THE LAW ON NEW YORK NO-FAULT

by

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I. Fundamentals

1. The Comprehensive Automobile Insurance Reparations Act, initially codified in 1973, and re-codified in 1984 as Article 51 of the Insurance Law of the State of New York

   a) Limited legislative comments can be found in the Governor's memorandum Approving L. 1973, ch. 12, 1973 N.Y. Legis. Ann., at 298; and Report of the Joint Legislative Committee on Insurance (NY Legis doc, 1973, No. 18).

2. Part 65 (Regulation 68) of Title 11 of the New York Official Compilation of Codes Rules

   a) Cited as 11 NYCRR sec 65 et sec, these are the regulations implementing the No-Fault Law. They are promulgated by the Superintendent of Insurance and carry the force of law. So long as the regulations are consistent with Article 51 of the Insurance Law, the Insurance Department has "broad authority" to implement them.

      (1) Regulations inconsistent with the enabling legislation have been struck down. Kurcsics v. Merchants Mut. Ins. Co., 49 N.Y.2d 451 (1980) (Regulation limiting recovery of lost wages struck down). Rachlin v. Lewis, 96 Misc.2d 701, 409 N.Y.S.2d 594 (Sup. Ct. New York Cnty. 1978) (Regulation preventing attorney from charging client a fee struck down).

      (2) Courts have also placed judicial limitations on the language of a regulation. State Farm Ins. Co. v. Mallela, 4 N.Y.3d 313 (2005) (Investigations into licensure status limited to situations where the carrier can show "good cause" prohibiting such inquiries "unless they can demonstrate behavior tantamount to fraud.")

   b) The most recent version of the regulations, effective April 5, 2002, including final adoption of the Fourth Amendment to Regulation 68-C, effective April 1, 2013, and final adoption of the Sixth Amendment to Regulation 68-D, can be found at the New York State Insurance Department's website:

      http://www.dfs.ny.gov/insurance/r68_link.htm.

   c) State Administrative Procedure Act (SAPA) – The only published explanation of the Superintendent's intentions regarding proposed regulations.

3. Court and Arbitration Decisions

a) Many lower and Master Arbitration decisions are published in the "No-Fault SUM Reporter," which also includes articles and topics regarding no-fault coverage. Not all decisions are published; thus, decisions contrary to those in the SUM Reporter may exist.

b) Arbitration awards may be confirmed into judgments in the Courts, but otherwise carry no precedent.

c) Rulings in both a plenary action and arbitration can be *res judicata* and collateral estoppel with respect to each other.

(1) A.B. Medical Services PLLC et. Al. v. USAA General Insurance Co., 9 Misc.3d 19, 23, 801 N.Y.S. 2d 475 (Sup. Ct. App. T. 2nd Dept. 2005). Collateral estoppel cannot be invoked against different medical providers by insurer.

(2) Electrodiagnostic & Physical Med PC v. Maya Insurance Co., 45 Misc. 3d 1208(A), 3 N.Y.S.3d 284 (District Court, Nassau County, 2014). Collateral estoppel can be invoked against an insurer even if the proceedings involve different medical providers/claimants.

4. Advisory Opinions and Circular Letters

a) Anyone may seek the opinion of the General Counsel of the State Insurance Department. Such informal opinions do not carry the force of law.

(1) Aetna Cas. & Sur. Co. v. County of Nassau, 221 A.D.2d 107, 645 N.Y.S.2d 480 (2nd Dept. 1996). Superintendent issued informal opinion letter not binding on the Court.

(2) Rehab. Medical Care of New York, P.C. v. Travelers Ins. Co., 188 Misc.2d 176, 727 N.Y.S.2d 247 (Sup. Ct. App. T. 2nd Dept. 2001). Even though the Insurance Department had published a September 27, 2000 letter agreeing with the lower court decision finding the assignment to be invalid, Appellate Term reverses and finds language of recourse in assignment does not invalidate assignment.

(3) Sunrise Medical Imaging, PC v. Liberty Mutual Insurance Co, NYLJ 2/21/01, p.28, c.2 (District Court, Nassau County). Court specifically declined to follow the reasoning of the same September 27, 2000 opinion letter.

b) In other instances, informal opinion letters can be instrumental in shaping the law. For example, the Department's informal opinion letters were adopted by the court to create a *per se* prohibition against billing for services rendered by independent contractors. A.M. Med. Servs., P.C. v. Travelers Ins. Co., 23 Misc.3d 145(A),

889 N.Y.S.2d 504 (Sup. Ct. App. T. 2nd Dept, 11th and 13th Jud. Dists. 2009); Craig Antell, D.O. v. N.Y. Cent. Mut. Fire Ins. Co., 11 Misc.3d 137(A), 816 N.Y.S.2d 694 (Sup. Ct. App. T. 1st Dept. 2006).

II. Statute

NY CLS Ins § 5106:

(a) Payments of first party benefits and additional first party benefits shall be made as the loss is incurred. Such benefits are overdue if not paid within thirty days after the claimant supplies proof of the fact and amount of loss sustained. If proof is not supplied as to the entire claim, the amount which is supported by proof is overdue if not paid within thirty days after such proof is supplied. All overdue payments shall bear interest at the rate of two percent per month. If a valid claim or portion was overdue, the claimant shall also be entitled to recover his attorney's reasonable fee, for services necessarily performed in connection with securing payment of the overdue claim, subject to limitations promulgated by the superintendent in regulations.

(b) Every insurer shall provide a claimant with the option of submitting any dispute involving the insurer's liability to pay first party benefits, or additional first party benefits, the amount thereof or any other matter which may arise pursuant to subsection (a) hereof to arbitration pursuant to simplified procedures to be promulgated or approved by the superintendent.

(c) An award by an arbitrator shall be binding except where vacated or modified by a master arbitrator in accordance with simplified procedures to be promulgated or approved by the superintendent. The grounds for vacating or modifying an arbitrator's award by a master arbitrator shall not be limited to those grounds for review set forth in article seventy-five of the civil practice law and rules. The award of a master arbitrator shall be binding except for the grounds for review set forth in article seventy-five of the civil practice law and rules, and provided further that where the amount of such master arbitrator's award is five thousand dollars or greater, exclusive of interest and attorney's fees, the insurer or the claimant may institute a court action to adjudicate the dispute de novo.

III. Regulations

Four sections:
11 NYCRR 65-1 Prescribed policy endorsements
11 NYCRR 65-2 Rights and liabilities of Self-Insurers
11 NYCRR 65-3 Claims processing
11 NYCRR 65-4 Arbitration/Litigation

A. Mandatory Personal Injury Protection (11 NYCRR 65-1.1)

The company will pay first-party benefits to reimburse for basic economic loss sustained by an eligible injured person on account of personal injuries caused by an accident arising out of the use or operation of a motor vehicle or a motorcycle

during the policy period and within the United States of America, its territories or possessions, or Canada.

Regardless of actual policy terms, policy will be read as containing the term of the mandatory endorsement.

Covered by Multiple Policies: Where the injured person is considered an "eligible injured person" under multiple policies (i.e., personal policy and policy insuring the vehicle involved in the accident), the first carrier to receive the bill is obligated to make payments. Disputes between carriers must be raised in an intercompany arbitration, and may not be raised as a defense to the applicant's claim. M.N. Dental Diagnostics, P.C. a/a/o Burgos v. GEICO, 24 Misc.3d 43, 884 N.Y.S.2d 549 (Sup. Ct. App. T. 1st Dept., 2009).

First-party benefits, other than death benefits, are payments equal to basic economic loss, including medical expense, work loss, other expense and, when death occurs, a death benefit as herein provided.

B. Assignment of Benefits (11 NYCRR 65-3.11)

1. Eligible Injured Person has the right to assign benefits to health care providers and employers (for lost wage claims). The assignee has a right to enforce the payments of benefits through arbitration and litigation. A health care provider submitting a claim pursuant to an assignment is a claimant in his own right. Rosenblum v. Government Emp. Ins. Co., 41 N.Y.2d 966, 394 N.Y.S.2d 879 (1977).

2. Assignment is limited to "providers of health care services as covered under section 5102(a)(1) of the Insurance Law, or to the applicant's employer for loss of earnings from work as authorized under section 5102(a)(2) of the Insurance Law. 65-3.11 Entitled "Direct payments."

3. Under the theory that a billing provider that hires a health care worker as an independent contractor is not truly the "provider of health care services," section 65-3.11 and the Department's interpretation thereof, are the basis of decisions barring a provider from seeking payment for services provided by independent contractors. A.M. Med. Servs., P.C. v. Travelers Ins. Co., 23 Misc.3d 145(A), 889 N.Y.S.2d 504 (Sup. Ct. App. T. 2nd Dept. 2009); Craig Antell, D.O. v. N.Y. Cent. Mut. Fire Ins. Co., 11 Misc.3d 137(A), 816 N.Y.S.2d 694 (Sup. Ct. App. T. 1st Dept. 2006).

4. In litigation, Plaintiff Assignee is not required to prove the existence of a valid assignment unless the carrier has requested verification in a timely manner or challenged the status in a timely valid Denial of Claim form. Hospital for Joint Diseases v. Travelers Prop. Cas. Ins. Co., 9 N.Y.3d 312 (2007); see also Presbyterian Hospital in the City of New York v. Aetna Casualty and Surety Company, 233 A.D.2d 433, 650 N.Y.S.2d 602 (2nd Dept. 1996) (the failure to "allege any deficiency in the hospitals

assignment in its denial of claim, "resulted in a waiver of "any such defense"); Hospital for Joint Diseases v. Allstate, 21 A.D.3d 348, 800 N.Y.S.2d 190 (2nd Dept, 2005); Medwide Medical Supply v. Country-Wide Insurance Company, 8 Misc.3d 131(A), (Sup. Ct. App. T. 2nd Dept. 2005).

5. Even though at common law, "no particular words" are required to accomplish an assignment, the Department has mandated the use of a prescribed Assignment of Benefits Form (NF- AOB). 65-3.11(b)(2).

6. The AOB prohibits health care providers from pursuing payment directly from the patient, even if the health care provider is unable to obtain reimbursement from the insurance carrier. The regulations allow for certain exceptions to this rule such as the patient's failure to have insurance coverage or for a patient's violation of policy conditions.

7. The form requires the signature of the patient and the health care provider.

8. The insurance carrier can condition payment upon the claimant's submission of the original AOB. 65-3.11(c).

9. In lieu of executing the AOB, the claimant can complete an authorization of benefits to the provider which allows payment to be made to such but does not transfer all first party rights and benefits to bring an arbitration or plenary action on its behalf.

C. Notice (of the accident) (11 NYCRR 65-1.1 and 11 NYCRR 65-2.4)

1. A claimant's time frame for the submission of "written notice" of an accident is 30 days after the accident. "Written notice" is defined as reasonably obtainable information regarding the time, place and circumstances of the accident.

2. The most common way of providing written notice is by the submission of an Application for No-Fault Benefits (NF-2). However, sufficient notice can also be provided by submission of a police report, motor vehicle accident report (MV-104) or a letter. The insurance carrier, within a certain prescribed time frame, may request that a completed NF-2 be submitted. See 11 NYCRR 65-3.5(f).

3. Failure to submit "written notice" within 30 days may be excused if there is "clear and reasonable justification" for such failure. The burden lies with the claimant to demonstrate such an excuse, although the carrier must advise the claimant in its denial that such late notice will be excused if it can provide such.

4. Where the insurer determines that "clear and reasonable justification" was not established, the regulations provide for a special expedited arbitration proceeding to resolve such disputes. See 11 NYCRR 65-4.5 (b)(1)-(8).

5. An applicant may request a special expedited arbitration within 30 calendar days after mailing of the denial of claim by the insurer. The applicant is required to make a complete submission supporting his/her position, at the time of the request.

6. Applications for special expedited arbitration must be submitted to the American Arbitration Associations' ("AAA") conciliation center and are to comply with the requirements for initiation of arbitration contained in section 11 NYCRR 65 4.2(b)(1).

D. Proof of Claim (Submission of bills)(11 NYCRR 65-1.1 and 65-2.4)

1. The no-fault regulations require a claimant submit medical bills within 45 (previously 180 days) days after the date service was rendered.

2. Claims must be submitted within 45 days, not received by insurer within 45 days. New York Diagnostic Med. Care, P.C. v Geico Cas. Ins. Co., 2012 NY Slip Op 50681(U)(Sup. Ct. App. T. 2nd Dept., 9th and 10th Jud Dist., 2012).

3. As with the "written notice" requirement, failure to submit "proof of claim" within 45 days may be excused "if there is a clear and reasonable justification."

a) Synergy First Medical, PLLC a/a/o Orozco v. ELRAC, 26 Misc3d 131(A), (Sup. Ct. App T. 1st Dept., 2010). The court held that plaintiff failed to raise a triable issue of fact with respect to whether it had a reasonable justification for a nine-day delay in submitting such proof. Plaintiff's bald and unelaborated assertion that the delay was attributable to a staffing issue, i.e. the absence of unidentified employee responsible for preparing claims because of a family emergency is insufficient to raise a triable issue of fact.

b) Compare with Bronx Expert Radiology a/a/o Castillo v. Clarendon National Ins. Co., 23 Misc3d 133(A) (Sup. Ct. App T. 1st Dept., 2009). In this case plaintiff established that it submitted a correspondence explaining its reasonable justification for the late notice. Defendant's motion for summary judgment was denied and the court upheld the denial of the motion because the defendant did not establish whether it gave any consideration to plaintiff's reasonable justification. Relying on the Matter of Medical Society v. Serio, 100 N.Y.2d 854 (2003), the court noted that the carrier must ensure due consideration of denial of claims based upon late filings and must give appropriate considerations for situations where the claimant has difficulty in ascertaining the insurer's identity or inadvertently submits a claim to the incorrect insurer.

c) In SZ Medical, P.C. v. Country-Wide Ins. Co., 817 N.Y.S.2d 851 (Sup. Ct. App. T. 2nd Dept 2006), the Appellate Term determined

> that a denial, based upon late submission of proof of claim is defective as a matter of law if it fails to comply with the statutory mandate of 11 NYCRR §65-3.3 which requires the carrier to advise the applicant that late notice will be excused upon a showing of "reasonable justification." The Court found that when an insurer's Denial of Claim form fails to advise a claimant that a late submission of a claim will be excused upon a showing of reasonable justification, the insurer "waive(s) reliance on the 45-day rule as a basis to deny the claims." Id.; accord, Central Bronx Medical, P.C., a/a/o Maria Gomez v. Countrywide Ins. Co., No. 47757/2005, (Civil Ct., County of Bronx, October 27, 2005)(a denial, based upon late submission of proof of claim, is defective as a matter of law if it fails to advise the applicant that late notice will be excused where the applicant can provide reasonable justification of the failure to give timely notice); Metro Medical P.C., a/a/o William Lopez v. Countrywide Ins. Co., No. 52890/03, (Civil Ct., County of Bronx, February 17, 2006) (the Court held that a denial of claim form, based upon late submission of the bill, and not containing the statutorily required language of 11 NYCRR § 65-3.3(e), was invalid).

