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HEADLINE: The Thicket of First-Party No-Fault Benefits Actions;
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BODY:

As time progresses, more pathways open through the thicket of first-party no-fault benefits actions. Many issues have been resolved but new ones continue to confound practitioners in this complex area of law.[1]

Difficult issues in this evolving area of insurance law include the medical provider's need to prove "standing" as part of its prima facie case, the insurer's ever-expanding defenses regarding "lack of coverage," licensing requirements and fraudulent incorporation, improper self-referrals, and what constitutes a sufficient showing for proof of mailing. Several recent decisions have provided us with a better understanding of these thorny issues.

Standing

As in any case, a plaintiff must show standing to properly assert its claims. First-party no-fault benefits actions are no different. The appellate courts continue to reaffirm the medical provider's burden to provide an assignment of benefits to prove standing.

A.B. Medical Services PLLC a/a/o Turenne v. State Farm Mutual Auto. Ins. Co., 4 Misc3d 141(A) (App Term, 9th & 10th Jud Dists 2004). While many of the technical deficiencies in the actual assignment can be waived (

Nyack Hospital a/a/o Watson v. Metropolitan Property & Casualty Ins. Co., 16 AD3d 564 [2d Dept 2005];

Laufer a/a/o Winston v. Lumberman's Mutual Casualty Co., 9 Misc3d 133(A), 2006 NY Slip Op 51632(U) [1st Dept 2005]), the medical provider's submission of an unsigned assignment form resulted in the dismissal of the action due to lack of standing.

New York and Presbyterian Hospital v. New York Central Mutual Fire Ins. Co., 2006 NY Slip Op 05336 (2d Dept 2006).

Non-Precluded Defenses

In the landmark case of Presbyterian Hospital in the

City of N.Y. a/a/o DeGuisto v. Maryland Casualty Co., 90 NY2d 274 (1997), the Court of Appeals declared that "an insurer may be precluded from interposing a statutory exclusion defense for failure to deny a claim within 30 days as required by Insurance Law ?5106(a)." Id., at 282. Yet even if the insurer fails to pay or deny a claim within 30 days, it may still raise certain defenses, which are not precluded after 30 days. The Court of Appeals distinguished between "an insurer's denial of liability based upon a policy exclusion and a breach of a policy condition from an insurer's denial based on lack of coverage, such as where no contractual relationship exists with respect to the subject vehicle and incident [citing

Zappone v. Home Ins. Co., 55 NY2d 131, 136-137 (1982)]."

Presbyterian, 90 NY2d at 283. It is within this understanding that the "lack of coverage" defense has evolved.

The most common lack of coverage defense is the "infamous" staged accident allegation. For instance, the Court of Appeals has held that an untimely disclaimer or denial does not prevent the insurer from raising a lack of coverage defense "premised on the fact or founded belief that an alleged injury does not arise out of an insured incident," but was instead a deliberate event staged in furtherance of a scheme to defraud the insurer.

Central General Hospital a/a/o Mandresh v. Chubb Group of Ins. Cos., 90 NY2d 195, 199 (1997),

Mount Sinai Hospital v. Triboro Coach Inc., 263 AD2d 11 (2d Dept 1999). The underlying rationale of the

Central General Hospital holding is that an insurer may refuse to pay a claim on the ground that the "allegedly causative event" was not covered at all by the insurance carrier. 90 NY2d at 202. Because the payment cannot be made without the condition being met, the defense can be asserted whether or not the claim was timely denied.

Central General Hospital "stands for the proposition that the preclusion remedy does not apply to a defense of no coverage at all." Id.

After these Court of Appeals pronouncements, the "lack of coverage" or condition precedent defense has been expanded to include at least four more situations. Three of the situations listed below are significant because they do not directly address the coverage status of the parties, nor of the incident, yet they remain conditions precedent for the insurer's payment.

The first expansion is where the assignor was not an "eligible injured person" who did not "regularly reside" as a defined relative with the insured to be covered under the applicable insurance policy pursuant to 11 NYCRR ?65-1.1(d) & (g). The insurer is not precluded from asserting this defense despite an untimely denial.

Psych. & Massage Therapy Assoc, PLLC a/a/o Przyborouwski v. Progressive Casualty Ins. Co., 2006 NY Slip Op

51351 (U) (App Term, 2d & 11th Jud Dists 2006).

Further expanding the "lack of coverage" defense is the requirement for appropriate licensing and incorporation. Under New York's Insurance Regulations, all applicable state and local licensing requirements necessary to perform medical services must be met for the provider to be reimbursed. 11 NYCRR ?65-3.16(a)(12). This licensing requirement also encompasses the withholding of payments to fraudulently incorporated enterprises.

State Farm Mutual Auto. Ins. Co. v. Mallela, 4 NY3d 313 (2005) (

Mallela). In

A.B. Medical Services PLLC a/a/o Chavarria v. Utica Mutual Ins. Co., 11 Misc3d 71, 73 (App Term, 2d & 11th Jud Dists 2006) (

Utica), the court held that "a defense based upon plaintiffs' allegedly fraudulent corporate licensure is not precluded [by an untimely denial]." Similarly, in

First Help Acupuncture P.C. a/a/o Guerrero v. State Farm Ins. Co., 12 Misc3d 130(A) (App Term, 2d & 11th Jud Dists 2006), the Appellate Term reiterated that holding, stating that "[t]he defense that a provider is fraudulently licensed and hence ineligible for reimbursement of no-fault benefits under 11 NYCRR ?65-3.16(a)(12), is a non-waivable defense and is therefore not subject to the 30-day preclusion rule."

