American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Central Park Physical Medicine P.C. (Applicant)	AAA Case No.	17-19-1143-0557
	Applicant's File No.	GTLCPK032519.040
- and -	Insurer's Claim File No.	0367806060101059
	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-D.D.

1. Hearing(s) held on 02/09/2021
   Declared closed by the arbitrator on 03/16/2021

   George T. Lewis from Law Offices of George T. Lewis, Jr., PC participated in person for the Applicant

   Christa Varone from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 1,010.46**, 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 record reveals that Assignor-D.D., a 51-year-old female, claimed injuries as the driver of a motor vehicle involved in an accident that occurred on 8/5/2018. Applicant seeks reimbursement for a lumbar epidural injection under fluoroscopy, epidurography, and injectable medication conducted on 2/28/2019. Respondent denied the claim based on the 120-day rule. While Respondent denied the bill based on the 120-day rule, 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 fora lumbar epidural injection under fluoroscopy, epidurography, and injectable medication. 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.

PRIORITY OF PAYMENT

Arbitrator Mitchell Lutsig conducted a well-reasoned analysis of the priority of payment regulation in *Cypress Acupuncture, P.C. and Enterprise Rent A Car*, AAA Case No. 17-17-1069-3720, (10/10/2018), which is cited in pertinent part herein.

> In addition to establishing payment of the policy limits, the insurance carrier must also demonstrate that the payments which led to the depletion of policy benefits were made in compliance with 11 NYCRR § 65-3.15 (Computation of basic economic loss). *See* Nyack Hospital v. General Motors Acceptance Corp., 8 N.Y.3d 294 (2007); New York & Presbyterian Hospital v. Allstate Ins.Co., 12 A.D.3d 579, 580 (2 Dept. 2004). *See also* Doshi Diagnostic Imaging Service P.C. v. State Farm Mutual Automobile Insurance Company , AAA Case No.: 17-15-1014-9374 (Arbitrator Andrew Horn,12/23/16).
> 11 NYCRR § 65-3.15 provides that:
>
> > (w)hen 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 therefor 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, at the same time, the payments shall be made in the order of rendition of services.
>
> 11 NYCRR § 65-3.15 does not preclude an insurer from paying other providers' claims during a time that the 30-day statutory period in which to pay or deny a claim is tolled pursuant to a request for additional verification, *see* Nyack Hospital v. General Motors Acceptance Corp,, 8 N.Y.3d 294 (2007); Mount Sinai Hosp. v. Country Wide Ins. Co. 85 A.D.3d 1136 (2d Dept. 2011), nor does it bar an insurer, following the timely denial of a claim, from paying other providers' undisputed claims pending resolution of the dispute, *see* Allstate Prop & Cas. Ins. Co., v. Northeast Anesthesia &

Pain Mgt., 2016 N.Y. Slip Op. 50828(U) (App. Term 1 Dept. 2016); Harmonic Physical Therapy, P.C. v. Praetorian Ins. Co., 2015 NY Slip Op 50525(U) (App Term 1st Dept.,2015); AAA Integrated Medical Rehab & Diagnostic P.C. and Geico Ins. Co., Case No. 412013081427, AAA Assessment No. 17 991 R 25938 14 (Master arb. Victor J. Hershdorfer, May 9, 2014). In such instances, an insurer's payments are made in compliance with the priority of payment regulation because they were made before the insurer was obligated to pay the disputed claim. *Id.*

However, the Respondent has failed to convince me that a bill which has not been denied despite proof of mailing of same automatically loses its place on the priority-of-payment line. *See Neofitios Stefanidies, MD PC v. New York City Transit Authority*, AAA Case No.: 17-16-032-0153 (Arbitrator Mitchell Lustig, 10/30/17), aff'd by Master Arbitrator Robert Trestman, 99-16-1032-0153 (2/10/18).

Such an argument was resoundingly rejected in a case strikingly on point, Westchester Medical Center v. Philadelphia Indemnity Company, 69 A.D.3d 613, 892 N.Y.S.2d 484 (2 Dept. 2010), wherein claim forms "were mailed on April 23, 2008, and signed for by the (insurer) on April 28, 2008", at which time, "according to the (insurer's) own records, there were still sufficient funds remaining under the policy to pay (the) bill". In response, the insurance carrier offered "an affidavit, which … averred that there was no record of the bill in question in (its) computer system". The Appellate Division found that the affidavit "was insufficient" because "the affiant failed to show any knowledge of the office procedures employed in the handling of billing forms received" at the insurer's office, and, accordingly, rejected the insurer's exhaustion defense.

In Mount Sinai Hospital v. Dust Tr Inc., 962 NYS 2d 307, 104 A.D.3d 823 (2 Dept. 2013), the appellate court rejected an insurer's motion to vacate a judgment because of "partial exhaustion of…coverage" because "the evidence submitted in support" was insufficient to establish that the "purported payments were made in compliance with 11 NYCRR Section 65-3.15."

