

NO FAULT 30-DAY RULE

Insurance Law §5106(a) provides that payment of no-fault first-party benefits “shall be made as the loss is incurred”. According to 11 NYCRR 65.15(d)(6), “[i]n lieu of a prescribed application for motor vehicle no-fault benefits submitted by an applicant and a verification of hospital treatment (NYS Form N-F 4), an insurer shall accept a completed hospital facility form (NYS Form N-F 5) * * * submitted by a provider of health services with respect to the claim of such provider.”

No-fault benefits are overdue if not paid “within thirty days after the claimant supplies proof of the fact and amount of loss sustained.” Insurance Law § 5106 [a]. Similarly, 11 NYCRR 65.15 (g) (3) [i] provides: “Within 30 calendar days after proof of claim is received, the insurer shall either pay or deny the claim in whole or in part.” A duly filed claim can only be properly denied “on the prescribed denial of claim form”. An insurer that fails to properly deny a claim within 30 days as required by these statutory provisions may be precluded from interposing a defense to the plaintiff’s lawsuit. *See, e.g. Presbyterian Hosp. in City of N.Y. v. Maryland Cas. Co.*, 90 NY2d 274 (1997); *Presbyterian Hosp. v. Atlanta Cas. Co.*, 210 AD2d 210 (2d Dept. 1994). The only statutory exception to this precise timetable is provided in 11 NYCRR 65.15 (d) (1), which reads: “Within 10 business days after receipt of the completed application for motor vehicle no-fault benefits, the insurer shall forward, to the parties required to complete them, those prescribed certification forms it will require prior to payment of the initial claim. The insurer is entitled to receive all items necessary to verify the claim directly from the parties from whom such verification was requested.” Thereafter, “[s]ubsequent to the receipt of one or more of the completed prescribed verification forms, any additional verification required by the insurer

shall be requested within 10 business days of receipt of the prescribed verification forms.”
11 NYCRR 65.15 [d][2]. *Mt. Sinai Hospital v. Triboro Coach, Inc.*, ___ AD2d___, (2d Dept.
1999) (NYLJ 12/8/99, p. 25, col. 3).

Basis for Denial

What is the effect of an insurance company’s failure to adhere to the “30-day rule”?
The answer depends on the reason advanced by the insurer for its denial of claim. If the
insurer is asserting a “lack of coverage” defense as the basis for its denial, the untimeliness
of its denial does not prevent it from resisting the claim on that ground before the arbitrator
or before the court. *Central General Hospital v. Chubb Group*, 90 NY2d 195, 199 (1997).
However, if the reason advanced by the insurer does not implicate a “coverage” matter, the
failure to comply with the time restriction will preclude the insurer from raising such defense
in the no-fault action or arbitration. *Presbyterian Hospital v. Maryland Cas. Co.*, *supra*.
Discussing the distinction between “coverage” and “non-coverage” defenses, the Court of
Appeals, in *Central General Hospital v. Chubb Group*, *supra*, explained:

“The insurer is not precluded, despite its untimely disclaimer, from raising as a
defense its denial of liability on the ground that the services rendered to treat the injuries
at issue did not arise from a covered accident. That is the narrow kind of coverage matter
contemplated and implicated by the *Zappone* rationale and its antecedents, albeit under
different Insurance Law provisions. We note, however, that we are not addressing
questions as to aggravation of injuries out of successive events and like problems which
ordinarily would not be pure matters of coverage but rather spinoffs and different legal and

procedural complications involving varying factual disputation, variation and resolution, perhaps even in discrete alternative forums.

“As noted earlier, moreover, we further differentiate between Chubb’s arguable defense that the allegedly causative event was not covered at all and its assertion that the hospital treatments were medically excessive. The latter type of excusal from payment of some part of no-fault benefits -- a matter of degree at best -- does not ordinarily constitute the kind of lack of coverage classification contemplated or implicated by Zappone. Thus, an excessive medical treatments assertion should not provide dispensation from usual and pertinent Insurance Law time notification requirements and might suffer a preclusion remedy for violations.”

