NEW YORK STATE BAR ASSOCIATION

NO FAULT INSURANCE FUNDAMENTALS:

SERIOUS INJURY THRESHOLD NO FAULT COVERAGE

Robert A. Glick, Esq.
Brand Glick & Brand, P.C.

NYSBA

NYSBACLE

Top Twenty Drivers' Statements

20."A truck backed into my windshield and into my wife's face."

19. "The telephone pole was approaching, I was attempting to swerve out of its way when it struck the front end."

18. "The guy was all over the road. I had to swerve a number of times before I hit him."

17. "I pulled away from the side of the road glanced at my mother-in-law and headed off the embankment."

16. "I had been driving for 40 years when I fell asleep at the wheel and had an accident."

Top Twenty Drivers' Statements

15. "The pedestrian had no idea which way to run, so I ran over him."

14. "I thought my window was down but found out it was up when I put my head through it."

13. "Coming home, I drove into the wrong house and collided with a tree I don't have."

12. "In an attempt to kill a fly, I drove into a telephone pole."

11. "I was on my way to the doctor with rear end trouble when my universal joint gave way causing me to have an accident."

Top Twenty Drivers' Statements

10."I was driving in the wrong lane, but I was there first. The car that ran into me didn't show up until much later."

9. "I had been shopping for plants all day and was on my way home. As I reached an intersection, a hedge sprang up, obscuring my vision."

8. "I told the police that I was not injured, but on removing my hat, I found that I had a fractured skull."

7. "I saw a slow-moving, sad-faced old gentleman as he bounced off the hood of my car."

6. "My car was legally parked as it backed into the other vehicle."

Top Twenty Drivers' Statements

5. "As I approached the intersection, a stop sign suddenly appeared in a place where no stop sign had ever appeared before. I was unable to stop in time to avoid the accident."

4. "A pedestrian hit me and went under my car."

3. "The indirect cause of the accident was a guy in small car with a big mouth."

2. "A bee flew in my window and forced me to hit the pedestrian."

1. "The gentleman behind me struck me on the backside. He then went to rest in the bush with just his rear end showing."

THE SERIOUS INJURY THRESHOLD

Brand Glick & Brand, P.C.
Attorneys at Law

NYSBA

LICARI v. ELLIOT

While there is little doubt that the plaintiff suffered discomfort as a result of the accident, the court has no choice but to enforce the legislative mandate and dismiss the complaint when a plaintiff fails to meet the burden of proving the threshold requirement of establishing a prima facie case that he sustained a serious injury within the meaning of the statute . . .

***Licari v. Elliot*, 57 N.Y. 2d 230, 441 N.E. 2d 1088, 455 N.Y.S.2d 570 (1982).**

STATUTORY INTENT

The legislative intent of the no-fault system was to eliminate frivolous claims, restrict recovery to major significant injuries.

A specific goal of the no-fault system is to prevent minor automobile personal injury cases from being litigated.

NEW YORK INSURANCE LAW SECTION 5104(a):

…in any action by or on behalf of a covered person against another covered person for personal injuries arising out of negligence in the use or operation of a motor vehicle in this state, there should be no right of recovery for non-economic loss, except in the case of serious injury, or for basic economic loss.

NEW YORK INSURANCE LAW SECTION 5104(a):

…in any action by or on behalf of a covered person against another covered person for personal injuries arising out of negligence in the **use or operation** of a motor vehicle in this state, there should be no right of recovery for non-economic loss, except in the case of serious injury, or for basic economic loss.

NEW YORK INSURANCE LAW SECTION 5104(a):

…in any action by or on behalf of a covered person against another covered person for personal injuries arising out of negligence in the **use or operation** of a motor vehicle in this state, there should be no right of recovery for non-economic loss, except in the case of **serious injury**, or for basic economic loss.

