American Arbitration Association

NO-FAULT ARBITRATION TRIBUNAL

In the Matter of the Arbitration between

Shahid Mian MD P.C. a/a/[redacted] *Applicant*

-and-

State Farm Mutual Automobile Insurance Company *Respondent*

AAA ASSESSMENT NO.: 99-17-1061-3330
NO.: [redacted]

AAA CASE NUMBER:

MASTER ARBITRATION AWARD

I, Steven Rickman, the undersigned MASTER ARBITRATOR, appointed by the Superintendent of Insurance and designated by the American Arbitration Association pursuant to regulations promulgated by the Superintendent of Insurance at 11 NYCRR 65-4.10, having been duly sworn, and having reviewed and considered the proofs and allegations of the parties, make the following AWARD.

Part I. Summary of Issues in Dispute

Did the no-fault arbitrator render an award that was arbitrary, capricious, irrational, or incorrect as a matter of law?

Part II. Findings, Conclusions, and Basis Therefor

As required by 11 NYCRR Section 65.4.10 (c) (3), I hereby conclude that the facts alleged in the submitted documents set forth a ground for review pursuant to Subdivision (a) of Section 65-4.10.

Applicant instituted the No-Fault arbitration seeking to be compensated $5,148.89 for various medical services (physical therapy, office visits, diagnostic nerve testing) rendered to the EIP from 4/28/16 through 1/12/17 allegedly necessitated by an automobile accident that occurred on 11/7/15. At the time of the hearing Applicant amended the disputed amount downward to $4,569.41 to reflect two claims which were not presented to the Respondent (dates of service 11/23/16 and 12/29/16), and to acknowledge payments made by Respondent which were not applied to the original amount in dispute. Except for the two claims allegedly never received and one paid in full (and withdrawn as reflected in the downward amendment), all the remaining claims were timely denied (either partially denied based upon fee schedule or fully denied based upon being outside the elected scope of OBEL). Subsequently, Respondent's $50,000.00 PIP policy became exhausted, and although the $25,000.00 OBEL was not exhausted (the disputed claims at issue were determined by the arbitrator to be outside the scope of the OBEL election). The "OBEL" denials will not be addressed in this appeal since the merits of said denials were not rebutted by the Applicant (as indicated in the lower award) nor were these denials addressed in Appellant's brief. In an award dated 6/26/18, the arbitrator sustained the policy exhaustion defense and denied Applicant's claim in its entirety. Applicant-Appellant seeks to vacate the award on the grounds that it is irrational, arbitrary, capricious, and incorrect as a matter of law.

ARBITRATOR MOLESSO'S PERTINENT FINDINGS & DETERMINATON

"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), 15 N.Y.S.3d 711 (Table), 2015 N.Y. Slip Op. 50525(U), 2015 WL 1649002 (App. Term 1st Dept. Apr. 14, 2015).

In opposition, Applicant's counsel cited to the decision of the Appellate Term, Second Department in Alleviation Medical Services, P.C. v Allstate, 2017 N.Y. Slip Op.27097 (App. Term 2d, 11th and 13th Jud. Dists. 2017), in which the Court held that where the insurer issued a denial thereby implicitly declaring that the claim was fully verified, the claim is payable in the order in which it was received. As a result, the Court denied the insurer's motion for summary judgment dismissing the complaint regardless of the subsequent exhaustion of available coverage. I decline to follow Alleviation as I find the reasoning in the Harmonic case more persuasive.

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).

There is ample case law establishing that where an insurer demonstrates that it paid a claim up to the policy limits, it is not obligated to pay the claim in full, even despite an untimely denial. Mount Sinai Hospital v. Zurich American Insurance Co., 15 A.D. 3d 550, 790 N.Y.S. 2d 216 (2d Dept.

2005), New York & Presbyterian Hospital v.Progressive Casualty Insurance Company, 5 A.D. 3d 568, 774 N.Y.S. 2d 72 (2d Dept. 2004); Nyack Hospital v. General Motors Acceptance Corporation, 27 A.D. 3d 96, 808 N.Y.S. 2d 399 (2d Dept. 2005).

Respondent has met their burden in proving exhaustion of the policy. In support of its position, Respondent has uploaded the declarations page, the policy, cashed drafts and a payment log. The payment log indicates the PIP policy limits have been exhausted. Although OBEL coverage has not been exhausted, Respondent maintains the billed services are outside the scope of OBEL coverage. In support of their position, Respondent submits the form entitled "Election of Option - Optional Basic Economic Loss Coverage" wherein the Assignor elected how the additional coverage was to be spent. Applicant has not proffered evidence to rebut or refute Respondent's position that the services were outside the scope of the OBEL coverage. Based on the foregoing, Respondent has demonstrated its underlying policy has been exhausted and the services provided do not fall within the OBEL coverage. Accordingly, the claim is denied. Any further issues raised in the hearing record are held to be moot and/or waived insofar as not specifically raised at the time of hearing."

