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SIU SPOTLIGHT

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WELCOME

Welcome to the SIU Spotlight Second Issue!

As we move deeper into 2025, insurance carriers face an evolving landscape of fraud threats that demand heightened vigilance and adaptive defense strategies. The proliferation of AI-driven fraud schemes, increased regulatory scrutiny, and the persistent challenge of organized fraud rings continue to put pressure on insurers across all lines of coverage.

Despite these challenges, however, the industry is responding with innovative solutions. In this issue, we'll explore key case law developments, emerging fraud trends, and best practices for insurers looking to stay ahead of the curve in 2025. ◆

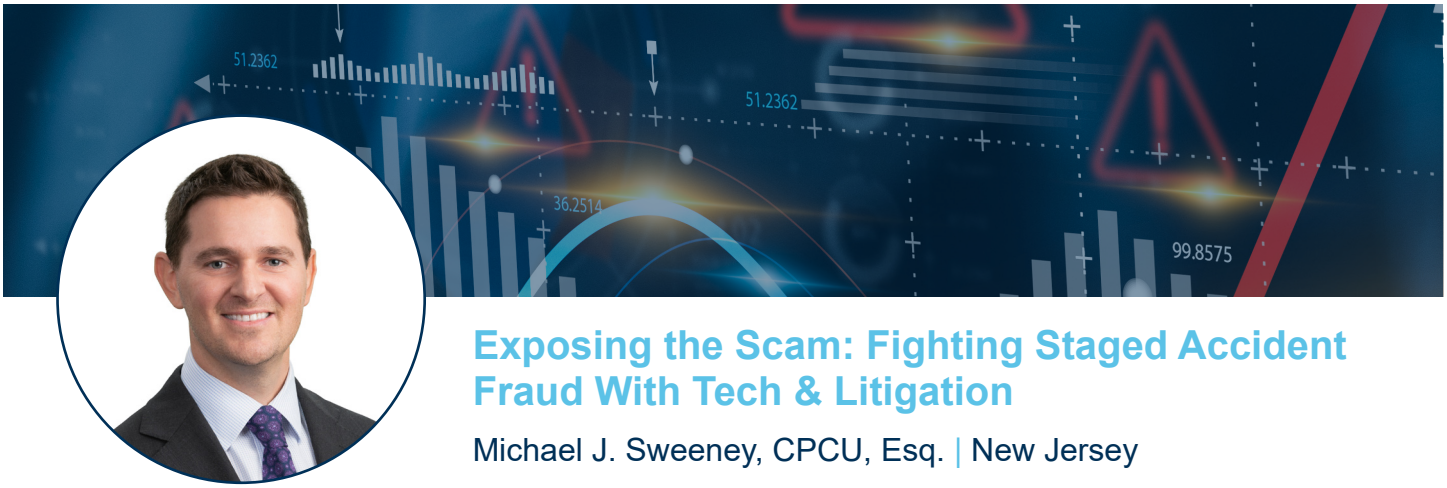
Comments, thoughts and questions are welcomed. Thanks for reading!

Ariel Brownstein

Changes in Fraud and SIU: Expanding Our Focus on Staged Accident Fraud

As staged accidents become a more prevalent form of insurance fraud, our Insurance Fraud & Special Investigation Unit (SIU) Practice Group has expanded its focus to address this growing trend. Staged vehicle collisions, orchestrated slip-and-fall incidents, and exaggerated injury claims are driving up costs across industries, particularly in trucking, retail, hospitality, and property management. These schemes are becoming more sophisticated, requiring deeper investigation and a proactive legal approach.

Our team has been handling fraudulent claims for years, but we're now placing even greater emphasis on identifying, defending, and taking legal action against staged accident schemes. By leveraging fraud intelligence resources and working closely with clients during investigations, we're able to stay ahead of emerging tactics and strengthen defenses against these claims. As always, we remain committed to keeping you informed and prepared as the landscape of fraud continues to evolve. ◆



Exposing the Scam: Fighting Staged Accident Fraud With Tech & Litigation

Michael J. Sweeney, CPCU, Esq. | New Jersey

With increasingly sophisticated techniques,organized fraud rings target both commercial trucking fleets and private passenger vehicles in schemes designed to fabricate accidents and exploit the insurance claims process. These fraudulent activities have led to significant financial losses for insurance carriers and businesses, driving up premiums and creating unnecessary litigation. However, recent advancements in technology and legal strategies have given businesses and insurers powerful tools to combat these criminal enterprises.

This article examines common fraud tactics involving fabricated motor vehicle losses, outlines key preventive measures, and explores proactive legal strategies that businesses and insurers can implement to mitigate risk and deter fraudulent claims.

The Mechanics of Staged Accidents

Staged automobile accidents follow a common set of patterns, often orchestrated by multiple vehicles acting in concert to create the illusion of a legitimate collision. These schemes typically include:

- **Forced Merging Collisions**: A fraudster vehicle double-parks or obstructs traffic, compelling the insured driver to maneuver around it. At that moment, another vehicle initiates a low-speed collision, making it appear as though the insured driver was at fault.