4. The insurance carrier is required to establish standards for review of late proof of claim, which must include situations in which the claimants have difficulty determining the identity of the insurance carrier, or inadvertently submit a claim to the wrong insurance carrier, although it apparently does not have to release such standards to claimants/public. See 11 NYCRR 65-3.5(l).

5. There is no provision for a special expedited arbitration for the issue of late "proof of claim."

6. The carrier must accept proof of claim on a document other than the prescribed form if it contains substantially the same information. 11 NYCRR 65-3.5(f).

E. Payment within 30 days.

1. From Ins. Law 5106(a):

> …benefits are overdue if not paid within thirty days after the claimant supplies proof of the fact and amount of loss sustained. If proof is not supplied as to the entire claim, the amount which is supported by proof is overdue if not paid within thirty days after such proof is supplied.

2. From 11 NYCRR 65-3.8:

> Payment or denial of claim (30-day rule). (1) No-fault 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 of this Subpart.

F. Verification Requests

1. An insurance carrier has 15 business days (old regulations 10 business days) after its receipt of a no-fault claim within which to request additional verification. 11 NYCRR 65-3.5(b). Note 2013 Amendment: applicant must supply verification under applicant's control or possession within 120 days from initial request or provide written proof with reasonable justification for failure to comply. 65-3.5(o).

2. The Regulations set forth claims practice principles for all carriers to follow. "The insurer shall assist the applicant in the processing of the claim. Do not treat the applicant as an adversary." 11 NYCRR 65-3.2(b).

3. When a carrier makes a determination that it wishes to request additional verification, there must be good reason for the request and it should be done as expeditiously as possible. 11 NYRCC 65-3.2(c).

4. Verification requested must be necessary. 11 NYCRR 65-3.2(c); Omega Diagnostic Imaging, P.C. v. MVAIC, 29 Misc.3d 129(A) (Sup. Ct. App T. 1st Dept. 2010): Requests for applicant to obtain from the out-of-state driver of the vehicle that struck the assignor an "affidavit of no insurance" "were not proper, since there was no 'good reason' for defendant to demand that plaintiff and its assignor obtain an affidavit from the driver, who is neither a party to this action nor under the control of either plaintiff or its assignor (see 11 NYCRR 65-3.2(c))."

5. Brownsville Advance Med., P.C. v Country-Wide Ins. Co. 33 Misc.3d 1236(A), 941 N.Y.S.2d 536 (Table) (Nassau Dist Ct, 2012) Country-Wide's repetitive verification demands upon Brownsville are contrary to 11 NYCRR 65-3.2(b) that provides an applicant or claimant should not be treated as an adversary and verification of facts should not be requested unless the insurer has a good reason for doing so. In this case, Country-Wide offers no reason why it has repeatedly demanded identical verification from Brownsville, even though the information demanded in the verification requests has previously been provided and available on public websites.

6. Before April, 2013 Amendment, untimely requests for additional verification were, in essence, void and did not toll the 30-day period to pay or deny the claim. See Ocean Diagnostic Imaging v. Utica Mut. Ins. Co., 2005 NY Slip Op 51747U, 9 Misc. 3d 138A (Sup. Ct. App. T. 2nd Dept. 2005).

7. Under 2013 Amendment pertaining to claims for services rendered on

or prior to April 1, 2013, an insurer's failure to adhere to prescribed time frame, does not negate applicant's obligation to comply with request for additional verification. Further, insurer's "nonsusbstantive technical or immaterial defect or omission" does not negate applicant's obligation to comply. 65-3.5 (p).

8. Delay Letters: A delay letter, merely informing a claimant that a decision to pay the claim is delayed pending an investigation, is inadequate to toll the 30-day time period. Melbourne Medical, P.C. v. Utica Mutual Ins. Co., 4 Misc. 3d 92, 781 N.Y.S. 2d 819 (Sup. Ct. App. T. 2nd Dept. 2004); Rigid Medical of Flatbush, P.C., v New York Central Mutual Fire Insurance Company, 816 N.Y.S.2d 700 (Sup. Ct. App. T. 2nd Dept. 2006).

9. The insurer has the right to require the patient to appear for an insurer's medical examination; however the insurer shall schedule the examination to be held within 30 calendar days from the date of receipt of the prescribed verification forms. 11 NYCRR 65-3.5(d).

10. The carrier may also request that the applicant appear for an Examination Under Oath (EUO). All examinations under oath and medical examinations requested by the insurer shall be held at a place and time reasonably convenient to the applicant and medical examinations shall be conducted in a facility properly equipped for the performance of the medical examination. The insurer shall inform the applicant at the time the examination is scheduled that the applicant will be reimbursed for any loss of earnings and reasonable transportation expenses incurred in complying with the request. 11 NYCRR 65-3.5(e).

11. A request for an examination under oath must based upon objective standards to support the use of such examination. The fact that the EUO must "reasonably be required" indicates that an insurer does not have an unfettered right to obtain the examination. 11 NYCRR 65-3.5(e), which requires that there is specific objective justification supporting the use of an examination under oath. In addition, claim practice principles promulgated by the Insurance Department preclude an insurer's request for further verification of a claim unless there is good reason to do so, 11 NYCRR 65-3.2 (c).

G. Follow-up Requirements

1. If any requested additional verification (e.g., IME, EUO or other medical documentation) has not been supplied to the insurer thirty calendar days after the original request, the insurer shall, within ten calendar days, follow-up with the recalcitrant party "either by telephone call, properly documented in the file, or by mail." 11 NYCRR § 65-3.6(b). Follow-up request must be sent to applicant's attorney as well. The failure to do so has been determined by a master arbitrator to be a material defect and not excused by 65-3.5(p). Matter of Alpha Imaging Consultants and Maya Assurance Co., 17 991 R 16377 (Harris Levy, May 19, 2014). (Note:

although arbitration awards are not biding precedent, language can be used as persuasive authority).

2. Pre-2013 Amendment case law: Follow-up provision interpreted as follows: Where an insurer fails to issue a timely follow-up request to its initial verification request, the thirty-day claim determination period is not tolled. See, A.B. Medical Services v. Utica Mut. Ins. Co., 2005 NY Slip Op 25456, 10 Misc. 3d 50 (Sup. Ct. App. T. 2nd Dept. 2005). An insurer's failure to strictly comply with follow-up procedures and timetable verification set out in No-Fault law and governing regulations preclude the insurer from denying No-Fault coverage benefits to medical service providers, as insured's assignor. Infinity Health Products, LTD., v. Eveready Ins. Co., 2008 N.Y. Slip Op 28271 (Sup. Ct. App. T. 2nd Dept., 2nd and 11th Jud Dist., 2008); Bronx Med. Services v. Windsor Ins. Co., 2003 NY Slip Op 50885 U, 2003 WL 21173634 (Sup. Ct. App T. 1st Dept. 2003).

3. Under 2013 Amendment for claims for services rendered on or prior to April 1, 2013, an insurer's failure to adhere to prescribed time frame, does not negate applicant's obligation to comply with request for additional verification. Further, insurer's "nonsusbstantive technical or immaterial defect or omission" does not negate applicant's obligation to comply. 65-3.5 (p).

4. If the 30 days has lapsed, and the insurance carrier has failed to make a timely follow-up request thereafter, the carrier will be deemed to have failed to pay or deny the claim within the statutory time. King's Med. Supply Inc. v. Allstate Ins. Co., 2005 NY Slip Op 50451U, 7 Misc. 3d 128A (Sup. Ct. App. T. 2nd Dept. 2005). Under new Regulation, this proposition may not stand.

5. Follow-up provisions in relation to agreed upon adjournments of examinations: A voluntary re-scheduling of an examination is not considered to be a failure to appear.

   a) DVS Chiropractic, P.C. v Interboro Ins. Co., 36 Misc.3d 138(A), Slip Copy, 2012 WL 3139771 (Table)(Sup. Ct. App. T. 2nd Dept. 2012) "Defendant denied the claims based upon the alleged failure by plaintiff's assignor to appear at duly scheduled examinations under oath (EUOs). However, according to the affidavit submitted by defendant, the initial EUO had twice been rescheduled by mutual agreement, prior to the dates set for each. We do not consider a mutual rescheduling, which occurs prior to the date of that scheduled EUO, to constitute a failure to appear." Id.

   b) Vitality Chiropractic, P.C. v. Kemper Ins. Co., 14 Misc.3d 94, 831 N.Y.S.2d 637 (Sup. Ct. App. T. 2nd Dept. 2006).

c) Canceling of IME by the injured person. Five Boro Psychological Servs., P.C. v Praetorian Ins. Co. 2012 NY Slip Op 51336(U) 36 Misc.3d 133(A) (Sup. Ct. App. T. 2nd Dept. 2012). (Carrier must still establish that second scheduled IME after patient allegedly canceled first appointment, was not a mutual rescheduling).

H. Amendment to rule that a claim could not be denied until verification was received.

1. Previous rule: Pursuant to 11 NYCRR § 65-3.8(a)(1) (formerly 65.15(g)(1)(i)), a claim for no-fault benefits need not be paid or denied until all demanded verification is provided.

2. 2013 Amendment for claims for services rendered on or after April 1, 2013: insurer can deny the claim if over 120 days since initial request for verification and applicant has not submitted the verification under applicant's control or possession, unless applicant provided written proof giving a reasonable justification to comply. 65-3.8(b)(3).

I. Response to Verification Request

1. Even under the new Amendment, an insurer unhappy with the applicant's response to a request for additional verification is obligated to note any defects in the response. It cannot sit idle and fail to act upon the response. All Health Medical Care, P.C. v. Government Employees Ins., 2 Misc.3d 907, 771 N.Y.S.2d 832 (N.Y. City Civ.Ct., 2004).

J. As it is incumbent upon claimant to comply with all proper verification requests made by insurer in order to receive payment, it is equally incumbent upon insurer to expedite the processing of the claim. There is no provision of the No Fault regulations or case law that allows an insurance company to remain silent in the face of a legitimate, albeit insufficient, verification response. It is inconsistent with the goals of the No Fault law in encouraging swift payment of claims to allow an insurance company to ignore a response to its verification request merely because it believes the response to be inadequate. Id.

K. Examinations Under Oath ("EUO") (11 NYCRR 65-3.5(d) & (e))

1. Under the post 2002 regulations, an insurance carrier is authorized to request an examination under oath of the claimant or their assignees as often as may be "reasonably" required. Consequently, injured parties, as well as health care providers may be required to submit to such examinations. Insurance carriers must demonstrate a "specific objective justification" in support of their use of a EUO to be submitted to the State Insurance Department for review, although there does not appear to be any requirement that the carrier provide the claimant with such rationale as recently held by the Appellate Term determining that an insurer does not have to provide the insurer's objective standards as to when EUO's are requested. See Metro Psychological Servs., PC v. 21st Century N. Am.

Insurance Co., 2015 NY Slip Op. 50470(U) (Sup. Ct. App.T. 2nd Dept. 2015). However, insurer must still show the trier of fact that the request is reasonable. Rutland Medical, PC v. State Farm Insurance Co., 995 N.Y.S.2d 465, 466 (Kings Civil Court, 2014); see also American Transit Insurance Company v. Jaga Med. Servs., P.C., 2015 NY Slip. Op. 03925 (1st Dept. 2015):

> The reason for the EUO request is a fact essential to justify opposition to plaintiff's motion for summary judgment motion, and such fact is exclusively within the knowledge and control of the movant. Further discovery on plaintiff's handling of the claim so as to determine whether, inter alia, the EUO's were timely and [properly requested is also essential to justify opposition. (*citations omitted*).

2. 11 NYCRR 65-3.5(e) adopts the same rules for EUOs as those in effect for Independent Medical Examinations (IMEs), including that the examinee is entitled to reasonable transportation costs and lost earnings as compensation.

3. Examinations Under Oath are subject to the follow-up requirements set forth in the regulations. Bronx Med. Services v. Windsor Ins. Co., 2003 NY Slip Op 50885 U, 2003 WL 21173634 (Sup. Ct. App. T. 1st Dept. 2003).

4. Caveat: Under post 2013 amendment, this means whatever requirement is not deemed a technical defect by the courts.

5. As noted above the requests for an examination under oath must be reasonable; however the Appellate Term 2nd Department has been requiring an objection be made to preserve a challenge to an examination under oath. Crescent Radiology, PLLC v American Tr. Ins. Co., 2011 NY Slip Op 50622(U) (31 Misc 3d 134(A)) (Sup. Ct. App. T. 2nd Dept. 2011) ("Moreover, plaintiff does not claim to have responded in any way to defendant's request for an EUO. Therefore, plaintiff will not be heard to complain that there was no reasonable basis for the EUO request.").

   a) COMMENT: It is hard to see how silence, particularly on the part of an unrepresented health care provider, can be construed as a waiver of objection to an improper or unreasonable request for Examination Under Oath. In general, waiver is the intentional knowing relinquishment of a right. I think this line of cases may weather the test of time.

L. Insurer Medical Examinations (IME). 65-3.5(d) & (e).

1. Retroactive IMEs/No Shows

   a) An insurance carrier will often schedule medical examinations for the insured and then deny payment when the insured fails to attend

two scheduled exams in the same specialty. Denial of payment retroactively back to date of accident is commonly referred to as the "retroactive IME" issue.

b) The appearance of the insured for IMEs at any time is a condition precedent to the insurer's liability on the policy. The Appellate Division held that an insurer could successfully deny a claim where a claimant fails to appear for an IME regardless of whether or not the failure to appear occurs before the submission of the claim or after the submission. Stephen Fogel Psychological, P.C. v. Progressive Cas., 35 A.D. 3d 720, 827 N.Y.S. 2d 217 (2nd Dept. 2006).

c) However, in order to succeed in a motion for summary judgment based on a claimant's failure to appear for an IME or EUO, the insurer must "submit evidence in admissible form from anyone with personal knowledge of the nonappearances." See, Chi Acupuncture, P.C. v. Kemper Auto & Home Insurance Co., No. 2005-01893 SC (Sup. Ct. App. T. 2nd Dept., 9th & 10th Dist., 2007) (concerning IME demands); see also Crossbridge Diagnostic Radiology, P.C. v Progressive Ins. Co., 2008 NY Slip Op 51761(U), 20 Misc 3d 143(A) (Sup. Ct. App. T. 2nd Dept., 2nd and 11th Jud Dists 2008)("Since the affidavit submitted by defendant was insufficient to establish Mr. Cherry's nonappearance at said EUOs, defendant failed to raise a triable issue of fact"); Stephen Fogel Psychological, P.C. v. Progressive Cas., 35 A.D. 3d 720, 827 N.Y.S. 2d 217 (2nd Dept 2006)(carrier has burden to establish nonappearance at IME).

d) Insurer must demonstrate that claimant failed to appear at the first and second EUO. New Way Medical Supply Corp. v. MVAIC, 46 Misc.3d 129(A) (Sup. Ct. App. T. 2nd Dept. 2014). In New Way, sworn transcript attached to insurer's motion for summary judgment only established nonappearance at second EUO, not the first; thus, defendant failed to establish prima facie entitlement to summary judgment.

