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

Gerald Lebovits

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## Take Me Out to The Ball Game 2013

### Brooklyn Bar Association 5th Annual Brooklyn Cyclones Outing

***By Aimee L. Richter, Esq.***

**On Thursday night of July 18, this past summer, members of the** Brooklyn Bar Association, their family and friends went to Coney Island to watch a baseball game. One hundred and twenty-five tickets were sold to our colleagues, to watch the Mahoning Valley Scrappers play the Brooklyn Cyclones at MCU Park.

Scheduled for 7:00 p.m., everyone arrived clad in their finest BBA polo shirts, tee shirts and hats, prepared for a night of studiously observing the art of our national pastime, baseball. But wait, it was at least 100 degrees! How would we brave this heat? We consumed large quantities of water and ice cream! We chatted, laughed, traded stories, took pictures and enjoyed the heat wave together.

I can't tell you who won the game —you can look it up on line, but I can tell you that this was one of the best ways to enjoy what was one of the hottest nights of the summer. Our members and their friends and families were relaxed, casual and enjoying a beautiful outdoor evening, in which baseball was the back-drop. And then we all raced home to enjoy some well deserved air conditioning. We can't wait for next year, to do it again.


Brooklyn Bar Association on the MCU Score Board. *See pages 6 for more.*

# No Fault, No Foul: Litigating First-Party-Benefit Cases-Part II

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*University School of Law. The authors thank David S. Streiner, Esq., for his suggestions to this article and Natalie J. Puzio, an undergraduate student at Villanova University, for her research. This article expands on Judge Lebovits and Kimberly Schirripa's no-fault article published in volume 61, page 1, of the Brooklyn Barrister in May 2009.*

Jane, who was injured in a motor vehicle accident involving the use or operation of an insured motor vehicle, seeks treatment at Medical Provider X. Jane is insured by Insurance Carrier Y under an insurance policy that provides for "No-Fault" Personal Injury Protection ("PIP") medical benefits. In exchange for her treatment, Jane assigns her right to receive these benefits to Medical Provider X. After treating Jane, Medical Provider X submits directly to Insurance Carrier Y claims for payment for the health-related services it performed on Jane. Insurance Carrier Y does not pay Medical Provider X, and Medical Provider X sues Insurance Carrier Y in the New York City Civil Court. What happens at trial depends on numerous factors, including what reason, if any, Insurance Carrier Y had for non-payment, in which judicial department the suit was brought, and sometimes which judge is presiding in Civil Court where the case is heard.

Litigation based on Article 51 of the New York Insurance Law and its supplemental regulations, 11 N.Y.C.R.R. 65, otherwise known as the "No-Fault" Insurance Law, dominates the court calendars of the N.Y.C. Civil Courts.i This litigation is unique from other forms of civil litigation; it arises purely from statute and has no parallel in the common law. Due to the litigation arising from this relatively new and sometimes ambiguous statute, the trial and appellate judges who hear and rule on "No-Fault" cases are often left to interpret the statute and its regulations and fill in the blanks to arrive at fair and just results that are consistent with the rules of evidence and other areas of law.ii From this, the burdens of proof and evidentiary rules differ by judicial department, by courthouse, and even by the individual trial judges within the courthouses. In other words, depending on the case's venue and trial judge, plaintiffs' and defendants' jobs at trial will be significantly different because the judicial departments have formed different evidentiary requirement and because the individual trial judges interpret those requirements differently.

This Article aims to describe with particularity how a no-fault trial proceeds with a focus on how it can and does proceed in different ways depending on venue and judge. Part I of this Article discusses how the medical providers-plaintiffs establish their prima facie case at trial and how the requirements differ in the judicial departments. Part II discusses how insurers-defendants establish their defenses at trial and how the trial judges significantly affect that. Part III of this article discusses what the providers-plaintiffs' options are at trial once an insurer-defendant has established its defense.

1. Provider-Plaintiff's Prima Facie Case

A no-fault trial can proceed in several ways depending on the insurer-defendant's defense(s) for non-payment, but it always begins with the provider-plaintiff's bills. Due to the volume of no-fault cases and to limit the triable factual issues to those legitimately in dispute, plaintiffs and defendants will stipulate that the plaintiff has established its prima facie case. Stipulating to the plaintiff's prima facie case means that the plaintiff will not have to put forth an initial case. In exchange for that stipulation, the plaintiff will often stipulate that the defendant issued timely denials pursuant to N.Y.C.R.R. 65-3.8iii preserving its defenses, and to the qualifications of the defendant's expert witness if there is one. If the trial involves a defense that the provider-plaintiff's services were not "medically necessary," the parties may also stipulate to admitting into evidence relevant documents, such as the expert's written report, which discusses why the services at issue were allegedly not "medically necessary," and the injured-insured's medical records the expert reviewed when forming an opinion about the medical necessity of the services at issue. When these types of stipulations are in effect, a plaintiff may rest upon the stipulations, and the trial immediately proceeds to the defendant's defense(s).

