INSURANCE LAW

No-Fault Miscellany: Arbitration, IMEs, Burden of Proof and Fraud Prevention

By **Norman H. Dachs** And **Jonathan A. Dachs**

In an article in this space written more than 13 years ago,[1] we called to the attention of disgruntled attorneys, dissatisfied with the then-current state of affairs with respect to the litigation and/or arbitration of no-fault disputes, that a private alternative dispute resolution (ADR) company had entered the field. That organization, National Arbitration and Mediation (NAM), based in Great Neck, had announced that effective Aug. 1, 2000, it would begin accepting no-fault demands for arbitration, with a stated goal of providing claimants, health care providers and no-fault insurers with a "new, more cost effective and efficient alternative option for resolving no-fault disputes." Of course, both the insurer and the claimant were required to agree in advance to submit their dispute to this alternate forum. Although some insurers agreed in advance to submit to NAM whenever an applicant so requested, it does not appear that this program received wide acceptance.

Undaunted, NAM has recently decided to again venture into the murky waters of no-fault arbitration. In a recent press release, NAM announced that it will be administering the arbitration of no-fault claims, to resolve disputed medical claims between medical providers, claimants and auto insurance carriers. NAM states that "after insight and input from no-fault professionals, its no-fault program was specifically developed to reduce legal and administrative expenses for insurance companies, while providing an expeditious and cost effective claim resolution process for the applicants."

In view of the fact that it is believed that NAM's third-party personal injury division makes up approximately 70 percent of the New York market, its entry in the no-fault area, which is comprised of many of the same carriers and applicant firms, may well be a significant development. Of course, the proof of the pudding will be in the eating.

'Independent' Medical Exams

Coincidentally, in the same prior column, we took note of a Dateline NBC report that aired on June 23, 2000, and found that certain doctors who had been providing "paper reviews" for a certain well-known insurer were slanting their reports toward denial of claims—even to the point of "adjusting" previously written reports to conform to the wishes of the insurer that was paying their fees for such reports. Seemingly in response thereto, the Legislature passed the Injured Workers' Protection Act, Workers' Compensation Law §137 (effective March 19, 2001) which provided, inter alia, as follows:

> Governor Andrew Cuomo has announced that his administration had banned a "first round" of 18 doctors and other health providers from billing New York's no-fault insurance system.

• Independent Medical Examiners were to be paid according to the fee schedule established pursuant to Workers' Compensation Law §13. The intent of this change was to remove the financial incentive of many doctors to conduct hundreds of "IMEs" per year in order lucratively to supplement their income. In other words, the thought went, insurance companies would no longer be able to buy medical opinions.

• Claimants and their attorneys were required to be provided a copy of the examiner's medical report on the same day that the report was submitted to the insurer and the workers' compensation board. In this way, opportunities for forgery and/or unauthorized changes would be minimized.

• Doctors who conduct IMEs would have to be licensed to practice medicine in the state of New York, and board certified. In addition, the examinations would be required to take place in a medical facility and the claimant could only be examined by a doctor with a specialty in the area of the injury. This change was enacted to eliminate the practice of flying doctors in from out of state to conduct examinations in hotel rooms, a practice that was apparently prevalent in New York at that time.

• IME notices were required to advise the claimant that he or she had the right to videotape the examination or have a witness of their choice present throughout the examination.

• Any doctor, carrier or employer who causes, directs or encourages a report that differs substantially from the examining doctor's professional opinion would be guilty of fraud.

Lobbying efforts undertaken at that time to extend that legislation to medical examinations conducted in personal injury actions and to no-fault claims apparently fell on deaf ears, and no such rules were applied in those contexts. In light of recent adverse publicity involving physicians hired by insurers to conduct physical examinations who have been playing fast and loose with the truth in rendering their reports or in testifying at trial, it seems appropriate to suggest that the time has come to renew such efforts.

If, indeed, the Legislature is to consider such remedial legislation, we repeat the recommendation we made in 2000, designed to further discourage and avoid fraudulent practices and/or the appearance of unfairness: All defense medical examinations should be » Page 8

NORMAN H. DACHS *and* JONATHAN A. DACHS *are partners at Shayne, Dachs, Sauer & Dachs, In Mineola.*

No-Fault

« Continued from page 3

conducted by a panel of doctors selected by a committee consisting of representatives of the plaintiffs' and defendants' bar, paid by a fund contributed to by insurance companies, and assigned randomly. In this way, examining doctors will not be hired, paid or assigned by the insurer, and will, therefore, not be beholden to the insurer. The performances of these panel doctors should be reviewed on a regular basis for patterns indicative of prejudice or abuse. In that way, the "IME" can finally begin to be thought of as a truly independent medical examination. Both the plaintiffs' and defendants' bars will surely benefit from that improved perception.

