

A04-485, A04-486, A04-487, A04-488, A04-489

STATE OF MINNESOTA

IN SUPREME COURT

**Isles Wellness, Inc., n/k/a Minneapolis Wellness, Inc.,
Mn Licensed Physical Therapists, Inc., n/k/a A Licensed
Physical Therapy, Inc., and Licensed Massage Therapists, Inc.,
n/k/a Twin Cities Licensed Massage Therapy, Inc.,**

Appellants,

vs.

**Progressive Insurance Co., a Delaware Corporation
doing business in the State of Minnesota,**

**Respondent (A04-485, A04-486,
A04-489),**

**Allstate Indemnity Co., a Delaware Corporation
doing business in the State of Minnesota,**

Respondent (A04-487, A04-488).

APPELLANTS' REPLY BRIEF

MICHAEL J. WEBER
Atty. Reg. No. 0243267

WEBER LAW OFFICE
2801 Hennepin Ave. S., Ste. 200
Minneapolis, MN 55408
(612) 296-8080

ATTORNEY FOR APPELLANTS

RICHARD S. STEMPEL
Atty. Reg. No. 161834

STEMPEL & DOTY, PLC
41 Twelfth Ave. N.
Hopkins, MN 55343
(925) 935-0908

ATTORNEY FOR RESPONDENTS

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ARGUMENT

AS A MATTER OF LAW, RESPONDENTS CANNOT USE THE CORPORATE PRACTICE OF MEDICINE DOCTRINE TO AVOID PAYING APPELLANTS FOR REASONABLE AND NECESSARY CHIROPRACTIC SERVICES.

Throughout Appellants' operations, Appellants hired licensed chiropractic doctors who directly and independently provided reasonable and necessary chiropractic services to Respondents' insureds. Appellants operated in this ethical manner, consistent with good public policy, despite being in a legal predicament. Specifically, during the entire time of Appellants' operations, any corporate practice of medicine doctrine ("CPMD") in Minnesota was unclear. Moreover, Minnesota law was silent about the CPMD's explicit applicability to chiropractic.¹ In fact, it was not until after Appellants closed and ceased operations that the Minnesota Supreme Court decided CPMD's applicability to chiropractic in *Isles Wellness #1*.² Yet, throughout Respondents' entire brief and its citations to other state laws, Respondents ignore these very critical facts. By ignoring these critical facts, Respondents' analysis is superficial and deficient.

Moreover, a more careful analysis of Respondents' argument reveals many other superficial and deficient legal analyses. For example, Respondents fail to adequately address the critical challenges clearly raised by Appellants' initial brief:

¹ In response to Appellants' inquiry, the Minnesota Board of Chiropractic Examiners did not have a position on the applicability of any CPMD to chiropractic. Appellants also consulted a well-known, respected, and large Minneapolis law firm to ensure the legality of their corporate organization and operations. Moreover, a unanimous Minnesota Court of Appeals and three of seven Supreme Court Justices opined that CPMD did not apply to chiropractic. See Appellants' Br. at 4-6, 10-11, 25.

The confusion for legal experts was that *Granger*, the only Minnesota case referencing the doctrine, involved an unlicensed individual directly practicing medicine without a license. *Granger* did not involve the CPMD's classic scenario of a general corporation employing a physician, and it did not discuss the applicability of the CPMD to other healthcare professions. See *Granger v. Adson*, 190 Minn. 23, 250 N.W. 722 (1933).

² *Isles Wellness, Inc. v. Progressive N. Ins. Co.*, 703 N.W.2d 513 (Minn. 2005) [hereinafter *Isles Wellness #1*].

