May, 2009

No Fault, No Foul: Litigating First-Party-Benefit Cases—Part I

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THE OFFICIAL PUBLICATION OF THE BROOKLYN BAR ASSOCIATION

BROOKLYN BARRISTER

©2009 Brooklyn Bar Association | MAY 2009 | VOL. 61 NO.8

President-Elect John Lonuzzi Participates in ABA Bar Leadership Institute in Chicago

Joining some 300 other emerging leaders of lawyer organizations from across the country at the American Bar Association's Bar Leadership Institute (BLI) at the Chicago Marriott Hotel Downtown on March 12-14 was President-Elect John Lonuzzi.

The BLI is held annually in for incoming officials of local and state bars, special focus lawyer organizations, and bar foundations. The seminar provides the opportunity to confer with ABA officials, bar leader colleagues, executive staff, and other experts on the operation of such associations.

John Lonuzzi joined ABA President H. Thomas Wells, Jr. of Birmingham, AL, and ABA Executive Director Henry F. White, Jr. in sessions on bar governance, finance, communications, and planning for his presidential term. Various ABA entities briefed the participants on resources available from the ABA for local, state, national, and specialty bar associations and foundations.

The BLI is sponsored by the ABA Standing Committee on Bar Activities and Services and the ABA Division for Bar Services as part of the Association's long-standing goal of fostering partnerships with state and local bars and related organizations.

American Bar Association President H. Thomas Wells, Jr., President-Elect John Lonuzzi, Executive Director Avery Eli Okin, Esq., CAE and American Bar Association Executive Director and COO Henry F. White, Jr.

No Fault, No Foul: Litigating First-Party-Benefit Cases

By Hon. Gerald Lebovits and Kimberly Schirripa, Esq*

In a first-party no-fault case, aggrieved parties can be the injured persons or their health-care providers operating under an assignment of rights. The aggrieved have two options to address their legal disputes with an insurer: binding arbitration or filing a breach-of-contract suit. An insured who has a direct contract with its insurance company may seek recovery under that contract in a first-party benefit claim for health-care expenses incurred as a result of physical and mental injuries sustained in a motor-vehicle accident. Although health-care providers do not have a direct contract with the injured party's insurer, they can still be a first-party claimant by virtue of an assignment the insured makes to the provider to enable the provider to collect no-fault benefits under the insured's insurance policy.[1]

Difficult issues arise in no-fault first-party benefit actions. Attorneys who represent the plaintiff medical provider or the defendant insurance company must cross

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1.5 Million Reasons To Join The BBA Lawyer Referral Service

By Roseann S. Heibert

The Brooklyn Bar Association Lawyer Referral Service has hit a milestone. Lawyer Referral Service ("LRS") attorneys have received a record $1.5 million dollars in fees from referred cases since June 1, 2008. The LRS has received percentage fee income of over $154,000.00 as a result. This figure does not include any fees under $500.00 that the attorneys collected, from which the LRS does not take a percentage. This income, along with consultation fees and LRS panel membership fees, have brought in a total of over $245,000.00; this is the most the LRS has ever taken in. The monies will allow the LRS to add additional staff hours, update equipment and expand the service to better serve the community.

The BBA LRS panel added 21 new attorneys for fiscal year 2008-2009. The LRS has maintained an average of 155 to 165 panel attorneys. BBA LRS panel memberships will be up for renewal on June 1st 2009 through November 30th 2009.

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What's Inside

No Fault, No Foul: Litigating First-Party-Benefit Cases (Continued from page 1)

each "t" and dot each "i" to uphold their client's interests. This article outlines the claims process and some difficult legal issues affecting health-care providers/assignees and insurers.

Overview

New York enacted its no-fault law to compel insurance companies to pay legitimate motor-vehicle-accident-related medical expenses, lost earnings, and incidental costs, regardless of who is to blame for the accident. The New York legislature designed the law to speed compensation without long, drawn-out litigation over fault and amounts owed. The legislature enacted detailed regulations providing specific requirements to pay no-fault benefits, but many issues during the claims-submission process lead to litigation.

No-fault cases are generally brought against insurance companies by health-care providers seeking payment of benefits. The New York City Civil Court hears most of these no-fault cases; the amount in controversy rarely exceeds the $25,000 jurisdictional minimum required to maintain the action in Supreme Court. The providers typically allege that the insurer failed to pay a claim timely or improperly denied the claim.

When a health-care provider files a complaint, the provider will often immediately move for summary judgment — even before the parties conduct disclosure. The parties adjourn many of these summary-judgment motions and the actions can sit on the courts' calendars for months. Most no-fault cases are resolved by motion or settlement. However, some issues, such as whether the services were medically necessary do lead to trials.