- **Sudden Braking Scenarios**: A fraudulent actor abruptly stops in front of a truck, forcing a rear-end collision. In some cases, an accomplice vehicle blocks the truck from changing lanes, thereby preventing the driver from avoiding an impact with the claimant vehicle.

- **Phantom Accidents**: No actual collision occurs, but claimants submit fabricated police reports and medical documentation alleging significant injuries. In many such instances, an accomplice driver will pose as a “Good Samaritan” who slows in traffic in order to allow the claimant vehicle (with unrelated damages) to pull along side the target vehicle and allege that an accident has occurred.

- **Multiple Passenger Injury Claims**: Fraudulent claims often involve multiple occupants in the claimant vehicle, each alleging injuries that require extensive (and often unnecessary) medical treatment, including surgeries, to inflate the value of their claims.

Leveraging Technology to Prevent Fraud

One of the most effective defenses against staged accidents is the strategic use of technology to document incidents and provide irrefutable evidence of their occurrence. Businesses and insurers should consider implementing the following:

- **Front and Rear-facing Dashboard Cameras (dashcams)**: Dashcams capture real-time footage of roadway conditions, vehicle movements, and collisions. These devices have dropped dramatically in price in recent years and can provide indispensable video evidence which can immediately refute fraudulent claims by demonstrating how the alleged accident was intentionally caused.

- **Event Data Recorders (EDRs)**: Also known as vehicle "black boxes," EDRs track speed, braking, and other driving metrics. EDR data can be used to challenge fraudulent claims by showing that no impact occurred, that an incident was intentionally caused, or that the insured vehicle was not at fault.

- **Rapid-Response Investigations**: In the aftermath of a suspicious accident, investigators should promptly collect available video evidence from nearby traffic cameras and businesses. Likewise, investigators should waste no time in performing background checks of the claimants, which can reveal patterns of prior fraudulent claims, potential connections to known fraud rings through usage of common telephone numbers and addresses, and past criminal convictions.

Legal Strategies to Combat Fraudulent Claims

While technology provides a strong deterrent against fraud, businesses and insurers must also adopt an assertive legal approach to prevent fraudulent claims from resulting in costly settlements. The following strategies can be particularly effective:

- **Declaratory Judgment Actions**: If evidence suggests that a claim is fraudulent, businesses and insurers should consider filing a declaratory judgment action seeking a court ruling that no liability exists. This preemptive legal maneuver places the burden on fraudsters to justify their claims and can prevent the case from escalating into protracted litigation.

- **Counterclaims for Fraud**: When a lawsuit based on a fraudulent claim is filed, defendants should consider asserting counterclaims for fraud, misrepresentation, and conspiracy. A well-documented counterclaim can serve as a deterrent, signaling that fraudulent actors will face legal consequences rather than quick settlements.

- **Vigorous Litigation Defense**: Fraudsters often rely on the assumption that insurers will settle rather than incur the costs of litigation. By aggressively defending against fraudulent claims and utilizing video and EDR evidence, businesses and insurers can shift this calculation.

Where appropriate, defense counsel should seek early dismissal of claims based on fraudulent allegations and request sanctions against claimants who engage in bad-faith litigation.

Conclusion

Staged accidents and fraudulent insurance claims pose a substantial threat to insurance carriers, commercial enterprises, and private individuals. However, by leveraging advanced technology, conducting thorough investigations, and taking an aggressive legal approach, the insurance industry can effectively combat these criminal schemes. ◆

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Florida Court Limits Privilege for Claim File Notes in Depositions

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It is a situation that many attorneys and insurance professionals have encountered in the past. A plaintiff is deposing an adjuster, and the defense attorney states or asks to not waive privilege of claim file notes for the deponent to review them. Usually these notes contain the basic claim information needed for a deposition in addition to the confidential insurer's mental impressions and claim determinations. Sometimes the claim notes will even include the entire special investigations diary. If careful attention is not paid to the plaintiff's response, it just might so happen that all of those notes are now subject to discovery and the plaintiff's review.

In 2024, the Florida's Third District Court of Appeal, in *Hamilton v. Citizens Property Insurance Corporation*, 390 So.3d 700 (Fla. 3d DCA 2024), ruled that there is no such thing as a generic "claim file privilege" for a deponent to review the claim notes during a deposition. In the *Hamilton case*, Citizens Insurance actually obtained a protective order from the trial court for its corporate representative to review and rely on portions of its claim file during a deposition without waiving privilege or allowing the plaintiff to review the used materials. On *certiorari* review, the Third District reversed this order as a departure from the essential requirements of Florida law.