Likewise, the court in NYU Hospitals Center-Hospital v. State Farm, NYLJ 12/08/16 (Sup. Ct. Nassau Cty., Steinman, J.), recently ruled that an insurance carrier "cannot rely upon an after-the-fact exhaustion defense" after it "simply breached the terms of the policy by failing to timely pay (the hospital) the amount properly due."

The Court of Appeals decision in Nyack Hosp. v. General Motors Acceptance Corp., 8 N.Y.3d 294, 301 (2007) is also instructive. In that action, the no-fault insurer paid out other claims after its receipt of the plaintiff hospital's claim- substantially exhausting its policy- while it awaited additional verification from the hospital. The Appellate Division granted summary judgment to the insurer based on the exhaustion defense. The Court of Appeals modified the decision, finding that that the insurer was entitled to pay subsequent verified claims while awaiting information from the hospital, but that the insurer's obligation to pay the hospital arose when the insurer received the requested information.

The Court in Nyack denied the insurer's summary judgment motion and remitted the case back to the trial court, holding, that, pursuant to 11 NYCRR Section 65-3.15 "the insurer should have paid the hospital ahead of any unpaid verified claims for services rendered or expenses occurred later than the services billed by the hospital, up to the policy limits." Of course, if 11NYCRR 65-3.15 had no teeth and the exhaustion of the policy in and of itself was a complete defense for the insurer, there would be no reason for the Court to reverse the grant of summary judgment and remand the matter to the trial court.

As noted by Arbitrator Shawn Kelleher in *Paul Brisson M.D. v. Selective Insurance Company of America*, AAA Case No.: 17-16-1050-3111 (8/20/18):

> "The Court in Nyack could have adopted a strict "50 is 50" rule (advocated by the Respondent's counsel in the within matter). However, the Court of Appeals specifically rejected same by remanding the matter to the trial court to determine the amount available on the policy when the subject claim became verified. Had the Court adopted a rigid "50 is 50" approach, it would have not mattered that the carrier paid the bill late, i.e. more than 30 days after the bill was verified. Therefore, it matters not that there were no funds available at the time of the hearing; it only matters if there were funds available at the time the claim was verified."

Adopting Respondent's position, which would permit an insurer to improperly delay paying or denying claims "runs counter to the no-fault regulatory scheme, which is designed to promote prompt payment," *see* Nyack Hosp v. General Motors Acceptance Corp., 8 N.Y.2d 294, 300 (2007).

As the court explained in NYU Hospitals Center-Hospital v. State Farm Mut. Auto Ins. Co., NYLJ 12/08/16 (Sup. Ct. Nassau Cty., Steinman, J.), "(p)olicy considerations militate against (the insurance carrier's) position" and concluded that the "loss … should fairly fall upon the insurer, which breached its obligation under the policy and violated the regulatory payment scheme."

After careful review of the record, I find that Respondent has failed to establish that there were insufficient funds to pay the bills that were not denied by the Respondent.

In reaching my determination herein, I am also persuaded by the reasoning of my fellow No-Fault arbitrators, who have held similarly.; D*oshi Diagnostic Imaging Service P.C. v. State Farm Mutual Automobile Insurance Company*, AAA Case No.: 17-15-1014-9374 (Arbitrator Andrew Horn,12/23/16); *Friendly RX Inc. D/BA Friendly RX Pharmacy v. State Farm Mutual Automobile Insurance Company*, AAA Case No.: 17-15-1004-8062 (Arbitrator Corinne Pascariu, 4/3/17), aff'd by Master Arbitrator Victor Hershdorfer, 99-15-1044-8062; *Lutheran Medical Center v. American Transit Insurance Company*, AAA Case No.: 17-15-1022-1541 (Arbitrator Andrew Horn, 12/16/16), aff'd by Master Arbitrator Richard

Ancowitz, 99-15-1022-1541; *City-Wide Rehab PT PC v. Ameriprise Insurance Company*, AAA Case No.: 17-14-9021-9518 (Arbitrator Rhonda Barry, 11/23/15).

POLICY EXHAUSTION

Legal Standard

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). For additional premiums, extra coverage is available for purchase such as Additional Personal Injury Protection (APIP) as well as Optional Basic Economic Loss (OBEL) which provides $25,000 more in coverage. *See*Insurance Law 5102 (a)(5).

The computation of basic economic loss can be found in 11 NYCRR §65-3.15: "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 therefor 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, at the same time, the payments shall be made in the order of rendition of services."

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. Countrywide Ins. Co. v. Swah, 272 A.D.2d 245 (1st Dept. 2000).

