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Expert Analysis
No-Fault Insurance **Wrap**-Up

ON CLASS ACTIONS, ENDORSEMENTS AND NEW REGS, EXPERT REPORTS

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Class Action: The Appellate Division, Second Department, found that a class action challenging GEICO's '[systematic reduction of] reimbursement for medical equipment and supplies,' can be certified as a class action, but not with its current class representative.

In Globe Surgical Supply v. GEICO Ins. Co.,[FN1] the Appellate Division found that the proposed class met the requirements of CPLR §902 and §901, rejecting GEICO's argument that its defenses would raise issues that would 'predominate over any common questions of law or fact.' In rejecting the argument, the court found that GEICO would be precluded from offering a fraudulent billing defense, that the 'calculation of damages is not dispositive to the issue of class certification,' that damages would be 'easily manageable,' that a prima facie case 'can be easily made out by the class members,' that a class action would in fact be superior than fully litigating each case individually, and finally that 'documented costs' is not part of plaintiff's prima facie case for recovery of claims for medical supplies.

However, the court held that Globe was not an adequate representative of the class. Critically, inter alia, Globe's owner was charged with insurance fraud for attempting to stage accidents and thereafter bill insurance companies. While he pleaded guilty to a lesser charge of disorderly conduct, the court noted he displayed an intent to put his interests above the class members by invoking his Fifth Amendment rights at his prior deposition, and could be subject to a counterclaim by GEICO. The court determined that Globe's attempt to defend itself against such counterclaim 'would preoccupy him and detract from his representation of the class.'

It is likely that a new class representative will be presented and this case will eventually be heard on its merits.

Endorsements, 'New Regs'

When the **no-fault** regulations were amended in 2002, the mandatory endorsement was amended to require claims be submitted to insurers within 45 days of the date medical services were rendered, and also provided for an insurer's right to require a claimant's presence at an examination under oath. Since then, insurers seeking to enforce these requirements have been required by the appellate courts to establish both that the underlying insurance policy was issued after April 5, 2002 (the effective date of the new regulations) and that the policy contained an endorsement providing such defense.

However, in Eagle Chiropractic v. Chubb Indem. Ins. Co.,[FN2] the Appellate Term for the 9th and 10th Judicial districts determined that where the underlying insurance policy was issued after April 5, 2003 (one year from the effective date of the new regulations) an insurer need not provide proof of the applicable endorsement. The court reasoned:

In the instant case, the plaintiffs' assignor was allegedly injured in an automobile accident on Nov. 12, 2004 and defendant received plaintiff's claims for the ser vices at issue more than 45 days after the services were rendered. Since an automobile insurance policy which contained the prior version of the Endorsement would have expired no later than in April 2003 (see Insurance Law §3425[8]), the automobile insurance policy applicable to the claims at issue in the instant case was required to contain the current endorsement which sets forth the 45-day time limit for the submission of claims and defendant need not prove that the instant automobile insurance policy contained such endorsement.

Conversely, in Eagle Surgical Supply Inc. v. Progressive Cas. Ins. Co.,[FN3] the Appellate Term for the 2nd and 11th Judicial districts required the insurer to demonstrate that the policy in effect contained the applicable endorsement, even though the accident occurred more than three years after the effective date of the new regulations.

While the court in Eagle Chiropractic was correct that the policy in that case must have, as a matter of law, been issued after the effective date of the new regulations, that fact is determinative of nothing. It must be stressed that the mandatory endorsement in the new regulation[FN4] provides only for the minimum benefits that must be included in the policy. Indeed, that section sets forth policies that must, '[C]ontain provisions providing minimum first-party benefits equal to those set out below in the mandatory personal injury protection endorsement.'

Of course, an insurer can always choose to provide terms more favorable to the insured than those set forth in 11 N.Y.C.R.R. §65-1.1(a).[FN5] In other words, just because the insurer had the right under the new regulations to require a claimant to submit to an examination under oath (EUO) and submit its claims within 45 days, does not mean that the insurance policy actually contained those contract terms.

While it is true that Insurance Law §3103(c) requires courts to enforce policies that stray from the required policy endorsement[FN6] as if the policy contained the required endorsement, such maxim is only invoked where the policy contains an endorsement less favorable to the insured.[FN7] Indeed, where the court finds the actual endorsement is 'more favorable to policyholders' than the mandatory endorsement, the actual endorsement must be enforced.

Accordingly, then, while the date of the issuance of the policy is important to determine whether the insurer was permitted to require an EUO or compliance with the '45 day rule,' it is irrelevant concerning whether the actual policy at issue contained such provisions. Therefore, an examination of the actual endorsement used in the subject policy remains the only way to determine the propriety of an EUO or 45-day defense.

