American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Choi Acupuncture, P.C. (Applicant)	AAA Case No.	17-18-1107-0339
	Applicant's File No.	n/a
- and -	Insurer's Claim File No.	0129727420101028
	NAIC No.	35882
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-C.W.

1. Hearing(s) held on 03/04/2020
   Declared closed by the arbitrator on 03/04/2020

   Rima Nayberg from Law Offices of Rima Nayberg P.C participated by telephone for the Applicant

   Wayne Mitchell from Law Office of Goldstein, Flecker & Hopkins participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 773.28**, 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 claim was 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 Assignor-C.W., a 51-year-old female, claimed injuries as the driver of a motor vehicle involved in an accident that occurred on 8/14/2016. Applicant seeks reimbursement for acupuncture and cupping services performed from 7/25/2017

through 8/30/2017. Respondent partially denied the claims based on the Independent Medical Examination of Kevin Spears, L.Ac., effective 7/7/2017. While Respondent timely denied the bills based upon the lack of medical necessity, the determinative issue presented is whether the Respondent has established that the policy of insurance is exhausted?

4. Findings, Conclusions, and Basis Therefor

Applicant seeks reimbursement for acupuncture and cupping services. This case was decided based upon the submissions of the Parties as contained in the electronic file maintained by the American Arbitration Association, and the oral arguments of the parties' representatives. There were no witnesses. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

11 NYCRR 65-4.5 (o) (1) (Regulation 68-D), reads as follows: The arbitrator shall be the judge of the relevance and materiality of the evidence offered and strict conformity to legal rules of evidence shall not be necessary. The arbitrator may question any witness or party and independently raise any issue that the arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department Regulations.

POLICY EXHAUSTION

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. An insured is entitled to receive first-party benefits under the No-Fault Law equal to his basic economic loss, up to $50,000 less the deductions set forth in the Insurance Law and, hence, an insurer may reduce the $50,000 basic economic loss limit by taking deductions representing Social Security disability benefits received and 20% of lost earnings. Normile v. Allstate Ins. Co., 60 N.Y.2d 1003, 471 N.Y.S.2d 550 (1983), aff'g, 87 A.D.2d 721, 448 N.Y.S.2d 907 (3d Dept. 1982). 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. 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. Swah, 272 A.D.2d 245 (1st Dept. 2000).

A defense of no coverage due to the exhaustion of No-Fault insurance policy's limit may be asserted by an insurer despite its failure to issue a NF-10 denial of claim form within the requisite 30 day period. New York & Presby. Hosp. v. Allstate Ins. Co., 12 A.D.3d 579, 580 (2d Dept. 2004); Flushing Traditional Acupuncture, P.C. v. Infinity Group, 2012 NY Slip Op 22345 (App Term 2d, 11th & 13th Jud Dists, November 26, 2012); Crossbridge Diagnostic Radiology v. Encompass Ins., 24 Misc.3d 134(A), 2009 NY Slip Op 5141(U) (App Term 2d,11th & 13th Jud Dists, 2009). An Arbitrator's award directing payment in excess of the limits of an insurance policy exceeds the arbitrator's power and constitutes grounds for vacatur of the award. Matter of Brijmohan v. State Farm Ins. Co., 92 N.Y.2d 821, 822 (1998); Countrywide Ins. Co. v. Swah, 272 A.D.2d

245 (1st Dept. 2000). Note that the Swah case, *supra*, has been cited at least six times for this proposition. *See*, Matter of Motor Vehicle Accident Indemnification Corp. v. Am. Country Ins. Co., 2015 NY Slip Op 02714, 126 A.D.3d 657, 4 N.Y.S.3d 487 (App. Div.); Breeze Acupuncture, P.C. v. Allstate Ins. Co., 2018 NY Slip Op 50138(U), 58 Misc. 3d 1217(A) (Civ. Ct.); Ameriprise Ins. Co. v. Kensington Radiology Grp., P.C., 2017 NY Slip Op 51911(U), 58 Page 3/6 4. 5. 6. Misc. 3d 144(A) (App. Term); Allstate Prop. & Cas. Ins. Co. v. Ne. Anesthesia & Pain Mgmt., 2016 NY Slip Op 50828(U), 51 Misc. 3d 149(A), 41 N.Y.S.3d 448 (App. Term); Allstate Ins. Co. v. Countrywide Ins. Co., 2013 NY Slip Op 33179(U) (Sup. Ct.); Allstate Ins. Co. v. Auto One Ins. Co., 2012 NY Slip Op 50874(U), 35 Misc. 3d 140(A), 953 N.Y.S.2d 548 (App. Term).

