WBASNY

The Women's Bar Association of the State of New York

presents

Convention 2023
Continuing Legal Education Series

No-Fault Insurance: Preserving Lost Earnings Claims

June 3, 2023
9:00 am - 10:00 am

Presenter: Jeanne M. Vinal, Esq.

Vinal & Vinal, P.C.

No-Fault Insurance: Preserving Lost Earnings Claims

No-Fault 2023:
PRESERVE AND PROTECT YOUR FIRM AND YOUR CLIENT

Vinal & Vinal, P.C.
193 Delaware Avenue
Buffalo, NY 14202
716-832-5900

Vinallaw.com
Fax: 716-832-6735
Email Jeanne at vinalesq@aol.com
Email Jen at Jen@vinallaw.com

Presented by
Jeanne Vinal, Esq.

Vinal & Vinal, P.C.
No-Fault Insurance Training Seminar

GOALS OF THE PROGRAM

1. Increase knowledge of No-Fault rules and best practices.
2. Protect your clients and firm so all claims are properly made and returned.
3. Make informed decisions about No-Fault
4. Prevent No-Fault issues from decreasing the value of your PI case.
5. Help your firm uniformly practice the best strategies for handling No-Fault.
6. Increase your personal value to the firm and to your clients.

Doing No-Fault well won't necessarily increase the value of your case BUT it:

- Will prevent decrease in value
- Will increase client satisfaction
- Will decrease client dissatisfaction
- Will put more money in client's pocket
- Will lessen the chance that client will get a loan on the case or take a settlement that's too low or call every day out of fear and desperation
- Will decrease chance of inadvertent policy violation

Theme for 2023: PRESERVE AND PROTECT

- First, the idea is to have the client take charge of their No-Fault issues.
- Second, to have the client realize that the No-Fault issues are separate from the issues involving the case against the other driver.
- Third, to focus on preserving No-Fault claims.
- Finally, to preserve your time from No-Fault to maximizing the PI claim.

Today's No-Fault Climate and Trends

1. **Fraud Allegations continue to be on the rise.**

    - With crucial protection, with denials of injured party's claims.
    - Suing doctors for the return of millions denied.
    - Insurance carriers giving literally millions statewide to "train" police, fire and DA's is fraud.
    - Rules strictly enforced against the injured person and doctor, while carrier violations are forgiven.
    - EUO's and verification and denials more aggressive.

The Basics of No-Fault Law

No-Fault is Based in Contract Law, Albeit Heavily Regulated Contract Law, not Negligence

Remembering that No-Fault is the contract between the carrier and the insured will help preserve claims.

In a negligence action, your client can recover for their pain and suffering and losses in excess of basic economic loss against all persons directly or vicariously liable for the collision to the extent of the defendant's negligence.

Insurance is a contract offered for sale and once purchased, is a contract between the insurance carrier and the insured.

The people protected by the policy are the insured, all additional insureds as stated in the policy, such as family members, who reside with the named insured, the driver, the passengers, pedestrians struck, and third party beneficiaries of the contract, most notably the assignee – medical provider. There is a contractual relationship and rights and duties derived from that contract on both sides.

Since the 1970s, New York has required all drivers to contract for No-Fault insurance. No-Fault insurance means that regardless of fault, there will be universal coverage for "Basic Economic Loss." Basic Economic Loss generally means lost wages and medical expenses. Therefore, regardless of who is at fault, everyone who is involved in a car collision, is supposed to have their wages paid and their medical bills paid. The purpose of this is to promote stability in the family, prevent people from going on public assistance, losing their houses, etc.

Unlike a purely private contract, a No-Fault insurance contract is governed by statutory law. As part of the statute, the Legislature gave authority to the Insurance Department to issue regulations implementing the statute.

In exchange for this protection of all drivers, individual drivers gave up their right to sue the responsible parties in cases where there was no "serious injury." In the last few years, there has been some terrible case law throwing out so many cases on the serious injury threshold. It has become a huge part of the personal injury practice.