I note an opinion letter from the Office of General Counsel of the New York State Insurance Department (now the Department of Financial Services, or "DFS"), dated 7/30/2008, noting as follows: "Upon exhausting the amount of no-fault 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 no-fault benefits are exhausted as the patient is now an uninsured person." *See also* Long Island Radiology v. Allstate, 36Ad 3d 763 2d Dept. (2007).

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 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).

Furthermore, subsequent to the issuance of a denial, a No-Fault insurer may pay uncontested claims and satisfy arbitration awards. If the governing policy's coverage limits have been exhausted by the time the former claim is litigated, the insurer may assert that fact as a defense. Harmonic Physical Therapy, PC v. Praetorian Ins. Co., 47 Misc.3d 137(A), 15 N.Y.S.3d 711 (Table), 2015 NY Slip Op 50525(U)(App. Term, 1 Dept., Apr. 14, 2015).

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 or OBEL coverage available on this policy. Respondent also submits a payment ledger showing $28,700.20 in medical claims and $13,531.04 in lost wage claims totaling $42,231.24 has been paid out with $7,768.76 in offsets applied to the lost wage payments. Thus, Respondent alleges that the offsets, when combined with the payments made towards medical and lost wages claims, have exhausted the $50,000.00 PIP limit. Respondent issued a global denial on 10/17/2019 advising that the No-Fault policy limits has been exhausted.

Insurance Law § 5102(b) states:

> (b) "First party benefits" means payments to reimburse a person for basic economic loss on account of personal injury arising out of the use or operation of a motor vehicle, less:
>
> > (1) Twenty percent of lost earnings computed pursuant to paragraph two of subsection (a) of this section.
> >
> > (2) Amounts recovered or recoverable on account of such injury under state or federal laws providing social security benefits, or workers' compensation benefits, or disability benefits under

> article nine of the workers' compensation law, or medicare benefits, other than lifetime reserve days and provided further that the medicare benefits utilized herein do not result in a reduction of such persons' medicare benefits for a subsequent illness or injury. Further, the no-fault regulations make it clear that an insurer is entitled to apply offsets to a lost wage claim.

11 NYCRR § 65-3.16(b) states: (1) Benefits from other sources shall not be considered as an offset against or a deduction from loss of earnings, unless article 51 of the Insurance Law expressly provides for such offset or deduction. In addition, 11 NYCRR § 65-3.19 provides a lengthy discussion of the types and amounts of offsets that can be applied to a lost wage payment.

At the hearing, Applicant argued Respondent cannot prove that the policy is exhausted without submitting evidence supporting the offsets. Furthermore, Applicant argued that Respondent cannot assert an offset for NYS disability, as 11 NYCRR § 65.3.19(f) requires an insurer to:

> (1) provide the IP with a notice and proof of claim for disability benefits (DB 450) and,
> (2) notify an injured party's employer that the employer is required to process the injured party's disability benefits if the injured party is covered.

Applicant further argued that a carrier cannot assert a NYS disability benefit unless it has complied with the requirements above.

Applicant was directed to submit a post hearing brief outlining their arguments with supporting case law and arbitration decisions. Respondent was given an opportunity to submit a responsive post hearing brief. Specifically, I directed the following:

> **Briefs due from Applicant by 02/19/2021:**
> Applicant is directed to submit a post hearing brief by 2/19/2021 with memorandum of law and supporting case law in support of their arguments regarding the NF-6 and priority of payment.
> **Briefs due from Respondent by 03/05/2021:**
> Respondent may submit a post hearing brief in response by 3/5/2021 in support of their position that the policy is exhausted, priority of payment was properly followed, and any arguments raised by Applicant at hearing or in post hearing submission.

Applicant did not comply with my post hearing directive. Respondent submitted a detailed explanation of how they calculated the relevant lost wage offsets along with a memorandum of law in opposition to Applicant's arguments regarding the NF-6 via a post-hearing submission.

Respondent argued that the lost earnings offset imposed upon the injured person's lost earnings claim must each be included in the calculation of the total amount utilized to determine whether the $50,000.00 of no-fault coverage has been exhausted. Respondent further argues in the brief: "… the Regulations are clear that an insurer may deduct an

offset when an individual is entitled to disability. 11 NYCRR §65-3.19(f)(1) states that "Whenever an eligible injured person is entitled to disability benefits under article 9 of the Workers' Compensation Law, the insurer shall be entitled to an offset...".

Respondent submitted the claimant's NF-6, signed by Linda Dean, the "Senior Leave of Absence Specialist" for the claimant's employer. Respondent notes that the NF-6 states: "[Assignor-D.D.] is employed as a security guard full-time and that she has been employed there since 04/18/13. Question 6 on the NF-6 asks, 'Is the employee required to pay for DBL coverage through payroll deductions,' to which Ms. Dean answered 'YES'. Ms. Dean wrote that the company's disability provider is Unum and the policy number is 422849. Additionally, Ms. Dean wrote on the NF-6 that the claimant 'is eligible for NYDBL.' Clearly, [Assignor-D.D.] is entitled to disability benefits, and therefore, GEICO is entitled to deduct the disability offset. *See* 11 NYCRR §65-3.19(f)(1)".