Despite the legislature's intent to simplify first-party-benefit litigation, these cases are litigated heavily.[2] The courts render published decisions almost daily on the various issues that arise during litigation. A number of Web sites provide links to recent opinions and promote discussions of these opinions and their implications.[3]

The Claims Process

The general framework for payment of first-party benefits derives from Insurance Law § 5106(a), which provides that (1) payments of first-party benefits and additional first-party benefits shall be made as the loss is incurred and (2) benefits are overdue if not paid within 30 days after the claimant supplies proof of the fact and the amount of loss sustained. Interpreting Insurance Law § 5106, the Superintendent of Insurance promulgated Regulation 68 and codified it under 11 N.Y.C.R.R. 65. Section 65 contains the requirements to submit, verify, deny, and pay first-party benefits.

The process begins when injured parties notify their insurer of an accident. Injured parties typically submit an "Application for Motor Vehicle No-Fault Benefits" (N.Y.S. Form NF-2). In seeking medical treatment after a car accident, injured parties routinely assign to their respective health-care providers their right to collect payment for the health-care services rendered. These providers include hospitals, orthopedists, radiology facilities, acupuncturists, chiropractors, physical-therapy offices and dentists.

For the health-care provider to collect payment timely from the injured party's no-fault insurer, the provider must comply with the notice condition precedent in 11 N.Y.C.R.R. 65-2.4(c), which requires the provider to submit a written proof of claim to the insurer for service expenses within 45 days after the services are rendered.[4] Providers usually comply with this provision by submitting a "Verification of Treatment by Attending Physician or Other Provider of Health Service" (N.Y.S. Form NF-3). Unless "the applicant can provide reasonable justification of the failure to give timely notice,"[5] reliance on the 45-day claim-submission rule is waived if the insurer fails to inform the claimant that a late notice of claim will be excused.

Within 10 business days after receiving the completed no-fault application, the insurer must forward verification forms for health-care or hospital treatment to the injured party or that party's assignee. After receiving the completed verification forms, the insurer may seek additional verification or further proof of claim from the injured party or the assignee within 15 business days.[6] For example, the insurer may seek additional medical documentation or an independent medical examination (IME) of the injured party. If the insurer seeks an IME, the exam must be held within 30 calendar days from the insurer's receipt of the initial verification forms.[7] Additionally, the insurer may seek an examination under oath (EUO), which "must be based upon the application of objective standards so that there is specific objective justification supporting the use of such examination."[8]

If any requested "additional verification" is not supplied to the insurer 30 calendar days after the original request, § 65-3.6(b) requires that the insurer, within 10 calendar days, follow-up with the recalcitrant party "either by telephone call, properly documented in the file, or by mail." Section 65-3.6(b) also provides that at the same time as the follow-up, "the insurer shall inform the applicant and such party's attorney of the reason(s) why the claim is delayed by identifying in writing the missing verification and the party from who it was requested."

After receiving the notice and proof of claim, the insurer must pay or deny the claim within calendar 30 days.[9] No-fault benefits are overdue if not paid within these 30 days. An insurer that denies the claim often uses a prescribed "Denial of Claim Form" (N.Y.S. Form NF-10), which must provide a detailed explanation for the denial.

The Assignee's Prima Facie Case

The plaintiff assignee's goal in litigating a no-fault first-party-benefit case is to establish a prima facie case at the outset of the litigation so that summary judgment is granted and the providers are paid for their services. To establish a prima facie case, plaintiffs must meet their initial burden of proof to demonstrate (1) standing to bring the action and (2) the submission of a timely completed proof of claim that the insurer did not pay or deny within 30 days. Defendants have the burden to demonstrate a timely and proper denial, a burden triggered only if the plaintiff establishes a prima facie case.

Standing

As with every type of litigation, a plaintiff must have a right to make a legal claim to commence litigation. Health-care providers seeking first-party no-fault benefits are no different.

A provider can establish standing by submitting a properly completed assignment-of-benefits form. The assignor should sign and date the form, which should contain the assignor and assignee's name and the date of the accident. The insurance regulations do not require authentication of signatures on assignment forms. If the assignment-of-benefits form does not contain all the appropriate information, the insurer can assert as a defense to the benefits claim that the assignment was deficient or defective.

