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

'WORKERS' COMP' DEFENSE, ATTORNEY'S FEES, SELF-INSURERS

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Historically, the defense of 'Workers' Comp'that is, that the claimant was injured in the course of his or her employment and therefore is not entitled to **no-fault** benefits—has been misunderstood and misapplied by both sides of the bar, as well as the judiciary. Some have argued that if a claimant was injured during the course of employment, he or she was not entitled to any **no-fault** benefits; others understood that although Workers' Compensation insurance is primary in such cases, **no-fault** benefits are nevertheless available as secondary insurance, covering certain basic economic loss above such coverage limits provided by the Workers' Compensation insurer.[FN1] Moreover, some courts have held that **no-fault** benefits are available only if the Workers' Compensation insurer denies liability for payment of benefits. Finally, many have argued that primacy of Workers' Compensation insurance is a 'lack of coverage defense,'[FN2] and therefore non-precludable[FN3] by the failure to render a denial in accordance with the '30-day rule.'[FN4]

Last year, in Fair Price Medical Supply Corp. v. Travelers Indem. Co.,[FN5] the Court of Appeals set forth a litmus test to determine whether a proposed defense is subject to the '30-day rule,' or constitutes a non-precludable 'lack of coverage defense':

[D]etermining whether a specific defense is precluded under Presbyterian or available under Chubb entails a judgment: Is the defense more like a 'normal' exception from coverage (e.g., a policy exclusion), or a lack of coverage in the first instance (i.e., a defense 'implicat[ing] a coverage matter')?[FN6]

The Court reasoned that where 'there was an actual accident and actual injuries...coverage legitimately came into existence, thus removing this fact pattern from the realm of cases where preclusion would create coverage where it never existed.'[FN7]

Following Fair Price, practitioners questioned the effect the holding would have on many defenses that were historically considered 'lack of coverage defenses,' including the 'independent contractor' and 'Mallela' defenses.[FN8]

Turning to the question of whether the defense of primacy of Workers' Compensation insurance survives Fair Price's preclusionary rule, the Appellate Division, in Westchester Medical Center v. Lincoln Gen. Ins. Co.,[FN9] held that such defense is precluded if not raised in a timely denial. The Court held:

[T]he defendant's possible entitlement to offset any **no-fault** benefits it pays by any recovery pursuant to a Workers' Compensation claim does not constitute a defense of lack of coverage, which is not subject to the requirement that there be timely service of the disclaimer.[FN10]

The question remains, then, what effect does a timely denial of a claim based on the defense of primacy of Workers' Compensation insurance have upon the viability of an action brought to recover **no-fault** benefits on such claim? The Appellate Division, in Westchester Medical Center v. American Transit Ins. Co.,[FN11] addressed this issue. In that case, the plaintiff moved for summary judgment alleging the defendant neither paid nor denied its claim within 30 days and therefor was liable thereon. The lower court granted plaintiff's motion, and defendant appealed.

On appeal, the Appellate Division reversed, finding defendant had timely denied the claim based on the allegation that the claimant was entitled to Workers' Compensation benefits. Defendant requested the court search the record and dismiss the action and refer such to the Workers' Compensation Board for a determination as to whether the claimant was entitled to Workers' Compensation benefits. The Appellate Division refused, noting defendant, 'failed to proffer competent evidence in admissible form of the alleged facts giving rise to its contention that Workers' Compensation benefits are available.'[FN12]

The rule concerning the defense of 'Workers' Comp' can be stated as follows: Such defense must be asserted in a timely denial, or it is waived; if asserted in a timely denial, such is sufficient to raise a triable issue of fact precluding summary judgment; however, in order to result in the matter being dismissed and referred to the Workers' Comp Board, the insurer must come forward with 'competent evidence in admissible form of the alleged facts giving rise to its contention that Workers' Compensation benefits are available. '[FN13]

Counterclaims Barred

Where an insurer fails to raise a certain defense required to be preserved in a timely denial and is thereafter compelled to pay the provider's claim, may the insurer bring a counterclaim to recover the monies paid? In Cornell Medical, P.C. v. Mercury Cas. Co.,[FN14] the Appellate Term has answered such query in the negative.

