American Tr. Ins. Co. v New York Presbyt. Hosp./Queens
2020 NY Slip Op 34150(U)
December 8, 2020
Supreme Court, New York County
Docket Number: 657233/2019
Judge: Debra A. James
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SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: HON. DEBRA A. JAMES **PART** IAS MOTION 59EFM

Justice

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AMERICAN TRANSIT INSURANCE COMPANY,

Plaintiff,

- v -

NEW YORK PRESBYTERIAN HOSPITAL/QUEENS F/K/A HOSPITAL MEDICAL CENTER OF QUEENS, as assignee of MATHIAS VIEL,

Defendants.

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INDEX NO. 657233/2019

MOTION DATE 03/05/2020

MOTION SEQ. NO. 001

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 001) 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 38, 39, 40, 41, 42, 43, 44, 45 were read on this motion to/for JUDGMENT - SUMMARY.

ORDER

Upon the foregoing documents, it is

ORDERED that plaintiff's motion for summary judgment is denied; and it is further

ORDERED and ADJUDGED that defendant's cross motion for summary judgment is granted, the complaint is dismissed and on its counterclaims, defendant is awarded $13,018.06, plus statutory prejudgment interest on that amount pursuant to 11 NYCRR § 65-3.9 and Insurance Law § 5106 (a) at an interest rate of two percent per month, from November 26, 2018 until the date of the decision and order on this motion, and thereafter at the statutory rate, as calculated by the Clerk, together with costs

and disbursements to be taxed by the Clerk upon submission of an appropriate bill of costs, and it is further

ORDERED that defendant's motion for an award of attorneys' fees and costs is granted and such claim is severed; and it is further

ORDERED that a Judicial Hearing Officer ("JHO") or Special Referee shall be designated to hear and report to this Court on the following individual issues of fact, which are hereby submitted to the JHO/Special Referee for such purpose: the issue of the amount due to the defendant for reasonable attorneys' fees; and it is further

ORDERED that this matter is hereby referred to the Special Referee Clerk (Room 119M, 646-386-3028 or spref@nycourts.gov) for placement at the earliest possible date upon which the calendar of the Special Referees Part (Part SRP), which, in accordance with the Rules of that Part (which are posted on the website of this court at www.nycourts.gov/supctmanh at the "References" link under "Courthouse Procedures"), shall assign this matter to an available JHO/Special Referee to hear and report as specified above; and it is further,

ORDERED that counsel for the defendant shall, within 15 days from the date of entry of this Order, submit to the Special Referee Clerk by fax (212-401-9186) or email, an Information Sheet (which can be accessed at the "References" link on the

court's website) containing all the information called for therein and that, as soon as practical thereafter, the Special Referee Clerk shall advise counsel for the parties of the date fixed for the appearance of the matter upon the calendar of the Special Referees Part; and it is further,

ORDERED that the defendant shall serve a proposed accounting of attorneys' fees within 24 days from the date of this order and the plaintiff shall serve objections to the proposed accounting within 20 days from service of the defendant's papers and the foregoing papers shall be filed with the Special Referee Clerk at least one day prior to the original appearance date in Part SRP fixed by the Clerk as set forth above; and it is further,

ORDERED that the parties shall appear for the reference hearing, including with all witnesses and evidence they seek to present, and shall be ready to proceed, on the date first fixed by the Special Referee Clerk subject only to any adjournment that may be authorized by the Special Referees Part in accordance with the Rules of that Part; and it is further,

ORDERED that the hearing will be conducted in the same manner as a trial before a Justice without a jury (CPLR 4320[a]) (the proceeding will be recorded by a court reporter, the rules of evidence apply, etc.) and, except as otherwise directed by the assigned JHO/Special Referee for good cause shown, the trial

of the issues specified above shall proceed from day to day until completion; and it is further

ORDERED that any motion to confirm or disaffirm the Report of the JHO/Special Referee shall be made within the time and in the manner specified in CPLR 4403 and Section 202.44 of the Uniform Rules for the Trial Courts.

DECISION

Plaintiff insurance company, American Transit Insurance Company, brings this claim pursuant to Insurance Law § 5106 (c) for a trial de novo concerning a no-fault insurance claim submitted to plaintiff by defendant. Defendant, a hospital, counterclaims for payment of no-fault benefits for services that the hospital rendered to a car accident victim Mathias Viel (Mathias).

