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Smith & Brink, P.C.

1325 Franklin Avenue, Suite 320

Garden City, NY 11530

P: (347) 710-0050

F: (347) 710-0055

www.smithbrink.com

Verification: Friend or Foe?

No-Fault was initially designed to be a quick, painless system where people injured in car accidents could access treatment easily, bills would be submitted by providers and paid by insurers in a timely manner, ultimately negating the need for an adversarial system. In theory, a provider submits a bill to the insurance company, and the insurer has 30 days from the date of receipt of said bill to either pay it or deny it. However well-intentioned the designers of the law were, No-Fault has evolved into a minefield of convoluted rules and exceptions, resulting in a "Gotcha!" mentality that reigns in courts and arbitrations. Every so often the No-Fault regulations are amended to make things move more smoothly, and give guidance to the misguided. But in the wavy waters of verification, an exception to the 30 day pay or deny rule, the regulations must be expertly navigated by insurers in order to stay afloat.

Under No-Fault regulations, should an insurer decide to partake in the verification process, there is a strict timeline to abide by. Once a bill is received by an insurer, the insurer has 15 business days to request any additional verification required to establish proof of claim. 11 NYCRR 65-3.5(b). Once the initial verification request is sent, the provider is on notice to submit a response to said request. If no response is received by the insurer, then the insurer must send a follow-up request within 30-40 days of the initial request.

If 120 days passes from the initial verification request and no response is received by the insurer, the insurer may deny the bill. (11 NYCRR 65-3(o)). If for some reason the insurer's initial request for verification exceeds 15 business days from the date of receipt of the bill, then the insurer's time to deny the bill is lessened by the number of late days. Confused yet? Welcome to the world of verification.

Notwithstanding these nuances, verification can be a useful tool to verify claims. If used properly it can even be a viable defense for insurers to use in denying claims for no-fault reimbursement. This issue will break down the verification process and highlight the necessary components for establishing a solid verification defense in light of all the new rules and technicalities.

What makes a verification request "proper"?

a. *Timeliness of the Request*

The first step in establishing a solid verification defense is to ensure that the requests themselves are made in a timely manner. It cannot be stressed enough that any small deviation could be detrimental to insurers. As mentioned earlier, upon receipt of a bill from the provider of services, the first request for verification must be mailed by the insurance company within 15 business days of that date in order to toll the time to pay or deny said bill. 11 NYCRR 65-3.5(b). If thirty days passes and no response is received, the insurer must send a follow up request within ten days renewing their request and advising the provider that the verification is still outstanding. As long as the initial request and follow up request are made in a timely manner pursuant to the regulations, the foundation is set to move forward.

b. *Proper Request vs. Simple Delay*

First and foremost, an insurer must make sure that the verification request actually requests *something*, and does not merely state that the bill is delayed "pending the investigation of the accident, etc." It cannot be stressed enough that absent an actual request, the time to pay or deny the bill is not tolled. *See,* New Way Acupuncture P.C. v. New York Cent. Mut. Fire Ins. Co., 2015 NY Slip Op 51706(U)(App. Term 2d Dep't 2015)(holding that mere notification that a bill was being delayed absent a specific request was insufficient to toll defendant's time to pay or deny the bill.)

c. *Propriety of a Request*

Next, it is necessary to determine what actually constitutes a "proper" verification request. On the one hand, there is no hard and fast definition of the term, but there are certain good faith principles that are highlighted in the regulations and should be considered by insurers when requesting additional verification. First, there should be a good faith basis to seek the verification. 11 NYCRR 65-3.2(a-f). Second, the request should have a "rational or reasonable relationship to the specific provider's claim". 11 NYCRR 65-3.2(c); *See also,* Garden State Anesthesia Assoc., PA v. Progressive Cas. Ins., 41 Misc. 3d 996, 997 (Nas. Cty. Dist. Ct. 2013). In other words, insurers should initially ask themselves: Will I be able to process this claim without the verification I requested?

On the other hand, case law and subsequent parts of the regulations paint a broader picture of what is appropriate to ask for. For example, 11 NYCRR 65-3.5(c) states that "the insurer is entitled to receive all items necessary to verify the claim directly from the parties from whom verification was requested." *See also,* Nyack Hosp. v. General Motors Acceptance Corp., 2007 NY Slip OP 02439, 8 N.Y.3d 294 (N.Y. 2007) (Holding that additional verification includes all information necessary for the insurer to determine whether the claim submitted by the healthcare provider is payable.) This suggests that insurers are essentially entitled to "everything under the sun" in terms of what they can request. However generous this may seem, one must read between the lines and recognize that there are in fact limitations.

