

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Alexander Rances, DO PC
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No.	17-23-1317-5594
Applicant's File No.	3123335
Insurer's Claim File No.	0018585750101249
NAIC No.	22063

ARBITRATION AWARD

I, Josh Youngman, 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: IP

1. Hearing(s) held on 08/16/2024
Declared closed by the arbitrator on 08/16/2024

Melissa Scotti, Esq. from Law Offices of Andrew J. Costella Jr., Esq. participated virtually for the Applicant

A representative from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$178.26**, 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

This dispute involves a claim for PIP benefits brought by the applicant as an assignee of a 48-year old female (K.H.) who was a pedestrian who sustained injuries in a motor vehicle accident that occurred on April 6, 2022. The evidence shows following the accident the injured party (IP) sought treatment and underwent a procedure requiring anesthesia on April 6, 2022.

The evidence further shows the respondent denied the claim seeking reimbursement for the anesthesia based on an Independent Medical Examination (IME) performed by Sammy Dean, M.D. dated January 13, 2022.

Further, the respondent has now argued that the PIP policy limits have been reached and that they cannot be compelled to pay out more than the policy limits.

The threshold issue is whether the respondent has presented sufficient proof to show that the policy limits have been reached, and if not, the issues presented are whether the applicant submitted sufficient evidence to make out a prima facie case, and if so, whether the respondent submitted sufficient evidence to sustain their lack of medical necessity defense.

4. Findings, Conclusions, and Basis Therefor

This Award is rendered after diligent review and consideration of the parties' evidence submitted to and maintained by the American Arbitration Association's electronic case filing system, "MODRIA," as well as the parties' oral arguments and any testimony presented at this matter's hearing. Evidence that was submitted after this matter's "closing" and without this Arbitrator's authorization was not considered.

The threshold issue is whether the policy limit has been exhausted. Ins. Law § 5102 states that basic economic loss means up to \$50,000.00 per person. In Hospital for Joint Diseases v. Hertz Corp., 22 A.D.3d 724 (2nd Dept. 2005), the Second Department held "when an insurer has paid the full monetary limits set forth in the policy, its duties under the contract of insurance cease." When an insurer has paid the full monetary limits set forth in the policy, its duties under the contract of insurance cease and an arbitrator would be exceeding his or her authority in issuing an award in excess of the policy limits. Countrywide Ins. Co. v. Swah, 272 A.D.2d 245 (1st Dept. 2000). A defense of no coverage due to the exhaustion of a No-Fault insurance policy's limit may be asserted by an insurer despite its failure to issue a NF-10 denial of claim form within the requisite 30-day period. New York & Presby. Hosp. v. Allstate Ins. Co., 12 A.D.3d 579, 580 (2d Dept. 2004).

After carefully reviewing the evidence presented, I find the respondent has submitted sufficient evidence to show the benefits available per the subject insurance policy have been exhausted. The respondent has demonstrated that \$50,000.00 in no-fault benefits have been paid by the submission of a payment log noting all payments made under this policy (which shows \$37,500.00 in medical payments, \$10,000.00 in lost wage payments and \$2,500.00 in applicable lost wage offsets). The respondent also submits a global denial of claim form.

The respondent further submits a declarations page that shows the policy had \$100,000.00 in PIP benefits. Further, the respondent has not submitted any evidence to show the \$100,000.00 in APIP coverage has been exhausted.

As stated above, however, the evidence shows that the IP was a pedestrian. Per the Mandatory Endorsement for APIP contained in 11 NYCRR § 65-1.3, those eligible for APIP coverage include:

- (a) the named insured and any relative who sustains personal injury arising out of the use or operation of any motor vehicle;
- (b) the named insured and any relative who sustains personal injury arising out of the use or operation of any motorcycle while not occupying a motorcycle;
- (c) any other person who sustains personal injury arising out of the use or operation of the insured motor vehicle while occupying the insured motor vehicle; or
- (d) any other person who sustains personal injury arising out of the use or operation of any other motor vehicle (other than a public or livery conveyance) while occupying such other motor vehicle, if such other motor vehicle is being operated by the named insured or any relative.

Thus, the regulations do not contemplate APIP coverage for those injured while a pedestrian. The issue of a pedestrian's eligibility to recover APIP benefits was addressed by Master Arbitrator Peter J. Merani in his award rendered under AAA Old Case Number: 4120-1206-7730, where he analyzed 11 NYCRR § 65-1.3 and stated:

Under the above categories the eligible injured persons who are entitled to the additional first party benefits under the APIP coverage are the named insured and any relative who sustains personal injury out of the use or operation of any motor vehicle and any other person (other than the insured or relative of the insured) who sustains injury while occupying a vehicle operated by the named insured or a relative. The injured person in this case was not occupying a motor vehicle but instead was a pedestrian and as such is not defined as an eligible injured person under the extended coverage afforded by the additional personal injury protection (APIP) endorsement. Pursuant to the language contained in the regulation the insurer is required to pay additional first party benefits to an "eligible injured person". The pedestrian injured person in this case does not fall into the category of an eligible injured person under the APIP coverage.

