

A Critical View of Minnesota No-Fault

By T. Joseph Kane Crumley¹

The No-Fault Act is the principal legal authority facing those injured in auto accidents in Minnesota.

This article assembles legal issues related to the Act, strategies for claimants, and recommendations for legislative reform of Minnesota insurance law.

Table of Contents

I. THE BENEFITS 4

A. MEDICAL EXPENSES..... 4

 1. *Reasonable charges for necessary treatment*..... 5

 a) ‘Managed Care’ banned from no-fault..... 5

 2. *Palliative Treatment* 6

 a) Massage Therapy..... 6

 3. *Psychiatric treatment*..... 7

 4. *Prosthetics and other objects*..... 7

 5. *Transportation costs* 7

B. NON-MEDICAL BENEFITS 10

 1. *Disability and Income Loss* 10

 a) Unemployed When Injured..... 11

 b) Partial Loss of Earnings 12

 c) Depletion of Sick or Vacation Leave..... 12

 d) Loss of Wages During Treatment 12

 2. *Self-Employment Loss of Earnings*..... 12

 a) Substitute Employees..... 13

 b) Loss of Tangible Things of Economic Value 13

¹ © Copyright 2011 T. Joseph Kane Crumley. Version 5.91a dated 1/23/11. Printed 02/09/11. Portions published in *A No-Fault Arbitration Primer*, MINNESOTA TRIAL LAWYER (Spring 1993), and *An Updated No-Fault Arbitration Primer*, MINNESOTA TRIAL LAWYER (Spring 1999). Updated version available at www.minnesotapersonalinjury.com

Joe studied law at William Mitchell College of Law, while serving as law clerk to two Ramsey County Judges. He is a partner at Bradshaw & Bryant, PLLC. He served as 2007-2008 President of the Minnesota Association for Justice (formerly Minnesota Trial Lawyers Association) and is also past President of both the Warren Burger Inn of Court and the Minnesota Consumer Alliance. He is a Martindale-Hubbell AV-rated attorney and has been named a Super Lawyer many times by Minnesota Law & Politics Magazine. He is a Board Certified Civil Trial Specialist of the Minnesota State Bar Association.

| | | |
|-------------|--|-----------|
| c) | Loss of “Other Earnings from Work” | 14 |
| g) | Loss of a Scholarship | 14 |
| 3. | <i>Replacement Services</i> | 14 |
| a) | Primary Homemaker..... | 14 |
| 4. | <i>Rehabilitation</i> | 17 |
| 5. | <i>Death Benefits</i> | 20 |
| C. | STACKING | 21 |
| II. | COVERAGE | 22 |
| A. | ACCIDENT LOCATION | 22 |
| B. | “LOSS FROM INJURY” | 23 |
| C. | MOTOR VEHICLES | 23 |
| D. | MOTORCYCLES | 25 |
| 1. | <i>Riders</i> | 25 |
| 2. | <i>Pedestrian struck by motorcycle</i> | 25 |
| III. | SOURCES OF COVERAGE..... | 25 |
| A. | COLLATERAL PAYMENTS | 25 |
| 1. | <i>Accident, health, and disability payments</i> | 25 |
| 2. | <i>Medical Assistance</i> | 26 |
| 3. | <i>Coordinating workers' compensation and no-fault</i> | 26 |
| a) | Replacement Services..... | 26 |
| b) | Wages..... | 26 |
| c) | Partial Wage Loss..... | 27 |
| d) | Stacking..... | 27 |
| 4. | <i>Workers' Compensation Denials.</i> | 27 |
| 5. | <i>Other denials</i> | 29 |
| 6. | <i>Work Comp Settlements.</i> | 30 |
| B. | APPORTIONMENT | 30 |
| 1. | <i>Prior accidents</i> | 30 |
| 2. | <i>Settlement of Later Accident</i> | 33 |
| 3. | <i>Prior Non-automobile accidents</i> | 33 |
| C. | CAUSATION STANDARDS | 35 |
| IV. | PRACTICAL ISSUES-DUTIES AND OBLIGATIONS | 36 |
| A. | INSURED’S DUTIES | 36 |
| 1. | <i>Notice to Insurer - Application for Benefits</i> | 36 |
| 2. | <i>Statute of Limitations</i> | 37 |
| 3. | <i>Adverse Exams</i> | 37 |
| a) | Geographic Requirement | 38 |

| | |
|--|-----------|
| b) Duty to Attend Adverse Exam..... | 39 |
| 4. <i>Paper Reviews and Audits</i> | 43 |
| 5. <i>Lapse in Treatment and Disability</i> | 44 |
| 6. <i>Mitigation</i> | 46 |
| B. INSURER’S DUTIES..... | 46 |
| V. AUTO INJURY CLAIMS..... | 47 |
| A. THRESHOLDS..... | 47 |
| B. MEDICAL COSTS OVER \$4,000..... | 47 |
| 1. <i>X-Rays CT scans and MRI scans</i> | 47 |
| VI. DISPUTES..... | 48 |
| A. ARBITRATION..... | 48 |
| 1. <i>Jurisdiction</i> | 48 |
| a) Jurisdictional Amount (\$10,000)..... | 48 |
| (1) Limiting Claims to \$10,000..... | 48 |
| (2) No-fault claims cannot be split..... | 49 |
| (3) Claim may grow to exceed \$10,000 after filing..... | 49 |
| (4) Arbitrating old bills in a new arbitration. | 49 |
| (a) Post hearing, pre-award bills | 50 |
| (b) Pre-hearing undenied bills..... | 50 |
| (c) Missed bills. | 50 |
| c) 30-day Time Limitation..... | 51 |
| d) Timeliness of Jurisdiction Objection. | 51 |
| 2. <i>Subject matter</i> | 52 |
| 3. <i>Filing</i> | 52 |
| 4. <i>Discovery</i> | 52 |
| 5. <i>Hearing</i> | 52 |
| a) Burden of Proof..... | 52 |
| b) Evidence | 53 |
| (1) Admissibility..... | 53 |
| (2) Sufficiency..... | 54 |
| 6. <i>Decision</i> | 54 |
| 7. <i>Judgment and Satisfaction</i> | 54 |
| 8. <i>Appeals</i> | 54 |
| 9. <i>Why Arbitration?</i> | 54 |
| B. EFFECTS OF LITIGATION ON FUTURE CLAIMS | 55 |
| 1. <i>Trial of Underlying Tort Claim.</i> | 55 |
| 2. <i>Settlement of Underlying Tort Claim</i> | 56 |
| 3. <i>Uninsured/Underinsured Motorist Arbitrations</i> | 57 |

| | | |
|----|---|----|
| 4. | <i>No-Fault Arbitration</i> | 57 |
| 5. | <i>No-Fault Settlement</i> | 58 |
| 6. | <i>Prior Worker’s Compensation Decision</i> | 58 |
| 7. | <i>Settlement of Worker’s Compensation Claim</i> | 58 |
| C. | REMEDIES | 59 |
| 1. | <i>Insurers’ Remedies</i> | 59 |
| a) | Mistakenly-paid Benefits v. Intentional Misrepresentation | 59 |
| 2. | <i>Claimants</i> | 59 |
| a) | Costs and Disbursements -Arbitration | 59 |
| b) | Mandatory Interest/Penalty | 60 |
| c) | Attorneys' Fees/Sanctions | 63 |

I. The Benefits

Minn. Stat. § 65B.44, subd.1 states:

Basic economic loss benefits shall provide reimbursement for all loss suffered through injury arising out of the maintenance or use of a motor vehicle . . . consisting of:

\$20,000 for medical expense loss arising out of injury to any one person; and

(b) a total of \$20,000 for income loss, replacement services loss, funeral expense loss, survivor's economic loss, and survivor's replacement services loss arising out of the injury to any one person.

The Act requires that there be an actual expenditure for medical and most other benefits.²

No-fault benefits do not fall under the Municipal Tort Liability Caps.³ Thus, each injured person is entitled to full no-fault benefits, separate and apart from liability damages paid under the municipal cap.

A. Medical Expenses

The Act details medical expense benefits:

² For example, in-home nursing services provided by the spouse are not compensable when the insured is not required to pay for those services. Great West Cas. Co. v. Kroning, 511 N.W.2d 32 (Minn. 1994).

³ Loven v. City of Minneapolis, et. al. __ N.W.2d __ (Minn. File No. C5-00-1925 March 7, 2002).

Medical expense benefits shall reimburse all reasonable expenses of necessary medical, surgical, x-ray, optical, dental, chiropractic, and rehabilitative services . . . and all other reasonable transportation expenses incurred in traveling to receive covered medical benefits, hospital, extended care, and nursing services⁴

1. Reasonable charges for necessary treatment

a) 'Managed Care' banned from no-fault.

There is no formal managed care system in Minnesota No-Fault. Attempts to legislate managed care have failed repeatedly. For a time, insurers attempted to bypass the Act by organizing or hiring various managed care entities to review their bills. In the fall of 2000, Blue Cross/Blue Shield of Minnesota began administering managed care services in certain Illinois Farmers no-fault auto claims. A fairly developed no-fault managed care system appeared to have sprung up overnight.

In 2002, the legislature amended 65b.44, adding:

(b) Notwithstanding any other law to the contrary, a person entitled to basic economic loss benefits under this chapter is *entitled to the full medical expense benefits set forth in subdivision 2*, and may not receive medical expense benefits that are in any way less than those provided for in subdivision 2, or that involve any *preestablished limitations on the benefits*. Medical expenses must be reasonable and must be for necessary medical care as provided in subdivision 2. This paragraph shall not be deemed to alter the obligations of an insured or the rights of a reparation obligor as set forth in section 65B.56.

(c) *No reparation obligor* or health plan company as defined in section 62Q.01, subdivision 4, *may enter into or renew any contract that provides, or has the effect of providing, managed care services to no-fault claimants*. For the purposes of this section, "managed

⁴ Minn. Stat. § 65B.44, subd. 2 (2006).

care services" is defined as any program of medical services that uses health care providers managed, owned, employed by, or under contract with a health plan company.⁵

Any use of preexisting limitations, such as U&C databases, etc., or other attempts at managed care are now banned by the act.

2. Palliative Treatment

Insurers often attack physical therapy and chiropractic treatments, asserting that they only treat symptoms, rather than cure. These arguments should fail. The standard is not whether a particular treatment is curative. There is no authority for denying payment of medical expenses solely on the basis that the treatment was intended to relieve pain rather than cure a condition. Surely, no insurer would argue that anesthesia during a surgery and pain pills following the surgery are not payable because they are palliative and not curative.

The Act explicitly requires payment of reasonable charges for necessary treatment. The Court of Appeals has twice held that if the injured person benefits in some way from the treatment, it meets the reasonable and necessary standard. In Ruppert v. Milwaukee Mut. Ins. Co.,⁶ the Court of Appeals found that medical benefits were payable because the trial court did not make an explicit finding that Ruppert was cured requiring no further treatment.⁷ In Wolf v. State Farm Ins. Co., the insured's testimony that "the chiropractic treatments made her feel better" was sufficient to meet the reasonable and necessary standard.⁸

a) Massage Therapy.

An unpublished Minnesota Court of Appeals case approves massage therapy treatment as reasonable.⁹

⁵ Minn. Stat. §65B.44, Subdivision 1 (b,c) (2006) *emphasis added*.

⁶ 392 N.W. 2d 550(Minn. Ct. App. 1986).

⁷ 392 N.W.2d at 556.

⁸ 450 N.W.2d at 360 (Minn. Ct. App. 1990).

⁹ VanLangen v. Western National Ins. Group, Minn Ct. App. unpub'd (No. C9-02-149 filed 7-23-02).

3. Psychiatric treatment.

Psychiatric treatment for panic attacks was held not compensable when unrelated to physical injury.¹⁰ This decision of the Court of Appeals contradicts the No-Fault Act itself. “Basic economic loss benefits shall provide reimbursement for all loss...”¹¹ Loss is defined in part, “...economic detriment is loss although caused by pain and suffering or physical or mental impairment.”¹²

4. Prosthetics and other objects

The act provides specifically for payment of prosthetic devices.¹³ In the past, arbitrators have awarded mattresses, cervical pillows, and other devices and objects. However, the Court of Appeals, in a published case, has specifically held a mattress not to qualify because it is neither a prosthetic device nor a service.¹⁴

5. Transportation costs

Mileage to and from treatments and parking costs must be reimbursed as “all reasonable expenses for ... transportation expenses incurred in traveling to receive other covered medical expense benefits.”¹⁵ These are actual costs to the claimant, and should be paid in full. The IRS business expense rate is considered by some to be a fair average, and is highly accessible.¹⁶

¹⁰ Anderson v. AMCO Ins. Co., 541 N.W.2d 8 (Minn. App 1995), *rev. denied* (February 19, 1996).

¹¹ Minn. Stat. § 65B.44, subd. 1 (2006).

¹² Minn. Stat. § 65B.43, subd. 7 (2006) (Emphasis added).

¹³ Minn. Stat. § 65B.44, subd. 2(a) (2006).

¹⁴ Gilder v. Auto-Owners Ins. Co., 659 N.W.2d 804 (Minn.App.,2003).

¹⁵ Minn. Stat. § 65B.44, subd. 2 (2008).

¹⁶The IRS website <http://www.irs.gov/taxpros/article/0,,id=156624,00.html> summarizes 12 years of mileage rates, including these business rates:

| Year | Rate/ mile | Source |
|-----------------|---------------|--|
| 1997 | \$.315 | Rev. Proc. 96-63 , 1996-2 C.B. 420 |
| 1998 | \$.325 | Rev. Proc. 97-58 , 1997-2 C.B. 587 |
| 1/1/99-3/31/99 | \$.32 | Rev. Proc. 98-63 , 1998-2 C.B. 818 |
| 4/1/99-12/31/99 | \$.31 | Announcement 99-7 , 1999-1 C.B. 306 |
| 2000 | \$.325 | Rev. Proc. 99-38 , 1999-2 C.B. 525 |
| 2001 | \$.345 | Rev. Proc. 2000-48 , 2000-2 C.B. 570 |

Occasionally, no-fault insurers assert a low mileage rate for reimbursement of transportation expenses. Sometimes they will attempt to use the IRS “medical rate” as the seemingly appropriate rate, as medical transportation costs for medical treatment. However, the so-called “IRS medical rate” is artificially capped to reduce deductibility as a matter of policy.¹⁷

Keep in mind that the Act reimburses “reasonable transportation costs.”¹⁸ The IRS medical and charitable rates are not intended in any way to resemble the actual or reasonable costs. They are reduced rates to provide some minimal deductibility, similar to the medical deduction itself, where your first huge chunk of medicals (7.5% of your Adjusted Gross Income) are not deductible.

The IRS “medical rate” is explicitly based on only *variable* costs, such as gasoline, maintenance, etc.¹⁹ Thus, it clearly only compensates for a portion of the transportation cost.

