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NO-FAULT INSURANCE **WRAP**-UP

Prima Facie: 'Dan Medical' Softened?

David M. **Barshay** and Mitchell S. Lustig

As practitioners in this area are well aware, during the last year the Second Department's Appellate Term has rigidly applied the business record exception to hearsay[FN1] to medical providers' attempts to move their claim forms into evidence as part of their prima facie case.[FN2]

As previously reported in this space, there is a split between the First and Second Department appellate terms concerning the propriety of these attempts. However, just last month, the Second Department's Appellate Term markedly softened the ‘Dan Medical‘ line of cases, agreeing with the First Department's Appellate Term that admissions by the insurer as to receipt of the medical provider's claim and the insurer's action thereupon can establish the provider's prima facie case.[FN3]

In Delta Diagnostic, plaintiff's motion for summary judgment was supported by an affirmation from plaintiff's counsel, an affidavit by a corporate officer of plaintiff and various documents annexed thereto. The affidavit executed by plaintiff's corporate officer stated in a conclusory manner that the documents attached to plaintiff's motion papers were plaintiff's business records. In opposition to the motion and on appeal, the defendant argued that since the affidavit submitted by plaintiff's corporate officer was insufficient to establish that said officer possessed personal knowledge of plaintiff's practices and procedures so as to lay a foundation for the admission, as business records, of the documents annexed to plaintiff's moving papers, plaintiff failed to make a prima facie showing of its entitlement to summary judgment. The Appellate Term, citing Dan Medical, agreed, holding that plaintiff failed to make a prima facie showing of its entitlement to summary judgment.

In prior cases where the court found plaintiff's proofs insufficient under Dan Medical, the court's inquiry ended there, and the plaintiff's motion was denied. However, departing from these previous decisions, the Appellate Term found the insufficiency in the plaintiff's proofs were cured by the insurer's admission that it received plaintiff's claim and acted thereupon. Critically, although the claim forms were never admitted into evidence, the Appellate Term granted summary judgment to the plaintiff based on defendant's admissions.

This decision is a significant departure from Dan Medical and may indicate that the Second Department's Appellate Term is now adopting the position of the First Department's Appellate Term, which previously held a medical provider could establish its prima facie case based on the insurer's admissions, even without the claim forms in evidence.[FN4]

Attorney's Fees and Interest

There had been a growing dispute in the lower courts concerning how attorney's fees are to be awarded after a lawsuit or arbitration where the medical provider prevails.[FN5] Insurers maintained attorney's fees were due based on the aggregate of all claims submitted for a single assignor. The insurers' argument relied on a 2003 informal opinion letter of the Insurance Department.[FN6] Conversely, claimants maintained attorney's fees were due on each separate NF-3 or functional equivalent submitted to the insurer. The claimants' argument relied on several appellate and lower-court decisions.

On Dec. 27, 2007, the Appellate Division for the Third Department in LMK Psychological Services, PC v. State Farm Mutual Automobile Ins. Co.,[FN7] ruled in accordance with what the medical providers had argued, and granted attorney's fees on each NF-3 or functional equivalent submitted to the insurer. Critically, the Appellate Division rejected the Insurance Department's opinion letter, finding it was an inappropriate interpretation of the statute and contrary to well-settled case law. Moreover, the court found the interpretation urged in the opinion letter undermines the goal of the **no-fault** law to fully compensate a claimant for economic loss resulting from the wrongful denial of a claim and wastes judicial assets by encouraging the commencement of multiple actions in order to recover the maximum available counsel fees. Finally, concerning the deference to be accorded to Insurance Department opinions, the court held: ‘Although we ordinarily give deference to the agency's interpretation of its own regulations, such deference need not be accorded where, as here, the interpretation conflicts with the explicit language of the controlling statute.‘[FN8]

Until the Court of Appeals or another Appellate Division rules on these issues, the LMK decision is binding on all trial courts and appellate terms throughout the state,[FN9] and should put an end to this controversy, for now.

Concerning interest due on overdue **no-fault** claims, the Appellate Term for the Second Department previously held that interest on such claims is tolled where the claimant fails to initiate a lawsuit or arbitration within 30 days of receipt of the denial and then resumes only when such action is initiated.[FN10] However, in LMK, the court held insurers are not entitled to a tolling of the interest in cases where the insurer failed to properly and timely handle the claim. This is a substantial departure from previous cases on this issue, and potentially exposes insurers to millions of dollars in additional liabilities.