Problems with standing arise when the assignee's name on the form does not match the named plaintiff in the complaint. When providers do business under another name, that name should appear as a named plaintiff as well. If the name on the assignment does not match the plaintiff's name in the complaint's caption, the action might be dismissed for lack of standing.[10] Standing is also an issue if the assignment contains a reservation-of-rights provision that reserves the assignee's right to collect money owed for service rendered from the assignor should the assignee not recover no-fault benefits. When that reservation of rights exists, the provider has no standing to sue.[11]

Proof of Timely Submission

Once it shows standing, the plaintiff must establish a timely proof-of-claim submission by submitting completed proof-of-claim forms. These forms typically include the policyholder's name, the provider's name and address, the policy number, the accident date, the date of health- care service, the place of service, a description of treatment or service rendered, and the charges billed. The provider must also demonstrate that it mailed the claim submission to the insurer.

Despite the submission of a duly executed proof of claim form, the health-care provider must be an eligible claimant to receive reimbursement for services rendered. Fraudulently incorporated medical corporations are ineligible to receive benefits.[12] Additionally, a billing provider is an ineligible claimant if it submits a claim form on behalf of an independent contractor identified as the treating physician.[13] To be eligible, the provider must be duly licensed and be the services' actual provider.

Regarding proof of mailing, "a properly executed affidavit of service raises the presumption that a proper mailing occurred, and a mere denial of receipt is not enough to rebut this presumption."[14] Despite this controlling legal principle, health-care providers often do not use affidavits of service in no-fault cases to demonstrate proof-of-claim submission. Instead, providers submit copies of mailing certificates, post-office ledgers, and sworn affidavits from personnel attesting to the method of service. These proofs do not give rise to the presumption of proper mailing. To demonstrate proof of mailing, the easiest method is to use and retain a return-receipt card. With this method, no doubt arises that the insurer received the mailing: The recipient needs to sign the card to receive the mailing.[15]

In most cases in which the proof of mailing was insufficient, problems existed with the affidavits submitted. The key is to make sure that the affiants (1) state that they mailed to the defendant the documents related to the claims for treatment rendered to the assignor and (2) explain their standard office-mailing procedure. Providing a certified mail receipt alone is insufficient proof of mailing.[16]

Another way to establish proof of mailing is for the insurer to concede in its denial of claim the date it received the claim. Doing so is deemed an admission and is sufficient proof of mailing.[17] This evidence is so compelling that the courts have found sufficient proof of mailing even when the plaintiff fails to submit the insurer's denial of claim, given that the court may search the record on a summary-judgment motion to find the missing elements of the plaintiff's prima facie case.[18]

Business Records

To establish a prima facie case, all the documents submitted to the court must be in admissible form. In other words, the health-care provider must establish that each document is a business record. Without that proof, the documents are inadmissible hearsay. The proper way to demonstrate that the records are business records is to submit an affidavit from an officer or billing manger setting forth their respective office duties and the office's business practices and procedures to support the inference that the attached documents are sufficiently accurate and trustworthy to merit their admission as business records. An affidavit from a corporate officer with no personal knowledge of the documents will not suffice.[19] The affidavit need not allege personal knowledge that the provider rendered services to the assignor or that the services were medically necessary.[20] An attorney's affirmation will not suffice. Attorneys do not have personal knowledge of the facts to establish the documents as business records.[21]

The Appellate Term, Second Department, has rejected attempts to use a notice to admit or the response to a written interrogatory to admit claim forms as business records, even when the insurer admitted in its response that it timely received a claim form.[22] The Appellate Term, First Department, however, has permitted an admission made in response to interrogatories to serve as admissible evidence that the insurer received a claim form timely.[23]

Medical Necessity And Causation

An issue has arisen over whether the assignee must demonstrate medical necessity or causation in addition to its proof-of-claim submission. The short answer is no. The two leading cases on medical necessity are *Amaze Med. Supply Inc. v. Eagle Ins. Co.*[24] and *Damadian MRI in Elmhurst, P.C. v. Liberty Mut. Ins. Co.*[25] The *Amaze* and *Damadian* courts held that a health-care provider's proof that it submitted a properly completed claim form establishes its prima facie case on a motion for summary judgment. Both courts rejected the contention that because no-fault compensation is available only for medically necessary health benefits, a health provider must establish the treatment's medical necessity by proof independent of the claim form.

With respect to causation, an assignee is similarly not required to prove as a threshold matter that the automobile accident caused the alleged medical condition and was unrelated to the injured person's medical history.[26] Causation is presumed in establishing a prima facie case. Requiring a claimant to establish causation would place an onerous burden on claimants. That would allow insurers to refrain from issuing timely disclaimers — and that would undermine the policy concerns underlying New York's no-fault legislation.

