

CALENDAR CALL

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HIT IN THE REAR IS NOT AUTOMATIC LOSS

In most cases, the act of running into a stopped vehicle automatically establishes a prima facie case of negligence and summary judgment will go to the lead car.

In spite of this general rule, a recent case in the Appellate Division, Second Department held that where the vehicle in the rear is able to raise an issue of fact as to the lead driver making a “sudden, negligent, or unexplained stop” then a court should not

grant the motion for summary judgment in favor of the lead vehicle.

In this case it is acknowledged that the lead car came to a sudden stop on the expressway at which point it was struck in the rear. The driver of the lead car claimed that he had to come to an abrupt stop in response to another vehicle abruptly exiting the expressway.

That car then moved for summary judgment claiming that

as the lead vehicle it is free from any liability.

However, in this case, the driver of the rear car was able to raise an issue of fact as to whether or not the driver of the lead vehicle had stopped suddenly for no apparent reason and without signaling his intentions.

Under these circumstances the Appellate Division found that it would be improper to grant summary judgment to the lead vehicle.

APPELLATE TERM GETS IT RIGHT

BG&S successfully defended an appeal of a lower court order which denied plaintiff’s motion for summary judgment. The case involved no-fault claims for medical supplies furnished to an assignor.

The trial court had found that defendant established an issue of fact with regard to medi-

cal necessity that required a trial.

The plaintiff claimed that although defendant’s peer review report was affirmed it was inadmissible because it referred to unaffirmed medical reports.

The Appellate Term, Second Department did not agree and

held that affirmed medical reports which refer to unaffirmed medical reports were admissible in opposition to a summary judgment motion and raised a triable issue of fact.

At least they allowed the defense of medical necessity as to a medical supplier.

STATE SENATE PASSES TOUGH AUTO FRAUD BILLS

On May 16, 2006 the New York State Senate passed a series of legislation which were meant to ease insurance fraud prosecutions and criminalize certain acts which were previously immune from criminal prosecution.

Upon the passage of these Bills, Senate Majority Leader Joseph L. Bruno, who estimated that as many as one-third of all auto insurance claims contain a certain element of fraud stated that *“auto insurance fraud is more prevalent in New York State than anywhere in the nation and it’s costing every driver in New York State more money”*.

The legislation would reduce, by one-half, the minimum value of property obtained in order

to be convicted of insurance fraud. In addition it would allow a prosecutor to combine the value of property obtained in separate incidents in order to base the charges on the total value of the property obtained. The legislation would also allow an organized auto fraud ring to be prosecuted under the Organized Crime Control Act.

Another part of this series of Bills makes it a crime to hire a “runner”. A runner is someone who receives money for obtaining individuals to participate in a scheme to defraud an insurance company. Under this Bill it would be a class “E” felony to either act as a runner or hire another person to act as a

runner.

Additionally, the Senate passed a Bill that will be known as **“Alice’s Law”** named after Alice Ross a 71 year old grandmother who was killed as the result of a staged accident. This Bill would make it a felony to participate in staging a motor vehicle accident.

Sen. Seward, who sponsored the bill, explained that *“These ‘accidents’ are... intentionally committed by criminals who then file fraudulent claims...”* he went on to add that in addition to costing insurers almost a **billion** dollars, such staged accidents *“...also pose a serious safety risk, as is demonstrated by the untimely death of Alice Ross”*.

STUPID HUMAN TRICKS

At least the street is clean.

A Manchester, New Hampshire man was arrested after stealing a street sweeper and taking it for a joy ride.

Michael Moran, who had been drinking to excess, spotted the unattended sweeper, hopped in and took it for a ride. He drove it several blocks before he was stopped and placed under arrest for driving under the influence and driving with-

out the owners permission. Upon his arrest, he said “it was a stupid thing to do.” No kidding.

The car made me do it.

Kevin Nicolle who was arrested in London after driving at speeds of up to 135mph and crashing into a traffic circle, claimed that the accelerator was stuck and he couldn’t slow down.

Unfortunately for Mr. Nicolle, an examina-

tion of the car showed that there were no mechanical defects.

Wake me when its over.

A pair of English soccer fans in Germany fell asleep in their van after a night of drinking. The van rolled across the street, hit another car and blocked traffic.

