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June 11, 2012

I. Comment To Proposed Changes To No-Fault Regulation 68 Regarding Insurer Requests For Additional Verification.

Revised Text:

New subdivisions (o) and (p) are added to section 65-3.5 to read as follows:
(o) 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. The insurer shall advise the applicant in the verification request that the insurer may deny the claim if the applicant does not provide within 120 calendar days from the date of the initial request either all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply. This subdivision shall not apply to a prescribed form (NF-Form) as set forth in Appendix 13 of this Title, medical examination request, or examination under oath request.

(p) With respect to a verification request and notice, an insurer's non-substantive technical or immaterial defect or omission, as well as an insurer's failure to comply with a prescribed time frame, shall not negate an applicant's obligation to comply with the request or notice.

Comment:

Requests for Verification Under the No-Fault Regulations

To appreciate the nature of the proposed change it is important to consider what a request for verification is under the No-Fault Regulations and to understand how insurance companies use, and often abuse, the verification process.

As currently enacted, the Regulations use the term "verification" when referring to information needed to verify the validity of a claim made to an insurance company

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seeking payment under the policy.[1] As such, the claim forms established by the Department of Financial Services are nominated in the Regulations as "prescribed verification forms." Upon receipt of the prescribed claim verification form, within time limits established by regulation, the insurer is entitled to request "additional verification" of the claim. The request may be in the form of a check list of pre-determined items, or it may be a narrative paragraph drafted by the individual claims representative. The items requested may be an examination of the applicant, or it may be a request for information or documentation. Typical requests ask the accident victim to provide EZPass records to verify where the vehicle was regularly garaged; his doctor to provide a copy of a pre-existing document related to the treatment, such as a copy of a prescription for an MRI; or; alternatively, the request may require the creation of a document that did not previously exist, such as a letter explaining why the patient required a particular course of treatment.

Under the current regulatory framework, an insurer is not permitted to deny a claim until it has received all verification requested. This ensures that the claim is decided based upon all the relevant information. This prohibition also tended to discourage -- but certainly does not eliminate -- unnecessary or overbroad requests, as the insurer is prevented from denying the claim until it receives the requested information. The proposed change would abandon this prohibition and allow a No-Fault insurer to deny claims, not based upon the merits of the claim, but merely because an applicant failed to fully comply within 120 days with any request made by an insurance company.

The proposed changes seek to drastically change the verification process, but at what cost, and for what benefit? Collectively, both applicants and insurance companies want changes that will combat fraud. Unfortunately, the proposed changes as written will not achieve the desired goal of deterring frauds and criminals from preying on the No-Fault system. As evidenced by the previous fraud-busting amendments, namely the addition of stricter time limits for applicants[2], sophisticated criminals will not be sidetracked by procedural hurdles. The refined criminal will go to great lengths to comply to ensure he may continue to perpetuate such crimes.

Moreover, the proposed change will result in denying benefits to the honest applicant, possibly unfamiliar with the No-Fault system, which has tried to comply with the onerous requests of the carrier, but has in someway fallen short in the carriers' eyes.

The proposed change is contradictory with regard to the erudition of the insurance adjuster. On one hand, the proposed change assumes the claims adjuster is well versed in the processing of claims and will only request that which is truly needed to process the

[1] 11 NYCRR 65-3.5(c) provides: The insurer is entitled to receive all items necessary to verify the claim directly from the parties from whom such verification was requested.

[2] 11 NYCRR 65-2.4 (c)- Submission of proof of claim by an applicant was shortened from 180 days to just 45 days. Similarly, 11 NYCRR 65-2.4. (b)-the notice requirement was amended to shorten the time applicant had to notify the carrier of the occurrence of an accident, requiring the insurance carrier receive written notice within 30 days. Notably, despite the strict time constraints imposed by the amendments, applicants compliance could still be excused with reasonable justification for the failure to comply.

claim. Conversely, the proposed change then promotes the careless processing of claims by insurance adjusters, allowing errors to be rectified or excused. Yet for the applicant, the proposed change ignores the possibility of an applicant who may not be familiar with the No-Fault Regulations, and offers absolutely no remedy for honest errors.

