STATE OF NEW YORK

Court of Appeals

APL-2017-00225

ANDREW CAROTHERS, M.D., P.C.,
A/A/O AUDREY WHITE,

Plaintiff-Appellant,

vs.

PROGRESSIVE INSURANCE COMPANY,

Defendant-Respondent.

Appellate Division Docket Number: 2013-10969.
Richmond County Index Number: 2217/06.

AMICUS CURIAE BRIEF ON BEHALF OF THE COALITION AGAINST INSURANCE FRAUD

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CORPORATE DISCLOSURE STATEMENT

In compliance with Rule 500.1(f) of the Rules of Practice for the Court of Appeals of the State of New York, The Coalition Against Insurance Fraud states the following:

1. The Coalition Against Insurance Fraud, Inc. is a corporation created June 2, 1993.
2. The Coalition Against Insurance Fraud, Inc. has neither parents, subsidiaries, nor affiliates.

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INTRODUCTION AND INTEREST OF THE AMICUS

The Coalition Against Insurance Fraud ("the Coalition") respectfully submits this Amicus Curiae brief in support of affirming the decision of the Appellate Division, Second Department, on appeal before this Court.

The Coalition is a national alliance uniting and advancing the interests of consumers, insurers, and government agencies in the pursuit of combating insurance fraud. The Coalition has been defending and empowering the interests of these diverse groups since 1993. This mission is ongoing and includes identifying court cases, such as the instant one, that present opportunities to bolster the legal doctrines which help to prevent insurance fraud.

This case presents the New York Court of Appeals with a compelling opportunity to reinforce the holding of this Court in *State Farm Mut. Auto. Ins. Co. v Mallela*, 4 NY3d 313 (2005), which validated 11 NYCRR 65-3.16 (a)(12) and recognized the "fraudulent incorporation" defense as a legitimate basis for the denial of no-fault claims to medical providers. This Court in *Mallela* was clear in laying out the requirements for investigating a medical provider suspected for fraudulent incorporation and reconsideration of these criteria is unnecessary. The holding in *Mallela* is consistent with the insurance laws of this state and is in line with the public policy goal of combating insurance fraud in the no-fault system.

The effects of reversing or modifying the holding in *Mallela* would be widespread throughout the insurance industry and would greatly dampen the intended effect of combating fraud in the no-fault system. Lessening the effect of *Mallela* and, thus, 11 NYCRR 65-3.16 (a)(12), would surely require insurance companies to pay no-fault claims to fraudulent or unlicensed medical providers who should not be entitled to such payments. The cost of these unwarranted payments would be passed on to consumers and policyholders, who would see an increase in premiums, undermining one of the primary goals of the no-fault system.

Additionally, a ruling modifying or reversing the holding in *Mallela* would create inconsistencies and confusion in New York Law. Such a ruling would not only be contrary to current regulations and long-established common law doctrines, but would further confuse the obligations that insurers and medical providers have under the no-fault system. Alternatively, a ruling that upholds and re-affirms the decision in *Mallela* will serve to reinforce the need for protecting New York residents from fraudulent and corrupt medical service providers.

Lastly, the long-term effect of overruling or otherwise compromising the decision in *Mallela* would be the equivalent of this Court legalizing the corporate practice of medicine. Without 11 NYCRR 65-3.16 (a)(12) as a clear defense to the payment of ineligible claims, insurance companies would be forced

to pay medical providers regardless of their organizational structure. The striking down, or even weakening, of the *Mallela* defense would give a green light to those seeking to defraud insurance companies, and through them their policyholders, by taking advantage of what would be an enormous vulnerability in the no-fault system.

FACTUAL BACKGROUND

At trial the jury found, among other things, that the appellant was fraudulently incorporated. Although the appellant refers to this as a "*Mallela* violation", the respondent insurers' defense is actually based on 11 NYCRR 65-3.16 [a][12]) (Appellant's Brief, p. 26). The Appellate Term upheld this finding (Appellant's Brief, p. 28) and the Appellate Division, Second Department, unanimously affirmed the findings of the lower courts regarding the *Mallela* violation and the propriety of the jury charge regarding the same (Appellant's Brief, p. 29).