2. Maximum Medical Improvement: Hobby v. CNA Ins. Co., 267 A.D.2d 1084, 700 NYS2d 346 (4th Dept 1999):

An insurance carrier terminated no-fault benefits based upon an examination by an IME doctor indicating that the insured reached "maximum medical improvement," meaning that medical treatment was no longer improving her condition rather it was merely relieving her pain.

The Appellate Division (Fourth Department) held, "that the Supreme Court properly granted plaintiff's motion for summary judgment compelling defendant, CNA Insurance Company (CNA),

to pay outstanding medical bills pursuant to the no-fault provisions contained in plaintiff's motor vehicle insurance policy."

The Court found no authority in the Insurance Law for discontinuing payment on the ground that the patient reached "maximum medical improvement." In fact, the Court found that Insurance Law 5102 (a)(1) provides up to $50,000 for "all necessary expenses" without limitation as to time, "provided that within one year after the date of the accident…it is ascertainable that further expenses may be incurred as a result of the injury."

M. Peer Review

1. Peer reviewer must establish a factual basis and a medical rationale for his or her opinion the testing or treatment was not medically necessary based upon generally accepted standards for the profession. See Nir v. Allstate Insurance Co., 7 Misc.3d 544 (Civil Ct. Kings Co. 2005).

2. Elmont Open MRI & Diagnostic Radiology, P.C. v GEICO Ins., 12 Misc.3d 133(A), 820 N.Y.S.2d 842 (Table) (Sup. Ct. App. T. 2nd Dept., 9th And 10th Judicial Dist., 2006) Conclusions of the peer review upon which the denial was based were not supported by a sufficient factual foundation and medical rationale to warrant rejection of the claims and, accordingly, were insufficient to support a defense of lack of medical necessity.

3. Park Neurological Servs. P.C. v GEICO Ins., 4 Misc.3d 95, 782 N.Y.S.2d 507, (Sup. Ct. App. T. 2nd Dept., 2004). A peer review finding no medical necessity due to the lack of sufficient information upon which the reviewer could make such a determination, "we find that the denial did not "fully and explicitly" set forth the reasons therefore (section 31 of the NF-10 form), did not inform plaintiff of defendant's position regarding the disputed matter, and, thus did not set forth a factual basis and medical rationale sufficient to establish the absence of medical necessity (see Amaze Med. Supply v Eagle Ins. Co., supra). Accordingly, defendant is precluded from asserting the defense of lack of medical necessity (Amaze Med. Supply v Eagle Ins. Co., supra)." Id.

N. Requirements for Denial

1. April, 2013 Amendment- 65-3.8(h): "insurer's non-substantive technical or immaterial defect or omission shall not affect the validity of a denial of claim form."

Note that 65-3.8(c)(1) requires that a denial of claim form be issued in duplicate; however, the Second Department has recently held insurer's failure to send denial in duplicate is not, on its own, a fatal error. Performance Plus Medical, PC v. Utica Mutual Insurance Co., 47 Misc.3d 129(A) (Sup. Ct. App. T. 2nd Dept. 2015). (*citations omitted*).

Also note that prior to the 2013 Amendment, in New York University Hospital Rusk Institute v. Hartford Accident and Indemnity Co., 32 A.D.3d 458 (Sup. Ct. App. T. 2nd Dept. 2006), the court held the defendant, insurer, was precluded from interposing a defense, as it did not comply with 11 NYCRR§65-3.8 (c)(1). Also pre-amendment, "A proper denial of claim must include the information called for in the prescribed denial of claim form (see 11 NYCRR 65-3.4 (c)(11)) and must 'promptly apprise the claimant with a high degree of specificity of the ground or grounds on which the disclaimer is predicated' " (Nyack Hosp. v State Farm Mut. Auto. Ins. Co., 11AD3d 664, 664 (2nd Dept. 2004), quoting General Acc. Ins. Groupv Cirucci, 46 NY2d 862, 864 (1979)). Incorrect information in denial of claim form invalidates the denial. St. Vincent's Hosp. & Med. Ctr. v New Jersey Mfrs. Ins. Co., 82 A.D.3d 871, 918 N.Y.S.2d 356 (2nd Dept. 2011): "[A] timely denial of a no-fault insurance medical claim alone does not avoid precluding an insurer from disclaiming or denying liability where the denial is factually insufficient, conclusory, vague, or otherwise involves a defense which has no merit as a matter of law (see Nyack Hosp. v Metropolitan Prop. & Cas. Ins. Co., 16 AD3d 564, 565, 791 N.Y.S.2d 658, 2nd Dept., 2005);" A timely denial does not avoid preclusion where said denial is factually insufficient, conclusory, vague, or otherwise involves a defense which has no legal merit. See Amaze Medical Supply v. Allstate Ins. Co., 3 Misc. 3d 43, 44, 779 N.Y.S. 2d 715 (Sup. Ct. App. T. 2nd Dept. 2004); an incomplete denial form is defective and insufficient to preserve a defense. Nyack Hosp. v Metropolitan Prop. & Cas. Ins. Co., 16 AD3d 564, 565, 791 N.Y.S.2d 658 (2nd Dept. 2005).

Comment: In light of 2013 Amendment, expect litigation over what constitutes "incomplete" and "defective."

Post-Amendment, incorrect bill amount on denial of claim form held to be "nonprejudicial mistake" and did not render the denial invalid. NYU-Hospital for Joint Diseases v. Allstate Insurance Co., 123 A.D.3d 781 (2nd Dept. 2014).

2. Insurers are required to preserve most grounds for denying a claim with specificity. The purpose of requiring specificity is to allow the claimant to assess "whether the insurer will be able to disclaim successfully." "…the insurer's responsibility to furnish notice of the specific ground on which the disclaimer is based is not unduly burdensome, the insurer being highly experienced and sophisticated in such matters." General Acc. Ins. Group v Cirucci, 46 NY2d 862, 864 (1979)).

3. The carrier must respond to each claim and cannot rely upon a denial previously furnished to the patient. "We hold that the no-fault law itself (Insurance Law art 51), and the regulations promulgated there under for settlement of claims (11 NYCRR 65.15), require that "When a provider of medical services (first) submits a claim as assignee of an insured, neither the statute nor the regulations contemplate the insurer simply sitting mute and failing to act upon the claim, silently and secretly relying upon an earlier (blanket) denial issued directly to the insured" (*citation omitted*). A & S Medical P.C. v. Allstate Ins. Co., 15 A.D.3d 170, 789 N.Y.S.2d 27 (1st Dept., 2005).

4. Court further reiterated rule that blanket denials are invalid to specifically deny a claim. Accord, Westchester Med. Center v. New York Cent. Mut. Fire Ins. Co., 81 A.D.3d 929, 917 N.Y.S.2d 275 (Sup. Ct. App. T. 2nd Dept. 2011).

O. Disputes between carriers

1. Insurance Law § 5105(b) requires that mandatory arbitration be used to resolve all disputes between insurers as to their responsibility for the payment of first-party benefits. 11 NYCRR 65–3.12(b) provides that "(i)f a dispute regarding priority of payment arises among insurers who otherwise are liable for the payment of first-party benefits, then the first insurer to whom notice of claim is given ... shall be responsible for payment to such person. Any such dispute shall be resolved in accordance with the arbitration procedures established pursuant to section 5105 of the Insurance Law and section 65–4.11 of this Part." M.N. Dental Diagnostics PC v GEICO, 81 A.D.3d 541, 916 N.Y.S.2d 598 (1st Dept. 2011).

P. Interest Accrual

1. As a penalty for an insurer's failure to timely pay a claim, interest is imposed on all overdue claims (2% per month simple interest under the New Regulations and 2% per month compounded for Old Regulation cases). Insurers cannot request that interest be waived even as a condition of settlement. 11 NYCRR 65-3.9.

2. Interest is tolled assuming the applicant fails to commence a civil action or arbitration within 30 days of receipt of a denial of claim, even if the denial of claim is invalid and untimely. 11 NYCRR 65-3.9 (c); LMK Psychological Servs., P.C. v State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 217, 879 N.Y.S.2d 14 (2009) (however, per opinion letter of Superintendent, interest tolling provision applies even when denial of claim is untimely).

3. Aetna Casualty & Surety Co. v. Whitestone General Hospital, 142 Misc.2d 67, 536 N.Y.S.2d 373 (Sup. Ct. N.Y. County 1988). The no-fault

insurer moved to re-settle an earlier signed judgment. The no-fault insurer argued that upon entry of judgment, the interest would accrue at the statutory rate of nine percent per annum (CPLR 5003 and 5004) and not at the rate of two percent per month as provided for in the Insurance Law, Section 5106. The Court denied the insurer's motion and held that:

> The policies of encouraging prompt payment of claims and reducing litigation outweigh limits on interest found elsewhere (including Section 3-a of the General Municipal Law). Matter of Mckenna v. County of Nassau, 134 N.Y.S.2d 286 (2nd Dept. 1983). Therefore, whether judgment is entered or not has no effect on the rate at which interest accrues. Id.

Q. Priority of Payments/Policy Exhaustion

1. 65-3.15: When claims aggregate to more than $50,000, payments for basic economic loss shall be made to the applicant and/or an assignee in the order in which each service was rendered or each expense was incurred, provided claims therefor were made to the insurer prior to the exhaustion of the $50,000. If the insurer pays the $50,000 before receiving claims for services rendered prior in time to those which were paid, the insurer will not be liable to pay such late claims. If the insurer receives claims of a number of providers of services, at the same time, the payments shall be made in the order of rendition of services.

2. Thus, payments must be issued in order of the rendition of the medical services, except when claims for the subsequent services were received before post-exhaustion claims. For example, Medical Provider "A" submitted claims for services rendered in April, 2015. The policy is then exhausted. Provider "B" subsequently submits a claim for services rendered in March, 2015. Pursuant to the exception in 65-3.15, although Provider "A's" claims are for later dates of service, Provider "A" is entitled to payment as A's claim was submitted first.

3. The Court of Appeals Court carved out another limited exception to the rule requiring payment in the order each service was rendered. Nyack Hospital v. GMAC, 8 N.Y.3d 294 (2007). The Nyack Court held that when an insurer exercises the right to request additional verification as discussed above in order to toll the time by which the insurer is obligated to pay the claim, while waiting to verify a pending claim, said insurer, is not prohibited from paying already verified claims.

IV. LITIGATION

A. Note: Most arbitrators follow the Courts in rendering their decisions.

B. Prima Facie Case and Burden of Proof

1. Dermatossian v. New York City Transit Authority, 67 N.Y.2d 219, 224, 501 N.Y.S.2d 784, 787 (1986)-- "(A) claimant to receive payment need only file a proof of claim and the insurers are obliged to honor it promptly or suffer the statutory penalties."

2. Attempts to Re-Define. The Department, displeased with the decision in Presbyterian Hospital v. Maryland Casualty Co. 90 NY.2d 274, 660 N.Y.S.2d 536 (1997), issues a January 11, 2000 opinion concluding that even when an insurer issues a late denial of claim, a medical provider still has the burden of establishing the medical necessity of the services rendered to the injured claimant. The courts roundly reject this view. Amaze Med. Supply, Inc. v. Eagle Ins. Co., 2 Misc. 3d 128(A), 784 N.Y.S.2d 918 (Sup. Ct. App. T. 2nd Dept. 2003).

3. Contrary to the January 11, 2000 Opinion Letter, the courts expressly hold that a medical provider is not required to prove the medical necessity of the services rendered to the injured claimant. A.B. Med. Servs., PLLC. v. Geico, 2 Misc. 3d 26, 773 N.Y.S.2d 773 (Sup. Ct. App. T. 2nd Dept. 2003); Inwood Hill Med., P.C. v. Allstate Ins. Co., 3 Misc. 3d 1110(A), 787 N.Y.S.2d 678 (Civ. Ct., N.Y. Co. 2004).

4. A medical provider establishes its prima facie entitlement to no-fault benefits by proving the submission of statutory claim forms setting forth the fact and the amount of the loss sustained and that payment of no-fault benefits were overdue. Audobon Physical Med & Rehab, P.C. v GEICO Ins. Co., 2009 NY Slip Op 50456(U) (Sup. Ct. App. T. 2nd Dept., 11th and 13th Jud Dist 2009) (citing Insurance Law § 5106 (a); Mary Immaculate Hosp. v Allstate Ins. Co., 5 AD3d 742 (2004)); A.B. Medical Services, PLLC, et al v Country-Wide Insurance Company, 2009 NY Slip Op 50583U (Sup. Ct. App. T. 2nd Dept., 9th and 10th Jud Dist 2009) (also citing Insurance Law § 5106 (a); Mary Immaculate Hosp. v Allstate Ins. Co., 5 AD3d 742 (2nd Dept. 2004)).

5. Additional Requirements imposed by the Second Department. Notably, the Appellate Division, Second Department grafted an additional requirement regarding establishing the plaintiff's prima facie entitlement to no-fault benefits. The plaintiff must establish that the proofs of claims forms at issue are business records under CPLR 4518. See Art of Healing Medicine, P.C. v. Travelers Home & Mar. Ins. Co., 864 N.Y.S.2d 792 (2nd Dept. 2008); Dan Med., P.C. v New York Cent. Mut. Fire Ins. Co., 14 Misc 3d 44 (Sup. Ct. App. T. 2nd Dept., 2nd & 11th Jud Dists. 2006)(Appellate Term denied a claimant's motion for summary judgment, asserting that the plaintiff had not established prima facie entitlement to No-Fault benefits, as the plaintiff "failed to demonstrate that he possessed sufficient personal knowledge of plaintiff's office practices and procedures

so as to lay a foundation for the admission of the annexed documents as business records").

6. However, the Appellate Division in Viviane Etienne Medical Care, P.C. v. Countrywide Ins. Co., 114 A.D.3d 33, 45 (2nd Dept. 2013) overruled the Art of Healing Court and held that satisfaction of business record requirement to establish truth of the merits of the claim is not required. See also, Optimal Well-being Chiropractic v. Chubb Indemnity Insurance Co., 46 Misc. 3d 129(A) (Sup. Ct. App. T. end Dept. 2014) (denial of claim admitted receipt of the bills thus bills were submitted and proof of claim established); see also AR Med. Rehabilitation, P.C. v. Sate-Wide Ins. Co., 2015 NY Slip Op 50631 (U) (Kings County Civil Ct., Judge Boddie, April 27, 2015).

