

IN THE MICHIGAN SUPREME COURT  
ON APPEAL FROM THE COURT OF APPEALS

COVENANT MEDICAL CENTER,

Plaintiff/Appellee,

Supreme Court Case No. 152758

Court Of Appeals Case No. 322108

v.

STATE FARM MUTUAL AUTOMOBILE  
INSURANCE COMPANY, a Michigan  
insurance corporation,

Saginaw County Circuit Court  
Case No. 13-020416-NF

Defendant/Appellant.

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**DEFENDANT-APPELLANT STATE FARM MUTUAL AUTOMOBILE INSURANCE  
COMPANY'S REPLY BRIEF**

**ORAL ARGUMENT REQUESTED**

**TABLE OF CONTENTS**

	<u>Page</u>
TABLE OF AUTHORITIES .....	ii
I. PROVIDERS DO NOT POSSESS A “CLAIM” FOR PIP BENEFITS. ....	1
II. SECTION 3112 CONFIRMS PIP BENEFITS BELONG TO THE INJURED PERSON, NOT A PROVIDER. ....	4
III. A PROVIDER DOES NOT PRESENT A “CLAIM OF SOME OTHER PERSON” UNDER SECTION 3112.....	7
IV. COVENANT AGREES A HEARING IS NOT REQUIRED. ....	9
CONCLUSION AND REQUEST FOR RELIEF .....	10
INDEX TO EXHIBITS.....	112
CERTIFICATE OF SERVICE .....	123

**TABLE OF AUTHORITIES**

	<b>Page(s)</b>
<b>CASES</b>	
<i>Belcher v Aetna Cas &amp; Surety Co,</i> 409 Mich 231; 293 NW2d 594 (1980).....	4, 6
<i>Blacksher v State Farm Mut Auto Ins Co,</i> unpublished opinion of the Court of Appeals issued July 21, 2016 (Docket No 324670) .....	10
<i>Bronson Methodist Hosp v Mich Assigned Claims Facility,</i> unpublished opinion of the Court of Appeals issued Feb 19, 2015 (Docket Nos 317864, 317866).....	5, 10
<i>Byker v Mannes,</i> 465 Mich 637; 651 NW2d 210 (2002).....	3
<i>Chiropractors Rehab Group PC v State Farm Mut Auto Ins Co,</i> 313 Mich App 113; 881 NW2d 120 (2015).....	2
<i>Clevenger v Allstate Ins Co,</i> 443 Mich 646; 505 NW2d 553 (1993).....	1
<i>Commire v Auto Club of Mich,</i> 183 Mich App 299; 454 NW2d 248 (1990).....	4
<i>Dean v Auto Club Ins Assoc,</i> 139 Mich App 266; 362 NW2d 247 (1984).....	6
<i>Hack Inv Co v Concrete Wall Co,</i> 356 Mich 416; 97 NW2d 106 (1959).....	1
<i>Hatcher v State Farm Mut Auto Ins Co,</i> 269 Mich App 596; 712 NW2d 744 (2005).....	4
<i>Mich Ass’n of Home Builders v City of Troy,</i> 497 Mich 281; 871 NW2d 1 (2015).....	5
<i>Michigan Head &amp; Spine Institute, PC v State Farm Mut Auto Ins Co,</i> 299 Mich App 442; 830 NW2d 781 (2013).....	10
<i>Miller v Citizens Ins Co,</i> 490 Mich 904; 804 NW2d 740 (2011).....	9

DYKEMA GOSSETT-A PROFESSIONAL LIMITED LIABILITY COMPANY-CAPITOL VIEW, 201 TOWNSEND STREET, SUITE 900-LANSING, MICHIGAN 48933

**STATUTES**

MCL 500.3105.....3, 4, 7

MCL 500.3105(4).....5

MCL 500.3107.....2, 3, 4, 7

MCL 500.3108.....4

MCL 500.3110(1).....7

MCL 500.3112..... passim

MCL 500.3116.....5

MCL 500.3121.....5

MCL 500.3145.....3

MCL 500.3148.....3

MCL 500.3151.....5

MCL 500.3157.....2, 3, 4, 7

MCL 500.3158.....5

MCL 500.3173.....5

Covenant Medical Center (“Covenant”) asks this Court to hold that a provider has an independent claim against an insurer for the payment of PIP benefits, even though such a claim does not exist in the plain language of the No-Fault Act; has no common law origins; and there is no contractual relationship between the parties. Covenant engages in textual gymnastics and leaps in logic in an attempt to create a right that was not granted by the Legislature. Providers do not have the right to claim against insurers for PIP benefits; they only have the ability to receive payments for the benefit of the injured person. Covenant’s argument to the contrary ignores basic rules of statutory construction and disavows the Act’s purpose, to protect “persons suffering injury,” *Clevenger v Allstate Ins Co*, 443 Mich 646, 651; 505 NW2d 553 (1993), reading the Act to instead protect providers. Covenant goes so far as to suggest that providers—not injured persons—“own” the PIP claims for medical costs.<sup>1</sup> But even if this Court disagrees with State Farm’s analysis of the Act with respect to the lack of a provider’s right to benefits, the Court of Appeals still erred in its interpretation of MCL 500.3112. Covenant is not “some other person” under that section, and no hearing is required before insurers can effectively settle claims with their insureds. This Court should reverse.

**I. PROVIDERS DO NOT POSSESS A “CLAIM” FOR PIP BENEFITS.**

If providers have any claim against insurers for PIP benefits, it must be found in the Act as providers had no such right under the common law, and have no contractual relationship with no-fault insurers. Because accepting Covenant’s argument would be in derogation of the common law, this Court must strictly construe the Act and Covenant must be able to identify where the statute plainly, in explicit terms, authorizes the action. *Hack Inv Co v Concrete Wall Co*, 356 Mich 416, 424; 97 NW2d 106 (1959). Covenant cannot do so, which should end the

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<sup>1</sup> See Covenant’s Brief on Appeal (“Resp Br”), p 12, claiming that the “injured person” does not “own[] the provider’s claim.”

inquiry.<sup>2</sup> Covenant not only fails to identify any explicit terms granting providers rights under the Act, it fails to read the Act as a whole, and fails to give words their plain and ordinary meaning. Instead, Covenant cherry picks sections (and even phrases within sections) to create a right that does not exist.<sup>3</sup>

Covenant hinges its argument on MCL 500.3157, which it contends “gives providers the right to charge a reasonable amount for treatment.” (Resp Br, p. 8.) From this alleged “right” flows the rest of Covenant’s analysis, namely:

- Section 3157 gives providers a right to charge a “reasonable amount”;
- Section 3107(1)(a) requires no-fault insurers to pay “reasonable charges”;
- Therefore, providers have the right to require insurers to pay their reasonable charges (and can bring an independent suit to enforce this right).

There are far too many gaps in this argument. Nowhere can Covenant point to any provision in the Act that states providers have a right to be directly *paid* PIP benefits. Rather, the Act provides that insurers are liable to pay reasonable charges incurred under personal protection insurance. It is the injured person who incurs such charges;<sup>4</sup> the injured person who is entitled to

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<sup>2</sup> Covenant suggests the issue of a provider’s right to benefits was waived. (Resp Br, p 34). That issue underlies this case, and more significantly, this Court’s order granting leave to appeal specifically directed the parties to address that question. This Court has also held the application for leave to appeal in *Chiropractors Rehab Group PC v State Farm Mut Auto Ins Co*, 313 Mich App 113; 881 NW2d 120 (2015), which directly raised the issue of provider rights, in abeyance pending its decision here. (July 26, 2016 Order in Docket No. 152807.) Because this Court has made this an issue in the case, it cannot be deemed to have been “waived” by a party.

<sup>3</sup> Although Covenant focuses its arguments on healthcare providers, its analysis would have to extend to any person who provides PIP services—attendant care providers, transportation services, home or vehicle modification services, etc.—because nowhere in the Act are providers categorized or treated differently based on their profession. Thus, while Covenant discusses only physicians and hospitals, the universe of “claimants” under its reading of the Act is much larger.

<sup>4</sup> Covenant argues that Section 3107 also supports its argument because providers “incur” costs by “front[ing] the cost of the treatment, including the cost of medical supplies, salaries, overhead, etc.” and the provider is “liable for or suffers that cost unless and until its charges are paid.” (Resp Br, p 10.) This argument lacks merit. Section 3107 refers to “all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured

the benefits; and it is the injured person (or a third party *for the injured person's benefit*) to whom the benefits may be paid. MCL 500.3105, 500.3107, 500.3112.