1. How do Respondents establish standing to enforce Minnesota's corporate practice of medicine doctrine ("CPMD")—a regulatory doctrine—when the CPMD does not provide insurance companies with any common law or statutory right to a private cause of action?
2. Assuming *arguendo* that CPMD makes Appellants' contracts void, which of Appellants' contracts do Respondents have standing to declare void, and how do those contracts relieve Respondent of their duty to pay their insureds' reasonable and necessary no-fault healthcare benefits?
3. Given that Minnesota law requires a case-specific analysis before finding contracts void on public policy grounds, how are Appellants' actions contrary to public policy, especially when licensed chiropractors independently and ethically provided all chiropractic care?

Instead of tackling these necessary challenges, Respondents prefer to make overbroad assertions based on inaccurate and superficial analyses of Minnesota cases as well as cases from other jurisdictions. Respondents repeatedly fail to completely describe and apply the applicable case law.

Respondents' failure to address these critical issues reveals the inadequacies of their argument. Under Minnesota law, Respondents' failure to address these issues generally amounts to a waiver of any opposition to them.³

In the end, both Minnesota law and Respondents' incomplete and deficient arguments reveal that Respondents lack the following: (1) standing to enforce the CPMD; and (2) an adequate public policy basis to avoid paying for reasonable and necessary no-fault health benefits, including those provided independently and directly by Appellants' licensed chiropractic doctors.

I. RESPONDENTS' FAIL TO ESTABLISH STANDING TO ENFORCE THE CORPORATE PRACTICE OF MEDICINE DOCTRINE.

Standing is a legal prerequisite that requires a party to have "a sufficient stake in a justiciable controversy to seek relief from a court."⁴ A cursory review of Respondents'

³ See also *Balder v. Haley*, 399 N.W.2d 77, 80 (Minn. 1987); see also *Riley v. 1987 Station Wagon*, 650 N.W.2d 441, 443 n.2 (Minn. 2002); *State v. Grecinger*, 569 N.W.2d 189, 193 n.8 (Minn. 1997).

own brief reveals deficiencies in their legal standing to enforce the CPMD. Without standing, Respondents' attempt to bring counterclaims based on the CPMD is legally deficient and fails.⁵

Despite the fact that standing is a necessary preliminary requirement to enforcing a claim, Respondents organize their argument in a counterintuitive and logically reverse manner. A logical organization would begin by analyzing this necessary prerequisite first instead of last. In fact, standing is the first issue addressed in Appellants' brief.

Respondents' organization raises suspicions about the weakness of Respondents' standing argument. A careful analysis of Minnesota law confirms that Respondents' argument for standing is deficient.

A. Respondents Cannot Rely On The Private Attorney General Statute To Overcome Their Lack Of Standing.

Respondents' primary argument for standing is based on the "Private Attorney General Statute," Minnesota Statutes, Section 8.31. Here, Respondents rely on this statute without doing the necessary legal analysis to determine whether it applies to this case. A complete analysis clearly demonstrates that Respondents do not have the right to enforce the CPMD through the Private Attorney General Statute.

It is true that the Private Attorney General Statute allows private causes of actions in some situations. But Respondents are mistaken that the analysis ends with a superficial and incomplete assertion of this statutory authorization.

Significantly, the CPMD is not listed among the examples of consumer protection statutes that are subject to private enforcement.⁶

Even more important, the Minnesota Supreme Court has specifically limited the use of the Private Attorney General Statute to those cases that meet the following criteria:

⁴ *State by Humphrey v. Philip Morris, Inc.*, 551 N.W.2d 490, 493 (Minn. 1996) (citing *Sierra Club v. Morton*, 405 U.S. 727, 731-32 (1972)).

⁵ See *Philip Morris, Inc.*, 551 N.W.2d at 493.

⁶ See Minn. Stat. § 8.31, subds. 1, 3a (2004).

(1) Those cases in which “[i]t’s simply impossible for the Attorney General’s Office to investigate and prosecute”; and (2) cases in which the “claimants . . . demonstrate that their cause of action benefits the public.”⁷ Respondents fail on both counts.

