62Q AND YOU!

An esoteric procedural no-fault love story

A recent court decision represents a win for everyone involved in the no-fault insurance system except medical providers who fail to follow their statutory procedural obligations. For the first time, there is Minnesota appellate case law that confirms Minnesota Section 62Q.75, subd. 3 means exactly what it says: If a provider fails to follow the requirements of Section 62Q, then the medical expenses billed are non-collectible from any individual.

By Rachel Bendtsen Beauchamp

In the world of small-value but frequent claims, there has been, perhaps, no battle harder fought with less likelihood of success than the Minnesota no-fault insurance providers defense against no-fault arbitrations. For many years, in addition to merit-based defenses, defense counsel have made an esoteric, often overlooked, and rarely successful argument that a little-known statute, Minnesota Section 62Q.75, subd. 3, offers a complete defense to claims that fall within its precise statutory language regarding timing and procedure for billing responsible providers. These arguments have fallen on largely deaf ears; no-fault arbitrators and Minnesota district courts frequently allowed claimants to recover no-fault awards for non-collectible medical expenses in spite of the plain language of 62Q.

In September 2017, *Western National Insurance Company v. Nguyen* confirmed for the first time that where a provider has failed to meet the conditions set forth in 62Q.75, subd. 3, both the no-fault insurer and the no-fault claimant are relieved of any legal obligation of reimbursement to the provider. (*Nguyen* also addressed procedural aspects of the billing requirements in 62Q, but these procedures are not the focus of this article.) This decision is a long-sought arrow in defense-counsel's limited quiver—and should also be embraced by claimants for relieving them of any burden as to non-collectible medical bills.

No-fault enactment

Since automobiles on roadways became commonplace, compensation for individuals injured by these machines has concerned the public and legislators. Minnesota enacted its first automobile-related financial responsibility legislation in 1933, with the Minnesota Safety Responsibility Act.[1] This Act, and its successors, dealt primarily with an actor's responsibility to an injured third-party, and, later, with first-party claims (such as uninsured motorist coverage) that required a third-party bad-actor.[2]

Minnesota's prior automobile insurance responsibility laws were largely repealed, replaced, and/or modified with the enactment of the Minnesota No-Fault Automobile Insurance Act in 1974

(the No-Fault Act).[3] The key aspects of the No-Fault Act were the creation of "basic economic loss benefits" (a category of first-party coverage that did not require a third-party bad actor), compulsory coverage (all individuals within the statutory scope were required to maintain minimum levels of insurance), and the imposition of "tort thresholds" (a restriction on the right to sue for damages in a tort action). These provisions remain the heart of Minnesota's no-fault system today.[4]

Fast-forward to the present, and Minnesota vehicle owners sometimes complain about the high cost of the mandatory no-fault coverage—but no one is more frustrated by the scope of Minnesota's No-Fault Act and its enforcement than insurers who must provide coverage of at least $20,000 in medical benefits and $20,000 in replacement services coverage as "basic economic loss benefits."[5] Now, Minnesota's no-fault scheme is largely regarded by insurers as giving claimants a blank check up to their limits of coverage (regardless of medical necessity) in addition to bodily injury tort claims, rather than as a useful tool to quell overuse of civil tort litigation. The odd twist on this position is that in the 1970s, many insurance companies supported the enactment of no-fault laws in order to stem rising tort costs and address increasingly aggressive plaintiffs' lawyers.[6]

No-fault abuse cannot be easily stemmed

It is generally accepted that there are abuses in the no-fault industry although these abuses are not "insurance fraud" as defined by Minnesota statute. Such abuses result in higher premiums for everyone with compulsory no-fault insurance—which is to say, every Minnesota auto-owner.[7] Insurers and government entities have thus far been less than successful in attempting to curb these abuses through lawsuits.[8]

Plaintiffs' attorneys may help stem predatory practices, but are often not involved with a client until significant overtreatment—often with predatory chiropractic, MRI, X-ray, or other providers who solicit clients directly from traffic accident records—has already taken place. However, responsible plaintiffs' attorneys who are involved with their clients shortly after injury can and often do counsel clients to stop chiropractic and other non-medical treatment early in order to preserve their client's access to necessary post-accident medical treatment before exhausting medical benefits.