“It is a well established rule of statutory construction that this Court will not read words into a statute.” *Byker v Mannes*, 465 Mich 637, 646; 651 NW2d 210 (2002). Yet to hold that Section 3157 creates a “right” of payment to the provider the Court would need to do just that, reading it as: “A physician...may charge *to an insurer* a reasonable amount...” or “The charge *to an injured person or his or her insurer* shall not exceed....” The Court would have to believe the Legislature intended to create a direct relationship between a provider and an insurer, where such relationship otherwise did not exist. But the Legislature knew when the Act was passed that providers would be performing services necessitated by accidents. If the Legislature intended to give providers the right to payment by the insurer, and the ability to bring suit to enforce such a right, it would have done so. The Act did not create a “new” system under which insurers have direct relationships with (and obligations to) any person that provided services to their insureds.<sup>5</sup>

Covenant’s argument does not comport with: the plain language of the Act; the Act read as a whole; the rules of statutory construction; or prior case law holding that the right to claim

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person’s care, recovery, or rehabilitation.” MCL 500.3107(1)(a) (emphasis added). Clearly, the Legislature did not intend to include a provider’s overhead costs as a “reasonable charge” that could be covered under the Act. In addition, Covenant admits that “incur” means “to become liable for.” (Resp Br, p. 10.) Yet Covenant cannot argue that providers “become liable” to pay their own selves. As for Covenant’s reliance on other Sections of the Act to create a right for providers: Section 3105 only defines bodily injury and under what circumstances benefits are payable; it says nothing about to whom benefits must be paid; Section 3145 is a statute of limitations that does not create rights that otherwise do not exist; and Section 3148 is an attorney fee provision that also does not create rights.

<sup>5</sup> The argument that Section 3157 would be nugatory if not read to give providers a right to payment (Resp Br, p. 8) is easily rebutted. Absent Section 3157, there would not be a ceiling on the charges in a no-fault case. When read as a whole, Section 3157 is a limitation on charges, designed to protect the injured persons; not a grant of rights, designed to protect providers.

benefits belongs to only the injured party or their dependents.<sup>6</sup> (It also ignores the common practice of insureds assigning their right to recover benefits to providers – why has that historically been done if not necessary?) Sections 3105, 3107, and 3157, relied upon by Covenant, do not grant rights to providers, nor does Section 3112.

**II. SECTION 3112 CONFIRMS PIP BENEFITS BELONG TO THE INJURED PERSON, NOT A PROVIDER.**

The first sentence of Section 3112 reads: “[PIP] benefits are *payable to or for the benefit of an injured person* or, in case of his death, to or for the benefit of his dependents.” (Emphasis added). It does not say benefits are payable to the injured person “or their providers.” It does not say benefits are payable to injured persons “or other claimants,” although Covenant argues it has no meaning unless read to *require* an insurer to pay PIP benefits to “another claimant” (meaning, providers). (Resp Br, p 11.) This provision *allows* an insurer to pay a medical bill directly to the provider so the injured person does not have to. The “claim” for PIP benefits still belongs to the injured person, Section 3112 simply permits an insurer to pay a provider directly. The ability to receive payment does not equate to a right to be paid; the existence of two payment *options* –as evidenced by the word “or”–does not create, as Covenant argues, “two”, “twin” “independent payment obligations.” (Resp Br, pp. 1, 11, 12.) Covenant’s analysis is flawed for several reasons.

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<sup>6</sup> See, e.g., *Belcher v Aetna Cas & Surety Co*, 409 Mich 231, 251; 293 NW2d 594 (1980); *Hatcher v State Farm Mut Auto Ins Co*, 269 Mich App 596, 600; 712 NW2d 744 (2005); *Commire v Auto Club of Mich*, 183 Mich App 299, 302; 454 NW2d 248 (1990). Dependents, unlike providers, have specific rights under the No-Fault Act. See, e.g., MCL 500.3108. The prior opinions from the Court of Appeals (but notably not from this Court) finding that providers have claims against insurers, heavily relied upon by Covenant (Resp Br, pp. 19-25) failed to interpret the Act and improperly built upon one another, as discussed in State Farm’s initial brief, pp. 22-26.

First, Covenant's assumption that it is a "claimant" because it provided services to an injured person, or submitted invoices for same, or filed a lawsuit, is inaccurate. Admittedly the Act does not define the term "claimant" (or "claim"), but it appears in many places where to read it as referring to anything other than the injured person or his or her dependents is nonsensical.<sup>7</sup> And those terms do *not* appear in the only two sections of the Act that expressly discuss providers (MCL 500.3157, 3158). Second, even if "claimant" could be read as broadly as Covenant asserts, that still does not give providers a right to payment. The Legislature obviously knew how to use the term "claimant," but did not say in Section 3112 that benefits are payable to "claimants." "We presume that the Legislature intended the meaning of the words used in the statute, and we may not substitute alternative language for that used by the Legislature." *Mich Ass'n of Home Builders v City of Troy*, 497 Mich 281, 288; 871 NW2d 1 (2015). Third, Covenant's reading does not make sense. "For the benefit of the injured person" implies one who does *not* have their own claim but is being paid in order to benefit the injured person. If providers had their own claims, there would be no reason to use the "for the benefit of" language, rather, the statute would state that benefits are payable "to the provider." But again, it does not, and this Court must assume that was for a reason.

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<sup>7</sup> See, e.g., MCL 500.3105(4) (exception for intentionally causing the injury); 500.3116 (set-offs for recovery from tort suits); 500.3121 (property protection benefits); 500.3151 (submission to physical exams). The absurdity of finding a provider to be a "claimant" under the Act is illustrated by *Bronson Methodist Hosp v Mich Assigned Claims Facility*, unpublished opinion of Court of Appeals issued Feb 19, 2015 (Docket Nos. 317864, 317866) (Ex. A), in which the provider argued that the Michigan Assigned Claims Plan ("MACP") should determine *its* eligibility for benefits under MCL 500.3173a, not the *injured person's* eligibility, because the provider, not the injured person, is the "claimant" thereunder. MCL 500.3173 precludes a person otherwise disqualified from receiving PIP benefits from receiving benefits from the MACP. But under Bronson's theory, a provider can apply to the MACP for benefits without knowledge of the injured person's actual eligibility and the claim must be assigned to an insurer. Thus, if providers are "claimants" under the Act, they are often in a better position than the injured persons themselves. This Court has held the application for leave to appeal in *Bronson* in abeyance pending its decision here. (Oct. 12, 2016 Order in Docket No. 151343.)

It is unclear when Covenant argues there are “twin” payment obligations whether they are saying that: (1) every encounter with a provider creates one claim with two “claimants” (the injured person and the provider) who can seek payment for the bills, or (2) providers are the sole claimants for their own bills; injured persons are the sole claimants for their own claims, such as wage loss; and Section 3112 requires the insurer to pay each for only their own claims. Regardless, both arguments fail. As to the former, as discussed above, there is nothing in the Act that recognizes a claim by providers for benefits. And every accident could create multiple “claimants” who could simultaneously seek payment for the same service (just as happened here), leading to conflicts between injured persons and their providers. As for the latter, that theory relegates the injured person to claims for work loss only, completely contrary to the language, and goals, of the Act.<sup>8</sup> In short, Section 3112 does not impose two payment obligations.

Covenant’s analysis of the remainder of Section 3112 is similarly problematic.<sup>9</sup> The third sentence sets forth a method the insurer can pursue if there is “doubt” as to the proper person<sup>10</sup> to receive benefits. Covenant contends because that sentence does not use the term “survivor’s loss” or dependents, it cannot be meant to address such scenarios. (Resp Br, p. 13.) But here too, this argument does not read the statute in context, and makes no sense. The “doubt” only

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<sup>8</sup> The Act was concerned not only with tort reform but also with keeping medical costs from increasing. Limitations were created in order to ensure that medical costs were kept down, including by placing a check on providers “who had no incentive to keep a doctor bill to a minimum.” *Dean v Auto Club Ins Assoc*, 139 Mich App 266, 273; 362 NW2d 247 (1984). Giving providers an independent right to payment will certainly not serve as such an incentive.

<sup>9</sup> The misinterpretation of the second sentence is discussed *infra*.

<sup>10</sup> Covenant makes much of the fact that the Act uses the term “person” here, suggesting it is therefore meant to include providers. (Resp Br, p. 12.) This Court, however, has recognized that the term “person” in the No-Fault Act must be examined in context because of its varying use throughout the Act. *Belcher*, 409 Mich at 257.

arises if there is a person claiming survivor's benefits who is not conclusively presumed to be a dependent under MCL 500.3110(1), not, as Covenant argues, when a provider and an injured person make a claim for the same medical charges. (Resp Br, p. 13.)<sup>11</sup> And the last sentence of the section then sets forth how *survivor* benefits are to be paid in the absence of a court order.

