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

AFTER 'LMK': CALCULATING INTEREST AND ATTORNEY'S FEES

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The Court of Appeals' much-anticipated decision in LMK Psychological Services, P.C. v. State Farm Mut. Auto. Ins. Co.[FN1] was handed down April 2, 2009. As practitioners in this area of law are well-aware, LMK concerned a dispute as to how interest and attorney's fees are calculated after a claimant's successful prosecution of a lawsuit or arbitration for the recovery of **no-fault** insurance benefits. Given that it is probably the most significant case concerning **no-fault** law in more than 10 years, a detailed examination of the case and its holdings, as well as the lower court opinions in which the issues addressed in LMK initially surfaced, is warranted.[FN2]

The Disputed Regulations

Concerning attorney's fees, 11 N.Y.C.R.R. §65-4.6(e) provides that such fees shall be limited to '20 percent of the amount of first-party benefits, plus interest thereon, awarded by the arbitrator or court, subject to a [minimum fee of $60 and a] maximum fee of $850.'

Concerning interest, 11 N.Y.C.R.R. §65-3.9(c) provides, 'If an applicant does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations, interest shall not accumulate on the disputed claim or element of claim until such action is taken.'

The Issues

In dispute were two relatively simple issues revolving around the interpretation of the abovecited regulations. First, there was discord concerning whether the minimum and maximum attorney's fees provisions were to be applied on each claim form submitted and sued upon in the subject action or arbitration, or, conversely, on the aggregate of the monies awarded by the court or arbitrator for each claimant, regardless of the number of claim forms submitted. The second issue was whether an insurer that has rendered an untimely or otherwise invalid denial is entitled to the statutory toll of the interest due on such claim.

Early Developments

Disputes concerning the proper interpretation of the regulations began innocently enough in 2003 during settlement negotiations between insurers' and claimants' attorneys. On Oct. 8, 2003, the Insurance Department issued an Opinion Letter concerning the attorney's fees issue, opining:

The minimum amount of attorney's fees awarded to an assignee health provider who has prevailed in a court action brought against a **No-Fault** insurer is based upon the aggregate amount of payment required to be reimbursed based upon the amount awarded for each bill which had been submitted and denied. The minimum attorney fee amount of $60 is not due and owing for each bill submitted as part of the total amount of the disputed claim sought in the court action.[FN3]

No similar Opinion Letter was rendered concerning the interest issue; however, **no-fault** claimants were emboldened by East Acupuncture, P.C. v. Allstate Ins. Co.,[FN4] which held that the interest toll does not apply to assignees.

The first published civil court case to address the attorney's fee issue was A.M. Medical Services, P.C. v. New York Central Mutual,[FN5] in which Judge Thomas Raffaele, Queens County, crystallized the issue for the slew of civil court decisions on this issue that followed. In that case, plaintiff argued that attorney's fees were due on each ‘bill,‘ while the insurer's position was that such fees should be awarded on the aggregate of all claims disputed for each claimant in the lawsuit.

Agreeing with neither party, the court ruled attorney's fees were to be calculated per ‘claim,‘ which the court defined as, ‘[T]he services and corresponding amounts contained on each NF-3 form or its functional equivalent, which is completed by the provider and tendered to the insurer.‘ Of note, the court disregarded the October 2003 Opinion Letter, finding its expected result on **no-fault** litigation ‘unreasonable on its face.‘ Following A.M. Medical's rationale were decisions from the Civil and District Courts in the counties of New York,[FN6] Suffolk,[FN7] Nassau,[FN8] and Queens.[FN9]

In a decision that proved prophetic, Marigliano v. N.Y. Cent. Mut. Fire Ins. Co.,[FN10] Civil Court Judge Peter Paul Sweeney deferred to the Opinion Letter, finding such interpretation ‘was neither irrational, unreasonable or counter to any statutory provision.‘

