

STATE OF MICHIGAN  
SUPREME COURT  
On Appeal from Michigan Court of Appeals

COVENANT MEDICAL CENTER,

Plaintiff/Appellee,

v.

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

Defendant/Appellant.

Supreme Court Case No. 152758

Court Of Appeals Case No. 322108

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

Richard E. Hillary, II (P56092)  
Christopher J. Schneider (P74457)  
MILLER JOHNSON  
Attorneys for Plaintiff/Appellee  
45 Ottawa Ave. SW, Ste. 1100  
Grand Rapids, MI 49503  
(616) 831-1700  
[hillaryr@millerjohnson.com](mailto:hillaryr@millerjohnson.com)

Jill M. Wheaton (P49921)  
Courtney F. Kissel (P74179)  
DYKEMA GOSSETT PLLC  
Attorneys for Defendant-Appellant  
2723 South State Street, Suite 400  
Ann Arbor, MI 48104  
Telephone: (734) 214-7629  
[jwheaton@dykema.com](mailto:jwheaton@dykema.com)

**BRIEF ON APPEAL OF DEFENDANT-APPELLANT**

**ORAL ARGUMENT REQUESTED**

**INDEX TO EXHIBITS**

**CERTIFICATE OF SERVICE**

**TABLE OF CONTENTS**

TABLE OF AUTHORITIES ..... iii

STATEMENT OF JURISDICTION..... vii

STATEMENT OF QUESTIONS INVOLVED..... viii

INTRODUCTION AND SUMMARY OF ARGUMENT ..... 1

STATEMENT OF FACTS AND MATERIAL PROCEEDINGS ..... 5

STANDARD OF REVIEW ..... 12

ARGUMENT..... 12

I. THE COURT OF APPEALS’ DECISION IS DEPENDENT ON THE FAULTY  
PREMISE THAT HEALTHCARE PROVIDERS POSSESS A “CLAIM” FOR  
PIP BENEFITS. .... 12

    A. Healthcare Providers Do Not Have A “Claim” Against A No-Fault Insurer  
    For PIP Benefits Under The No-Fault Act..... 14

    B. The Case Law Relied Upon By The Court Of Appeals Does Not Analyze  
    The No-Fault Act..... 22

    C. Providers Have No Contractual Right To A Claim..... 26

    D. Even Assuming Providers Have A Claim Against No-Fault Insurers, Such  
    A Claim Would Be A Derivative Claim At Best. .... 29

II. THE COURT OF APPEALS’ DECISION MISINTERPRETS SECTION 3112 –  
PROVIDERS DO NOT PRESENT “CLAIMS OF SOME OTHER PERSON”  
WITHIN THAT SECTION, AND HEARINGS ARE NOT REQUIRED BEFORE  
CLAIMS CAN BE SETTLED WITH INSUREDS. .... 33

    A. A Statutory Discharge Is Not The Only Way To Discharge An Insurer’s  
    Liability, Even If The Insurer Has “Notice” Of A Third Party’s Claim. .... 34

    B. A Provider Claim Is Not A “Claim Of Some Other Person” ..... 39

    C. Section 3112 Does Not Mandate Applying To The Circuit Court Even If  
    There Is A Dispute Over The Proper Person To Receive Payment ..... 41