First, Respondents fail to show how the Attorney General’s Office (whether independently or as counsel for the Minnesota Board of Chiropractic Examiners) is unable to investigate and pursue allegations of noncompliance with the CPMD.⁸

Second, Respondents’ fail to show how their enforcement of the CPMD in this case clearly benefits the public using the critical facts of this case.

In the present case, the public was not harmed by Appellants’ corporate organization. Appellants provided all healthcare services directly through appropriately licensed professionals who independently exercised their professional judgment. As already shown in Appellants’ initial brief, Appellants’ provision of chiropractic services was consistent with public policy.⁹ Based on the facts in this case, Respondents’ case does not actually benefit the public, and therefore, the Private Attorney General Statute does not provide Respondents with a cause of action against Appellants.

Instead of performing the necessary legal analysis of public benefit, Respondents attempt to rely on *Group Health Plan v. Philip Morris, Inc.*,¹⁰ incompletely describing the case as one allowing insurance companies to pursue consumer fraud actions on behalf of their members.¹¹ But Respondents’ description of the *Group Health Plan* decision is legally incomplete and overbroad.

⁷ See *Ly v. Nystrom*, 615 N.W.2d 302, 311, 313 (Minn. 2000).

⁸ For a discussion of the Attorney General’s right to pursue claims based on corporate formation, see Resp’ts’ [now Appellants’] Br. to Minn. Sup. Ct. at 10-11, *Isles Wellness #1*.

⁹ See Appellants’ Br. at 23-31 (in the context of analyzing whether Appellants’ contracts were void on public policy grounds). Note also that before Appellants began operations, a legal firm had advised Appellants that Minnesota did not have a CPMD applicable to chiropractic.

¹⁰ 621 N.W.2d 2, 6-11 (Minn. 2001).

¹¹ See Resp’ts’ Br. at 19.

Group Health Plan applied to non-profit managed care organizations that were pursuing a consumer fraud case against tobacco companies on behalf of their members and for the public good. Respondents, however, are not an entity analogous to the organizations in *Group Health Plan*. For example, unlike the *non-profit* managed care organizations in *Group Health Plan*—organizations that actually provided direct health care services to their members—Respondents are *for-profit* automobile insurance companies.

Related to this, while non-profit healthcare companies have statutory mandates that require them to act on behalf of the public good, Respondent automobile insurers have no analogous requirement.¹²

Clearly, Respondents' interests in pursuing the case against Appellants are not analogous to the underlying consumer fraud case against the tobacco companies in *Group Health Plan*. Appellants have previously shown the lack of public harm when licensed healthcare professionals directly and independently provide the healthcare services to Respondents' insureds.

Furthermore, Respondents are actually acting in a manner inconsistent with the interest of their insureds and, thus, the public. Respondents' insureds pay a premium that entitles them to have their reasonable and necessary healthcare claims covered. Instead of meeting their obligations to their insureds (i.e., paying for their reasonable and necessary healthcare claims), Respondents are trying to get out of these obligations to their insureds. Respondents are acting in the interest of their own profit motivations, seeking a windfall based on a superficial and incomplete analysis of Appellants' healthcare services.¹³

¹² See *Group Health Plan v. Philip Morris, Inc.*, 621 N.W.2d 2, 6 (Minn. 2001); *State by Humphrey v. Philip Morris Inc.*, 551 N.W.2d 490, 492 (Minn. 1996) (noting the unique statutorily stated purposes of non-profit healthcare companies, such as advancing the public health).

¹³ See, e.g., Appellants Br. at 28-31.)

Contrary to Respondents' assertions, a complete and accurate analysis of the Private Attorney General Statute reveals that it does not provide Respondents with standing in this case.

B. Respondents Cannot Rely On Minnesota Common Law To Overcome Their Lack Of Standing.

Respondents' common law argument for standing is similarly based on an inadequate legal analysis. In fact, as Appellants anticipated in their initial brief, Respondents' argument is so broad that, if successful, it would provide almost any party with standing to enforce almost any law.¹⁴

Instead of fully analyzing Minnesota law, Respondents cite several Minnesota Supreme Court cases from the early 1900s. Respondents take these cases out of context, to superficially assert that they have a cause of action under the CPMD.¹⁵ Respondents' cited cases, however, do not support their argument for standing.