To begin an unstipulated no-fault trial, the provider-plaintiff must establish its prima facie case through witness testimony, documentary evidence, or, depending on the judicial department, formal judicial admissions. Under N.Y.C.R.R. 65-2.4(c)iv and applicable caselaw, a provider-plaintiff establishes at trial its prima facie entitlement to payment of no-fault PIP benefits by showing by a preponderance of the evidence that it submitted a claim or bill to the defendant insurance carrier and that the claim or bill remains unpaid.v If the plaintiff fails to prove its *prima facie* case, the trial is over and the plaintiff loses. If the plaintiff succeeds, however, a presumption of medical necessity attaches to the billed-for services, and to prevail the insurer-defendant must prove an affirmative defense.

How a plaintiff proves its prima facie case depends on the case's venue. Most of the time, a plaintiff can establish the necessary facts through the testimony of one or two witnesses and by moving the relevant documents (bills, proof of mail-

***Please turn to page 3***

## What's Inside

**No Fault, No Foul Litigating First-Party-Benefit-Cases**
*Compiled by Gerald Lebovits, Esq. And Drew M. Gewuerz* .....Pg. 1

**The Docket**
*Compiled by Louise Feldman* .....Pg. 2

**New Members, September 2013** .....Pg. 2

**Legal Briefs**
*By Avery Eli Okin, Esq., CAE* .....Pg. 2

**Respectfully Submitted**
*By Andrew M. Fallek, Esq.* .....Pg. 3

**Committees and Sections 2013-14** ...Pg. 4, 5, 10, 11, 12

**Take Me Out To The Ball Game** .....Pg. 6

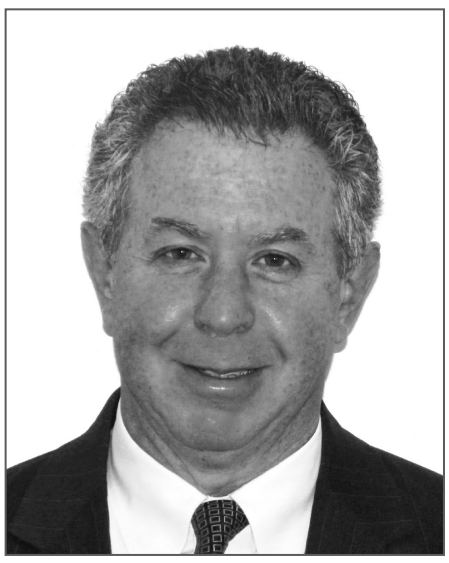
**Introduction to the Courts of Madagascar**
*By Barbara Grcevicl, Esq.* .....Pg. 7

PRESIDENT'S MESSAGE

# RESPECTFULLY SUBMITTED

***By Andrew Fallek, Esq.***

I can barely contain my enthusiasm. If you came to the Brooklyn Bar Association on September 23rd you had the opportunity to hear and meet United States Supreme Court Associate Justice Antonin Scalia. Forgive me if I sound a bit giddy and star struck. As the president of a bar association in the "coolest city in the world," some might expect me to be a little more, well, "cool." But the notion that any Supreme Court Justice, let alone Justice Scalia, the rock star justice of the court, would make a dedicated trip to 123 Remsen Street and spend more than three hours with our members represents a true milestone for this organization. Just in case you thought you knew something about Justice Scalia, I will tell you that he was friendly, engaging, gracious and that he made everyone feel comfortable in his presence. It was a truly great evening.



**President Andrew M. Fallek, Esq.**

None of this could have happened – and I do mean this quite literally— without BBA First Vice-President Arthur Aidala, who met Justice Scalia in Italy over twenty years ago and has maintained a close relationship with the Associate Justice. Arthur invited Justice Scalia to come to the Association to do a CLE and a book signing for the Justice's new work, *Reading Law: The Interpretation of Legal Texts*. The book's co-author, legal lexicographer and editor of *Black's Law Dictionary,* Professor Bryan Garner, jumped at the chance to come and the visit was arranged in record time—maybe a little too quickly. But I am happy to say that Executive Director Avery Okin, CLE Director Meredith Symonds and the BBA staff proved up to the task. Hosting a Supreme Court Justice presents a unique set of challenges, which include many security concerns, and Avery ran "no huddle" for a few weeks. Even an unexpected blitz on Remsen Street by a loud music playing Chabad "Sukkamobile" on Monday afternoon did not shake them. When the last bomb sniffing dog left the building on late Monday afternoon and officers from the NYPD counterterrorism unit stationed themselves in front of the building, we were ready to start.

After a brief reception in the Board of Trustees room, Justice Scalia and Professor Garner appeared seated side by side on the stage in the sold out Meeting room and maintained what can best be described as an open dialogue with each other. Scalia and Garner have obviously spent a lot of time together, and their entertaining faux bickering had shades of stand-up duos like Tommy and Dick Smothers and Burns and Allen with some Cicero thrown in for good measure. It was an extraordinary performance. First Vice-President Aidala added a comedic touch when (in reversed roles) he jovially pressed Justice Scalia to answer written questions from the audience.

We learned about *textualism*, which is the

*Please turn to page 9*

# *No Fault, No Foul...*

***Continued from page 1***

ing) into evidence through the witness(es). Depending on the trial's venue, the contents of the testimony will be different, and a witness may not even be required.

