The Michigan Auto No-Fault Law:
YOUR RIGHTS & BENEFITS
A Detailed Guide for Patients and Providers

8th Edition
Revision #1

Authored by Attorneys:
George T. Sinas • Stephen H. Sinas • Thomas G. Sinas

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because of the passage of the new 2019 no-fault legislation.
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Authored by Attorneys
George T. Sinas • Stephen H. Sinas • Thomas G. Sinas
of
THE SINAS DRAMIS LAW FIRM
Lansing, MI • Grand Rapids, MI • Kalamazoo, MI • St. Clair Shores, MI • Chicago, IL

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INTRODUCTION

A Quick Look:
Overview Of The No-Fault Law

The Michigan No-Fault Automobile Insurance Act (MCL 500.3101, et seq), went into effect in October 1973. This law creates a compulsory insurance system that obligates the owners or registrants of all motor vehicles required to be registered in Michigan to purchase an auto No-Fault insurance policy. Failure to purchase this required insurance subjects the owner or registrant of the motor vehicle to criminal prosecution, a fine, and/or imprisonment. The basic concept of the No-Fault Act is to guarantee payment of certain benefits to all accident victims, regardless of who was at fault in causing the accident. In order to fund such a system, however, the No-Fault Act imposes certain limitations on the rights of accident victims to bring liability claims against the at-fault drivers who cause the accident. It is this basic trade-off that forms the essence of Michigan’s No-Fault System.

Michigan is only one of a handful of states in this country to adopt a No-Fault System. Although the original intent was to simplify motor vehicle accident claims, in many respects, the opposite has occurred. There have been more than 3,000 Michigan appellate court decisions issued over the last 35 years interpreting various aspects of the No-Fault Act. In spite of all those cases, however, there are numerous legal issues which remain confusing and unresolved. Clearly, one thing has been learned over these past many years: It is critically important for accident victims to fully understand their legal rights, or they may lose them! Therefore, the purpose of this “Quick Look” is to inform patients and providers of the important legal rights and benefits to which they are entitled under the No-Fault Act so that those rights and benefits can be properly protected.

The first step in understanding the No-Fault Act is to understand the point that every motor vehicle accident that occurs in Michigan, or that involves Michigan residents, potentially creates two separate and distinct legal claims. The first claim is for No-Fault personal protection insurance benefits that are typically referred to as “No-Fault PIP benefits.” The second claim is the bodily injury tort liability claim that a victim can pursue against the at-fault driver in order to recover certain losses and damages that are not covered by PIP benefits. This claim is typically referred to as the “Tort liability claim.”

This brochure discusses both of these claims and related information in considerable detail. In order to help the reader better understand the subject matter and the contents of this brochure, the authors have created a “Quick Look” that appears on the following two pages and briefly discusses the basic nature of the No-Fault PIP benefits claim and the tort liability claim and indicates where, in this brochure, those topics are discussed.
A Quick Look: The PIP Benefit Claim

What are PIP benefits and when are they payable? See Chapters 1, 2, and 4

There are four (4) PIP benefits payable under the Michigan Auto No-Fault Law without regard to fault. They are as follows:

1. The allowable expense benefit, which is a lifetime benefit without a dollar cap that is payable for “all reasonable charges incurred for all reasonably necessary products, services, and accommodations for an injured person’s care, recovery, or rehabilitation.” This claim can be legally enforced by patients as well as their providers;

2. The work loss benefit, which is payable for three years and is calculated at 85% of gross income from work an injured person would have performed had he or she not been disabled, subject to a maximum monthly cap;

3. The replacement service expense, which is payable for three years and consists of a $20 per day allowance to reimburse the injured person for reasonably necessary domestic services; and

4. The survivors’ loss benefit, which is payable for three years to the surviving dependents of a person killed in a motor vehicle accident, and covers several types of losses.

PIP benefits are payable whenever anyone sustains an accidental bodily injury arising out of the ownership, operation, maintenance, or use of a motor vehicle. A motor vehicle does not include a motorcycle, but when a motorcycle is involved in an accident with a motor vehicle, No-Fault PIP benefits are payable.

What auto no-fault insurer pays PIP benefits? See Chapter 3

The typical rule is that the injured person turns to his or her own auto No-Fault insurance company. There are several exceptions to this rule, such as persons driving employer-provided vehicles, motorcyclists, persons who do not have auto No-Fault insurance, and other scenarios.

Are no-fault PIP benefits reduced by other benefits? See Chapter 3

If a person purchases a “coordinated No-Fault policy,” No-Fault benefits are reduced by amounts other health insurers would pay on behalf of the injured person. This does not happen if a person purchases an “uncoordinated No-Fault policy.” In addition, if “governmental benefits” are payable as a result of the accident, No-Fault benefits can be reduced by those governmental benefit sources.

What are the time limits for PIP benefit claims? See Chapter 3

A claim for No-Fault PIP benefits must be submitted in writing within one year of the date of the accident and must include the specific information required by the No-Fault Act. In addition, if any particular aspect of a claim is not paid, legal action must be filed within one year of the date that particular expense was incurred, or the right to enforce payment of that particular expense will be lost.
A Quick Look:
The Tort Liability Claim

What is a tort liability claim and what compensation is payable? See Chapter 6

An accident victim may be entitled to compensation in a “tort liability claim” if the accident is caused by the negligence (i.e., carelessness) of the other driver and the victim is able to satisfy the injury severity requirement that is applicable to the claim. There are two types of monetary damages that are recoverable in tort liability claims: noneconomic loss damages, such as pain and suffering, disability, loss of function, denial of social pleasure and enjoyment, and other quality of life losses; and excess economic loss damages, which are payable for certain out-of-pocket expenses that are not paid by No-Fault PIP benefits, such as income loss not covered by PIP benefits.

What are the injury severity requirements for tort liability claims? See Chapter 6

Tort liability claims seeking recovery of noneconomic loss damages require proof that the at-fault driver was negligent (i.e., careless) and that the injured person sustained a “threshold injury,” which the No-Fault Act defines as a “serious impairment of body function,” “permanent serious disfigurement,” or death. Tort liability claims for excess economic loss do not require proof of a threshold injury.

What happens when injuries result in death? See Chapter 6

Where a person dies as a result of a motor vehicle collision, a special kind of tort liability arises which is known as a “Wrongful Death Claim.” Wrongful death claims are pursued by the decedent’s Estate on behalf of family members.

Who pays compensation for the tort liability claim? See Chapter 6

Tort liability claims are paid by the insurance company for the at-fault driver. If the at-fault driver does not have liability insurance and the injured person has purchased “uninsured motorist coverage,” the victim’s uninsured motorist coverage will pay the claim. Similarly, if the at-fault driver does not have enough liability coverage to fully compensate the injured person, and if the injured person has purchased “underinsured motorist coverage,” the injured person can turn to this coverage for further compensation.

Is tort liability compensation reduced by any factors? See Chapter 6

A victim’s right to recover tort liability compensation is reduced by any negligence that is attributable to the injured victim. Therefore, if the injured victim is 20% responsible for the accident and the at-fault driver is 80% responsible, the victim’s liability damages will be reduced by 20%. However, if the victim is over 50% negligent in causing the accident, the victim cannot recover any compensation for noneconomic loss.

What are the time limits for tort liability claims? See Chapter 6

The statute of limitations for tort liability claims is three (3) years from the date of the accident. However, the limitation period for uninsured motorist claims and underinsured motorist claims may be shorter or longer than three years, depending upon the actual language in the applicable insurance policy.
Other Information Resources

Those readers who desire additional information regarding the operation of the Michigan Auto No-Fault Insurance Law and the various types of insurance coverages that are available in our Michigan No-Fault system, may wish to consult the other informational resources listed below:

• **www.cpan.us** – This is the website for the *Coalition Protecting Auto No-Fault (CPAN)*, which is a broad-based coalition of auto accident victims, medical providers, and attorneys who are committed to preserving and protecting the Michigan No-Fault Automobile Insurance Law so that it continues to provide the comprehensive coverage for those seriously injured in Michigan auto accidents. This website provides important information that includes, but is not limited to, further explanation about how the Michigan No-Fault Law works, updates regarding the legislative attempts to reform the Michigan No-Fault Law, and insights from auto accident victims.

• **www.autonofaultlaw.com** – This is an informative website that provides extensive information and videos that explain the details of the Michigan No-Fault Law. Furthermore, this site includes a blog that tracks important legal developments affecting the rights of Michigan motorists.

Prefatory Comment

This brochure has been prepared and distributed as a public service and is intended to provide valuable legal information regarding the rights of patients and providers under the Michigan auto no-fault law. However, it is not a substitute for legal advice from competent legal professionals who work extensively in this field. This is particularly true, because there have been a number of very important appellate court decisions in recent years that have significantly impacted this area of law. Therefore, individuals must be mindful of these decisions and exercise great caution in pursuing their claims.

*The Authors*

*May 2018*
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Any analysis of the No-Fault PIP benefit claim begins with understanding when PIP benefits are payable and who is eligible to receive these benefits. 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 PIP benefit system. Within that section is Section 3105(1), which sets forth the basic legal entitlement test for receipt of PIP benefits. This Section states:

“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.”

Section 3105(2) states that No-Fault benefits are “due under this chapter without regard to fault.” It is this section that gives “No-Fault” its name.

Notably, the entitlement language of Section 3105(1) is very broad and goes beyond the typical scenario of bodily injuries sustained in a motor vehicle collision. On the contrary, Section 3105(1) has been interpreted to extend entitlement benefits to a number of non-collision situations, such as injuries arising out of vehicle maintenance, loading and unloading property, and occupying a vehicle. More detailed information regarding the issue of entitlement to PIP benefits and related eligibility issues is set forth below.

