

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Sedation Vacation Perioperative Medicine
PLLC
(Applicant)

- and -

Integon General Insurance Corporation
(Respondent)

AAA Case No.	17-24-1341-1199
Applicant's File No.	NF 3746983
Insurer's Claim File No.	230421290-003
NAIC No.	22780

ARBITRATION AWARD

I, Paul Weidenbaum, 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 08/27/2024
Declared closed by the arbitrator on 08/27/2024

Vijay Gupta from The Law Office of Thomas Tona, PC participated virtually for the Applicant

Adva White from Law Offices of John Trop participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$646.68**, 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 arbitration arises out of perioperative block injections administered in connect with an 11/30/23 surgical procedure undergone by the injured person, a 45 year old male, who was involved in a motor vehicle accident which occurred on 5/16/23.

Whether Respondent's policy exhaustion defense can be sustained?

4. Findings, Conclusions, and Basis Therefor

This arbitration arises out of the fee for a perioperative block injection administered in connection with a surgical procedure undergone by the injured person, a 45 year old male, who was involved in a motor vehicle accident which occurred on 5/16/23. Applicant seeks reimbursement in the sum of \$646.68. Respondent timely issued an NF-10 Denial of Claim denying reimbursement based on medical necessity, which defense was supported by the peer review report of Dr. Levy dated 1/11/24. Subsequently, on 8/15/24, the policy limits exhausted.

POLICY EXHAUSTION

Respondent herein has submitted a payment ledger and argued that payments for lost earnings had decreased the sums available to pay other expenses. Respondent argued that the payment ledger demonstrated that the policy limits of \$50,000 for No-Fault benefits had been exhausted and a global denial had been issued based on policy exhaustion. The case of *Normile v. Allstate Insurance Co.*, 448 N.Y.S. 2d 907 (3rd Dept. 1982), affirmed 60 N.Y. 2d 1003, 471 N.Y.S. 2d 550, 459 N.E. 2d 843 (1983) considered whether the amount of disability and Social Security benefits, and the statutory reduction, are an offset against the amount of lost earnings, and, additionally, an offset against the No-Fault policy limit of \$50,000. The case cited is the controlling law on this issue. Under the *Normile* doctrine, an insurance carrier is entitled to deduct the offsets from the total coverage, which means in the instant case that Respondent has presented prima facie proof that the basic policy limit was exhausted.

The chronology of the case shows that Respondent timely issued an NF-10 Denial of Claim based on medical necessity, which defense was supported by the 1/11/24 peer review report of Dr. Levy. Subsequently, on 8/15/24, the policy limits exhausted. The case of *Harmonic Physical Therapy, P.C. v. Praetorian Ins. Co.*, 47 Misc. 3d 137[A] (App. Term 1st Dept.) is in accord with the recent Second Department case of *Alleviation Medical Services, P.C. v. Allstate Ins. Co.*, 55 Misc. 3d 44 (App. Term 2d Dept 2017), which mandates a priority of payment scheme in the Insurance Regulations with regard to an applicant's claims which pre-date the exhaustion of the policy limits. Respondent argues that a No-Fault carrier's obligations cease when the full policy limits have been paid, and any failure to issue a denial, or tardiness in the issuance of a denial, does not operate to create excess coverage, citing *Nyack Hospital v. GMAC*, 8 N.Y. 3d 294, 832 N.Y.S. 2d 880 (2007).

Respondent argues that this Court of Appeals case is dispositive, and that it stands for the proposition that Respondent cannot be obligated to pay more than the limits of its policy. It has been held that "Where, as here, 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 N.Y. v. Liberty Mut. Auto Ins. Co.*, 216 A.D. 2d 448; see *Hospital for Joint Diseases v. state Farm Mut. Auto Ins. Co.*, 8 A.D. 3d 533, 534; *New York & Prebyt. Hosp. v. Progressive Cas. Ins. Co.*, 5 A.D. 3d 568, 570. *Hospital for Joint Page Diseases v. Hertz Corp.*, 22 A.D. 3d 724, 2005 N.Y. Slip Op 07932 (App. Div., 2d Dept. 2005). 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 55, 790 N.Y.S. 2d 216 (2d Dept. 2005) When an insurance carrier "has paid the full monetary

limits set forth in its 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). It has been stated that "the cessation of those duties applies to a claim that was improperly denied, *Nyack Hosp. v. General Motors Acceptance Corp.*, 8 N.Y. 3d 294, 832 N.Y.S. 2d 880 (2007) even where the Denial of Claim (NF-10) form is not issued within 30 days." *New York and Presbyterian Hosp. v. Allstate Ins. Co.*, 12 A.D. 3d 579, 786 N.Y.S. 2d 68 (2d Dept. 2004); *Crossbridge Diagnostic Radiology v. Encompass Ins.*, 24 Misc. 3d 134(A), 2009 N.Y. Slip Op 51415(U) (App. Term 2nd, 11th & 13th Jud. Dists. 2009).

