NO-FAULT PIP BENEFIT CLAIMS

By: George T. Sinas

I. THE FOUR MAJOR NO-FAULT PIP BENEFITS

There are four (4) major types of no-fault PIP benefits compensable under the No-Fault Statute. These benefits are: (1) allowable expense benefits (i.e. care and treatment) for life; (2) wage loss benefits for a three-year period; (3) replacement service expenses for a three (3) year period; and (4) survivor's loss benefits for a three (3) year period where an accident results in death. These benefits are legally described in Sections 3107 and 3108 of the No-Fault Statute and are summarized below.

A. PIP Benefit #1: Allowable Expense Benefits

The Michigan No-Fault Law has the broadest and most generous medical expense and patient care provisions of any No-Fault Statute in the country. Section 3107(1)(a) states that an injured person is entitled to recover "*allowable expenses*" consisting of: ***"All reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery or rehabilitation."*** The statute contains no further definitions of the scope and extent of these "*allowable expenses*." It is clear, however, that these benefits are ***payable for life*** and are payable without regard to any "*cap*" or "*ceiling*." In other words, the allowable expense benefit is a benefit that is unlimited in amount and duration. Various court decisions have established that these benefits include a wide variety of products and services, some of which are explained below:

1. Medical Expenses — Under the statute, all reasonably necessary hospital expenses, physician charges, prescriptions, medical equipment, prosthetic devices, chiropractic treatment, psychological services, in-home care, and other related expenses are compensable as an allowable expense.

2. In-Home Nursing or Attendant Care — The statute uses the word "*services*," which the courts have interpreted to include in-home nursing care and unskilled attendant care. The court decisions also established that these in-home services can be rendered by relatives as long as the service is reasonably necessary and the charge for the service is reasonable in amount. In-home attendant care is a very important benefit for victims and family members of seriously injured auto accident victims. It enables such families to hire outside help or employ family members to render services that are reasonably necessary for the injured person's care, recovery and rehabilitation. Such services would include meal preparation, feeding, dressing, personal assistance, hygiene, bathing, transportation to medical treatment, in-home therapy, supervision and monitoring, etc. See *VanMarter v American Fidelity Fire Ins Co*, 114 Mich App 171 (1982); *Visconti v*

DAIIE, 90 Mich App 477 (1979); *Manley v DAIIE*, 425 Mich 140 (1986); and *Sharp v Preferred Risk Mutual Ins Co*, 142 Mich App 499 (1985).

3. Accommodations — The statute also uses the word "*accommodations*" in describing the allowable expense benefit. The courts have held that this term obligates an insurance company to pay for renovations to make a home or apartment handicapper accessible or, if necessary, to build a new residence for catastrophically injured persons where their prior residence cannot be reasonably adapted to provide for the injured person's care, recovery or rehabilitation. The Michigan Court of Appeals has held: ***"As long as housing larger and better equipped is required for the injured person than would be required if he were not injured, the full cost is an 'allowable expense.'"*** See *Sharp v Preferred Risk Mutual Ins Co, supra*. If an insurance company builds a new home for a catastrophically injured child, the courts may permit the insurance company or a court appointed trustee to hold legal title to all or a portion of the home, depending on the details of the case. See *Kitchen v State Farm Ins Co*, 202 Mich App 55 (1993). However, in *Williams v AAA Michigan*, 250 Mich App 249 (2002), the Court of Appeals held that when a no-fault insurance company builds a home for a catastrophically injured adult and the adult is willing to contribute his or her equity in their existing home to new home construction, then the injured adult is entitled to hold legal title to the newly constructed residence. Enforcing the right to the accommodation benefit can be a complicated matter. However, it is a crucial benefit for severely injured people.

4. Room and Board Expenses — The courts have also held that the allowable expense benefit includes compensation for room and board expenses which family members or others incur in connection with providing housing for a catastrophically injured auto accident victim if the victim would otherwise require institutionalization. The courts have held that: ***"Where an injured person is unable to care for himself and would be institutionalized were a family member not willing to provide home care, a no-fault insurer is liable to pay the cost of maintenance in the home."*** See *Reed v Citizens Ins Co of America*, 198 Mich App 443 (1993).