Understanding the first party No-Fault system will help your client be protected to the full extent intended by the Legislature in adopting this statute from the beginning. It is very important. You are here because you and your firm cares about the client even when there is no financial benefit for the lawyer to do that. It shows you what kind of people you are working for: people who do care and who do want to do the right thing and who are putting their money where their mouths are.

A contract is a mutual agreement whereby each party to the contract is agreeing to certain rights and duties to the other person in the contract.

Example: The reason the client has to go to the IME is because the contract requires them to go to the IME. Period. Thinking about it in terms of the contract makes it easier to explain the rights and duties to each other.

Basic Rules of Contract Law

The plain reading of a contract governs interpretation and meaning. Read the contract. "Experts" in contract law are generally just people who have read the contract, rather than relying on their adversary to read the contract.

Rights and Obligations are Expressed in the Contract.
Your Rights are in the Contract.

Ambiguities are construed against the drafter. If the language can mean one of two or more things, you take the language most favorable to the person who did NOT draft the contract. However, in No-Fault, most contracts are taken from the Regulations, so rarely will there be a claim of vagueness.

Practice Point: Get the declaration sheet and see if there are limits higher than the minimum.

Minimum:
$50,000 in basic PIP
$2,000/month maximum reimbursement of work loss
$25 per day household help reimbursement
$2,000 death benefit

Sometimes can be:
$50,000 PIP
$25,000 OBEL
$50,000 APIP
$3,000 work loss
$50 per day

Note: Hand-written language trumps typed language and typed language trumps the pre-printed form language. This can be important in the case of limits, especially in contracts that cover companies that have trucks in New York and other states too. If the declaration sheet is different in some way from the pre-printed form, the higher coverage applies. You can use this in PIP and in SUM claims, as well as in BI claims.

Statutes of limitations for CONTRACTS apply to No-Fault because it is a contract claim.

Note: Violation is a breach of contract, governed by **6-year statute of limitations**, running from the breach. It's not the three years you are used to in a negligence case against the other driver.

Extra Credit: The statute on a bus is less because there is no contract.

Get All Applicable Contracts

The first issue is to identify all applicable policies.

People have the false impression that a policy insures a car or a house, and do not realize a policy insures a person, not a car. Therefore, the client often will not tell you about other insurance contracts which may be applicable because the client is not thinking along those lines.

An "eligible injured person," or EIP, on any No-Fault policy includes:

a. the insured on the contract injured in the use and operation of any motor vehicle; and

b. any relative in the household of the insured injured in the use and operation of any motor vehicle.

Thus, if you are faced with a minimum No-Fault policy and your client's loss is in excess of that policy, consider other policies where your client is the insured or someone in his household is an insured.

Thus, if your client is a pedestrian, or occupant or driver of a vehicle he does not own, you must consider other insurance and notice the other carriers which may offer coverage.

Examples:

- Client earns $5,000 a month and is an occupant of car with Basic PIP - with Allstate.
- Client at home has a car with 50 PIP, $2,000 a month lost wages and 50 APIP but no additional monthly wage – with State Farm.
- Client lives with mom who owns a car with 50 PIP, 50 APIP with $4,000 a month lost wage limit – with Liberty Mutual.

Notify: Primary Allstate Policy and send completed application, BUT also notify Liberty Mutual on the additional $2,000 available in lost wages monthly.

The easiest way to notify the second No-Fault carrier is by certified letter with the demand for additional lost wage claim and enclose of copy of the primary policy's application.

Practice Point: APIP is a lien on your recovery only for amounts paid up to the amount of your settlement. Most adjusters do not know about APIP coverage. So after proper notice you may want to delay pursuing on the additional lost wage claim and instead await conclusion of your PI case. Your client will actually get the benefit of APIP rather than you working to recover the APIP for the carrier.

Law Governing No-Fault

Contract – includes the declarations page and all the endorsements. The valid contract is the law of the case so to speak and the court is to interpret the contract as a matter of law, not an issue of fact. (There are some exceptions to this such as when the meaning is not clear.)

REMEMBER THE LANGUAGE OF THE
CONTRACT IS THE LAW OF THE CASE.

