American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

JJL Chiropractic, PC (Applicant)	AAA Case No.	17-19-1119-7524
	Applicant's File No.	JJL-0136
- and -	Insurer's Claim File No.	BU201860150035005
	NAIC No.	Self-Insured
New York City Transit Authority (Respondent)		

ARBITRATION AWARD

I, Giovanna Tuttolomondo, 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

1. Hearing(s) held on 03/05/2020
   Declared closed by the arbitrator on 03/13/2020

   Gill Schapira, Esq. from The Law Office of Gill S. Schapira, P.C participated in person for the Applicant

   Lee-Ann Trupiano, Esq. from Jones, Jones, LLC participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 2,066.51**, 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 Assignor, HW, now a 53-year-old male, was a passenger in a motor vehicle involved in an accident on June 15, 2018. Following the accident, the Assignor sought medical attention for the injuries sustained in the accident. At issue in this case are claims totaling $ 2,066.51, representing EMG/NCV testing performed on the Assignor between August 7, 2018 and October 19, 2018. Respondent centrally maintains that the policy limits of $ 50,000.00 for Personal Injury Protection ("PIP") have been exhausted and that Applicant is not entitled to reimbursement. The issue presented is whether the policy limits have been exhausted, and if not, whether Respondent presents any other defense to these claims.

4. Findings, Conclusions, and Basis Therefor

The decision in this case is based upon the oral arguments of the parties' representatives at the hearing and upon my review of the submissions of the parties/post-hearing submissions made per my directives as contained in the Electronic Case Folder maintained by the American Arbitration Association. I have reviewed the documents in MODRIA as of the date of closing of this file and incorporate, and rely upon, said documents in making my decision. This decision is also based upon post-hearing submissions made per my directives.

11 NYCRR 65, also styled, "The Regulation," within Section 1 of the Mandatory Personal Injury Protection Endorsement, defines Basic Economic Loss as follows:

> Basic economic loss shall consist of medical expense, work loss, other expense and, when death occurs, a death benefit as herein provided. Except for such death benefit, basic economic loss shall not include any loss sustained on account of death. Basic economic loss of each eligible injured person on account of any single accident shall not exceed $50,000, except that any death benefit hereunder shall be in addition thereto.

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 City of New York v. Liberty Mut. Ins. Co., 216 A.D.2d 448628 N.Y.S.2d 396 (2d Dept. 1995); Hospital for Joint Diseases v. Hertz Corp., 22 A.D.3d 724803 N.Y.S.2d 670 (2d Dept. 2005). A policy exhaustion defense may be raised at any time, and need not be preserved in a timely denial because coverage cannot be created where coverage does not exist. Presbyterian Hosp. in City of New York v. Empire. Ins. Co., 220 A.D.2d 733633 N.Y.S.2d 340 (2d Dept. 1995). Nor does the failure to disclaim coverage does not create coverage which the policy was not written to provide." Id. (citing Zappone v. Home Ins. Co., 55 N.Y.2d 131, 432 N.E.2d 783 (1982).

As expressed in Black Bull Contracting, LLC v. Indian Harbor Ins. Co., 135 A.D.3d 40123 N.Y.S.3d 59 (1st Dept. 2016):

> "Disclaimer pursuant to section 3420(d) [now § 3420(d)(2)] is unnecessary when a claim falls outside the scope of the policy's coverage portion. Under those circumstances, the insurance policy does not contemplate coverage in the first instance, and requiring payment of a claim upon failure to timely disclaim would create coverage where it never existed."

The Office of General Counsel issued the following opinion on July 30, 2008, representing the position of the New York Insurance Department, which states, in pertinent part that:

> When a patient's available no-fault benefits are exhausted, the assignment of those benefits for health services rendered is no longer effective, as there are no other benefits available under the applicable policy. Whether the health care provider is thereafter able to bill the patient is dependent upon whether any other health services coverage is available and, if so, the contractual arrangement that the provider has with the patient and/or the insurer providing the other health services coverage. **See, New York State Department of Financial Services, OGC Op. No. 08-07-28.**

Finally, as set forth in Allstate Ins. Co. v DeMoura, 30 Misc.3d 145(A), 926 N.Y.S.2d 342 (Table) (App. Term 1st Dept. 2011), an arbitrator's award directing payment in excess of the $50,000.00 limit of a no-fault insurance policy exceeds the arbitrator's power and constitutes grounds for vacatur of the award.

Self-Insurers

11 NYCRR 65-2.2 provides:

Obligations of self-insurers. (a) In accordance with the provisions of article 51 of the New York Insurance Law and this Part, a self-insurer shall pay first party benefits to reimburse for basic economic loss sustained by an eligible injured person on account of personal injuries caused by an accident arising out of the use or operation of a motor vehicle within the United States of America, its territories or possessions, or Canada.

-and-

(c) Basic economic loss. Basic economic loss shall consist of medical expense, work loss, other expense and, when death occurs, a death benefit as provided in this section. Except for such death benefit, basic economic loss shall not include any loss sustained on account of death. Basic economic loss of each eligible injured person on account of any single accident shall not exceed $50,000, or $75,000 if the self-insurer elects to provide optional basic economic loss coverage, except that any death benefit shall be in addition thereto.

Herein, per the Affidavit of Seth Norman, a representative of Respondent, Respondent provides the minimum amount of No-Fault coverage ($ 50,000.00); coupled with the payment ledger/log indicating that the maximum amount for medical expenses, lost wages and related offsets, was paid out to several providers-assignees on behalf of the Assignor, Respondent establishes its policy exhaustion defense. I find that there are no further monies under the policy and therefore, no coverage for the Applicant's claims herein.

