



**TOURO UNIVERSITY**  
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**Touro Law Review**

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Volume 17 | Number 3

Article 8

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March 2016

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### **Recommended Citation**

Papa, Louis J. and Basile, Anthony (2016) "No-Fault Insurance Fraud: An Overview," *Touro Law Review*. Vol. 17: No. 3, Article 8.

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## NO-FAULT INSURANCE FRAUD: AN OVERVIEW

*Louis J. Papa<sup>1</sup> & Anthony Basile<sup>2</sup>*

### I. INTRODUCTION

This article presents a general overview outlining the current difficulties associated with fraudulent claims in the area of No-Fault insurance in New York. Over the past decade, insurance fraud has been increasing at an alarming rate. In New

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York, in the past five years alone, suspicious automobile accidents have sky-rocketed 848%.<sup>3</sup> In 1991, there were four hundred cases of suspected No-Fault auto insurance fraud in New York.<sup>4</sup> By 1999, that number had increased to 9,991.<sup>5</sup> The instances of fraud steadily increased each year during that span. Consequently, from 1994 to 1997, insurance fraud arrests increased 148%.<sup>6</sup>

Insurance fraud is not a victimless crime. Instead, the cost of this crime is spread amongst the policyholders. The average household is now paying an additional two hundred dollars for car insurance fraud.<sup>7</sup> Honest New Yorkers end up paying hundreds of millions of dollars each year in the form of higher insurance rates because of insurance fraud.<sup>8</sup> Amazingly, in many cases, the annual cost of insurance could well exceed the value of the car itself.<sup>9</sup>

The Coalition Against Insurance Fraud, an independent, nonprofit organization of consumers, government agencies and insurers, estimates that the cost of insurance fraud is more than eighty-five billion dollars.<sup>10</sup> Health insurance fraud, thought to be the single biggest component of the estimate, accounts for fifty-five billion dollars. When these costs are spread amongst the policyholders, fraud costs each family, on average, \$710.<sup>11</sup>

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<sup>3</sup> See Carl Campanile, *Crash Scams Driving Up Car Insurance*, THE NEW YORK POST, June 14, 1998, at 24.

<sup>4</sup> See Kenneth Lovett, *Empire State's Rates Go Sky High*, THE NEW YORK POST, June 25, 2000, at 6.

<sup>5</sup> See Campanile, *supra* note 1, at 24.

<sup>6</sup> See *Insurance Fraud Arrest Up 140% During Pataki Administration*, BUSINESS WIRE, February 2, 1998.

<sup>7</sup> See Campanile, *supra* note 3, at 24.

<sup>8</sup> Lawrence Goodman, *Bust 10 In Insure Scheme*, THE DAILY NEWS, Sept. 5, 1997, at 2.

<sup>9</sup> See *No-Fault Auto Insurance Fraud in New York Problems and Solutions*, INSURANCE INFORMATION INSTITUTE, at <http://www.iii.org/media/hottopics/insurance/nofaultauto> (last visited April 5, 2001).

<sup>10</sup> See *Insurance Fraud - How to Report It*, NEW YORK STATE INSURANCE DEPARTMENT, at <http://www.ins.state.ny> (last visited July 26, 1999).

<sup>11</sup> *Id.*

In addition, even taking into consideration the higher cost of medical treatment in New York, the average bodily injury claim is sixty-four percent higher in New York than any other state.<sup>12</sup> Indeed, the costs of No-Fault claims are rising faster in New York than anywhere else in the country.<sup>13</sup>

One phenomenon that has added to the cost of No-Fault insurance is proliferation of insurance fraud schemes. Some of the biggest No-Fault insurance schemes have involved what is known as a 'Personal Injury Mill'. The National Insurance Crime Bureau defines a 'Personal Injury Mill' as an establishment that repetitively takes advantage of insurers and policyholders by filing fraudulent claims.<sup>14</sup> The term 'miller' refers to the owner or operator of a Personal Injury Mill.<sup>15</sup> Additionally, there are four other possible participants in a Personal Injury Mill. They are the attorneys, the chasers (also known as cappers or runners), the claimants, and the medical practitioners.<sup>16</sup> The attorneys may be actively involved in running the mill, or they may be acting fraudulently by having knowledge that the diagnoses and treatment are contrived, but nevertheless relying on these services, making them the basis for a lawsuit, hoping to get an easy, profitable out-of-court settlement.<sup>17</sup> The chasers are people recruited by the mill in order to recruit clients and refer them to the doctors or lawyers depending on who is running the scheme.<sup>18</sup> Chasers are paid up to fifteen hundred dollars for each claimant they recruit to the mill.<sup>19</sup> Claimants may be unwitting victims with no knowledge that their claim is being used fraudulently, or they may be a knowing participant receiving a cash payment for

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<sup>12</sup> *Id.*

<sup>13</sup> See, *No-Fault Medical Fraud In New York State*, *supra* note 9; *Organized Rings Pushing Up Rates In New York*, at <http://www.insurancefraud.org> (last visited June 20, 2000).

<sup>14</sup> See INSURANCE FRAUD: HANDBOOK FOR INSURANCE PERSONNEL, National Insurance Crime Bureau (1999), at 9.

<sup>15</sup> *Id.*

<sup>16</sup> *Id.*

<sup>17</sup> *Id.* at 10.