Assignments and Court of Appeals

In Hospital for Joint Diseases v. Travelers Property Casualty Ins. Co.,[FN11] the medical provider's billing agent sent the insurer a hospital facility form (NYS Form NF-5), a UB-92 form and an assignment of benefits form (NYS Form NF-AOB). The assignment portion of the NF-5 and the assignment both indicated the patient's signature was ‘on file,‘ but neither form displayed the patient's actual signature. The insurer did not reject the forms or request verification of the assignment. After the insurer failed to pay or deny the claim within 30 days of its receipt, the medical provider commenced an action for payment of its bill as well as statutory interest and attorney's fees. In its answer, the insurer raised as an affirmative defense the lack of a valid assignment between the patient and the provider. Both parties moved for summary judgment and the Supreme Court found that the insurer's failure to timely contest the assignment precluded the carrier from litigating the medical provider's standing, and granted judgment in the provider's favor. The Appellate Division affirmed[FN12] and the Court of Appeals granted leave.[FN13]

The Court of Appeals determined that in an action to recover **no-fault** benefits — in derogation to the common-law burden present in almost every other type of action to establish the existence of a properly executed assignment[FN14] — an insurer's failure to timely request verification of the assignment during the claims determination period prevents the carrier from litigating the issue in the subsequent action. As one jurist-commentator noted of the decision, the Court of Appeals, ‘permitted the plaintiff's burden of proof to be satisfied by waiver.‘[FN15]

Moreover, while the Court would not hold that an assignment of benefits is a necessary component of a claimant's prima facie case, it determined that if any such burden does exist, an assignment form stating that the patient's signature is ‘on file‘ satisfies that burden where the carrier does not timely take action to verify the existence of a valid assignment.

Peer Reviews

Commonly, affirmed peer review reports are used by insurers to interject a triable issue of fact to defeat a medical provider's motion for summary judgment.[FN16] The peer review is seldom, if ever, used by the **no-fault** insurer as an offensive weapon to dismiss a provider's claim via the insurer's own summary judgment motion. However, recent case law at both the lower and appellate level suggests that the **no-fault** insurer may wish to re-examine the traditional function of the peer review and instead apply it offensively, rather than defensively.

In A. Khodadadi Radiology PC v. NY Cent. Mut. Fire Ins. Co.,[FN17] the Appellate Term for the Second Department granted an insurer's cross-motion for summary judgment on the grounds that the services provided were not medically necessary. The court noted, ‘Defendant's peer review report established prima facie that there was no medical necessity for the MRIs performed by plaintiff, which evidence was unrebutted, thereby entitling the defendant to [summary judgment].‘[FN18]

Likewise, in CPT Medical Services, PC v. New York Central Mutual Fire Insurance Co.,[FN19] the Appellate Term, First Department, reversed the lower court and granted the insurer's motion for summary judgment based upon an affirmed peer review where the medical provider only submitted an attorney's affirmation accompanied by an unsworn medical report in opposition.

Following the lead of the appellate courts, the Civil Court of the City of New York reached the same result in Presutto v. Travelers Ins. Co.[FN20] As noted by Judge Shlomo Hagler:

In this case, Dr. Miller's orthopedic evaluation and affirmed peer review report on January 29, 2003, based upon objective testing, were sufficient to demonstrate that the services rendered to [the assignors] were not medically necessary. In response to Dr. Miller's specifically detailed affirmed peer review report, plaintiff merely submits a terse Affidavit from Ray Presutto, a licensed massage therapist, averring that 'my office rendered reasonable and necessary medical services to plaintiff's assignors that were causally related and resulting from said accident.' This allegation is conclusory and insufficient as proof in admissible form to create an issue of fact requiring a trial.

The logic underpinning these cases is simple. By submitting sufficient evidence to establish a lack of medical necessity, the burden is shifted to the medical provider to raise a question of fact concerning such finding. In order to satisfy its burden, the medical provider must submit an affidavit from an appropriate medical professional attesting to the necessity of the services rendered. A medical provider who relies solely on the NF-3 or unsworn medical reports in response to such a motion runs the risk of having its case dismissed at the summary judgment stage.

