

MORE ON NO-FAULT

One year ago, in this column, we discussed what were at that time proposed amendments, and seven months later became adopted amendments, to the Insurance Department regulations governing no-fault claims. (See “Proposed Changes to No-Fault Regulations,” Dachs, N. and Dachs, J., July 13, 1999, p. 3, col. 1). 11 NYCRR, Part 65, known familiarly as “Reg. 68,” effective February 1, 2000, had, inter alia, established the shortest time period in the country for injured victims of motor vehicle accidents to notify the proper insurance carrier of the accident and claim, cutting the allowable time by two-thirds, from ninety days down to thirty days. “Reg. 68” also dramatically reduced the time for a claimant or medical provider to file a claim for compensation (reimbursement) for treatment by three-quarters, from 180 days down to forty-five days. And, “Reg. 68” changed the method of payment of interest on overdue mandatory no-fault benefits from a compound interest rate of 2% per month to a simple interest rate of 2% per month.

As individuals and organizations that were most directly and severely affected by these amendments, a unique coalition of consumers, doctors and other health providers, attorneys and small businesses commenced a declaratory/injunctive lawsuit against the Insurance Department seeking to overturn “Reg. 68” and to bar the enforcement of its rules.

As many of our readers probably already know, in a strongly worded 22-page decision signed on June 9, 2000 and entered on June 13, 2000, Justice Phyllis Gangel-Jacob, in *Medical Society of the State of New York, et al v. Levin*, Sup. Ct. N.Y. Co., Index No. 102167/2000, declared “Reg. 68” “invalid,” and “null and void” and enjoined its implementation and/or enforcement. Specifically, Justice Gangel-Jacob ruled that the

Insurance Department had “deliberately overlooked” its “clear obligations” under the public disclosure and review requirements of the State Administrative Procedures Act “in response to the interests of insurers and self-insurers, under the guise of implementing the prompt payment policy of the no-fault law, notwithstanding significant public comment in opposition, and that the promulgation of “Reg. 68” was “unlawful, arbitrary, capricious and an abuse of discretion.”

Interestingly, Justice Gangel-Jacob did not rule -- because she did not have to under the circumstances -- upon the Petitioners’ contention that “Reg. 68” was ultra vires, i.e., “the kind of regulatory attempt that so undermines the statutory purpose of the no-fault statutes as to be beyond even the generous reach of an administrative agency’s incidental regulatory powers” (see, Siegel, D., Siegel’s Practice Review, No. 96, June 2000, p. 1). The court did, however, examine the content of the amendments and did note the serious impact the shortened time periods would have on no-fault claims. In the words of Justice Gangel-Jacob, “It does not take a leap of faith to recognize the destructive impact the New Regulations will have on the ordinary people who make up the majority of covered persons who have suffered injury and who, at that most vulnerable and confusing time, must navigate the waters of bureaucracy as the only way to cover their costs or risk losing their entitlements. Nor is it difficult to recognize the concomitant adverse impact upon their health providers and assignees.” Yet, the failure by the Insurance Department to fulfill its important public notice requirements, as mandated by the State Administrative Procedure Act, was found by the court to be a sufficient ground upon which to overturn the amendment without determining whether it would be within the Insurance Department’s power to make the changes it did even if the promulgation procedures were properly

followed. Still, given the court's remarks concerning the impact of the changes, and its further comment that "it seems obvious that the New Regulations lack consistency with the essential purpose and legislative policy underlying the no-fault law," the strong implication is that if the ultra vires test had been reached and applied, the Insurance Department would woefully have failed that test.

Shortly after the announcement of Justice Gangel-Jacob's ruling, the Insurance Department announced its "disappointment" with the decision and filed a notice of appeal therefrom. On June 14, 2000, the Department issued a circular letter, Circular Letter No. 20 (2000), which declared that "The filing of the notice of appeal [presumably on that date] stays the effect of the lower court's order as a matter of law [pursuant to CPLR 5519(a), which provides the State with a stay of enforcement of an order or judgment appealed from once the Notice of Appeal is filed]. As a result of the stay, the revisions to Regulation 68 remain in effect."