<sup>18</sup> *Id.*

<sup>19</sup> See Susan Edelman & Murray Weiss, *Road to Riches Is Paved With Lies And Serial Scams*, THE NEW YORK POST, June 25, 2000, at 4.

their involvement.<sup>20</sup> The medical practitioners may fabricate the diagnoses and reports, may actually run the personal injury mill, and may also set up inflated billing schemes.<sup>21</sup>

An investigation into one such organization by the National Insurance Crime Bureau, along with law enforcement, took over eighteen months to uncover the depths of the involvement of the participants.<sup>22</sup> Recently, federal authorities uncovered such an insurance scam after a ten month investigation.<sup>23</sup> Authorities ultimately arrested over fifty-three people in New York, and uncovered more one million dollars in fraudulent settlements.<sup>24</sup> The mill was charging the insurance companies from ten to twenty thousand dollars for each fraudulent claimant's injuries.<sup>25</sup> One FBI agent was quoted as saying that this was "the tip of the iceberg" for insurance fraud in the state, which is well over seven thousand cases annually.<sup>26</sup> Personal Injury Mills are becoming increasingly commonplace, and there are many examples which illustrate this premise.<sup>27</sup>

Thus, the need for increased regulation of No-Fault insurance claims is evident. In the long run, increased regulation

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<sup>20</sup> See INSURANCE FRAUD, *supra* note 18, at 10.

<sup>21</sup> *Id.* at 11.

<sup>22</sup> *Id.* at 9.

<sup>23</sup> See Mike Claffey, *Feds Bust 53 in Car Crash Insurance Scam*, N.Y. DAILY NEWS, November 17, 2000, at 34.

<sup>24</sup> *Id.*

<sup>25</sup> *Id.*

<sup>26</sup> *Id.*

<sup>27</sup> See Susan Edelman and Maria Malave, *Clinic Eager to Treat Bogus Claim*, THE NEW YORK POST, June 25, 2000, at 4. (The New York Post recently sent an undercover reporter into an alleged Personal Injury Mill. When she entered, she told the receptionist that she wanted to collect money even though she had no injuries and no pain. She was told that she would have to put something down in order to see the doctor, and was also told that what you have to do is complain about pain. Complain that you always have pain. Complain about pain in your neck and back. When she went in to see the doctor, she told him she had no pain, but as he persisted, she finally told him she had pain in her neck and back. When she left the clinic, she was told she would have to come in for physical therapy three times a week, and she did not need an appointment. Additionally, she was also given a bag of expensive medical equipment with no instructions on how she should use them).

would result in enormous savings amongst the policyholders. In fact, better techniques of rooting out insurance fraud could decrease annual premium costs over one hundred million dollars.<sup>28</sup> Therefore, it is imperative that we begin to look at the factors that are behind the proliferation of No-Fault insurance fraud.

To that end, this article begins in Part II by setting out the procedure that must be followed, pursuant to the Comprehensive Motor Vehicle Insurance Reparations Act ("VRA"),<sup>29</sup> in order to bring a No-Fault insurance claim. Part III discusses what constitutes a fraudulent claim. Part IV discusses the use of Special Investigations Units by insurance companies. Part V discusses the denial of insurance claims. Part VI discusses the effects of the 30-day Rule on the detection of fraudulent claims and whether the rule should be enforced where fraud is present. Part VII addresses the recent developments in the New York State Legislature regarding amendments in order to help decrease the amount of insurance fraud. Part VIII will conclude the note.

## II. NO-FAULT INSURANCE CLAIMS UNDER THE VRA

The VRA sets forth the procedures that govern No-Fault insurance claims.<sup>30</sup> The purpose of the VRA is to expeditiously resolve the claims of individuals who sustain injuries arising out of the use or operation of the vehicle in which that person was a passenger.<sup>31</sup> The VRA mandates insurance companies to either

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<sup>28</sup> See *A Courtroom Victory*, THE BUFFALO NEWS, June 20, 2000, at 2b.

<sup>29</sup> N.Y. INS. LAW § 5101 *et. seq.* (McKinney's 2000 & Supp. 2002). The VRA was initially enacted in 1973 as the Comprehensive Automobile Insurance Reparations Act, L. 1973, c. 13, and was codified as N.Y. INS. LAW § 670 *et. seq.* The current Comprehensive Motor Vehicle Insurance Reparations Act was enacted in 1984, L. 1984, c. 367.

<sup>30</sup> N.Y. INS. LAW § 5101 *et. seq.*; see also 11 NYCRR § 65 *et. seq.* (2001) (regulations implementing the Comprehensive Motor Vehicle Insurance Reparations Act).

<sup>31</sup> See 11 NYCRR § 65-3 (Regulation 68-C). An eligible injured person is defined under 11 NYCRR § 65-1.1 as:

(a) the named insured and any relative who sustains personal injury arising out of any motor vehicle;

pay or deny a claim for No-Fault benefits within thirty days of receiving the claim. This rule is often referred to as the 'thirty day rule'.<sup>32</sup>

Notwithstanding any conclusions or additions barring such recovery, there is a practical procedure that has been followed and implemented in New York State to handle claims brought under the VRA. Procedurally, after an individual sustains an alleged personal injury, he or she is entitled to seek treatment directly from a health care provider, during which the individual must complete an assignment of benefits form.<sup>33</sup> In doing so, the individual transfers his or her contractual rights to seek

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- (b) the named insured and any relative who sustains personal injury arising out of the use or operation of any motorcycle, while not operating a motorcycle;
  - (c) any other person who sustains personal injury arising out of the use or operation of the insured motor vehicle in the State of New York while not occupying another motor vehicle; or
  - (d) any New York State resident who sustains personal injury arising out of the use or operation of the insured motor vehicle outside of New York while not occupying another motor vehicle.

<sup>32</sup> See N.Y. INS. LAW § 5106 (McKinney's 2000 & Supp. 2002). The statute states in pertinent part:

- (a) Payments of first party benefits and additional first party benefits shall be made as the loss is incurred. Such benefits are overdue if not paid within thirty days after the claimant supplies proof of fact and amount of loss sustained. 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. All overdue payments shall bear interest at the rate of two percent per month. If a valid claim or portion was overdue, the claimant shall also be entitled to recover his attorney's reasonable fee, for services necessarily performed in connection with securing payment of the overdue claim, subject to limitations promulgated by the superintendent in regulations.

See also 11 NYCRR § 65-3.8.