The third extension involves an alleged defense of "improper self-referral" in violation of Public Health Law (PHL) ?238-d. PHL ?238-d prohibits a referral by a health care provider to certain entities such as a medical supply house if the provider or such provider's immediate family has a financial interest in the entity unless the provider discloses the financial interest to the patient. In

Fair Price Medical Supply Corp. a/a/o Graham v. Elrac Inc., 2006 Slip Op 26269 (App Term, 2d & 11th Jud Dists 2006), the Appellate Term, Second Department relied upon its recent decision in

Utica to hold that an insurer's defense raising the provider's prohibited self-referral under PHL ?238-d is also not precluded even if the claim was not timely denied.

The fourth expansion is where a medical provider seeks to bill for services provided by an independent contractor. In such a case, the billing provider "is not a 'provider' of the medical services rendered within the meaning of 11 NYCRR ?65-3.11(a) and is therefore not entitled to recover 'direct payment' of assigned no-fault benefits from the defendant insurer."

Rockaway Blvd. Medical P.C. v. Progressive Ins., 9 Misc3d 52, 54 (App Term, 2d & 11th Jud Dists 2005). Such a defense is not subject to the 30-day preclusion rule and is not waivable. Id. Thus, a denial based on the treating physician being an independent contractor is not precluded even if otherwise untimely.

A.M. Medical Services, P.C. a/a/o Yaroshenko v. Liberty Mutual Ins. Co., 12 Misc3d 130(A) (App Term, 2d & 11th Jud Dists 2006).

Proof of Mailing

There are three distinct methods to demonstrate proof of mailing. The first and simplest method is to provide an affidavit from an individual with personal knowledge of the actual mailing. The second is where an acknowledgment serves as an admission by the adverse party that it received the subject document.

A.B. Medical Services a/a/o German v. New York Central Mutual Fire Ins. Co., 3 Misc3d 136(A) (App Term, 2d & 11th Jud Dists 2004);

Fair Price Medical Supply Corp. v. Elrac Inc., supra. The third and most common method is where the party provides proof of a standard office procedure, which ensures that documents are properly addressed and mailed.

Pardo v. Central Cooperative Insurance Co., 223 AD2d 832 (3d Dept 1996). The first and second methods are straight-forward. However, the third method is vexing as there is a dearth of authority that addresses the specific requirements to adequately set forth a standard office practice and procedure.

The courts discuss the sufficiency of proof of mailing in several contexts. These include cancellation notices sent by insurers to insureds, and denials of claims or requests for verification by insurers to healthcare providers. The standard of proof necessary to establish that a proper mailing was executed appears to be the same for each of these circumstances. See, e.g.,

Contemp. Med. Diag. & Treatment, P.C., a/a/o Boone and Villafane v. Government Employees Ins. Co., 6 Misc3d 137(A) (App Term, 2d & 11th Jud Dists 2005) (holding that standard of proof for mailing of verification requests are the same as for denial of claims, as per

Hospital for Joint Diseases v. Nationwide Mutual Ins. Co., 284 AD2d 374 [2d Dept 2001], and insurance cancellation notices, as per

Residential Holding Corp. v. Scottsdale Ins. Co., 286 AD2d 679, 680 [2d Dept 2001]). "Generally, proof of proper mailing gives rise to a presumption that the item was received by the addressee."

Residential Holding Corp., 286 AD2d at 680. However, "in order for the presumption [of mailing] to arise, office practice must be geared so as to ensure the likelihood that a notice . . . is always properly addressed and mailed."

Nassau Ins. Co. v. Murray, 46 NY2d 828, 830 (1978).

To establish proof of mailing, an affidavit should detail standard office policies and procedures regarding the processing of claims and it must also contain a statement of the affiant's personal knowledge that those policies and procedures have been followed in the instant case. See

Contemp. Med. Diag. & Treatment, P.C., a/a/o Boone and Villafane v. Government Employees Ins. Co., supra. Furthermore, there should be "testimony about office procedures relating to the delivery of mail to the post office, whether a practice existed of comparing the names on the mailing list with the names and addresses on the envelopes for accuracy, or whether anyone routinely checked that the total number of envelopes matched the number of names on the mailing list." In the

Matter of Lumbermens Mutual Casualty Co. (Collins), 135 AD2d 373, 375 (1st Dept 1987).

By inference, the affiant should state the following necessary details to show office practice and procedure including: 1) whether anyone compiled a list of intended recipients; 2) whether anyone checked that a corresponding envelope containing a verification request or a denial of claim form was properly addressed for each recipient; and 3) whether anyone established a procedure for affixing the appropriate postage and delivering the mail to the post office. The failure to properly allege some of the above details have resulted in courts holding that the showing was insufficient because the affiant's affidavit was conclusory.

New York and Presbyterian Hospital, a/a/o Udland v. Allstate Ins. Co., 29 AD3d 547 (2d Dept 2006). However, the appellate courts have recently modified this standard by holding that while the supporting affidavit may be insufficient to establish the presumption of mailing for the proponent of a summary judgment motion, it may suffice for the

opponent of the motion to raise triable issues of fact.

Response Medical Equipment a/a/o Applewhite v. General Assurance Co., 2006 NY Slip Op 51765(U) (App Term, 1st Dept 2006);

Boai Zhong Yi Acupuncture Services, P.C. a/a/o Grishina v. New York Central Mutual Fire Ins. Co., 12 Misc3d 135(A) (App Term, 2d & 11th Jud Dists 2006).

With more time and appellate guidance, additional pathways should open through the thicket of ever-evolving No-Fault case law.

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Endnotes:

1. For an overview, refer to my previous articles: "A Legal Overview of First-Party No-Fault Benefits Actions," New York Law Journal, Oct. 8, 2004, at 4, col. 4, and "Recent Developments in First-Party No-Fault Benefits Actions," NYLJ, Aug. 4, 2005, at 4, col. 4.

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