The Insurance Department apparently agrees with this conclusion. In a circular letter, the Insurance Department notified insurers that the 'new provisions will not be applicable to claims until policies containing the revised endorsements are issued and renewed.'[FN8] Moreover, the Circular Letter states that insurers 'must advise the Department of the effective date of issuance of the new endorsements.' If the new endorsement is automatically read into policies subject to the new regulations, there would be no need for the Insurance Department to issue any direction concerning the use of the new endorsements.

Res Judicata

• And Collateral Estoppel

In Support Billing & Mgt. Co. v. State Farm Mut. Ins. Co.,[FN9] plaintiff sued to recover claims for which it had previously discontinued with prejudice in an earlier action for the recovery thereof. Defendant moved to dismiss the subsequent action pursuant to CPLR R.3211(a)(5) and (7). Plaintiff opposed, arguing that 'it never had an opportunity to fully litigate the merits of the discontinued action.' The lower court dismissed the action. In affirming, the Appellate Term found that the prior stipulation discontinuing the action raised a presumption that it will have res judicata effect, and that the record lacked any indication that 'the parties, at the time of execution of the stipulation, intended that the stipulation not have res judicata effect.'

D.A.V. Chiropractic P.C. v. GEICO Indem. Co.,[FN10] also from the Appellate Term, Second Department, discussed the similar legal doctrine of 'collateral estoppel.'[FN11] The court found that a prior order in a separate case denying plaintiff's summary judgment motion and finding an issue of fact 'as to whether the policy was obtained by fraud' does not have collateral estoppel effect because it was not 'sufficiently final.'

Finally, in Uptodate Med. Ser v., P.C. v. State Far m Mut. Auto. Ins. Co.,[FN12] the Appellate Term had another occasion to discuss collateral estoppel. In this case, there was a prior arbitration proceeding between the parties in which the arbitrator found plaintiff ineligible to receive reimbursement of **no-fault** benefits because it was fraudulently incorporated. Plaintiff then brought suit in a civil court to recover benefits from defendant for an unrelated claim. Defendant moved to amend its answer to add affirmative defenses of both collateral estoppel and res judicata, as well as to dismiss the case based on those defenses. The lower court denied defendant's motion. In reversing, the Appellate Term reiterated the two elements that must be satisfied to invoke estoppel: that (1) the identical issue was decided in the prior action and is decisive in the present action; and (2) the party to be precluded for relitigating the issue had a full and fair opportunity to contest the prior issue.[FN13] The court further noted that the burden is on the party attempting to defeat the application of estoppel to establish the absence of a full and fair opportunity to litigate.[FN14]

Applying the foregoing to the instant case, the court found while defendant had established the requisite elements for the doctrine to apply, plaintiff failed to even address estoppel, let alone whether it did not receive a full and fair opportunity to litigate in the arbitration proceeding. Concerning the applicability of the doctrine to decisions rendered in arbitration, the court noted that where a party has freely elected to proceed to arbitration with the assistance of counsel despite the availability of a right to file in civil court and has had the opportunity to employ procedures substantially similar to those utilized in a civil court, it may be found that the party has had a full and fair opportunity to litigate the issue determined in the arbitration proceeding.

By now, insurers are well aware that merely producing a doctor to testify at trial, or providing a doctor's report (even if in admissible form) in a motion for summary judgment, does not guarantee victory on a lack of medical necessity defense. In a previous **wrap**-up,[FN15] the authors discussed two decisions from the Appellate Term indicating as much. Since then, three cases, one from the Appellate Term, First Department, one from the Appellate Term, Second Department, and one from Kings County Civil Court, cemented that maxim.

In OS Tigris Acupuncture, P.C. v. Liberty Mut. Ins.,[FN16] the Appellate Term, First Department, found that the independent medical examination (IME) report of defendant's chiropractor—even if it were admissible[FN17]—'only concluded that 'further' acupuncture treatment was not necessary' and that, by itself, is insufficient to defeat plaintiff's motion for summary judgment.

A Plus Med. P.C. v. GEICO,[FN18] involved a doctor that was never offered as an expert at trial.[FN19] The failure to qualify defendant's doctor as an expert was fatal to defendant's case, according to the trial court. The court also found, similar to the court's decision in OS Tigris Acupuncture P.C.,[FN20] that even if the court did accept the doctor's testimony as an expert, it was insufficient to show that the services provided were not medically necessary.

