Country-Wide Ins. Co. v Sun Orthopedic Surgery PC
2016 NY Slip Op 32345(U)
November 21, 2016
Supreme Court, New York County
Docket Number: 654031/2016
Judge: Carol R. Edmead
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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: IAS PART 35
---X
Country-Wide Insurance Company,

Petitioner,

-against-

Sun Orthopedic Surgery PC a/a/o Katie Wang,

Defendant.

---X

Index No. 654031/2016

DECISION & ORDER

CAROL R. EDMEAD, J.S.C.:

MEMORANDUM DECISION

In this Article 75 action, Petitioner Country-Wide Insurance Company (the "Insurer") moves pursuant to CPLR 7511(b)(1)(i) and (iii) to vacate a no-fault arbitration award issued by a lower arbitrator and affirmed by a master arbitrator in favor of Respondent Sun Orthopedic Surgery PC a/a/o Katie Wang (the "Medical Provider"; "Wang").[1] For the reasons set forth below, the Court denies the Petition and confirms the awards.

Background Facts

Katie Wang, the Medical Provider's assignee, was injured in a motor vehicle accident on May 15, 2011, and sought treatment from the Medical Provider thereafter for injuries to her left shoulder. Wang appeared for an independent medical exam (IME) on July 14, 2011, which resulted in the Insurer determining that no further treatment was necessary and issuing a general denial of all benefits effective July 24, 2011 (*Respondent Exh C*). Subsequent to that denial, Wang sought further treatment from the Medical Provider, including surgery. Because the Medical Provider did not submit claims for that additional treatment until March 13, 2015,

[1] To the extent that the Notice of Petition invokes both provisions, but the substantive Petition addresses only subsection (iii), the Court addresses only the latter.

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nearly four years after the subject accident, Insurer denied the claims as untimely on their face pursuant to 11 NYCRR 65-1.1, which directs that written proof of claim shall be submitted no later than 45 days after services are rendered.[2]

The parties proceeded to arbitration before Lower Arbitrator Rhonda Barry, Esq. (the "Lower Arbitrator"), who ruled in favor of the Medical Provider (*Insurer Exh A*, the "Lower Award"). In relevant part, Lower Arbitrator found that the Insurer's 2011 "disclaimer of coverage excused [the Medical Provider] from further compliance with conditions precedent regarding time limitations for submissions medical proofs of loss," including the 45-day period. Master Arbitrator Victor J. Hershdorfer (the "Master Arbitrator") confirmed the award on appeal (*Insurer Exh D*, the "Master Award"), finding that the Lower Award was not arbitrary, capricious, or incorrect as a matter of law.

The Insurer now petitions, pursuant to CPLR 7511(b)(1)(iii), to vacate both awards on the grounds that the Lower Arbitrator exceeded her power by issuing an irrational and arbitrary and capricious award unsupported by the evidence, and that the Master Arbitrator erred in affirming the award.

In support of its Petition, the Insurer argues that the Awards were improper because: first, the Medical Provider did not prove medical necessity for the services rendered; and second, the Medical Provider did not submit its claims within the applicable 45-day period under the insurance policy, or provide a reasonable justification for the delay.

In opposition, the Medical provider argues that the Petition is procedurally defective because it was not initiated properly under the CPLR through personal service. Substantively,

[2] The bills were first submitted (erroneously) to Oxford Insurance, Wang's personal insurer, which subsequently denied the claims on February 9, 2015 when it learned that the Insurer insured the vehicle in which Wang had been traveling. It is unclear when those claims were originally submitted though, in any event, "...the Medical Provider] waited nearly four years to receive documentation from Oxford that its claim had been rejected" (*Lower Award* at 3).

the Medical Provider contends that the Lower and Master Awards were not arbitrary or capricious by arguing: first, that the Medical Provider made a *prima facie* case of entitlement to the benefits sought merely by filing a proof of claim that remains unrebutted by the Insurer; and second, that the Insurer's denial of benefits absolved the Medical Provider from having to comply with the insurance policy's terms, including the 45-day claims submission period. The Medical Provider also requests attorneys' fees.

In reply, the Insurer argues: first, that the Petition was served properly *via* personal service upon the Secretary of State, the Medical Provider's registered agent; and second, that the Medical Provider has not demonstrated medical necessity for its claims.