In the First Department, witness testimony is not necessarily even required. The use of a notice to admit under C.P.L.R. 3123 and formal admissions made in response to interrogatories have been deemed sufficient to establish the necessary facts that constitute the plaintiff's prima facie case.vi A typical no-fault notice to admit seeks admissions on two facts: (1) the insurer-defendant received the subject claims or bills; and (2) payment is overdue in whole or in part.vii Provider-plaintiffs can establish their prima facie cases by simply reading the admissions into the record.viii Even if a defendant denies or objects to the solicited admissions in the First Department or fails to respond to a duly served notice to admit, a plaintiff may still establish its prima facie case because the failure to respond or deny with specificity is inappropriate to address a notice to admit and might constitute an admission.ix

The use of formal judicial admissions to establish a plaintiff's prima facie case is possible because of a split between the First and Second Departments as to the Second Department's rule that the contents of claims or bills are hearsay and can be admitted into evidence only by establishing that they are business records. In the First Department, if a plaintiff elects to instead use witness testimony to establish its prima facie case rather than by formal admissions, the testimony must include merely that a claim or bill for services was generated and submitted to the insurer and is overdue.

If the case is being tried in the Second Department, however, the Notice to Admit by itself will not be sufficient to establish a prima facie case. In contrast to the First Department, the Second Department requires proof that that the overdue bill constitutes a business record under C.P.L.R. 4518 of the provider of services. The Second Department formally added this requirement to the *prima facie* case in *Dan Medical, P.C. v. New York Cent. Mut. Fire Ins. Co.x* Due to *Dan Medical*, the plaintiff's witness must be able to testify to the provider's general business practices regarding the generation of bills for no-fault reimbursement, and that the actual bill or bills in dispute was or were generated pursuant with these business practices. Specifically, a witness must have personal knowledge and be able to testify that the bills or claim forms at issue were made in the regular course of business and that they reflect a routine, regularly conducted business activity, needed and relied on in the performance of the functions of the business, that it was in the regular course of business to make the bills/claim forms, and that the bills/claim forms at issue were made at the time of the acts, transactions, or occurrences or events described therein.xi Without that testimony, the contents of the bills/claim forms are inadmissible hearsay and cannot be used to establish the plaintiff's *prima facie* case.xii

In addition to establishing that the services in dispute were performed, a plaintiff must establish that it submitted the bills/claims in dispute to the insurer-defendant and that full payment has not been made. The plaintiff need not establish the timeliness of the bills or the whether the assignment of no-fault benefits was proper. Those facts constitute affirmative defenses and are not part of a provider plaintiff's *prima facie* case.xiii

Because the majority of no-fault cases are litigated years after the billed for services were performed, and the bills were generated and mailed, the witness(es) might not have personal knowledge of the generation and mailing of the specific bills in dispute. Witness(es) can overcome this lack of specific knowledge by establishing either that the provider-plaintiff's billing and mailing practices were the same in earlier years as they are now or when the witness was trained, or that the billing practices at the time of the subject bill's generation and mailing were likely adhered to because it was the company's general business practice of the company to do so at that time.

Although it is helpful to have supportive documentary proof of mailing, that proof is not necessary if a witness can establish standard office practice or procedure designed to ensure that items are properly addressed and timely mailed.xiv A certified mail receipt or post-office ledger alone is insufficient to give rise to the presumption of proper mailing and receipt.xv The

***Please turn to page 10***

# CALLING ALL WRITERS

## It's Time for the Third Annual Barrister Fiction Writing Contest

The Rules are as Follows:

1. All submissions must be received no later than January 30, 2014 at 5:00 pm by e-mail to Glenn Verchick, Editor-in-Chief, Brooklyn Barrister at gverchick@ginartelaw.com in pdf format.
2. All submissions must be works of fiction. It can be a short story or chapter from a novel and cannot exceed 10,000 words.
3. Contest limited to lawyers, judges, court personal, law firm employees and bar association employees, who hold said position in the State of New York at the time of submission. Not limited to Brooklyn Bar Association members.
4. Brooklyn Bar Association Editorial Board members are excluded.
5. The winner will be judge by the BBA Editorial Board and the winner will have his or her piece of fiction published in a 2014 issue of the Brooklyn Barrister.

**GOOD LUCK!**

**EDITOR'S NOTE:** For space reasons, the regular monthly State of Estates column authored by Hon. Bruce M. Balter and Paul S. Forster, could not be included in this issue. Look for that feature to resume in the November issue.



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# No Fault, No Foul...

***Continued from page 3***

key is to establish the standard office-mailing procedure and that the bills in dispute were mailed to the insurer defendant in a manner consistent with or pursuant to that standard procedure.xvi

Sometimes, the medical provider outsources the generation and mailing of the bills to a third-party medical billing company or law firm. In these cases, the third-party biller, despite not having personal knowledge of the medical provider's business practices and procedures, can overcome the bill's hearsay problem by testifying that the information contained in the bill was transferred from the medical provider to the third party and incorporated into the third-party's company records or that the information received from the medical provider is used in the third-party's day-to-day operations.xvii

In some cases, the insurer-defendant's denials, in and of themselves, can prove that the bills, if specifically identified and referenced, were submitted. Logically, if a denial of a particular bill is issued, the bill must have been mailed and received.xviii Similarly, a delay letter can be used as proof that the bill was submitted, but only if the delay letter specifically identifies the bill.xix At trial, both of these scenarios require in practice that the denial and delay letter can be authenticated or are stipulated into evidence.