**SECTION A  THE FIVE-PART ENTITLEMENT TEST**

Case law decided under Section 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:
Chapter 1 – Legal Entitlement to No-Fault PIP Benefits

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, but the bodily injury can be an aggravation or exacerbation of a pre-existing condition;

3. The bodily injury giving rise to the claim must be accidental in the sense that it was not caused intentionally by the claimant;

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; and

5. The injury must be closely related to the transportational function of a motor vehicle.

SECTION B      STATUTORY EXCLUSIONS AND DISQUALIFICATIONS

Although Section 3105(1) sets forth broad legal entitlement to benefits, this eligibility narrows considerably in certain situations. One scenario deals with injuries involving a “parked vehicle.” Another scenario involves specifically enumerated statutory disqualifications. These exclusions and disqualifications are discussed briefly below.

1. The Parked Vehicle Exclusion

Determining whether a person is entitled to PIP benefits is more complicated when person’s injury involves a parked vehicle. This situation is addressed in Section 3106, which provides that a person sustaining accidental bodily injury arising out of a parked vehicle is not entitled to PIP benefits unless the injury falls into one of the three (3) scenarios set forth in Section 3106(1). The first scenario is where the vehicle was parked

in such a way as to cause unreasonable risk of the injury that occurred. The second scenario is where the injury occurs as a direct result of physical contact with either (1) permanently-mounted vehicle equipment while that equipment was being operated or used, or (2) property that was being lifted onto or lowered from the vehicle in the loading or unloading process. The third scenario is where the person was injured while occupying, entering into, or alighting from a parked vehicle. The Michigan Supreme Court has also recognized a fourth scenario where the person sustains bodily injury while performing vehicle maintenance on a parked vehicle. It is important to keep in mind, however, that if a person is injured in an accident involving both a moving motor vehicle and a parked vehicle, the involvement of the moving motor vehicle makes it unnecessary for the injured person to fall into one of the four scenarios described above. This person will, in all likelihood, be entitled to PIP benefits, subject to otherwise satisfying the five-part entitlement test described above.

Section 3106(2) contains a very strict exclusion that may apply where a person’s injury involves a parked vehicle and occurs while a person was in the course of his or her employment. This section specifically provides that PIP benefits are not payable if the employee’s 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. However, this exclusion does not apply if the employee was occupying a motor vehicle or if the injury arose from the use or operation of some other motor vehicle. Furthermore, this exclusion does not apply if the employee sustains injury while actually driving a vehicle in the course of his or her employment. In that case, the employee would be entitled to recover workers’ compensation benefits and would also be entitled to recover PIP benefits for any amounts recoverable under the No-Fault Act that are not otherwise recoverable under Michigan’s workers’ compensation law.

2. The Statutory Disqualifications

In addition to satisfying the entitlement requirements of Section 3105 and Section 3106, it is also important to establish that an injured person is not otherwise statutorily disqualified under the provisions of Section 3113. This section disqualifies an injured person in four situations: (1) the person was willingly operating or willingly using a motor vehicle or motorcycle that was taken unlawfully, and the person knew, or should have known, that the motor vehicle or motorcycle was taken unlawfully; (2) the person was the owner or registrant of a vehicle involved in the accident that was not insured as required by the No-Fault Act; (3) the person was a foreign resident occupying a vehicle not registered in Michigan and not insured by a Michigan-authorized insurer; and (4) the person was operating a motor vehicle or motorcycle as to which he or she was

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7Section 3113. As amended, December 2014.
named as an excluded operator. The most important of these disqualifications is the second one, which disqualifies any person who is an owner or registrant of an uninsured motor vehicle that was involved in the accident. 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.

**SECTION C  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 categories: (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.

**SECTION D  OUT-OF-STATE RESIDENTS HURT 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 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 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.
As stated in the Introduction to this brochure, there are four separate and distinct PIP benefits payable under the Michigan No-Fault Act. Those four benefits will be discussed in this chapter. Each benefit covers a distinctly different type of loss and is subject to its own important legal rules and limitations. Moreover, these benefits have undergone significant change over the years as a result of appellate court decisions. Therefore, auto accident victims must make sure that they are fully informed of their legal rights to recover these important PIP benefits. The following sections will provide some important general concepts.

**SECTION A  THE ALLOWABLE EXPENSE BENEFIT—§3107 (1)(a)**

The No-Fault Act has the broadest and most generous medical-expense and patient-care provisions of any No-Fault insurance law in the country. Section 3107(1)(a) states that an injured person is entitled to recover “allowable expenses” consisting of: “All reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person’s care, recovery or rehabilitation.” The statute contains no further definitions of the scope and extent of the allowable expense benefit. It should be noted, however, that incorrect terminology is often used when determining whether a certain expense is compensable. For example, insurance companies sometimes refuse to pay a particular expense because it is not “medically necessary” or “medically appropriate” or because the injured person has reached “maximum medical improvement.” These are not the appropriate legal standards for determining if an expense is a compensable allowable expense. Rather, the appropriate question is whether the particular expense was reasonably necessary for an injured person’s care, recovery, or rehabilitation. In addition, it is clear that the allowable expense benefit is payable for life and is payable without regard to any monetary “cap” or “ceiling.” Various court decisions have established that these benefits include a wide variety of products and services. The scope and nature of the allowable expense benefit is discussed below.
1. **Medical Expenses**

Under Section 3107(1)(a), all reasonable charges incurred for reasonably necessary hospital expenses, physician services, prescription medication, various forms of therapy, medical equipment, prosthetic devices, chiropractic treatment, psychological therapy, in-home care, and other expenses are compensable allowable expenses.

2. **In-Home Attendant Care**

Section 3107(1)(a) 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, 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. 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, 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. This concept was reaffirmed by the Michigan Supreme Court in its 2012 decision in *Douglas v. Allstate Ins Co.*

Ultimately, the central issue in many attendant care cases is 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.

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9 *Douglas v Allstate Ins Co, 492 Mich. 241 (2012).*
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” for the injured person’s “care, recovery or rehabilitation”? 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. For example, in Sharp v Preferred Risk Mutual Ins Co, 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].” Thus, claims for family-provided attendant care have been frequently based upon the commercial rate that would be charged by a professional agency rendering the same services.

However, in the case of Douglas v Allstate Ins Co the Michigan Supreme Court cast doubt on the utilization of commercial rates to establish the value of family-provided care. In Douglas, the Court suggested that the compensation package payable to the employees of commercial rates is the more relevant standard. However, the calculation of a commercial employee’s compensation package should go beyond simple W-2 income and should include the value of the employee’s fringe benefits. As a result of the Douglas decision, 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 of Section 3107(1)(a). This will be discussed in Chapter 3. 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 caregiver 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. Therefore, those persons rendering attendant care to family members must be very clear that they

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Chapter 2 – No-Fault PIP Benefits in Detail

are providing the attendant care with the full expectation of being paid in accordance with the provisions of the No-Fault Act.

3. **Special Transportation and Mileage Expense**

For many years, the Michigan appellate courts held that, in certain circumstances, a No-Fault insurance company was obligated to pay for the purchase and modification of a motor vehicle for the transportation of a severely injured person. An example would be a person suffering spinal cord injuries or serious brain injuries who, because of the nature of their disability, now needs a handicap accessible, specially equipped van or other adapted vehicle. One such case that ruled an insurance company was obligated to pay the full cost of a handicap accessible van was the Court of Appeals decision in *Davis v Citizens Insurance Company of America.*\(^{13}\)

However, in 2013, the Michigan Supreme Court issued a major decision in the case of *Admire v Auto-Owners Insurance Company,*\(^ {14}\) which dramatically changed the rules regarding the compensability of special transportation. In the *Admire* case, the Supreme Court held that a No-Fault insurance company was obligated to pay for the cost of special adaptive equipment for a handicap accessible van, but the insurer was not obligated to pay for the base price of the van. Therefore, as a result of the *Admire* decision, No-Fault insurance companies are typically refusing to pay for the base price of a van and will only pay for the cost of purchasing and installing the special adaptive equipment.

It is important to note that in the *Admire* decision, the Supreme Court reaffirmed pre-existing law that an insurance company is obligated to pay for mileage to transport an injured person to and from necessary medical care and rehabilitation. However, injured people and their providers should be aware that Michigan courts have scrutinized whether personal transportation expenses are compensable. For example, in *ZCD Transportation v. State Farm Mutual Insurance Company,*\(^ {15}\) the Court of Appeals held that transportation for “personal trips” unrelated to the “care, recovery, or rehabilitation” of the person’s injuries were not compensable under Section 3107(1)(a).

With regard to the reimbursement of mileage expenses, there has been some dispute over the years as to the appropriate mileage rate that should be paid for medical transportation. Some court decisions have held that it is proper to utilize the State of Michigan mileage reimbursement rate as a guide.\(^ {16}\)

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\(^{16}\) *Swanteck v Automobile Club of Michigan Ins Group,* 118 Mich App 807 (1982).
4. **Home Accommodations**

Section 3107(1)(a) 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.’”

It should be noted that 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. However, in *Williams v AAA Michigan*, 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 his or her 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.

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.

Considerable uncertainty exists about the application of the *Admire* decision to home accommodation claims. Many insurance companies have attempted to use the *Admire* decision to deny or limit home accommodations claims—particularly those cases where the patient either needs a home addition or complete new home construction. It is important to emphasize that the *Admire* decision does not specifically deal with houses or residential accommodations. In that regard, *Admire* did not explicitly overrule the

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landmark Court of Appeals decision in *Sharp v Preferred Risk*, which held if housing larger and better equipped is required for the injured person than would be required if he were not injured, then the full cost is compensable. In addition, even if it is determined that *Admire* affects home accommodation claims, then the legal analysis in *Admire* will likely affect how housing expense claims are treated. For example, additions to existing homes may be treated differently than new construction. The future relationship between *Admire* and home accommodation claims is largely unknown. Suffice to say, however, that enforcing the right to the home accommodation benefit is a complicated matter that involves the resolution of many issues that can have long-term implications for severely injured people.

