American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Shahid Mian MD P.C. (Applicant)	AAA Case No.	17-24-1359-7790
	Applicant's File No.	SHM072324005
- and -	Insurer's Claim File No.	6699895580000001
	NAIC No.	14137
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Evelina Miller, 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: BR

1. Hearing(s) held on 01/16/2025
   Declared closed by the arbitrator on 01/16/2025

   Chris Economou Esq from Economou & Economou PC participated virtually for the Applicant

   Chad Meyers Esq from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$1,063.40**, 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 dispute arises from the underlying automobile accident of June 1, 2022, in which the Assignor (BR), a 42-year-old-male was involved. Thereafter, Assignor sought private medical attention, and was eventually evaluated by Applicant with complaints of pain in the neck, lower back, bilateral shoulders, right hand and the left knee back. Patient was recommended to undergo conservative care. The bill in dispute is for an office visits performed on 4/23/23-7/9/24 Respondent contends that the relevant policy has become exhausted.

The issue presented before me is whether Respondent was able to establish that the no-fault policy limits have been reached and are now exhausted

4. Findings, Conclusions, and Basis Therefor

I have reviewed the submissions contained in MODRIA which are maintained by the American Arbitration Association. These submissions are the record in this case. My decision is based on my review of that file, as well as the arguments of the parties at the hearing. All the parties at this hearing appeared via ZOOM.

I find that Applicant establishes its prima facie showing of entitlement to recover first-party no-fault benefits by submitting evidentiary proof that the prescribed statutory billing forms, setting forth the fact and 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 Co*.,5 A.D.3d 742, (2d Dept., 2004). Once an applicant establishes a prima facie case, the burden then shifts to the insurer to prove its defense. See *Citywide Social Work & Psy. Serv. P.L.L.C v. Travelers Indemnity Co., 3 Misc. 3d 608, 2004, NY Slip Op 24034 [Civ. Ct., Kings County 2004])*.

Applicant submitted the bills to the Respondent for dates of service of 4/23/23-7/9/24 for office visits. At the current hearing Respondent asserted the defense that the policy has been paid out in the amount of $50,000, and therefore all benefits have been exhausted on 9/25/23.

Section 65-3.15 (11 NYCRR 65-3.15) of the Regulations provides that when claims ag *gregate* to more than $50,000, payments shall be made in the order in which each service was rendered or each expense incurred, provided the claims 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.

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 Insurance Co., 15 A.D.3d 55, 790 N.Y.S.2d 216 (2d Dept. 2005)*. In addition, when an insurer "has paid the full monetary limits set forth in the 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 (2nd Dept. 1995). 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).*

Respondent submits a Payment Ledger showing that the Respondent paid up to the policy limits. It is of no issue that the policy carries No-Fault coverage of $50,000. Respondent submits insurance policy declaration page indicating that the no-fault coverage was $50,000.

Respondent has provided the payment leger; and the declaration page indicating that the $50,000 has become exhausted. The evidence showed that Respondent paid $50,000 dollars, up to policy limits.

Respondent contends that it properly complied with priority of payment regulation, and the policy has been paid out. As such, Applicant would not be entitled to reimbursement.

