

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Orthocare Tech, Inc
(Applicant)

- and -

Lancer Insurance Company
(Respondent)

AAA Case No. 17-18-1088-4099

Applicant's File No. SS-53797

Insurer's Claim File No. 1425919-02AF

NAIC No. 26077

ARBITRATION AWARD

I, Charles Blattberg, 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: Eligible injured person

1. Hearing(s) held on 11/21/2018
Declared closed by the arbitrator on 02/19/2019

Greg Itingen, Esq. from Samandarov & Associates, P.C. participated in person for the Applicant

Evan Klestzick, Esq. from McDonnell Adels & Klestzick, PLLC participated in person for the Respondent

2. The amount claimed in the Arbitration Request, \$ **2,595.50**, 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

The following hearings are being held and decided together as they contain common questions of law and fact. All documents submitted in any hearing will be considered in the award for any one hearing: Horizon Anesthesia Group, PC and Lancer Insurance Company, AAA Case No.: 17-18-1083-5968 (November 21, 2018 at 1:45 PM) where the anesthesia associated with a 6/13/17 right shoulder surgery is at issue; New Horizon Surgical Center LLC and Lancer Insurance Company, AAA Case No.: 17-18-1083-6011 (November 21, 2018 at 2:00 PM) where the facility fee associated with a 6/13/17 right shoulder surgery is at issue; Orthocare Tech, Inc and Lancer Insurance Company, AAA Case No.: 17-18-1088-4099 (November 21, 2018 at 2:30 PM) where a sheepskin pad

and the rental of a continuous passage motion (CPM) unit and a cold therapy unit (CTU) 6/16/17-7/13/17 are at issue. Respondent initially denied these claims based on a 9/5/17 peer review by Lisa Nason, M.D. and subsequently denied the claims based on policy exhaustion.

4. Findings, Conclusions, and Basis Therefor

THIS HEARING WAS CONDUCTED USING THE ELECTRONIC CASE FOLDER MAINTAINED BY THE AMERICAN ARBITRATION ASSOCIATION. ALL DOCUMENTS CONTAINED IN THAT FOLDER ARE MADE PART OF THE RECORD OF THIS HEARING.

THE ARBITRATOR SHALL BE THE JUDGE OF THE RELEVANCE AND MATERIALITY OF THE EVIDENCE OFFERED.

Based on a review of the documentary evidence, this claim is decided as follows:

Applicant establishes a prima facie case of entitlement to reimbursement of its claim by the submission of a completed NF-3 form or similar document documenting the facts and amounts of the losses sustained and by submitting evidentiary proof that the prescribed statutory billing forms [setting forth the fact and the amount of the loss sustained] had been mailed and received and that payment of no-fault benefits were overdue. See, *Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). I find that Applicant established a prima facie case for reimbursement.

The claimant was a 29 year-old male pedestrian who was involved in an accident with a motor vehicle on 4/19/17. The claimant reportedly injured his neck, right shoulder, right elbow, right hand, and low back. There may have been a reported loss of consciousness. There were no reported lacerations or fractures. Following the accident the claimant was transported to St. Barnabas Hospital where he underwent multiple radiographs; and was evaluated, treated, and released. On 5/2/17 the claimant presented to Maria Ciechorska, M.D. of Healthway Medical Care, P.C. and the claimant was prescribed durable medical equipment (consisting of a cervical collar, cervical traction unit, orthopedic pillow, lumbosacral orthosis, lumbar cushion, bed board, eggcrate mattress, orthopedic wrist support, and orthopedic shoulder support), MRIs (cervical spine, lumbar spine, right shoulder, right elbow, and right wrist) and the claimant was initiated on physical therapy and Kinesio taping. Reportedly on or around 5/2/17 the claimant presented to Acupuncture Now, P.C and was initiated on acupuncture and cupping. Contemporaneously or subsequently the claimant presented to SB Chiropractic Care, P.C. and was initiated on chiropractic treatment. On 5/16/17 the claimant underwent physical capacity (NIOSH) testing. The 5/23/17 right shoulder MRI interpreted by Mark Lodespoto, M.D. produced an impression of evidence for rotator cuff tendinitis and partial tear. On 5/24/17 the claimant presented to Delys Saint Hill, M.D. of Morley Medical Services, P.C. for an examination preliminary to upper extremities and lower extremities EMG/NCV testing performed the same day that suggested no evidence of

