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NO-FAULT INSURANCE **WRAP**-UP

Inquiries and Business Record Exception to Hearsay Rule

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This new quarterly article will update the practitioner as to recent developments in the emerging area of **no-fault** insurance litigation. It will endeavor to present a balanced view from the point of both the medical provider and the **no-fault** insurer. Authors David M. **Barshay** represents medical providers and Mitchell S. Lustig represents **no-fault** insurers.

Company Investigation Reports

In Hochhauser v. Electric Ins. Co.,[FN1] a landmark decision, the Appellate Division, Second Department, directly addressed the admissibility of insurance investigation reports and testimony concerning such reports under the business record exception to the hearsay rule.[FN2]

In Hochhauser, the insurer presented an insurance investigator who prepared an investigation report concluding the insured was not a covered person under the insurance policy. The investigator's report was based upon, inter alia, his interview with the insured. Plaintiff objected to the testimony based upon hearsay, which was overruled by the court. Thereafter, defendant was granted judgment on the issue.

On appeal, the Appellate Division reiterated the long-held maxim that for a report to be admissible under the business record exception to hearsay, each participant in the formulation of the record, from the initial declarant to the recorder of the information, must be acting within the scope of a business duty and if any of the participants 'in the chain' is acting outside the scope of a business duty, the record is inadmissible. See generally, Matter of Leon.[FN3]

The insurer argued the report was admissible under Matter of Leon and its progeny as the insured had a contractual duty to speak with the investigator based on the underlying insurance policy that required the insured to cooperate with the insurer during an investigation, and such contractual duty was akin to a 'business duty' as contemplated by Matter of Leon. In rejecting the argument and following the judicial trend towards prohibiting such reports,[FN4] the court noted that although there is indeed a contractual duty to cooperate and an insurer may even deny a claim based on an insured's failure to cooperate, the insured was outside the insurer's business enterprise and therefore was not communicating information to the insurer under the compulsion of a business duty. The fact that there was no business duty to report, but rather only a contractual one, rendered the statements and the report prepared based on those statements not inherently trustworthy, the very foundation of the business record exception to hearsay.

The question is, then, where does Hochhauser leave the practitioner faced with only his/her investigator's account of the investigation, where such investigation was based, at least in part, on the statements of the insured? Hochauserr suggests the insurer must produce the actual declarant, or establish the statements as admissible under some other hearsay exception. It is worth noting that the defendant in Hochhauser sought to have the insured's statement admitted also as a statement against interest, which the court rejected.[FN5]

Finally, in the **no-fault** context, what if the statement was made by the plaintiff's assignor? Would it then be admissible as a party admission, or admissible under the general rule of law that an assignee ‘stands in the shoes‘ of its assignor?[FN6] The answer would seemingly be, ‘no.‘ First, concerning a party admission, under New York law, an assignor is not a party to his/her assignee's subsequent litigation.[FN7] Second, pursuant to the ‘New York Rule,‘ declarations of an assignor, whether made before or after an assignment is executed, are inadmissible as against the assignee.[FN8] Finally, under a ‘stands in the shoes‘ analysis, this general rule does not affect the hearsay rules.[FN9] Rather, the defense against the assignor is properly available against the assignee, so long as it is proved by other than inadmissible out-of-court declarations.

Plaintiff's Prima Facie Case

Normally, to establish its prima facie case at trial, plaintiff presents an employee of the medical provider's office with personal knowledge of the provider's practice for creating and mailing bills to insurers. However, some plaintiffs attempt to short circuit this process by instead relying on defendant's sworn answers to plaintiff's interrogatories and defendant's response, or lack thereof, to the plaintiff's Notice to Admit. Currently, there is a split between the First and Second Department appellate terms concerning the propriety of these attempts.

While both departments agree plaintiff's prima facie case consists of evidentiary proof that the billing forms were submitted and that such are overdue,[FN10] they disagree significantly as to how the required facts may be proved.

In Empire State Psych. Svcs. v. Travelers Ins. Co.,[FN11] plaintiff called no witnesses and submitted no billing forms or assignment into evidence, but instead read into the record defendant's interrogatory responses, wherein defendant admitted it received plaintiff's bills and denied same. The Appellate Term for the 2nd and 11th Judicial Districts determined that without the billing forms in evidence, plaintiff did not establish its prima facie case.

Conversely, in Fair Price Medical Supply, Inc. v. St. Paul Travelers Ins. Co.,[FN12] under the same facts as above, again with no witnesses or billing forms or assignment in evidence, the First Department determined the admissions made by defendant in the interrogatories were sufficient to establish the factual elements of plaintiff's prima facie case. The court explicitly declined to follow the Second Department's holding in Empire State Psych. Svcs. v. Travelers Ins. Co.[FN13]

Without guidance from either the respective appellate divisions or the Court of Appeals, this rift between the departments will likely continue.

The results have also been mixed with regard to the use of a Notice of Admit to establish plaintiff's prima facie case,[FN14] but the appellate courts have yet to rule on the exact issue.

