

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Alexandre DeMoura M.D. PC dba New York Spine Institute (Applicant)	AAA Case No.	17-20-1174-9047
	Applicant's File No.	20-006556
	Insurer's Claim File No.	0554052720
- and -	NAIC No.	19232

Allstate Insurance Company
(Respondent)

ARBITRATION AWARD

I, Jennifer Jacques-Miller, 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 05/13/2021
Declared closed by the arbitrator on 05/13/2021

Michael Maddaloni, Esq. from Super & Licatesi P.C. participated in person for the Applicant

Michael Rago, Esq. from Law Offices Of Karen L. Lawrence participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 3,043.33**, 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
Whether or not Respondent presented sufficient evidence to establish that policy limits have been exhausted?

The EIP (AD) is a 63 year-old female passenger, injured in a motor vehicle accident on 06/19/19.

Applicant seeks an amount of \$3,043.33 for medical services performed on 09/23/19. Respondent denied Applicant's claim based upon policy limit exhaustion.

4. Findings, Conclusions, and Basis Therefor

I have completely reviewed all timely submitted documents contained in the ADR Center record maintained by the American Arbitration Association and considered all oral arguments. No additional documents were submitted by either party at the hearing. No witnesses testified at the hearing.

Analysis

Applicant has established its prima facie entitlement to reimbursement for no fault benefits as a matter of law based upon the submission of a properly completed claim form setting forth the amount of the loss sustained and that payment is overdue. *Mary Immaculate Hospital v. AllState Insurance Company*, 5 AD 3d 742, (2nd Dept. 2004).

In support of its policy exhaustion defense, Respondent submitted evidence demonstrating that the PIP policy of the striking vehicle was exhausted in that Progressive Insurance Company paid \$50,000.00 in PIP benefits. Respondent submitted its declarations pages indicating that Respondent's policy afforded \$50,000.00 in PIP benefits, \$25,000.00 in OBEL benefits and \$50,000.00 in APIP benefits. The policy additionally provides \$100,000.00 for each person for Automobile Medical Payments. Respondent contended that a total of \$125,000.00 in PIP benefits was afforded by this policy. Since the first \$50,000.00 was already paid by Progressive Insurance Company, the insurer for the striking vehicle, Respondent's \$25,000.00 OBEL limits and \$50,000.00 APIP limits were paid and exhausted as evidenced by Respondent's Medical Bill Loss History.

Respondent has established through policy documents and payment ledgers that PIP coverage to this EIP has been exhausted. There is an inherent inequity in permitting the creation of coverage beyond that which was contemplated by the parties. Respondent accepted a premium in exchange for which they agreed to provide \$50,000 in PIP benefits. As this has been exhausted, respondent cannot be held accountable for services rendered beyond the policy limits.

The no-fault regulations provide for a "priority of payments." According to 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 assignee in the order in which each service was rendered were 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 or other services, at the same time, the payment should be made in the order of rendition of the services." In *Nyack Hospital v. General Motors Acceptance Corp.*, 8 NY 3d 294 (2007), the Court of Appeals determined that an insurer which is waiting for information to verify as pending claim that causes aggregate claims to exceed \$50,000 is not prohibited by the priority of payments regulation 11 NYCRR 65-3.15 from paying verified claims in the meantime. Plaintiff in *Nyack* argued that after receiving the hospital bill, the carrier had to hold money in reserve pending the receipt of the verification. The claim is then placed "back in line" for payment as verification is complete. I have reviewed *Nyack*, supra, thoroughly and the decision does not require an insurer to create a reserve account for previously denied claims. There was no finding, ruling or even suggestion that a claim which had been reviewed and denied

retains its payment priority pending a determination by an arbitrator or court on the efficacy of the denial. In short, the Court determined that once a claim is verified, payment must be made in the order the claims was received. The Court did not require an insurer to devise a payment method for previously denied claims pending adjudication of potential liability.

Therefore, I find it reasonable to conclude that when an insurer properly and timely denies a submitted claim or seeks verification for which there is no response, the insurer cannot be held liable for benefits that exceed the \$50,000 contracted for in the instant policy. See, *Hospital for Joint Diseases v. State Farm Mutual Automobile Insurance Company*, 8 Ad 3d 533, 779 NYS 2d 534 (2d Dep.t 2004). In this case the denial is timely. Whether or not the respondent would be able to sustain its burden of proof at arbitration is irrelevant to the issue of exhaustion. Certainly the respondent is not required to prove the efficacy of its defenses when issuing its NF-10s. See, *New York University Hospital-Tisch Institute v. GEICO*, 117 AD 3d 1012 (2d Dept. 2014). Very simply, the denial is timely; its propriety is irrelevant to the issue of exhaustion.

Once the policy limits are exhausted respondent's obligation under the policy ceased. In *Harmonic PT v. Praetorian Ins Co*, 2015 NY Slip Op 50525(U) (4/14/15), the court found that the insurer is not precluded by 11NYCRR 65-3.15 from paying other providers legitimate claims subsequent to the denial plaintiff (applicant's) claims. The insurer does not have to delay payment on uncontested claims or binding arbitration awards.

Applicant cites to *Alleviation Medical Services, PC v. Allstate Insurance Company*, 2017 NY Slip Op 27097 (App. Term 2d Dept., 3/29/17). The court determined that defendant's denial of a claim based on lack of medical necessity implicitly declared that the claim at issue was fully verified and as such was payable in the order it was received in accordance with 11 NYCRR 65 - 3.15 and *Nyack Hospital*, supra. The court held that defendant's argument that it need not pay the claim at issue because the policy had subsequently exhausted lack merit. The decision does not indicate whether or not the subject denial was timely. To the extent that the finding supports payment in excess of the policy if the underlying claim was timely denied, it is an anomaly I cannot consider.