<sup>33</sup> See 11 NYCRR § 65-3.5 (detailing the procedures by which a claim must be brought); see also 11 NYCRR § 65-3.16 (setting forth benefits that claimants may receive).

reimbursement for professional services rendered, diagnostic tests performed, and supplies provided. Thus, individual claimants effectively relinquish their right of standing to seek reimbursement by assigning that right to their health care provider. However, under the procedure set forth by the regulations, there is no delay in the treatment of the patient, no delay in any of the diagnostic tests performed, nor is there a delay in providing the patient with any needed surgical supplies. In addition, other reasonable and necessary expenses, which could include transportation, are also provided in accordance with an assignment of benefits.<sup>34</sup> Therefore, these provisions ensure that an injured claimant is not prejudiced by the procedure, as they are still receiving medical care and usually never incur any out of pocket expenses.

Moreover, in an effort to decrease the amount of fraud in the insurance industry, New York mandates that insurance companies set up Special Investigation Units to handle fraudulent claims.<sup>35</sup> It is significant to note that the plaintiff/claimant can commence these claims in arbitration or in a court of law. Most Arbitrators feel that fraud is a coverage issue and is not governed by the 'thirty day rule'.<sup>36</sup>

It is our contention, however, that when there is a suspicion of fraud, the 'thirty day rule' should be extended in order to determine the merits of the claim. This would not prejudice the injured party, because while the insurance company has time to do a full investigation into the claim, the injured party would still be receiving all necessary medical care and reimbursement for all other reasonable expenses.

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<sup>34</sup> 11 NYCRR § 65-3.16(c).

<sup>35</sup> The requirement of insurance companies to have their own SIU teams at their disposal is found in both N.Y. INS. LAW § 409 (McKinney's 2000 & Supp. 2002) and 11 NYCRR § 86.6 (1998).

<sup>36</sup> See, e.g., *Midwood Medical Help/Willis Burgess v. Interboro Mutual Ind.*, American Arbitration Association Case Number: 17 980 42323 99 (New York June 7, 2001) (where the Arbitrator did not apply the 'thirty day rule', but instead held that "improper licensing and fraud were 'coverage' issues, which could be raised at any time.")



### III. FRAUDULENT CLAIMS

A fraudulent misrepresentation is a statement made by a person who at the time they make the statement, is aware that it is false.<sup>37</sup> This necessary element of awareness is called *scienter*.<sup>38</sup> In most jurisdictions, in order to recover damages for misrepresentation, *scienter*, or awareness, must be proven.<sup>39</sup> Once the misrepresentation has been established, the vast majority of jurisdictions hold that the contract is voided. The elements of fraudulent misrepresentations generally include: a knowingly false representation of a material fact, reliance, and injury.<sup>40</sup> These jurisdictions rely on the established principle that a fraudulent misrepresentation will vitiate all contracts.<sup>41</sup> Insurance companies are so paralyzed by healthcare providers and/or patient misrepresentations, that many states do not require a finding of actual fraud so long as the misrepresentation is a material one.<sup>42</sup>

Insurance fraud has been given a specific definition by the New York legislature:

A fraudulent insurance act is committed by any person who, knowingly, and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, self insurer, or purported insurer, or purported self insurer or any agent thereof, any

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<sup>37</sup> Emeric Fischer & Peter N. Swisher, *PRINCIPLES OF INSURANCE LAW* 282 (2d ed. 1994).

<sup>38</sup> *Id.*

<sup>39</sup> *Id.*

<sup>40</sup> *Id.*

<sup>41</sup> *Id.* at 288.

<sup>42</sup> *Id.* (The general rule in many states is that even though a misrepresentation made in an insurance contract is not willfully false or fraudulently made, if it is material to the risk of loss, it may nevertheless void the contract at the option of the insurer. So in these jurisdictions, a material misrepresentation of fact may still void the insurance policy if the insurer relies on it. Thus, in many states, actual fraud need not be established if the misrepresentation is material to the risk).

written statement as part of, or in support of, an application for the issuance of, or the rating of a commercial insurance policy, or certificate or evidence of self insurance for commercial insurance, or commercial self insurance or a claim for payment or other benefit pursuant to an insurance policy or self insurance program for commercial or personal insurance which he knows to: (i) contain materially false information concerning any fact material thereto; or (ii) conceal, for the purpose of misleading information concerning any material fact thereto.<sup>43</sup>

As with any affirmative defense, when an insurance company seeks to rely on this defense, it will have the burden of proving concealment or falsity of representations made by the insured to induce the issuance of a policy, or to prove the breach of an affirmative warranty, promissory warranty, or condition subsequent.<sup>44</sup> It bears emphasis once again that the essential elements of a cause of action for fraud are a representation of a material fact, falsity, *scienter*, deception, and injury.<sup>45</sup> Even an innocent misrepresentation as to specific diseases or ailments is sufficient to allow the insurer to avoid the contract of insurance or, alternatively, defeat recovery thereunder.<sup>46</sup> In addition, a defense sounding in equity to rescind, i.e., to set aside an insurance contract for material misrepresentation, does not require proof that the misrepresentation was made with intent to deceive.<sup>47</sup> Such defense is distinct from a suit for damages for false representation.<sup>48</sup>

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<sup>43</sup> N.Y. PENAL LAW § 176.05 (McKinney's 1999 & Supp. 2002).

<sup>44</sup> See *Insurance, Practice and Procedure*, 44 Am. Jur. 2d Insurance § 1933 (1982).

<sup>45</sup> See *New York Univ. v. Continental Ins. Co.*, 87 N.Y.2d 308, 316 (1995).

<sup>46</sup> *Id.*

<sup>47</sup> See *Sparer v. Travelers Ins. Co.*, 185 A.D. 861, 864, 173 N.Y.S. 673, 675 (1st Dep't 1919).