One of those limitations is requesting what has come to be known as "Mallela" type verification. Requests for things like bank statements and tax returns are generally not considered proper absent a reasonable basis for requesting them. Nevertheless, insurers should not be fooled by the word "reasonable". In this context one must have a *really* compelling reason to request these kinds of documents and be ready to back it up with facts. Failure to do so will put you in the murky waters of the notorious "fishing expedition", which is every plaintiff's favorite catchphrase when dealing with anything related to verification.

So, now you may be wondering, what can insurers actually request? While there is no enumerated list of what can and cannot be requested, we can look to arbitration decisions and case law to get an idea of what is acceptable and what is not. For example, in the Matter

of Pro Edge Chiropractic, PC v. Geico Insurance Company, AAA Case #17-15-1023-2957, the insurer requested documents such as referrals, prior treatment information, and medical clearance related to bills received for an MUA procedure. In this case the provider's claim was denied as premature for failure to provide a complete response to the insurer's request. Similarly, the Appellate Term held that an insurer's timely request for MRI films was sufficient to toll the 30-day period within which the insurer was required to pay or deny the subject bill. Radiology Today, P.C. v. New York Cent. Mut. Fire Ins. Co., 2001 NY Slip Op 52452(U), [34 Misc. 3d 139(A)].

In instances where EUO testimony by a provider raises questions regarding the possible use of independent contractors, arbitrators have generally held that requesting W-2s of employees is in fact reasonable and proper. *See,* Matter of BMJ Chiropractic PC v. Geico Insurance Company, AAA Case #17-15-1009-0651. A word to the wise on this issue: EUO testimony as well as an affidavit by the investigator at the insurance company explaining the investigation was essential to the success of the insurer to establish the propriety of the requests.

Conversely, in the Matter of Complete Diagnostic Radiology v. Allstate Insurance Company, AAA Case# 17-16-1029-3449, the arbitrator (and many others on related matters) was not so forgiving. In this case, the arbitrator held that a mere position statement is insufficient to establish good cause for requesting documents and information regarding corporate dealings with other persons and entities. The arbitrator noted that there was no sworn affidavit from an investigator, and suggested that the evidence submitted was not enough to justify the verification sought. It begs the question: would the outcome have been different if there was a sworn affidavit from the investigator that discussed the facts surrounding the investigation and why those documents were necessary?

Arbitrators and judges will not uphold these types of requests unless the insurer presents "case specific allegations", usually supported by a sworn affidavit from someone with knowledge of the facts. *See generally,* Pomona Med. Diagnostic, PC v. Adirondack Ins. Co., 36 Misc. 3d 127, 2012 , NY Slip Op 51165 (App. Term 1 Dep't).

The request must also advise the Provider that the claim may be denied if the Provider fails to provide all verification under its control or possession within 120 days of the initial request, or submit written proof providing reasonable justification for the failure to comply. 11 NYCRR 65-3(o). The inclusion of this language in the verification request is necessary for the insurer to reserve its right to deny the claims for the provider's failure to respond.

So, it is safe to say that when sailing the verification sea, insurers should follow this course:

1. Is the request timely?
2. Am I actually requesting *something* from the provider?
3. Do I have a good reason for requesting that *something*? Is that *something* necessary to process the bill(s) at issue?
4. Can I articulate the reasons I am making these requests with case specific facts rather than mere suspicion of wrongdoing?
5. Does my request advise the provider about the 120 day time limit to respond to avoid denial?

If the answer to all of these questions is in the affirmative, then the ball moves to the provider's court.

Responses – Or Lack Thereof

There is no provision of the No Fault Regulations allowing a claimant or insurance company to ignore a verification request or response. In fact, there is ample case law which provides that neither party may ignore communications from the other without risking its chance to prevail in the matter. Canarsie Chiropractic, P.C. v State Farm Mut. Auto. Ins. Co., 2010 NY Slip Op 50950(U) (2010); (*See also*, Media Neurology, P.C. v. Countrywide Ins. Co., 21 Misc 3d 1101(A); and Westchester County Medical Center v. NY Central Mutual Fire Ins. Co., 262 AD2d 553). Even when a claimant believes it need not comply with a verification request, the claimant still has a duty to communicate with the insurer regarding the request (see, Dilon Medical Supply Corp. v. Travelers Insurance Co., 7 Misc 3d 927). A failure to raise an objection to the request will even result in a waiver of the defense that the notices were defective and unreasonable. *Canarsie Chiropractic v. State Farm*, supra.

