

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Valor Chiropractic Wellness, PC  
(Applicant)

- and -

Adirondack Insurance Exchange  
(Respondent)

AAA Case No.	17-21-1212-8933
Applicant's File No.	SBG-10659-2497501
Insurer's Claim File No.	3907448
NAIC No.	Self-Insured

**ARBITRATION AWARD**

I, Stephen Czuchman, 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: the patient, RA.

1. Hearing(s) held on 09/02/2022  
Declared closed by the arbitrator on 09/02/2022

Jeremy Davis, Esq. from Sanders Grossman Aronova PLLC participated for the Applicant

Peter Pagones, Esq. from Law Offices of Bobbi J. Vilacha participated for the Respondent

2. The amount claimed in the Arbitration Request, **\$5,805.71**, 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 patient (RA), a then 54-year-old male, was injured in a motor vehicle accident on 6/6/19 as the driver of a motor vehicle involved in a collision with another motor vehicle. Applicant seeks to recover assigned first-party no-fault benefits consisting of charges for evaluations and chiropractic treatment of the patient rendered from 2/4/20 through 4/26/21. Respondent timely denied the claim, alleging a lack of medical necessity based on a 12/12/19 independent medical examination of the patient performed by Ji Kim, D.C., L.Ac., and that the charges were not in accordance with the applicable fee schedule. Respondent also avers that the patient's No-Fault policy limits are now exhausted.

The issue in dispute is whether respondent has substantiated the policy exhaustion defense.

#### 4. Findings, Conclusions, and Basis Therefor

These findings and conclusions are based on my review of the records on the ADR Center maintained by the American Arbitration Association as of the date the hearing was declared closed and oral argument at the hearing. 11 NYCRR § 65-4.5(o)(1) provides that an arbitrator shall be the judge of the relevance and materiality of the evidence offered, and strict conformity to the legal rules of evidence shall not be necessary. The arbitrator may question or examine any witness or party and independently raise any issue that the arbitrator deems relevant to making an award consistent with the Insurance Law and Department regulations.

The patient, a then 54-year-old male, was injured in a motor vehicle accident on 6/6/19 as the restrained driver of a minivan involved in a collision with an SUV. He did not seek immediate medical attention. He later reportedly came under the care of Kentia Jean-Charles, D.C., and underwent chiropractic treatment. Applicant billed respondent for evaluations and chiropractic treatment of the patient rendered from 2/4/20 through 4/26/21 as his assignee, and respondent denied the charges. Applicant subsequently requested no-fault arbitration of the claim on 7/27/21 in accordance with Insurance Law § 5106(b).

I determine that applicant has made out a prima facie case for reimbursement of the disputed charges. See *Ultra Diagnostics Imaging v. Liberty Mut. Ins. Co.*, 9 Misc.3d 97 (App Term 2d Dept 2005); *Viviane Etienne Med. Care v. Country-Wide Ins. Co.*, 25 NY3d 498 (2015) ("a plaintiff demonstrates prima facie entitlement to summary judgment by submitting evidence that payment of no-fault benefits [is] overdue, and proof of its claim, using the statutory billing form, was mailed to and received by the defendant insurer.")

Once an applicant health services provider makes out a prima facie case, the burden shifts to the respondent insurer to timely request additional verification, deny or pay the claim. *Hospital for Joint Diseases v. Travelers Prop. Cas. Ins. Co.*, 9 NY3d 312 (2007). 11 NYCRR § 65-3.8 provides that a no-fault insurer has thirty days from the date of receipt of a health services provider's proof of claim to pay or deny that claim in whole or in part. Most defenses unrelated to coverage are precluded if not preserved in a timely denial of claim. *Cent. Gen. Hosp. v. Chubb Group of Ins. Cos.*, 90 NY2d 195 (1997).

Here, respondent timely denied the disputed claim based on the 12/12/19 chiropractic and acupuncture IME of the patient conducted by Ji Kim, D.C., L.Ac., and the fee schedule. However, respondent maintains that the sufficiency of the lack of medical necessity and fee schedule defenses is of no moment, as the patient's no-fault policy limits are exhausted. Applicant argues that even if the patient's no-fault benefits are exhausted, respondent has failed to establish that its payments were made in accordance with 11 NYCRR § 65-3.15, the priority of payment regulation.

In support of the policy exhaustion defense, respondent submitted a copy of a policy declarations page indicating that the patient's policy carried \$50,000 in basic personal injury protection (PIP), \$25,000 in optional basic economic loss (OBEL), \$10,000 in Medical Payments (Med Pay), and no additional PIP (APIP) coverage from 3/16/19 through 3/16/20. Respondent submitted a copy of a payment log indicating that it has paid \$50,000 in no-fault benefits for health services to the patient's medical provider

assignees and to the patient for his loss of earnings and \$10,000 in Med Pay. There is a copy of the patient's NF-13 OBEL election of option form signed by the patient on 2/11/20, wherein he elected that the \$25,000 in OBEL coverage be spent on option number four, a combination of option 2 (loss of earnings from work, less statutory offsets) and option 3 (psychiatric, physical or occupational therapy and rehabilitation). There is also a copy of an 11/7/20 general denial of claim issued to the patient stating, "NY basic no-fault policy limits have been exhausted. Further payment will be issued under the Medical Payments and OBEL policy limit according to your coverage election."

I find the policy records, payment log, NF-13, and general denial sufficient to establish that the patient's No-Fault benefits under the policy through which applicant seeks reimbursement of this claim are exhausted.