<sup>48</sup> *Id.*

In No-Fault insurance cases, there is a dual motive for the claimant to fraudulently misrepresent their injuries. To be successful in a third-party bodily injury lawsuit, a claimant must meet the threshold requirements outlined in the Comprehensive Motor Vehicle Insurance Reparations Act.<sup>49</sup> In order for a claimant to collect damages from a third party outside of their No-Fault coverage, the claimant must prove serious injury, as defined in the statute.<sup>50</sup> If the injury is not a dismemberment, disfigurement or other permanent injury, it is necessary for the claimant to prove:

a medically determined injury or impairment of a non-permanent nature which prevents the injured person from performing substantially all of the material acts which constitute such person's usual and customary daily activities for not less than ninety days during the one hundred eighty days immediately following the occurrence of the injury or impairment.<sup>51</sup>

To prove this type of injury, it is necessary that the claimant have sufficient documentation by a medical practitioner.<sup>52</sup> This threshold requirement is difficult to achieve,

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<sup>49</sup> N.Y. INS. LAW § 5101 *et. seq.*

<sup>50</sup> N.Y. INS. LAW § 5102(d). (McKinney's 2000 & 2002) (The statute begins by illustrating several types of "serious injury." These types of injuries are: a) death; b) dismemberment; c) significant disfigurement; d) fracture; e) loss of a fetus; f) permanent loss of the use of an organ. These injuries are far less controversial than the above discussed non-permanent injuries, as the injury will become readily apparent upon medical examination. However, non-permanent injuries are far more subjective depending on the particular physician).

<sup>51</sup> *Id.*

<sup>52</sup> See *Delaney v. Rafferty*, 241 A.D.2d 537, 663 N.Y.S.2d 834 (2d Dep't 1997) (holding that without an objectively diagnosed injury, the plaintiff's subjective complaints of pain were insufficient to support a finding of serious injury as defined in N.Y. INS. LAW § 5102(d)); *Doyle v. Erie County Water Authority*, 113 A.D.2d 1016, 1017, 494 N.Y.S.2d 584, 585 (2d Dep't 1985) (holding that subjective complaints of the claimant without medical foundation

and requires substantial medical documentation.<sup>53</sup> Thus, there is an incentive for claimants and their attorneys to build up a claim in order to establish a basis for a potentially much more lucrative bodily injury suit.<sup>54</sup> In addition, the claimant may have a corrupt motive in substantiating a third-party physical injury, whereby not only is their claim for medical benefits fraudulent, but the very medical treatment itself is being fraudulently obtained.

#### IV. SPECIAL INVESTIGATION UNITS (SIU)

Special Investigation Units (SIU) have been created for the express purpose of combating No-Fault insurance fraud. Therefore, insurance carriers should retain the services of a diligent SIU investigator, beginning with the receipt of the claim.<sup>55</sup> Under both § 409, and the *Second Amendment to Regulation 95*, it is mandated that insurance companies in New York State employ their own Special Investigation Units in order to detect, investigate and prevent insurance fraud.<sup>56</sup> The purpose of these acts was to eradicate insurance fraud, as the New York legislature stated:

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were insufficient to establish a prima facie case of serious injury within the meaning of Insurance Law).

<sup>53</sup> See *Stipes v. Kopf*, 255 A.D.2d 502, 503, 680 N.Y.S.2d 175 (2d Dep't 1998) (holding that the plaintiff's evidence indicating that injuries consisted of a minor, mild or slight limitation is insignificant under 5102(d)); *Delaney v. Lewis*, 256 A.D.2d 895, 896, 682 N.Y.S.2d 270, 272 (3d Dep't 1998) (holding that a physical therapist is not competent to make a diagnosis or prognosis as to the permanency or duration of physical injury. Furthermore, the treating physician's records of a chronic cervical strain indicate that the plaintiff's complaints of pain formed the basis for such diagnosis and such subjective evidence was insufficient to establish the threshold requirement of serious injury).

<sup>54</sup> *No Fault Medical Fraud In New York State: Problems And Solutions*, at <http://www.iii.org/inside.p15?individuals=home=pip/whitepaper.html> (last visited April 5, 2001).

<sup>55</sup> See N.Y. INS. LAW § 409, see also 11 NYCRR § 86.6.

<sup>56</sup> *Id.*

[t]he legislature finds and declares that the business of insurance directly and indirectly affects all sectors of the public, business and government. It further finds that the business of insurance, including organization and licensing, the issuance of policies, and the adjustment and payment of claims and losses, involve many transactions which have the potential for abuse and illegal activities.<sup>57</sup>

The legislature also specifically stated that insurance fraud is illegal, stating:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.<sup>58</sup>

Both of these statutes mandate that insurance companies set up their own SIUs to investigate fraud.

The National Insurance Crime Bureau has published indicators used by the SIUs in detecting No-Fault insurance fraud.<sup>59</sup> The indicators of a claim involving medical fraud claim inflation are:

1. Three or more occupants in the claimant's vehicle; all of whom report similar injuries.

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<sup>57</sup> N.Y. INS. LAW § 401(a) (McKinney's 2000).

<sup>58</sup> *Id.* See also 11 NYCRR § 86.6.

<sup>59</sup> See INSURANCE FRAUD, *supra* note 14, at 11-13.

2. All injuries are subjectively diagnosed, such as headaches, muscle spasms, traumas, and inability to sleep.

3. Minor accident produces major medical costs, lost wages and unusually expensive demands for pain and suffering.

4. All of the claimants submit medical bills from the same doctor or medical facility.

5. Medical bills submitted are photocopies of the originals.

6. Summary medical bills are submitted without dates and descriptions of office visits and treatments, or treatment extends for a lengthy period without any interim bills.

7. Vehicle driven by claimant is an old clunker with minimal coverage.

8. Insured, even though legally liable for the accident, is adamant that claimants were responsible for the accident, indicating that the insured may have been targeted by the claimants.

9. Claimants retain legal representation immediately after the accident is reported.

10. Past experience demonstrates that the physician's bill and report, regardless of the varying accident circumstances, are always the same.

11. Treatment prescribed for various injuries resulting from differing accidents is always the same in terms of duration and type of therapy.