Concerning interest, prior to LMK, there was only one published case directly addressing the dispute. In Alpha Chiropractic P.C. v. State Farm Mut. Auto Ins.,[FN11] then Civil Court Judge Bernice Daun Siegal noted that while either a timely or untimely denial serves to toll interest, no toll of interest is applicable where no denial has been rendered. Alpha Chiropractic was subsequently affirmed on appeal.[FN12]

Then Came 'LMK'

Venued in Greene County Supreme Court, the LMK action sought payment of 12 causes of action, one each for 12 separate patients.[FN13] A decision was subsequently entered in which three of the causes of action were dismissed and plaintiff was awarded judgment on the other nine causes of action, the court finding defendant's denials either untimely or invalid. Of those nine, four contained multiple bills for a single patient, and five were single bill causes of action. Thereafter, plaintiff submitted a proposed judgment, which included attorney's fees and interest on each disputed bill, with interest running from 30 days after submission of the bills.

Defendant also submitted a proposed judgment, which included attorney's fees calculated based on each cause of action, with interest running from the date of commencement of the action. The court signed plaintiff's proposed judgment, and defendant appealed to the Third Department's Appellate Division.

The Third Department affirmed,[FN14] holding that because the insurer's denials were neither ‘proper‘ nor ‘timely,‘

the insurer was not entitled to a toll of the interest due. Moreover, concerning attorney's fees, the court determined attorney's fees are due on a ‘per claim basis,‘ rather than a ‘per assignor basis.‘ The court disregarded the Opinion Letter, finding such ‘[U]ndermines the goal of the **nofault** 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.‘

After its motion to reargue was denied,[FN15] the insurer was ultimately granted leave to appeal by the Court of Appeals.[FN16] In addition to briefs by the plaintiff and defendant, amici curiae briefs were submitted by various insurers and the Insurance Department. Oral argument was held on Feb. 11, 2009, before only six judges, Chief Judge Lippman having been just confirmed by the State Senate on that day.

Subsequent to oral argument, the Appellate Division, Second Department, in East Acupuncture, P.C. v. Allstate Ins. Co.,[FN17] on Feb.17, determined that even untimely denials entitle an insurer to the interest toll provided for by the regulation. This decision created a true conflict between the Appellate Divisions and made the Court of Appeals' LMK decision that much more eagerly anticipated.

On April 2, 2009, the Court of Appeals handed down its decision in LMK. Concerning attorney's fees, the Court deferred to the Opinion Letter, noting:

Because this interpretation is neither irrational, unreasonable, nor runs counter to the clear wording of the statute, it is entitled to deference. Thus, this Court accepts the Insurance Department's interpretation of its own regulation and, upon remittitur, directs Supreme Court to calculate attorneys' fees based on the aggregate of all bills for each insured.

Concerning interest, the Court likewise deferred to the Superintendent's interpretation that the accrual of interest is tolled, regardless of whether the particular denial at issue was timely.

The Impact

While the Court's decision regarding the tolling of interest is clear and unambiguous, there is less certainty as to what the Court's decision concerning attorney's fees means.

Undoubtedly, concerning interest, the rule is now that any specific[FN18] denial, timely or untimely, valid or invalid, or any proper payment, serves to toll interest, unless the claimant requests arbitration or institutes a lawsuit within 30 days after the receipt of such denial or proper payment. Conversely, where no denial has been issued, there is no toll of interest, and interest will run from 30 days after submission of the claim form.[FN19]

Concerning attorney's fees, there are four possible interpretations of the Court's decision and each has been bandied about by both sides of the **no-fault** insurance bar. Some have argued that the decision should be read to limit the maximum attorney's fees as applicable to each insured for all his or her claims. In other words, each insured gets a maximum total attorney fee of $850 for all of the potential $50,000 payable in basic economic loss. There appears to be little support in either the Regulations, the Opinion Letter, or the Court's decision to support this interpretation.