To sum up, under the Act, an insurer is liable (MCL 500.3105) to pay certain benefits for an injured person's care (MCL 500.3107). Section 3157 delineates the proper entities from whom services under MCL 500.3107(1)(a) may be provided and places limits on the charges. The benefits are payable either to the injured person *or* for their benefit. (MCL 500.3112). Looking at this structure as a whole, Covenant's argument fails. An injured person is the owner of a PIP claim – that is the person with whom the insurer generally has a contractual relationship; that is the person who received the services rendered by providers (and incurred the liability for such services), and the only person under the Act entitled to payments (either directly or indirectly), besides their dependents.

### III. A PROVIDER DOES NOT PRESENT A "CLAIM OF SOME OTHER PERSON" UNDER SECTION 3112.

Although this Court asked whether a provider constitutes "some other person" under the second sentence of Section 3112, the operative phrase is actually "the claim of some other person", which has two components, (1) a "claim", (2) of "some other person." First, as

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<sup>11</sup> Covenant's argument, and the Court of Appeals' opinion, place injured persons and their providers in direct competition for benefits. Not only does this not have any basis in the Act's plain language, it surely cuts against its goals. Under the Covenant reading of this third sentence, one accident can give rise to scores of individual "claims" for benefits – from the injured person, any service provider, any healthcare provider, or any other "person," for that matter – each of which may be adverse to each other and/or the insurer, resulting in endless litigation and increased costs and burden to the system. The real world results of this are best illustrated by the *amicus curiae* briefs submitted in support of State Farm. It is cause for concern that providers are equating themselves with injured persons under the Act and declaring their intention to fight injured persons head to head for benefits.

discussed in State Farm's initial brief, (pp. 34-39), this section provides one method of discharge and does not preclude other discharge mechanisms. To therefore apply it where the discharge was by settlement and release, as it was here, was in error.<sup>12</sup> Second, in any event, providers meet neither of these requirements. As discussed above, providers do not have "claims" for PIP benefits under the Act. And even if providers did have a "claim", at best, those claims would be derivative of those of the injured person. Thus, a provider's "claim" would be that of the injured person, in whose shoes the providers stand, not the claim "of some other person." Covenant argues its "claim" is that of "some other person" because it is "not influenced or controlled by the person to whom the...insurer pays benefits", i.e., the injured person. (Resp Br, p. 35.) But it most certainly is—Covenant has acknowledged that any claim it may have is dependent upon the injured person's eligibility for benefits. (*Id.*, p. 18.) If, for some reason, the injured person is not entitled to benefits under the policy, neither is the provider.<sup>13</sup> Because, at most, any claim by the provider is being asserted on behalf of the injured person, with the provider standing in their shoes, the provider is not "some other person" under Section 3112, even if that provision were relevant, which it is not.<sup>14</sup>

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<sup>12</sup> When this sentence is read in context, especially given the latter sentences of Section 3112, it is clear this mechanism was intended to apply to person competing for survivor loss claims, not to the submission of provider's bills to insurers.

<sup>13</sup> Indeed, query then why Covenant would presumably agree that they are bound by the injured person's or insured's actions and would not be entitled to payment by the insurer if, for example, the premiums had not been paid, or the injured person caused their own injuries, but are not bound if the injured person accepts payment for the medical bills and releases the insurer from any remaining claims related to the accident?

<sup>14</sup> Covenant attempts to equate an alleged provider's right to a loss of consortium claim, arguing that just as consortium claims cannot be settled by the primary plaintiff alone, and require the consent of the consortium plaintiff, neither should no fault claims for medical bills be allowed to be settled without the consent of the provider. (Resp Br, pp. 36-38.) Covenant fails to recognize some critical distinctions. Loss of consortium is a well-settled common law claim; providers, on the other hand, have no common law claim. In addition, a loss of consortium

#### IV. COVENANT AGREES A HEARING IS NOT REQUIRED.

Both parties agree that Section 3112 does not require a hearing. (Resp Br., p 41.) The Court of Appeals held otherwise.<sup>15</sup> As a result, insurance companies have had to hold what have become known as “Covenant hearings” to have settlements with their insureds and injured persons approved. The Court of Appeals misread the statute.

Section 3112 provides a way for an insurer to statutorily discharge its liability in certain circumstances – most likely in cases involving a deceased injured person where doubts might arise about the proper recipient for benefits.<sup>16</sup> While Section 3112 provides one “safe harbor” method of discharge, it certainly is not the only way an insurer may discharge its liabilities. In reality, no-fault disputes are most often resolved by way of settlement agreement and release, which this Court has recognized as essential to the no-fault system, and not by a Section 3112 apportionment order. That will no longer be the case, due to the Court of Appeals’ holding that any time an insurer is given written “notice” of an injured-party-dependent claim by a “third” party (which occurs in nearly every case if medical bills are considered sufficient notification for Section 3112 purposes), that insurer must apply to the Circuit Court for Section 3112 apportionment before making payments or otherwise be subject to potentially having to pay the same claims twice, as happened to State Farm here.

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spouse has their own set of damages, while a provider has no independent damages. Covenant also claims *Miller v Citizens Ins Co*, 490 Mich 904; 804 NW2d 740 (2011), supports its argument that a provider’s claim cannot be extinguished by a settlement with the insured. (Resp Br, p. 45.) But *Miller* provides such a settlement does not extinguish the provider’s claim *against the injured person*.

<sup>15</sup> “Instead, the statute *requires* that the insurer apply to the circuit court for an appropriate order directing how the no-fault benefits should be allocated.” (Emphasis added) (JA, p. 81a).

<sup>16</sup> If sentences two through five of Section 3112 were not intended to address events involving a deceased injured person, then why would the Legislature limit payees to those categories when there is no hearing?

**CONCLUSION AND REQUEST FOR RELIEF**

The consequences of these relatively new provider lawsuits are clear –more litigation and increased costs. Insurers are now at risk of being ordered to pay the same bills twice, or to pay double costs and fees,<sup>17</sup> or to pay through the MACP before eligibility for benefits has even been established<sup>18</sup>—the list could go on. In addition, there is confusion about when a provider is precluded from asserting its own “claim,” with *Michigan Head & Spine Institute PC v State Farm Mut Auto Ins Co*, unpublished decision of Court of Appeals, issued Jan. 21, 2016 (Docket No 324245)(Ex. A to State Farm’s initial brief) holding that a jury verdict in favor of the insurer bars a later suit by a provider, but with our case holding that a settlement with the insured does not act as such a bar. This confusion and chaos in the system can be obviated if this Court properly analyzes the No-Fault Act, which most of the lower courts have failed to do.

Defendant-Appellant requests that this Court reverse the Court of Appeals, reinstate the Circuit Court opinion and order, and further hold that providers do not have claims under the No-Fault Act.

Respectfully submitted,  
DYKEMA GOSSETT PLLC

Dated: October 20, 2016

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<sup>17</sup> See *Blacksher v State Farm Mut Auto Ins Co*, unpublished opinion of the Court of Appeals issued July 21, 2016 (Docket No 324670) (Ex. B) (holding that the insurer was liable to pay over \$200,000 in costs and fees to both the injured person’s attorney and the provider’s attorneys where only the provider was awarded damages, of approximately \$8,000).

<sup>18</sup> *Bronson* case, discussed in n. 7.

**INDEX TO EXHIBITS**

- A. *Bronson Methodist Hosp v Mich Assigned Claims Facility*, unpublished opinion of the Court of Appeals issued Feb 19, 2015 (Docket Nos 317864, 317866)
- B. *Blacksher v State Farm Mut Auto Ins Co*, unpublished opinion of the Court of Appeals issued July 21, 2016 (Docket No 324670)

**CERTIFICATE OF SERVICE**

On October 20, 2016 I e-filed this Brief on Appeal with the Michigan Supreme Court which will serve copies on all counsel of record.

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STATE OF MICHIGAN  
COURT OF APPEALS

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BRONSON METHODIST HOSPITAL,

Plaintiff-Appellant,

v

MICHIGAN ASSIGNED CLAIMS FACILITY,

Defendant-Appellee.

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UNPUBLISHED  
February 19, 2015

Nos. 317864, 317866  
Kalamazoo Circuit Court  
LC No. 2012-000600-NF

Before: BECKERING, P.J., and BORRELLO and GLEICHER, JJ.

