

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Right Choice Supply, Inc.  
(Applicant)

- and -

Avis Budget Group  
(Respondent)

AAA Case No. 17-22-1238-5896

Applicant's File No. LIP-14336

Insurer's Claim File No. 1997106231-PIP

NAIC No. Self-Insured

**ARBITRATION AWARD**

I, Rhonda Barry, 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 02/14/2023  
Declared closed by the arbitrator on 02/14/2023

Mark Fenelon, Esq. from Law Office of Ilya E. Parnas participated virtually for the Applicant

Joshua Shack, Esq. from Rubin, Fiorella, Friedman & Mercante LLP participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$3,522.64**, 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 EIP, "AT" is a 34 year old female injured in a motor vehicle accident on 5/27/19. Applicant seeks \$3522.64 for post operative DME dispensed to the EIP for DOS 1/24/20-2/26/20. Respondent denied applicant's claim for DOS 1/13/20-2/26/20 (\$1274.84) based upon lack of medical necessity according to the peer review and addendum of Julio Westerband, MD. There are no denials or requests for verification for all other dates of service. Applicant provides proof of actual mailing from the USPS. Respondent submits an affidavit of non-receipt.

Respondent further advises that the policy of insurance affording the EIP no fault benefits exhausted upon the decision of Arbitrator Mir in MSJR of Queens, PC v. Avis Budget Group, AAA # 17 - 20 - 1164 - 2932 (2/9/22).

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

Arbitrator Mir considered the efficacy of respondent's exhaustion defense in Van Siclen Chiropractic PC v. Avis Budget Group, AAA# 17 - 21 - 1191 - 4465 (6/26/22).

Respondent opines that collateral estoppel is applicable. It is within the arbitrator's authority to determine the preclusive effect of a prior arbitration. Matter of Falzone v. New York Central Mutual Fire Insurance Company, 15 NY3d 530, 914 NYS 2d 67, affirming, 64 A.D. 3d 1149 (4th Dep. 2009). I agree with respondent.

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 hearing. No witnesses testified at hearing.

#### ANALYSIS

Applicant has established its prima facie entitlement to reimbursement for no fault benefits 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, (2<sup>nd</sup> Dept. 2004). Westchester Medical Center v. Lincoln General Ins. Co., 60 AD 3d 1045 (2<sup>nd</sup> Dept. 2009).

While a policy exhaustion claim is not precluded as a result of an untimely denial, the insurer must still make out a triable issue of fact in support of the defense. Westchester Medical Center v. Progressive Casualty Insurance Company, 2009 NY Slip Op 31556 (U), 2009 WL 216-0548 (Supreme Court Nassau County J. Lally 2009). In support of this defense respondent offers the declarations page for the subject policy and a payment ledger showing medical expenses and lost wages paid as well as offsets. Respondent's policy has been fully exhausted.

As a general rule, applicant cannot get blood from a stone. Respondent has established through policy documents and payment ledgers that PIP coverage to this EIP exhausted as of 2/9/22. 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.

*For DOS 2/13/20 - 2/26/20 (\$1274.84)* respondent's 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). The policy is exhausted, and applicant's claim is denied.

Applicant submitted Certificates of Mailing from the USPS indicating that the claims for \$2247.80, DOS 1/24/20 - 2/12/20 were purportedly timely mailed to respondent. However, the claims were sent to PO Box 14517, Lexington, KY 40512. In a detailed affidavit from Lisa Todd, no-fault claims litigation representative for respondent's third party administrator, Sedgwick Claims Management Services, respondent credibly explains that this is an incorrect address. Ms. Todd explains that the correct address for Avis bills being handled by Sedgwick is PO Box 94696, Cleveland, OH 44101. This is the address on respondent's NF 10. Included in applicant's submission are letters (dated 3/13/20) from Sedgwick in Lexington Kentucky. The letter advises that Sedgwick administers claims benefits for multiple clients. Sedgwick Kentucky was unable to match the claim number. Applicant offers no explanation as to why its claims were mailed to this address.

In Nyack Hospital v. General Motors Acceptance Corp., 8 NY 3d 294 (2007), the insurer requested additional verification to process the submitted claim. While verification was pending it continued to pay other providers and lost earnings to the EIP. Subsequently, the policy exhausted. Plaintiff argued that the insurer violated 11 NYCRR§ 65-3.15

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.