The Proposed Change Permitting Denial For Not Responding With 120 Days.

As previously stated, the proposed regulation will permit a No-Fault insurer to deny claims solely based on an applicant's failure to fully comply within 120 days with any request made by an insurance company. The proposed regulation authorizes such denials even if the failure, or delay, did not prejudice the insurance company.[3]

The proposed change would permit insurers to demand additional verification at any time. Compliance would be required even if the claim was paid, already overdue, or had been already denied for some other reason. In other words, these proposed changes would allow the insurer to create additional reasons to avoid payment merely by requesting more information. This is contrary to established precedent and public policy of informing applicants why their claim is not being paid.[4]

Under this proposal, a carrier that failed to take any action on a claim for months, and who would (under Presbyterian v. Maryland Casualty Company[5],) be obligated to pay the claim, can simply re-open the claim by asking for new information. Similarly, an insurance company that realizes that a court or arbitration proceeding is not going its way can manufacturer new defenses simply by asking for more information. This also is contrary to long established precedent that once a claim is denied a carrier may no longer create additions reasons for non-payment by insisting on further compliance with additional proof of claim requirements.[6]

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[3] By contrast, Insurance Law 3420 permits an insurer to disclaim coverage on late notice grounds only where the insured's untimely notice has prejudiced the insurer.

[4] It has long been the law in New York that carriers "must promptly apprise the claimant with a high degree of specificity of the ground or grounds on which the disclaimer is predicated. Absent such specific notice, a claimant might have difficulty assessing whether the insurer will be able to disclaim successfully." General Acc. Ins. Group v. Cirucci, 46 N.Y.2d 862, 387 N.E.2d 223 (1979).

[5] 90 N.Y.2d 274, 660 N.Y.S.2d 536 (1997)

[6] Under currently law, the carrier "may not after repudiating liability create grounds for its refusal to pay by demanding compliance with the examination and proof of loss provisions of the policy" (Lentini Bros. Moving & Stor. Co. v. New York Prop. Ins. Underwriting Assn., 53 N.Y.2d 835, 836, 440 N.Y.S.2d 174, 422 N.E.2d 819). Defendant must "stand or fall upon the defense upon which it based its refusal to pay" (Beckley v. Otsego County Farmers Coop. Fire Ins. Co., supra, at 194, 159 N.Y.S.2d 270)…" King v. State Farm, 218 A.D.2d 863, 630 N.Y.S.2d 397 (3rd Dept, 1995).

Prompt Resolution?

Ironically, the Department's stated justification for the 120-day deadline—establishing prompt resolution of claims—only works in favor of the insurance company. A carrier is permitted to deny a claim after 120 days, and further permits a carrier to re-open the claim by making further demands, **at any time**. In sharp contrast to the lenient treatment afforded the insurance company, applicants already saddled with the shortest notice and proof of claim time frames in the country (30 and 45 days respectively), get no second chances.

Easier for the Insurance Companies, Harder on the Applicants.

The proposed regulation would result in a severe imbalance, allowing sophisticated insurance company adjusters, who process claims for a living, to rectify errors, while providing no recourse for the unsophisticated claimant who makes an honest error. While it was not the intent in drafting the proposed change, equity demands that these proposed changes be evaluated and reformulated to ensure that such a double standard does not result from their implementation.

The Department's proposal excuses insurance companies from full compliance with the Department's own Regulation, by declaring that "non-substantive technical or immaterial defect or omission" shall not excuse compliance with every request. Here again, the Department's stated justification (reduction of litigation and arbitration proceedings) is actually directly at odds with the result attained. Currently there are clearly defined standards for the issuance of verification requests, providing a clear direction to the insurance carriers and providing an objective standard for compliance. Requiring compliance with requests that do not comply with the regulations actually encourages more litigation. By excusing "technical non-substantive" defects, additional litigation will of necessity result, as it is impossible to predict in advance whether any particular defect would be deemed substantive or non-substantive.