12. Medical bills indicate routine treatment being provided on Sundays or holidays.<sup>60</sup>

The following are possible indicators of fraudulent medical treatment:

1. Diagnosis is inconsistent with treatment.
2. Treatment for extensive injuries is protracted though the accident was minor.
3. Boilerplate medical reports are identical to other reports from same doctor.
4. Worker's compensation insurer and health carrier are billed simultaneously; payment is accepted from both.
5. Injured worker protests about returning to work and never seems to improve.
6. Summary medical bills are submitted without dates or descriptions of office visits.
7. Medical bills submitted are photocopies of originals.
8. Extensive or unnecessary treatment for minor, subjective injuries.
9. Treatment directed to a separate facility in which the referring physician has a financial interest (especially if this is not disclosed in advance).
10. Referral for treatment/testing to facility close to referring facility.

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<sup>60</sup> *Id.* at 11.

11. Minor accident produces major medical costs, lost wages and unusually expensive demands for pain and suffering.

12. Injured worker cancels or fails to keep appointment, or refuses a diagnostic procedure to confirm an injury.

13. Treatment dates appear on holidays or other days that facilities would not normally be open.

14. Injured worker immediately referred for a wide variety of psychiatric tests, when the original claim involved trauma only. These claims are usually present with vague complaints of stress.<sup>61</sup>

There are many indicators of when a claim might be fraudulent. It takes the SIU's a substantial amount of time to go through the files to both find the fraudulent indicators, and then to also see if they are in fact fraudulent.

## V. DENYING A NO-FAULT CLAIM

The 'thirty day rule' set forth in New York under the VRA states that an insurance company has thirty (30) days to either deny or pay a claim for No-Fault benefits.<sup>62</sup> The apparent purpose of this rule is the protection of claimants, mandating that once proof of fact and proof of loss have been proven, the insurance company must expeditiously resolve the claim. Given the time constraints this rule places on insurance companies, the insurance companies must use the limited number of tools at their disposal to their greatest advantage to weed out fraudulent claims.

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<sup>61</sup> *Id.* at 12.

<sup>62</sup> See N.Y. INS. LAW § 5106, *supra* note 32.



*Verification*

One of the tools that insurance companies have at their disposal when considering possible fraud is the right to request additional verification of the claim before paying the claim. Indeed, such a request is the only way under the statute of extending the 'thirty day rule.'<sup>63</sup> The regulation states that an insurance company may request additional information from the claimant to verify the accuracy of the claim. The insurer has ten days from the time it receives the claim to request this additional information.<sup>64</sup> If this information is not supplied by the claimant within thirty calendar days, the insurer has ten more days to send a follow-up request for additional information.<sup>65</sup> During this time, the insurer must also inform the claimant and his/her attorney, of the reason why the payment or denial of the claim is being delayed, by identifying the missing verification, and the party from whom it was requested.<sup>66</sup>

Assuming that the claimant complies, the insurance carrier has thirty days from the receipt date of the requested verification to then issue a denial or to pay the claim in whole or in part. Upon the discussion of the 'thirty day rule', the statute states in pertinent part:

No fault benefits are overdue if not paid within 30 calendar days after the insurer receives proof of

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<sup>63</sup> For example, when dealing with a Professional Corporation, (referred to as a P.C.), the following could be requested in the verification letter:

Certificate of Incorporation

Names and identities of all Officers, Directors and Shareholders

Licenses of all Officers, Directors and Shareholders

<sup>64</sup> 11 NYCRR § 65-3.5 states in pertinent part:

Within 10 business days after receipt of the completed application for motor vehicle no-fault benefits (NYS Form N-F 2) or other substantially equivalent written notice, the insurer shall forward, to the parties required to complete them, those prescribed verification forms it will require prior to payment of the initial claim.

<sup>65</sup> 11 NYCRR § 65-3.6(a).

<sup>66</sup> 11 NYCRR § 65-3.6(b).

claim, which shall include verification of all the relevant information requested pursuant to section 65-3.5 of this subpart . . . . Except as provided in subdivision (e) of this section, an insurer shall not issue a denial of claim form (NYS Form N-F-10) prior to its receipt of verification of all the relevant information requested pursuant to section 65-3.5 or this subpart (e.g., medical reports, wage verification, etc.)<sup>67</sup>

An example of how verification procedures impact claims is illustrated by the case of *Westchester County Medical Center v. New York Cent. Fire Ins. Co.*<sup>68</sup> In *Westchester*, the Appellate Division of New York dismissed the plaintiff's claim against the defendant when the defendant proffered evidence that a timely demand for further verification of the claim was made by letter and that, when such verification was not received within thirty days, a timely follow-up letter was mailed and similarly never responded to.<sup>69</sup> The court held that the defendant's denial of the claim was timely, and that the thirty day rule will not begin to run if the insurance company makes a demand for further verification.<sup>70</sup>

It is crucial that an insurance carrier not confuse a delay letter with a request for additional verification. They are not the same and only a request for verification will operate to delay issuing a denial while an SIU investigation is ongoing. By contrast, a delay letter informs the claimant and the claimant's attorney that as a result of noncompliance with the insured's request for verification, the processing of the submitted application for benefits is being delayed pending receipt of all

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<sup>67</sup> 11 NYCRR § 65-3.8.

<sup>68</sup> 262 A.D.2d 553, 692 N.Y.S.2d 665 (2d Dep't 1999).

<sup>69</sup> *Id.* at 555, 692 N.Y.S.2d at 667.

<sup>70</sup> *Id.* (The Defendant would not have been precluded from defending these claims even if the court determined that as a matter of law the defendant did not comply with the 'thirty day rule'. The court explained that since the defense was that the injuries did not arise from an automobile accident, the 'thirty day rule' was inapplicable).

materials requested for verification.<sup>71</sup> This delay letter does not suspend the time frames, but serves as a memo discussing the temporary delay in processing of the application.<sup>72</sup> Thus, it is the request for additional verification and not the letter of delay that acts to extend the statutorily imposed limit.

