American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Sinai Diagnostics LLC (Applicant)	AAA Case No.	17-23-1317-9978
	Applicant's File No.	167.107
- and -	Insurer's Claim File No.	32-26G0-02S
	NAIC No.	25178
State Farm Mutual Automobile Insurance Company (Respondent)		

ARBITRATION AWARD

I, Elyse Balzer, 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: TG

1. Hearing(s) held on 01/22/2025
   Declared closed by the arbitrator on 01/22/2025

   Naomi Cohn from Tsirelman Law Firm PLLC participated virtually for the Applicant

   Jason Egielski from Sarah C. Varghese & Associates participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$159.47**, 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 seeks payment for the technical component of upper and lower testing of the autonomic nervous system function performed on 10/25/21 on the 64-year-old female eligible injured person TG, who sustained injuries as the driver of a vehicle involved in an accident on 10/20/21.

   The issue was whether this claim should be denied due to policy exhaustion.

   The parties agreed that the above issue was the only issue in contention.

All of the documents contained in the electronic case folder (ECF) for this case, maintained by Modria for the AAA, were reviewed.

The arbitration hearing was conducted via Zoom, as all arbitration hearings have been conducted telephonically since March 15, 2020 and via Zoom since February 2021 due to the COVID-19 pandemic.

4. Findings, Conclusions, and Basis Therefor

On 10/25/21, upper and lower testing of TG's autonomous nervous system function was performed.

Applicant seeks payment for the technical component of this testing.

Respondent issued a timely denial on 11/3/21, and paid half of the amount billed by applicant.

At the hearing, respondent maintained that this claim should be denied due to policy exhaustion.

At the hearing, respondent maintained that the policy limits for no-fault benefits had been exhausted.

To support the exhaustion defense, respondent submitted:

Denial to eligible injured person care of her attorneys, dated 7/12/22, stating that no-fault benefits had been exhausted;

Payment log, as of 7/14/22, showing a deductible of $200.00 and payment of medical expenses of $49,800.00;

Declarations page for policy no. 221-9331-C03-32 issued to eligible injured person TG, showing no-fault benefits limits of $50,000.00.

It has been held that "[W]here 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 City of N.Y. v Liberty Mut. Auto Ins. Co*., 216 AD2d 448; see *Hospital for Joint Diseases v State Farm Mut. Auto Ins. Co*., 8 AD3d 533, 534; *New York & Presbyt. Hosp. v Progressive Cas. Ins. Co.*, 5 AD3d 568, 570)." *Hospital for Joint Diseases v. Hertz Corp*, 22 AD3d 724, 2005 NY Slip Op 07932 (App Div, 2d Dep't 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 AD3d 55, 790 NYS2d 216 (2d Dep't 2005).

When an insurance carrier "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 AD2d 448, 628 NYS2d 396 (2d Dep't 1995).

It has been stated that "(t)he cessation of those duties applies to a claim that was improperly denied, Nyack Hosp. v. General Motors Acceptance Corp, 8 NY3d 294, 832 NYS2d 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 AD3d 579, 786 NYS2d 68 (2d Dep't 2004*); Crossbridge Diagnostic Radiology v Encompass Ins.*, 24 Misc.3d 134(A), 2009 NY Slip Op 51415(U)" (App Tm, 2nd, 11th & 13th 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 Mut Ins. Co.*, 8 AD3d 533, 2004 NY Slip 05413 (App Div, 2nd Dep't 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 AD3d 568, 774 NYS2d 72 (2d Dep't 2004).

In *Metrocare Medical PC & GEICO*, AAA Case No 17 17 1057 4462 (award) Arbitrator Lucille DiGirolamo wrote about the current state of the applicable law on the issue of policy exhaustion in no fault cases.