They finally woke up with the police rocking the van and banging on the windows.

THE COURTS ARE AT IT AGAIN

A recent decision in Supreme Court, Nassau County has potentially far-reaching impact on the manner in which insurers can defend themselves against claims involving radiology services that the insurer has determined to be medically unnecessary.

A radiology medical provider brought suit, proposed as a class action, seeking a judgment declaring that a no-fault insurance carrier may not defend radiology claims based upon a lack of medical necessity. That medical provider named several large auto insurance carriers as defendants.

Although the Court denied plaintiff's motion for summary judgment to the extent of certifying the class of all radiological facilities is not yet ripe, the Court nevertheless granted plaintiff's motion to the extent of holding that no-fault carriers may not raise the defense of a lack of medical necessity directly against radiological facilities. Yes, you read that right.

Plaintiff's main argument is that since radiological facilities only receive referrals of patients from other doc-

tors, but do not examine the patients themselves, they cannot challenge the issue of medical necessity.

The Court reiterated the usual standard that a no-fault provider establishes entitlement to reimbursement for claims upon showing proof that it was submitted, stating the fact and amount of the loss and that it is now overdue. The burden then shifts to the carrier to demonstrate that a defense exists.

Under normal circumstances, when medical necessity is at issue, the carrier has the burden of demonstrating a timely denial (that is, within 30 days, or possibly longer depending on whether proper verification requests were made) and that the services or supplies in question were not necessary. The Court further acknowledged that New York Insurance Law Article 51 and Insurance Department Regulation 68 limit no-fault medical reimbursement to necessary services.

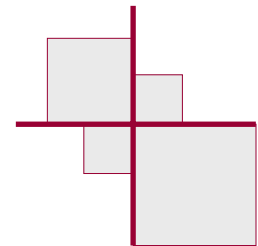
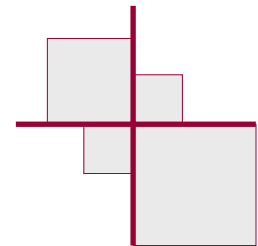
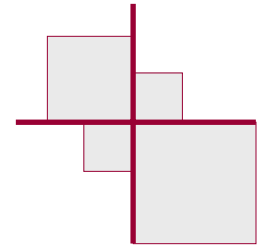
Nevertheless, in spite of the clear mandate of these regulations, the Court held that "a radiologist should not be required to investigate

every prescription for radiology tests in order to receive no-fault payments for tests admittedly performed." Therefore, a carrier may not raise a lack of medical necessity as a defense in an action regarding such claims.

Instead of simply denying an invalid claim in accordance with the no-fault regulations, this court stated that the carrier "should be able to challenge through subrogation the treating physician or medical provider who prescribed the test."

It is difficult to imagine a more transparent attempt at judicial legislation. Indeed, the judge lamented that the "court system is inundated with no-fault claims litigation." Apparently, this court believes the solution to an overburdened court calendar is to mandate that a carrier pay for an unfounded claim and then commence a separate action to recover that improper payment. In other words kick the ball into another judge's court.

Thankfully, as of this writing, the carriers are still able to seek a modification or appeal of the order.



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BG&S HELPS CLARIFY MALELLA

In a recent case in Civil Court, Bronx County, **BG&S** as counsel for the defendant, entered into a stipulation with counsel for the plaintiff, agreeing that the issues in dispute would be determined on written briefs in lieu of live testimony. The parties further agreed that the sole issue to be determined would be *whether an insurer is permitted to deny unpaid claims arising under the "old Regulation" on the grounds that the professional*

service corporation was fraudulently incorporated.

It is important to note that the carrier was not required to prove that the medical provider was, in fact, fraudulently incorporated in order to prevail in this matter.

The judge, after reviewing both parties' Trial Memoranda, concluded that the Malella defense of fraudulent incorporation can be raised even as to those claims arising under the "old

Regulation." Since this was the only issue to be determined, the judge dismissed plaintiff's complaint with prejudice.

In opposing this issue, many plaintiffs often overlook that the actual claims at issue in the Malella decision were claims that had matured prior to the amendment of Regulation 68.

There are nevertheless a few "independent" judges who do not follow the Court of Appeals on this issue.