Article 51 of the Insurance Law

Article 51 is the statutory requirement that every owner of a motor vehicle in NYS must have No-Fault coverage. Ins. Law § 5103.

§5103(a) covers who gets coverage.

§5103(b) contains the exclusions.

Deductible is covered in §5103(c).

Self-insureds are created by 5103(e).

Motorcycles and ATV occupants can opt out of No-Fault per §5103(f)(page 52).

Pedestrians struck by a motorcycle do get coverage.

Practice Point – If you see a declarations sheet for a motorcycle with a small charge for No-Fault, this is just coverage for pedestrians struck by motorcycles. (This section also allows excluding of use of vehicle in commission of a felony).

§5102 contains definitions. Most important for No-Fault are §5102:

(a) Basic economic loss;
(b) First party benefits; and
(c) Covered person.

§5106 codified fair settlement practices. There are further specified in Section 2 of 11 NYCRR 65.

§5107 required No-Fault for non-residents injured in NYS for any company which does write in NYS. A list is on NYS Department of Financial Service's website.

§5108 incorporates Workers' Compensation fee schedule for charges and gives the Insurance Commission the right to issue regulations.

Regulations: 11 NYCRR 65
Insurance Department Opinion Letters
Insurance Department Circular Letters
Case Law
Arbitration Decisions

The regulations called "Regulation 68" are 11 NYCRR 65.

Five sections:

1. What must be included in every policy;
2. What must be provided by self-insured;
3. Claims process;
4. Arbitration process; and
5. New provisions – allows insurance department to prohibit a provider from billing No-Fault.

Insurance Department Opinion Letters

The Court of Appeals in LMK Psychological Services P.C. v. State Farm, 12 NY 3d 217 (2009) held that the Insurance Department (now Department of Financial Services or DFS) has a right to interpret its own regulations which basically trumps even a court. So these are important.

We have attached important opinion letters which you can use when arguing with a carrier.

Circular letters: They are few, but important at times when there are violations of the regulations repeatedly warranting the Insurance Department (now DFS) to send a letter to all carriers advising a violation. Some are attached hereto and you may use when arguing with an adjuster.

Case law: The different departments have different presentation on No-Fault issues.

For Example, the statute of limitations against a transit authority in the Fourth Department is 2 years, but it's 3 down state. No-Fault is a changing area of law.

Some cases of Regulations: 11 NYCRR 65

- Insurance Department Opinion Letters
- Insurance Department Circular Letters
- Case Law
- Arbitration Decisions of interest – recent and otherwise:

Court of Appeals Case

Someone is injured exiting a bus and falls into a hole. Generally, the first step off a vehicle and the last step into a vehicle are covered by No-Fault. Here, the Court of Appeals held that the injury did not arise out of the use or operation of a motor vehicle. Great dissent, but is a scary case. Insurance carriers are pushing this. However, I read it as an intervening tortfeasor's analysis on causation.

Domotor v. State Farm, (2nd Department case) 9 AD 3d 367 (2d Dept. 2001) held that once an insurance company issues a general denial on lost wages, this relieves the EIP from obligation to submit claims timely, but better practice is to keep submitting as this changes. Use case to explain non-submitted claims if you find yourself in that situation but do not use it as a basis to put yourself in that position.

No-Fault Application

There are three ways of looking at the No-Fault application. It can be:

a. ONE way of satisfying the required 30-day notice to the carrier.

b. a method of making a claim, especially for lost wages (which must be claimed within 90 days, different from the 45 day limit for medical claims), and should therefore be taken seriously (filling in all blanks, etc).

c. considered an answer to a verification request, which must be answered within 120 days.

The carrier is entitled to written notification of the claim and is entitled to use the No-Fault application as written verification within 30 days. **Failure to give written notice of the claim within 30 days is a policy violation and will result in denial of all benefits**. This is extremely harsh. It is contained in the policy because of what was known as "Regulation 68". (The No-Fault regulations are in 11 NYCRR 65, but Regulation 68 are the changes made in the 90s which were fought against hard by NYSTLA and the Medical Society, but eventually came into being.) "Regulation 68" provides that the carrier can include in the policy a requirement that the No-Fault

application must be filed within 30 days and all medical bills received within 45 days. This is called the 45 day rule and the 30 day rule.

