

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Clinton Medical Office, P.C.
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No.	17-21-1200-2818
Applicant's File No.	CF13015684
Insurer's Claim File No.	0604463610101035
NAIC No.	35882

ARBITRATION AWARD

I, Ann Lorraine Russo, 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: patient

1. Hearing(s) held on 06/30/2022
Declared closed by the arbitrator on 06/30/2022

TinaMarie Franzoni, Esq. from Choudhry & Franzoni, PLLC participated for the Applicant

Diana Gonzalez, claims representative from Geico Insurance Company participated for the Respondent

2. The amount claimed in the Arbitration Request, **\$3,773.38**, 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 dispute in this case is for the nonpayment by the respondent for medical and testing services provided to the thirty-six-year-old male patient from 11/2/2020 through 12/8/2020 for a motor vehicle accident on 8/15/2020. The respondent timely denied the services based upon a peer review report and has now issued a denial subsequently providing that the respondent's policy limits were exhausted.

4. Findings, Conclusions, and Basis Therefor

I have reviewed the documents in the electronic case folder as of the date of the hearing and oral arguments of counsel for the respective parties. No witness testimony was presented at the hearing.

This case is a companion case with two other cases for the same applicant, patient and date of accident on 8/15/2020 for different services bearing American Arbitration Association case numbers 17 21 1200 0293 and 17 20 1185 7582.

The dispute in this case is for the nonpayment by the respondent for medical and testing services provided to the thirty-six-year-old male patient from 11/2/2020 through 12/8/2020 for a motor vehicle accident on 8/15/2020. The respondent timely denied the services based upon a peer review report and has now issued a denial subsequently providing that the respondent's policy limits were exhausted. It was noted that this arbitrator rendered a decision in respondent's favor based upon the policy exhaustion. See American Arbitration Association case number 17 21 1217 0751. Applicant provided that this case is for a different applicant and services. Respondent provided that no additional documentation has been submitted to alter the decision in the prior case. The respondent did submit a copy of the payment ledger and policy in support of the policy exhaustion in that case and in this case. Applicant has not submitted any opposition to the respondent's policy exhaustion position in this case. The amount in dispute is \$3,773.38 for the services in this case.

Respondent's defense of exhaustion of the limits of the policy is persuasive in this case. Respondent did submit prima facie evidence of policy exhaustion and applicant did not dispute or refute this evidence in any way. In addition, case law makes it quite clear that where an insurer demonstrates that it paid a claim up to the policy limits it is not obligated to pay the claim in full, despite an untimely denial. *New York & Presbyterian Hospital v. Progressive Casualty Ins. Co.*, 5 A.D.3d 568, 774 N.Y.S.2d 72 (2d Dept. 2004). An insurer is not required to pay a claim where the policy limits have been exhausted. *Mount Sinai Hospital v. Zurich American Insurance Co.*, 15 A.D.3d 550, 790 N.Y.S.2d 216 (2d Dept. 2005). The 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. *New York and Presbyterian Hospital v. Allstate Ins. Co.*, 12 A.D.3d 579, 786 N.Y.S.2d 68 (2d Dept. 2004); *Crossbridge Diagnostic Radiology v. Encompass Insurance*, 24 Misc.3d 134(A), 2009 N.Y. Slip Op. 51415(U), 2009 WL 1911909 (App. Term 2d, 11th & 13th Dists. June 23, 2009).

The applicant's counsel argued that the issue here is what to do with a prior submitted portion of bills that were submitted and subsequently the policy is limits are exhausted by respondent. The question of how No-Fault claims are to be paid is controlled by Section 65-3.15 (11 NYCRR 65-3.15) of the Regulations. This section provides that when claims aggregate to more than the policy payments shall be made in the order in which each service was rendered or each expense incurred, provided the claims were made to the insurer prior to the exhaustion of the policy. The respondent's documentation support that the policy was exhausted. Applicant's counsel argued that the exhaustion occurred after the applicant's bill but prior to the arbitration by applicant in this case. Respondent thereafter exhausted the policy limits. The respondent

continued to pay other claims made under the policy until the policy limit was exhausted. Respondent contends that the limits of the policy are exhausted. Applicant's counsel argued that the applicant should not have lost its priority to payment of no-fault benefits. Essentially, the Applicant argues that the cost of their services should have been reimbursed since they were billed to the respondent before the policy was exhausted.