The cases cited by Respondents stand for the general proposition that those wronged should have a cause of action under common law or equity.¹⁶ This general proposition is actually consistent with the prerequisite of standing: A party must have been wronged to have a cause of action.

Instead of actually applying this general proposition to the facts of the present case, Respondents superficially assert that these cases provide them with standing to enforce the CPMD. Respondents assert that they "have been harmed by the Appellants' violation of the . . . CPMD," without explaining how Respondents have been actually and

¹⁴ See Appellants' Br. at 17-18.

¹⁵ See Resp'ts' Br. at 21-22, 21 n.64 (citing *Sullivan v Minneapolis & Rainy River Ry. Co.*, 121 Minn. 488, 142 N.W. 3 (1914); *Quirk v. Everett*, 106 Minn. 474, 119 N.W. 63 (1909); *Rogers v. Clark Iron Co.*, 104 Minn. 198, 116 N.W. 739 (1908)).

¹⁶ See Resp'ts' Br. at 21, 21 n.64.

specifically harmed.¹⁷ In order to use these cases for standing, Respondents are required to show some actual harm that Appellants' business organization caused to Respondents.

Even though *Isles Wellness #1* concluded Appellants' chiropractic clinics failed to comply with the CPMD, the Court did not state that Respondents were harmed by Appellants' corporate organization.¹⁸ To the contrary, Respondents cannot show any harm when their insureds and claimants received everything bargained for: (i) direct healthcare services (ii) from appropriately licensed providers (iii) who were able to independently exercise their professional judgment.

Respondents' legal analysis is insufficient. Respondents cannot pursue a cause of action when they have not demonstrated any specific harm by Appellants. Thus, Respondents also have no standing to enforce the CPMD under common law.

C. Respondents Lack Standing To Assert That Appellants' Contracts Are Void.

In Appellants' initial brief, Appellants noted that even if all of their contracts are void under *Granger*, Respondents fail to explain their leap of logic in then concluding that they are relieved of paying Appellants' reasonable and necessary healthcare claims. It is a leap of logic because Respondents fail to identify which of Appellants' supposedly voided contracts relieves Respondents of their obligation to pay their insureds' no-fault healthcare claims.¹⁹

Despite knowing this clear logical deficiency, Respondents do not even try to address it. Instead, Respondents continue to make overly broad and incorrect assertions based on an incomplete and superficial legal analyses: First, Respondents claim that they can deem all of Appellants' contracts void, regardless of Respondents' connection to the contracts. Second, Respondents claim they do not even need to contest any of the

¹⁷ See Resp'ts' Br. at 21.

¹⁸ *Isles Wellness, Inc. v. Progressive N. Ins. Co.*, 703 N.W.2d 513 (Minn. 2005)

¹⁹ See Appellants' Br. at 21-23.

contracts. And, finally, Respondents claim that somehow the voided contracts relieve Respondents of their duty to pay their insureds' no-fault healthcare benefits.²⁰

Significantly and perhaps unintentionally, Respondents' choice of language reveals a significant problem with their argument. Respondents broadly assert that not only are Appellants' *contracts* void, but also "*any duty* to pay for services on the part of the Respondents is void."²¹ Thus, Respondents' choice of language reveals that Respondents cannot rely only on voiding all of Appellants' contracts (regardless of whether the contracts in fact are in violation of public policy). Instead, for Respondents to be relieved of paying for Appellants' reasonable and necessary healthcare services, the CPMD must also void *any duty* in general to Appellants.

Thus, the voided duties would not be limited to those based on a contract with Appellant. Instead, the voided duties would apparently include statutory duties, common law duties, and even duties to others, such as Respondents' insureds, based on Appellants' underlying healthcare services to the insureds.