In both departments, a provider-plaintiff need not establish that the services in dispute were medically necessary. A presumption of medical necessity attaches to the billed for services once the plaintiff establishes that it generated and mailed the bill or bills.xx

2. Insurer-Defendant's Initial Burden & Affirmative Defenses to Non-Payment

After a provider-plaintiff establishes its prima facie right to reimbursement of first-party no-fault benefits, an insurer-defendant must prove that it complied with the regulations and issued a denial the plaintiff's claim in a timely fashion —30 days from the date of receipt of the plaintiff's claimxxi —or had a legal justification for not doing so before being able to put forth an affirmative defense. The insurer-defendant's requirements for proving generating and mailing a denial are the same as the provider-plaintiff's in the respective judicial departments. To give rise to the presumption of proper mailing, the defendant must establish that the insurance company generated and mailed the denial forms, or set forth a sufficiently detailed description of the standard office generation and mailing procedures.xxii Depending on the judicial department, the defendant can accomplish this via formal judicial admissions or testimony establishing that the denials are business records under C.P.L.R. 4518.

With a few exceptions, a defendant's choice of defense at trial is limited to those grounds cited in the denial.xxiii Moreover, many defenses are waived and cannot be asserted at trial if not preserved in a timely denial. For many defenses, a defendant will first have to establish that it issued a timely denial and the denial must have been highly specific as to the basis or reason(s) (defenses) for the denial. If it cannot do so, the defendant will be precluded from offering the defense(s) that should have been but were not preserved in a timely denial. But if it can, it then has the opportunity to present its defense(s).

Most defenses require testimony from an employee of the insurance company or third-party vendor, an investigator, or expert witness. The content of the testimony depends on the basis or reason(s) for the denial. Between the insurance law, regulations, and caselaw, the insurer-defendant has many defenses to non-payment. The defenses fall into two categories: those that must be preserved in a timely denial of claim, and those that do not need to be preserved and are non-waivable.

Common defenses, such as that the provider-plaintiff assigned a monetary value to its service that is higher than it is allowed to under the New York Workers' Compensation Fee Schedule, the provider-plaintiff's service(s) in dispute were not "medically necessary," provider fraud (i.e., unnecessary or excessive treatment or fraudulent or excessive billing practices), services were provided by independent contractors,xxiv and untimely proof of claim must be preserved and asserted in a timely denial of claim or the defendant cannot present them at trial.xxv Defenses relating to lack of coveragexxvi are non-waivable and do not need to be preserved in a timely denial to be asserted at trial. Examples of these defenses are, that the underlying motor vehicle accident was staged, a medical provider's fraudulent incorporation, procuring of the insurance policy by fraud, and the claimant is not an eligible injured person entitled to no-fault benefits under the PIP Endorsement (failure to file a timely notice of claim).xxvii

Additionally, in the First Department, defenses such as failure to appear at an examination under oath ("EUO") and independent medical examination ("IME"), are considered a breach of the insurance policy contract and thus do not need to be preserved and asserted in a timely denial to be presented at trial.xxviii In the Second Department, however, those defenses must be asserted in a timely denial or are waived.xxix

A defendant's choice of evidence largely depends on which defense(s) it presents. For example, if a defendant denied the bills in dispute under the 30 day notice-of-claim rulexxx or 45-day rule to submit a claim,xxxi the defendant will typically have a claims representative or other employee testify to the defendant's business practices and procedures regarding the receipt of mail, and that the notice of claim and/or bills in dispute were not timely received or received at all. If a defendant attempts to establish a fee-schedule defense (that the plaintiff overbilled for the services it performed), it will typically have a claims representative who is certified in the Workers' Compensation Fee Schedule testify to the proper rates of reimbursement for the plaintiff's geographic region. If the defense is a policy violation, such as the assigner's non-appearance at an examination under oath ("EUO") or independent medical examination ("IME"), a claims representative or third-party scheduling vendor will typically testify to the generation and mailing of at least two scheduling letters to the requested individual. Additionally, a defendant will have a representative or employee of the attorney/doctor who was scheduled to perform the EUO/IME testify to the requested individual's non-appearance. A "bust statement" is supportive but not required.

Although the Regulations mandate specific requirements for EUO's and IME's, such as that they must be at times and places reasonably convenient to the applicant and inform them that they will be reimbursed for any loss of earning and reasonable transportation expenses incurred in compliance with the insurer's request,xxxii the insurer-defendant need not prove these facts at trial.xxxiii

If the defense is that there is outstanding verification or that the insurance policy's funds have been exhausted, a representative from the insurer or underwriter will testify to those facts. If fraud is alleged, a defendant will typically have an investigator testify regarding an investigation into the fraud and its results.

