American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Uptown Healthcare Management Inc d/b/a East Tremont Medical Center (Applicant)	AAA Case No.	17-24-1362-3764
	Applicant's File No.	N/A
- and -	Insurer's Claim File No.	24-2972702
	NAIC No.	24279
Progressive Casualty Insurance Company (Respondent)		

ARBITRATION AWARD

I, Deepak Sohi, 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: EIP

1. Hearing(s) held on 03/18/2025
   Declared closed by the arbitrator on 03/18/2025

   Robin Grumet from Law Offices of Hillary Blumenthal LLC (Hoboken) participated virtually for the Applicant

   Michael Canfield from Progressive Casualty Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$4,447.06**, was NOT AMENDED at the oral hearing.
   Stipulations WERE made by the parties regarding the issues to be determined.

   The parties stipulated that Applicant established a prima facie case of entitlement to No-Fault compensation with respect to its bills. The parties also stipulated that Respondent's NF-10 denial of claim forms weretimely issued.

3. Summary of Issues in Dispute

This arbitration arises out of a right knee arthroscopy procedure and anesthesia services provided to the EIP, a36-year-old male, who was involved in a motor vehicle accident on3/20/2024. Applicant is seeking reimbursement for the facility fee for the right knee arthroscopy procedure and anesthesia services provided to the EIP on date of service 6/18/2024. Respondent argues that the subject insurance policy has been exhausted.

4. Findings, Conclusions, and Basis Therefor

This case was decided on the submissions of the parties as contained in the Electronic Case Folder (ECF) maintained by the American Arbitration Association and the oral arguments of the parties' representatives at the hearing. No witnesses testified at the hearing. I reviewed the documents contained in the ECF for both parties and make my decision in reliance thereon.

POLICY EXHAUSTION

RIGHT KNEE ARTHROSCOPY

ANESTHESIA SERVICES

DATE OF SERVICE 6/18/2024

At the hearing, Respondent argued that the EIP had utilized all the funds available for No-Fault benefits. The threshold issue is whether the policy limit of $50,000.00 has been exhausted. In Hospital for Joint Diseases v. Hertz Corp., 22 AD3d 724, 2005 NY Slip Op 07932 (App Div., 2nd Dept.), the Court held "when an insurer has paid the full monetary limits set forth in the policy, its duties under the contract of insurance cease." Additionally, 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 support of its contention Respondent submitted the Declarations Page of the subject insurance policy and a payment log/PIP ledger demonstrating

that $50,000.00 in No-Fault benefits has been utilized as of the date of the payment log/PIP ledger. Respondent has provided appropriate documentation to demonstrate that the $50,000.00 in coverage available to the EIP, has in fact been paid, and there remains no further coverage for the requested services herein. Respondent maintains that the EIP's Personal Injury Protection (PIP) benefits under the policy have been exhausted.

At the hearing, in opposition to Respondents contention regarding the exhaustion of the subject insurance policy, Applicant's counsel proffered the "priority of payment" argument. Applicant's argument is that since the subject insurance policy was not exhausted at the time the Applicant's bills were received by Respondent that Applicant's bills should have been paid ahead of any bills subsequently received by Respondent. Consequently, Applicant contends that its bills should be reimbursed without regard for the exhaustion of the subject insurance policy. In support of this argument, Applicant's counsel relies upon the decision of the Appellate Term, Second Department in Alleviation Medical Services, P.C. v Allstate, 2017 N.Y. Slip Op.27097 (App. Term 2nd, 11th and 13th Jud. Dists. 2017).

I decline to follow the decision in Alleviation. Rather, I choose to follow the decision of the Appellate Term, First Department in Harmonic Physical Therapy v. Praetorian Insurance Company, 47 Misc.3d 137(A), 2015 N.Y. Slip Op. 50525(U) (App. Term 1st Dept. 2015) which holds that claims do not hold a place in the timely denied priority of payment line ahead of subsequently filed claims that were reimbursed by Respondent. Moreover, the Insurance Regulations do not require a carrier to set aside funds for all claims that are denied. Such action would diminish the funds available for claims that were not denied.

After carefully reviewing the evidence presented, I find in favor of Respondent. Respondent has demonstrated that there is no remaining coverage available for this claim as the subject insurance policy has been exhausted. Therefore, Applicant's claims must be denied.

This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator. Any further issues raised in the hearing record are held to be moot and/or waived insofar as not raised at the time of the hearing.

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

03/18/2025
(Dated)

Deepak Sohi

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:
0e7ac9ad20842d252447fb805bce0daa

Electronically Signed

Your name: Deepak Sohi
Signed on: 03/18/2025