The Regulation stated above does not specifically address the circumstances presented here as it provides only that where the policy limit is exhausted 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. However, in *Nyack Hosp. v. General Motors Acceptance Corp.*, 27 AD3d 96, 2007 NY Slip Op 02439[8 NY3d 294], the Court stated "we are asked in this no-fault action to decide whether an insurer that is waiting for information to verify a pending claim that causes aggregate claims to exceed the policy limitations is prohibited by the priority of payment regulation (11 NYCRR 65-3.15) from paying already verified claims in the meantime. For the reasons that follow, we conclude that the priority of payment regulation does not preclude these payments".

In *Nyack*, the Applicant risked the policy limit being exhausted as the verification process proceeded because the Regulation **REQUIRES PAYMENT OF VERIFIED CLAIMS WITHIN 30 DAYS OF VERIFICATION** (emphasis added). In this case, also the regulation required payment of verified claims within 30 days of verification even while the applicant herein decided how to proceed with its claim. The regulation required respondent to pay all verified claims until exhaustion of its policy limits. Respondent did so. It would be patently unfair to have fully verified claims delayed or not paid while waiting for all properly denied claims to be adjudicated. The *Nyack* case while admittedly dealing with unverified claims nonetheless held that the priority of payment regulation does not preclude payment of already verified claims while another claim is being verified or where a claimant whose claim has been denied seeks redress through whatever means available. In terms of policy exhaustion, respondent indicated that the contract of insurance herein was for the policy limitations for no fault benefits and once it is exhausted the insured is no longer obligated to issue further payment. See *Hospital for Joint Diseases, et al. v. State Farm Insurance Co.*, 8 A.D.3d. 533 (2d. Dept., 2004); *Nyack Hospital v. General Motor Acceptance Corp.*, 8 N.Y.3d 294 (1997).

Applicant argued that the court's decision in *Alleviation Med. Servs., P.C. v Allstate Ins. Co.* 2021 NY Slip Op 08159, February 24, 2021 further supports the court's holding in the lower *Alleviation Med. Servs., P.C. v Allstate Ins. Co.*, 55 Misc. 3d 44, App. Term., 2 Dept. (nd March 29, 2017), and that the recent Appellate Divisions holding supports that the applicant is entitled to payment on its claims, as the claim was due because it had priority of payment over those payments which had exhausted the policy. The Appellate Term, First Dept. in the case of *Harmonic Physical Therapy, P.C. v. Praetorian Ins. Co.*, 47 Misc3d 137(A) (App. Term 1 Dept. 2015) specifically rejected the argument that 11 NYCRR 65-3.15 precluded an insurer from paying other providers' legitimate claims after it had denied Harmonic's claim. In *Harmonic Physical Therapy, P.C. v Praetorian Ins. Co.*, 47 Misc. 3d (App. Term 1 Dept., Decided on April 14, 2015), the Court held that an insurer was not precluded by 11 NYCRR 65-3.15 from paying other providers' legitimate claims subsequent to the denial of the providers claims and

that adopting the provider's position, which would require defendant to delay payment on uncontested claims, or 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"(Nyack Hosp. v General Motors Accept. Corp., 8 NY3d at 300). Judge Miles upheld the exhaustion of policy defense in Harmonic. I agree with the court's reasoning and decision in Harmonic. There is no evidence that Respondent acted in bad faith to require it pay above and beyond the policy limits. Respondent issued payments at the time that it processed the claims and presented a valid defense. Respondent now argues that it does not even have to get to the defense because the policy limits have been exhausted and it is under no obligation to make further payments. I agree with the Respondent. I do not agree with the court's holding in Alleviation.