cervical or lumbosacral radiculopathy; but suggested bilateral sensory median neuropathy (Carpal Tunnel Syndrome). On 6/5/17 the claimant presented to Robert D. Haar, M.D. for an orthopedic consultation in regard to his right shoulder with complaints of shoulder pain rated 8/10 on the Visual Analog Scale. Examination of the shoulder revealed tenderness to palpation over the AC joint and bicipital groove. There were positive Neer's, Hawkin's and an equivocal O'Brien's tests. The claimant's range of motion was restricted. The claimant was recommended for right shoulder surgery. On 6/9/17 the claimant underwent range of motion and manual muscle testing (ROM/MMT) that suggested 16% cervical spine impairment, 21% lumbar spine impairment, and 34% whole spine impairment. On 6/13/17 Dr. Haar performed right shoulder surgery (consisting of operative arthroscopy, debridement of rotator cuff tears, debridement of labrum tear, subacromial decompression, and major synovectomy) and prescribed a sheepskin pad and the use of a continuous passage motion (CPM) unit, a cold therapy unit (CTU), and pneumatic DVT prevention system. At issue are the sheepskin pad and the rental of a continuous passage motion (CPM) unit and a cold therapy unit (CTU) 6/16/17-7/13/17.

Pursuant to Insurance Law § 5106(a) and the Insurance regulations, an insurer must either pay or deny a claim for motor vehicle no-fault benefits, in whole or in part, within 30 days after an applicant's proof of claim is received (*see* Insurance Law § 5106[a]; 11 NYCRR 65-3.8[c]; *see also* 11 NYCRR 65-3.5). *Infinity Health Products, Ltd. v. Eveready Ins. Co.*, 67 A.D.3d 862, 864, 890 N.Y.S.2d 545, 547 (2d Dept. 2009). The 30-day period in which to either pay or deny a claim is extended where the insurer makes a request for additional verification within the requisite 15-[business] day time period (*see Montefiore Med. Ctr. v. Government Empls. Ins. Co.*, 34 AD3d 771; *New York & Presbyt. Hosp. v. Allstate Ins. Co.*, 31 AD3d 512). *Kingsbrook Jewish Medical Center v. Allstate Insurance Co.*, 61 A.D.3d 13, 17-18, 871 N.Y.S.2d 680, 683 (2d Dept. 2009). If the requested verification is not received within 30 days, the insurer must send a follow-up letter within 10 days thereafter (*see* 11 NYCRR 65.15[e][2]). *New York & Presbyterian Hospital v. American Transit Insurance Co.*, 287 A.D.2d 699, 700, 733 N.Y.S.2d 80, 81-82 (2d Dept. 2001). Thus, a timely additional verification request tolls the insurer's time within which to pay or deny a claim (*see Fair Price Med. Supply Corp. v. Travelers Indem. Co.*, 10 NY3d at 563; *New York & Presbyt. Hosp. v. Countrywide Ins. Co.*, 44 AD3d 729, 730). *Kingsbrook Jewish Medical Center v. Allstate Insurance Co.*, *supra* at 18, 871 N.Y.S.2d at 683 (2d Dept. 2009).

