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A Khodadadi Radiology P.C. v NYCTA
2006 NY Slip Op 50832(U)
Decided on April 24, 2006
Civil Court, Kings County
Baily-Schiffman, J.
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Decided on April 24, 2006

Civil Court, Kings County

A KHODADADI RADIOLOGY P.C. a/a/o Helen Boddie Khan, Plaintiff,

against

NYCTA - MaBSTOA, Defendant.

106407/04

Loren Baily-Schiffman, J.

This is an action to recover benefits pursuant to the no-fault provisions of Insurance Law §5106 and regulations promulgated thereunder. Plaintiff provider, as

assignee of patient Helen Boddie Khan, moves this Court for summary judgment. Plaintiff asserts that it has made out its *prima facie* case, that defendant's denials were late and do not raise defenses that can be asserted more than thirty (30) days after receipt of the claim and do not sufficiently apprise plaintiff provider of the basis for the denial. Defendant moves for summary judgment on the basis that because the assignor was a passenger in a bus at the time of the accident and had an insured vehicle in her household, she was required to submit her claim to the company insuring her household vehicle. The failure to submit the claim to the appropriate insurance company, defendant submits, is a coverage defense which permits the defense to be asserted beyond the thirty (30) day period after receipt of the claim without preclusion. Defendant also asserts that plaintiff has not made out its *prima facie* case because it has not proven that the assignor was injured on a bus. [*2]

In a motion for summary judgment, the moving party must make out a *prima facie* case of entitlement to judgment as a matter of law, offering sufficient evidence to establish the absence of any material issues of fact. ***Alvarez v. Prospect Hosp., 68 NY2d 320, 324 (1986)***. After making out a *prima facie* case, the burden shifts to the party opposing the motion to present sufficient evidence to show that there are material issues of fact in controversy which require a trial. ***Id.*** In a claim for no-fault benefits by a provider, the Plaintiff's *prima facie* case is established by "*the submission of a complete proof of claim and the amount of the loss. (See Insurance Law §5106[a]; Mary Immaculate Hosp. v. Allstate Ins. Co., 5 AD3d 742 [2004]; Amaze Med. Supply Inc. v. Eagle Ins. Co., 2 Misc 3d 128[A], 2003 NY Slip Op 51701[U]{App Term, 2d & 11th Jud Dists])*". ***Ocean Diagnostic Imaging PC A/A/O Jean Baptists Turenne, Johnson Turenne, v. State Farm Mutual Automobile Insurance Company, NYLJ, Sept 24, 2004, p. 28, col. 5 (App Term 2d & 11th Jud Dists, 2004)***.

Pursuant to Insurance Law §5101 et seq. and the regulations promulgated thereunder, 11 NYCRR §65.15 (g)(3), an insurer must either pay or deny a claim for no-fault benefits within thirty (30) days of receipt. The thirty (30) day period may be extended by an insurer's request for verification of the claim within ten (10) business

days for claims covered by the regulations in effect prior to April 5, 2002 and fifteen (15) business days for claims covered by the regulations that came into effect on April 5, 2002. ***11 NYCRR 65.15 (d) & (e)***. If any insurer fails to timely deny a claim, the insurer is precluded from raising any defenses to the claim other than lack of coverage and fraud. ***Presbyterian Hosp. v. Maryland Cas. Co., 90 NY2d 274, 278 (1997); Presbyterian Hosp. v. Aetna Cas. & Sur. Co., 233 AD2d 433 (2d Dept, 1996); Central Hospital v. Chubb, 90 NY2d 195 (1997); Mt. Sinai v. Triboro Coach, 263 AD2d, 11 (2d Dept 1999).*** An insurer's failure to raise objections within the ten (10) or fifteen (15) day verification period constitutes a waiver of any defenses based thereon. ***Id.***