Proof of Mailing

While the Appellate Division, Second Department, had consistently held an insurer could establish timely mailing through an affidavit describing ‘the standard office practice or procedure used to ensure that items were properly addressed and mailed,‘[FN15] the Appellate Term for the 2nd and 11th Judicial Districts in Contemp. Med. Diag & Treatment v. Government Employees Ins. Co.,[FN16] added the further requirement that proof of the standard office

practice must come from an employee charged with the ‘duty to ensure compliance‘ with such practice, or with ‘personal knowledge of such compliance.‘[FN17] This additional requirement, known as the ‘competent evidence‘ test, placed an almost insurmountable burden upon the insurer to establish timely mailing; and the lower courts typically would find the insurer's proof of mailing inadequate.[FN18]

Indeed, the **no-fault** claims examiner is primarily responsible for determining the validity of a claim submitted by the provider and is not typically charged with a duty to ‘ensure compliance‘ with the office practice for mailing; nor can the claims examiner possibly be expected to possess ‘personal knowledge of such compliance.‘ Accordingly, to satisfy the ‘competent evidence‘ test, the insurer was required to submit two separate affidavits to establish mailing; to wit, one from the claims examiner setting forth the basis and foundation for the insurer's denial, and a second from the supervisor of the mail room who is responsible for ‘ensuring compliance‘ with the insurer's mailing practice.

However, in Delta Diagnostic Radiology v. Chubb Group of Ins.,[FN19] the Appellate Term clarified its prior decision in Contemp. and in no uncertain terms effectively erased the ‘competent evidence‘ test for mailing. Rather, the court aligned itself with the mailing requirements as set forth by the Appellate Division and discussed above. The court held: ‘[A]s 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 and procedure used to ensure that the items were properly addressed and mailed.‘[FN20]

Accordingly, an insurer can now establish a presumption of timely mailing by presenting an affidavit from its claims examiner stating:

(1) it is the standard office practice of the insurer to mail the denial or verification request on the same day the document is generated;

(2) a clerical employee places the denial or verification request into an envelope and checks the name and addresses on the envelopes to ensure it matches the provider's name and address as indicated on the document; and

(3) the same clerical employee places the mail in the outgoing mail bin where it is delivered to the exclusive control of the United States Post Office.

IME No-Shows

In Stephen Fogel Psychological, P.C. v. Progressive Cas. Ins. Co.,[FN21] the Appellate Division, Second Department, held an insurer could deny a provider's claim retroactively to the date of loss for an assignor's failure to attend independent medical examinations (IMEs). In theory, Fogel was a substantial victory for the **no-fault** insurer; however, in practice, it has turned out to be otherwise.

While the Second Department denied the medical provider's motion for summary judgment, it also denied the insurer's motion to dismiss as the insurer failed to establish, by admissible evidence from someone with ‘personal knowledge,‘ that it mailed the notices of the IMEs to the assignor and that the assignor failed to appear.[FN22]

Fogel has since been extended by the Appellate Term, Second Department, to also apply to situations where an insurer is not seeking affirmative relief to dismiss the complaint, but rather is opposing a motion for summary judgment. Thus, the Appellate Term has granted medical providers summary judgment where the insurer, in opposition to the motion, failed to submit an affidavit from an individual with personal knowledge that the IME notices were mailed and that the assignor failed to appear for the IMEs.[FN23]

While the **no-fault** insurer can more easily establish the mailing of the IME notices, it is extremely difficult, if not impossible, for the insurer to establish that the assignor failed to appear for the IMEs. The only individual who would

have personal knowledge of the assignor's failure to appear would be the IME doctor or an employee at the doctor's office. However, obtaining an affidavit from the doctor or an employee at the doctor's office could prove extremely burdensome.

Arguably, an affidavit or testimony from the IME vendor, rather than from the IME doctor's office, asserting that the assignor failed to appear for the scheduled IMEs (no-show letter) may be sufficient to raise a triable issue of fact as to the assignor's nonappearance. Moreover, at least one court has held that an insurer can satisfy this burden without the testimony of the doctor or an employee at the doctor's office.[FN24]

In Foster Diagnostic Imaging, P.C. v. General Assur. Co.,[FN25] the court held that because the doctor had a business duty to impart accurate information to the vendor and the vendor in turn had a business duty to impart accurate information to the insurer, computer records maintained by the vendor were sufficient to establish nonappearance.

However, the Appellate Term appears to demand the insurer submit three separate affidavits to successfully defend a motion for summary judgment: one from the **no-fault** claim's examiner attesting to the timeliness of the insurer's denial; another from the IME vendor attesting to the mailing of the IME notices; and a third from the IME doctor or an employee at the doctor's office stating, with personal knowledge, that the assignor failed to appear.

It was the clear intent of the Fogel court to assist the insurers in their battle against fraud.[FN26] It is inconceivable that the Fogel decision should now be used as a sword against those same insurers when opposing a provider's motion for summary judgment. The **no-fault** defense bar may wish to appeal this issue to the Second Department.