In contrast, no-fault insurance providers have very limited ability to prevent non-medically necessary overtreatment, non-accident-related treatment, or predatory treatment except through the use of independent medical examinations and cutting off benefits.[9] An insurer may only deny benefits to a claimant under limited circumstances.[10] If a denial has been issued, the claimant is entitled to bring a claim for mandatory no-fault arbitration for any claim up to $10,000.[11] The majority of no-fault arbitrators are plaintiffs' attorneys.[12]

In addition, the burden of proof for recovery in a no-fault arbitration is low, requiring only that an arbitrator agree the accident was a "probable factor" in the claimed injury.[13] As a result, counsel on both sides of the aisle are aware that no-fault arbitrations more often than not result in a plaintiff-side decision, regardless of the actual weight of the evidence.

Insurers are discouraged from denying even questionable benefits, because awards in arbitration are subject to a significant interest penalty of 15 percent annually for previously denied benefits.[14] There is very limited right of appeal to the courts from a no-fault arbitration, and no right of appeal on the basis that the arbitrator made a decision against the greater weight of the evidence.[15]

Despite the uphill odds, no-fault insurance providers continue to cut off benefits for overtreatment in an attempt to limit no-fault abuse. In addition, insurers have denied claims for medical expense benefit reimbursement on the basis that no medical expenses are due or owing pursuant to Section 62Q.75, subd. 3—an argument that has, until now, found even less traction than the insurers' merit-based defenses relying on independent medical examinations. Generally, a 62Q argument follows an insurer's denial of benefits based on an IME, and is therefore often a second ground for denying payment of benefits. Unlike a merits defense, a 62Q defense is a purely legal defense that should simply result in a "yes" or "no" after application of the statute's requirements.

Section 62Q: The esoteric no-fault defense

No-fault insurers have long argued that they cannot legally be held liable for medical expense benefits that have not been properly billed by providers; the argument relies on an underutilized section of Minnesota Statutes Chapter 62Q – Health Plan Companies. Without a careful reading, it would appear that Chapter 62Q could have no possible relevance to a no-fault claim brought under the Chapter 65B No-Fault Act. But the Legislature specifically included no-fault medical benefits in the very last line of Section 62Q.75, subdivision 3, which provides that the billing guidelines and requirements for health care providers are applicable to "reparation obligors for treatment of an injury *compensable under chapter 65B[.]*" Despite this explicit language, parties have argued for years about its applicability to no-fault claims.

In its entirety, Minnesota Statutes section 62Q.75, subdivision 3 reads:

> Unless otherwise provided by contract, by section *16A.124, subdivision 4a*, or by federal law, the health care providers and facilities specified in subdivision 2 must submit their charges to a health plan company or third-party administrator within six months from the date of service or the date the health care provider knew or was informed of the correct name and address of the responsible health plan company or third-party administrator, whichever is later. A health care provider or facility that does not make an initial submission of charges within the six-month period shall not be reimbursed for the charge and may not collect the charge from the recipient of the service or any other payer. The six-month submission requirement may be extended to 12 months in cases where a health care provider or facility specified in subdivision 2 has determined and can substantiate that it has experienced a significant disruption to normal operations that materially affects the ability to conduct business in a normal manner and to submit claims on a timely basis. Any request by a health care provider or facility specified in subdivision 2 for an exception to a contractually defined claims submission timeline must be reviewed and acted upon by the health plan company within the same time frame as the contractually agreed upon claims filing timeline. This subdivision also applies to all health care providers and facilities that submit charges to workers' compensation payers for treatment of a workers' compensation injury compensable under chapter 176, or to reparation obligors for treatment of an injury compensable under chapter 65B.

The language of 62Q.75, subd. 3, is certainly *plain*—but not particularly easy to decipher even for those schooled in legalese. Parsed, this no-fault defense requires:

- The provider or facility must meet the definition found in subdivision 2; and
- the provider or facility must have been notified of "the correct name and address of... the reparation obligor for treatment of an injury compensable under chapter 65B"; and
- the provider or facility must have failed to make an initial submission of the disputed charge (to the correct entity) within six months from (a) the date of service; or (b) the date it was informed of the correct name and address of the... reparation obligor.

