

Lenox Hill Radiology v. N.Y. Central Mut. Fire Ins. Co.

NASSAU COUNTY Insurance Law

August 06, 2008

Judge Engel

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PLAINTIFF HOSPITAL sought to recover monies for performing MRIs on its assignor's cervical and lumbar spine. Defendant insurance company moved for summary judgment, arguing that the fees charged for the MRIs were in excess of the Workers' Compensation fee schedule. Plaintiff argued that defendant failed to submit proper proof showing that the fees were in excess of the fee schedule. To support its motion defendant relied on a decision from a federal court judge holding that fees charged for MRIs by no-fault first party benefit providers should be in accordance with the fee schedule. The court held that defendant's reliance on this decision was misplaced because federal case law was at best persuasive in the absence of state authority. Furthermore, while the federal decision might ultimately prove to be correct, the court found that defendant still failed to provide the court with any proof in admissible form which supported its fee schedule theory. Defendant's motion was denied.

**Lenox Hill Radiology v. N.Y. Central Mut. Fire Ins. Co.,
27821/02**

Decided: July 25, 2008

Judge Andrew M. Engel

NASSAU COUNTY
District Court

Representation:

For plaintiff: By Michael Hayes Esq.

Baker, Sanders, Esqs.

For the Defendant: By Paul Schneider, Esq.

Gullo & Associates, Esqs.

Judge Engel

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DECISION and ORDER

The Plaintiff commenced this action on or about July 15, 2002 seeking to recover \$1,791.16, plus interest and counsel fees, in no-fault first party benefits for services allegedly provided to its assignor, which remained unpaid by the Defendant. Issue was joined on or about August 2, 2002. The Defendant now moves for summary judgment against the Plaintiff, dismissing the Complaint. The Plaintiff opposes this motion and cross-moves for summary judgment, requesting the entry of a judgment for the amount demanded in the Complaint, or in the alternative, a declaration as to the sufficiency of the Plaintiff's prima facie case, the dismissal of the Defendant's affirmative defenses and the imposition of sanctions against the Defendant. The Defendant opposes the cross-motion.

The parties do not dispute the following essential facts of this claim: The Plaintiff performed MRIs of its assignor's cervical and lumbar spine on January 4, 2002. The Plaintiff submitted its bill for these services, dated April 5, 2002, in the total sum of \$1,791.16, to the Defendant, which received same on April 11, 2002. On April 24, 2002 Defendant sent a verification request to the Plaintiff and the Plaintiff's assignor seeking records from Mark Heyligers, D.C., the referring chiropractor. On May 28, 2002, not having received the requested records within thirty (30) days, the Defendant sent a follow-up verification request to the Plaintiff and the assignor. The requested verification information was received by the Defendant on June 5, 2002. On July 1, 2002 the Defendant made a partial payment in the sum of \$1,571.24 and denied the balance of the Plaintiff's claim, \$219.92, asserting that the fees charged for the MRIs in question were in excess of the Workers' Compensation fee schedule.¹

DEFENDANT'S MOTION

In support of its motion for summary judgment, the Defendant argues that the Plaintiff improperly billed one hundred (100 percent) percent for both the cervical and lumbar MRIs. According to the Defendant, the Plaintiff was required to charge the same fee for MRIs as is called for in the Worker's Compensation fee schedule, Ground Rule 3b, for diagnostic x-ray procedures to two (2) remote parts of the body, which calls for the payment of one hundred (100 percent) percent of the greater single x-ray fee charged and seventy five (75 percent) percent of the lesser x-ray fee. Applying this fee schedule for such x-rays to MRIs the Defendant alleges that it has paid the Plaintiff's claim in full, requiring dismissal of the Complaint.

In opposition to the Defendant's motion the Plaintiff initially argues that although the Defendant's denial of claim was received within thirty (30) days of the Defendant's receipt of the requested verification information, the denial was nevertheless untimely. The Plaintiff accuses the Defendant of "us[ing] the verification protocols to delay payment of the claim, and then (sic) once it determined the services were medically necessary, sought out a different basis to refuse payment. The verification requests do not extend the time in which the defendant has to deny the claim unless the defendant bases its denial on the requested verification." (Hayes Affirmation 4/2/08)² The Plaintiff further posits that "a failure by the insurer to issue a denial when it is in possession of the necessary information serves as a waiver of any right to deny a claim based on such information." (Hayes Affirmation 4/2/08) The Plaintiff does not cite any case law or regulation that supports either of these propositions. The controlling regulations and case law are, in fact, contrary to the Plaintiff's argument.