On the other hand, the standard mileage rate for business (listed in the table above), is based on the *both fixed and variable costs* of operating an automobile²⁰ Included are depreciation, insurance and other fixed and variable costs.²¹ The number is based on an annual study conducted by Runzheimer International, an independent contractor, for the IRS.²² The IRS notes that the

| | | |
|-----------------|--------|---|
| 2002 | \$.365 | Rev. Proc. 2001-54 |
| 2003 | \$.36 | Rev. Proc. 2002-61 |
| 2004 | \$.375 | Publication IR-2003-121 10/15/03 http://www.irs.gov/newsroom/article/0,,id=114320,00.html |
| 1/1/05-8/31/05 | \$.405 | Publication IR-2005-99, 9/9/05 http://www.irs.gov/newsroom/article/0,,id=147423,00.html |
| 9/1/05-12/31/05 | \$.485 | Publication IR-2005-99, 9/9/05 http://www.irs.gov/newsroom/article/0,,id=147423,00.html |
| 2006 | \$.445 | Publication IR-2005-138 http://www.irs.gov/newsroom/article/0,,id=151226,00.html |
| 2007 | \$.485 | Publication IR-2006-168 , 11/1/06 http://www.irs.gov/taxpros/article/0,,id=156624,00.html |
| 1/1/08-6/30/08 | \$.505 | Publication IR-2007-192, 11/27/07 http://www.irs.gov/newsroom/article/0,,id=163828,00.html |
| 7/1/08-12/31/08 | \$.585 | Publication R-2008-82, 6/23/08 http://www.irs.gov/newsroom/article/0,,id=184163,00.html |
| 2009 | \$.55 | Publication IR-2008-131, 11/24/08 http://www.irs.gov/newsroom/article/0,,id=200505,00.html |

Informal telephone inquiries to the Minnesota Department of Insurance confirm that use of the IRS rate is the de facto standard, although the Department takes no official position.

¹⁷ The Charitable mileage rate is capped by statute at an antiquated 14 cents per mile. Publication IR-2008-82 <http://www.irs.gov/newsroom/article/0,,id=184163,00.html>.

¹⁸ Minn. Stat. § 65B.44, subd. 2 (2008).

¹⁹ Publication IR-2007-192 - <http://www.irs.gov/newsroom/article/0,,id=176030,00.html>

²⁰ Publication IR-2007-192, Nov. 27, 2007 - <http://www.irs.gov/newsroom/article/0,,id=176030,00.html>.

²¹ Publication R-2008-82, June 23, 2008 - <http://www.irs.gov/newsroom/article/0,,id=184163,00.html>.

²² Id.

standard rate is “used as a benchmark by the federal government and many businesses to reimburse their employees for mileage.²³ The business rate is obviously a more reasonable estimate of the actual cost of transportation.

Another more accurate assessment of the costs related to vehicular use is computed by the nonprofit American Automobile Association. These studies factor in all costs associated with auto use, such as gas and oil, tires, maintenance, insurance, licenses, registration, taxes, depreciation and even finance charge costs. These usually compute to substantially higher than the maximum IRS rate.²⁴

²³ Id.

²⁴ The 1994-2005 portions of the table below are contained in: <http://www.aaanewsroom.net/Main/Default.asp?CategoryID=4&ArticleID=361>. 2006 and 2007 are from <http://www.aaanewsroom.net/Main/Default.asp?CategoryID=4&ArticleID=529>. 2008 and 2009 are from <http://www.aaanewsroom.net/Main/Default.asp?CategoryID=4&ArticleID=672>.

AAA's ANNUAL DRIVING COST ESTIMATES

| YEAR | COST PER YEAR | COST PER MILE |
|-------|---------------|---------------|
| 2009 | \$8,095 | 54.0 cents |
| 2008 | \$8121 | 54.1 cents |
| 2007 | \$7,823 | 52.2 cents |
| 2006 | \$7,834 | 52.2 cents |
| 2005 | \$8,410 | 56.1 cents |
| 2004* | \$8,431 | 56.2 cents |
| 2003 | \$7,754 | 51.7 cents |
| 2002 | \$7,533 | 50.2 cents |
| 2001 | \$7,654 | 51.0 cents |
| 2000 | \$7,363 | 49.1 cents |
| 1999 | \$7,050 | 47.0 cents |
| 1998 | \$6,908 | 46.1 cents |
| 1997 | \$6,723 | 44.8 cents |
| 1996 | \$6,389 | 42.6 cents |
| 1995 | \$6,185 | 41.2 cents |
| 1994 | \$5,916 | 39.4 cents |

*AAA adopted a revised methodology for calculating driving costs to more fully capture costs incurred by average drivers.

“Your Driving Costs” 2005 American Automobile Association further breaks down costs by type of car and average mileage.

(www.aapublicaffairs.com/Main/Default.asp?SectionID=&CategoryID=3&SubCategoryID=9&ContentID=23&)

| 2005 Vehicle | 10,000 Miles/Year | 15,000 Miles/Year | 20,000 Miles/Year |
|---------------------------------------|-------------------|-------------------|-------------------|
| Chevrolet Cavalier 4-cyl., 2.2 liter | 59.9 cents | 47.6 cents | 42.0 cents |
| Ford Taurus 6-cyl., 3.0 liter | 69.1 cents | 57.2 cents | 51.4 cents |
| Mercury Grd Marquis 8-cyl., 4.6 liter | 75.7 cents | 63.4 cents | 57.2 cents |
| Chevrolet Blazer 6-cyl., 4.3 liter | 77.7 cents | 63.8 cents | 56.7 cents |

Advocates should review the insurer's payment logs to make sure that mileage has been paid since initiation of the claim. Often, the insurer will stipulate to pay mileage corresponding to undisputed past treatments.

Don't forget that if you've got other "reasonable expenses," they are compensable and should be submitted to the insurer. For certain clients, the cost of a taxi or a bus card is the most reasonable expense.

B. Non-Medical Benefits

1. Disability and Income Loss

The No-Fault statute describes disability and income loss benefits:

Disability and income loss benefits shall provide compensation for 85% of the injured person's loss of present and future gross income from inability to work proximately caused by the nonfatal injury subject to a maximum of \$250 per week.²⁵

| | | | |
|---|------------|------------|------------|
| Dodge Caravan 6-cyl., 3.0 liter | 66.1 cents | 55.3 cents | 50.0 cents |
| <i>Fuel costs based on the late-2004 average gas price of \$1.939 per gallon.</i> | | | |

From "Your Driving Costs" 2004 American Automobile Association:

| 2004 Vehicle | 10,000 Miles/Year | 15,000 Miles/Year | 20,000 Miles/Year |
|--------------------------|-------------------|-------------------|-------------------|
| Chevrolet Cavalier LS | 56.8 cents | 44.8 cents | 39.2 cents |
| Ford Taurus SEL Deluxe | 71.0 cents | 58.4 cents | 52.1 cents |
| Mercury Grand Marquis LS | 79.0 cents | 65.4 cents | 58.5 cents |

Even the 2008 AAA Your driving cost report, which estimates 54.1 cents per mile uses 2.94/gallon as their gasoline price! <http://www.aaanewsroom.net/Assets/Files/200844921220.DrivingCosts2008.pdf>

A North Carolina AAA report pegs the number at 63 cents a mile for 2008. http://www.bizjournals.com/charlotte/stories/2008/04/28/daily26.html?ana=from_rss

²⁵ Minn. Stat. § 65B.44, subd 3 (2006). If there are stacked policies, the weekly benefit maximums are also stacked. Peterson, 315 N.W.2d 601.

This subdivision uses the proximate cause standard explicitly. If the accident had a “substantial part in bringing about the injury,”²⁶ the carrier must pay wage loss benefits.

For the “typical worker”, wage loss benefits are straightforward. However, calculation of benefits for anyone but the totally disabled, forty-hour-per-week worker can be complicated. Consequently, no-fault insurers and even claimants' attorneys often fail to realize the full benefits available. This results in economic hardship to many injured people.

a) Unemployed When Injured

Unemployment benefits. A person injured while unemployed usually qualifies for no-fault benefits. If the person is receiving (or is qualified to receive) unemployment benefits before the injury, the no-fault carrier must pay wage loss benefits.²⁷ Payment is made at 100% of the unemployment rate, presumably because the unemployment benefit rate is already discounted from gross wages.

An unemployed person that would have gone to work but for the injury is entitled to full wage loss benefits. There are several approaches to this issue.

Definite Offer. The injured person must simply show that he or she “had a definite offer of employment or had consistently been employed such that a specific future period of employment could reasonably be predicted.”²⁸

See also McKenzie v. State Farm Mut. Auto. Ins., 441 N.W. 2d 832 (Minn. Ct. App. 1989) [paralegal student's inability to take advantage of higher earning potential](#). (part-time employee deserved no-fault benefits based on full time wage where she showed she would have worked full time but for the injury.); Zitzloff, 1998 WL 481888 (court deferred to arbitrator assuming arbitrator found claimant had been consistently employed).

²⁶ Zitzloff v. State Farm Mut. Ins. Co., 1998 WL 481888 (Minn. App 1998) (unpublished), *rev. denied* (August 18, 1998). *See also* Minnesota Practice, Jury Instruction Guides, Civil, JIG III, 140 (Direct Cause) (3d Ed. 1986).

²⁷ Minn. Stat. § 65B.44, subd. 3 (2006)

²⁸ Keim v. Farm Bureau Ins. Co., 482 N.W.2d 823 (Minn. Ct. App. 1992).

b) Partial Loss of Earnings

Partially disabled people who are unable to work full-time or return to the same type of work are eligible for income loss benefits.²⁹ They receive 85% of the difference between the pre-injury and post-injury wages.³⁰

c) Depletion of Sick or Vacation Leave

For a variety of reasons, some people use sick pay when they are injured in an accident rather than no-fault benefits. The Court of Appeals has held that people who deplete their sick pay because of their injuries clearly deserve reimbursement from their insurer.³¹ This is true even if it produces a double recovery or windfall for the claimant.³² The no-fault insurer should have paid for the loss of earnings in the first place and should not avoid payment simply because another source has made payment. Unlike other losses paid by third parties, there is no double recovery. The claimant suffers actual loss -- loss of their vacation or sick leave benefit.

d) Loss of Wages During Treatment

Since Hoeschen, the Act has been amended to require insurers to repay vacation and sick time lost *during treatment*.³³ Wages lost during treatment are fully compensable, including sick and vacation benefits lost during treatment.³⁴

2. Self-Employment Loss of Earnings

Loss of earnings for self-employed persons is computed through one of the three prongs set forth in Rindahl v. National Farmers Union Ins. Co.:³⁵

- (1) Costs incurred for substitute employees;

²⁹ Prax v. State Farm Mut. Auto. Ins. Co., 322 N.W.2d 752 (Minn. 1982).

³⁰ *Id.* See also Chacos v. State Farm Mut. Auto. Ins. Co., 368 N.W.2d 343 (Minn. Ct. App. 1985), *rev. denied* (March 6, 1985).

³¹ See, Hoeschen v. Mutual Service Cas. Ins. Co., 359 N.W.2d 677, 679 (Minn. 1985).

³² *Id.* at 680.

³³ Minn. Stat. § 65B.44, subd. 3 (2006).

³⁴ Minn. Stat. § 65B.44, subd. 3 (2006).

³⁵ 373 N.W.2d 294 (Minn. 1984).

- (2) Loss of tangible things of economic value; or,
- (3) Loss of “other earnings from work”.³⁶

a) Substitute Employees

The No-Fault Act states:

Loss of income includes the costs incurred by a self-employed person to hire substitute employees to perform tasks which are necessary to maintain the income of the injured person, which are normally performed by the injured person, and which cannot be performed because of the injury.³⁷

For example, the insurer must reimburse a self-employed farmer for the cost of hiring an additional farm hand while the farmer is injured.

b) Loss of Tangible Things of Economic Value

Under the statute, income includes “tangible things of economic value produced through work.”³⁸ Thus, loss of tangible things of economic value equals loss of income. Tangible things of economic value include “insurance benefits, disability coverage and pensions,” as well as other items such as “vegetable garden produce, proceeds of a household business, such as crafts or daycare, and labor furnished to the farm business.”³⁹ Imaginative MTLA members have successfully argued that health insurance premiums are “tangible things of economic value.”⁴⁰

³⁶ *Id.* at 299. The self-employed claimant must show actual loss of income. Rotation Engineering v. Secura Ins. Co., 497 N.W. 2d 292 (Minn. Ct. App. 1993). *But see* Northrup v. State Farm Mut. Auto. Ins. Co., 1998 WL 846548 (Minn. Ct. App. 1998) (unpublished) (despite vast increase in wages after injury and working full time as consultant, both pre-injury laborer earnings and post-injury consultant earnings must be considered in determining lost income).

³⁷ Minn. Stat. § 65B.44, subd. 3 (2006).

³⁸ Minn. Stat. § 65B.43, subd. 6 (2006).

³⁹ Hoper v. Mut. Serv. Cas. Ins. Co., 359 N.W.2d 318, 321 (Minn. Ct. App. 1984).

⁴⁰ See Ekre, *Reimbursement of Health Insurance Premiums Under No-Fault*, MINNESOTA TRIAL LAWYER 27 (Spring 1998).

c) Loss of “Other Earnings from Work”

Self-employed individuals often find it difficult to prove their lost earnings. For example, in service industries, there is no “loss of tangible thing of economic value.” Hiring substitute employees may not be appropriate or practical. For example, the claimant may be the owner of a small business that has never produced a profit on paper, or paid the owner a wage. If there is a loss of the gross income of the business, that loss is compensable.⁴¹

g) Loss of a Scholarship

Loss of a college athletic scholarship that paid for tuition, room, and board does not constitute loss of income under the Act.⁴²

3. Replacement Services

The Act reimburses

[A]ll expenses reasonably incurred . . . in obtaining usual and necessary substitute services . . . that . . . the injured person would have performed not for income but for direct personal benefit or for the benefit of the injured person's household⁴³

“Reasonable expense incurred” generally requires an actual monetary expenditure.⁴⁴

a) Primary Homemaker

Injury to a homemaker, however, triggers replacement services *even without actual economic loss* and even if the homemaker is separately employed outside the home. The statute provides:

⁴¹ Rindahl, 373 N.W.2d 294 at 299-300 (Minn. 1985). See also Banishoraka v. Credit General Ins. Co., 1995 WL 450496 (Minn. Ct. App. 1995) (unpublished) (injured taxi driver returned to work by opening a limousine service within his restrictions; comparing earnings on two businesses acceptable.); Dahly v. Great West Cas. Co., 1996 WL 679689 (Minn. Ct. App. 1996) (unpublished) (truck driver injured in first year of business awarded \$14,000).

⁴² Roquemore v. State Farm Mut. Auto. Ins. Co., ___ N.W.2d ___ (Minn. Ct. App. C8-99-1930, May 23, 2000).

⁴³ Minn. Stat. § 65B.44, subd. 5 (2006).

⁴⁴ Nadeau v. Austin Mut. Ins. Co., 350 N.W.2d 368 (Minn. 1984).

If the non-fatally injured person normally, as a full time responsibility, provides care and maintenance of a home with or without children, the benefit to be provided under this subdivision shall be the reasonable value of such care and maintenance or the reasonable expenses incurred in obtaining usual and necessary and substitute care and maintenance of the home, whichever is greater.⁴⁵

“Full time responsibility” only means primary responsibility for management of the household. The injured person may be employed outside the home, even on a full-time basis. If he or she is the primary homemaker, the reasonable value of care and maintenance of the home, *as well as loss of income benefits*, must be paid by the insurer.⁴⁶

Replacement services benefits are paid under income loss coverage and are subject to the same maximums.⁴⁷

The Problem. Unfortunately, few people know that they have this benefit and few insurers ever tell. Despite fifteen years of practice representing auto accident victims, I have never seen a non-represented person bring this claim. Similarly, I have never seen an insurer properly notify their insured of this benefit.

In every case I have had involving a ‘Primary Homemaker’, I have been able to bring a claim for benefits. Most have succeeded. Depending on the severity of the injuries, the size of the household, and the availability of benefits⁴⁸, these claims have ranged from a few hundred dollars to the full \$20,000 benefit.

Notice. An insurer commits an Unfair Claims Practice when they fail:

... *to notify an insured* who has made a notification of claim *of all available benefits or coverages*

⁴⁵ Minn. Stat. § 65B.44, subd. 5 (2006).