On the other end of the spectrum, some have argued that the decision changes nothing, and attorney's fees are awarded on a ‘per bill‘ basis, so long as each bill has its own representative cause of action. This interpretation apparently stems from the Court's statement that, ‘[T]he Superintendent has interpreted a claim to be the total medical expenses claimed in a cause of action pertaining to a single insured.‘ However, this suggested interpretation fails for several reasons. First, such an interpretation would render meaningless both the Court's reversal of the Third Department's decision and its deference to the Opinion Letter.

Moreover, it is important to realize that the underlying complaint in the Supreme Court contained a separate cause of

action for each claimant, with multiple bills for that claimant making up each such cause of action. Accordingly, the Court's usage of the ‘cause of action‘ language concerning the underlying Complaint comports with the Superintendent's Opinion that attorney's fees are awarded on the aggregate of all the bills, regardless of how pleaded.

Another suggested interpretation is that attorney's fees are subject to a maximum of $850 for all claims for a single claimant, for a single medical provider, regardless of the number of arbitrations or lawsuits. And still another interpretation is that attorney's fees are subject to a maximum of $850 for all claims for a single claimant, for a single medical provider, per arbitration or lawsuit.

The two latter possible interpretations are the most realistic and will surely be the subject of much dispute in the lower courts. Perhaps the answer lies not in any attempted interpretation of the language used by the Court of Appeals, but rather in the Opinion Letter deferred to by the Court. A review of such Letter appears to indicate that the minimum and maximum attorney's fees are applicable to each lawsuit. Indeed, therein the Superintendent was asked to determine the following question:

When an assignee **No-Fault** provider submits bills for health services rendered to an eligible injured person to that person's insurer, and such bills are either denied or partially paid and the provider thereafter initiates a court action to contest the denials of the multiple bills which results in a payment award to the provider, is the provider entitled to a minimum attorney's fee of $60 for each denied bill now required to be paid, or is the proper amount of attorney's fees based upon the aggregate sum of all bills awarded reimbursement by the Court in the single action that was commenced?[FN20]

In answering the query, the Superintendent opined:

The minimum amount of attorney's fees awarded to an assignee health provider who has prevailed in a court action brought against a **No-Fault** insurer is based upon the aggregate amount of payment required to be reimbursed based upon the amount awarded for each bill which had been submitted and denied.[FN21]

Accordingly, and of course subject to interpretations by the various courts, the rule appears to be that the minimum and maximum statutory attorney's fees are awarded: (1) on the aggregate of a single medical provider's bills; (2) for a single patient; (3) per each arbitration or lawsuit; regardless of when the claims were submitted, or how many claims were submitted, and regardless of how the plaintiff's attorney pleads the causes of action.

Certainly, based upon this interpretation, some plaintiff's attorneys will file individual suits for each claim form submitted in order to maximize attorney's fees. Likewise, some insurers will undoubtedly seek to consolidate actions in order to avoid paying attorney's fees. The propriety of such tactics will be left to the individual civil and district courts. However, the effect that such tactics will have on the applicable attorney's fees payable remains to be seen. As an example, an open question is whether individually initiated actions subsequently consolidated are due attorney's fees based on the now consolidated action, or do they maintain their individuality concerning the award of attorney's fees and interest.

Moreover, there are some interesting questions concerning the ‘retroactive‘ impact of LMK on pending lawsuits and arbitrations, as well as cases previously settled or resolved, but not yet paid. Regarding pending lawsuits and arbitrations—meaning those ‘active‘ cases already in the court or arbitration systems that have not yet been settled or otherwise disposed of—the holdings of LMK concerning interest and attorney's fees should be fully applicable, without any relevant ‘retroactivity‘ analysis.[FN22]

Concerning matters that have been settled, yet remain unpaid, where the settlements reflect terms ‘in violation‘ of LMK, it is highly unlikely that any such settlements would be vacated by the courts.[FN23] Finally, concerning matters where the court or arbitrator has, prior to the Court of Appeals' decision, rendered a decision in the claimant's

favor and the judgment remains unpaid, it is doubtful that any such judgment would be vacated or modified, especially in instances where more than 30 days have elapsed and the insurer has taken no action on the judgment.