Defendant moves, pursuant to CPLR 3212, for an order granting summary judgment dismissing the complaint and for judgment on its counterclaims in the sum of $13,018.06, plus statutory interest pursuant to 11 NYCRR § 65-3.9, attorneys' fees for this action pursuant to 11 NYCRR § 65-4.10 (j) (4) and attorney fees awarded in an arbitration and master arbitration. Plaintiff cross-moves, pursuant to CPLR 3212, for an order granting summary judgment in its favor against defendant (NYSCEF Doc. No. 29).

It is well settled that "the proponent of a summary judgment motion must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to demonstrate the absence of any material issues of fact" (Alvarez v Prospect Hosp., 68 NY2d 320, 324 [1986]). It is also well settled that "[o]nce this showing has been made . . . the burden shifts to the party opposing the motion for summary judgment to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the action" (id.).

In moving, defendant's position is that it properly submitted claims to plaintiff for Mathias' care, but plaintiff did not pay or deny the claims in accordance with the no-fault law and regulations. In opposition, and in moving on its cross motion, plaintiff's position is that defendant's action on these claims is premature, because the 30-day statutory period within which plaintiff has to pay or deny the claims has not begun to run, as defendant has yet to respond adequately to plaintiff's verification requests for additional proof.

In a no-fault first-party insurance case, a medical provider/assignee seeking payment for services provided to a car accident victim meets its prima facie burden on summary judgment by submitting "proof of billing, namely, that the billing forms were mailed to and received by the defendant insurer, and that

the insurer failed to either pay or deny the claim within the requisite 30-day period" (Viviane Etienne Med. Care, P.C. v Country-Wide Ins. Co., 114 AD3d 33, 44 [2d Dept 2013], affd 25 NY3d 498 [2015] [internal quotation marks and citation omitted] [affidavit submitted by provider's billing company employee demonstrated that the annexed claim forms constituted evidence in admissible form]; New York Hosp. Med. Ctr. of Queens v Country Wide Ins. Co., 82 AD3d 723, 723 [2d Dept 2011]; see Westchester Med. Ctr. v Lincoln Gen. Ins. Co., 60 AD3d 1045, 1045-46 [2d Dept 2009] [plaintiff made a prima facie showing "by submitting evidence that the prescribed statutory billing forms had been mailed and received, and that the defendant had failed to either pay or deny the claim within the requisite 30-day period"]).

In response to the submission of a no-fault claim, an insurer may seek relevant information for verification of the claim, and, if the verification request is timely, the insurer's 30-day deadline to pay or deny the claim is tolled (Viviane Etienne Med. Care, P.C. v Country-Wide Ins. Co., 25 NY3d 498, 505-06 [2015]; see Mount Sinai Hosp. v New York Cent. Mut. Fire Ins. Co., 120 AD3d 561, 563 [2d Dept 2014] [absent response to the second, or follow-up, request for verification, the time in which the insurer must decide whether to pay or deny the claim is indefinitely tolled]; St. Vincent Med. Care, P.C. v Country

Wide Ins. Co., 80 AD3d 599, 600 [2d Dept 2011] ["since the plaintiff did not fully comply with the defendant's verification requests, the 30-day period within which the defendant was required to pay or deny the claim did not commence to run"]; Infinity Health Prods., Ltd. v Eveready Ins. Co., 67 AD3d 862, 864 [2d Dept 2009] ["insurer does not have to pay or deny a claim until it has received verification of all of the relevant information requested"]). Where the insurer's deadline is tolled, the provider's claim must be dismissed as premature (Hospital for Joint Diseases v New York Cent. Mut. Fire Ins. Co., 44 AD3d 903, 904 [2d Dept 2007]).

In moving, defendant provides affidavits of its billing company's employee, and mailing receipts, to demonstrate the timely mailing to plaintiff of a "Hospital Facility Form" (NF-5), a "NYS Form NF-AOB," and a "UB-04" form, providing documentation of the hospital bill, and plaintiff's receipt of these documents on May 21, 2018. Defendant's billing company's employee avers that payment has not been made. Thus, defendant has met its prima facie burden on its motion. In opposition to defendant's motion and in support of its cross motion, plaintiff submits copies of verification requests and proof of mailing. Plaintiff contends that defendant has not responded to plaintiff with the information sought, thus tolling the 30-day period within which plaintiff is required to pay or deny

defendant's claim. Plaintiff further contends that it is entitled to proper proof of the claim.

