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Superior Court of New Jersey,
Appellate Division.

NORTH JERSEY BRAIN & SPINE CENTER,
Plaintiff–Appellant,
v.
HEREFORD INSURANCE COMPANY,
Defendant–Respondent.

A-1116-13T1
|
Argued Sept. 23, 2014.
|
Decided Jan. 13, 2015.

On appeal from the Superior Court of New Jersey, Law Division, Bergen County, Docket No. L–4812–12.

**Attorneys and Law Firms**

David M. Estes argued the cause for appellant (Mazie, Slater, Katz & Freeman, L.L.C., attorneys; Mr. Estes, on the brief).

David J. Dickinson argued the cause for respondent (McDermott & McGee, L.L.P., attorneys for respondent; Richard M. Tango, of counsel; Michael W. Cartelli, on the brief).

Before Judges MESSANO and HAYDEN.

**Opinion**

PER CURIAM.

***1** In March 2011, a female New Jersey resident suffered injuries while a passenger in a livery car insured under a New York automobile policy issued by defendant Hereford Insurance Co. ("Hereford"). The policy provided no-fault, personal injury protection (PIP) benefits up to a limit of $200,000.[1] After being admitted to Hackensack University Medical Center ("the Hospital") on March 29, spinal surgery was performed upon the woman by doctors affiliated with plaintiff North Jersey Brain and Spine Center on April 2. On April 12, the patient assigned "all payments for medical services rendered" to plaintiff.

Meanwhile, on April 8, plaintiff submitted claims to Hereford for services rendered to the woman in the amount of $280,575.[2] In a letter dated April 18, Hereford notified plaintiff that processing of the claim was delayed because it had not received a "NYSID [New York State Insurance Department] PIP Application for Benefits" and the patient's complete hospital records. On April 20, plaintiff resubmitted its claim to Hereford. Hereford completed "[f]inal verification" of the claim on April 22. In her deposition, Agatha Porter, Hereford's claims supervisor, acknowledged that plaintiff's claim was "fully ready to be processed and paid" on that date.

Porter testified that because of "a delay in processing," Hereford did not present plaintiff with a reimbursement offer until July 8, 2011. She acknowledged that Hereford's policy and procedures required that all claims for PIP benefits "be processed within [thirty] days of the date of ... final verification."

Hereford's offer was $66,034.02, an amount determined by Medical Audits Bureau, Inc., a company Porter described as a "vendor [Hereford] use[d] for fee scheduling of all ... high-exposure bills, meaning any hospital surgery bills." Porter testified that plaintiff's financial manager, Lee Goldberg, rejected the offer in a July 8 email that is not part of the record. Porter informed Goldberg that Hereford intended to make a decision on the case "either way" by July 14.

Porter testified that the Hospital's bill was submitted to Hereford "[a] few days after [plaintiff's]." Porter explained the company's policy and procedure, stating, "the bill received first would be paid if there was verification, and in this particular case, the verification applied to both bills, both [plaintiff's] and the [H]ospital['s]. [Plaintiff] refused the recommended payment. The hospital bill was paid next."

On July 14, 2011, Hereford paid $150,000 to the Hospital. On the same day, Hereford denied plaintiff's entire claim because "[t]he policy limit of $200,000 under New York State No–Fault ha[d] been exhausted."

Plaintiff filed suit against Hereford, alleging breach of contract, breach of the implied covenant of good faith and fair dealing, as well as bad faith, and seeking the equitable remedy of reformation. After discovery, both parties moved for summary judgment.

  

***2** The judge denied plaintiff's motion and granted Hereford summary judgment dismissing plaintiff's complaint. The judge reasoned:

> [I]n a claim to recover no-fault insurance benefits under New York law, a defendant's failure to issue a denial of the claim within [thirty] days does not preclude a defense that the coverage limits of the subject policy have been exhausted. When a carrier has paid the full monetary limits set forth in the policy, its duties under the contract of insurance cease.... The facts are undisputed, and [d]efendant has raised a defense to plaintiff's breach of contract claim....
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> Additionally, [p]laintiff argues that Hereford was obligated to pay [p]laintiff's claim prior to [the Hospital's] claim according to New York law.... In the present case, [p]laintiff's bill was submitted to [d]efendant before [the Hospital's] bill. The bills became verified on the same day. It appears to this court that [d]efendant complied with New York law because it attempted to pay out [p]laintiff's claim first, but its offer was rejected.

The judge did not specifically address plaintiff's other causes of action. He issued conforming orders, and this appeal ensued.