APPLICANT-APPELLANT'S CONTENTIONS

That the arbitrator incorrectly rejected Applicant's arguments regarding priority of payment and its reliance on Alleviation Medical Services, P.C. v. Allstate Ins. Co., 55 Misc.3d 44 (App. Term, 2d Dept. 2017) as well as other arbitration awards and case law.

Respondent violated NYCRR Section 65-3.15 (priority of payment rule). Respondent had funds available to pay the subject claim when it had a perfected claim in hand. Applicant clearly had a priority of payment as it had submitted its claims before subsequent claims were paid.

The arbitrator explained that the denial was not supported by any evidence of proper fee reduction, but still upheld the same. (It should be noted that this argument is baseless. There is nothing in the award indicating that the arbitrator determined that the denials were not supported by any evidence of proper fee schedule reduction).

RESPONDENT-APPELLEE'S CONTENTIONS

Following the timely payment and denial of the claims for dates of service 4/28/16 through 11/2/16 the underlying policy limit of $50,000.00 had been exhausted. There is no applicable coverage under Respondent's policy and no further payments can be made, as a matter of law. Moreover, four of the claims for dates of service 11/17/16 and 1/12/17 totaling $3,900.23 were for services outside the scope of the OBEL election, which was not rebutted by the Applicant as reflected in Arbitrator Molesso's decision and not addressed in the Appellant's brief in support of the appeal. (It should be noted that Respondent's denials (attached to the brief) are all timely on its face. Furthermore, while Appellant's brief maintains that the fee schedule reductions were unsupported and improper, nowhere is it argued that the denials were issued late. At the hearing, Applicant amended the dispute downward partially to acknowledge payments received from Respondent. Late denials and/or late partial payments do not appear to have been raised by Applicant at the hearing or in Appellant's brief. Thus, the denials herein were all timely issued.)

When the insurer has paid the full monetary limits set forth in the policy, its duties under the contact of insurance cease. Country-Wide Ins. Co. v. Sawh, 272 A.D.245 1st Dept. 2000). An arbitrator's award directing payment in excess of the limits of the 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), Country-Wide Ins. Co. v. Sawh, supra.

THE ROLE OF THE MASTER ARBITRATOR

A master arbitrator is limited in his ability to review. Pursuant to the Court of Appeals in Matter of Petrofsky v. Allstate Ins. Co., 54 N.Y.2d 207 (1981), a master arbitrator may not engage in an extensive factual review (a de novo review of the matter originally presented to the lower arbitrator), weigh and assess the credibility of the evidence, and then on that basis make independent findings of fact.

It is for the arbitrator below to determine what evidence or testimony to accept or reject, and what inferences should be drawn as supported by the evidence. The evaluation of the weight, credibility, persuasiveness, and admissibility of the evidence is exclusively within the province of the lower arbitrator. Pursuant to NYCRR 65-4.10(a)(4) an award may be vacated or modified upon the grounds that it is incorrect as a matter of law. However, "A master arbitrator exceeds his statutory power by making his own factual determination, by reviewing factual and procedural errors committed during the course of the arbitration, by weighing the evidence, or by resolving issues such as the credibility of the witnesses." Matter of Richardson v. Prudential Property & Cas. Co., 230 A.D.2d 861(2d Dept 1996); Matter of Allstate Insurance Co. v. Keegan, 201 A.D.2d 774 (2d Dept 1994); Mott v. State Farm Insurance Co., and Smith v. Firemens Insurance Co., 55 N.Y.2d 224 (1982).

LEGAL ANALYSIS

Applicant contends that Respondent violated the priority of payment provision of the regulations (11 NYCRR 65-3.15) since at the time the disputed bills were received by Respondent there was still funds available for payment of the claim. The policy only became exhausted when Respondent paid out other subsequent claims. Applicant maintains that since Respondent violated the priority of payment provision it is now obligated to pay in excess of the policy limits. I reject Applicant's argument under the circumstances of this case.

