



**STATE OF NEW YORK  
INSURANCE DEPARTMENT**  
25 BEAVER STREET  
NEW YORK, NEW YORK 10004

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Governor

Gregory V. Serio  
Superintendent

The Office of General Counsel issued the following opinion on September 2, 2004, representing the position of the New York State Insurance Department.

**RE: No-Fault Denials**

**Question Presented**

After a No-Fault insurer has denied all future benefits for continued treatment by a health provider of an eligible injured person based upon the negative findings of an insurer's medical examination of that person, must the insurer continue to issue denials for claims for continued treatment which are submitted subsequent to the issuance of the denial for all future benefits?

**Conclusion**

Yes. Pursuant to Section 5106(a) of the Insurance Law and Sections 65-3.8(a)(1) and 65-3.8(c) of Department No-Fault Regulation 68, whenever a No-Fault provider submits a claim for reimbursement to an insurer, the insurer must pay or deny the claim within 30 calendar days after receipt of proof of claim. There is no provision in either the No-Fault statute or regulation which relieves an insurer of the obligation to pay or issue a denial on all claims for benefits submitted. Neither does the statute or regulation relieve an applicant for benefits of their responsibility to submit claims in order to be eligible for the payment of benefits, even after receiving a denial of all future benefits.

**Facts**

The inquirer represents an insurer and presents a situation where, as a result of a negative Chiropractic insurer medical examination ("IME"), the insurer has issued a denial of all future claims for chiropractic services rendered. The chiropractor has continued to treat the eligible injured person notwithstanding this denial and has continued to submit claims for reimbursement for services rendered. The inquirer questions whether it is necessary for the insurer to continue to issue future

denials for these additional claims submitted. For purposes of the inquirer's question, the Department assumes that all claims for payment and all denials of claims were submitted and issued on a timely basis.

## **Analysis**

N.Y. Ins. Law § 5106(a) states that "Payments of first party benefits shall be made as the loss is occurred. Such benefits are overdue if not paid within thirty days after the claimant supplies proof of the fact and amount of loss sustained."

N.Y. Code R. & Regs. tit. 11 § 65-3.8(a)(1) (2002) (Department Regulation 68), states that in the section entitled "Payment or denial of claim (30 day rule)", it is stated that "No-fault benefits are overdue if not paid within thirty calendar days after the insurer receives proof of claim, which shall include verification of all of the relevant information requested pursuant to section 65-3.5 of this subpart...". Section 65-3.8(c) simply states "Within 30 calendar days after proof of claim is received, the insurer shall either pay or deny the claim in whole or in part."

With respect to requesting reimbursement for health services rendered (i.e. "loss"), under the prescribed New York No-Fault endorsement found in N.Y. Code R. & Regs. tit. 11 § 65-1.1(d) (2002), under the Proof of Claim provision for medical claims, it states that "In the case of a claim for health service expenses, the eligible injured person or that person's assignee or representative shall submit written proof of claim to the Company, including full particulars of the nature and extent of injuries and treatment received and contemplated, as soon as reasonably practicable but, in no event later than 45 days after the date services are rendered...".

Accordingly, the obligation of an applicant to submit timely claims to be eligible for reimbursement remains continuous, irrespective of whether an insurer has denied a claim and indicated that all future claims will be denied. Once an insurer is in receipt of a subsequent claim, pursuant to Section 65-3.8 (c), the insurer must issue a timely 30 day denial. Even when a claim is submitted after the insurer indicated it would not pay future benefits, based upon the negative findings of the insurer's medical examination, the insurer's obligation to pay or deny that claim within 30 days remains.

It should be noted that while in the inquirer's facts the inquirer states that "the claim has been properly denied on numerous occasions...", that, of course, presumes that the results of the insurer's medical examination would be sufficient to overcome the proof of claim presented by an applicant for benefits when the denial is disputed and goes to arbitration or court for resolution. If it is determined that the claims for health services denied based upon the IME were, in fact, medically necessary, the fact that an applicant may not have submitted additional bills based upon the previous IME may serve to time-bar the payment of subsequent claims.

Accordingly, an applicant for benefits must also continue to submit their claims on a timely basis in order to protect their rights to reimbursement, in the event that it is ultimately established that the services rendered were medically necessary despite a negative IME report.

For further information one may contact Supervising Attorney Lawrence M. Fuchsberg at the New York

City Office.