By far the most objectionable aspect of this proposal is the strict time frame and high legal standard imposed only on applicants seeking No-Fault benefits. Under the Department's proposal, within 120 days an applicant must provide "*either* all such verification under the applicant's control or possession *or* written proof providing reasonable justification for the failure to comply." (*emphasis added*). This use of "either" and "or" imposes a requirement that both the verification and the explanation for any non-compliance must be made within 120 days. As drafted, the Regulation does not permit an applicant to produce a justification for non-compliance at a later date. For example, an applicant who believed in good faith that he had fully responded to the carrier's demand, upon receipt of a denial citing a deficiency in the response, will not be permitted to subsequently establish why any omission was reasonably justified.

This approach is intentionally hostile to applicants and is inconsistent with other time limitations imposed on applicants by the Department's regulations. For example, if a

claim is Denied for late Notice or late Proof of Claim, the regulations require that the Denial of Claim form inform the applicant that the failure to comply with the notice provision of the policy "will be excused where the applicant can provide reasonable justification of the failure to give timely notice." Even though the standards for compliance with the Notice and Proof of Claim provisions are clearly defined by the policy and the regulations, applicants are still afforded an opportunity to present a reason after the claim has been denied.

By contrast, requests for additional verification are not defined by the policy or the regulations but are drafted by the individual insurance company and as such change on a case by case basis. They may be a simple request for a single document, or they may be a multiple page questionnaire, filed with complex "if, x then give us y" questions, and requiring the production of thousands of pages of documents.

To illustrate, we provide the following real world illustrations, using language taken from recent demands for additional verification of No-Fault claims:

- "If you believe that the New York State Medicaid program has not established a fee payable for the product(s) then you must provide the following: The basis upon which you believe the New York State Medicaid program has not established a fee item(s) for which you seek payment."
- "All documentation concerning 'Additional Paid in Capital' as indicated on Schedule L of the U.S. Income Tax Return [name of provider] for 2004, 2005, 2006 and 2007 and proof of payment thereof."
- "Name and license (if applicable) of the person(s) that provided and/or supervised each service/test (both technical and professional aspect; A list of any other individuals who work at or for the PC and a description of the relationship between each individual and the PC; For each individual identified in response to items above, all documents related to the employment status of the individuals including, but not limited to, their personnel files."
- "To render a decision on your bill, please supply the following verification: proof of ownership of the machines used (including name, model # and age of machine used and UCC filing); if any machine used for testing is leased, provide copy of lease; provide documentation, including logs or other records regarding ownership and maintenance of the machines utilized for the testing including any and all maintenance and service contracts; identify how often testing equipment is calibrated and identify if any vendor is used for this service (provide copies of checks to such vendors if such vendors were used); copies of paychecks to technicians performing the tests; identify who employs the technicians performing the testing identify all employees involved in the testing for the bill submitted, including both the technical and professional components (identifying specifically whether they performed the test or acted in a supervisory capacity); identify days of the week and hours worked by the physicians reading the test including identification of where reading takes place; identify the manner in which the films are provided to the reader of the films; identify any manager or management company involved for the submitted bill, including any entity involved in the administration or billing or was consulted or employed anyone involved in the

performing, processing or administration of the submitted bill; and provide all documents that relate to the referral that was provided to you for the test, including all documentation supplied with the referral. Please also supply a copy of the actual films for the submitted bill."

Requests such as these that demand a description of the "*grounds*" for a particular "*belief*"; that request a broad classification of "documentation *concerning*" or "documentation, including logs or other records *regarding*"; or "all documents *related* to the employment status including, but not limited to, their personnel files"; are capable of vastly different levels of interpretation and a wide variety of responses may be considered compliant – or, in the eyes of the insurer, non-compliant.

After receiving a denial, the innocent well intentioned applicant is not permitted to provide a "reasonable justification for the failure to comply." The proposed regulation requires this justification to be provided in advance of any denial of benefits. As drafted, the proposed regulation requires the applicant to predict in advance whether a response will be deemed non-compliant, and have a preemptive justification filed.