30 Day Rule: Late notice of the claim is VERY SERIOUS as it can result in the total loss of all benefits.

If your client arrives during the 30 days following the loss, it is your responsibility to make sure that the application is received BY THE PROPER carrier within the 30 days. Failure to do so can result in complete denial, so just do it and drop everything else to make sure it's done right.

If your client comes in after the 30 days and has not filed the application, DO NOT immediately despair or refuse to take the case. There are exceptions:

Exceptions: ER bill was sent to the carrier; police report with injuries was filed. If the hospital sent in their ER bill within 30 days, this is a complete exception to the policy violation portion of the application.

You must still get the application in so that all claims are not "delayed" forever pending receipt of the application. The Insurance Department issued an opinion letter on this point and sent out two Circular Letters to carriers on this point. Despite this, carriers still always seem to send out denials --- EVEN TO THE HOSPITAL ON THE ER BILL.

Extra Credit: Hospital bills are even more involved than a regular medical bill. It covers the same information as a No-Fault application. However, not all the treatment at a hospital is billed using the hospital bill. Some treatment is billed using the regular biller's Health Insurance Claim Form 1500. Also, hospital bills must be received within 30 days to satisfy the 30 day rule; this is important as the hospital has 45 days to bill. New York and Presbyterian Hospital v. Country-Wide Ins., 17 NY 3d 586 (2011).

Practice Point: What to do when there is a denial for a late NF application.

First, get the police report. Were injuries noted? If so, send the carrier letter that the denial is invalid due to the police report. Second, check the police report to see if the person was taken by ambulance to the ER. If so, then call the hospital billing and see if they were paid, or if denied, if the bill was sent in to the right carrier within the 30 day period. Usually it is. If the bill was sent in within 30 days, then you can send a letter to

the carrier saying that the denial is invalid. You must still get the application in to avoid delay for that verification.

If the application was not submitted and the police report said no injuries and the client did not ever go to the ER, then your client has a tough row to hoe on this point. If there is no lost wage claim and other insurance, such as Medicaid, then it may not matter too much, except that the client will have to repay Medicaid needlessly. However, I would still have them send in the application as soon as possible, indicate the excuses, such as they are, and continue to send in the bills, etc.

We can and do arbitrate the issue of late application frequently, both when there are excuses as required by regulation and when there are not. When there are the excuses, we feel confident that we have a good chance we will win. When there is no good basis, we hold our breath and cannot be assured of winning at all, but we will still try.

The Following Generally Are NOT Valid Excuses For Late Application:

- "I sent to the carrier for the other car."
- "I didn't realize it had to be sent in."
- "The carrier sent me application on the 28th day after the collision and I thought I had more time."
- "I wasn't sure that I was going to make a claim."
- Law office failure

DO IT RIGHT THE FIRST TIME IF YOU GET THE CLIENT DURING THE FIRST 30 DAYS - Take the time to do it right and to make sure you are doing it right.

Who is the primary carrier?

- 2 Car MVC: Everyone gets the primary coverage from the policy from the car in which they are a driver/passenger

- Car versus pedestrian: Pedestrian covered primarily by the striking car's policy.

- Passenger on bus: Bus covers if and only if the passenger on the bus does not have a vehicle and does not have a car and there is no car in the household.

Extra credit: Motor Vehicle Accident Indemnity Corporation (MVAIC) is NOT the carrier if there is any other possible carrier. Don't send to MVAIC unless you really know it's them, because otherwise they take too long to tell you it's the wrong carrier.

Practice Point: If there is a possible SUM claim or UM claim, send notice of that separately to the carrier, not the NF adjuster, and send it certified mail, return receipt requested. Please tickle 30 days to see if response.

When it comes back, you are checking the contents of the application and whether all injures are included and what injuries are included and to verify the wage information.

Contents of the Application

You should review the application sent in by your client before you were retained or when you are filling it out.