⁴⁶ Rindahl, 373 N.W.2d at 297. Cf. Guenther v. Austin Mut. Ins. Co., 398 N.W.2d 80 (Minn. App 1986), *rev. denied*.

⁴⁷ Minn. Stat. § 65B.44, subd. 1(b) (2006).

⁴⁸ If the insured has already collected wage loss or other nonmedical benefits, the coverage will have been depleted or exhausted.

which the insured may be eligible to receive under the terms of a policy and of the documentation which the insured must supply in order to ascertain eligibility;⁴⁹

The notices insurers provide describe other benefits, but ignore Primary Homemaker Replacement Services.⁵⁰

After failing to provide notice of the benefit, most insurers attempt to retroactively set conditions of proof. But how can the insurer complain that the insured did not:

- keep a diary,
- keep lists of exactly who performed exactly what duty,
- secure contemporaneous disability slips, take photos of the messy home, etc.,

when the insurer has committed an Unfair Claims Practice by failing to notify them of this benefit! The insurer was in the best position to make sure that the claimant was aware of their benefits and any prove the insurer would require ***from the very beginning. The Fair Claims Practice violation amounts to a waiver of any but the most minimal prima facie proof requirements. Their retroactive defenses will fail because of their own inaction.***

Some insurers complain that Claimants that are represented by counsel somehow lose their right to notification of the benefit. However, there is no authority that the insurer's responsibility is somehow conditional or delegable. On the contrary, most insurers continue to send these letters directly to the insured even after being notified of the representation. In addition, many attorneys are initially retained regarding the third party claim, and are not yet representing the injured person until benefits are denied.⁵¹

⁴⁹Minn. Stat. §72A.201, Subd. 4 (5) (2006).

⁵⁰ The notices will often describe the standard out-of-pocket Replacement Service or substitute service, but occasionally, the notices fail to reference any sort of Replacement Services *at all*. (e.g. *American Family notice dated 12/23/98 in author's file.*)

⁵¹ Many lawyers are unaware of the benefit. Numerous seminars with titles such as "The Forgotten Benefit" have been given to both attorneys and insurers.

Why do insurers fail to provide more meaningful notice? Obviously, limiting claims may be a major reason. It is also likely that the very nature of the benefit is difficult for them. This is the only PIP benefit that does not require an out of pocket expenditure or easily enumerated amount. They may also feel that “reasonable value” is not easily calculable and subject to some ambiguity. For whatever reason, insurers do a miserable job of notifying their insureds of the existence of Primary Homemaker Replacement Services.

Such excuses should fall on deaf ears. Arbitrator should take every opportunity to punish insurers who engage in such “accidental on purpose” cost-saving efforts. To be sure, for every late primary homemaker claim that is brought, many, many more will never see the light of day.

Thousands of Minnesotans are losing a valuable benefit.

4. Rehabilitation

Various “Rehabilitation benefits” are described in a variety of places in Minn. Stat §65B.44, and are further defined and regulated under §65b.45. There is some dispute as to the amount and limit of non-medical rehabilitation.

Unlimited Vocational Rehabilitation Benefits? There is an argument that there is *NO maximum dollar limit on occupational rehabilitation benefits in the No-Fault Act*. There is a very old Attorney General Opinion to the contrary, but such an opinion has no precedential effect, and precedes an important statutory amendment. In fact, various changes to the Act over the years have strengthened this interpretation of the Act.

One big argument against this interpretation has disappeared. The Act was amended in 1999 to change “maximum of \$40,000” in benefits to “*minimum* of \$40,000”

Medical rehabilitation and occupational (or vocational) rehabilitation are different things. Common sense tells us this. So does the Act. Minn. Stat § 65B.45 has not been substantially amended since enactment. Subd. 2 states:

An injured person who has undertaken a procedure or treatment for rehabilitation or a course of rehabilitative occupational training, *other than medical rehabilitation procedure or treatment*, shall give notice to the reparation obligor of having undertaken the procedure, treatment, or training within 60 days after a rehabilitation expense exceeding \$1,000 has been incurred for the procedure,

treatment, or training, unless the reparation obligor knows or has reason to know of the undertaking...⁵²

Thus, *medical rehabilitation procedures and treatment are differentiated from other types of rehabilitation, including rehabilitative occupational training.*

Minn. Stat. §65B.44, Subdivision 1 provides:

Inclusions. (a) Basic economic loss benefits shall provide reimbursement for *all loss* suffered through injury arising out of the maintenance or use of a motor vehicle, subject to any applicable deductibles, exclusions, disqualifications, and other conditions, *and* shall provide a *minimum* of \$40,000 for loss arising out of the injury of any one person, consisting of: (1) \$20,000 for medical expense loss arising out of injury to any one person; and (2) a total of \$20,000 for income loss, replacement services loss, funeral expense loss, survivor's economic loss, and survivor's replacement services loss arising out of the injury to any one person.

The statute originally provided for a maximum of \$30,000 coverage; now it provides for a *minimum* of \$40,000. This \$40,000 is not intended to cover the entire benefit, but rather the minimum that must be provided, as explained in paragraphs (1) and (2). *Neither of those paragraphs lists occupational or vocational rehabilitation as one of the benefits subject to the \$40,000 limit.*

Subdivision 2 provides more detail on the medical expenses:

Subd. 2. Medical expense benefits. (a) Medical expense benefits shall reimburse all reasonable expenses for necessary:

(1) medical, surgical, x-ray, optical, dental, chiropractic, and rehabilitative services, including prosthetic devices; (2) prescription drugs; (3) ambulance and all other transportation expenses incurred in traveling to receive other covered medical expense benefits; (4) sign

⁵² Minn. Stat § 65B.45 Subd. 2 (2006).

interpreting and language translation services, other than such services provided by a family member of the patient, related to the receipt of medical, surgical, x-ray, optical, dental, chiropractic, hospital, extended care, nursing, and rehabilitative services; and (5) hospital, extended care, and nursing services. (b) Hospital room and board benefits may be limited, except for intensive care facilities, to the regular daily semiprivate room rates customarily charged by the institution in which the recipient of benefits is confined. (c) Such benefits shall also include necessary remedial treatment and services recognized and permitted under the laws of this state for an injured person who relies upon spiritual means through prayer alone for healing in accordance with that person's religious beliefs. (d) Medical expense loss includes medical expenses accrued prior to the death of a person notwithstanding the fact that benefits are paid or payable to the decedent's survivors. (e) Medical expense benefits for rehabilitative services shall be subject to the provisions of section 65B.45.

Paragraph (e) refers to **medical expense benefits for rehabilitation** (isn't that what it says?) and subjects it to *some* of the same limitations as occupational or vocational rehabilitation listed in 65B.45 (but not the notice requirement, as discussed above).

It makes sense that vocational rehabilitation be open-ended. Vocational rehabilitation or retraining will vary from person to person, and can be expensive, but is limited to those severe cases where the added expense is reasonable.

Since occupational rehabilitation is apparently a potentially unlimited benefit, §65B.45 adds some additional requirements that are not necessary for medical rehabilitation. Notice is required to the insurer within 60 days of exceeding \$1000. Either side may make a motion in an action or bring an action in district court to allow the court to assess reasonableness.

There has been almost no litigation on this portion of the no-fault act. If the right case comes along, the practitioner should consider this argument.

5. Death Benefits

Death benefits are similar, but not identical, to injury benefits. Medical expenses accrued before death must be paid.⁵³ Funeral and burial expenses are a paltry \$2,000,⁵⁴ including flowers and other expenses.⁵⁵ Survivors economic loss benefits provide up to \$200 per week to dependents for loss of “contributions of money or tangible things of economic value, not including services.”⁵⁶ The Act establishes some presumptions about who is a dependent.⁵⁷ There is no loss when identical AFDC benefits were paid through a guardian sister after the mother’s death.⁵⁸

A recent Supreme Court decision restricts the class of people who may be considered dependents. In *Auto Owners Ins. Co. v. Perry*⁵⁹, the court held that a live in girlfriend is not eligible for Dependent benefits. The dissent⁶⁰ eloquently criticizes the majority⁶¹ for ignoring the language of the act, the legislative history, and the likely production of absurd results.

A decedent’s ex-wife *Peevy v. Mutual Services Casualty Insurance Co.*, in which a decedent’s ex-wife sought survivors’ economic loss benefits under the decedent’s no-fault automobile insurance policy. 346 N.W.2d 120, 121 (Minn. 1984).

Dahle v. Aetna Casualty & Surety Insurance Co., 352 N.W.2d 397 (Minn. 1984), offers some support for Perry’s reading of section 65B.44, subd. 6, the facts of that case are distinguishable from those before us. The issue we resolved in *Dahle* was

⁵³ Minn. Stat. § 65B.44, subd. 2 (2006).

⁵⁴ Minn. Stat. § 65B.44, subd. 4 (2006).

⁵⁵ *Forcier v. State Farm Mut. Auto. Ins. Co.*, 310 N.W.2d 124 (1981).

⁵⁶ Minn. Stat. § 65B.44, subd. 6 (2006).

⁵⁷ *Id.*

⁵⁸ *Pacheco v. State Farm Mutual Auto. Ins. Cos.*, 2000 WL _____, (Minn. Ct. App. C4-00-197 July 25, 2000) (Unpublished)

⁵⁹ ___ N.W. 2d ___ (2008).

⁶⁰ Page, J., joined by Meyer, J.

⁶¹ Justice Barry Anderson.

whether a posthumous child qualifies as a “surviving dependent” under the statute, and we emphasized that posthumous children are afforded protection elsewhere under Minnesota law. *Id.* at 400-01. *Dahle*, which involved a claim brought on behalf of an actual “child” of the decedent, cannot be fairly read as authority for the proposition that others, such as friends, acquaintances, or a girlfriend or boyfriend residing with the decedent, are entitled to benefits. *Dahle* involved children, who are entitled to

Survivor's replacement services of up to \$200 per week are paid only for actual expenses incurred.⁶² The Act provides no “primary homemaker” benefit in death cases.⁶³

C. Stacking

Before October 1, 1985, stacking of no-fault benefits was automatic in many circumstances.⁶⁴ Since that date, the insurer must “notify policyholders that they may elect to have two or more policies added together.”⁶⁵ Not only are the policy limits stacked, but the individual weekly benefit limits are stacked as well.⁶⁶

There is authority that the owner’s purchase of no-fault stacking may not benefit mere passengers, but may be restricted to the named insured and resident relatives.⁶⁷

In many circumstances, your clients may not even know that they explicitly elected stacking and paid an additional premium. No-fault carriers often fail in their obligation to inform claimants or their attorneys of the additional benefits

⁶² Minn. Stat. § 65B.44, subd. 7 (2006).

⁶³ Hoper, 359 N.W.2d 318.

⁶⁴ Wasche v. Milbank Mut. Ins. Co., 268 N.W. 2d 913 (Minn. 1978).

⁶⁵ Minn. Stat. § 65B.47, subd. 7(2008).

⁶⁶ Peterson v. Iowa Mutual Ins. Co., 315 N.W. 2d 601 (Minn. 1982).

⁶⁷ In Johnson v. State Farm Mut. Auto. Ins. Co., 551 N.W. 2d 232 (Minn. Ct. App. 1996), the Court of Appeals held that the stacking purchased by the car owner extended to the plaintiff, who was insured only because he was a passenger in the vehicle. The Supreme Court, in a summary order, reversed. Johnson v. State Farm Mut. Auto. Ins. Co., 556 N.W.2d 214 (Minn. 1996). There is little reference to the policy language in either decision. The parties had agreed the injured person was not an insured under the other two stacked policies.

available. It is important to demand a certified copy of your client's policy from the insurer. A declarations sheet is a poor substitute and should not be accepted.

If the insurer did not offer stacking, the courts should reform the policy to include stacking, as in pre-1985 underinsured motorist stacking cases.⁶⁸ Multiple mailed notices are sufficient as a matter of law, according to a recent Court of Appeals case.⁶⁹

Whenever the policy limits are likely to be exceeded, the claimant's attorney should ask the no-fault insurer to document the offer of stacking. If the insurer cannot show that they notified their insured of the right to elect stacking, the claimant's attorney should insist that the policy limits of all insured cars should be stacked.

II. Coverage

A. Accident Location

The Act prescribes universal coverage for accidents occurring in Minnesota:

If the accident causing injury occurs in this state, ***every person*** suffering loss from injury arising out of maintenance or use of a motor vehicle or as a result of being struck as a pedestrian by a motorcycle has a right to basic economic loss benefits.⁷⁰

For accidents out of state, (in the United States and Canada), insureds are covered, as well as:

(2) the driver and other occupants of a secured vehicle, other than (a) a vehicle which is regularly used in the course of the business of transporting persons or property and which is one of five or more vehicles under common ownership, or (b) a vehicle owned by a government other

⁶⁸ See Holman v. All Nation Ins. Co., 288 N.W. 2d 244 (Minn. 1980), and progeny.

⁶⁹ Pecinovsky v AMCO Insurance Co., 613 NW2d 804 (Minn. Ct. App. 2000). The intermediate court took the interesting tack of quoting and then disregarding what it characterized as Supreme Court *dictum* from Meister v. Western National Mutual Ins. Co., 479 N.W. 2d 372 (Minn 1992). *Id.* at 808.

⁷⁰ Minn. Stat. §65B.44 Subdivision 1 (2006).

than this state, its political subdivisions, municipal corporations, or public agencies. The reparation obligor may, if the policy expressly states, extend the basic economic loss benefits to any stated area beyond the limits of the United States, United States possessions and Canada.

Thus, fleets of five or more vehicles, and those owned by other states and the federal government may exclude coverage for out of state accidents. Insurers may choose to extend coverage to countries other than the U.S. and Canada.

B. “Loss from Injury”

Causation. No-fault insurers use a variety of arguments to dispute that the accident caused the injuries. Claims adjusters, and even some defense attorneys, apparently feel that *any* possible alternate explanation for the injuries excuses the insurer from paying benefits. However, the No-Fault Act provides for payment of *all* economic loss “suffered through injury arising out of the maintenance or use of a motor vehicle.”⁷¹

While the Act does not define “from injury” the courts have addressed the causation standard. In Ruppert v. Milwaukee Mutual Ins. Co.,⁷² the Court of Appeals stated:

The test, of course, is not whether the trauma . . . might, only in the realm of possibility, have been a factor in producing a certain result, but whether it was a factor or *at least a probable factor* in producing the claimed result.⁷³

The “probable factor” test is usually very easy to satisfy. In most no-fault arbitrations, the accident will be *at least* a probable factor, and the arbitrator should award the benefits.

C. Motor Vehicles

Marked police cars are not motor vehicles, and thus do not require no-fault coverage.⁷⁴ Strange as that may seem, it does follow the dictates of the statute.

⁷¹ Minn. Stat. § 65B.44, subd. 1 (2006).

⁷² 392 N.W.2d 550 (Minn. Ct. App. 1986), *review denied* (October 22, 1986).

⁷³ 392 N.W.2d at 556 (emphasis added), *citing* Kenney v. Chicago Great Western Railway Co., 245 Minn. 284, 290, 71 N.W.2d 669, 673 (1955), *quoting* Berg v. Ullveig, 244 Minn. 390, 398, 70 N.W.2d 133, 138 (1955).

The No-Fault Act uses motor vehicle licensing as the trigger for coverage.⁷⁵ Since a marked police car does not need to be licensed, it is not considered a motor vehicle for purposes of the act.

The ramifications of are many, and not all negative.

