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Reasonable Efforts: Providers Can Make No-Fault Claim Without Appealing Health Insurer's Denial

By: Mark C. Vanneste **December 9, 2016**

St. John Macomb-Oakland Hospital v State Farm, ___ Mich App ___ (2016), for publication on December 8, 2016, involved a December 9, 2011 car accident. The injured party, who was State Farm's insured, had a coordinated no-fault policy and separate health insurance. The insured, who suffered a closed-head injury as a result of the accident, was referred to St. John's partial day hospitalization program for closed-head injuries. St. John made a claim for payment with the insured's health insurer.

St. John's services began on May 6, 2013 and, on November 14, 2013, the health insurer's administrator sent a denial letter to the insured indicating that the partial day hospitalization program was not medically necessary based on the opinion of a physician advisor who reviewed the medical records. The denial also indicated that an internal appeal was available. Additionally, if the claimant disagreed with the internal appeal, the claimant could request an external independent review.

On January 9, 2014, St. John requested a similar denial letter with regard to other dates of service so that it could request payment from State Farm, which it did. After State Farm refused to pay, St. John filed a complaint. State Farm moved for summary disposition arguing that St. John had failed to make reasonable efforts to obtain payment from the health insurer because it had failed to pursue the available appeal. The trial court denied State Farm's motion finding that there was a genuine issue of material fact regarding whether St. John had made reasonable efforts with the health insurer.

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Since the Supreme Court decided *Tousignant v Allstate* in 1993, it has been clear that a claimant is required to make *reasonable efforts* to obtain payment from a health insurer when there is a coordinated policy involved. Only once the claimant has done so and the claim has been denied is the no-fault carrier potentially liable. What constitutes reasonable efforts has been a point of contention.

In this published opinion issued on December 8, 2016, the Court of Appeals ruled that simply making a claim with a health insurer and being denied is enough to qualify as reasonable effort. This is the case even when the claimant fails to take readily available steps to make an internal or external appeal of the health insurer's denial. Exhausting the health insurer's appeal process is not necessary for the claimant to demonstrate that reasonable efforts have been made.

After the denial, State Farm filed a motion for reconsideration arguing that St. John had failed to submit evidence showing that it made reasonable efforts. State Farm also argued that the trial court had improperly shifted the burden of proof, forcing it to demonstrate that the health insurer had made an incorrect determination. The trial court agreed and ultimately granted State Farm's motion dismissing the case. St. John appealed.

On appeal, the Court of Appeals noted that the limited issue was whether St. John had produced evidence that it made reasonable efforts to obtain payment from the health insurer before seeking payment from State Farm. St. John argued that it should not have been required to appeal the health insurer's denial. The Court of Appeals ultimately agreed with St. John and reversed the trial court's decision.

The *St. John* Court first pointed out that, when an individual chooses to coordinate his no-fault coverage and health insurance coverage, the health insurer is primary. In *Tousignant v Allstate Ins Co*, 444 Mich 301; 506 NW2d 844 (1993), the Michigan Supreme Court cited a previous decision standing for the proposition that a plaintiff must "use reasonable efforts to obtain payments that are available." State Farm and St. John disputed what actions St. John was required to take in order to establish that it had made reasonable efforts.

While the Court of Appeals agreed that a claimant must take *some action* toward receiving payment from the health insurer before seeking payment from the no-fault insurer, the Supreme Court did not specify what actions must be taken in order to establish that "reasonable efforts" had been made. Whereas in *Tousignant* the plaintiff made no efforts at all to obtain benefits from the health insurer, St. John did make *some effort*. A claim was made with the health insurer and was denied. The *St. John* Court concluded that making a claim qualified as "reasonable effort" and that St. John did not have a requirement to appeal the medical necessity determination.

The *St. John* Court also discussed a more recent opinion in *Adanalic v Harco Nat'l Ins Co*, 309 Mich App 173; 870 NW2d 731 (2015). In that case, the Court decided whether a no-fault insurer was excused from paying benefits when a claimant had a worker's compensation claim denied and did not pursue appeal. The *Adanalic* Court pointed out that both the worker's compensation system and the no-fault system are intended to provide prompt payment of benefits and that the claimant should not need to engage in lengthy and costly challenges of denials in order to turn to the no-fault insurer. Likewise, the *St. John* Court opined that the purpose of the coordinated benefits statute was to prevent duplicative recovery and that, in this case, St. John would not receive benefits from two sources.

Lastly, the *St. John* Court differentiated the circumstances here from that in *Farm Bureau Gen Ins Co v Blue Cross Blue Shield of Mich*, 314 Mich App 12; 884 NW2d 853 (2015). In that case, Blue Cross had a participation agreement with a provider under which the provider assumed financial responsibility for the services provided to the insured. The agreement also required that the provider followed certain pre-authorization requirements and detailed an appeals process for an initial denial. After Blue Cross approved and paid for 14 days of treatment denying additional time, the provider simply submitted the claim to the patient's no-fault carrier.

The *Farm Bureau* Court concluded that under "unique circumstances" neither the no-fault insurer nor the health insurer was responsible for payment because of the provisions in the agreement between Blue Cross and the provider. More specifically, the provider had agreed to assume full financial responsibility for claims that were denied as medically unnecessary. Therefore, the patient did not have any legal responsibility for payment and it was, therefore, not incurred by her absolving the no-fault carrier of liability for the bill. The *St. John* Court differentiated this case because the provider's contract with Blue Cross was the dispositive circumstance.

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