As a background, the Appellate Term had previously suggested such an action may be sustainable. In Fair Price Medical Supply Corp v. Travelers Indem. Co.,[FN15] a case that eventually reached the Court of Appeals, the Appellate Term was faced with a situation where defendant alleged plaintiff billed for services it never actually provided. While finding that such defense was precluded for defendant's failure to assert such in a timely denial, the court noted 'in passing' that, '[A]n insurer precluded from defending a claim based on provider fraud is not without remedy; after paying such a claim, the insurer, for example, may have an action to recover benefits paid under a theory of fraud or unjust enrichment.'[FN16]Fair Price was eventually affirmed by both the Appellate Division[FN17] and the Court of Appeals,[FN18] however without comment as to the Appellate Term's possible remedy.[FN19]

While counterclaims in **no-fault** actions were extremely rare,[FN20] the lower courts that did reach the issue were split, with some holding such a counterclaim is barred,[FN21] while others held such could survive a motion to dismiss.[FN22]

Turning to Cornell, in that case defendant moved, inter alia, to amend its answer to interpose a counterclaim seeking damages for unjust enrichment based upon plaintiff having obtained payment in excess of the Workers' Compensation fee schedules. Plaintiffs opposed defendant's motion, arguing that since defendant failed to timely deny the claim based upon such alleged overcharging, it should not be allowed to assert a counterclaim with respect thereto. The lower court denied defendant's motion, and defendant appealed. In affirming, the Appellate Term held:

In our opinion, since defendant's proposed counterclaim pertains to a defense which is precluded due to defendant's

untimely denials, the Civil Court properly denied the branch of defendant's motion seeking leave to amend the answer to assert the counterclaim.[FN23]

Accordingly, it now appears that the insurers' remedy hinted at by the Appellate Term in Fair Price is not viable and will not survive a motion to dismiss.

Attorney's Fees

When the ‘New Regulations‘ were promulgated in 2002, 11 N.Y.C.R.R. §65-4.6(i) was made part thereof. That section provides, in part: ‘[I]f the charges by a health care provider...exceed the limitations contained in the schedules established pursuant to section 5108 of the Insurance Law, no attorney's fee shall be payable by the insurer.‘ However, the new section is ‘[N] ot [] applicable to charges that involve interpretation of such schedules or inadvertent miscalculation or error.‘[FN24] As noted by the Court of Appeals, the new section was adopted in order to deter health care providers from filing claims in excess of the amount to which they are statutorily entitled.[FN25]

In the nine years since the promulgation of 11 N.Y.C.R.R. 65-4.6(i), no published case addressed the applicability of the provision, until Cornell Medical, P.C. v. Mercury Cas. Co.[FN26] In that case, defendant made a motion, inter alia, to dismiss plaintiff's cause of action for attorney's fees, alleging plaintiff charged in excess of the applicable fee schedule. The motion was denied and appealed by defendant. In dismissing the attorney's fees cause of action, the Appellate Term noted:

[A]fter defendant made a prima facie showing that the amounts charged by plaintiffs...were in excess of the fee schedules, the burden shifted to plaintiffs to show that the charges involved a different interpretation of such schedules or an inadvertent miscalculation or error. Plaintiffs failed to proffer any evidence to meet that burden. Accordingly, defendant was entitled to summary judgment dismissing the second and eighth causes of action.[FN27]

It is important to note that once an insurer has established the charges were excessive, the Appellate Term makes clear that in order to preserve its attorney fee, the burden is on the medical provider to show that the coverage involves an interpretation of the fee schedule or was a result of inadvertent miscalculation or error.

A significant win for insurers, this will surely be the new ‘hot button‘ issue in **no-fault** litigation.

'Self-Insurers'

It is well-settled that claims for **no-fault** benefits against insurers enjoy the six-year statute of limitations provided by CPLR §213(2);[FN28] and such claims against the Motor Vehicle Accident Indemnification Corporation (MVAIC) are governed by the lesser three-year statute of limitations contained in CPLR §214(2).[FN29]

CPLR §213(2) provides, in part, ‘an action upon a contractual obligation or liability, express or implied‘ must be commenced within six years; CPLR §214(2) provides, in part, ‘an action to recover upon a liability, penalty or forfeiture created or imposed by statute‘ must be commenced within three years. Of dispute was which of these provisions applied to **no-fault** claims against ‘selfinsurers.‘

While no appellate court had squarely addressed the issue, in the context of uninsured motorist claims, the Appellate Division had previously held that such claims are subject to a six-year statute of limitations.[FN30] The court reasoned:

From an injured claimant's perspective, the right to obtain uninsured motorist protection from a self-insurer is no less than the corresponding right under a policy issued by an insurer...[therefore] a claim for uninsured motorist benefits

against a self-insured vehicle owner, while statutorily mandated, remains contractual rather than statutory in nature, and, as such, is subject to the sixyear statute of limitations.[FN31]

Just last month, in Spring World Acupuncture, P.C. v. NYC Transit Authority[FN32]—in which the author's firm was counsel to plaintiff— the Appellate Term unambiguously held that **no-fault** claims against self-insurers are governed by CPLR §213(2)'s six-year limitation, effectively ending this dispute.