PER CURIAM.

Bronson Methodist Hospital filed suit after the Michigan Assigned Claims Plan (MACP) (successor to the Michigan Assigned Claims Facility) peremptorily denied its application for assignment of Bronson's claim for payment of medical services provided for the benefit of an injured driver. Before conducting any discovery, the MACP moved to dismiss Bronson's suit, arguing that it had no legal duty to assign Bronson's claim to an insurer. The circuit court granted summary disposition, ruling that Bronson's patient either maintained no-fault insurance from which the patient could seek recovery or the patient illegally failed to maintain insurance, rendering Bronson ineligible for claim assignment.

We hold that the circuit court jumped the gun, as the evidence presented with the MACP's summary disposition motion did not factually support that immediate dismissal is warranted. Accordingly, we vacate the circuit court orders dismissing Bronson's claims and imposing sanctions against it, and remand for further proceedings.

I. BACKGROUND

On July 6, 2012, Cody Esquivel was involved in a single vehicle accident. Esquivel was intoxicated and peeled out of a driveway, causing his 2002 Jeep to roll over and strike a large landscaping boulder. Although Esquivel was unconscious at the scene and had to be airlifted to Bronson, Esquivel ultimately suffered only a broken finger and bruising on his left flank. The final bill from Bronson for Esquivel's treatment was \$21,914.22.

Bronson discharged Esquivel within 24 hours of his accident. No one from the hospital collected information regarding Esquivel's no-fault automobile insurance coverage before he left. Thereafter, the hospital was unable to locate Esquivel. A bill sent to his last known address was returned unopened. Further investigation revealed an updated phone number and address.

By the time Bronson attempted to contact the phone number it had been disconnected, and mail to the new address went unanswered. Bronson also submitted an investigatory request to the Secretary of State and learned that the vehicle involved in the accident was titled in Esquivel's name.

In the meantime, Bronson filed an application for benefits with the Michigan Assigned Claims Facility, which has since been reconfigured into the Michigan Assigned Claims Plan (MACP).<sup>1</sup> In response to the application question, "On the date of the accident, did you have motor vehicle insurance?" Bronson responded, "unknown." Bronson similarly indicated that it was unknown whether any relatives living with Esquivel or the "driver of the involved motor vehicle" carried no-fault insurance. The MACP denied Bronson's application, asserting "The owner or co-owner of an uninsured motor vehicle . . . involved in an accident is not eligible for benefits."

Bronson subsequently filed a complaint for declaratory judgment and mandamus requiring the MACP to approve the application and assign the claim to a servicing insurer. Bronson contended that the MACP was statutorily obligated to assign the claim pursuant to MCL 500.3172(1), which provides:

A person entitled to claim because of accidental bodily injury arising out of the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle in this state may obtain personal protection insurance [PIP] benefits through the assigned claims plan if [1] no [PIP] is applicable to the injury, [2] no [PIP] applicable to the injury can be identified, [3] the [PIP] applicable to the injury cannot be ascertained because of a dispute between 2 or more automobile insurers concerning their obligation to provide coverage or the equitable distribution of the loss, or [4] the only identifiable [PIP] applicable to the injury is, because of financial inability of 1 or more insurers to fulfill their obligations, inadequate to provide benefits up to the maximum prescribed.

Bronson asserted that it had been unable to identify the insurance applicable to the injury, supporting its application for benefits.

In lieu of an answer, the MACP filed a motion for summary disposition pursuant to MCR 2.116(C)(8) and (10). The MACP speculated that Esquivel, as the vehicle's registered owner, either maintained an insurance policy from which coverage must be sought or he failed to maintain insurance, in which case both he and Bronson would be precluded from seeking no-fault coverage from any insurer pursuant to MCL 500.3113<sup>2</sup> and MCL 500.3173.<sup>3</sup> Under either

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<sup>1</sup> Bronson was required to file its application with the MACP within one year of Esquivel's accident or forever lose its opportunity to make a claim for reimbursement. See MCL 500.3145(1).

<sup>2</sup> The statute provides that "[a] person is not entitled to paid [PIP] benefits" if "[t]he person was the owner or registrant of a motor vehicle . . . involved in the accident with respect to which the security required by [MCL 500.3101 or MCL 500.3102] was not in effect." MCL 500.3113(b).

scenario, the MACP continued, neither Bronson nor Esquivel would be entitled to assignment of the claim to an outside insurance company. The MACP accused Bronson of negligently releasing Esquivel without securing insurance information and then shifting the duty of investigation onto the agency. The statute, the MACP contended, places the burden of identifying applicable insurance on the party filing an application with the agency. The MACP premised this interpretation on MCL 500.3172(1)'s declaration that "a person entitled to claim" benefits must show that no insurance coverage is applicable or identifiable. The MACP also sought to impose sanctions against Bronson for filing a frivolous suit.

Bronson retorted that MCL 500.3172(1) contains four statutory conditions that "trigger eligibility for assigned claim benefits." Here, Bronson argued, that no insurance provider could be identified triggered eligibility. Moreover, Bronson asserted, it complied with the administrative rules governing applications to the MACP, see Mich Admin Code, R 11.07, and included all required information and documentation. Upon receipt of this application, the MACP was required by MCL 500.3173a(1) to "make an initial determination of a claimant's eligibility for benefits under the assigned claims plan and . . . deny an obviously ineligible claim." Bronson's claim was not "obviously ineligible," it argued, because there was no evidence that Esquivel had not maintained insurance on the day of the accident and Bronson had not been able to identify any applicable insurance. As such, the Mich Admin Code, R 11.103 required the MACP to assign the claim to a servicing insurer, and the servicing insurer would then be obligated to conduct an expeditious investigation pursuant to Mich Admin Code, R 11.109. If the servicing insurer's investigation revealed an applicable insurance policy, it then would be entitled to reimbursement. And contrary to the MACP's arguments, Bronson contended that nothing in the statutes required Bronson to establish at the time of application that no statutory coverage exclusions applied.

At the summary disposition hearing, the MACP expounded upon situations it believed should qualify for assignment when applicable insurance could not be identified.

A hit-and-run accident where the claimant is a pedestrian and the car takes off and they don't know if there is insurance on that car or not; but, because the person is a pedestrian, they're entitled to benefits.

Perhaps a person is a passenger in a car and, for one reason or another, the insurance can't be determined for that car. That person would be entitled to benefits even though . . . there is no identifiable insurance.

But where the injured party was the registered owner of the vehicle, the MACP insisted, no claim should be permitted. Rather, the hospital was required to establish whether the patient had insurance or not. And under either scenario, Esquivel would be ineligible for claim assignment, supporting the MACP's decision to deny the application.

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<sup>3</sup> This provision states: "A person who because of a limitation or exclusion in [MCL 500.3105 to 500.3116] is disqualified from receiving [PIP] benefits under a policy otherwise applying to his accidental bodily injury is also disqualified from receiving benefits under the assigned claims plan."

Bronson then clarified the relief it requested in the complaint:

[W]e're not asking the [MACP] to pay the claim. We have a declaratory judgment action asking the [MACP] to assign the claim to a servicing insurer to process and deny the claim potentially or pay the claim. But we're only, at this point in time, seeking the assignment of this claim to a servicing insurer. That's how this works. The [MACP] gets our application for benefits and then assigns it to a servicing insurer.

Bronson agreed with the MACP that "this can play out in two different ways," one ending with coverage from some insurer and the other ending in no coverage. However, Bronson disagreed with the MACP that the outcome was clear at such an early stage:

It could play out with the servicing insurer—Let's assume it's State Farm, for example, will get this claim and identify that Mr. Esquivel had insurance—higher priority insurance, in which case that insurance carrier will pay the claim[.]

Or State Farm, if they're the servicing insurer, will conclude after the assignment and with proper discovery where we get our day in court and we have the ability to litigate it, that, in fact, our patient Mr. Esquivel was an uninsured owner of a motor vehicle and consequently excluded from coverage.

One of those two situations is going to play out here, I have little doubt. But scenario number one could play out just as well as scenario number two. What that means is at this point in time, when all we're asking for is the [MACP] to assign the claim to a servicing insurer, we cannot say and the [MACP] cannot say that this patient is obviously ineligible for no-fault benefits because he very well may be entitled to no-fault benefits. That's not the [MACP's] call, that's the servicing insurer's decision.

The MACP responded that it simply does not have the resources suggested by Bronson to shift the burden of investigation onto the agency. The MACP thereby ignored Bronson's direct averment that it was actually placing the investigatory burden on the insurer assigned the claim.