Thus, due to the fact the evidence shows the IP was a bicyclist, I find the IP is entitled to the \$50,000.00 in PIP coverage but not the \$100,000.00 in APIP coverage.

As stated, above, the evidence is sufficient to show that \$50,000.00 in PIP coverage has already been paid. As such, there is no further applicable coverage available.

Further, to the extent the applicant argues there were funds remaining on the policy when their verified and complete claims were received, and therefore the claims should have been paid in compliance with 11 NYCRR § 65-3.15, I disagree.

11 NYCRR § 65-3.15 states:

When 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.

Thus, the applicant states the evidence shows claims for services rendered after the date of service in dispute were made and argues those payments violated 11 NYCRR § 65-3.15.

The applicant's interpretation of 11 NYCRR § 65-3.15, however, appears logical if said section of the no-fault regulations is read in isolation and without context. The same no-fault regulations, however, also contain 11 NYCRR § 65-3.8(c), which states:

Within 30 calendar days after proof of claim is received, the insurer shall **either pay or deny** the claim in whole or in part.

(1) If the insurer denies a claim in whole or in part involving elements of basic economic loss or extended economic loss, the insurer shall notify the applicant or the authorized representative on the prescribed denial of claim form, in duplicate, and shall furnish, if requested by the applicant, one copy of all prescribed claim forms submitted by or on behalf of the applicant thereto. However, where a denial involves a portion of a health provider's bill, the insurer may make such a denial on a form or letter approved by the department which is issued in duplicate. No form or letter shall be approved unless it contains substantially the same information as the prescribed form which is relevant to the claim denied. (emphasis added).

There are also numerous other provisions of the no-fault regulations that discuss an insurer's option to pay or deny a claim. Thus, the no-fault regulations clearly provide a mechanism for an insurer to deny a claim instead of paying a claim. I find the above-referenced interpretation of the no-fault regulations, however, fails to consider the respondent's ability to deny a claim and relies on an interpretation that a claim is overdue despite the fact that claim was denied.

My interpretation of the no-fault regulations is that 11 NYCRR § 65-3.15 controls the order claims should be paid for claims where the respondent has chosen to pay. In the instant matter, however, the evidence shows the respondent chose to deny the claims, an option explicitly provided by 11 NYCRR § 65-3.8(c).

Furthermore, to the extent that the applicant may rely upon *Alleviation Med. Servs., P.C. v Allstate Ins. Co.*, 2017 NY Slip Op 27097 (App. Term 2d Dept. 2017), as the respondent timely denied the claim prior to the exhaustion of the policy, I find that Alleviation is an incorrect pronouncement of the law. The decision fails to consider the statutory language which states that basic economic loss means "up to fifty thousand dollars...." See Ins. Law 5102. Further, I believe that the First Department decision in

Harmonic Physical Therapy, P.C. v Praetorian Ins. Co., 47 Misc 3d 137(A)(App. Term 1st Dept. 2015) is the correct and logical pronouncement of the law. As the Court in Harmonic states:

Contrary to plaintiff's contention, defendant 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" (*Nyack Hosp. v General Motors Accept. Corp.*, 8 NY3d at 300).

In addition, I am aware of the Appellate Division's decision in Alleviation Med Servs., P.C. v. Allstate Ins. Co., 2021 NY Slip Op 08159 (App. Div. 2d Dept. 2021) and do not find that it changes my stance in any way relevant to the instant dispute.

Thus, the disputed claim is denied.

Further, as stated by the Supreme Court of the State of New York, County of New York in the matter of Country-Wide Ins. Co. v. Sayed Physical Therapy, P.C., 2022 NY Slip Op 31874(U) (Sup. Ct. NY County 2022):

It is not the duty of the arbiter, be it an arbitrator or Court, to parse [through] hundreds of pages of exhibits to make a out a claim or defense for a party (*see e.g. Barsella v. City of New York*, 82 A.D.2d 747, 748 [1st Dept 1981]); such duty belongs to counsel, as advocate. Failing to elucidate evidence in support of a party's claim is not error of the arbitrator but is rather error of counsel, and such failure does not render an arbitrator's award arbitrary and capricious (*see Stephen Fogel Psychological, P.C. v. Progressive Cas. Ins. Co.*, 35 A.D.3d 720, 721 [2d 2006]).

Thus, any issues not referenced above are held to be moot and/or waived insofar as they were not sufficiently raised at the time of the hearing.

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 CA
SS :
County of San Diego

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

08/21/2024
(Dated)

Josh Youngman

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:
458b837c780dfe909105a71025ad1543

Electronically Signed

Your name: Josh Youngman
Signed on: 08/21/2024