The appellant now seeks review of the Second Department's decision. While there are many issues raised on this appeal, the Coalition is primarily concerned with the appellant's argument regarding the trial court's jury charge for fraudulent incorporation. According to the appellant's brief, "at the core of this appeal is the scope of a *Mallela* violation itself, which includes the trial court's *Mallela* jury charge" (Appellant's Brief, p. 25).

Appellant argues that its case is both factually distinguishable from *Mallela* and that it was an error for the trial court to develop a charge on the fraudulent incorporation defense that "included more than 13 separate factors" and did not "mention fraud or fraudulent intent" (Appellant's Brief, pp. 25-6).

However, beyond merely arguing that *Mallela* is distinguishable or that the trial court's jury charge was made in error, the appellant has expanded its argument in a seeming attempt to actively do violence to the doctrine based on this Court's decision in *Mallela.*

The appellant argues in its brief that "[i]n the years since *Mallela* was decided... the insurance industry has used that decision to expand its holding and justify non-payment of no-fault medical claims that this Court never contemplated" (Appellant's Brief, p. 7). The appellant also argues that "*Mallela* has been improperly expanded and fundamentally misapplied by the lower courts" (Appellant's Brief, p. 8).

The arguments made by the appellant regarding this Court's decision in *Mallela* are inaccurate and unnecessary. Far from only requesting review of the specific application of *Mallela* to its case at the trial level, the appellant has attempted to use its platform to publicly lobby against 11 NYCRR 65-3.16 (a)(12) and New York doctrine regarding fraudulent incorporation in general. The appellant has launched an unwarranted attack on a case that has been vital to combating fraud in New York's insurance marketplace merely because the appellant believes that case has been invoked to its detriment.

As such, the Coalition Against Insurance Fraud has filed this amicus brief, respectfully requesting that the Court reject the appellant's arguments

regarding the *Mallela* doctrine and affirm the standards and holdings set forth by that case and its progeny, including the decision of the Appellate Division, Second Department, presently before the Court.

ARGUMENT

POINT I

HISTORY OF COMBATING FRAUD IN THE NEW YORK NO-FAULT SYSTEM

In 1973, the New York legislature enacted the Comprehensive Automobile Insurance Reparations Act, commonly known as the no-fault law. The goal of the no-fault law was to promote "the prompt payment resolution of injury claims, limiting costs to consumers and alleviating unnecessary burdens on the court." *Pommels v Perez,* 4 NY3d 566 (2005).

The state set out to accomplish this goal through a regulatory system that imposed strict time limitations on insurers and medical providers for the processing and payment of no-fault claims. Initially, there were no regulations that explicitly allowed insurers to identify, investigate or deny claims to unlicensed or fraudulently licensed medical providers. Unfortunately, this meant that the system was ripe for exploitation by individuals who sought to manipulate the system in an effort to defraud insurance companies and their policyholders.

A. THE PROBLEM OF MEDICAL PROVIDER FRAUD

This Court recognized that widespread insurance fraud had become a major issue for New York's no-fault system by 1999 and that combating such fraud became a priority for the then-called New York State Department of Insurance. *Med. Soc'y v Serio*, 100 NY2d 854, 861 (2003).

In *Med. Soc'y*, this Court highlighted this abuse in the no-fault system in deciding whether the superintendent of the Department of Insurance had the authority to promulgate regulations to combat fraud. *Id.* at 861. The Court noted that between 1992 and 2001, reports of suspected automobile insurance fraud rose by 275%, the majority of which occurred under the no-fault system. *Id.*

This Court noted that "reports of no-fault fraud rose from 489 cases in 1992 to 9,191 in 2000, a rise of more than 1700%" and described the typical scheme that was used to commit such fraud as follows:

> Specifically, ringleaders (often associated with organized crime) would purchase minimum automobile insurance, perhaps under a fraudulent name, on wrecked or salvaged vehicles, and recruit others to fill up the vehicles and participate in staged accidents (typically sideswipes or fender benders). Those purported victims were then steered to corrupt medical clinics, called "medical mills," where they feigned aches, pains and soft tissue injuries. The medical mills would then generate stacks of medical bills for each passenger, detailing treatment and tests that were unnecessary or never performed.