    D. The Court Of Appeals’ Decision Is Contary To The Goals Of The No-Fault  
    Act. .... 42

CONCLUSION AND RELIEF REQUESTED ..... 43

INDEX TO EXHIBITS..... 44  
CERTIFICATE OF SERVICE ..... 45

**TABLE OF AUTHORITIES**

	<b>Page(s)</b>
<b>Cases</b>	
<i>Ameritech Mich v PSC (In re MCI)</i> , 460 Mich 396; 596 NW2d 164 (1999) .....	14
<i>Bahri v IDS Property Cas Ins Co</i> , 308 Mich App 420; 864 NW2d 609 (2014).....	29
<i>Barclae v Zarb</i> , 300 Mich App 455; 834 NW2d 100 (2013) .....	20
<i>Belcher v Aetna Casualty &amp; Surety Co</i> , 409 Mich 231; 293 NW2d 594 (1980).....	14, 16, 19, 26
<i>Bombalski v Auto Club Ins Ass’n</i> , 247 Mich App 536; 637 NW2d 251 (2001).....	17
<i>Chiropractors Rehabilitation Group v State Farm</i> , 313 Mich App 113; 881 NW2d 120 (2015).....	13, 18, 22, 24
<i>Clark v Progressive Ins Co</i> , 309 Mich App 387; 872 NW2d 730 (2015) .....	31, 37
<i>Cruz v State Farm Mut Auto Ins Co</i> , 466 Mich 588; 648 NW2d 591 (2002).....	5
<i>Davey v DAIIE</i> , 414 Mich 1; 322 NW2d 541 (1982) .....	5
<i>Dean v Auto Club Ins Ass’n</i> , 139 Mich App 266; 362 NW2d 247 (1984).....	5
<i>DiPonio Constr Co, Inc v Rosati Masonry Co, Inc</i> , 246 Mich App 43; 631 NW2d 59 (2001).....	12
<i>Dolson v Sec’y of State</i> , 83 Mich App 596; 269 NW2d 239 (1978).....	5
<i>Elsner v Farmers Ins Group</i> , 364 Ark 393; 220 SW3d 633 (Ark 2005).....	27
<i>Fieger v Comm’r of Ins</i> , 174 Mich App 467; 437 NW2d 271 (1988).....	20
<i>Frankenmuth Mut Ins Co v Marlette Homes</i> , 456 Mich 511; 573 NW2d 611 (1998) .....	14
<i>Gooden v Transamerica Ins Corp</i> , 166 Mich App 793; 420 NW2d 877 (1988).....	5
<i>Hatcher v State Farm</i> , 269 Mich App 596; 712 NW2d 744 (2006).....	19, 26
<i>Heikkeinen v Aetna Cas &amp; Sur Co</i> , 124 Mich App 459; 335 NW2d 3 (1981).....	35
<i>In re Fitch Drain</i> , 346 Mich 81; 77 NW2d 450 (1956).....	23
<i>In re Hales Estate</i> , 182 Mich App 55; 451 NW2d 867 (1990).....	19, 26
<i>Jozwiak v Northern Mich Hosps</i> , 207 Mich App 161; 524 NW2d 250 (1994) .....	32

<i>Koenig v City of South Haven</i> , 460 Mich 667; 597 NW2d 99 (1999).....	27
<i>Lakeland Neurocare Ctrs v State Farm Mutual Auto Ins</i> , 250 Mich App 35; 645 NW2d 59 (2002).....	passim
<i>LaMothe v Auto Club Ins Ass'n</i> , 214 Mich App 577; 543 NW2d 42 (1995) .....	22, 25
<i>Lansing Schools Ed Ass'n v Lansing Bd of Ed</i> , 487 Mich 349; 792 NW2d 686 (2010) .....	22
<i>Lewis v Aetna Casualty &amp; Surety Co</i> , 109 Mich App 136; 311 NW2d 317 (1981).....	36
<i>Ludmer v Erie Ins Exchange</i> , 295 Pa Super 404; 441 A2d 1295 (1982).....	27
<i>Manuel v Gill</i> , 481 Mich 637; 753 NW2d 48 (2008) .....	41
<i>Michigan Head &amp; Spine Institute, PC v State Farm Mut Auto Ins Co</i> , 299 Mich App 442; 830 NW2d 781 (2013) .....	11, 23, 25, 36
<i>Michigan Head and Spine Institute, PC v State Farm Mutual Auto Ins Co</i> , unpublished decision of the Court of Appeals, issued Jan. 21, 2016 (Docket No 324245).....	30
<i>Miller v Citizens Ins Co</i> , 490 Mich 904; 804 NW2d 740 (2011) .....	38
<i>Miller v State Farm Mut Auto Ins Co</i> , 410 Mich 538; 302 NW2d 537 (1981) .....	6, 18, 20, 35
<i>Moody v Home Owners Ins Co</i> , 304 Mich App 415; 849 NW2d 31 (2014) .....	passim
<i>Morse v Deschaine</i> , 13 Mich App 101; 163 NW2d 693 (1968).....	32
<i>Moss v Pacquing</i> , 183 Mich App 574; 455 NW2d 339 (1990) .....	32
<i>Munson Medical Center v Auto Club Ins Ass'n</i> , 218 Mich App 375; 554 NW2d 49 (1996).....	22, 23, 24, 25
<i>Parrish Chiropractic Ctrs, PC v Progressive Cas Ins Co</i> , 874 P2d 1049 (Colo 1994) .....	27
<i>Perkovic v Zurich American Ins Co</i> , 312 Mich App 244; 876 NW2d 839 (2015).....	35
<i>Pinckney Comm Schools v Continental Casualty Co</i> , 213 Mich App 521; 540 NW2d 748 (1995).....	15
<i>Proudfoot v State Farm Mut Auto Ins Co</i> , 469 Mich 476; 673 NW2d 739 (2003) .....	17
<i>Regents of Univ of Mich v State Farm Mut Ins Co</i> , 250 Mich App 715; 650 NW2d 129 (2002).....	11, 22, 25
<i>Rite-Way Refuse Disposal, Inc v Vanderploeg</i> , 161 Mich App 274; 409 NW2d 804 (1987).....	20

