American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

JTK Chiropractic Care PC (Applicant)	AAA Case No.	17-24-1346-0534
	Applicant's File No.	GTLJTK013124.013
- and -	Insurer's Claim File No.	055882567
LM General Insurance Company (Respondent)	NAIC No.	36447

ARBITRATION AWARD

I, Robyn McAllister, 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: Assignor

1. Hearing(s) held on 10/08/2024
   Declared closed by the arbitrator on 10/17/2024

   George Lewis, Esq. from Law Offices of George T. Lewis, Jr., PC participated virtually for the Applicant

   Kathleen Raedy, Claims Representative from LM General Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$1,214.72**, 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

   Whether Respondent properly partially denied Applicant's claim for performing spinal ultrasounds for Assignor (JSL), a 40 year-old male driver, in connection with treatment of injuries sustained in a motor vehicle accident on January 18, 2024, based on the Workers' Compensation Fee Schedule, and whether Respondent established that the policy limits have been exhausted.

4. Findings, Conclusions, and Basis Therefor

Applicant sought reimbursement in the amount of $1214.72 for the balance owed for performing ultrasounds of the cervical, thoracic and lumbar regions on January 31, 2024 for Assignor (JSL), a 40 year-old male driver, in connection with treatment of injuries sustained in a motor vehicle accident on January 18, 2024. Respondent timely and partially denied Applicant's claim predicated on the Workers' Compensation Fee Schedule. Respondent further asserted that the policy limits have been exhausted.

This decision is based on the oral arguments of counsel or other representative at the hearing and the documents submitted. I have reviewed the documents contained in the ADR Center as of the date of this award. Applicant established its prima facie case since Respondent's denial acknowledged receipt of Applicant's bill. *See Viviane Etienne Medical Care, P.C. v. Country-Wide Ins. Co.,* 25 N.Y.3d 498 (2015); *AR Medical Rehabilitation v State-Wide Insurance Company*, 49 Misc.3d 919 (Civil Ct., Kings Co. 2015).

At the hearing, Respondent argued that it properly partially denied Applicant's claim based on the Fee Schedule. I disagree. The same Fee Schedule defense was previously rejected by this Arbitrator in *JTK Chiropractic PC v. Liberty Mutual Insurance Company*, 17-22-1276-8582. In that case, I concluded that Respondent's coder analysis was less persuasive than Applicant's coder. Likewise, in the instant case, Respondent submitted a similar coder letter by Melissa Simon, CMC and I remain more persuaded by the analysis set forth by Applicant's coder, Maureen Norman, RMC. Therefore, I find that Respondent's partial denial was without merit.

In any event, Respondent argued that the no-fault benefits were exhausted by my prior award in the linked case *Meds And Beyond Inc v. LM General Insurance Company*, 17-24-1345-3477, and that Applicant may not recover more than the limits of the policy. I agree.

In the above-referenced case, I stated as follows:

Respondent asserted that the policy was almost exhausted and that Applicant may not recover more than the policy limits. I agree. In support of its defense, Respondent submitted the declarations page of the insurance policy and payout ledger, which established that there is only $174.60 of available no-fault benefits remaining.

"An insurer is not required to pay a claim where the policy limits have been exhausted." Mount Sinai Hospital v. Zurich American Insurance Co., 15 A.D.3d 550 (2d Dept. 2005). Where 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 Ins. Co., 8 A.D.3d 533, (2d Dept. 2004) citing Presbyterian Hosp. in the City of New York v. Liberty, 216 A.D.2d 448 (1995).

Thus, in the instant case, Applicant is not entitled to reimbursement beyond the policy limits since any award would exceed my authority. See Acuhealth Acupuncture, P.C. v. New York City Transit Authority, 2016 NY Slip Op. 50297(U)(Sup. Ct. Kings Co. March 1, 2016, (Genovisi, J.), aff'd 167 A.D.3d 869 (2d Dept. 2018).

Furthermore, the Appellate Division, First Department recently reaffirmed that an arbitrator exceeds his or her authority by awarding in excess of the policy limits. In Matter of DTR Country-Wide Insurance Company v. Refill Rx Pharmacy, Inc., 2023 NY Slip Op 00179, the Court stated as follows:

Vacatur of the award was warranted under CPLR 7511(b)(1)(iii) as the lower arbitrator exceeded his power by issuing an award exceeding the contractual limit for the subject no-fault coverage policy of $50,000, and the master arbitrator erred in affirming. Once a no-fault insurer "has paid the full monetary limits set forth in the policy, its duties under the contract of insurance cease" (Countrywide Ins. Co. v Sawh, 272 AD2d 245 [1st Dept 2000]). An arbitrator's award directing payment beyond the monetary limit of a no-fault insurance policy exceeds the arbitrator's power and constitutes grounds for vacatur of the award (see Matter of Brijmohan v State Farm Ins. Co., 92 NY2d 821, 823 [1998];see also Matter of Ameriprise Ins. Co. v Kensington Radiology Group, P.C., 179 AD3d 563[1st Dept 2020]). Country-Wide was not precluded from raising the issue of policy exhaustion before the court, even if it was not before the arbitrators in the underlying arbitration (id. at 564).