5. **Rehabilitation**

The statutory definition of the allowable expense benefit specifically references “rehabilitation.” However, the exact meaning of “rehabilitation” is not defined in the No-Fault Act. Therefore, appellate court decisions are very important in understanding this significant component of the allowable expense benefit. In this regard, recent decisions of the Michigan Supreme Court have given a broad definition to the concept of “rehabilitation.” For example, in the cases of *Griffith v State Farm* and *Douglas v Allstate Ins Co*, the Court made this statement, “expenses for recovery or rehabilitation are costs expended in order to bring an insured to a condition of health or ability sufficient to resume his preinjury life.”

The Michigan appellate courts have also made it very clear that the term “rehabilitation” includes not only physical rehabilitation, but also “vocational rehabilitation.” Therefore, if a person sustains an injury in a motor vehicle accident that permanently disables the person from returning to his or her former employment, the reasonable expense of retraining, reeducating, and placing the injured person in a new occupation is covered. In holding that vocational rehabilitation is part of the allowable expense benefit, the Michigan appellate courts have rejected the argument that a No-Fault insurer is only required to return the injured person to his or her pre-accident occupation, as opposed to elevating the victim to a higher functional vocational level reasonably consistent with the person’s capabilities. The court decisions that deal with vocational rehabilitation have also held that, in certain circumstances, the cost of vocational rehabilitation may include tuition and related housing expenses that are incurred in connection with pursuing a formal vocational program.

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Clearly, the fact that the Michigan No-Fault Law provides for broad rehabilitation and vocational retraining is very important in assisting severely injured patients to return to productive lives.

6. **Guardian/Conservator Expenses**

Michigan appellate courts have long held that where a seriously injured person requires a probate court to appoint a Guardian or Conservator, the costs of appointing and maintaining such a probate fiduciary are recoverable as an allowable expense benefit. This principle was first articulated in the case of *Heinz v Auto Club Insurance Association.* However, in more recent cases, the appellate courts have limited what is compensable under Section 3107(1)(a) for guardian and conservatorship services. In these recent cases, the Court of Appeals held that conservatorship expenses were not compensable for “ordinary and necessary services” such as protecting the patient’s interests in connection with real estate disputes, managing the patient’s debts, and processing insurance claims. Rather, guardianship and conservatorship expenses were limited by the court in these cases to those services that were directly related to the injured person’s care, recovery, or rehabilitation.

7. **Causation: The Legally-Required Relationship Between Accident Injuries and Claimed Expenses**

For many years, there has been one major legal issue at the center of the allowable expense benefit claim — **the issue of causation.** This issue deals with the legally required connection that must be demonstrated between an auto accident injury and the claimed expense in order to make that expense payable under the allowable expense provisions of Section 3107(1)(a). In other words, to what extent must the auto accident injury be the cause of the need for the claimed expense? This issue has been analyzed in several different contexts by our appellate courts. A few of those scenarios are briefly discussed below.

a. **Aggravation of Pre-Existing Conditions**

Many years ago, Michigan appellate court decisions established that if a person sustains an aggravation or exacerbation of a pre-existing injury or condition as a result of a motor vehicle accident, that person is entitled to claim allowable expense benefits for the aggravated/exacerbated condition. In the case of *Mollitor v Associated Truck Lines,*

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the Court was very direct in recognizing this principle when it held, “an injured person may recover if he can demonstrate that the accident aggravated a pre-existing condition. . . .”

b. Multiple Causes of Injury

Michigan appellate courts have also made it clear that the motor vehicle accident that gives rise to a claim for PIP benefits need not be the only cause of the need to incur the allowable expense at issue. Specifically in the cases of *Shinabarger v Citizens Insurance Company* and *Scott v State Farm Insurance Company*, the Michigan Court of Appeals held that a sufficient causal connection is demonstrated if the motor vehicle accident is “one of the causes” of the need to incur the expense, even though there may be other, unrelated and independent causes. However, the Court also cautioned that the causal connection between the motor vehicle accident injury and the need for the claimed benefits must be more than incidental.

c. Successive Accidents

A related causation issue is presented in cases where an auto accident results in a physical disability which then subsequently causes another accident that causes a new injury. This issue was addressed by the Michigan Supreme Court in the case of *McPherson v McPherson*, which involved a man who sustained a severe brain injury in a motor vehicle accident a number of years earlier that had caused him to develop a seizure disorder. Several years after that accident, the man was involved in a new motor vehicle accident caused by that seizure disorder and, as a result, he sustained a severe spinal cord injury. The Supreme Court held that the medical expenses related to the spinal cord injury did not qualify as allowable expenses that were sufficiently related to the patient’s first accident so as to make those injuries compensable with PIP benefits payable because of that first accident. The Court held that the relationship between the brain injury sustained by the patient in the first accident and the subsequent spinal cord injury caused by the second accident was too remote to justify payment of benefits. It is important to note that the *McPherson* decision only deals with successive accidents, not successive injuries. Therefore, if a person sustains an injury in a motor vehicle accident that then results in a second injury or condition, *McPherson* does not preclude recovery of benefits.

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d. Reimbursable Allowable Expenses vs. Unreimbursable Expenses of an Uninjured Life

Another aspect of the causation issue deals with those situations where the claimed allowable expense resembles an expense that the injured person would have incurred even if he or she had not been injured in the subject auto accident. There have been four major Michigan Supreme Court cases that have addressed this issue in various contexts. All of these cases make the point that any allowable expense benefit claimed under Section 3107(1)(a) must be demonstrated to be “for” the claimant’s “injury.” In other words, the plaintiff’s injury or disability must cause the need for the allowable expense at issue. Accordingly, unless the claimed expense is reasonably necessary for the care, recovery, or rehabilitation of the injured person, it is not compensable. The Supreme Court’s decisions in these cases have shed important light on the issue of causation and what type of expenses are compensable under the Michigan No-Fault Act. These four decisions, and the contexts in which they were decided, are summarized below.

- **Ordinary Food Consumed at Home: Griffith v State Farm**

In the Griffith\(^\text{33}\) case, the Supreme Court held that the cost of non-medical, non-special dietary food unrelated to a motor vehicle injury and consumed by a person who is cared for at home, is not a recoverable allowable expense benefit under Section 3107(1)(a). In holding that the No-Fault insurer was not responsible for this type of ordinary food expense, the Court emphasized that the patient’s food needs after his auto accident injury had not been affected and differed in no way from his dietary needs before his injury. However, the Court recognized an exception for identical food served to an injured person in a hospital setting. In drawing that distinction, the Court reasoned that food provided to an injured person in an institutional setting is compensable even though the injured person’s food needs were not affected by the injury because the injured person had limited or no choice in selecting the food he or she consumed. The Court also recognized another exception for products that were specifically designed to accommodate a person’s disability, even though the product replaced a similar product that the injured person would have used had he or she not been injured. The example the Court gave of this exception would be “medical shoes” that are specifically designed to accommodate the patient’s foot injury.

- **Cooking an Injured Person’s Food: Johnson v Recca**

In Johnson v Recca\(^\text{34}\), the Supreme Court held that services rendered to an injured person in his or her home must relate to the person’s injury, rather than ordinary household

\(^{33}\text{Griffith v State Farm, 472 Mich 521 (2005).}\)

\(^{34}\text{Johnson v Recca, 492 Mich 169 (2012).}\)
services, in order to constitute “care” under the allowable expense provisions of Section 3107(1)(a). Based upon this distinction, the Court held that the expense of cooking an injured person’s food was not recoverable under Section 3107(1)(a) because the injured person would have required the cooking of food before the accident. However, the expense related to feeding the cooked food to the injured person was compensable under Section 3107(1)(a), because the injured person would not have been fed by others before the accident. In so holding, the Johnson Court stated, “allowable expenses do not include expenses for products or services that are required after the injury in a manner indistinguishable from those required before the injury.”

**Family-Provided Attendant Care: Douglas v Allstate**

In *Douglas v. Allstate Insurance Company*, the Court focused on attendant care services rendered to the injured person by his family. The Court emphasized that in order for those services to be compensable under Section 3107(1)(a), they must be services that are rendered “for” the care, recovery, or rehabilitation as a result of his or her injured state. In this regard, the Court stated, “although services for an insured’s care need not restore a person to his pre-injury state, the services must be related to the insured’s injuries to be considered allowable expenses.”

**Handicap-Accessible Vans: Admire v Auto-Owners**

In the *Admire* decision, the Supreme Court created new guidelines for determining what expenses were compensable as allowable expenses under the provisions of Section 3107(1)(a) and which were not. In this regard, the Court created three (3) categories of expenses. The first of these categories is “ordinary every day expenses.” The Court held that these expenses were not compensable and stated, “any product, service, or accommodation consumed by an uninjured person over the course of his or her everyday life cannot qualify because it lacks the requisite causal connection with effectuating the injured person’s care, recovery, or rehabilitation.” The second category of expense was referred to by the Court as “expenses of a wholly different essential character than expenses borne by the person before the accident.” The Court held that this type of expense was fully compensable. In so holding, the Court said, “If an expense is new in its essential character, and thus actually for the injured person’s care, recovery, or rehabilitation, §3107(1)(a) requires that it be covered in full regardless of whether the expense represents an increase or decrease in the injured person’s preaccident costs.” The third category of expense created by the Court was characterized as “special accommodations or modifications to an ordinary item.” The Court stated that expenses in this category “present a particular challenge” and should be divided into two sub-categories: those involving “combined products;” and those involving “integrated products.” Combined products are those that can be “separated

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easily into unit costs” and only the unit costs that are “of a new character” are compensable under Section 3107(1)(a). Integrated products, on the other hand, are those that involve “the blending of an ordinary expense with one that is for the injured person’s care, recovery, or rehabilitation in a way that the resulting product or accommodation cannot be separated easily into unit costs,” and are fully compensable, “because the entire expense, including those portions of the expense that might otherwise be considered ordinary, is necessary for the person’s care, recovery, or rehabilitation.” Based upon this analytical framework, the Court in Admire held that a No-Fault insurer was not obligated to pay the base price cost of a handicap accessible van because the van itself was considered to be an ordinary expense. The No-Fault insurer was only required to pay for the adaptive equipment that was installed on the van to make it accessible for the injured person because that equipment was separable under the “combined product” category.

