6/24/2008 N.Y.L.J. 3, (col. 1)

New York Law Journal
Volume 239

Tuesday, June 24, 2008

NO-FAULT INSURANCE **WRAP**-UP

On Attorney's Fees, Verification Requests, Intoxication

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Court of Appeals: In Fair Price Medical Supply Corp. v. Travelers Indem. Co.,[FN1] the Court of Appeals, in a 5-2 opinion, granted plaintiff's cross-motion for summary judgment and denied defendant's motion for the same relief, holding a defense of fraud based upon the allegation that the services billed for were never provided is waived if not preserved in a timely denial of claim.

The insured had indicated in a written questionnaire requested by Travelers that he did not receive any medical equipment, even though Travelers received a claim for such from plaintiff. Despite having the questionnaire within 30 days of receipt of the plaintiff's claim, Travelers waited two years to deny the claim.

The Court of Appeals noted whether a specific defense is precluded under Presbyterian[FN2] or available under Chubb[FN3] hinges on whether the defense is more like a ‘normal‘ exception from coverage (e.g., a policy exclusion), or a lack of coverage (i.e., a defense implicating a coverage matter), the former being precludable and the latter not. The Court found that where there is ‘an actual accident and actual injuries‘ coverage is invoked and Presbyterian's preclusion rule applies. The Court found unavailing defendant's argument that preclusion would require them to pay a **no-fault** claim it might not have been obligated to honor if timely disclaimed, finding that the same could be said of any policy defense subject to preclusion.

In dissent, Judges Robert S. Smith and Eugene F. Pigott Jr. said that a defense that the services were never provided should be treated as a ‘lack of coverage‘ defense, obviating the need for a timely denial. They reasoned, ‘Neither the insurance policy at issue here nor any other covers wholly fabricated claims.‘

Attorney's Fees and Interest

As previously reported in this space,[FN4] in late 2007, the Appellate Division for the Third Department in LMK Psychological Services, PC v. State Farm Mutual Automobile Ins. Co.,[FN5] held that attorney's fees are payable on a ‘per claim‘ basis (per each bill submitted), rather than a ‘per action‘ basis (per the aggregate of all bills in the lawsuit or arbitration). In March 2008, State Farm's motion for reargument and permission to appeal to the Court of Appeals was denied.[FN6] In April, the Appellate Term, Second Department, followed LMK and reversed a civil court order that granted attorney's fees on a ‘per action‘ basis.[FN7] The Appellate Term reasoned that it was bound by LMK under stare decisis and also that the Second Department's Appellate Division previously determined attorney's fees in a

similar manner as the Third Department did in LMK.[FN8] While the Appellate Term, First Department, has not yet ruled on the issue, it is anticipated that that court will hold it is also bound by LMK.[FN9]

Concerning interest, the court in LMK held that insurers are not entitled to a tolling of the interest in cases where the insurer failed to properly and timely handle the claim, regardless of when the claimant brings the lawsuit or arbitration for recovery of the bill.[FN10] On June 10, the department of Insurance issued a circular letter reminding insurers of their obligations with respect to settling **no-fault** claims.[FN11]

In sum, the letter advises insurers that it is unlawful for the insurer, or counsel representing the insurer, ‘to suggest or require, as a condition of settlement of a contested claim, waiver of any interest that is due.‘ The letter also put the burden on the insurer ‘to take all necessary measures to ensure‘ that its employees and legal counsel fully comply with the proscription. Finally, the Insurance Department noted that it will enforce compliance with the mandate through, inter alia, ‘targeted investigations of insurers,‘ when warranted.

• 'Per Se' Rule Against Summary Judgment in Staged Accident Cases? New York County Civil Court Judge Arlene P. Bluth held that decisions of the Appellate Term indicate there is a ‘per se rule against summary judgment dismissing a claim based on staged accident.‘[FN12] In an in-depth, well-reasoned analysis, Judge Bluth noted that the Appellate Term, when faced with uncontroverted evidence that an automobile accident was staged, reversed the lower court's grant of summary judgment to defendant on that ground.[FN13] Judge Bluth found it compelling that even though the assignor and insured in that case withdrew their claims with prejudice after being confronted with suspicious facts about their multiple accidents, and the court ordered a sanctions hearing against the plaintiff's attorney for pursuing the appeal when ‘faced with facts which clearly support a founded belief of fraud,‘ the court nevertheless refused to affirm summary judgment to the defendant.

While Judge Bluth's reasoning behind her finding of this unwritten ‘per se‘ rule is perfectly sound and logically deduced based on the Appellate Term's rulings, it is hard to believe that the Appellate Term intended to produce a ‘per se‘ rule against summary judgment in these circumstances. How the appellate courts will address these motions in light of Judge Bluth's well-founded concerns about this ‘per se‘ rule remains to be seen.