Obviously, there are issues you will want to look at from the BI side such as prior inconsistent statements, thinking about future claims as to injuries noted, etc., however from the No-Fault side, we are concerned most with two issues: ascertainability and notice of claims for direct payment being lost wage(s), mileage, household help and expenses paid.

Triggering and other direct claims: There is a 30 day rule for the carriers too whereby they must either pay or deny or request further verification within 30 days of receipt of the specific claim. That's easy with regard to medical bills because the 30 days starts to run when the carrier receives the bill. However, with wage loss claims and other direct claims, it is often a little cloudier as to when the claim for lost wages is actually made. The application is generally the first claim for lost wages (and other claims) and should be viewed as such.

Therefore, try to be as specific as possible about lost wage claims when you are assisting the client in completing the application and when you are reviewing the application filled out by the client previously.

You do not need to be specific about the injuries such as L4-5 herniation, but rather the body parts, such as head, neck, back, and shoulder.

What Lost earnings are Covered and For How Long:

- Lost earnings incurred during the first three years. 80% less offsets.
- Not three years of lost wages, just during the first year

Lost Earnings Claim must be received by carrier within 90 days:

- Get off work slips monthly even though you don't have to technically (due within 90 days).

THIS REQUIREMENT CONTINUES EVEN AFTER DENIAL

No Fault has no real "anticipatory repudiation" as in most contracts, except in lost wages in State Farm v. Domotor which incorporates anticipatory repudiation. However, it is better to have the client continue to get and submit the off work slips monthly for the practical reason of getting that proof in.

The best practice is to have the client get off work slips from the doctor and have the client send them in directly to the carrier with a note: "Enclosed are the off work slips; please pay my lost wages." This triggers payment and makes it so that they have to pay, deny or ask for further verification and if they do not, they are late and that makes it easy to win the case. The client should keep a copy and send one copy to you, but should send it in themselves.

Please tell the client that they must apply for disability directly as most clients do not know that they do and no attorneys really do that for them. The carrier will deduct that amount whether they get it or not and the client will be upset if they never know about it. Disability starts the second week and runs for 26 weeks at 50% of lost wages up to a maximum of $170 weekly. Some may have already been used due to prior time off during the year (e.g., pregnancy, prior injury).

Please note that the carrier will deduct 100% of the wages even though at most they pay 80%. The carrier will also deduct from the policy the amount of the disability

and the Social Security Disability paid or which would have been paid had the client properly applied.

Certain employers do not have to provide disability such as county employers. Often, the carrier will still deduct until you show there is no disability.

Advanced Lost Wages

Lost wage payments do not make money for the PI attorney. However, getting lost wages does make the case go smoother so that the client continues to have income.

Maximum lost wages under basic PIP is $2,000 per month. Therefore, if your client has only basic PIP and earns more than $2,500 per month, the most No-Fault will pay is $2,000 per month and the carrier can deduct certain offsets.

Example:

- Client earns $4,000 per month with only basic PIP
- No-Fault pays during the first week.
- Actual gross loss is $923 ($4,000 per month at per week rate)
- Maximum No-Fault considers $577 per week ($2,500 per month at per week rate)
- So, client is already out $364 per week – (that's a gas bill and an electric bill)

Disability pays $170 (but often waits 10 weeks to send it)

No-Fault then pays $263.

So, instead of a gross check of $923, the injured party gets $170 from disability and $263 from the No-Fault.

The carrier deducts $577 from the policy. It pays $263, but deducts $577.

The carrier gets to deduct the amount paid plus the 20% offset plus and other mandatory offsets.

Deciding which offsets can be deducted from the $2,000 PIP limit. A general rule is that if the pay replacement was a voluntary choice that is the equivalent of a savings account, the carrier does not get to deduct it. If the replacement is mandatory and everyone similarly situated gets it, then the carrier gets the offset.

Mandatory offsets are NYS mandated disability and Social Security Disability.

Wage replacements that are not offsets are:

- Employer purchased long term disability policies (but see if that policy has an offset <u>from</u> No-Fault)
- Savings account
- Sick days – the employee could have banked and cashed out at retirement.