1. First, we know a **pedestrian** struck by a marked police officer **cannot receive no-fault benefits from the police car's insurance**. That's the simplest holding of the case.
2. Probably, that **pedestrian may be excluded from no-fault coverage from ANY policy**. That's because the holding is based on a marked police car being excluded from the definition of a motor vehicle. Under the No-Fault Act, a person has the right to claim basic economic loss benefits if he or she has been injured by the "maintenance or use of a motor vehicle." If the policy was properly written, the private carrier could exclude coverage as well. Since many policies simply track the Act, most or all these policies may exclude the coverage. The court noted:

We recognize that the use of the plain meaning of "motor vehicle" will result in a class of accident victims being uncompensated under the Act, including pedestrians or passengers who happen to be injured by any of the vehicles that are not required to be registered under Chapter 168.

3. ***There are no thresholds*** on liability actions that don't arise out of the maintenance or use of a motor vehicle. ***Many minor injury third party claims will actually have much higher value.***
4. Don't assume the involvement of a police car always excludes coverage. Just as a farmer on a tractor or an Amish person in a horse-drawn cart (not motor vehicles) receives no fault when hit by a car (a motor vehicle), so does the person in the police car hit by another 'real' motor vehicle.

⁷⁴ Mutual Service Casualty Ins. Co. v. League of Minnesota Cities Ins. Trust, 659 N.W.2d 755 (Minn. 2003).

⁷⁵ "Motor vehicle" means every vehicle, other than a motorcycle or other vehicle with fewer than four wheels, which (a) ***is required to be registered pursuant to chapter 168***, and (b) is designed to be self-propelled by an engine or motor for use primarily upon public roads, highways or streets in the transportation of persons or property, and includes a trailer with one or more wheels, when the trailer is connected to or being towed by a motor vehicle. Minn. Stat. § 65B.43 Subd. 2. (2006), *emphasis added*.

D. Motorcycles

1. Riders

For the purposes of sections 65B.41 to 65B.71, injuries suffered by a person while on, mounting or alighting from a motorcycle do not arise out of the maintenance or use of a motor vehicle although a motor vehicle is involved in the accident causing the injury.⁷⁶

Thus, motorcycle riders are excluded from the benefits of the Act.

2. Pedestrian struck by motorcycle

Pedestrians struck by motorcycles are specifically included in the Act.⁷⁷

III. Sources of Coverage

A. Collateral Payments

There is no set-off or reduction of benefits for payments made by other insurers, except workers' compensation benefits actually paid. "Basic economic loss benefits shall be primary with respect to benefits, except for those paid or payable under a workers' compensation law."⁷⁸

1. Accident, health, and disability payments

No-fault carriers have no right to coordinate benefits with accident, disability or health carriers.⁷⁹ Coordination of benefits by these other insurers is allowed, but not required. The Supreme Court has recognized and accepted that some double recovery may occur in these circumstances.⁸⁰ Since no-fault is primary,

⁷⁶ Minn. Stat. § 65B.44, Subd. 3 (2006).

⁷⁷ Minn. Stat. § 65B.44, Subdivision 1, Subd. 2 (2006).

⁷⁸ Minn. Stat. § 65B.61 (2006).

⁷⁹ Minn. Stat. § 65B.61, subd. 3 (2006). See *Wallace v. Tri-State Ins. Co.*, 302 N.W.2d 337 (Minn. 1980) (health care benefits); *Hoeschen v. Mutual Service Cas. Ins. Co.*, 359 N.W.2d 677, 679 (Minn. 1985). (army paid health care costs); *Demning v. Grain Dealers Mut. Ins. Co.*, 411 N.W.2d 571 (Minn. Ct. App. 1987) (social security benefits). Minn. Stat. § 473.405 (1992), which gave the MTC (now MCTO) a deduction for most government benefits paid, has been repealed. Laws 1994 Ch. 628, art. 3, §209(a).

⁸⁰ *Wallace*, 302 N.W.2d at 340. See *Stout* (Note 82, *supra*).

benefits not paid by the no-fault insurer must be awarded regardless of whether other sources have paid, or may pay in the future.

2. Medical Assistance⁸¹

The No Fault carrier must repay the full amount of the bill, not the discounted amount paid by Medical Assistance.⁸² The case reiterates “if there is to be a windfall either to an insurer or to an insured, the windfall should go to the insured.”⁸³ This is even the case where the insured is not the premium payer.⁸⁴

3. Coordinating workers' compensation and no-fault

People hurt in motor vehicle accidents while working are eligible for both workers' compensation and no-fault benefits. Because workers' compensation benefits are primary,⁸⁵ and the benefits are often more extensive than no-fault benefits, the no-fault benefits are often forgotten. However, there are many circumstances where no-fault benefits *will supplement*, and even *substitute* for workers' compensation benefits.

a) Replacement Services. Since there are no workers' compensation replacement services benefits, the no-fault carrier must pay.

b) Wages. The No-Fault Act details what wage loss benefits should be paid over and above workers' compensation payments.⁸⁶ Usually, the no-fault carrier pays the difference between the 85% no-fault rate⁸⁷ and the 66-2/3% workers' compensation rate.⁸⁸ Thus, in many cases the no-fault carrier is responsible for paying the added 18-1/3% of the wage loss. There is, however, a major restriction on this benefit. The no-fault carrier does not have to pay anything if the work comp payment exceeds the maximum

⁸¹ Most of the country uses the term ‘Medicaid’ for the benefits that Minnesota calls ‘Medical Assistance’.

⁸² Stout v. AMCO Ins. Co., 645 N.W.2d 108 (Minn. 2002).

⁸³ *Id.*, citing Wallace and Van Tassel v. Horace Mann Mut. Ins. Co., 296 Minn. 181, 187, 207 N.W.2d 348, 352 (1973).

⁸⁴ *Id.*

⁸⁵ Minn. Stat. § 65B.61, subd. 1 (2006).

⁸⁶ Minn. Stat. § 65B.61, subd. 2, 2a (2006).

⁸⁷ Minn. Stat. § 65B.44, subd. 3 (2006).

⁸⁸ Minn. Stat. §176.101, subd. 1, 2, 3a, 4 (2006).

weekly no-fault benefits⁸⁹ -- \$250 in injury cases⁹⁰ or \$200 in death cases.⁹¹ Consequently, the no-fault carrier will usually only need to supplement wage loss benefits for workers grossing less than \$375 per week.

c) Partial Wage Loss. Higher wage workers should receive the 18-1/3% benefit if their injury requires them to return to work at lower wages. Both no-fault⁹² and workers' compensation⁹³ provide partial wage loss benefits at their respective 85% and 66-2/3% benefit levels. Thus, a worker grossing \$1,000 per week before the accident who can only return to work part time, or at a lower paying job paying only \$900 per week should receive \$66.67 of temporary partial payments from the workers' compensation carrier and \$18.33 from the no-fault carrier.

d) Stacking. In the rare circumstances where the worker owns multiple vehicles and purchases stacking of no-fault benefits, the weekly maximums are also stacked. Thus, an injured worker with three stacked vehicles has maximum no-fault benefits of \$750 per week, which exceeds the maximum workers' compensation rate.⁹⁴

4. Workers' Compensation Denials. What if the workers' compensation carrier denies payment? The no-fault carrier must pay.

A claim for basic economic loss benefits shall be paid without deduction for the benefits which are to be subtracted pursuant to section 65B.61, if these benefits have not been paid to the claimant before the reparation benefits are overdue or the claim is paid. The obligor is entitled to reimbursement from

⁸⁹ Minn. Stat. § 65B.61, subd. 2, 2a (2006).

⁹⁰ Minn. Stat. § 65B.44, subd. 3 (2006).

⁹¹ Minn. Stat. § 65B.44, subd. 6 (2006).

⁹² Prax v. State Farm Mut. Ins. Co., 322 N.W.2d 752 (Minn. 1982).

⁹³ Minn. Stat. §176.101, subd. 2 (2006).

⁹⁴ Now capped at \$615 per week. Minn. Stat. § 176.101, subd. 1 (b)(1).

the person obligated to make the payments or from the claimant who actually receives the payments.⁹⁵

The language above is quite clear. When the benefits are due, the no-fault carrier must pay, and seek reimbursement from the workers' compensation carrier.

In Raymond v. Allied Property & Cas. Ins. Co.,⁹⁶ the workers' compensation carrier denied medical and wage payments, claiming the auto accident was not work related. The no-fault carrier refused payments, and the plaintiff was awarded over \$10,000 in a no-fault arbitration. The Court of Appeals affirmed the arbitrator's award, holding that §65B.54 is clear and unambiguous, and that benefits denied by the workers' compensation carrier must be paid by the no-fault carrier. The court noted that the purpose of the No-Fault Act is to provide prompt payment of economic benefits.⁹⁷

In Klinefelter v. Crum & Forster Ins. Co.,⁹⁸ the Court of Appeals extended that rationale. In Klinefelter, a worker litigated benefits within the work comp system. The claim was denied by the work comp judge, who was then affirmed by the Workers Compensation Court of Appeals. The worker then arbitrated and won over \$8000 in benefits, and the no-fault carrier appealed. The court, Judge Gordon Schumaker writing, ruled that the workers compensation and no-fault laws were too dissimilar for the arbitration to be estopped, and the arbitrator was within his powers to award the benefits.

These cases make sense. The worker was injured in a car accident. Auto insurance premiums were paid. The injured worker should receive at least the minimum benefits paid for in those premiums.

The policy decisions that led to the many restrictions on workers compensation have no application here. The auto carrier must not receive a premium windfall based on political compromises related to the workers compensation statute.

⁹⁵ Minn. Stat. § 65B.54, subd. 3 (2006) (*emphasis added*).

⁹⁶ 546 N.W.2d 766 (Minn. Ct. App. 1996), *rev. denied* (April 30, 1996).

⁹⁷ 546 N.W.2d at 767-68. *But see Holden v. Illinois Farmers*, 1998 WL 40500 (Minn. Ct. App. 1998), *rev. denied* March 26, 1998 (unpublished) (upholding coverage exclusion in employer's no-fault policy for co-employee injuries because workers' compensation was primary).

⁹⁸ 675 N.W.2d 330 (Minn. Ct. App. 2004).

Raymond and Klinefelter may provide an attractive alternative to workers' compensation litigation. Benefits denied by the workers' compensation carrier should be submitted immediately to the no-fault carrier, along with a copy of Raymond. The no-fault carrier must pay the benefit and then pursue the workers' compensation carrier. Even if the no-fault carrier denies payment, the worker may find the no-fault arbitration more attractive than litigating the workers' compensation denial. With the restrictions on Roraff and Heaton attorney fees, the 15% no-fault statutory penalty may provide a better remedy.⁹⁹

5. Other denials. What if the workers' compensation carrier denies benefits with a defense unique to the workers' compensation system? The no-fault carrier should pay. The defenses unique to workers' compensation have little or no application to no-fault.

For example, workers' compensation temporary total disability benefits are limited to 104 weeks,¹⁰⁰ temporary partial to 225 weeks.¹⁰¹ There is no such limit to no-fault wage benefits. If the disability still exists, the no-fault carrier should pay the full benefit after the workers' compensation benefits expire.

What about the artificial 'twelve week rules'¹⁰² limiting workers' compensation payments for chiropractic care and physical therapy? Should the bills be paid by no-fault after the denial?

What about workers' compensation managed care? Can the employee who wants to go outside the system simply opt for no-fault payments? These benefits should be available to workers, regardless of the restrictions of the workers compensation system.

Read the statute. The no-fault carrier must “provide reimbursement for all loss suffered through injury . . . arising out of the maintenance or use of a motor vehicle.”¹⁰³ This includes “all reasonable expenses for necessary medical,

⁹⁹ See Roraff v. State of Minnesota, 288 N.W.2d 15 (1980), Heaton v. J. E. Freyer and Company, 36 W.C.D. 316 (1983).

¹⁰⁰ Minn. Stat. § 176.101, subd. 1 (f) (2006).

¹⁰¹ Minn. Stat. § 176.101, subd. 2(6) (2006).

¹⁰² See generally, Minnesota Rules, Chapter 5221.

¹⁰³ Minn. Stat. § 65B.44, subd. 1 (2006).

surgical . . . chiropractic, and rehabilitative services,”¹⁰⁴ as well as “85% of the injured person's loss of present and future gross income.”¹⁰⁵ Finally, remember “basic economic loss benefits are primary except for those paid or payable under a workers' compensation law.”^{106,107}

6. Work Comp Settlements. See Section VI.B.4 for a discussion of settlement.

Practice Tip. In all work injuries arising from maintenance or use of a motor vehicle, the attorney should consider potential no-fault claims. To make sure this remains available, the attorney should submit an application for benefits on a timely basis to avoid later claims of prejudice.¹⁰⁸

B. Apportionment

1. Prior accidents

For a short time, the Court of Appeals allowed an insurer to apportion benefits to an earlier accident to avoid payment.¹⁰⁹ The Supreme Court effectively

¹⁰⁴ Minn. Stat. § 65B.44, subd. 2 (2006).

¹⁰⁵ Minn. Stat. § 65B.44, subd. 3 (2006).

¹⁰⁶ Minn. Stat. § 65B.61, subd. 1 (2006).

¹⁰⁷ Some have argued that Minn. Stat. § 176.136 prevents arbitrations where there have been work comp denials. The plain language of the statute indicates otherwise:

Subd. 2. Excessive fees. If the employer or insurer determines that the charge for a health service or medical service is excessive, no payment in excess of the reasonable charge for that service shall be made ***under this chapter*** nor may the ***provider*** collect or attempt to collect from the injured employee or any other insurer or government amounts in excess of the amount payable under this chapter unless ... (Emphasis added).

This statute does not prevent the patient from pursuing payment under another Chapter (Namely, 65B). Only the provider is restricted from pursuing another insurer. Unlike the workers compensation arena, providers don't have any standing in no-fault litigation, anyway.

¹⁰⁸ See Notes 124-127, *supra*.

¹⁰⁹ In Rodgers v. Progressive Specialty Ins. Co., 499 N.W.2d 61, (Minn. Ct. App. 1992), *rev. denied* (June 22, 1993), the treating physician indicated that 50% of the treatment in dispute was “due to” the Progressive accident, and 50% was due to a prior accident. Rodgers' attorney apparently did not dispute the apportionment. Rather, Rodgers claimed that Progressive must pay *all* the bills, even those that he incurred “due to” the earlier accident. The Court of Appeals disagreed, holding that only the 50% of the treatments that arose from the second accident were Progressive's responsibility.

eliminated insurer apportionment in Great West Casualty Co. v. Northland Ins. Co.,¹¹⁰ and again in Scheibel v. Illinois Farmers Insurance¹¹¹

In Scheibel, an arbitrator had found, (and the parties had agreed) that “Scheibel’s injuries were 35 percent attributable to the first accident and 65 percent attributable to the second.”¹¹² The \$20,000 limits from the second accident had been exhausted, and Scheibel wanted Farmers to pay from the first accident limits.

The court held that the “over-arching policy” of the Minnesota No-Fault Act “is to promote full but not over-compensation of injured persons.”¹¹³ To fulfill that purpose, the court held that the second accident has no right to reduce benefits:

Consistent with our language in *Great West, Illinois Farmers, as the insurer on the second accident, is obligated to pay the maximum policy limit of \$20,000 for Scheibel’s injuries regardless of the extent to which each accident contributed to the injuries.*¹¹⁴

The Court then held that the first accident must step in and pay:

Because both accidents *cumulatively caused* Scheibel’s injuries and because his medical expenses are not fully reimbursed under the policy limits attributable to the second accident, we hold that Scheibel is entitled to additional reimbursement under his policy with Illinois Farmers for losses attributable to the first accident...