While an insurer is required to show more than the mere exhaustion of benefits and must also demonstrate that the payments which led to the depletion of policy benefits were made in compliance with 11 NYCRR § 65-3.15 (Computation of basic economic loss), see *Nyack Hosp. v. General Motors Acceptance Corp., 8 N.Y.3d 294 (2007); New York & Presby. Hosp. v. Allstate Ins. Co., 12 A.D.3d 579, 580 (2d Dept. 2004), 11 NYCRR § 65-3.15* does not preclude an insurer or self-insurer from paying other providers' claims during a time that the 30-day statutory period in which to pay or deny a claim is tolled pursuant to a request for additional verification, /see *Nyack Hosp. v. General Motors Acceptance Corp., 8 N.Y.3d 294 (2007); Mount Sinai Hosp. v. Country Wide Ins. Co., 85 A.D.3d 1136 (2d Dept. 2011),* nor does it bar an insurer or self-insurer, following the timely denial of a claim, from paying other providers' undisputed claims pending resolution of the dispute, *see Allstate Prop. & Cas. Ins. Co. v. Northeast Anesthesia & Pain Mgt., 2016 NY Slip Op 50828(U) (App Term 1st Dept. May 31, 2016); Harmonic Physical Therapy, P.C. v. Praetorian Ins. Co., 2015 NY Slip Op 50525(U) (App Term 1st Dept., April 14, 2015); Integrated Medical Rehab & Diagnostic P.C. and Geico Ins. Co., AAA Case No. 412013081427, AAA Assessment No. 17 991 R 25938 14 (Master arb. Victor J. Hershdorfer, May 9, 2014).* In such instances, the payments are made in compliance with the priority of payment regulation because they were made before the insurer or self-insurer was obligated to pay the disputed claim. Id.

To the extent that the Appellate Term for the Second Department's recent decisions in *Island Life Chiropractic, P.C. v. Commerce Ins. Co., 2017 NY Slip Op 50856(U) (App Term 2d, 11th & 13th Jud Dists. June 23, 2017); Ortho Passive Motion, Inc. v. Allstate Ins. Co., 2017 NY Slip Op 50771(U) (App Term 2d, 11th & 13th Jud Dists. June 2, 2017); Alleviation Med. Servs., P.C. v. Allstate Ins. Co., 2017 NY Slip Op 27097 (App Term 2d, 11th & 13th Jud Dists. March 29, 2017),* are at odds with the holdings set forth in *Allstate Prop. & Cas. Ins. Co. v. Northeast Anesthesia & Pain Mgt., 2016 NY Slip Op 50828(U) (App Term 1st Dept. May 31, 2016); Harmonic Physical Therapy, P.C. v. Praetorian Ins. Co., 2015 NY Slip Op 50525(U) (App Term 1st Dept., April 14, 2015),* I decline to follow them.

Since the insurer's payments were made following its timely denial, Respondent demonstrated its compliance with the priority of payment regulation. See *Allstate Prop. & Cas. Ins. Co. v. Northeast Anesthesia & Pain Mgt., 2016 NY Slip Op 50828(U) (App Term 1st Dept. May 31, 2016); Harmonic Physical Therapy, P.C. v. Praetorian Ins. Co., 2015 NY Slip Op 50525(U) (App Term 1st Dept., April 14, 2015).*

Furthermore, an Arbitrator's award directing payment in excess of the limits of an insurance policy exceeds the arbitrator's power and constitutes grounds for vacatur of the award. *Matter of Brijmohan v. State Farm Ins. Co., 92 N.Y.2d 821, 822 (1998); Countrywide Ins. Co. v. Sawh, 272 A.D.2d 245 (1st Dept. 2000).* The evidentiary proof submitted by respondent demonstrates that it issued timely denials as to applicant's claims on various grounds, while the governing insurance policy's coverage limits had been exhausted through payment of no-fault benefits to other providers and that such payments were made in compliance with the priority of payment regulation. *Harmonic Physical Therapy, P.C. v. Praetorian Ins. Co., 47 Misc3d 137(A) (App. Term 1 Dept. 2015).*

Conclusion:

Based on my evaluation of the material presented I find that the policy exhaustion precludes the Applicant from collecting on this claim. Coverage does not exist beyond the policy limits. Once the limits are exhausted, it is as if no policy was ever in effect. The insured, or the insured's assignees, have received the full benefit of the policy purchase. In addition, the facts of this case indicate that the Respondent complied with the priority of payment regulation, all other matters are therefore moot. *Harmonic, supra* .

Accordingly, Applicants request for reimbursement 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 Kings

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

02/17/2025
(Dated)

Evelina Miller

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:
701de7281bb0fdb25a2f0c516346acb9

Electronically Signed

Your name: Evelina Miller
Signed on: 02/17/2025