### *Examinations Under Oath*

In addition to requesting verification, an insurer involved with an alleged fraudulent claim can exercise its contractual right to insist on conducting extensive Examinations Under Oath (EUO) of the claimant.<sup>73</sup> The insurer may also conduct extensive EUOs of the health care providers, if assigned the right to do so from the patient. In doing so, the insurance carrier must proceed as if the time frames within which to deny or pay the claim were in effect.

New York case law establishes that an insurance company is entitled to take an Examination Under Oath of its insured whenever it suspects a fraudulent claim has been submitted.<sup>74</sup> This right by the insurance company dates back to 1884 in *Clafin v. Commonwealth Insurance Company*<sup>75</sup> where the United States Supreme Court upheld an insurance company's right to conduct an Examination Under Oath. Similarly, in *Dyno-Bite v. Travelers Companies*,<sup>76</sup> the court, in upholding the insurance company's right to conduct an Examination Under Oath, stated:

The company is entitled to obtain, promptly and while the information is still fresh, 'all knowledge and all information as to other sources and means of knowledge, in regard to the facts material to

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<sup>71</sup> See 11 NYCRR § 65-3.6(b); 11 NYCRR § 68.15.

<sup>72</sup> *Id.*

<sup>73</sup> See 11 NYCRR § 65-3.5.

<sup>74</sup> See *Hudson Tire Mart v. Aetna Cas. & Sur. Co.*, 518 F.2d 671, 674 (2d Cir. 1975); See also *Dyno-Bite v. Travelers Companies*, 80 A.D.2d 471, 473, 439 N.Y.S.2d 558, 560 (4th Dep't 1981).

<sup>75</sup> 110 U.S. 81 (1884).

<sup>76</sup> *Dyno-Bite*, 80 A.D.2d at 471, 439 N.Y.S.2d at 558.

their rights to obtain them to decide upon their obligations, and to protect them against fraudulent claims. And every interrogatory that is relevant and pertinent in such an examination is material, in the sense that a true answer to it is of the substance of the obligation of the assured . . .<sup>77</sup>

It is well settled case law in New York that the willful failure to appear for an Examination Under Oath, or the willful failure to cooperate with the insurance company's investigation by intentionally refusing to answer relevant questions or produce relevant documents, is a breach of terms and conditions precedent to coverage.<sup>78</sup> Additionally, it is similarly established in New York that an insured cannot attempt to refuse to answer specific questions at an Examination Under Oath, or to avoid appearing at all, by claiming the Fifth Amendment privilege against self-incrimination.<sup>79</sup> Courts have held that if an insured refuses to testify at an Examination Under Oath on the basis of the Fifth Amendment, the cooperation clause of the policy will be breached and the claim denied.<sup>80</sup>

The defense of non-cooperation applies to actions in assigned risk policies, as well as actions to recover damages for personal injuries and property damage.<sup>81</sup> In order to disclaim coverage on the grounds of an insured's lack of cooperation, the carrier must demonstrate three things:

1. That the insurance company acted diligently in seeking to bring about the insured's cooperation;

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<sup>77</sup> *Id.* at 473, 439 N.Y.S.2d at 560 (quoting *Clafin v. Commonwealth Ins. Co.*, 110 U.S. 81, 94-95).

<sup>78</sup> 80 A.D.2d at 475, 439 N.Y.S.2d at 561; *Pizzirusso v. Allstate Insurance Co.*, 143 A.D.2d 340, 532 N.Y.S.2d 309 (2d Dep't 1988).

<sup>79</sup> *See Dyno-Bite*, 80 A.D.2d at 475, 439 N.Y.S.2d at 561.

<sup>80</sup> *Id.* *See also* *Van Opdorp v. Merchants Mut. Ins. Co.*, 55 A.D.2d 810, 390 N.Y.S.2d 279 (4th Dep't 1976).

<sup>81</sup> *See Allstate Ins. Co. v. Loester*, 675 N.Y.S.2d 832, 834 (Sup. Ct. 1998); *Thrasher v. U.S. Liability Ins. Co.*, 19 N.Y.2d 159, 168 (1967).

2. That the efforts employed by the insurer were reasonably calculated to obtain the insured's cooperation; and
3. That the attitude of the insured, after his cooperation was sought, was one of willful and invalid obstruction.<sup>82</sup>

In addition, under an automobile insurance policy, if the policy language does not contain a statute of limitations clause, under New York law, the six-year statute of limitations for breach of contract applies to the auto policy.<sup>83</sup> For additional personal injury protection (PIP), the plaintiff's subrogation rights are subject to the same three-year tort statute of limitations, measured from the date of the accident, as though the cause of action had been brought by the insured.<sup>84</sup>

#### V. IMPACT OF THE THIRTY DAY RULE ON DETECTION OF FRAUDULENT CLAIMS

The mandate that every insurer must either pay or deny a claim for No-Fault insurance was promulgated on September 1, 1984.<sup>85</sup> At that time, insurance fraud was not as big of a problem, certainly not to the extent that it has been during the last several years. The two New York laws mandating the 'thirty day rule' were not put into effect until 1996, a time when fraudulent insurance claims had become a major problem in New York.<sup>86</sup> Due to the legislative history of these two laws, and the seriousness with which the Legislature has been trying to detect and eliminate fraudulent activity within the state, it would be

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<sup>82</sup> See *Loester*, 675 N.Y.S.2d at 834.

<sup>83</sup> See *Allstate Ins. Co. v. Morrison*, 267 A.D.2d 381, 700 N.Y.S.2d 74 (2d Dep't 1999).

<sup>84</sup> See *Nationwide Mutual Ins. Co. v. Motor Vehicles Accident Indemnification Corp.*, 198 A.D.2d 358, 604 N.Y.S.2d 119 (2d Dep't 1993).

<sup>85</sup> See NY INS. LAW § 5106.

<sup>86</sup> NY INS. LAW § 409; 11 NYCRR 86.6.

nonsensical to apply the 'thirty day rule' to cases in which there is a strong suspicion of fraudulent activity.