Discussion

Procedural Arguments

Contrary to the Insurer's argument, service of the Petition upon counsel for the Medical Provider did not, by itself, confer jurisdiction. While CPLR 2103 allows papers to be served upon a party *via* that party's attorney, it allows such service only in a "pending action." Because review of an arbitration award is a "first application arising out of an arbitrable controversy," it must be commenced *via* the filing of initiating pleadings—in the case of this special proceeding, a petition (CPLR 304; *Eagle Ins. Co. v. Republic W. Ins. Co.*, 21 Misc.3d 1121(A) [Sup Ct, Nassau County 2008], *citing Star Boxing, Inc. v. DaimlerChrysler Motors Corp.*, 17 AD3d 372, 792 NYS2d 564 [2d Dept 2005]; *accord Vento v All. Holding Companies, Ltd,* 139 AD3d 530, 530, 33 NYS3d 13 [1st Dept 2016]). Pursuant to CPLR 403[c], a notice of petition must be served in the same manner as a summons—service upon a party's attorney alone is not sufficient.

Nevertheless, jurisdiction over the Medical Provider was, as argued by the Insurer, conferred *via* personal service upon the Secretary of State, the Provider's registered agent under

Business Corporation Law (BCL) 306. The Medical Provider has not disputed the validity of such service, and has acknowledged the Provider's status as a properly incorporated New York State medical corporation subject to the BCL (*Affirm in Opp* ¶ 3; *NYSCEF* 26; CPLR 311[a][1], *citing* BCL 306). Thus, though service of the Petition by regular mail alone was not sufficient to confer jurisdiction, personal service of the Petition upon the Medical Provider's registered agent was proper.

Substantive Arguments

Generally, an arbitrator will only be deemed to have "exceeded" his or her power within the meaning of CPLR 7511(b)(1)(iii) under three circumstances: (1) the arbitrator has clearly exceeded a specifically enumerated limitation on his authority, (2) the decision is irrational, or (3) the award violates a strong public policy (Alexander, Practice Commentaries, CPLR 7511:5, *citing Kowaleski v. New York State Dep't. of Correctional Services*, 2010, 16 NY3d 85, 90, 917 NYS2d 82, 85, 942 NE2d 291, 294 [2010]; *Falzone v New York Central Mut. Fire Ins. Co.*, 2010, 15 NY3d 530, 534, 914 NYS2d 67, 68, 939 NE2d 1197, 1199 [2010]).

However, where, as here, the parties are required by statute to arbitrate their dispute, due process requires "closer judicial scrutiny of the arbitrator's determination" (*Motor Vehicle Accident Indemnification Corp. v. Aetna Casualty & Surety Co.*, 89 NY2d 214, 223, 652 NYS2d 584, 674 NE2d 1349 [1996]; *Cigna Property & Casualty v Liberty Mut. Ins. Co.*, 12 AD3d 198, 783 NYS2d 810 [1st Dept 2004]). This "more exacting standard" applies to both issues of fact and law, provides that an award "must have evidentiary support and cannot be arbitrary and capricious" (*City School District of the City of N.Y. v McGraham*, 17 NY3d 917, 918, 934 NYS2d 768, 770, 958 NE2d 897, 898 [2011]). Notably, an arbitrator's decision may be upheld even where it is incorrect as a matter of law (*MVAIC v Aetna*, 89 NY2d at 224 [because multiple

authorities had reasonably disagreed on the relevant issue, the arbitrator's decision was not "arbitrary or capricious or unsupported by any reasonable hypothesis"]).

As discussed by the Lower Arbitrator, the no-fault regulations (and therefore the applicable insurance policy) provide that written proofs of claim must be submitted by medical providers within 45 days or, if submitted after that time, must be accompanied by a reasonable justification for the delay (*Lower Award* at 2-3, citing 11 NYCRR 65-1.1 and 11 NYCRR 65-3.3[e]). The Lower Arbitrator found that the Medical Provider's justification – that proofs of claim were submitted to the wrong insurer – was not "reasonable" within the meaning of the regulations (*Lower Award* at 3, *citing Schoenberg v N.Y.C. Transit Auth.*, 39 Misc3d 128(A), 971 NYS2d 74 [App Term 2d Dept 2013]).

Nevertheless, the Lower Arbitrator held that the Insurer's general denial constituted a complete repudiation of liability under its policy, which in turn excused the Medical Provider from compliance with conditions precedent to said policy, including the 45-day claim submission period (*Lower Award* at 3-4, *citing State Farm Ins. Co. v Domotor*, 266 AD2d 219, 220 [2d Dept 1999]). "The insurance carrier must stand or fall upon the defense upon which it based its refusal to pay … because no treatment was necessary" (*id.*).

