 91.*

Therefore, it is well settled that an insurer may include the amount attributable to the deduction/offset for disability payments paid to the injured person and the amount attributable to the deduction/offset of 20% of the injured person's lost earnings (each applied in accordance with Insurance Law section 5102 (a) (2) and it (b) (1)) when calculating the exhaustion of the insurer's no-fault coverage.

As noted by **Arbitrator Melissa Melis** in **Applicant v Geico Ins. Co. AAA Legacy No. 412011047712 (August 21, 2012):**

Under Insurance Law § 671 (now § 5102), a covered person who sustained lost earnings of more than $1,000 per month could recover as first party No-Fault benefits 80% of actual lost earnings up to a maximum of $1,000 per month. Kurcsics v. Merchants Mutual Ins. Co., 49 N.Y.2d 451, 426 N.Y.S.2d 454 (1980).

In calculating the lost earnings component of first-party benefits, the state disability benefits setoff enumerated in the Insurance Law is to be deducted by No-Fault carriers from the statutorily specified monthly "outer limit" rather than from the gross or actual wage loss of the injured insured. Heitner v. Government Employees Ins. Co., 64 N.Y.2d 834, 486 N.Y.S.2d 933 (1985), rev'g, 103 A.D.2d 111, 479 N.Y.S.2d 51 (2d Dept. 1984) for reasons stated at 118 Misc.2d 752, 461 N.Y.S.2d 195 (Sup. Ct. Nassau Co. 1983). …

It is improper for an arbitrator, in calculating the amount of lost earnings to be awarded, to not apply as an offset Social Security disability benefits paid to the claimant's spouse and child (as required by the No-Fault regulations), even if the insurer failed to forward necessary forms to the claimant to pursue Social Security benefits and failed to continue first-party benefits until he began to receive Social Security disability benefits paid to him. Karmilowicz v. Allstate Ins. Co., 77 A.D.2d 131, 432 N.Y.S.2d 698 (1st Dept. 1980). Insurance Law § 5102a(2) deducts or offsets from the definition of lost earnings first party benefits of 20 percent. In Balanca v. GEICO General Insurance Co., 13 Misc.3d 90 (App Term, 2d & 11th Dists 2006).

Therefore, while the respondent reimbursed the EIP $2,376.46 for lost wages, the respondent is allowed an additional $594.12 write off per Insurance Law section 5102 (a) (2). Based on the foregoing, the respondent is entitled to add $2,970.58 for wage claims in calculating noâfault expenses.

Thus, adding the sum of $2,970.58 to the $47,029.42 that had already been reimbursed for medical expenses allows for the $50,000.00 in No-fault benefits paid on behalf of the EIP herein.

Accordingly the claim is denied 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 claim is DENIED in its entirety

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

12/19/2017

(Dated) Victor Moritz

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:
51fb84e27b8e6aa0652c1164c04cc669

Electronically Signed

Your name: Victor Moritz
Signed on: 12/19/2017