THE MICHIGAN NO-FAULT AUTOMOBILE INSURANCE LAW:

Your Rights and Benefits©

A Practical Guide For Patients and Providers

7th Edition

By:

GEORGE T. SINAS

SINAS DRAMIS LAW FIRM

SINAS, DRAMIS, BRAKE, BOUGHTON & McINTYRE, P.C.

Attorneys at Law

Main Office:
3380 Pine Tree Road, Lansing, MI 48911-4207
(517) 394-7500 ph | (517) 394-7510 fax | email: sinasdramis@sinasdramis.com

www.sinasdramis.com

About the Author

George T. Sinas

George T. Sinas is a senior shareholder in the law firm of ***Sinas, Dramis, Brake, Boughton & McIntyre, P.C.***, Lansing, Michigan, commonly referred to as the ***Sinas Dramis Law Firm***. He is engaged in the full-time practice of law, which he limits to the representation of seriously injured people and their medical providers. Mr. Sinas received his bachelor's degree from the University of Michigan and his law degree from Wayne State University.

Mr. Sinas has been recognized in every edition of the book, ***The Best Lawyers in America*** since 1989 in the field of personal injury law. In 2003 he was recognized by Michigan Lawyers Weekly as one of Michigan's ***10 Lawyers of the Year.*** Also in 2003, he received the ***Leo A. Farhat Outstanding Attorney Award*** from the Ingham County Bar Association. In 2005, he received the ***Professional Service Award*** from the Brain Injury Association of Michigan for his advocacy on behalf of persons suffering serious brain injury. Mr. Sinas has also been listed in every edition of ***Michigan Super Lawyers*** since it was first released.

Mr. Sinas has written two text books and numerous articles on the subject of the Michigan Automobile No-Fault Insurance Act. He is also an Adjunct Professor at the Michigan State University College of Law and serves as ***General Counsel to the Coalition Protecting Auto No-Fault (CPAN)***, a broad-based coalition of medical providers and consumer groups working together to preserve and protect the Michigan auto no-fault system. He is a past ***President of the Michigan Association for Justice (formerly the Michigan Trial Lawyers Association)*** and a past ***Chairperson of the Negligence Law Section, State Bar of Michigan.***

About the Firm

SINAS, DRAMIS, BRAKE, BOUGHTON & McINTYRE, P.C.

ATTORNEYS AT LAW

3380 Pine Tree Road, Lansing, MI 48911
(517) 394-7500 ph • (517) 394-7510 fax • www.sinasdramis.com

The law firm of ***Sinas, Dramis, Brake, Boughton & McIntyre, P.C.*** was established in Lansing, Michigan in 1951. The firm was founded by two young lawyers, Thomas G. Sinas and Lee C. Dramis, who built on a close personal relationship to create a law firm that would become, over the next half century, one of the most respected in the State of Michigan. The firm, commonly referred to as the ***Sinas Dramis Law Firm***, is best known for its excellent reputation representing plaintiffs in matters dealing with serious personal injury and wrongful death.

The law firm's competence in these areas of law is reflected by the fact that five of its attorneys (*George T. Sinas, Timothy J. Donovan, James F. Graves, Bryan J. Waldman and the now retired, Barry D. Boughton*) have been recognized in the national publication, ***The Best Lawyers in America,*** in the field of plaintiffs' personal-injury litigation. Another member of the firm *(Bernard F. Finn)* has been recognized in ***The Best Lawyers in America*** in the field of family law. Three members of the law firm (*George T. Sinas, Bryan J. Waldman and the late, Lee C. Dramis*) have served as ***President of the Michigan Trial Lawyers Association***. In addition, two members of the law firm (*George T. Sinas and Timothy J. Donovan*) have served as ***Chairperson of the State Bar Negligence Law Section***. One former member of the law firm (*Donald L. Reisig*) served as ***President of the State Bar of Michigan***.

In recognition of the 50th anniversary of the ***Sinas Dramis Law Firm***, the Michigan Legislature honored the firm with a Special Tribute Resolution which stated:

> *The continuing success of the Sinas Dramis Law Firm is indicative of its constant dedication to serving its clients. They have earned a statewide reputation of excellence . . . and are deserving of high recognition. They have distinguished themselves not only as professionals, but as leaders throughout the Lansing community. They have set a standard for legal representation that is difficult . . . to match.*

In 2010, the ***Best Lawyers in America***, in conjunction with ***US News & World Report***, ranked the ***Sinas Dramis Law Firm*** as a *"Tier 1"* firm in the area of plaintiffs' personal-injury law – the only law firm in the Lansing, Michigan area to receive that significant distinction.

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INTRODUCTION

The No-Fault Automobile Insurance Act (MCL 500.3101, et seq.) was adopted by the Michigan Legislature in 1972 and went into effect in October of 1973. Michigan is only one of a handful of states in the country to adopt a no-fault system. Although the original intent was to simplify motor-vehicle claims, in many respects, the opposite has occurred. There have been approximately 3000 appellate-court decisions written over the last 35 years interpreting various aspects of the Michigan No-Fault Act. In addition, there are numerous issues which remain confusing and unresolved. Clearly, however, one fact has emerged from the past four decades of the Michigan no-fault experiment: ***it is critically important for consumers and accident victims to understand their rights.*** *In many situations, it is a person's ignorance of these rights that results in a loss of benefits and a denial of compensation.*

The basic concept of no-fault is to guarantee payment of certain insurance benefits to all victims of motor-vehicle accidents regardless of who was at fault. In order to fund such a system, however, the no-fault law imposes certain limitations on the rights of accident victims to bring tort liability claims against the negligent parties who inflicted the injury.

Under the Michigan No-Fault Act, it is helpful to always remember that every motor-vehicle accident that occurs in this state has ***two separate and distinct claims****. The first is for* ***no-fault personal protection insurance (PIP) benefits****. The second is the* ***tort liability claim*** *against the party at fault for recovery of noneconomic damages and excess economic damages. These claims are summarized below.*

A. The No-Fault Benefits Claim

Under the statute, an auto-accident victim has the right to recover certain "no-fault benefits" (usually from the victim's own insurance company) regardless of who caused the accident and regardless of whether the injured person was driving a motor vehicle, was a passenger in a motor vehicle, or was a pedestrian or a bicyclist. These no-fault benefits are often referred to by a variety of terms, all of which mean the same thing. The legally correct name for no-fault benefits is ***"personal protection insurance benefits."*** *They are also called "PIP benefits," "no-fault benefits," or "first-party benefits." Basically, there are four types of no-fault benefits payable under the Michigan system: (1) allowable medical and rehabilitation expenses for life; (2) wage loss benefits for a three-year period; (3) replacement service expenses for a three-year period; and (4) survivor's loss benefits for a three-year period when an accident results in death. These no-fault benefits will be discussed in greater detail in Part One of this brochure.*

B. The Tort Liability Claim Against the Party at Fault

Under the Michigan No-Fault Act, an accident victim also has the right to pursue a tort liability claim against the driver at fault to recover those damages that are not compensable with no-fault benefits. The compensation recoverable in these liability claims includes damages for "noneconomic loss" and "excess economic loss." Claims for noneconomic loss require proof that the injury suffered by the victim constitutes either "serious impairment of body function" or "permanent serious disfigurement." Where the at-fault driver causes an accident resulting in death, the decedent's estate can pursue a tort liability claim for damages under the Michigan Wrongful Death Act. These liability claims will be discussed in greater detail in Part Two of this brochure.

PART ONE: THE NO-FAULT PIP CLAIM

SECTION 1: LEGAL ENTITLEMENT TO NO-FAULT BENEFITS

An analysis of the no-fault PIP claim begins with understanding when no-fault PIP benefits are payable. This issue is commonly referred to as *"entitlement to benefits."* The pivotal statutory section regarding entitlement to no-fault benefits is Section 3105, which is considered the *"gateway"* to the no-fault first-party system. Within that section, subsection 3105(1) is the key provision. In one sentence, this subsection sets forth the following entitlement test: *"Under personal protection insurance an insurer is liable to pay benefits for accidental bodily injury arising out of the ownership, operation, maintenance or use of a motor vehicle as a motor vehicle, subject to the provisions of this chapter."* Subsection 3105(2) states that no-fault PIP benefits *"are due under this chapter without regard to fault."* It is this later subsection that gives "no-fault" its name.

As is apparent, the entitlement language of Subsection 3105(1) is very broad and goes beyond bodily injuries sustained in traditional motor-vehicle collisions. On the contrary, this section has been interpreted to extend entitlement to benefits to non-collision situations, such as cases involving vehicular maintenance, vehicular loading and unloading, and vehicular occupancy.