5. Rehabilitation — The courts have also held that the allowable expense benefit includes not only services for the physical rehabilitation of the injured person, but also the reasonable expense of vocational rehabilitation, job retraining and job placement. Furthermore, the courts have rejected the argument that a no-fault insurer is only obligated to restore the injured person to his or her "*pre-accident status*" as opposed to elevating the victim to a higher functional level reasonably consistent with the person's capabilities. The fact that the Michigan system provides full physical as well as vocational rehabilitation is a very important benefit for seriously injured victims. See *Bailey v DAIIE*, 143 Mich App 223 (1985); *Kondratek v Auto Club Ins Ass'n*, 163 Mich App 634 (1987); and *Tennant v State Farm Mutual Automobile Ins Co*, 143 Mich App 419 (1985).

6. Special Transportation — The courts have also held that, in certain situations, an insurance company may be obligated to pay for the purchase and/or modification of a motor vehicle for the transportation of a seriously injured person. An

example would be persons suffering spinal cord injuries or serious brain injuries who, because of the nature of their disability, now need a handicapper equipped van or other specially adapted vehicle in order to be transported. Depending upon the facts of the case, the insurer's obligation may be to equip an existing vehicle with handicapper equipment or to fully fund the purchase of a new vehicle with such equipment. The issue of whether a new vehicle should be purchased or an existing vehicle specially equipped, is determined by what is considered "*reasonably necessary*" for the injured person's care, recovery or rehabilitation. See *Davis v Citizens Ins Co of America*, 195 Mich App 323 (1992).

7. Medical Mileage — The courts have also held that an insurance company is obligated to pay mileage to transport an injured person to and from necessary medical care or rehabilitation. There is some dispute as to the appropriate mileage rate but some court decisions have held it is proper to utilize the State of Michigan mileage reimbursement rate as a guide. See *Swantek v Automobile Club of Michigan Ins Group*, 118 Mich App 807 (1982).

8. Guardian Expenses — The courts have held that where a seriously injured person requires the appointment of a guardian or conservator, the costs of appointing and maintaining such a Probate fiduciary are recoverable as an allowable expense. See *Heinz v Auto Club Ins Ass'n*, 214 Mich App 195 (1995).

B. PIP Benefit #2: Work Loss Benefits

Section 3107(1)(b) provides that where an injured victim cannot work as a result of an auto accident, work loss benefits are payable for up to a maximum of three (3) years. The statute defines work loss benefits as compensation for ***"loss of income from work an injured person would have performed during the first 3 years after the date of the accident if he or she had not been injured."*** Under the statute, work loss benefits are payable at the rate of 85 percent of gross pay, including overtime. However, the work loss benefit cannot exceed a ***monthly maximum*** which is adjusted in October of every year to keep pace with the cost of living. These COLA adjustments, however, only apply to accidents occurring after each adjustment date. Therefore, the monthly maximum applicable at the time of the injured victim's accident is the monthly maximum that continues to apply for the remainder of that person's three (3) year benefit period. Set forth below is an itemization of the monthly maximum benefit levels that have been in effect for the last five (5) years:

10/1/00	$3,898.00
10/1/01	$4,027.00
10/1/02	$4,070.00
10/1/03	$4,156.00
10/1/04	$4,293.00

In addition, other important principles regarding work loss benefits are summarized below:

1. The Applicable Disability Standard and the Duty to Mitigate — Under the statute, it is not necessary to prove that the injured person is completely disabled from performing any type of employment. On the contrary, the statute requires payment of work loss benefits if the injured person cannot perform the work the injured person "*would have performed*" had the accident not occurred. In addition, the courts have held that wage loss benefits must include salary increases, overtime and other merit raises that would have been received during the person's disability. See *Lewis v DAIIE*, 90 Mich App 251 (1979) and *Farquharson v Travelers Ins Co*, 121 Mich App 766 (1982). Any income earned by the injured person during a period of disability reduces the wage loss benefit otherwise payable for that same period. See *Snellenberger v Celina Mutual Ins Co*, 167 Mich App 83 (1988). The courts have also imposed an obligation on the injured person to "*mitigate damages*" by seeking alternative employment if such employment was available and if it was otherwise "*reasonable*" under the circumstances for the injured person to accept it. See *Bak v Citizens Ins Co*, 199 Mich App 730 (1993).