Although the currently enacted regulations permit an applicant to submit a reasonable justification for untimely compliance with the clearly defined Notice or Proof of Claim provisions of the policy *after* the claim has been denied, the current proposal would require all evidence justifying the failure to comply with a demand for verification (which is not clearly defined by regulation, and is completely up the carrier) must be submitted within *before* the claim is accepted or denied.

<u>Rewarding Abusive Verification Requests</u>

The proposed regulation presumes that insurance companies only request information that is necessary to verify the claims. This is simply not true. As we have repeatedly told the Department, insurance companies often abuse the verification process to extend the time to consider the claim, to avoid the payment of legitimate claims, and to manufacture technical non-substantive defenses. Decisions identifying this abusive conduct are matters of public record.

For example, in <u>Brownsville Advance Medical, PC v Country-Wide Insurance,</u> 33 Misc.3d 1236(A), 941 N.Y.S.2d 536 (Table), 2011 WL 6355291 (N.Y.Dist.Ct.2011) the court criticized Country-Wide Insurance Company's common claim practice of repeatedly requesting as additional verification, items that had been previously provided to the insurer. "In this case, Country–Wide offers no reason why it has repeatedly demanded identical verification from Brownsville, even though the information demanded in the verification requests has previously been provided." Ultimately, the court determined that, "A provider should not have to repeatedly provide documentation it has already provided unless the insurer can establish a reasonable basis and rational need for demanding this material anew."

The language of proposed regulation would require an applicant faced with repeated requests for previously provided information, to "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." This regulation would reward the improper conduct condemned in the Brownsville decision, by requiring "within 120 days" either another unnecessary submission "or written proof providing reasonable justification for the failure to comply."

The conduct criticized by the court in the Brownsville decision is not an isolated example. Triboro Medical Supply Inc. / Antoine Dubois (Applicant) - and - Progressive Casualty Insurance Company, AAA Case No. 412011085623 (April 3, 2012) in addition to demanding an examination under oath, Progressive also asked for the following additional verification:

- Bank statements for all accounts in the name of your corporation from the time of incorporation to present; and
- Documents showing the accounts receivable and accounts payable for your corporation from the time of incorporation to the present.

Arbitrator Wolf found that Progressive's verification requests were improper, "Based upon the foregoing, and after reviewing all of the evidence, I find that Respondent has failed to establish an objective reasonable basis for requesting the EUO of Applicant *or for requesting the verification contained in the EUO scheduling letters*. I further find that the information requested in the EUO scheduling letters was overbroad, vague and unduly burdensome. (*emphasis added.)*

Similarly in Cornelia Pain Management & Rehab - and -Geico Insurance Company, AAA Case No. 412011071802 (March 29, 2012) Geico requested, among other items:

- all bank accounts utilized by the applicant professional corporation since its inception;
- and copies of bank statements and bank accounts of the applicant professional corporation.

Arbitrator Richard G. Martino condemned the request and the conduct of the carrier in making the request: "I find the requested outstanding items unreasonable, and furthermore, I find these requests go to the level of harassment of Dr. Bhattacharya and the professional corporation herein."

Indeed, the American Arbitration Association New York No-Fault Arbitrators regularly condemn the common insurance company practice of demanding unnecessary and burdensome information from those seeking payment for services rendered to accident victims:

- Joseph Vitoulis DC PC v State Farm Mutual Automobile Insurance Company., AAA: 412011081164. In finding Respondent had all the necessary information to process the claim, Arbitrator Obiajulu held "Respondent's verification request was invalid since no additional information was needed…"])
- Healing Medical Care PC v Allstate Insurance Company, AAA: 412009032386 where Arbitrator Higgins determined ["portions of

the requests including lease agreements between Applicant and other companies, without any claim that Applicant was improperly incorporated, constitute a fishing expedition. Likewise, copies of prescriptions for medical supplies are unreasonable and invalid requests…for these reasons, the "verification requests" failed to toll Respondent's claim determination period."].