7. In Jamaica Med. Supply, Inc. v. Kemper Cas. Ins. Co., 30 Misc. 3d 142A (Sup. Ct. App. T. 2nd Dept. 2011), the App Term 2nd Dept. created (yet) another new prima facie requirement for medical suppliers-- i.e. delivery of supplies to the assignor.

8. The Appellate Term of the First Department always refused to follow the new standard and simply cites the prior law when restating the prima facie requirements. For example, the Court in Milman v Allstate Ins. Co., 30 Misc. 3d 128A (Sup. Ct. App. T. 1st Dept. 2010) relied on Mary Immaculate Hosp. v. Allstate Ins. Co., 5 A.D.3d 742, 742-743 (2nd Dept 2004) regarding the prima facie requirements. In pertinent part, Mary Immaculate provides: "Contrary to the defendant's contention, the plaintiff hospitals made a prima facie showing of their entitlement to judgment as a matter of law by submitting evidentiary proof that the prescribed statutory billing forms had been mailed and received, and that payment of no-fault benefits was overdue…"

9. In Fair Price Med. Supply, Inc. v. St. Paul Travelers Ins. Co., 16 Misc 3d 8, 838 NYS2d 848 (Sup. Ct. App. T. 1st Dept., 2007), the Appellate Term sustained a plaintiff's prima facie case at trial based solely on defendant's responses to plaintiff's demand for verified written interrogatories. Unlike Bajaj v. General Assurance, 18 Misc. 3d 35 (Sup. Ct. App. T. 2nd Dept., 2007), the Court in Fair Price did not require the submission of evidentiary proof of the transaction sued upon. Further, the same Court in 2010 allowed the provider to meet prima facie requirements via a Notice to Admit in Central Nassau Diagnostic Imaging PC v. GEICO, 905 N.Y.S.2d 431(Sup. Ct. App. T. 1st Dept. 2010). Clearly, the Appellate Terms disagree over this point.

C. Burden of Proof

1. Once plaintiff has submitted Proof of Claim to a carrier, carrier-defendant must then come forward with evidence of a deficiency or a claimed defect in the forms and preserve said defense in a timely denial of claim, or such defense shall be waived. Presbyterian Hospital v. Aetna Casualty &

Surety Co., 658 NYS2d 245 (2nd Dept 1997); Quality Medical Healthcare, P.C. v. Lumberman's Mutual Casualty Co., (Sup. Ct. App. T. 1st Dept. 2002); Park Health Center v. Eveready Ins. Co., 2001 NY Slip Op 40665(U) (Sup. Ct. App. T. 2nd Dept. 2001); see also Fair Price Medical Supply Corp. v. Travelers Indem. Co., 10 N.Y.3d 556, 890 N.E.2d 233 (2008); Hospital for Joint Diseases v. Travelers Property Casualty Ins. Co., 9 N.Y.3d 312 (2007).

2. Under the no-fault laws, the issue of medical necessity is a matter for the defendant to plead and prove as a defense (i.e. to prove that the services were medically unnecessary.) That rule is consistent with the remedial nature of the no-fault laws, which are intended to "assure that every auto accident victim will be compensated for substantially all of his (or her) economic loss, promptly, and without regard to fault." Hernandez v Aetna Casualty and Surety Co., 146 Misc. 2d 938, 553 N.Y.S.2d 633 (Civ. Ct., New York County, 1990). Vinings Spinal Diagnostic, P.C. v Liberty Mutual Insurance Company, 186 Misc. 2d 287, 717 N.Y.S.2d 466 (2000), citing Central General Hospital v Chubb Group, 228 A.D.2d 406, 643 N.Y.S.2d 654 (2nd Dept., 1996). Defendant that failed to submit any proof supporting basis for denial, including the independent medical examination report upon which denial was based, failed to establish lack of medical necessity of the services. NJ/NY Pain Management v. Allstate Insurance Company, 3 N.Y.S.3d 285 (Sup. Ct. A.T. 2nd Dept. 2014).

3. **IIP PRACTICE TIP:** NJ/NY Pain language is very powerful: "In the absence of 'evidentiary facts' showing that a 'bona fide' issue exists as to the medical necessity of the services here at issue, plaintiff's cross motion for summary judgment was properly granted." See Id. In other words, issuing a denial of claim form is not enough for the insurer to establish the insurer's defense/meet the burden of proof.

4. Placing the burden of proof upon the insurance carrier is also consistent with the Appellate Division's decision in Mount Sinai Hospital v. Triboro Coach Inc., 263 A.D.2d 11, 19, 699 N.Y.S.2d 77, 83 (2nd Dept., 1999) wherein the Court specifically rejected the carrier's claims that the claimant bears the burden of proof.

5. Logically, then, the defendant has the burden to come forward with proof in admissible form to establish "the fact" or the evidentiary "foundation for its belief" that the patient's treated condition was unrelated to his or her automobile accident (Central Gen. Hosp. v. Chubb Group of Ins. Cos., supra; compare CPLR 3215; CPLR 317, 5015(a)(1)).

> Notwithstanding Triboro's repeated arguments to the contrary, it would not be reasonable to insist that a plaintiff hospital must prove as a threshold matter that its patient's condition was "caused" by the automobile accident and was unrelated to his/her entire previous medical history. The policy concerns underlying the no-

> fault legislation would thereby be undermined, and insurers would be motivated to refrain from issuing timely disclaimers in order to impose such an onerous threshold burden upon claimants.

Mount Sinai Hospital v. Triboro Coach Inc., supra.

D. Most defenses are limited to those issues preserved in a timely valid Denial of Claim form.

1. State Farm Insurance Company v. Domotor, 226 A.D.2d 219, 697 N.Y.S.2d 348 (2nd Dept., 1999) ("(t)he insurance carrier must stand or fall upon the defense upon which it based its refusal to pay.")

2. King v. State Farm, 218 A.D.2d 863, 630 N.Y.S.2d 397 (3rd Dept., 1995) (No-Fault carrier must "stand or fall upon the defense upon which it based its refusal to pay.")

3. Government Employees Insurance Co v. Concord Orthopedic Supply, Inc., Index No. 123363/98 (Supreme Court, New York County, June 8, 1999)(Upholding a master arbitrator's finding that "(a)n award which denies benefits on grounds not raised by the insurer in its denial of claim is incorrect as a matter of law.")

4. Subia v. Cosmopolitan Mutual Insurance Company, 80 Misc.2d 1090, 364 N.Y.S.2d 118 (Supreme Ct, Queens Cty, 1975) (Defense stricken from answer where it was not raised in the denial of claim.)

5. The Appellate Division long ago rejected the insurer's switching of defenses as follows:

> If an insurance company refuses to pay a loss under a fire insurance policy on the ground that the insured had caused the loss by his own act of arson, it must justify its refusal upon the ground put forward by it. The insured may sue the company at once and put it to its proof. The insurance company must then stand or fall upon the defense upon which it based its refusal to pay. It may not thereafter attempt to create other grounds for refusal to pay by demanding compliance by the insured with other incidental provisions of the policy with which it had not demanded compliance prior to its repudiation of liability.
>
> (Beckley v. Otsego County Farmers Coop., 3 A.D.2d 190, 194 (3rd Dept. 1957)

E. The Rule of Preclusion

1. The rules of law emerging from the Courts are as follows: An untimely (not within 30 days of receipt by the carrier) denial precludes the carrier from preserving the defense contained in the denial of the claim with few exceptions. Medical necessity is a defense to be raised by the Defendant

and subject to preclusion. Consequently, if medical necessity is raised in an untimely denial, the Defendant is precluded from denying the claim and therefore challenging the adequacy of Plaintiff's demonstration of medical necessity (i.e. the Plaintiff's prima facie case). Accordingly, the Plaintiff's prima facie burden is satisfied by the mere submission of the statutory forms of proof of claim.

2. The Thirty-Day Rule: No-fault benefits are overdue if not paid within 30 days. An insurer's failure to pay or deny a claimant's claim with thirty days of its receipt results in the insurer being precluded from denying the claim. The insurer's time may be tolled when it makes certain timely requests for additional verification. A timely request restarts the 30-day clock in which to pay or deny the claim. The carrier shall have 30-days from the time in which it receives the verification response to issue payment or issue its denial. With respect to an Examination Under Oath or Independent Medical Examination, the all verification is deemed to have been received on the day in which the examination was held. 11 NYCRR 65-3.8 (a)(1)

3. Presbyterian Hospital v. Maryland Casualty Co., 90 N.Y.2d 274, 660 N.Y.S.2d 536 (1997): The Court of Appeals adopted the Appellate Division's holding that "**preclusion of the insurance company's ability to deny the claim** is the appropriate remedy where…the insurance company neither denies a claim within 30 days after receiving it nor seeks to extend that time by requesting verification in the prescribed forms." (Emphasis added).

4. NY and Presbyterian Hospital v. Empire Insurance Co, 728 NYS2d 684 (2nd Dept 2001): Carrier is precluded from raising defense that proof of claim was not submitted within 180 days from services. This would also now apply to the 45-day regulation.

5. Insurer precluded from raising any affirmative defenses to the claim, including lack of medical necessity. East Cost Acupuncture, P.C. v. N.Y. Cent. Mut. Ins., 18 Misc. 3d 139(A), 859 N.Y.S.2d 894 (Sup. Ct. App. T. 2nd Dept. 2d and 11th Jud. Dists. 2008).

6. April, 2013 Amendment provides that no payment is due "under any circumstances" when the services were not provided or when the claimed fees exceed permissible fee schedule. 65-3.8 (g)(1).

7. Courts in the past have held that fee schedule discrepancies are subject to preclusion: The defense that the charges were not submitted in accordance with the fee schedule is subject to preclusion if not interposed in a timely denial of claim: New York Hosp. Med. Ctr. of Queens v. Country-Wide Ins. Co., 295 A.D.2d 583, 586 (2nd Dept. 2002) (defense based on claimant's alleged use of an incorrect billing code precluded by an untimely denial); Rigid Med. of Flatbush, P.C. v. New York Cent. Mut. Fire Ins. Co., 11 Misc.3d 139(A), 2006 N.Y. Slip Op 50582(U) (Sup. Ct.

App. T. 2nd Dept. 2006) (defense based on "nonconformity with the Worker's Compensation fee schedules" precluded); S & M Supply Inc. v. Progressive Ins. Co., 8 Misc.3d 138(A), 2005 N.Y. Slip Op 51312(U) (Sup. Ct. App. T. 2nd Dept. 2d & 11th Jud Dists 2005) (defense, "in effect, of excessive charges" precluded); Benson Med., P.C. v. Progressive Northeastern Ins. Co., 12 Misc.3d 144(A), 2006 N.Y. Slip Op 51427(U) (Sup. Ct. App. T. 2nd Dept. 2d & 11th Jud Dists 2006)(untimely denial of claim precludes defense based on application of fee schedules to specific services provided); AVA Acupuncture, P.C. v. New York Central Mutual Fire Insurance Company, 13 Misc.3d 140(A), 831 N.Y.S.2d 351 (Sup. Ct. App. T. 2nd Dept. 2d & 11th Jud Dists 2006) ("Since defendant failed to establish that it timely denied plaintiff's claims, it is precluded from asserting its defenses of lack of medical necessity and that the fees charged by plaintiff were excessive (see Presbyterian Hosp. in City of N.Y. v. Maryland Cas. Co., 90 N.Y.2d 274 (1997)").

8. Now, in the post-amendment world, fee schedule may be raised at any time. See Saddle Brook Surgicenter, LLC v. Allstate Insurance Co., 2015 Slip Op 25099, (Bronx Civil Ct. 2015) (*citing* to 65-3.8 (g)(1).

   Comment: Although, the defense is not precluded, insurer still has burden of proof that the fee schedule amount is incorrect. NJ/NY Pain ,supra, (insurer must proffer evidence showing *bona fide* issue).

9. Similarly, Courts in the past have held that alleged billing fraud is a precluded defense. See Fair Price Medical Supply Corp. v. Travelers Indem. Co., 10 N.Y.3d 556 (2008): Court of Appeals held that allegations of billing fraud are precluded. Under Fair Price, even assuming a provider bills for medical supplies that were never provided (or, by inference, bills for medical services that were never provided) the defense that the supplies were not provided (or, by inference, that the services were never rendered) is subject to the rule of preclusion if not set forth in a timely denial of claim form. Of course, "lesser" forms of billing fraud are also subject to preclusion under Fair Price. See for example Valley Psychological, P.C. v. Liberty Mutual Ins. Co., 290 N.Y.S.2d 987 (3rd Dept. 2007) (relying upon Court of Appeal's 1997 no-fault decisions in determining that the rule of preclusion is applicable to no-fault billing fraud); Country-Wide Ins. Co. v. Zablozki, 684 N.Y.S.2d 229 (1st Dept.1999); LMK Psych. Serv. P.C. v. Liberty Mut. Ins. Co., 816 N.Y.S.2d 587 (3rd Dept. 2006); Bonetti v. Integon Nat. Ins. Co., 703 N.Y.S.2d 217 (2nd Dept.2000); Triangle R. Inc. v Progressive Ins. Co. 2012 NY Slip Op 51685(U) (App. T., 1st Dept 2012).

10. Like fee schedule, pursuant to 65-3.8 (g) (1), allegations that the services were not rendered is no longer subject to preclusion, but again remember that the insurer still has the burden of proof.

F. The "Exceptional Exceptions" to preclusion

1. Central General Hospital v. Chubb Group of Ins. Co., 90 N.Y.2d 195 (1997): The Court of Appeals carved out a narrow exception to the 30-day rule by holding that the issue of "lack of coverage" is not subject to preclusion despite an untimely denial. Defendant has burden to establish, through admissible form, the premise based upon well-founded facts (not speculation) that the exception applies. See Mt. Sinai Hospital v. Triboro Coach Inc., 263 A.D.2d 11 (2nd Dep't 1999).

    a) Note, again, it is NOT plaintiff's burden to show that the injuries sustained in the automobile accident are causally related. The court held "[T]he insurer has the burden to come forward with proof in admissible form to establish "the fact" or "a founded belief" that the alleged injury did not arise out of an insured incident." Id. In fact, you can cite to this case when insurers try to shift the burden of improper fee schedule and fraudulent billing to the claimant (in addition to the NJ/NY Pain case).

2. State Farm Ins. Co. v. Mallela, 4 N.Y. 3d 313 (2005): Carrier can withhold no-fault reimbursement to a health care provider that is not incorporated in accordance with NY Business Corporation Law § 1507. Such inquiries, however, are limited solely to situations where there exists "good cause" to do so. Note that Mallella ineligibility grounds are limited to filing fraudulent licensure documents and to incidents of non-physicians running aspects of the practice. See, e.g., H & H Chiropractic Servs., P.C. v. Metropolitan Prop. & Cas. Insurance Co., 2015 NY Slip Op 25132 (Queens Civil Court, Judge Love, April 24, 2015) (noting that fee splitting between medical provider and third party billing company is not a Malella ineligibility defense available to insurers in a no-fault action).