But neither *Granger* nor *Isles Wellness #1* is as broad as Respondents assert. Even so, when Minnesota law does not support Respondents' position, Respondents just broadly and superficially assert that it does.

In actuality, at a minimum, Respondents must identify how and why Appellants' voided contracts relieve Respondents of their obligations to pay for their insureds' reasonable and necessary healthcare benefits. Respondents do not do so because they cannot.

²⁰ See Resp'ts' Br. at 22-23.

²¹ See, e.g., Resp'ts' Br. at 22.

II. RESPONDENTS FAIL TO EXPLAIN THE LEGALLY REQUIRED PUBLIC POLICY RATIONALE FOR CONSIDERING APPELLANTS' CONTRACTS VOID AS A MATTER OF LAW.

As Appellants outlined in their initial brief for both the Court and Respondents, noncompliance with a law does not alone dictate that a party's contracts are void on public policy grounds.²² Despite being provided this clear Minnesota law, Respondents' first strategy is to simply ignore the law. Specifically, Respondents fail to analyze whether Appellants actually violated public policy. Instead, Respondents limit their argument to superficial assertions. In contradiction to Minnesota law, Respondents simply assert that Appellants' contracts are void based solely on Appellants' noncompliance with the CPMD,²³ contrary to the more complete analysis required by Minnesota law.

Respondents also use a second strategy, specifically, asserting inaccurate "facts"²⁴ to the Court. Respondents' inaccurate "facts," however, violate the following: (1) Minnesota's summary judgment standard that requires the evidence to be viewed in the light most favorable to Appellants (the party against whom summary judgment was granted)²⁵; and (2) the overwhelming weight of the evidence.²⁶

With both strategies, Respondents' superficial public policy analysis contradicts Minnesota law. The reason Respondents are unable to provide a more thorough and accurate analysis is because Appellants' actual provision of chiropractic services complied with public policy. Consistent with public policy, licensed chiropractic doctors directly and independently provide Appellants' reasonable and necessary chiropractic services.

²² See Appellants' Br. at 23-28.

²³ See, e.g., Resp'ts' Br. at 16, 22-24.

²⁴ See, e.g., Resp'ts' Br. at 16, 24.

²⁵ See Appellants' Br. at 13, 13 n.38 (noting how Respondents similarly ignored this basic summary judgment standard in their previous briefs in *Isles Wellness #1*).

²⁶ See Appellants' Br. at 4-11; see also Resp'ts' [now Appellants'] Br. to Minn. Sup. Ct. at 9-17, *Isles Wellness #1*.

Therefore, Appellants' contracts are not contrary to public policy, and the contracts should not be void.

III. RESPONDENTS WRONGLY ATTEMPT TO RELY ON A NEW JERSEY CASE THAT IS INAPPLICABLE TO THE PRESENT ISSUE AND A NEW YORK CASE THAT ACTUALLY SUPPORTS APPELLANTS' POSITION.

Respondents implicitly acknowledge the weakness of their argument under Minnesota law. Instead of relying on Minnesota law, Respondents' primary argument is based on two cases from other jurisdictions, specifically from New Jersey and from New York.²⁷ Respondents, however, rely on a superficial analysis of these two out-of-state cases. Respondents fail to address and mischaracterize critical facts in these cases. A more appropriate analysis of the cases reveals: (1) the New Jersey case did not even decide the issue claimed by Respondents; and (2) the New York case actually supports Appellants'—not Respondents'—case.

