SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: HON. CAROL R. EDMEAD **PART** IAS MOTION 35EFM

Justice

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COUNTRY-WIDE INSURANCE COMPANY

Plaintiff,

- v -

LDU THERAPY INC.,

Defendant.

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INDEX NO. 650691/2020

MOTION DATE 10/20/2020

MOTION SEQ. NO. 001

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 001) 2, 9, 10, 11, 13, 15, 16, 17, 18, 19, 20, 21

were read on this motion to/for VACATE - DECISION/ORDER/JUDGMENT/AWARD.

Upon the foregoing documents, it is

ORDERED that the petition of Petitioner Country-Wide Insurance (Motion Seq. 001) is denied in its entirety; and the Award of the Lower Arbitrator, as affirmed by the Master Arbitrator, is confirmed; and it is further

ORDERED that the cross-petition (Motion Seq. 001) of Respondent LDU Therapy Inc. ("Respondent") for the confirmation of the Award is granted; and it is further

ORDERED that Respondent's application for attorney's fees in the amount of $2,805 is granted; and it is further

ORDERED that the Clerk shall enter judgment accordingly; and it is further

ORDERED that counsel for Respondent shall serve a copy of this order, along with notice of entry, on all parties within 20 days of entry.

MEMORANDUM DECISION

In this Article 75 action, Petitioner Country-Wide Insurance Company seeks, pursuant to CPLR 7511(b)(1)(iii), an order vacating a no-fault arbitration award dated October 30, 2019 (the "Award") issued in favor of Respondent LDU Therapy Inc. Respondent opposes and cross-moves for the confirmation of the Award.

For the reasons set forth below, the Court denies the petition to vacate the Award and accordingly grants the cross-petition.

BACKGROUND FACTS

Imran Khan, Respondent's assignor, was injured in an automobile accident on May 7, 2016 and sought medical treatment from Respondent from February 7, 2017 through March 21, 2017 (NYSCEF doc Nos. 1, ¶¶ 3-5; 3, p. 1). Respondent thereafter submitted medical bills to Petitioner for reimbursement. Petitioner sent requests for verification but neither denied nor paid Respondent's claim (NYSCEF doc No. 3, p. 2).

The parties then proceeded to arbitration before arbitrator Eva Gaspari (the "Lower Arbitrator") on June 20, 2019. At the proceeding, Petitioner argued that arbitration was premature as its verification requests were still outstanding and that any award issued in arbitration would exhaust the policy limit (NYSCEF doc No. 1, ¶ 7). The Lower Arbitrator rejected both arguments, finding that Respondent answered the verification requests in full and that at the time Respondent's claim for reimbursement became due, there was enough money remaining on the policy to satisfy the claim (NYSCEF doc No. 3, pp. 2-3). Accordingly, the Lower Arbitrator issued the Award in favor of Respondent herein and granted its claim in the amount of $3,026.00, plus interest and attorney's fees (NYSCEF doc No. 3).

On September 13, 2019, Petitioner sought review of the Award on the ground that the Lower Arbitrator erred in awarding Respondent $3,026.00 as the subject $50,000 policy had only a $777.15 remaining balance and, thus, any award over $777.15 would exhaust said policy (NYSCEF doc No. 5). Master Arbitrator Frank Godson affirmed the Award, finding that the Lower Arbitrator's analysis was reasonable and consistent with applicable regulations and relevant Court decisions (NYSCEF doc No. 6).

Petitioner now seeks vacatur of the award. Petitioner argues that the Lower Arbitrator exceeded her power as the Award directs payment in excess of the monetary limit of the subject no-fault insurance policy. In support, Petitioner submitted to the Court its payment ledger and insurance declaration page to show that the $50,000 policy limit has been fully exhausted (*see* NYSCEF doc No. 7).

In opposition, Respondent asserts that Petitioner was required to pay properly verified claims in the order of receipt. Respondent maintains that the term "claim" under 11 NYCRR 65-3.15 means "verified claims," *i.e.*, claims as to which the healthcare provider has submitted additional information requested by the insurer (NYSCEF doc No. 13, ¶ 15). As Respondent alleges it fully complied with Petitioner's additional requests for information, Respondent avers that its claim had been fully verified. Moreover, according to Respondent, at that time its claim was verified, Petitioner had "ample funds" to pay Respondent's claim. Simultaneous to opposing the Petition, Respondent cross-moves for confirmation of the Award and seeks an award of attorney's fees.