A. The Five-Part Test Regarding Legal Entitlement

Case law decided under Subsection 3105(1) has, over many years, produced a five-part test that determines whether an injury victim is entitled to recover no-fault PIP benefits. The five elements of this test are as follows:

1. *There must be a "motor vehicle" involved in the accident, as that term is defined in the statute [see Section 3101(2)(e)];*

2. *The claim must involve some form of bodily injury, rather than some latent medical condition or disease [see Wheeler v Tucker Freight Lines, 125 Mich App 123 (1983)];*

3. *The bodily injury giving rise to the claim must be accidental in the sense that it was not caused intentionally by the claimant [see Mattson v Farmers Insurance Exchange, 181 Mich App 419 (1989) and Miller v Farm Bureau, 218 Mich App 221 (1996)];*

4. *There must be a sufficient causal nexus between the injury and the use of a vehicle such that the use of the vehicle is one of the causes of the injury, even though there may be other causes, provided that the connection between the injury and vehicle use is more than incidental or fortuitous [see Shinabarger v Citizens Insurance Co, 90 Mich App 307 (1979); Thornton v Allstate, 425 Mich 643 (1986); Marzonie v ACIA, 441 Mich 522 (1992); Bourne v Farmers, 449 Mich 193 (1995); and Morosini v Citizens, 461 Mich 303 (1999)]; and*

5. *The injury must be closely related to the transportational function of a motor vehicle [see McKenzie v ACIA, 458 Mich 214 (1998)].*

B. The Parked-Vehicle Exclusion

Although Subsection 3105(1) sets forth a broad legal entitlement to benefits, this test narrows considerably if a *"parked vehicle"* is involved in the injury-producing scenario. Parked vehicle situations are addressed in Subsection 3106(1) of the Act, which states that an accidental bodily injury arising out of a parked vehicle is not compensable with no-fault benefits unless the injury falls into one of the three (3) exceptions set forth in Subsection 3106(1). These exceptions deal with vehicles parked in a way that cause unreasonable risk of injury; injuries occurring as a result of contact with vehicle equipment or with property being loaded or unloaded; and injuries occurring while the victim is occupying, entering into, or alighting from a vehicle. The case law has also recognized a fourth common-law exception to the parked-vehicle bar involving injuries sustained in the course of *vehicular maintenance*. [See *Miller v Auto-Owners, 411 Mich 633 (1981)*]. Unfortunately, the statute does not define a *"parked vehicle,"* and therefore, that is sometimes an issue. It is also important to note that Subsection 3106(2) contains a very strict exclusion dealing with work-related injuries which provides that PIP benefits are not payable if the injury gives rise to the payment of workers' compensation benefits and the employee sustained the injury while loading, unloading, or doing mechanical work on a vehicle or while entering into or alighting from the vehicle, unless the injury arose from the use or operation of some other motor vehicle. This work-related exception does not apply, however, when an employee sustains injury while actually operating a vehicle.

C. Statutory Disqualifications

In addition to satisfying the entitlement requirements of Section 3105 and Section 3106, it is also important to establish that the victim is not otherwise statutorily disqualified under the provisions of Section 3113. This section disqualifies injury victims in three situations: (1) the victim was using a vehicle he or she had taken unlawfully; (2) the victim was the owner or registrant of a vehicle involved in the accident that was not insured as required by the No-Fault Act; and (3) the victim was a foreign resident occupying a vehicle not registered in Michigan and not insured by a Michigan-authorized insurer. The most important of these

disqualifications is the second one, which disqualifies uninsured owners and registrants. This disqualification underscores the fact that the Michigan no-fault system is a *compulsory insurance system* that obligates the owner or registrant of any vehicle required to be registered in Michigan to buy the statutorily mandated auto no-fault insurance.

D. Out-of-State Accidents

No-fault PIP benefits are also payable in certain situations involving out-of-state accidents. This issue is addressed in Section 3111 of the Michigan No-Fault Act, which states that no-fault PIP benefits *"are payable for accidental bodily injury suffered in an accident occurring out of this state, if the accident occurs within the United States, its territories and possessions or in Canada"* and if the injured person falls into one of two classifications: (1) the injured person is a named insured under a Michigan no-fault policy or the spouse or a resident relative of a person who is a named insured under a Michigan no-fault policy; or (2) the injured person is an occupant of a vehicle whose owner or registrant insured that particular vehicle under a Michigan no-fault policy.

E. Out-of-State Residents Injured in Michigan

There are a number of circumstances where citizens of other states who are injured in motor-vehicle accidents occurring in Michigan are entitled to recover Michigan no-fault PIP benefits. For example, benefits are payable to nonresidents who are: (a) injured while occupying a motor vehicle insured with a Michigan no-fault PIP policy, or, (b) injured while a non-occupant (pedestrian, bicyclist, motorcyclist) as a result of the operation of a motor vehicle that is insured with a Michigan no-fault PIP policy. In addition, Section 3163 of the Act provides that out-of-state residents who are insured by auto insurance companies authorized to do business in the State of Michigan can recover Michigan no-fault PIP benefits when they travel into Michigan in out-of-state vehicles and sustain injury in a motor-vehicle accident occurring in Michigan. However, Section 3163 provides that in certain circumstances, out-of-state residents may be subject to a $500,000.00 cap on PIP benefits. This is a complicated issue that needs to be analyzed carefully if an out-of-state claimant is drawing benefits under the provisions of Section 3163 of the Act.

SECTION 2: THE FOUR MAJOR NO-FAULT PIP BENEFITS

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

A. PIP Benefit #1: Allowable Expenses

The Michigan No-Fault Law has the broadest and most generous medical-expense and patient-care provisions of any No-Fault Act in the country. Subsection 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.

1. The Scope of Allowable Expenses

- **Medical Expenses** — Under the Act, all reasonable charges for 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.

- **In-Home Attendant Care or Nursing Services** — The Act uses the word "services," which the courts have interpreted to include unskilled and skilled in-home attendant care and nursing services. As with any allowable expense, these services must be "reasonably necessary" and the amount claimed must be a "reasonable charge." As long as these requirements are established, court decisions have made it clear that in-home attendant care and nursing services rendered by family, friends, and neighbors of the injured person are compensable under the Act. In addition, the injured person has a right to hire a commercial in-home health care agency to render these services either in lieu of, or to supplement, family-provided attendant care. See *Manley v DAIIE, 425 Mich 140 (1986)*; *Sharp v Preferred Risk Mutual Ins Co, 142 Mich App 499 (1985)*; *VanMarter v American Fidelity Fire Ins Co*, *114 Mich App 171 (1982)*; and *Visconti v DAIIE, 90 Mich App 477 (1979)*. The in-home attendant care benefit is very important for seriously injured auto-accident victims and their families. It enables them to hire outside help or employ family members so that the injured person can remain at home rather than be institutionalized. Attendant care covers a wide range of "hands on services," including bathing, dressing, feeding, personal assistance, meal preparation, personal hygiene, transportation to medical care, administration of medications, overseeing in-home therapies, etc. In addition, the court decisions have made it clear that attendant care benefits go beyond "hands on care" and include the monitoring and supervision of the patient. The central issue in many of these cases is simply whether the patient can be left alone at any time during a 24-hour day. If not, then attendant care benefits are likely payable for any period of time during which the injured person requires someone to be in attendance.

Family-provided attendant care claims frequently result in disputes with no-fault insurers. These disputes typically involve two major issues: (1) How many hours of attendant care are "reasonably necessary"? and (2) What hourly or per diem rate is a "reasonable charge"? The statute does not specifically or definitively address these issues and neither does any appellate-court decision. Therefore, each case is evaluated on its own merits. Regarding the reasonableness of the charges, there are court decisions that hold it is appropriate to consider commercial rates charged by professional agencies for similar services. In *Sharp v Preferred Risk Mutual Ins Co, 142 Mich App 499 (1985)*, the Court of Appeals stated, *"comparison to rates charged by institutions provides a valid method for determining whether the amount of an expense was reasonable and for placing a value on comparable services performed [by family members]."* Pursuant to this concept, claims for family-provided attendant care are frequently based upon the commercial rate that would be charged by a professional agency rendering the same services. However, no-fault insurance companies rarely voluntarily pay attendant care claims at the commercial rate, arguing that the hourly rate earned by the agency employee is a better indicator of the reasonable value of the services. Therefore, there are frequent disagreements between claimants and insurance companies regarding the reasonable value of family-provided attendant care. In addition, insurers often dispute the amount of hours that are reasonably necessary for a patient's care. Therefore, these two issues, hours and rates, require careful thought and documentation.

It is also important to point out that, as with all allowable expenses, claims for family-provided attendant care are subject to the "incurred" requirement. This will be discussed in Section 7 D. In order for an expense to be deemed "incurred," it must either be paid by or on behalf of the patient or the patient must become liable or obligated to pay the expense. Recently, the Michigan Supreme Court held that in cases involving family-provided attendant care, the care giver must have an expectation of being compensated for rendering attendant care rather than simply providing the care out of a sense of obligation, duty, commitment, loyalty, or compassion. See *Burris v Allstate, 480 Mich 1081 (2008)*. Therefore, those persons rendering attendant care to family members must be very clear that they are providing the attendant care with the full expectation of being paid in accordance with the provisions of the Michigan No-Fault Act.

