PERSONAL INJURY PROTECTION (PIP)

I. THE CONTRACT

The plaintiff's action against the defendant is a claim of breach of contract. A contract is an agreement between two or more parties or businesses to do or not to do certain things.

Where there is an agreement to the policy. **In this case, the parties agree that the defendant had issued a Massachusetts motor vehicle insurance policy to** *[the insured party]* **. This is a contract. The contract included a provision for Personal Injury Protection — otherwise called, PIP — benefits, which cover certain medical expenses incurred by the operator or any passenger in the insured vehicle arising out of a motor vehicle accident. This benefit is provided regardless of who was at fault, or who caused the accident.**

Where there is no agreement as to the existence of the policy, the plaintiff has the burden to establish that a contract existed.

Where no private health insurance exists. **A person, either the operator or a passenger in a motor vehicle that is covered by a Massachusetts motor vehicle insurance policy, who is injured in a motor vehicle accident, is entitled to certain payments from the insurance company that issued the policy. The**

Personal Injury Protection — or PIP — provisions of the policy cover all reasonable expenses incurred within two years after the accident for necessary medical treatment, up to a limit of $8,000 per person.

G.L. c. 90, § 34A.

Where private health insurance exists. **A person, either the operator or a passenger in a motor vehicle that is covered by a Massachusetts motor vehicle insurance policy, who is injured in a motor vehicle accident, is entitled to certain payments from the insurance company that issued the policy. The Personal Injury Protection — or PIP — provisions of the policy cover all reasonable expenses incurred within two years after the accident for necessary medical treatment, up to a limit of $2,000 per person.**

If an injured person has health insurance, the health insurer pays the balance of any expenses for necessary medical treatment beyond the first $2,000. If any of those expenses are not covered by the injured person's health insurance plan, the injured person may submit (his) (her) unpaid bills to the PIP insurer for payment, up to a limit of an additional $6,000. This may include such things as deductibles and copayments required under the health insurance plan.

G.L. c. 90, § 34A.

Again, this is called Personal Injury Protection, or PIP for short. PIP coverage is afforded to an operator or passenger in an insured vehicle, and it covers treatment provided by doctors, chiropractors, and physical therapists, as well as other types of medical treatment.

G.L. c. 90, § 34A.

As I indicated, PIP benefits are payable without regard to an injured person's negligence or fault, or anyone else's negligence or fault for that matter. Regardless of who, if anyone, was negligent or at fault for the accident, an injured operator or passenger who is covered by PIP is entitled to these benefits. Thus, you may not consider who was at fault for the accident in any way in your deliberations.

G.L. c. 90, § 34A; *Murphy v. Bohn*, 377 Mass. 544, 549 (1979).

PIP payments must be made within a certain time frame. An insurance company that provides PIP benefits is required by law to pay all reasonable medical expenses for necessary medical services within 30 days of its receipt of the bills and the treatment records supporting such bills.

G.L. c. 90, § 34A; G.L. c. 90, § 34M; *Brito v. Liberty Mut. Ins. Co.*, 44 Mass. App. Ct. 34, 36-37 (1997), *rev. denied*, 426 Mass. 1109 (1998).

When a PIP insurer does not pay the medical bills in full within 30 days of its receipt of the bills and the medical records, (a medical provider) (an injured person) whose bills are not fully paid has the statutory right to file a lawsuit against the PIP insurer to recover a judgment for the unpaid balance of (its) (his) (her) bills.

G.L. c. 90, § 34M; *Ny v. Metropolitan Prop. & Cas. Ins. Co.*, 51 Mass. App. Ct. 471, 476, *rev. denied*, 435 Mass. 1103 (2001).

Where an insurance company fails to make timely payment of personal injury protection benefits but tenders payment prior to trial – commonly known as a "Fascione" payment, see *Fascione v. CNA Ins. Cos.*, 435 Mass. 88 (2001) -- the plaintiff may refuse payment and then sue for payment, costs, and attorney's fees under G.L. c. 90, § 34M. *Barron Chiropractic & Rehab., P.C. v. Norfolk & Dedham Group*, 469 Mass. 800 (2014), *rev'g in part* 2013 Mass. App. Div. 76.

If a medical provider.

Essentially, the plaintiff steps into the shoes of the injured person, and is itself considered a beneficiary of and a party to the insurance contract. The plaintiff, as an unpaid medical provider, therefore may sue to enforce its rights under the insurance contract. As it is deemed a party to the contract, it is also bound by the obligations the injured driver or passenger has under the same contract or policy.