Before us, plaintiff argues the judge permitted Hereford to apply the exhaustion defense "retroactively." In other words, plaintiff argues that at the time Hereford was required under New York law to pay or deny the claim, i.e., within thirty days of the claim's verification, the policy had not been exhausted. Plaintiff also argues that the judge misapplied summary judgment standards because there were disputed material facts that foreclosed the grant of summary judgment to Hereford. Lastly, plaintiff argues that the judge erred in dismissing those counts in its complaint that were not breach of contract claims.

Hereford argues that under New York law, since both plaintiff's and the Hospital's claims were verified at the same time, the company had the right to negotiate with the providers and parcel out the policy proceeds accordingly. Alternatively, Hereford was permitted to simply choose which bill to pay. As a result, even if Hereford did not process plaintiff's claim in a timely fashion as required by New York law, any delay was immaterial because plaintiff could prove no damages as a result of that breach. Hereford also contends that dismissal of plaintiff's entire complaint was appropriate because all of the claims, however couched, were dependent upon a breach of the insurance contract.

We have considered these arguments in light of the record and applicable legal standards. We reverse and remand the matter to the Law Division for further proceedings.

In reviewing a grant of summary judgment we " 'employ the same standard ... that governs the trial court.' " *W.J.A. v. D.A.*, 210 *N.J.* 229, 237 (2012) (quoting *Henry v. N.J. Dep't of Human Servs.*, 204 *N.J.* 320, 330 (2010)). We first determine whether the moving party demonstrated there were no genuine disputes as to material facts. *Atl. Mut. Ins. Co. v. Hillside Bottling Co.*, 387 *N.J.Super.* 224, 230 (App.Div.), *certif. denied*, 189 *N.J.* 104 (2006).

> ***3** [A] determination whether there exists a "genuine issue" of material fact that precludes summary judgment requires the motion judge to consider whether the competent evidential materials presented, when viewed in the light most favorable to the non-moving party, are sufficient to permit a rational factfinder to resolve the alleged disputed issue in favor of the non-moving party.
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> [*Brill v. Guardian Life Ins. Co. of Am.*, 142 *N.J.* 520, 540 (1995).]

We then decide "whether the motion judge's application of the law was correct." *Atl. Mut. Ins. Co.*, *supra*, 387 *N.J.Super.* at 231. In this regard, our review is plenary, owing no deference to the judge's legal conclusions. *Manalapan Realty, L.P. v. Twp. Comm.*, 140 *N.J.* 366, 378 (1995).

The parties agree that New York law applies. In New York, "a no-fault claimant's right (or that of his or her assignee) to recover first-party benefits derives primarily from the terms of the relevant contract of insurance." *Mandarino v. Travelers Prop. Cas. Ins. Co.*, 831 *N.Y.S.*2d 452, 454 (App.Div.2007). Pursuant to New York law, an insurer must pay benefits "within thirty days after the claimant supplies proof of the fact and amount of loss sustained." *N.Y. Ins. Law* § 5106(a) (Consol.2014); *see also N.Y. COMP. CODES R. & REGS.* tit. 11, § 65–3.8(a)(1) (2014) ("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 the relevant information requested...."). The regulations provide that within thirty days of verification, the insurer has two options: either "pay or deny the claim in whole or in part." *N.Y. COMP. CODES R. & REGS.* tit. 11, § 65–3.8(c). "If proof is not supplied as to the entire claim, the amount which is supported by proof is overdue if not paid within thirty days after such proof is supplied." *N.Y. Ins. Law* § 5106(a); *see also N.Y. COMP. CODES R. & REGS.* tit. 11, § 65–3.8(d) ("Where an insurer denies part of a claim, it *shall pay benefits* for the undisputed

  

elements of the claim. Such payments shall be made without prejudice to either party." (emphasis added)).

The regulations carefully prescribe the way a claim must be rejected. The insurer must advise the claimant that disputes may be submitted to arbitration, or that the claimant "may bring a lawsuit to recover the amount of benefits [it] claim[s] to be entitled to." *N.Y. COMP. CODES R. & REGS.* tit. 11, App. 13. Notably, even when the insurer's denial involves only "a portion of a health provider's bill," the notice must "contain[ ] substantially the same information as the prescribed form which is relevant to the claim denied." *Id.* § 65–3.8(c)(1).

Under New York's no-fault statute, "[a]ll overdue payments shall bear interest at the rate of two percent per month." *N.Y. Ins. Law* § 5106(a). Additionally, successful claimants are "entitled to recover [their] attorney's reasonable fee, for services necessarily performed in connection with securing payment of the overdue claim." *Ibid.*

***4** Here, Hereford did not pay or deny plaintiff's claim within thirty days after it was fully verified, i.e., by May 22, 2011. Hereford's only explanation for the delay was an unspecified "delay in processing" the claim. Hereford's failure amounted to a breach of the insurance contract. *Mandarino, supra,* 831 *N.Y.S* .2d at 454. "Where ... a carrier has failed to comply with the ... statutory schedule, preclusion of the insurance company's ability to deny the claim is the appropriate remedy." *Presbyterian Hosp. v. Atlanta Casualty Co.,* 619 *N.Y.S.*2d 337, 338 (App.Div.1994) (internal quotation marks omitted).