It's a—Fishing expedition is [an] understatement. It's a hail Mary pass that they can somehow conscript the [MACP] into being a defendant in a litigation and trying to use resources that they believe it has that the [MACP] does not, in fact, have to locate a higher priority insurer that they hope exists.

The burden's on them. They've got until September of this year to find that insurer if it's out there.

Ultimately, the circuit court granted the MACP's summary disposition motion. The court credited the MACP's declaration that it denied the application for assignment because it determined that Esquivel owned the vehicle and therefore was clearly ineligible for assigned claim benefits, reading MCL 500.3113 and MCL 500.3173 together.

Under these provisions, because Mr. Esquivel owned the motor vehicle involved in the accident, neither [PIP] benefits nor benefits under the [MACP] may be paid out for him. As such, [Bronson] was obviously ineligible for benefits under the [MACP], and the [MACP] correctly denied [Bronson's] claims, I find.

The court declared "wrong" Bronson's assertion that it satisfied MCL 500.3172(1) because it could not identify applicable insurance:

First, 3172(1) has been characterized by courts as setting forth the circumstances under which defendant may receive or obtain the assigned claims benefits, not when defendant must accept a claim, *Spencer v Citizens Insurance Company*, 239 Mich App 291 at 301; *Spectrum Health v Grahl*, 270 Mich App 248 at 251 to '52.

Instead, MCL 500.3173a governs when defendant must accept or deny a claim. Thus, 500.3172(1) is not dispositive on the issue of when defendant must accept or deny a claim.

Second, statutes that relate to the same subject are to be read and construed together. . . .

Accordingly, 500.3172(1) must be read together with the statutes that provide limitations and exclusions on who may receive assigned claims benefits and how [the MACP] is to handle these claims, including MCL 500.3113, MCL 500.3173, and MCL 500.3173a.

When reading these statutes together, 500.3172(1) provides the general rule for eligibility; MCL 500.3173 provides exceptions to that rule; and MCL 500.3173a requires defendant to take both statutes into account when determining whether to deem a person obviously ineligible for purposes of deciding whether to deny assignment of his or her claim.

\* \* \*

In light of what I think is a plain reading of the above described statutes, [Bronson's] pleadings, and the documentary evidence submitted fail to convince me that genuine issues of material fact exist for trial; and conversely, [the MACP] has satisfied its burden.

The MACP thereafter renewed its request for attorney fees and costs, claiming that Bronson's claims were frivolous. Counsel asserted that with the creation of the MACP, newly designated investigators discovered that significant waste had occurred under the prior regime:

In January of this year, the Assigned Claims Facility was dissolved, and it was moved into a semi-governmental organization called the Assigned Claims Plan from a wholly governmental organization that was operated through the secretary of state.

And, the reason was, it was discovered that there was a lot of claims coming through the [MACP] that had absolutely no business being there, and a[n] effort is being made at this time to get those claims out so that the plan can provide the benefits to the people who are entitled to them and . . . that it will not be weighed down by claims from people that have no right bringing a claim against the plan.

The MACP's counsel continued that he discussed the agency's stance with Bronson's counsel, but Bronson refused to back down. Accordingly, counsel contended, Bronson filed its lawsuit knowing "that it did not have a right of recovery against the [MACP], and it was an effort to conscript the [MACP] to do its work for Bronson Hospital and try and locate—if possible—a higher priority insurer; and that is not what the [MACP] exists for."

Bronson denied the frivolity of its claims. Bronson argued that it was "unclear" whether Esquivel was the owner of an uninsured vehicle. As an applicable insurer could not be identified, Bronson requested assignment of the claim under the language of MCL 500.3172(1). This was a reasonable interpretation of the statute, Bronson maintained. The complaint was filed in good faith "where there had been no other clear and unequivocal case law addressing this precise issue." That the circuit court rejected Bronson's interpretation did not render its claims frivolous, Bronson concluded.

The circuit court granted the MACP's request for \$4,654.85 in attorney's fees and costs pursuant to MCR 2.625 (frivolous claims). The court found that Bronson "had no reasonable basis to believe that" its claims were legally supported. "This wasn't even a close call on this case," the court emphasized. "There just was nothing that I could see that [Bronson] could hang its hat on here, and it was on a fishing expedition, and it was done at their own peril."

The circuit court subsequently denied Bronson's motion for reconsideration, and this appeal followed.

## II. STANDARDS OF REVIEW

The MACP sought summary disposition under both MCR 2.116(C)(8) and (10). The circuit court considered evidence beyond the pleadings and thereby granted the MACP's motion under (C)(10). *Lugo v Ameritech Corp, Inc*, 464 Mich 512, 515 n 1; 629 NW2d 384 (2001). We review de novo a lower court's decision on a summary disposition motion. *Island Lake Arbors Condo Ass'n v Meisner & Assocs, PC*, 301 Mich App 384, 392; 837 NW2d 439 (2013). "Summary disposition is appropriate under MCR 2.116(C)(10) if there is no genuine issue regarding any material fact and the moving party is entitled to judgment as a matter of law." *Id.*, quoting *West v Gen Motors Corp*, 469 Mich 177, 183; 665 NW2d 468 (2003). "In reviewing a motion under MCR 2.116(C)(10), this Court considers the pleadings, admissions, affidavits, and other relevant documentary evidence of record in the light most favorable to the nonmoving party to determine whether any genuine issue of material fact exists to warrant a trial." *Walsh v Taylor*, 263 Mich App 618, 621; 689 NW2d 506 (2004).

We also review de novo underlying issues of statutory interpretation. *Barelae v Zarb*, 300 Mich App 455, 466; 834 NW2d 100 (2013).

The goal of statutory interpretation is to discern and give effect to the intent of the Legislature. To that end, the first step in determining legislative intent is the language of the statute. If the statutory language is unambiguous, then the Legislature's intent is clear and judicial construction is neither necessary nor permitted. [*Id.* at 466-467 (citations omitted).]

### III. SUMMARY DISPOSITION IMPROPERLY GRANTED

The circuit court erred in granting the MACP's motion for summary disposition before the parties conducted any discovery. Whether Esquivel failed to maintain statutorily required insurance for his vehicle constitutes an unresolved question of fact. The MACP presented no evidence that Esquivel was not insured. And Bronson has been unable to identify any applicable no-fault insurer. As such, it is not yet certain that Esquivel and thereby Bronson is ineligible for assignment of this claim to a servicing insurer. Alternatively stated, a fact question exists as to whether Esquivel was or was not insured, and thereby whether Bronson is "obviously ineligible" to seek no-fault benefits. Accordingly, summary disposition was at least premature.

"Enactment of the Michigan no-fault insurance act signaled a major departure from prior methods of obtaining reparation for injuries suffered in motor vehicle accidents. . . . Under this system, losses are recovered without regard to the injured person's fault or negligence." *Spencer v Citizens Ins Co*, 239 Mich App 291, 300; 608 NW2d 113 (2000). In the normal course, a party injured in a motor vehicle accident will seek benefits under his or her own no-fault policy, or through the policy of a family member. *Id.* at 301. As a last resort, when a liable insurer cannot be immediately identified or in some circumstances, when an injured party does not have insurance, the claim for benefits is placed before the MACP. *Id.*, *Hunt v Citizens Ins Co*, 183 Mich App 660, 665; 455 NW2d 384 (1990).

As noted, MCL 500.3172(1) provides, "A person entitled to claim because of accidental bodily injury arising out of the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle in this state may obtain [PIP] benefits through the [MACP] if . . . no [PIP] applicable to the injury can be identified." The MACP must "make an initial determination of the claimant's eligibility for benefits under" the plan but may only deny an application if based on "an obviously ineligible claim." MCL 500.3173a. If the claim is not "obviously ineligible," the MACP must "promptly" assign the claim to a servicing insurer. Mich Admin Code, R 11.108(3). Upon assignment, the servicing insurer "shall investigate the claim expeditiously." Mich Admin Code, R 11.109(1). The insurer assigned by the MACP stands in a position of last priority, *Hunt*, 183 Mich App at 665, and may seek to transfer a claim and to secure reimbursement if a higher priority insurer as identified in MCL 500.3114 or MCL 500.3115 is discovered. In the meantime, however, the injured party continues to receive benefits from the assigned insurer.