Prevailing authority indicates that Respondent may include the amount attributable to the deduction/offset for lost earnings payments paid to the injured person and the deduction/offset of 20% of the injured person's lost earnings (each applied in accordance with Insurance Law section 5102 (a) (2) and (b) (1)) when calculating the exhaustion of the respondent's no-fault coverage. Prevailing authority also indicates that Respondent may include the amount attributable to payments made to the injured person for disability when calculating the exhaustion of the respondent's no-fault coverage.

I agree with Arbitrator Josh Youngman's analysis of this same argument made by Applicant's attorney in *WestMed Medical Group, PC and Geico Insurance Company*, AAA Case No. 17-19-1132-7875, [7/7/2020], cited by Respondent in their post hearing submission, which stated in pertinent part:

> *I note that the regulations do not definitely assert that a carrier cannot claim a NYS disability offset without complying with the above-referenced requirements, as 11 NYCRR § 65-3.19(f)(2) states:*
>
> > *(2) The insurer shall provide the applicant with a notice and proof of claim for disability benefits (DB 450), which has been printed on buff-colored paper and, in addition, shall notify the applicant's employer that such employer is required to process the applicant's disability benefits claim if its employees are covered for such benefits by the Workers' Compensation Law. The notification to the employer should be sent along with the Employer's Wage Verification Report (NYS Form N-F-6). Unless the insurer has complied with the above, it shall not take an offset for New York State disability benefits until it verifies that the applicant is actually receiving statutory disability benefits (emphasis added).*
>
> *Further, the applicant has not produced any evidence to show that the respondent's offsets were improper or that the IP was not entitled to a statutory source of disability such as NYS disability. The applicant further fails to provide any evidence that shows the IP was not receiving statutory disability benefits (or other benefits that are properly taken as an offset) or that the respondent failed to verify as much.*

> *I also note that per NY Work Comp L § 211 (2015), employers in New York State are obligated to provide disability coverage to covered employees, which is relevant since the applicant's NF-2 shows she was employed by a New York company.*

The Appellate Division, Third Department, in Normile v Allstate Ins. Co., 87 A.D.2d 721, 448 N.Y.S.2d 907 (3rd Dept. 1982); affirmed 60 N.Y.2d 1003, 459 N.E.2d 843 N.Y. (1983) 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."

Further, the Appellate Term for the 2nd and 11th Judicial Districts in Balanca v. Geico General Ins. Co., 13 Misc.3d 90, 827 N.Y.S.2d 408, (App. Term 2nd 11th Dist. 2006) 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 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."

Respondent paid a maximum of $2,000.00 per month according to the chart provided and took the appropriate 20% offset of that amount. The total amount of the offsets applied has been justified by the lost wages paid per month. As with the case decided by Arbitrator Youngman, Applicant has not produced any rebuttal evidence to show that the Respondent's offsets were improper or that the claimant was not entitled to a statutory source of disability such as NYS disability. Applicant further fails to provide any evidence that shows the claimant was not receiving statutory disability benefits (or other benefits that are properly taken as an offset) or that the Respondent failed to verify as much. In this case, the claimant is also employed by a NY company, which is obligated to provide disability coverage to covered employees pursuant to NY Work Comp L § 211 (2015).

Notably, I previously decided in seven linked cases, including *Healthwise Medical Associates, P.C. v. Geico Ins. Co.,* AAA Case No.: 17-19-1118-1245, heard on 2/3/2021, *Jonathan Lewin, MD, PC v. Geico Ins. Co.*AAA Case Nos.: 17-19-1125-6664 and17-19-1125-8354 and *Advanced Recovery Equipment & Supplies, LLC v. Geico Ins. Co.,*AAA Case No.: 17-19-1122-7159, heard on 10/20/2020, and *Tova Diagnostic v. Geico Ins. Co.,*AAA Case Nos.: 17-19-1132-6820, 17-19-1128-3434 and 17-19-1122-2394, heard on 12/15/2020, that Respondent demonstrated that the policy at issue was exhausted. While these decisions are not entitled to collateral estoppel effect as the Applicants are different, the decisions are persuasive as the same Assignor and insurance policy are at issue in this case and Respondent submitted identical proofs. These cases were not appealed.

Applicant further 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 bill was 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 Applicant responded to the verification request. 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 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.

CONCLUSION

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.

04/13/2021
(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

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Electronically Signed

Your name: Eileen Hennessy
Signed on: 04/13/2021