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 (and also as lower arbitrator) I have consistently 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 arbitra-

tors 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, AAA Case # 17-17-1059-2784 Arbitrator Phyllis Saxe, AAA Case # 17-17-1063-0175 Arbitrator Elyse Balzer, AAA Case # 17-17-1058-7250 Arbitrator Debbie Kotin Insdorf, AAA Case # 17-17-1071-6688 Arbitrator Tracy Morgan, AAA Case # 17-17-1068-5289 Alana Barran, AAA Case # 17-16-1044-3810 Arbitrator Steven Celauro, AAA Case # 17-17-1062-6818 Arbitrator Rhonda Barry, AAA Case # 17-16-1045-6728 Arbitrator Amanda R. Kronin, AAA Case # 17-16-1036-6900 Arbitrator Lucille S. DiGirolomo,) As previously indicated, all the denials herein were timely issued. Thus, I specifically find that Respondent did not violate the priority of payment provision in this case.

In support of its argument Applicant relies upon Alleviation Medical Services, P.C. v. Allstate, 2017 N.Y. Slip Op.27097 (App. Term 2nd, 11th and 13th Jud. Dists. 2017). However, I decline to follow this decision since it is inconsistent with Regulatory intent. 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 timely denied claims do not hold a place in the priority of payment line ahead of subsequently filed claims that were paid by the Respondent.

Clearly, the First and Second Departments have conflicting views regarding policy exhaustion and its interplay with the priority of payment provision. The arbitrator's decision not to follow Alleviation Medical Services, P.C. v. Allstate, (and instead rely upon Harmonic) was not irrational nor contrary to what could be fairly described as settled law. See In the Matter of State Farm Mutual Auto Ins.Co. v. Lumbermens Mutual Casualty Co., 18 AD3d 762 (2005).

Furthermore, the arbitrator found that: *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.* See, Allstate Ins. Co. v. DeMoura, 2011 N.Y. Slip Op. 50430(U) (App. Term, 1st Dept. 2011)." Pursuant to 11 NYCRR Section 65-4.10(a) (2) an award by an arbitrator may be vacated on the ground that it required the insurer to pay amounts in excess of the policy limitations for any element of first-party benefits. See, also Countrywide Ins. Co. v. Sawh, 272 A.D.2d 245 (1st Dept. 2000); Matter of Brijmohan v. State Farm Ins. Co., 92 N.Y.2d 821 (1998). The arbitrator's view regarding her lack of authority to direct payment in excess of the no-fault policy is supported by case law and the regulations.

In Acuhealth Acupuncture, P.C. v. New York City Transit Authority, 2016 NY Slip Op 50297(U) the petitioner commenced a proceeding pursuant to CPLR 7511 (b) seeking to vacate the Master Arbitrator's award as arbitrary, capricious, irrational, and in violation of the no-fault law. In that case despite the carrier issuing late and/or no denials to the disputed bills, the lower arbitrator held that Applicant could not recover since any such award (over the policy limitation) would exceed her authority. The Master Arbitrator sustained the award finding that it had a rational basis. The Master Arbitrator indicated that the lower arbitrator correctly refused to exceed the authority granted by statute and case law. Justice Lara J. Genovese rejected the petitioner's reliance upon Nyack Hospital v. General Motors

Acceptance Corporation, 832 N.Y.S.2d 880 (2007), since it was a court proceeding, not an arbitration. To quote Justice Genovese: "Petitioner's reliance on Nyack is insufficient to warrant a determination that the master arbitrator's award was arbitrary, capricious or incorrect as a matter of law." She further stated that the petitioner "has not presented any appellate authority permitting the arbitrator to exceed a specific enumerated limitation on the arbitrator's power by rendering an award in excess of the policy limits. The master arbitrator in confirming the lower arbitration award had evidentiary support and a rational basis, and was not arbitrary, capricious, irrational, or without a plausible basis."

Similarly, in the case at bar Appellant has not presented any appellate authority permitting the arbitrator to exceed a specific enumerated limitation on the arbitrator's power by rendering an award in excess of the policy limits. "With respect to determinations of law, the applicable standard in mandatory no-fault arbitration is whether any reasonable hypothesis can be found to support the questioned interpretation" Fiduciary Ins. Co. v. American Bankers Ins. Co. of Florida, 132 AD3d 40 (2nd Dept. 2015). Here, the arbitrator's questioned interpretation of the law is reasonably supported by case law and regulation(s).

An arbitrator is not required to justify his/her award. It must merely be evident that there exists a rational basis for it upon a reading of the record. Dahn v. Luchs, 92 A.D.2d 537 (1983). Upon a reading of the record I am satisfied that there was sufficient evidence presented wherein the arbitrator could rationally sustain upholding the policy exhaustion defense.

I find that the arbitrator's determination was not irrational, arbitrary, capricious or incorrect as a matter of law.