The MACP correctly states that an injured party "who because of a limitation or exclusion in [MCL 500.3105 to MCL 500.3116] is disqualified from receiving [PIP] benefits" from an assigned insurer through the MACP. MCL 500.3173. And MCL 500.3113(b) provides that "[a] person is not entitled to be paid [PIP] benefits" if he or she is "the owner or registrant of a motor vehicle . . . involved in the accident" and did not maintain statutorily required no-fault insurance at the time of the accident. The MACP also correctly posits that if Esquivel or a

family member in his household maintained no-fault insurance at the time of the accident, that insurer would take priority under MCL 500.3114(1).

It is not clear on this undeveloped record, however, that one of these scenarios exist. Esquivel's insurance status remains unknown. When he is deposed, the material fact missing from the no-fault equation will emerge. MACP has not yet carried its burden as the moving party to demonstrate with admissible evidence, rather than speculation, that Bronson was "obviously ineligible" to make a claim for benefits.

The MACP proffered the Michigan State Police accident report with its summary disposition motion. The report identified the vehicle involved in the accident, including its vehicle identification and license plate numbers. The vehicle was at that time registered to Cody Eleazar Esquivel. The report contains no information regarding Esquivel's no-fault insurance, or lack thereof. A corresponding fire department incident report also identified the vehicle and driver, but left blank sections designated for insurance information. The MACP provided Bronson's application for claim assignment, indicating that Esquivel's insurance information was "unknown." Finally, the MACP attached a letter that it had sent to Bronson, expressing its belief that the burden fell on Bronson to establish entitlement to benefits before the claim would be assigned.

Bronson supplemented the record evidence with its medical records pertaining to Esquivel's treatment. The records indicate that when Esquivel first arrived at the hospital, he was intubated, rendering him unable to communicate. Once extubated, Esquivel remained too intoxicated or confused to appropriately answer questions. When Esquivel's parents arrived, medical personnel asked them medical and psychological history questions. However, there is no indication in the medical records that Bronson staff questioned Esquivel, once he was sober, regarding his no-fault automobile insurance. The records also do not include any reference to Esquivel's health insurance provider, if any.

Bronson also provided evidence of its attempts to locate Esquivel to secure insurance information after his release. Bronson made a Freedom of Information Act request to the Michigan State Police for the accident report. Bronson submitted the letter it sent to Esquivel three months after the accident at the address listed in the police report. Bronson included a copy of the enveloped returned as undeliverable and stamped "Attempted – Not Known, Unable to Forward." Bronson attached identification and address information provided by the Secretary of State and discovered through an "Accurint" Internet search, both of which led to some stale contact information. Mail submitted to the most current address discovered for Esquivel went unanswered and unreturned.

Ultimately, nothing in the record establishes that Esquivel was actually uninsured. And no applicable insurance has been identified, despite Bronson's efforts. Thus, at this juncture, Bronson's claims fall squarely within that portion of MCL 500.3172(1) addressing claims for which "no personal protection insurance applicable to the injury can be identified." The existence of a central material fact question—whether or not Esquivel had insurance at the time of the accident—precluded summary disposition, and the circuit court erred in granting the MACP's motion and request for sanctions.

We vacate and remand for further proceedings consistent with this opinion. We do not retain jurisdiction. As this case involves a question of public policy, Bronson may not tax its costs under MCR 7.219.

/s/ Jane M. Beckering  
/s/ Stephen L. Borrello  
/s/ Elizabeth L. Gleicher

**B**

STATE OF MICHIGAN  
COURT OF APPEALS

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ADIA BLACKSHER,

Plaintiff-Appellee,

and

SANDEEAH BLACKSHER,

Appellee,

and

MCLAREN MEDICAL CENTER,

Intervening Plaintiff-Appellee,

v

STATE FARM MUTUAL AUTOMOBILE  
INSURANCE COMPANY,

Defendant-Appellant.

UNPUBLISHED

July 21, 2016

No. 324670

Genesee Circuit Court

LC No. 08-089055-NF

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Before: SAWYER, P.J., and HOEKSTRA and GLEICHER, JJ.

PER CURIAM.

Defendant, State Farm Mutual Automobile Insurance Company (State Farm), appeals as of right an order awarding no-fault attorney fees and costs to plaintiff Adia Blacksher<sup>1</sup> and intervening plaintiff, McLaren Medical Center (McLaren). We affirm in part, reverse in part, and remand for further proceedings consistent with this opinion.

State Farm first argues that the law of the case doctrine applies to bar the award of attorney fees to Blacksher and McLaren. We disagree. “Generally, an issue is not properly

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<sup>1</sup> Plaintiff Sandeeah Blacksher is not involved in this appeal; we will therefore refer to Adia as “Blacksher.”

preserved if it is not raised before, addressed, or decided by the circuit court or administrative tribunal.” *Polkton Charter Twp v Pellegroni*, 265 Mich App 88, 95; 693 NW2d 170 (2005). The issue whether this Court’s prior opinion in this case constituted the law of the case was not raised, addressed, or decided in the trial court, but that is because this Court’s prior opinion was issued *after* the entry of the order now being appealed and *after* the filing of the present appeal. “Although this Court need not review issues raised for the first time on appeal, this Court may overlook preservation requirements if the failure to consider the issue would result in manifest injustice, if consideration is necessary for a proper determination of the case, or if the issue involves a question of law and the facts necessary for its resolution have been presented.” *Smith v Foerster-Bolser Constr, Inc*, 269 Mich App 424, 427; 711 NW2d 421 (2006). The applicability of the law of the case doctrine presents a question of law, *Duncan v Michigan*, 300 Mich App 176, 188; 832 NW2d 761 (2013), and the necessary facts to resolve the issue are in the record. Accordingly, we will review the issue. “Whether the law of the case doctrine applies is a question of law that we review de novo.” *Id.*

“Generally, the law of the case doctrine provides that an appellate court’s decision will bind a trial court on remand and the appellate court in subsequent appeals.” *Duncan*, 300 Mich App at 188-189 (quotation marks omitted). “Under the law of the case doctrine, if an appellate court has passed on a legal question and remanded the case for further proceedings, the legal questions thus determined by the appellate court will not be differently determined on a subsequent appeal in the same case where the facts remain materially the same.” *Grievance Administrator v Lopatin*, 462 Mich 235, 259; 612 NW2d 120 (2000) (quotation marks omitted). A lower court is likewise bound and “may not take action on remand that is inconsistent with the judgment of the appellate court. Thus, as a general rule, an appellate court’s determination of an issue in a case binds lower tribunals on remand and the appellate court in subsequent appeals.” *Id.* at 260.

It is the duty of the lower court, on remand, to comply strictly with the mandate of the appellate court. However, the law of the case doctrine applies only to issues implicitly or explicitly decided in the previous appeal. The law of the case doctrine’s rationale is to maintain consistency and avoid reconsideration of matters once decided during the course of a single lawsuit; the doctrine does not limit an appellate court’s power but, rather, is a discretionary rule of practice. A trial court fails to follow the law of the case when it revisits a matter on which this Court has already ruled. [*Schumacher v Dep’t of Natural Resources*, 275 Mich App 121, 128; 737 NW2d 782 (2007) (quotation marks, ellipsis, and citations omitted).]

“Thus, a question of law decided by an appellate court will not be decided differently on remand or in a subsequent appeal in the same case. This rule applies without regard to the correctness of the prior determination.” *Driver v Hanley*, 226 Mich App 558, 565; 575 NW2d 31 (1997) (citation omitted).

This Court’s prior opinion in this case, *Blacksher v State Farm Mut Auto Ins Co*, unpublished opinion per curiam of the Court of Appeals, issued December 4, 2014 (Docket Nos. 312107, 315678), did not decide a legal question that is at issue in the present appeal. In the prior appeal, this Court held that the trial court did not err in denying State Farm’s motion for

attorney fees under MCL 500.3148(2), which provides: “An insurer may be allowed by a court an award of a reasonable sum against a claimant as an attorney’s fee for the insurer’s attorney in defense against a claim that was in some respect fraudulent or so excessive as to have no reasonable foundation.” In the present appeal, State Farm challenges the award of attorney fees to Blacksher and McLaren under an attorney fee provision different from the provision at issue in the prior appeal. In particular, the trial court awarded attorney fees to Blacksher and McLaren under MCL 500.3148(1), which states:

An attorney is entitled to a reasonable fee for advising and representing a claimant in an action for personal or property protection insurance benefits which are overdue. The attorney’s fee shall be a charge against the insurer in addition to the benefits recovered, if the court finds that the insurer unreasonably refused to pay the claim or unreasonably delayed in making proper payment.

Therefore, whereas the attorney fee issue in the prior appeal was whether, under MCL 500.3148(2), the no-fault claim was so excessive as to lack a reasonable foundation, the attorney fee issue in the present appeal is whether, under MCL 500.3148(1), State Farm unreasonably refused to pay the claim or unreasonably delayed in making proper payment.