NEW YORK INSURANCE LAW SECTION 5102(d):

A personal injury which results in death; dismemberment; significant disfigurement; a fracture; loss of fetus; permanent loss of a body organ, member, function or system; permanent consequential limitation of use of a body organ or member; significant limitation of use of a body function or system; or a medically determined injury or impairment of a non-permanent nature which prevents the injured person from performing substantially all material acts which constitute such person's usual and customary daily activities for not less than ninety days during the one hundred eighty days immediately following the occurrence of the injury or impairment.

NEW YORK INSURANCE LAW SECTION 5102(d):

A personal injury which results in death; dismemberment; significant disfigurement; a fracture; loss of fetus; permanent loss of a body organ, member, function or system; permanent consequential limitation of use of a body organ or member; significant limitation of use of a body function or system;

OR

A medically determined injury or impairment of a non-permanent nature which prevents the injured person from performing substantially all of the material acts which constitute such person's usual and customary daily activities for not less than ninety days during the one hundred eighty days immediately following the occurrence of the injury or impairment.

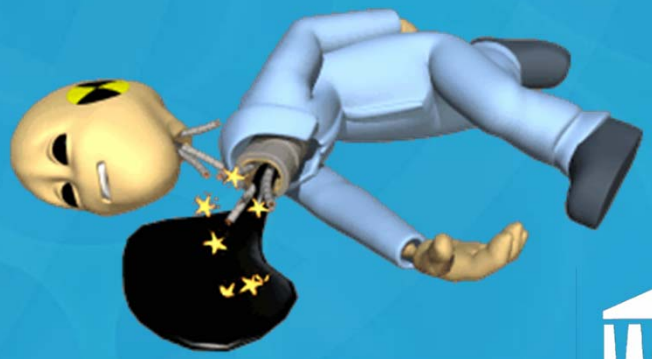
A Personal injury which results in:

- **Death;**
- **Dismemberment;**
- **Significant disfigurement;**
- **Loss of fetus;**
- **Fracture;**
- **Permanent loss of a body organ, member, function or system;**

Oberly v. Bangs Ambulance,
96 N.Y.2d 295 (May, 2001)

Oberly v. Bangs Ambulance, 96 N.Y.2d 295 (May, 2001)

For a permanent loss of use of a body organ, member, function or system to qualify as a "serious injury," the loss of use must be ***total.***



A Personal injury which results in:

- **Death;**
- **Dismemberment;**
- **Significant disfigurement;**
- **Loss of fetus;**
- **Fracture;**
- **Permanent loss of a body organ, member, function or system;**
- **Permanent consequential limitation of use of a body organ or member;**
- **Significant limitation of use of a body function or system; OR**

A medically determined injury or impairment which prevents the injured person from performing substantially all of the material acts which constitute such person's usual and customary daily activities for not less than ninety days during the one hundred eighty days immediately following the occurrence of the

injury or impairment.

Permanent or Consequential Limitation of a Body Organ or Member

Significant Limitation of use

Limitation *must* be permanent *and* total

Limitation must be to a *body organ or member*

Significant Limitation of Use of a Body Function or System

Significant Limitation of use

Limitation *need not* be permanent

Limitation must be to a *body function or system*

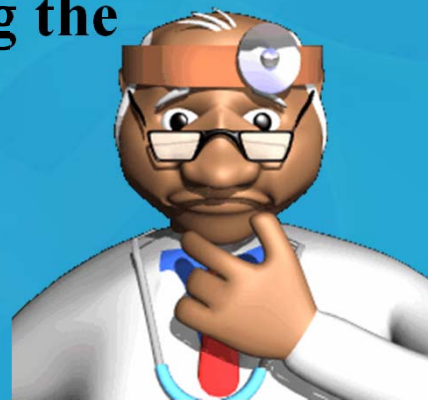
90/180 Day Rule

The inability to perform the required acts lasted for at least 90 days during the first 180 days following the accident;

Substantially all of his usual activities (material acts) were curtailed;

Competent medical evidence that he sustained an injury or impairment as a result of the accident; and

Competent medical evidence that the injury sustained was a cause of the alleged disability or impairment during the applicable period.