Sufficiency of Responses

Sufficiency of responses is generally determined through a case by case analysis of the facts. A sufficient response will either provide the requested information

or documentation, advise the insurer that the requested verification does not exist or is not in the provider's possession, or object to the verification request as being improper, unduly burdensome, unfounded, harassing and/or unnecessary, thereby preserving the issue for trial. *See,* Victory Medical Diagnostics, P.C. v. Nationwide Property & Casualty Ins. Co., 36 Misc. 3d 568 (2012). Notably, in the event that the provider fails to provide the verification, then it must also provide reasonable justification for its failure to do so.

Partial Responses

There are differing views on the issue of partial responses by providers. For example, there is case law holding that a defendant is not obligated to pay or deny a claim until *all the demanded verification* is provided by the plaintiff. Compas Med., P.C. v Travelers Ins. Co., 2016 NY Slip Op 51441(U)(App. Term 2d Dep't 2016); Westchester Med. Ctr. v. Country Wide Ins. Co., 2011 NY Slip Op 03838 (2011). The court in *Eagle Surgical Supply, Inc. v. Travelers Indem. Co.* held that the record demonstrated that the plaintiff failed to provide *all of the requested additional verification*, and as a result, summary judgment in favor of the defendant was appropriate. Eagle Surgical Supply, Inc. v. Travelers Indem. Co., 2010 NY Slip Op 51775(U) (2010).

More recently, the Appellate Term, Second Department recently addressed an interesting issue about the content and form of Plaintiff's responses. In *Excel Surgery Center, LLC v. Fiduciary Ins. Co.*, the plaintiff responded to the defendant's timely verification requests by informing the defendant, by letter, that it, as an ambulatory facility, did "not possess all the medical records" that the defendant sought. Excel Surgery Center, LLC v. Fiduciary Ins. Co. of America, 2017 NY Slip Op 50408(U) (App. Term, 2d Dep't 2017). The plaintiff in *Excel* directed the defendant to "request any additional information directly from the treating provider." *Id.* The Court noted that the plaintiff's response failed to "refer to any specific request or state that plaintiff was not in possession of any of the items requested by defendant." *Id.* Following receipt of the plaintiff's letter, the defendant in *Excel* elected to remain silent by not paying, denying, nor issuing a follow-up request addressing the letter. The Appellate Term, Second Department affirmed the lower court ruling and held that because the plaintiff failed to make a showing that it had provided the defendant with all of the requested medical records which were within the plaintiff's possession, the 30-day period for the defendant to pay or deny the claims did not begin to run. *Id.*

The decision in *Excel* is of note in that it confirms that there is at least a minimum showing that a plaintiff provider must make for its response to be deemed sufficient. *See also*, D & R Medical Supply v. American Transit Ins. Co., 32 Misc. 3d 144(A) (App. Term, 2d Dep't 2011) (holding that a provider's response was insufficient where it "merely stated that the supplies at issue had been provided pursuant to a doctor's prescription and did not advise defendant of the name of the doctor who had issued the prescription or where the doctor was located so that defendant could try to obtain the requested information from the prescribing doctor.").

Does this imply that an insurer need not respond if a response is incomplete?

Absolutely not. In fact, the insurer should respond within 30 days of receipt of any response. Although case law may appear to be in favor of insurers in terms of incomplete responses, in practice, the onus is on insurers to respond to ANY submissions made, complete or incomplete. The cases mentioned above were extremely nuanced and should not draw any inference that insurers can freely ignore incomplete or unresponsive submissions.

In fact, courts prefer that an insurer take action and advise the provider of any deficiencies in the provider's response rather than remaining silent. The courts have reasoned that to allow otherwise would in effect provide defendant with the means of delaying payment of the claim indefinitely while the provider believes it has provided a sufficient response. *See,* All Health Medical Care, P.C. v. GEICO, 2004 NY Slip Op 24008 (Civ. Ct., Queens Co. 2004); Media Neurology, P.C. v. Countrywide Ins. Co., 2008 NY Slip Op 51902(U) (Civ. Ct., Kings Co. 2008). If a response is incomplete, the best practice is to send a letter to the provider acknowledging receipt of the items received, and advising them of the outstanding items.

Moving Forward…

Why must it be so complicated? The nuances consistent with the 120-day rule will continue to be litigated and arbitrated. Now that providers' claims can be denied for failure to provide verification, the creativity level to avoid complying with verification requests has increased.

Often there is disagreement between providers and insurers as to whether responses are complete or objections are valid. The problem really escalates when there is constant back and forth between the parties regarding these issues. Often, providers will merely respond to requests with objections that the request is "overly broad and outside the scope of verification". To which an insurer can essentially respond and say that nothing is outside the scope of verification of a specific claim. This back and forth is a game of provider-insurer tug of war. There is no real resolution as to whether the verification is complete, or whether the request was appropriate until the provider files for arbitration or commences litigation.