The New Jersey case on which Respondents rely is *Liberty Mutual Insurance Co. v. Hyman*. But, unlike Respondents' description of *Liberty Mutual Insurance Co.*, a more careful analysis of the New Jersey case reveals that it involved a very different situation than the present case:

1. Unlike the present case, the court noted that several of the patients of the lay-owned clinic made material misrepresentations regarding their entitlement of insurance benefits. Therefore, unlike the present case, there was a significant, additional basis for denial of insurance coverage: fraudulent conduct by the insureds.²⁸
2. Unlike Minnesota law during Appellants' operations, New Jersey had an already existing statutory corporate practice of medicine prohibition that was clearly applicable to chiropractors at the time of the lay-owned clinic's operations.²⁹

²⁷ See Resp'ts' Br. at 8-13 (discussing *Liberty Mut. Ins. Co. v. Hyman*, 759 A.2d 894 (N.J. Super. Ct. Law Div. 2000) and *State Farm Mut. Auto. Ins. Co. v. Mallela*, 827 N.E.2d 758 (N.Y. 2005))

²⁸ See *Liberty Mut. Ins. Co.*, 759 A.2d at 901.

²⁹ See *Liberty Mut. Ins. Co.*, 759 A.2d at 897; N.J. Stat. Ann. § 14A:17-3(1).

3. Unlike the present case, the New Jersey case was uncontested. Only the insurance company submitted a brief to the appellate court. The clinic did not even appear: “No one appeared for defendants.”³⁰
4. Most importantly, the *Liberty Mutual* court did not actually decide whether the insurance company was required to pay a lay-owned clinic for its reasonable and necessary healthcare services. At the trial court, the lay-owned clinic defaulted by failing to even answer the insurance company’s complaint. Based on this default, the Superior Court of New Jersey considered the clinic to “concede that its bills for services rendered to the individual defendants herein are not entitled to PIP coverage.” Thus, unlike Respondents’ claim, the New Jersey court did not actually decide this issue; instead the court considered the clinic to have conceded the issue based on the clinic’s default at the trial court and the clinic’s failure to write a brief or appear in the appellate matter.³¹

Unlike Respondents’ description of the case, *Liberty Mutual Insurance Co.* is focused on analyzing the applicability of CPMD to chiropractic (even though the CPMD was already clearly applicable based on New Jersey statutory law). The New Jersey court did not decide the issue of the clinic’s right to reimbursement from the insurance company. The court noted that the clinic *conceded* the issue based on their total non-response.

If the Minnesota Supreme Court solely read Respondents’ description of *Liberty Mutual Insurance Co.*, the Minnesota Supreme Court would never know the New Jersey case’s critical facts or the limits of the case’s holding.

Respondents’ superficial analysis is even more egregious with the New York case, *State Farm Mutual Automobile Insurance Co. v. Mallela* (“*Mallela (2005)*”).³² Respondents downplay a critical change in New York regulatory law that drives what might superficially appear to be conflicting decisions between *State Farm Mutual Automobile Insurance Co. v. Mallela* (“*Mallela (2001)*”)³³ and *Mallela (2005)*.

³⁰ *Liberty Mut. Ins. Co.*, 759 A.2d at 894.

³¹ *Liberty Mut. Ins. Co.*, 759 A.2d at 900-01.

³² 827 N.E.2d 758 (N.Y. 2005)

³³ 175 F. Supp.2d 401 (E.D.N.Y. 2001).

The current state of Minnesota law is more similar to *Mallela (2001)* than *Mallela (2005)*, so Appellants focused on *Mallela (2001)* in their initial brief. As Appellants noted, *Mallela (2001)* held that, even though clinics were organized in contradiction to a clear New York CPMD, the insurance company was required to pay for the clinic's reasonable and necessary healthcare services.³⁴

Anticipating Respondents' likely superficial analysis of New York law, however, Appellants also addressed *Mallela (2005)* in their initial brief.³⁵ Nevertheless, it is disappointing that Respondents misrepresent Appellants' initial brief to the Court when Respondents state: "Interestingly, the Appellants have elected to ignore [*Mallela (2005)*]."³⁶

The critical facts in the *Mallela* cases are that *after Mallela (2001)*, New York had a significant *addition* to its relevant regulatory law regarding a non-compliant clinic's right to insurance payments. Specifically, after *Mallela (2001)* was decided, the New York's Superintendent of Insurance implemented a regulation explicitly stating that a provider is not entitled to reimbursement of no-fault benefits if the provider does not meet New York state or local licensing requirements—which would include New York's CPMD.³⁷