A carrier may present sufficient evidence to establish that the subject policy limits for personal injury protection benefits had been exhausted by prior claims. *Hospital for Joint Diseases v. State Farm Mut. Auto Ins. Co.*, 8 A.D. 3d 533, 2004 N.Y. Slip Op 05413 (App. Div., 2d Dept. 2004). 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 Hosp. v. Progressive Cas. Ins. Co.*, 5 A.D. 3d 568, 774 N.Y.S. 2d 72

In *Metrocare Medical, P.C. v. GEICO*, AAA Case No. 17-17-1057-4462 (10/18/17), Arbitrator DiGirolamo wrote about the current state of the applicable law on the issue of policy exhaustion in No-Fault cases. In relevant part, Arbitrator DiGirolamo's decision stated: "Respondent argues that the policy insurance limits were paid, and, therefore, even if Applicant prevails on the issue of medical necessity or fee schedule, it is not entitled to receive payment. In support of this defense, Respondent has submitted the policy declaration page and payment log. Applicant's counsel does not dispute Respondent's proof. However, he argues that Applicant's claims were presented prior in time to other claims that were reimbursed and that it was entitled to recover payment for the subject services despite the policy being exhausted, citing to *Alleviation Med. Servs., P.C. v. Allstate Ins. Co.*, 55 Misc. 3d 44, 2017 N.Y. Slip Op 27097 (Sup. Ct., App. Term 2d Dept. 2017). I disagree.

The Courts 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. *Champagne v. State Farm Mutual Automobile Insurance Co.*, 185 A.D. 2d 835; *Presbyterian Hospital in the City of New York as assignee of Kenneth Mandel v. Liberty Mutual Insurance Company*, 216 A.D. 2d 448, 628 N.Y.S. 2d 396 (2d Dept. 1995); *Hospital for Joint Diseases v. State Farm Mutual Automobile Insurance Coverage*, N.Y.L.J., June 25, 2004, page 29, column 5. This holding remains the same whether the Respondent issues a timely, late, or no denial. The Courts have held that a new policy, or additional coverage, in excess of the contractual amount, could not be created by virtue of a late denial. *Presbyterian Hospital in the City of New York as assignee of Kenneth Mandel v. Liberty Mutual Insurance Company*, supra, *Zappone v. Home Ins. Co.*, 55 N.Y.2d 131, 432 N.E. 2d 783, 447 N.Y.S. 2d 911 (1982).

In *Nyack Hospital v General Motors Acceptance Corp.*, 8 N.Y. 3d 294, 832 N.Y.S. 2d 880 (2007), the Court of Appeals held that an insurance carrier need not set aside money for claims that have been properly delayed or denied in anticipation of future litigation. Pursuant to the No-Fault Regulation, Respondent was bound to continue to process and

pay claims from other health providers as they became due and owing. Several Arbitrators have determined to follow the holding in *Harmonic Physical Therapy, P.C. v. Praetorian Ins. Co.*, 47 Misc. 3d 137(A), 15 N.Y. S. 3d 711, 2015 N.Y. Slip Op 50525(U) (Sup. Ct. App. Term, 1st Dept. 2015) wherein the Court determined that timely denied claims do not hold a place on the priority of payment line to subsequently filed claims that were paid by Respondent. (See Arbitrator Lustig in AAA Case Number 17-16-1028-9763; Arbitrator Aspir in AAA Case Number 17-16-1031-8999; Arbitrator Vera in AAA Case Number 17-16-1031-8952; Arbitrator Schor in AAA Case Number 17-16-1027-5184, and Arbitrator Adelson in AAA Case Number 17-16-1030-9621)."

In AAA Case Number 17-15-1025-5294, Arbitrator Rickman stated the following: "to reiterate, the general rule as stated in *Hospital for Joint Diseases et al v. State Farm Mutual Automobile Ins. Co.*, 8 A.D. 3d 533, 534 (2d Dept. 2004) is that when an insurer has paid out the full monetary limits set forth in the policy its duty to pay under the contract ceases to exist. While sitting as a Master Arbitrator, I previously ruled in numerous cases that a timely denied claim does not hold a place on the priority of payment line to subsequently filed claims that were paid by the Respondent. To require Respondent to hold money in reserve for claims it was not then obligated to pay (such as when Respondent issued a timely denial) would directly contradict the regulations which emphasize the prompt time limits for the submittal and processing of claims. See, for example, Master Arbitration Award by Steven Rickman, dated 9/8/11 in *Stay In Touch Massage Therapy, P.C. v. Liberty Mutual Ins. Co.*, Case # 17 991 R 20902 11. Multiple arbitrators have subsequently relied upon the award (and other similar Master Awards I issued) to arrive at the same conclusion (see, for example, AAA Case # 41203065361 Arbitrator Burt Feilich, AAA Case # 17-15-1004-4577 Arbitrator Eylan Schulman, AAA Case No.412013004537 Arbitrator Mitchell Lustig, AAA Case # 412013072907 Arbitrator Charles Blattberg). Thus, I specifically find that Respondent did not violate the priority of payment provision." Arbitrator Rickman stated that he follows *Harmonic Physical Therapy v. Praetorian Insurance Company*, supra, and finds the reasoning expressed by the Alleviation Court faulty. In AAA case No. 17-15-1025-1793, Arbitrator Grob stated: "...Applicant's reliance on the priority of payment rule and/or Alleviation Med. Servs., P.C. v. Allstate Ins. Co. ...is, in this forum's view, misplaced.

