

MEDICAL PROVIDERS AND THE NO-FAULT LAW

By: George T. Sinas

I. MANAGED CARE UNDER THE NO-FAULT LAW

A. Basic Concept

When the Michigan Legislature enacted the No-Fault Automobile Insurance Law in 1973, it did not draft a statute that utilizes managed care concepts, as did other states that enacted a no-fault system. On the contrary, the Michigan No-Fault Law is purely a **fee for services system** obligating a no-fault insurer to pay all “**allowable expenses**” as defined in the statute. The Michigan Law does not contain any provisions that specifically grant no-fault insurance companies the authority to invoke principles of managed care or to act as “*gatekeepers*” regarding a person's medical and rehabilitation treatment. Moreover, it is clear that, with certain exceptions, most persons injured in motor vehicle accidents have a legally protected “*right to choose*” their own care providers. In this regard, the Michigan Supreme Court has held “***the No-Fault Act preserves to the injured person a choice of medical service providers.***” See *Morgan v Citizens Insurance Company*, 432 Mich 640 (1989). Based upon these principles, a no-fault insurance company cannot dictate what kind of medical treatment an injured person receives, the identity of the medical providers who will render that care, or the circumstances under which the care is rendered. On the contrary, the role of the no-fault insurance company is to honor its statutory duty to pay “*all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery or rehabilitation*” as required by §3107(1)(a).

There is probably one exception to the basic principle that no-fault is not a managed care system and that is the situation that exists for patients who are members of HMOs and who also have coordinated no-fault coverages. Patients in this situation must be careful to comply with the dictates of the Supreme Court's opinion in *Tousignant v Allstate Ins Co*, 445 Mich 301 (1993).

B. The Use of Case Managers

No-fault insurance companies frequently hire “*case managers*” to assist the insurance company in processing a claim for benefits. The No-Fault Statute does not specifically require a patient to work with a case manager selected by a no-fault insurance company. Moreover, the law does not specifically give case managers the right to have verbal communications with a patient's medical providers if the patient does not consent to such communications. If a patient consents to work with an insurance company case manager, but later determines that the case manager is not acting in the best interests of the patient, the patient is legally entitled to stop any further dealings with that case manager.

If a case manager is involved in the patient's care, the patient should insist that any "*conflicts of interest*" be resolved in favor of the patient. Many certified case managers are members of the *Case Management Society of America (CMSA)*. This organization publishes ethical standards which clearly imply that a case manager's first loyalty is to the patient, not the insurance company that pays for the case manager's services. In this regard, the 1996 CMSA Standards of Practice state in pertinent part, at pages 19-20:

*"The case manager will: . . . 3. Be knowledgeable about and act in accordance with the Americans with Disabilities Act and **other state and federal laws protecting the rights of the client, including Workers' Compensation laws when applicable to the case manager's practice.** . . . 6. Seek appropriate resources for resolution of **legal questions.** 7. Be **knowledgeable about benefits** and benefits administration. 8. Provide services within the scope of practice defined by community and published practice standards.*

. . .

The case manager will: . . . 2. Act as a client advocate to the end that information is provided to the individual to make an informed health decision. . . . 4. Seek appropriate resources and consultation to help formulate ethical decisions. . . ."

If a patient's injury and resultant condition is such that case management services can be demonstrated to be "*reasonably necessary services for the patient's care, recovery or rehabilitation,*" then the patient probably has the legal right to hire a case manager selected by the patient and to submit the costs of that case management to the no-fault insurance company for payment as an "*allowable expense*" under §3107(1)(a) of the Act.