The Insurance Department Regulations in effect at the time the claim herein arose provided, in pertinent part, "Within 30 calendar days after proof of claim is received, the insurer shall either pay or deny the claim in whole or in part" 11 N.Y.C.R.R. Â§65.15(g)(3). Insurance Law Â§5106 similarly provided that no-fault first party "benefits are overdue if not paid within thirty days after the claimant supplies proof of the fact and amount of loss sustained." See: [New York & Presbyterian Hospital v. Progressive Casualty Insurance Company, 5 A.D.3d 568, 774 N.Y.S.2d 72 \(2nd Dept. 2004\)](#) The Regulations further provided that this thirty (30) day period may be extended by the insurer's timely demand for verification of the Plaintiff's claim. See: 11 N.Y.C.R.R. Â§65.15(d) and (e); and, "[n]o-fault benefits are overdue if not paid within 30 calendar days after the insurer receives verification of all of the relevant information requested pursuant to subdivision (d) of this section." See: 11 N.Y.C.R.R. Â§65.15(g)(1)(i); [Westchester County Medical Center v. New York Cent. Mutual Fire Insurance Company, 262 A.D.2d 553, 692 N.Y.S.2d 665 \(2 Dept. 1999\)](#) Moreover, "an insurer is not obligated to pay or deny a claim until all demanded verification is provided (citations omitted)." [Hospital for Joint Diseases v. New York Central Mutual Fire Insurance Company, 44 A.D.3d 903, 844 N.Y.S.2d 371 \(2nd Dept. 2007\)](#); See also: [New York & Presbyterian Hospital v. Progressive Casualty Insurance Company, supra.](#); [Westchester County Medical Center v. New York Cent. Mutual Fire Insurance Company, supra.](#); [Mount Sinai Hosp. v. Chubb Group of Ins. Companies, 43 A.D.3d 889, 843 N.Y.S.2d 634 \(2nd Dept. 2007\)](#); [Nyack Hospital v. General Motors Acceptance Corporation, 27 A.D.3d 96, 808 N.Y.S.2d 399 \(2nd Dept. 2005\)](#) In fact, 11 N.Y.C.R.R. Â§65.15(g)(2)(iii) specifically provided that "an insurer shall not issue a denial of claim form (NYS Form N-F 10) prior to its receipt of verification of all of the relevant information requested pursuant to subdivision (d) of this section (e.g., medical reports, wage verification, etc.)[]" See: [New York Hospital Medical Center of Queens v. Country-Wide Insurance Company, 295 A.D.2d 583, 744 N.Y.S.2d 201 \(2nd Dept. 2002\)](#); [Summit Psychological, P.C. v. General Assurance Company, 9 Misc.3d 8, 801 N.Y.S.2d 117 \(App.Term 9th and 10th Jud. Dists. 2005\)](#); [Shtarkman v. Allstate Insurance Company, 8 Misc.3d 129\(A\), 801 N.Y.S.2d 781 \(App.Term 2nd and 11th Jud. Dists. 2005\)](#); and, if the Defendant had issued a denial, on the basis of an alleged fee schedule violation, without asserting the defense of lack of medical necessity, before the requested medical records

were received, the Defendant would have been deemed to have waived a possible defense of lack of medical necessity. [S&M Medical Supply v. Allstate Insurance Company, 2003 N.Y. Slip Op. 51191](#) (App. Term 2nd and 11th Jud. Dists. 2003)

The clear prohibition against issuing a denial of claim before all demanded verification information is received notwithstanding, the relevance of the medical records sought by the Defendant before issuing its denial is patent. "Defendant is not required to provide a blank checkbook to plaintiff. Rather, defendant is entitled to find out whether and why each MRI was prescribed; in other words, the carrier is entitled to inquire as to the medical necessity before it pays the bills." [Lenox Hill Radiology v. Global Liberty Insurance, ___ Misc.3d ___, 858 N.Y.S.2d 587 \(Civ.Ct. N.Y. Co. 2008\)](#) Given the nature of the Defendant's fee schedule defense, that it is only obligated to pay one hundred (100 percent) percent of the more expensive MRI and seventy-five (75 percent) percent of the less expensive MRI, this issue would not arise if the Defendant was of the opinion that one or both MRI were not medically necessary. It is only after receiving the requested medical verification that the Defendant was able to determine that the MRIs were medically necessary and the fees it believed it was then obligated to pay.

Alternatively, the Plaintiff argues that the Defendant has failed to submit proper proof in admissible form that Plaintiff's bills were in excess of the appropriate Worker's Compensation Fee Schedule. On this score, the Plaintiff is correct.