- Phildov Anesthesiology Group v Geico AAA: 412011078139 in holding Respondent's verification requests invalid, the arbitrator reasoned ["such information is really irrelevant to the claim… I find that Respondent failed to toll its 30-day period to pay or deny the claim."].
- Thayer Medical PC v State Farm, AAA:412011040114 [Arbitrator Obiajulu premised her determination that Respondent's verification requests were not valid on two principles; 1) that Respondent had in its possession all the information required to process the claim and 2) a portion of the information requested was impossible, as such information did not exist.].
- Hollis Medical Care PC v Country-Wide Insurance Company, AAA: 412010040684, where Respondent's request for a lease agreement was held as an invalid verification request.; see also Bay Medical PC v St. Paul Travelers Insurance AAA: 412008018165, where Arbitrator Resko held "I find Respondent's verification requests to be improper as the information sought has not been demonstrated to be necessary and relevant to verify the claims."
- In Advanced Billing Asscoaites Inc. v State Farm AAA:412011003962, Arbitrator McNamara determined Respondent's requests for the make, model and cost of medical equipment which was rented, not purchased, was irrelevant to the processing of the claim ["In reviewing the documents which were provided and determining whether or not the Respondent had all the relevant information and whether they acted in good faith in demanding additional documentation, I must take into consideration whether or not it had the necessary information in accordance with the regulations in order to make payment and determine whether or not payment was proper and demand was in good faith… I find in favor of Applicant."]
- All Boro Psychological Services, PC v Country-Wide Insurance Company, AAA: 412011054080, ["It also appears that the additional request for verification was unnecessary and requested in bad faith."]
- In Alexis Fichera LMT v USAA Insurance Co. AAA: 412011060237, Arbitrator Held awarded Applicant, finding ["the initial verification request that were issued in response to the bills, while timely, were unreasonable where same included, inter alia, information already in the possession of the Respondent. By way

of example, the bills list the EIP's name and address, and the request for same in a verification request bespeaks of a pro forma claims processing, rather than a bona fide request for unknown information. Further, I find that the follow-up requests are, at minimum, confusing where same include a request for a 'resubmission," albeit without clarification as to what was previously submitted and which remained outstanding."]

- IDF Medical Diagnostic PC v Geico, AAA; 412010030692, ["Respondent has substantially breached these tenets of the No-Fault Regulation having issued unduly burdensome and unnecessary requests for items of verification. Respondent has requested a multitude of documents without any viable explanation as to the reason it has deemed these items necessary to verify this bill. As a result, I find that Respondent has not acted in good faith within the guidelines of the regulation."]
- Dov J. Berkowitz MD v Country-Wide Insurance, AAA: 412009046577, where Arbitrator Weisman found Respondent's verification requests invalid, holding " the requests do not relate to this patient or to the claims submitted for payment by this Applicant. Rather, they are global in nature, and as such they fail to comply with the intent of the No-Fault Regulation which permits a Respondent to request specific information needed in order to decide whether to pay or deny a specific claim. These particular requests constitute an overbroad fact-finding mission undertaken in the absence of evidence that Respondent has any indicia of suspicion of any violation of law. Further, these requests state that "your failure to provide the documents listed above or to conduct the on-site inspection, may result in denial of payment." This warning is found to be onerous, burdensome and threatening to a medical provider. As a result, I find that these vague, overly burdensome, global requests are improper and thus are inadequate to extend the Respondent's time in which to issue denials." And she goes on to state "tenets of the regulation have been substantially breached herein by Respondent, having issued unduly burdensome and unnecessary requests for items of verification. Respondent has requested a multitude of documents without any viable explanation as to the reason it has deemed these items necessary to verify this claim. As a result, I find that Respondent has not acted in good faith within the guidelines of the regulation. Further, the additional, generic letters are found to be onerous, confusing and overlapping."