Further, to the extent that, absent the second accident, Scheibel would still have a viable claim under his Illinois Farmers policy for injuries suffered in the first accident, *he is entitled to payment for medical expenses attributable to the first accident that remain unreimbursed after the \$20,000 policy limit for*

¹¹⁰ 548 N.W.2d 279 (Minn.1998).

¹¹¹ 615 N.W.2d 34 (Minn. 2000).

¹¹² Scheibel at ____.

¹¹³ Scheibel at ____.

¹¹⁴ Scheibel at ____ (*emphasis added*).

the second accident has been paid. However, Scheibel is entitled to recover only that unreimbursed portion of his total medical expenses attributable to the first accident, up to the \$20,000 policy limit applicable to the first accident. Conversely, he cannot recover for any loss attributable to the second accident from coverage for the first accident.¹¹⁵

There are questions not clearly answered. For example, the court accepted the arbitrator's and the parties' apportionment without comment. What formula will be used to calculate the exposure of the first accident, once the limits of accident 2 are exhausted? Clearly, there will be no apportionment by the second accident insurer. Once those limits are exhausted, is the plaintiff limited to the percentage apportioned to the first accident? The Scheibel court states only that the recovery is limited to "only that unreimbursed portion of his total medical expenses attributable to the first accident, up to the \$20,000 policy limit..."

On remand, the Scheibel¹¹⁶ calculations were simple. The arbitrator's 65% apportionment to the second accident almost equaled the \$20,000 limits, and so enforcing the 35% apportioned to the first accident meant that 100% of the bills will be paid.

But what if the apportionments are not so neatly aligned with the policy limits? What if the percentage apportioned to the second accident exceeds those policy limits?

The competent defense attorney will certainly argue that the first accident need only pay up to the percentage of the apportionment, even if that leaves bills unreimbursed.

The claimant's lawyer has the better argument. The Scheibel court made it clear that full compensation was the "over-arching" concern. As long as the uncompensated benefits are attributable to the first accident, that insurer should pay.

Under Scheibel, apportioning the higher amount to the first accident will tend to increase the recovery. This is because even if the second accident is only

¹¹⁵ Scheibel at ____ (*emphasis added*).

¹¹⁶ Scheibel v. Illinois Farmers Ins. II, ____ N.W. 2d ____ No. CX-01-165 (Minn. Ct. App. July 24, 2001), *rev. denied*.

10% responsible, the second policy must pay till exhausted. The Claimant could then argue for 90% of the bills under the first accident.

The best tactic for the claimant's lawyer may still be to avoid apportionment altogether. If the doctor indicates that each of the injuries is a *substantial cause* of the need for *all* treatment, then each of the insurers will probably remain responsible for the full amount.

2. Settlement of Later Accident

What if the claimant has settled the later accident, and thus the limits are not exhausted? This was addressed in Khawaja v. State Farm Mut. Auto. Ins. Co.¹¹⁷ Khawaja had settled the second accident for slightly less than the policy limits, and then proceeded to arbitrate subsequent bills against the insurer for the first accident. The Court of Appeals held that the claimant must “eat the gap” between:

...to the extent that the insured has medical expenses attributable to the first accident that remain unreimbursed after the second insurer has discharged its obligation, the first insurer's liability under its policy with the insured is confined to those expenses that are above the insured's policy limit for the second accident.

3. Prior Non-automobile accidents

What if the prior accident did not involve an auto? The Supreme Court addressed this in Pususta v. State Farm,¹¹⁸ where the Claimant had been previously injured in a fall from a horse.

The Court underscored that Scheibel was still good law in multiple auto accident cases:

Within the no-fault system, i.e., where there are multiple auto accidents involved, imposing liability solely on the insurer at the time of the most recent accident to the extent such coverage fully compensates the claimant serves the

¹¹⁷ 631 N.W.2d 106 (Minn. Ct. App. 2001)

¹¹⁸ 632 N.W.2d 549 (Minn. 2001).

legislative goals of ensuring prompt payment of expenses and minimizing litigation.¹¹⁹

The court then notes a different standard when the prior accident was not automobile related:

Where, as here, one cause of injury arises within the no-fault system and one outside that system, our focus is on whether the loss arose out of the use of an automobile and whether reimbursement is for only those medical expenses resulting from injuries caused by the use or maintenance of an automobile.

The Pususta case should not be over read. The court only wishes that the auto carrier not be forced to pay for problems solely arising from non-auto cases. If the auto accident aggravates some prior condition, then the no-fault carrier is responsible for that aggravation.

However, there is no indication in the No-Fault Act that the legislature intended to modify the well-settled concept from tort law that damages are those attributable to a particular injury and the aggravation of a pre-existing physical condition. ***Requiring compensation for any aggravation of a pre-existing condition is what is meant by accepting the insured with any conditions she had at the time.*** Accepting the insured with the conditions she had does not mean that the insurer is liable for the expenses that the pre-existing condition, “running its normal course, would itself have caused if there had been no aggravation * * *.” ***The insurer is liable for the expenses related to injuries caused or aggravated by the automobile accident.***¹²⁰

The court concludes:

Thus, we reverse and remand and instruct the arbitrator to award those reasonable medical expenses for treatment of

¹¹⁹ Pususta at ____.

¹²⁰ Id. At ____ . Citations and footnote omitted.

injuries *caused by, or aggravated by, the automobile accident*. The arbitrator must determine the extent to which the medical expense relates to an injury that was a natural and reasonable incident or consequence of the use of the vehicle. *Medical expenses for injuries caused solely by the horse-riding accident shall be denied.*¹²¹

C. Causation Standards

So what is the current legal standard for medical causation? Ruppert's "probable factor" sounds more expansive than "proximate cause". Rodgers, ignoring Ruppert, rejected "proximate cause" out of hand, but Great Western and Scheibel have overruled the Rodgers ruling. Pususta goes off on another tangent.¹²²

¹²¹ Id. At _____. Citations omitted. The second sentence is interesting. Here, and in an earlier paragraph, the court quotes from the Continental Western. Ins. Co. v. Klug 415 N.W.2d 876 (Minn. 1987) line of cases. This reliance seems misguided and unhelpful, as briefly referenced in Justice Gilbert's Pususta dissent.

The Klug standard states:

[1] The first consideration is the extent of causation between the automobile and the injury...[T]he vehicle must be an "active accessory" in causing the injury. This causation standard was clarified to be "something less than proximate cause in the tort sense and something more than the vehicle being the mere situs of the injury." ...

[2] If a court finds a requisite degree of causation, it should next determine whether an act of independent significance occurred, breaking the causal link between "use" of the vehicle and the injuries inflicted...

[3] If a court finds a requisite degree of causation and no intervening independent act, it must consider one final inquiry. Though there may be a causal link between use of the car and the injury, the court must determine what type of "use" of the automobile was involved. ...[C]overage should exist only for injuries resulting from use of an automobile for transportation purposes.

Id. At 878. The Klug line of cases addresses a different area of causation-- whether the accidents and injuries themselves are sufficiently related to use of a motor vehicle to bring them into the auto coverage (e.g. in Klug, driving the car alongside another to shoot them). That is, whether the auto accident is really an auto accident. In almost all apportionment cases, it is undisputed that the injuries or aggravations arose from an auto accident or accidents. What is disputed is the portion of the treatment arising from the accidents, and the Klug standard is out of place in that discussion.

Regardless, Claimant's attorneys may want to cite the quite minimal Klug standards of "something less than proximate cause in the tort sense and something more than the vehicle being the mere situs of the injury" and "coverage should exist only for injuries resulting from use of an automobile for transportation purposes," etc.

¹²² See N. 121, *supra*.

The Act specifically uses proximate cause as the standard for wage loss benefits.¹²³ Why have a separate standard for medical expense benefits? It makes little sense to use one standard for wage loss and another for medical expenses.

By stating that the two accidents “*cumulatively caused*” the injuries the Scheibel court introduces a new term into the apportionment debate. But in using that term, it is clear that the court is *near* the proximate cause standard.

While Great West and Scheibel do not specifically use the term, it appears that *proximate cause* (or an even more expansive standard) may be the standard of causation for no-fault medical benefits.

IV. Practical Issues-Duties and Obligations

A. Insured’s Duties

1. Notice to Insurer - Application for Benefits

The Act has no time limit for providing notice of claim to the insurer. However, a no-fault policy may require notice within six months.¹²⁴ Even where the policy does include a notice provision, the injured person is only ineligible to the extent the insurer shows *actual prejudice*.¹²⁵

Even where the insurer's rights have been prejudiced, the insurer must have given notice of the potential prejudice or any attempt to deny benefits will be considered an unfair claim practice.¹²⁶ It is an unfair claim practice to fail to notify the insured in writing 60 days before the expiration of time for giving notice.¹²⁷

The claimant's attorney should determine whether notice of the claim has been provided as soon as the file is opened. Some claimant's attorneys like to “lie

¹²³ Minn. Stat. § 65B.44, subd. 3 (2006).

¹²⁴ Minn. Stat. § 65B.55, subd. 1 (2006).

¹²⁵ *Id.*, but see Williams v. League General, ¹²⁵ 1999 WL ____ (Minn. Ct. App. C6-99-758, 10/12/99) (unpublished), where a four and one-half year delay, and various other causation problems, supported a dismissal for prejudice.

¹²⁶ Minn. Stat. § 72A.201, subd. 4(6) (2006).

¹²⁷ Minn. Stat. § 72A.201, subd. 4(11) (2006).

low” and avoid sending a letter of representation to the no-fault insurer. They feel that the letter may trigger an early adverse exam. While this may be true, the lawyer who does not send a letter of representation must be doubly sure that the client notifies the proper no-fault carrier of the injury and that benefits are being paid.

2. Statute of Limitations

There is no statute of limitations specific to the No-Fault Act. In a recent published case, the Court of Appeals held that the six-year contract statute¹²⁸ applies, and starts to run when benefits are terminated.¹²⁹ The six year underinsured motorists statute of limitation begins to run at judgment or settlement of the underlying claim.¹³⁰ However, the court has held that the uninsured motorist statute of limitations begins running on the date of accident.¹³¹ Where possible, the prudent advocate will start any arbitration or lawsuit long before the sixth anniversary of the accident.

3. Adverse Exams

The No-Fault Act provides that

[a]ny person with respect to whose injury benefits are claimed under a plan of reparation security shall, upon request of the reparation obligor from whom recovery is sought, submit to a physical examination by a physician or physicians selected by the obligor as may reasonably be required.¹³²

¹²⁸ Minn. Stat. § 541.05, subd. 1(1) (2006).

¹²⁹ Entzion v. Illinois Farmers Ins. Co., __ N.W. 2d __ (Minn. Ct. App. Slip Op. No. A03-742 Filed 3-23-04). Previously, the case of Cummins v. American Family Mut. Ins. Co., 1992 WL 13053 (Minn. Ct. App. 1992) (unpublished), followed Spira v. American Standard Ins. Co., 361 N.W. 2d 454 (Minn. Ct. App. 1985), *rev. denied* March 29, 1985 (uninsured motorist case).

¹³⁰ Oanes v. Allstate 617 N.W.2d 401 (Minn. 2000).

¹³¹ Weeks v. American Family Mut. Ins. Co., 580 N.W.2d 24 (Minn. 1998); Beaudry v. State Farm Mut. Auto. Ins. Co., 518 N.W.2d 11 (Minn. 1994). These cases are easily distinguishable from the no-fault arena, where benefits, like injuries, are ongoing. Otherwise, no-fault carriers could simply stop paying benefits six years post-accident. There is no support for such a result in logic or the Act.

¹³² Minn. Stat. § 65B.56, subd. 1 (2006).

a) Geographic Requirement

The statute clearly outlines exactly where the physical examination must be performed:

Such examinations shall be conducted within the city, town, or statutory city of residence of the injured person. If there is no qualified physician to conduct the examination within the city, town, or statutory city of residence of the injured person, then such examination shall be conducted at another place of the closest proximity to the injured person's residence.¹³³

When the insurer violates this provision, the injured person should not be obligated to attend. Be careful, though. It is currently very questionable when it is valid to refuse to attend an exam.¹³⁴ The prudent advocate will inform the insurer of the objection, so perhaps the insurer will reset the exam, and not incur a cancellation fee.¹³⁵

The Act only allows the adverse exam outside the injured person's city or town when “there is no qualified physician to conduct the examination” within the city or town. This rarely occurs. Whether in the metro area, or greater Minnesota, very few towns or cities have no qualified physicians practicing within their boundaries.

Who is a “qualified physician?” An *orthopedic surgeon* who treats problems of the musculoskeletal system is qualified to testify as to the reasonableness of *chiropractic* care, despite having no direct or practical experience with chiropractors or their field.¹³⁶ Would a chiropractor, trained in the nervous system and the musculoskeletal system, be similarly qualified to testify

¹³³ *Id.*

¹³⁴ An unreasonable failure to attend an adverse exam warrants suspension of benefits. Neal v. State Farm Mut. Ins. Co., 529 N.W. 2d 330, (Minn. 1995). See Notes 138 -144 below.

¹³⁵ In Ortega v. Farmers Insurance Group, 474 N.W.2d 7 (Minn. Ct. App. 1991), the claimant did not make any objection and simply failed to show up for the exam. Although the failure to notify the insurer was not the fatal flaw, the arbitrator, the trial court and the appellate court all commented on that failure. The denial of benefits was confirmed, with the appellate court noting that the statute allows the arbitrator to consider failure to attend an exam.

¹³⁶ Wolf, 450 N.W.2d at 361.

regarding the treatment of orthopedic surgeons, neurologists and physical therapists?

Many insurers argue that there is no qualified physician because commercial adverse exam scheduling services do not schedule exams in or near the client's hometown. Since the vast majority of the exams done by such services are on behalf of insurers and defense attorneys, such an argument tries to equate “qualified physician” with “insurance company doctor.”

To counter this, many claimants’ attorneys submit pages from the Yellow Pages to the arbitrator to prove that there are qualified physicians in the client's hometown. Better still, many doctors will sign affidavits that they are willing and able to do independent exams if requested. In addition, the Board of Chiropractic Examiners maintains a list of the names and addresses of all chiropractors in the state registered to perform “independent” exams. Claimant's attorneys should keep an up-to-date copy of that list and submit it to the arbitrator when helpful.

Even if the insurer is able to prove that there is no qualified physician available, they do not have *carte blanche* to schedule the examination anywhere. The exam must be conducted “at another place of the closest proximity to the injured person's residence.” The insurer again has the burden of showing that the location it has requested is the place of closest proximity. Failing that, the injured person arguably should have no obligation to attend such an examination.¹³⁷

b) Duty to Attend Adverse Exam

In the past, the courts held that there is no duty to attend an adverse examination after the insurer has breached its contract. Refusing or delaying benefits could be found to be breach of contract, relieving the insured from the duty to attend the adverse exam and preventing the insurer from using the failure to attend as a basis for terminating benefits.¹³⁸

¹³⁷ *But see Ortega*, 474 N.W.2d at 9-10 (upholding arbitrator’s denial of benefits where claimant, who lived in Forest Lake, failed to attend an IME with a neurologist in New Brighton and failed to object to the location of the exam; the court stated that because there was no neurologist in Forest Lake the insurer was entitled to the IME in New Brighton, without discussion of whether another doctor of a different specialty would have been “qualified”).

¹³⁸ *Maryland Casualty Co. v. Harvey*, 474 N.W.2d 189 (Minn. Ct. App. 1991), *overruled by Neal v. State Farm Mut. Ins. Co.*, 529 N.W.2d 330 (Minn. 1995); *Milwaukee Mutual Ins. Co. v. Murphy*, 474 N.W.2d 438 (Minn. Ct. App. 1991).