Plaintiff's Prima Facie Case

Plaintiff asserts that it submitted its proof of claim to defendant and the claim was not paid or denied within thirty (30) days of receipt by defendant. Plaintiff's moving papers contain a denial of claim form dated October 25, 2001 which acknowledges receipt of the claim on April 2, 2001. This denial is late on its face. The denial, wherein defendant admits receipt of the claim on a particular day, confirms that the claim was received and establishes plaintiff's *prima facie* case. ***Residential Holding Corp. v. Scottsdale Ins. Co., 286 AD2d 679 (2d Dept 2001); Amaze Med. Supply Inc. v. New York Cent. Mut. Ins. Co., 6 Misc 3d 126 (A), 2004 NY Slip Op 51680 (App Term, 2d & 11th Jud Dists).***

In addition to the lateness of defendant's denial, plaintiff asserts that it is entitled to summary judgment on the basis that defendant's denial is insufficient to "*promptly apprise the claimant with a high degree of specificity of the ground or grounds on which the disclaimer is predicated*". ***General Accident Ins. Group v. Cirucci, 46 NY2d 862, 864 (1979); Nyack Hospital v. State Farm Mutual Automobile Ins. Co., 2004 WL 2394038 (2d Dept 2004)***.

Defendant's Opposition [*3]

Defendant does not claim that its denial is not late. In fact, defendant's motion

papers do not contain the affidavit of anyone concerning the mailing of the denial. Moreover, defendant does not assert that it requested verification of the claim and that the denial was mailed within thirty (30) days of receipt of the verification information. Defendant submits no document indicating opposition to plaintiff's motion. Rather, defendant cross-moves for summary judgment.

Defendant's Motion for Summary Judgment

Defendant asserts that it is entitled to summary judgment on the basis that the assignor was injured while a passenger in a bus and was the owner of an insured vehicle at the time of the accident. Defendant relies on Insurance Law §5103 for this proposition. Although defendant does not provide the Court with the subsection on which it relies, the Court surmises that defendant is relying on §5103 (a)(1) which states:

> In the case of occupants of a bus other than operators, owners, and employees of the owner or operator of the bus, the coverage for first party benefits shall be afforded under the policy or policies, if any, providing first party benefits to the injured person and members of his household for loss arising out of the use or operation of any motor vehicle of such household. In the event there is no such policy, first party benefits shall be provided by the insurer of such bus.

Insurance Law §5103(a)(1).

Defendant takes the position that this defense impacts insurance coverage for the submitted claim and, therefore, it need not deny the claim within thirty (30) days after receipt.

Defendant submits that plaintiff's was required to prove in its claim that the assignor was involved in the alleged accident and the failure to do so warrants summary judgment in defendant's favor. Defendant provides no statutory or case law citation for this proposition. Rather, defendant submits the Affidavit of a bus driver that he was driving a bus on September 1, 2000 that was involved in an accident, but he has no "record or recollection" of a passenger on his bus named Helen Boddie

Khan at the time of the accident. On this basis, as well, defendant seeks summary judgment dismissing plaintiff's action.

Plaintiff's Opposition

Plaintiff asserts the following bases on which defendant's motion for summary judgment should be denied:

1.Defendant, without explanation, submitted two (2) separate denials to plaintiff's claim on different bases; [*4]

2.Both of defendant's denials are dated more than thirty (30) days after defendant acknowledged receipt of the claim and are, therefore, late.

3.The first denial, dated May 22, 2001, does not comply with the requirements of ***General Accident Ins. Group v. Cirucci, 46 NY2d 862 (1979)*** that it "apprise the claimant with a high degree of specificity of the ground or grounds on which the disclaimer is predicated". ***Id*** Plaintiff asserts that defendant's failure to cite to the applicable Insurance Regulation, §65-3.12(a)(9), is fatal to its denial and requires that summary judgment be denied as defendant has failed to establish its entitlement to judgment as a matter of law.

4.The transcript of the 50-h hearing annexed to defendant's motion papers is without evidentiary effect as it is unsigned, citing to this Court's decision in ***JSI Expert Service v. Liberty Mutual Ins. Co., 2005 NY slip Op 50513 (Civil Ct. Kings Co. 2005)***.

5.Defendant submits no proof that assignor's vehicle was insured on the date of the subject accident as the "Expansion Reports" annexed to its motion papers as Exhibit D are merely unexplained and unauthenticated computer generated documents for which no foundation has been laid. Accordingly, these documents have no evidentiary effect.