2. The Interplay Between Work Loss Benefits, Sick Leave, Vacation and Wage Continuation Benefits — Our courts have held that a no-fault insurance company cannot reduce wage loss benefits by an injured person's sick leave, vacation time or employer provided wage continuation benefits. Therefore, if an injured person is receiving sick pay or is drawing on vacation time during a period of disability, the no-fault insurer must pay full wage loss benefits. See *Orr v DAIIE*, 90 Mich App 687 (1979). Similarly, where an employer continues paying wages under a wage continuation plan, the no-fault insurer must pay full no-fault wage loss benefits without regard to the wage continuation payments. See *Brashear v DAIIE*, 144 Mich App 667 (1985); *Spencer v Hartford Accident & Indem Co*, 179 Mich App 389 (1989); and *Wesolek v City of Saginaw*, 202 Mich App 637 (1993).

3. Temporarily Unemployed Persons — The statute also contains a special provision for those persons who are considered "*temporarily unemployed*" at the time of an auto accident injury. Such individuals are entitled to no-fault wage loss benefits based upon the last month of full time employment. This provision appears in §3107(1)(a) which states: ***"Work loss for an injured person who is temporarily unemployed at the time of the accident or during the period of disability shall be based on earned income for the last month employed full time preceding the accident."*** The statute does not define "*temporarily unemployed*." Court decisions however, have focused on a variety of factors including the length of time of the unemployment, the reasons for the unemployment, the injured person's work history, and the subjective and objective evidence of the person's intention to return to employment. The courts have stated, however, that a person who is completely physically disabled from working for reasons unrelated to a car accident is not entitled to no-fault work loss benefits. See *MacDonald v State Farm Mutual Ins Co*, 419 Mich 146 (1984) and *Williams v DAIIE*, 169 Mich App 301 (1988).

4. Self-Employed Persons — Self-employed accident victims are entitled to recover wage loss benefits but oftentimes experience great difficulty with insurance companies in establishing the appropriate level of benefits. The courts have held that a self-employed person's business expenses should be deducted from his or her gross receipts in order to determine the proper work loss benefit level. The courts, however, have rejected the principle that all business expenses reported on Schedule C of the individual's tax returns are fully and automatically deductible from gross receipts. The question of which business-related expenses should be deductible from the gross receipts of a self-employed person is a question of fact that is typically determined on a case-by-case basis. See *Adams v Auto Club Ins Ass'n*, 154 Mich App 186 (1986).

C. PIP Benefit #3: Replacement Service Expense Benefits

Under the No-Fault Statute, an injured person may also receive reimbursement, in an amount not to exceed $20 per day, for expenses incurred in having others perform reasonably necessary services that the injured person would have performed for non-income producing purposes. This benefit is payable for the first three (3) years following an accident. These benefits are defined in Section 3107(1)(c) as expenses ***"reasonably incurred in obtaining ordinary and necessary services in lieu of those that, if he or she had not been injured, an injured person would have performed during the first 3 years after the date of the accident, not for income but for the benefit of himself or herself or of his or her dependent."*** Some important principles regarding these replacement service expense benefits are summarized below:

1. Nature of the Benefit — Replacement service expenses are typically domestic related. They include things such as housekeeping, yard work, laundry, home maintenance, babysitting, etc. As with attendant care, replacement services may be rendered by relatives as long as the service is something the injured person used to do, is reasonably necessary and the amount charged is reasonable. The statute prohibits payment of replacement services for income producing activities. Therefore, self-employed persons cannot hire substitute workers and obtain reimbursement for that expense under this particular benefit. Furthermore, the $20 per day maximum benefit is not cumulative and thus, if it is not used in one particular day, it is lost. It is not necessary that an injured person actually pay cash for the service as long as he or she has "*incurred*" the expense in the sense of becoming obligated to pay the service provider. It is very important to keep careful records with regard to replacement service claims. These claims should be documented by signed receipts from the person who rendered the service, explaining what was done, when it was done and the charge incurred. Oftentimes, a doctor's statement confirming the need for the service is necessary.