This decision raises the question why, if a self-insurer that is forced to provide first-party benefits by statute is bound by the six-year statute of limitations, should MVAIC be any different?[FN33] Perhaps it is because MVAIC, unlike self-insurers, is a statutory creation and would not exist but for Insurance Law §5201.[FN34] Conversely, self-insurers, while statutorily permitted to exist, are not created by statute.[FN35] Moreover, it has been held that a self-insurer, 'By electing to be self-insured, [] stands in the same position as any other insurer under the **No-Fault** Law.'[FN36]

While it remains to be seen whether the appellate courts will revisit the applicable statute of limitations concerning MVAIC, the general rule now is clear: Actions for recovery of **no-fault** benefits against insurers and self-insurers, including the NYC Transit Authority, must be brought within six years, while such actions against MVAIC must be brought within three years.

Late Notice of Claim

The 'New Regulations,' effective April 5, 2002, reduced the time in which to submit proof of claim from 180 to 45 days after the date of service; this is commonly referred to as the '45-day rule.' At the same time, as a counter-balance to the shortened time frame, the New Regulations relaxed the standard for accepting late f ilings, replacing the previous rigid rule that late filings were permitted only when written proof showed that compliance with a deadline was 'impossible,' with a standard excusing a tardy submission when there is a 'clear and reasonable justification' for the delay.

In addition, pursuant to 11 N.Y.C.R.R. §65-3.5(l), insurers are required to establish standards for review of their determinations that a claim was submitted late, including, but not limited to, appropriate consideration for demonstrated difficulty in ascertaining the identity of the insurer and inadvertent submission to the incorrect insurer. Finally, insurers are required, pursuant to 11 N.Y.C.R.R. §65-3.3(e), when denying a claim for late notice to advise the claimant that late notice will be excused where the claimant can provide reasonable justification of the failure to give timely notice. The failure to utilize the prescribed language in this regard renders a denial on such basis a nullity.[FN37]

Other than an insurer's failure to utilize the required language, there is a dearth of case law concerning the 45-day rule. In one lower court case—Hempstead Pain & Medical Services, P.C. v. General Assur. Co., in which the author's firm was counsel to the plaintiff—the court determined that plaintiff's explanation that it mistakenly submitted its claim to the wrong insurer served as a valid reason to excuse its failure to comply with the 45-day rule.[FN38] However, no published case ever addressed what steps an insurer must take when presented with a claimant's excuse for late notice of claim.

In Bronx Expert Radiology v. Clarendon Nat. Ins. Co.[FN39] the Appellate Term was faced with this exact question. In that case, plaintiff's claim was admittedly submitted untimely, but was accompanied by correspondence attempting to explain its delay in filing such. Defendant timely denied the claim and after the plaintiff brought suit, moved for summary judgment, which was denied.

In affirming, the Appellate Term noted that an insurer, upon receipt of an untimely claim and a proffered excuse therefore, must give 'appropriate consideration' of plaintiff's excuse. The court further reasoned that, 'Inasmuch as the

record does not indicate whether defendant gave any consideration to plaintiff's explanation for its tardy submission as required by the regulations, we sustain the denial of defendant's motion for summary judgment.'[FN40]

It is clear, therefore, that in the face of an untimely claim submission with an excuse therefor, an insurer must not only give appropriate consideration to the proffered excuse before denying such claim, but must also be able to demonstrate the consideration given. In this regard, it is important to note that 11 N.Y.C.R.R. §65-3.5(l) requires insurers to establish procedures, based upon objective criteria, to ensure appropriate consideration of denials based upon late submission of claims, including supervisory review of all such determinations. Moreover, the section also demands that such standards be available for review by department examiners. Accordingly, to ensure that 'appropriate consideration' of an excuse is given, and to increase the probability that its denial will survive scrutiny, insurers should resort to their established procedures and be able to explain such procedures and the reasons therefore to the court.

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FN1. Insurance Law §5102(b)(2).