Call for Further Clarification

As set forth herein, there are several possible interpretations of the Court of Appeals' decision and the Opinion Letter, and open questions concerning the effect of consolidation. Rather than these issues consuming the already overburdened resources of the lower courts, and being the subject of infighting among the **No-Fault** insurance bar, and with the Court of Appeals already evidencing its intention to defer to the Superintendent on this issue, a call is respectfully made for the Superintendent to issue a new Opinion clarifying the attendant issues.

Bad Faith Cause of Action

In an earlier **Wrap**-Up,[FN24] the authors discussed whether, after the Court of Appeals' decision in Bi-Economy Market Inc. v. Harleysville Ins. Co. of N.Y.,[FN25] a bad faith cause of action exists in the **no-fault** insurance context. The authors concluded that while it appears as if one is available, its application remains to be seen. On March 25, 2009, the first case on this issue, Savino v The Hartford,[FN26] was rendered.

In Savino, the insured, as a result of an automobile accident, required surgery on her shoulder and knee. While she underwent the shoulder surgery, she was unable to receive surgery on her knee because the defendant refused to pay for the hospital, surgical and anesthesia expenses incurred from the shoulder surgery. Defendant denied reimbursement for the shoulder surgery expenses based on an IME, which found that the insured's injuries were either resolved or resolving. By several written addenda, the IME doctor also opined that the shoulder surgery had no ‘causally related medical necessity‘ to the accident.

Thereafter, the insured brought suit, seeking punitive damages, extra-contractual damages and compensatory damages, based on the allegation that she could not receive needed medical treatment because the defendant's doctor ignored ‘numerous medical records submitted for review that contained opinion or data at odds with the conclusion of defendant's doctor's opinion.‘ Plaintiff further argued that defendant's doctor recommended a follow-up visit after the initial exam, but no further examination was scheduled or took place.

The defendant moved for summary judgment, alleging that even if defendant's refusal to provide **no-fault** benefits was incorrect, an insured is not entitled to recover for any extra-contractual damages including non-economic losses for pain and suffering and that plaintiff's recovery is limited to the coverage available under the **No-Fault** insurance policy.

While the Court dismissed the punitive damages claim, it found, relying on Bi-Economy,[FN27] that plaintiff's papers ‘support a finding that The Hartford's conduct was possibly a breach of good faith and fair dealing, ‘[FN28] potentially entitling the insured to extra-contractual and compensatory damages in excess of the policy limits, and denied defendant's motion concerning these claims. In this regard, the Court permitted plaintiff to conduct limited discovery, but also granted defendant leave to renew its motion after completion of such discovery.

At this juncture, it is apparent that a bad-faith cause of action, at the very least, will survive a motion to dismiss for failure to state a cause of action.[FN29] This certainly adds a new dynamic to **no-fault** litigation. Whether plaintiffs will ultimately be successful, however, remains to be seen.

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FN1. —N.E.2d—, 2009 N.Y. Slip Op. 02481 (2009).

FN2. For additional information and discussion of LMK, see http:// www.nycoveragecounsel. blogspot.com. Available there is a replay of a 'Webinar' hosted by Mura & Storm, PLLC, in which Roy A. Mura, counsel for several insurers, and the authors participated.

FN3. http://www.ins.state.ny.us/ogco2003/ rg031004.htm.

FN4. 8 Misc.3d 849 (N.Y.City Civ.Ct., 2005) rev'd 15 Misc.3d 104 (App. Term 2nd and 11th Jud. Dists. 2007) aff'd. 873 N.Y.S.2d 335 (2d Dept. 2009); cf. Chao v. Country-Wide Ins. Co., 11 Misc3d 1090(A) (N.Y. Dist. Ct. 2006) (J. Paradiso).

FN5. 7/24/2006 NYLJ 25, (col. 1) (N.Y. City Civ. Ct. 2006).