In Neal v. State Farm Mut. Ins. Co.,¹³⁹ however, the court held that the insurer could suspend benefits after a failure to attend an exam. The court implied the suspension was not forfeiture, and vested the arbitrator with considerable fact-finding power:

That the insurer suspends, rather than terminates, payment until the claimant has, upon request, submitted to a physical examination scheduled in accordance with the statutory guidelines seems eminently reasonable. Thereafter, during the arbitration process, the parties may produce evidence of either the reasonableness of the refusal to attend the IME so as to warrant the reinstatement of benefits, in the case of the claimant, or the appropriateness of the suspension of benefits for the claimant's lack of cooperation¹⁴⁰

Of course, reasonableness is in the eye of the beholder. For the most part, the courts tended to support an arbitrator's decision on reasonableness of a refusal to attend.¹⁴¹ To determine the proper course of action, the attorney needed only predict the future ruling of an unknown arbitrator!

Following Neal, State Farm appeared before the Court of Appeals on a number of refusal cases. The Court of Appeals decided three of these cases, Hovland v. State Farm¹⁴², Weaver v. State Farm¹⁴³, and Chorske v. State Farm¹⁴⁴ within a

¹³⁹ 529 N.W. 2d 330 (Minn. 1995). Essentially, unpaid benefits do not automatically equate to a breach of contract excusing a refusal. Reasonableness of the refusal will be decided at arbitration, and the insurer may suspend benefits until the insured attends an exam or an arbitrator decides the non-attendance was reasonable.

¹⁴⁰ *Id.*

¹⁴¹ See State Farm Mut. Auto. Ins. Co. v. O'Leary, 1998 WL 523805 (Minn. Ct. App. 1998) (unpublished) (arbitrator's determination that claimant's refusal to attend IME was reasonable and a factual finding fully within arbitrator's authority) and Jacobsen v. Auto Owners Ins. Co., 1996 WL 523805 (Minn. Ct. App. 1996) (unpublished) where the court held that the insurer may suspend benefits until the claimant attends a legally-set exam. "[T]hen the arbitrator may decide, based on the evidence, whether to reinstate benefits or suspend them due to lack of cooperation and prejudice to the insurer." The claimant had refused to attend two adverse exams. Eventually, the claimant attended an adverse exam, the examiner supported the wage loss claim and the arbitrator's award of benefits was affirmed.

¹⁴² 593 N.W. 2d 271 (Minn. Ct. App. 1999) *Reversed*, Weaver et. al. v. State Farm, 609 N.W. 2d 878 (Minn. 2000). The claimant had suffered an aggravation of a prior injury, and received benefits. After an apparent two and one-half year gap in treatment, Hovland incurred another \$3,000 in treatment. State Farm suspended benefits and asked for an adverse exam. Hovland refused to attend until State Farm paid the outstanding bills, and proceeded to arbitration. The arbitrator, apparently without making any factual findings, awarded a portion of the claim. The district court vacated the award.

one month and the Supreme Court consolidated the cases for review. In Weaver et. al. v. State Farm,¹⁴⁵ the Supreme Court decided this trio, providing further guidance.

The court held that:

[A]s a general proposition, the arbitrator has jurisdiction to award, suspend or deny benefits. To achieve the consistency desired in interpreting the no-fault act, this court and the district court review de novo the arbitrator's legal determinations necessary to granting relief.

As to claimants:

We conclude that under the no-fault statute refusal presents an issue of reasonableness, which is a fact issue to be determined by the arbitrator.

Insurers also have to be reasonable:

It is for the arbitrator to determine the reasonableness of the request for the IME and the refusal, and to also order an appropriate remedy, which may include suspension of payment for disputed benefits until the claimant submits to an IME...

It appears the legislature intended to allow the insurer to withhold payment during a reasonable investigation period or pending arbitration over the disputed claim, subject to a 15 percent interest penalty after 30 days if the insured prevails.

Nonpayment of bills does not equal unreasonableness:

¹⁴³ 1999 WL 293929 (Minn. Ct. App. C9-98-1859, May 11, 1999) (unpublished) *Affirmed*, Weaver et. al. v. State Farm, 609 N.W. 2nd 878 (Minn. 2000). Decided the same day as Hovland, a different panel came to the opposite result on similar facts. Judge Amundson, citing *Keim v. Farm Bureau Ins. Co.*, *supra*, pointed out that a reviewing court should assume that an arbitrator did not exceed his or her authority. Judge Amundson reasoned that since the benefits were awarded, the arbitrator must have found the refusal to attend reasonable.

¹⁴⁴ 1999 WL 3666608 (Minn. Ct. App. C1-98-2231, June 8, 1999) (unpublished). *Reversed*, Weaver et. al. v. State Farm, 609 N.W. 2nd 878 (Minn. 2000). The district court had confirmed the award, finding that the arbitrator "could have" found the refusal to attend reasonable. The Court of Appeals extended Hovland, without citing *Weaver*, characterizing the district court's deferral "speculative."

¹⁴⁵ 609 NW 2nd 878 (Minn. 2000). (Rehearing denied May 24, 2000).

However, because nonpayment of some claims was contemplated by the legislature, it would appear the insured has no right based on the insurer's nonpayment to refuse a reasonably requested IME.

The arbitrator's authority is limited:

...An arbitrator is not authorized to award payment for medical treatment after finding the IME request with respect to that treatment was reasonable and necessary to the determination of benefits and its refusal unreasonable...

The court outlines the remedies available to an arbitrator:

If the IME request was reasonable and its refusal unreasonable, the arbitrator may award or ratify the insurer's suspension of disputed payments until an IME is completed. If the arbitrator finds that the insurer is so prejudiced by the unreasonable failure to attend an IME that the insurer cannot defend against the claim, the arbitrator may proceed to deny benefits for which the IME is necessary.

Where the arbitrator has determined that a request for an IME was unreasonable and the refusal reasonable, the arbitrator may or may not proceed to award benefits. For example, where the arbitrator finds that an IME is unnecessary, the arbitrator may proceed to award or deny benefits based on the record presented.

The court concludes:

In sum, the refusal to attend an IME on the basis that the insurer has not paid outstanding claims may or may not prevent the arbitrator from ordering that benefits be paid. ***It is for the arbitrator to decide the reasonableness of the IME request and the reasonableness of the claimant's response to the request. The arbitrator has authority on a case by case basis to award, suspend or deny benefits when the insured has refused to attend an independent medical examination because of nonpayment of a disputed claim.*** The relief awarded is subject to de novo review by the district court, however.

In most cases, practitioners should simply send their clients to all adverse exams, and save the complaints for the hearing. If the no-fault exam was

obviously set just to harass the client, good arbitrators will consider that when assessing the award.

If the client has already failed to attend an adverse exam, and you feel the failure may be found unreasonable, ask the carrier to reschedule the exam. If the carrier refuses, your client's error will seem less prejudicial.

Another unpublished case provides further refinement of 'reasonableness' in scheduling of adverse exams. In Swan v. Milwaukee Ins. Co.,¹⁴⁶ the district court held that a refusal to attend a last-minute adverse exam set the week before surgery was reasonable, and awarded benefits. Judge Amundson's panel agreed, noting:

Swan offered to attend a post-surgery IME, but Milwaukee refused her offer... However, examinations after surgery are valid and often seen in insurance, workers' compensation, and malpractice cases...

If Swan had waited until after the surgery to notify Milwaukee, Milwaukee would have been obligated to pay the bills for the surgery or could have required an IME at that time...

Because pre-surgery notice is not required, Milwaukee has not met its burden of demonstrating prejudice as a result of Swan's refusal to attend a pre-surgery IME.¹⁴⁷

4. Paper Reviews and Audits

Paper reviews have always been a fairly poor substitute for an actual exam. It is questionable whether an arbitrator could deny bills based on a mere review of records rather than the exam allowed by the Act.

Audits or bill reductions based on databases or schedules of "Usual and customary" charges have been barred by statute.¹⁴⁸

¹⁴⁶ 1999 WL ____ (Minn. Ct. App. C5-99-332, November 23, 1999) (unpublished).

¹⁴⁷ *Id.* at ____.

¹⁴⁸ Section I.A.1.a) above, Managed Care Barred from No-Fault.

5. Lapse in Treatment *and* Disability

There is no authority in the Act allowing termination of benefits simply because of a gap in treatment, however,

A plan of reparation security may provide that in any instance where a lapse occurs in the period of disability or in the medical treatment ... and a person subsequently claims additional benefits based upon an alleged recurrence of the injury for which the original claim for benefits was made, *the obligor may require reasonable medical proof of such alleged recurrence*; ... such coverages *may contain* a provision terminating eligibility for benefits after a prescribed period of lapse of disability and medical treatment, which period shall not be less than one year.¹⁴⁹

Thus benefits may only be terminated when the insurer can show:

1. That the policy contains a lapse provision;
2. There was a one-year lapse of treatment; *and*
3. There was a one-year lapse of disability.

A one-year lapse of *treatment* is usually straightforward; just look at the bills and records. A one year lapse in *disability* was a bit more difficult, especially given the lack of a general definition of “disability” in the Act. However, the Supreme Court has now affirmed a definition of “disability” as “*anything affecting the normal, physical and mental abilities of a person.*”¹⁵⁰ Thus, almost any residual

¹⁴⁹ Minn. Stat. § 65B.55, subd. 2 (2006) (emphasis added).

¹⁵⁰ Thomas v. Western National Ins. Group, 562 N.W.2d 289 (Minn. 1997). Note that the court held that ‘disability’ was “to be interpreted by its plain and ordinary meaning,” and that the arbitrator did not err by giving the above-quoted definition.

In Kirsila v. State Farm Mutual, Hennepin County District Court File No. 763885 (January 31, 1980), State Farm agreed in a written stipulation to use an interpretation of “disability”:

(b) Absent further definition of the term “disability” in Minn. Stat. § 65B.55(2), whether by judicial interpretation, statutory chance or regulatory authority interpretation, State Farm will interpret said term to include any reduction in ability to work or perform daily activities whether by permanent injury or disfigurement.

(c) If a period of more than one year passes during which time a no-fault claimant does not obtain medical treatment but nevertheless is afflicted with a “disability” as defined above, then State Farm shall not deny coverage based on the one-year termination provision.

disability, no matter how small, would prevent a lapse of disability. Apparently, a complete cure of all symptoms and injuries for one year is required before benefits lapse.

An unpublished case confirms this. In VanLangen v. Western National Ins. Group,¹⁵¹ the plaintiff stopped seeing her neurologist, but continued to have symptoms. After a gap in treatment, she secured massage therapy for three years without a referral. When she found out the treatment might be compensable under the no-fault act, she secured a referral slip after the fact. Western argued that this amounted to a lapse in treatment.

The Court of Appeals reinstated the arbitrator's award, holding:

...Minn. Stat. § 65B.55, subd. 2 sets forth a two-prong test for a lapse provision to properly apply, *each* of which is necessary for termination of no-fault benefits...The plain language of the statute requires a lapse of both medical treatment and disability.¹⁵²

In addition the court commented on burden of proof for affirmative defenses:

The lapse provision provides a basis for excluding what would otherwise be a covered loss. As such, *this is an affirmative defense, and the insurer bears the burden of persuasion as to the application of the exclusion.*¹⁵³

Fair Claims notice. The Fair Claims Act requires insurers to provide at least 60 days notice of the one-year lapse.¹⁵⁴ There are few insurers sending appropriate lapse warnings. An arbitrator should not enforce a lapse provision where there has been no notice.

Kirsila, *supra*, Stipulation of Settlement at pp. 3-4 (emphasis added). It appears the court has adopted a definition similar to that in the Kirsila stipulation.

¹⁵¹ Minn Ct. App. unpub'd (No. C9-02-149 filed 7-23-02).

¹⁵² Id. Emphasis in original.

¹⁵³ Id. Emphasis added.

¹⁵⁴ Minn. Stat. § 72A.201, subd. 6 (2006).

Some insurers attempt to skirt this requirement by sending notice of the lapse provision immediately after the accident, rather than when the lapse is about to occur. Such a notice clearly subverts the letter and spirit of the Act, and should not be given any effect.

Permanent Injury. Finally, where there is a finding of a permanent injury, there can be no lapse of disability.¹⁵⁵

6. Mitigation

Injured persons are required to mitigate their income losses if they are capable of performing substitute work:

Compensation . . . shall be reduced by any income from substitute work . . . the injured person would have earned in *available appropriate* substitute work which the injured person was capable of performing but *unreasonably* failed to undertake.¹⁵⁶

Of course, the substitute work must be appropriate and the failure to work must have been unreasonable. In addition, if no appropriate work is immediately available, the no fault carrier should continue to pay benefits for a reasonable time. If not for the accident, the person would still have the original job.¹⁵⁷

B. Insurer's Duties

Prompt Payment

¹⁵⁵ Ferguson, 348 N.W.2d at 734 (Minn. 1984). (“There may be occasions where plaintiff may not need treatment for a period of more than one year. However, when a jury determines that an insured has incurred a future medical disability, this precludes a lapse of disability and prevents enforcement of any policy provision adopted pursuant to § 65B.55, subd. 2.”).

¹⁵⁶ Minn. Stat. § 65B.44, subd. 3 (2006) (emphasis added).

¹⁵⁷ *But see* Darby v. American Family Ins. Co., 356 N.W.2d 838 (Minn. Ct. App. 1984) (income loss benefits not payable when claimant able to return to work, even if job not available) Pulju v. Metropolitan Property & Cas., 1996 WL 91655 (Minn. Ct. App. 1996) (unpublished) (claimant able to return to usual work, but needed substitute worker months later to start new business; not compensable). *See also* Kelly v. American Family Ins. Co., 1993 WL 369050 (Minn. Ct. App. 1993) (injured person who was partially disabled must make reasonable efforts to mitigate wage loss).

V. Auto Injury Claims

A. Thresholds

The No-Fault Act limits tort claim. A plaintiff can recover noneconomic damages only if:

- ...the injury results in:
 - (1) permanent disfigurement;
 - (2) permanent injury;
 - (3) death; or
 - (4) disability for 60 days or more.¹⁵⁸

Or the value of the medical care exceeds \$4,000, excluding:

..the amount of medical expense benefits paid, payable, or payable but for an applicable deductible for diagnostic X-rays and for a procedure or treatment for rehabilitation and not for remedial purposes or a course of rehabilitative occupational training...¹⁵⁹

B. Medical Costs over \$4,000

1. X-Rays CT scans and MRI scans

“Diagnostic x-rays,” do not count toward the \$4000 threshold.¹⁶⁰ In an unpublished case, *Safinia v. Kruse*,¹⁶¹ a Court of Appeals panel held that MRI and CT scans should also be excluded.

This decision has been highly criticized, and has questionable persuasive value. First, it is unpublished. Second, the core holding of the case is centered on overturning a jury finding of the 60-day disability.

Finally, while the court attempts to finesse the similarities of x-rays, CT and MRI scans, the language of the statute is clear and unambiguous. X-

¹⁵⁸ Minn. Stat. § 65B.51, subd. 3(b) (2010).

¹⁵⁹ Minn. Stat. § 65B.51, subd. 3(a) (2010).

¹⁶⁰ Minn. Stat. § 65B.51, subd. 3 (a)(4) (2006).

¹⁶¹ 1997 WL 118200, unpub. (Minn. App., Mar. 18, 1997), review denied (Minn., May 28, 1997).

rays are x-rays. The legislature was perfectly capable in 1974 of excluding diagnostic tests or diagnostic imaging.