The long line of arbitration decisions gives ample proof of the bad behavior perpetrated by carriers in utilizing the verification process as a vehicle for undue delay. As evidence above, carriers make absurdly broad demands with the intention to bog down, discourage,

or delay a claimant. The Department's proposed regulations will only encourage future misconduct in an effort to avoid the payment of legitimate claims.

The Regulations do not require insurers to seek prior approval before they make such onerous and improper demands. Each of the aforementioned arbitration decisions finding the insurance company conduct in requesting unnecessary and burdensome verification was forwarded to the Department of Financial Services. Yet the practice continues unabated. Rather than chastising the carriers for the recurring abuse of the process, the proposed regulation literally incentivizes carriers to worsen their bad acts; indeed, they reward miscreants by dangling the carrot of the 120 day dismissal, replete with the impossible burden on a claimant to justify their failure to comply with a carrier demand before the claimant even knows that the carrier deems the demand to have gone unsatisfied.

<u>The Heavy Burden Placed On Applicant Seeking To Have Compliance Excused.</u>

Merely providing "a reasonable justification for the failure to comply" will not satisfy the burden imposed by the proposed regulation. The proposal explicitly requires "written *proof* providing reasonable justification for the failure to comply." The use of the word "proof" suggests that the evidence must be in legally admissible form. The language chosen by the drafters of this proposal requires, (1) a written response, (2) that proves there is a justification for the failure to response and (3) that that justification was reasonable. It is difficult to imagine that an unsophisticated accident victim, medical biller, or even doctor, would be able to reliably draft such a document without the guidance of an attorney.

<u>Denial Of The Right To Find Out If The Request Is Valid Before The Claim Is Forfeit.</u>

The proposed regulations deny applicants the ability to obtain a ruling on the propriety of a carrier's demand without subjecting the applicant to automatic forfeiture. An applicant faced with the most burdensome demand for unnecessary information or documents, or for production of his employees confidential personal files, faces a Hobson's Choice respond to every demand, or risk that a judge or arbitrator will later rule in the applicant's favor.

Insurance Law 5106(b) requires:

> Every insurer shall provide a claimant with the option of submitting ***any dispute*** involving the insurer's liability to pay first party benefits, or additional first party benefits, the amount thereof or any other matter which may arise pursuant to subsection (a) hereof to arbitration pursuant to simplified procedures to be promulgated or approved by the superintendent.

Emphasis Added.

Unfortunately, the time frames established in the proposed regulations are insufficient to permit an applicant or assignee to obtain a ruling regarding a disputed verification request or before the claim is forfeit.

The regulatory framework proposed, requiring applicants to anticipate ahead of time whether an arbitrator or judge will ultimately decide a particular verification request was unreasonable, is unworkable and patently unfair to applicants. The reasonableness of any particular request is necessarily dependent on the circumstances of the claim. Unless one knows why the carrier is requesting the information, it is impossible to fairly evaluate the reasonableness of the request. Carriers are not required to disclose to applicants why additional verification has been requested, but that is the information relied upon by arbitrators and judges to evaluate the request. In the 120 day period during in which an applicant is required to make a decision regarding compliance, the applicant does not have a frame of reference from which to evaluate the request. The proposed regulation requires applicants to make a decision regarding compliance in complete ignorance of the context of the request. The penalty for guessing incorrectly is forfeiture of the claim. This framework is fundamentally unfair and violates basic concepts of due process.

The inclusion of the 120-day deadline makes it more imperative that the Department provide a dispute resolution process, such as expedited arbitration, where an applicant or assignee can "stop the clock" to obtain an impartial ruling on abusive requests without fear that merely requesting such a ruling will result in forfeiture of the claim.

The Effect of the Proposed Changes To No-Fault Regulation 68 Regarding Insurer Requests For Additional Verification.

These proposed changes will have several deleterious effects. First, it will further delay the payment of legitimate claims by encouraging carriers to make even more unnecessary, irrelevant or burdensome demands in the hope that the failure to fully respond will result in forfeiture of the claim. This forfeiture will occur without regard to lack of prejudice to the carrier, and cannot be cured by subsequently submitted evidence establishing a justification for the failure to comply.