The mandatory PIP endorsement set forth at 11 NYCRR § 65-1.1 provides that a no-fault insurer "will 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...during the policy period..." and that "[b]asic economic loss of each eligible injured person on account of any single accident shall not exceed \$50,000..." 11 NYCRR § 65-3.15, the priority of payment regulation, states 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." In *Nyack Hosp. v. General Motors Acceptance Corp.*, 8 NY3d 294 (2007), the Court of Appeals held that while an insurer is not obligated to hold benefits in reserve for delayed or denied claims, it may be required to pay more than the policy limits if it fails to pay a verified claim in favor of payments for services rendered or expenses incurred later than the unpaid verified claim, which exhaust the policy. *Id.*, at 301. See *Alleviation Med. Servs., P.C. v. Allstate Ins. Co.*, 55 Misc.3d 44 (App Term 2d Dept 2017) (Insurer's motion for summary judgment based on policy exhaustion denied because it failed to establish that its payments exhausting the policy were made in compliance with 11 NYCRR § 65-3.15) *aff'd* 191 AD3d 934 (2d Dept 2021); But see *Harmonic Physical Therapy, P.C. v. Praetorian Ins. Co.*, 47 Misc. 3d 137(A) (App Term 1st Dept 2015) (11 NYCRR § 65-3.15 does not preclude a no-fault insurer from paying other providers' legitimate claims subsequent to the denial of a claim for a lack of medical necessity).

A policy exhaustion defense is not subject to preclusion, so it does not need to be preserved in a timely denial of claim. *Presbyterian Hosp. v. General Accident Ins. Co. of Am.*, 29 AD2d 479 (2d Dept 1996); *New York & Presbyt. Hosp. v. Allstate Ins. Co.*, 12 AD3d 579 (2d Dept 2004); *Crossbridge Diagnostic Radiology v. Encompass Ins.*, 24 Misc.3d 134(A) (App Term 2d Dept 2009); *Flushing Traditional Acupuncture, P.C. v. Infinity Group*, 38 Misc.3d 21 (App Term 2d Dept 2012). Accordingly, the fact that respondent failed to timely preserve the policy exhaustion defense is of no moment. *Acuhealth Acupuncture P.C. v. New York City Tr. Auth.*, 50 Misc.3d 1228(A) (Sup Ct Kings County 2016).

An insurer is not required to pay a claim when the policy limits have been exhausted, *Hosp. for Joint Diseases v. State Farm Mut. Auto. Ins. Co.*, 8 AD3d 533 (2d Dept 2004); *Mount Sinai Hospital v. Zurich American Ins. Co.*, 15 AD3d 550 (2d Dept 2005), since

"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 the City of New York v. Liberty Mut. Ins. Co.*, 216 AD2d 448 (2d Dept 1995).

While the courts may issue a decision requiring an insurer to pay claims over the policy limits under *Nyack* and *Alleviation*, an arbitrator exceeds his or her authority by issuing an award in excess of the policy limits. See *Countrywide Ins. Co. v. Sawh*, 272 AD2d 245 (1st Dept 2000); *Brijmohan v. State Farm Ins. Co.*, 92 NY2d 821 (1998); *Sagona v. State Farm Ins. Co.*, 218 Ad2d 660 (2d Dept 1995); *Allstate Ins. Co. v. Silver*, 225 AD2d 690 (2d Dept 1996); *Spears v. New York City Transit Authority*, 262 AD2d 2d 493 (2d Dept 1999); *Allstate Ins. Co. v. Auto One Ins. Co.*, 35 Misc.3d 140(A) (App Term 2d Dept 2012). See 11 NYCRR § 65-4.10(a)(2); CPLR §7511(b)(1).

It is uncontroverted that the patient contracted with the respondent for \$50,000 in PIP coverage, \$25,000 in OBEL coverage, and \$10,000 in Med Pay coverage, that respondent has paid the full basic PIP policy limits to the patient and his medical provider assignees for his loss of earnings with statutory offsets and medical expenses resulting from the 6/6/19 motor vehicle accident, that respondent has paid the full Med Pay limits, and that the patient elected that the OBEL coverage only be spent on loss of earnings and psychiatric, physical or occupational therapy and rehabilitation, which are not the subject of this claim. Respondent's failure to timely disclaim coverage does not create coverage that the policy was not written to provide. *Zappone v. Home Ins. Co.*, 55 NY2d 131 (1982). The Office of General Counsel of the New York State Insurance Department, the predecessor to the Department of Financial Services, issued an opinion letter on July 30, 2008 regarding no-fault medical fees after exhaustion of benefits which provides that "[u]pon exhaustion of the amount of no-fault benefits available to the assignor (i.e. \$50,000 or more if the assignor has additional OBEL coverage), the assignment is no longer effective." (2008 Ops Ins Dept 08-07-28 [www.dfs.ny.gov/insurance/ogco2008/rg080728.htm]). The Insurance Department interpretation of the no-fault regulations "is entitled to deference unless irrational or unreasonable." *Stephen Fogel Psychological, P.C. v. Progressive Cas. Ins. Co.*, 35 Ad3d 720 (2d Dept 2006); *LMK Psychological Servs, P.C., v. State Farm Mut. Auto. Ins. Co.*, 12 NY3d 217 (2009). Accordingly, since the patient's PIP policy limits are exhausted, his assignment of benefits to the applicant is no longer effective.

For the foregoing reasons, based on a fair preponderance of the credible evidence, the claim is denied in its 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 Suffolk

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

09/06/2022

(Dated)

Stephen Czuchman

#### **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:**  
599b33fc0f47a408f46257308d3b6efe

### **Electronically Signed**

Your name: Stephen Czuchman  
Signed on: 09/06/2022