To prevail, the movant must first make a showing of entitlement to judgment, as a matter of law, [Bank of New York v. Granat, 197 A.D.2d 653, 602 N.Y.S.2d 942 \(2nd Dept. 1993\)](#), tendering evidentiary proof in admissible form. [Friends of Animals, Inc. v. Associate Fur Manufacturers, Inc., 46 N.Y.2d 1065, 416 N.Y.S.2d 790 \(1979\)](#). It is only thereafter incumbent upon the party opposing summary judgment to "demonstrate by admissible evidence the existence of a factual issue requiring a trial of the action or tender an acceptable excuse for his failure so to do." [Zuckerman v. City of New York, 49 N.Y.2d 557, 427 N.Y.S.2d 595 \(1980\)](#). The movant's failure to make such a showing, regardless of the sufficiency of opposing papers, mandates the denial of a summary judgment motion. [Winegrad v. New York University Medical Center, 64 N.Y.2d 851, 487 N.Y.S.2d 316 \(1985\)](#)

In support of its motion, the Defendant relies upon the affirmation of counsel, which is of no probative value, [Zuckerman v. City of New York, supra.](#); [Morissaint v. Raemar Corp., 271 A.D.2d 586, 706 N.Y.S.2d 165 \(2nd Dept. 2000\)](#); [Citbank, N.A. v. Joffe, 265 A.D.2d 291, 696 N.Y.S.2d 190 \(2nd Dept. 1999\)](#), the conclusory statement of one of its Litigation Examiners to the effect that the appropriate fee "[f]or multiple diagnostic x-ray procedures: for two remote parts, the charge shall be the greater fee plus 75 percent of the lesser fee[,]" (Chase Affidavit 11/28/07, ¶2) and the unreported decision of Hon. Denny Chin, from the United States District Court for the Southern District of New York, in *Brentwood Pain & Rehabilitation Services, P.C., et. ano. v. Allstate Insurance Company, et. al.*, docket number 06 Civ. 3994 (DC), holding that the fees charged for MRIs by no-fault first party benefits providers shall be in accordance with the Worker's Compensation Fee Schedule, Ground Rule 3b, for diagnostic x-ray procedures to two (2)

remote parts of the body.

The Defendant's reliance on Judge Chin's decision is misplaced. "Federal case law is at best persuasive in the absence of State authority; it is largely irrelevant to a peculiarly local question" [Cox v. Microsoft Corporation, 290 A.D.2d 206, 737 N.Y.S.2d 1 \(1st Dept. 2002\)](#) A determination by the federal court, "while entitled to great weight, is not binding on this court." [New York Rapid Transit Corporation v. City of New York, 275 N.Y. 258, 9 N.E.2d 858 \(1937\) affd 303 U.S. 573, 58 S.Ct. 721, 82 L.Ed. 1024 \(1938\)](#); See also: [People v. Kin Kan, 78 N.Y.2d 54, 571 N.Y.S.2d 436 \(1991\)](#); [Walker v. Walker, 51 A.D.2d 1029, 381 N.Y.S.2d 310 \(2nd Dept. 1976\)](#); [People v. Weiner, 63 A.D.2d 722, 405 N.Y.S.2d 282 \(2nd Dept. 1978\)](#) Nor is Judge Chin's decision entitled to preclusive effect, pursuant to the doctrine of collateral estoppel, as the Plaintiff was neither a party nor in privity with a party to that proceeding. [Ryan v. New York Telephone Co., 62 N.Y.2d 494, 478 N.Y.S.2d 823 \(1984\)](#); See also: [Choi v. State, 74 N.Y.2d 933, 550 N.Y.S.2d 267 \(1989\)](#); [G. Rama Const. Enterprises, Inc. v. 80-82 Guernsey Street Associates, 43 A.D.3d 863, 841 N.Y.S.2d 669 \(2nd Dept. 2007\)](#)

While Judge Chin's decision might ultimately prove to be correct, the Defendant herein has failed to provide the court with any proof in admissible form which supports its fee schedule theory. This court notes that before *Brentwood Pain & Rehabilitation Services, P.C., et. ano. v. Allstate Insurance Company, et. al.*, was removed to the Federal Court, Justice Joan A. Madden, sitting in the Supreme Court of the New York State, New York County, denied a defense motion to dismiss on the same grounds now asserted by the Defendant herein. In refusing to give Justice Madden's decision preclusive effect, under the doctrine of law of the case, Judge Chin noted, inter alia, that Justice Madden "did not have the benefit of the additional letters that have been submitted to this Court." *Brentwood Pain & Rehabilitation Services, P.C., et. ano. v. Allstate Insurance Company, et. al.*, supra. at p. 21. This court presently finds itself in the same position as Justice Madden.