The proposed regulations require compliance with requests made at any time. There is nothing in the proposed regulation that would prohibit an insurance carrier from creating additional grounds for avoiding payment by demanding information, after the claim as been paid or denied for an unrelated reason.

The proposed changes employ a double standard which excuse sophisticated insurers from strict compliance with the regulations and excuse "non-substantive technical or immaterial defect or omission," while the lay applicant or unsophisticated doctor or medical biller, is held to a strict 120 day deadline, with no meaningful avenue of appeal or recourse.

Imposing a 120 deadline without any tolling to permit a request for a ruling from a judge or an arbitrator essentially precludes an applicant from obtaining a decision. In our

repeated prior requests to the Department, we have referenced the need for applicants and assignees, faced with deadlines to comply with verification requests, to have access to a forum where they can seek a ruling regarding demands for verification and examinations under oath without fear that the mere act of seeking a ruling will itself result in the expiration of the time for compliance.

Presumably, the Department did not intend for such inequality to result from the proposed change. The Department certainly would not make thoughtful policy choices that fashion a callous double standard with more lax rules for insurers than claimants, furthering EUO abuse, and ignoring the proliferation of such abuses. NYFAIR would be glad to work diligently with the Department to craft a more balanced set of rules in order to achieve the same goals.

II. Comment To Proposed Changes Purporting to Exempt Defenses from the 30 Day Rule of Preclusion.

Revised Text:

Subdivisions (g) through (j) of section 65-3.8 are relettered subdivisions (i) through (l) and new subdivisions (g) and (h) are added to read as follows:

(g) Proof of the fact and amount of loss sustained pursuant to Insurance Law section 5106(a) shall not be deemed supplied by an applicant to an insurer and no payment shall be due for such claimed services under any circumstances:

(1) when the claimed services were not provided to an injured party;
or
(2) for those claimed service fees that exceed the charges permissible under the schedules prepared and established pursuant to Insurance Law sections 5108(a) and (b) for services rendered by New York medical providers.

Comment:

While we applaud the Department's goal to prevent reimbursement in excess of the established schedules or for services that were not provided, this revised section is cumbersome and strangely worded. It is difficult to imagine its practical effect on court and arbitration proceedings. Typically, the applicant has the burden of establishing that Proof of Claim was submitted to the insurer, and thereafter the insurer may establish its defenses. The section essentially "deems" such proof to have been "not supplied" in two circumstances—two circumstances that may not even exist in a specific case.

There is a more effective and clearer way to accomplish the Department's aim, without the confusing "shall not be deemed" language and without running afoul of what the

Appellate Courts have determined to be a claimant's *prima facie* case. Accordingly, we suggest the following language be used:

> **The failure to issue a Denial in accordance with section 65-3.8 shall not preclude the insurer's from raising the following defenses:**
>
> 1. **That the services billed for in a claim were not provided to the applicant;**
>
> 2. **That certain portions of the charges for services in a claim exceed the charges permissible under the schedules prepared and established pursuant to section 5108 (a) and (b) of the New York Insurance Law.**"

III. Comment To Proposed Changes Excusing Full Compliance with Rules of Issuance of Denial of Claim forms.

Revised Text:

> (h) With respect to a denial of claim (NYS Form N-F 10), an insurer's non-substantive technical or immaterial defect or omission shall not affect the validity of a denial of claim.

Comment:

As with Proposed Section 65-3.5(p), the Department's proposal excuses insurance companies from full compliance with the Department's own regulation. As previously indicated, the Department's stated justification (reduction of litigation and arbitration proceedings) is actually directly at odds with the result attained. There are clearly defined standards for the issuance of Denial of Claim forms, providing a clear direction to the insurance carriers and providing an objective standard for compliance. The proposal will actually encourages more litigation by excusing "non-substantive technical or immaterial defect or omission", since will be impossible to predict in advance whether any particular defect is substantive or non-substantive, material or immaterial.