

5 Things To Know About No-Fault

(1) Use and Operation

11 N.Y.C.R.R. §65-2.1 states that an insured is entitled to recover “basic economic loss” sustained as a result of injuries arising from the “use and operation” of a motor vehicle.

“Use and Operation” is defined to include “the loading or unloading” of a motor vehicle. Notably, however, that would not include an accident whereby a person’s injuries are produced by an instrumentality other than the vehicle itself, in which no-fault first-party benefits are not available. See Walton v. Lumbermens Mut.Cas.Co., 88 N.Y.2d 211, 644 N.Y.S.2d 133(1996).

When arguing that an injury either does or does not arise from the “use and operation” of a motor vehicle, the test set out by the Second Department in the matter of Manhattan & Bronx Service Transit Operating Authority (Willie Gholson) 71 A.D.2d 1004, 240 N.Y.S.2d 290 (2 Dept. 1979) is useful. The Gholson Court set forth three rules to determine an insurer’s liability when the “use or operation” of a motor vehicle is at issue. The test is as follows:

- 1) The accident must have arisen out of the inherent nature of the automobiles;
- 2) The accident must have arisen within the natural territorial limits of the automobile, and the accident use, loading, or unloading must have terminated;
- 3) The automobile must not merely contribute to or cause the condition which produces the injury, but must, itself produce the injury.

(2) Maximum Medical Necessity

Often no-fault carriers base their denials on the fact that the treatment pursued no longer helps or provides any type of benefits to the insured. This is sometimes referred to as “maximum medical improvement”. The Fourth Department has held that alleged maximum medical improvement of the insured does not justify discontinuation of further benefits which are otherwise “necessary” within the meaning of Insurance Law §5102(a)(1). Hobby v. CNA Ins. Co., 267 A.D.2d 1084, 700 N.Y.S.2d 346(4 Dept., 1999).

Claimants have a strong argument that denials based upon “maximum medical improvement” are invalid pursuant to the holding in Hobby. Claimants often argue that

treatment which is rendered at a time of “maximum medical improvement” provides pain relief or other palliative benefits.

However, the buzz word “maximum medical improvement” can sometimes be misleading. Notwithstanding this Fourth Department holding in Hobby, it remains a viable argument that treatment is no longer “necessary” where it is not improving or otherwise benefitting the insured in any way. It is significant that where certain treatment is *not* providing any “curative” or “palliative” benefits, it may no longer be medically necessary within the meaning of the no-fault endorsement. In Ray Gaul and Commercial Union Ins. Co., 268 A.D.2d 816, 701 N.Y.S.2d 643 (3 Dept., 2000), the Third Department upheld an arbitrator’s decision that no-fault benefits were no longer implicated for massage therapy over seven years after the accident where the treatment was no longer improving the insured’s condition. This decision can be used to refute the Fourth Department’s holding in Hobby. It may also aid in persuading an arbitrator to focus on whether the medical benefits are “necessary” and ignore any buzz words such as “maximum medical improvement”. It is important to switch the focus from the distinction from palliative and curative medical benefits to “necessary” benefits. See also, no-fault arbitration decisions: *In Re Singleton and Firemen’s Fund Ins. Co.*, NF 2601 (1996); *In Re Dr. Robert Goebel a/a/o Scorcia and Liberty Mutual Ins. Co.*, NF 2626 (1996); *Curativity*, NF-2167 (1998) for arbitration decisions holding that medical treatment that is not “curative” is not medically necessary.

(3) Statute of Limitations on a Subrogation Claim Arising out of APIP

A no-fault insurer is entitled to bring a subrogation action against a tortfeasor causing injury to its insured after APIP benefits have been paid out. New York Courts have established that the statute of limitation on that subrogation claim runs from the date of accident. AllState Ins. Co. v. Stein, 1 N.Y.3d 416, 775 N.Y.S.2d 219 (2004).