The motion judge accepted this proposition. He reasoned, however, that Hereford was entitled to raise the defense of exhaustion of the policy limits. As applied by New York courts, when "an insurer has paid the full monetary limits set forth in [a] policy, its duties under the contract of insurance cease." *Presbyterian Hosp. v. Liberty Mut. Ins. Co.,* 628 *N.Y.S.*2d 396, 397 (App.Div.1995).

Plaintiff argues that the judge erred because when Hereford breached its contractual obligations to plaintiff, the policy was not exhausted. Therefore, plaintiff contends it was entitled to summary judgment on its breach of contract claim, and Hereford was not entitled to summary judgment as a matter of law.

Several New York cases have considered the effect of an insurer's failure to comply with the statutory timelines upon the insurer's ability to later assert an affirmative defense or deny coverage. In some situations, New York courts have precluded defenses based upon the insurer's failure to timely deny a no-fault claim.

For example, in *Presbyterian Hospital v. Maryland Casualty Co.,* 683 *N.E.*2d 1, 4–5 (N.Y.1997), the Court of Appeals held "that an insurer may be precluded from interposing a statutory [5][540] exclusion defense for failure to deny a claim within [thirty] days as required by" statute. Those statutory exclusions are contained in *N.Y. Ins. Law* § 5103(b) and include claims for intentionally-caused injuries, claims resulting from intoxicated driving and claims resulting from certain violations of law; exhaustion is not one of the statutory exclusions. In *Fair Price Medical Supply Corp. v. Travelers Indemnity Co.,* 890 *N.E.*2d 233, 237–38 (N.Y.2008), the Court held that even an insurer's defense of fraud by the insured would be precluded if not asserted within the thirty-day time frame.

An entirely different line of cases have held, however, that insurers are not precluded from asserting certain defenses even if they violated the statutory timeframes. For example, in *Central General Hospital v. Chubb Group of Insurance Cos.,* 681 *N.E.*2d 413, 416 (N.Y.1997), the Court agreed that the untimely denial of the plaintiff's claim did not bar the insurer from raising a defense of lack of coverage. *See also Presbyterian Hosp. v. Atlanta Casualty Co., supra,* 619 *N.Y.S.*2d at 338 (recognizing cases in which late denial of claim did not bar insurer's defense because "the claimant, the vehicle, or the subject event was facially outside of the four corners of the insurance contract").

***5** In *Presbyterian Hospital v. Liberty Mutual Insurance Co.,* 628 *N.Y.S.*2d 396, 397 (App.Div.1995), the plaintiff claimed an insurance company's late denial of claim was untimely and therefore the defense of exhaustion was precluded. The court disagreed, concluding that "[t]he defendant's tardiness in issuing its denial of claim could not thereafter create a new policy or additional coverage in excess of the amount contracted for." *Ibid.*

A year later, in *Presbyterian Hospital v. General Accidents Insurance Co. of America,* 645 *N.Y.S.*2d 516, 517 (App.Div.1996), the same court held that exhaustion was not precluded as a defense when an insurer violated the no-fault thirty-day rule. There, the plaintiff had a $50,000 policy and made a timely demand for his no-fault benefits. *Ibid.* The insurer issued a late partial denial of claim, informing the insured that only $9,608.88 remained in the policy. *Ibid.* The court ruled that the partial exhaustion defense was permitted, stating "[a]n untimely denial of claim will not operate to preclude a defense that the coverage limits of the subject policy have been exhausted." *Ibid.* (citing *Presbyterian Hosp. v. Liberty*

  

*Mut. Ins. Co., supra*, 628 *N.Y.S.*2d at 396). The Court reasoned "[t]he defendant's tardiness in issuing its denial of claim could not thereafter create a new policy or additional coverage in excess of the amount contracted for." *Ibid.* (citing *Zappone v. Home Ins. Co.*, 432 *N.E.*2d 783 (N.Y.1982); *Albert J. Schiff Assocs. v. Flack*, 417 *N.E.*2d 692 (N.Y.1980)).

We conclude plaintiff was entitled to partial summary judgment on its breach of contract claim, and Hereford was entitled to assert the defense of exhaustion, despite that breach. Unfortunately, that does not end our consideration of whether Hereford was entitled as a matter of law to judgment dismissing plaintiff's breach of contract claim.