Complicated Issues:

1. **Unemployment**: If you are on Unemployment and get into a motor vehicle collision, No-Fault should replace Unemployment at the full amount (no 20% offset) but only for the period the EIP would have received unemployment but for the collision.

2. **Layoff and Call Backs**: If you client is on Unemployment for a known call back later, such as a construction worker in the winter or a school worker in the summer, then No-Fault should pick up Unemployment until the date the worker would have returned to work at 80% (less any other offsets).

Practice Point: If your client knows they will return to work, then add all wage information and employer information on the application with expected date of return and tell client to send carrier exact notice of date he would have returned but for the motor vehicle collision.

3. **Hired but did not start:** We get a lot of these claims, which does not mean there are a lot of them, but does mean the carrier fights them hard. Ask your client to keep any documents or notes or any proof she was hired. E.g., e-mail, phone message, or letter.

The employer verification often confuses the issue and gives the carrier a cause to deny, even when they know the facts.

4. **SSI or Welfare:** We take the position that No-Fault is an offset to SSI and Welfare, not the other way around as these are poverty programs. This is usually a fight.

5. **Self-employed People:** These claims are always complicated as to what is the amount of lost earnings.

Schedule C is not always the answer as you may have deductions which are really a tax incentive and do not change real costs (e.g., business use of a house, business paid cell phones, 179 deductions on equipment, etc.) These should be added back in.

Replacement labor trumps other calculations if your client has that and there is no 20% offset.

For business loss, you must provide what they want and then the client has to figure out what the loss is. If you are going to do an economist report in your case, that is awesome proof. We are considering doing that in our cases for the business loss. There are many ways to calculate the lost wage component. This is an area I really do love to do, because I love math, but they are very complicated and time consuming on the part of us and the client as well.

We'll be glad to discuss the issue of business loss on a case by case basis as they are very fact specific.

You may want to have the client take what is given along the way, but write "UNDER PROTEST" on each check and AFTER the "UNDER PROTEST", endorse the check and keep a copy front and back to preserve their rights on this issue.

Social Security Disability

The carrier can require the injured person to apply for Social Security Disability. Your client should do so as to not do so is a violation of the policy.

If no doctor has told them that they were completely disabled, I do not have them apply because it is a violation of the statement that they have to make that they are completely disabled. Instead, I send a letter to the carrier.

No-Fault is supposed to pay if the client cannot go back to the job they were doing.

Social Security Disability should pay only if the person cannot be gainfully employed in any job in the community.

Our firm handles SSD and SSI claims. If your firm does not, you may want to have us apply for them to give proof to the No-Fault carrier of application, to make sure the correct onset date is given as this is confusing to people and can negatively impact your personal injury case if they use an onset date before the collision. Also, we make sure the SSD offset is done correctly.

FEEL FREE TO CALL ME WITH ANY QUESTIONS ON THIS

Unusual Cases and Issues

Intoxication: Intoxication is a valid basis for denial, but is often abused by carriers. We have arbitrated cases where:

a. Ticketed for DWI, but it was really Diabetes;
b. Hospital listed alcoholism as a diagnosis, but there was no proof of acute intoxication;
c. Injured party was intoxicated but that was not the cause of the collision as he was the passenger, stopped at a red light, or rear ended; and
d. Ambulance and ER bills (no valid subject of denial).

Assault: Intentional collisions can be a valid ground for denial. However, interestingly, the Court of Appeals held that whether it was intentional must be from the insured's point of view. State Farm Ins. Co. v. Langan, 16 NY 3d 349 (2011)(injured party died after driver purposely ran into a crowd and was convicted of murder and court held that from decedent's point of view it was an accident – meaning an unexpected occurrence).

Last Step In and First Step Out: This is clearly covered. Regulation 11 NYCRR 65-1.1(d) includes in other definitions "occupying" means in or upon or entering into or alighting from. However, the Court of Appeals held that a person stepping off a bus was not covered as the injury was caused because she stepped into a hole. Civdanes v. City of New York, 20 NY 3d 925 (2012).