In response, the attorneys for the Petitioners moved in the Appellate Division, First Department on June 21, 2000 for an Order declaring that the self-executing invalidation portion of Justice Gangel-Jacob's Order needs no further enforcement and, therefore, no automatic stay applies. Alternatively, they requested pursuant to CPLR 5519(c), a vacatur of any automatic stay. A further request for expedited relief was made and heard by Justice Wallach, who declined to issue a stay to either party and, instead, set the matter down to be fully submitted on July 10, 2000, with a decision to be rendered by July 14, 2000. Based upon the foregoing, various plaintiffs/claimants have advised their members that, to be on the safe side, they should continue to proceed as if "Reg. 68" is still in full force and effect. We will continue to advise our readers of developments as they occur.

No-Fault Arbitration

In a recent column, we noted that effective December 1, 1999, the function of conciliating no-fault disputes had been transferred from the Insurance Department to the American Arbitration Association (AAA), and that, accordingly, the AAA would now be administering the entire arbitration process, from pre-arbitration conciliation through the arbitration hearing itself. (See “No-Fault Update and the ‘Top Ten’,” Dachs, N. and Dachs, J., March 14, 2000, p. 3, col. 1).

It should be noted, however, that arbitration is not the only forum for restoring no-fault disputes, such disputed being subject to litigation in the courts, at the option of the insured/claimant. See Insurance Law §5106(b). It should also be noted that the AAA is not necessarily the only forum for the arbitration of no-fault disputes. Although, as previously noted, under the current system, the no-fault regulations require disputing parties to utilize the services of the AAA, as in other types of cases, parties to a no-fault dispute are not prohibited from agreeing to shift the dispute to an alternative forum.

With this in mind, National Arbitration and Mediation (NAM), an alternative dispute resolution (ADR) company based in Great Neck, New York, which is one of the highest volume ADR providers to the insurance industry, has recently announced that, effective August 1, 2000, it will begin accepting New York no-fault demands for arbitration to provide health care providers, no-fault insurers and claimants a new, more cost-effective and efficient alternative option for resolving no-fault disputes. Of course, both the insurer and the claimant must agree to submit to this alternate forum. Some insurers have agreed in advance to submit to NAM when a claimant so requests.

In a recent press announcement, NAM's Associate General Counsel, William Snyder, stated that "Given the size and nature of no-fault disputes, it is imperative that the process remain financially feasible for the parties. NAM will still charge a \$40.00 filing fee to the claimant [the same as the AAA]. However, carriers will be paying 40% to 50% less in hearing fees than they are paying under the current system. At the same time, given NAM's computer infrastructure and the experience of our case administrators, we should be able to schedule no-fault hearings within sixty days of the filing of the [demand]. NAM also plans to allow claimants to pay for bulk filings with one payment, either by check or credit card and to file demands by e-mail, fax or regular mail. In addition, NAM's rules will not require parties to submit the documents they intend to rely upon at the arbitration until ten days prior to the hearing. Moreover, NAM has eliminated entirely the existing mandatory conciliation process which it believes to be largely ineffective and wasteful. As in its other ADR areas, NAM has retained a panel of attorneys and former judges to serve as no-fault arbitrators. It remains to be seen, of course, whether parties will avail themselves of this alternative arbitration forum and, if so, whether they will be pleased that they did.

"Independent" Medical Examinations

Recently, the media has been replete with stories involving various forms of fraud in the automobile insurance field. Indeed, the aforementioned "Reg. 68" was, according to the Insurance Department, enacted in large measure to reduce fraud and abuse of the

system. A recent series in The New York Post decried that “Scam artists are having a field day with New York’s no-fault auto-insurance system – staging accidents and filing millions of dollars in bogus medical claims that drive up insurance costs,” and pointed to “Hundreds of ‘medical bills’ [that] routinely blitz insurers with bills for big ticket diagnostic tests, treatments, and medical equipment for people who claim they were injured in staged or phantom fender-benders” See “Road to Riches is Paved With Lies and Serial Scams,” N.Y. Post, June 25, 2000. According to the Post, based upon a review of hundreds of court and government documents, together with dozens of interviews with investigators and scam participants, accidents are orchestrated or fabricated in various ways:

