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Prepared: 06/01/10

Addressing Denial of Medical Payments Coverage ("PIP")

Medical payment coverage ("PIP") is often provided through a patient's automobile policy. This type of coverage is an option available to a insured since it is not mandated by state law. New statutes now establish a minimal coverage at ten thousand dollars ($10,000). This new statute became effective with policies issued after November 1, 2009. Health care providers - particularly Chiropractors – can experience difficulty in receiving prompt payment under these medical pay provisions. Automobile policies will provide medical pay coverage to both the named insured and all passengers in the named insured's vehicle who sustained injuries in an automobile accident, **regardless as to the fault for that accident**. Unfortunately, the patients who rely upon this coverage for payment of health care bills occasionally find that insurance companies are less than responsive in providing that coverage when claims are submitted. There are generally **four (4) arguments used by insurance companies** in denying or limiting payment of medical pay coverage.

First, the insurer will assert that medical pay coverage is only "secondary" to another health insurance policy available to the patient. Obviously, if the patient does not have health insurance coverage, the medical pay coverage applies and becomes "primary" as a source of payment for claims. If this type of assertion is made, a Chiropractor may wish to have his **patient produce a copy of the automobile policy** to determine the accuracy of this argument. Even if this assertion is accurate, the Chiropractor should remind his patient that any deductible amounts not covered by health insurance can still be submitted to the automobile insurer for medical pay coverage.

A second argument often made by the insurer is that the **treatment is either unreasonable or unnecessary**. In these situations, the Chiropractor has **several options available**. First, the Chiropractor should **send a letter** to the automobile insurer requesting a **detailed explanation** of the basis for denying payment. In addition, the doctor should insist that all communication relating to reasonableness or necessity of treatment be **addressed directly to the doctor's office**, rather than through the patient. The doctor should also request a thorough explanation of the

"appeals" process available to the patient/insured in challenging the determination denying coverage. Finally, the Chiropractor may wish to request **an assignment of rights or claims** from the patient so that further legal action can be initiated directly by the treating doctor. The advantage of this approach is discussed later.

The final argument often made for denying medical pay coverage is that the **claims where not timely submitted** or that the insurer requires "further information" before the claim can be paid. Generally, the only time limitation associated with the submission of claims is that many policies have language allowing payment only on claims incurred **within one (1) year of the accident**. In other respects, the insurer has a "good faith" duty to its insured to promptly and reasonably pay all claims. As such, the insurer cannot wait an unreasonable length of time before paying the claim. If those situations develop, the Chiropractor should remind the insurer of its duty to the policy holder and the provisions of the Wisconsin Administrative Code requiring "prompt" handling of all insurance claims.

A final argument commonly asserted is based upon a **"contractual" obligation** of the doctor to submit claims to a health insurer rather than the medical pay provider. This argument may be persuasive in situations where the doctor is part of an HMO or other preferred provider plan. In those situations, the doctor may have contractually agreed to treat patients for substantially **lower reimbursement rates** than those rates paid under medical pay provisions. However, in most situations, the patient has the ultimate right to determine whether claims are paid through PIP coverage or (the non-HMO/preferred provider) health insurance plan. The doctor may wish to remind the patient that he/she is the **insured who can determine the choice of coverage** and avoid deductibles/co-payments if claims are submitted through automobile, medical payments coverage.

Concerning trend involves injured patients' attorneys who are insisting upon the use of health insurance. This request is often made as a means of maximizing their clients' (patients') recovery by minimizing the rate of reimbursement to the doctor. In these situations, the doctor may be able to claim **full** reimbursement for charges from PIP coverage **after** reduced reimbursement payments by the health insurer. This option is again difficult to assert or not available in the HMO/preferred provider situation.

In the final analysis a Chiropractor experiencing difficulty in receiving payments under medical pay coverage may need to **consider legal representation**. In Wisconsin, only the patient, and not the treating doctor, has standing to file litigation against the insurer for an unreasonable denial of medical pay benefits. As noted earlier, the Chiropractor may be able to have the **patient sign an Assignment of Claim form** which would transfer or assign all of the patients rights directly to the Chiropractor. Assignment of Claims forms are legally enforceable documents which would allow the doctor to directly sue the Insurance Company.

There can be interesting results when a Chiropractor aggressively pursues medical pay coverage or takes an Assignment of Claim directly from the patient. It has been this office's experience that many disputes are often quickly resolved following the mailing of a letter directly from counsel representing the Chiropractor. In other situations, a **small claims action** can be filed since the amount in dispute is often under $5,000.00. In those situations, most insurance companies will either pay the claim or negotiate a compromise on the claim in order to avoid the cost of litigating in small claims court.

Under unique fact situations, the patient or Chiropractor with an Assignment of claims may even be able to **recover substantial punitive damages for the unreasonable denial of medical pay benefits**. In a noteworthy case from the Federal Court in Oregon, an insurer sued State Farm Automobile Insurance after it denied the payment of a medical claims based upon a phony medical analysis by a doctor whom State Farm regularly relied upon to deny or reduce the claims. Under the facts of this case, it was found that State Farm regularly relied upon "paper reviews" to deny payment of claims when State Farm had a history of utilizing the same outside reviewers who routinely denied claims. In an Idaho case, State Farm delayed payments of medical claims for over three years. The jury awarded the insured damages for the denial of the claim; together with damages for emotional distress and punitive damages of $9.5 million dollars.

Overall, the treating doctor should be aggressive in insisting that the insurance company provide a detailed explanation for the denial of any claims. Also, all communication with the insurer should be promptly and correctly noted in some written

format to verify the details should litigation ultimately become necessary. The doctor and patient should be **suspicious of utilization reviews which routinely deny payment of Chiropractic claims**. If there are persistent delays or unsatisfactory explanations for delays, the patient and/or doctor may wish to consult with an attorney to determine whether the denial of medical pay benefits can form the basis for a lawsuit against the insurer.