Having failed to "proffer sufficient evidence to establish as a matter of law that [Plaintiff's] claims reflected the incorrect amount for the services provided . . . the court . . . denie[s] defendant's motion for summary judgment." [Triboro Chiropractic and Acupuncture, PLLC v. New York Central Mutual Fire Insurance Company, 15 Misc.3d 145\(A\), 841 N.Y.S.2d 824 \(App.Term 2nd and 11th Jud. Dists. 2007\)](#)

PLAINTIFF'S MOTION

The Plaintiff will establish "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 (citations omitted)." [Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D.3d 742, 774 N.Y.S.2d 564 \(2nd Dept. 2004\)](#); See also: [A.B. Medical Services, PLLC v. Liberty Mutual Insurance Company, 39 A.D.3d 779, 835 N.Y.S.2d 614 \(2nd Dept. 2007\)](#); [Westchester Medical Center v. AIG, Inc., 36 A.D.3d 900, 829 N.Y.S.2d 180 \(2nd Dept. 2007\)](#); [New York & Presbyterian Hospital v. American Transit Insurance Company, 45](#)

[A.D.3d 822, 846 N.Y.S.2d 352 \(2nd Dept. 2007\)](#) Benefits are overdue "if not paid within 30 calendar days after the insurer receives verification of all of the relevant information requested pursuant to subdivision (d) of this section." 11 N.Y.C.R.R. Â§65.15(g)(1)(i); See also: Insurance Law Â§5106(a); [Presbyterian Hospital in the City of New York v. Maryland Casualty Company, supra. at 278, 660 N.Y.S.2d 536, 537 \(1997\)](#); [Fair Price Medical Supply Corp. v. Travelers Indemnity Company, 42 A.D.3d 277, 837 N.Y.S.2d 350 \(2nd Dept. 2007\)](#); [New York and Presbyterian Hospital v. Selective Insurance Company of America, 43 A.D.3d 1019, 842 N.Y.S.2d 63 \(2nd Dept. 2007\)](#) Plaintiff's prima facie case does not require a showing that the fees it charged were in accordance with the Workers' Compensation fee schedule. [AVA Acupuncture, P.C. v. GEICO General Ins. Co., 17 Misc.3d 41, 844 N.Y.S.2d 570 \(App.Term 2nd and 11th Jud. Dists. 2007\)](#) Plaintiff's prima facie case does require that a proper business record foundation be laid, See: [Dan Medical, P.C. v. New York Central Mutual Fire Insurance Company, 14 Misc.3d 44, 829 N.Y.S.2d 404 \(App. Term 2nd & 11th Jud. Dists. 2006\)](#); [Fortune Medical, P.C. v. Allstate Insurance Co., 14 Misc.3d 136, 836 N.Y.S.2d 492 \(App. Term 9th & 10 Jud. Dists. 2007\)](#); [Ontario Medical, P.C. v. Sea Side Medical, P.C., 15 Misc.3d 129, 839 N.Y.S.2d 435 \(App. Term 9th & 10 Jud. Dists. 2007\)](#); [V.S. Medical Services, P.C. v. One Beacon Insurance, 14 Misc.3d 142, 836 N.Y.S.2d 504 \(App. Term 2nd & 11th Jud. Dists. 2006\)](#), for the admission of the "properly completed claim form, which suffices on its face to establish the 'particulars of the nature and extent of the injuries and [health benefits] received and contemplated' (11 NYCRR Â§65-1.1), and the 'proof of the fact and amount of loss sustained' (Insurance Law Â§5106[a]).]" [Amaze Medical Supply Inc. v. Eagle Insurance Company, 2 Misc.3d 128, 784 N.Y.S.2d 918 \(2nd and 11th Jud. Dist. 2003\)](#); [Damadian MRI In Elmhurst, P.C. v. Liberty Mutual Insurance Company, 2 Misc.3d 128\(A\), 784 N.Y.S.2d 919 \(App. Term 9th and 10th Jud. Dists. 2003\)](#) "[T]o the extent defendant insurer issued denial of claim forms or admitted receipt of plaintiff's claim forms, . . . said admissions were not concessions of the facts asserted in plaintiff's claim forms, and it was plaintiff's burden to proffer such evidence in admissible form ([Midborough Acupuncture, P.C. v. New York Cent. Mut. Fire Ins. Co., 13 Misc.3d 132\(A\), 2006 N.Y. Slip Op. 51879\[U\], 2006 WL 2829993 \[App. Term, 2d & 11th Jud. Dists.\]](#))." [Bajaj v. General Assurance, 18 Misc.3d 25, 852 N.Y.S.2d 576 \(App.Term 2nd and 11th Jud. Dists. 2007\)](#) Distinguished from the case sub judice is the circumstance where the defendant pays the claim in full after litigation is commenced and the only issues remaining are the amount of interest and/or attorney's fees to be paid. In such a case, a plaintiff's failure to lay a proper business record foundation for the admission of its claim form will be overlooked. [Delta Diagnostic Radiology, P.C. v. Progressive Casualty Insurance Co., 18 Misc.3d 128\(A\), 856 N.Y.S.2d 23 \(App.Term 2nd and 11th Jud. Dists. 2007\)](#)