Id. at 861.

Key to this scheme to defraud insurers was the use of "corrupt medical clinics" that could abuse the timing requirements of the no-fault system, which place a heavy burden of compliance on insurance carriers and grant the benefit of the doubt to the medical providers submitting bills. Because of this

imbalance, the Department of Insurance estimated that the rise in insurance fraud was costing policyholders $100 more per year in premiums. *Id.* at 861.

To combat the widespread problem of fraud in the no-fault system, the Department of Insurance decided to balance the goal of prompt payment with the goal of giving insurers the tools necessary to detect and investigate fraud within the system. The Superintendent of Insurance set up a no-fault unit within the Frauds Bureau and began promulgating amendments to the regulation including "a reduction in the time frames applicable to the filing of notices and proofs of claim – a consequence of the Superintendent's determination that much of the abuse was associated with the lengthy time frames within which claims could be presented to insurers." *Id.* at 861-862.

In the notice of adoption for the revised regulation, the Superintendent noted that "the Insurance Department is taking this action in order to implement a new regulation which will ensure that the public receives the benefit of reduced fraud and abuse provided by the proposed regulation at the earliest possible moment." *Id.;* 2001-19 NY St. Reg. 17.

In deciding whether the Superintendent had the authority to make such amendments to the regulation, this Court held that:

> [the Superintendent's] expert judgment that the reduced time frames will not have the effect of excluding a significant number of legitimate claims is not to be second-guessed by the courts. As represented at oral

> argument by counsel for respondents, in the year and a half that the regulations have been in effect, petitioners' predictions that thousands of innocent accident victims will fail to meet the new filing deadlines and be denied benefits, or that hospitals or other medical providers will prove unable to bill for services within 45 days, appear not to have materialized. In any event, the Superintendent has determined that the revised regulations are the most effective means of advancing the legislative intent of providing prompt payment of benefits as the loss is incurred, while reducing rampant abuse. That being so, this Court may not substitute its judgment for that of the Superintendent, but may determine only whether the Superintendent acted within the scope of his lawfully delegated authority. Since the Superintendent's determination was neither irrational nor unreasonable, neither arbitrary nor capricious, the regulations must be upheld.
>
> *Id.* at 867-8.

This Court's decision in *Med. Soc'y*, *supra*, set the precedent that the department responsible for regulating the no-fault law has the authority to balance the competing interests of prompt payment of claims with detection of fraud and to determine the best manner in which to amend the regulation to that end. This foundation later allowed for the this Court to validate the Superintendent's promulgation of 11 NYCRR 65-3.16 (a)(12) and to recognize that preventing the corporate practice of medicine further services the public interest of combating fraud in the no-fault system.

B. THE PROBLEM OF CORPORATE PRACTICE OF MEDICINE

An important component of the on-going effort to combat fraud in the insurance industry has been the recognition by New York courts of a long-standing common law doctrine preventing the corporate practice of medicine. This well-established doctrine provides the backbone for 11 NYCRR 65-3.16 (a)(12) and the *Mallela* defense, as further set forth below.

New York courts have long forbidden the corporate practice of medicine under the concern that it would create ethical conflicts and undermine the quality of care afforded to patients. *See, State Farm Mut. Auto. Ins. Co. v Mallela,* 372 F3d 500, 503 (2nd Cir 2004); *see, also, People v John H. Woodbury Dermatological Institute,* 192 NY 454 (1908); *AIU Ins. Co. v Deajess Med. Imaging, P.C.,* 24 Misc 3d 161 (Sup Ct, 10th Jud Dist 2009).