Arbitrator DiGirolamo's decision was:

Respondent argues that the policy of 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 NY Slip Op 27097 (Sup. Ct, App.T. 2d Dep't 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.D. 396 (2d Dept. 1995); *Hospital for Joint Diseases Etc. v. State Farm Mutual Automobile Insurance Company*, N.Y.L.J. June 25, 2004, page 29 col. 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 Regulations, 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 NY Slip Op 50525(U) (Sup. Ct. App. T. 1 Dep't 2015) wherein the Court determined that timely denied claims do not hold a place in the priority of payment line to subsequently filed claims that were paid by the 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 No. 17-15-1025-5294, Arbitrator Rickman stated:

> 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 (2nd 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 Respondent. To require Respondent to hold money in reserve for claims it was not then currently 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 PC v. Liberty Mutual Ins. Company*, Case # 17 991 R 20902 11. Multiple arbitrators have subsequently relied upon this 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 S. Lustig, AAA Case # 412013072907 Arbitrator Charles P. 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., PC v Allstate Ins. Co.* (2017 NY Slip Op 27097, 2017 N.Y. Misc. LEXIS 1018) 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 limits. (See, *Acuhealth Acupuncture, P.C. v New York City Tr. Auth.*, 50 Misc3d 1228 [A]).

I note the case law clearly holds that an arbitrator's award in excess of the $50,000.00 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. T. 1 Dep't 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 City of N.Y. v General Acc. Ins. Co. of Am.*, 229 AD2d 479, 645 N.Y.S.2d 516 (2d Dep't 1996); also *see Presbyterian Hosp. 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 368 (Table), 2009 N.Y. Slip Op. 51415(U), 2009 WL 1911909 (Supreme Ct. App. T. Dep't 2009).

The Court in *Flushing Traditional Acupuncture, P.C. v. Infinity Group*, 2012 N.Y. Slip Op. 22345, 2012 WL 5974095 (Supreme Ct. App. T. 2d Dep't 2012) opined 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 AD2d 448).

[W]here, 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 AD2d 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 contracted for (see, e.g., *Zappone v Home Ins. Co.*, 55 NY2d 131; *Schiff Assocs. v Flack*, 51 NY2d 692; *Employers Ins. v County of Nassau*, [***3] 141 AD2d 496)" (*Presbyterian Hosp. v Liberty Mut. Ins. Co*., 216 AD2d 448, *supra*).

Accordingly, Applicant's claim is denied in its entirety

I agree with Arbitrator Di Girolamo 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." *Champagne v. State Farm Mutual Automobile Insurance Co*., supra; *Presbyterian Hospital in the City of New York as Assignee of Kenneth Mandel v. Liberty Mutual Insurance Company*, supra; *Hospital for Joint Diseases Etc. v. State Farm Mutual Automobile Insurance Company*, supra.

Respondent has presented evidence "sufficient to establish that the subject policy limits for personal injury protection benefits had been exhausted by prior claims. No triable issue of fact was raised by the plaintiffs in opposition to the defendant's motion." *Hospital for Joint Diseases v. State Farm Mut. Auto. Ins. Co.*, 2004 NY Slip 05413 (2d Dep't 2004). The question of respondent's payment, and whether it was sufficient, is moot in light of the policy (i.e., coverage) exhaustion.

The decision in the appeal of *Alleviation Med. Servs., P.C. v Allstate Ins. Co.*, 55 Misc.3d 44, 2017 NY Slip Op 27097 (Sup. Ct, App.T. 2d Dep't 2017) does not offer any precedential value.

In *Alleviation Med. Servs., P.C. v Allstate Ins. Co.*, 2021 NY Slip Op 08159 (2d Dep't 2021) the Appellate Division, Second Department wrote:

> Ordered that the order dated March 29, 2017, is affirmed, with costs.
>
> In June 2011, the plaintiff commenced the instant action against the defendant in the Civil Court of the City of New York, Queens County, seeking to recover the sum of $4,748.69 for treatment provided to its assignor in April 2011, following a motor vehicle accident that occurred on October 20, 2010. The plaintiff alleged, among other things, that a no-fault claim and verification were sent to the defendant on April 19, 2011, and that the defendant failed to properly deny the claim or request additional verification in compliance with no-fault regulations.
>
> In May 2014, the defendant moved for summary judgment dismissing the complaint, arguing that the benefits under the no-fault policy had been exhausted. The Civil Court denied the defendant's motion, and the Appellate Term of the Supreme Court for the Second, Eleventh, and Thirteenth Judicial Districts affirmed. The defendant appeals, and we affirm, albeit on different grounds than those relied upon by the Civil Court or the Appellate Term.