Of course, it is sometimes difficult to distinguish between what is a “coverage” issue and what is not. As the Second Department recently stated in Mt. Sinai Hosp. v. Triboro Coach, Inc., supra:

“While it may be argued that the exceptional exemption first outlined in Schiff and Zappone is reserved for ‘pure matters of coverage’ rather than ‘factual disputation[s]’ (Central Gen. Hosp. v. Chubb Group of Ins. Cos., supra, at 202), clearly the question of whether an injury was entirely preexisting (i.e., not covered) or was in whole or in part the result of an insured accident (i.e., covered) is hybrid in nature, and cannot be resolved without recourse to the medical facts. This conclusion is compelled by the very language of Central General, which permits an insurer to claim the exemption only if it can show that its diagnosis of the plaintiff’s condition is ‘premised on *the fact or founded belief* that the

alleged injury does not arise out of an insured incident' (*Central Gen. Hosp. v. Chubb Group of Ins. Cos.*, supra, at 199, emphasis supplied)."

Effect of Preclusion

What effect does an insurer being "precluded" from, for example, "offering the defense of excessive treatment" (*Country-Wide Ins. Co. v. Zablocki*, 257 AD2d 506 (1st Dept. 1994) have with respect to the claimant's burden of proof? Must he or she make a prima facie showing of his or her entitlement to recover the denied no-fault benefits? If so, what is the nature and extent of the prima facie showing that the claimant must make?

An argument can be made that inasmuch as the insurer may no longer deny the claim on the basis that the treatment was unnecessary or excessive, the claimant need only establish that the treatment was for injuries that resulted from a covered accident or that arose "out of an insured incident." *Central General Hospital v. Chubb Group*, supra. Stated otherwise, where the insurer is precluded from denying a claim on the basis that treatment was excessive or unnecessary, the claimant need not establish affirmatively that the treatment was necessary or that it was not excessive. Since the insurer is precluded from denying the claim on these grounds, that question is no longer at issue and need not be independently established, even prima facie.

Such an argument would be consistent with the effect given to preclusion in "a parallel universe and more general context." *Presbyterian Hosp. v. Maryland Cas. Co.*, supra. When an insurer is precluded from disclaiming for late notice because of its own non-compliance with the "reasonably possible" requirement of Insurance Law §3420(d) for giving written notice of disclaimer, see *Hartford Ins. Co. v. County of Nassau*, 46 NY2d

1028 (1979), it would be curious, at least, to suggest that the insured, in order to be entitled to coverage under the policy, must first show, prima facie, that he or she gave timely notice to the insurer when the fact that the insured's notice was late, even if conceded, is the very thing that the insurer is precluded from raising. Similarly, to require claimant to establish, prima facie, that he was not intoxicated would appear to render meaningless the holding in Presbyterian Hosp. v. Maryland Cas. Co., supra, that the insurer's non-compliance with the 30-day rule precluded it "from interposing a statutory exclusion defense for failure to deny a claim within 30-days as required by Insurance Law §5106(a) and 11 NYCRR 65.15(g)(3)." See also Bennett v. State Farm Ins. Co., 147 AD2d 779, (3d Dept. 1989).

Insurers' fears that not requiring claimants to prove prima facie that their claims are "valid" would encourage fraudulent claims was effectively answered by the Court of Appeals in Presbyterian Hospital v. Maryland Cas. Co., supra, as follows:

"The tradeoff of the no-fault reform still allows carriers to contest ill-founded, illegitimate and fraudulent claims, but with a strict, short-leashed contestable period and process designed to avoid prejudice and red-tape dilatory practices."

Recent Decisions

Few court decisions directly confront this question. For example, in Westchester County Medical Center v. NY Central Mut. Ins. Co., __ AD2d __, 692 NYS2d 665 (2d Dept. 1999), summary judgment was denied, notwithstanding the failure to deny the claim within thirty days, for the reason, inter alia, that "plaintiff's moving papers failed to establish prima facie entitlement to judgment as a matter of law on its claim that the injuries for which payment was sought arose from an automobile accident covered under the subject policy"

(emphasis added). This, however, is consistent with Central General's requirement that what must be shown is that the injuries for which treatment was rendered arose "out of an insured incident."