SUMMARY JUDGMENT

Burden of Proof

Defendant's Burden

Initially the burden of proof is on the Defendant to present competent evidence that the plaintiff did not sustain a "serious injury" within the meaning of §5102(d).

Plaintiff's Burden

After the defendant meets his initial burden, ***the burden of proof shifts to the Plaintiff*** to prove that he has suffered a "serious injury."

GRANTING SUMMARY JUDGMENT ON LIABILITY DOES NOT ESTABLISH SERIOUS INJURY

Granting of the plaintiff's motion for summary judgment as to liability does not automatically create a finding that the plaintiff sustained a serious injury, when the issue of serious injury was not raised in the motion.

Zeca v. Riccardelli

(May 8, 2002)

PLAINTIFF MUST ESTABLISH *"OBJECTIVE"* PROOF

Toure v. Avis Rent-A-Car Systems

Manzano v. O'Neill

Nitti v. Clerrico

(July, 2002)

TOURE, MANZANO & NITTI

"Expert Opinions not backed by objective proof will not be sufficient to establish a serious injury"

SUMMARY JUDGMENT

Satisfying the Burden

- **Medical proof**
- **Subjective complaints are not sufficient**
- **Sworn medical statements are required**
- **Tracking the statutory language is not sufficient**
- **Conclusory statements are not sufficient**
- **Sworn medical opinions must be formed shortly after examining the plaintiff**
- **Include plaintiff's affidavit to establish plaintiff has been out of work or can't partake in daily activities**

RECENT CASES

Pommells v. Perez

Brown v. Dunlap

Carrasco v. Mendez

(Decided April, 2005)

Pommells/Brown/Carrasco

- Three cases consolidated for appeal purposes.
- Proof of a herniated disc, without additional objective medical evidence establishing significant physical limitations is in sufficient.
- Unexplained interruptions (gaps or terminations) in treatment may not satisfy plaintiff's burden.
- A plaintiff is not required to continue treatment that would be "palliative in nature" – but it must be explained.
- A Plaintiff's failure to refute preexisting conditions that caused the plaintiff's injuries will not survive summary judgment.

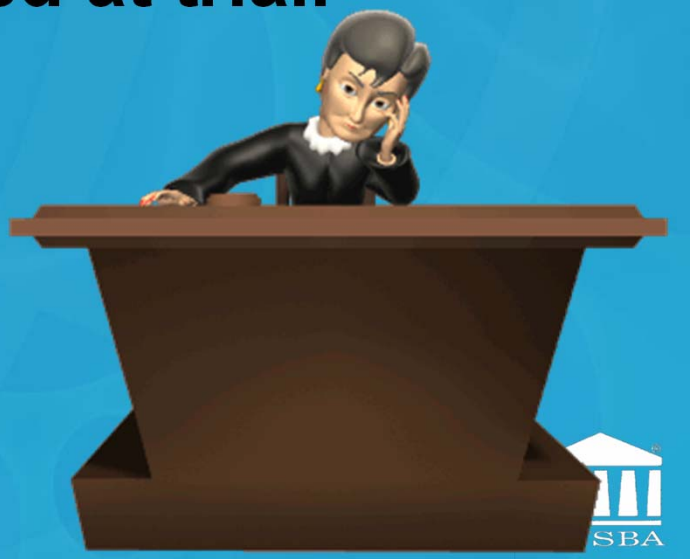
The Impact of Pommells/Brown/Carrasco

Where there are significant gaps in treatment and/or pre-existing injuries, plaintiffs can no longer escape dismissal of their claims by having a physician causally relate the injury to the accident.

Plaintiff must be able to explain these significant causation issues or provide a reasonable excuse.

TRIAL

If the plaintiff makes a threshold showing sufficient to defeat the defendant's motion for summary judgment, the issue of whether there has been a "serious injury" becomes a question of fact to be determined at trial.