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The Insurer's Burden Of Proof

After the provider submits notice and proof of claim to the insurer, the onus shifts to the insurer to pay or deny the claim within 30 days. An insurer that denies the claim must submit adequate proof of mailing that it mailed the denial timely. The insurer's requirements are the same as the provider's. If the insured intends to rely on a claims adjuster's affidavit, the adjuster must have personal knowledge that the insurance company mailed the denial forms, or the adjuster must set forth a sufficiently detailed description of the standard office mailing procedure to give rise to a presumption of mailing.[27]

The insurer must use the proper statutory forms for the denial to be valid.[28] An insurer that fails to use the correct form will be precluded from asserting a number of defenses, even if the denial was timely.[29]

General Obligation Law § 13-105 provides that an "assignee stands in the shoes of the assignor" and takes the assignment subject to pre-existing liabilities. This rule is broadly applied in the Second Department to provider-assignee claimants for no-faults benefits.[30] The First Department has not adopted this broad application. The First Department dictates that "to the extent [a] defendant seeks to invoke the general rule that an assignee is subject to the same defenses as would be available against its assignor . . . the rule, as codified, finds no application in circumstances where . . . the assigned claim is 'regulated by special provision of law.'"[31]

Verifications & Counting
The 30-Day Calendar

Confusion surrounds how to count the 30 calendar days in which the insurer must pay or deny a claim and how verification requests can affect the counting. Section 65-3.8(j) provides that any deviation from the rules set out in § 65-3.8 shall reduce the 30 calendar days allowed. The example given in § 65-3.8(j) occurs when an insurer sends an application for motor vehicle no-fault benefits 15 days after notice is received at the address of the insurer's claim-processing office instead of 5 business days. The 30 calendar days permitted by § 65-3.8(a) are reduced to 20 calendar days in which the insurer must pay or deny a claim.

The Court of Appeals in *Hospital for Joint Diseases v. Travelers Prop. Cas. Ins. Co.* rationalized the various references to the 10 and 15 day verification deadlines following receipt of a claim. The court found that "[u]pon receipt of one or more of the prescribed verification forms used to establish proof of claim, such as the NYS Form NF-5, an insurer has 15 business days within which to request 'any additional verification required by the insurer to establish proof of claim.'"[32] If a claimant submits an application for no-fault benefits (NYS Form NF-2) without verification forms, "the insurer has 10 business days to forward the 'prescribed verification forms it will require prior to payment of the initial claim.'"[33] Because providers often use the NF-3 verification-of-treatment form instead of the NF-2 form as their proof of claim, the court considered that submission a first verification, moving the stage of proceedings directly to the 15-day verification period permitted under § 65-3.5(b). It is unclear whether that procedure affects an insurer's entitlement to two opportunities to request verification. An insurer's verification rights under § 65-3.5(a) are not limited to the

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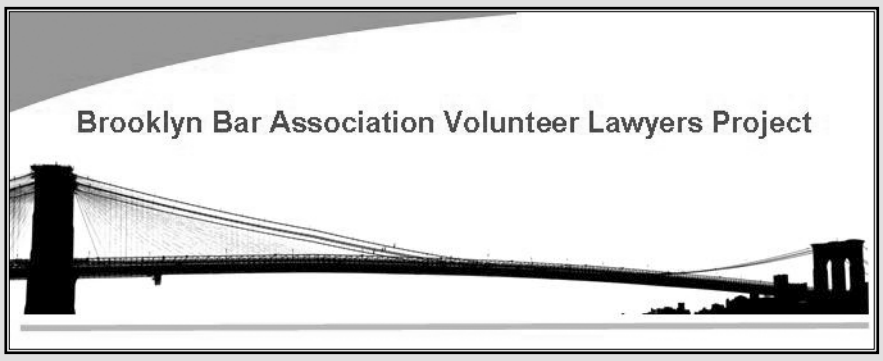

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types of verification listed on the NF-3 form.

Delay letters do not toll the 30-day claim-determination period. Even if the delay letter is entitled a verification request, an insurer may not rely on that letter, which informs a claimant merely that a decision on the claim is delayed pending an investigation, without specifying a particular form of verification and the person or entity from whom the verification is sought.[34]

The Insurer's Defenses

Even if an assignee were to comply with every notice requirement in 11 N.Y.C.R.R. 65, an insurer may raise a litany of defenses to deny or disclaim paying no-fault benefits. An insurer has the right to deny a claim based on deficiencies in the assignee's proof of claim, lack of medical necessity, unnecessary or excessive treatment, fraudulent or excessive billing, improper use of billing codes and fee schedules, that the assignee is not a "provider" under 11 N.Y.C.R.R. 65-3.11, lack of coverage, that the automobile incident was staged to defraud, and that the insurance policy was procured fraudulently.