Other Issues

OBEL Choice: Note, when deciding on OBEL, think about the exhaustion issue with lost wages and other replacements and the lien.

IMEs

- You MUST go to them
- TWO STRIKES (consecutive misses) AND YOU ARE OUT ON EVERYTHING
- If you can't go, then document, document, document
- Go even if benefits stop
- Go rather than fight unreasonableness

Please note that there are not too many excuses for not going which will hold up and if there are two IMEs missed, they will cancel all insurance benefits and many times this will be upheld. It is much safer and better to just go regardless of the inconvenience.

Please note again, as with the application that these are looked at two ways. First, it is a policy violation and second, it is a verification request. Please note: recently carriers have started denying back benefits which were "pended" for the IME. In the past, they only denied future bills and wages, but now they can deny past as well and they do.

Please note in my letter on the No-Fault IME, I am not as kind about rescheduling as the firms whose letters I have seen, because it is so important to make sure they know they have to go and the consequences of not going.

EUO

YOU MUST GO TO THE EUO. Again, failure to go is both a policy violation and a verification request.

The verification request is outstanding until the EUO is done. Therefore, the carrier need not deny any bills until the EUO is done and therefore there is no live issue to arbitrate until it is done.

- Often used to allege fraud claims, very dangerous; need as much prep as the EBT
- Only need to go to one
- Only insured, applicant for benefit or the assignee of applicant for benefits need to go.
- Don't have anyone else go. No good will come of it.

Verification Requests and Delay Letters

A delay letter is not a denial. This "pends" the claim. The carrier has 30 days after the receipt of a bill to pay, deny or request verification. If there is a request for verification, they must send out two letters requesting verification and in the past they could just sit on the bill. The recent amendment converts the delay into a denial after 120 days.

However, the No-Fault application and lost wage claims and EUO's do not convert to a denial after 120 days, but continue to send the claim. You should review the delay letter to make sure you sent for the medical involved and then decide if any action is required. Generally none is and the provider will take care of the issue, such as a request for SOAP notes.

There are two exceptions where you might want to act. If it's a wage loss claim, you could call the client and ask them to call or go to the employer to get the form or to the doctor. Failure to get the wages causes a great deal of stress on the client and the family of the client and dissatisfaction with the process so it's worth doing.

Practice Point: Please note that really the answer to a verification request is an answer to the verification request which puts the ball back into the carrier's court and requires them to pay or deny within 30 days. Answer the verification request as follows: In response to your request for verification, please be advised as follows: Enclosed is _____. As to _____, we do not have this in our possession and neither does our client. This answers your verification request.

Failure to Deny Timely

As stated above, the carrier has 30 days to pay, deny or request verification on each bill it receives. If the carrier fails to do so, the carrier is waiving most defenses (except fraud and no coverage at all). Mount Sinai Hosp. v. NYCM, (2d Dept 8/13/14)(where hospital billed on wrong form, received verification request, which it answered and denied and then billed on correct form, same date of service, and carrier did not respond. The Court held waiver of defenses).

The 45 and 30 Day Rules and 120 Day Verification Requests

Once the carrier receives the claim for lost earnings, the carrier *has 30 days to pay or deny or request verification*. **If the carrier fails to do so, then the carrier has breached the contract and loses many of their defenses**.

Finally, new regulations provide that "minor defects" by the carrier in notices or in verification requests do not negate the applicant's requirement to answer them. Therefore, even if the verification request is slightly defective, you must answer the request to protect your rights.

Our theme this year is PRESERVE AND PROTECT. This applies to making the claims and answering verification requests. The carriers do not appear to be acting in good faith in many cases and seem to have as their goal delaying payment and denying valid bills on technicalities and shopping for peer review doctors and IME doctors who do not appear to be independent, but appear often to be giving the carrier a basis for denial regardless of the need. (There are some good IME doctors, but they seem to be the exception rather than the rule.)

Don't give them more time to find a bogus peer review doctor. Answer verification requests immediately.