Respondent received the bill at issue on 7/21/17 and timely requested verification on 8/2/17 in the form of "Claimant/Patient had right shoudler surgery on 6/13/17. We are waiting for the right shoulder MRI films/disc from Bronx Medical Diagnostic. After we receive the films/disc your bill will be considered for payment." Applicant's counsel argued that Respondent's 8/2/17 verification request was nothing more than a delay letter as it does not specifically ask for anything from Applicant. However, the verification letter was copied to Bronx Medical Diagnostic, PC. In seeking additional verification, an insurer is not limited to seeking it from the applicant. *Doshi Diagnostic Imaging Services v. State Farm Ins. Co.*, 16 Misc.3d 42, 842 N.Y.S.2d 153 (App. Term 9th & 10th Dists. 2007). Whether the applicant possesses the verification requested or it is in the hands of the referring physician, it cannot shift its obligation to verify a claim to the insurer. *D & R Medical Supply, Inc. v. Clarendon Nat. Ins. Co.*, 22 Misc.3d 1127(A),

881 N.Y.S.2d 362 (Table), 2009 N.Y. Slip Op. 50306(U), 2009 WL 485262 (Civ. Ct. Kings Co., Genine D. Edwards, J., Feb. 26, 2009). A verification request for "a narrative report of the patient's initial consultation from the prescribing/ referring physician (Dr. Goldman)" is reasonable. *Custom Orthotics, Ltd. v. Government Employees Ins. Co.*, 25 Misc.3d 545, 883 N.Y.S.2d 884 (Civ. Ct. Queens Co. 2009). [T]he No-Fault carrier may inquire into their medical necessity by requesting a letter of medical necessity from the referring physician and a claim form with a valid provider's signature. *Lenox Hill Radiology v. Global Liberty Ins.*, 20 Misc.3d 434, 858 N.Y.S.2d 587 (Civ. Ct. Kings Co. 2008). As such I find the bill at issue was timely denied based on the 9/5/17 peer review by Lisa Nason, M.D. (in light of verification that was requested and received). There is also a 12/6/17 denial which states "The policy limits have been exhausted as of 12/6/17." Respondent submitted copies of the Policy Declarations Pages (confirming a \$50,000.00 policy limit with respect to PIP benefits), the affidavit of Senior No-Fault Representative Kelley Teague-Quereshi, and a handwritten payment ledger which indicates that \$50,000.00 in medical payments were made. After carefully reviewing all of Respondent's submissions I am persuaded that the policy limits were exhausted. Respondent argued that an insurer is not required to pay a claim where the policy limits have been exhausted. (See, *Mount Sinai Hospital v. Zurich American Ins. Co.*, 15 AD3d 550 790 N.Y.S. 2d 216 (2nd Dept. 2005)). Moreover, Respondent argued that a policy exhaustion defense would not be precluded even if it was determined that the denial of claim form was not issued within 30 days. (See, *New York and Presbyterian Hospital v. Allstate Ins. Co.*, 12 AD3d 579, 786 N.Y.S.2d 68 (2nd Dept. 2004).

Applicant argued that Respondent should not be relieved of having to pay the claim. Applicant argued that if I determined that the total amount of the claim was to be paid, then Respondent should pay the claim since it was received prior in time to claims of other providers which were paid. In other words, Applicant argued that the insurer would be obligated to set aside money for all denied claims pending the possibility of ensuing litigation/arbitration which may be filed within six years. This would also mean not paying subsequently received claims and would hold up the payment of claims for services which the carrier found medically necessary.

The Court of Appeals addressed a similar issue in *Nyack Hospital v. General Motors Acceptance Corp.*, 8 NY3d 294, 832 N.Y.S.2d 880 (2007). The *Nyack* Court found that an insurer which is waiting for information to verify a pending claim that causes aggregate claims to exceed \$50,000 is not prohibited by the priority-of-payment regulation - 11 NYCRR 65-3.15. The Court noted that to hold up payment of other medical providers bills to wait for additional verification of a previously received bill would contravene the requirement that the other bills be paid or denied within 30 days. Similarly, where services were paid pursuant to fee schedule, having the insurer set aside funds in the anticipation of litigation would contravene the requirement that other bills be paid within 30 days. Once the policy limits are exhausted, the insurer is not obligated to make any further payments to an assignee or an assignor, notwithstanding a priority of claim or an overturned denial. The New York State Insurance Department Office of General Counsel issued an opinion on 7/30/08 stating that once the policy limits are exhausted, the assignment of benefits becomes ineffective. (OGC Op. No. 08-07-28).