State Farm suggests that the discussion in this Court’s prior opinion of the conflicting medical evidence establishes that a bona fide question of factual uncertainty existed, such that State Farm did not unreasonably refuse to pay the claim or unreasonably delay in making proper payment. It is true that “[a] delay in making payments is not unreasonable if it is based on a legitimate question of statutory construction, constitutional law, or factual uncertainty.” *Ivezaj v Auto Club Ins Ass’n*, 275 Mich App 349, 353; 737 NW2d 807 (2007) (quotation marks omitted). But the inquiry required by MCL 500.3148(1) is whether the insurer’s *initial* refusal to pay the expense was unreasonable. *Id.* at 353-355. This Court’s prior opinion did not decide whether State Farm’s initial refusal to pay the claimed expenses was unreasonable. That is, this Court did not address whether State Farm had a reasonable basis for its refusal to pay the claim *at the time the claim was first submitted*. See *id.* at 355. Instead, this Court’s prior opinion noted the conflicting medical evidence *at trial* and concluded that the claim was not so excessive as to lack a reasonable foundation and that the verdict was not inconsistent or against the great weight of the evidence. This Court did not discuss which, if any, of the evidence supporting State Farm’s position at trial was available to State Farm when it initially refused to pay or delayed making proper payment. Because this Court’s prior opinion did not decide the question under MCL 500.3148(1) that is presented in this appeal, the law of the case doctrine is inapplicable.

State Farm next challenges the award of no-fault attorney fees to Blacksher and McLaren on the ground that the trial court clearly erred in failing to focus on the facts surrounding the disputed expenses and instead relying on the jury verdict awarding no-fault expenses. We disagree.

In *Moore v Secura Ins*, 482 Mich 507, 516; 759 NW2d 833 (2008), our Supreme Court set forth the standard for reviewing a trial court’s decision whether to award attorney fees pursuant to MCL 500.3148(1):

The trial court's decision about whether the insurer acted reasonably involves a mixed question of law and fact. What constitutes reasonableness is a question of law, but whether the defendant's denial of benefits is reasonable under the particular facts of the case is a question of fact. This Court reviews de novo questions of law, but we review findings of fact for clear error. A decision is clearly erroneous when the reviewing court is left with a definite and firm conviction that a mistake has been made. Moreover, we review a trial court's award of attorney fees and costs for an abuse of discretion. An abuse of discretion occurs when the trial court's decision is outside the range of reasonable and principled outcomes. [Quotation marks and citations omitted.]

As discussed, MCL 500.3148(1), the no-fault attorney fee provision at issue, states:

An attorney is entitled to a reasonable fee for advising and representing a claimant in an action for personal or property protection insurance benefits which are overdue. The attorney's fee shall be a charge against the insurer in addition to the benefits recovered, if the court finds that the insurer unreasonably refused to pay the claim or unreasonably delayed in making proper payment.

As our Supreme Court explained in *Moore*, 482 Mich at 517:

MCL 500.3148(1) establishes two prerequisites for the award of attorney fees. First, the benefits must be overdue, meaning "not paid within 30 days after [the] insurer receives reasonable proof of the fact and of the amount of loss sustained." MCL 500.3142(2). Second, in postjudgment proceedings, the trial court must find that the insurer "unreasonably refused to pay the claim or unreasonably delayed in making proper payment." MCL 500.3148(1). Therefore, assigning the words in MCL 500.3142 and MCL 500.3148 their common and ordinary meaning, "attorney fees are payable only on overdue benefits for which the insurer has unreasonably refused to pay or unreasonably delayed in paying." *Proudfoot v State Farm Mut Ins Co*, 469 Mich 476, 485; 673 NW2d 739 (2003) (emphasis omitted).

"When an insurer refuses to make or delays in making payment, a rebuttable presumption arises that places the burden on the insurer to justify the refusal or delay." *Attard v Citizens Ins Co of America*, 237 Mich App 311, 317; 602 NW2d 633 (1999). An insurer's refusal to pay or delay in paying no-fault benefits is reasonable if it is based on a legitimate question of statutory construction, constitutional law, or factual uncertainty. *Moore*, 482 Mich at 520; *Attard*, 237 Mich App at 317. An insurer is not required to reconcile conflicting medical opinions or to "go beyond" the medical opinions of the defense medical experts. *Moore*, 482 Mich at 521-522. "The determinative factor in our inquiry is not whether the insurer ultimately is held responsible for benefits, but whether its initial refusal to pay was unreasonable." *Ross v Auto Club Group*, 481 Mich 1, 11; 748 NW2d 552 (2008). "Otherwise stated, an insurer's initial refusal to pay benefits under Michigan's no-fault insurance statutes can be deemed reasonable even though it is later determined that the insurer was required to pay those benefits." *Moore*, 482 Mich at 525.

In making the reasonableness determination, a trial court clearly errs if it fails to focus on the facts surrounding the disputed expenses and instead concludes that the refusal to pay was unreasonable because the jury awarded the disputed expenses. *Bonkowski v Allstate Ins Co*, 281 Mich App 154, 171; 761 NW2d 784 (2008). In *Bonkowski*, 281 Mich App at 172, the trial court stated in its written judgment that it had found that the insurer unreasonably refused to make proper payment of no-fault benefits. But this Court concluded that the trial court had failed to make the requisite factual findings to support an attorney fee award:

Notwithstanding the above-cited conclusion [that the refusal was unreasonable], our review of the record reveals no factual findings to support the conclusion reached by the trial court. It appears from the record that the trial court, when awarding attorney fees to plaintiff, only considered the jury's conclusion that [the insured] was entitled to greater compensation than that offered by defendant. Thus, we are left with a definite and firm conviction that the trial court simply based its conclusion on the jury's verdict. This was error. [*Id.*]

In this case, the trial court initially failed to make the requisite factual findings to establish that State Farm's refusal to pay no-fault expenses was unreasonable. After quoting the language of MCL 500.3148(1), the trial court stated, in relevant part:

I think, clearly, there is evidence to show that part of the claim was not paid and that it was unreasonable – it was an unreasonable refusal to do so; that is borne out again by the verdict that McLaren has received in the amount of \$8,000 or so. Uh, so based on that, I do think that the Plaintiffs have met the – the first requirement.

Secondly, uh, to pay the claim or reasonably delay making proper payment; I think that, again, the jury seems to have spoken on that; and so I think, when you look at the statute, there's no question that the Plaintiffs have shown that they are entitled to attorney fees in this case.

Although the trial court vaguely referred to “evidence” in concluding that the refusal to pay part of the claim was unreasonable, the court did not focus on the facts surrounding the disputed expenses; the record was bereft of any fact-specific findings that this Court could meaningfully review. Rather than discussing any evidence concerning the claimed expenses, the trial court referred twice to the jury verdict. The trial court's failure to focus on or address any specific facts surrounding the disputed expenses while instead referencing the jury verdict amounted to clear error. *Bonkowski*, 281 Mich App at 171. See also *Moore*, 482 Mich at 522 (holding that the trial court must “engage in a fact-specific inquiry” when determining whether the refusal to pay was unreasonable).

To provide the trial court an opportunity to fully address this issue and place its findings on the record, we twice remanded the matter to the trial court to do so. After the second remand, the trial court fully stated its reasons on the record. Having reviewed the trial court's opinion, we are satisfied with its explanation. Accordingly, we affirm the trial court's grant of attorney fees.

State Farm further suggests that this Court should hold *as a matter of law* that a legitimate question of factual uncertainty existed and therefore that State Farm's refusal to pay the disputed expenses was reasonable. We disagree. As discussed, the relevant inquiry is whether the insurer's *initial* refusal to pay was unreasonable. *Ross*, 481 Mich at 11. State Farm never identifies in its appellate brief exactly *when* it initially refused to pay the expenses that the jury determined should have been paid and *what* basis State Farm had to refuse to pay the benefits *at that time*. Instead, State Farm's principal appellate brief focuses primarily on the medical evidence presented at trial that favored State Farm's position without elucidating whether that evidence was available to State Farm when it initially refused to pay the disputed expenses. State Farm did not receive the defense medical examination reports until various points in 2008, *after* the delay or refusal to pay expenses that were submitted to State Farm for services rendered in the fall of 2007. In its reply brief, State Farm discusses the emergency room and EMS records, which State Farm interprets as not indicating that a head injury occurred.<sup>2</sup> Therefore, the matter had to be resolved factually by the trial court based upon the information available to it. As stated above, we are satisfied that the trial court properly resolved the issue after remand.