3. Notably, the staged accident "fraud" defense differs from a "billing fraud" defense[1]—when carriers raise a billing fraud defense, they typically do not take issue regarding whether the assignor was injured in a legitimate automobile accident and sought treatment from the assignee with respect to injuries suffered therein. Intentional Act. A staged accident is different from a suicide attempt. Nyack Hosp. v. Allstate Ins. Co., 84 A.D.3d 1331, 84 A.D.3d 1331, 923 N.Y.S.2d 890 (2nd Dept. 2011). (Defendant's defense that the injuries were caused by the driver's intentional act in an attempt to commit suicide was precluded due to the carrier's failure to issue a timely denial of claim form.)

[1] A carrier's fraud related defense must be established through admissible evidence. Unsupported conclusions and "suspicions" as well as "unsubstantiated hypotheses and suppositions" are insufficient to raise a triable issue of fact. See, A.B. Medical Services PLLC v Eagle Ins. Co., 3 Misc 3d 8, 776 NYS2d 434 (2d Dept 2002); A.B. Medical Services PLLC v Lumbermen's Mutual Casualty Co., NYLJ, September 30, 2003, at 17, col 1(Civ Ct Kings County, Schack, J.); Bonetti v Integon National Ins. Co., 269 AD2d 413, 703 NYS2d 217 (2d Dept 2000); Melbourne Medical, P.C. a/a/o Cabreja v Utica Mutual Ins. Co., 4 Misc.3d 92, 781 N.Y.S.2d 819 (App Term 2d & 11th Jud Dists, 2004).

4. "Priority of payments" (i.e. between No-Fault insurers) is NOT a "coverage" defense. M.N. Dental Diagnostics PC v GEICO, 81 A.D.3d 541, 916 N.Y.S.2d 598 (1st Dept. 2011).

5. Exhaustion of limits is a coverage defense that need not be preserved in a timely denial of claim form. New York and Presbyterian Hospital v. Allstate Ins. Co., 12 A.D.3d 579 (2nd Dept. 2004); Allstate Ins. Co. v DeMoura, 30 Misc.3d 145(A), 926 N.Y.S.2d 342 (Table) (Sup. Ct. App. T. 1st Dept. 2011).

6. Independent Contractor. Allegation that the services billed for are not reimbursable pursuant to 65-3.11(a) as they were rendered by an independent contractor and not the billing provider is now a precluded defense if not preserved in timely denial. A.M. Medical Services v. Progressive Casualty Insurance Co., 101 A.D.3d 53, 65 (2nd Dept. 2012). Note that the Appellate Division disagreed with the Appellate Term which held previously that the independent contractor defense was not a defense subject to waiver. A.M. Med. Servs., P.C. v. Progressive Casualty Insurance Co., 22 Misc. 3d 70, 72, 877 N.Y.S.2d 633 (2008).

7. Failure to appear at IME.

   a) First Department: Not Subject to Preclusion.

      (1) Unitrin Advantage Ins. Co. v Bayshore Physical Therapy, PLLC, 82 AD3d 5 (1st Dept. 2011), lv. Denied 17 NY 3d 705 (2011).

   b) Second Department: Subject to Preclusion.

      (1) Eastern Star Acupuncture, P.C. v American Tr. Ins. Co., 2011 NY Slip Op 52205(U) (33 Misc 3d 141(A)) (Sup. Ct. App. T. 2nd Dept. 2011). Since defendant did not deny this claim based upon the failure of plaintiff's assignor to appear for the IMEs, this defense is precluded with respect to this claim (see Presbyterian Hosp. in City of NY v Maryland Cas. Co., 90 NY2d 274, 286 (1997); Westchester Med. Ctr. v Lincoln Gen. Ins. Co., 60 AD3d 1045 (2nd Dept 2009); but see Unitrin Advantage Ins. Co. v Bayshore Physical Therapy, PLLC, 82 AD3d 559 (1st Dept 2011).

G. Workers Compensation:

1. No-Fault coverage is secondary to Workers Compensation coverage.

   a) The Workers Compensation Board has primary jurisdiction to resolve the question of coverage. Liss v Trans Auto Sys., 68 NY2d 15, 21 (1986); LMK Psychological Serv., P.C. v American Tr. Ins. Co., 64 AD3d 752 (2nd Dept. 2009)).

b) Appellate Term has been ordering applicants to make a prompt application to the board. A.B. Med. Servs., PLLC v American Tr. Ins. Co. 2012 NY Slip Op 51505(U) (36 Misc 3d 142(A)) (Sup. Ct. App. T. 2nd Dept. 2012).

c) More than "mere speculation" must support application for dismissal of No-Fault action in favor of workers compensation. A.B. Med. Servs. PLLC v. Am. Transit Ins. Co., 801 N.Y.S.2d 776 (Sup. Ct. App. T. 2nd Dept. 2005).

d) Workers Compensation applicability is an offset and not a coverage defense exempted from the rule of preclusion. Westchester Med. Center v Lincoln General Ins. Co, 60 A.D.3d 1045, 877 N.Y.S.2d 340 (2nd Dept. 2009). Further, the position must be supported by more than hearsay.

H. Discovery

1. Discovery is limited to preserved or non-precludable unpreserved defenses.

a) It is palpably improper to order discovery on unpreserved defenses. Triangle R. Inc. v Progressive Ins. Co. 2012 NY Slip Op 51685(U) (Sup. Ct. App. T. 1st Dept. 2012). The Triangle Court held:

> The defendant-insurer's notice of deposition—pertaining to its defense of provider fraud based on fraudulent billing practices—was palpably improper (see Dhue v Midence, 1 AD3d 279 (1st Dept. 2003)), since defendant is precluded from raising this defense due to its failure to timely deny plaintiff's no-fault first-party claim within the 30-day statutory period (see Fair Price Med. Supply Corp. v Travelers Indem. Co., 10 NY3d 556, 565 (2008)). This is so irrespective of defendant's claim that the fraudulent billing was part of a widespread scheme to defraud insurers (see Fair Price Med. Supply Corp. v Travelers Indem. Co., 42 AD3d 277, 285 (2nd Dept. 2007), affd 10 NY3d 556 (2008)). Id.
>
> Note: Under 2013 Amendment, allegations that services were not rendered are not precluded, but case may still be used for the premise that discovery may only be ordered for preserved defenses subject to waiver.

b) It is also improper for a court to order plaintiff to produce a medical witness for a deposition when the defense is staged accident. Flatlands Med., P.C. v Allstate Ins. Co. 2012 NY Slip Op 50582(U) (35 Misc 3d 127(A)) (Sup. Ct. App. T. 2nd Dept. 2012).

I. Summary Judgment Issues

1. Prima Facie (discussed above in IV (A.))

2. Proof of Mailing

a) Timely mailing maybe established by submitting an affidavit from "...an employee with knowledge of the (party's) standard office practices and procedures designed to ensure that items were properly addressed and mailed (citations omitted)." St. Vincent's Hospital of Richmond v. Government Employee's. Ins. Co., 50 A.D.3d 1123 (2nd Dept. 2008).

b) Specifically, in Delta Diagnostic Radiology, P.C. v. Chubb, 847 NYS2d 322 (Sup. Ct. App. T. 2nd Dept., 11th & 13th Jud. Dists 2007) the Appellate Term expressly limited its determination in Contemporary as follows:

> Rather, as the Appellate Division has repeatedly noted, it is sufficient for the affiant to set forth that he or she possessed personal knowledge that the mailing occurred or describe the standard office practice or procedure used to ensure that items were properly addressed and mailed (see e.g. New York & Presbyt. Hosp. v. Allstate Ins. Co., 29 A.D.3d 547, 814 N.Y.S.2d 687 (2nd Dept. 2006); Residential Holding Corp. v. Scottsdale Ins. Co., 286 A.D.2d 679, 729 N.Y.S.2d 776 (2nd Dept. 2001), supra; Hospital for Joint Diseases v. Nationwide Mut. Ins. Co., 284 A.D.2d 374, 726 N.Y.S.2d 443 (2nd Dept. 2001)).(Id.) (emphasis added).

c) The mere denial by plaintiff's medical biller of receipt of the verification requests did not overcome the presumption that proper mailing had occurred and that plaintiff had received the verification requests. Nassau Ins. Co. v Murray, 46 N.Y.2d 828, 414 N.Y.S.2d 117 (1978).

d) The Appellate Term First Department now agrees with the Second Department and also does not require the proof of mailing affiant to be the individual tasked with ensuring compliance with mailing procedures. As the Court provided in Lenox Hill Radiology, P.C. v. Tri-State Consumer Ins. Co., 919 NYS2d 755 (Sup. Ct. App. T. 1st Dept. 2010):

> The witness's credible and consistent account of the mailing procedures generally followed by defendant, including how the mail was systematically picked up during the work day, when it would "go out," and what steps would be taken if a verification letter was returned as

undeliverable (an event which, the witness noted, did not occur here), "obviated the necessity of producing a witness with personal knowledge of the actual mailing" of defendant's verification letters (see Badio v Liberty Mut. Fire Ins. Co., 12 AD3d 229, 230 (1st Dept. 2004)). Nor was it incumbent upon defendant to produce a witness, such as a mail clerk or other clerical employee, whose duty it was to ensure compliance with its mailing procedures or who possessed personal knowledge of such compliance**.**

3. Medical Necessity

a) The insurer makes a prima facie showing of its entitlement to summary judgment dismissing the complaint by establishing that it had timely denied the claims on the ground of lack of medical necessity (see Residential Holding Corp. v Scottsdale Ins. Co., 286 AD2d 679 (2nd Dept. 2001); Delta Diagnostic Radiology, P.C. v Chubb Group of Ins., 17 Misc 3d 16 (Sup. Ct. App. T. 2nd Dept. 2d & 11th Jud Dists 2007)), and by submitting an affirmed peer review report from its doctor setting forth a factual basis and medical rationale for his conclusion that the services rendered were not medically necessary (see Delta Diagnostic Radiology, P.C. v Integon Natl. Ins. Co., 24 Misc 3d 136(A) (App Term, 2d, 11th & 13th Jud Dists 2009); Delta Diagnostic Radiology, P.C. v American Tr. Ins. Co., 18 Misc 3d 128(A), 856 N.Y.S.2d 23 (App Term, 2d & 11th Jud Dists 2007); A. Khodadadi Radiology, P.C. v NY Cent. Mut. Fire Ins. Co., 16 Misc 3d 131(A) (Sup. Ct. App. T. 2nd Dept., 2d & 11th Jud Dists 2007)).

b) A conclusory peer review does not meet the insurer's prima facie burden for summary judgment in the first instance. See Devonshire Surgical Facility, Carnegie Hill Orthopedic Servs., P.C. v American Tr. Ins. Co., 2011 NY Slip Op 50513(U)(Sup. Ct. App. T. 1st Dept. 2010)("Even assuming that defendant issued timely denials of plaintiffs' claims (see Country-Wide Ins. Co. v Zablozki, 257 AD2d 506 (1st Dept. 1999), lv denied 93 NY2d 809 (1999)), the peer review report relied upon by defendant to deny plaintiffs' claims is conclusory and fails to set forth sufficient facts to raise triable issues with respect to its defense of lack of medical necessity (see East Coast Acupuncture Servs., P.C. v American Tr. Ins. Co., 14 Misc 3d 135(A), 2007 NY Slip Op 50213(U)(2007))."); Pomona Med. Diagnostics, P.C. v GEICO Ins. Co., 2011 NY Slip Op 50276(U)(App. Term 1st Dept. 2011)("(t)he report of defendant's peer review doctor, which relied on the assignor's medical records , raised a triable issue of fact as to whether the services provided by plaintiff were medically necessary. Contrary to defendant's contention, however, its submissions did not conclusively establish as a matter of law its

defense of lack of medical necessity, and its cross motion was properly denied"); Cf Enko Enters. Intl., Inc. v Clarendon Natl. Ins. Co., 30 Misc. 3d 127A (App. Term 1st Dept. 2011)("Defendant demonstrated, through the affirmed peer review report of a physician, that the medical supplies plaintiff-provider afforded to its assignor were not medically necessary (*see generally CPT Medical Services, P.C. v New York Cent. Mut. Fire Ins. Co.*, 18 Misc 3d 87 (2007)).

c) Additional Requirement imposed by 2nd Dept.

(1) Appellate Term in the Second Department imposes an additional requirement: To rebut a prima facie showing of lack of medical necessity, the plaintiff must submit the affidavit of an expert that refers to, or discusses, the determination of defendant's doctor. Pan Chiropractic, P.C. v Mercury Ins. Co., 897 N.Y.S.2d 671 (App Term, 2d, 11th & 13th Jud Dists 2009). The Appellate Term, First Department, has NOT followed this decision.

4. Expert Testimony: Courts generally require some showing that the affiant qualifies as an expert before accepting opinion testimony. Price v. New York City Housing Auth., 92 N.Y.2d 553 (1998); Caprara v. Chrysler Corp., 52, N.Y.2d 114, rearg. dnd. 52 N.Y.2d 1073 (1981); Meiselman v. Crown Heights Hospital, 285 N.Y. 389 (1941). To qualify as an expert, the witness must possess "...the requisite skill, training, education, knowledge or experienced from which it can be assumed that the information imparted or the opinion rendered is reliable (citations omitted)." Matott v. Ward, 48 N.Y.2d 455, 460 (1979); De Hernandez v. Lutheran Medical Center, 46 A.D.3d 517 (2nd Dept. 2007).

a) Different standard imposed by 2nd Dept.: However, the Appellate Term (9th and 10th) relieved this burden, at least where the provider failed to lodge a timely objection, by allowing a neurologist to establish lack of medical necessity of chiropractic treatment. See Vining Spinal Diagnostic, P.C. v. Geico General Ins. Co., 29 Misc.3d 132(A) (Sup. Ct. App. T. 2nd Dept. Dists. 2010) (neurologist peer addresses chiropractic treatment).