Safinia has not been cited in any later case. Numerous district courts have held that Safinia was wrongly decided, and have refused to exclude scan costs from the thresholds.

VI. Disputes

A. Arbitration

1. Jurisdiction

a) Jurisdictional Amount (\$10,000)

Claims against no-fault insurers of \$10,000 or less on the date of filing must be arbitrated.¹⁶² Claims may not be split into multiple arbitrations to avoid the jurisdictional limit.¹⁶³ The total amount of damages claimed includes losses incurred, but not yet denied by the insurer at the time the petition is filed.¹⁶⁴ However, filing an arbitration for \$2,600 in medical bills 19 days before surgery pushed the outstanding bills to \$35,000 was acceptable, even when the no-fault carrier is notified of the change in the claim only one day prior to the hearing.¹⁶⁵

(1) Limiting Claims to \$10,000

Even if outstanding benefits are more than \$10,000 as of the date of the filing of the arbitration, the claimant may voluntarily limit the claim to \$10,000 to maintain AAA jurisdiction.¹⁶⁶

What if the outstanding benefits are less than \$10,000, but the statutory interest penalty forces the total over \$10,000? Must the excess penalty be waived to

¹⁶² Minn. Stat. § 65B.525, Subdivision 1 (2006).

¹⁶³ *Id.* Even where a wage loss witness failed to appear at the hearing, the arbitrator granted the claimant's request to dismiss without prejudice and re-file the wage claim within 60 days, and the hearing went forward on medical bills alone, the court held that the wage loss was impermissibly split, and thus waived. Auto-Owners Ins. Co. v. Makhoulfi, 1996 WL 745228 (Minn. App 1996) (unpublished).

¹⁶⁴ Hippe v. American Family Ins. Co., 565 N.W.2d 439 (Minn. Ct. App. 1997).

¹⁶⁵ Karels v. State Farm Ins. Co., 617 N.W.2d 432 (Minn.App. 2000).

¹⁶⁶ Brown v. Allstate Ins. Co., 481 N.W.2d 17 (Minn. 1992).

maintain jurisdiction? **Recently, the Court of Appeals ruled that the interest/penalty was not counted as part of the \$10,000 jurisdictional limit.**¹⁶⁷

This makes sense. The statute details that mandatory submission to binding arbitration occurs:

[W]here the claim at the commencement of the arbitration is in an amount of \$10,000 or less against any insured's reparation obligor *for no-fault benefits*....¹⁶⁸

The interest award is a penalty for non-payment in a timely manner, not a "no-fault benefit" as defined by 65B.44 or 65B.45.

Similarly, the courts have held that the penalty must be paid, even when it exceeds the no-fault policy limits.¹⁶⁹ It would be unfair to force the claimant to waive the penalty, or file a lawsuit in district court.

(2) No-fault claims cannot be split

Claims for medical and wage benefits cannot be split into separate arbitrations in order to maintain arbitration jurisdiction.¹⁷⁰

(3) Claim may grow to exceed \$10,000 after filing

Jurisdiction is determined by the amount of the claim at the time the petition is filed. Jurisdiction is maintained, even if the amount claimed grows to exceed \$10,000 after the date of filing.¹⁷¹

(4) Arbitrating old bills in a new arbitration.

¹⁶⁷ American Family Ins. Group v. Kiess, 680 N.W.2d 552 (Minn. App. 2004). (*cert. granted on other issue*).

¹⁶⁸ Minn. Stat. § 65B.525 Subd. 1 (2006)

¹⁶⁹ McGoff v. AMCO Ins. Co., 575 N.W.2d 118 (Minn. Ct. App. 1998).

¹⁷⁰ Charboneau v. American Family Ins. Co., 481 N.W.2d 19, 21 (Minn. 1992). In *dicta*, the court opines that claims for comprehensive and collisions damages may be brought separately from no-fault claims. *Id.* at 21, 22.

¹⁷¹ Charboneau v. American Family Ins. Co., 481 N.W.2d 19 (Minn. 1992); No-Fault Rule 6.

Typically, claims not presented at an arbitration hearing are deemed waived. However, there are a few instances where bills incurred before the arbitration may be presented at a subsequent arbitration.

(a) Post hearing, pre-award bills

No Fault carriers often deny bills incurred before the last arbitration hearing. Clearly, bills incurred after the hearing has been closed, but before the award is issued were not previously claimed, and should be included in the new hearing.

(b) Pre-hearing undenied bills

In the weeks before arbitration, treatment may have been incurred. If the bills were not issued to the insurer or claimant, how can they have been denied? Bills not yet denied by the carrier are not “in controversy” and thus should fall outside of the scope of what is a “claim” for purposes of jurisdiction.

(c) Missed bills. In two separate unpublished cases, the Court of Appeals has allowed arbitration of bills which predated an earlier arbitration.

The court found that it was permissible to arbitrate bills that had been incurred prior to an earlier wage loss and property damage arbitration. In Peschong v. AMCO Ins. Co.,¹⁷² the claimant had arbitrated wage loss and property damage shortly after her crash. Meanwhile, some of her medical treatment was unpaid. The insurer had not issued a denial of the medical claims, and indeed medical bills had not even been sent to the respondent at the time of the first arbitration; Given that, and that there was no evidence that respondent was attempting to evade the jurisdictional ceiling, the arbitrator’s award was affirmed.

Similarly, in Heintz v. Farm Bureau Mut. Ins. Co.,¹⁷³ bills that had been incurred after the adverse exam and cutoff were arbitrable because claimant had not received the bills by the time of the hearing, and because there was no evidence of manipulation or that she was attempting to evade the jurisdictional limit. The court even disregarded a “satisfaction and acknowledgment” that the Claimant had signed following payment of the previous award.

¹⁷² 1999 WL 171508 (Minn. Ct. App. C9-98-1859, March 30, 1999) (unpublished).

¹⁷³ 2001 WL 118551 (Minn. Ct. App. c9-00-1491, February 13, 2001) (unpublished).

c) 30-day Time Limitation. The Rules require that the arbitrator issue an award within 30 days of the close of the arbitration.¹⁷⁴ The courts have found this requirement to be jurisdictional, and it will be strictly enforced.¹⁷⁵ Obviously, this can cut both ways. Advocates should do their best to ensure that favorable arbitration awards are made within 30 days. The trick, of course, is knowing which awards will be favorable before they are made!

Objecting to a late award can be tricky. The remedy is a new hearing, usually in front of the same arbitrator!¹⁷⁶

d) Timeliness of Jurisdiction Objection. Defenses to jurisdiction must be raised prior to the hearing or are waived.¹⁷⁷ However, going forward with the hearing after written objection does not waive the written objection. In Regenscheid v. Farm Bureau Mut. Ins. Co.,¹⁷⁸ a health insurer's last minute assertion of subrogation put the claim well over \$10,000, prompting the claimant to ask to withdraw from arbitration. The insurer not only refused, but wrote that the its "refusal to allow withdrawal of the Arbitration Petition in no way should be construed as a waiver by Farm Bureau of the jurisdictional limit..." The arbitrator awarded \$24,000, and the insurer appealed.

The Supreme Court, reversing the trial court and the Court of Appeals, held that, while written objection must be made, going forward with the arbitration did not amount to a waiver.

Thus, the insurer is allowed it cake, and to eat it, too. By refusing the withdrawal and going forward with the arbitration, the insurer ensures itself two bites at the apple. If respondent loses at the arbitration, they can then appeal to the district court.

¹⁷⁴ No-Fault Rules, Rule 30, (September 7, 1999).

¹⁷⁵ Barneson v. Western Nat'l Mut. Ins. Co., 486 N.W.2d 176 (Minn. Ct. App. 1992).

¹⁷⁶ The Barneson panel held that the prejudice from the "lengthy delay" was sufficient to order a new arbitrator. Typically, without findings of prejudice, the original arbitrator hears the rehearing. See, Metropolitan Airports Commission v. Police Federation, 443 N.W.2d 519, 525 (Minn. 1989).

¹⁷⁷ Ranzau v. Metropolitan Property & Casualty, 1999 WL ____ (Minn. Ct. App. C6-99-775, November 23, 1999) (unpublished).

¹⁷⁸ __ N.W. 2d __ (Minn. File # CX-01-862 filed October 25, 2002).

Any time an insurer makes a substantive objection, claimant would be wise to consider withdrawing the claim from arbitration. The Regenscheid problem (less than ten days before hearing) might be avoided by requesting that insurer allow withdrawal, and if not, the arbitrator grant a continuance in the hearing, to allow the case to be withdrawn more than ten days before the new hearing.

2. Subject matter

3. Filing

4. Discovery

The Minnesota No-Fault Arbitration Rules generally discourage discovery in no-fault arbitrations. Rule 12 states that, “the voluntary exchange of information is encouraged,” while “formal discovery is discouraged.” There are exceptions for medical reports, medical authorizations, employment records and authorizations when the wage loss is in dispute, and specific documentary evidence necessary to substantiate the amounts claimed.¹⁷⁹ Rule 12 provides that a party desiring added formal discovery must make a showing of good cause.

An unpublished case has held that the failure to attend a statement under oath is a breach that voids the contract.¹⁸⁰

5. Hearing

a) Burden of Proof

The insurer has the burden of proving that the claimant is not entitled to benefits. This is a reversal of the usual burden of proof, based on the unique policies of the Minnesota No-Fault Act. In Wolf v. State Farm Ins. Co.,¹⁸¹ the Court of Appeals defined the burden of proof:

We do not agree with State Farm's position that the initial burden of proof was on Wolf to establish her entitlement to benefits by presenting evidence on the issues of causation and necessity. An insured has a right to basic economic loss benefit under the

¹⁷⁹ No-Fault Rules, Rule 12, (September 7, 1999).

¹⁸⁰ Metropolitan Property & Casualty v. King, (Minn. Ct. App. unpublished slip. op. C9-02-1737 5-6-03, 2003 WL21008323)

¹⁸¹ 450 N.W.2d 359 (Minn. Ct. App. 1990).

Minnesota No-Fault Act. Once an insurer receives reasonable proof of the fact and amount of loss realized, it has a duty to respond to an insured's claim in a timely manner. Assuming State Farm received reasonable proof of Wolf's losses, the burden was on it to establish Wolf was not entitled to benefits.¹⁸²

Every claimant should provide the arbitrator a copy of the Wolf decision. In cases where the insurer does not have a credible independent exam or some other strong rebuttal evidence, the insurer fails to satisfy its burden of proof and the arbitrator should award the claimed benefits.

b) Evidence

(1) Admissibility.

The Minnesota No-Fault Arbitration Rules state:

The arbitrator shall be the judge of the relevancy and materiality of any evidence offered and conformity to legal rules of evidence shall not be necessary. The parties shall be encouraged to offer, and the arbitrator shall be encouraged to receive and consider, evidence by affidavit or other document, including medical reports, statements of witnesses, officers, accident reports, medical texts, and other similar written documents which would not ordinarily be admissible as evidence in the courts of this state.¹⁸³

By making no-fault claims subject to mandatory arbitration, the legislature's purpose was:

To speed the administration of justice, to ease the burden of litigation on the courts of this state, and to create a system of small claims arbitration to

¹⁸² 450 N.W.2d at 362 (citations omitted).

¹⁸³ No-Fault Rules, Rule 24, (September 7, 1999).

decrease the expense of and to simplify litigation...¹⁸⁴

Clearly, allowing complex discovery beyond simple information exchange or requiring strict adherence to the Rules of Evidence would be contrary to the intent of the statute.

(2) Sufficiency.

The arbitrator has considerate discretion in fact finding. The Courts may only examine whether the facts were within the arbitrator's authority to decide; "We may not examine the underlying evidence and record, or otherwise delve into the merits of the award."¹⁸⁵ Thus, there is no requirement that the claimant testify, if the arbitrator is satisfied with the proof.¹⁸⁶

6. Decision

7. Judgment and Satisfaction

8. Appeals

Where a claimant missed four or five AMEs, some of which were ordered by the arbitrator, the court held the arbitrator's order denying dismissal and giving claimant one more chance was an interlocutory order dealing with discovery matters, and therefore the district court lacked jurisdiction to review the arbitrator's order.¹⁸⁷

9. Why Arbitration?

Many different issues can arise in no-fault arbitrations, and preparation is important. No-fault arbitrations are typically an ancillary part of representation. As attorneys, we become accustomed to the harsh tactics of no-fault insurers. We forget that denial of no-fault benefits is often the most surprising and traumatic part of the litigation for the client.

¹⁸⁴ Minn. Stat. § 65B.42, subd. 4 (2006).

¹⁸⁵ Liberty Mutual v. Sankey, __ N.W.2d __ (Minn. Ct. App. C1-99-1364 February 1, 2000).

¹⁸⁶ Id.

¹⁸⁷ State Farm Mut Ins. Co v. Ahmed, 689 N.W.2d 306 (Minn. Ct. App. 2004).

Because relatively few tort actions are tried, clients seldom see their lawyer actually *lawyering*. In a no-fault arbitration, your clients see you in action, advocating for their rights. Successful representation in the arbitration will not only “pay the bills,” but it will cement the relationship between you and your client.

B. Effects of Litigation on Future Claims

What effect will a previous resolution of a claim have on current no-fault benefits or third party liability? The answer depends a great deal on the form and forum of the previous decision. Under the doctrine of collateral estoppel, once an issue is decided in litigation, it may not be relitigated. In general, where:

1. An issue in the present litigation is identical to one in a prior proceeding;
2. There is a final judgment on the merits;
3. The estopped party was a party to the previous adjudication; and
4. There was a full and fair opportunity to be heard on the issue;

the party will be estopped from relitigating the issue.¹⁸⁸

1. Trial of Underlying Tort Claim.

Trial of an underlying tort case will often, but not always, affect future no-fault benefits. In Ferguson v. Illinois Farmers Ins. Group Co.,¹⁸⁹ the jury awarded \$10,000 for future medical expenses. The court held that the liability carrier must pay the damages awarded by the jury. The no-fault carrier could take a credit for the payment, but must begin paying again when the actual bills exceeded the plaintiff’s net recovery of future medical expenses from the tortfeasor.¹⁹⁰

¹⁸⁸ Aufderhar v. Data Dispatch Inc., 452 N.W.2d 648, 650 (Minn. 1990); *see also* Johnson v. Consolidated Freightways, Inc., 420 N.W.2d 608 (Minn. 1988); Ellis v. Minneapolis Comm'n on Civil Rights, 319 N.W.2d 702 (Minn. 1982).

¹⁸⁹ 348 N.W.2d 730 (Minn. 1984).

¹⁹⁰ *Id.* at 733.

Similarly, in Simpson v. American Family,¹⁹¹ the Court of Appeals extended the Ferguson analysis to income loss. Even though the wage loss is not exactly the same as earning capacity, jury awards for loss of earning capacity must be exhausted by actual income loss before the insurer must pay no-fault wage loss benefits.

However, jury denial of benefits may be different. For example, an underinsured motorist jury verdict denying damages for loss of earning capacity does not bar arbitration of subsequent wage loss.¹⁹² The court held that “no-fault benefits are specific in nature and require proof of loss as opposed to the more prospective analysis for loss of earning capacity.”¹⁹³

The Supreme Court finally addressed wage losses in Nelson v. American Family Ins. Co.¹⁹⁴. American Family had denied wage loss benefits in Nelson’s out of state accident. Nelson succeeded in the underlying tort action in securing \$37,000 in wage benefits, then sued American Family for the no-fault benefits that she should have been paid.

The Court of Appeals had denied the claim, saying the Act forbade double recovery, but the Supreme Court reversed. Nelson was allowed to recover \$6,666.67 (plus statutory interest) from her no-fault insurer to compensate her for her attorneys fees paid corresponding to the \$20,000 in wage loss benefits. The court explains this result puts both parties where they would have been if American Family had paid the benefits and subrogated.