The appellate court found that the notion of a "claim file privilege" as carte blanche to use materials during testimony without providing an opportunity for the opposing party to review violated the Florida Evidence Code. The Third District specifically cited to Section 90.613 Fla. Stat. as basis for its ruling, which states: ▸

> When a witness uses a writing or other item to refresh memory while testifying, an adverse party is entitled to have such writing or other item produced at the hearing, to inspect it, to cross-examine the witness thereon, and to introduce it, or, in the case of a writing, to introduce those portions which relate to the testimony of the witness, in evidence.

Section 90.613, Fla. Stat. (2023).

This section is commonly referred to as refresh recollection and is often used when a witness cannot remember helpful information, such as basic date, time, and location details. Without § 90.613, Fla. Stat., there is no ability for a witness to aid their testimony by reviewing documentation during a deposition. The Third District specifically ruled the "statute is clear and unambiguous: if a witness, during his or her deposition testimony, relies on a written document to refresh his or her recollection, those portions of the document that relate to the witness's testimony must be produced to the opposing party, resulting in a waiver of an otherwise applicable privilege." Id. (Citing to *Soler v. Kukula*, 297 So. 2d 600, 601-02 (Fla. 3d DCA 1974).

The Appellate Court grants *certiorari* jurisdiction, essentially immediate review, to review the protective order because there would be "no practical way to determine after judgment what the testimony would be or how it would affect the result" at a trial. As such, an insurer's attempt to rely on such privilege in a deposition and to refuse to follow § 90.613, Fla. Stat., would result in an swift reversal. The court did note that the only exception recognized for § 90.613 is for relevance. Even so, if challenged, the materials would be subject to an in camera review by the trial judge. While the irrelevant information may be removed, the privileged litigation material would remain waived.

The practical considerations of the *Hamilton v. Citizens* opinion are readily apparent. Insurance professionals should take care to not have sensitive or confidential information before them when being deposed, even if the information is part of a larger file being used to recollect specific facts of the case. Pre-writing basic claim background information on to a separate document may be the best manner to exclude privileged material from ever being incidentally disclosed in a deposition.

While great in consequence, the Third District's opinion also provides an excellent instructional guide on how to keep sensitive information protected for all parties. ◆

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Did the Cat Move the Ladder?

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In 2024 there were several important New York labor law decisions across the Appellate Divisions and even at the Court of Appeals. It is easy to ignore some of these cases given the ongoing "Fraudemic." However, in midst of this storm, one appellate decision has given defense counsel some firm ground on which to defend a standard § 240(1) case, particularly one involving a fall from a ladder. So what does a cat have to do with anything? Let me explain.

New York Labor Law § 240(1), also known as the scaffold law, provides in relevant part:

> All contractors and owners and their agents, except owners of one- and two-family dwellings who contract for but do not direct or control the work, in the erection, demolition, repairing, altering, painting, cleaning or pointing of a building or structure shall furnish or erect, or cause to be furnished or erected for the performance of such labor, scaffolding, hoists, stays, ladders, slings, hangers, blocks, pulleys, braces, irons, ropes, and other devices which shall be so constructed, placed and operated as to give proper protection to a person so employed.

Once judgment under this statute is granted, liability is absolute, and it doesn't matter what the plaintiff was doing or if they were comparatively negligent.

While there are some limited defenses available —such as an uncovered worker, a non-covered activity, a recalcitrant worker, sole proximate cause—these are all very fact-specific and are typically not available in a standard fall-from-a-ladder case. Unfortunately, the majority of cases involving a fall from a ladder are simply liability dead-ends, where the plaintiff testifies they climbed up the ladder to do work, it shook and they fell. Often the plaintiff will testify they knew the ladder was unsafe, but they "wanted to get the job done." These facts pled, bare in an affidavit, are enough for a plaintiff to move for early summary judgment after joinder of issue and before any depositions or initial discovery have taken place.

Again, defendants are hard pressed to come up with a defense. The purpose of the statute itself, which was created to protect workers by charging owners and general contractors with absolute liability, seems to fall by the wayside. Ladder cases in recent years seem to follow the same exact fact pattern. Still, the courts seem to simply adopt the circular logic without even looking at the underlying facts—the plaintiff fell because there was a violation; there was a violation because the plaintiff fell.

Anyone who has defended a ladder case has found it extremely frustrating. The testimonies are usually the exact same. "The ladder moved." "The ladder shifted." "The ladder shook." This testimony is enough to trigger liability, no matter how ridiculous or unbelievable the remainder of the plaintiff's testimony may be or what led up to the ladder mysteriously moving. I am tempted sometimes to ask the plaintiff, "Did a cat move it? Were there cats on the jobsite?" Because, frankly, that would be a much more credible explanation than the ladder just moving.

Enter *Simpertegui v. Carlyle House Inc.,* (2024 Slip Op 02609, First Department/App Docket 2023-02362), where the plaintiff alleged he fell from a ladder while performing brickwork. He claimed the ladder suddenly shook while he was about seven feet off the ground (shocking) and he fell. The plaintiff moved for summary judgment pursuant to Labor Law § 240(1), which was granted by the Bronx Supreme Court.