Defendant does not dispute the timeliness of plaintiff's initial June 7, 2018 verification request. Such request states that the submitted assignment of benefits form was incomplete, because "on file," was written on the form in place of an actual signature. In the June 7, 2018 verification request, plaintiff requested that defendant resubmit the completed assignment of benefits form with the claimant's, Mathia's, signature. The request further states that the submitted NF-5 was incomplete as the "authorization portion," was not signed by the claimant, Mathias, and that that portion of the NF-5 had to be "completed in lieu of the completed assignment of benefits form" (NYSCEF Doc. No. 23 [emphasis added]). Plaintiff also stated that "the application for no fault benefits is signed by claimant's son, Steven Viel" (Steve), and that the "claim is pending documents to show [Steve] has the authority to sign on behal[f] of the claimant" (id.).

On August 14, 2018, in response to the June 7, 2018 verification request, defendant mailed to plaintiff a copy of signed forms, including the NYS Form NF-AOB, which is an assignment of benefits form, dated April 27, 2018. On that form the name "Mathias Viel" is signed (the AOB Form). The record reflects that plaintiff received a copy of the signed AOB Form

and had it on August 16, 2018. Defendant also mailed a notarized "verification," dated May 6, 2018, signed by Steve (the Steve Verification). In the Steve Verification, Steve stated that he lives in the home with his father Mathias, as caretaker, and that Mathias is confined to a wheelchair, elderly and not physically capable of signing "any applicable legal paperwork" (NYCEF Doc. Nos. 23).1

On September 5, 2018, plaintiff sent defendant another verification request asking defendant to provide:

> "proof of incapacity as defined by Public Health Law §2994-a and §2994-c, proof of priority as surrogate as defined by Public Health Law §2994-c, or a power of attorney naming Steve Viel as attorney-in-fact, a health care proxy, or a living will naming Steve Viel as guardian" (the Authorization Request) (NYSCEF Doc. No. 33).

Plaintiff also submits a letter, dated September 25, 2018, to which defendant responded that plaintiff should refer to the medical records that defendant had previously sent to plaintiff for proof of Mathias' incapacity, and indicated that it was again providing the AOB Form and the Steve Verification (NYSCEF Doc. No. 35). On September 20, 2018, plaintiff again sent defendant a verification request seeking the same information plaintiff previously sought in the Authorization Request. Plaintiff submits a response from defendant, dated October 4, 2018, stating that the requested items had already been addressed in its September 25, 2018 response

(id.). Plaintiff again responded with a verification request seeking the information in the Authorization Request. Plaintiff contends that the August 13, 2018 response was not satisfactory, and thus amounted to no response at all.

"An insurer shall be entitled to receive proper proof of claim" (11 NYCRR § 65-3.8 [f]). Through its arguments and submissions, plaintiff makes clear that the gravamen of what it sought from defendant concerns the assignment of Mathias' benefits. Indeed, plaintiff's initial, June 7, 2018, request was for an assignment of benefits signed by the claimant, Mathias, or an authorization in lieu of the assignment of benefits. Defendant responded to that request with the signed AOB Form (see New York Hosp. Med. Ctr. of Queens v Country Wide Ins. Co., 82 AD3d 723, 723 [2d Dept 2011] [provider responded "by providing exactly what was requested of it"]). Plaintiff's receipt of the signed AOB Form in response to its request rendered moot plaintiff's initial verification requests for proof of Steve's authority to sign for Mathias. Plaintiff never objected to the adequacy of the AOB Form, or requested follow up directly relating to that form or as to whether it was Mathias' signature on the form. At that point, plaintiff had the hospital bill and the AOB Form, assigning Mathias' no-fault insurance benefits to defendant.

In further support of its cross motion, defendant contends that hospital documents submitted to plaintiff by defendant demonstrate that Mathias was incapacitated after April 26, 2018, and, thus, did not sign the AOB Form, which is why plaintiff began to seek verification of Steve's authority. Specifically, plaintiff argues that the hospital documents state that a proxy was needed as Mathias was not responsive. However, the documents that plaintiff submits contradict such assertion. Those documents, the hospital's "Emergency Department Consent Form," "General Consent for Treatment" (General Consent) and "General Authorization and Release" (Release) (NYSCEF Doc. No. 42), are all dated April 26, 2018, the date of the accident. The Emergency Department Consent, which indicates that it was signed at 2:41p.m., states that Mathias was either unable or unwilling to answer whether or not he wanted a family member notified. The General Consent and the Release forms, which indicate that they were signed at 11:30 p.m., are each signed with Mathias' name, have his name printed under the signature, and contain a witness' signature (id.). The General Consent and Release each also contain a box to check if the patient is unable to sign, but the box is not checked on either form.