*Schmalfeldt v North Pointe Ins Co*, 469 Mich 422; 670 NW2d 651 (2003)..... 27

*Shanafelt v Allstate Ins. Co.*, 217 Mich App 625; 552 NW2d 671 (1996)..... 17

*Shavers v Attorney General*, 402 Mich 554; 267 NW2d 72 (1978) ..... 5

*Sizemore v Smock*, 430 Mich 283; 422 NW2d 666 (1988)..... 23

*Spencer v Citizens Ins Co*, 239 Mich App 291; 608 NW2d 113 (2000)..... 5

*Stanton v City of Battle Creek*, 466 Mich 611; 647 NW2d 508 (2002)..... 12

*TBCI, PC v State Farm Mut Auto Ins Co*, 289 Mich App 39; 795 NW2d 229 (2010)..... 29, 30

*Tebo v Havlik*, 418 Mich 350; 343 NW2d 181 (1984) ..... 5

*United States v Allstate Ins Co*, 754 F2d 666 (CA 6, 1985) ..... 27

*US Fid Ins & Guar Co v Mich Catastrophic Claims Ass’n*, 484 Mich 1; 795 NW2d 101  
(2009)..... 6, 35

*Wyoming Chiropractic Health Clinic, PC v Auto-Owners Ins Co*, 308 Mich App 389; 864  
NW2d 598 (2014) ..... 11, 20, 24, 25

**Statutes**

MCL 500.3104..... 21

MCL 500.3105 ..... passim

MCL 500.3107 ..... passim

MCL 500.3108..... 21

MCL 500.3109..... 21

MCL 500.3110..... 20, 21, 40

MCL 500.3111 ..... 21

MCL 500.3112..... passim

MCL 500.3113..... 21

MCL 500.3114..... 7, 15, 21, 29

MCL 500.3115..... 21

MCL 500.3121 ..... 21

MCL 500.3123 ..... 21

MCL 500.3125 ..... 21

MCL 500.3142 ..... 21, 25

MCL 500.3145 ..... 15, 21, 22, 34

MCL 500.3157 ..... 7, 17, 21

MCL 500.3158 ..... 17, 18

MCL 600.1405 ..... 27

MCL 600.5821 ..... 22

MCL 600.8301 ..... 30

**Other Authorities**

Black’s Law Dictionary ..... 15, 17, 29

Random House Webster’s College Dictionary (1995) ..... 17

Webster’s Intermediate Dictionary (1972) ..... 15, 39

**Rules**

MCR 2.116..... 9

MCR 7.303..... vii

**STATEMENT OF JURISDICTION**

On October 22, 2015, the Court of Appeals, in a published opinion, reversed the Saginaw County Circuit Court’s grant of summary disposition in favor of Defendant-Appellant State Farm Mutual Automobile Insurance Company (“State Farm”). On December 3, 2015, State Farm timely applied to this Court for leave to appeal the Court of Appeals’ decision. On May 27, 2016, this Court issued an order granting State Farm’s application. This Court has jurisdiction over this appeal pursuant to MCR 7.303(B)(1).

**STATEMENT OF QUESTIONS INVOLVED**

The Court of Appeals, in a published decision, reversed the Circuit Court’s grant of summary judgment to State Farm, and held that a settlement and release between an insured and State Farm, his No-Fault insurer, over personal protection insurance (“PIP”) benefits, including all medical bills, did not bar a subsequent suit by the insured’s health care provider, Plaintiff-Appellee Covenant Medical Center (“Covenant”), for payment of medical bills, because State Farm had prior written notice of Covenant’s claim (in the form of bills sent to State Farm by Covenant), and therefore, under MCL 500.3112, State Farm was required to ask the Circuit Court for an order apportioning the benefits.

Should this Court reverse where:

- a. The No-Fault Act does not grant providers a claim against insurers for PIP benefits;
- b. Even assuming a provider had a claim against insurers under the No-Fault Act, such claim would be derivative of the insured’s claim; therefore, if the insured is not eligible for PIP benefits for any reason, including the signing of a release, neither is the provider;
- c. For both of these reasons, a request to an insurer by a provider for payment of bills for PIP services rendered is not a “claim of some other person”, and MCL 500.3112 does not apply; and
- d. An apportionment order under MCL 500.3112 is only a process that an insurer may invoke when it wants confirmation from the court regarding who is the proper recipient of survivor benefits, and is not, as the Court of Appeals held, a mandatory proceeding that must always be held to approve the apportionment of settlement proceeds with an insured after a provider (or more likely, providers plural) have put the insurer on notice that they provided PIP services to the insured?