5. Admissibility of Medical Records:

a) Plaintiff may not challenge the reliability of its own medical records. Urban Radiology, P.C. v Tri-State Consumer Ins. Co., 27 Misc 3d 140(A), 911 N.Y.S.2d 697, 2010 NY Slip Op 50987(U) (App Term, 2d, 11th & 13th Jud Dists 2010)

6. Records Relied Upon By The Expert: In the general law pertaining to the lack of medical necessity defense, the movant must provide the court with copies of the medical records the expert reviewed and relied upon in

rendering an opinion. See Whylie v. Con Edison, Inc., 79 A.D.3d 739 (2nd Dept. 2010); Cariddi v. Hassan, 45 A.D.3d 516 (2nd Dept. 2007). Further, an expert's opinion must be based upon facts either personally known to the expert or facts in the record. Opinion testimony for matters outside personal knowledge or in the record must be based upon facts that are generally relied upon by the profession in general. *Prince-Richardson On Evidence* §7-308. Evidence that the out-of-court reports are reliable to fall in this exception. Wagman v. Bradshaw, 292 A.D.2d 84 (2nd Dept. 2002). (MRI report was not shown to be reliable in order to allow expert to base opinion on said report). Note in Wagman, the underlying MRI films were not produced.

a) However, the Appellate Term (9th and 10th Jud Dists) effectively countermanded these principals in the No-Fault realm in Elmont Open MRI & Diagnostic Radiology, P.C. v. New York Cent. Mut. Fire Ins. Co., 30 Misc. 3d 126A (App. Term 9th & 10th Jud. Dists. 2010).

7. Defects in Proof: Even though the failure to make such prima facie showing requires a denial of a motion for summary judgment, regardless of the sufficiency of the opposing papers (Alvarez v. Prospect Hospital, 68 N.Y.2d 320 (1986)), the Appellate Term for the Second Department has overlooked such defects:

a) Summary judgment granted on an improperly affirmed chiropractors report absent objection by opposing party. Continental Medical, PC v. Mercury Casualty Co, 22 Misc.3d 134(A) (App. Term 2nd, 11th & 13th Jud. Dists. 2010).

b) Also note how the Court recently dealt with CPLR 2106 barring a chiropractor from submitting an affirmation instead of an affidavit in Auto One Insurance Co. v. Hillside Chiropractic, P.C., 126 A.D.3d 423 (1st Dept. 2015). The Court vacated an arbitrator's award on the basis that rejection of affirmed chiropractor's report was improper due to relaxed rules of evidence in arbitration. Also note that holding is contrary to the discretion arbitrators are afforded by regulation when accepting and rejecting evidence. The arbitrator "shall be the judge of the relevance and materiality of the evidence offered, and strict conformity to the legal rules of evidence shall not be necessary." 11 NYCRR 65-4.5.

c) No requirement to establish the admissibility of medical records, since they are being admitted for the non-hearsay purpose. Medical Associates, P.C. v. Interboro Ins. Co., 34 Misc.3d 154(A), Slip Copy, 2012 WL 762579 (Table), N.Y.Sup. App. Term, 2012. ("The purpose of the peer review report submitted by defendant was not to attempt to prove that plaintiff's assignor was injured as documented in her medical records, or that she was treated as set

forth in those records, but to establish that, assuming the facts set forth therein were true, the treatment allegedly provided by plaintiff was not medically necessary.")

d) In Active Imaging, P.C. v Progressive Northeastern Ins. Co, 918 N.Y.S.2d 396 (App. Term 2d Dept. 2010), the Appellate Term of the 2nd, 11th and 13th Judicial Districts came to a similar conclusion by simply determining that the medical records relied upon by the insurer's peer are not a portion of the insurer's "prima facie showing."

Plaintiff contends that defendant failed to establish its prima facie entitlement to summary judgment since, although defendant's peer review doctor listed the medical reports and/or records of third parties that he had reviewed in reaching his conclusion that the services rendered were not medically necessary, defendant failed to annex to its moving papers copies of these documents. We reject this contention since these reports and records are not part of defendant's prima facie showing. We note that, pursuant to CPLR 3212 (f), a court has discretion to deny a motion for summary judgment or order a continuance to permit affidavits to be obtained or disclosure to be had, if "facts essential to justify opposition may exist but cannot then be stated." However, plaintiff failed to "put forth some evidentiary basis to suggest that discovery might lead to relevant evidence" … and the "mere hope" that discovery will uncover the existence of a material issue of fact is insufficient to delay a summary judgment determination… id.

8. Fee Schedule: The same court that holds that the medical record relied upon by the peer review doctor need not be included in the motion, ruled in Megacure Acupuncture, P.C. v Clarendon Natl. Ins. Co. 2011 NY Slip Op 52199(U) (33 Misc 3d 141(A)) (App Term, Second Dept 2011), that the relevant portion of the fee schedule must be annexed to a motion for summary judgment based upon a fee schedule reduction.

9. Misrepresentation: Jamaica Dedicated Med. Care PC v. Praetorian Insurance Co., 2015 NY Slip Op. 50605(U) (Sup. Ct. AT 2nd Dept. April 16, 2015). Allegation that insured lied about his address in procuring the policy was unsupported as defendant's summary judgment motion relied upon investigative report containing inadmissible hearsay.

J. Trial Practice

1. Admissibility of Transcripts: It is an abuse of discretion for trial court not to allow party to introduce the transcript of a physician taken pursuant to CPLR 3117(a)(4) Infinity Health Prods., Ltd. v Unitrin Advantage Ins. Co., 36 Misc.3d 142(A), Slip Copy, 2012 WL 3240128 (Table)(App. Term 2d Dept. 2012).

2. Substitute Peer: While the carrier is limited to the medical rationale and reasoning contained in the peer report supporting the initial denial, it is error to prevent the carrier from calling a different expert at trial so long as his testimony is limited to the reasoning articulated in the original report. Metropolitan Med. Supplies, LLC v GEICO Ins. Co., 2012 NY Slip Op 51490(U) (36 Misc 3d 141(A)), Appellate Term, Second Department.

3. The use of a Notice to Admit, Interrogatories and other Admissions to establish the plaintiff's prima facie case is an accepted practice in First Department. See Central Nassau Diagnostic Imaging, P.C. v. GEICO, 905 N.Y.S.2d 431, 433 (Sup. Ct. A.T. 1st Dept.). In contrast, the Appellate Term for the Second Department has held that a plaintiff cannot establish that its claims forms are business records via a notice to admit-- even if the carrier admits to the authenticity of said claims forms, the plaintiff must establish that is claims forms are business records under CPLR 4518. Bajaj v General Assur., 2007 NY Slip Op 27487 (App Term, 2nd and 11th Jud Dists 2007) (leave to appeal denied).

   Comment: Viviane Etienne Medical Care, P.C. c. Countrywide Ins. Co., 114 A.D.3d 33, 45 (2nd Dept. 2013), did away with requirement to establish the claim forms as business records so it would seem that use of Notice to Admit to establish prima facie case may be permissible.

   Also, Notice to Admit may only be used to dispose of matters "as to which the party requesting the admission reasonably believes there can be substantial dispute at trial" CPLR 3123(a). Thus, insurers may not use Notice to Admit to establish the assignor failed to appear at IME's. See Excel Imaging, PC v. Encompass Insurance Co., Queens Civil Court, Index No. 087594/09 (Hon. Ulyesses B. Leverett).

4. Third Party Billing

   a) In New York Hospital Medical Center of Queens v. Country Wide Ins. Co., 82 A.D.3d 723, 917 N.Y.S.2d 322 (2nd Dept. 2011) the Appellate Division determined that the hospital provider appropriately proved its claims forms as business records through the testimony of an employee of a third-party billing company.

   b) In contrast, the Appellate Term, 2nd Department has, thus far, refused to allow any third-party biller to prove up the provider's medical records. See e.g., Viviane Etienne Medical Car, P.C. v. Countrywide Ins. Co., 2011 NY Slip Op 21039 (App. Term 2nd, 11th & 13th Jud. Dists. 2011)(plaintiff denied summary judgment because the affidavit of a third party medical biller was insufficient to establish claim forms and bill were business records); Carothers v GEICO Indem. Co., 29 Misc. 3d 126A (App. Term 2nd, 11th & 13th Jud. Dists 2010).

5. Collateral Estoppel: The results of trial for one period of treatment are not binding for other post-IME treatments. Huntington Med. Plaza, P.C. v Travelers Indem. Co. 2011 NY Slip Op 21471 (34 Misc 3d 874) (2011) "There is no case law of which this court is aware that makes an IME's finding conclusive as to all post-IME treatment, that is, on the basis of a previous finding that there is no medical necessity for any other post-IME treatments not previously litigated."

K. Attorney fees (11 NYCRR 65-4.6):

1. Prior to February 4, 2015 Amendment: In addition to the interest penalty described above, a claimant is also entitled to recover attorney's fees where a "valid claim or portion" was denied or overdue. Insurance Law §5106(a). In this regard, once a lawsuit has been commenced, 11 NYCRR 65-4.6(2)(e) provides that attorneys' fees shall be "20 percent of the amount of first-party benefits, plus interest thereon, awarded by the arbitrator or court, subject to a maximum fee of $850."[2]

2. 11 NYCRR 65-4.6(b)(1) increased the attorney fee from $60 to $80 for denied claims resolved by the Conciliation center AAA prior to a hearing.

3. However, if the claim was simply overdue, but not denied, the attorney fee remains $60.

4. Recent Amendment to Regulation: For matters commenced after February 3, 2015, there is no longer a minimum attorney fee. Maximum attorney fee increased to $1,360.00. 65-4.6 (b) and (d).

5. Under the former Regulation and 2015 Amendment: if the issue involves a policy issue as enumerated on the denial of claim form, the attorney can receive a fee for up to $70.00 an hour, subject to a maximum of $1,400.00, along with an additional $80.00 per appearance. 11 NYCRR 65-4.6 (c), formerly 65-4.6 (d) (1) & (2). Under both Regulations, if a dispute is deemed "novel or unique in nature as to require extraordinary skills or services" an arbitrator or court may award fees in excess of the limitations enumerated in 65-4.6.

6. LMK Psychological Services P.C. v. State Farm Mutual Automobile Insurance Co., 12 N.Y.3d 217 (2009). - Court of Appeals held attorney fees are to be calculated based upon aggregate of bills for each injured party, rather than a per claim basis.

V. ARBITRATION

[2] Smithtown General Hosp. v. State Farm Mut Ins Co., 207 A.D.2d 338, 615 N.Y.S.2d 426 (2nd Dept., 1994), See also, Hempstead Gen Hosp v. Insurance Company of North America, 208 A.D.2d 501, 617 N.Y.S.2d 478 (2nd Dept.,1994). Deepdale General Hospital v. American Colonial Ins. Co., 142 Misc.2d 115, 535 N.Y.S2d 876 (Dist Ct. Nassau Cty, 1988) aff'd 144 Misc.2d 917, 550 N.Y.S.2d 526 (App Term, 2nd Dept., 1989).

1. The emergency amendments revised the way in which supporting documents are to be submitted by the parties. The Applicant must submit all documents supporting its position along with its request for arbitration. Following this initial submission, "no additional documents may be submitted by the applicant other than bills or claims for ongoing benefits." 11 NYCRR 65-4.2 (b)(3)(i). The Respondent has 30 days to provide its documents after which time the "written record shall be closed." 11 NYCRR 65-4.2(b)(3)(ii) & (iii).

2. The amendments also allow for a quicker scheduling of hearings in situations where the Applicant files promptly. Accordingly, an Applicant filing for arbitration within 90 days after a claim is denied or overdue shall have a hearing scheduled within 45 days after transmittal from the conciliation center. 11 NYCRR 65-4.2(i)(ii).

3. A more significant amendment pertains to the imposition of costs. An arbitrator is permitted to impose administrative costs upon the applicant or apportion them between the parties if the arbitrator determines that the Applicant's request "was frivolous, was without factual or legal merit or was filed for the purpose of harassing the Respondent." 11 NYCRR 65-4.2(t)(i).

4. 11 NYCRR 65-4.5 The regulations allows disputes submitted to AAA that involve less than $2000 to be determined upon the written submission of the parties.

5. 11 NYCRR 65-4.5(o)(1) greatly increases the power of an arbitrator to raise any issue or demand any information they feel necessary to adjudicate the matter.

6. 11 NYCRR 65-4.6(b)(1) increases the attorney fee from $60 to $80 for denied claims resolved by the Conciliation center AAA prior to a hearing.

7. However, if the claim was simply overdue, but not denied, the attorney fee remains $60. The SID apparently values a denied claim more than one that the insurer simply ignored.

8. A medical provider establishes its prima facie entitlement to no-fault benefits by proving the submission of statutory claim forms setting forth the fact and the amount of the loss sustained and that payment of no-fault benefits were overdue. Audobon Physical Med & Rehab, P.C. v GEICO Ins. Co., 2009 NY Slip Op 50456(U) (Sup. Ct. App. T. 2nd Dept. 2nd, 11th and 13th Jud Dist 2009) (citing Insurance Law § 5106 (a); Mary Immaculate Hosp. v Allstate Ins. Co., 5 AD3d 742 (2004)); A.B. Medical Services, PLLC, et al v Country-Wide Insurance Company, 2009 NY Slip Op 50583U (Sup. Ct. App. T. 2nd Dept., 9th and 10th Jud Dist 2009) (also citing Insurance Law § 5106 (a); Mary Immaculate Hosp. v Allstate Ins. Co., 5 AD3d 742 (2nd Dept. 2004)).

9. 11 NYCRR 65-4.6(j) provides that if the charges submitted by a health service provider are in excess of those allowed under the fee schedule, no attorney's fee shall be owed. This provision does not apply to interpretations of the fee schedule, however.

10. Review of arbitration awards:

a) The mechanism for appealing an arbitration award is filing a master arbitration with the American Arbitration Association & Article 75 Petition filed in court is the mechanism for appealing master arbitration award.

b) There is a limited right to review. Both master arbitration and article 75 review are generally limited to grounds enumerated in CPLR 7511 (b):

> (i) corruption, fraud or misconduct in procuring the award; or
>
> (ii) partiality of an arbitrator appointed as a neutral, except where the award was by confession; or
>
> (iii) an arbitrator, or agency or person making the award exceeded his power or so imperfectly executed it that a final and definite award upon the subject matter submitted was not made; or
>
> (iv) failure to follow the procedure of this article, unless the party applying to vacate the award continued with the arbitration with notice of the defect and without objection.

c) Master Arbitration review also includes review of awards that are incorrect as a matter of law, but this does not include procedural or factual errors at the lower arbitration. 65-4.10.

d) Petrofsky v. Allstate Insurance Company, 445 N.Y.S.2d 77 (1981) expanded master arbitration review to include "review the determination of the arbitrator to assure that the arbitrator reached his decision in a rational manner [and] that the decision was not arbitrary and capricious."

e) The Appellate Division in Matter of Nyack Hospital v GEICO, 139 A.D.2d 515; 526 N.Y.S.2d 614 (2nd Dept., 1988), found that an Arbitrator exceeded his power by denying No-Fault insurance benefits to a hospital on the basis of intoxication, where the only evidence offered to establish insured's intoxication was a copy of hospital's records setting forth results of hospital-administered blood test, which was admitted without any showing of its authenticity and satisfactory care in collection of sample and its analysis. Although arbitrators are not bound by the technical rules

of evidence, admission of the test result was improper where no other evidence or basis in reason appeared in record to support finding of intoxication. Once the blood test result was excluded, there was no basis to support the conclusion of intoxication requiring a vacature of the award.

