American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Joseph A Raia MD PC (Applicant)	AAA Case No.	17-23-1287-6028
	Applicant's File No.	DK23-330125
- and -	Insurer's Claim File No.	22-6179783
	NAIC No.	11770
Progressive Casualty Insurance Company (Respondent)		

ARBITRATION AWARD

I, Charles Blattberg, 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: Eligible injured person

1. Hearing(s) held on 07/31/2024
   Declared closed by the arbitrator on 09/23/2024

   Evan Polansky, Esq. from Korsunskiy Legal Group P.C. participated virtually for the Applicant

   Erin Ferrone from Progressive Casualty Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$1,085.72**, 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

   The claimant was a 46-year-old male who was injured in or by a motor vehicle on 10/6/22. Following the accident, the claimant sought treatment. At issue is electrodiagnostic testing performed by Applicant on 12/6/22. Respondent initially raised a fee schedule defense and subsequently raised a defense of policy exhaustion.

4. Findings, Conclusions, and Basis Therefor

Based on a review of the documentary evidence, this claim is decided as follows:

Applicant establishes a prima facie case of entitlement to reimbursement of its claim by the submission of a completed NF-3 form or similar document documenting the facts and amounts of the losses sustained and by submitting evidentiary proof that the prescribed statutory billing forms [setting forth the fact and the amount of the loss sustained] had been mailed and received and that payment of no-fault benefits were overdue. See, *Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). I find that Applicant established a prima facie case for reimbursement.

The claimant was a 46-year-old female restrained rear seat passenger of a motor vehicle that was involved in an accident on 10/6/22. The claimant reportedly injured her neck, left shoulder, left wrist, upper back, lower back and left knee. There was no reported loss of consciousness. There were no reported lacerations or fractures. There was no reported emergency treatment sought or received. On 10/10/22 the claimant presented to Idy Liang, N.P. of Atlantic Medical & Diagnostic, PC with complaints of headaches, cervical spine pain rated 8/10 (where 0 is no pain and 10 is the worst pain), left shoulder pain rated 5/10, left wrist pain rated 5/10, thoracic pain rated 9/10, lumbar pain 10/10 and left knee pain rated 7/10. Nurse Liang conducted ultrasonic examination of the lumbar spine using a Butterfly IQ+ transducer that indicated muscle patterns of lumbar spine consistent with diffuse and focal echogenic deflections at paraspinal musculature. This pattern is highly suggestive of muscle spasms of musculature at bilateral L4-L5, L5-S1. Nurse Liang performed lumbar trigger point injections under ultrasonic guidance, 4 sites. Nurse Liang prescribed Lidocaine 5% topical ointment, Cyclobenzaprine 7.5 mg tablets and Diclofenac 3% topical gel. Nurse Liang prescribed durable medical equipment (DME) consisting of a S.A.M. (Sustained Acoustic Medicine) device, water circulating vacu-thermal therapy unit with pump, cervical collar, cervical pillow, Game Ready System, lumbar sacral support, lumbar cushion, bed board, egg crate mattress, orthopedic car seat, lumbar cushion, EMS unit 4 leads with TENS/EMS placement belt, infrared heating lamp and a massager. The claimant was recommended for physical therapy, chiropractic treatment, acupuncture, MRIs (cervical spine, thoracic spine, lumbar spine, left shoulder, left wrist and left knee), psychiatric evaluation, EMG/NCV testing of upper/lower extremities and orthopedic evaluation for upper or lower extremity joints. The 11/4/22 left knee MRI interpreted by Robert D. Solomon, M.D. produced an impression of joint effusion, irregular partially torn ACL and partial LCL tear. On 11/8/22 the claimant presented to Richard E. Pearl, M.D. for an orthopedic consultation with complaints of continuous left knee pain rated 7/10. Examination revealed warmth and moderate fluid appreciation upon medial and lateral aspect of the patella. There was significant crepitus upon flexion, extension, and positive bulging sign. There was clicking and tenderness. Tenderness was appreciated upon the anterior and medial joint line. Drawer test was positive. McMurray sign was positive as well. Apley's compression test was positive. There was positive varus stress upon external rotation and extension of the knee test. There was positive instability to AP and rotational stress. Range of motion was from 0-90°/0-120°. The claimant was recommended for arthroscopy. On 12/6/22 the claimant presented to Joseph A. Raia, M.D. (Applicant) for upper extremities and lower extremities EMG/NCV testing that suggested evidence consistent with left ulnar sensory neuropathy, but no evidence of

cervical and lumbar radiculopathy. On 12/17/22 Robert Drazic, D.O. (surgeon) and Joshua Leonardo, P.A. (surgical assistant) performed left knee surgery consisting of arthroscopic partial medial and lateral meniscectomies, debridement of the anterior cruciate ligament, coblation arthroplasty of the patella, trochlea and lateral tibial plateau, removal of loose bodies, major synovectomy, lysis of adhesions, medial plica excision and arthrocentesis. At issue is the 12/6/22 electrodiagnostic testing performed by Dr. Raia. Upon receipt of the bill at issue Respondent timely partially paid $1,605.08 and timely denied the $1,085.72 remainder at issue here as being billed in excess of fee schedule.