State Farm next asserts challenges to the trial court's awards of costs to Blacksher and McLaren. "We review for an abuse of discretion the trial court's ruling on a motion to tax costs under MCR 2.625. However, whether a particular expense is taxable as a cost is a question of law. We review questions of law *de novo*." *Guerrero v Smith*, 280 Mich App 647, 670; 761 NW2d 723 (2008) (citation omitted). "The determination whether a party is a 'prevailing party' for the purpose of awarding costs under MCR 2.625 is a question of law, which this Court reviews *de novo*." *Fansler v Richardson*, 266 Mich App 123, 126; 698 NW2d 916 (2005).

MCR 2.625(A)(1) provides: "Costs will be allowed to the prevailing party in an action, unless prohibited by statute or by these rules or unless the court directs otherwise, for reasons stated in writing and filed in the action." "The power to tax costs is purely statutory, and the prevailing party cannot recover such expenses absent statutory authority." *Guerrero*, 280 Mich App at 670.

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<sup>2</sup> State Farm's failure to address the information available to it during the specific timeframe when it initially refused to pay benefits may be attributable to the simplistic jury verdict form, which failed to identify the specific expenses that were owed; the jury indicated on the verdict form that \$8,012.80 was owed for the services at McLaren but did not identify *when* those expenses were incurred, and the parties could not mathematically reconstruct how the jury reached its decision. As discussed in this Court's prior opinion, the parties stipulated to the simplistic verdict form, *Blacksher*, slip op at 8-9, and "[a] party cannot stipulate with regard to a matter and then argue on appeal that the resulting action was erroneous." *Id.* at 9, quoting *Hodge v Parks*, 303 Mich App 552, 556; 844 NW2d 189 (2014). Because the case is being remanded, we leave it to the trial court on remand to determine whether and, if so, how the timeframe during which the disputed expenses were incurred can be determined in this case.

MCR 2.625(A) states the starting presumption, that in any action or proceeding, whether legal or equitable, costs shall be allowed as a matter of course to the prevailing party. This does not mean, of course, that every expense incurred by the prevailing party in connection with the proceeding may be recovered against the opposing party. The term “costs” as used in MCR 2.625(A) takes its content from the statutory provisions defining what items are taxable as costs. [*Beach v State Farm Mut Auto Ins Co*, 216 Mich App 612, 622; 550 NW2d 580 (1996), quoting 3 Martin, Dean & Webster, Michigan Court Rules Practice (3d ed), pp 720-721 (brackets omitted).]

State Farm contests Blacksher’s status as a prevailing party entitled to tax costs. MCR 2.625(B)(2) provides the following rule for determining whether a party prevailed:

In an action involving several issues or counts that state different causes of action or different defenses, the party prevailing on each issue or count may be allowed costs for that issue or count. If there is a single cause of action alleged, the party who prevails on the entire record is deemed the prevailing party.

The fact that a plaintiff recovered damages that were less than the total amount of damages sought does not preclude that plaintiff from being deemed the prevailing party under MCR 2.625(B)(2). *McMillan v Auto Club Ins Ass’n*, 195 Mich App 463, 466; 491 NW2d 593 (1992). In order to be considered a prevailing party, a party must show at a minimum that its position was improved by the litigation. *Fansler*, 266 Mich App at 128. Blacksher is a prevailing party under MCR 2.625(B)(2). The jury determined that Blacksher suffered an accidental bodily injury arising out of the ownership, operation, or use of a motor vehicle and that she incurred allowable expenses arising out of that injury. The jury awarded only \$8,012.80 to McLaren as the amount of allowable expenses that State Farm had not already paid. The fact that the jury did not award the full amount of damages that Blacksher sought does not preclude designating Blacksher as a prevailing party. *McMillan*, 195 Mich App at 466. Although McLaren intervened in this case, Blacksher litigated the claim as well, including before McLaren intervened. And Blacksher would have owed to McLaren the \$8,012.80 awarded in the verdict if the jury had not made that award. Thus, Blacksher’s position improved as a result of the litigation. *Fansler*, 266 Mich App at 128. On the entire record, we conclude that Blacksher was appropriately deemed a prevailing party.

State Farm next argues that the costs award to Blacksher included items for which there was no statutory authority to tax costs. We agree. Although the trial court did not expressly designate the items for which it allowed costs, the costs award appears to have been based on the itemized invoice appended to Blacksher’s supplemental motion for attorney fees and costs. Included in the invoice were copying charges, postage expenses, case evaluation fees, mileage expenses, parking expenses, courier fees, costs to obtain the trial transcripts for a posttrial motion or for the prior appeal in Docket No. 312107, costs for some depositions with respect to which the transcripts were not filed in the clerk’s office, and exhibit presentation board costs. There is no statutory authority to award these costs. See MCL 600.2549 (“Reasonable and actual fees paid for depositions of witnesses *filed in any clerk’s office* . . . shall be allowed in the taxation of costs only if, at the trial or when damages were assessed, the depositions were read in evidence, except for impeachment purposes . . . .”) (emphasis added); MCL 600.2543(2) (“Only if the

transcript is desired for the purpose of moving for a new trial or preparing a record for appeal shall the amount of reporters' or recorders' fees paid for the transcript be recovered as a part of the taxable costs of the prevailing party in the motion, in the court of appeals or the supreme court."); *Van Elslander v Thomas Sebold & Assoc, Inc*, 297 Mich App 204, 223; 823 NW2d 843 (2012) ("Although the cost of trial transcripts constitutes a taxable cost in an appeal, it is inappropriate to include the cost of transcripts prepared for an appeal as costs recoverable by the prevailing party in a civil action.") (citations omitted); *Guerrero*, 280 Mich App at 673 ("No statute or court rule allows the taxation of expenses related to the general copying of documents."); *id.* at 674 ("[C]ase evaluation fees, formerly known as mediation fees, are not taxable as costs."); *id.* at 673 ("Although the traveling expenses of witnesses may be taxed as costs, there is no statute or court rule allowing for the taxation of the traveling expenses of attorneys or parties.") (citations omitted); *id.* at 672-673 ("The expense of exhibit enlargement is not a taxable cost."). Because the trial court lacked statutory authority to award the costs challenged on appeal, we vacate in part the costs award to Blacksher and direct the trial court on remand to enter an amended judgment excluding from the costs award the items for which there is no statutory authority to tax costs.<sup>3</sup>

State Farm next asserts that the award of costs to McLaren was comprised of uncollectable consultation or contractor fees predicated on invoices from two attorneys, P. David Palmiere and Charles J. Gerlach, who were not employed by the office of McLaren's counsel and who never entered an appearance in this case. Palmiere charged \$280, and Gerlach charged \$2,463.65, which together amount to \$2,743.65, the entire amount awarded as costs to McLaren. State Farm notes that these fees were not recovered as part of the attorney fee award and that no statutory provision allows the recovery of such consultation or contractor fees as taxable costs. We agree. There is no statutory authority allowing the award of fees for legal consultants or contractors as taxable costs. McLaren asserts that, although Palmiere and Gerlach are attorneys, they provided nonlegal services that can be taxed as costs. McLaren suggests that Palmiere conducted medical research for McLaren's counsel and that Gerlach "performed similar types of non-lawyer services." McLaren cites no support in the record for this assertion, and the invoices manifestly refer to legal services that Palmiere and Gerlach provided to McLaren's counsel, including consultations on legal issues. Because there is no statutory authority allowing these consultant fees as taxable costs, and because the entire costs award to McLaren appears to be comprised of these fees, the costs award to McLaren is reversed. *Guerrero*, 280 Mich App at 670. State Farm further argues that other costs sought by McLaren included mileage and parking expenses; State Farm correctly notes that, as discussed earlier, there is no statutory authority to tax such expenses as costs. Again, however, it appears that the entirety of the costs award in favor of McLaren was comprised of the consultant fees that could not be taxed.

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<sup>3</sup> The trial court did not itemize the costs that it awarded. The invoice of costs that Blacksher submitted below came to a total of \$19,343.20, but the trial court awarded \$16,871.79 in costs to Blacksher. If the trial court has already excluded any of the items for which there is no statutory authority to tax costs, then the trial court should not, of course, exclude those items a second time on remand.

Affirmed in part, reversed in part, and remanded for further proceedings consistent with this opinion. No costs, neither party having prevailed in full. We do not retain jurisdiction.

/s/ David H. Sawyer  
/s/ Joel P. Hoekstra  
/s/ Elizabeth L. Gleicher