- **Accommodations** — The Act 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 handicap 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. In this regard, 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 the equity in their existing home toward the construction of the new home, then the injured adult is entitled to full legal ownership of the newly constructed residence. Where the new home is fully titled in the name of the injured person, the courts have, in some circumstances, permitted the insurance company who paid for the home to have a security interest in the property for a reasonable period of time so that the insurer's investment can be recouped and transferred to another home should the patient need to move in the future. See *Payne v Farm Bureau, 263 Mich App 521 (2004)*. In addition to the cost of a residence, accommodation claims also involve issues as to whether insurance companies are obligated to pay the ongoing expenses related to home ownership, such as property taxes, homeowners insurance, maintenance expenses, utilities, etc. In addition, issues arise as to whether the family members of the injured person residing in the home are obligated to contribute to the expense of constructing and maintaining the residence as a form of "rent" for being able to live there. Clearly, enforcing the right to the accommodation benefit can be a complicated matter that involves the resolution of many issues that can have long-term implications for severely injured people.

- **Room and Board Expenses** — In 1993 the Court of Appeals held that room and board expenses for a severely injured person cared for at home are compensable under Subsection 3107(1)(a) where the *"injured person is unable to care for himself and would be institutionalized were a family member not willing to provide home care."* See *Reed v Citizens Ins Co of America, 198 Mich App 443 (1993)*. However, the Supreme Court reversed the *Reed* case in *Griffith v State Farm, 472 Mich 521 (2005)* and also held that the expense of nonmedical food for persons cared for at home is not a recoverable benefit. Still, room and board charges incurred by institutionalized patients for any type of food served in *a hospital or residential facility* continue to be compensable under the statute.

- **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 no-fault 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)*.

- **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 outfitted 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)*.

- **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)*.

- **Guardian Expenses** — The courts have held that where a seriously injured person requires the probate-court 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)*.

2. The Causation Requirement Applicable to Allowable Expense Claims

In recent years, there has been increasing discussion and some uncertainty as to exactly what legal causation standard is applicable to the payment of allowable expense claims under Subsection 3107(1)(a) of the No-Fault Act. Many years ago, the causation issue was addressed in the context of *entitlement to no-fault benefits* under Subsection 3105(1), which was discussed in Section 1 of this brochure. One of the leading causation cases dealing with entitlement to benefits is the decision in *Shinabarger v Citizens Insurance Co, 90 Mich App 307 (1979)*. In that case, the Court held that the language of Subsection 3105(1) making benefits compensable for injuries *"arising out of the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle,"* is satisfied *"where use of the vehicle is one of the causes of the injury . . . even though there exists an independent cause. . . almost any causal connection or relationship will do . . ."* Subsequent appellate decisions applied this *Shinabarger* standard in a variety of cases dealing with entitlement to benefits. Over time, the question developed whether the "arising out of" causation standard adopted by the *Shinabarger* case applied to determine the liability of a no-fault insurance company to pay allowable expenses under Subsection 3107(1)(a) of the Act.

This issue was recently decided by the Court of Appeals in the case of *Scott v State Farm, 278 Mich App 578 (2008)*. In that decision, the Court of Appeals held that the *Shinabarger* causation standard applicable to the entitlement issues under Subsection 3105(1) also applies to the allowable expense claims under the provisions of Subsection 3107(1)(a). Therefore, if an auto-accident injury is one of the causes for a person's need for medical services, the no-fault insurer is obligated to pay the entire amount of the claim, even though there may be other causes contributing to the need for those services.

3. The "Griffith Problem" and Its Impact on Allowable Expense Claims

On January 14, 2005, the Michigan Supreme Court decided the case of *Griffith v State Farm, 472 Mich 521 (2005),* which some insurance companies contend substantially impacts the types of products, services, and accommodations that are compensable under the No-Fault Act. Until the courts provide further clarification of the *Griffith* case, the legal interpretation of this decision by many insurance companies should be viewed cautiously and skeptically. To avoid an over extension of the *Griffith* holding, it is important to understand the specific issue involved in the *Griffith* case and the Court's ruling regarding that issue. In *Griffith*, the Court held that a no-fault insurer was not responsible for paying the costs of *non-medical/non-special dietary food expenses* of a catastrophically injured person who was cared for at home because the injured person's dietary needs had not been altered in any way by the accident. In other words, the victim's food needs after the accident were identical to what they were before the accident. As such, there was absolutely no relationship between the person's injury and his food needs. In that situation, the Court held that the no-fault insurer had no obligation to pay for the victim's in-home food expenses.

Insurance companies, however, frequently cite *Griffith* for the proposition that a no-fault insurer never has an obligation to pay for any products, services, or accommodations that the injured person would have needed had there not been an accident. Therefore, because most injured persons require some form of housing, transportation, and personal maintenance before an injury, no-fault insurers argue they should have no obligation to pay for such preexisting needs after an accident occurs. However, a close reading of the *Griffith* decision indicates that *Griffith* should not be extended to cases where accident-related injuries have, in some way, affected the patient's pre-accident needs. In other words, if a catastrophic injury affected a claimant's housing needs so that the person's housing needs *are now different than they were before the accident*, then there should be a sufficient causal relationship obligating a no-fault insurer to pay benefits for all of those preexisting, but now changed, needs. Such an analysis would also be consistent with the earlier opinion of the Court of Appeals in *Sharp v Preferred Risk Mutual Insurance Co, supra* which was referenced in Section 2 A 1 and the causation analysis set forth in Section 2 A 2. Therefore, a proper reading of the decisions in *Scott v State Farm* and *Griffith v State Farm* produce a simple three-part test that should be applied to determine an insurer's liability to pay allowable expense claims under Subsection 3107(1)(a) of the Act. Under this three-part test, an insurer would be responsible to pay 100% of an allowable expense claim if the patient establishes the following elements: (1) the patient's injuries either materially affected his pre-accident need for the services at issue or the injuries

were one of the reasons why the patient needs these services; (2) the services at issue are reasonably necessary for the patient's care, recovery, and rehabilitation; and (3) the charge for the services is reasonable.

B. PIP Benefit #2: Work Loss Benefits

Subsection 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 years. The statute defines work loss benefits as compensation for ***"loss of income from work an injured person would have performed during the first three 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 cost-of-living 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-year benefit period. Set forth below are the monthly maximum benefit levels that have been in effect for the last 10 years:

10/1/01 . . . . . $4,027.00	10/1/06 . . . . . $4,589.00
10/1/02 . . . . . $4,070.00	10/1/07 . . . . . $4,713.00
10/1/03 . . . . . $4,156.00	10/1/08 . . . . . $4,948.00
10/1/04 . . . . . $4,293.00	10/1/09 . . . . . $4,878.00
10/1/05 . . . . . $4,400.00	10/1/10 . . . . . $4,929.00

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 is available and if it is 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-paid 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 no-fault 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)*. However, if the injured person has purchased a *coordinated benefits no-fault policy*, a no-fault insurer may reduce no-fault wage loss benefits by the amount the person receives from wage continuation plans that are in the nature of *"other health and accident coverage*." See *Jarrad v Integon, 472 Mich 207 (2005)*.

3. *Temporarily Unemployed Persons*

The Act 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 Section 3107a, 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. Moreover, the courts have stated 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 Mut 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 no-fault 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. Therefore, the question of which business-related expenses should be deductible from the gross receipts of a self-employed person to arrive at the proper wage loss benefit level payable under the no-fault law 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 Expenses

Under the No-Fault Act, 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 domestic-type services that the injured person would have performed for non-income-producing purposes. This benefit is payable for the first three years following an accident. These benefits are payable under Subsection 3107(1)(c) for 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 three 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 and friends as long as the service is something the injured person used to perform, 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 a cumulative benefit 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 performed 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 vs. 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 Subsection 3107(1)(a) and is discussed in Section 2 A 1. 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 Subsection 3107(1)(c). The distinction is crucial as "replacement services" are limited to $20 per day and terminate three 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 types of service claims so as to avoid the application

of the $20-per-day/three-year limitation 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 Section 3108 and funeral and burial expenses under Subsection 3107(1)(a) of the No-Fault Act. Survivor's loss benefits are payable for three 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, which include after-tax income, lost fringe benefits, and replacement service expenses. Survivor's loss benefits are payable under Section 3108 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 and his/her family 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" (e.g., 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 538 (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 an 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 Subsection 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 Act 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 Act also states that the dependency of the surviving spouse terminates upon death or remarriage of the surviving spouse.