If the defense is not asserted at the right time, the insurer will waive the defense and thus will be precluded from asserting it during litigation. For example, unless an insurer sends a verification request within 10 days of the claim's receipt, an insurer waives any defense it might have asserted that the claim form was deficient or lacking in specificity.[35] If an insurer fails to issue a timely denial within the 30-day time period, the insured waives its right to assert such defenses as lack of medical necessity,[36] provider fraud (*i.e.*, unnecessary or excessive treatment or fraudulent or excessive billing),[37] untimely proof of claim,[38] and improper use of billing codes and fee schedules.[39]

Although timely and valid requests for EUOs and IMEs toll the 30-day time period for an insurer to pay or deny a claim, the Appellate Division, Second Department, has found that untimely denials will also preclude the insurer from asserting an alleged breach of a policy condition such as an assignor's failure to appear for a EUO.[40] The court reasoned that "such an alleged breach does not serve to vitiate the medical provider's right to recover no fault benefits or to toll the 30-day statutory period."[41] Therefore, patient EUO no-shows, and presumably IME no-shows, require timely denials.

The preclusion rule does not apply to a defense based on lack of coverage, even if the denial is untimely.[42] Preclusion is also inapplicable if the provider is fraudulently licensed and hence ineligible for reimbursement of no-fault benefits.[43] Furthermore, preclusion is unavailable if the assignor failed to file a timely notice of claim or to seek leave to file a late notice of claim. In these circumstances, the assignor is not a "covered person" under Insurance Law § 5221(b)(2), a condition precedent to recovering no-fault benefits.[44] An insurer will also not be precluded from asserting that the incident was staged to defraud,[45] that the cost of unprescribed medical equipment is not a recoverable no-fault benefit,[46] that the assignee is not a "provider" of medical services within 11 N.Y.C.R.R. 65-3.11,[47] or that the insurance policy was fraudulently procured.[48] Finally, a denial of benefits based on a violation of Public Health Law § 238-a, which prohibits practitioners from making a referral to a health-care provider with which the practitioner or immediate family member has a financial relationship, is not precluded by a failure to deny the claim with the statutory 30 days.[49]

Conclusion

No-fault regulations, while appearing straightforward at first glance, have led to numerous issues in first-party-benefit-litigation disputes. Unrealized has been the hope that no-fault legislation would lead to less litigation. The legislation has produced confused, contested, and copious litigation. To prevail, counsel must cross all "t's and dot all "i's"

** Hon. Gerald Lebovits is a Judge of the New York City Civil Court, Housing Part, and an adjunct professor at St. John's University School of Law. Kimberly Schirripa is a senior associate at Lester Schwab Katz & Dwyer, LLP*

[1] Third-party claims, by contrast, are those in which the injured parties pursue their claims for pain and suffering directly against the at-fault person or the at-fault person's insurance company.

[2] For an excellent outline of the case law, see Ariel E. Belen, *Summary of Recent Decisions of the Appellate Term — Second Judicial Department on No-Fault Insurance Law*, 2008 Summer Judicial Seminar (revised Apr. 29, 2008).

[3] *See, e.g.*, *No-Fault Paradise*, http://nofaultparadise.blogspot.com (last visited Apr. 14, 2009); *New York Civil Law: No-Fault Law*, http://nylaw.typepad.com/new_york_civil_law/nofault_law (last visited Apr. 14, 2009).

[4] 11 N.Y.C.R.R. 65-2.4(a) ("No action shall lie against the self-insurer unless, as a condition precedent thereto, there shall have been full compliance with the terms of this section.").

[5] *Id.* § 65-3.3(e).

[6] *Id.* § 65-3.5(b).

[7] *Id.* § 65-3.5(d).

[8] *Id.* § 65-3.5(e).

[9] *Id.* § 65-3.8(a)(1) & (c).

[10] *See, e.g.*, *Park Health Ctr. v. Green Bus Lines, Inc.*, 2002 N.Y. Slip Op. 40029(U) (App. Term 2d & 11th Jud. Dists. 2002) (finding that caption's reference to Park Health Center as plaintiff did not warrant dismissal; although assignment named Dr. Jamil M. Abraham, M.D., P.C. as assignee, plaintiff's billing agent's affidavit stated that plaintiff was "Park Health Center d/b/a Jamil M. Abraham, M.D., P.C." and complaint identified Jamil M. Abraham, M.D., P.C., as plaintiff).