Lastly, the Office of the General Counsel of the New York State Insurance Department (now the Department of Financial Services, or "DFS") issued an opinion on 7/30/2008 stating that an assignment of benefits is wholly ineffective once the policy limits are exhausted (OGC Op. No. 08-07-28). The proper recourse for an assignee/provider is to submit the claim to the claimant's private health insurer or bring an action against the claimant/assignor.

ANALYSIS

In support of the contention that the policy has been exhausted, Respondent submits a copy of the declaration page for the policy at issue, which shows it is a New York Policy, which contains Personal Injury Protection (PIP) coverage in the amount of $50,000.00. There is no additional PIP coverage available on this policy. Respondent also submits a payment ledger showing that $50,000.00 has been paid out on this policy as of 11/8/2019. Respondent issued a global denial on 11/12/2019 advising "the policy carries No-Fault coverage of $50,000.00 which has been exhausted. Please submit your bill to the patient's private health insurance carrier." Applicant did not submit any evidence to rebut the Respondent's defense of policy exhaustion. Based upon a review of Respondent's submission it has demonstrated the policy at issue has been exhausted.

Notably, I previously decided in the linked case of*Hillcrest Medical Care, P.C. v. Geico Ins. Co.,* AAA Case No.: 17-18-1089-6211, which was issued on 3/5/2020, that Respondent demonstrated that the policy at issue has been exhausted. While this decision is not entitled to collateral estoppel effect as the Applicant is different, the decision is persuasive as the same Assignor and insurance policy are at issue in this case. Specifically, the award stated in pertinent part:

> *In support of the contention that the policy has been exhausted, Respondent submits a copy of the declaration page for the policy at issue, which shows it is a New York Policy, which contains Personal Injury Protection (PIP) coverage in the amount of $50,000.00. There is no additional PIP coverage available on this policy. Respondent also submits a payment ledger showing that $50,000.00 has been paid out on this policy as of 11/8/2019. Respondent issued a global denial on 11/12/2019 advising "the policy carries No-Fault coverage of $50,000.00 which has been exhausted. Please submit your bill to the patient's private health insurance carrier." Applicant did not submit any evidence to rebut*

> *the Respondent's defense of policy exhaustion. Based upon a review of Respondent's submission it has demonstrated the policy at issue has been exhausted.*
>
> …
>
> *Applicant's claim is denied in its entirety. This decision is in full disposition of all claims for No-Fault benefits presently before this arbitrator.*

Based upon a review of Respondent's submission it has demonstrated the policy at issue has been exhausted.

As with the linked case, Applicant argued that the Respondent must pay beyond the coverage limits on the grounds that there was money available when the claim was received, and thus, if its denial is not sustained, it had a priority of payment under 11 NYCRR 65-3.15. Citing to Alleviation Med. Svcs. P.C. v. Allstate, 55 Misc.3d 44, 2017 N.Y. Slip Op. 27097 (App. Term, 2nd, 11th and 13th Jud. Dists.) contending that since there was money left on the policy when the Applicant's bills were received by the Respondent and denied, that this bill should be paid if the denial is deemed invalid, e.g., upon a finding at arbitration that the services were medically necessary and billed in accordance with the Fee Schedule. I respectfully disagree. In Alleviation, *supra.*, the Appellate Term upheld the Civil Court's denial of summary judgment to the defendant insurance company on the issue of policy exhaustion. Thus, I do not interpret the decision in Alleviation, *supra.*, to overturn the long line of case law that clearly states an insurer's liability ends upon exhaustion of its policy limits. Noteworthy is the court's recognition of the holding in 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. 2015).

I choose to follow the decision of the Appellate Term, First Department in Harmonic Physical Therapy v. Praetorian Insurance Company, supra, which holds that that subsequent verified and undisputed claims had a priority of payment under 11 NYCRR §65-3.15 before the disputed claim of the plaintiff provider. In other words, denied claims do not hold a place in the priority of payment line ahead of subsequently filed claims that were paid by the Respondent.

The court in Harmonic Physical Therapy, *supra*, stated, in part, "Contrary to plaintiff's contention, defendant was not precluded by 11 NYCRR §65-3.15 from 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'".

Applicant's claim is denied in its entirety. This decision is in full disposition of all claims for No-Fault benefits presently before 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 New York
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.

03/17/2020
(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:
70a58f75959deab43e41a59b16d2061f

Electronically Signed

Your name: Eileen Hennessy
Signed on: 03/17/2020