Lenox Hill Hosp. v Government Empls. Ins. Co.
2009 NY Slip Op 31125(U)
May 1, 2009
Supreme Court, New York County
Docket Number: 19771/08
Judge: Antonio I. Brandveen

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SHORT FORM ORDER

SUPREME COURT - STATE OF NEW YORK

Present: **ANTONIO I. BRANDVEEN**
J. S. C.

LENOX HILL HOSPITAL, a/a/o MARYANN BERGER; THE NYACK HOSPITAL, a/a/o MARILYN LEVINE; THE NEW YORK AND PRESBYTERIAN HOSPITAL, a/a/o ANTIONE DENNIS, Plaintiff, - against - GOVERNMENT EMPLOYEES INSURANCE COMPANY, Defendant.	TRIAL / IAS PART 31 NASSAU COUNTY Index No. 19771/08 Motion Sequence No. 001

The following papers having been read on this motion:

Notice of Motion, Affidavits, & Exhibits 1
Answering Affidavits 2
Replying Affidavits 3
Briefs: Plaintiff's / Petitioner's .....
Defendant's / Respondent's .....

The plaintiff health care providers move for summary judgment pursuant to CPLR 3212. The underlying action brought pursuant to Insurance Law § 5106 (a) involves the failure of the defendant insurance company to pay three separate no-fault billings. The defendant opposes the motion. This Court has carefully reviewed and considered all of the papers submitted with respect to this motion.

> the plaintiff hospitals made a prima facie showing of their entitlement to judgment as a matter of law by submitting evidentiary proof that the prescribed statutory billing forms had been mailed and received, and that payment of no-fault benefits was overdue (***see*** Insurance Law § 5106 [a]; 11 NYCRR

65.15 [g] [3]; ***St. Luke's Roosevelt Hosp. v American Tr. Ins. Co.***, 1 AD3d 498 [2003]; ***St. Luke's Roosevelt Hosp. v Allstate Ins. Co.***, 303 AD2d 743 [2003]; ***New York & Presbyt. Hosp. v Allstate Ins. Co.***, 295 AD2d 412 [2002]; ***see also Matter of Pradip Das/N.Y. Med. Rehab v Allstate Ins. Co.***, 297 AD2d 321 [2002])

Mary Immaculate Hosp. v. Allstate Ins. Co., 5 A.D. 3d 742, 743, 774 N.Y.S.2d 564 [2nd Dept.,2004].

Pursuant to both the Insurance Law and the regulations promulgated by the Superintendent of Insurance, an insurer is required to either pay or deny a claim for no-fault automobile insurance benefits within 30 days from the date an applicant supplies proof of claim (***see***, Insurance Law § 5106 [a]; 11 NYCRR 65.15 [g] [3]). Failure to pay benefits within the 30-day requirement renders benefits "overdue," and all overdue payments bear interest at a rate of 2% per month (Insurance Law § 5106 [a]; 11 NYCRR 65.15 [h]). Additionally, a claimant is entitled to recover attorney's fees where a "valid claim or portion" was denied or overdue (Insurance Law § 5106 [a]; 11 NYCRR 65.15 [i]). Notably, interest and attorney's fees are prescribed sanctions only in late payment circumstances, not as to untimely denials of claims

Presbyterian Hosp. in the City of New York v. Maryland Cas. Co., 90 N.Y.2d 274, 278, 660 N.Y.S.2d 536 [1997].

When an eligible covered person, or that person's assignee, submits to an insurer a claim for first-party no-fault automobile insurance benefits, the insurer is required to either pay the claim or deny it within 30 days after the applicant supplies proof of claim (***see*** Insurance Law § 5106[a]; 11 NYCRR former 65.15[g][3]). Amounts not paid within the 30-day time frame are "overdue," and the applicant may commence an action against the insurer to recover such amounts (Insurance Law § 5106[a]). In such an action, an insurer that has failed to either pay or deny the claim within the 30-day period may be precluded from interposing a defense (***see Presbyterian Hosp. in City of N.Y. v. Maryland Cas. Co.***, 90 N.Y.2d 274, 660 N.Y.S.2d 536, 683 N.E.2d 1; ***New York & Presbyt. Hosp. v. Allstate Ins. Co.***, 30 A.D.3d 492, 819 N.Y.S.2d 268; ***Nyack Hosp. v. State Farm Mut. Auto. Ins. Co.***, 11 A.D.3d 664, 784 N.Y.S.2d 136)

Fair Price Medical Supply Corp. v. Travelers Indem. Co., 42 A.D.3d 277, 280, 837 N.Y.S.2d 350 [2nd Dept., 2007].

In Presbyterian, the Court discussed the rationale for applying the potentially harsh remedy of preclusion against insurers in the context of no-fault insurance claims: "No-fault reform was enacted to provide prompt uncontested,

> first-party insurance benefits. That is part of the price paid to eliminate common-law contested lawsuits. Indeed, contrary to the insurer's assertions, preclusion of this type was an available remedy at common law, and if this important facet of the juridical rights and remedies among the various interested parties is to be deemed eliminated, it must be evident more plainly and expressly as this would be in derogation of a common-law protection. The tradeoff of the no-fault reform still allows carriers to contest ill-founded, illegitimate and *fraudulent* claims, but within a strict, short-leashed contestable period and process designed to avoid prejudice and red-tape dilatory practices" (90 N.Y.2d at 285, 660 N.Y.S.2d 536, 683 N.E.2d 1 [emphasis added; citation omitted])

Fair Price Medical Supply Corp. v. Travelers Indem. Co., 42 A.D.3d, ***supra***, at 282-283.