Plaintiff further argues that, in response to its verification requests seeking proof of Mathias' incapacity,

defendant did not deny that Mathias was incapacitated, or that Steve signed the authorization of benefits, but responded by providing a legally insufficient power of attorney, signed by Steve. However, the Steve Verification is dated May 6, 2018, and does not state that it addresses April 26-27, 2018, the date of the Mathias' treatment at the hospital. Plaintiff merely speculates that defendant's lack of denial of Mathias' incapacitation and submission of the Steve Verification means that Mathias was not able to sign the AOB Form on April 27, 2018. In any event, this is not a case of a provider's failure to respond to an insurer's verification requests (compare Infinity Health Prods., Ltd., 67 AD3d at 864 [provider failed to respond at all to two requests for verification]; Hospital for Joint Diseases v New York Cent. Mut. Fire Ins. Co., 44 AD3d at 904 [insurer "offered unrebutted proof that the hospital ignored its verification requests"]; Hospital for Joint Diseases v ELRAC, Inc., 11 AD3d 432 [2d Dept 2004] [insurer's verification requests ignored]; New York & Presbyt. Hosp. v American Tr. Ins. Co., 287 AD2d 699, 700 [2d Dept 2001] [provider did not respond to insurer's request for medical records and written reports relating to the claim]). Plaintiff received responses including the signed AOB Form and as the October 4, 2018 response indicating that the requested items had already been addressed in defendant's earlier response/submission. Plaintiff did not

deny or pay the claim, but merely repeatedly sent out the same verification request.

Plaintiff's argument that defendant could have provided proof from an attending physician as to whether Mathias was incapacitated ignores that plaintiff did not request that defendant provide such information from an attending physician. While plaintiff may have deemed defendant's response, concerning Steve, as inadequate to comply with the Public Health Law, after an insurer receives a substantive response to a verification demand, its conduct in repeatedly sending out the same verification request is not consistent with the no-fault law's objective "to provide a tightly timed process of claim, disputation and payment" (Hospital for Joint Diseases v Travelers Prop. Cas. Ins. Co., 9 NY3d 312, 319 [2007] [internal quotation marks and citation omitted]).

"[A] carrier that fails to deny a claim within the 30-day period is generally precluded from asserting a defense against payment of the claim" (id. at 318). Consequently, the court finds plaintiff's remaining arguments unpersuasive, and that defendant is entitled to summary judgment on its claim.

> "An insurer's failure to pay or deny a claim within 30 days carries substantial consequences. By statute, overdue payments earn monthly interest at a rate of two percent and entitle a claimant to reasonable attorneys' fees incurred in securing payment of a valid claim (see Insurance Law § 5106 [a])" (id. at 317-318; see also 11 NYCRR § 65-3.9 [a]

["All overdue mandatory and additional personal injury protection benefits due an applicant or assignee shall bear interest at a rate of two percent per month, calculated on a pro-rata basis using a 30-day month"]).

While defendant is entitled to interest, attorneys' fees and costs and disbursements, an evidentiary hearing is warranted on the question of the reasonableness of billing rate, and proof of the hours that defendant's counsel expended on the matter. Therefore, defendant's request for reasonable attorneys' fees is referred to a special referee to hear and report. The court notes that defendant is not entitled to "any time spent by . . . in applying for and substantiating" attorneys' fees (Matter of GEICO Ins. Co. v AAAMG Leasing Corp., 148 AD3d 703, 706 [2d Dept 2017][attorneys' fee award does not include a "fee upon a fee"]).

12/8/2020
DATE

DEBRA A. JAMES, J.S.C.

CHECK ONE:	[X]	CASE DISPOSED		[ ]	NON-FINAL DISPOSITION		
	[ ]	GRANTED	[X] DENIED	[ ]	GRANTED IN PART	[ ]	OTHER
APPLICATION:	[ ]	SETTLE ORDER		[ ]	SUBMIT ORDER		
CHECK IF APPROPRIATE:	[ ]	INCLUDES TRANSFER/REASSIGN		[ ]	FIDUCIARY APPOINTMENT	[X]	REFERENCE