The Courts and Master Arbitrators have consistently held that where an insurer has paid the full monetary limits set forth in the insurance policy, its duty under the contract of insurance ceases. See *Allstate Ins. Co. v. Demoura*, 30 Misc.3d 145(A), 926 N.Y.S.2d 342 (App. Term First Dept. 2011); *Mount Sinai Hospital v. Geico Ins. Co.*, 17 991 R 40969 (Master Arb F. Godson July 25, 2014) ("even if an insurer's basis for a denial is eventually rejected by a court or arbitrator, if it had good faith belief that it did not owe applicant's claim . . . it did what it was required to do, namely, pay those claims that were ready for payment."). Respondent argued that even if I find that the denial was not timely, proper, and substantiated, they cannot be obligated to pay the claim since the policy has been exhausted. In support of its policy exhaustion defense, respondent has submitted a copy of the records documenting the payment already made by respondent. Applicant asserts that applicant is entitled to payment because its bill was received by respondent prior to bills from other providers which were subsequently paid, and respondent did not process the subject claim in accordance with the priority-of-payment rule set forth in 11 NYCRR 65-3.15. I disagree with counsel for applicant's argument.

Where a service has been found not to be medically necessary, or some other valid basis, to hold up other providers' bills for payment for a period of years until litigation/arbitration over the bill at issue has been commenced and completed would contravene the requirement that the other providers' bills be paid within 30 days. See, In *Nyack Hospital v. General Motors Acceptance Corporation*, 8 N.Y.3d 294, 832 N.Y.S.2d 880 (2007). I therefore find that in this matter respondent acted pursuant to its obligations under the regulations and is not liable because of the exhaustion of money available under the policy. While applicant argued that because its complete claim was received by the insurer prior to the policy being exhausted and payment was not made the insurer violated the priority rule it ignores the fact that the claim had already been processed and the regulations do not require an insurer who denies a claim to set up a reserve in the event that its position will later be challenged. In reviewing all the evidence and case law I find that Respondent properly continued to pay all claims under the policy until exhaustion of the policy limits following applicant's bills. Therefore, there is proof of payment and applicant's claim is now made against an exhausted policy and must be denied in its entirety

11 NYCRR 65-3.15, which states that when claims exceed the policy limits "payments for basic economic loss shall be made . . . 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." An insurer is not required to pay a claim where the policy limits have been exhausted, *Mount Sinai Hospital v. Zurich American Insurance Co.*, 15 A.D.3d 55, 790 N.Y.S.2d 216 (2d Dept. 2005); When an insurance carrier "has paid the full monetary limits set forth in the policy, its duties under the contract of insurance cease", See *Presbyterian Hosp. in the City of New York v. Liberty Mut. Ins. Co.*, 216 A.D.2d 448, 628 N.Y.S.2d 396 (2d Dept. 1995), and; The cessation of those duties applies to a claim that was improperly denied, *Nyack Hospital v. General Motors Acceptance Corp.*, 8 N.Y.3d 294, 832 N.Y.S.2d 880 (2007), even where the a Denial of Claim (NF-10) form is not issued within 30 days, *New York and Presbyterian Hospital v. Allstate Ins. Co.*, 12 A.D.3d 579, 786 N.Y.S.2d 68 (2d Dept. 2004); *Crossbridge Diagnostic Radiology v. Encompass Insurance*, 24 Misc.3d 134(A), 2009 N.Y. Slip Op. 51415 (U), 2009 WL 1911909 (App. Term 2d, 11th & 13th Dists. June 23, 2009).

An improper Denial of Claim, like a failure to disclaim coverage, cannot create coverage which the policy was not written to provide, See *Zappone v Home Ins. Co.*, 55 N.Y.2d 131, 134, 447 N.Y.S.2d 911, (1982) and *Country Wide Ins. Co. v. Sawh*, 272 A.D.2d 245 (2000). 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, 6 N.Y.S.2d 216 (2d Dept. 2005). In this case, Respondent asserts the exhaustion of policy limits defense, a timely denial is not required. See, *New York & Presbyterian Hospital v. Progressive Casualty Ins. Co.*, 5 A.D.3d 568, 774 N.Y.S.2d 72 (2d Dept. 2004). The respondent has established that the policy limits were exhausted, and the applicant's claim is denied.

Based upon the evidence presented, it is the opinion of this Arbitrator that the respondent has established that the policy has been exhausted in this case.

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

07/02/2022

(Dated)

Ann Lorraine Russo

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:
40bd0097193d6a44c90586852e10d24c

Electronically Signed

Your name: Ann Lorraine Russo
Signed on: 07/02/2022