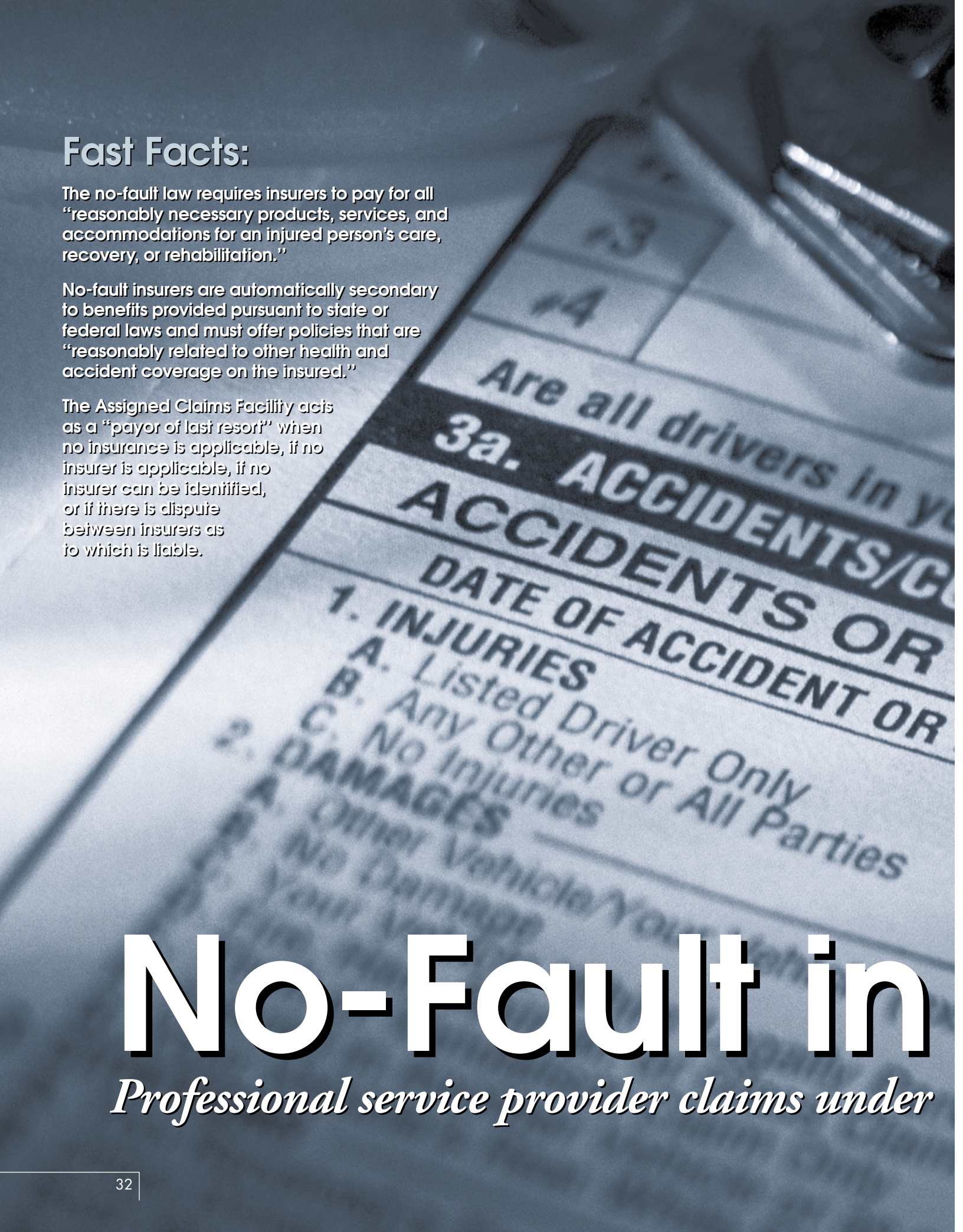

Fast Facts:

The no-fault law requires insurers to pay for all "reasonably necessary products, services, and accommodations for an injured person's care, recovery, or rehabilitation."

No-fault insurers are automatically secondary to benefits provided pursuant to state or federal laws and must offer policies that are "reasonably related to other health and accident coverage on the insured."

The Assigned Claims Facility acts as a "payor of last resort" when no insurance is applicable, if no insurer is applicable, if no insurer can be identified, or if there is dispute between insurers as to which is liable.

No-Fault in

Professional service provider claims under

Michigan *the No-Fault Act*

In 2001, over $1 billion in no-fault personal insurance protection benefits were paid, most to health care providers, representing a sizable revenue stream. Although insurers frequently challenge provider charges, there are no mandatory fee screens as there are with workers' compensation, Medicare, Medicaid, or Blue Cross and Blue Shield (BCBS). Yet few providers track their no-fault revenue or understand the opportunities available under the No-Fault Act. This article begins with a short primer on key aspects of the no-fault law, and follows by discussing some current issues.