The takeaway here is that if there is *anything* outstanding or problematic with the provider's response, make sure you address it in writing to preserve your position.

Verification Issues in Litigation & Arbitration Today

One common issue arising in litigation is establishing non-receipt of verification by insurers. The case law on this issue is troubling and conflicting. Insurers bring motions for summary judgment including affidavits attesting to non-receipt of the requested verification. These affidavits have been held to be conclusory and insufficient by courts based on a failure to adequately describe the office practices and procedures regarding the receipt and processing of incoming mail. In other words, courts are essentially requiring a sufficiently detailed showing of procedures in retrieving, opening, and indexing mail and in maintaining files on existing claims in order for insurers to prevail. E4 Servs., Inc. v National Liab. & Fire Ins. Co., 2014 NY Slip Op 51124(U)(App. Term 1st Dep't 2014) The troubling part? The fact that there are a number of Appellate Term cases that found affidavits by the owners of medical facilities sufficient to give rise to a presumption that the requested verification had been mailed to and received by defendants, without attaching the verification that was purportedly mailed, or including the alleged dates that the verification was mailed. Compas Med., P.C. v Praetorian Ins. Co., 2015 NY Slip Op 51776(U)(App. Term 2d Dep't 2015) Seems like a serious double standard.

Another issue is *where* providers are sending their responses. Insurers have offices all over the country. Providers seem to have free range as to where they send their responses, placing yet another burden on insurers to direct those responses to the correct department. In fact, 11 NYCRR 65-.3.5(b) states:

> "…If a claim is received by an insurer at an address other than the proper claims processing office, the 15 business day period for requesting additional verification shall commence on the date the claim is received at the proper claims processing office. In such event, the date deemed to constitute receipt of claim at the proper claim processing office shall not exceed 10 business days after receipt at the incorrect office."

Whether the provider mails their response or faxes it is irrelevant so long as they can prove that it was sent to an insurer's office.

Interestingly enough, the tide on this issue may be turning toward the insurer. Some arbitrators have started to recognize the inherent inequity and burden of this reading of the regulation. For example, in the Matter of Precision Imaging of New York v. Allstate, AAA Case # 17-15-1018-1181, the arbitrator held that it was inappropriate for the provider to mail verification responses to Allstate's claims processing center in Iowa, when the requests specifically stated that the responses should be sent to its Brooklyn office. The arbitrator went on to say that: "It is not up to the Applicant to unilaterally decide at which address it will correspond with Respondent, especially when the verification requests contain explicit instructions as to where the responses should be sent."

Similarly, in the Matter of 21st Century Pharmacy, Inc. v. Allstate, AAA Case # 41-17-1034-0550, the arbitrator held that Applicant's mailing of verification responses to Allstate's facility in Iowa was not in compliance with the verification requests that clearly informed them to send their responses to the Brooklyn address. This is a good development for insurers, and hopefully, with proper knowledge and effective advocacy, it will eventually become the norm.

Conclusion

So the question remains: are verification requests really an effective tool or rather, an added burden on insurers?

Requesting verification is a concept that was originally designed to be an effective tool for insurers. Ideally, it gives insurers the right to request information that can be vital to their investigations against fraudulent providers. Whether seeking financial information to verify a provider's business or reports regarding a specific treatment administered to a particular patient, the concept established that providers have the duty to cooperate with insurers and provide whatever information necessary in order for insurers to determine whether a claim is compensable.

However, as with all areas of the law, limits must be established to prevent insurance companies from going on "fishing expeditions" or using this tool to unfairly delay or deny claims. So the courts, as mentioned in the various cases above, attempted to establish those limits. This resulted in a higher burden being placed on insurers with regards to the reasons to request further verification, as well as to the sufficiency of the responses to verification received by providers. Knowledge of the regulations and emerging case law is key to keeping up with this ever evolving aspect of no-fault law. The one definitive rule is that remaining silent to a provider's response can be detrimental to an insurer's defense in court.

To further complicate things, in an instance where there is a fraudulent provider that an insurer is investigating for Mallela issues, it is extremely tricky for an insurer to request information without "giving the treasure map" to the provider of its investigation. How far must an insurer go to comply with the regulations without compromising its position?

So, to answer the question as to whether verification requests really are an effective tool: Absolutely yes. **BUT**, only if they are issued timely and properly. When executed with precision, verification requests and the responses that follow serve as an integral part of the claims process and SIU investigations. As highlighted above, it is imperative for insurers to have their proverbial ducks in a row when requesting verification, or risk having entire investigations run aground on seemingly meaningless technicalities.