Possibly the most commonly tried defense is that the plaintiff was not entitled to reimbursement because the services it performed were not "medically necessary." Under 11 N.Y.C.R.R. 65-3.8(b)(4), an insurer-defendant may deny claims for reimbursement of no-fault benefits based on medical examination and "peer reviews."xxxiv

The terms "medically necessary," "medical necessity," or any other derivative are not specifically defined by the Insurance Law or its Regulations. Due to the lack guidance on the issue, the judges who decide this factual issue (the overwhelming majority of no-fault trials are bench trials) rely heavily on expert testimony and witness credibility when deciding whether the defendant's non-payment was properly justified based on this defense.xxxv

Even though the plaintiff is not affirmatively required to establish that its services in dispute were "medically necessary" when putting forth its prima facie case, a presumption of "medical necessity" attaches to those services once the plaintiff's prima facie case is established.xxxvi From this, it is a defendant's burden to prove, if not precluded from doing so, that the services in dispute were medically unnecessary.xxxvii At trial, one or more "independent" doctors who are deemed experts by the court will testify to the injured insured person's physical health and overall medical condition at the time that the services in dispute were rendered, and then opine whether the treating physician should or should not have performed the services at issue. The "independent" expert doctors could have formed their opinions based on a review of the injured insured person's medical records relating to the injuries and treatment received from the provider plaintiff and other medical providers arising from the motor vehicle accident or from physically examining the injured insured person at an independent medical examination. A defendant may call the reviewing or examining doctor as a witness to have the doctor offer opinion about the medical necessity of the plaintiff's services, or have a substitute doctor testify to the original peer/IME doctor's opinion if it is preserved in the written peer review or IME report.

With regard to peer review reports, the defendant must pass a preliminary hurdle regarding the sufficiency of the report that before testimony of its contents is permitted. The peer review report must "set[] forth a sufficiently detailed factual basis and medical rationale for the claim's rejection" to support a viable denial on grounds of medical necessity. xxxviii Plaintiffs can move to preclude the testimony based on the peer review report is being facially defective if it does not set forth a sufficiently detailed factual basis and medical rational regarding the alleged lack of medical necessity of the service(s) it reviewed.xxxix If the trial judge finds that the peer review report itself is sufficient, testimony may proceed and the trial judge will determine if the testimony is adequate to establish a lack of medical necessity.

Typically, the expert's testimony will closely follow the reasons set forth in the peer or IME report. Depending on which venue the case is tried in, who the presiding judge is, the defendant will have different evidentiary restrictions. Many New York City Civil Court judges have no reservations about allowing substitute doctors to testify and the scope of the substitute's testimony, in numerous published opinions, other Civil Court judges have ruled that substitute doctors may not testify in place of the original.xl The ground behind not permitting substitute doctors to testify is that they cannot authenticate the original doctor's peer review or IME report to admit into evidence. These judges have ruled that the peer report is inadmissible hearsay.xli Absent a stipulation between the parties to the admission into evidence of the peer review or IME report, there is no material in evidence upon which the expert's opinion can be based.xlii

At least one Civil Court judge has ruled that the peer review report itself, in evidence, is sufficient to establish the defendant's burden of proof of proving that the plaintiff's services lacked medical necessity and that live testimony is not required, particularly where the plaintiff does not offer a witness or any evidence on rebuttal.xliii

A defendant may also face different hurdles from different judges about the admissibility of the medical records the peer review/IME doctors used when forming their opinion regarding medical necessity. Although the medical records are hearsay, expert witnesses may testify that they relied upon specific, inadmissible out-of-court material to formulate an opinion, provided (1) it is of a kind accepted in the profession as reliable as a basis in forming a professional opinion, and (2) evidence presented to establish the reliability of the out-of-court material referred to by the witness.xliv Additionally, an expert witness may testify to the contents of the medical records in a non-hearsay purpose. The expert is not using the records for their truth to establish that the injured insured person sustained certain injuries and received certain treatment but is merely opining that assuming the facts set forth in the records are true and the treatment allegedly provided was not medically necessary.xlv

Despite these rulings, Civil Court judges inconsistently apply these holdings that makes for unexpected results at trial. Although some judges allow all the records' contents to come into evidence, others only allow into evidence the contents of the medical records generated by the provider-plaintiff to come. Notably, at least one Civil Court judge requires a HIPAA Authorization from the injured insured person for a no-fault trial to proceed on the merits.xlvi

If the parties get past the evidentiary issues and an expert witness testifies on the defendant's behalf about why the service in dispute was not medically necessary, plaintiffs will cross-examine the witness to discredit the expert's opinion. Peer reviewers are routinely challenged on the adequacy and source of the documents they reviewed to prepare their reports. At least one Civil Court judge has expressed doubt about the reliability of the method by which peer review doctors are supplied with the records to review because they come from a third-party vendor, not from the treating physicians or insurance carriers.xlvii

3. Plaintiff's Rebuttal Case

After an insurer-defendant rests, the provider-plaintiff will have the opportunity to rebut the defendant's evidence. Depending on the defendant's case and defenses, a plaintiff can rebut the defendant's case on procedural grounds and on the merits of the defense.

For example, if a plaintiff wants to rebut the defendant's submission that it issued a timely denial, the plaintiff, at this point in the trial, come forward with evidence that the denial was untimely. Although the insurer-defendant is entitled to the presumption that, in the normal course of business, it will mail a denial on the date of the issuance of the denial,xlviii the plaintiff may submit evidence to the contrary to rebut the presumption.

If a defendant establishes a defense, such as a lack of medical necessity, by a preponderance of the evidence, the burden shifts to the plaintiff to rebut that defense presumption. If a defendant established that the services in dispute were not medically necessary, the plaintiff may have the treating physician/chiropractor/acupuncturist or rebuttal expert testify to rebut the presumption of lack of medical necessity.