Verification Requests

In Park Slope Medical and Surgical Supply Inc. v. Country-Wide Insurance Co.,[FN14] the Civil Court of Richmond County addressed a much-debated issue: Must an insurer wait 30 days after the initial verification request to send a follow-up request under 11 N.Y.C.R.R. 65-3.6(b)? Two earlier cases have addressed the issue, with differing results. In Psych. & Massage Therapy Assoc., PLLC v. Progressive Casualty Ins. Co.,[FN15] the insurer sent its follow-up request five days early. Nevertheless, the court determined such was proper, as the statutory language should not be interpreted to penalize an insurer for being too prompt in processing a claim. Conversely, in Seaside Medical PC v. State Farm Mut. Auto. Ins. Co.,[FN16] the court held that the failure to ‘strictly adhere to the language of the regulation‘ was fatal since the **no-fault** law is ‘in derogation of the common law and must be strictly construed.‘

In Park Slope, the court determined the literal meaning of the statute was unclear and thus resorted to an analysis of the ‘spirit and purpose‘ of the law. The court determined that penalizing the insurer for being too prompt would hamper a major objective of the **no-fault** law: Prompt payment of claims. Finding the ‘early‘ follow-up sufficient, plaintiff's action was dismissed as premature.

There is an error in the court's opinion, but it is unclear how much impact such had on the court's ultimate determination. The court said that the Appellate Term addressed Psych. & Massage Therapy Assoc. on appeal and found the insurer not precluded from asserting a lack of coverage defense. However, no appeal was ever taken in that case. The appellate case cited by the court, while involving the same parties, was an entirely different case.[FN17]

Under Park Slope, the question is also left open as to how long, if not 30 days, an insurer must wait before sending a follow-up verification request. Arguably, under a Park Slope or Psych. & Massage Therapy Assoc. rationale, an insurer can send the initial and follow-up requests one day apart and still be held to have complied with the regulation.

EUOs

In a case of apparent first impression, in All-Boro Medical Supplies Inc. v. Progressive Northeastern Ins. Co.[FN18] the court was asked to determine whether an insurer is entitled to an examination under oath (EUO) prior to receipt of plaintiff's claim (a 'pre-claim' EUO), and if so, what the interplay is of the verification timetables if the claim is received after the EUO is requested but prior to it actually being conducted.

In that case, the plaintiff's assignor was involved in an accident on Jan. 5, 2005. The insurer, by letter dated Jan. 28, 2005, requested the assignor submit to an EUO on April 21, 2005. Plaintiff's claim was received on Feb. 14, 2005. The assignor failed to appear for the EUO and a second request was made by letter dated April 22, 2005, for an EUO to be held on May 3, 2005. The assignor again failed to appear and the insurer issued a denial of plaintiff's claim on May 18, 2005, within 30 days of the assignor's second failure to appear, but more than three months after receipt of plaintiff's claim.

Answering the first question in the affirmative, the court found the Second Department's decision in Stephen Fogel Psychological, PC v. Progressive Cas. Ins. Co.,[FN19] allowing pre-claim IMEs (independent medical examinations) instructive and found no reason why EUO's should be treated differently.

Concerning the second inquiry, the court determined that the insurer, upon receipt of the claim on Feb. 14, 2005, was required to adhere to the statutory and regulatory scheme for the processing of the claim. To wit, pay or deny the claim within 30 days of receipt or timely request additional verification. The court held:

Here, while defendant had already scheduled [the assignor's] EUO for April 21, 2005 before it had received the claim, if defendant insisted upon conducting the EUO before deciding whether to pay or deny the claim, it had no choice but to reschedule the EUO to a date within 30 calendar days from Feb. 14, 2005, the date it received the claim. As a matter of law by failing to reschedule the EUO, defendant could not assert [the assignor's] failure to appear for the EUO as its basis to deny the claim.

Intoxication

A rather troublesome opinion for insurers attempting to prove an intoxication defense has been recalled and vacated. While it is generally accepted that an insurer to prevail on such defense must prove both that the insured was intoxicated at the time of the accident and that such intoxication was the proximate cause of the accident, late in 2007, the Appellate Division, Second Department, greatly restricted an insurer's ability to marshal admissible evidence in support of the defense.

In Westchester Medical Center v. Progressive Cas. Ins. Co.,[FN20] the Appellate Division held that lab results showing intoxication, even if contained in certified hospital records, are inadmissible without a showing of satisfactory care in the collection of the blood sample and its analysis. Under this case, insurers would be required to lay bare evidence of a chain of custody and control of the blood sample from the initial drawing of the blood through the lab analysis, including testimony from lab technicians, hospital personnel and anyone else involved in the taking, handling and analysis of the sample.

This past month, on reargument, the court recalled and vacated its own decision,[FN21] and relying on its own precedent from 2000[FN22] determined that lab results contained in a certified hospital record are prima facie proof of intoxication at the time of the accident.

In sum, after this decision, insurers seeking to successfully disclaim based on an intoxication defense need only submit a certified hospital record evidencing lab results of intoxication (such now being prima facie proof of intoxication at the time of the accident) and that the accident was caused by such intoxication.