4. Funeral and Burial Expenses

Subsection 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.

SECTION 3: GOVERNMENTAL BENEFIT SETOFFS

A. Basic Concept

Under the Michigan No-Fault Act, a no-fault insurance company is permitted to reduce no-fault PIP benefits by any governmental benefits paid or payable to the injured person. This governmental benefit setoff provision is set forth in Subsection 3109(1) of the statute, which states: ***"Benefits provided or required to be provided under the laws of any state or federal government shall be subtracted from the personal protection insurance benefits otherwise payable for the injury."*** The question of what kind of governmental benefit can be set off against PIP benefits and what cannot, is often a complicated issue. The courts have adopted a two-fold test that must be met before a governmental benefit can be subtracted from PIP benefits: first, the governmental benefit must be payable as a result of the auto accident, and second, it must serve the same purpose as the no-fault benefit. See *Jarosz v DAIIE, 418 Mich 565 (1984)*. Some governmental benefits have "flunked" this two-part test and, therefore,

cannot be set off against no-fault benefits. For example, the $225.00 "death benefit" payable under the U.S. Social Security Act cannot be offset against the no-fault funeral and burial expense benefit. See *Gier v Auto-Owners Ins Co*, *244 Mich App 336 (2001)*. In the case of *Wood v Auto-Owners*, *469 Mich 401 (2003)* the Michigan Supreme Court adopted a specific formula for calculating no-fault survivor's loss benefits in cases where claimants are receiving governmental benefits and a portion of the survivor's loss benefit represents replacement services. Subject to this formula, the Court ruled that governmental benefits cannot be set off against that part of no-fault survivor's loss benefits that represents replacement services.

B. Types of Governmental Benefits Resulting in Setoff

The courts have issued many decisions regarding the governmental benefit setoff provision of the Act and have held that, depending upon the facts of the case, the following kinds of governmental benefits can be deducted from PIP benefits: ***(1) Social Security disability benefits; (2) Social Security survivor's benefits; (3) Workers' Compensation benefits; and (4) certain kinds of veterans or military benefits.***

C. Medicare Benefits

Unlike other types of governmental benefits, Medicare benefits are not payable for any expense that is compensable under an automobile no-fault insurance system. Therefore, a no-fault insurance company cannot take the position that an auto accident victim must first turn to Medicare because the federal law prohibits Medicare from paying benefits to persons insured under a no-fault system. ***Therefore, an accident victim should never knowingly submit, nor permit a treating medical provider to submit, any medical expenses to Medicare for payment if the expenses are otherwise covered under the Michigan No-Fault Act***. If Medicare mistakenly pays medical expenses that should have been paid by no-fault insurance, the Medicare program has the legal right to seek reimbursement from a variety of sources, including the responsible no-fault insurer, the medical provider receiving the Medicare payment, and under certain circumstances, even the patient. This is an area that requires great caution for both patients and providers.

D. Medicaid

As with Medicare, persons insured by Medicaid cannot submit auto accident-related expenses to Medicaid for payment if they are covered by auto no-fault insurance. Medicaid only pays the medical expenses of those individuals who are "medically indigent." A person who is entitled to recover reimbursement for medical expenses under the Michigan No-Fault Act is not medically indigent and, therefore, not eligible for Medicaid benefits for that particular expense. Accordingly, the no-fault insurance company must pay the full amount of all medical expenses even though the accident victim might otherwise be entitled to Medicaid.

As with Medicare recipients, persons insured by Medicaid should not submit, nor allow treating medical providers to submit, auto-accident-related medical expenses to Medicaid for payment. If the Medicaid program mistakenly pays medical expenses that should have been paid by no-fault insurance, Medicaid has powerful reimbursement rights similar to the Medicare program referenced above.

SECTION 4: DETERMINING WHAT INSURER HAS PRIORITY DUTY TO PAY BENEFITS

The Michigan No-Fault Act 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 Sections 3114 and 3115 of the Act.

A. The General Rule

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 injured 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 motor vehicle, is a passenger in another vehicle, or is a pedestrian or a bicyclist.

B. Exceptions to the General Priority Rule

There are exceptions to the general rule of priority stated above. 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. Likewise, if the injured person was operating a motorcycle and is injured in an accident involving a motor vehicle, the motorcyclist must first turn to the insurer of the owner, registrant, or operator of the motor vehicle involved in the accident for payment of PIP benefits.

C. Injured Persons Who Have No Auto Insurance

If an injured person does not have a personal no-fault insurance policy and does not live with a relative who has a no-fault insurance policy, 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, however, such a non-covered individual sustains injury while a non-occupant of a motor vehicle (e.g., a pedestrian or a bicyclist), then the person obtains PIP benefits from the "vehicle involved" in the accident.

D. Owners of Uninsured, Involved Vehicles

The Act is very strict with accident victims who own uninsured vehicles that are involved in the accident. Subsection 3113(b) states that a person is completely disqualified from recovering no-fault PIP benefits if the person was the owner or registrant of an uninsured motor vehicle that was involved in the accident. This disqualification is discussed in Section 1 C.

E. Assigned Claims Facility

If no-fault coverage is not available through any of the previously mentioned sources and if the injured person is not statutorily disqualified from receiving benefits, then the injured person must submit his or her claim for no-fault benefits to the ***Michigan Department of State, Assigned Claims Facility***. This is a governmental office that has been established as the "place of last resort" for auto-accident victims. 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 the date of this brochure, the address and phone number of the Assigned Claims Facility is:

Michigan Department of State
Assigned Claims Facility
7064 Crowner Drive
Lansing, MI 48918-1412
(517) 322-1875

SECTION 5: COORDINATION OF BENEFITS (THE RELATIONSHIP BETWEEN NO-FAULT PIP BENEFITS AND HEALTH INSURANCE COVERAGES)

A. Basic Concept

Under the Michigan no-fault system, an insured person may purchase either an ***"uncoordinated benefits"*** or a ***"coordinated benefits"*** no-fault insurance policy. If the insured purchases an *uncoordinated* benefits 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

another health insurance policy. 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 that are not paid by other applicable health or accident insurance coverage. In other words, a no-fault benefits policy that is coordinated is *secondary* to traditional health insurance plans such as Blue Cross Blue Shield, health coverage through health maintenance organizations (HMOs), and health coverage through preferred provider organizations (PPOs). In light of the fact that the premium charged for a coordinated benefits policy is less than the premium for an uncoordinated policy, the majority of Michigan auto insurance consumers have purchased (either knowingly or unknowingly) coordinated no-fault coverages. The statutory section that permits coordinated no-fault policies is Section 3109a, which states that a coordinated no-fault policy is coordinated only with respect to the person named in the policy, the spouse of the insured and any relative of either domiciled in the same household. Therefore, unless the injured person falls into one of those three categories, no-fault benefits payable under such a coordinated policy cannot be coordinated with other health coverages.

B. The Mechanics of No-Fault Coordination of Benefits

1. Conflicting Coordinated Policies

Sometimes an injured person will be insured under a coordinated no-fault policy and a health insurance policy that also has language that coordinates its coverages with other health and accident coverages, such as no-fault insurance. When that happens, the two policies are conflicting, with each attempting to make itself secondary to the other coverages. In this situation, the Michigan Supreme Court has held that where there are two conflicting coordination of benefits clauses, the conflict is resolved in favor of the auto no-fault insurance company, thus making the health insurance primary and the auto no-fault insurance secondary. See *Federal Kemper Ins Co v Health Ins Admin*, *424 Mich 537 (1986)*. However, where the no-fault policy is uncoordinated and the health insurance policy is coordinated, the no-fault policy is primary and the health insurance policy is secondary. See *Smith v Physicians Health Plan, Inc*, *444 Mich 743 (1994)*.

2. Uncoordinated Policies

Although it is not a common occurrence, sometimes an injured person has an uncoordinated no-fault policy and an uncoordinated health insurance policy. In that situation, neither of the two policies will be able to coordinate with any other coverages. Therefore, this creates a potential "*double dip*" situation where medical expenses are payable under both policies. The courts have held that where both the no-fault policy and the health insurance policy are uncoordinated, the injured person is indeed legally permitted to double recovery (payment under each policy) as a higher premium was theoretically paid to obtain two uncoordinated coverages. See *Haefele v Meijer, Inc*, *165 Mich App 485 (1987)*.

C. ERISA Health Plans — A Different Rule

Many individuals are insured through their employment under an employer self-funded health plan established pursuant to a federal statute known as the Employee Retirement Insurance Security Act (ERISA). ERISA plans are different than traditional health insurance coverage such as Blue Cross Blue Shield. If the injured person is insured under an ERISA plan and if the plan contains a coordination of benefits clause making it secondary to auto no-fault coverages, the courts have enforced such provisions even where the no-fault plan also has a coordinated benefits provision. In other words, where a no-fault policy is coordinated and an ERISA plan is coordinated, unlike the situation with health insurance, the auto no-fault plan will be primary and the ERISA plan will be secondary. See *Auto Club Ins Ass'n v Frederick & Herrud, 443 Mich 358 (1993)*. The result may be different, however, if there is some ambiguity in the language of the ERISA plan. See *Auto-Owners v Thorn Apple Valley, 31 F.3d 371 (6th Cir. 1994)*.

