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DISTRICT COURT OF NASSAU COUNTY
FIRST DISTRICT: CIVIL PART 2

LONG BEACH MEDICAL CENTER
a/o JANICE TORREY-ONEAL

Plaintiff(s),

- against -

LANDMARK INSURANCE COMPANY

Defendant(s).

Present:
Hon. Michael A. Ciaffa

Index No. CV-008924-11

The following papers have been considered by the Court on this motion: submitted February 3, 2012

Papers Numbered

Notice of Motion, Affirmation & Exhibits Annexed..... 1 - 2
Affirmation in Opposition..... 3
Reply Affirmation..... 4

Defendant moves for summary judgment dismissing plaintiff's no-fault claim. Plaintiff opposes the motion.

Plaintiff's claim involves hospital services provided to plaintiff's assignor (Janice Torrey-ONeal) on December 1, 2009. According documents in defendant's moving papers, plaintiff's claim was received on January 28, 2010. Several weeks later, on February 25, 2010, defendant issued a denial of the claim on the ground that plaintiff's services had been provided more than 45 days before the claim was received. See 11 NYCRR §65-1.1.

As required by regulation, the denial advised plaintiff that its late notice "will be excused where the applicant can provide reasonable justification of the failure to give timely notice." See 11 NYCRR §65-3.3(e). By letter dated March 29, 2010, plaintiff's account representative submitted a written explanation for the delayed bill submission to defendant's claims department. The letter explained that plaintiff's claim for payment for surgical services had mistakenly remained in "unbilled status" due to "an unforseen

clerical error," and that plaintiff's bill was belatedly mailed on January 25, 2010, "little more than a week late." The letter "kindly" asked defendant to "review this bill again" and to reconsider the denial. The letter added: "11 NYCRR 65-1 was not written as a permanent deadline...There are exceptions to the regulation as in this case...We apologize for our lateness and hope that you will reconsider and take into consideration that we have provided you with a reasonable justification...Please feel free to contact me if you should require any additional explanation in writing."

Approximately three weeks later, defendant issued a "General/Blanket Denial," dated April 22, 21010, informing claimant (Janice Torrey-ONeal) and her attorney that "[t]he eligible injured party has exhausted the maximum no-fault coverage of $50,000.00. No further payments can be made under the Basic Personal Injury Protection Coverage."

Following commencement of this action and joinder of issue, defendant filed the instant motion, seeking summary judgment on two grounds: (1) untimeliness of plaintiff's claim; and (2) exhaustion of benefits. Defendant seeks summary judgment on both grounds.

Addressing, first, defendant's exhaustion of benefits defense, the Court concludes that defendant's moving papers fail to make a prima facie showing of entitlement to judgment on that defense, as a matter of law, through submission of proof in proper evidentiary form. Among other defects, defendant's moving papers fail to lay a proper business record foundation (CPLR 4518) for the "payment log" record of claims paid under the subject policy. See, e.g. Westchester Medical Center v Progressive Casualty Ins. Co., 2009 NY Slip Op 31556 (Sup Ct Nassau Co.). Moreover, defendant's papers, on their face, present unanswered questions as to whether the policy benefits were exhausted at the time plaintiff submitted its claim to defendant in late January, 2010. See, e.g. Westchester Medical Center v. Auto One Ins Co., 2007 NY Slip Op 33595 (Sup Ct Nassau Co). Accordingly, defendant's motion for summary judgment is DENIED with respect to the exhaustion of benefits defense.

The Court turns, next, to defendant's alternative contention that the action should be dismissed on account of plaintiff's late claim for no-fault benefits. Our state's current no-fault regulations include closely "circumscribed time frames" for submission of claims for no-fault benefits by claimants and their medical providers. See New York and Presbyterian Hosp v. Country-Wide Ins. Co., 17 NY3d 586, 589 (2011), quoting Hosp. for Joint Diseases v. Travelers Prop Cas. Inc. Co., 9 NY3d 312, 317 (2007). One generally applicable "condition precedent" to an action for no-fault benefits is the submission of "written proof of claim to the [Insurance] Company...as soon as reasonably practicable but, in no event later than 45 days after the date services are rendered." 11 NYCRR 65-1.1(d). The current 45 day time limit significantly shortened the period from 180 days "in order to, among other things, prevent the fraud and abuse the Superintendent [of Insurance] linked to the lengthy [prior] time frames." New York and Presbyterian Hosp v. Country-Wide Ins. Co., supra, 17 NY3d at 591.

However, another regulation (11 NYCRR 65-3.3[e]) provides a safety valve of sorts. It states: "when an insurer denies a claim based upon the failure to provide timely written notice of claim or timely submission of proof of claim by the applicant, such denial must advise the applicant that late notice will be excused where the applicant can provide reasonable justification of the failure to give timely notice." Pursuant to these safety-valve procedures, an insurer must "establish standards for review of its determinations that applicants have provided late notice of claim or late proof of claim," in accordance with procedures which are "based on objective criteria." 11 NYCRR 65-3.5(l). Such standards may "not be limited to" circumstances involving "demonstrated difficulty in ascertaining the identity of the insurer [or] inadvertent submission to the incorrect insurer." Id. Rather, as Judge Hackeling has explained, the fundamental intent of the safety-valve regulations is to require insurers to fairly consider "bona fide claims which were subject to bureaucratic delay or mishap." Hempstead Pain & Medical Services, P.C. v. General Assurance Co., 13 Misc3d 980, 983 (Dist Ct Suffolk Co. 2006).

Absent proof that defendant actually established standards and objective criteria consistent with this intent, the Court will not defer to the defendant's decision to reject the plaintiff's request for reconsideration without explanation. At least in situations where the delay is relatively brief, as here, plaintiff's claim of "clerical error" appears to fall squarely within the broad category of "bureaucratic delays or mishaps" that may be excused. Moreover, defendant does not demonstrate in its moving papers that it conducted a meaningful "supervisory review" of plaintiff's request for reconsideration of its belated claim. See 11 NYCRR 65-3.5(l) (requiring insurer procedures to include "supervisory review of all such determinations").

In short, upon the instant record, the Court concludes that defendant has failed to establish its entitlement to judgment, as a matter of law, upon either its "exhaustion of benefits" or "late claim" defenses. Accordingly, defendant's motion is DENIED in all respects.

So Ordered:

Michael A Ciaffa
District Court Judge

Dated: February 16, 2012

cc: Law Offices of Bryan M. Rothenberg
Friedman, Harfenist, Kraut & Perlstein, LLP