Applicant does not dispute that stacking is not permitted. Applicant does not dispute that the \$50,000.00 PIP benefits along with Respondent's OBEL and APIP limits have exhausted. Applicant contends that the \$100,000.00 Automobile Medical Payments benefits are still available and Applicant should be reimbursed pursuant to those benefits. It is Applicant's position that the Automobile Medical Payments coverage is part of the Mandatory Personal Injury Protection Endorsement as excess insurance referring to the priority order of payments rather than an exclusion of it. Pursuant to the Insurance Law and Regulation 68, it is payable regardless of fault.

Respondent contends that Automobile Medical Payments coverage is supplemental coverage over the mandatory no-fault coverage. As the jurisdiction of this arbitration forum is limited to the resolution of disputes under the mandatory coverage required by the New York Insurance Law for no-fault benefits, the resolution of any disputes concerning Automobile Medical Payments benefits is outside the scope of No-Fault and the jurisdiction of this forum.

The general rule is stated in *Hospital for Joint Diseases, et al v. State Farm Mutual Automobile Insurance Company*, 8 AD 3d533 (2d Dep.t 2004) is that when an insurer has paid out the full monetary limits set forth in the policy its duty to pay under the contract ceases to exist. While sitting as a master arbitrator I previously ruled in numerous cases that a timely denied claim does not hold a place on the priority of payment line to subsequently filed claims that were paid by respondent. To require respondent to hold money in reserve for claims it was not then currently obligated to pay (such as when respondent issued a timely denial) would directly contradict the regulations which emphasize the prompt time limits for the submittal and processing of claims." *Allan Hausknecht MD Central Neurology PC v. Geico Insurance Company*, 17-14- 1001-2866 (Arbitrator Rickman, 11/5/15).

Respondent's Policy Endorsement provides that first-party benefits are payments equal to basic economic loss reduced by any applicable deductible, 20 percent of loss of earnings (to the extent that the basic economic loss consists of such earnings) or amounts recoverable under social security disability, workers' compensation benefits or disability benefits under New York Workers' Compensation Law. Further, that basic economic loss of each eligible injured person shall not exceed \$75,000.00, the last \$25,000.00 of which represents Optional Basic Economic Loss coverage payable after the first \$50,000.00 of basic economic loss has been exhausted. Section II Excess Coverage indicates that if motor vehicle medical payments coverage is afforded under the policy, such coverage shall be excess insurance over any Mandatory PIP, OBEL or APIP benefits. Part II of the Policy under Automobile Medical Payments Coverage specifically excludes injuries to any person to the extent that medical expenses are paid or payable to or on behalf of that person under any mandatory or additional personal injury protection benefits.

It is clear from the statutory language and policy language that the Automobile Medical Payments benefit is separate and distinct from first-party benefits. The additional first party benefits referred to by Ins. Law 5106(b) pertains to APIP. Further, Automobile Medical Payments benefits are not mandatory. It is an optional coverage. Contrary to the Applicant's contention, such coverage is not governed by Insurance Law Article 51 or the Regulations. While 11 NYCRR 65-1 Mandatory Personal Injury Protection Endorsement (New York) Section II, pertaining to excess insurance, mentions Medical Payment coverage along with disability coverage and uninsured coverage, it defines these coverages as excess over Mandatory PIP, OBEL and APIP thus distinguishing such coverages from Mandatory No-Fault.

I am in agreement with Arbitrator Keith Tola who determined in *Physical Therapy of North Queens v National and General Insurance Company, f/k/a GMAC AAA Case Number: 17-14-9049-9475* that "*...the within arbitration forum is only for resolution of disputes under No-Fault -- the mandatory coverage required by the New York Insurance Law for first party benefits. See Insurance Law § 5106(b). I lack jurisdiction to review determinations by an insurer of its Med Pay coverage. This coverage is separate from that for personal injury protection (a/k/a No-Fault or first party benefits). My resolution of the within dispute must relate solely to issues involving personal injury protection (a/k/a No-Fault, or first party benefits). As such, while it appears there is some coverage remaining under the Medical Payment Coverage portion of the policy, I lack jurisdiction to award it, or simply to address a claim of entitlement to it.*"

"Once the bill is challenged, the burden is on the applicant to initiate the process to determine liability of the bill. In the interim an insurance carrier has no authority to reject the payment of validly submitted unchallenged bills on the basis that the no-fault policy limits may be exceeded by taking into consideration a reserve fund paid changed bills." Arbitrator Jacob, AAA# 412009041706. Respondent was not required to anticipate that Applicant would demand arbitration or serve a summons and complaint.

In Leonid Reyfman MD v. State Insurance Company, AAA#412012085520 Arbitrator Wolf 4/2/13 found that, "at the time respondent issued a denial to applicant, the subject policy limits had not been exhausted, and therefore, respondent's policy exhaustion defense did not exist at that time. Respondent issued its denial to the applicant predicated on an IME cut off. Regardless an insurer is not required to pay a claim when the policy limits have been exhausted. See, Mount Sinai Hospital v. Zürich Insurance Company, 15 A.D. 3d 550 (2d Dep.t 2005).

Decision

Since the Respondent exhausted its policy limits prior to the hearing of this matter, I find that there are no available funds to satisfy the Applicant's claim. Accordingly, the Respondent's defense of policy exhaustion is sustained and Applicant's claim is denied. The policy is exhausted and all other issues are moot. I find in favor of the respondent and the 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, Jennifer Jacques-Miller, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

05/17/2021
(Dated)

Jennifer Jacques-Miller

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:
654e2142139e72bd3ca10ac65989f1d9

Electronically Signed

Your name: Jennifer Jacques-Miller
Signed on: 05/17/2021