SECTION B  THE WORK LOSS BENEFIT — §3107(1)(b)

Section 3107(1)(b) provides that where an injured victim cannot work as a result of an auto accident, work loss benefits are payable for up to a maximum of three 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 No-Fault Act, work loss benefits are payable at the rate of 85% 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:

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<tr>
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</tr>
</tbody>
</table>

Other important principles regarding work loss benefits are summarized below.

1. **The Applicable Disability Standard**

Under the No-Fault Act, 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 work loss benefits must include salary increases, overtime, and other merit raises that would have been received during the person’s disability.\textsuperscript{37} Any income earned by the injured person during a period of disability reduces the wage loss benefit otherwise payable for that same period.\textsuperscript{38}

2. \textit{The Duty to Mitigate}

Michigan appellate courts have imposed an obligation on an injured person who is receiving wage loss benefits 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 such alternative employment. This principle was recognized by the Michigan Court of Appeals in the case of \textit{Bak v Citizens Insurance Company}.\textsuperscript{39} The exact scope and nature of the duty to mitigate remains unclear. Therefore, once a physician has cleared an injured person to return to work, the person should begin searching for appropriate employment within his or her medical limitations.

3. \textit{The Interplay Between Work Loss Benefits, Sick Leave, and Vacation}

Michigan appellate courts have held that a No-Fault insurance company cannot reduce work loss benefits by an injured person’s sick leave and vacation time. Therefore, if an injured person is receiving sick pay or is drawing on vacation time during the period of disability, the No-Fault insurer must pay full No-Fault work loss benefits.\textsuperscript{40}

4. \textit{Wage Continuation Benefits}

When an employer continues paying wages to an injured person under a “wage continuation plan,” the No-Fault insurer may or may not be required to pay No-Fault wage loss benefits depending upon the situation. If the auto No-Fault policy is an uncoordinated No-Fault policy (described in Chapter 3), then the insurance company must pay full No-Fault work loss benefits without regard to the wage continuation benefits.\textsuperscript{41} However, if the injured person has purchased a coordinated No-Fault policy (described in Chapter 3), the No-Fault insurer may reduce No-Fault work loss benefits by the amount

\textsuperscript{40} \textit{Orr v DAIIE}, 90 Mich App 687 (1979).
the person receives from wage continuation plans that are in the nature of “other health and accident coverage.”

5. Temporarily Unemployed Persons

The No-Fault 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 work 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 No-Fault Act 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.

6. Self-Employed Persons

Self-employed accident victims are entitled to recover work 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 work loss benefit level payable under the No-Fault law is a question of fact that is typically determined on a case-by-case basis.

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SECTION C  THE REPLACEMENT SERVICE BENEFIT — §3107(1)(c)

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 Section 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. The No-Fault Act 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. The Difference Between Attendant Care Benefits and Replacement Service Expenses

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 Section 3107(1)(a) and is discussed above. 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 Section 3107(1)(c). The distinction is crucial because replacement services are limited to $20 per day and terminate three years from the date of the accident, whereas allowable expense services are not subject to a monetary cap 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.

The importance regarding the difference between attendant care and replacement service expenses was made particularly clear in two Michigan Supreme Court decisions: Douglas v Allstate Insurance Company and Johnson v Recca. In these cases, the Court recognized various important principles, including:

• Ordinary household services do not constitute an allowable expense under Section 3107(1)(a), but rather, are a replacement service expense under Section 3107(1)(c). To further illustrate the difference, the court held that preparing food for an injured person was a replacement service expense, but feeding the injured person was an allowable expense; and

• Supervision and on-call services rendered to a severely injured person could, depending on the circumstances, be compensable as an allowable expense under Section 3107(1)(a), if such supervision was necessitated by the nature of the person’s injuries.

SECTION D THE SURVIVOR’S LOSS BENEFIT—§3108

When 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 Section 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 that 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 and specifically include:

“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;” 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 the amounts that would have been attributable to the personal consumption of the decedent.47

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 Section 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 income 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. Furthermore, 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 No-Fault Act also states that the dependency of the surviving spouse terminates upon death or remarriage of the surviving spouse.48

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48MCL 500.3110(3).
4. **Funeral and Burial Expenses**

Section 3107(1)(a) provides for a separate “funeral and burial expense” benefit that 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 E THE MICHIGAN CATASTROPHIC CLAIMS ASSOCIATION**

Frequently, discussions regarding the No-Fault Act, involve references to the *Michigan Catastrophic Claims Association*, typically referred to as the “MCCA.” This is an entity that was created by the Legislature in Section 3104 of the No-Fault Act. The MCCA is, in essence, a reinsurance organization that reimburses auto No-Fault insurers for an injured person’s PIP benefits that exceed a certain monetary threshold, which is periodically adjusted. The PIP insurer that is responsible for the claim continues to handle the claim, but is ultimately reimbursed by the MCCA. For a person who was injured in 2014, the MCCA will reimburse the person’s PIP insurer once the total amount of PIP benefits paid by that insurer exceeds $530,000.

In 2008, the Michigan Supreme Court rendered an important decision in *USF&G v MCC*, regarding the nature and operation of the MCCA. In that case, the Court held that the MCCA could not refuse to reimburse an insurer who paid a claim on the basis that the MCCA questioned the “reasonableness” of the payment. However, the Court held that the MCCA could impose certain procedural guidelines that No-Fault insurers would be required to follow in the processing of catastrophic claims.

The net practical effect the *USF&G* decision is that it has empowered the MCCA to now become a “super claims adjuster” in virtually every catastrophic claim. As a result, the MCCA frequently tells No-Fault insurers what it will and will not reimburse, thereby effectively controlling what gets paid. As a result, decisions regarding the claims of catastrophically injured patients for home accommodations, special vehicular transportation, and in-home attendant care are frequently made by the MCCA rather than the injured person’s insurer. Unfortunately, this direct involvement of the MCCA in processing catastrophic claims has, in many situations, resulted in delay and has caused unnecessary litigation. Therefore, patients who have claims that involve the MCCA should be very mindful about this problematic situation and take action accordingly.

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SECTION F  PROPERTY PROTECTION INSURANCE (PPI) BENEFITS

In addition to providing PIP benefits for bodily injury, the No-Fault Act also requires the payment of property damage benefits in certain limited situations. These benefits are payable under Section 3121 and are legally known as “property protection insurance benefits” and informally referred to as “PPI benefits.” These benefits generally compensate property owners for economic loss when physical property is damaged as a result of the operation of a motor vehicle. Like PIP benefits, PPI benefits are payable without regard to fault. When PPI benefits are payable, they cover two distinct types of loss: (1) physical damage to or destruction of the property and (2) loss of use of the property damaged or destroyed. The maximum amount payable for PPI benefits cannot exceed $1,000,000.

The statute contains several very important exclusions from PPI benefits. The most important of these is the exclusion pertaining to motor vehicles. In this regard, Section 3123(1) states that PPI benefits are not payable for damage to “vehicles and their contents, including trailers . . . unless the vehicle is parked in a manner as not to cause unreasonable risk of the damage which occurred.” In other words, PPI benefits are never payable for collision damage to motor vehicles unless the motor vehicle was reasonably parked. PPI benefits are also excluded under Section 3123(1) where the property that was damaged was owned by a person, spouse, or relative named in the No-Fault policy and that person was also the owner, registrant, or operator of the motor vehicle involved in the accident, out of which the property damage occurred. Another exclusion is referenced in Section 3123(2) which states that PPI benefits are not payable for property damage arising from motor vehicle accidents that occur outside the state of Michigan.

Section 3125 of the Act provides that PPI benefits are payable from insurers in the following order of priority: (1) the insurers of owners or registrants of vehicles involved in the accident; and (2) the insurers of operators of vehicles involved in the accident. The question of when a motor vehicle is deemed to be “involved in the accident” can be rather complex. PPI benefits are controlled by a very short statute of limitations which is contained in Section 3145(2) of the Act and which provides that a lawsuit to recover PPI benefits cannot be commenced later than one year after the accident. Therefore, people having PPI claims must move quickly to protect their rights.

This description of PPI benefits is not meant to be complete, but is simply an introduction to a subject that can be quite complicated.
CHAPTER 3
PROCESSING THE NO-FAULT PIP BENEFIT CLAIM

Even though the No-Fault Act was originally intended to simplify and expedite the payment of auto insurance claims, it has, in many circumstances, created considerable complexity. This is particularly true with regard to the processing and payment of claims for PIP benefits. This chapter will address some of those issues, including the determination of which No-Fault insurance company is obligated to pay a claim (the priority issue); the rules applicable to the coordination of No-Fault benefits with other health and accident coverages; the time limitations and proof requirements applicable to PIP claims; the issue of independent medical examinations; and the availability of penalty sanctions that may be applicable to insurance companies who do not honor their legal obligations. Each of those issues will be discussed separately below.

