American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Brenner Chiropractic (Applicant)	AAA Case No.	17-24-1332-8764
	Applicant's File No.	NF 3743890
- and -	Insurer's Claim File No.	0421244290101044
	NAIC No.	35882
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Aladar Gyimesi, 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 07/26/2024
   Declared closed by the arbitrator on 07/26/2024

   Odisina Okeya, Esq. from The Law Office of Thomas Tona, PC participated virtually for the Applicant

   Elba Cornier, Claim's Representative from Geico Insurance Company participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **$540.00**, 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

   In contention are Applicant's bills in the total sum of $540.00, in connection with four Chiropractic Manipulative Treatments (hereinafter CMTs) with physical medicine modalities rendered on September 2, September 30, November 11 and November 18, 2023 by Russell Brenner (D.C.), relative to a 34 year old female operator EIP who was involved in a motor vehicle accident on April 26, 2023. Applicant sought reimbursement at a rate of $135.00 per service date. On December 2, 2022, following the allegedly negative results of a chiropractic IME conducted on November 15, 2022 by Frank McNally (D.C.), Respondent issued its global denial. In furtherance thereof, all No-Fault benefits pertaining to chiropractic care were denied effective as of December 10, 2022. On December 12, 2023, Respondent issued an additional global denial. Pursuant thereto

the EIP and, inter alia, the within Applicant were advised that "[t]he policy carries no-fault coverage of $50,000.00 which has been exhausted. Please submit your bill to the patient's private health insurance carrier". Upon receipt of the reimbursement requests of Applicant in controversy, Respondent issued four, timely, denials predicated upon lack of medical necessity and/or policy exhaustion defenses. The entire amount initially sought by the Applicant is in dispute. The issues presented are the validity of Respondent's policy exhaustion and lack of medical necessity defenses.

4. Findings, Conclusions, and Basis Therefor

I have reviewed the pertinent documentation contained within the ADR Center as of the date of the hearing. Any issues contained in the record, not specifically raised at the time of the hearing, are considered by this Arbitrator to be moot and/or waived by the parties. This Award is based upon the oral argument, if any, of counsel and an analysis of the timely submission(s) of the respective parties hereto.

No-Fault Regulation 65-3.15, which controls the issue of priorities of claim payments, provides that:

> Computation of basic economic loss. When claims aggregate to more than $50,000, payments for basic economic loss shall be made to the Applicant and/or an assignee in order in which each service was rendered or 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 of services, at the same time, the payment shall be made in order of rendition of services.

"An insurer is not required to pay a claim where the policy limits have been exhausted…[W]here, as here an insurer has paid the full monetary limits set forth in the policy, its duties under the contract of insurance cease". Hospital for Joint Diseases v. State Farm Mutual Automobiles Inc. Co., 8 A.D. 3d 533, 779 N.Y.S. 2d 534 (App Div, 2nd Dept. - 2004); Hospital for Joint Diseases v. Hertz Corp., 22 A.D. 3d 724, (App Div, 2nd Dept. - 2005) (additional citations omitted.) An assignee âstands in the shoes of the Assignor and has no greater rights than its Assignor". Long Island Radiology v. Allstate, 36 A.D. 3d 763, 830 N.Y.S. 2d 192 (App Div., 2nd Dept. - 2007). Once the limits of an auto policy are exhausted, the Assignor must rely on other available insurance coverage. Opinion Letter of the Office of General Counsel of the New York State Insurance Dept. dated July 30, 2008. In Nyack Hospital v. General Motor Acceptance Corp., 8 N.Y. 3d 294, 832 N.Y.S. 2d 880 (Ct. of App. - 2007), the Court of Appeals determined that No-Fault Regulation 65-3.15 did not require the No-Fault carrier to put aside money with respect to a claim received earlier in time but which had been delayed for verification. The Court held that other duly received claims should be paid notwithstanding a prior in time claim delayed for verification. The Court reasoned to hold otherwise would require an insurer, once it was aware of a claim, to create a

reserve against the policy limits pending determination of its liability on any disputed claim. The Court opined that the notion of such a reserve âruns counter to the No-Fault Regulatory scheme, which is designed to promote prompt payment of legitimate claims". The Court rebuked creation of such a reserve since it could also potentially result in the No-Fault carrier's payment of No-Fault benefits in excess of its policy limits. More importantly, since the No-Fault carrier could not have paid other legitimate claims while the delayed claim was pending, one of the main goals of the No-Fault system, for the prompt submission and resolution of claims, would be thwarted. Although the Nyack case deals with a claim delayed pending verification the Court's rationale, insofar as its negative view of any requirement a carrier create a reserve and that prompt payment of claims should be encouraged, also has applicability in my judgment where, as here, Respondent continues to process and pay any ripe and valid claims until such time as the policy limits have been exhausted. In accord with the Nyack rationale, Respondent should not be required to create a reserve relative to the instant claim pending the processing of valid claims pursuant to the same policy of insurance. Nor should the Respondent in my view be obligated, once its policy is exhausted, to make any further payments to an Assignee of the Assignor if any of Applicant's claims are awarded herein.