New York has adopted by regulation a priority regime when multiple claims are made. It states, "[i]f the insurer receives claims of a number of providers of services, at the same time, the payments shall be made in the order of rendition of services." *N .Y. COMP. CODES R. & REGS.* tit. 11, § 65–3.15. However, *verified* claims for later-in-time services may be paid before *unverified* claims for earlier provided services. *Nyack Hosp. v. Gen. Motors Acceptance Corp.*, 864 *N.E.*2d 1279, 1282–84 (N.Y.2007).

The judge properly held that the competing claims of plaintiff and the hospital were verified on the same date.[3] He reasoned that because plaintiff had rejected partial payment, Hereford's obligations to plaintiff ended, and the insurer was free to pay the remainder of the policy to the hospital without any further liability.

Hereford asserted before us that it was free to pay *either* verified bill. We find no authority for that proposition in its brief, and our independent research fails to reveal any reported New York case that supports that principle. We have, however, located an advisory opinion from the State of New York Insurance Department that may provide some support.

***6** In advisory opinion, *Priority of Payments in a No–Fault Claim*, Op. State of N.Y. Ins. Dep't (Dec. 24, 2002), the Office of General Counsel advised insurers that once all claims are verified, " 'payments shall be made *in the order of rendition of services.*' " *Id.* at 1 (emphasis added) (quoting *N.Y. COMP. CODES R. & REGS.* tit. 11, § 65–3.15). The opinion then explains, "[a] claimant may not indicate to the No–Fault insurer which particular bills for elements of basic economic loss are to be paid by the insurer, or how benefits are to be allocated." *Ibid.*

It is not clear from the record when plaintiff provided its services to the patient, and whether at least some of those services were provided prior to those provided by the hospital. Moreover, neither party addressed in the Law Division the potential effect of *N.Y. COMP. CODES R. & REGS.* tit. 11, § 65–3.8(c)(1). Pursuant to that regulation, for denials involving "a portion of a health provider's bill," the insurer's letter to the claimant must "contain [ ] substantially the same information as the prescribed form which is relevant to the claim denied." Had Hereford complied with this regulation when it partially denied plaintiff's bill by offering partial payment, plaintiff might have accepted the offered payment without prejudice to its arbitration rights and its right to file suit.[4]

We reluctantly conclude that a remand is necessary because the record is not entirely clear regarding when the services set forth in plaintiff's and the hospital's bills were provided. We also remand so the judge may consider, upon proper briefing by the parties, whether the priority regulations apply, and whether New York's regulations requiring notice that acceptance of payment without prejudice to arbitration rights and legal action apply to an offer of partial payment.

Further, as noted, the judge's written opinion only addressed the breach of contract claim, even though Hereford's motion sought dismissal of the entire complaint and the order entered, in fact, dismissed the entire complaint. In failing to address the other issues, the judge ran afoul of *Rule* 1:7–4(a). *See Oslacky v. Borough of River Edge*, 319 *N.J.Super.* 79, 85–86 (App.Div.1999) (remanding for violation of *Rule* 1:7–4(a) where judge failed to address portion of plaintiff's claim).

Whether a party may prevail on claims of bad faith or breach of the covenant of good faith and fair dealing in the absence of a successful breach of contract claim obviously presents a purely legal issue under New York law. We might otherwise attempt to decide the issues even in the absence of the judge's consideration of plaintiff's contentions. However, neither party has presented us with *any* authority on this issue from New York in their briefs. We refuse to apply de novo review in light of this shortcoming. On remand, the judge may consider the arguments of the parties and address the issue as appropriate.

***7** Reversed and remanded for further proceedings consistent with this opinion. We do not retain jurisdiction.

**All Citations**

Not Reported in A.3d, 2014 WL 7510327

  

Footnotes

1 The record does not contain the policy.

2 The record is somewhat unclear as to the precise date. In its subsequent letter denying the plaintiff's claim, Hereford indicated that it received the claim on April 11, 2011.

3 Plaintiff contends there is a factual dispute on this issue because a date stamp on one of the Hospital's documents in the record indicates that it was received after plaintiff's claim. However, the testimony of Porter that "the verification applied to both bills" was unrebutted. The undisputed fact is that plaintiff's claim, even if received earlier, was verified at the same time as the Hospital's claim.

4 We do recognize that at least one court has said that whether this regulation applies to "partial payment" of a medical bill remains an open question. *See King's Med. Supply Inc. v. Travelers Prop. Cas. Corp.,* 756 *N.Y.S.*2d 385, 389–90 (Civ.Ct.2003). We also recognize that even if plaintiff accepted partial payment, Hereford's exhaustion defense was potentially available as to the balance of plaintiff's claim.