A thirty day time frame for an insurance company to detect, investigate, and determine conclusively that there was fraudulent activity is nearly impossible. This is especially true because much of the No-Fault insurance fraud in New York is the result of highly organized groups with an expertise in avoiding detection.<sup>87</sup> As mentioned earlier, a federal investigation of one of these fraud rings by federal investigators took over ten months to complete. Moreover, an investigation by the National Insurance Crime Bureau took eighteen months to complete.<sup>88</sup>

In addition, Personal Injury Mills take advantage of the 'thirty day rule' by accumulating bills for individual claimants and then sending them in bulk to insurance companies at the last minute. Suspicious cases often involve multiple claimants receiving hundreds of treatments from numerous providers. The documentation associated with a single claim could be a foot or more thick.<sup>89</sup> It is an understatement to say that a thorough review of these claims is time consuming. The pressure to process claims in a speedy manner is what makes it work for criminals. The combination of tremendous volume coupled with the obligation to turn it over quickly creates a fertile ground for fraud.<sup>90</sup> The way to attack such insurance fraud is through comprehensive investigation and enforcement, which is impossible to do in thirty days. In order to detect and eliminate the fraudulent activity in No-Fault insurance claims, it is necessary that insurance companies have longer than thirty days.

New York case law seems to differentiate between denying a claim based on lack of coverage and denying a claim

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<sup>87</sup> See INSURANCE FRAUD, *supra* note 14 (discussing how organized fraud rings are responsible for a significant portion of insurance fraud, especially in the area of no-fault automobile insurance).

<sup>88</sup> See Claffey, *supra* note 23, at 34.

<sup>89</sup> See *No-Fault Auto Insurance Fraud in New York, Problems and Solutions*, *supra* note 9.

<sup>90</sup> See Edelman, *supra* note 27, at 4.

based upon no coverage.<sup>91</sup> When these cases are read together, combining the policy reasons behind the holdings in each of these cases, along with the strong policy considerations behind decreasing the amount of insurance fraud, it is clear that the thirty day rule should not apply to fraudulent claims.

For instance, in *Zappone v. Home Insurance*, the court distinguished between denying a claim based upon a policy exclusion when a condition in the policy has been breached, and denying a claim based upon lack of coverage.<sup>92</sup> The court stated that the insurer is not subject to preclusion (not being able to defend the claim if the insurer did not pay or deny within thirty days), in the lack of coverage situation where there was never any insurance in effect.<sup>93</sup> In *Presbyterian Hospital v. Maryland Casualty Co.*, the Court held the defendant insurance company was precluded because the claim was not paid or denied in thirty days.<sup>94</sup> In that case, the defendant was attempting to assert the defense that the claimant was intoxicated, which would forfeit her rights under the policy.<sup>95</sup> The court held that the defendant was precluded from asserting the defense, stating that the Legislature and Superintendent surely did not intend to afford insurers greater rights in this particular respect with regard to No-Fault insurance.<sup>96</sup> This holding was specific to the particular respect of intoxication. The Court then looked at policy by stating:

The insurer's more restrictive contention and interpretation is not otherwise supportable in logic, analysis or policy, because it would frustrate a

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<sup>91</sup> See *Central Gen. Hosp. v. Chubb Group of Ins. Co.*, 90 N.Y.2d 195, 659 N.Y.S.2d 246 (1997); *Presbyterian Hosp. v. Maryland Casualty Co.*, 90 N.Y.2d 274, 660 N.Y.S.2d 536 (1997); *Zappone v. Home Ins.*, 55 N.Y.2d 131, 447, N.Y.S.2d 911 (1982).

<sup>92</sup> 55 N.Y.2d at 136-37, 447 N.Y.S.2d at 914. (See also N.Y. INS. LAW § 3420 (McKinney's 2000 & Supp. 2002), whereby an insurer is statutorily obligated to give written notice "as soon as is reasonably possible" should it decide to disclaim based upon a policy exclusion).

<sup>93</sup> *Id.* at 138, 447 N.Y.S.2d at 915.

<sup>94</sup> 90 N.Y.2d at 281, 660 N.Y.S.2d at 539.

<sup>95</sup> *Id.* at 278, 660 N.Y.S.2d at 537.

<sup>96</sup> *Id.* at 283, 660 N.Y.S.2d at 541.

core and essential objective in these particular insurance regulations that is, to provide a tightly timed process of claim, disputation and payment.<sup>97</sup>

There is no doubt that quick resolution is an essential objective when the claim is legitimate, and the denial is dependent on the terms of the insurance policy. However, when a fraudulent claim is suspected, the overriding goal is not to provide a tightly timed process of claim, disputation and payment; rather, it is to detect, investigate, and eliminate the fraudulent claim. These policy considerations prevail over a quick termination of the no fault claim.

In *Central General Hospital v. Chubb Group*, the New York Court of Appeals again addressed this issue, clearly leaving room for a defendant insurance company to be protected from the preclusion remedy.<sup>98</sup> The Court held that the defendant insurance company was not precluded, despite its failure to reject the claim within the thirty day period, because the defendant was asserting a lack of coverage defense premised on the fact that the alleged injury did not arise out of the insured incident.<sup>99</sup> Strict compliance with the time requirements of both the statute and regulations may be obviated and the preclusion remedy rendered unavailable when denial of claims is premised on lack of coverage.<sup>100</sup> There is no contesting the fact that fraud is a lack of coverage defense, as the activity is illegal in itself. Therefore, it seems logical that the 'thirty day rule' should not be a tool used to preclude defendants from asserting the defense that the claim is fraudulent.

## VI. RECENT DEVELOPMENTS AND POSSIBLE SOLUTIONS

Because of the recent increase in insurance fraud in No-Fault claims, and the inadequacy of the present regulations to

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<sup>97</sup> *Id.* at 281, 660 N.Y.S.2d at 539.

<sup>98</sup> 90 N.Y.2d at 199, 659 N.Y.S.2d at 248.