I am cognizant of Alleviation Med. Servs., P.C. v. Allstate Ins. Co., 2017 NY Slip Op 27097 (App. Term 2d, 11th and 13th Jud. Dists. 2007), often cited in support of the proposition that an insurer must award benefits in excess of the insurance policy.

I do not find that an insurer must pay benefits in excess of the insurance policy. Coverage may not be created where none exists. It is the Arbitrator's position that a party-*in this case, the Assignee-provider*-who stands in the shoes of the Assignor, cannot demand more than what was bargained for (under the insurance policy and contract which the Assignor and Assignee is bound by), as in a standard contract matter. The policy of insurance under which the Applicant brings this Arbitration provides that $ 50,000.00 in benefits coverage must be paid out. Here, the maximum amount under the policy of insurance was paid out. The insurer has performed its duties under the policy of insurance.

Within the No-Fault sphere, there is the possibility that an Assignor or insured will treat with various and many providers; evidently, there will be providers who will be excluded from coverage based on policy exhaustion. There is also the circumstance where an insurer will timely deny a claim but its defense will ultimately be found to lack merit. However, the insurer should not be penalized because some providers are quicker than others to submit their claims or in their race to file for reimbursement via Arbitration or litigation. Moreover, the Insurance Laws and Regulation are designed to ensure payment of benefits, up to monetary limits; they are not designed to allow each and every provider to recover payments simply by virtue of an Assignment of Benefits.

I note also that the Court, in Alleviation Med. Servs., P.C. v. Allstate Ins. Co, refers ("but see") to Harmonic Physical Therapy, P.C., v. Praetorian Insurance Company, 47 Misc.3d 137(A)15 N.Y.S.3d 711 (Table) 2015 N.Y. Slip Op. 50525(U)(App. Term, 1st Dept. 2015). In that case, the Court held:

> "The evidentiary proof submitted by defendant established that, following the timely denial of plaintiff-provider's claim on the ground of lack of medical necessity, the governing insurance policy's coverage limits had been exhausted through payment of no-fault benefits in satisfaction of arbitration awards rendered in favor of other health care providers, and that such payments were made in compliance with the priority of payment regulation (*see* 11 NYCRR 65-3.15; *Nyack Hosp. v General Motors Acceptance Corp.*, 8 NY3d 294 [2007]; *New York and Presbyt. Hosp. v Allstate Ins. Co.*, 28 AD3d 528 [2006]). In opposition, plaintiff failed to raise a triable issue. ***Contrary to plaintiff's contention, defendant was not precluded by 11 NYCRR 65-3.15from paying other providers' legitimate claims subsequent to the denial of plaintiff's claims***. Adopting plaintiff's position, which would require defendant to delay payment on uncontested claims, or, as here, on binding arbitration awards - pending resolution of plaintiff's disputed claim - "runs counter to the no-fault regulatory scheme, which is designed to promote prompt payment of legitimate claims."" [emphasis added].

It is interesting that the Alleviation Court cited Harmonic, considering that it runs counter to its holding. This illustrates a divergence in opinion on the issue of exhaustion.

However, I find that the reasoning in Harmonic is in line with the spirit of the Insurance Laws and Regulation and, along with the reasons set forth above, I find that Applicant is not entitled to reimbursement.

I am also cognizant of a case recently decided by the Appellate Division, First Department, on January 23, 2020, Matter of Ameriprise Ins. Co. v. Kensington Radiology Group, P.C., 2020 NY Slip Op 00500. It has been advocated in other cases before this Arbitrator that the Decision in Ameriprise Ins. Co. appears to follow the holding in Alleviation Med. Servs., P.C. v. Allstate Ins. Co., 2017 NY Slip Op 27097 (App. Term 2d, 11th and 13th Jud. Dists. 2007) and essentially, undermines, if not vitiates, the reasoning in Harmonic Physical Therapy, P.C., v. Praetorian Insurance Company, 47 Misc.3d 137(A)15 N.Y.S.3d 711 (Table) 2015 N.Y. Slip Op. 50525(U)(App. Term, 1st Dept. 2015).

However, I do not agree. The Decision in Ameriprise Ins. Co. does not affirmatively state that payment may be awarded in excess of the policy limits. In addition, the Appellate Division in its Decision, references Matter of Brijmohan v. State Farm Ins. Co., 92 N.Y.2d 821 (1998), in expressing that,

> "The defense that an award exceeds an arbitrator's power is so important that a party my introduce evidence for the first time when the other party tries to confirm the award."

The Court of Appeals, in Brijmohan, stated:

> "A limitation on the arbitrator's power "will not be waived if the party relying on it asserts it at Special Term in opposition to an application for confirmation" (*Matter of Silverman [Benmor Coats]*,61 N.Y.2d 299, 309; *see*, CPLR 7511 [b] [1] [iii]). Here the arbitration clause of the policy incorporated by reference the rules of the American Arbitration Association, which in turn provided that the **arbitrator "shall render a decisionnot in excess of the applicable policy limits." The declarations page produced at the confirmation proceeding demonstrates that the arbitrator's award was beyond the policy limits and therefore in excess of the arbitrator's powers** (*see, Matter of Silverman [Benmor Coats]*, *supra*)." [emphasis added]

Thus, simply, the Arbitrator lacks authority to award payment in excess of the policy limits.

Respondent has established its defense predicated upon policy exhaustion. I need not reach any other defenses as they are moot. Applicant's claims are denied in their 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, Giovanna Tuttolomondo, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

03/14/2020
(Dated)

Giovanna Tuttolomondo

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:
4360f45f2104e721f9698e1df87b6bc4

Electronically Signed

Your name: Giovanna Tuttolomondo
Signed on: 03/14/2020