The Lower Arbitrator considered the Insurer's submission of a September 2, 2004 opinion letter issued by the New York State Insurance Department, which came to the opposite conclusion as *Domotor*; and found that the letter was "contrary to appellate law and the legal premise that the no-fault regulations must be strictly construed" (*Lower Award* at 4). Based on this analysis, the Lower Arbitrator found that, after the Insurer's general denial, the Medical Provider had no obligation to comply with the 45-day claim submission deadline, and that the Insurer's denial on that basis was improper because the Provider had established a *prima facie*

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entitlement to payment *via* submission of its claims. On appeal, the Master Arbitrator found that the Lower Award was not arbitrary, capricious, or incorrect as a matter of law (*Insurer Exh D*).

The Court finds no basis to disturb either Award because they are supported by the record and precedent. The Lower Award considered the relevant regulations and precedent and, based on *Domotor*'s holding, rejected the Insurer's argument to the contrary. The Insurer's reliance here upon *J.R. Dugo, D.C. v Allstate Ins. Co.* (26 Misc 3d 1215(A) [Civ Ct, Richmond County 2010]) is misplaced because that case is non-precedential and, more importantly, distinguishable.[3]

Though the *Dugo* court did find that "no presumption of medical necessity attache[d] to the services rendered by the [medical provider]," the court did so only because the provider failed to submit *any* proof of claim, timely or not (*Dugo* at *2).[4] Implicit in that holding, and the reason it is distinguishable from the situation here, is that the submission of a claim – even an untimely claim, where the delay has been forgiven by the Insurer's policy repudiation – creates a presumption of medical necessity. Other cases state this principle explicitly (*see Presutto v Travelers Ins. Co.*, 17 Misc 3d 1121(A) [Civ Ct NY County 2007], *citing Dermatossian v N.Y.C. Transit Auth.*, 67 NY2d 219, 224, 501 NYS2d 784, 787 [1986] ["A claimant to receive payment need only file a proof of claim ... and the insurers are obligated to honor it promptly or suffer the statutory penalties ..."]; *accord Amaze Med. Supply Inc. v Eagle Ins. Co.*, 2 Misc 3d 128(A) [App Term 2d Dept 2003]). To the extent that a claim with supporting documentation was eventually

[3] Notably, like the Lower and Master Awards, the *Dugo* court cited favorably to *Domitor*, agreeing that an insurer's unequivocal repudiation of liability meant that the insurer "could not insist upon adherence to the terms of its policy," including the 45-day claim submission requirement (*Dugo, citing Domotor*, 266 AD2d at 220 *and Mtr. Of Arbitration between N.Y. Medical Health v. NYC Transit Auth.*, 2009 NY Slip Op 51526U, 24 Misc3d 1219A [Civil Ct, Kings County 2009]).

[4] Indeed, the *Dugo* Court found that even the failure to submit *any* claim did not foreclose a medical provider from subsequently proving medical necessity at trial (*Dugo* at *2).

submitted, and to the extent that the medical necessity of the claim remains substantively unrebutted, there is no basis to disturb the Lower and Master awards' findings.

Finally, with respect to the Medical Provider's request for fees, the general rule is that attorneys' fees and disbursements are incidents of litigation and the prevailing party may not collect them from the loser unless an award is authorized by agreement between the parties or by statute or court rule (*A.G. Ship Maintenance Corp. v Lezak*, 69 NY2d 1, 5 [1986]). To the extent that the Medical Provider does not cite any such provisions to justify additional attorneys' fees above what was already granted by the Lower and Master Arbitrators, the Court confirms those amounts, but declines to award anything further.

Conclusion

Based on the foregoing, it is hereby

ORDERED that the Petition of Country-Wide Insurance Company is denied in its entirety, and the awards of the Lower and Master Arbitrator are confirmed; and it is further

ORDERED that the application of Respondent Sun Orthopedic Surgery for fees is denied; and it is further

ORDERED that the Clerk may enter judgment accordingly, upon presentation of a proposed judgment consistent with this opinion; and it is further

ORDERED that Respondent shall, within 20 days of entry, serve a copy of this Order with notice of entry upon all parties.

This constitutes the decision and order of the Court.

Dated: November 21, 2016

Hon. Carol R. Edmead, J.S.C.

HON. CAROL R. EDMEAD
J.S.C.