This hearing was held open for Respondent to "*upload an updated PIP ledger*." In a post hearing submission Respondent uploaded an updated Payments Summary and an 8/5/24 denial that states "*Please be advised that No Fault benefits available under the above captioned policy have exhausted. All further No Fault benefits will be denied."* Respondent submitted copies of the Policy Declarations Pages (confirming a $50,000.00 policy limit with respect to PIP benefits) and a Payments Summary that demonstrated $50,000.00 in medical and OEL (other economic loss) payments were made which exhausted the PIP policy limits. After carefully reviewing all of Respondent's submissions I am persuaded that the policy limits were exhausted.

Knowing that the policy was possibly exhausted at the time of the hearing Applicant's counsel argued that if I determined that the total amount of the claim was to be paid, then Respondent should pay the claim since it was received prior in time to claims of other providers which were paid. In other words, Applicant argued that the insurer would be obligated to set aside money for all denied claims pending the possibility of ensuing litigation/arbitration which may be filed within six years. This would also mean not paying subsequently received claims and would hold up the payment of claims for services which the carrier found medically necessary.

The Court of Appeals addressed a similar issue in *Nyack Hospital v. General Motors Acceptance Corp.*, 8 NY3d 294, 832 N.Y.S.2d 880 (2007). The *Nyack* Court found that an insurer which is waiting for information to verify a pending claim that causes aggregate claims to exceed $50,000 is not prohibited by the priority-of-payment regulation - 11 NYCRR 65-3.15. The Court noted that to hold up payment of other medical providers bills to wait for additional verification of a previously received bill would contravene the requirement that the other bills be paid or denied within 30 days. Similarly, where services were paid pursuant to fee schedule, having the insurer set aside funds in the anticipation of litigation would contravene the requirement that other bills be paid within 30 days. Once the policy limits are exhausted, the insurer is not obligated to make any further payments to an assignee or an assignor, notwithstanding a priority of claim or an overturned denial. The New York State Insurance Department Office of General Counsel issued an opinion on 7/30/08 stating that once the policy limits are exhausted, the assignment of benefits becomes ineffective. (OGC Op. No. 08-07-28).

There is no evidence that Respondent acted in bad faith. There is no evidence in this case that Respondent acted improperly or wrongfully in issuing this denial. Furthermore, I do not believe, in light of the clear language of the Statute and Regulation, that I have

the authority to increase the amount of statutory, regulatory and contractually limited coverage, even were I to find some evidence of bad faith.

Respondent's defense that the policy limits have been exhausted would be dispositive of this claim without requiring a determination of the issue of fee schedule. For the reasons set forth below Respondent would only have to pay this award up to the limits of the policy.

11 NYCRR Section 65-3.15 provides as follows: "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 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, all at the same time, the payments shall be made in the order of rendition of the services."

Case law dictates that 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 550, 790 N.Y.S.2d 216 (2d Dept. 2005). 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. *Crossbridge Diagnostic Radiology v. Encompass Insurance*, 24 Misc.3d 134(A), 890 N.Y.S.2d 368 (Table), 2009 N.Y. Slip Op. 51415(U), 2009 WL 1911909 (App. Term 2d, 11th & 13th Dists. June 23, 2009). See also, *New York & Presbyterian Hospital v. Allstate Ins. Co.*, 12 A.D.3d 579, 786 N.Y.S.2d 68 (2d Dept. 2004); *Flushing Traditional Acupuncture, P.C. v. Infinity Group*, 2012 NY Slip Op. 22345 (App Term 2d, 11th & 13th Jud Dists Nov. 26, 2012). Where 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 New York v. Liberty Mut. Ins. Co.*, 216 A.D.2d 448, 628 N.Y.S.2d 396; see also, *Hospital for Joint Diseases v. State Farm Mutual Automobile Ins. Co.*, 8 A.D.3d 533, *Champagne v. State Farm Mut. Auto. Ins. Co.*, 185 A.D.2d 835, 837, 586 N.Y.S.2d 813, *Hospital for Joint Diseases v. Hertz Corp.*, 22 AD3d 724, 2005 NY Slip Op. 07932. In addition, policy exhaustion may be proven by submitting a payment log or payment register establishing when and to whom payments made totaling the policy limits. See *St. Vincent's Hospital & Medical Center, etc. v. Allstate Insurance Company*, 294 AD2d 425, 742 N.Y.S.2d 350 (2002).