D. Special Concerns for Patients with Coordinated No-Fault Policies and Managed-Care Health Plans

Consumers who are insured under a coordinated no-fault policy and who also are members of HMOs are confronted with special rules if they seek treatment outside of the HMO program. The Michigan Supreme Court has held that if the service or treatment is available within the HMO and the patient seeks the service or treatment outside of the HMO without following proper procedures to obtain HMO approval, the no-fault insurer is not obligated to pay for any of the cost of the service or treatment obtained outside of the HMO. See *Tousignant v Allstate Ins Co, 444 Mich 301 (1993)*. This rule, however, should only apply where the specific medical service is available within the HMO program. Where it is not, the no-fault insurer should not be released from its obligation to pay for treatment, if the treatment is otherwise "reasonably necessary" under Subsection 3107(1)(a). For example, if chiropractic treatment was deemed "reasonably necessary" under Subsection 3107(1)(a) and chiropractic services were not available through a patient's HMO, the patient's no-fault insurance company would be obligated to pay for that chiropractic treatment. See *Sprague v Farmers Ins Exch, 251 Mich App 260 (2002)*.

The *Tousignant* decision dealt with patients who have health coverage through an HMO plan. Recently, however, some no-fault insurers have attempted to extend the *Tousignant* holding to patients who have health insurance coverage with *preferred provider plans* (PPO's). In other words, if a patient has health insurance that will pay the full cost of a particular service if rendered by a *participating provider*, a coordinated no-fault insurer may attempt to deny payment of all or some of the medical expenses that the patient incurs by treating with a *non-participating provider*. As of the present date, no appellate court has specifically approved such an extension of the *Tousignant* holding to PPO's. Nevertheless, great caution should be used in these situations.

SECTION 6: MOTORCYCLES AND NO-FAULT

A. When PIP Benefits Are Payable to Motorcyclists

Under the No-Fault Act, a motorcycle owner is not required to purchase mandatory no-fault insurance coverages. Consequently, a person operating a motorcycle who sustains injury is not entitled to no-fault PIP benefits unless the accident involved *"**a motor vehicle**."* Under the No-Fault Act, a motor vehicle is defined as *"a vehicle, including a trailer, operated or designed for operation upon a public highway by power other than muscular power which has more than 2 wheels. . . . Motor vehicle does not include a farm tractor or other implement of husbandry which is not subject to the registration requirements of the Michigan vehicle code . . .*" Under this definition, a motorcycle is not a motor vehicle. Therefore, motorcyclists who run off the road, hit trees or collide with other motorcycles are not entitled to no-fault PIP benefits. However, if a motorcyclist sustains an injury in a collision involving a vehicle that falls within the statutory definition of "*motor vehicle*," the motorcyclist is entitled to recover no-fault PIP benefits because his or her injury is deemed to be one "arising out of" the operation of some form of "*motor vehicle*." The PIP benefits payable to motorcyclists in these situations are the same as the PIP benefits payable in traditional auto accidents, which are discussed in Section 2.

The No-Fault Act also contains an important disqualification applicable to motorcycle owners. Under this disqualification, a motorcycle owner who has not purchased traditional liability coverage for his or her motorcycle (commonly referred to as *PLPD coverage*) is not eligible to recover no-fault PIP benefits in a motorcycle–motor vehicle accident. This qualification, however, extends only to the owner of the motorcycle. A non-owner passenger on board the uninsured motorcycle is not prohibited from recovering PIP benefits.

Motorcyclists should also be aware that there is a special form of "motorcycle no-fault PIP" insurance that motorcycle owners can purchase as an optional coverage. This optional coverage is referred to in Subsection 3103(2) of the No-Fault Act, which states that no-fault insurance companies are required to make this coverage available to motorcycle owners/registrants in increments of $5,000 or more. The statute states that this coverage is *"for the payment of first-party medical benefits only"* in situations where the owner or registrant of the motorcycle is injured in a motorcycle accident that *does not involve a motor vehicle*. Therefore, this coverage would come into play where a motorcyclist sustains injury in a non-motor-vehicular collision, such as a collision with another motorcycle, running off the road, striking a tree, etc. The phrase *"first-party medical benefits"* is not defined in the No-Fault Act; presumably it refers to the allowable expense benefit defined in Subsection 3107(1)(a) of the Act. Optional motorcycle PIP coverage can be purchased on a primary or coordinated basis.

B. Priority Insurers for Motorcycle PIP Claims

The priority rules applicable to motorcycle accidents are contained in Subsection 3114(5) of the statute. This subsection states that an operator or passenger of a motorcycle who sustains bodily injury arising out of an accident involving a motor vehicle, must claim no-fault PIP benefits from insurers in the following order of priority: (1) the insurer of the owner or registrant of the motor vehicle involved in the accident; (2) the insurer of the operator of the motor vehicle involved in the accident; (3) the auto no-fault insurer of the operator of the motorcycle involved in the accident; and (4) the auto no-fault insurer of the owner or registrant of the motorcycle involved in the accident. A person who is injured while an operator or passenger of a motorcycle and who is unable to recover benefits under any of the above referenced four levels of priority, will draw benefits through the Michigan Assigned Claims Facility, which is referenced in Section 4 E.

C. Tort Claims for Motorcyclist Injury

In addition to having the right to recover no-fault PIP benefits in accidents involving motor vehicles, an injured motorcyclist is also entitled to pursue a ***tort liability claim*** against the at-fault driver who causes the accident. This liability claim is controlled by the same rules applicable to traditional motor-vehicle liability claims. Therefore, where the motorcyclist is claiming noneconomic-loss damages against the at-fault motor-vehicle operator, the motorcyclist must show that his or her injury is a *threshold* injury, and that the motorcyclist was not more than 50-percent comparatively negligent. To learn more about the subject of liability claims, see the detailed information presented in Part Two of this brochure.

SECTION 7: TIME LIMITATIONS, CLAIM PROCEDURES, AND ENFORCEMENT OF CLAIMS

A. Statutory Time Limitations Applicable to No-Fault Claims

The No-Fault Act contains two very strictly enforced time limitations for processing claims for no-fault PIP benefits. These rules must be carefully followed in order to properly protect the claim. Failure to observe these procedures and limitations can result in a loss of benefits. These two important rules are summarized below.

1. The One-Year-Notice Rule

Section 3145 of the No-Fault Act specifies that a plaintiff must provide written notice to the appropriate insurance company within one-year of the date of the accident. This 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 notice within the one-year period will result in the complete forfeiture of the claim unless some legally recognized exception applies.

2. The One-Year-Back Rule

Assuming written notice has been given to the insurance company within the first year of the accident, a claimant must be prepared to take legal action if a particular expense is not paid by the insurance company within one year of the date the expense is incurred. If legal action is commenced, the claimant may not recover benefits for any portion of the expense incurred more than one year before the legal action was commenced, unless some legally recognized exception applies.

B. Exceptions to the Statutory Time Limitations

1. Minors and Mentally Incompetent Persons

For many years, Michigan appellate case law recognized an important exception to the one-year-back rule in cases brought by minors or mentally incompetent persons. The courts held that because of certain provisions in the Michigan Revised Judicature Act (MCL 600.5851), neither the one-year-notice rule nor the one-year-back rule applied to claims brought by minors or those who were mentally incapable of comprehending their legal rights.

In the case of *Cameron v ACIA, 476 Mich 55 (2006)*, the Michigan Supreme Court overturned all of this earlier law and ruled that there was no exception to the enforceability of the one-year-back rule for minors or mentally incompetent persons. Therefore, that portion of the claim incurred by the minor or mentally incompetent person more than one year from the date suit was filed was declared unenforceable by the *Cameron* decision.

On July 31, 2010, the Michigan Supreme Court overruled its decision in *Cameron v ACIA* in the case of *University of Michigan Regents v Titan, 487 Mich 289 (2010)*. In this decision, the Court held that *Cameron* was wrongly decided, and therefore, the one-year-back rule is not applicable to bar the claims of minors and mentally incompetent persons. Therefore, as long as *UM Regents v Titan* remains enforceable case law precedent, the claims of minors and mentally incompetent persons should be filed even though the claims were incurred prior to one year before filing suit.