Of course, an expert, if relying upon hearsay, must show that the material 'is of a kind accepted in the profession as

reliable in forming a professional opinion.‘ In Supple Mind Acupuncture, P.C. v. State Farm Ins. Co.,[FN21] defendant's expert testimony relied almost entirely on a police report, statements, photographs, and a repair estimate. The expert testified without objection by plaintiff. The Appellate Term, Second Department held that because no foundation was offered for the out-of-court material relied upon, the trial court properly entered judgment for plaintiff. The Appellate Term found plaintiff's failure to object to be of no import because, ‘no judgment, even in a small claims action, can rest entirely on hearsay evidence.‘[FN22]

Article 75 Proceedings

In a case of first impression and rare **no-fault** decision from the Appellate Division, Fourth Department, the court in Matter of Lowe (Erie Ins. Co.),[FN23] held that the 90-day time limit of CPLR §7511(a) to ‘vacate or modify an arbitration award‘ begins to run from the date it was received, not on the date it was mailed. It rejected respondent's argument that ‘Insurance Department Regulations governing master arbitration proceedings do not apply to CPLR Article 75 proceedings,‘ finding that 11 N.Y.C.R.R. 65-4.10(e)(3)'s use of the word ‘delivery‘[FN24] should be interpreted consistently with the language of CPLR §7511(a), which provides that ‘[a]n application to vacate or modify an award may be made by a party within ninety days after its delivery to him.‘ Otherwise, ‘CPLR 7511 (a) would have different measuring dates, depending on what type of arbitration was sought to be reviewed, and that would be an untenable distinction.‘

EUOs and Verification

Two decisions from the Appellate Term, Second Department, discussed examinations under oath. One discussed the timing of the actual examination; the other discussed the propriety of a verification request.

In Eagle Surgical Supply Inc. v. Progressive Cas. Ins. Co.,[FN25] the Appellate Term held that pursuant to the new regulations, an examination under oath is not subject to the 30-day scheduling requirement of 11 N.Y.C.R.R. §65-3.5(d). In coming to that determination, the court reasoned that with the removal of the phrase ‘examination under oath‘ from 11 N.Y.C.R.R. §65-3.5(d) by an emergency amendment in 2002,[FN26] and the Legislature's failure to reintroduce that language in subsequent amendments, the Legislature intended to exclude examinations under oath from the 30-day scheduling requirement.

In applying that reasoning, the court found that defendant's EUO, although not scheduled within 30 days of receipt of the bills, needed only to be scheduled in a reasonable manner, noting that the Insurance Department requires that ‘verification proceed as expeditiously as possible.‘[FN27] In this case, the court found waiting 39 days to schedule the examination was not unreasonable.

In Alur Med. Supply Inc. v. Progressive Ins. Co.,[FN28] defendant argued that its time to pay or deny the claim was tolled due to plaintiff's assignor's failure to appear for an EUO. Defendant's ‘request‘ merely advised, ‘All benefits remain delayed pending the patient's cooperation in the investigation of this claim Including, but not limited to, her duly executed sworn statement taken at an examination under oath.‘ The Appellate Term, Second Department, found defendant's letter did not toll the time to pay or deny the claim because the ‘letter did not constitute a proper request for verification since it neither demanded nor required a response.‘

The Appellate Term, Second Department, continues to be split as to whether Dan Medical[FN29] can be raised for the first time on appeal. In Mary Immaculate Hosp. v. New York Cent. Mut. Fire. Ins. Co.,[FN30] and Nyack Hosp. v. New York Cent. Mut. Fire Ins. Co.,[FN31] the Appellate Term for the 9th and 10th Judicial districts held that defendant's argument that plaintiff failed to lay a proper foundation for its bills was not preserved because it was raised for the first time on appeal. In both decisions, the court cited, using a ‘c.f.‘ introductory signal, to Bath Med. Supply Inc. v. Deerbrook Ins. Co.,[FN32] a decision from the 2nd and 11th Judicial districts. In that case, the Appellate Term for the 2nd and 11th Judicial districts allowed defendant to address the foundation issue for the first time on appeal.

'Langan' (Redux):

As previously mentioned in this space,[FN33] in State Farm Mut. Auto Ins. Co. v. Langan,[FN34] the Appellate Division, Second Department, held that an insurer must show that the injured party was complicit in staging the accident for the insurer to prevail on a 'staged accident defense.' In Matter of General Assur. Co. v. Rahmanov,[FN35] the Appellate Division, First Department, concurred.