The Alleviation action was a court proceeding without arbitral antecedents, and it is this distinction which is dispositive. It is one thing for the Court, where appropriate, to render judgment which constrains a carrier to provide benefits beyond the limits of its policy, it is quite another to equate the authority of this forum with that of the judiciary. Notably, the Applicant has presented no appellate authority permitting an arbitrator to exceed a specific enumerated limitation on his or her power by rendering an award in excess of contractual policy limit. (See, *Acuhealth Acupuncture, P.C. v. New York City Tr. Auth.*, 50 Misc. 3d 1228(A)."

I note the case law clearly holds that an arbitrator's award in excess of the \$50,000 limit of an insurance policy exceeds the arbitrator's power. *Allstate Ins. Co. v. Demoura*, 2011 N.Y. Slip Op 50430(U)(Sup. Ct. App. Term 1st Dept. 2011). Therefore, I concur with my colleagues in following the Court's decision in *Harmonic Physical Therapy*. As to the untimely denial, an 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); *Presbyterian Hosp. in the City of N.Y. v. General Acc. Ins. Co. of Am.*, 229 A.D. 2d 479, 645 N.Y.S. 2d 516 (2d Dept. 1996); also see *Presbyterian Hospital of N.Y. v. Liberty Mut. Ins. Co.*, supra; *Crossbridge Diagnostic Radiology v. Encompass Insurance*, 24 Misc. 3d 134(A), 890 N.Y.S. 2d 3768 (Table), 2009 N.Y. Slip Op 51415(U), 2009 WL 1911909 (Supreme Court, App. Term, 2d Dept. 2009).

The Court in *Flushing Traditional Acupuncture, P.C. v. Infinity Group*, 2012 N.Y. Slip Op 22345, 2012 WL 5974095 (Supreme court, App. Term 2d Dept. 2012) opined that a defense of no coverage due to the exhaustion of an insurance policy's limit may be asserted by an insurer despite its failure to issue an NF-10 denial of claim form within the requisite 30-day period. So too in *Presbyterian Hospital in the City of New York v. General Accident Insurance company of America*, supra, the Court stated: "An untimely denial of claim will not operate to preclude a defense that the coverage limits of the subject policy have been exhausted (See, *Presbyterian Hosp. v. Liberty Mut. Ins. Co.*, 216 A.D. 2d 448). Where, as here, an insurer has paid the full monetary limits set forth in the policy, its duties under the contract of insurance cease (see, *Champagne v. State Farm Mut. Auto Ins. Co.*, 185 A.D. 2d 835, 837). The defendant's tardiness in issuing its denial of claim could not thereafter create a new policy or additional coverage in excess of the amount for (see, *Zappone v. Home Ins. Co.*, 55 N.Y. 2d 131; *Schiff Assocs. V. Flack*, 51 N.Y. 2d 692; *Employers . V. County of Nassau*, 141 A.D. 2d 496)". Accordingly, Applicant's claim is denied in its entirety. While the Applicant argues that the case of *Alleviation Medical Services, P.C. v. Allstate Insurance Co.*, 217 N.Y. Slip Op 27097, App. Term 2nd, 11th & 13th Jud. Dists., March 29, 2017, is applicable, I am in agreement with Arbitrator DiGirolamo that once the policy/coverage limits have been paid an insurer's obligation ceases and that "this holding remains the same whether the Respondent issues a timely, late, or no denial".

Respondent herein has presented evidence "sufficient to establish that the subject policy limits or personal injury protection benefits had been exhausted by prior claims. No triable issue of fact was raised by plaintiffs in opposition to defendant's motion." *Hospital for Joint Diseases v. State Farm Mut. Auto Ins. Co.*, 2004 N.Y. Slip Op 05413 (2d Dept. 2004).

Based upon the proof presented herein, I find that Respondent has proven, by a fair preponderance of the credible evidence, that the applicable policy/coverage limits have been exhausted. All remaining issues are moot. Accordingly, this claim must be denied in its entirety. This decision is in full disposition of all claims for reimbursement of No-Fault benefits presently pending before this Arbitrator.

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

08/27/2024

(Dated)

Paul Weidenbaum

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:
46f138797a1c2486e57540e874fb1555

Electronically Signed

Your name: Paul Weidenbaum
Signed on: 08/27/2024