'Re-Peers'

In another interesting case, the Appellate Term for the Second Department ruled on the propriety of ‘re-peers.‘[FN21] A ‘re-peer‘ occurs when the original peer reviewer whose opinion was the basis of the insurer's denial of the claim is unavailable to testify and the insurer retains a new peer reviewer to support its defense at trial. The Appellate Term for the First Department had previously allowed such substitution so long as the new reviewer would be ‘subject to full cross-examination and his testimony would be limited to the basis for denial set forth in the original peer review report.‘[FN22] In a case of first impression in the Second Department, the Appellate Term allowed the substitute testimony as well, under the same conditions set forth by the First Department.[FN23]

David M. **Barshay** is a partner at Baker, Sanders, **Barshay**, Grossman, Fass, Muhlstock and Neuwirth in Mineola. Mitchell S. Lustig is an attorney associated with Nicolini, Paradise Ferretti & Sabella, in Mineola. David M. Gottlieb and Jill Lakin Schatz assisted with the preparation of this article.

FN1. CPLR 4518(a).

FN2. Dan Med., PC v New York Cent. Mut. Fire Ins. Co., 14 Misc.3d. 44 (App. Term 2nd and 11th Jud. Dists. Dec. 1, 2006).

FN3. Delta Diagnostic Radiology, PC v. Progressive Cas. Ins. Co., 18 Misc.3d 128(A) (App. Term 2nd and 11th Jud. Dists. Dec. 27, 2007).

FN4. Fair Price Medical Supply Inc. v. St. Paul Travelers Ins. Co., 16 Misc.3d 8 (App Term 1st Dept. 2007).

FN5. See generally, Alpha Chiropractic, PC v. State Farm Mut. Auto. Ins. Co., 14 Misc.3d 673 (N.Y. City Civ. Ct. 2006) cf. Marigliano v. New York Central Mut. Fire Ins. Co., 13 Misc.3d 1079 (N.Y. City Civ. Ct. 2006).

FN6. http://www.ins.state.ny.us/ogco2003/rg031004.htm (last visited Jan. 17, 2008).

FN7. 2007 N.Y. Slip Op. 10444 (3rd Dept. Dec. 27, 2007).

FN8. Id.

FN9. Fairbanks Gardens Co. v. Gandhi, 168 Misc2d 128 aff'd. 244 AD2d 315 (2nd Dept. 1997); Striver 140 LLC v. Cruz, 1 Misc3d 29 (App. Term 1st Dept. 2003); Mountain View Coach Lines Inc. v. Storms, 102 AD2d 663 (2nd Dept. 1984).

FN10. East Acupuncture, PC v Allstate Ins. Co., 15 Misc3d 104 (App. Term 2nd and 11th Jud. Dists. 2007).

FN11. 9 NY3d 312 (2007).

FN12. 34 AD3d 532 (2nd Dept. 2006).

FN13. 8 NY3d 807 (2007).

FN14. Society of Plastics Industry Inc. v. County of Suffolk, 77 NY2d 761 (1991) ('Whether a person seeking relief is a proper party to request an adjudication is an aspect of justiciability which, when challenged, must be considered at the outset of any litigation…. [A] litigant must establish its standing in order to seek judicial review.')

FN15. Honorable Shlomo S. Hagler. Outside Counsel: 'A **No-Fault** Holiday Gift: 'Hospital for Joint Diseases,'' Dec. 14, 2007 NYLJ 4, (col. 3).

FN16. See generally, Delta Diagnostic Radiology, PC v. American Manufac. Mut. Ins. Co., 12 Misc.3d 145(A) (App. Term 2nd and 11th Jud. Dists. 2006).

FN17. 16 Misc3d 131(A) (App. Term 2nd and 11th Jud. Dists. 2007).

FN18. Id.

FN19. 2007 N.Y. Slip Op. 27526 (App. Term 1st Dept. 2007).

FN20. 17 Misc3d 1121(A) (N.Y. City Civ. Ct. New York County 2007).

FN21. Dilon Medical Supply Corp. v. New York Cent. Mut. Fire Ins. Co., 18 Misc3d 128(A) (App. Term 2nd and 11th Jud. Dists. 2007).

FN22. Home Care Ortho. Med. Supply Inc. v. American Mfrs. Mut. Ins. Co., 14 Misc3d 139(A) (App. Term 1st Dept. 2007).

FN23. Dilon Medical Supply Corp. v. New York Cent. Mut. Fire Ins. Co., 18 Misc.3d 128(A) (App. Term 2nd and 11th Jud. Dists. 2007).
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