In writing the decision for *Metroscan Imaging P.C. v GEICO Ins. Co.,* 13 Misc 3d 35 (Sup Ct, App Term 2d Dept 2006), the Appellate Term, Second Department set forth the history of the common law doctrine influencing the *Mallela* defense and found support for it dating back almost a hundred years.

The Appellant Term found that the result in *Mallela* was in accord with the common law, which has "historically denied compensation to unlicensed providers of services for which a regulatory license is required." *See Metroscan*, 13 Misc 3d at 38; *citing, Bendell v De Dominicis,* 251 NY 305 (1929); *Spivak v Sachs,*

16 NY2d 163 (1965); *Price v Close,* 302 AD2d 374 (2d Dept 2003); *Gordon v Adenbaum*, 171 AD2d 841 (2d Dept 1991); *P.C. Chipouras & Assoc. v 212 Realty Corp.*, 156 AD2d 549 (2d Dept 1989); *Unger v Travel Arrangements*, 25 AD2d 40, 44 (1st Dept 1966).

Similarly, other cases in New York have held that proper licensing is a condition precedent to a medical provider being paid, and had done so even immediately prior to this Court's decision in *Mallela. See 563 Grand Med. P.C. v Allstate Ins. Co.,* 6 Misc 3d 1019 (Civ Ct, Kings County 2005) ("Cases in New York have held that proper licensing of a medical provider is a condition precedent to payment of benefits under the No-Fault Law." Citing *Valley Physical Medicine and Rehabilitation, P.C. v New York Central Mutual Insurance Company*, 193 Misc 2d 675 [2d Dept 2002]).

Accordingly, under the common law, even "prior to the effective date of 11 NYCRR 65-3.16 (a)(12)... fraudulently incorporated medical corporations were not entitled to recover a judgment against an insurer for assigned first-party no-fault benefits. *See Metroscan*, 13 Misc 3d at 39. The promulgation of 11 NYCRR 65-3.16 (a)(12) by the Superintendent of insurance "merely codified the common-law rule to the extent that it barred recovery by unincorporated or fraudulently incorporated medical service providers for first-party no-fault benefits." *Id.*

As noted above, this Court has regularly determined that the promulgation of insurance regulations is well within the scope of authority for the Superintendent of the Department of Insurance (now the Department of Financial Services) and the "interpretation, if not irrational or unreasonable, will be upheld in deference to his special competence and expertise with respect to the insurance industry, unless it runs counter to the clear wording of a statutory provision." *New York Public Interest Group v New York Dept. of Ins.,* 66 NY2d 444, 448 (1985); *see also Kurcsics v Merchants Mut. Ins. Co.,* 49 NY2d 451, 459 (1980).

In amending the regulation on September 21, 2004, the Superintendent issued a notice of adoption responding to concerns that the "proposed regulation is inconsistent with the no-fault enabling legislation." 2004-40 NY St. Reg. 12. In doing so, he noted that there was "nothing in the legislation that would exempt health providers from having to meet all New York licensing requirements." *Id.* He also noted a number of situations, which were intended to be addressed by the regulation, including ones where "corporations have had their income siphoned off by management companies through costly rental agreements, billing and maintenance services." *Id.*

This set the ground-work for this Court's decision in *Mallela,* discussed further below, where this Court noted that the Superintendent

promulgated 11 NYCRR 65-3.16 (a)(12) to "combat rapidly growing incidences of fraud in the no-fault regime, fraud that he has identified as correlative with the corporate practice of medicine by non-physicians." *Id.* at 320 n 2.

Given the foregoing, any adverse ruling against the holding in *Mallela*, and its validation of 11 NYCRR 65-3.16 (a)(12), would undermine the longstanding public policies in New York of combating fraud in the no-fault insurance system and preventing the corporate practice of medicine. It would also require this Court to review its decision in *Serio*, which granted authority and deference to the department responsible for promulgating regulations with respect to the no-fault system. A challenge to this Court's holding in *Mallela* is essentially a challenge to the authority of the Department of Financial Services and its efforts to combat fraud and protect patients from improperly licensed medical providers.