PRACTICAL CONSIDERATIONS

- **Initial case analysis: Does the plaintiff meet the threshold?**
- **Use the Threshold as a tactic during settlement discussions**
- **Obtain all medical records and review them carefully**
- **Does the plaintiff need to be examined to determine if he/she will meet the threshold?**
- **Remember, courts are not inclined to grant summary judgment**
- **Be sure the examining physician uses objective tests**
- **Be sure your proofs are submitted in proper form**

NO FAULT LAW

Brand Glick & Brand, P.C.
Attorneys at Law

NYSBA

INTRODUCTION

What is a no-fault claim?

- A breach of contract claim.
- Six (6) year statute of limitations period based upon the failure of the insurer to reimburse for medical treatment tendered due to injuries sustained a motor vehicle accident.

ARBITRATION vs. LITIGATION

Contrast and Comparison

Arbitration

- Inexpensive
- Two-step process:
  - Conciliation: Mediation phase where both parties exchange respective position, followed by Arbitration
- Relaxed rules of evidence
  (i.e. no requirement to authenticate documents)
- No discovery required
- Claimant customarily fails to provide
  all necessary documents to administer claim
  (failure to produce initial evaluation, treatment notes, or letter of medical necessity)
- For Claims under $2,000, appearance not required.

ARBITRATION vs. LITIGATION

Contrast and Comparison

Litigation

- Slow moving (due to plaintiff inaction)
- Expensive (discovery i.e. written interrogatories, document production)
- Rules of evidence in force (i.e. IME physicians must testify as to IME cut-off)
- Courts unfavorably view no-fault claims

APPEALS

Master Arbitration

Appellate Division

Same Results.

Unlikely to overturn prior decision.

GROUNDS TO VACATE ARBITRATION DECISION

- The rights of a party were prejudiced by:
  - Corruption, fraud or misconduct in procuring the award
  - Partiality of the arbitrator
  - The arbitrator exceeded his/her power.

INDEPENDENT MEDICAL EXAMINATION

- Scheduling letters:
  - If represented, sent to attorney of record;
  - May schedule any time. Generally one month after accident;
  - Letter must contain mandatory reimbursement for transportation and/or lost income;
  - All treatment before first IME no-show must be paid in full;
  - For fractures, bulges, and/or herniations, schedule orthopedist;
  - For soft tissue injuries, refer to neurologist;
  - If psych, chiropractor, or acupuncture, received, refer to IME physician in each discipline.

PEER REVIEW(s)

- Situations when it should be considered:
  - Unnecessary and frivolous medical testing and treatment;
  - Availability of alterative low-cost treatment;
  - Unscientifically proven medical testing (CPT: Current perception threshold testing);
  - Who should perform peer reviews?
    - Doctors – Doctors - Doctors
      A treating physician's opinion will carry significantly more weight than a nurse practitioner second guessing his/her prognosis.

FORM NF-10

- Must include the following:
  - Signed and dated including dates of service billed and when they were received by insured;
  - Must include ***all bases*** upon which the claim is being denied;
  - If conducting SIU investigation and/or peer review, do not send NF-10 -- Send delay letter;
  - Unless you have a valid coverage defense (no policy), an untimely denial will be fatal.

"DELAY" LETTERS

- What are their purpose?
  - To advise the claimant and/or medical provider of an on-going investigation or permit sufficient time outside the 30 days to verify the treatment tendered by requesting additional information or to conduct peer reviews.
- When do you send them?
  - Within 15 days of receipt of the first bill:
    - If claim is still pending, send another delay letter within 10 days;
    - If on-going, send one at least once a month;
    - When investigation completed, send NF-10. In NF-10, refer back to all dates of delay letters.

OGC OPINIONS

For all questions not fully addressed in the NY PIP regulations, the NYS Insurance Department for the Office of General Counsel prepare opinion letters on written question presented.

NOTICE REQUIREMENTS

- The time for claimant to submit written notification of an accident is 30 days.
- Notice is satisfied by the insurer's receipt of an MV-104 or other accident report indicating injury, the applicant's submission of an NF-2 application for no-fault benefits, or by the insurer's receipt of a completed hospital facility form (NF-3).
- When an insured denies a claim based upon late notice, the denial must advise the applicant that late notice will be excused where the applicant can provide reasonable justification of the failure to give timely notice.