2. Bill Submission – no longer an exception

For many years, Michigan appellate case law recognized another exception to the one-year-back rule. This exception applied to suspend the running of the one-year-back rule from the date an insurance company received a request for payment of a particular expense until the date the insurance company formally denied payment of that particular expense. In other words, the Michigan appellate courts held that the one-year-back rule did not run during the time that a no-fault insurance company was considering whether it was going to pay or not pay the claim. Unfortunately, however, the cases which recognize this "bill submission" exception to the one-year-back rule were specifically overruled by the Michigan Supreme Court in the case of *Devillers v ACIA, 473 Mich 562 (2005)*. Therefore, under the *Devillers* case, unless some other legal exception applies, payment of a no-fault claim can only be enforced if a lawsuit is filed within one year of the date the expense in question is incurred. Moreover, in the case of *Community Resource Consultants v Progressive, 480 Mich 1097 (2008)*, the Court held that for purposes of applying the one-year-back rule, an expense is deemed to be incurred on the date the services are actually rendered. Therefore, patients and providers can no longer rely upon the "bill submission" exception to the one-year-back rule and must move quickly to enforce their legal rights.

C. The Requirement of Reasonable Proof

A no-fault insurance company is not obligated to pay any benefits until the insurer *"receives reasonable proof of the fact and of the amount of loss sustained."* See Subsection 3142(2). If an insurer does not pay benefits within 30 days after receiving such reasonable proof, the benefit is deemed "overdue." Unfortunately, the statute does not define the concept of "reasonable proof." In one decision, the Michigan Court of Appeals held that a claimant is not required to document "*the exact amount of money that is [owed]. The statute requires only reasonable proof of the amount of loss, not exact proof.*" See *Williams v AAA Michigan, 250 Mich App 249 (2002)*. Ordinarily, no-fault insurance companies require that the claimant submit several types of claim forms before payment on a claim is made. Typically, these three forms are: (1) an application for no-fault benefits; (2) an attending physician's report form; and (3) an employer's wage loss verification form. It is advisable for the claimant to provide these forms to the no-fault insurance company so that the claimant cannot later be accused of failing to provide "reasonable proof."

D. The Incurred Requirement

No-fault insurance companies have a legal obligation to pay claims for allowable expenses under Subsection 3107(1)(a) and replacement service expenses under Subsection 3107(1)(c) only when the expense has been *"incurred."* The statute does not define the word "incurred." However, a number of Michigan appellate cases have held that to incur an expense, a person

must have either paid for the expense or become legally obligated to pay the expense. The incurred requirement has been very problematic for many patients, particularly those with catastrophic injuries who require products, services, and accommodations that are very expensive, e.g., handicapper housing, special vehicular transportation, residential facility admission, etc. Unless the injured person has *"incurred"* expenses for such items, the insurer has no legal responsibility to pay the expense. There are several ways that patients can *"incur"* expenses other than by paying the full cost of the item in cash. These include entering into contracts to purchase the product, service, or accommodation or borrowing money to pay for the needed item. In addition, patients can file *"declaratory judgment"* lawsuits asking for a court to rule that an insurer will be liable to pay for the cost of certain specific products, services, and accommodations once the injured person has incurred the expense for such items. However, declaratory-judgment actions typically do not permit the plaintiff to recover penalty sanctions under the No-Fault Act for interest and attorney fees. Therefore, declaratory-judgment actions are frequently not as effective as traditional lawsuits for unpaid benefits that are filed after the plaintiff has incurred the expenses which are the subject of a claim.

E. The Independent Medical Examination (IME)

Section 3151 of the No-Fault Act 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 (often referred to as an "*independent medical examination*" *(IME)*), however, is subject to a general requirement of "*reasonableness*." Section 3152 of the Act states that a claimant who undergoes such an independent medical examination may request a copy of the report. Section 3153 of the Act 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. However, claimants should never ignore a notice from their insurer that an IME has been scheduled. An unjustified failure to appear for such an exam could jeopardize the claim.

F. Statutory Penalties for Non-Payment of Benefits

The No-Fault Act contains specific penalties that can be assessed against no-fault insurance companies who do not honor their legal obligations to pay claims as required by the law. There are basically two penalties contained in the statute: (1) penalty interest and (2) penalty attorney fees. These are summarized below.

1. Penalty Interest

Section 3142 of the No-Fault Act states that when an insurance company does not pay no-fault benefits within 30 days after receiving reasonable proof of the fact and the amount of the loss sustained, the insurer must pay simple interest at the rate of 12 percent per annum on the overdue expense. Moreover, the statute provides that "*if reasonable proof is not supplied as to the entire claim, the amount supported by reasonable proof is overdue if not paid within thirty days after the proof is received by the insurer.*" This means that an insurance company cannot legally withhold payment on the entire claim if only a portion is in dispute. If this happens, the portion that is not in dispute is overdue and the 12-percent-interest penalty is collectible. See *Farquharson v Travelers, 121 Mich App 766 (1982)* and *McKelvie v ACIA, 203 Mich App 331 (1994)*. Moreover, the courts have held that if an injured person is required to file a lawsuit against the insurance company to collect benefits and if the lawsuit results in an actual judgment in favor of the injured person, then the injured person is also entitled to recover "civil judgment interest" under the provisions of the Revised Judicature Act and the Michigan Court Rules.

2. Penalty Attorney Fees

Section 3148 of the No-Fault Act states 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.*" Therefore, if a claim is "overdue" because an insurance company did not make payment within 30 days after receiving reasonable proof and if the court further finds that the delay or denial was "unreasonable," then the insurance company will be ordered to pay attorney fees to the injured person. Appellate case law has held that an award of attorney fees under Section 3148 may be based upon an hourly rate or, where otherwise appropriate, on the basis of a contingency fee. See *Butler v DAIIE, 121 Mich App 727 (1982); In Re Estate of L'Esperance, 131 Mich App 496 (1084);* and *University Rehab Alliance v Farm Bureau, 279 Mich App 691 (2008).*

G. The Need for Legal Action

If a dispute cannot be resolved through negotiation with the claims adjuster, a lawsuit may be necessary. If the amount in dispute exceeds $25,000, the case must be filed in circuit court. If the amount in dispute is less than that, the case must be filed in district court. In certain situations, the probate court may have concurrent jurisdiction. If there is any uncertainty or confusion as to whether legal action is appropriate to enforce a PIP claim, the injured person should promptly consult a lawyer well versed in handling cases under the Michigan No-Fault Automobile Insurance Act. The number of PIP lawsuits filed in recent years has been significant, indicating that claim denials are increasing. Although the decision to file a lawsuit should not be made without careful consideration, accident victims must take appropriate steps to protect their rights and benefits. There are many types of disputes that often require accident victims to become proactive and file legal action to protect their claims, including:

- disputes about the existence of a qualifying injury;
- disputes about medical causation;
- disputes about the amount of medical expenses;
- disputes about the amount or necessity of attendant care or replacement services;
- disputes about the necessity and nature of home accommodations;
- disputes about the necessity and nature of motor-vehicle transportation;
- disputes about work disability and earnings level;
- disputes about priority of payment; and
- disputes about coordination of benefits and benefit reductions.

SECTION 8: MEDICAL PROVIDERS AND THE NO-FAULT LAW

A. Basic Rule: The No-Fault Law Is Not Managed Care

When the Michigan Legislature enacted the No-Fault Automobile Insurance Act in 1973, it did not draft a statute that utilizes managed-care concepts, as have other states that enacted a no-fault system. On the contrary, the Michigan No-Fault Act is purely a *fee-for-services system* obligating a no-fault insurer to pay all "*allowable expenses*" as defined in the statute. The Michigan Act 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 Subsection 3107(1)(a).

There is one notable 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*, *supra*. For patients in that situation, see the earlier discussion in Section 5 D entitled *"Special Concerns for Patients with Coordinated No-Fault Policies and Managed Care Health Plans."*

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 Act 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 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 should have 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 Subsection 3107(1)(a) of the Act.

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 that 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 (emphasis added):

> *"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. . . ."*

C. The Pre-Authorization-of-Payment Issue

There is no legal authority in the Michigan No-Fault Act or in any appellate-court decision that authorizes a no-fault insurance company to require *pre-authorization* of payment before medical expenses are legally payable. 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 Act is not a *managed-care system*. Rather, it is a *fee-for-services system*. Therefore, patients and their medical providers are not obligated to obtain pretreatment authorization from no-fault insurance companies. If the patient's medical providers are willing to verify that the prescribed services were *"reasonably necessary,"* this is typically sufficient to impose legal liability on the no-fault insurance company for payment of the charges, regardless of whether the insurer pre-authorized the treatment.

D. Legal Claims by Medical Providers

Several years ago, the Michigan Court of Appeals issued two decisions that gave some powerful legal weapons to medical providers who are not promptly paid by auto no-fault insurance companies. These decisions were a great victory for medical providers and their auto accident patients and will go a long way to making the playing field more level in no-fault insurance payment disputes. One of these rulings 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 Section 3142 of the No-Fault Act and the ***"penalty attorney fee"*** provisions of Section 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-percent 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 Act 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 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 actions in their own name 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-percent interest on the balance owing. Likewise, if the medical provider can establish that the payment was *unreasonably delayed or denied* the medical provider can recover actual attorney fees from the noncompliant 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, protect no-fault patients. In this regard, the Court in *Lakeland Neurocare Centers* held:

> *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.