C. The Pre-Authorization of Payment Issue

There is no legal authority in the Michigan No-Fault Statute or in any appellate court decision that authorizes a no-fault insurance company to demand "**pre-authorization**" of payment before medical services can be rendered to a patient. Under the law, a no-fault insurance company must pay any and all "**allowable expenses**" regardless of whether the insurance company was notified about the expense before the service was rendered. This is true because the Michigan No-Fault Law is not a "*managed care system.*" Rather, it is a "*fee for services system.*" Therefore, patients and their medical providers should resist any efforts by a no-fault insurance company to impose a "*payment pre-authorization requirement.*" If the patient's medical providers are willing to verify that the prescribed services are "*reasonably necessary,*" this is typically sufficient to impose legal liability on the no-fault insurance company for payment of the charges. If a no-fault insurance company claims it has a right to require pre-authorization because of a specific endorsement contained in the insurance policy, the patient should consult legal counsel to determine if such an endorsement is legally valid.

D. Fee Schedules and Medical Bill Auditing

Recently, many insurance companies have refused to pay the full amount of a doctor bill or hospital charge because the insurance company claims the charges are not “reasonable” within the meaning of §3107(1)(a). Sometimes, the insurance company supports its denial of the claim by referring to certain “**fee schedules**” which are utilized in Workers’ Compensation cases or utilized to determine what benefits are payable under health insurance policies or governmental benefit programs. The Court of Appeals has clearly held that it is improper for a no-fault insurance company to use fee schedules to determine the extent to which medical expenses are compensable under §3107(1)(a) of the statute. See *Munson Med Ctr v Auto Club Ins Ass’n*, 218 Mich App 375 (1996) and *Mercy Mt Clemens Corp v Auto Club Ins Ass’n*, 219 Mich App (1996). Moreover, Michigan voters rejected the use of fee schedules for no-fault claims when they defeated Proposal D in the November 1992 election and Proposal C in the November 1994 election. Therefore, it is not proper for no-fault insurance companies to utilize fee schedules to deny no-fault claims.

Faced with this reality, many no-fault insurance companies have adopted an alternative strategy of sending a patient’s medical expenses to a so-called independent auditing company for a “**medical audit**,” i.e., an opinion as to whether the charges are “reasonable.” Typically, these medical audits result in a portion of the charges being denied. When this happens, the patient is caught in the middle between the provider and the no-fault insurance company. This can create problems for the patient, including an interruption in medical treatment. To avoid this situation, the Michigan Insurance Commissioner has issued Bulletin 92-03 which requires that no-fault insurance companies protect the patient from any collection efforts undertaken by the medical provider and to inform the provider that the dispute is solely between the insurer and the provider and does not involve the patient. The Michigan Court of Appeals has also issued two recent decisions that give medical providers the legal right to directly sue, in the provider’s name, no-fault insurance companies that refuse to pay medical related expenses that are overdue under the statute. See *Lakeland Neurocare Centers v State Farm Mutual Auto Ins Co*, 250 Mich App 35 (2002) and *Regents of the University of Michigan v State Farm Mutual Ins Co*, 250 Mich App 719 (2002).

E. The Independent Medical Examination (IME)

Section 3151 of the No-Fault Statute provides that when the mental or physical condition of a person is at issue, the no-fault insurance company can request to have the claimant examined by a physician of its choice. The right to conduct such an examination, however, (often referred to as an “*independent medical examination*”) is subject to a general requirement of “*reasonableness*.” Section 3152 of the statute states that a claimant who undergoes such an independent medical examination may request a copy of the report. Section 3153 of the statute provides that if a claimant refuses to submit to an independent medical examination, a court can issue orders that are appropriate under the circumstances, including prohibiting the claimant from introducing any evidence of his or her mental or physical condition. Clearly, independent medical examinations are often

biased in favor of the insurance company. Many independent medical examiners work for disability evaluation groups who are closely aligned with insurance companies. Thus, they may have a built-in bias or prejudice against injured claimants. If bias or prejudice on the part of the independent medical examiner can be demonstrated, the examiner's opinions or conclusions may possibly be excluded from evidence.