NOTICE REQUIREMENTS

(CONTINUED)

- What is clear and reasonable justification?
  - The OGC advised that "it would be difficult to create an encompassing list which would have uniform applicability, but the new proposal includes provisions that require insurers to establish reasonable objective standards for review of late notice of claim and late submission of proof of claim.
  - The regulation specifies that appropriate consideration must be given to pedestrians and non-related occupants of motor vehicles who may have difficulty ascertaining the insured.
  - Additionally, a denial for late submission should not be based upon a third-party's failure to provide the information necessary to establish the claim.

PROOF OF CLAIM

- Failure by any medical provider to submit written proof of claim within 45 days from the date of service is required to ensure payment.
- An insurer may deny based upon a violation of the 45 day rule except in the instant where "there is a clear and reasonable justification" for the delay in forwarding the billing.

	REGULATION 68-A	1ST AMENDMENT TO REG. 68-C	1ST AMENDMENT TO REG. 68-D
Policy Conditions			
Notice Requirement of Claim	30 Days	---	---
Medical	45 Days	---	---
Work Loss	90 Days	---	---
Other Necessary Expenses	90 Days	---	---
Relief for Failure to Comply	Demonstrate clear and reasonable justification for failure to comply. File for expedited arbitration.		
Claim Practice Procedures			
Acknowledgement of Claim	Section 65-3.4(b) Application within 5 business days. If claim sent to incorrect office, application must be forwarded within at least 10 business days.		
Procedures	Section 65-3.5(a) Send other forms with NF2. Speeds up process.	---	---
	Section 65-3.5(b) May request any information "to establish proof of claim."	---	---

	REGULATION 68-A	1ST AMENDMENT TO REG. 68-C	1ST AMENDMENT TO REG. 68-D
Examination Under Oath	Section 65-3.5(3) Insurer must have objective standard for conducting examination under oath.	---	---
Late Notice	Section 65-3.5(l) Carrier must establish standards for review of late notice of claim and late proof of claim. Must have supervisory review of claims denied.	---	---
Electronic Data	Section 65-3.5(k) Carriers with more than 1,000 policies are required to establish procedures for receipt of claims, notices, and verification by fax or electronic transmittal.	---	---
Interest on Overdue Claims	Section 65-3.9 % simple interest	---	---
Attorney's Fees:	Section 65-3.10(a)	---	---
No Denial	Increases attorney fee prior to arbitration to 20% of amount overdue plus any interest subject to maximum of $60.00		
Denial Issues	Section 65-3.10(a) $80.00 attorney fee due when a claim is denied and settled prior to arbitration.		
Direct Payments	Section 65-3.11(a) Limits assignment to health care services as provided in Section 5102(a)(1) and Section 5102(a)(2) of Insurance Law.	--- Requires provider to submit properly executed assignment on NF-3 or NF-AOB.	---

	REGULATION 68-A	1ST AMENDMENT TO REG. 68-C	1ST AMENDMENT TO REG. 68-D
Direct Payments (Cont'd)	---	Section 65-3.11(c) Insurer may request in writing original assignment.	---
Medical Benefits	Section 65-3.16(a)(12) Provider of health care benefits must meet State and local licensing requirements.	---	
Optional Arbitration Procedures			
Special Expedited Arbitration	Section 65-4.5(b) To resolve disputes that solely involve late notice of claim. Conciliation Center will walk claim through. Will be mailed to arbitrator within 1-2 days. Arbitrator has 10 days to issue decision. Rocket Docket.	---	Section 65-4.2(b)(3) Applicant to submit all supporting documents with arbitration request. Document submitted later will be marked "late" (except additional or on-going benefits). Carrier has 30 days to respond to arbitration notice from Conciliation Center otherwise marked "late." Insurer may, in writing, request additional 30 calendar days to respond.

PRIMA FACIE CASE AND BURDEN OF PROOF

- If the denial is untimely, the insurer is precluded from raising any defenses to the applicant's claim for no-fault benefits
- Therefore, as long as the provider is able to establish that it performed the services billed, any challenge as to the medical necessity of such treatment is barred under the 30 day rule.