If a defendant asserted and established a fee-schedule defense or defense based on outstanding verification requests, the plaintiff may have its own fee schedule expert or employee of the plaintiff testify to the compliance with the fee schedule and verification requests.

An interesting scenario arises when a defendant defends the action based on the 45-day rule. A provider plaintiff must submit its claim to the insurer defendant within 45 days from the date of service(s) for which it is seeking reimbursement. Part of the plaintiff's prima facie case is proving that the bills in dispute were mailed to the defendant. The plaintiff must establish submission by a preponderance of the evidence to meet its prima facie burden and shift the burden of proof to the defendant to prove a defense to non-payment. If the defendant justifies non-payment based on the allegation that the bills in dispute were not served on it within 45 days from the date of service(s), and establishes this fact at trial by a preponderance of the evidence, the burden shifts to the plaintiff to rebut the defense. As a matter of practicality, however, the plaintiff would not be allowed to call its prima facie witness and have the witness re-testify to the mailing of the bills; that testimony would be redundant. In this scenario, the fact-finder would have to assess the character and truthfulness of both parties' witnesses, examine any supporting documentary evidence, and essentially rule based solely on credibility.

4. Conclusion

The no-fault statute is not a particularly long one, and the sections relevant to the thousands of trials occurring in the Civil Courts each year are few. Yet each trial is a puzzle that can be put together in numerous configurations. Due to the volume of cases, more new issues are discovered and new arguments made than possibly any other area of law. It is inevitable that more pieces will be added to the puzzle, causing the law within and across the judicial departments to become either more or less uniform as it is analyzed, debated, and decided.

i Mitchell S. Lustig & Jill L. Schatz, *Overview of No-Fault Litigation in New York State*, N.Y. St. B.J. 50 (Nov./Dec. 2010) (stating that approximately one-third of the entire New York City Civil Court calendar is composed of no-fault cases).

ii *See Socrates Psychological Svcs., P.C. v. Progressive Cas. Ins. Co.*, 7 Misc. 3d 642, 643, 791 N.Y.S.2d 394, 396 (Civ. Ct. Queens County 2005) (stating that in no-fault actions "Civil Court judges are the foot soldiers required to address, in the first instance, various novel legal issues, until their appellate colleagues, often weighing the pragmatic consequences of a particular holding, get the opportunity to review decisions and thereby formulate a body of governing jurisprudence").

iii This regulation provides that an insurer has 30 calendar days after proof of claim is received either to pay or deny the claim in whole or in part. No-fault benefits are overdue if not paid within 30 calendar days after the insurer receives proof of claim, which shall include verification of all the relevant information requested.

iv This regulation provides that written proof of claim for payment of health services shall be submitted to the insurer no later than 45 days after the date services are rendered without reasonable justification for delay.

v *Mary Immaculate Hosp. v. Allstate Ins. Co.*, 5 A.D.3d 742, 742-43, 774 N.Y.S.2d 564, 564 (2d Dep't 2004) (stating that plaintiff's prima facie case is no more than the submission of a bill that was overdue when an action was commenced. The Appellate Division, First Department, explicitly followed *Mary Immaculate. See Countrywide Ins. Co. v. 563 Grand Medical, P.C.*, 50 A.D.3d 313, 314, 855 N.Y.S.2d 439, 440 (1st Dep't 2008). So did the Third Department, *See LMK Psychological Services, P.C. v. Liberty Mut. Ins. Co.*, 30 A.D.3d 727, 728, 816 N.Y.S.2d 587, 589 (3d Dep't 2006).

vi *See Villa v. N.Y.C.H.A.*, 107 A.D.2d 619, 621, 484 N.Y.S.2d 4, 5 (1st Dep't 1985) (holding that "there was nothing improper in asking defendant to confirm its written acknowledgement of the filing of that claim and its subsequent failure to indicate any defects in that notice"); *Fair Price Medical Supply, Inc. v. St. Paul Travelers Ins. Co.*, 16 Misc. 3d 8, 9, 838 N.Y.S.2d 848, 848-49 (App. Term 1st Dep't 2007) ("Inasmuch as defendant's verified answers to the interrogatories constituted admissions of a party, which are admissible as evidence, defendant may not now be heard to argue that plaintiff failed to submit proof that the claims had been

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# RESPECTFULLY SUBMITTED

*Continued from page 3*

term Justice Scalia prefers to describe his method of interpreting statutes. Both authors believe that the meaning of a statute (or a will or contract) is to be derived from the language used. As they state in their book, "In their full context, words mean what they conveyed to reasonable people at the time they were written." The authors have combed through ancient texts and more recent sources to create a compendium of canons of interpretation to assist judges in reading text and they shared these canons with the audience. Justice Scalia also talked about some of the actual practices used to create and publish so-called "legislative history" and forcefully explained why it cannot be relied on to explain the meaning of a statute. We also learned that under no circumstances should you refer to Justice Scalia as a "strict constructionist."

Contrary to what many people think, textualism is a methodology that often defies the expectations of liberals and conservatives. Justice Scalia has voted to protect the rights of criminal defendants and to permit flag burning as an exercise of the First Amendment. He would be the first to tell you, however, that the words themselves, and not his private opinions on the substantive issues, dictated the result.