A second similar decision 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)*.

Medical providers who treat auto accident patients should be aware of these appellate decisions and not hesitate to utilize them if an auto insurance company has not complied with its obligations under Michigan no-fault law. 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 remember that the No-Fault Act contains a short statute of limitations, which, in the case of claims brought by patients, typically will expire one year after the date a service is rendered. Providers should assume that this limitations period applies to them, and therefore, enforcement action should not be delayed. For more information regarding the statute of limitations, see Section 7 of this brochure.

E. 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 Subsection 3107(1)(a). Sometimes, the no-fault insurance company supports its denial of the claim by referring to certain *fee schedules* that 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 Subsection 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 46 (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*." In the case of *Advocacy Org v ACIA, 472 Mich 91 (2005)*, the Michigan Supreme Court approved the basic concept of medical-bill auditing, but did not render any ruling on any specific methodology regarding how audits should be conducted.

Typically, 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 that 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. However, it is doubtful whether this bulletin can legally cut off the right of a medical provider to sue a patient to recover the balance that remains unpaid after an audit. Therefore, patients and providers should pay close attention to whether any portion of their medical expenses is being denied because of a no-fault insurance company audit. If this is happening, patients and providers should consult with legal counsel to determine what legal rights they may have regarding the unpaid amount.

PART TWO: THE TORT LIABILITY CLAIM

SECTION 1: TYPES OF TORT LIABILITY CLAIMS

A. Basic Principles

If a person sustains bodily injury in a motor-vehicle accident caused by the fault (i.e., negligence) of another motorist, the Michigan No-Fault Act permits the victim to pursue a liability claim. This liability claim (also called the ***tort claim***) permits the victim to recover compensation for two distinct types of damages: ***excess economic loss*** and ***noneconomic loss***. These two types of damage claims will be discussed in greater detail below.

In order to successfully pursue a liability claim for either noneconomic loss or excess economic loss, the injured person must first prove that the other driver was, to some significant extent, at fault for the accident. The legal word for fault is *negligence,* which is nothing more than the failure to act as a reasonably careful person would act under the same or similar circumstances. Violations of the Michigan Motor Vehicle Code, including speeding, failing to stop at a stop sign, failing to yield, running a red light, improper lane usage, etc. are all evidence of negligence. If both the injured party and the other driver were, in some way, negligent in causing the accident, the injured party may still recover damages, but the amount of those damages will be reduced by the percentage of the injured party's fault. This is referred to as the ***rule of comparative negligence.***

An accident victim who has a valid liability claim under the Michigan No-Fault Act is entitled to be compensated for that claim by the insurance company of the negligent party. If litigation is required to enforce that claim, the lawsuit must name the negligent party. However, the damages are actually paid by the negligent party's insurance company up to the amount of liability insurance coverage carried by the negligent party. If the damages exceed the negligent party's liability insurance coverage, the negligent party may be personally responsible for the excess.

B. Claims for Noneconomic Damages

Under Michigan law, ***noneconomic damages*** consist of those losses that affect a person's ***quality of life***, such as pain and suffering, incapacity, disability, loss of function, diminished social pleasure and enjoyment, mental anguish and emotional distress, scarring and disfigurement, etc. Under Section 3135 of the Michigan No-Fault Act, an accident victim is only entitled to recover damages for noneconomic loss if the victim sustained a "***threshold injury***." Under the Act, a threshold injury consists of one or more of the following: ***(1) serious impairment of body function; (2) permanent serious disfigurement; or (3) death***.

In 1995, the Michigan Legislature enacted an important amendment to the No-Fault Act (1995 PA 222) that, in Subsection 3135(7), redefined the threshold element of "*serious impairment of body function*." The new definition states: "***serious impairment of body function means an objectively manifested impairment of an important body function that affects the person's general ability to lead his or her normal life***." The Legislature did not, however, define the threshold element of "*permanent serious disfigurement*." The issue of whether an injury rises to the level of "*serious impairment of body function*" or "*permanent serious disfigurement*" is a matter that depends upon the facts and circumstances of each individual case. Obviously, the more serious the injury, the more likely that the injury "*crosses the threshold*." However, the courts have held that an injury need not be permanent in order to be a "*serious impairment of body function*."

In the case of ***Kreiner v Fischer, 471 Mich 109 (2004)***, the Michigan Supreme Court significantly restricted the type of injuries that can qualify as a *serious impairment of body function*. In this decision, the Court held that the injured person's normal life before the accident must be compared with his or her life after the accident, in order to determine if the injury resulted in a change in the "course or trajectory" of the injured person's life. Although the *Kreiner* case affirmed the legal principle recognized in previous cases that the injured person need not prove a permanent injury or a permanent disability, the *Kreiner* decision created, what many people believed, was an unduly restrictive definition of the *serious impairment of body function* threshold.

On July 31, 2010, the Michigan Supreme Court overruled its earlier decision in *Kreiner v Fischer* in the case of *McCormick v Carrier, 487 Mich 180 (2010)*. In *McCormick*, the Court held that the *Kreiner* "course and trajectory" standard was wrong. The Court held that the 1995 statutory definition of *serious impairment of body function* only requires that the injured victim prove that an injury has had "*an influence on some of the person's capacity to live in his or her normal manner of living*." The Court in *McCormick* went on to say that the statutory requirement that an impairment be "objectively manifested" is established if there is "*an impairment that is evidenced by actual symptoms or conditions that someone other than the injured person would observe or perceive as impairing a body function*."

Clearly the *McCormick* decision has made the *serious impairment of body function* threshold less restrictive than it was under the *Kreiner* case. However, the real impact of the *McCormick* decision will not be known until our appellate courts have had more time to apply its principles. In light of the Supreme Court's decision in *McCormick*, it has become ***critically important*** for auto-accident victims to consult with attorneys who are very knowledgeable about the Michigan No-Fault Act in order to learn whether their injury satisfies the legal definition of the threshold elements of "*serious impairment of body function*" and/or "*permanent serious disfigurement*."

The 1995 amendments to the Michigan No-Fault Act also provide that noneconomic damages are not recoverable if the injured person is more than 50 percent comparatively negligent. In addition, injured persons are precluded from recovering noneconomic damages under the 1995 amendments if they were driving an uninsured motor vehicle at the time of the accident

which was owned by the injured person. Therefore, in assessing liability claims for the noneconomic loss, it is important to thoroughly evaluate and compare the conduct of the victim and the other driver and to also determine if the victim complied with the mandatory insurance requirements of the statute.

C. Claims for Excess-Economic-Loss Damages

Excess-economic-loss damages consist of those past, present, and future out-of-pocket expenses that are not compensable by no-fault PIP benefits. The No-Fault Act provides that if an injured person suffers excess-economic-loss damages, then the injured person can recover those damages in the liability claim against the negligent driver who caused the accident. For example, these excess-economic-loss damages would be recoverable if the injured person has a high income and the monthly no-fault wage loss benefit does not fully compensate that person for his or her full lost wages. Similarly, if the injured person is disabled permanently or for an extended period of time and, as a result, will sustain a loss of income beyond the three-year no-fault work loss benefit period, then excess-economic-loss could be recovered in the liability claim. With regard to claims for excess-economic-loss damages, it is very important to emphasize that the No-Fault Act and case law are very clear that ***an injured person need not prove a threshold injury (serious impairment of body function or permanent serious disfigurement) in order to recover excess-economic-loss damages***. It is also important to note that under the 1995 amendments to the No-Fault Act, liability claims for excess-economic-loss are not prohibited where the injured person was more than 50 percent comparatively negligent or where the injured person was the owner and operator of an uninsured motor vehicle involved in the accident.

D. Wrongful-Death Liability Claims

If a person sustains wrongful death as a result of the negligence of a third party, the estate of the injured person is entitled to pursue a wrongful-death liability claim against the party at fault for purposes of recovering noneconomic damages and certain economic-loss damages. Wrongful-death liability claims are controlled by the ***Michigan Wrongful Death Act (MCL 600.2922)***. In addition, where the wrongful death arises out of a motor-vehicle accident, then the provisions of the ***Michigan No-Fault Automobile Insurance Act (MCL 500.3101, et seq)*** will also control the claim. In this situation, it is imperative that the requirements and procedures of both statutes be strictly observed.