POINT II

THE *MALLELA* DECISION

The Coalition's primary concern with respect to this matter is preserving and reinforcing this Court's decision in *State Farm Mut. Auto. Ins. Co. v. Mallela*, 4 NY3d 313 (2005).

In writing its decision in *Mallela*, this Court held that "insurance carriers may withhold payment for medical services provided by fraudulently incorporated enterprises to which patients have assigned their claims." *Id.* at 319.

Specifically, this Court answered the Second Circuit's certified question of whether:

> a medical corporation that was fraudulently incorporated under N.Y. Business Corporation Law §§ 1507, 1508, and N.Y. Education Law § 6507 (4)(c) [is] entitled to be reimbursed by insurers, under New York Insurance Law §§ 5101 *et seq.*, and its implementing regulations, for medical services rendered by licensed medical practitioners (372 F.3d 500, 510 [2004]).

This Court answered that "such corporations are not entitled to reimbursement." *Id.* at 320.

In making its holding, this Court specifically upheld as "valid" (*Id.* at 321) the regulation set forth at 11 NYCRR 65-3.16 (a)(12), which "excluded from the meaning of 'basic economic loss' payments made to unlicensed or fraudulently licensed providers, thus rendering them ineligible for reimbursement." *Id.* at 320. Moreover, this Court noted the importance of this regulation in allowing carriers to "look beyond the face of licensing documents to identify willful and material failure to abide by state and local law." *Id.* at 321.

In its brief, the appellant erroneously ascribes the basis of the fraudulent incorporation defense to this Court's decision in *Mallela*. It is important to note, however, that this Court did not create the fraudulent incorporation defense in *Mallela*; it merely recognized that 11 NYCRR 65-3.16 (a)(12), which permits insurers to deny no-fault benefits to fraudulently incorporated providers, was valid and supports insurers' investigations into this issue. To this extent, this Court did

set forth some guidelines regarding when it would generally be appropriate for an insurer to conduct such an investigation.

In responding to the medical provider's concern that the regulation would be used as a "vehicle for delay and recalcitrance" (*Id.* at 322), this Court explicitly stated that the regulatory scheme "does not permit abuse of the truth-seeking opportunity" that the regulation authorizes, noting that an insurance company would be unable to show "good cause" for an investigation unless it could demonstrate "behavior tantamount to fraud." *Id.* at 322. As to what "behavior tantamount to fraud" meant, this Court stated that "[t]echnical violations will not do" and set forth specific examples of technical violations that "will not rise to the level of fraud" such as "failure to hold an annual meeting, pay corporate filing fees or submit otherwise acceptable paperwork on time[.]" *Id.* at 322.

In other words, this Court already built a "firewall" into the *Mallela* decision to prevent overreaching by insurance companies that would invoke 11 NYCRR 65-3.16 (a)(12). The holding of *Mallela*, and the application of 11 NYCRR 65-3.16 (a)(12), are clearly limited to those providers who are suspected of being fraudulently incorporated for some reason more than a mere technical violation.

Through *Mallela*, this Court showed its clear support for the Superintendent of Insurance's conclusion that 11 NYCRR 65-3.16 (a)(12) was

necessary to help curtail fraud in the no-fault system. The public policy effect of such a decision is obvious. Fraudulently incorporated medical providers inherently lead to higher costs, less effective medical treatment, and an overall mistrust of the no-fault system. When a medical provider is billed inflated rates for routine services, the burden of these costs are inevitably passed down to consumers and policyholders.

However, even in supporting 11 NYCRR 65-3.16 (a)(12) and its stated policy goal of reducing fraud in the no-fault system, this Court was conscious of the potential for inappropriate investigations and denials of payments due to unnecessarily investigating or withholding reimbursement from legitimate medical providers.