A copy of the book was included in the CLE program and the Justice and the professor patiently signed about 200 books before heading out to dinner with Arthur Aidala and his family. Thanks again Arthur for an unforgettable evening.

# *No Fault, No Foul...*

*Continued from page 8*

mailed and received, and that they were overdue."). For an in-depth discussion on the use of notices to admit in no-fault litigation, see David M. Barshay & David M. Gottleib, *Use of Notice to Admit in No-Fault Insurance Litigation*, *available at* www.bakersanders.com/article/?0737 (last visited Aug. 1, 2013).

vii Barshay & Gottlieb, *supra* note 6.

viii *See Fair Price Med. Supply, Inc. v. St. Paul Travelers Ins. Co.*, 16 Misc. 3d 8, 9, 838 N.Y.S.2d 848, 848 (App. Term 1st Dep't. 2007) (holding that plaintiff established its prima facie case by reading into record that defendant's formal admissions bills in dispute were received and partially paid, despite no witnesses or documentary evidence submitted).

ix *See Kowalski v. Knox*, 293 A.D.2d 892, 893, 741 N.Y.S.2d 291, 292 (3d Dep't 2002) (holding that plaintiff's prima facie case was established through defendant's failure to respond to plaintiff's notice to admit); *see also Barnes v. Schul Private Car Service*, 59 Misc. 2d 967, 968, 301 N.Y.S.2d 907, 908 (Sup. Ct. Kings County 1969) (discussing that failing to properly respond to Notice to Admit constitutes admissions).

x *Dan Medical, P.C. v. N.Y. Cent. Mut. Fire Ins. Co*., 14 Misc. 3d 44, 47, 829 N.Y.S.2d 404, 406 (App. Term 2d Dep't 2006).

xi Lustig & Jill L. Schatz, *supra* note 1, at 51.

xii *Id.*

xiii *See Hosp. for Joint Diseases v. Travelers Property Cas. Ins. Co.*, 9 N.Y.3d 312, 319, 849 N.Y.S.2d 473, 476 (2007) (holding that deficiency in an assignment is not a coverage issue and this failure to timely address defect in assignment of benefits waives defense).

xiv *See N.Y. & Presbyterian Hosp. v. Allstate Ins. Co.*, 29 A.D.3d 547, 547-48 814 N.Y.S.2d 687, 688 (2d Dep't 2006).

xv *Id.* ("[C]ertified mail receipt and the United States Postal Service 'Track and Confirm' printout do not prove that the particular claim . . . was actually received where . . . no evidence that this claim was mailed to [defendant] under that certified mail receipt number and no signed certified mail return receipt card has been produced.").

xvi Gerald Lebovits & Kimberly Schirripa, *No Fault, No Foul: Litigating First-Party-Benefit Cases*, 61 Brooklyn Barrister 1 (May 2009).

xvii *In re Carothers v. GEICO Indem. Co.*, 79 A.D.3d 864, 865, 914 N.Y.S.2d 199, 200 (2d Dep't 2010).

xviii Lawrence N. Rogak, *Rogak's New York No-Fault Law and Practice* 100 (2009 ed.) (citing *Delta Diagnostic Radiology, P.C. v. Progressive Cas. Ins. Co.*, 2007 N.Y. Slip Op 52453(U), *1 (App. Term 2d Dep't 2007); *Magnezit Medical Care, P.C. v. N.Y. Cent. Mut. Fire Ins. Co.*, 2006 N.Y. Slip Op 52515(U), *1 (App. Term 2d Dep't 2006)).

xix *Id.* (citing *Boai Zhong Yi Acup. Servs., P.C. v. Travelers Ins. Co.*, 14 Misc.3d 129(A), 2006 N.Y. Slip Op 52516(U), *1 (App. Term 2d Dep't 2006)).

xx *A.B. Med. Servs. v. GEICO Ins.*, 2 Misc. 3d 26, 27, 773 N.Y.S.2d 773, 773 (App. Term 2d Dep't 2003)

xxi N.Y.C.R.R. 65-3.8(c).

xxii Lebovits & Schirripa, *supra* note16.

xxiii *State Farm Ins. Co. v. Domotor*, 226 A.D.2d 219, 221, 697 N.Y.S.2d 348, 350 (2d Dep't 1999) (finding that insurance carrier's defense must stand or fall on the reason appearing in its denial of claim).

xxiv Recently, the Appellate Division, Second Department, overturned the Appellate Term's holding that an independent-contractor defense is non-precludable and that an insurer is not obligated to issue a denial to assert the defense. In *A.M. Med. Servs., P.C. v. Progressive Cas. Ins. Co.*, 101 A.D. 3d 53, 56, 953 N.Y.S.2d 219, 221 (2d Dep't 2012), the Second Department, held that the defendant insurer was precluded from raising an independent contractor defense by virtue of its failure to specify the ground for denial in its denial of claim. Under the doctrine of horizontal stare decisis, this is now the prevailing law until another judicial department or the Court of Appeals issues a contrary rule. *See Mountain View Coach Lines, Inc. v. Storms*, 102 A.D.2d 663, 664, 476 N.Y.S.2d 918, 920 (2d Dep't 1984).

xxv Lebovits & Schirripa, *supra* note 16.