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. In short, the Court determined that once a claim is verified, payment must be made in the order the claims was received. The court further stated that, "The no-fault regulations provide that "[n]o - [f]ault benefits are overdue if not paid within 30 calendar days after the insurer receives proof of claim, which shall include verification of all relevant information requested pursuant to section 65 - 3.5" (11 NYCRR 65 - 3.8 [a] [1]) ... This language contemplates that an insurer must pay or deny only a verified claim... within 30 calendar days of receipt and, conversely is not obligated to pay any claim until it has been so verified.

Once GMAC received the requested verification on 10/20/03, "the insurer should have paid the hospital ahead of any other unpaid verified claims for services rendered." Significantly the Court remanded the case back to the Supreme Court for further proceeding.

In NYU Hospital Center - Hospital v. State Farm Mutual Automobile Insurance Company, NYLJ 12/8/16 (Supreme Court Nassau County, Steinman, J., Index Number 000091/16, 10/26/16), State Farm did not timely deny the submitted claim or argue that the claim was in excess of the NYS Workers Compensation fee schedule. Its sole defense was exhaustion of the policy limits. The court analyzed the Court of Appeals decision in Nyack, supra and opined, that although the "Appellate Division granted summary judgment to the insurer based on exhaustion... the Court of Appeals modified the decision finding that the insurer was entitled to pay subsequent verified claims while awaiting information from the hospital but the insurer's obligation to pay the hospital arose when the insurer received the requested information... The court denied the insurer summary judgment motion and remitted the action back to the trial court holding that pursuant to 11 NYCRR§ 65 - 3.15 the insurer shall pay the hospital ahead of any unpaid verified claims for services rendered or expenses incurred later than the services billed by the hospital up to the policy limits. Of course, if 11 NYCRR 65 - 3.15 had no teeth and the exhaustion of the policy in and of itself is a complete defense to the insurer, it would have been no reason for the Court to reverse the grant of summary judgment and remand the matter to the court trial court." The after the fact exhaustion defense was unsustainable.

When an insurer *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 Dept. 2004). (Emphasis added). Harmonic Physical Therapy, PC v. Praetorian Insurance Company, 47 Misc. 3d 137 (A), 2015 NY Slip Op 50525 () (App. Term 1st Dept. 2015).

An insurer's failure to abide by regulatory requirements is pivotal to its burden of proving policy exhaustion. If an insurer disregards the very specific time constraints enunciated in the no-fault regulations and fails to timely deny or seek verification of the submitted claim it has effectively acted in bad faith and with reckless disregard of the applicant's rights. See, General Motors Acceptance Corp. v. New York Central Mutual Insurance Company, 116 AD 3d 468 (1st Dept. 2014). If bad faith is established an insurer can be compelled to pay in excess of the policy limits. However, "[a]n insurer does not breach of duty of good faith when it makes a mistake in judgment or behaves negligently" General Motors Acceptance Corp., supra citing Federal Insurance Company v. North America Specialty Insurance Company, 83 AD3d 401 (1st Dept. 2011).

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 [amount] contracted for in the instant policy. See, Harmonic Physical Therapy, PC, supra, Hospital for Joint Diseases v. State Farm Mutual Automobile Insurance Company, supra. If an insurer fails to seek verification or deny a submitted claim at the same time it remits payment to other providers, the defense of exhaustion should fail. While exhaustion may be used as a shield against claims in excess of policy limits, it cannot be used as a sword to challenge claims properly and timely submitted for payment while coverage remained available.

In 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. I disagree with that finding to the extent that it supports payment in excess of the policy if the underlying claim was timely denied.

If a denial is timely the insurer complied with the no fault regulations and satisfied the legislative intent of the "Comprehensive Automobile Insurance Reparations Act" by promoting prompt resolution of injury claims, limiting cost to consumers, and alleviating unnecessary burdens on the courts (see, Governor's Mem approving L 1973, ch 13, 1973 McKinney Sessions of Laws of New York, at 2335)." Pommells v. Perez, 4 NY 3d 566, 797 NYS 2d 380 (2005). The same should apply to timely verification requests for which there is no response.

In this case, respondent has adequately established that the claims were not received prior to applicant's demand for arbitration by which time, the available no fault benefits had exhausted. Respondent's defense based upon exhaustion of benefits sustained.

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 NY  
SS :  
County of Nassau

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

02/16/2023  
(Dated)

Rhonda Barry

### **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:**

543cea9f8f003bf59cf8fabf0eaf892c

### Electronically Signed

Your name: Rhonda Barry  
Signed on: 02/16/2023