The defendants appealed to the First Department. In a short, but powerful decision, the Appellate Division found that the defendant raised triable issues of fact to defeat the summary judgment motion and reversed the lower court's ruling.

First, the plaintiff provided two separate dates of accident. He cited July 28, 2017, as the accident date in a workers' compensation form and at a hearing. Later, at his deposition, he stated his accident date was July 31, 2017. While mixing up accident dates is usually not dispositive, video footage shows the plaintiff working on both days. Furthermore, no accidents were reported on those dates.

Second, he claimed he personally reported his accident to his supervisor, Abraham Diaz. Mr. Diaz confirmed the plaintiff did not report an accident to him on either date. He also provided phone records to prove the plaintiff never called him to report the accident.

Finally, the court noted the plaintiff first went to the hospital days after the employer fired him for absenteeism.

The defendants also argued on appeal the plaintiff never put forth any evidence that the ladder itself was defective, either from his own recollection or witnesses. Specifically, the plaintiff testified he was not aware if his feet came off the ladder. The court did not mention these issues, and it seems they were more concerned with his overall credibility: "Defendants raised triable issues of fact sufficient to defeat the motion by identifying various inconsistencies in plaintiff's account of the accident, thus calling into question his overall credibility and circumstances underlying his claimed injuries."

This decision is important because it highlights the importance of getting all specific facts surrounding the plaintiff's accident, not just focusing on the happening of the accident itself. Defendants should seek to obtain testimony from all co-workers, supervisors, or anyone else at the jobsite who can testify as to whether an accident happened or was reported at all. Even if an accident was reported, the initial complaints or accident reports, workers' compensation filings, testimony provided by the plaintiff, and records of the first medical treatment should all be compared and analyzed when assessing the plaintiff's credibility. Obviously, phone, video and metadata must also be scrutinized to the extent they are available.

This may be the first in a significant line of cases where the New York State courts start seriously looking at the circumstances of ladder falls, not just providing the typical rubber stamp treatment. After all, a cat was not on the jobsite. ◆

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Fraud Act and RICO Claims Belong in Court, Says NJ Appellate Court

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The ongoing battle over whether disputes under the Insurance Fraud Prevention Act (the Fraud Act) and the New Jersey Anti-Racketeering Act (RICO) can be litigated in court recently resulted in a favorable determination for insurance carriers in the New Jersey Appellate Division case of *Allstate v. Carteret Comprehensive Care, PC, et al.,* No. A-4605-91 (App. Div. January 9, 2025).

In March 2023, Allstate Insurance filed a complaint against more than 30 defendants, alleging violations of the Fraud Act and RICO, among other claims. A group of defendants moved to dismiss the complaint and compel arbitration. On October 27, 2023, the trial court issued three orders granting the moving defendants' request, compelling all claims asserted by Allstate to arbitration under the Automobile Insurance Cost Reduction Act (AICRA). The trial court ruled that AICRA's language mandated arbitration for all disputes concerning the recovery of Personal Injury Protection (PIP) benefits, that any party to the dispute could invoke arbitration, and that the arbitration provision covered a broad range of legal disputes related to PIP benefits.

Allstate appealed the order dismissing the complaint and compelling arbitration, arguing the trial court erred because: (1) AICRA could not strip the right to a jury trial as guaranteed by the Fraud Act and RICO; (2) AICRA only mandates arbitration for disputes regarding the recovery of medical expense benefits under PIP; (3) AICRA, the Fraud Act, and RICO do not support the conclusion that fraud claims can be subject to PIP arbitration; and (4) statutory interpretation does not support the notion that claims under the Fraud Act and RICO should be arbitrated.

The Appellate Division distinguished the objectives of the PIP arbitration process from those of the Fraud Act and RICO. The court emphasized that PIP arbitrators have limited discovery enforcement powers and discovery in PIP arbitration is confined to assessing the nature, extent, and validity of a PIP claim. Furthermore, PIP benefits are statutory in origin, and remedies for their denial are restricted to interest and attorneys' fees.

In contrast, the Fraud Act and RICO serve broader purposes, such as combating insurance fraud and addressing serious threats to New Jersey's political, social, and economic institutions. The Fraud Act allows for the recovery of compensatory damages, investigative expenses, costs, attorneys'

fees, and, when a pattern of fraud is established, treble damages. RICO provides both civil and criminal sanctions. The court astutely noted that PIP arbitration regulations do not expressly provide for injunctive relief, compensatory damages, treble damages, or attorneys' fees for an insurance carrier.

Additionally, the court highlighted that PIP arbitration rules do not allow for (1) broad discovery, (2) discovery from third parties, or (3) the joinder of third parties. Ultimately, the court concluded that AICRA's history demonstrated that PIP arbitration was intended as an expedited and streamlined process strictly for resolving PIP benefit disputes.