xxvi *Central Gen. Hosp. v. Chubb Group of Ins. Cos.*, 90 N.Y.2d 195, 199, 659 N.Y.S.2d 246, 248 (1997) (stating that an untimely disclaimer or denail does not prevent the insurer from raising a lack of coverage defense "premised on the fact or founded belief that the alleged injury does not arise out of an insured incident.").

xxvii For a list of defenses that have been held to constitute "lack of coverage defenses," see Lustig & Schatz, *supra* note 1.

xxviii *Unitrin Advantage Ins. Co. v. Bayshore Physical Therapy, PLLC*, 82 A.D.3d 559, 560, 918 N.Y.S.2d 473, 474 (1st Dep't 2011) (holding that denial premised on breach of condition precedent to coverage voids policy ab initio and that, in cases, insurer cannot be precluded from asserting a defense premised on no coverage).

xxix *See Westchester Med. Ctr. v. Lincoln Gen. Ins. Co.*, 60 A.D.3d 1045, 1046-47, 877 N.Y.S.2d 340, 342 (2d Dep't 2009).

xxx N.Y.C.R.R. 65-2.4(b).

xxxi *Id*. 65-2.4(c).

xxxii *Id*. 65-3.5.

xxxiii *See Stephen Fogel Psychological, P.C. v. Progressive Cas. Ins. Co*., 35 A.D.3d 720, 721, 827 N.Y.S.2d 217, 219 (2d Dep't 2006) (stating that defendant required to establish mailing of notices and subject's non-appearance); *Crossbridge Diagnostic Radiology, P.C. v. Progressive Cas. Ins. Co.*, 20 Misc. 3d 143(A), 2008 N.Y. Slip Op. 51761(U), *1-2 (App. Term 2d Dep't 2008).

xxxiv *A.B. Med. Servs. PLLC. v. Allstate Ins. Co.*, 2 Misc. 3d 127(A) (App. Term 2d Dep't 2003) (stating that defense of lack of medical necessity may be based on medical examination or peer review report, as implicitly provided by 11 N.Y.C.R.R. 65-3.8(b)(4)).

xxxv *See Behavioral Diagnostics v. Allstate Ins. Co*., 3 Misc.3d 246, 249, 776 N.Y.S.2d 178, (Civ. Ct. Kings County 2004) (stating that definition of "medical necessity," "determination of the issue turns on credibility, since courts cannot rely solely on the examining physician, but must consider whether the treatment had a 'valid medical purpose' and resulted in an 'actual medical benefit'").

xxxvi *A.B. Med. Servs. v. GEICO Ins.*, 2 Misc. 3d 26, 27, 773 N.Y.S.2d 773, 773 (App. Term 2d Dep't 2003).

xxxvii *Id.*, 773 N.Y.S.2d 773, 773.

xxxviii *Amaze Med. Supply v. Eagle Ins. Co.*, 2 Misc. 3d 128(A), 2003 N.Y. Slip Op. 51701(U), *1 (App. Term 2d Dep't 2003).

xxxix *See generally Eagle Surgical Supply Inc. v. Mercury Casualty Co.*, 2012 N.Y. Slip Op 51286(U), *1 (App. Term 2d Dep't 2012) (holding peer-review report insufficient where doctor merely asserted that he had insufficient documentation and information); *Citywide Social Work & Psy. Serv., P.L.L.C. v. Travelers Indem. Co.*, 3 Misc. 3d 608, 616, 777 N.Y.S.2d 241, (Civ. Ct. Kings County 2004) (A peer review report may be found insufficient when unsupported or controverted by evidence of 'generally accepted medical/professional practice).

xl *See, e.g.*, *Park Slope Med. & Surgical Supply, Inc. v. Metlife Auto & Home Ins. Co.*, 35 Misc.3d 686, 687, 940 N.Y.S.2d 482, 483 (Civ. Ct. Queens County 2012).

xli *Id.*

xlii *Id. See also Wagman v. Brandshaw*, 292 A.D.2d 84, 87, 739 N.Y.S.2d 421, 424 (2d Dep't 2002) ("Inasmuch as [a] written report is inadmissible, logic dictates that testimony as to its contents is also barred from admission into evidence.").

xliii *All Boro Psychological Svcs., P.C. v. GEICO Gen. Ins. Co*., 34 Misc. 3d 1219(A), 2012 N.Y. Slip Op. 50137(U), *2-4 (Civ. Ct. Kings County 2012).

xliv *Id.*

xlv *Urban Radiology, P.C. v. Tri-State Consumer Ins. Co.*, 27 Misc. 3d 140A, 2010 N.Y. Slip Op. 50987(U), *1-2 (App. Term. 2d Dep't 2010).

xlvi *Eagle Surgical Supply, Inc. v. GEICO Ins. Co.*, 33 Misc.3d 1227(A), 2011 N.Y. Slip Op 52142(U), *1-2 (Civ. Ct. Bronx Couty 2011).

xlvii *See Consol. Imaging P.C. v. Travelers Indem. Co.*, 30 Misc.3d 1222(A), 2011 N.Y. Slip Op 50159(U), *2 (Civ. Ct. Richmond County 2011).

xlviii State of New York, Insurance Department, Superintendent of Insurance, Opinion Letter of May 24, 2004 ("It is presumed that, in the normal course of business, a No-Fault insurer will mail a denial on the date of issuance of the denial, subject to any evidence presented to the contrary.").