Even broken down into its elements, the terms of the statute may remain somewhat complex. In a nutshell, the health care provider must bill the no-fault insurer for the disputed amount within six months after being informed that the no-fault insurer is the correct legal entity to be billed for the disputed date of service. The most important language in the statute is that the no-fault insurer has a complete defense to payment because "*a provider who has failed to comply with the above section is not entitled to collect payment on the misdirected bill from any individual or entity.*"[16]

Defense counsel have long argued that this section of 62Q provides a complete defense where all the elements have been met. The argument is simple: If the medical provider has not complied with the statute, then the amount billed is not owed by any person or entity. If the provider has no right to collect amounts billed from the patient, then the patient (claimant) cannot recover the amounts from the no-fault insurer. Despite the plain language, many arbitrators and district court judges remained unconvinced that 62Q applied to no-fault claims.

Western National Insurance Company v. Nguyen

On September 18, 2017, no-fault insurers and defense counsel were vindicated in their persistent argument for the plain language application of 62Q when the Minnesota Court of Appeals confirmed that an insured's claim for medical-expense benefits from a no-fault insurer is barred if the statute's application results in the billed amounts being uncollectible pursuant to 62Q.75, subd. 3, because under those circumstances the insured has not suffered a "loss."[17]

In *Nguyen*, no-fault claimant Nguyen suffered an injury for which he initially received no-fault benefits from Western National Insurance Company. In May 2012, Western National requested an independent medical examination (IME) of Nguyen and, following receipt of the IME report finding that no further treatment was reasonable or necessary, denied all future benefits. Nguyen filed for no-fault arbitration and the no-fault arbitrator denied Nguyen's claim in its entirety.

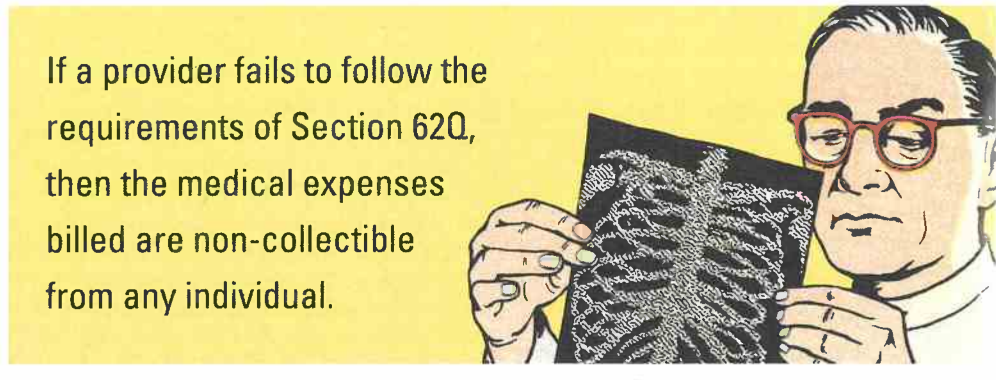
In February 2014, Nguyen sought additional treatment through a new provider, Center for Diagnostic Imaging (CDI). CDI submitted one bill for one of Nguyen's first visits to Western National. Western National sent correspondence to CDI in May 2014 denying coverage for Nguyen's treatment pursuant to the prior IME and arbitration. Although Nguyen continued treating with CDI, CDI did not submit any further bills to Western National. Nguyen treated with CDI throughout 2014 and incurred charges of more than $10,000. Only the one bill was ever submitted to Western National.

In April 2016, Nguyen again filed for no-fault arbitration against Western National requesting payment of the CDI bills. Western National defended the claim on its merits and also asserted that all dates of service except the first one were not recoverable because the bills were not submitted to Western National within the statutory timeframe and, therefore, were now uncollectible by CDI as against *either* Western National or Nguyen pursuant to Section 62Q.75, subd.3. The new arbitrator ignored the prior arbitration decision and application of Section 62Q and awarded $11,695.23 in medical expenses, interest, and fees.

