NEW YORK COURT OF APPEALS ROUNDUP

NO-FAULT REGULATIONS: WHAT INSURERS CAN(NOT) USE TO DENY CLAIMS

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The Court of Appeals recently considered the grounds under which an insurer may deny a healthcare provider's claim under New York's no-fault statute and also the application of the New York equivalent to the federal Chevron doctrine. In *Government Employees Insurance Co. v. Mayzenberg*, the Court of Appeals deferred to the Department of Financial Services' (DFS) interpretation that a regulation does not permit an insurer to deny a provider's claim on the basis that the provider committed professional misconduct by paying for patient referrals. The majority decision was authored by Judge Rivera, joined by Judges Garcia, Singas, Cannataro, Troutman and Halligan. Chief Judge Wilson dissented.

The 1973 Comprehensive Automobile Insurance Reparations Act, known as the no-fault statute, supplanted common-law tort actions for most victims of automobile accidents. The statute requires that insurers provide their policyholders who are injured in auto accidents with up to $50,000 in medical care costs and other first party benefits, regardless of fault in the underlying accident. Injured policyholders typically assign their claims for payment of medical care costs to their care providers which then make claims for reimbursement to the insurers.

In 2001, DFS amended its regulations relating to the no-fault statute to combat fraud. In particular, "medical mills" had been submitting fraudulent bills to insurers based on fake auto injuries and medical services. To provide insurers a tool to combat this fraud, DFS promulgated 11 NYCRR 65-3.16(a)(12), which provides: "[a] provider of health care services is not eligible for reimbursement under [the no-fault statute] if the provider fails to meet any applicable New York State or local licensing requirement necessary to perform such service in New York or meet any applicable licensing requirement necessary to perform such service in any other state in which such service is performed." 11 NYCRR 65-3.16(a)(12).

In the case at hand, Plaintiffs Government Employees Insurance Company and its affiliates (GEICO) filed suit in the United States District Court for the Eastern District of New York seeking declaratory judgment that pursuant to 11 NYCRR 65-3.16(a)(12) defendants were not entitled to reimbursement for certain no-fault benefit claims. GEICO alleged that defendants engaged in a kickback scheme whereby one of the defendants—a licensed acupuncturist—paid the other defendants—unlicensed individuals—for patient referrals in violation of New York law prohibiting payment for patient referrals. GEICO alleged that in the two years leading up to the lawsuit, the acupuncturist paid nearly 80% of his revenue for patient referrals.

The District Court granted GEICO summary judgment finding that the acupuncturist had engaged in a scheme to defraud GEICO by procuring reimbursements that were then paid as kickbacks to unlicensed persons, and that GEICO therefore appropriately denied his claim for additional reimbursements under 11 NYCRR 65-3.16(a)(12). On appeal, the Second Circuit found it unclear whether the kickback violation rendered the acupuncturist ineligible under the regulation and certified the following question:

If an insurer determines a healthcare provider has improperly paid others for patient referrals, in violation of [New York law], can the insurer deny payment for no-fault benefits on the ground that the

provider 'fail[ed] to meet' a 'necessary' State or local licensing requirement under [11 NYCRR 65-3.16 (a)(12)]?

The Court of Appeals accepted certification and answered the question in the negative.

The Court of Appeals relied heavily on an amicus brief submitted by DFS taking the position that 11 NYCRR 65-3.16(a)(12) permits insurers to deny payment only where the provider has failed to satisfy pre-licensing requirements, such as obtaining valid certificates of authority and incorporation. On the other hand, DFS took the position that professional misconduct that may merit loss of license is not a basis for denial under 11 NYCRR 65-3.16(a)(12). DFS asserted that it has sole discretion to determine whether a provider has committed misconduct and should lose its license and therefore its ability to collect no-fault reimbursements.

The Court of Appeals applied New York's version of Chevron-deference to DFS's interpretation of 11 NYCRR 65-3.16(a)(12). The United States Supreme Court overruled Chevron deference to federal agencies in *Loper Bright Enterprises v. Raimondo*, 603 U.S. 369 (U.S. 2024). However, it remains New York law that "as a general rule, courts must defer to an administrative agency's rational interpretation of its own regulations in its area of expertise." *Andryeyeva v. N.Y. Health Care, Inc.*, 33 N.Y.3d 152, 174 (2019) (citation and quotation marks omitted).

The Court of Appeals found DFS's interpretation was rational, comported with the plain text of the regulation and was not foreclosed by the two prior Court of Appeals decisions regarding the scope of 11 NYCRR 65-3.16(a)(12), *State Farm Mutual Automobile Insurance Co. v. Mallela*, 4 N.Y.3d 313 (2005) and *Andrew Carothers, M.D., P.C. v. Progressive Insurance Co.,* 33 N.Y.3d 389, 406 (2019). The court explained that Mallela and Carothers stood for the proposition that an insurer could deny a claim under 11 NYCRR 65-3.16(a)(12) on the basis that a license was fraudulently procured or that the provider had violated a "foundational statutory requirement for licensure" that voided its license, but that those cases did not hold the regulation could be used to deny a claim on the basis of professional misconduct that might cause the provider to lose its license.

The court emphasized also that insurers are not left without recourse to deny claims based on apparent provider misconduct. Among other things, the court indicated that an insurer could argue that denial is appropriate under 11 NYCRR 65-3.16(a)(12) in the case of a kickback scheme because the provider has "effectively ceded control" of the medical practice to "unlicensed individuals"—i.e., those receiving kickbacks for referring patients—and therefore has not satisfied licensing requirements.

Such an argument might be persuasive in the Mayzenberg matter, where the vast majority of the acupuncturist's revenue was apparently paid out in kickbacks to his unlicensed co-conspirators. However, given the procedural posture and certified question, the Court of Appeals did not address the application of such an argument to the present fact pattern.

In dissent, Chief Judge Wilson argued that DFS's interpretation should be given no deference because it was "taken without sound basis." Chief Judge Wilson opined that DFS's interpretation was contrary to that taken by DFS in Mallela and Corothers and also stressed that while DFS claimed sole discretion to determine whether a provider should lose its ability to collect no-fault reimbursements as a result of misconduct, DFS has rarely exercised this important tool. According to data published by DFS, over the last 11 years, it has not placed a single provider on its list of providers deemed unauthorized to receive no-fault payments.

Mayzenberg serves as a reminder that while federal agencies no longer receive Chevron deference, deference to State agency interpretations of their regulations continues to be the law in New York. Further, while the case clarifies the limits of 11 NYCRR 65-3.16(a)(12) and removes one basis on which claims can be denied under that regulation, the case also provides important guidance on how no-fault insurers may deny fraudulent claims in accordance with New York regulations. Among other things, insurers can argue that a provider's license was procured by fraud, that the provider has violated

foundational licensing requirements, that an expense was unnecessary or not actually incurred by the provider, or that a provider has effectively ceded control of the medical practice to unlicensed individuals.

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