The court also rejected the defendants' argument that they had a right to arbitration under Allstate's Decision Point Review Plan (DPRP). It determined that by referencing *N.J.A.C.* 11:3, Allstate had made clear that arbitration under its DPRP was no broader than PIP arbitration under AICRA. Since the plan's scope was identical to AICRA, the defendants had no independent right to arbitration under the DPRP.

Additionally, Allstate argued that interpreting AICRA to require arbitration for insurance fraud claims would violate its constitutional right to a jury trial under the Fraud Act and RICO. The New Jersey Constitution guarantees the right to a jury trial for statutory causes of action sounding in law, as affirmed in *Lajara*. While private parties may waive this right through arbitration agreements, the Legislature cannot mandate such waivers without allowing for a *de novo jury trial, per Jersey Central Power & Light*.

The court noted that arbitration for PIP claims is permissible because there is no constitutional right to a jury trial for determining PIP entitlements, as established in *Endo Surgi Center*. By limiting AICRA's arbitration provision to PIP claims and excluding fraud claims, the court avoided potential constitutional conflicts, adhering to the principle of statutory interpretation that preserves constitutionality.

A key issue was the conflicting decision from the Third Circuit in *Government Employees Insurance Co. v. Mount Prospect Chiropractic Center*, 98 F.4th 463 (3d Cir. 2024). In *GEICO*, the Third Circuit held that Fraud Act claims are arbitrable under AICRA. However, the Appellate Division noted that this decision was not binding on the case before it and disagreed with the Third Circuit's interpretation of New Jersey law.

The Appellate Division found that the Third Circuit had reasoned that AICRA's arbitration provisions implicitly encompassed fraud claims but had overlooked the distinct legislative purposes of AICRA and the Fraud Act. The Third Circuit also relied on arbitration agreements in GEICO's DPRP and assignment forms, but the Appellate Division had already determined that these were limited by AICRA's regulations to PIP arbitration. Ultimately, the Appellate Division rejected the Third Circuit's conclusions as unpersuasive.

Given the impracticalities of litigating Fraud Act and RICO claims through arbitration, the Appellate Division correctly distinguished between PIP claims involving medical providers—intended for arbitration—and claims brought by insurance carriers under the Fraud Act and RICO, which were meant to be litigated in court.

After a series of setbacks in federal court on these issues, this decision by the Appellate Division strengthens insurance carriers' ability to investigate and litigate Fraud Act and RICO claims in the appropriate judicial forum rather than through limited arbitration proceedings. ◆

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Auto Glass Litigation in Florida: A Closer Look at Two Landmark Cases

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Auto glass litigation in Florida has become a significant area of concern for both insurance companies and repair businesses. Disputes between insurers and auto glass repair shops often revolve around billing practices, consumer protection, and the legitimacy of claims. Two recent cases, *Gov't Employees Insurance Co. v. Glassco Inc.*, No. SC2023-1540 (Fla. Sept. 25, 2024), and *State Farm Mutual Automobile Insurance Company et al. v. At Home Auto Glass LLC et al.,* 8:21-cv-00239-TPB-AEP, have shaped the legal landscape for auto glass repair disputes in the state.

An analysis of these cases offers insight into the complex relationship between insurance companies, repair shops, and the Florida Motor Vehicle Repair Act (FMVRA) and Florida Deceptive and Unfair Trade Practices Act (FDUTPA). This article examines both cases and their implications for the auto glass industry in Florida.

Gov't Employees Insurance Co. v. Glassco Inc.

In *Gov't Employees Insurance Co. v. Glassco Inc.,* the Florida Supreme Court issued a landmark decision in September 2024 which concluded that an insurance company does not have the right to sue an auto glass repair shop for violating the Florida Motor Vehicle Repair Act (FMVRA). This has resulted in significant implications for the auto glass industry in Florida, particularly regarding the processing and payment of claims by insurance companies.

Background of the Case

The case arose after Government Employees Insurance Company (GEICO) sued Glassco Inc., a repair shop, alleging it had violated the FMVRA by failing to provide a written estimate for windshield repairs, as required by Florida law. GEICO argued this failure to provide the necessary written estimate made the repair invoice invalid, and the insurer refused to pay for the repairs.

Florida Supreme Court's Ruling

After five years of litigation, the Florida Supreme Court ruled that GEICO could not sue Glassco under the FMVRA. The court clarified that the statute in question, Section 559.921(1), does not grant an insurance company a cause of action when a repair shop fails to provide a written estimate. Moreover, the court ruled, even if there was an alleged violation of the FMVRA, it did not invalidate a completed repair invoice, meaning the repair shop was still entitled to be paid for services rendered. ▸

Key Takeaways

The Florida Supreme Court emphasized that the FMVRA does not provide a private cause of action for insurers to sue repair shops. Insurance companies cannot withhold payment on the grounds that an auto glass repair shop violated the statute by not providing a written estimate or invoice. The decision clarified that insurance claims must be processed and paid according to the contractual terms, regardless of FMVRA violations, unless those violations directly harm the customer. The court's ruling highlights that the statute's protections are aimed at consumers, not insurance companies, and insurers do not have the right to enforce these protections in court.