By Wayne J. Miller, Michael R. Shpiece, and Ronni Tischler

The Michigan No-Fault Law

The no-fault law[1] requires insurers to pay for all "reasonably necessary products, services, and accommodations for an injured person's care, recovery, or rehabilitation"[2] if the injured person was injured in a motor vehicle accident.[3] There are no limits on the dollar amount of benefits, the time within which benefits must be obtained or the type of care that will be covered. More importantly, a provider may charge and the insurer must pay a "reasonable amount."[4] This reasonable amount is not limited to the Medicaid fee screen, the workers' compensation fee screen, or the amount the provider accepts from other payors;[5] in fact, the amount that the provider accepts from other payors has been held to be irrelevant to the determination of the "reasonable charge."[6] As long as the services are reasonably necessary and the charges are reasonable, there is no limit on the dollar amount or the length of treatment. Some claims have involved millions of dollars and lasted decades.

A final important feature of Michigan's No-Fault Act is that (with a few exceptions) somebody will pay—even if the patient is uninsured. The Assigned Claims Facility acts as a "payor of last resort" when no insurance is applicable, if no insurer can be identified, or if there is a dispute between insurers as to which is liable. The Assigned Claims Facility has been reluctant to accept claims directly from providers, but it does accept claims filed by the patient. A recent court of appeals decision strongly suggests that providers can be "claimants" to the facility.[7]

Issues Facing Providers

While there are many issues facing providers seeking benefits under the no-fault law, this article will address six key ones.

Notice and Timelines

A major problem providers face is compliance with the deadlines imposed by the No-Fault Act, the so-called "one-year rules."[8] There are actually two rules. First, notice must be given to the insurer within one year of the accident, and second, even if timely notice is given, a lawsuit can only obtain benefits for services incurred within one year of the filing of the lawsuit. Because of these deadlines, it is very important for providers to notify every conceivable insurer as soon as possible. If you notify an insurer who has no liability, all you have done is wasted a stamp. If you fail to notify the insurer, your claim may well be barred permanently. Although the one-year back rule can be tolled in some cases,[9] providers are well advised to strictly adhere to these timelines.

Coordination of Benefits

No-fault insurers are automatically secondary to benefits provided pursuant to state or federal law,[10] and must offer policies that are "reasonably related to other health and accident coverage on the insured."[11] The authors believe about 85 percent of Michigan insureds have coordinated no-fault coverage. Although insureds are supposed to be offered a choice of a coordinated or uncoordinated policy, many agents do not enter into a detailed discussion of the pros and cons of this choice, but rather simply ask the insured if he or she has BCBS and automatically issue a coordinated policy if the answer is "yes."

Although these coordination provisions raise a host of issues, one of special concern to providers is the *Tousignant* doctrine.[12] In that case, the Michigan Supreme Court ruled that an insured who has purchased coordinated coverage must primarily seek health treatment from her health insurer. So, for example, if the patient has HMO coverage, she must seek treatment from her HMO's providers. The no-fault carrier has no obligation to provide medical care, at least as long as the care is available at an adequate quality from the HMO. If treatment is not available from the HMO or if the quality of the treatment is inadequate, the no-fault insurer is again liable to pay for care.[13] The problem facing a provider is as follows: when a motor vehicle accident victim presents, the provider must not only determine who her no-fault carrier is, but also (a) whether she has coordinated coverage and, if so, who her health carrier is; and (b) if the provider does not participate with the carrier, whether the patient could reasonably obtain treatment from a provider who has contracted with the health carrier. Failure to conduct this analysis could result in the patient being the provider's sole source of payment.

Attorney Fees

A matter of some annoyance to health care providers has been the receipt of calls by attorneys proudly announcing that they have obtained no-fault benefits to pay the provider's bill and that they will conveniently deduct their one-third fee from that paid by the insurer. Often unspoken, but always present, is the expectation that the provider will accept two-thirds as payment in full and not seek the difference from the patient. Although the rules are clear, this continues to raise an amazing amount of litigation.

Of course, an attorney and patient are free to enter into a contract and, as long as the terms do not violate any law or ethical standard, the attorney is free to collect a fee from the patient-client. The problem arises when the attorney attempts to collect that fee from a stranger to the retainer agreement—the service provider—who may have retained its own counsel or decided that no counsel was necessary. Why should the service provider have to pay for services that were not sought and, in many cases, provided no or only minimal benefit? For example, in one case the patient's attorney's successful effort in obtaining no-fault benefits required the hospital to refund a much greater Medicare payment.