The plaintiffs' attorney states, in a supporting affirmation dated December 29, 2008, the plaintiff seeks payment for health services render to Maryann Berger, on the first cause of action during August 11, 2008 through August 13, 2008, arising from an October 15, 2007 automobile accident. The plaintiffs' attorney states the plaintiff billed the defendant with a proper hospital facility form (N-F2) and a UB-04 for payment of the $9,944.95 hospital bill by certified mail, return receipt requested. The plaintiffs' attorney states the defendant received that bill on September 10, 2008, yet failed to either pay it or issue a denial the claim form.

The defense attorney concedes, in an opposing affirmation dated February 13, 2009, the defendant received that bill on September 10, 2008, but an independent medical doctor found the treatment rendered was wholly unrelated to a GEICO covered loss, and the hospitalization was the net result of an organic condition. The defense attorney maintains the defendant timely mailed a denial to the plaintiff on October 2, 2008, since there was no casual relationship and medical necessity established, so no money is due nor owing to the plaintiff on the first cause of action.

The plaintiffs' attorney states, in a reply affirmation dated February 19, 2009, the defense relies on a peer review of the defense expert to state the patient's injuries were not casually related to the October 15, 2007 automobile accident, but that conclusion was based in part on a review of the hospital records and operative report. The plaintiffs' attorney points out the defense expert, under the review of medical records, states the plaintiff hospital's progress notes are illegible, so the defense expert could not have drawn a proper conclusion from the hospital record when he could not review the entire hospital record. The plaintiffs' attorney further states, at the beginning of the defense expert's report under purpose, the defense expert states he had been asked to perform an orthopedic surgical review to determine the medical necessity for the surgical procedures. The plaintiffs' attorney notes, in the concluding paragraph, the defense expert states the casual relationship and medical necessity had not been established which is inconsistent with the stated purpose of the defense expert's peer review. The plaintiffs' attorney adds, in the history regarding the patient from the defense expert, it states it was reported the patient sustained a whiplash type injury to her neck and back; had fractured a vertebra in her back; and had prior cervical spine surgery. The plaintiffs' attorney also observes the patient reported neck pain radiating to her arms associated weakness, and tingling, acute vertebral fracture.

> the insurer who asserts entitlement to the "exceptional exemption" must "come forward with proof in admissible form to establish 'the fact' or the evidentiary 'foundation for its belief' that the patient's treated condition was unrelated to his or her automobile accident" (***id.*** at 19-20, 699 N.Y.S.2d 77). This Court determined that in applying Central General Hospital, "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 " (***id.*** at 19, 699 N.Y.S.2d 77

> [emphasis added]).
> This Court further emphasized that the underlying purpose of the No-Fault Law would be undermined if a plaintiff hospital were required to prove as a threshold matter that a patient's condition was caused by the accident and unrelated to his or her entire medical history. Under such circumstances, "insurers would be motivated to refrain from issuing timely disclaimers in order to impose such an onerous threshold burden upon claimants" (***id.*** at 20, 699 N.Y.S.2d 77). The burden of proving the lack of a nexus between an accident and medical treatment therefore falls upon the insurer seeking to deny payment (***id.*** at 19-20, 699 N.Y.S.2d 77)

Kingsbrook Jewish Medical Center v. Allstate Ins. Co., 871 N.Y.S.2d 680, 684 [2 Dept., 2009].

The Second Department also holds "[a] timely denial alone does not avoid preclusion where said denial is factually insufficient, conclusory, vague or otherwise involves a defense which has no merit as a matter of law [citation omitted]" (***Nyack Hosp. v. State Farm Mut. Auto. Ins. Co.***, 11 A.D.3d 664, 665, 784 N.Y.S.2d 136 [2nd Dept., 2004])

Here, the plaintiffs have established a *prima facie* case in the first cause of action by showing the defendant received the N-F2 by certified return receipt requested, and the bill payment is overdue. The defendant has failed to meet its burden of proving the lack of a nexus between an accident and medical treatment in seeking to deny payment to the plaintiff.

The defense attorney states, in the opposing affirmation, the second cause of action is moot. The defense attorney states defendant received the $6,018.94 bill on September 8, 2008, and timely and properly paid it on December 5, 2006. The defense attorney asserts the denial referenced by the plaintiff is moot because it addresses a bill, not a proper hospital facility form (N-F2) sent directly by the hospital, and evincing a $6,695.42.94 bill, not a proper amount given it was not the proper DRG code. The defense attorney maintains the health care provider is made whole by the check mailed on December 5, 2006. The defense

attorney states, in that opposing affirmation, the second cause of action is moot. The plaintiff's attorney does not address this contention in the plaintiff's reply papers. The Court finds, in opposition, the defense has shown a triable issue of fact which hinders summary judgment on the second cause of action.

The plaintiffs' attorney states, in the supporting affirmation, the third cause of action is withdrawn.

Accordingly, the motion is granted solely with respect to the first cause of action, and in accord with this decision.

So ordered.

Dated: **May 1, 2009**

ENTER:

J. S. C.

FINAL DISPOSITION XXX NON FINAL DISPOSITION