To recover a claim for unpaid PIP benefits, the plaintiff must prove, by a preponderance of the evidence, the following five things:

First: **That the defendant issued a Massachusetts motor vehicle insurance policy insuring a specific motor vehicle;**

Second: **That (the plaintiff's patient) (the plaintiff) was injured in an accident while in the motor vehicle that was covered by the Massachusetts motor vehicle insurance policy issued by the defendant;**

Third: **That (the plaintiff provided) (the plaintiff received) reasonable and necessary medical treatment for those injuries. In part, this means that the treatment underlying a patient's medical expenses arose from the injury suffered by the (patient) (plaintiff).**

Fourth: **That the plaintiff submitted reasonable proof to the defendant that medical expenses had been incurred; and**

Fifth: **The amount of those reasonable and necessary medical expenses.**

As I stated, the plaintiff must prove all five things by a preponderance of the evidence. If the plaintiff fails to prove any one of those five things by a preponderance of the evidence, you must find for the defendant.

II. REASONABLE AND NECESSARY EXPENSES

The fact that bills were incurred and submitted does not necessarily mean that they were reasonable and necessary. If the bills arose from an injury suffered in the accident, a medical service is medically necessary and, therefore, compensable and properly due and payable under the PIP provisions of the policy, if the treatment is calculated to prevent, diagnose, prevent the worsening of, alleviate, or ease, correct, or cure conditions that cause suffering or pain. The requirement is satisfied if it is shown that the treatment was rendered by a competent provider and represented a bona fide effort to ease or treat an injury.

See Moe v. Secretary of Admin. & Fin., 382 Mass. 629, 634-35 (1981).

For treatment to be medically necessary and compensable under the law and the PIP provisions of the insurance policy, it need not be absolutely necessary or required. The standard is not one of absolute necessity or indispensable medical need. It is enough for the plaintiff to meet (his) (her) (its) burden of proof if it was wise to administer the treatment under the circumstances known at the time of the treatment. The treatment need only be a bona fide effort by a competent medical provider to treat and reduce the injury in the light of the facts known to him when the services were rendered.

Victum v. Martin, 367 Mass. 404, 409 (1975); *Hunt v. Boston Terminal Co.*, 212 Mass. 99, 101 (1912).

The plaintiff has introduced into evidence the bills and the treatment records of the patient, sworn and subscribed under the pains and penalties of perjury. These records and bills are evidence that you may consider in determining whether the treatment rendered to the (patient) (plaintiff) was medically necessary and causally related to the accident and whether the amount charged for those services was reasonable. Whether the treatment provided was medically necessary and whether the amount of the charges for such treatment was reasonable are questions of fact for you to decide.

G.L. c. 233, § 79G.

Your determination of whether the treatment of the (patient) (plaintiff) was necessary need not be an "all or nothing" determination. You may find that all of the treatment was necessary. In that case, if you also find that all of the other elements have been established, you must return a verdict for the plaintiff in the full amount of (his) (her) (its) reasonable bills for treatment. Or, you may find that some of the treatment was necessary and some of it was not. In that case, if you also find that all of the other elements have been established, you must return a verdict for the plaintiff in the amount of the reasonable bills for that part of the treatment that you find to have been medically necessary. You may find that none of the treatment was necessary. In that case, you must return a verdict for the defendant.

III. THE DUTY TO COOPERATE

Because this matter is based on a contract, each party has rights and obligations. (As I said earlier, the plaintiff's right to payment comes from the injured person or patient.) The defendant is relieved of its obligation to pay unpaid bills if (the plaintiff) (the injured person, the patient,) has not met certain obligations under the contract or policy.

In every case, an injured person is required to notify the insurer about the accident within at least two years from the date of the accident. If such notification is not provided within two years, the injured person may not recover benefits. If such notification is provided within two years, an insurer has a contractual right to determine promptly — while the evidence and memories are still fresh -- the validity of any loss for which it might be liable. What is "prompt" depends on the specific facts in the case. Where notice is provided within two years, but an insurer raises untimely notice as a defense, the insurer may avoid liability only if it can show it was actually prejudiced by the late notice. In this regard, generalities are not sufficient to show prejudice. The insurer must identify the precise manner in which its interests have suffered. A number of factors are considered in determining whether an insurer has suffered actual prejudice, including the length of the delay, the loss of critical evidence or testimony from material witnesses despite diligent

good faith efforts on the part of the insurer to locate them, or some other facts showing that the delay in reporting the accident caused actual harm to the insurer's interest. The defendant has the burden of proof on this issue.