<sup>99</sup> *Id.*

<sup>100</sup> *Id.*



adequately aid insurance companies in detecting and eliminating fraud, there have been several proposed amendments to the current insurance legislative framework in New York.<sup>101</sup> One of the problems in getting such legislation passed is the great disparity between the Senate and the Assembly in how to deal with the grave problem of insurance fraud.<sup>102</sup> The Republican Senate's proposals are focused on aiding insurance companies, while the Democrat Assembly leans towards laws strengthening consumer protections for insurance customers.<sup>103</sup>

One such proposal initiated by the Senate is to use ten million dollars of an accumulated twelve million dollar fund from fees collected as a surcharge on insurance premiums to bolster local fraud investigations.<sup>104</sup> Use of the money in this way is logical because the funds are contributed by all of the state's policyholders that will benefit directly from the elimination of this type of fraud.<sup>105</sup>

The Senate has also proposed that the criminal penalties for participating in insurance fraud be increased.<sup>106</sup> One such bill, a Runner Bill, would make the act of being a middleman between a claimant and a medical provider or attorney a Class E felony.<sup>107</sup> The Assembly has proposed that a special prosecutor in the state's attorney general's office be created, and that more

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<sup>101</sup> See Jordan Rau, *Insurance Fraud Up, Solutions Hard to Find*, NEWSDAY, April 4, 2001, at A6.

<sup>102</sup> James M. Odato, *Lawmakers Set Sights On \$12M Insurance Fund*, at <http://www.insurancefraud.org> (April 6, 2001).

<sup>103</sup> *Id.* See also Rau, *supra* note 101, at A6 (discussing how Republicans are accused of pointlessly increasing punishments for activities that are already illegal; Democrats are blamed for being reluctant to give insurers more leeway in investigating potential fraud).

<sup>104</sup> *Id.* See also *No-Fault Medical Fraud In New York, Problems and Solutions*, *supra* note 9.

<sup>105</sup> *Id.*

<sup>106</sup> *Id.* See Odato, *supra* note 102; Rau, *supra* note 101.

<sup>107</sup> See *No-Fault Medical Fraud In New York, Problems and Solutions*, *supra* note 9 (discussing how the passage of such a bill would permit the prosecution of a key party to no-fault fraud).

investigators be added to the state Insurance Department's fraud bureau.<sup>108</sup>

The above legislation would be helpful in diminishing the astonishingly high amount of No-Fault insurance fraud in New York. However, without allowing insurance companies longer than thirty days to deny or pay a claim when there is fraud suspected, these measures will not be substantially effective. Republicans in New York have proposed such a measure.<sup>109</sup> The 'thirty-day rule' would be waived only if the insurance company suspects fraud, and has reported that suspicion to the Insurance Frauds Bureau, or if the carrier is questioning the causality of injuries in the accident.<sup>110</sup> This would greatly benefit both insurance companies and innocent policyholders. Innocent policyholders would not be prejudiced at all by such an amendment, as insurance companies would still be required to pay or deny their claims in thirty days. Rather, they would benefit in seeing their insurance policies decrease with the declining amount of fraudulent claims being paid by insurance companies. Furthermore, such a measure would allow insurance companies a great deal more latitude in eliminating con men, who are currently thriving by taking advantage of loopholes in the system and making enormous amounts of money, while simultaneously surcharging our policies.<sup>111</sup>

## VII. CONCLUSION

Fraudulent claims are a pervasive problem within No-Fault insurance in New York. It has risen to such an extreme amount that the New York State Legislature has stepped in to ensure that every insurance company has developed a unit of personnel to investigate and eliminate the high amount of fraudulent claims within the state. The insurance companies need

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<sup>108</sup> See Rau, *supra* note 101.

<sup>109</sup> *Id.* See *No-Fault Medical Fraud In New York, Problems and Solutions*, *supra* note 9.

<sup>110</sup> *Id.*

<sup>111</sup> See Rau, *supra* note 101 (quoting Senator Dean Skelos (R-Rockville Center)).

cooperation from law enforcement, arbitrators, and the courts to lessen the amount of insurance fraud. This will, in turn, decrease the costly insurance policies within the state.

Forcing insurance companies to either deny or pay claims where there is suspected fraud within thirty days will essentially tie their hands behind their backs, and leave them powerless to do anything about the amount of fraudulent claims. Even with the ability to request additional information if a claim is suspected to be fraudulent, it is difficult to see how additional information will help a SIU investigator come to that conclusion, when the claimant is not going to offer any proof of a fraudulent claim. Furthermore, in a number of cases there is no additional information that can be obtained from the provider because the fraud is perpetuated by the patient, and any information that would help in the investigation is in the hands of the fraudulent claimant.

Innocent claimants are still protected by the 'thirty day rule', and the policy considerations of quick dispositions of these claims are still met. In order to prevent preclusion under the 'thirty day rule', insurance companies have to have some idea of the alleged fraudulent activity, and if the claimant is innocent he will be protected. Additionally, if payment is delayed because of a suspicion of fraud, there is no burden to be carried by the injured. During this time they are still receiving all their necessary medical care and other reasonable expenses.

While the recent developments within the New York State Legislature are a step in the right direction, there needs to be cooperation and more support conferred on insurance companies in their fight against insurance fraud. The one measure promulgated by the Legislature that would see the quickest, most drastic result in the fight against insurance fraud would be to give insurance companies more than thirty days to pay or deny a No-Fault claim when they suspect fraudulent behavior. This is especially true because the thirty day requirement is the biggest loophole in the No-Fault regulations, and those responsible for insurance fraud know it and utilize it to enable them to get their fraudulent claims paid quickly without dispute from the insurance companies.

2001

*NO-FAULT INSURANCE FRAUD*

637

When considering the recent case law, the policies behind the new statutes mandating SIU teams, the policies behind the 'thirty day rule', the recent pervasiveness of fraud throughout the insurance industry, and the recent developments in the New York State Legislature attempting to find a way to combat fraudulent insurance claims, it is clear that the thirty day rule should not have any application where there is fraudulent activity suspected in a No-Fault claim.

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