Accordingly,

1. ☐ the request for review is hereby denied pursuant to 11 NYCRR 65-4.10 (c) (4)
2. ☒ the award reviewed is affirmed in its entirety
3. ☐ the award or part thereof in favor of ☐ applicant ☐ respondent hereby reviewed is vacated and remanded for a new hearing ☐ before the lower arbitrator ☐ before a new arbitrator
4. ☐ the award in favor of the ☐ applicant ☐ respondent hereby reviewed is vacated in its entirety

—or—

5. ☐ the award reviewed is modified to read as follows:

A. The respondent shall pay the applicant no-fault benefits in the sum of

_____ Dollars ($_____), as follows:

Work/Wage Loss	$_____
Health Service Benefits	$_____
Other Reasonable and Necessary Expenses	$_____
Death Benefit	$_____
Total	$_____

B1. ☐ Since the claim(s) in question arose from an accident that occurred prior to April 5, 2002, the insurer shall compute and pay the applicant the amount of interest computed from

_____ at the rate of 2% per month, compounded, and ending with the date of payment of the award, subject to the provisions of 11 NYCRR 65-3.9(c) (stay of interest).

B2. ☐ Since the claim(s) in question arose from an accident that occurred on or after April 5, 2002, the insurer shall compute and pay the applicant the amount of interest computed from

_____ at the rate of 2% per month and ending with the date of payment of the award, subject to the provisions of 11 NYCRR 65-3.9(c) (stay of interest).

C1. ☐ The respondent shall also pay the applicant _____ dollars ($_____) for attorney's fees computed in accordance with 11 NYCRR 65-4.6(d). ***The computation is shown below*** (attach additional sheets if necessary).

–or–

C2. ☐ The respondent shall also pay the applicant an attorney's fee in accordance with 11 NYCRR 65-4.6(e). However, for all arbitration requests filed on or after April 5, 2002, if the benefits and interest awarded thereon is equal to or less than the respondent's written offer during the conciliation process, then the attorney's fee shall be based upon the provisions of 11 NYCRR 65-4.6(b).

C3. ☐ Since the charges by the applicant for benefits are for billings on or after April 5, 2002, and exceed the limitations contained in the schedules established pursuant to section 5108 of the Insurance Law, no attorney's fee shall be payable by the insurer. See 11 NYCRR 65-4.6(i).

D. ☐ The respondent shall also pay the applicant forty dollars ($40) to reimburse the applicant for the fee paid to the Designated Organization for the arbitration below, unless the fee was previously returned pursuant to an earlier award

PART III. (Complete if applicable.) The applicant in the arbitration reviewed, having prevailed in this review,

A. the respondent shall pay the applicant ---------- dollars ($---------- for attorney's fees computed in accordance with 11 NYCRR 65-4.10 (j). The computation is shown below (attach additional sheets if necessary)

B. If the applicant requested review, the respondent shall also pay the applicant SEVENTY-FIVE DOLLARS ($75) to reimburse the applicant for the Master Arbitration filing fee.

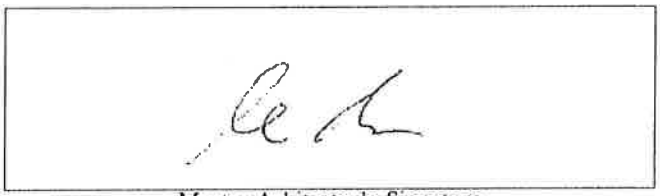
This award determines all of the no-fault policy issues submitted to this master arbitrator pursuant to 11 NYCRR 65- 4.10

State of Florida

County of Palm Beach. ☐ SS:

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

9/16/18
Date


Master Arbitrator's Signature

IMPORTANT NOTICE

This award is payable within 21 calendar days of the date of mailing. A copy of this award has been sent to the Superintendent of Insurance.

This master arbitration award is final and binding except for CPLR Article 75 review or where the award, exclusive of interest and attorney's fees, exceeds $5,000, in which case there may be court review de novo (11 NYCRR 65- 4.10(h)). A denial of review pursuant to 11 NYCRR 65-4.10 (c) (4) (Part II (1) above) shall not form the basis of an action de novo within the meaning of section 5106(c) of the Insurance Law. A party who intends to commence an Article 75 proceeding or an action to adjudicate a dispute de novo shall follow the applicable procedures as set

forth in CPLR Article 75. If the party initiating such action is an insurer, payment of all amounts set forth in the master arbitration award which will not be subject of judicial action or review shall be made prior of the commencement of such action.

Date of mailing:_____

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