No-Fault Burden of Proof

In a scholarly and exhaustive majority opinion authored by Justices Reinaldo E. Rivera, in which Justices Daniel D. Angiolillo and Thomas A. Dickerson concurred, in *Viviane Etienne Medical Care v. Country-Wide*, __AD2d__, __NYS2d__, 2013 N.Y. Slip Op. 08430, 2013 WL6645443 (2d Dept. 2013), the Appellate Division, Second Department, recently reiterated the well-known (but worth repeating) rule that "An insurer that fails to pay or deny a claim within the 30 days following its receipt of the proof of claim is subject to substantial consequences. That insurer is generally precluded from asserting a defense against payment of the claim. The only exception that the Court of Appeals has carved out is where an insurer raises a defense of lack of coverage. Indeed, the Court of Appeals has concluded that even a claim of fraud must be contested by an insurer within the tight deadlines of the no-fault regime, or else the insurer is precluded from asserting such a claim. While the Court of Appeals has recognized that preclusion may require an insurer to pay a no-fault claim it might not have had to honor if it had timely denied the claim, it has emphasized that the provision of prompt uncontested, first-party insurance benefits is part of the price paid to eliminate common-law contested lawsuits," [Citations and internal quotation marks omitted]. The question remains, however, what exactly does this mean in terms of the burden of proof that a plaintiff must meet in an action brought to recover unpaid no-fault benefits?

The above-named three judges, in their rather convincing opinion, held that "by demonstrating that its prescribed statutory billing forms used to establish proof of claim (11 NYCRR 65-1.1) were mailed to and received by the defendant and that the defendant failed to either timely pay or deny the claims," the plaintiff established, prima facie, its entitlement to judgment as a matter of law.

On the other hand, in an equally persuasive opinion, the dissenting justices, L. Priscilla Hall and Robert J. Miller, disagreed. They felt that although defendant's failure to timely pay or deny the claim results in preclusion of most defenses, that does not relieve the plaintiff of establishing not only that bills were submitted but that the plaintiff's claim is valid and meritorious, comparing the situation to that of a defendant that has defaulted or whose answer has been stricken, in which cases the plaintiff must submit requisite proof of facts constituting the claim by affidavit of or complaint verified by a person with knowledge of those facts.

In view of the 3-2 split, the order of the Appellate Division is appealable as of right to the Court of Appeals. We suspect that the insurer will not allow this decision to exist without a further fight.

Banning Providers

For many years, certain owners and operators of professional service corporations or other similar business entities in New York have abused the no-fault insurance system, engaging in such activities as intentionally staging accidents and billing no-fault insurers for health services that were either unnecessary or not even provided. Such fraud has certainly caught the eye of the governor and the superintendent of the Department of Financial Services because it costs no-fault insurers tens, if not hundreds, of millions of dollars per year, which the insurers ultimately pass on to the consumers in the form of higher automobile insurance premiums. It also threatens the affordability of health care and, thus, the health, safety and welfare of the public.

> Superintendent Benjamin M. Lawsky stated, "No-Fault auto insurance fraud drives up costs for every single New Yorker on the road. A dirty doctor is typically the key ingredient in these schemes and cutting them out can have a major impact."

A provider of health care services is not eligible for reimbursement under section 5102(a)(1) of the Insurance Law "if the provider fails to meet any applicable New York state or local licensing requirement necessary to perform such service in New York or meet any applicable licensing requirement necessary to perform such service in any other state in which such service is performed." 11 NYCRR §65-3.16(a)(12). Pursuant to this regulation, the Court of Appeals, in *State Farm Mut. Auto Ins. v. Mallela*, 4 NY3d 313 (2005), held that "insurance carriers may withhold payment for medical services provided by fraudulently incorporated enterprises. *Mallela* was decided on March 29, 2005. The Legislature subsequently enacted Insurance Law §5109 ("Unauthorized providers of health services" L. 2005, c. 423, §1), which became effective on Aug. 2, 2005. There is no indication in §5109, or its legislative history, that this statute was intended to overrule *Mallela*. See *Allstate v. Belt Parkway Imaging*, 78 AD3d 592 (1st Dept. 2010).