DISCUSSION

"Judicial review of an arbitration award is narrowly circumscribed, and vacatur limited to instances where the award is violative of a strong public policy, is irrational, or clearly exceeds a

specific limitation on an arbitrator's power" (*Matter of New York City Tr. Auth. v Phillips*, 162 AD3d 93 [1st Dept 2018] [internal citation and quotation marks omitted]).

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 [1st Dept 1996]). 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 [NY Ct App, 1998]; *Countrywide Ins. Co. v. Sawh,* 272 A.D.2d at 245 [1st Dept 2000]; 11 NYCRR 65-1.1).

In this case, the contractual limit for the Personal Injury Protection (No Fault) coverage under the policy is $50,000 (NYSCEF doc No. 7). Petitioner insists that this $50,000 was mostly exhausted when the arbitration was commenced on June 20, 2019, as only $777.15 remained available from the policy at that time. Respondent contends, however, that Petitioner should have paid Respondent's claim after it was verified on June 25, 2017, two years prior to the arbitration and when the policy limit was still not yet exhausted.

After considering the arguments provided by the parties and the applicable case law on this issue, the Court finds for Respondent.

In the case of *Nyack Hospital v General Motors Acceptance Corp.* (8 NY3d 294 [2007]), the Court of Appeals ruled that the priority-of-payment regulation (11 NYCR 65-3.15) comes into play when an insurer receives the additional verification it requested from claimant. Thus, at that point of receipt, the Court of Appeals explained that an insurer should pay claimant "ahead of any other unpaid verified claims for services rendered or expenses incurred later than the services billed by [claimant], up to the policy's limits."

Here, the Lower Arbitrator found, based on evidence submitted by the parties, that Petitioner requested additional verification on April 3, 2017 and May 4, 2017 (NYSCEF doc No. 3, p. 2), and that Respondent responded to these requests in full on June 20, 2017 (*Id.*). Petitioner does not dispute these factual findings. Thus, following the ruling in *Nyack Hospital,* the priority-of-payment rule was triggered when Petitioner received said response on June 25, 2017.[1] At that point, Respondent's claim should have been paid ahead of other unpaid verified claims for services rendered or expenses incurred later than the services rendered by Respondent from February 7, 2017 through March 21, 2017. Moreover, Petitioner was required to make such payment no later than July 25, 2017 in accordance with 11 NYCRR 65-3.8 [a] [1] which states that "[n]o-[f]ault benefits are overdue if not paid within 30 calendar days after the insurer receives proof of claim, which shall include verification of all of the relevant information requested pursuant to section 65-3.5."

Despite Petitioner's obligations, the Lower Arbitrator found that "[Petitioner] continued to pay out other subsequent medical claims as they were submitted. At that time respondent had available funds with which to pay [Respondent's] claims." (NYSCEF doc No. 3, p. 3). The Lower Arbitrator's findings have a rational basis. An examination of the ledger submitted by Petitioner shows that by the end of July 2017, payments were made for medical services rendered through June 2017, exhausting the policy up to $29,488.93. Therefore, at that point, $20,511.07 remained and could have been used to satisfy Respondent's claim. Given that the coverage for the subject policy in this case was not yet exhausted when Respondent's claim became due, the Lower

[1] Petitioner does not claim in any of its papers that it did not receive the response. The Lower Arbitrator, providing for additional five days to cover for mailing of the verification response, presumed that Petitioner received said response on June 25, 2017, thus:

> "Accordingly, allowing for time for mailing of the verification response, this claim having been fully verified, the Respondent was required to pay or deny this claim on or before July 25, 2017, which was 30 days after the date the claim was verified." (NYSCEF doc No. 3 at p. 2).

Arbitrator's Award of $3,026.00 was not in excess of the contractual limits and, thus, the Lower Arbitrator did not exceed her power.