In limiting the extent to which insurers could investigate suspected *Mallela* violations, this Court struck a balance between these competing concerns and was able to create a narrow but effective tool that insurers may use to deny claims to fraudulently incorporated providers while providing protection to legitimate providers. In practice, the standard has worked exactly as the Court intended and the appellant only attacks it on this appeal because it has been invoked to the appellant's detriment.

POINT III

THE CASE ON APPEAL DOES NOT REQUIRE THE COURT TO DISTURB *MALLELA*

The appellant seeks review of the Second Department's decision in *Andrew Carothers, M.D., P.C. v Progressive Ins. Co.* (150 AD3d 192 [2d Dept 2017]) because, among other reasons, the appellant believes that its case is factually distinguishable from *Mallela* and that it was an error for the trial court to develop a charge on the fraudulent incorporation defense that "included more than 13 separate factors" and did not "mention fraud or fraudulent intent" (Appellant's Brief, pp. 25-6).

However, beyond merely arguing that *Mallela* is distinguishable or that the trial court's jury charge was made in error, the appellant has expanded its argument in a seeming attempt to actively do violence to the doctrine based on this Court's decision in *Mallela*. To this extent, the appellant's brief contains an entire point of law titled: "As generally interpreted since 2005, and as specifically applied in this case, *Mallela* is inconsistent with no-fault insurance laws and applicable insurance regulations" (Appellant's Brief, p. 45).

Not content with merely asserting that the lower courts misapplied the holding of *Mallela* to the facts of its case or to the jury charge at issue, the appellant has taken the dramatic, and unsupportable, position that the very holding of *Mallela* itself is no longer legitimate or consistent with New York laws and

regulations. It is difficult to imagine what the appellant could have intended by stating that *Mallela* is "inconsistent" with the "applicable insurance regulations" as one of those regulations must surely be 11 NYCRR 65-3.16 (a)(12), which *Mallela*, itself, validated.

The Coalition urges the Court that it is entirely unnecessary to review *Mallela* and 11 NYCRR 65-3.16 (a)(12) with the severity urged by the appellant. This appeal can be decided by merely determining whether the trial court properly instructed the jury with respect to the fraudulent incorporation defense in the underlying trial. This is exactly how the Second Department, appropriately, framed and decided the issue. ("In sum, the jury charge, read as a whole, adequately conveyed the correct legal principles on 'fraudulent incorporation' as established by *Mallela*." *Andrew Carothers, M.D., P.C. v Progressive Ins. Co.*, 150 AD3d 192, 203 [2d Dept 2017]).

The appellant begins its brief by arguing that *Mallela* has been "expanded and weaponized to avoid paying no-fault claims without regard to the merit of the claims themselves" (Appellant's Brief, p. 3). However, in this same paragraph, the appellant states that the "trial below is the first known jury trial of a *Mallela* defense" (Appellant's Brief, p. 3).

Firstly, if the above is true, it is difficult to imagine how the appellant can believe that *Mallela* has been effectively "weaponized" by insurance carriers if

there has only been a single jury trial on the issue in the past 13 years. If *Mallela* has been "weaponized", at all, it has been done solely to protect New York consumers from fraudulent medical providers and the higher insurance premiums they cause.

Secondly, the appellant consistently mistakes this Court's decision in *Mallela* for the source of a fraudulent incorporation defense, rather than 11 NYCRR 65-3.16 (a)(12), as would be proper. If anything, the appellant evidently means to say that this single provision of the regulation has been "expanded and weaponized." Such an assertion would still be incorrect, but the appellant's frequent attacks on this Court's decision in *Mallela* are misguided. As laid out above, *Mallela* recognized the validity of 11 NYCRR 65-3.16 (a)(12) and laid out guidelines for investigations of suspected fraudulent incorporation; it did not, in and of itself, serve as the source for the defense at issue in this suit.