More recently, in Matter of Lam Quan, MD, PC v. GEICO Gen. Ins. Co., 2024 NY Slip Op 00174 (1st Dept 2024), the Court reiterated its position as follows:

As stated in Matter of New Millenium Pain & Spine Medicine., PC v Progressive Cas. Ins. Co. "[t]he fact that the arbitrator followed First Department precedent in Harmonic Physical Therapy, P.C. v Praetorian Ins. Co. (47 Misc 3d 137[A], 2015 NY Slip Op 50525[U] [App Term, 1st Dept 2015]), rather than Second Department precedent in Alleviation Med. Servs., P.C. v Allstate Ins. Co. (55 Misc 3d 44, 49 [App Term, 2d Dept 2017], affd on other grounds 191 AD3d 934 [2d Dept 2021]), does not warrant reversal. To the contrary, this Court has held 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" (220 AD3d 578, 578 [1st Dept 2023]).

Therefore, I find that it is beyond my scope of authority to award beyond the limits of the policy.

Accordingly, Applicant is awarded $174.60, and the remainder of its claim is denied.

Likewise, in the instant case, for the reasons noted above, I find that it is beyond the scope of my authority to award beyond the limits of the policy and Applicant is not entitled to any additional reimbursement.

I was not persuaded by Applicant's assertion at the hearing that Respondent failed to prove that it was entitled to the NYS disability offsets taken for Assignor's lost wage payments. In support of its defense, Respondent submitted the NF-6 signed by Assignor's employer's benefits manager, which stated that Assignor was employed as a Steward by Mandarin Oriental and was receiving NYS disability payments from its insurer Standard Insurance Company.

In addition, I was persuaded by Arbitrator Daugherty's award in *Dynamism Physical Therapy, PC v. Geico Insurance Company*, 17-23-1292-0679, wherein she addressed the same issue. The Arbitrator stated as follows:

In the instant matter Respondent has uploaded a copy of the insurance policy declaration page establishing that the policy carried a $50,000.00 limit. Respondent has also provided an itemized payment ledger indicating that the policy limit has been reached including payment of medical claim, lost wages and in consideration of offsets.

Applicant argues that Respondent has not established that it is entitled to a disability offset, noting that line 6 of the Employer's Wage Verification Report is marked "NO" in response to the question "Has employee received, is employee receiving or is employee entitled to receive New York State Disability Benefits as a result of this accident?" Similarly, Applicant also noted that Box 22 of the NF-2 is also marked "No" in response to the question of whether Assignor has received or is eligible to receive payments under New York State Disability.

Respondent argues that Assignor was a full-time employee working 40 hours per week at an hourly rate of $15.50 pursuant to the Employer's Wage Verification Report and was eligible for New York State Disability Benefits by law.

In regard to offsets, 11 NYCRR 65-3.19(f) states:

(1) Whenever an eligible injured person is entitled to disability benefits under article 9 of the Workers' Compensation Law, the insurer shall be entitled to an offset equal to the lesser of:

(i) 50 percent of the applicant's average weekly wage loss not to exceed $170 per week; or

(ii) the actual dollar amount of the disability benefits being received where the employer's plan provides a maximum payment of less than $170 per week. The $170 per week previously referred to shall be adjusted whenever section 204 of the Workers' Compensation Law is amended to provide a higher statutory dollar maximum. The offset shall be applicable during the statutory 26-week benefit period beginning seven days after the accident date except in the case where lower benefits are paid in exchange for a longer benefit period. In no event shall the offset for New York State disability benefits exceed the weekly statutory dollar maximum multiplied by the maximum statutory benefit period (currently $170 × 26 weeks = $4,420).

(2) The insurer shall provide the applicant with a notice and proof of claim for disability benefits (DB 450), which has been printed on buff-colored paper and, in addition, shall notify the applicant's employer that such employer is required to process the applicant's disability benefits claim if its employees are covered for such benefits by the Workers' Compensation Law. The notification to the employer should be sent along with the employer's wage verification report (NYS form NF-6). Unless the insurer has complied with the above, it shall not take an offset for New York State disability benefits until it verifies that the applicant is actually receiving statutory disability benefits.

<u>Standing</u>

Assuming arguendo, for a moment, that Respondent properly applied the offsets to Assignor's lost wages, the policy limit has been reached and no further monies are due and owing on the policy. However, assuming arguendo the opposite for a moment, the question turns to whether the funds incorrectly held against Assignor's individual lost wage claim are available to other individual claims on the policy. I find that they are not. Applicant does not have standing to dispute the disability offsets applied to Assignor's lost wages.

The payment ledger reflects that Respondent applied $6,570.40 in offsets for $9,009.60 in lost wages. The allocation of funds for offsets applied against Assignor's claim for lost wages was applied between March 2, 2020 and September 1, 2020. If the funds were incorrectly applied Assignor could have contested the application of the offsets. There is no evidence that Assignor contested the application of the disability offsets, so they remain. To hold otherwise and allow a treating provider standing to dispute the application of the offsets would open the door for medical providers to dispute the validity of claims paid out on a policy to other providers because the funds paid reduce the money available on the policy to them. Does a chiropractor have standing to dispute the medical necessity of a right knee surgery simply because the funds paid on the right knee surgery reduce the amount available to the chiropractor for treatment rendered? Finding so would contradict the no-fault system goals of prompt resolution of claims.

Likewise, in the instant case, I am persuaded by Arbitrator Daugherty's analysis and adopt the same herein.

Accordingly, 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 Westchester

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

10/21/2024
(Dated)

Robyn McAllister

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:
a47df715f5b04a914703ddc8cd0b8b5b

Electronically Signed

Your name: Robyn McAllister
Signed on: 10/21/2024