Provider Fraud

In June of this year, the Appellate Division, Second Department in Fair Price Medical Supply Corp. v. Travelers Indem. Co.,[FN27] affirmed the Appellate Term's much-disputed holding that the defense of medical provider fraud, outside of the now-exempt fraud in the incorporation,[FN28] regardless of how egregious the fraud is, is waived if not set forth by the insurer in a timely denial of the claim.[FN29] In September, the Appellate Division granted leave to the Court of Appeals, certifying the question: 'Was the opinion and order of this court… properly made?'[FN30] The Court of Appeals' decision will be greatly anticipated by all practitioners in this area of law and will be reported on in this space upon issuance of the decision.

Conclusion

Given the fluid state of **no-fault** law in New York, there will be many more interesting cases to report on in the future.

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FN1. 2007 N.Y. Slip Op. 08037 (2nd Dept. 2007).

FN2. C.P.L.R. R.4518.

FN3. 48 NY2d 117 (1979); See also, Johnson v. Lutz, 253 NY 124 (1930).

FN4. State Farm Mut. Auto. Ins. Co. v. Langan, 18 AD3d 860 (2nd Dept. 2005) (Eyewitness to accident lacked business duty to report).

FN5. Id. at 6.

FN6. See generally, General Obligations Law §13-105; Arena Const. Co., Inc. v. J. Sackaris & Sons, Inc., 282 AD2d 489 (2nd Dept. 2001).

FN7. See generally, Bennis v. Thomas, 204 NYS2d 58 (N.Y. Sup. Ct. 1960).

FN8. See, Richardson on Evidence, Farrell 11th ed. §8-242. §8-239, §8-241; CPT Medical Service, P.C. v. Utica Mut. Ins., 12 Misc.3d 237 (N.Y. City. Civ. Ct. 2006); JSI Expert Service v. Liberty Mutual Ins. Co., 7 Misc3d 1009(A) (N.Y. City Civ. Ct. 2005).

FN9. Paige v. Cagwin, 7 Hill 361 (1843); CPT Medical Services, P.C. v. Utica Mutual Insurance, 811 NYS2d 909 (N.Y. City Civ. Ct. 2006).

FN10. Radiology Today, P.C. v. Citiwide Auto Leasing Inc., 15 Misc.3d 92 (App. Term 2nd and 11th Jud. Dists. 2007); East Coast Psychological, P.C. v. Allstate Ins. Co., 13 Misc.3d 133(A)(App. Term. 1st Dept. 2006).

FN11. 13 Misc.3d 131(A)(App. Term 2nd and 11th Jud. Dists. 2006).

FN12. 16 Misc.3d 8 (App. Term 1st Dept. 2007).

FN13. Supra.

FN14. New York Law Journal, Outside Counsel, 'Use of Notice to Admit in **No-Fault** Insurance Litigation,' Aug. 6, 2007 at 4, (2007); Letters to the Editor: 'Using Notice to Admit Still Unsettled,' Aug. 13, 2007 NYLJ at 2, (2007).

FN15. New York and Presbyterian Hospital v. Allstate Ins. Co., 29 AD3d 547 (2nd Dept. 2006).

FN16. 6 Misc3d 137(A)(App. Term 2nd and 11th Jud. Dists. 2005).

FN17. Supra.

FN18. See, Ava Acupuncture, P.C. v. Elco Admin. Svcs. Co., 10 Misc.3d 1079 (A)(N.Y. City Civ. Ct. Kings Co. 2006); Harbor Medical & Diagnostic, P.C. v. Allstate Ins. Co., 11 Misc3d 1063 (A)(N.Y. City Civ. Ct. Queens Co. 2006).

FN19. 17 Misc3d 16 (App. Term 2nd and 11th Jud. Dists. 2007).

FN20. Id. at 18.

FN21. 35 AD3d 720 (2nd Dept. 2006).

FN22. Id. at 721.

FN23. First Help Acupuncture, P.C. v. Progressive Northeastern Ins. Co., 15 Misc.3d 144(A)(App. Term 2nd and 11th Jud. Dists. 2007).

FN24. Foster Diagnostic Imaging, P.C.v. General Assur. Co., 10 Misc3d 428 (N.Y. City Civ. Ct. Kings Co. 2005).

FN25. Id.

FN26. See, Matter of Medical Soc'y. of State of N.Y. v. Serio, 100 NY2d 854 (2003).

FN27. 42 AD3d 277 (2nd Dept. 2007).

FN28. A.B. Medical Services, PLLC v. Utica Mut. Ins. Co., 11 Misc3d 71 (App. Term 2nd and 11th Jud. Dists. 2006).

FN29. 9 Misc.3d 76 (App. Term 2nd and 11th Jud. Dists. 2005).

FN30. 2007 N.Y. Slip Op. 78445(U)(2nd Dept. 2007).
11/9/2007 NYLJ 3, (col. 1)

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