G.L. c. 175, § 112; *Darcy v. Hartford Ins. Co.*, 407 Mass. 481, 486-87 (1990).

The defendant is entitled to require the injured person to submit to a medical examination by a licensed medical practitioner of its choosing to assist the defendant in determining the amount of medical bills that are "due and payable" as Personal Injury Protection benefits. The defendant may deny payment of such benefits based on the failure of the injured person to attend such an examination without good cause. It is the defendant who has the burden of proof on this issue.

Ortiz v. Examworks, Inc., 470 Mass. 784, 792 (2015).

An injured person who makes a PIP claim may also be required to submit to what is called an examination under oath, or "EUO," if the request is reasonable. The insurer's right to an EUO is not unlimited in time. It must be exercised within a reasonable time after the insurer is notified of the accident or the right is forfeited. What is reasonable depends on the facts of each case. If the request for an EUO is reasonable, and the injured person refuses to comply with the defendant's request, the defendant may deny payment of

PIP benefits without any proof of prejudice to the defendant's interest arising from the refusal. A willful, unexcused refusal to submit to an examination under oath constitutes a material breach of contract, discharging the insurer's liability under the contract. Once again, the burden of proof on this issue is on the defendant.

See Lorenzo-Martinez v. Safety Ins. Co., 58 Mass. App. Ct. 359, 363-64 (2003).

The law provides that an injured person has an affirmative obligation to provide a PIP insurer with information upon request and in a timely manner. Noncooperation of an injured person is a defense for an insurer in any suit for Personal Injury Protection benefits. Actual prejudice to the insurer's interest must be demonstrated. An insurer is not relieved of its obligations under an insurance contract if it fails to carry its burden of proving that its interests were materially prejudiced due to the lack of cooperation by the injured person.

Commonwealth v. Darcy, 407 Mass. 481, 489 (1990); *see also Action Physical Therapy & Rehab. v. Amica Mut. Ins. Co.*, 2003 Mass. App. Div. 127, 129.

The intentional furnishing of false information of a material nature, either before or at trial, is also a breach of the cooperation clause and a defense for an insurer. Cooperation requires that there must be an effort to tell the truth, no matter who is helped or hurt. Although an injured person making a PIP

claim must be truthful, a misstatement concerning a trivial or inconsequential matter or an honest mistake would not constitute a breach of the cooperation clause. But deliberate and willful falsification of material facts violates the terms of the insurance contract.

Williams v. Travelers Ins. Co., 330 Mass. 476, 479 (1953); *Action Physical Therapy & Rehab.,* 2003 Mass. App. Div. 127, 129 (citing *Jertson v. Hartley*, 342 Mass. 597, 602 (1961)).

If a medical provider. **This means that an insurer can deny a medical provider's claim for unpaid bills when the patient failed to cooperate in the investigation of the claim. This is because the same defenses that would be available to the insurer in a suit for PIP benefits brought by the injured person himself are available in a suit brought by the injured person's medical provider.**

See Chiropractic Health Care Ctrs. v. Amica Mut. Ins. Co., 2003 Mass. App. Div. 130, 132.

NOTES:

1. **Other out-of-pocket losses.** In addition to medical expenses, PIP coverage provides for the payment of two other kinds of out-of-pocket losses. If the injured person was employed at the time of the accident, PIP pays 75% of his or her average weekly wage over the 52-week period preceding the date of the accident. G.L. c. 90, § 34A; *Flanagan v. Liberty Mut. Ins. Co.*, 383 Mass.195, 197 (1981). If the injured person was not working when the accident happened, the PIP insurer must also pay for diminution in earning power. The statute and the standard motor vehicle policy also provide for "replacement services," that is, reasonable expenses incurred in paying nonfamily members to perform the "ordinary and necessary services" that the injured person would have otherwise performed "for the benefit of himself and/or members of his household." G.L. c. 90, § 34A.

Noncooperation by healthcare provider. A District Court judge has ruled that a PIP insurer cannot force a healthcare provider making a claim for unpaid bills to attend an examination under oath and refuse to pay the claim based on the provider's refusal to submit. The judge found that the noncooperation defense contained in the PIP statute is limited to noncooperation by an injured party. There does not appear to be a Massachusetts appellate decision on this issue. *See VIP Physical Therapy, Inc. v. Government Employees Ins. Co.*, Springfield District Court (Jan. 8, 2015), Lawyers Weekly No. 16-001-15.