SECTION A  PRIORITY DUTY TO PAY PIP BENEFITS — §3114 AND §3115

The first issue to consider when processing a claim for PIP benefits is to determine what insurance company is legally responsible for paying benefits. In that regard, 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 No-Fault Act.

1. The General Rule of Priority

The general rule contained in these sections is that an injured person receives 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.

2. 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.

3. **Injured Persons Who Do Not Have Auto No-Fault 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, pursuant to Section 3115 of the No-Fault Act.

4. **Owners of Uninsured Involved Vehicles**

The No-Fault Act has a very strict rule regarding accident victims who own uninsured vehicles that are involved in the accident. Section 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 Chapter 1.

5. **The Assigned Claims Plan**

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 is entitled to claim PIP benefits through the Assigned Claims Plan, which is administered by the Michigan Auto Insurance Placement Facility. The Assigned Claims Plan has been established as the “*insurer 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, phone number and website of the Michigan Auto Insurance Placement Facility is:

Michigan Auto Insurance Placement Facility  
P. O. Box 532318  
Livonia, MI 4813-2318  
(734) 464-1100  
(734) 464-0009 (fax)  
www.maipf.org
SECTION B  TIME LIMITS AND PROOF REQUIREMENTS

1. Time Limitations Applicable to PIP Benefit Claims

The No-Fault Act contains two very strictly enforced time limitations for processing claims for 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.

a. 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.

b. 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.

c. 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. Those cases 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. However, in two Supreme Court cases, Cameron v ACIA\(^{50}\) and Joseph v Allstate Insurance Company\(^{51}\), the Michigan Supreme Court overturned those earlier decisions and held 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 a minor or a mentally incompetent person that is older than one-year from

the date a lawsuit was filed, is unenforceable by virtue of the Cameron and Joseph decisions. However, the one-year-notice rule continues to be inapplicable to the claims or minors or incompetent persons, as that rule has been construed to be a true statute of limitations and, therefore, subject to the tolling provisions of MCL 600.5851.

d. 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.\(^{52}\) 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,\(^{53}\) 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 can only satisfy the one-year-back rule by filing a lawsuit against the No-Fault insurer within one year from the date the expense was incurred.

2. The Reasonable Proof Rule

Under Section 3142(2) of the No-Fault Act, a No-Fault insurer is not obligated to pay any benefits until the insurer “receives reasonable proof of the fact and of the amount of loss sustained.” If an insurer does not pay benefits within 30 days after receiving such reasonable proof, then payment of 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.”\(^{54}\) 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

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\(^{52}\)Devillers v ACIA, 473 Mich 562 (2005).


to provide these forms to the No-Fault insurance company so that the claimant cannot later be accused of failing to provide “reasonable proof.”

3. **The Incurred Rule**

No-Fault insurance companies have a legal obligation to pay claims for allowable expenses under Section 3107(1)(a) and replacement service expenses under Section 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. This also means that a No-Fault insurance company is not obligated to preauthorize payment of a particular benefit. Thus, the patient has to either pay for the expense or become legally obligated to pay the expense before requesting reimbursement from a No-Fault insurer.

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., handicap-accessible 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 do not permit the plaintiff to recover penalty sanctions under the No-Fault Act for interest and attorney fees (see Section F below). Therefore, declaratory judgment actions are not as effective as traditional lawsuits for unpaid benefits that are filed after the plaintiff has incurred the expenses that are the subject of a claim.

**SECTION C  GOVERNMENTAL BENEFIT SETOFFS — §3109(1)**

1. **The Basic Concept**

Under the Michigan No-Fault Act, a No-Fault insurance company is permitted to reduce PIP benefits by any governmental benefits paid or payable to the injured person. This governmental benefit setoff provision is set forth in Section 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. In interpreting the language of Section 3109(1), the Michigan Supreme Court has held that “benefits” are “provided or required to be provided” if the benefits pass this two-part test: 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.55 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, because the death benefit was payable as a result of the person’s death and not payable to cover actual cost incurred for funeral and burial expenses as required under Section 3107(1)(a).56 It should be noted that in situations where a claimant is receiving survivor’s loss benefits that include replacement services and is also receiving government benefits that are subject to setoff, the calculation of the setoff can be complicated under Michigan appellate case law.57

2. **Types of Governmental Benefits Resulting in Setoffs**

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.

3. **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 for payment of auto-related medical expenses because 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.

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55[Jarosz v DAIIE, 418 Mich 565 (1984).](#)
56[Gier v Auto-Owners Ins Co, 244 Mich App 336 (2001).](#)
57[Wood v Auto-Owners, 469 Mich 401 (2003).](#)
receiving the Medicare payment, and under certain circumstances, even the patient. This is an area that requires great caution for both patients and providers.

4. Medicaid Benefits

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 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 D  UNCOORDINATED V. COORDINATED PIP POLICIES

1. The Basic Concept

The No-Fault Act allows a person to 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 obligated to pay only 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,
Chapter 3 – Processing the No-Fault PIP Benefit Claim

No-Fault benefits payable under such a coordinated policy cannot be coordinated with other health coverages.

2. Complications of Coordinated PIP Policies

People who purchase coordinated policies should understand that their decision can have serious practical and legal implications. From a practical standpoint, those drawing benefits from coordinated policies must go through the tedious process of first submitting their medical expenses to their health insurer, waiting for a response, and then submitting the remainder of the unpaid bills to their auto insurer. There are also significant legal complications for those drawing benefits from coordinated policies, which are discussed below.

a. 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. 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.

b. ERISA Health Plan Complications

Many individuals are insured through their employment under an employer self-funded health plan established pursuant to a federal law 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, there can be confusion over whether the auto or health insurer is primarily responsible to pay medical bills. That is, if the ERISA 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 ordinary health insurance, the auto No-Fault plan will be primary and the ERISA plan will be secondary.

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60Auto Club Ins Ass’n v Frederick & Herrud, 443 Mich 358 (1993).
result may be different, however, if there is some ambiguity in the language of the ERISA plan.61 Such confusion can be avoided by purchasing an uncoordinated auto insurance policy.

In addition, because of the complex interplay between federal and state law, ERISA health plans have special “lien” right that other health insurers do not have. Specifically, in some situations, an ERISA health plan may be able to assert a lien against the patient’s bodily injury tort liability claim (discussed in Chapter 6). Again, this potential problem can be avoided by purchasing an uncoordinated auto insurance policy.

c. Managed Care Health Plan Complications

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.62 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 Section 3107(1)(a). For example, if chiropractic treatment was deemed “reasonably necessary” under Section 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.63

Although earlier court decisions dealt with patients who had health coverage through HMO plans, some No-Fault insurers have attempted to extend the concepts in those cases 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 this approach. Nevertheless, great caution should be used in these situations.

The recent passage of the Affordable Care Act ("ACA") will require many Americans to purchase health insurance. In cases involving auto accident injuries, questions may arise as to whether the PIP insurer or the ACA insurer has primary responsibility to pay medical expenses. A related question is whether the ACA coverage should be considered a "governmental benefit" and thus subject to the governmental benefit setoff provisions of Section 3109(1). Based upon prior appellate case law principles, it is unlikely that the courts will find that an ACA health insurance policy is a "governmental benefit" and therefore subject to setoff. However, if the injured person has purchased a coordinated PIP policy, the ACA policy will be primary under Section 3109a, with the PIP insurer paying those allowable expenses not covered under the ACA policy.

It should be further noted that ACA policies will not cover all expenses covered under Section 3107(1)(a) of the No-Fault Act. Specifically, under the ACA, all private health insurance plans must offer "essential health benefits." However, many of these essential benefits can be limited in scope and duration. Ultimately, even though the ACA provides an expansive form of health insurance coverage, the ACA does not provide the same type of comprehensive coverage available under the No-Fault Act, especially for the catastrophically injured.

3. Uncoordinated PIP Policies

Although not as common as coordinated policies, many Michigan citizens have purchased uncoordinated No-Fault coverage. They have done so either because they do not have health insurance available to them, or because they want to avoid some of the complexities and pitfalls associated with coordinated coverages. As previously stated, an uncoordinated No-Fault policy pays benefits without regard to whether there are other private insurance coverages. An uncoordinated policy makes life a great deal simpler for auto accident victims. That is because victims drawing benefits from uncoordinated policies do not have to deal with both health and PIP insurers at the same time. In addition, in most cases, victims who draw benefits from uncoordinated policies do not have to worry about a PIP insurer placing a lien against their tort liability claim (See Chapter 6, Section E, for a complete discussion about liens on tort liability claims.).

Finally, uncoordinated policies create the possibility that, in certain limited circumstances, an injured person may have the legal right to "double-dip" and have medical expenses payable under the PIP policy as well as the health insurance policy. In recent years, the appellate courts have considerably narrowed when a double-dip situation can, if ever, occur. However, if a PIP policy and a health insurance policy are both truly uncoordinated and have no language whatsoever prohibiting duplication of
benefits, an injured person remains, theoretically, entitled to a double recovery on the basis that a higher premium was paid to obtain two uncoordinated coverages.\textsuperscript{64} However, in the case of \textit{Harris v ACIA and Blue Cross/Blue Shield},\textsuperscript{65} the Supreme Court set forth very significant limitations on the right to double-dip in the case of a motorcyclist who was injured when he was struck by an automobile. In that situation, due to the language of the health insurance policy and the fact that the injured person was drawing benefits under a policy purchased by someone else, there was no right to double-dip.

\textbf{SECTION E  \hspace{1em} INDEPENDENT MEDICAL EXAMINATIONS}

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 undergo “a mental or physical examination by physicians.” This section does not give the insurer the right to send claimants to other types of practitioners, such as psychologists or neurophysiologists. Moreover, the right to conduct such an examination (often referred to as an “independent medical examination” (IME)) 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.