The ethics opinions are fairly clear. A lawyer has a duty to advise a client that a no-fault claim may be initiated without assistance.[14] If, after being fully informed, the client elects to have the lawyer proceed, the lawyer may only charge a fee reasonable under all the circumstances. The lawyer may not charge the provider if the insurer voluntarily pays.[15] The lawyer may charge the provider if the insurer involuntarily pays only if (1) the lawyer has first notified the provider in writing of the lawyer's contemplated legal action, (2) the provider has had a reasonable opportunity to advise the lawyer that it wishes to pursue its interest in the matter without the assistance of the lawyer's legal service, and (3) the provider has not so notified the lawyer.[16] Attorneys cannot collect fees in violation of the Michigan Rules of Professional Conduct. *Evans & Luptak, PLC v Lizza,* ___ Mich App ___, 2002 Mich App LEXIS 676, No. 223927 (May 3, 2002). *Aetna v Starkey,* 116 Mich App 640 (1982) is not contrary. That case permitted an attorney to collect a fee from the no-fault proceeds where the provider knew of the attorney's activity and acquiesced in it. If the attorney acts without notifying the provider or after the provider objects, he becomes essentially a volunteer and cannot collect a fee from the provider.[17]

No-Fault Penalties: Interest and Attorney Fees

Another opportunity that many providers ignore is the No-Fault Act's penalty provisions. If benefits are not paid within 30 days after the insurer receives "reasonable proof" of the fact and the amount of the loss, they accrue simple interest at the rate of 12 percent.[18] Obviously, this could run into a lot of money. We advise providers to send a copy of its bill to each potential insurer as soon as possible and retain documentation of the date on which it was sent.

The No-Fault Act also provides that an attorney fee may be awarded against the insurer if the insurer "unreasonably refused to pay the claim or unreasonably delayed in making proper payment."[19] This is a tougher standard than that applicable to no-fault penalty interest.[20] "However, when the only question is which of two insurers will pay, it is unreasonable for an insurer to refuse payment of benefits" and both carriers will be required to pay half of the attorney fees awarded.[21]

An additional item comes up in the context of litigation. In addition to attorney fees and no-fault interest, a successful claimant is also entitled to "RJA interest," which will be assessed on the total judgment—including no-fault penalty interest and attorney fees.[22] Depending on the situation, this could result in interest accruing at 17 percent or more!

The Rights of Providers to Bring Claims

Two recent court of appeals decisions make clear that providers may make direct claims for no-fault benefits.[23] Although a provider

Key Points for Providers

1. Identify all possible no-fault insurers, promptly notify them of the accident, and send them a bill. Don't rely on the patient to protect your rights.
2. If no insurer appears or if there is a dispute, don't despair; file a claim with the Assigned Claims Facility.
3. Keep track of the one-year deadlines.
4. When you receive a letter from the patient's attorney, decide if you want the attorney to represent your interests. If you do, enter into an explicit retainer agreement and agree upon a fee. If you do not, clearly notify the attorney.
5. If an insurer fails to pay within 30 days after "reasonable proof" has been supplied, talk to the insurer. Try to understand the reason for nonpayment. If the insurer has a reasonable concern, discuss and resolve it. If the insurer has no reasonable basis for delay and nonpayment, pursue penalties.

may have derivative actions, it also has direct claims for PIP benefits.[24] Thus, it is now clear that a provider may directly sue a no-fault carrier. But, there are two additional possibilities: assignment and intervention.

The provider can obtain an assignment from the patient and bring the claim as the patient's assignee. Of course, this depends on the willingness of the patient to cooperate. Although the No-Fault Act prohibits an assignment of a right to benefits payable in the future,[25] that prohibition does not apply to an assignment of past- or presently-due benefits.[26]

The second avenue, intervention, is supported by statute[27] and court rule.[28] See, e.g., *Vestevich v West Bloomfield Twp*[29] (permissive intervention "properly allowed where the intervenor's interests *'may be'* inadequately represented by one of the existing parties."), *Johnson v Michigan Mutual,* 180 Mich. App 314 (1989), and *Botsford Hosp v Citizens,* 195 Mich App 127 (1992).