In this matter, as per a tendered declaration sheet reflecting a policy in force on the date of the EIP's motor vehicle accident, Respondent has submitted proof consistent with the claimed policy limits of $50,000.00 in No-Fault benefits. Respondent has also provided a compilation of its payment of first party benefits to the EIP's assignees. Pursuant thereto, $50,000.00 in medical expenses were paid on the EIP's behalf. It is lastly recognized that the accuracy and authenticity of such a total payment has not been contested by the within Applicant. When all of the above is considered, it appears the applicable policy limits of $50,000.00 have been exhausted.

It should be further acknowledged that this Arbitrator is fully aware of the decision rendered in Alleviation Med. Servs., P.C. v. Allstate Ins. Co., 55 Misc. 3d 44, (App Term, 2nd Dept-2017). Although the Appellate Division, Second Department heard an Appeal of the Appellate Term decision, in my judgment, it did not confirm the lower court's claim priority determination. Alleviation Med. Services., P.C. v. Allstate Ins. Co., 191 A.D. 3d 934, 143 N.Y.S. 3d 395, (App Div, 2nd Dept-2021). It is further observed the First Department, Appellate Term, has adopted a view contrary to the Appellate Term Alleviation Court and that this Arbitrator sits in the First Department. In Harmonic Physical Therapy v. Praetorian Insurance Co., 47 Misc. 3d 137 (A), 2015 NY Slip Op 50525 (U), (App Term, 1st Dept-2015), citing Nyack Hospital v. General Motor Acceptance Corp., the Court concluded the No-Fault carrier "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'".

It is additionally observed that the Appellate Term, First Department, recently issued a decision wherein the Court considered, as here, the timely denial of a claim that was complete upon its presentment. Allstate Fire & Cas. Ins. Co v. Branch Med., PC. 2022

NY Slip Op 50277 (U). After noting that where an insurer "has paid the full monetary limits set forth in its policy its duties under the contract of insurance" cease", and an Arbitrator's Award in excess of the monetary limits of a No-Fault insurance policy exceeds the Arbitrator's power (internal citations omitted), the Court held that "petitioner was not precluded by 11 NYCRR 65-3.15 from paying other legitimate claims subsequent to the denial of Respondent's claims" (internal citations omitted). "Adopting Respondent's position, which would require petitioner to delay payment on uncontested claims pending resolution of Respondent's disputed claims 'runs counter to the No-Fault regulatory scheme, which is designed to promote prompt payment of legitimate claims'" (internal citations omitted). The Appellate Division, First Department, very recently re-affirmed Harmonic Physical Therapy's precedent in concluding that, "in awarding a claim after a policy has been exhausted, an Arbitrator exceeded his or her power since an insurer's duties cease upon the insurer's payment of the contractual limit on its No-Fault policy". Matter of New Millennium Pain & Spine Medicine, PC v. Progressive Cas. Ins. Co., 2023 NY Slip Op 05369 (App Div- 1st Dept-October 24, 2023).

Following a thoughtful evaluation of the aforementioned case law, I find the position of the Court of Appeals as set forth in Nyack Hospital v. General Motor Acceptance Corp., and as most recently embodied in the First Department cases of Harmonic Physical Therapy v. Praetorian Insurance Co., Allstate Fire & Cas. Ins. Co v. Branch Med., PC., and Matter of New Millennium Pain & Spine Medicine, PC v. Progressive Cas. Ins. Co. to be controlling vis-à-vis the priority of claims and a No-Fault carrier's policy exhaustion defense. After carefully considering all of the evidence presented in this matter, I find Respondent's documentation to be probative of its proffered exhaustion defense. I conclude no further No-Fault benefits are available to the EIP and/or her assignees such as the Applicant herein. In light of my above conclusion, I need not consider any other defense interposed with respect to the CMTs with physical medicine modalities rendered to the within EIP from September 2 through November 18, 2023. Applicant's reimbursement requests, relative thereto, are denied. It is lastly observed my within determination is consistent with the prior Award of this Arbitrator, rendered in the matter of Sunil Butani M.D. PC a/a/o S.R. and Geico Insurance Company and bearing AAA Case No. 17-23-1327-6469, wherein Respondent's identical exhaustion defense was considered.

Accordingly, after a careful review of all the evidence and due regard for the argument of counsel, my Award is in favor of the Respondent. I find Respondent has no duty to provide further No-Fault benefits to the EIP, and by extension her assignees, following exhaustion of the policy limits applicable to claims such as that of the Applicant herein. Consequently, Applicant's 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 NY
SS :
County of NY

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

08/01/2024
(Dated)

Aladar Gyimesi

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:
242cd9cdec2cb346425bcd3a0ff59fc1

Electronically Signed

Your name: Aladar Gyimesi
Signed on: 08/01/2024