This decision is a critical development for both auto glass repair businesses and insurers. It limits the ability of insurance companies to challenge invoices for minor procedural violations and reinforces the need for clear contractual terms when processing claims. However, the ruling can be altered only through legislative change, which would require action from Florida lawmakers.

State Farm Mutual Automobile Insurance Company et al. v. At Home Auto Glass LLC et al.

In *State Farm Mutual Automobile Insurance Company et al. v. At Home Auto Glass LLC et al.,* a federal district court examined whether At Home Auto Glass violated the Florida Deceptive and Unfair Trade Practices Act (FDUTPA) by unlawfully soliciting business and obtaining insurance payments through improper means. State Farm Mutual Automobile Insurance Company had paid over $1 million to At Home Auto Glass for windshield repairs and replacements, but the insurer alleged At Home Auto Glass had engaged in unfair practices by obtaining customer assignments and insurance payments through deceptive means.

Background of the Case

State Farm's lawsuit accused At Home Auto Glass of unlawfully contracting with its insured customers and soliciting business through practices that violated Florida's consumer protection laws. State Farm argued the glass repair shop had engaged in deceptive actions by obtaining assignments of benefits (AOB) from customers, which allowed them to bill State Farm directly for the cost of windshield repairs. The insurer sought damages and declaratory relief, claiming that At Home Auto Glass's actions were unfair and deceptive.

Court's Ruling

The court ultimately ruled against State Farm, stating that At Home Auto Glass had not violated FDUTPA or engaged in unjust enrichment. The court found that there was no evidence to suggest that any customer had been harmed or financially impacted by At Home Auto Glass's practices. In fact, customers received the services they had been promised, a windshield repair or replacement at no cost to them.

The court also noted there was no evidence showing that At Home Auto Glass had acted unjustly in obtaining payment from State Farm; the insurer had paid for services rendered according to the contracts with its insureds. Furthermore, the court declined to issue a declaratory judgment at the summary judgment stage, stating that such a decision was more appropriately handled by a state court as the case involved Florida state law.

Key Takeaways

This case is significant in that it clarifies how FDUTPA applies to auto glass repair practices in Florida. The court's ruling underscores that, to prevail in a FDUTPA claim, the plaintiff must demonstrate there was actual harm to consumers. Since there was no evidence of consumer harm, the court dismissed the claims of unfair trade practices.

The case also emphasizes that, while repair shops like At Home Auto Glass, may benefit from the assignment of benefits system, it does not automatically mean they have acted unlawfully or unfairly, as long as the consumer receives the service they contracted for.

The decision also highlights the importance of having clear evidence of customer harm in cases alleging deceptive trade practices.

For insurers, this ruling demonstrates that the mere existence of AOB contracts or the use of third-party repair services does not automatically constitute a violation of consumer protection laws.

Conclusion

Both the *Gov't Employees Insurance Co. v. Glassco Inc.* and *State Farm Mutual Automobile Insurance Company et al. v. At Home Auto Glass LLC et al.* cases have set important precedents for auto glass litigation in Florida. These decisions provide clarity on how insurers can challenge auto glass repair invoices and what constitutes unfair or deceptive business practices under Florida law.

For repair shops, these rulings reinforce the importance of maintaining compliance with state regulations and being transparent with customers about the services provided.

For insurance companies, the rulings highlight the need to process claims in accordance with contractual obligations and consumer protections, while understanding the limits of their legal standing in disputes with repair businesses.

As the landscape of auto glass litigation in Florida continues to evolve, these cases serve as essential guidelines for both insurers and repair shops, ensuring that the legal framework governing the industry remains clear and equitable. However, as these rulings indicate, any future changes to the laws or litigation practices may come from legislative reforms rather than judicial action. Therefore, stakeholders in Florida's auto glass repair industry must stay informed about these developments to navigate the complexities of auto glass claims effectively.◆

Changes to NJ's Open Public Records Act and Implications for SIU

Matthew Burdalski, Esq. | New Jersey

In June 2024, New Jersey Governor Phil Murphy signed into law Senate Bill 2930, enacting significant amendments to New Jersey's Open Public Records Act (OPRA). These changes, effective September 3, 2024, were made with the stated intent to modernize public records access, enhance transparency, and protect personal information. As access to public records is often a tool for SIU in investigating insurance claims, it will be important to understand the changes and how they may impact your investigation.

The New Jersey Open Public Records Act, N.J.S.A. 47:1A-1 et. seq., was passed in 2002. It replaced New Jersey's former Right to Know Law and also expanded the definition of a public record. The amendments passed late last year enacted changes to everything from the method to obtaining public records to which records can be provided and how. Some of the most relevant and important changes which should be noted by SIU follow.