There is no evidence that Respondent acted in bad faith. There is no evidence in this case that Respondent acted improperly or wrongfully in issuing this denial. Furthermore, I do not believe, in light of the clear language of the Statute and Regulation, that I have the authority to increase the amount of statutory, regulatory and contractually limited coverage, even were I to find some evidence of bad faith.

Respondent's defense that the policy limits have been exhausted would be dispositive of this claim without requiring a determination of the issue of medical necessity. For the reasons set forth below Respondent would only have to pay this award up to the limits of the policy.

11 NYCRR Section 65-3.15 provides as follows: "When claims aggregate to more than \$50,000, 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. If the insurer pays the \$50,000 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, all at the same time, the payments shall be made in the order of rendition of the services."

Case law dictates that an insurer is not required to pay a claim where the policy limits have been exhausted. *Mount Sinai Hospital v. Zurich American Ins. Co.*, 15 A.D.3d 550, 790 N.Y.S.2d 216 (2d Dept. 2005). An insurer's failure to issue a denial of the claim within 30 days does not preclude a defense that the coverage limits of the subject policy have been exhausted. *Crossbridge Diagnostic Radiology v. Encompass Insurance*, 24 Misc.3d 134(A), 890 N.Y.S.2d 368 (Table), 2009 N.Y. Slip Op. 51415(U), 2009 WL 1911909 (App. Term 2d, 11th & 13th Dists. June 23, 2009). See also, *New York & Presbyterian Hospital v. Allstate Ins. Co.*, 12 A.D.3d 579, 786 N.Y.S.2d 68 (2d Dept. 2004); *Flushing Traditional Acupuncture, P.C. v. Infinity Group*, 2012 NY Slip Op. 22345 (App Term 2d, 11th & 13th Jud Dists Nov. 26, 2012). Where an insurer "has paid the full monetary limits set forth in the policy, its duties under the contract of insurance cease" *Presbyterian Hosp. in the City of New York v. Liberty Mut. Ins. Co.*, 216 A.D.2d 448, 628 N.Y.S.2d 396; see also, *Hospital for Joint Diseases v. State Farm Mutual Automobile Ins. Co.*, 8 A.D.3d 533, *Champagne v. State Farm Mut. Auto. Ins. Co.*, 185 A.D.2d 835, 837, 586 N.Y.S.2d 813, *Hospital for Joint Diseases v. Hertz Corp.*, 22 AD3d 724, 2005 NY Slip Op. 07932. In addition, policy exhaustion may be proven by submitting a payment log or payment register establishing when and to whom payments made totaling the policy limits. See *St. Vincent's Hospital & Medical Center, etc. v. Allstate Insurance Company*, 294 AD2d 425, 742 N.Y.S.2d 350 (2002).

In *Allstate Ins. Co. v. DeMoura*, the court states, "When an insurer "has paid the full monetary limits set forth in the policy, its duties under the contract of insurance cease" (*Countrywide Ins. Co. v. Sawh*, 272 AD2d 245 [2000]). A defense that the coverage limits of the policy have been exhausted may be asserted by an insurer despite its failure to issue a denial of the claim within the 30-day period (*New York & Presby. Hosp. v. Allstate Ins. Co.*, 12 AD3d 579 [2004]), **and an arbitrator's award directing payment in excess of the \$50,000 limit of a no-fault insurance policy exceeds the arbitrator's power and constitutes grounds for vacatur of the award**(see *Matter of Brijmohan v.*