Under the Michigan Wrongful Death Act, close relatives of the decedent are entitled to be compensated for certain specific damages they may have suffered as a result of the decedent's death. These damages include loss of financial support; loss of services; and most importantly, loss of the love, affection, companionship and society of the decedent. Those relatives entitled to be compensated for such losses include surviving spouses, children, parents, grandparents, brothers and sisters, and stepchildren of the decedent. However, in order to pursue a

wrongful-death claim, the statute requires that an estate be formally opened in the name of the decedent and that a Personal Representative be appointed for that estate by the probate court with jurisdiction over the matter. The wrongful-death claim is then pursued in the name of the decedent's estate, not in the individual names of the surviving relatives.

The designation of the Personal Representative is controlled by the Michigan probate law. Under the probate law, certain family members are given "*preference*" in terms of the appointment of a Personal Representative. In this regard, the parents of a deceased child have statutory preference to be appointed Personal Representative of the child's estate. Similarly, a surviving spouse has statutory preference to be appointed Personal Representative of the estate of his or her deceased spouse. Where the decedent is a non-married adult with children, the statutory preference regarding the appointment of a Personal Representative resides with the children, but it can only be enforced by an appropriate adult acting on the child's behalf after being formally appointed by the probate court. Therefore, the first order of business in pursuing a wrongful-death claim is to identify the person or persons who should be appointed Personal Representative of the decedent's estate and file an appropriate petition in the probate court seeking to open an estate and designate a Personal Representative. Once this is done, the wrongful-death claim can be officially pursued.

SECTION 2: PROTECTING THE LIABILITY CLAIM

In light of the fact that no-fault PIP benefits do not fully compensate auto-accident victims for all of the damages they sustain, the liability claim is oftentimes the only way a victim can be "made whole." Therefore, if a motor-vehicle accident results in serious injury or death as a result of the fault of another driver, the injured person or the person's estate should seriously consider pursuing a liability claim for noneconomic loss and excess economic loss.

Many accident victims significantly weaken their liability claim by not moving quickly to protect it. This is unfortunate because it is a virtual certainty that in serious injury cases, the insurance company for the party at fault will indeed move quickly to conduct a thorough investigation for purposes of building a defense to the claim. Therefore, the injured victim must counter that effort by taking appropriate steps in a timely fashion. In this regard, the injured victim should do the following.

A. Initiate a Thorough Investigation

The victim should arrange to have his or her legal representative investigate the accident as soon thereafter as possible. Such an investigation should include interviewing all witnesses, photographing the scene, photographing all vehicles involved in the accident (both inside and outside), taking measurements at the scene, collecting physical evidence at the scene, interviewing police officers, etc. The victim can do this by either hiring a competent private investigator or by retaining a lawyer or law firm who specializes in motor-vehicle personal-injury work.

B. Photograph Injuries and Document the Course of Treatment

Where a victim has sustained significant visible injury, such as lacerations, burns, surgical scarring or other disfigurement, those visible injuries should be thoroughly photographed as soon as possible with excellent camera equipment. In addition, photographs or videos should be taken of certain kinds of medical treatment (e.g., inpatient hospitalizations, physical therapy, burn treatment, etc.). If photographic equipment is not available to the victim's family, then arrangements should be made for a professional photographer to take these photographs.

C. Avoid Investigators or Adjusters Representing the Interests of the Party at Fault

As previously indicated, the insurance company for the party at fault will be conducting an investigation soon after the accident. One of the first things that is typically done in connection with such an investigation is to contact the victim and ask the victim to give a statement, either in writing or by tape recorder. The victim should refuse to do this unless he or she has first consulted with an attorney specializing in personal-injury law regarding the advisability of such an interview. In this regard, it is important to remember what the police tell suspects in criminal cases prior to taking statements: *"What you say can and will be used against you!"*

D. Refuse to Sign Medical Authorizations, Except Those Requested by the Victim's Own No-Fault Insurance Company

Oftentimes, the injured person will be asked by an insurance adjuster for the party at fault to provide a signed medical authorization release form enabling that adjuster to obtain all of the victim's medical records and speak with the victim's physicians. The victim should refuse to sign such an authorization until the victim has first talked with an attorney specializing in personal-injury law to discuss the situation.

E. Avoid Premature Settlement Negotiations Without Proper Legal Advice

Many times the insurance company representing the party at fault will approach a seriously injured victim and offer to make a settlement of the bodily injury tort claim in exchange for the victim signing a full release of liability. It is ***absolutely foolhardy*** to consider entering into such settlement negotiations with an insurance company unless all of the following facts have first been established: (1) the victim is reasonably certain that he or she is fully recovered from all accident related injuries; (2) the victim has fully investigated the accident and knows the identities of any and all potential defendants and insurance companies who may have liability; (3) the release is only a release of the liability claim and not a release of any other

rights the victim may have; (4) the victim has completely researched whether such a settlement would jeopardize other claims the victim may have against other parties or against the victim's own insurance company for additional benefits, such as underinsured motorist benefits; and (5) the victim has obtained competent legal advice from a motor-vehicle personal-injury specialist regarding the wisdom of entering into such a settlement. Remember, once a release is signed, the victim can never "undo the deal."

SECTION 3: LIABILITY CLAIMS INVOLVING UNINSURED MOTORISTS OR UNDERINSURED MOTORISTS

Oftentimes, the injuries suffered by an auto-accident victim are caused by a negligent party who either had no liability insurance or had inadequate liability insurance to fully compensate the injured person. In these situations, the uninsured or underinsured negligent driver is typically not collectible. However, if uninsured-motorist coverage and/or underinsured-motorist coverage has been purchased by the injured person or the owner of the vehicle occupied by the injured person, then the injured person will be able to pursue the liability claim against the insurance company that issued the uninsured/underinsured coverage. Basic principles regarding uninsured and underinsured motorist claims are summarized below.

A. Uninsured-Motorist Benefits

If an injured person's policy includes ***uninsured-motorist coverage***, and if the injury was caused by an uninsured driver, the injured victim will be able to assert his/her liability claim directly against his/her own insurance company who will then "stand in the shoes of the negligent driver." The injured person will be able to recover noneconomic damages and excess economic damages up to the limits of his/her uninsured coverage in exactly the same manner they would had the negligent party been insured. If the injured person did not purchase uninsured-motorist coverage but was a passenger in a vehicle that was covered by uninsured-motorist coverage, the injured person may very well be covered under that policy.

B. Underinsured-Motorist Claims

If the injured person purchased ***underinsured-motorist coverage*** and if the injury was the result of the negligence of someone who has inadequate liability limits to fully compensate the injured person, he/she can pursue that portion of the liability claim not covered by the at fault driver's insurance through the injured person's own insurance company in much the same manner as one would pursue an uninsured-motorist claim. If the injured person did not purchase underinsured-motorist coverage but was a passenger in a vehicle that was covered by underinsured-motorist coverage, the injured person may very well be covered under that policy.

There are certain strict rules that must be followed so that the underinsured-motorist claim is not jeopardized. For example, underinsured-motorist policies typically require that the injured person completely exhaust the negligent party's liability limits before pursuing the claim for underinsured-motorist coverage. In addition, most policies require that the injured person obtain written consent from his/her insurance company before settling with the negligent party. There may be other very important conditions set forth in the policy that must be complied with in order to pursue such a claim, such as shorter notice-of-claim requirements. Failure to follow these policy conditions can result in the loss of underinsured-motorist benefits. ***Therefore, extreme caution is necessary to protect these claims!***

CONCLUSION

The passage of the Michigan No-Fault Automobile Insurance Act has spawned the creation of a large body of complex law. Clearly, Michigan citizens have very substantial rights under the no-fault law. ***However, it is only when people have a complete understanding of their legal rights, that they will be assured of receiving all benefits and recovering all damages to which they are legally entitled.*** In cases of serious bodily injury, it is always advisable to talk to experienced attorneys who fully understand the Michigan no-fault system and who regularly handle no-fault automobile-accident cases. Victims who deal directly with insurance companies without the benefit of competent legal advice, are often short changed. ***This is one area where ignorance can be very costly***! For more information regarding Michigan no-fault law, please contact the author of this brochure.

SINAS, DRAMIS, BRAKE, BOUGHTON & McINTYRE, P.C.

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George T. Sinas
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Stephen H. Sinas

Thomas G. Sinas (1922-1985) • *Lee C. Dramis (1922-1981)* • *Richard J. Brake (Retired)* • *Barry D. Boughton (Retired)* • *Kenneth G. McIntyre (Of Counsel)*

Main Office:

3380 Pine Tree Road, Lansing, MI 48911-4207
Phone (517) 394-7500 | Fax (517) 394-7510 | email: sinasdramis@sinasdramis.com

www.sinasdramis.com

SINAS, DRAMIS, BRAKE, BOUGHTON & McINTYRE, P.C.
ATTORNEYS AT LAW

3380 Pine Tree Road, Lansing, MI 48911
(517) 394-7500 ph | (517) 394-7510 fax
www.sinasdramis.com

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