Pursuant to Ins. L. §5109(a), the superintendent, in consultation with the Commissioner of Health and the Commissioner of Education, shall by regulation, promulgate standards and procedures for investigating and suspending or removing the authorization for providers of health services to demand or request payment for health services as specified in Ins. L. §5102(1)(a) upon findings reached after investigation. Moreover, pursuant to 11 NYCRR §65-5.2(a), the superintendent of the Department of Financial Services has the authority to investigate any allegations "regarding providers of health services engaging in any of the unlawful activities set forth in Insurance Law §5109(b)."

Those unlawful activities are: (1) being guilty of professional or other misconduct or incompetency in connection with medical services rendered under Article 51 of the Insurance Law; or (2) exceeding the limits of the provider's professional competence in rendering medical care under Article 51, or knowingly making a false statement or representation as to a material fact in any medical report made in connection with any claim under that Article; or (3) soliciting or employing another to solicit for himself or herself or for another, professional treatment, examination or care of an injured person in connection with any claim under Article 51; or (4) refusing to appear before, or to answer upon request of, the Commissioner of Health, the superintendent, or any duly authorized officer of the state, any legal question, or to produce any relevant information concerning his or her conduct in connection with render-

ing medical services under Article 51; or (5) engaging in patterns of billing for services which were not provided.

Pursuant to the regulation, after the investigation, the superintendent will send to the Commissioner of Health and the Commissioner of Education a list of any providers he believes may have engaged in any of the above listed unlawful activities. Within 45 days of receipt of the list, the commissioners of Health and Education must notify the superintendent in writing whether they agree that there is a reasonable basis to proceed with notice and a hearing to determine de-authorization to demand or request payment for medical services in connection with any claim under the no-fault law.

Upon consideration of the hearing officer's report and recommendation, the superintendent may issue a final order prohibiting the provider from demanding or requesting any payment for medical services in connection with any claim under the no-fault law, and requiring the provider to refrain from subsequently treating, for remuneration, as a private patient, any person seeking medical treatment under Article 51 of the Assurance Law. See 11 NYCRR §65-5.5(c).

In a press release dated Oct. 31, 2013, the Department of Financial Services announced that Gov. Andrew Cuomo had on that date announced that his administration had banned a "first round" of 18 doctors and other health providers from billing New York's no-fault insurance system as part of his administration's statewide initiative to stop fraudulent health service providers and medical mills.

As stated by the governor, "Defrauding the State's No-Fault auto insurance system is illegal and drives up costs for honest drivers across the state, and my administration simply will not allow such actions to go unpunished. Doctors and medical service providers who conspire to abuse the system should know that New York is watching and will not hesitate to take appropriate actions to shut down fraud when it occurs."

In a similar vein, Superintendent Benjamin M. Lawsky stated, "No-Fault auto insurance fraud drives up costs for every single New Yorker on the road. A dirty doctor is typically the key ingredient in these schemes and cutting them out can have a major impact. Our investigation is continuing and other doctors should think twice about the consequences before trying to rip off the no-fault insurance system."

The list of the first 18 doctors and other health service providers to be banned from billing under the no-fault insurance system can be obtained by viewing the press release at http://www.dfs.ny.gov/about/press2013/pr1310311.htm.

According to the New York Insurance Association (NYIA), which has clarified the rules for no-fault decertification,[2] most of the de-authorizations in this initial group were pursuant to stipulations, which followed the statutory language prohibiting further (future) demands or requests for payment. Accordingly, those doctors and health service providers would not be prevented from collecting on previously billed claims. However, three orders rendered after administrative hearings go further than the statutory language and prohibit the receipt of any payments, including previously submitted bills.

Moreover, if a PC is owned by a banned provider, the PC is also barred from billing and collecting. And, if the banned provider was merely an employee of a PC, the PC itself is not banned from billing under No-Fault, but the PC cannot bill under no-fault for treatment provided by the banned employee/provider.[3]

1. See Dachs, N. and Dachs, J., "More on No-Fault," NYLJ, July 11, 2000, p. 3, col. 1.

2. See Albany Update 2013.25: Nov. 20, 2013 at http://nyia.org/?p=5731#more-5731.

3. Cassandra A. Kazukenas, an associate at Hurwitz & Fine, provided the information and sources regarding unauthorized providers of health services.