More recently, the court of appeals discussed intervention in the unpublished decision of *Marsack v Citizens,* Ct. App. No. 190356 (Dec. 6, 1996). The court permitted intervention as of right under MCR 2.209(A), holding:

> *As demonstrated above, the hospital has an interest in the subject matter of the litigation. Further, insofar as Michigan law does not permit a "hospital lien" on insurance proceeds, we find that intervention is necessary to permit the hospital to protect its interest in the PIP benefits paid to plaintiff, who has an outstanding bill with the hospital. Cf* Tucker v. Clare Bros. Limited, *196 Mich App 513, 517–518; 493 NW2d 918 (1992). Finally, neither plaintiff nor defendant represented the hospital's interest in being paid in full. We conclude that the hospital fulfilled the requirements to intervene in the present action as of right.*

Intervention should be easily available and, for service providers, it should be presumed. Nevertheless, it has been our experience that judges are unpredictable on their approaches to intervention. Some allow it; some don't. Denial of the right to intervene is difficult to reconcile with the above cases. If intervention is not allowed, the service provider has the ability to pursue a separate direct action. Also, intervention is obviously not available where no lawsuit has been filed.

Audits

Starting around 1990, no-fault insurers began resorting to professional auditors to assist them in determining whether the charges of professional service providers are "reasonable and customary." This created a series of problems. The auditors routinely violated the 30-day payment protocol under MCL 500.3142, thereby further slowing down payments. They typically slashed the allowable charges of service providers, often by resorting to databases that were proprietary and whose contents were unknown to the service providers. (These databases were amalgamations of fee schedules allowed in a variety of other contexts such as workers' compensation, BCBS, Medicare, etc. Often, there were statistical and conceptual problems with the databases.) Service providers would often seek collection of these unpaid balances from their often impecunious patients, thereby damaging their patient's credit records.

Two appellate decisions have made clear that no-fault insurers cannot use the type of databases that they were using.[30] The court went so far as to hold in *Mercy Mt Clemens Corp v ACIA*[31] that the insurer could not obtain discovery as to amounts the hospital actually accepted from other third-party payors, such as Medicare, Medicaid, BCBS, worker's compensation, HMOs, and PPOs. This information, the court held, was irrelevant. Nonetheless, auditors continue to claim charges are too high and insurers unilaterally slash reimbursements.

Conclusion

Practicing in the no-fault arena on behalf of service providers is challenging and never dull. As noted above, however, there are road blocks that must be considered and carefully negotiated in order to avoid having your claims denied. But paying close attention to the process and knowing your rights can make treating automobile accident victims a financially satisfying experience, particularly in this era of managed care. ✦

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Footnotes

1. MCL 500.3101 et seq.
2. MCL 500.3107(1)(a).
3. MCL 500.3105.
4. MCL 500.3157.
5. See, e.g., *Munson Medical Center v Auto Club Ins Ass'n,* 218 Mich App 375 (1996), lv den, 453 Mich 959, reconsid den 454 Mich 890.
6. *Mercy Mt Clemens Corp v Auto Club Ins Ass'n,* 219 Mich App 46 (1996), lv den 456 Mich 877.
7. *Lakeland Neurocare Centers v State Farm Mut Auto Ins Co,* 250 Mich App 67 (2002).
8. MCL 500.3145(1).
9. Such as minority, disability, etc. Also see *Regents of The University of Michigan v State Farm Mut Ins Co,* 250 Mich App 719 (2002) (statute not applicable to government agencies).
10. MCL 500.3109(1).
11. MCL 500.3109a.
12. *Tousignant v Allstate Ins Co,* 444 Mich 301 (1993).
13. *Sprague v Farmers Ins Exchange,* ___ Mich App ___, 2002 Mich App LEXIS 702, No. 227400 (2002).
14. Formal Ethics Opinion C-223 (Jan 1983).
15. Formal Ethics Opinion C-226; *Garcia v Farmers Ins Exchange,* 226 Mich App 254, 257 (1997).
16. C-226.
17. *Abston v Aetna Casualty,* 131 Mich App 26 (1983).
18. MCL 500.3142.
19. MCL 500.3148(1).
20. *Shanafelt v Allstate,* 217 Mich App 625 (1996).
21. *Regents of The University of Michigan v State Farm Mut Ins Co,* 250 Mich App 719 (2002), citing *Kalin v DAIIE,* 112 Mich App 497 (1982).
22. *Wood v DAIIE,* 413 Mich 573 (1982), *Attard v Citizens Ins Co of America,* 237 Mich App 311 (1999).
23. *Regents,* supra, and *Lakeland,* supra.
24. *Regents,* supra.
25. MCL 500.3143.
26. *Professional Rehabilitation Associates v State Farm,* 228 Mich App 167 (1998).
27. MCL 500.3112.
28. Intervention can be of right, MCR 2.209(A), or by permission, MCR 2.209(B)(2).
29. 245 Mich App 759, 761–762 (2001).
30. See, e.g., *Munson Medical Center v ACIA,* 218 Mich App 375 (1996) and *Hicks v Citizens Ins Co,* 204 Mich App 142 (1994).
31. 219 Mich App 46 (1996); lv den 456 Mich 876 (1997).