Verification Requests

Although the regulations clearly state carriers should not demand verification of facts unless there are good reasons to do so (11 NYCRR § 65-3.2), some requests may seem improper, unreasonable, or completely irrelevant to getting your claim paid.

The verification request is not a subpoena requiring response, but in practical terms, the injured party or his assignee (i.e. the medical provider) must respond to each request in order to keep their claim alive. If the injured party or his assignee (i.e. the medical provider) does not respond, the carrier can deny payment for failing to respond. If the injured party or his assignee (i.e. the medical provider) do not respond within 120 days, the carrier can deny the claim altogether for violation the 120 day rule. Once the injured party or his assignee (i.e. the medical provider) respond, the duty to act shifts to the carrier who has 30 days to pay, deny, or request more information.

Under the new regulations, the carrier may deny your claim if their verification request goes unanswered for 120 days. Importantly, this 120 rule applies to claims filed on or after April 1, 2013. 11 NYCRR § 65-3.5(o).

Specifically, the new regulation provides, in pertinent part:

> An applicant from whom verification is requested shall, within 120 calendar days from the date of the initial request for verification, submit all such verification under the applicant's control or possession **or** written proof providing reasonable justification for the failure to comply.
>
> 11 NYCRR § 65-3.5(o)

Why the Carrier is Allowed Such Broad, Invasive Verification Requests

The issue is who decides if your response to a verification request is adequate with the new regulations effective 2/1/13 and the consequence of a wrong position. Prior to February 2013, if the provider objected to a demand, the carrier had to respond to that objection and the worst thing that could happen to you was to have the claim pended. We would arbitrate those claims and either the arbitrator would find the demand unreasonable and order the bill paid, or find that the claim was valid and dismiss our action without prejudice. Then, the provider had to respond to the request and once responded to, the carrier had 30 days to pay, deny, or request further verification. Thus, in the "old days" (pre-2013), the worst that could happen was delay (and possibly exhaustion).

Now, with the new regulations, there is real risk. If there has not been proper compliance with a verification request within 120 days, the provider risks non-payment permanently.

Best Practice: Send every abusive verification request to the Insurance Department (now DFS) so they know what is really going on. Second, respond (either by providing or objecting) and provide what you can with private information redacted, so that at least you provided.

This is a developing area and there are no hard answers yet, but we will keep you posted. [Instead of doing these seminars once a year, we have been doing them twice a year since these regulations came out in 2013 and we intend to keep doing that.] As of the writing of this book, there are no opinion letters and no court decisions deciding this topic of what is the consequence of objecting to a verification request timely, but not providing the documents requested on a claim of privacy.

There is no guarantee objections to verification requests will result in payment. A court could find that you should have responded. As there are no cases on point at the time of this writing since the new regulations came into effect, we cannot predict with any certainty as to how the regulation will be implemented.

Again, many of these are just to delay to get their peer, so as part of yourself preservation, encourage the injured party or his assignee (i.e. the medical provider) to answer the verification request immediately by fax and on the 31st day after you respond, if you have received no denial, send us the file to file as a late denial or await until the case is over at your choice.

The theme is PRESERVE AND PROTECT so that verification requests don't turn into policy violations and so that you don't let the carrier delay payment and do not give the carrier any extra time to get a third peer that denies the claim.

When to Arbitrate Collateral Estoppel

In an ideal world the best time to arbitrate is after your PI case is done.

However, it is not always an ideal world and sometimes chances have to be taken.

We have arbitrated successfully for lost wages during the PI case and, in fact, have won all of those. This was done knowingly because the client really could not last without it and we thought we had a good case and the PI attorney did not want the client to get a loan or to get another attorney. It causes us a stomach ache, but we have done it and we will do it.

In a wage loss claim, there is likely a collateral estoppel effect. However, since you cannot recover the first $50,000 in basic economic loss, it might not be such a gamble anyway.

Caveat/Disclaimer: This course is meant to be a training session of the best practices given the realities of practice in New York State. Please remember that we arbitrate on cases where there is less than the best situation every single day and we love doing it.

We love doing your No-Fault work.