VI. AFFIRMATIVE LITIGATION

A. Common Law Fraud, Unjust Enrichment (Recoupment)

B. Declaratory Judgment

1. Declaratory relief may be appropriate. State Farm Mut. Auto. Ins. Co. v Anikeyeva, 89 A.D.3d 1009, 934 N.Y.S.2d 196 (2nd Dept. 2011).

2. However, Insurance Law 5106(b) requires the insurer to afford first-party claimants the "option" to select the arbitration forum pursuant to simplified procedures promulgated by the Superintendent of Insurance. Insurance Law § 5106(b) provides, in pertinent part:

> Every insurer shall provide a claimant with the option of submitting any dispute involving the insurer's liability to pay first party benefits, or additional first party benefits, the amount thereof or any other matter which may arise pursuant to subsection (a) of this section to arbitration pursuant to simplified procedures to be promulgated or approved by the superintendent….

3. As the Court of Appeals stated in Roggio v. Nationwide Mut. Ins. Co., "(T)he clear thrust of section 5106 is to provide no-fault claimants with an opportunity for immediate redress, and by arbitration to offer a mechanism where disputes over reimbursable expenses can be resolved more swiftly and economically than is generally possible in plenary suits." 66 N.Y.2d 260, 264 (1985). "A legislative objective in enacting the No-Fault Law was to reduce significantly the burden of automobile personal injury litigation on the courts…." Id. By providing the first-party claimant the option to arbitrate its claims, Insurance Law § 5106(b) significantly advances this objective. See Id.

4. The Conditions to the No-Fault Mandatory Personal Injury Protection Endorsement (found at 11 NYCRR 65-1.1) also requires the insurer to afford the claimant the option to arbitrate claims pursuant to procedures promulgated by the Superintendent. As the Condition provides:

> Arbitration. In the event any person making a claim for first-party benefits and the Company do not agree regarding any matter relating to the claim, such person shall have the option of submitting such disagreement to arbitration pursuant to procedures

promulgated or approved by the Superintendent of Insurance. (Conditions, 11 NYCRR 65-1.1.)

5. The Federal Arbitration Act (9 USC § 2) requires that any ambiguities in the arbitration clause at issue, insofar as they exist, to be read in favor of arbitration. See CompuCredit Corp. v. Greenwood, 132 S.Ct. 665, 69 (2012).

6. The applicant's right to arbitrate has prohibited actions to recover funds paid:

   a) Country-Wide Ins. Co. v. Frolich, 465 NYS2d 446 (NY City Civ. Ct. 1983)(court granted medical provider's motion to compel arbitration where an insurer had initially paid benefits but subsequently filed a lawsuit to recover the payment).

   b) It also prevents filling of an action by an insurer seeking a declaration that it has no obligation to pay benefits under the policy. American Transit Ins. Co. v. Augustin F. Sanchez, MD, et al, Index No. 55609/11 (Civil Court New York County, Kathryn E. Freed, January 31, 2012).

      > Further, as the Defendant's exercised their statutory rights under Insurance Law § 5106(b) and commenced arbitrations to adjudicate/dispose of their claims and seek recovery of statutory no-fault benefits, it is this court's finding and opinion that those decisions in arbitration ultimately control and Insurance Law § 5106(b) was properly complied with and is the controlling statute to allow and encourage parties to effectively and economically pursue arbitration to seek reimbursement arising from disputed no-fault claims seeking first party benefits.

   c) Allstate Ins. Co. v. Lyons, 843 F.Supp.2d 358, 379 (E.D.N.Y. 2012) Motion to Compel arbitration granted as to any unpaid claims, but distinguished the common law fraud claims.

7. Caveat: The election to arbitrate is not available to an applicant that has already sought resolution of a dispute regarding the underlying claim in a judicial proceeding. Roggio v. Nationwide Mut. Ins. Co., 66 N.Y.2d 260 (1985). This does not apply to different medical providers who are not barred from bringing an action seeking reimbursement in a different forum from the prior medical provider. A.B. Medical Services PLLC et al v. USAA General Insurance Co., 9 Misc.3d 19, 23, 801 N.Y.S. 2d 475 (Sup. Ct. App. T. 2nd Dept. 2005).

8. Attorneys Fee for prevailing defendant in a DJ action

a) "(A)n insured who is 'cast in a defensive posture by the legal steps an insurer takes in an effort to free itself from its policy obligations,' and who prevails on the merits, may recover attorneys' fees incurred in defending against the insurer's action… an insurer's duty to defend an insured extends to the defense of any action arising out of the occurrence, including a defense against an insurer's declaratory judgment action." See U.S. Underwriters Ins. Co., 3 N.Y. 3d. at 597-98, *citing* Mighty Midgets Inc., 47 N.Y. 2d. at 21.

b) Attorney fees are not available for an insured that was a prevailing plaintiff in a DJ action. Estee Lauder Inc. v OneBeacon Ins. Group, LLC, 31 Misc.3d 379, 918 N.Y.S.2d 825, (NY Supreme Ct., 2011).

C. Sometimes used as a mechanism to raise defenses that would have been precluded.

1. Successfully: Unitrin Advantage Ins. Co. v Bayshore Physical Therapy, PLLC, 82 AD3d 5 (1st Dept. 2011), lv. Denied 17 NY 3d 705 (2011). Missed IME

2. Unsuccessfully: Mercury Cas. Co. v. Encare, Inc., 90 A.D.3d 475, 934 N.Y.S.2d 390 (1st Dept. 2011). Fee Schedule.

VII. MOTOR VEHICLE ACCIDENT INDEMNIFICATION CORPORATION

A. MVAIC is a statutorily created entity created to protect New York residents from uninsured motorists.

1. INS LAW §5202- Definitions:

(b) "Qualified person" means (i) a resident of this state, other than an insured or the owner of an uninsured motor vehicle and his spouse when a passenger in such vehicle, or his legal representative, or (ii) a resident of another state, territory or federal district of the United States or province of the Dominion of Canada, or foreign country, in which recourse is afforded, to residents of this state, of substantially similar character to that provided for by this article, or his legal representative. It does not include any operator of or passenger on a snowmobile. In this subsection, "operator" means every person who operates or is in actual physical control of a snowmobile, whether or not it is under way.

2. INS LAW § 5201: This article is intended to provide no-fault benefits for qualified persons for basic economic loss arising out of the use and

operation in this state of an uninsured motor vehicle, as provided herein and in the comprehensive motor vehicle insurance reparations act. The legislature determines that it is a matter of grave concern that those persons are not recompensed for their injury and financial loss inflicted upon them and that the public interest can best be served by closing such gaps in the motor vehicle financial security act and the comprehensive motor vehicle insurance reparations act through the continued operation of the motor vehicle accident indemnification corporation.

3. Ins Law 5221

(b)(1) Notwithstanding the provisions of this article, the corporation shall also provide for the payment of first party benefits to a qualified person for basic economic loss arising out of the use or operation in this state of an uninsured motor vehicle.

(2) A qualified person who has complied with all the *applicable* requirements of this article shall be deemed to be a covered person and shall have only such rights as a covered person may have under article fifty-one of this chapter. *emphasis added*

IIP PRACTICE TIP: Some requirements of Article 52 may not apply to those seeking no-fault benefits. For example Ins law 5208 requires the affidavit to state the person has a cause of action (in tort) against the owner of the uninsured/unidentified vehicle. Since no fault benefits are not conditioned upon one having a cause of action (in tort or otherwise) against the owner of the vehicle, the affidavit need not allege anything regarding a cause of action.

IIP PRACTICE TIP: If you have a properly sworn Notice of Intention to Make Claim with MVAIC, the form can be used to establish the residence of the claimant and is thus qualified. See Central Radiology Services, PC v. MVAIC, 46 Misc.3d 74, 76 (Sup. Ct. AT 2nd Dept. 2014) (Parties stipulated that notice of intention was received by MVAIC but unclear as to whether form was sworn and indicated residence of claimant).

(3) The corporation shall have only those rights and obligations which are applicable to an insurer subject to article fifty-one of this chapter.

….

(6) If a controversy arises between the corporation and an insurer concerning the obligation to pay first party benefits, payment of first party

benefits by the corporation shall not be stayed pending resolution of the controversy. Any such controversy shall be solely resolved by submission to mandatory arbitration pursuant to procedures promulgated or approved by the superintendent. Such procedures shall, to the extent practicable, be those applicable to insurers pursuant to section five thousand one hundred five of this chapter.

4. Conditions Precedent to Coverage Ins Law § 5208-Notice of Claim: There are different Notice Requirements Depending on the Underlying Facts:

a) Where Qualified Person has a Cause of Action Against Owner/Operator of Designated Uninsured:

(1) Within 180 days of the accrual of the cause of action, file an Affidavit stating:

(a) The person has a cause of action for damages arising out of the accident and setting forth the facts in support

(b) That the cause of action is against the owner or operator of a designated uninsured motor vehicle, and

(c) the person is making a claim for such damages

(2) A Qualified Person files with MVAIC an affidavit within 180 days of the accrual of the cause of action stating the person making a claim for damages against owner or operator of uninsured vehicle and facts in support.

b) Where Qualified Person has a Cause of Action Against Someone Whose Identity is Unascertainable (hit and run)

(1) Accident must be reported to governmental agency within 24 hrs of accident, unless it is shown that it was not reasonably possible to make such a report or that it was made as soon as was reasonably possible.

(2) Within 90 days of the accrual of the cause of action, file an Affidavit stating:

(a) the person has the cause of action for damages arising out of the accident and setting forth the supporting facts,

(b) the cause of action is against a person whose identity is unascertainable, and

(c) the person is making a claim for those damages.

c) Where the insurer of the person alleged to be liable disclaims coverage.

(1) Affidavit to MVAIC within 180 days of the affiant's receipt of notice of the disclaimer or denial of coverage, stating:

(2) The person has a cause of action for damages arising out of the accident for damages and setting forth the supporting facts,

(3) The insurers of the person alleged to be liable for the damages have disclaimed liability or denied coverage because of some act or omission of the person alleged to be liable including the denial of coverage based upon the lack of a policy of insurance in effect at the time the cause of action arose;

(4) In a case of denial of coverage based upon the lack of a policy of insurance in effect at the time the cause of action arose, timely reasonable efforts had been made to ascertain insurance coverage.

d) Where the Affidavit is not filed in a timely manner, either due to infancy, incapacity, or erroneous information from the department of motor vehicles or police report, the statute provides a mechanism for service of late notice, including permitting an action requesting judicial permission to file an untimely Affidavit.

e) MVAIC makes a form affidavit entitled Notice of Intention to Make Claim available on its website. Although completion of this from may satisfy the requirements of Ins. Law 5208, the statute does not require the use of any particular form.

f) "Since defendant established that there had been no timely filing of a notice of claim and that leave had not been sought to file late notice of claim, plaintiff's assignor is not a covered person." East Gun Hill Medical, P.C. v. MVAIC, 47 Misc.3d 129(A) (Sup. Ct. AT 2nd Dept. 2015).

B. Qualification:

1. Despite the fact that a "Qualified Person" is defined by statute, MVAIC refuses to process any claims until it has determined that the person is "Qualified."

2. The courts do not agree with MVAIC's definition of "Qualified".

a) "We reject the defendant's contention that the 30-day time requirement contained in 11 NYCRR 6.15 (g) (3) does not apply to it until after it has 'qualified' an injured party. The corporation

shall have only those rights and obligations which are applicable to an insurer subject to article fifty-one of this chapter." New York Hospital Medical Center v. MVAIC, 784 N.Y.S. 2d 593 (2nd Dept. 2004).

3. Kipor Medicine P.C. v MVAIC, 880 N.Y.S.2d 459 (Civ Court Kings County, February 23, 2009, Hon. Noach Dear, J.C.C.) ("The defense that a person seeking first-party no-fault benefits from MVAIC is not a 'qualified person' within the meaning of Insurance Law § 5202 (b) is a coverage defense . . . . upon which MVAIC would have the burden of proof . . . . Here, no evidence was submitted demonstrating that plaintiff's assignor was not a 'qualified person.'")

C. Household Affidavit

1. MVAIC insists that all applicant's seeking benefits complete a "Household Affidavit" listing the name, date of birth, social security number, and relationship of all resident's household at the time of the accident.

a) Article 52 does not require such an affidavit.

b) The courts do not agree with MVAIC:

(1) Intuitive Chiropractic, P.C. v. MVAIC, 34 Misc.3d 144(A), Slip Copy, 2012 WL 326699 (Table) (App. Term 2nd Dept. 2012). On appeal, defendant contends that plaintiff was not entitled to summary judgment because plaintiff's assignor was not a qualified person since he failed to provide defendant with a household affidavit or written proof of lack of insurance. This argument lacks merit because plaintiff's assignor's status as a qualified person is not dependent upon defendant's receipt of these documents (see Insurance Law § 5202(b).

(2) Liberty Orthopedics, PLLC v. MVAIC, 20 Misc.3d 136(A), 2008 N.Y. Slip Op 51533(U) (App Term, 2d & 11th Jud Dists 2008).

(3) Intuitive Chiropractic, P.C. v. MVAIC, 34 Misc.3d 144(A), (App. Term , 2012).

2. Proof of Claim (Submission of bills):

a) Even thought the statute requires the filing of the Affidavit as late as 90 days after a hit and run accident or 180 from the accident or disclaimer of coverage, bills must still be submitted with 45 days of the date of service, See NY Arthroscopy & Sports Medicine, PLLC v Motor Vehicle Accident Indemnification Corporation, 15 Misc. 3d 89 (App. Term, 1st Dept. 2007).

(1) Practice Tip: If there is any doubt as to the existence of valid coverage, MVIAC should immediately be put on notice by sending a copy of any bills to preempt any late bill submission defense.

3. Request for Additional Verification

a) MVAIC demands for verification brought without "good reason" are invalid (e.g. affidavits of no insurance from offending drivers and the like):

(1) Omega Diagnostic Imaging, P.C. v. MVAIC, 29 Misc. 3d 129A (App Term 1st Dept. 2010): "Nor is the action premature on the ground that there is an outstanding verification request. Defendant served on plaintiff and its assignor requests that they obtain from the out-of-state driver of the vehicle that struck the assignor an "affidavit of no insurance." The requests, however, were not proper, since there was no "good reason" for defendant to demand that plaintiff and its assignor obtain an affidavit from the driver, who is neither a party to this action nor under the control of either plaintiff or its assignor (see 11 NYCRR 65-3.2(c))."