Proof of Mailing

The lower courts continue to issue conflicting decisions concerning the quantum proof necessary to establish timely mailing of denials and verification requests. The difficulties with this issue stem from varied interpretations of the common-law test for mailing: 'Proof of actual mailing or a standard office practice and procedure designed to ensure that the items are properly addressed and mailed.'[FN23]

In Lenox Hill Radiology PC v. Global Liberty Ins.,[FN24] the Civil Court, New York County, granted the insurer's motion to dismiss the plaintiff's action as premature where the plaintiff failed to respond to the insurer's verification requests. In support of its motion, the insurer submitted an affidavit from its claims examiner describing the insurer's standard office practice and procedure for the mailing of the verification requests.

Although the claims examiner did not swear it was her duty to ensure compliance with defendant's mailing procedures or assert that she herself dropped the verification requests in the mailbox, the court nevertheless held that it is enough that 'the defendant submitted admissible evidence in the form of an affidavit of an employee with knowledge of the defendant's standard office practice or procedures designed to ensure that the items were properly addressed and mailed.'

Conversely, in Carle Place Chiropractic v. New York Cent. Mut. Fire Ins. Co.,[FN25] the District Court of Nassau County adopted by a more rigid interpretation of the common-law test for mailing. In denying an insurer's motion for summary judgment, the court held that an affidavit by a claim's examiner, similar to the one accepted by the court in Lenox Hill Radiology, was insufficient to demonstrate that insurer's denial was timely mailed because it, 'does not take into account the possibility that an item of mail might get misplaced or lost anywhere between the desk at which it is printed and the United States Post Office.'

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FN1. 2008 N.Y. Slip Op. 04946 (2008).

FN2. Presbyterian Hosp. in City of N.Y. v. Maryland Cas. Co., 90 NY2d 274 (1997).

FN3. Central Gen. Hosp. v. Chubb Group of Ins. Co., 90 NY2d 195 (1997).

FN4. **No-Fault** Insurance **Wrap**-Up Jan. 31, 2008 NYLJ 3, (col. 1).

FN5. 46 AD3d 1290 rearg. denied 2008 N.Y. Slip Op. 67834(U) (3rd Dept. 2008).

FN6. Id.

FN7. Fortune Medical, PC v. New York Central Mut. Fire Ins. Co., 2008 N.Y. Slip Op. 28218 (App. Term 2nd and 11th Jud. Dists. 2008).

FN8. See, Smithtown Gen. Hosp. v. State Farm Mut. Auto. Ins. Co., 207 AD2d 338 (2nd Dept. 1994).

FN9. See, Striver 140 LLC v. Cruz, 1 Misc3d 29 (App. Term 1st Dept. 2003).

FN10. **No-Fault** Insurance **Wrap**-Up Jan. 31, 2008 NYLJ 3, (col. 1).

FN11. http://www.ins.state.ny.us/circltr/2008/cl08_14.htm (last visited 6/16/08); See also, 11 NYCRR §65-3.9(b).

FN12. AA Acupuncture Service, PC v. State Farm Mutual Auto. Ins. Co., 19 Misc.3d 1139(A) (N.Y. City Civ. Ct. 2008); See also, 'Summary Judgment Barred in Fake Auto Accident Case,' Daniel Wise, June 5, 2008 NYLJ 1, (col. 4).

FN13. A.M. Medical Services, PC v. Nationwide Mut. Ins. Co., 12 Misc3d 143 (A) (App. Term 2nd and 11th Jud. Dists. 2006).

FN14. 19 Misc3d 1138 (A) (N.Y. City Civ. Ct. Richmond Cty. 2008).

FN15. 5 Misc3d 723 (N.Y. City Civ. Ct. Queens Cty. 2004).

FN16. 12 Misc.3d 1127 (N.Y. City Civ. Ct. Richmond Cty. 2006).

FN17. Compare, Psych. & Massage Therapy Assoc., PLLC a/a/o Kendra Harrell v. Progressive Casualty Ins. Co., 5 Misc3d 723 (N.Y. City Civ. Ct. Queens Cty. 2004) with Psych. & Massage Therapy Assoc., PLLC a/a/o Gregory Przyborouwski v. Progressive Casualty Ins. Co., 12 Misc3d 140(A) (App. Term 2nd and 11th Jud. Dists. 2006).

FN18. 2008 N.Y. Slip Op. 28207 (N.Y. City Civ. Ct. Kings Cty. 2008).

FN19. 35 AD3d 720 (2nd Dept. 2006).

FN20. 46 AD3d 675 (2nd Dept. 2007).

FN21. Westchester Medical Center v. Progressive Cas. Ins. Co., 2008 N.Y. Slip Op. 04867 (2nd Dept. 2008).

FN22. Rodriguez v. Triborough Bridge and Tunnel Authority, 276 AD2d 769 (2nd Dept. 2000).

FN23. Residential Holding Corp. v. Scottsdale Ins. Co., 286 AD2d 679 (2nd Dept. 2001).

FN24. 2008 N.Y. Slip Op. 28197 (N.Y. Civ. Ct. N.Y. Cty. 2008).

FN25. 19 Misc3d 1139(A) (Dist. Ct. Nassau Cty. 2008).
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