Western National moved the district court to vacate the arbitration award, claiming the arbitrator exceeded its authority by awarding legally uncollectible amounts to the claimant in violation of 62Q. The claimant argued that Section 62Q does not apply to no-fault claimants; that Western National could not be the reparation obligor after denying any obligation to pay the bills following the IME; and that he was entitled to collect the amount billed regardless of whether he would be forced to pay those amounts to the provider.[18]

The district court applied the plain language of Section 62Q.75, subd. 3, and vacated all but $1,027.25 (the initial CDI bill submitted to Western National) of the award.[19] The court concluded that Section 62Q.75, subd. 3 applied to the claim. Therefore, because CDI submitted only the one bill to Western Mutual within the six-month statutory timeframe, CDI was barred from collecting any remaining charges. Therefore, Nguyen did not experience any "loss" that would entitle him to recover no-fault benefits. The court explained that by operation of the statute, Nguyen could not have suffered a "loss" because the amounts billed never became "due."

Nguyen appealed the district court's decision and argued that Section 62Q.75, subd. 3 could not apply to him because it applies only to health-care providers and health-plan companies and he was not a health-care provider.[20] He also argued again that he was entitled to recover the amounts billed even if he cannot be held liable for repayment to the provider.



Nguyen's appeal was joined by plaintiffs' counsel advocacy group the Minnesota Association of Justice (MAJ), which argued that Section 62Q could apply as between a provider and a no-fault insurer, but could have no effect on the no-fault insurer's legal obligation to pay no-fault medical expense benefits to a claimant. *Amicus* asserted the application of 62Q would leave a no-fault claimant contractually obligated to repay medical service bills to the provider, despite the fact that Sections 62Q and 65B specifically prohibit any such obligation. *Amicus* also asserted that application of 62Q to bar no-fault arbitration claims is contrary to the goals and obligations of the No-Fault Act.

Western National reiterated that 62Q.75, subd. 3, by its plain language applies to no-fault claims and, when its specific statutory obligations have been

met, neither a no-fault insured claimant nor a no-fault insurance provider could be legally obligated to make payment for the medical providers' incorrectly billed dates of service.

The court agreed that 62Q does not apply to no-fault *claimants*, but likewise agreed with Western National that when 62Q has extinguished the *provider's* right to bill for treatment, it has likewise extinguished a claimant's right to make a no-fault claim for those dates of service because the claimant has not experienced any "loss." In other words, if 62Q has extinguished the provider's right to recover the billing charge, the claimant has no right to receive those uncollectible amounts as a windfall.

Nguyen and 62Q benefit... you!

Nguyen represents a win for everyone involved in the no-fault system except medical providers who fail to follow their statutory procedural obligations. For the first time, there is Minnesota appellate case law that confirms 62Q means exactly what it says: If a provider fails to follow the requirements of Section 62Q, then the medical expenses billed are non-collectible from any individual.[21]

The application of 62Q is far from a panacea in addressing problematic no-fault claims. It applies in very particular circumstances requiring a specific set of preliminary facts; but, where those facts exist, the application of 62Q is a complete bar to any recovery of those amounts. This can act to facilitate closure and/or resolution of stale claims for benefits from insureds who have not treated in a lengthy time and would otherwise be receiving a windfall from a successful no-fault arbitration.

When 62Q applies, those amounts billed will magically vanish from any no-fault ledger. Therefore, from the insurers' side, defending against a claimant with excessive overtreatment, prevailing on a 62Q defense could actually have the unfortunate result of simply extending the timeframe for a problematic claim; once those old claims are removed, they may simply be replaced with additional, newer, dates of service until the $20,000 medical benefits limit has been reached. However, by this same token, Nguyen is not just a benefit to no-fault insurers—it is a benefit to the claimants who have fought so hard against its application. In fact, application of 62Q can act to the truly injured insured's benefit by extending the reach of the insured's medical no-fault benefits. Where an insured is brushing up against the no-fault limits, the application of Section 62Q to old billings that were not procedurally correct will allow the insured to utilize no-fault funds that would otherwise be exhausted to easily access and pay for additional medically essential treatment.