[11] *S & M Supply, Inc. v. Nationwide Mut. Ins. Co.*, 3 Misc. 3d 138(A), 787 N.Y.S.2d 681 (App. Term 2d & 11th Jud. Dists. 2004); *Rehab. Med. Care of N.Y., P.C. v. Travelers Ins. Co.*, 188 Misc. 2d 176, 177, 727 N.Y.S.2d 247 (App. Term 2d & 11th Jud. Dists. 2001).

[12] *See* § 65-3.16(a)(12) (barring no-fault benefit reimbursement to any provider that "fails to meet any applicable New York State or local licensing requirement"); *Midwood Acupuncture, P.C. v. State Farm Mut. Auto. Ins. Co.*, 14 Misc. 3d 131(A), 836 N.Y.S.2d 486 (App. Term 2d & 11th Jud. Dists. 2007).

[13] *A.B. Med. Servs., PLLC v. Liberty Mut. Ins. Co.*, 9 Misc. 3d 36, 801 N.Y.S.2d 690 (App. Term 2d & 11th Jud. Dists. 2005); *Craig Antell, D.O., P.C. v. N .Y. Cent. Mut. Fire Ins. Co.*, 11 Misc. 3d 137(A), 816 N.Y.S.2d 694 (App. Term 1st Dep't 2006).

[14] *Kihl v. Pfeffer,* 94 N.Y. 2d 118, 122, 700 N.Y.S.2d 87, 90 (1999).

[15] *Ocean Diagnostic Imaging, P.C. v. Travelers Prop. Cas. Corp.*, 8 Misc. 3d 130(A), 801 N.Y.S.2d 779 (App. Term 2d & 11th Jud. Dists. 2005).

[16] *See, e.g.*, *PDG Psychological P.C. v. Progressive Cas. Ins. Co.*, 12 Misc. 3d 144(A), 824 N.Y.S.2d 766 (App. Term 2d & 11th Jud. Dists. 2006); *SpineAmericare Med., P.C. v. State Farm Mut. Auto. Ins. Co.*, 13 Misc. 3d 135(A), 831 N.Y.S.2d 350 (App. Term 9th & 10th Jud. Dists. 2006).

[17] *Dilon Med. Supply Corp. v. State Farm Mut. Auto Ins. Co.*, 13 Misc. 3d 141(A), 831 N.Y.S.2d 358 (App. Term 2d & 11th Jud. Dists. 2006); *Delta Diagnostic Radiology, P.C. v. Allstate Ins. Co.*, 13 Misc. 3d 135(A), 831 N.Y.S.2d 352 (App. Term 9th & 10th Jud. Dists. 2006).

[18] *Oleg Barshay, D.C., P.C. v. State Farm Ins. Co.*, 14 Misc. 3d 74, 76, 831 N.Y.S.2d 821, 822 (App. Term 2d & 11th Jud. Dists. 2006); *PDG Psychological P.C. v. Utica Mut. Ins. Co.*, 11 Misc. 3d 128(A), 815 N.Y.S.2d 496 (App. Term 2d & 11th Jud. Dists. 2006).

[19] *A.B. Med. Servs., PLLC v. Amex Assur. Co.*, 19 Misc. 3d 130(A), 859 N.Y.S.2d 900 (App. Term 2d & 11th Jud. Dists. 2008); *Fortune Medical, P.C. v. Allstate Ins. Co.*, 14 Misc. 3d 136(A), 836 N.Y.S.2d 492 (App. Term 9th & 10th Jud. Dists. 2007).

[20] *Ocean Diagnostic Imaging v. State Farm Auto. Ins. Co.*, 4 Misc. 3d 141(A), 798 N.Y.S.2d 346 (App. Term 9th & 10th Jud. Dists. 2004).

[21] *Ont. Med., P.C. v. SeaSide Med., P.C.* 15 Misc. 3d 129 (A), 839 N.Y.S.2d 435 (App. Term 2d & 11th Jud. Dists. 2007).

[22] *Dan Med. P.C. v. N.Y. Cent. Mut. Fire Ins. Co.*, 14 Misc. 3d 44, 47, 829 N.Y.S.2d 404, 406-07 (App. Term 2d & 11th Jud. Dists. 2006); *Empire State Psychological Servs. v. Travelers Ins. Co.*, 13 Misc. 3d 131(A), 824 N.Y.S.2d 753 (App. Term 2d & 11th Jud. Dists. 2006).

[23] *Fair Price Med. Supply Inc. v. St. Paul Travelers Ins. Co.*, 16 Misc. 3d 8, 9, 838 N.Y.S.2d 848, 849 (App. Term 1st Dep't 2007).