As previously indicated, the Defendant herein concedes, both in its denial of claim form and in its motion papers, that the Plaintiff's claim was timely received. These admissions cure any defect which may exist in the Plaintiff's proof of mailing. [Prestige Medical & Surgical Supply Inc. v. Clarendon National Insurance Company, 13 Misc.3d 127\(A\), 824 N.Y.S.2d 758 \(App. Term 2nd and 11th Jud. Dists. 2006\)](#); [Magnezit Medical Care, P.C. v. New York Central Mutual Fire Ins. Co., 12 Misc.3d 144\(A\), 824 N.Y.S.2d 763 \(App. Term 2nd and 11th Jud. Dists. 2006\)](#) The parties also agree that \$219.92 of that claim

remains unpaid. The Plaintiff, however has failed to lay a proper business record foundation for the admission of its claim form.

The Plaintiff attempts to lay this foundation through the affidavit of Nicole Simeona, who advises the court that she is "employed by plaintiff's counsel[,] (Simeona Affidavit 4/3/08) not by the Plaintiff. Ms. Simeona further avers that she is "intimately familiar with the administration of all aspects of the collection department." (Simeona Affidavit 4/3/08) She does not indicate whose collection department, the Plaintiff's or her employer's. Moreover, nowhere does Ms. Simeona allege that she has any knowledge of the Plaintiff's record keeping practices and the creation of the Plaintiff's claim form.

Accordingly, those branches of the Plaintiff's cross-motion which seek summary judgment, or in the alternative, partial summary judgment are denied.

That branch of the Plaintiff's cross-motion which seeks an order dismissing the Defendant's affirmative defenses is granted to the extent of dismissing the Defendant's Second and Third Affirmative Defenses, alleging lack of medical necessity and failure to comply with policy conditions, respectively. The defense of lack of medical necessity was waived by the Defendant's failure to issue a timely denial of claim asserting such defense. [Central General Hospital v. Chubb Group of Insurance Companies, 90 N.Y.2d 195, 659 N.Y.S.2d 246 \(1997\)](#); [Presbyterian Hospital in the City of New York v. Maryland Casualty Company, 90 N.Y.2d 274, 660 N.Y.S.2d 536 \(1997\)](#) Additionally, both the Second and Third Affirmative Defenses merely plead conclusions of law and fail to allege any facts. See: [Plemmenou v. Arvanitakis, 39 A.D.3d 612, 833 N.Y.S.2d 596 \(2nd Dept. 2007\)](#); [Petracca v. Petracca, 305 A.D.2d 566, 760 N.Y.S.2d 513 \(2nd Dept. 2003\)](#); [Staten Island-Arlington, Inc. v. Wilpon, 251 A.D.2d 650, 676 N.Y.S.2d 469 \(2nd Dept. 1998\)](#) The Defendant's remaining affirmative defenses relate to the Defendant's claim that it paid the Plaintiff, in full, pursuant to the appropriate Workers' Compensation fee schedule.

Finally, that branch of the Plaintiff's motion which seeks the imposition of sanctions against the Defendant, pursuant to 22 N.Y.C.R.R. Â§130-1, for alleged frivolous conduct, is denied. "People who live in glass houses should not throw stones."

This constitutes the decision and order of this court.

1. While the Plaintiff's papers in opposition to the Defendant's motion question the Defendant's proof of service of the Defendant's verification requests and denial, at oral argument the Plaintiff conceded the timeliness and receipt of the Defendant's verification requests, as well as the fact that the Defendant issued its denial within thirty (30) days of its receipt of the requested verification information. For this reason, the court will not address the Defendant's proof of service of the verification requests or the denial.
2. The Plaintiff has failed to number either the paragraphs or pages of the papers it submits on this motion.