2. An Important Distinction: Attendant Care Services v Replacement Services — There is a "*gray area*" with regard to certain kinds of personal care services rendered to an injured person in his or her home. If the service is related to the injured person's "*care, recovery or rehabilitation*," it is an "*allowable expense*" payable under §3107(1)(a). If the service is not related to personal care, recovery or rehabilitation but is

more in the nature of a domestic service, it is probably a "*replacement service expense*" payable under §3107(1)(c). The distinction is crucial as "*replacement services*" are limited to $20 per day and terminate three (3) years from the date of the accident, whereas "*allowable expense services*" are unlimited in amount and are payable for life. Therefore, those service providers rendering care to an injured person in the person's home must be careful to separate the two (2) types of service claims so as to avoid the application of the $20 per day/three (3) year limitations in situations where the claim is properly payable as an allowable expense benefit. Sometimes insurance companies blur this distinction, resulting in inadequate reimbursement to accident victims.

D. PIP Benefit #4: Survivor's Loss Benefits

Where a motor vehicle accident results in death, dependents of the decedent are entitled to recover "*survivor's loss benefits*" under §3108 and funeral and burial expenses under §3107(1)(a) of the No-Fault Statute. Survivor's loss benefits are payable for three (3) years and are subject to the same maximum monthly benefit ceiling which is applicable to work loss claims. Survivor's loss benefits are comprised of several components including after-tax income, lost fringe benefits and replacement service expenses. Survivor's loss benefits are defined in Section 3108 as compensation for the *"loss . . . of contributions of tangible things of economic value . . . that dependents of the deceased . . . would have received for support during their dependency . . . if the deceased had not suffered the accidental bodily injury causing death and expenses, not exceeding $20 per day, reasonably incurred by these dependents during their dependency . . . in obtaining ordinary and necessary services in lieu of those that the deceased would have performed for their benefit if the deceased had not suffered the injury causing death."* Important principles regarding survivor's loss benefits are summarized below:

1. Multiple Elements of the Claim — The courts have held that the survivor's loss benefit is a multifaceted benefit that includes several important and distinct elements, including: (1) the after tax income earned by the decedent; (2) the value of fringe benefits that were available to the decedent but are now lost or diminished because of his/her death; (3) any other activity that resulted in the production of "*contributions of tangible things of economic value*" (i.e., exchanging services with neighbors); and (4) the same type of replacement service expense benefit payable in non-death cases. The courts have also held that survivor's loss benefits are not to be reduced by amounts attributable to the personal consumption of the decedent. See *Miller v State Farm Mut Auto Ins Co*, 410 Mich 528 (1981).

2. A Single Monthly Ceiling — Unlike non-death cases where it is possible to recover work loss benefits up to the monthly maximum plus the additional amount of $20 per day in replacement service expenses, all elements of survivor's loss benefits are capped by the monthly maximum limitation, including the replacement service component. Therefore, the sum total of all elements of the survivor's loss claim cannot exceed the monthly maximum cap applicable to no-fault work loss benefits under §3107(1)(b).

3. Eligible Claimants — Only those persons who are classified as a "*dependent*" of the decedent may make a claim for survivor's loss benefits. Section 3110 of the statute states that spouses and children under 18 are conclusively presumed to be dependents of the deceased. In addition, children over 18 but physically or mentally incapacitated from earning are considered to be a dependent of a parent with whom the child lives or from whom the child was receiving support regularly at the time of the parent's death. Dependency continues for children over the age of 18 if they are engaged "*full time in a formal program of academic or vocational education or training*." In all other cases, questions of dependency and the extent of dependency are to be determined in accordance with the facts as they exist at the time of death. The statute also states that the dependency of the surviving spouse terminates upon death or remarriage.

4. Funeral and Burial Expenses — Section 3107(1)(a) provides for a separate "*funeral and burial expense*" benefit which shall not be less than $1,750 or more than $5,000, depending upon the type of coverage the accident victim was carrying at the time of the accident. These benefits apply to the charges of a funeral home, grave site and related expenses.