However, two very recent decisions have honed in more sharply on this issue - one indirectly, the other head-on. In Mt. Sinai Hosp. v. Triboro Coach, Inc., supra, the court rejected "Triboro's repeated arguments to the contrary" and held that "it would not be reasonable to insist that a plaintiff hospital must prove as a threshold matter that its patient's condition was 'caused' by the automobile accident and was unrelated to his/her entire previous medical history. The policy concerns underlying the no-fault legislation would thereby be undermined, and insurers would be motivated to refrain from issuing timely disclaimers in order to impose such an onerous threshold burden upon claimants."

The second -- a Civil Court, New York County case -- is particularly instructive. In Metroscan Imaging v. American Transit Ins. Co., NYLJ 12/10/99, p. 27, col. 5, Judge Karen Smith, in a remarkably exhaustive scholarly opinion worthy of reading in its entirety, concluded that where the insurer fails to adhere to the 30 day time limitation in a "non coverage" situation, the only prima facie showing the claimant must make is that a claim was made on the required forms and that the forms were mailed to the insurer, he or she must present a copy of the assignment of benefits to the medical provider (where applicable), and must show that the defendant failed to comply with the terms of the statute and regulations. As the Court explained with respect to non-coverage type objections:

"Defendant's other objections, i.e. that the services provided were excessive and were not medically necessary, that there was fraud and illegal self-referrals, are not

cognizable exceptions to the general rule that all claims must be paid or denied within thirty days of submission....”

Review of Arbitrator’s Award

What remedy is available to a claimant if the arbitrator either refuses to apply the 30-day rule when its application is clearly warranted, or where the arbitrator misapplies it by requiring the claimant to prove the issue that the insurer is precluded from raising in defense of the claim? Since either scenario would constitute an error of law, and since a “master arbitrator possesse[s] the authority to vacate the initial arbitrator’s legally incorrect award” (see *Matter of State Farm Insurance Company v. Domotor*, ___ AD2d ___, 697 NYS2d 348 (2d Dept. 1999)); see also *State Farm v. Spelotros*, 257 AD2d 577 (2d Dept. 1999), the claimant’s remedy is to seek review by a master arbitrator. Assume, however, that the master arbitrator’s award, either affirming or vacating on a question of law the first arbitrator’s award, is, itself, incorrect as a matter of law, may the court, in a proceeding pursuant to CPLR Article 75 vacate the master arbitrator’s award? Unlike the master arbitrator, who possesses the authority to vacate an award which is “incorrect as a matter of law” (11 NYCRR 65.18(a)(4)), the court’s power to vacate a master arbitrator’s award is more limited. As explained in *Smith v. Fireman’s Insurance Company*, 55 NY2d 224 (1982):

“Thus, it is clear that the vacatur was based upon the master arbitrator’s determination that the arbitrator had made an error of law. Such a determination is within the master arbitrator’s powers of review. Having made that determination, the courts are limited in their further review of the master arbitrator’s resolution of that error of law, since

we generally will not vacate an arbitrator's award where the error claimed is the incorrect application of a rule of substantive law (citations omitted) unless it is so 'irrational as to require vacatur.'"

Of course, the distinction between an award that is simply legally erroneous and one that is irrational is, essentially, one that is subjective in nature. What may be simply wrong to one court may be "dead wrong" or irrational to another.

Finally, it should be noted that a different remedy is available when the master arbitrator's award is \$5,000 or greater, exclusive of interest and attorney's fees. In such case, either party may, in lieu of an Article 75 proceeding, institute a court action to adjudicate the dispute de novo. 11 NYCRR 65.18(h)(1)(ii).

Anticipatory Breach

If the no-fault insurer notifies its insured that it is denying all no-fault benefits, must the insured, nevertheless, continue to submit bills for health care services subsequently incurred before he or she may seek to recover such unpaid benefits? In State Farm Ins. Co. v. Domotor, supra, the Second Department held that the insurer's denial based upon its medical expert's opinion that the insured no longer required treatment "excused the [claimant] from further compliance with conditions precedent (see, 11 NYCRR 65.12) regarding time limitations for submitting medical proofs of loss for the treatments she nevertheless continued to undergo," the court further stating that "an insurance carrier may not, after repudiating liability, create grounds for its refusal to pay by demanding compliance with proof of loss provisions of the policy. Rather, the insurance carrier 'must stand or fall upon the defense upon which it based its refusal to pay,' i.e., because 'no treatment [was] necessary.'"