\textbf{SECTION F  \hspace{1em} PENALTIES FOR NON-PAYMENT OF NO-FAULT PIP 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. These basic penalties are (1) penalty interest and (2) penalty attorney fees.

\textsuperscript{65}Harris \textit{v} ACIA and Blue Cross/Blue Shield, 494 Mich 462 (2013).
The statute does not make reference to any other penalties that can be imposed on a PIP insurer that does not honor its obligation to pay benefit. These two statutory penalties are summarized below.

1. **Penalty Interest**

Section 3142 of the No-Fault Act states that when an insurance company does not pay PIP 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% 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.” Therefore, 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% interest penalty is collectible.\(^66\) 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 PIP benefits are “overdue” and “if the court finds that the insurer unreasonably refused to pay the claim or unreasonably delayed in making proper payment.” This requires a showing of two elements. First, it must be shown that the claim is “overdue” because an insurance company did not make payment within 30 days after receiving reasonable proof. Second, the court must find that the delay or denial was “unreasonable.” This latter point is significant because it requires a judicial finding of unreasonableness. As a practical matter, such a judicial finding cannot occur until there has been a trial or other motion that sets forth evidence of the insurance company’s conduct. Nevertheless, if an injured person can meet the required showing, Michigan courts have 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.\(^67\) A claimant’s ability to claim attorney fees turns about the unique facts and circumstances of each case.


Motorcyclists are not required to buy mandatory auto No-Fault insurance. However, motorcyclists sustaining injury in accidents involving motor vehicles are entitled to full payment of No-Fault PIP benefits. Therefore, motorcycle accidents create a separate and distinct class of claimants who are subject to certain special rules, which are summarized in this Chapter.

**SECTION A  MOTORCYCLIST ENTITLEMENT TO NO-FAULT PIP BENEFITS**

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 involves “a motor vehicle,” which 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 Chapter 2.

Section 3113 of the No-Fault Act also contains two important disqualifications applicable to motorcycle owners. First, 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 PIP benefits in a motorcycle–motor vehicle accident. This disqualification, however, extends only to the owner or registrant of the motorcycle. In other words, a non-owner passenger on board an uninsured motorcycle
is not prohibited from recovering PIP benefits. Second, a motorcyclist who operates a motorcycle as to which he was named as an excluded operator is not eligible to recover No-Fault PIP benefits in a motorcycle-motor vehicle accident. Thus, it is very important for motorcyclists to know who is listed as an excluded driver on their policy.

SECTION B IDENTIFYING THE RESPONSIBLE NO-FAULT PIP INSURER IN MOTORCYCLE CLAIMS

The priority rules applicable to motorcycle accidents are contained in Section 3114(5) of the statute. This Section 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 Assigned Claims Plan, which is discussed in Chapter 3.

SECTION C THE INTERPLAY BETWEEN HEALTH INSURANCE AND PIP BENEFITS IN MOTORCYCLE CLAIMS

What happens when an injured motorcycle operator or passenger has health insurance and is also entitled to No-Fault PIP benefits? The answer to this question can be quite complicated. The No-Fault insurer of the motor vehicle involved in the accident must pay the medical expenses of the injured person on a primary basis without regard to whether the injured person also has health insurance. If the injured motorcyclist is also covered under a health insurance policy, that health insurance policy may, in very limited circumstances, also be obligated to pay benefits, unless that health insurance policy has coordination or exclusionary language that makes health insurance coverage secondary. If the health insurance policy does not contain such language, a very rare “double recovery” situation could exist. There are also rare situations where injured motorcyclists are required to collect No-Fault PIP benefits from their own auto insurer because the motor vehicle involved in the accident was uninsured. In those situations, any health insurance available to the injured motorcyclist will pay on a primary basis if the injured person’s auto No-Fault insurance policy was a “coordinated benefits” policy. This can be a complex issue and will often require a more complete legal analysis depending upon the specific facts of the case.
SECTION D  MOTORCYCLE ACCIDENTS IN OTHER STATES

The No-Fault Act also provides that a Michigan resident who sustains injury operating or riding a motorcycle in another state can recover No-Fault PIP benefits, as long as the motorcyclist was, at the time of the accident, a named insured under a Michigan auto No-Fault insurance policy or was the spouse or resident-relative of someone who was insured under a Michigan auto No-Fault insurance policy. In that situation, the Michigan motorcyclist would recover No-Fault PIP benefits directly from the motorcyclist’s auto No-Fault insurer. Presumably, in order to recover PIP benefits in an out-of-state accident, it would be required to show that the injury arises out of a “motor vehicle accident,” as opposed to an accident solely involving motorcycles. However, that point has not been specifically addressed by Michigan Appellate Courts and the issue is not absolutely clear. This is because the out-of-state accident provisions of Section 3111 of the No-Fault Act speak only about “accidental bodily injury suffered in an accident occurring out of this state.” This section does not refer to a “motor vehicle accident.” However, it is unlikely that a motorcyclist could recover PIP benefits if they are injured in an accident occurring outside of Michigan that did not involve a motor vehicle in some way.

SECTION E  SPECIAL MOTORCYCLE NO-FAULT FIRST-PARTY COVERAGE

Motorcyclists should also be aware that there is a special form of medical insurance that motorcycle owners can purchase as optional coverage. This optional coverage is referred to in Section 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 Section 3107(1)(a) of the Act. Optional motorcycle PIP coverage can be purchased on a primary or coordinated basis.
SECTION F THE HELMET LAW AND ITS IMPACT ON NO-FAULT PIP BENEFIT ELIGIBILITY

In 2012, the Michigan Legislature passed a new law (MCL 257.658 et seq.) that permits motorcyclists, under certain circumstances, to legally ride a motorcycle without wearing crash helmets. One such requirement for a motorcyclist to legally ride without a crash helmet is that the motorcyclist purchase $20,000 “first-party medical benefits,” as described above. As previously stated, these benefits are different from and should not be confused with traditional PIP benefits. Therefore, if a motorcyclist chooses to ride without a helmet and is injured in a motorcycle-motor vehicle accident, the motorcyclist should be entitled to PIP benefits, regardless of the helmet law.

SECTION G BODILY INJURY TORT LIABILITY CLAIMS FOR MOTORCYCLISTS

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% comparatively negligent. To learn more about the subject of liability claims, see the detailed information presented in Chapter 6 of this brochure.
Although the No-Fault Act was primarily intended to benefit people who suffered bodily injury in motor vehicle accidents, the law has also had a significant impact on medical providers who render the care and rehabilitation that is necessary to properly treat auto accident victims. In recent years, the rights of medical providers to obtain payment for their services have come under increasing pressure. Now, more than ever, medical providers need to be knowledgeable about their legal rights under the No-Fault Law, so they can be proactive in the protection of those rights. This Chapter will briefly discuss various issues relating to medical providers and their role in the Michigan No-Fault system.

SECTION A  NO-FAULT IS NOT MANAGED CARE

When the Michigan Legislature enacted the No-Fault 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 No-Fault Act is purely a fee-for-services system obligating a No-Fault insurer to pay all allowable expense benefits, as defined in the statute. The No-Fault 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, in Morgan v Citizens Insurance Company, the Michigan Supreme Court has held “the No-Fault Act preserves to the injured person a choice of medical service providers.” 68 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

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accommodations for an injured person’s care, recovery or rehabilitation” as required by Section 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 Insurance Company. For patients in that situation, see the earlier discussion in Chapter 3 entitled “Managed Care Health Plan Complications.”

SECTION B THE PRE-AUTHORIZATION OF PAYMENT ISSUE

There is no legal authority in the 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 No-Fault Act is not a managed-care system, but a fee-for-services system. Therefore, patients and their medical providers are not obligated to obtain pretreatment authorization from No-Fault insurance companies. However, while patients or providers are not required to obtain preauthorization, a No-Fault insurance company is also not obligated to provide preauthorization of payment to an injured person if requested to do so. This means that a patient must incur a medical expense at the risk of the No-Fault insurer refusing to pay for the expense. (See Chapter 3, Section B for a discussion of the “incurred” requirement.).

SECTION C THE USE OF CASE MANAGERS

No-Fault insurance companies frequently hire case managers to assist the insurance company in processing an injured person’s claim for benefits. As stated above, the No-Fault Act allows the injured person to choose his or her own medical providers. Therefore, an injured person is not required 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 has the right to stop working 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 Section 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 imply that a case manager’s first loyalty is to the patient, not the insurance company that pays for the case manager’s services.

SECTION D  FEE SCHEDULES AND MEDICAL BILL AUDITING

Recently, many insurance companies have refused to pay the full amount of a doctor bill or hospital charge because the insurance company claims the charges are not “reasonable” within the meaning of Section 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 Section 3107(1)(a) of the statute. See Munson Med Ctr v Auto Club Ins Ass’n69 and Mercy Mt Clemens Corp v Auto Club Ins Ass’n. 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,70 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.

**SECTION E  THE LEGAL RIGHTS OF MEDICAL PROVIDERS**

1. **The New Normal: Covenant v State Farm**

For the last two decades, decisions from the Michigan Court of Appeals have consistently held that medical providers who render care to motor vehicle accident patients have a direct legal right to sue auto insurance companies who do not pay the provider’s charges. Based on those Court of Appeals decisions, it became common practice for medical providers to file lawsuits, in their own name, against no-fault insurers who denied the provider’s charges. All of that, however, dramatically changed in 2017 when the Michigan Supreme Court issued its decision in *Covenant v State Farm,* In the *Covenant* case, the Michigan Supreme Court overturned all of that longstanding precedent and held that providers do not have a direct, independent legal cause of action against no-fault insurance companies to enforce payment of the provider’s charges because the no-fault statute itself did not specifically confer such a right. In this regard, the Court held, “*We therefore hold that health care providers do not possess a statutory cause of action against no-fault insurers for recovery of personal protection insurance benefits under the no-fault act.*” In so holding, the Court decreed that it is only the patient who possesses the direct legal right to sue no-fault insurance companies for non-payment of no-fault benefits.