6.Defendant's "coverage" defense is not the type of defense that survives the thirty (30) day preclusion rule, citing to Insurance Regulations §§65-3.12(b) and).

7.Plaintiff is not required to submit proof in its claim that the assignor was involved in an accident.

Discussion

The Court finds that plaintiff has made out its *prima facie* case. The caselaw establishing the requirements of plaintiff's *prima facie* case have previously been cited herein and are not in doubt. Defendant has cited the Court to no authority whatsoever that requires that plaintiff also prove in its claim that the assignor was involved in an accident in order to obtain first-party No Fault benefits. After the *prima facie* case has been established, the burden then shifts to defendant to show by admissible proof that there are material facts in controversy requiring a trial. Defendant has not even attempted to meet this burden. Rather, defendant has attempted to show that it is entitled to judgment as a matter of law dismissing the complaint. Defendant has failed to meet this burden as well.

While generally the Court credits plaintiff's argument that the proof defendant relies on, the 50-h transcript and the "Expansion Reports", is inadmissible, the stronger argument is that the defense asserted by defendant is not a "coverage" defense that prevents preclusion if not submitted within thirty (30) days of receipt of the claim. The Court is most persuaded by [*5]plaintiff's argument concerning the interplay of Insurance Regulations establishing a procedure to be followed when a dispute arises regarding priority of payment among insurers otherwise liable for the payment of first-party benefits. The applicable regulations read as follows:

> §65-3.12b. If a dispute regarding priority of payment arises among insurers who otherwise are liable for the payment of first-party benefits, then the first insurer to whom notice of claim is given pursuant to section 65-3.3 or subdivision 65-3.4 (a) of this subpart, by or on behalf of an eligible injured person, shall be responsible for payment to such person. Any such dispute shall be resolved in accordance with the arbitration procedures established pursuant to section 5105

of the Insurance Law and section 65-4.11 of this Part.

§65-3.12c. If the source of first-party benefits is at issue because the status of the injured person as a pedestrian or an occupant of a motor vehicle is in dispute, the insurer to whom notice of claim was given or if such notice was given to more than one insurer, the first insurer to whom notice was given shall, within 15 calendar days after receipt of notice, obtain an agreement with the other insurer or insurers as to which insurer will furnish no-fault benefits. If such an agreement is not reached within the aforementioned 15 days, then the insurer to whom such notice was first given shall process the claim and pay first-party benefits and resolve the dispute in accordance with the arbitration procedures established pursuant to section 5105 of the Insurance Law and section 65-4.11 of this Part.

It is clear to the Court that the procedures established by the above quoted regulations are to prevent exactly what has occurred in this case: denial of the claim because one insurer believes another insurer is liable to the provider. Defendant believes that it is not responsible for payment of the subject claim because another insurance company is liable. Rather than follow the procedures set forth in the above regulations, defendant denied the claim, putting the burden on the provider or the assignor. What the regulations require defendant to do is either pay the claim and then work it out with the other insurance company, by arbitration if necessary, or notify the other insurance company and obtain agreement as to which company will pay the claim and resolve the dispute by arbitration, if necessary. What the regulations do not permit is the denial of the claim on the basis that another insurance company is responsible: the procedure followed by defendant regarding the subject claim.

The Court finds not only that the defense asserted by defendant is not a "coverage" defense that would prevent preclusion where the denial is submitted more than thirty (30) days after receipt of the claim, but that the defense asserted by defendant is not available as a matter of law. **Insurance Regulations §§65-3.12 b&c.** As defendant has raised no other defenses, plaintiff's motion for summary judgment is granted and defendant's motion for summary judgment is denied. Judgment is granted to plaintiff in the sum of $878.67 plus statutory costs, disbursements, interest and attorneys fees. Should plaintiff wish to make a claim for additional attorneys fees, the Court will entertain papers on the issues of entitlement to additional fees and

documentary support for the fees sought if served and presented to this Court in Room 705 on or [*6]before May 8, 2006. Opposition, if any, is to be served and presented to this Court on or before May 22, 2006.

This constitutes the Decision and Order of the Court.

DATED:April 24, 2006

LOREN BAILY-SCHIFFMAN, J.C.C.