[24] 2 Misc. 3d 128(A), 784 N.Y.S.2d 918 (App. Term 2d & 11th Jud. Dists. 2003).

[25] 2 Misc. 3d 128(A), 784 N.Y.S.2d 919 (App. Term 9th & 10th Jud. Dists. 2003).

[26] *Mount Sinai Hosp. v. Triboro Coach*, 263 A.D.2d 11, *passim*, 699 N.Y.S.2d 77, *passim* (2d Dep't 1999); *Bronx Radiology, P.C. v. N.Y. Cent. Mut. Fire Ins. Co.*, 17 Misc. 3d 97, 99, 847 N.Y.S.2d 313, 314 (App. Term 1st Dep't 2007).

[27] *See Vista Surgical Supplies, Inc. v. State Farm Mut. Ins. Co.*, 14 Misc. 3d 135(A), 836 N.Y.S.2d 495 (App. Term 2d & 11th Jud. Dists. 2007); *Prestige Med. & Surgical Supply, Inc. v. Clarendon Nat. Ins. Co.*, 13 Misc. 3d 127(A), 824 N.Y.S.2d 758 (App. Term 2d & 11th Jud. Dists. 2006).

[28] *Mount Sinai Hosp. v. Triboro Coach,* 263 A.D.2d 11, 17, 699 N.Y.S.2d 77, 81-82 (2d Dep't 1999); *SpineAmericare Med., P.C. v. U.S. Fid. & Guar. Co.*, 12 Misc. 3d 138(A); 824 N.Y.S.2d 766 (App. Term 9th & 10th Jud. Dists. 2006).

[29] *Nyack Hosp. v. Metropolitan Prop. & Cas. Ins. Co.*, 16 A.D.3d 564, 565, 791 N.Y.S.2d 658, 659 (2d Dep't 2005).

[30] *Long Is. Radiology v. Allstate Ins. Co.*, 36 A.D.3d 763, 765, 830 N.Y.S.2d 192, 194 (2d Dep't 2007).

[31] *A&S Med. P.C. v. Allstate Ins. Co.*, 196 Misc. 2d 322, 324, 764 N.Y.S.2d 767, 768 (App. Term 1st Dep't 2003), *aff'd*, 15 A.D.3d 170, 171, 789 N.Y.S.2d 27, 28-29 (1st Dep't 2005) (quoting General Obligation Law § 13-105).

[32] 9 N.Y.3d 312, 317, 849 N.Y.S.2d 473, 474 (2007) (quoting 11 NYCRR 65-3.5(b)).

[33] *Id.* at 317 n.2, 849 N.Y.S.2d at 474 n.2 (quoting 11 NYCRR 65-3.5(a)).

[34] *Ocean Diagnostic Imaging P.C. v. Citywide Auto Leasing Inc.*, 8 Misc. 3d 138(A), 806 N.Y.S.2d 446 (App. Term 2d & 11th Jud. Dists. 2005).

[35] *Mount Sinai Hosp. v. Triboro Coach*, 263 A.D.2d 11, 16, 699 N.Y.S.2d 77, 81 (2d Dep't 1999); *St. Clare's Hosp. v. Allcity Ins. Co.*, 201 A.D.2d 718, 720, 608 N.Y.S.2d 325, 327 (2d Dep't 1994).

[36] *Vista Surgical Supplies, Inc. v. State Farm Mut. Ins. Co.*, 14 Misc. 3d 135(A), 836 N.Y.S.2d 495 (App. Term 2d & 11th Jud. Dists. 2007); *Church Ave. Med. Care v. Allstate Ins. Co.*, 189 Misc. 2d 340, 341, 731 N.Y.S.2d 582, 583 (App. Term 9th & 10th Jud. Dists. 2001).

[37] *M.G.M. Psychiatry Care P.C. v. Utica Mut. Ins. Co.*, 12 Misc. 3d 137(A), 824 N.Y.S.2d 763 (App. Term 2d & 11th Jud. Dists. 2006); *Ultra Diagnostics Imaging v. Liberty Mut. Ins. Co.*, 9 Misc. 3d 97, 98-100, 804 N.Y.S.2d 532, 533-34 (App. Term 9th & 10th Jud. Dists. 2005).

[38] *Radiology Today, P.C. v. Allstate Ins. Co.*, 11 Misc. 3d 135(A), 816 N.Y.S.2d 700 (App. Term 2d & 11th Jud. Dists. 2006).