In *Allstate Ins. Co. v. DeMoura*, the court states, "When an 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 [2000]). A defense that the coverage limits of the policy have been exhausted may be asserted by an insurer despite its failure to issue a denial of the claim within the 30-day period (*New York & Presby. Hosp. v. Allstate Ins. Co.*, 12 AD3d 579 [2004]), **and an arbitrator's award directing payment in excess of the $50,000 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, 822 [1998]; *Countrywide Ins. Co. v. Sawh*, 272 AD2d at 245; 11 NYCRR 65-1.1)." *Allstate Ins. Co. v. Moira*, 30 Misc.3d 145 (A), [App Term, 1st Dept. 2011]{Emphasis added}. In *Allstate Insurance Company v.*

Countrywide Insurance Company,2013 NY Slip Op. 33179 (December 12, 2013 Sup. Ct., NY Co.), the Court, in addressing a motion to vacate an arbitration award pursuant to CPLR 7511, noted that "with respect to arbitration proceedings concerning no-fault insurance benefits, **an arbitration award made in excess of the contractual limits of an insurance policy has been deemed an action in excess of authority** (*State Farm Ins. Co. v. Credle*,228 A.D.2d 191, 643 N.Y.S.2d 97, 98 [1st Dept 1996]){Emphasis added}." The Court further noted that "**Such excess of authority constitutes grounds for vacatur of the award** (*See Matter of Brijmohan v. State Farm Ins. Co.*, 92 N.Y.2d 821, 822 [1998]){Emphasis added}."

At the hearing Applicant's counsel cited *Alleviation Medical Services. P.C. v. Allstate Insurance Company*, 49 N.Y.S. 3d 814, 2017 N.Y. Slip Op. 27097 in support of the position that Respondent should not be relieved of having to pay the claim.

Subsequent to denial of a claim on the ground of lack of medical necessity, a No-Fault insurer may pay uncontested claims and satisfy arbitration awards, such that if by the time the former claim is litigated, the governing policy's coverage limits have been exhausted the insurer may assert that fact as a defense. *Harmonic Physical Therapy, P.C. v. Praetorian Ins. Co.*, 47 Misc.3d 137(A), 2015 N.Y. Slip Op. 50525(U) (App. Term 1st Dept. Apr. 14, 2015). *Harmonic Physical Therapy, P.C.* is in conflict with *Alleviation Medical Services, P.C. v. Allstate Ins. Co.*, 55 Misc.3d 44, 45 (App. Term 2d, 11th & 13th Dists. 2017), wherein the Court stated, "As we read *Nyack Hosp.*to hold that fully verified claims are payable in the order they are received (*see*11 NYCRR 65-3.8 [b] [3]; 65-3.15; *Nyack Hosp.*, 8 NY3d 294), defendant's argument-that it need not pay the claim at issue because defendant paid other claims after it had denied the instant claim, which subsequent payments exhausted the available coverage-lacks merit (*see*11 NYCRR 65-3.15; *cf. Nyack Hosp.*, 8 NY3d 294; *but see 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])." I find that the reasoning in *Harmonic Physical Therapy, P.C.* is more persuasive than that in *Alleviation Medical Services, P.C.* I decline to follow the holding in the latter case.

The facts here - a timely denial - distinguishes this case from *Nyack Hospital v. General Motors Acceptance Corp.*, 8 N.Y.3d 294 (2007), and *NYU Hospitals Center - Hospital for Joint Diseases v. State Farm Mutual Automobile Ins. Co.*, Sup. Ct. Nassau Co., Leonard Steinman, J., Oct. 26, 2016). In both cases, the insurer had to pay No-Fault benefits despite policy exhaustion since the respective denials were not timely issued.

Additionally, Applicant's counsel highlighted the fact that the holding of *Alleviation Medical Services. P.C. v. Allstate Insurance Company* was affirmed. [See, *Alleviation Med. Servs., P.C. v. Allstate Ins. Co.*, 2021 N.Y. Slip Op. 08159 (A.D., 2d Dept., 2/24/21)]. Although the issue of coverage exhaustion was raised therein, the Court without ruling on the issue stated the following: "While the defendant submitted records indicating that the subject no-fault policy had been exhausted in 2013, the defendant's submissions failed to establish its prima facie entitlement to judgment as a matter of law. Although the defendant submitted an affidavit from one of its employees that set forth the defendant's ordinary business practice of receiving, recording, and denying no-fault claims from medical providers, the affidavit is bereft of any specific information

regarding this claim. The defendant failed to submit the no-fault application, verification, any request for verification, or any denial associated with the plaintiff's claim for payment." As such, the Court held there were procedural and evidentiary issues remaining as to when the claim was denied, and the basis and efficacy of the denial. The Court also acknowledged that an insurer is not required to pay a claim where the policy limits have been exhausted. [Citing, *Hospital for Joint Diseases v. State Farm Mut. Auto Ins. Co.*, 9 A.D.3d 534, 534]. Therefore, based on the above, Respondent has established that the policy limits were exhausted and Applicant's No-Fault claim is denied.

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

10/23/2024
(Dated)

Charles Blattberg

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:
a710327924626fc3e3fcb225a573d063

Electronically Signed

Your name: Charles Blattberg
Signed on: 10/23/2024