State Farm Ins. Co., 92 NY2d 821, 822 [1998]; *Countrywide Ins. Co. v. Sawh*, 272 AD2d at 245; 11 NYCRR 65-1.1)." *Allstate Ins. Co. v. Moira*, 30 Misc.3d 145 (A), [App Term, 1st Dept. 2011]{Emphasis added}. In *Allstate Insurance Company v. Countrywide Insurance Company*, 2013 NY Slip Op. 33179 (December 12, 2013 Sup. Ct., NY Co.), the Court, in addressing a motion to vacate an arbitration award pursuant to CPLR 7511, noted that "with respect to arbitration proceedings concerning no-fault insurance benefits, **an arbitration award made in excess of the contractual limits of an insurance policy has been deemed an action in excess of authority** (*State Farm Ins. Co. v. Credle*, 228 A.D.2d 191, 643 N.Y.S.2d 97, 98 [1st Dept 1996]){Emphasis added}." The Court further noted that "**Such excess of authority constitutes grounds for vacatur of the award** (*See Matter of Brijmohan v. State Farm Ins. Co.*, 92 N.Y.2d 821, 822 [1998]){Emphasis added}."

On 11/21/18 (the day of the hearing) Applicant uploaded arbitration awards and copies of court decisions in support of the position that Respondent cannot argue policy exhaustion as the reason not to pay this claim. At the hearing Applicant's counsel cited *Alleviation Medical Services, P.C. v. Allstate Insurance Company*, 49 N.Y.S. 3d 814, 2017 N.Y. Slip Op. 27097 in support of this position. This hearing was held open for Respondent "to submit copies of court decisions/arbitration awards in reply to Applicant's supplemental submission made 11/21/18 (the day of the hearing) and their arguments involving the decision in *Alleviation Med. Servs., P.C. v. Allstate Ins. Co.*, 2017 NY Slip Op. 27097 (App Term 2d, 11th & 13th Jud Dists. March 29, 2017)." Despite follow-up no post hearing submissions were made.

Subsequent to denial of a claim on the ground of lack of medical necessity, a No-Fault insurer may pay uncontested claims and satisfy arbitration awards, such that if by the time the former claim is litigated, the governing policy's coverage limits have been exhausted the insurer may assert that fact as a defense. *Harmonic Physical Therapy, P.C. v. Praetorian Ins. Co.*, 47 Misc.3d 137(A), 2015 N.Y. Slip Op. 50525(U) (App. Term 1st Dept. Apr. 14, 2015). *Harmonic Physical Therapy, P.C.* is in conflict with *Alleviation Medical Services, P.C. v. Allstate Ins. Co.*, 55 Misc.3d 44, 45 (App. Term 2d, 11th & 13th Dists. 2017), wherein the Court stated, "As we read *Nyack Hosp.* to hold that fully verified claims are payable in the order they are received (*see* 11 NYCRR 65-3.8 [b] [3]; 65-3.15; *Nyack Hosp.*, 8 NY3d 294), defendant's argument-that it need not pay the claim at issue because defendant paid other claims after it had denied the instant claim, which subsequent payments exhausted the available coverage-lacks merit (*see* 11 NYCRR 65-3.15; *cf. Nyack Hosp.*, 8 NY3d 294; *but see Harmonic Physical Therapy, P.C. v Praetorian Ins. Co.*, 47 Misc 3d 137[A], 2015 NY Slip Op. 50525[U] [App Term, 1st Dept 2015])." I find that the reasoning in *Harmonic Physical Therapy, P.C.* is more persuasive than that in *Alleviation Medical Services, P.C.* I decline to follow the holding in the latter case.

The facts here -- a timely denial -- distinguish this case from *Nyack Hospital v. General Motors Acceptance Corp.*, 8 N.Y.3d 294 (2007), and *NYU Hospitals Center - Hospital for Joint Diseases v. State Farm Mutual Automobile Ins. Co.*, Sup. Ct. Nassau Co., Leonard Steinman, J., Oct. 26, 2016). In both cases, the insurer had to pay No-Fault benefits despite policy exhaustion since the respective denials were not timely issued.

Therefore, based on the above, Respondent has established that the policy limits were exhausted and Applicant's claim is denied.

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

04/03/2019
(Dated)

Charles Blattberg

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:
bb5c4d00859aae67393d998532db3960

Electronically Signed

Your name: Charles Blattberg
Signed on: 04/03/2019