FN6. Marigliano v. New York Cent. Mut. Fire Ins. Co., 15 Misc.3d 766 (N.Y.City Civ.Ct., 2007) (S. Hagler) aff'd. 22 Misc.3d 131(A) (App. Term 1st Dept. 2009). The authors were involved in this case.

FN7. Trump Physical Therapy, P.C. v. State Farm Mut. Auto. Ins. Co., 18 Misc.3d 1116(A) (N.Y. Disc. Ct. 2008) (J. Hackeling). The authors were involved in this case.

FN8. Midwood Total Rehab. Medical, P.C. v. State Farm Mut. Auto. Ins. Co., 16 Misc.3d 480 (N.Y. Dist. Ct. 2007) (J. Miller).

FN9. Valley Stream Medical & Rehab., P.C. v. Allstate Ins. Co., 15 Misc.3d 576, 831 (N.Y. City Civ. Ct., 2007) (J. Lebedeff); Alpha Chiropractic, P.C. v. State Farm Mut. Auto Ins. Co., 14 Misc.3d 673 (N.Y. City Civ. Ct. 2006) (J. Siegal) aff'd. 20 Misc.3d 141(A) (App. Term 2nd and 11th Jud. Dists. 2008). The authors were involved in Alpha Chiropractic.

FN10. 13 Misc.3d 1079 (N.Y. City Civ. Ct. 2006). The authors were involved in this case.

FN11. 14 Misc.3d 673 (N.Y. City Civ. Ct. 2006).

FN12. 20 Misc.3d 141(A) (App. Term 2nd and 11th Jud. Dists. 2008).

FN13. The original action consisted of 38 causes of action for 38 different claimants. This was subsequently reduced to 22 causes of action and then through extensive motion practice and agreement between the parties, was eventually reduced to 12 causes of action.

FN14. LMK Psychological Services, P.C. v. State Farm Mut. Auto. Ins. Co., 46 A.D.3d 1290 (3d Dept. 2007).

FN15. 2008 N.Y. Slip Op. 67834(U) (3rd Dept. 2008).

FN16. 10 N.Y.3d 717 (2008).

FN17. 873 N.Y.S.2d 335 (2d Dept. 2009).

FN18. As opposed to a 'general denial,' which does not address the specific claim at issue.

FN19. Alpha Chiropractic, P.C. v. State Farm Mut. Auto Ins. Co., 14 Misc.3d 673 (N.Y. City Civ. Ct. 2006) (J. Siegal) aff'd. 20 Misc.3d 141(A) (App. Term 2nd and 11th Jud. Dists. 2008).

FN20. http://www.ins.state.ny.us/ogco2003 /rg031004.htm.

FN21. Id.

FN22. cf. State Farm Mut. Auto. Ins. Co. v. Robert Mallela, 4 N.Y.3d 313 (2005) (‘Retroactivity‘ relevant because change in Regulation, rather than only interpretation of existing Regulation).

FN23. See generally, Yonkers Fur Dressing Co. v. Royal Ins. Co., 247 N.Y. 435 (1928).

FN24. **No**-**Fault** Insurance **Wrap**-Up, April 30, 2008 NYLJ at p. 3.

FN25. 10 N.Y.3d 187 (2008).

FN26. 2009 NY Slip Op 30823(U) (Sup. Ct., Suffolk County, 2009).

FN27. The Court also cited to a recent article in the New York Law Journal, ‘State Insurer Bad Faith Law After 'Bi-Economy’ and 'Panasia,'‘ March 13, 2009 NYLJ at p. 4, which is illustrative.

FN28. The cause of action for ‘bad faith‘ or consequential damages rests upon ‘the covenant of good faith and fair dealing,‘ implicit in contracts of insurance. Bi-Economy, supra.

FN29. Defendant made what appears to be a tactical decision, ‘not to move for judgment on the facts, but instead [argue that] as a matter of law, the Plaintiff is not entitled to either punitive damages or compensatory damages in this action under New York law.‘
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