The identical analysis should hold true where unpaid past medical is collected in the liability trial. An insured should then be able to collect the attorney fees and costs portion of the benefits from the no-fault carrier.

2. Settlement of Underlying Tort Claim.

The settlement of an underlying tort claim, and the amount of any such settlement, are usually irrelevant to the no-fault claim. Settlement with the at-

¹⁹¹ __N.W.2d __ (Minn.App # C9-99-964 1-4-2000).

¹⁹² State Farm Mut. Auto. Ins. Co. v. Spartz, 588 N.W.2d 173 (Minn. Ct. App. 1999), *rev. denied* (March 30, 1999).

¹⁹³ *Id at* __.

¹⁹⁴ __N.W.2d __ (Minn. # C4-01-226 8-29-2002).

fault party does not affect the statutory right to no-fault benefits.¹⁹⁵ If the insured has paid medical bills out of a third party settlement, the no-fault carrier must reimburse their insured.

Attorneys must be careful, however, that the tort settlement agreement or release does not recite or categorize amounts for future economic loss. In LeBeau v. John Deere Ins. Co.,¹⁹⁶ the parties allocated a specific amount for expected medical expenses in the tort claim settlement agreement. Because the agreement recited a specific amount for medical expenses, the court felt Ferguson controlled.¹⁹⁷ The court allowed the no fault carrier a credit for the recited medical expenses.¹⁹⁸ As in Ferguson, the no-fault carrier must resume payments after the credit is exhausted.

3. Uninsured/Underinsured Motorist Arbitrations.

Does an arbitration decision affect later matters? In Aufderhar v. Data Dispatch, Inc.,¹⁹⁹ the plaintiff was prevented from relitigating damages that had been denied in a previous uninsured motorist arbitration.

However, in State Farm v. Spartz,²⁰⁰ a claimant was allowed to pursue a no-fault wage loss claim despite a previous UIM jury finding of no loss of earning capacity. The UIM trial had focused on whether a loss would occur in the future and the no-fault case would assess whether a loss had actually occurred thereafter.

4. No-Fault Arbitration.

The Minnesota Supreme Court has amended the no-fault rules to eliminate any estoppel effect of no-fault arbitrations.²⁰¹ Before that, the courts had split on

¹⁹⁵ Balderrama v. Milbank Mut. Ins. Co., 324 N.W.2d 355 (Minn. 1982).

¹⁹⁶ 574 N.W.2d 83 (Minn. Ct. App. 1998), *rev. denied* (March 26, 1998).

¹⁹⁷ *Id.* at 85.

¹⁹⁸ *Id.*

¹⁹⁹ 452 N.W.2d 648 (Minn. 1990).

²⁰⁰ 588 N.W.2d 173 (Minn. App. 1999).

²⁰¹ “Given the informal nature of no-fault proceedings, the no-fault award shall not be the basis for a claim of estoppel or waiver in any other proceeding.” No-Fault Rules, Rule 32, (September 7, 1999).

the issue.^{202, 203} One post-amendment case has indicated the rule change simply codified the law.²⁰⁴

5. No-Fault Settlement.

The Court of Appeals has addressed the effect of a settlement of no-fault benefits on a subsequent third party claim. In Pemberton v. Theis,²⁰⁵ the plaintiff had settled all no-fault benefits for \$2,331, and the release specifically reserved liability claims. The court held that future medical expenses were noneconomic damages, and thus not subject to the thresholds. Still, the district court's deduction of the full amount from the future medical expenses awarded by the jury was found to be not clearly erroneous.

6. Prior Worker's Compensation Decision.

As more attorneys pursue the no-fault benefits available where worker's compensation denies benefits, the question of the effect of the hearings in the two parallel jurisdictions is arising.

The

7. Settlement of Worker's Compensation Claim.

A settlement of the worker's compensation claim will affect no-fault benefits. In American Family v. Udermann,²⁰⁶ a workers compensation settlement included language that explicitly settled chiropractic benefits. The worker had never gone to a chiropractor. Nevertheless, the court held that the work comp settlement eliminated the no-fault carrier's right of reimbursement, and therefore the worker was not entitled to no-fault chiropractic benefits.

²⁰² In Ferguson v. Lehto, 1990 WL 119357 (Minn. Ct. App. 1990) (unpublished) the plaintiff's wage loss claim against the tortfeasor was dismissed because the benefits had been denied in a prior no-fault arbitration.

²⁰³ In Hornamen v. State Farm Ins. Co., 1994 WL 567639 (Minn. Ct. App. 1994) (unpublished), the arbitrator's denial did not estop additional claims and a separate no-fault arbitration. Since the original arbitrator did not indicate the reasons for the denial, there was no way to determine its application to subsequent treatment.

²⁰⁴ Johnson v. Milbank State Auto Ins. Co., 2000 WL _____ (Minn. Ct. App. C8-99-1359 2-29-2000) (unpublished).

²⁰⁵ 668 N.W.2d 692 (Minn. Ct. App. 2003).

²⁰⁶ __N.W.2d __ (Minn Ct. App. CX-00-2214 7-10-2001).

C. Remedies

1. Insurers' Remedies

a) Mistakenly-paid Benefits v. Intentional Misrepresentation

2. Claimants

a) Costs and Disbursements -Arbitration

The No-Fault Arbitration Rules allow reimbursement of all costs:

The arbitrator may grant *any remedy or relief that the arbitrator deems just and equitable* consistent with the Minnesota No-Fault Act. The arbitrator may, in the award, include arbitration fees, expenses, rescheduling fees and compensation²⁰⁷

For a time, the courts did not allow the arbitrator to award expert witness fees,²⁰⁸ but the 2003 amendments to the rules eliminated that limitation. In Kerber, the court relied on the old Rule 32, which specifically provided that parties pay for their own witnesses.²⁰⁹ Rule 32 now states:

Generally each side should pay its own expenses. *An arbitrator does, however, have the discretion to direct a party or parties to pay expenses as part of an award.*²¹⁰

Thus witness fees are again taxable at the arbitrator's discretion.

²⁰⁷ No-Fault Rules, Rule 32, (September 7, 1999).

²⁰⁸ Kerber v. Allied Group Ins., 516 N.W.2d 568 (Minn. App. 1994).

²⁰⁹ *Id.* at 570.

²¹⁰ No-Fault Rules, Rule 32, (August 5, 2003), *emphasis added*.

All of the claimant's actual costs of pursuing the arbitration should be awarded. For example, in Dunsmore v. Allstate Insurance Co.,²¹¹ Judge Steven Swanson confirmed an arbitrator's award of the costs of securing medical records, including costs for medical records obtained before arbitration was initiated. Costs of records from medical providers whose medical expenses were not awarded were also ordered.

Medical records and reports are often secured for use in the no-fault arbitration. Although narrative reports are often also used in a liability claim, they are not typically admissible in a jury trial, and are thus not taxable as costs in a District Court trial. Since they are admissible in the no-fault arbitration, all medical record and narrative report costs should be taxed against the insurer. Similarly, the photocopy costs for the arbitration booklets, as well as the arbitration filing fee, should be taxed as costs against the insurer. The claimant should also request that the insurer be ordered to pay the arbitrator's fee.

By their very nature, no-fault benefits are reimbursement for actual losses already incurred. Where a claimant ultimately prevails in proving entitlement to those benefits, equity demands that the arbitrator assess the actual cost of prevailing against the insurer. Failure to do so results in less than the reimbursement mandated by the No-Fault Act.

The arbitrator should not worsen this already harsh result by denying the costs that the claimant was forced to incur because the insurer wrongfully denied benefits.

b) Mandatory Interest/Penalty

There is a mandatory penalty on all overdue benefits. Benefits are overdue if not paid within 30 days after the insurer receives reasonable proof of loss.²¹² In the past, courts have ordered payment even when insurers had a good faith basis to deny coverage.²¹³ The Supreme Court even required payment of

²¹¹ Hennepin County District Court File No. 90-10277, (order and memorandum dated September 27, 1990).

²¹² Minn. Stat. § 65B.54 subd. 1 (2006). The insurer may instead accumulate bills for 30 days, and pay them within 15 days thereafter.

²¹³ Record v. Metropolitan Transit Authority, 284 N.W.2d 542 (Minn. 1979).

interest where they *retroactively* changed their interpretation of the law,²¹⁴ and where there was a valid coverage dispute between two insurers.²¹⁵

Interest Calculation. The date from which interest is calculated is often important. In the past, the courts had consistently calculated interest from “the *earliest* date Plaintiff gave reasonable notice of a *possible claim* of right.”²¹⁶

However, in American Family v. Kiess,²¹⁷ the Supreme Court took a more conservative view. The court interpreted the statute to require ***actual notice*** of subsequent losses to the insurer after an adverse exam.

Many insurers will laud this decision as the end of retroactive interest awards. In her concurrence, Justice Meyers pointed out the somewhat impractical nature of the majority decision:

It is at odds with the purposes of the Act to insist that an injured person continue to submit medical bills to a no-fault insurer that has discontinued benefits and directed the injured person to submit his or her bills elsewhere. In the practice of no-fault law in this state, an insured simply should not bear the burden of having to analyze and interpret discontinuation letters in relation to the larger statutory scheme in order to determine whether to follow the instructions given by an insurance company. Rather, because insurance companies are sophisticated entities well-versed in the nuances and intricacies of the Act, they should bear the risk of being equitably estopped from asserting their right to notice in those cases where the insured has been harmed by reasonably relying on statements in a discontinuation letter.

²¹⁴ Steich v. American Family Mut. Ins. Co., 358 N.W.2d 396 (Minn. 1984).

²¹⁵ Pederson v. All Nation, 294 N.W.2d 693 (Minn. 1980). When denying a claim, a no-fault insurer was held to voluntarily assume the risk of paying interest when benefits were ultimately awarded. *Id.* at 696.

²¹⁶ Haagenson v. National Farmers Union Prop. & Cas. Co., 277 N.W. 2d 648, 653 (Minn. 1979) (emphasis added). *See also* Pederson, 294 N.W.2d at 696.

²¹⁷ 697 N.W.2d 617 (Minn. 2005). The Claimant’s attorney confirms “kēs” as the pronunciation.

Thus, I would hold that, in cases in which an insured receives a letter like the one at issue here, then reasonably relies on the insurance company's instructions in such a way that subverts the purposes of the No-Fault Act, the insurer is equitably estopped from asserting its right to notice under section 65B.54, subd. 1.²¹⁸

Kiess involved a surgery that occurred almost a year after the cutoff letter. There is little indication in either Kiess or the underlying Court of Appeals opinion²¹⁹ whether the pre-cutoff treatment was similar or different in nature from the subsequent treatment and surgery. The health insurer paid for the surgery and waived subrogation after Keiss's attorney told them there were "significant causation and liability issues."

Many cases will seem distinguishable. Will it matter that the claimant is undergoing a course of ongoing treatment that is denied? What about insurers that specifically deny any and all future treatment *and demand that providers stop sending additional billings*? Certainly specifically asking the insured and the medical providers to stop submitting future bills should be seen as waiver of notice.

In a perfect world, all bills would continue to be promptly sent to the no-fault carrier, and documentation of the submission would be clearly noted in the doctor's chart or ledger and provided to the claimant's attorney.

In this imperfect world, practitioners should continue to send a letter to the no-fault carrier immediately after the termination. The letter should warn the carrier that the treatment is continuing, that interest will be sought, and that they will waive notice of ongoing billings unless they specifically request them from the claimant's attorney *and* all the providers. Meanwhile, medical providers should bill no-fault carriers till the cows come home.

Interest Mandatory. The award of statutory penalty/interest is not a matter of arbitrator discretion. Where no-fault benefits are awarded, the award of statutory penalty interest must follow on those amounts. Several district courts have held that where a no-fault arbitrator has failed to make such an award, the

²¹⁸ Kiess at 623, 624 (Justice Meyer concurring, joined by Justice Page).

²¹⁹ Am. Family Ins. Group v. Kiess, 680 N.W.2d 552 (Minn. Ct. App. 2004).

arbitration award must be modified to include interest.²²⁰ The mandatory, non-discretionary nature of the interest award is further emphasized by No-Fault Arbitration Rule 32, which now states that “the arbitrator must award interest when required by Minn. Stat. § 65B.54.”²²¹

The 15% No-Fault interest replaces prejudgment interest under Minn. Stat. § 549.09²²², and it accrues through judgment.²²³ Thereafter, post judgment interest is calculated under Minn. Stat. § 549.09.²²⁴ Interest continues to accrue through the pendency of the appeal process.²²⁵

Interest must be paid, even if it exceeds policy limits.²²⁶ Interest is not included in the \$10,000 jurisdictional limit.²²⁷ Payment of interest cannot reduce the available policy limits. Finally, failure to pay overdue interest violates the Fair Claims Practices Act.²²⁸

c) Attorneys' Fees/Sanctions

In 1993 the Supreme Court amended Rule 32 of the Rules of No-Fault Arbitration, removing an arbitrator's power to award attorneys' fees.²²⁹ A significant number of arbitrators had previously awarded attorneys' fees, but

²²⁰ See, e.g., Corona v. Farmers Ins. Co., Hennepin County District Court File No. 90-18298 (order and memorandum dated November 29, 1990).

²²¹ No-Fault Rules, Rule 32, (September 7, 1999).

²²² Burniece v. Illinois Farmers, 398 N.W.2d 542 (Minn. 1987), Motschenbacher v. New Hampshire Ins. Group, 402 N.W.2d 119, 125 (Minn. Ct. App. 1987)(*Rev. denied* 4/29/87).

²²³ Motschenbacher, 402 N.W.2d 119 at 125, Liberty Mut. Ins. Co. v. Sankey, 605 N.W.2d 411, 414 (Minn.Ct. App. 2000).

²²⁴ Motschenbacher, 402 N.W.2d 119 at 125, Sankey, 605 N.W.2d 411 at 414. More recently, the interest/penalty has been found to accrue through the pendency of the appeal process. Weaver v. State Farm, 1999 WL 293929 (Minn. Ct. App. C9-98-1859, May 11, 1999) (unpublished), (*affirmed on other issue*, Weaver v. State Farm Ins. Companies, 609 N.W.2d 878 (Minn. 2000)).

²²⁵ *Id.*

²²⁶ McGoff, 575 N.W.2d 118.

²²⁷ Am. Family Ins. Group v. Kiess, 680 N.W.2d 552, 556-7 (Minn. Ct. App. 2004) (*affirmed on other issue*).

²²⁸ Minn. Stat. § 72A.201, subd. 6 (10) (2006).

²²⁹ No-Fault Rules, Rule 32, (September 7, 1999).

the appellate courts had indicated that attorney fees were unavailable in no-fault disputes.²³⁰ Absent legislation, attorney fees will not be available in no-fault arbitrations.

In certain cases, the insurer may move in district court to vacate or modify an arbitration award. If frivolous, the court should impose civil sanctions.²³¹ The Minnesota Supreme Court has implied that in extreme cases, tort damages may apply.²³²

²³⁰ Garrick v. Northland Ins. Co., 469 N.W. 2d 709 (Minn. 1991); Empire Fire and Marine v. Carlson, 476 N.W.2d 666 (Minn. Ct. App. 1991).

²³¹ Minn. Stat. § 549.211 (2006).

²³² Haagenson, 277 N.W.2d 648 (Minn. 1979). *See also* M. Steenson, Minnesota No-Fault Automobile Insurance, 173-0-176 (1991-98) for an excellent discussion of potential tort remedies.