Interest and Attorney's Fees

Accrual of interest and application of attorney's fees continue to be a hot topic in **no-fault** circles.[FN36] With the Court of Appeals scheduled to hear oral argument in LMK Psychological Services, P.C. v. State Farm Mutual Automobile Ins. Co.[FN37] this February and argument recently heard by the Appellate Division, Second Department in East Acupuncture, P.C. v. Allstate Ins. Co.,[FN38] on Nov. 20, 2008, these issues should be settled within the year.

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FN1. 2008 N.Y. Slip Op. 10583 (2nd Dept. 2008).

FN2. 19 Misc.3d 129(A) (App. Term 9th and 10th Jud. Dists. 2008).

FN3. 21 Misc.3d 49 (App. Term 2nd and 11th Jud. Dists. 2008).

FN4. 11 N.Y.C.R.R. §65-1.1(a).

FN5. Helfaer v. John Hancock Mut. Life Ins. Co., 51 Misc2d 869, rev'd 30 AD2d 102, reinstated 26 NY2d 699 (1970).

FN6. Insurance Law §3103(c).

FN7. Cutler v. Hartford Life Ins. Co., 22 NY2d 245 (1968); Zurich Ins. Co., v. Martinez, 24 Misc2d 437 aff'd. 14 AD2d 754 (1st Dept. 1961).

FN8. http://www.ins.state.ny.us/circltr/2002/cl02_09.htm.

FN9. 21 Misc.3d 136(A) (App. Term 2nd and 11th Jud. Dists. 2008).

FN10. 21 Misc.3d 138(A) (App. Term 9th and 10th Jud. Dists. 2008).

FN11. See generally, SIEGEL-NYPRAC §442.

FN12. 2009 N.Y. Slip Op. 50046(U) (App. Term 2nd and 11th Jud. Dists. 2009).

FN13. See generally, Kaufman v. Lilly Co., 65 NY2d 449 (1985).

FN14. Id.

FN15. **Barshay** and Lustig, ' **No-Fault** Insurance **Wrap**-Up: Inquiries and Business Record Exception to Hearsay Rule,' NYLJ Nov. 9, 2007, p. 3, col. 1.

FN16. 21 Misc3d 129(A) (App. Term 1st Dept. 2008).

FN17. The court found that the doctor's report failed to comply with CPLR R.2106.

FN18. 21 Misc3d 799 (N.Y. City Civ. Ct. 2008) (J. Gold).

FN19. Both parties stipulated that the only issue at trial would be whether defendant made out its burden of showing a lack of medical necessity for the services provided.

FN20. Supra.

FN21. 2008 NY Slip Op 51856(U) (App. Term 2nd and 11th Jud. Dists. 2008) .

FN22. Id.

FN23. 56 AD3d 130 (4th Dept. 2008).

FN24. 11 N.Y.C.R.R. §65-4.10 (e)(3) reads in relevant part:
Delivery of award to parties. The parties shall accept as delivery of the award the placing of the award or a true copy thereof in the mail, addressed to the parties or their designated representatives at their last known addresses, or by any other form of service permitted by law (emphasis added).

FN25. 21 Misc3d 49 (App. Term 2nd and 11th Jud. Dists. 2008).

FN26. Effective April 5, 2003.

FN27. Citing to 11 N.Y.C.R.R. §65-3.2 (c) (Internal quotation omitted.)

FN28. 21 Misc3d 134(A) (App. Term 2nd and 11th Jud. Dists. 2008).

FN29. Dan Med., P.C. v. New York Cent. Mut. Fire Ins. Co., 14 Misc3d 44 (App. Term 2nd and 11th Jud. Dists. 2006).

FN30. 21 Misc3d 130(A) (App. Term 9th and 10th Jud. Dists. 2008).

FN31. 21 Misc3d 133(A) (App. Term 9th and 10th Jud. Dists. 2008).

FN32. 14 Misc3d 135(A) (App. Term 2nd and 11th Jud. Dists 2007).

FN33. **Barshay** and Schatz, 'Intentional Accidents Are Covered Under **No-Fault**, ' NYLJ Sept. 30, 2008, p. 3, col. 1.

FN34. 55 AD3d 281 (2nd Dept. 2008).

FN35. 56 AD3d 332 (1st Dept. 2008).

FN36. See generally, **Barshay** and Lustig, 'On Attorney's Fees, Verification Requests, Intoxication,' NYLJ June 24, 2008, p. 3, col. 1.

FN37. 46 AD3d 1290 rearg. denied 2008 N.Y. Slip Op. 67834(U) lv. granted 10 NY3d 717(2008).

FN38. 15 Misc3d 104 (App. Term 2nd and 11th Jud. Dists. 2007).
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