FN2. Central General Hospital v. Chubb Group, 90 N.Y.2d 195 (1997).

FN3. Presbyterian Hosp. v. Maryland Cas. Co., 90 N.Y.2d 274 (1997).

FN4. 11 N.Y.C.R.R. §65-3.8.

FN5. 10 N.Y.3d 556 (2008).

FN6. Id. at 565.

FN7. Id.

FN8. See, Outside Counsel, 'Restoring 'Exceptional Exemption': Effect of 'Fair Price'?' Moroff and Rosenberger, NYLJ, 4, (col. 4) 9/9/2008.

FN9. 60 A.D.3d 1045 (2d Dept. 2009).

FN10. Id. at 1046; cf. O'Hurley-Pitts v. Diocese of Rockville Centre, 57 A.D.3d 633 (2d Dept. 2008).

FN11. 875 N.Y.S.2d 246 (2d Dept. 2009).

FN12. Id.; cf. Infinity Health Products, Ltd v. New York City Transit Authority, 21 Misc.3d 136(A)(App. Term 2nd and 11th Jud. Dists. 2008).

FN13. Id.

FN14. 2009 N.Y. Slip Op. 29228 (App. Term 2nd, 11th and 13th Jud. Dists. 2009).

FN15. 9 Misc.3d 76 (App. Term 2nd and 11th Jud. Dists. 2005).

FN16. Id. at 79-80.

FN17. 42 A.D.3d 277 (2d Dept. 2007).

FN18. 10 N.Y.3d 556 (2008).

FN19. Interestingly, although the Court of Appeals' decision is silent on the issue, such was discussed at oral argument before the Court.

FN20. Hempstead Pain and Medical Services, P.C. v. Progressive Cas. Ins. Co., 2003 N.Y. Slip Op. 51319(U)(N.Y. Dist. Ct. 2003) (J. Asarch) ('[T]his Court has yet to see a counterclaim in a **no-fault** action.')

FN21. Devonshire Surgical Facility v. GEICO, 14 Misc.3d 1208(A)(N.Y. City Civ. Ct. 2006) (J. Jaffe).

FN22. Carnegie Hill Orthopedic Services, P.C. v. GEICO, 19 Misc.3d 1111(A)(N.Y. Sup. Ct. 2008) (J. Palmieri).

FN23. Cornell Medical, P.C. v. Mercury Cas. Co., supra.

FN24. Id.

FN25. Medical Society v. Serio, 100 N.Y.2d 854 (2003).

FN26. 2009 N.Y. Slip Op. 29228 (App. Term 2nd, 11th and 13th Jud. Dists. 2009).

FN27. Id.

FN28. See, Mandarino v. Travelers Property Cas. Ins. Co., 37 A.D.3d 775 (2d Dept. 2007). CPLR §213(2) provides, in part, 'an action upon a contractual obligation or liability, express or implied' must be commenced within six years.

FN29. See, MVAIC v. Aetna Cas. & Sur. Co., 89 N.Y.2d 214 (1996). CPLR §214(2) provides, in part, 'an action to recover upon a liability, penalty or forfeiture created or imposed by statute' must be commenced within three years.

FN30. See, Elrac Inc. v. Suero, 38 A.D.3d 544 (2d Dept. 2007).

FN31. Id. at 545.

FN32. 2009 N.Y. Slip Op. 29229 (App. Term 2nd, 11th and 13th Jud. Dists. 2009).

FN33. http://nofaultdefenseattorneys.blogspot.com/2009/05/six-year-sol.html.

FN34. See, MVAIC v. Aetna Cas. & Sur. Co., 89 N.Y.2d 214 (1996); See also, Pinnacle Open MRI, P.C. v. Republic Western Ins. Co., 18 Misc.3d 626 (N.Y. Dist. Ct. 2008) (J. Engel).

FN35. Pinnacle Open MRI, P.C. v. Republic Western Ins. Co., supra.

FN36. Matter of Ins. Fund, 212 A.D.2d 98 (4th Dept. 1995).

FN37. See, SZ Medical P.C. v. Country-Wide Ins. Co., 12 Misc.3d 52 (App. Term 2nd and 11th Jud. Dists. 2006).

FN38. Hempstead Pain & Medical Services, P.C. v. General Assur. Co., 13 Misc.3d 980 (N.Y. Dist. Ct. 2006) (J. Hackeling).

FN39. 23 Misc.3d 133(A) (App. Term 1st Dept. 2009).

FN40. Id.
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