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73Covenant, supra, at 196.
2. **Provider Options in the Post-Covenant World**

Even though the *Covenant* decision marks a radical departure from prior appellate court rulings, it does not mean that medical providers have no legal remedies to protect their interests in getting paid for services they render to auto accident victims. Set forth below is a brief discussion about the rights that providers continue to possess to enforce payment of their charges in this post-*Covenant* world.

**a. Legal Enforcement Actions Against Patients**

Even though the Supreme Court in *Covenant* held that providers cannot sue no-fault insurance companies for payment of services, the provider retains the right to legally pursue the patient for non-payment of services rendered by the provider. If a provider does file a lawsuit against a patient for non-payment of services, a question arises as to whether the patient’s insurance company would have a duty to defend the patient in such a lawsuit. In an old ruling by the Michigan Insurance Commissioner in *Insurance Bulletin 92-03*, the Commissioner declared that a no-fault insurance company would be required to provide such a defense to the patient if sued by the provider. Such a declaration by the Commissioner, however, is probably not legally binding.

It should also be noted that, some no-fault insurance companies have recently taken the position that medical providers are legally precluded from pursuing collection actions against their patients and, in fact, in some cases, insurance companies have asked trial courts to bar such provider collection actions. The authors believe that such a legal theory has no validity, especially given the Supreme Court’s decision in *Covenant*. Therefore, it is reasonable for providers to conclude that they have the legal right to pursue their patients directly to collect the unpaid balance for services rendered by the provider to the patient until the Michigan Appellate Courts rule otherwise.

**b. Provider Intervention Actions**

It is clear under the *Covenant* decision, that the patient has the legal right to file a lawsuit directly against the patient’s no-fault insurance company for non-payment of services rendered to the patient. If a patient files such a lawsuit, it would appear under prior appellate case law, that the provider would have the right to “legally intervene” in the patient’s lawsuit, under certain provisions in the Michigan Court Rules, in an effort to better protect the provider’s interests. The extent to which an intervening provider would be permitted to directly participate in a patient’s lawsuit, however, has not yet been clearly determined in the post-*Covenant* world. Nevertheless, providers should be aware that they likely have “intervention rights” that could be exercised in the context of patient-filed litigation.
c. **Patient Assignment of Benefits**

It is important to note that in Footnote 40 of the *Covenant* decision, the Supreme Court recognized the legal principle that a patient’s right to legally pursue an insurance company for payment of a provider’s charges may properly be assigned by the patient to the provider, who can then pursue, in the provider’s name, the patient’s legal right to collect from the insurance company. Specifically, Footnote 40 states, “Moreover, our conclusion today is not intended to alter an insured’s ability to assign his or her right to past or presently due benefits to a health care provider.” This right of a patient to assign benefits to a provider has become a major focus in the post-*Covenant* world. In order to better understand this issue, it is important for providers to appreciate certain legal principles applicable to assignments of benefits.

An “assignment of rights” is a legal device that allows a party who has a clearly established legal right to sue a particular defendant, to assign that right to another party to pursue that right. The no-fault statute implicitly recognizes the viability of the assignment mechanism by virtue of the provisions of Section 3143 of the Act. That is the only provision in the No-Fault Act that specifically references assignment of benefits and it simply states that, “an agreement for assignment of a right to benefits payable in the future is void.” Therefore, this statutory provision seems to clearly imply that, as long as an assignment is limited to enforcing the patient’s right to recover payment for services that were rendered in the past (as opposed to the future), the assignment would be valid. Indeed, such an interpretation was recognized in the case of *Professional Rehabilitation Associates v State Farm*. In that case, the Court of Appeals held that it is only the assignment of a future right to PIP benefits that is prohibited under the No-Fault Act.

It is becoming abundantly clear that a number of legal issues are likely to arise in the post-*Covenant* world regarding the extent to which patients can assign their legal rights to their providers to receive payment for services rendered by the provider to the patient. Some of these problems are briefly discussed below:

- **Problem #1: The Anti-Assignment Clause**

Some insurance companies have inserted language in their insurance policies that prohibits a patient from assigning benefits. Typically, this language states something to the effect that the patient may not assign any benefits under the policy and, in the event of such an assignment, the assignment becomes void. Even though the Supreme Court’s decision in *Covenant* seems to imply that an assignment of benefits by a patient to a provider is valid, it is important to recognize that the Supreme Court was not specifically asked to decide the issue of what would happen if the patient’s insurance

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policy actually prohibited such assignments. Therefore, this unresolved issue should be a matter of concern for providers. Moreover, this issue clearly illustrates the fact that if providers choose to obtain and utilize patient assignments, they must exercise great care in drafting these assignments so that they are precise and legally proper.

- Problem #2: Prior Claim Precedent Rules

One of the potential problems with patient assignments is the question of what would happen if a lawsuit based on the assignment was actually litigated and resulted in a victory for the insurance company? In that situation, would the insurance company’s victory be procedentially binding on the patient and all other providers who subsequently seek to pursue a legal action against the insurer? Whether such negative consequences would occur depends upon how our appellate courts apply the legal doctrines of res judicata and collateral estoppel. Simply stated, these related doctrines prohibit the re-litigation of issues and claims that were previously decided in an earlier lawsuit. Therefore, if a patient assigns his or her legal rights to a particular provider, and the main issue in that case is whether the patient is legally entitled to recover no-fault benefits, and the provider loses the lawsuit, the question will then be whether the insurance company will now be able to legally refuse payment of all other claims regarding that same patient because the lawsuit resulted in a finding that the patient was not legally entitled to benefits? The same problem arises if a specific factual issue is litigated in an earlier lawsuit, such as whether the patient actually suffered a brain injury in the subject motor vehicle accident and the lawsuit results in a factual determination that no such brain injury was suffered. Can the insurer then argue that neither the patient nor any other medical provider can recover damages for brain-injury-related services? It is clear from the above discussion that medical providers should not think that obtaining patient assignments is a panacea for all Covenant-related problems. This is simply not the case. Providers who solicit assignments from patients should be well aware of the fact that an unsuccessful enforcement action on the assignment may be disastrous to the patient and all other providers.

- Problem #3: Ethical Considerations and the Need for Great Caution

Patient assignments also raise a host of ethical concerns. Are providers and their lawyers, who solicit patient assignments, subject to any ethical constraints in how they may do so? If legal action on the assignment is unsuccessful and the patient is thereby prejudiced by the defeat, is the provider or the provider’s legal counsel liable in any way to the patient? These are all very serious questions that require providers to exercise great caution in how they approach the issue of patient assignments. Before taking any action, providers are well advised to reach out to the patient to determine if the patient has legal counsel and then to discuss the collection issue with the patient’s legal counsel before the provider makes any decision about whether to solicit and enforce a patient’s assignment of benefits.
CHAPTER 6

THE BODILY INJURY TORT LIABILITY CLAIM

As stated in the Introduction to this brochure, the Michigan No-Fault Act has preserved the right of seriously injured auto accident victims to pursue “tort liability claims” against the at-fault drivers who have caused the injury. These tort claims are primarily intended to recover compensation for various losses and damages that are not compensable by No-Fault PIP benefits. However, it is important to note that the No-Fault statute has placed significant limitations on the right to pursue these bodily injury tort liability claims. This Chapter will discuss the legal rules and procedures applicable to tort liability claims.

SECTION A  BASIC PRINCIPLES OF THE BODILY INJURY TORT LIABILITY CLAIM

If a person sustains bodily injury in a motor vehicle accident caused by the fault (i.e., negligence) of another motorist, the 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 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.

SECTION B CLAIMS FOR NONECONOMIC LOSS

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 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 that, in Section 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, 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.

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On July 31, 2010, the Michigan Supreme Court overruled its earlier decision in *Kreiner v Fischer* in the case of *McCormick v Carrier*. 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 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 No-Fault Act also provide that noneconomic damages are not recoverable if the injured person is more than 50% 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.

**SECTION C CLAIMS FOR EXCESS ECONOMIC LOSS**

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 for an extended period of time and, as a result, will sustain a loss of income beyond the three-year No-Fault work loss

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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% comparatively negligent or where the injured person was the owner and operator of an uninsured motor vehicle involved in the accident.

**SECTION 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 No-Fault Act 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 E LIENS ON TORT LIABILITY CLAIMS

Every tort liability claim requires a careful analysis of whether there are any potential liens that could be asserted against any monetary recovery resulting from that claim. Typically, such liens are asserted by insurance companies or other payors who pay benefits to an injured person who pursues additional compensation through a tort claim. If the lien is valid and substantial, it can have enormous implications for auto accident victims who pursue tort liability claims.

There are several types of liens that can potentially apply to auto tort liability claims. The first is a lien claimed by auto No-Fault insurers who pay PIP benefits to the injured person. Such liens are very limited and controlled by Section 3116 of the No-Fault Act, and mainly arise in out-of-state accidents.

Another type of lien is a workers’ compensation lien, which can occur when a person suffers an auto accident injury in the course of his or her employment. These liens are controlled by the Michigan Workers’ Compensation Act and important appellate case law.77

Yet another type of lien is one asserted by a health insurance company or plan that pays medical expenses on behalf of an injured person. If the benefits were paid by a traditional health insurance policy, then the health insurer’s lien rights are very limited and are typically treated the same as the liens of PIP insurers.78 However, if the medical expenses were paid by a self-funded ERISA health plan, the lien can be very broad because the lien is controlled by federal law, which gives lien holders more expansive rights.