THE EBB AND FLOW OF PIP FRAUD

- Medical no-fault (PIP) claim costs are rising faster in New York than anywhere else in the country.
- The sudden surge in claims costs is the result of greater frequency of claims as well as extraordinarily large increases in the average cost per claim.
- Medical no-fault claim frequency in New York is 30% above the median no-fault state while New York's average cost per claim is more than double the no-fault median.
- The rise in frequency and cost of medical no-fault claims cannot be explained by any economic factors such as increases in medical inflation.

THE ANATOMY OF A FRAUD

- The more common crimes associated with auto insurance are staged accidents, stolen identities, fraudulent police reports, and “jump-ins.”
- Owners and managers of medical clinics pay “runners” or recruiters to arrange minor auto accidents and send individuals supposedly injured in the accidents to the clinics for treatment.
- Although staged accidents are intended to cause no real injuries to the defendant driver or passengers, the accidents are reported to police so that a record can be created to support the fraudulent insurance claims.
- Medical bills often reach $10,000 to $20,000 per passenger and can go as high as $50,000 per passenger under the New York no-fault law. A single staged accident with multiple claimants generally results in billings for hundreds or even thousands of treatments.

THE MANY FACES OF MEDICAL FRAUD

Flaws in New York's no-fault laws have permitted perpetrators of fraud to get away with a surprisingly wide array of abuses. Virtually all insurers have indicated significant fraud and abuse in the following areas:

- **Provider Billing**
- **Durable Medical Suppliers**
- **Transportation "Provider" Bills**
- **Lost Wages**
- **Household Help**

THE MANY FACES OF MEDICAL FRAUD

(continued)

- **Exotic Medical Treatments:**
  - **Aromatherapy**
  - **Biofeedback**
  - **Acupuncture**
  - **Psychotherapy**
  - **Massages**
  - **Whirlpool Sessions**
  - **Electrical Stimulation**
  - **Thermography**
- **Treatment Frequency**

OTHER TYPES OF FRAUD

- ***Identity Fraud***
- ***Bounced Checks***
- ***Garaging***

GARAGING INVESTIGATION

- Circumstantial proof required to disclaim coverage *ab initio* (retroactive to the inception date of the policy)
  - All NF-2, NF-3 and police report record a NY address.
  - Initial reservations of rights letter.
  - Retention of NY investigator to obtain NYSDMV information and visit location of insured and secure insured recorded statement (if not represented).
  - Send SIU adjuster to alleged MA address listed on policy to ascertain whether its a valid address and/or whether the individual ever lived or principally garaged their vehicle at the location.
  - Trace report establishing insured residential history.
  - Registration and licensing of vehicle and insured.
  - Schedule EUO as last resort to bolster investigation.

CASES OF INTEREST

- Payment priority
- Insurer must show lack of medical necessity.
- Establishing fraud requires clear and convincing evidence.

CASES OF INTEREST
(CONTINUED)

- Blanket disclaimers do not eliminate insurer's obligation to pay or deny claims within 30 days.
- Verification requests sent within 25 days considered timely.
- Insurer's failure to timely disclaim coverage precludes it from denying claims

CASES OF INTEREST
(CONTINUED)

- Insurer can request verification of medical necessity from medical supply company.
- Non-payment complaint against insurer dismissed for assignor's failure to appear at pre-claim exam.
- Court defines medical necessity.

CASES OF INTEREST
(CONTINUED)

- Discovery motion denied for failure to include denial of claim or demand for verification forms.
- Insurer met burden to show accident was staged by using circumstantial evidence.

NEW YORK STATE BAR ASSOCIATION

NO FAULT INSURANCE FUNDAMENTALS:

SERIOUS INJURY THRESHOLD
NO FAULT COVERAGE

Tuesday, May 16, 2006

Robert A. Glick, Esq.
Brand Glick & Brand, P.C.

NYSBA

NYSBACLE