II. GENERAL RULES REGARDING PROCESSING PIP CLAIMS

The Michigan No-Fault Law sets forth many important rules and requirements regarding the processing of no-fault PIP benefits claims. These rules can be quite complex. Set forth below is a summary of some of the basic principles that accident victims should understand. However, this summary is not complete nor is it intended to be an exhaustive analysis of claim processing procedures. Therefore, injured persons should consult with attorneys who are knowledgeable about the No-Fault Law to more thoroughly understand their rights and obligations under the statute.

A. Coordination of Benefits

Under the Michigan No-Fault Act, an insured person may purchase either an ***uncoordinated*** benefits or a ***coordinated*** benefits no-fault insurance policy. If the insured purchases an ***uncoordinated*** policy, the no-fault insurance company is obligated to pay no-fault benefits even though similar benefits may be payable to the injured person under other health and accident coverages. On the contrary, if the insured person has purchased a ***coordinated*** benefits no-fault insurance policy, the no-fault insurer is only obligated to pay those expenses and benefits which are not paid by other health and accident coverage.

If the injured person is covered under an employer's self-funded ***ERISA Health Plan***, the coordination rules may be different. Moreover, if the injured person has coordinated no-fault coverages and is covered under an ***HMO plan***, the injured person's no-fault insurance company is not required to pay for medical expenses incurred by the

injured person for medical treatment obtained outside the HMO, unless that treatment was not available or was not of adequate quality within the HMO.

B. Governmental Benefit Setoffs

Under the No-Fault Statute, a no-fault insurance company is permitted to reduce no-fault PIP benefits by any governmental benefits paid or payable to the injured person. Section 3109(1) of the statute states that, "*Benefits provided or required to be provided under the laws of any state or the federal government shall be subtracted from the personal protection insurance benefits otherwise payable for the injury*." Governmental benefits which have been deemed proper setoffs include, but are not limited to social security disability benefits, social security survivor's benefits, workers' compensation benefits and certain veterans or military benefits.

C. Medicare and Medicaid Benefits

Federal and state law is clear that Medicare must never be billed for any medical expense that is compensable under no-fault. Therefore, a no-fault insurance company cannot take the position that an auto accident victim must first turn to Medicare. Federal law prohibits Medicare from paying auto related medical expenses that are compensable with no-fault PIP benefits. Similarly, Medicaid cannot be billed for auto accident related expenses where those expenses would be covered by no-fault PIP benefits. Therefore, a no-fault insurance company cannot refuse to pay medical expenses that would otherwise be payable by Medicaid had the injured person not had no-fault coverage.

D. Payment Priority Rules

The No-Fault Statute contains a "*priority of payment*" system that determines which no-fault insurer has primary liability for payment of PIP benefits. This priority system is set forth in §3114 and §3115 of the Act. The general rule contained in these sections is that an injured person receives no-fault PIP benefits from his or her own no-fault insurance company (assuming they are insured under a no-fault policy) or from a no-fault policy issued to the insured person's spouse or a relative of either domiciled in the same household. This general rule applies regardless of whether the injured person is driving or occupying his or her own vehicle, is a passenger in another vehicle, or is a pedestrian or bicyclist. However, there are exceptions to this general rule of priority. For example, if the injured person was occupying a vehicle furnished by his or her employer, then the employer's no-fault insurance company must pay PIP benefits.

If an injured person does not have a no-fault insurance policy and does not live with a relative who has no-fault insurance, then priority of payment obligations are determined based upon whether the person was an occupant or a non-occupant of a motor vehicle at the time of the accident. If such a person sustained injury while an occupant of a motor vehicle, then the injured person obtains no-fault PIP benefits from the owner or operator of

the vehicle occupied. If the non-covered victim sustained injury while a non-occupant of a motor vehicle (i.e., a pedestrian or bicyclist), then the non-covered person would obtain no-fault PIP benefits from the "*vehicle involved*" in the accident.