AllState v. Stein involved an insured who was involved in a motor vehicle accident on May 24, 2005. The insured commenced a personal injury action against the tortfeasor on August 2, 1996. As of June 29, 1998, all basic economic loss (PIP) were exhausted, and the insurer began to pay APIP benefits to its insured. Thereafter, the insurer paid more than \$42,000 in APIP benefits. Thus, the insurer became subrogated to the personal injury recovery. Thereafter, on February 20, 2001, a settlement in the amount of \$300,000 was approved by a Court. Notably, that settlement agreement specifically provided that the insurer’s subrogation claim would be preserved. At that point, the insurer did not attempt to recover any portion of the personal injury settlement. Instead, the insurer commenced an action as subrogee of the insured on May 4, 2001, against the tortfeasor. The New York Court of Appeals held that the insurer’s action was time-barred and dismissed the action. The Court held that the insurer, as subrogee, stands in the shoes of the insured, and was therefore required to bring the suit within three years after the date of the accident – rather than on the date the APIP benefits were paid. The Court so held despite the insurer’s

argument that “if the statute of limitations on a subrogation claim runs from the date of the accident, the claim may be time-barred before the right of subrogation exists, so that the subrogee would never have an opportunity to bring suit on the claim. This means that an insurer’s right of subrogation may be extinguished before it arises.” See also Nationwide Ins. Co. V. Moccia, 243 A.D.2d 692, 63 N.Y.S.2d 640 (2 Dept., 1997).

Pursuant to this rule, it is important to be aware of the statute of limitations, and advise your insurer-clients of such. If possible, as soon as the APIP benefits begin to be paid out, commence suit.

(4) Interest

If a no-fault claim is not paid within thirty (30) calendar days after the insurer receives the Health Insurance Claim Form and verification of all the requested information, interest will be due at the rate of 2% per month, calculated on a pro rata basis, using a thirty day month. 11 N.Y.C.R.R. 65-3.9 (a).

Where a denial is issued, and an applicant does not request arbitration or institute a lawsuit within thirty days after the receipt of the Denial of Claim Form, interest shall not accumulate until such action is taken. 11 N.Y.C.R.R. 65-3.9.

Where an applicant who has submitted a dispute to arbitration or the Court unreasonably delays the proceeding, interest shall not accumulate. 11 N.Y.C.R.R. 65-3.9.

These interest statutes should not be ignored when dealing with a no-fault claim. Specifically, if you are defending a no-fault claim, keep in mind that interest accumulates rapidly after the commencement of the arbitration or the lawsuit. In cases of the arbitration, the American Arbitration Association will often move discovery and deadlines along. However, in the cases of lawsuits, absent Court intervention, discovery may take a significant amount of time and allow for significant interest to accumulate.

On the other hand, if you are representing an applicant for no-fault benefits which have been denied, it is important to promptly respond to all discovery requests and provide the insurer and/or the insurer’s attorney with the requested information. Failing to do so could result in a tolling of interest at your client’s expense.

(5) Requests for Verification

The insurer has thirty days to either pay or deny a claim. This clock begins to run after all the information demanded has been provided. New York & Presbyterian Hosp. v. Progressive Cas. Ins. Co., 5 A.D.3d 568 (2 Dept., 2004).

Typically, where an insurer has requested verification on a claim, and that information has not been provided, the matter is not ripe for arbitration or a lawsuit. Verification requests, however, must be properly documented in order to ensure no finding against the insurance carrier relating to failure to deny the claim within thirty days.

A King's County Court Judge recently held that the no-fault insurer must inform the claimant/provider of any deficiencies in verification request responses. In that case, the healthcare service provider provided certain responses to verification requests by the insurer. However, all of the information was not complete. Instead of notifying the provider that further documentation was required, the insurer remained silent. After the insurer did not issue a denial within the requisite amount of time, the healthcare provider commenced suit. When the insurer raised the defense that the matter was not ripe because additional verification had not been provided, and no denial had been issued, the Court stated that it was incumbent on the Defendant to inform the provider that its response was insufficient or incomplete. The Court, therefore, granted the provider's Motion for Summary Judgment and awarded no-fault benefits to the provider. Media Neurology, P.C. v. Countrywide Ins. Co., Slipcopy, 2008 W.L.4291153, N.Y. City Civ. Ct., 2008.