"Under the no-fault system, payments of benefits 'shall be made as the loss is incurred'" (*Matter of Medical Socy. of State of N.Y. v Serio*, 100 NY2d 854, 860 [2003], quoting Insurance Law §5106 [a]). Under this regulatory scheme, "an insurer shall pay benefits directly to the 'applicant,' or, upon assignment by the applicant, 'shall pay benefits directly to providers of health care services'" (*East Acupuncture, P.C. v Allstate Ins. Co.*, 61 AD3d 202, 207 [2009], quoting 11 NYCRR 65-3.11 [a]). In addition, "an insurer is required to either pay or deny a claim for no-fault automobile insurance benefits within 30 days from the date an applicant supplies proof of claim" (*Presbyterian Hosp. in City of N.Y. v Maryland Cas. Co.*, 90 NY2d 274, 278 [1997]; *see* Insurance Law §5106 [a]). However, "[a]n insurer is not required to pay a claim where the policy limits have been exhausted" (*see Hospital for Joint Diseases v State Farm Mut. Auto. Ins. Co.*, 8 AD3d 533, 534 [2004]) since, where payments made by an insurer meet or exceed the policy limits, "its duties under the contract of insurance cease" (*Presbyterian Hosp. in City of N.Y. v Liberty Mut. Ins. Co.*, 216 AD2d 448, 448 [1995]; *see* 11 NYCRR 65-3.15).

"[A]n insurer must pay or deny only a verified claim-that is, a claim that has been verified to the extent compliance with section 65-3.5 dictates in the particular case-within 30 calendar days of receipt; and, conversely, is not obligated to pay any claim until it has been so verified" (*Nyack Hosp. v General Motors Acceptance Corp.*, 8 NY3d 294, 299 [2007]). Once claims have been verified they are subject to the priority of payment regulation, 11 NYCRR 65-3.15 (*see Nyack Hosp. v General Motors Acceptance Corp.*, 8 NY3d at 300).

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. "While a witness may read into the record from the contents of a document which has been admitted into evidence, a witness's description of a document not admitted into evidence is hearsay" (*Wells Fargo Bank, N.A. v Sesey*, 183 AD3d 780, 783 [2020] [citation and internal quotation marks omitted]). Because "a review of records maintained in the normal course of business does not vest an affiant with personal knowledge" (*JPMorgan Chase Bank, N.A. v Grennan*, 175 AD3d 1513, 1517 [2019]), the employee's assertions as to the contents of the no-fault file are inadmissible hearsay (*see Wells Fargo Bank, N.A. v Sesey*, 183 AD3d at 783; *U.S. Bank N.A. v 22 S. Madison, LLC*, 170 AD3d 772, 774 [2019]). Accordingly, there are issues of fact remaining as to when the claim was denied, and the basis and efficacy of the denial (*see Paulin v Needham*, 28 AD3d 531 [2006]).

The parties' remaining contentions, including those raised by the amici curiae, need not be reached in light of our determination.

Clearly the Appellate Division found that there were multiple issues of fact (when was the claim denied? What was the basis of the denial? What was the efficacy of the denial) which had not been proven at trial, and affirmed the Appellate Term decision on "different grounds than those relied upon by the Civil Court or the Appellate Term."

The Appellate Division declined to consider the issue of priority of payment and exhaustion by stating that "(t)he parties' remaining contentions, including those raised by the amici curiae, need not be reached in light of our determination." The Appellate Division based its decision on a failure of proof, and its decision does not change my opinion on the issue of exhaustion.

In this case, applicant did not present any proof to show that respondent mishandled this claim in any way.

Based on the proof presented to me, I find that respondent has proven, by a fair preponderance of the credible evidence, that the policy/coverage limits have been exhausted. Accordingly, this claim must be 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 Westchester

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

02/21/2025
(Dated)

Elyse Balzer

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:
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Electronically Signed

Your name: Elyse Balzer
Signed on: 02/21/2025