Attorney Fees

Previously, requestors who were successful in court with respect to denied records requests were entitled to recover attorney's fees. The new law limits the right to recover fees only upon a showing that the public agency "unreasonably denied access, acted in bad faith, or knowingly and willfully violated" OPRA. Further, if the records are provided within seven days of a lawsuit, attorney's fees may be awarded only if the agency "knew or should have known" that the denial violated OPRA.

Protective Orders Against Disruptive Requests

Public agencies can now seek protective orders against individuals or entities whose records requests are intended to "substantially interrupt the performance of government function." This was previously unavailable to public agencies. This potentially allows courts to issue orders to limit the scope or number of records requested.

Public Records on Websites

Agencies are now *required* to make records available on publicly accessible websites "to the extent feasible." These websites must include a search function, and custodians must assist requestors in locating records online. This has the benefit of potentially streamlining the process of accessing public records, assuming the records are properly and fully placed online. Further, agencies may now be in compliance of specific records requests by directing the requestor to the online source provided they offer assistance in locating the records.

Model Request Form

There will now be a model request form that must be utilized by each public agency and used when requesting public records. The new model request form will include additional questions regarding commercial purpose, whether the records are being sought in connection with litigation, and the addition of new exemptions in the Exemptions Checklist section.

Definition of "Commercial Purpose"

The amendments introduce a new category of requestor—those seeking records for a "commercial purpose." In addition to commercial entities, this category covers individuals who intend to use the records for the sale, solicitation, rent or lease or a service, or any use by which the user expects to profit either through commission, salary, or fee. Importantly for SIU, those requestors must certify that the records are for a commercial purpose and must provide the intended use of the records. The failure to do so can result in fines. Exemptions apply to journalists, educational institutions, and certain non-profits. The commercial purpose definition is not currently well defined and will likely be the subject of future litigation for clarification.

Limitations on Use During Legal Proceedings

The amendments to the OPRA law restricts parties to a legal proceeding from requesting records that are the subject of a court order, including pending discovery requests. Requestors must now certify whether their request is connected to a legal proceeding. In short, once litigation has been commenced, requestors will be foreclosed from seeking public records through the OPRA process. Notably, legal proceeding is not specifically defined in the statute, and this provision will apply regardless of whether the agency is a party to the proceeding or not. This is especially important for SIU. Requests for needed records or information important to your investigation must be made as early as possible and prior to any litigation being filed.

Expanded Definition of Personal Identifying Information

This definition now includes birth dates, personal email addresses, debit card and bank account information, home addresses, personal telephone numbers, personal information of juveniles under 18 (excepting MVC and elections information), HIPPA data, and indecent graphic images, all with the stated intent of enhancing the protection of personal data.

Responses and Response Time

Agencies must respond to proper requests, in writing, "as soon as possible but not later than seven (7) days after receipt of the request." The response must address each item requested by either: granting access; denying access; seeking clarification of the request; or requesting an extension of time.

Other Relevant Changes

- **Identical Request**: Agencies are no longer required to respond to identical requests for the same information from the same requestor if no information has changed.
- **Appeal Timeframe**: Requestors must appeal the denial of their request within 45 days.
- **Records Kept by Others**: Agencies are not obligated to respond to requests for records kept by separate public agencies.
- **Vague Requests**: Agencies are not required to respond to a request if it does not identify with specificity the information/ documentation sought.

- **Security Footage**: Footage of public buildings is exempt unless the request identifies a specific incident that occurred, or a specified date and limited time period at a particular building.

These amendments were enacted with the stated purpose of balancing the public's right to access information with the need to protect personal privacy and prevent the misuse and abuse of the records request process. However, from a SIU perspective, the changes may have the effect of limiting access and transparency on the part of the agencies.

It is crucial for the SIU community to familiarize itself with the new provisions to ensure compliance and maintain the ability to access public records necessary for effective and efficient claims investigations and determinations. SIU should take care to familiarize itself with the OPRA process and the new potential limitations and roadblocks to accessing public records. Additional care should be taken to ensure compliance with the updated processes and regulations when making records requests as well as the remedies available when encountered with failures to full comply or respond. ◆

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Interested in training your claims professionals?

Contact **Ariel Brownstein** at **ACBrownstein@mdwcg.com** or **856.414.6075** for training opportunities in **2025** and **2026**.

Three Members of Insurance Fraud & SIU Practice Group Elected Shareholders

Matthew A. Gray (Melville, NY) primarily defends insurance carriers in disputes involving New York Personal Injury Protection (PIP) claims. A member of the firm's Fraud/Special Investigation Practice Group, he is experienced in defending clients against intentional/staged losses and medical provider fraud. He has extensive motion practice experience and with alongside his fellow colleagues to obtain favorable decision for each of his clients, whether through litigation or arbitration. Matthew holds a B.A. and M.A. from St. John's University and earned his J.D. from the Touro University Jacob D. Fuchsberg Law Center. He is admitted to practice in New York.