The appellant attempts to further support its argument when it cites to a "very recent example of abuse of *Mallela*" in the case of *Matter of Country-Wide Ins. Co. v Bay Needle Care Acupuncture, P.C.*, 162 AD3d 407 (1st Dept 2017). (Appellant's Brief, p. 45, n. 11). This case is merely the denial of a petition to vacate an arbitration award in which a AAA arbitrator held that the insurer had "failed to meet its burden of providing clear and convincing evidence of fraudulent incorporation." *Id.* This case makes no determination regarding the appropriateness

of the underlying insurer's investigation and merely states that the arbitrator and master arbitrator were within their powers in making their decisions.

Another case cited by the appellant, *Masigla v United Servs. Auto. Ass'n*, 58 Misc 3d 147(A) (Sup Ct, App Term, 2d Dept 2018), did not even make a decision with respect to the carrier's fraudulent incorporation defense. It merely stated that the plaintiff's tax returns were not discoverable while holding that the plaintiff "has not demonstrated that the remaining items at issue are privileged or palpably improper." *Id.* at 3.

The appellant also cites to *Pro-Align Chiropractic, P.C. v Travelers Prop. Cas. Ins. Co.*, 58 Misc 3d 857 (Dist Ct, 3d Dist Suffolk County, 2017), a case in which an insurer did not even deny the claim for fraudulent incorporation but for "the failure of plaintiff's assignor to fully comply with defendant's written verification requests, thereby rendering the action premature." *Id.* at 858. This case only tangentially involves a *Mallela* defense insofar as the insurer was evidently seeking verification regarding suspected fraudulent incorporation. Id. at 866.

These cases, according to the appellant, show that "*Mallela* is spawning complex and convoluted litigation issues in violation of the goals of no fault." (Appellant's Brief, p. 45).

Quite to the contrary, these cases are evidence that the *Mallela* decision is working as intended. These cases show that arbitrators and trial-level

courts are making factual determinations to ascertain whether insurers are investigating conduct that is "tantamount to fraud" or whether they are potentially overreaching and withholding reimbursement to non-fraudulent providers. Such cases are inevitably going to exist if the standard set forth in *Mallela* is working properly.

Indeed, it would be more disturbing if there were no cases at all in which a court or arbitrator ever found that an insurance company overstepped itself in identifying "technical violations" rather than behavior that is "tantamount of fraud." To the contrary, lower level courts and arbitrators have clearly taken the precautions acknowledged by this Court to heart and have engaged in the exact sort of balancing act encouraged by *Mallela.*

Of course, the appellant's cherry-picked cases in its brief also ignore the great majority of medical providers across the state who are routinely reimbursed medical benefits without ever falling under suspicion of having been fraudulently incorporated. However, the appellant evidently believes that the mere existence of litigation regarding the application of 11 NYCRR 65-3.16 (a)(12) is somehow proof that it has been "expanded and weaponized." In actuality, the cases cited by the appellant, at most, only cite to *Mallela* and do nothing to expand the holding of this Court.

To the contrary, a review of the case law after the *Mallela* decision shows that the courts actually attempted to *limit* the use of the *Mallela* defense by imposing more specific requirements and limitations as how insurers may investigate the same.

For example, in *Concourse Chiropractic, PLLC v State Farm Mut. Ins. Co.,* 35 Misc 3d 1213(A) (Dist Ct, Nassau County 2012), *mod by* 42 Misc 3d 131(A), the court was presented with the issue of whether an insurer could request documents in advance of an EUO in relation to a potential *Mallela* defense. *See Id.* The court held that nothing in the no-fault regulations allowed an insurer to make such demands as part of an EUO or verification requests. It found the requests for voluminous corporate records to be impermissible and improper, and "an abuse of the EUO and the entire verification process." *See Id.*

While the trial-level decision in *Concourse* was later modified, it is difficult to imagine how one could read such a case as the "expansion" of this Court's decision in *Mallela*, which allows for fact-finding courts to determine under what circumstances an insurer properly investigates a fraudulent incorporation defense. If anything, courts have attempted to limit the extent to which insurers may conduct such investigations.