The cases relied upon by Petitioner are inapposite. In *Brijmohan v State Farm Insurance* (92 NY2d 821 [1998]), the insurer failed to correct claimant's statement during the arbitration that the coverage in question was $100,000, when in fact the policy only covered losses up to $10,000. Thus, the Court vacated the Award of $75,000 as it was beyond the correct policy limit. Here, there is no dispute that the policy limit is $50,000 and that at the time Respondent's claim became due, there was enough money from the policy to satisfy the same. In *New York and Presbyterian Hosp. v Allstate Ins. Co.* (12 AD3d 579 2d Dept 2004]), the Second Department reversed the Supreme Court's order granting summary judgment in favor of plaintiff because defendant demonstrated that there were issues of fact as to whether it partially exhausted the coverage limits of the policy by other "no-fault" payments and whether such payments were in compliance with 11 NYCRR 65.15 (n). The Court further held that the defendant's failure to issue a denial of the claim within 30 days did not "preclude a defense that the coverage limits of the subject policy have been exhausted." The case at bar is different. Here, the Lower Arbitrator already made a finding as to whether Petitioner exhausted the coverage limits when Respondent's claim became due and payable. Her finding that coverage was still then available to satisfy Respondent's claim has a rational basis in fact and law. Moreover, *New York and Presbyterian Hosp* cites two prior cases as basis for its ruling, *Presbyterian Hosp. in City of N.Y. v General Acc. Ins. Co. of Am.*, (229 AD2d 479 [1996]) and *Presbyterian Hosp. of N.Y. v Liberty Mut. Ins. Co.*, (216 AD2d 448 [1995]). In these two cases, however, the insurer exhausted the coverage limit at the time of denial and before the services for which the claim arose were even rendered.

The Court therefore denies Petitioner's application to vacate the Award and accordingly confirms the same pursuant to CPLR §7511 (3)(e).

Attorney's Fees

Respondent seeks an award of attorney's fees pursuant to 11 N.Y.C.R.R. §65-4.10(j)(4). In support, Respondent submitted an affirmation detailing the hours spent by its counsel preparing the opposition to Petitioner's petition and the cross-petition for confirmation (see NYSCEF doc No. 5). In the affirmation, Respondent' counsel avers that they spent a total of 9.35 hours of legal work. Respondent seeks attorney's fees in the amount of $2,805 pursuant to counsel's billing rate of $300 per hour.

The Court finds that Respondent is entitled to attorney's fees. In *Matter of Country-Wide Ins. Co. v. Bay Needle Care Acupuncture, P.C.*, 162 AD3d 407 [1st Dept 2018], the court held that the "Supreme Court has authority to award attorney's fees as this is an appeal from a master arbitration award pursuant to 11 NYCRR 65-4.10 (j) (4), which, in pertinent part, provides: "The attorney's fee for services rendered in connection with . . . a court appeal from a master arbitration award and any further appeals, shall be fixed by the court adjudicating the matter." (see also *Matter of GEICO Ins. Co. v. AAAMG Leasing Corp.*, 148 AD3d 703 [2d Dept 2017]). Thus, Respondent's application for attorney's fees in the amount of $2,805 is granted.

CONCLUSION

Based on the foregoing, it is hereby

ORDERED that the petition of Petitioner Country-Wide Insurance (Motion Seq. 001) is denied in its entirety; and the Award of the Lower Arbitrator, as affirmed by the Master Arbitrator, is confirmed; and it is further

ORDERED that the cross-petition (Motion Seq. 001) of Respondent LDU Therapy Inc. ("Respondent") for the confirmation of the Award is granted; and it is further

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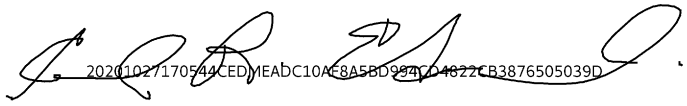

10/27/2020
DATE

CAROL R. EDMEAD, J.S.C.

CHECK ONE:	[X]	CASE DISPOSED		[ ]	NON-FINAL DISPOSITION		
	[ ]	GRANTED	[X] DENIED	[ ]	GRANTED IN PART	[ ]	OTHER
APPLICATION:	[ ]	SETTLE ORDER		[ ]	SUBMIT ORDER		
CHECK IF APPROPRIATE:	[ ]	INCLUDES TRANSFER/REASSIGN		[ ]	FIDUCIARY APPOINTMENT	[ ]	REFERENCE