STATE OF MICHIGAN

COURT OF APPEALS

TERRA KONIECZNY,

Plaintiff-Appellant,

v

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY,

Defendant-Appellee.

UNPUBLISHED
April 16, 1999

No. 206172
Monroe Circuit Court
LC No. 96-004463 NF

Before: Hood, P.J., and Holbrook, Jr. and Whitbeck, JJ.

PER CURIAM.

The trial court granted defendant's motion for summary disposition pursuant to MCR 2.116(C)(10) and dismissed plaintiff's claim for medical expenses under Michigan's no-fault insurance act, MCL 500.3101 *et seq*.; MSA 24.13101 *et seq*. Plaintiff appeals as of right, and we affirm.

This Court reviews decisions on motions for summary disposition de novo. *Spiek v Dep't of Transportation*, 456 Mich 331, 337; 572 NW2d 201 (1998). A motion brought pursuant to MCR 2.116(C)(10) is reviewed to determine whether the affidavits, pleadings, depositions, or any other documentary evidence establishes a genuine issue of material fact to warrant a trial. *Id.* All reasonable inferences are resolved in the nonmoving party's favor. *Bertrand v Alan Ford, Inc*, 449 Mich 606, 618; 537 NW2d 185 (1995).

Plaintiff argues that the trial court erred in granting summary disposition because she has established genuine issues of fact regarding defendant's liability for her medical expenses. We disagree.

The following facts are not in dispute in this case. Plaintiff was involved in an automobile accident and suffered related injuries, including the development of "excruciating headaches." She was covered by a no-fault insurance policy issued by defendant, and a health insurance policy issued by Paramount Health Care Plan, presumed to be a health maintenance organization (HMO). The policies were coordinated. Plaintiff's primary physician through Paramount attempted to obtain a referral for plaintiff to treat at a headache clinic in Chicago. The request was denied by Paramount, which indicated that the services sought were available within the provider network. Plaintiff was informed of her right

to appeal this decision. A second request by plaintiff's physician was similarly rejected, and although plaintiff was again informed of her right to appeal the decision, she chose not to do so. Plaintiff, without obtaining a referral from Paramount, sought treatment at the headache clinic in Chicago and then submitted the bills to defendant, which refused to pay.

MCL 500.3109a; MSA 24.13109(1) requires no-fault insurers to offer, at a reduced premium, personal injury protection benefits which are coordinated with benefits available from other health and accident coverage[1]. *Yerkovich v AAA*, 231 Mich App 54, 59-60; 585 NW2d 318 (1998), lv pending. The coordination of benefits clause serves to contain automobile insurance and health insurance costs while eliminating duplicative recovery. *Major v ACIA*, 185 Mich App 437, 441; 462 NW2d 771 (1990) (citation omitted). Where no-fault coverage and health coverage are coordinated, the health insurer is primarily liable for plaintiff's medical expenses. *Tousignant v Allstate Ins Co*, 444 Mich 301, 307; 506 NW2d 844 (1993); *Yerkovich*, *supra* at 60. The consequence of coordinating a no-fault policy with an HMO policy provided by an employer has been stated as follows:

> When an employer opts for coverage by an HMO . . . there is generally limited choice of physicians or facilities because the HMO generally designates the physicians and facilities where services will be performed. When the "other health coverage" coordinated with no-fault coverage is coverage by an HMO, the no-fault insured will thus have limited choice of physicians or facilities through the HMO. [*Tousignant, supra* at 309.]

If the insured, whose health insurer is an HMO, wants to maintain a wide choice of physicians and facilities, she may do so by not coordinating her policies. See *Id.* at 310.

In *Tousignant, supra* at 307, the Court stated:

> We conclude . . . that the legislative policy that led to the enactment of §3109a *requires an insured who chooses to coordinate* no-fault and health coverages *to obtain payment and services* from the health insurer *to the extent of the health coverage available from the health insurer*. [Emphasis added.]

See also *Owens v ACIA*, 444 Mich 314, 320-321; 506 NW2d 850 (1993), where the Court indicated that when a plaintiff chooses to coordinate policies, he agrees to avail himself of health care coverage provided by the health insurer.

Plaintiff claims that *Tousignant* does not control the outcome of this case because it does not apply where, as here, the health insurer failed to provide appropriate care. She also claims that it does not apply because, unlike the plaintiff in *Tousignant*, she claimed that necessary medical care was unavailable or inadequate, and in this case, Paramount would not or could not provide necessary and appropriate treatment. She argues that there is a factual and legal dispute as to whether proper medical treatment was available from Paramount such that she was required to obtain services from it. We disagree.

Here, Paramount's medical director denied plaintiff's request for an out-of-plan referral. Plaintiff was clearly informed that the requested services were available through the provider network. In responding to the motion for summary disposition, plaintiff failed to properly rebut that there was health coverage available from Paramount. Without providing any affidavits, depositions, or other documentary evidence, plaintiff simply claimed and concluded that treatment was not available from the health insurer[2]. She based this conclusion on the unsupported assertion that her primary physician had determined that the out-of-plan provider would provide a more appropriate and more effective type of treatment that was not available within the plan. Plaintiff's reliance on her physician's speculation about whether appropriate treatment could be provided by network physicians and facilities was not sufficient to oppose the motion for summary disposition. See *Libralter Plastics, Inc v Chubb Group of Ins Cos*, 199 Mich App 482, 486; 502 NW2d 742 (1993). A non-moving party having the burden of proof on a dispositive issue may not rest upon mere allegations or denials in the pleadings, but must, by documentary evidence, set forth specific facts showing that there is a genuine issue for trial. *Quinto v Cross & Peters Co*, 451 Mich 358, 362; 547 NW2d 314 (1996).

We conclude that there is simply no basis to find a question of fact existing as to whether adequate treatment was available through Paramount, particularly where we are confronted with the denial letters that state otherwise. There is also no evidence that Paramount failed to provide appropriate treatment, refused treatment or refused payment for treatment, especially where no appeal was taken from the denial of the referral[3]. We also note that while there is evidence that plaintiff and her primary physician sought a referral to the Chicago clinic, there is no evidence that either plaintiff or her physician sought to obtain appropriate medical services from Paramount before plaintiff went to that clinic. Therefore, to the extent that there was health coverage available from the health insurer, plaintiff was obligated to obtain payment and services from it. *Tousignant, supra* at 307; *Owens, supra* at 321. Because plaintiff has failed to present evidence sufficient to raise any issues of fact as to whether defendant is liable for her medical expenses, we affirm the trial court's grant of summary disposition.

Affirmed.

/s/ Harold Hood
/s/ Donald E. Holbrook, Jr.
/s/ William C. Whitbeck

[1] MCL 500.3109a; MSA 24.13109(1) provides:

> An insurer providing personal protection insurance benefits shall offer, at appropriately reduced premium rates, deductibles and exclusions reasonably related to other health and accident coverage on the insured. The deductibles and exclusions required to be offered by this section shall be subject to prior approval by the commissioner and shall apply only to benefits payable to the person named in the policy, the spouse of the insured and any relative of either domiciled in the same household. [*Id*.]

[2] In response to the motion for summary disposition, plaintiff refers to an affidavit by the primary care physician, which allegedly discussed the issue of whether appropriate treatment was available. This affidavit, however, is not attached to the brief in opposition to summary disposition, and it is not in the lower court file. It was not before the trial court.

[3] We are mindful that plaintiff argues that any appeal would have been futile and pointless. Plaintiff's argument, however, is based on sheer speculation and not on any affidavits or other documentary evidence.