If no-fault coverage is not available through any of the previously mentioned sources, then the injured person must submit his or her claim for no-fault benefits to the ***Michigan Secretary of State Assigned Claims Facility***. When a claim is submitted to the Facility, it is randomly assigned to one of the many auto insurance companies authorized to do business in the State of Michigan. As of this date, the address and phone number for the Assigned Claims Facility is:

Assigned Claims Facility
Michigan Department of State
Lansing, MI 48918-1412
(517) 322-1875

E. Disqualification from PIP Benefits

The Michigan no-fault system is a ***compulsory insurance system***. Under this system, the owner or registrant of a motor vehicle required to be registered in the State of Michigan must purchase no-fault insurance. If an owner or registrant does not purchase the required no-fault coverage, they are subject to criminal penalties. More importantly, §3113(b) states that if a person was the owner or registrant of an uninsured motor vehicle that was involved in the accident, the person is completely prohibited from recovering no-fault PIP benefits. This is true regardless of whether the insured owner was completely innocent in causing the accident.

F. Time Limitations

The No-Fault Act contains very strictly enforced time limitations for processing claims for no-fault PIP benefits. These limitations must be carefully observed in order to properly protect the claim. Failure to observe these time limitations can result in a loss of benefits.

There are basically two (2) one year time limitation periods contained in the No-Fault Statute. The first is referred to as the ***one year notice rule***. This rule requires that written notice be submitted to the appropriate no-fault insurance company within one year of the date of the accident. The written notice must include the name and address of the claimant/injured person as well as the time, place and nature of the injury. Failure to provide this written notice within the one year period will result in the complete forfeiture of the claim unless the no-fault insurance company paid no-fault PIP benefits at some point during the one year following the accident. The second one year rule is referred to as the ***one year back rule***. This rule states that if it is necessary to file a lawsuit to recover unpaid PIP benefits, the lawsuit cannot recover benefits for any expense incurred more

than one year before the lawsuit was commenced. Therefore, every PIP claim expense has its own separate one year enforcement period. Accordingly, accident victims must be very vigilant in pursuing collection of unpaid benefits. If the no-fault insurance company is not going to pay the claim, a lawsuit must be filed within one year of the date the expense is incurred in order for payment to be enforceable.

At the present time, there is considerable confusion regarding whether the one year notice rule and the one year back rule apply to children and those individuals who are severely mentally impaired. For over 25 years, the law in Michigan has been that the one year notice rule set forth in the No-Fault Act does not apply to children and mental incompetents. However, in July 2004, the Michigan Court of Appeals issued an opinion in *Cameron v ACIA*, 263 Mich App 95 (2004), reversing this rule of law and holding that the one year notice rule and the one year back rule set forth in the No-Fault Act do indeed apply to children and mentally impaired adults. The *Cameron* decision has been appealed to the Michigan Supreme Court. In addition, remedial legislation is being prepared for introduction in the Michigan Legislature to reverse *Cameron*. Therefore, it is unclear whether the *Cameron* decision will continue to be controlling legal precedent. This is a very important issue because if *Cameron* is reversed, then children and persons suffering from significant mental disability will, once again, be able to pursue legal action to retroactively recover unpaid benefits without regard to the one year notice rule and the one year back rule.

G. Penalty Sanctions

The No-Fault Statute contains two (2) specific penalties that can be assessed against a no-fault insurance company that does not honor its legal obligation to pay no-fault PIP claims. The two (2) penalties contained in the statute are: (1) *statutory interest* and (2) *statutory attorney fees*.

The statutory interest sanction is set forth in §3142 of the No-Fault Statue and provides that an insurance company that does not pay no-fault benefits within 30 days after receiving reasonable proof of the fact and the amount of the loss must pay simple interest at the rate of 12 percent per annum on the overdue expenses.

The statutory attorney fee sanction is set forth in §3148 of the Act and provides that an injured person is entitled to collect reasonable attorney fees against an insurance company if the court finds that the insurer unreasonably refused to pay the claim or unreasonably delayed in making proper payment.

When no-fault insurance companies do not honor their legal obligation to pay no-fault PIP claims, these two (2) sanctions — statutory interest and statutory attorney fees — should be aggressively pursued by the injured person.