- The participants fill a car with 3-4 passengers and deliberately run into an unsuspecting car – preferably a Lexus or BMW driven by a lone or elderly woman.
- They set up a sideswipe or fender-bender between two cars driven by participants in the swindle.
- They call a local livery service, four people pile into the limo and direct the driver to a location where cohorts in another car cause a collision.
- They buy a wreck or salvaged vehicle, insure it, and pretend to have an accident. Then they file insurance claims, reporting hit-and-runs in which all of the participants are hurt.
- After the “accidents,” the claimants, all feigning aches and pains, are steered to corrupt medical clinics, where at least \$3,500 to \$7,500 per patient in bills are run up for diagnostic tests, such as MRIs, and nerve conduction studies, and for office visits, “therapies” that often consist of a back-rub or a heat treatment, and prescribed equipment such as massagers, electrical simulators and biofeedback.

On the other side of the coin, a recent exposé on Dateline NBC (that aired on June 23, 2000), reporting the results of a fifteen month long investigation into what happens

behind-the-scenes when an insurance company decides to challenge a medical claim after an automobile accident, strongly denounced a practice used by the insurer under investigation, State Farm, but also used by almost every major insurer in the country. That practice, known as “paper reviews,” involves the use of what are supposed to be the opinions of independent, objective doctors to assist the insurer to decide whether it should pay a claim in a questionable case. These outside doctors’ reports are called “paper reviews” because only the patients’ paperwork, medical records and accident reports are examined, not the patient him or herself. Among the findings of the Dateline NBC report was evidence that:

- Some State Farm employees secretly helped author the supposedly independent medical reports, dictating changes to medical opinions that led to lower recommended payments for medical claims.
- A sophisticated database, which one paper review company boasted could predict the likelihood of injury in a specific accident, never even existed. The results of the bogus database were cited in at least 100 reports sent to State Farm as a reason not to pay a claim.
- The reports produced by both paper review companies used by State Farm were consistently slanted toward the denial of claims.
- One paper review company hired people with no medical training to write “doctor’s opinions,” which State Farm and other insurance companies used to justify denying or cutting back a claim.
- At both paper review companies, doctors’ names were forged on reports neither they nor any other doctor had ever seen.

In addition to these “paper reviews”, claimants and their attorneys have long complained about corruption in the physical examinations conducted by doctors retained for that purpose by the insurers, contending that those short, relatively unthorough

examinations are not at all “independent” as they are proclaimed to be, but, rather, defense oriented and calculated to find against the plaintiff/insured/claimant.

Just last month, the Injured Workers’ Protection Act was passed, to become effective December 11, 2000. That legislation amends the Workers’ Compensation Law, by inter alia, attempting to revamp the “independent medical examination” by removing the built-in biases against claimants. Some of the highlights of this legislation are the following:

- Independent Medical Examiners are prohibited from charging any more than the amount the attending physicians in the same specialty would charge. The intent of this change is to remove the financial incentive of many doctors to conduct hundreds of “IMEs” per year to lucratively supplement their income. In other words, the thought goes, insurance companies will not be able to buy medical opinions any longer.
- Claimants and their attorneys must be provided a copy of the examiner’s medical report on the same day that the report is submitted to the insurer and the workers’ compensation board. In this way, opportunities for forgery and/or unauthorized changes will be minimized.
- Doctors who conduct “IMEs” will have to be licensed to practice medicine in the State of New York. In addition, the examinations will have to take place in a medical facility and the claimant can only be examined by a doctor who has a speciality 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, which was apparently prevalent in New York.
- A doctor will not be allowed to perform an “IME” if he or she or another member of a “preferred provider organization or managed care provider” to which the doctor belongs has treated or examined the claimant for the condition for which the “IME” is requested.
- IME notices will now have to advise the claimant that he or she has the right to videotape the examination or have a witness of their choice present throughout the examination.
- Any doctor, carrier or employer who attempts to influence a doctor’s opinion or changes a doctor’s opinion will be guilty of fraud.

As it currently stands, the legislation only applies to workers’ compensation claims and examinations. Lobbying efforts are underway to extend this legislation to medical

examinations in personal injury actions, including no-fault examinations, as well. If the Legislature is to consider such an approach, we offer the following additional recommendation, designed to further discourage and avoid fraudulent practices and/or the appearance of unfairness: all IMEs should be 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 truly an independent medical examination. Both plaintiffs and defendants will surely benefit from that improved perception.