The appellant's lament that courts have gone "down the slippery slope departing from the clear mandate in *Mallela* that payment ineligibility requires

"behavior tantamount to fraud,'" appears to have very little to do with New York courts in general and everything to do with the specific court that declined to issue the appellant's requested jury instruction.

As such, not only is the appellant's argument concerning *Mallela* unnecessarily broad, even if tailored to the specific facts of the appellant's case, it ignores a number of cases that have found that the *Mallela* requirement of establishing "good cause" by showing "conduct tantamount to fraud" only applies when an insurer is delaying payment for an investigation, not when the insurer and medical provider have become litigants to an action. *See*, *Matter of Travelers Indem. Co. v Milan Med., P.C.*, 2009 NY Slip Op 31604(U) (Sup Ct, New York County 2009).

Once in litigation, an insurer need not demonstrate "good cause" for requesting corporate documents, and instead must show that the documents requested are "material and necessary in the prosecution of the action." *One Beacon Ins. Group, LLC v Midland Med. Care, P.C.,* 863 NYS2d 728, 741 (2nd Dept 2008); *See* CPLR 3101 (a). What is "material and necessary" is left to the sound discretion of the court and includes "any facts bearing on the controversy which will assist preparation for trial by sharpening the issues and reducing delay and prolixity. The test is one of usefulness and reason." *Lexington Acupuncture,*

P.C. v General Assur. Co., 35 Misc 3d 42 (App Term, 2d Jud Dept 2012); *See also, Allen v Crowell-Collier Publ. Co.*, 21 NY2d 403, 406 (1968).

As such, one could imagine that similar standards would apply once a defense premised on 11 NYCRR 65-3.16 (a)(12) goes to trial. Neither *Mallela* nor any other reported New York decision provides that such a defense can only be upheld where the insurer has proven behavior "tantamount to fraud." If anyone is seeking to over-interpret *Mallela*, it is seemingly the appellant who is doing so, by arguing that this Court's holding as it relates to "delay[ing] the payment of claims to pursue investigations" extends to an insurer's burden at trial to support a denial under 11 NYCRR 65-3.16 (a)(12).

Regardless, while the appellant engages in hyperbole regarding the need to review the very foundation of *Mallela* itself ("the decision has spawned a cottage industry of litigation") (Appellant's Brief, p. 51), it is clear that the appellant's disagreement lies only in the trial court's jury charge regarding the "tantamount to fraud" language. It is certainly possible to review whether the trial court properly instructed the jury in the context of this case, as did the Second Department, without reviewing the underlying basis and wisdom of the holding in *Mallela* or an insurer's right to rely upon 11 NYCRR 65-3.16 (a)(12) in order to investigate and potentially deny benefits on the basis of fraudulent incorporation.

CONCLUSION

For the reasons given above, the Coalition Against Insurance Fraud respectfully submits that the decision of the Appellate Division, Second Department, should be affirmed, specifically with respect to its holding as pertains to fraudulent incorporation and the *Mallela* defense.

DATED: Buffalo, New York
January 8, 2019

Respectfully submitted,

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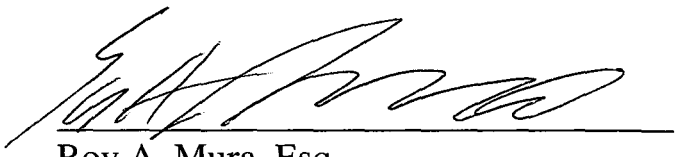
PRINT AND WORD COUNT CERTIFICATION

The undersigned hereby certifies pursuant to the Court of Appeals Rules of Practice 500.13(c)(1) that this brief was prepared on a computer using the word-processing system, Microsoft Word. A proportionally-spaced typeface, Times New Roman, was used at point size 14. The brief is double-spaced. The total number of words in this brief is 6,005.

DATED: Buffalo, New York
January 8, 2019

Respectfully submitted,



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