The future of 62Q and Nguyen

For as long as defense counsel have been arguing the plain language of Section 62Q, the plaintiffs' bar has been opposing its application on the policy basis. Minnesota courts follow the "plain language" rule for the interpretation of statutes, meaning that courts are not free to ignore the letter of the statute in search of the Legislature's intentions. Therefore, even assuming claimants are correct and 62Q somehow violates the spirit of the No-Fault Act, the correct entity to address any revisions to the plain language of Section 62Q is the Legislature. The battle for the interpretation of current Section 62Q is not over, however; a Petition for Review by the Minnesota Supreme Court was filed by Nguyen on October 16, 2017. In addition, CDI has filed a motion to participate as *amicus curiae* on the basis that application of the plain language of 62Q as articulated in *Nguyen* cannot stand because it will impact the entire healthcare industry in Minnesota and create unworkable confusion (although how following the law will suddenly be unworkable is unclear).

After 12 years of argument, a relatively obscure statute, with clear language but limited application to relatively low-value claims, has finally received appellate interpretation and appears to be heading to Minnesota's highest court. Assuming review is accepted, resolution of the appeal will take an average of a year, during which time *Nguyen* is the law. Assuming review is not accepted, and/or in the meantime, *Nguyen* and 62Q will operate to prevent medical providers from collecting improperly billed amounts, and provide a complete defense to no-fault claims that fall within its specific purview. ▲

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Notes

[1] Minnesota Safety Responsibility Act. Act of Apr. 21, 1933, ch. 351, 1933 Minn. Laws. 574 (repealed and replaced 1945, repealed 1980).

[2] *Id.* & Act of 4/16/1945, ch. 285, 1945 Laws 483 & Amendments, (repealed 1974).

[3] Minnesota No-Fault Automobile Insurance Act. Act of Apr. 11, 1974, ch. 408 §33, 1974 Minn. Laws. 762, 786.

[4] Minn. Stat. §65B.41-71.

[5] §65B.44, subd. 1.

[6] James M. Anderson, et al The U.S. Experience with No-Fault Automobile Insurance: A Retrospective 37 (Rand Institute for Civil Justice, 2010).

[7] Fraud Working Group Report, Recommendations to Senate Commerce Committee, *presented by* Fraud Working Group, (Minnesota Senate 2014); *see also*, No Fault Automobile Insurance Task Force, Report to the Legislature (2016).

[8] *See e.g. Illinois Farmers Insurance Company v. Mobile Diagnostic Imaging, Inc.*, 2014 WL 4104789 (D. Minn. 10/25/2014) (federal case alleging abuses of no-fault system dismissed after summary judgment motion); *but see, USA v. Forthun, et al*, 16-CR-00339-MJD-FLN (D. Minn. Filed 12/20/2016) (one of a series of federal fraud cases commenced against Twin Cities chiropractors for no-fault fraud scheme).

[9] *Wolfe v. State Farm*, 450 N.W.2d 359 (Minn. Ct. App. 1990).

[10] *Id.*

[11] Minn. Stat. §65B.525.

[12] American Arbitration Association Minnesota No-Fault Arbitrator Panel 2017 Recertification Report. *https://www.adr.org/sites/default/files/document_repository/2017_Recertification_Report.pdf* (last visited 11/2/2017).

[13] *See Ruppert v. Milwaukee Mut. Ins. Co.*, 392 N.W.2d 550, 558 (Minn. Ct. App. 1986).

[14] Minn. Stat. §65B.54.

[15] Minn. Stat. §572B.23; *Ortega v. Farmers Ins. Group*, 474 N.W.2d 7, 8 (Minn. Ct. App. 1991).

[16] §62Q.75, subd. 3.

[17] *W. Nat'l Ins. Co. v. Nguyen*, No. A17-0314, 2017 WL 4105224 (Minn. Ct. App. 9/18/2017) *petition for cert filed*, 10/16/2017.

[18] *W. Nat'l Ins. Co. v. Nguyen*, 2017 WL 1806934 *4 (Minn. Dist. Ct. 1/19/2017) *overruled by*, *Nguyen*, No. A17-0314, 2017 WL 4105224 (Minn. Ct. App. 10/18/2017) *petition for cert filed*, 10/16/2017.

[19] *Id.*

[20] *Nguyen*, No. A17-0314, 2017 WL 4105224 (Minn. Ct. App. 9/18/2017) *petition for cert filed*, 10/16/2017.

[21] *Id.*