4. Exhaustion of Identified Sources of Insurance.

a) On its own motion for summary judgment, or at a trial, the applicant may be required to show that it exhausted identified avenues of insurance. Hauswirth v American Home Assur. Co., 244 AD2d 528, 664 N.Y.S.2d 466 (2nd Dept. 1997)

(1) Importantly, if the plaintiff and/or its assignor are aware of the identity of the owner of the vehicle which plaintiff's assignor was driving at the time of the accident, the plaintiff is required to exhaust its remedies against the vehicle's owner before seeking relief from MVAIC. Doctor Liliya Med., P.C. v. MVAIC, 2008 NY Slip Op 52453U (App Term 2nd Dept, 2nd and 11th Jud Dists 2008) (citing Hauswirth v American Home Assur. Co., 244 AD2d 528, 664 N.Y.S.2d 466 (1997)); Complete Med. Servs. of N.Y., P.C. v MVAIC, 20 Misc 3d 137(A), 867 N.Y.S.2d 373, 2008 NY Slip Op 51541(U) (App Term 2nd Dept., 2d & 11th Dists 2008))("If plaintiff unsuccessfully exhausts its remedies against the driver and the owner of the taxicab, plaintiff may assert a claim against MVAIC pursuant to Insurance Law § 5218 (c). However, until plaintiff exhausts its remedies, its claim against MVAIC is premature").

(a) COMMENT: It does not appear that a plenary legal action is required to "exhaust" the plaintiff's remedies against an identified driver/insurance policy (i.e. action for declaratory relief) in all instances, assuming other proof of lack of availability of coverage is sufficient regarding the identified vehicle and insured. In the least, lack of coverage regarding the identified vehicle/insured will have to be proved through admissible evidence. **IIP PRACTICE TIP:** Document efforts to "exhaust remedies" in detailed Affidavit. For instance, contacting the other state's DMV.

b) Assuming the identity of the owner of the vehicle occupied by the insured is known, the plaintiff is required to "exhaust its remedies" against the vehicle owner before seeking relief from MVAIC, at least in the Second Department.

(1) Delta Diagnostic Radiology, P.C. v. MVAIC, 57 Misc.3d 130 (A) (Sup. Ct. App. T. 2nd Dept. 2015). "Since plaintiff and its assignor had sufficient information to identify the owner of the Pennsylvania vehicle in which plaintiff's assignor was a passenger at the time of the accident, plaintiff, as assignee, was required to exhaust its remedies against the vehicle's owner before seeking relief from MVAIC." (*citations omitted*).

(2) South Nassau Orthopedic Surgery & Sports Medicine, PC v MVIAC, 30 Misc. 3d 131A (App. T. 2nd Dept. 2011): The Appellate Term overturned the denial of MVAIC's motion for summary judgment reasoning: "Plaintiff, as assignee, is required to exhaust its remedies against the owner of the vehicle in which plaintiff's assignor was riding before seeking relief from MVAIC…"

(3) Staten Is. Chiropractic Assoc, PLLC v MVAIC, 910 N.Y.S.2d 409 (App Term 2nd, 2010): Since plaintiff and its assignor were aware of the identity of the owner of the vehicle which struck plaintiff's assignor, plaintiff, as assignee, was required to exhaust its remedies against the vehicle's owner before seeking relief from MVAIC (Hauswirth v. American Home Assur. Co., 244 A.D.2d 528 [1997]; Modern Art Med., P.C. v. MVAIC, 22 Misc.3d 126[A], 2008 N.Y. Slip Op 52586[U] [App Term 2nd Dept., 2d & 11th Jud Dists 2008]; Doctor Liliya Med., P.C. v. MVAIC, 21 Misc.3d 143[A], 2008 N.Y. Slip Op 52453[U] [App Term, 2d & 11th Jud Dists 2008]; Dr. Abakin, D.C., P.C. v. MVAIC, 21 Misc.3d 134[A], 2008 N.Y. Slip Op

52186[U] [App Term 2nd Dept., 2d & 11th Jud Dists 2008]; Complete Med.Servs. of NY, P.C. v. MVAIC, 20 Misc.3d 137[A], 2008 N.Y. Slip Op 51541 [U] [App Term 2nd Dept., 2d & 11th Dists 2008]). Until plaintiff exhausts its remedies, its claim against MVAIC is premature (Complete Med. Servs. of NY, P.C. v. MVAIC, 20 Misc.3d 137[A], 2008 N.Y. Slip Op 51541[U]).

c) Applicant is not always required to demonstrate exhaustion: Socrates Medical Health, P.C. a/a/o Betty Perez, v MVAIC, 2011 NY Slip Op 51961(U) (33 Misc 3d 132(A)), (App Term, 1ST Dept 2010). In opposition to plaintiff's prima facie showing of entitlement to judgment as a matter of law on its complaint seeking recovery of assigned first-party no-fault benefits, defendant MVAIC failed to raise a triable issue with respect to its lack of coverage defense. Defendant failed to submit any competent proof establishing that plaintiff's assignor was not qualified to receive no-fault benefits (see Englington Med., P.C. v Motor Veh. Acc. Indem. Corp., 81 AD3d 223, 229 (2nd Dept. 2011); Matter of MVAIC v Interboro Med. Care & Diagnostic PC, 73 AD3d 667 (1st Dept. 2010)). Nor did defendant show that plaintiff was required to "exhaust its remedies" prior to commencing this action (see Omega Diagnostic Imaging, P.C. v MVAIC, 29 Misc 3d 129(A), 2010 NY Slip Op 51779(U) (App Term, 1st Dept 2010)); RAZ Acupuncture, P.C. v. MVAIC, 2009 NY Slip Op 52362U, 1 (App. Term 2nd Dept., Aug. 31, 2009)("MVAIC's moving papers made a prima facie showing that Respondent's assignor is not a "qualified person" (Insurance Law § 5202 [b]) and, thus, that he is not a "covered person" [emphasis added]); S&L Med. P.C. v MVAIC, 2010 NY Slip Op(U) (App Term 1st Dept Nov. 5, 2010) ("While MVAIC was not precluded by its conceded untimely denial of Respondent's claim from asserting the defense that the Respondent's assignor was not qualified to receive no-fault benefits [see Matter of MVAIC v. Interboro Med. Care & Diagnostic P.C., 73 AD3d 667 (1st Dept. 2010)], MVAIC failed to establish that defense at trial."; Omega Med. Diagnostic v. MVAIC, 2011 NY Slip Op 50275 (U) (App. Term, First Dept., February 25, 2011).; Bronx Expert Radiology, P.C. a/o Carmen Rodriguez v. MVAIC, 36 Misc. 3d 145(A) (App. Term 1st Dept. 2012) ("On this record, and given the denial of coverage letter from the putative insurer…defendant failed to raise a triable issue as to whether there was a policy of insurance in effect at the time of the accident.")(*citing* Pomona Med. Diagnostic v. MVAIC, 30 Misc 3d 132 (a), 2011 NY Slip Op 50042 (U) App Term, 1st Dept. 2011).

5. Payment or Denial Within 30 Days

a) MVAIC is bound by the 30 Day Rule: New York Hospital Medical Center v. MVAIC, 784 N.Y.S. 2d 593 (2nd Dept. 2004)

6. However, the failure to issue a Denial of Claim does preclude MVAIC from presenting a defense that there is insurance coverage available, but the burden is on MVAIC to establish the defense. MVAIC v. Interboro Medical Care & Diagnostic PC, 73 A.D.3d 667, 902 N.Y.S.2d 45, (1st Dept., 2010)

a) S&L Med. P.C. v MVAIC, 918 N.Y.S.2d 400 (App Term 1st Dept Nov. 5, 2010) ("While MVAIC was not precluded by its conceded untimely denial of plaintiff's claim from asserting the defense that the plaintiff's assignor was not qualified to receive no-fault benefits … MVAIC failed to establish that defense at trial.")

7. Similarly, in its own motion for summary judgment seeking dismissal of plaintiff's case, MVAIC cannot rely on the plaintiff's failure to prove the absence of available insurance. In Englington Med., P.C. v Motor Veh. Acc. Indem. Corp., 916 N.Y.S.2d 122 (AD 2nd Dept. 2011), the court held:

> "Since MVAIC failed to meet its prima facie burden on its motion for summary judgment, the burden never shifted to Englington to submit, in proper admissible form, evidence sufficient to raise a triable issue of fact (*see Alvarez v Prospect Hosp.*, 68 NY2d 320, 324), despite MVAIC's contention that Englington had the burden of proving that Cruz's vehicle was not required to carry insurance, and failed to meet that alleged burden. In its brief, MVAIC asserts that "(i)t is well settled in this Department that the party seeking benefits from MVAIC bears the burden of establishing that the injured party is a qualified person' who complied with all applicable requirements of Article 52." However, in light of the procedural posture of this case, MVAIC misconstrues the burden applicable to the parties, which is a fundamental aspect of a motion for summary judgment. As the movant, MVAIC must first come forward with admissible evidence demonstrating, prima facie, the absence of material issues of fact and that, on those facts, it is or would be entitled to judgment as a matter of law. MVAIC's burden on a motion for summary judgment cannot be satisfied merely by pointing out gaps in the plaintiff's case (see e.g. Shafi v Motta, 73 AD3d 729, 730 (2nd Dept.); Gamer v Ross, 49 AD3d 598, 600 (2nd Dept.); Totten v Cumberland Farms, Inc., 57 AD3d 653, 664 (2nd Dept.); DeFalco v BJ's Wholesale Club, Inc., 38 AD3d 824, 825 (2nd Dept.))."

8. MVAIC's uncertified DMV reports are inadmissible to prove available coverage in the First Department, (and also failed to support MVAIC's position in that respect regarding its "coverage" defense) Pomona Med Diagnostic v. MVAIC, 30 Misc. 3d 132A (App Term 1st Dept. 2011).

9. MVAIC has a duty to investigate claims, and cannot merely demand that the applicant or insured perform additional investigations when the provider has already disproven coverage from the indicated carrier. MVAIC v NYC East-West Acupunture, P.C., 910 N.Y.S.2d 38 (1st Dept. 2010) "We conclude that the arbitrator did not abuse his discretion in refusing to grant MVAIC an adjournment. The arbitrator's decision not to grant a postponement in order to allow MVAIC to investigate an adversary's contention was within his sound discretion and powers. Here, the record establishes that because of East-West's letter dated October 27, 2004, MVAIC had been on notice for approximately three years that GEICO denied East-West's claim on the basis that neither Chu nor a vehicle insured by GEICO was involved in the underlying hit-and-run motor vehicle accident." Id.

10. Insurance Code in police report is prima facie evidence of available insurance coverage. Matter of Auto One Ins. Co. v Hutchinson et al, 898 N.Y.S.2d 161 (2nd Dept. 2009) (not an MVAIC case).

11. Ins. Law §5214 does not bar the entry of default judgment against MVIAC (i.e. contrary to MVAIC's frequent argument that it does). AB Medical Servs., PLLC v MVAIC, 901 N.Y.S.2d 904 (App. Term 1st Dept. 2009).

D. Statute of Limitations

1. Actions Against Insurers: Courts have long held that actions seeking No-Fault benefits from a carrier were governed by the six-year statute of limitations applicable to contract actions.

   a) Benson v Boston Old Colony Ins. Co., 134 A.D.2d 214; 521 N.Y.S.2d 14 (1st Dept., 1987).

   b) Mandarino v. Travelers Prop. Cas. Ins. Co., 831 N.Y.S.2d 452, (2nd Dept., 2007).

2. Actions Against MVAIC: As right to No-Fault benefits from the Motor Vehicle Accident Indemnification Corporation is statutory in nature, actions seeking No-Fault benefits from MVAIC are governed by a 3 year statute of limitations.

   a) Kings Highway Diagnostic Imaging, P.C. v MVAIC, 19 Misc 3d 69, 860 N.Y.S.2d 794 (App Term, 2d & 11th Jud Dists 2008

3. Actions against NYC Transit Authority: The Appellate Division for the First Department has determined that the statute of limitations to commence a no-fault action against the NYC Transit Authority is 3 years. Richard Denise M.D., P.C. a/a/o Trapp v. NYC Transit Authority, 96 A.D.3d 561 (1st Dept. 2012). In contrast, the Appellate Term for the Second Department, relying on Matter of ELRAC v. Suero, 38 Ad3d 544, 831 N.Y.S2d 475 (2nd Dept. 2007), lv. denied 9 NY3d 811 (2007), has treated the NYC Transit Authority as any other self-insured and has

applied a 6 year statute of limitations. Spring World Acupuncture P.C. a/a/o Diep v. NYC Transit Authority, 24 Misc3d 39, 884 N.Y.S.2d 556, App Term Second Dept. May 22, 2009.

4. Actions Against Self-Insured's: The Appellate Division for the Second Department has held that the statute of limitations for a person to claim uninsured motorists benefits is six years. "The respondents' claim for uninsured motorist benefits against a self-insured vehicle owner, while statutorily mandated, remains 'contractual rather than statutory in nature.'" Matter of ELRAC v. Suero, 38 Ad3d 544, 831 N.Y.S2d 475 (2nd Dept. 2007), lv. denied 9 NY3d 811 (2007).

5. The Nassau County District Court addressed the issue of statute of limitations after Suero and provided a well-reasoned explanation as to why the statute of limitations for No-Fault actions is six-years as against both insurers and self-insurers. "

> As recognized in Mandarino v. Travelers Property Casualty Ins. Co., 37 A.D.3d 775, 831 N.Y.S.2d 452 (2nd Dept.2007), "the inclusion of terms in an insurance contract, which might be mandated by various statutes or regulations, does not necessarily alter the fundamentally contractual nature of the dispute between the insured (or is or her assignee), on the one hand, and his or her no fault' insurer on the other hand." In such circumstance, this liability is no less created or imposed upon one issuing a policy of insurance than it is upon a self-insurer who contracts for the leasing of its vehicle, which carries with it the assurance of its financial ability to satisfy the Motor Vehicle Financial Security Act and to pay judgments and claims. See: Guercio v. Hertz Corporation, supra.; ELRAC, Inc. v. Ward, supra.; Nassau Insurance Company v. Guarascio, supra. The court can see no logical reason why an insurer who contracts for the mandated coverage should be subjected to a six (6) year statute of limitations, while a self-insured owner/lessor who contracts for the lease of its vehicle, may limit its liability to those actions **838 commenced within three (3) years of their accrual. The logical extension of such a holding would be to encourage insurance companies to refrain from issuing policies of insurance or excluding no-fault endorsements therefrom, allowing them to argue that their obligations are imposed by statute alone, reducing their exposure, in contravention of the statutory and regulatory scheme.
>
> Pinnacle Open MRI v. Republic Western Insurance Company, 18 Misc3d 626 (NY Dist. Ct. 2008).

That same Court in further analyzing Suero noted that uninsured motorist endorsement and No-Fault endorsement are the same and therefore self-insureds are also subject to the six-year statute of limitations for no-fault actions.