The Medicaid and Medicare programs may also have lien rights with regard to auto tort liability claims. These liens are asserted on behalf of governmental bodies and controlled by detailed state and federal law. Proper processing of the PIP benefit claim can often avoid altogether or substantially reduce these liens.

77Great American v Queen, 410 Mich 73 (1980).
A complete discussion regarding tort liens is beyond the scope of this publication. **Suffice to say, however, that the issue of a potential lien must be carefully considered in all auto liability claims in order to protect the injured person’s right to receive monetary compensation for their injuries.**

**SECTION F LIABILITY CLAIMS FOR UNINSURED AND UNDERINSURED MOTORIST BENEFITS**

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.

1. **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.

   There are certain strict rules that must be followed so that an uninsured motorist claim is not jeopardized, particularly in the case of hit-and-run accidents. Many insurance policies contain specific rules about what a victim must do in order to preserve a claim for uninsured motorist benefits when there is a hit-and-run. Moreover, the Michigan Supreme Court has strictly enforced these notice rules, even in extreme situations. For example, in 2012, the Michigan Supreme Court issued **DeFrain v State Farm Mutual Automobile Insurance Company,**79 where it held that an insurer could deny uninsured motorist benefits to seriously injured victim of a hit-and-run because the victim did not

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provide timely notice, despite the fact that the victim was incapacitated. Therefore, extreme caution is necessary to protect these claims!

2. Underinsured Motorist Benefits

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.

As with uninsured motorist claims, 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. Once again, extreme caution is necessary to protect these claims!

SECTION G  TIME LIMITATIONS ON LIABILITY CLAIMS

As a general rule, a tort liability action against the at-fault driver must be filed within three years from the date of the motor vehicle collision. However, when a person intentionally injures another with a motor vehicle, the injured person will have an intentional tort action against the wrongdoer that may be subject to a two-year statute of limitations. There can be exceptions to these general rules for minors and people who are deemed to be mentally incompetent and unable to protect their own legal rights. Furthermore, in wrongful death actions, the three-year statute of limitations can be extended depending upon when the personal representative of the decedent’s estate is appointed. However, whether any exceptions apply to a particular statute of limitations requires careful analysis of the facts of each case by an experienced attorney.

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80MCL 600.5805 (10).
81MCL 600.5805 (2).
82MCL 600.5851 et seq.
It is also very important to understand that the time limitations for uninsured and underinsured motorist benefits are based upon the terms of the insurance policy providing those benefits. These policies can include strictly enforced rules about when the insurance company must be notified about the subject collision, and when the injured person must provide notice to the insurance company about his or her intention to bring a claim for uninsured or underinsured motorist benefits. If the injured person does not abide by these notice requirements, he or she may be prohibited from pursuing the claim altogether. Furthermore, it is possible for these policies to include a time limitation that is shorter than the general statute of limitations period. Therefore, it is critically important for the injured person to closely examine the terms of any applicable insurance policy providing uninsured or underinsured motorist benefits to determine all the pertinent time limitations that must be followed in order to preserve and protect any claim for those benefits.

SECTION H LIABILITY CLAIMS BETWEEN FAMILY MEMBERS AND “STEP-DOWN” PROVISIONS

Some insurance companies sell auto insurance policies that contain very controversial provisions known as “step-downs.” These provisions apply most often when one family member (e.g., spouse, child, parent, sibling, etc.) pursues a tort liability claim under that policy against another family member with whom they live. Step-down provisions can also apply when the policy holder or a member of his or her family is injured while riding in a family vehicle driven by a non-family member. Step-down provisions reduce the amount of liability insurance coverage available to the injured family member down to the state-mandated minimum of $20,000, regardless of how much liability insurance was purchased by the policy holder or the severity of the injury. In other words, these provisions treat the policy holder and his or family members more harshly than strangers injured in the same accident. Unfortunately, Michigan appellate courts have upheld an insurance company’s enforcement of step-down provisions, even in catastrophic injury cases. Sadly, few people know that that they have a step-down provision in their policy until it is too late.
Even though the Michigan No-Fault Act, as written, creates broad and expansive legal rights for seriously injured persons, those rights can be jeopardized if injured persons do not clearly understand the nature of their rights and the many things that should be done to protect them. Set forth below are some specific suggestions for protecting an injured person’s claim for PIP benefits and the injured person’s tort liability bodily injury claim.

SECTION A  PROTECTING THE PIP BENEFIT CLAIM

It is very important for an injured person to move quickly to establish their right to receive No-Fault PIP benefits so that necessary medical treatment is not delayed or denied. Among other things, the PIP benefit claimant should do the following:

(1) Determine whether the injury occurred in such a manner as to create eligibility for No-Fault PIP benefit coverage.

(2) Determine the appropriate insurer that has priority responsibility for payment of the PIP claim.

(3) Submit appropriate written notice of the claim that fully complies with Section 3145 of the Michigan No-Fault Act. This is particularly important with regard to the description of injuries, which must be thorough and comprehensive.

(4) Take photographs of the injuries and the vehicular damage.

(5) In cases of serious injury, determine whether the accident victim would benefit from the services of an independent case manager. If so, the patient’s primary physician should be asked to write a prescription for case management services.
(6) Be mindful of the time limitations applicable to enforcing claims for PIP benefits—particularly the one-year-notice rule and the one-year back rule.

(7) If the No-Fault policy is a coordinated policy, determine whether the patient’s health insurance plan is applicable to auto injuries and, if so, any limitations with respect to coverage under that plan.

(8) Submit all claims for No-Fault benefits in writing, with proper documentation complying with the “reasonable proof” rule. Copies of all submitted correspondence should be retained to document the fact that it was submitted.

(9) At the first sign of claim denial or claim dispute, consult with a professional who has specialized expertise in matters dealing with the Michigan No-Fault Law.

**SECTION B  PROTECTING THE BODILY INJURY TORT LIABILITY CLAIM**

Where motor vehicular accidents result in serious injury or death as a result of the fault of another driver, the injured person or the person’s estate should immediately determine whether a tort liability claim should be pursued. 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 be taking quick action to conduct a thorough investigation for purposes of building a defense to the claim. Therefore, the injured person should also move quickly and do certain things to protect the tort liability claim, which include the following:

(1) The injured person should initiate a thorough investigation through an appropriate investigator or legal representative. Such an investigation should include interviewing witnesses, photographing the scene and the vehicles involved in the accident, taking measurements, collecting physical evidence, interviewing police officers, etc.

(2) The injured person should arrange for photographs to be taken of the injuries and the course of treatment. This is particularly true in cases involving visible injuries such as burns, wounds, surgical scarring, etc. Such photographs should be taken with excellent equipment, so as to insure proper detail.
(3) The injured person should avoid speaking with investigators or insurance adjusters representing the interest of the party at fault. Frequently, such discussions are contrary to the best interests of the injured person.

(4) The injured person should refuse to sign any documents, releases, or other types of authorizations that have been requested by investigators or insurance adjusters representing the interest of the party at fault.

(5) The injured person should avoid conducting any 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:

a. The victim is reasonably certain that he or she has fully recovered from all accident-related injuries;

b. The victim has fully investigated the accident and knows the identity of any and all potential defendants and insurance companies who may have liability;

c. The release is only a release of the liability claim and not a release of any other rights the victim may have;

d. The victim has completely researched whether such a settlement will jeopardize other claims the victim may have against other parties or against the victim’s own insurance company for additional benefits, such as uninsured or underinsured motorist benefits; and

e. 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 cannot “undo the deal.”
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 visit the informational website, www.autonofaultlaw.com. Also, please feel free to contact the authors of this brochure.

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MAY 2018
About the Law Firm

The Sinas Dramis Law Firm was started in 1951 in Lansing, Michigan by Thomas G. Sinas, who was joined a short time later by his friend, Lee C. Dramis, to establish the firm that bears their name today. Over the many years since it was founded, the Sinas Dramis Law Firm has primarily focused its practice on the representation of seriously injured patients and their providers throughout the state of Michigan, particularly in cases involving motor vehicle collisions. Their practice in this field of law includes cases involving semitruck collisions, motorcycle accidents, bicycle injuries, pedestrian injuries, and claims for no-fault PIP benefits on behalf of patients and medical providers.

The attorneys at the Sinas Dramis Law Firm have also been very involved in professional leadership activities. In that regard, one of its partners was President of the State Bar of Michigan; three partners were Presidents of the Michigan Association for Justice; two partners were Chairs of the State Bar Negligence Law Section; and two partners were Presidents of the Ingham County Bar Association. The Sinas Dramis Law Firm has offices in Lansing, Michigan, Grand Rapids, Michigan, Kalamazoo, Michigan, St. Clair Shores, Michigan and Chicago, Illinois.

The law firm has also been extensively involved in numerous activities designed to educate consumers and professionals about the operation of the Michigan Auto No-Fault Law, including writing, lecturing, teaching, and testifying about that subject in many different forums. The law firm’s commitment to informing Michigan citizens of their legal rights has recently resulted in the law firm creating a series of informational websites dedicated to “Helping People Know the Law.” These websites contain very helpful and practical legal information that is essential for the public to know—particularly with regard to matters dealing with personal injury.
“Helping People Know the Law”

The Sinas Dramis Law Firm has developed a network of sites dedicated to help people understand their legal rights regarding personal injury and family law matters. Please visit the following websites to learn more.

- AutoNoFaultLaw.com
- SinasDramis.com
- SDMichiganFamilyLaw.com
- MichiganBicycleLaw.com
- SDChicagoInjuryLaw.com
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