II. CLAIMS BY MEDICAL PROVIDERS

On February 15, 2002, the Michigan Court of Appeals gave some powerful legal weapons to medical providers who are not promptly paid by auto no-fault insurance companies. The decision is a great victory for providers and their auto accident patients and will make the playing field more level in no-fault insurance payment disputes. The ruling came in the case of ***Lakeland Neurocare Centers v State Farm Mutual Automobile Insurance Company***, 250 Mich App 35 (2002). In this unanimous opinion, the Court held that the “**penalty interest**” provisions of §3142 of the No-Fault Act and the “**penalty attorney fee**” provisions of §3148 of the No-Fault Act may be enforced by medical providers against no-fault insurance companies who do not honor their payment obligations under the statute. Section 3142 renders an insurer liable for 12% interest if payment is not made within 30 days after the insurer receives “*reasonable proof of the fact and of the amount of loss sustained.*” Section 3148 of the statute renders an insurer liable for attorney fees if the insurer has “*unreasonably refused to pay the claim or unreasonably delayed in making proper payment.*” The Court held that these two (2) penalty provisions are enforceable not only by auto accident patients, but also by the medical providers who render care to those patients. In so holding, the Court acknowledged that medical providers who treat auto accident patients have a right to commence legal enforcement action against no-fault insurance companies to recover payment for medical services rendered to patients insured by those companies. If a medical provider can demonstrate that payment was overdue, the medical provider can recover 12% interest on the balance owing. Likewise, if the medical provider can establish that the payment was “*unreasonably refused or unreasonably delayed*” the medical provider can recover actual attorney fees from the recalcitrant insurer.

In reaching this important holding, the Court reasoned that giving enforcement powers to medical providers furthered the purposes and goals of the No-Fault Act to avoid medical payment delays. Furthermore, such a ruling would shift the loss from providers to insurance companies, and, in the process, protected no-fault patients. In this regard, the court stated:

“ . . . The goal of the no-fault system was to provide victims of motor vehicle accidents assured, adequate, and prompt reparation for certain economic losses. The no-fault act does not, however, accomplish its purpose or goal by sanctioning actions of no-fault insurers that include unreasonable payment delays and denials of no-fault benefits which force the commencement of legal action by the injured person's health care provider.

Moreover, the no-fault act may not be used by a no-fault insurer as a vehicle to shift the burden of the injured person's economic loss to a health care provider or as a weapon against rightful payees to a payee's unjustified economic detriment. . . . Failing to permit the attempted enforcement of the penalty provisions in situations involving unreasonable and unjustified payment behavior would reward that behavior while ignoring the cost exacted at the expense of a rightful no-fault benefit payee.

Finally, the enforcement of these penalty provisions against a recalcitrant no-fault insurer also serves to offer some protection against further economic loss faced by an injured person. The impermissible payment behavior of an insurer has an economic impact on the injured person, both directly and indirectly, usually in the form of damaged credit ratings, difficulties in securing health care services, harassment, and lawsuits initiated by health care providers for reimbursement. Permitting the imposition of these penalty provisions by health care providers provides a legitimate and enforceable incentive to no-fault insurers to perform their payment obligations, imposed by operation of law, in a reasonable and prompt manner.”

Approximately two (2) weeks before the Court of Appeals released its opinion in *Lakeland Neurocare Centers*, a similar opinion was issued by the Court of Appeals in the case of ***Regents of the University of Michigan v State Farm Mutual Insurance Company and Travelers Insurance Company***, 250 Mich App 719 (2002). The decisions of the Michigan Court of Appeals in *Lakeland Neurocare Centers* and *Regents of the University of Michigan* empower medical providers to fight back when no-fault insurance companies improperly withhold payment for medical services rendered to auto accident victims. Therefore, providers should immediately review their no-fault insurance accounts receivable and make an informed decision as to whether legal enforcement action should be undertaken in light of these cases. In making this decision, however, it is important to keep in mind that the No-Fault Statute contains a short statute of limitations which, in the case of claims brought by patients, typically will expire one year after the date an expense is incurred. It is not clear whether this one year statute of limitations will apply to enforcement claims brought by medical providers. However, until the Court of Appeals rules to the contrary, providers should assume that the limitations period is short and therefore, enforcement action should not be delayed.