[39] *New York Hosp. Med. Ctr. of Queens v. Country-Wide Ins. Co.*, 295 A.D.2d 583, 584-86, 744 N.Y.S.2d 201, 203-04 (2d Dep't 2002); *Rigid Med. of Flatbush, P.C. v. N.Y. Cent. Mut. Fire Ins. Co.*, 11 Misc. 3d 139(A), 816 N.Y.S.2d 700 (App. Term 2d & 11th Jud. Dists. 2006).

[40] *See Westchester Med. Ctr. v. Lincoln Gen. Ins. Co.*, 2009 NY Slip Op 02589 (2d Dep't Mar. 31, 2009). For a link to this opinion and a discussion of it, see *It's No-Fault of NY: New York State No-Fault Insurance Law News, Analysis and Commentary*, http://nynofaultlaw.blogspot.com (last visited Apr. 14, 2009).

[41] *Id.*

[42] *Central Gen. Hosp. v. Chubb Group of Ins. Cos.*, 90 N.Y.2d 195, 199-203, 659 N.Y.S.2d 246, 248-50 (1997); *Hosp. for Joint Diseases v. Allstate Ins. Co.*, 21 A.D.3d 348, 349, 800 N.Y.S.2d 190, 191-92 (2d Dep't 2005).

[43] *First Help Acupuncture P.C. v. State Farm Ins. Co.*, 12 Misc. 3d 130(A), 819 N.Y.S.2d 209 (App. Term 2d & 11th Jud. Dists. 2006).

[44] *Ocean Diagnostic Imaging v. Motor Veh. Acc. Indem. Co.*, 8 Misc. 3d 137(A), 803 N.Y.S.2d 19 (App. Term 2d & 11th Jud. Dists. 2005).

[45] *Careplus Med. Supply Inc. v. Allstate Ins. Co.*, 9 Misc. 3d 131(A), 808 N.Y.S.2d 916 (App. Term 2d & 11th Jud. Dists. 2005); *A.B. Med. Servs. v. Eagle Ins. Co.*, 3 Misc. 3d 8, 9, 776 N.Y.S.2d 434, 436 (App. Term 9th & 10th Jud. Dists. 2003).

[46] *Amaze Med. Supply Inc. v. Eagle Ins. Co.*, 2 Misc. 3d 139(A), 784 N.Y.S.2d 918 (App. Term 2d & 11th Jud. Dists. 2004).

[47] *Health & Endurance Med. P.C. v. Liberty Mut. Ins. Co.*, 19 Misc. 3d 137(A), 866 N.Y.S.2d 92 (App. Term 2d & 11th Jud. Dists. 2008).

[48] *A.B. Med. Servs. PLLC v. Commerical Mut. Ins. Co.*, 12 Misc. 3d 8, 11-12, 820 N.Y.S.2d 378, 381-82 (App. Term 2d & 11th Jud. Dists.2006).

[49] *Fair Price Med. Supply Corp. v. ELRAC Inc.,* 12 Misc. 3d 119, 121, 820 N.Y.S.2d 679, 681 (App. Term 2d & 11th Jud. Dists. 2006); *Ozone Park Med. Diagnostic Assocs. v. Allstate Ins. Co.*, 180 Misc. 2d 105, 106-07, 689 N.Y.S.2d 616, 617 (App. Term 9th & 10th Jud. Dists. 1999).

Brooklyn Bar Association Lawyer Referral Service Briefs (Continued from page 1)

The LRS has been donating part of its good fortune to the Brooklyn Bar Association Volunteer Lawyers Project (VLP). Along with the VLP, the LRS has also been sponsoring community education seminars that are open to the general public. After all, the motto of the LRS is "we are in the business of public service." The LRS continues doing brown bag lunches at senior centers around Brooklyn. This program is in conjunction with Allen Harper of The Neighborhood Project, which is part of the Kings County District Attorney's Office. We are currently scheduling these outreach sessions every other month. LRS attorneys are volunteering their time and should be commended for it.

We are currently advertising on Google to broaden the LRS' internet presence. This advertising campaign will tie in with the improved website that was completed last year. Our other advertising efforts include the yellow pages, the Brooklyn Cyclones program, the Brooklyn Daily Eagle, especially the quarterly real estate pullout section, and the New York Daily News. We are always looking for new and economical outlets to advertise the LRS.

I am excited about the future of the LRS, and I hope the attorneys of the Brooklyn Bar Association and the legal community in general, are as well. As always, I welcome any input or suggestions that you may have. If you would like to get further information or to join our Lawyer Referral Service panel, please contact me directly at my private line at (718) 222-3357.

Roseann Heibert is Director of the Brooklyn Bar Association Lawyer Referral Service.