After the new regulation had been implemented, its effect on non-compliant clinics' right to reimbursement was considered in *Mallela (2005)*. Consistent with the regulation, the *Mallela (2005)* court held that after the effective date of that regulation (April 2002), insurance companies could pursue claims of fraud and unjust enrichment to recover funds paid to "fraudulent corporations". Importantly, however, *Mallela (2005)* did *not* overturn *Mallela (2001)*. Rather, as in *Mallela (2001)*, the *Mallela (2005)* court

³⁴ See *State Farm Mut. Auto. Ins. Co. v. Mallela*, 175 F. Supp.2d 401 (E.D.N.Y. 2001); Appellants' Br. at 19-21.

³⁵ Appellants' Br. at 20-21 n.57.

³⁶ Compare Resp'ts' Br. at 13 with Appellants' Br. at 20-21 n.57.

³⁷ N.Y. Comp. Codes R. & Regs. tit. 11, § 65-3.16(a)(12).

held that insurance companies could not recover funds paid to non-compliant clinics prior to the effective date of the regulation.³⁸

In Respondents' brief, Respondents superficially analyze New York law, ignoring the full holding of *Mallela (2005)*. *Mallela (2005)* actually co-exists quite logically with *Mallela (2001)*. Each case has a different result because of a significant amendment to New York regulatory law. An insurance company has no authority to withhold payment of healthcare services, based solely on noncompliance with the CPMD, unless an explicit law provides that right.

Minnesota has no law allowing Respondents to withhold payment of no-fault healthcare benefits based solely on a clinic's corporate formation. Thus, both *Mallela (2005)* and *Mallela (2001)* support Appellants' position at this time. Applying the reasoning of the *Mallela* courts, until there is clear Minnesota law allowing insurance companies to withhold payment of no-fault healthcare services based solely on the CPMD, Respondents have no right to withhold payment of Appellants' healthcare services.

Appellants provided chiropractic services directly through duly licensed chiropractic doctors, and Respondents' insureds and claimants received the benefit of Appellants' services. Therefore, Respondents must pay for Appellants' reasonable and necessary healthcare services.

³⁸ *Mallela*, 827 N.E.2d at 761.

CONCLUSION

For the above reasons, Appellants respectfully request that the Court reverse the trial court's order, thereby allowing Appellants to obtain reimbursement from Respondents for Appellants' reasonable and necessary healthcare services.

Respectfully submitted,

DATED: July 31, 2006



Michael J. Weber (License No. 0243267)
Weber Law Office
2801 Hennepin Ave. S., Ste. 200
Minneapolis, MN 55408
Office (612) 296-8080
Fax (612) 825-6304

ATTORNEY FOR APPELLANTS

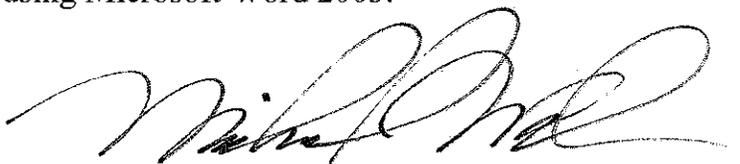
CERTIFICATION OF BRIEF LENGTH

I certify that this reply brief conforms to the requirements of the Minnesota Rules of Civil Appellate Procedure, Rule 132.01, Subdivisions 1 and 3, for a reply brief produced with a proportional font.

The length of the brief is 370 lines and 3,875 words.

This brief was prepared using Microsoft Word 2003.

DATED: July 31, 2006



Michael J. Weber (License No. 0243267)
Weber Law Office
2801 Hennepin Ave. S., Ste. 200
Minneapolis, MN 55408
Office (612) 296-8080
Fax (612) 825-6304

ATTORNEY FOR APPELLANTS