Jonathan C. Magpantay, CPCU (Mount Laurel, NJ) focuses on large loss and medical provider fraud, including the filing of affirmative litigation recovery and RICO actions across the country. A Chartered Property and Casualty Underwriter (CPCU), he also handles insurance coverage disputes, bad faith litigation and general defense litigation. He has broad experience in New Jersey Personal Injury Protection (PIP) litigation and appears regularly before the courts and administrative bodies. Jonathan is a member of the Asian Pacific American Lawyers Association of New Jersey (APALA-NJ) and the National Filipino American Lawyers Association (NFALA). A graduate of the University of Pittsburgh and Rutgers University School of Law, he is admitted to practice in New Jersey, the District of Columbia, and Michigan.

Michael J. Sweeney, CPCU (Mount Laurel, NJ) investigates and defends large loss and medical provider fraud matters. He has litigated and filed affirmative litigation recovery and RICO actions in many states, recovering tens of millions of dollars in restitution and recovery on behalf of the insurance industry. A Chartered Property and Casualty Underwriter (CPCU), Michael has extensive experience handling insurance coverage disputes, SIU investigations, bad faith allegations, and general defense litigation. He is a graduate of the University of Delaware and Villanova University School of Law, and is admitted to practice in New Jersey.

2024 New York Metro Super Lawyer Rising Stars

Matthew A. Gray (Melville, NY) was among five attorneys from our New York City and Long Island offices selected to the 2024 edition of *New York Metro Super Lawyers* magazine. Matthew was listed in the Insurance Coverage practice area. A Thomson Reuters business, Super Lawyers is a rating service of lawyers from more than 70 practice areas who have attained a high degree of peer recognition and professional achievement.

Each year, no more than 2.5 percent are selected for Super Lawyer Rising Stars. The selection process is multi-phased and includes independent research, peer nominations and peer evaluations. A description of the selection methodology can be found **here**.

Thought Leadership

February 19, 2025 – **Jeffrey Rapattoni** (Mount Laurel, NH) co-presented the webinar "Bad Faith Legal Update" to members of International Association of Special Investigation Units (IASIU). Topics included current legislation affecting the SIU and anti-fraud professionals, case-specific legal decisions affecting the SIU community, as well as trending decisions and pending legislation.

January 16, 2025 – **Jeffrey Rapattoni** (Mount Laurel, NJ) discussed "Ethical Considerations for the SIU" at the National Insurance Crime Bureau's (NICB) Mid-Atlantic Major Medical Fraud Task Force Training Event in Philadelphia. Designed for NICB agents covering Pennsylvania, New Jersey and Delaware, the program will provided information and strategies related to the prevention, detection, and prosecution of insurance fraud and crime.

October 29, 2024 – **Jeffrey Rapattoni** (Mount Laurel, NJ) presented the webinar "Legal/ Ethics Update" at the Ohio Chapter of IASIU Fall Training.

October 22, 2024 – **Matthew Burdalski** and **Ari Brownstein** (both of Mount Laurel, NJ) presented "Cracking the Case: Investigating Chiropractic Care from Record Review to Examination Under Oath" at the New Jersey Special Investigators Association's 33rd annual seminar.

October 3, 2024 – **Jeffrey Rapattoni** (Mount Laurel, NJ) delivered two presentations at the National Insurance Crime Bureau's Medical & Work Comp Fraud Conference. In "Ethics and the Investigator," he discussed the evolving legal landscape and its impact on ethical practices in the SIU industry, offering best practices for maintaining efficiency while upholding ethical standards. In "Measuring an SIU Program's Success – in an Ever-Changing Environment," Jeff and Jay Bobrowsky, CIFI, FCLS, from the State Compensation Insurance Fund of California, explored the challenges SIU managers face in balancing program goals with customer service and accountability in a shifting market.

August 26–27, 2024 – **Jeffrey Rapattoni** (Mount Laurel, NJ) participated in three seminars at the 2024 IASIU Conference. He presented "SIU Ethics," "Building a Better Major Case: From Investigation to Suit," and "Legal Updates."

June 27, 2024 – **Sean Greenwalt** (Tampa, FL) co-presented at the Florida Insurance Fraud Education Committee's (FIFEC) annual conference. "No Tipping, Please: Responding to Gratuitous Payment, Coverage, and Policy Disputes," tackled all the new and old challenges to PIP exhaustion and policy limits.

Upcoming Events:

April 16 – 17	2025 Pennsylvania Insurance Fraud Conference, Hershey, PA
May 5 – 7	18th Annual NEIASIU, Leominster, MA
June 5 – 6	IASIU, Chicago, IL
June 9 – 10	Coalition Against Fraud Midyear Meeting, Chicago, IL
June 16	NJSIA Golf Glassic, Knob Hill Golf Club, Englishtown, NJ
August 24 – 27	2025 IASIU Annual Conference, Denver, CO
October 20 – 22	NJSIA, Atlantic City, NJ