Defendant-Appellant State Farm answers:	“Yes”
Plaintiff-Appellee Covenant Medical Center would answer:	“No”
The Circuit Court would answer:	“Yes”
The Court of Appeals would answer:	“No”
This Court should answer:	“Yes”

## INTRODUCTION AND SUMMARY OF ARGUMENT

The issues presented in this case, as framed by the Court's May 27, 2016 Order granting leave to appeal, are threefold. First, whether providers have a claim against a no-fault insurer for PIP benefits, and if so, if that claim is independent or derivative of the claims of the insured. Second, is a provider "some other person" under Section 3112 of the No-Fault Act (MCL 500.3112)? And third, does Section 3112 require that providers be given notice before an insurer settles any claims with the insured and a hearing be held to determine how such settlement proceeds are to be distributed between the insured accident victim and his or her no-fault benefit providers? The answer to each question is "no."

By way of background, State Farm's insured, Jack Stockford, filed suit against State Farm seeking PIP benefits. State Farm and Mr. Stockford reached an agreement to resolve their dispute and a release (the "Release") was executed in which State Farm was released from all claims and damages incurred as a result of the accident, including (but not limited to) medical expenses. Mr. Stockford also agreed to indemnify and hold State Farm harmless from any liens or demands made by any of his health care providers, including Covenant, which had earlier sent bills to State Farm for services provided to Mr. Stockford. The Release also expressly stated that it was the intention of the parties that State Farm have no further liability for any claims related, directly or indirectly, to Mr. Stockford's accident.

After the Release was executed, Covenant filed suit against State Farm seeking payment of its alleged accident-related medical bills. State Farm moved for, and was granted, summary disposition, with the Circuit Court holding that PIP benefits are not payable for the benefit of an insured if the insured has signed a release and settled his or her claims with the insurer. The Court of Appeals reversed, holding the Release did not discharge State Farm's liability to Covenant because State Farm had prior written notice of Covenant's "claim." The Court of

Appeals further held that Section 3112 required State Farm to apply to the Circuit Court for an order directing how PIP benefits should be apportioned.

The Court of Appeals' decision is based on what it erroneously called "well-settled" law "that a medical provider has independent standing to bring a claim against an insurer for the payment of no-fault benefits." (Court of Appeals' Opinion, Joint Appendix ("JA") 80a-82a.) This underlying premise is wrong. Section 3112 allows insurers to *elect* to pay a provider of no-fault services directly "for the benefit of" the insured; a choice the insurer can make to speed up the payment process. However, neither that provision, nor any other provision of the No-Fault Act, grants providers a "claim" against an insurer for benefits that belong to another, namely, the injured person. The No-Fault Act, in fact, discusses the rights of injured persons only, as well as the *obligations* of providers when it comes to the provision of no-fault services. Nowhere are providers given any rights in general, or a right to claim benefits from a no-fault insurer in particular.

It is therefore not surprising that the cases relied on by the Court of Appeals finding providers have such rights lack any meaningful statutory analysis. The idea began with two cases in which the insurer did not contest the provider's ability to bring suit for case-specific reasons. These cases were subsequently cited as authority for the proposition that providers have the right to PIP benefits, and then, to find that they may bring suit to recover such benefits. But analysis of the No-Fault Act demonstrates nothing grants any rights to providers, or implies a Legislative intent to confer such rights. Indeed, such a holding is contrary to this Court's statements that PIP benefits belong only to the injured person and their dependents. It is also contrary to the goals of the No-Fault Act, which was established to ensure prompt payment of benefits to injured persons, without delay, with reduced factual disputes, and with a reduced

burden on the courts. Allowing *more* people to bring suit in *more* courts over the *same* accident undermines each of these goals. Providers have no claim for PIP benefits. For this reason alone, Section 3112 does not apply. The Circuit Court correctly dismissed Covenant’s suit, and the Court of Appeals erred in its decision.

The Court of Appeals also erred in interpreting Section 3112 to mean a provider’s “claim”—assuming one exists—is “the claim of some other person” under the No-Fault Act. In particular, Section 3112’s statutory discharge provision states that “[p]ayment by an insurer in good faith of personal protection insurance benefits, to or for the benefit of a person who it believes is entitled to the benefits, discharges the insurer’s liability to the extent of the payments unless the insurer has been notified in writing of the claim of some other person.” This discharge provision applies when an insurer has written notice of “the claim of some other person”; it does not apply where, as here, the provider’s so-called “claim” and the insured’s claim are, at best, one in the same.

Indeed, assuming the No-Fault Act gives providers a “claim” against no-fault insurers for PIP benefits—which it does not—any such claim would arise from and be derivative of the insured’s claim. The provider has no insurance contract with the insurer. And, in the absence of a party injured in an automobile accident, there is absolutely no link between a provider and an insurer. The provider’s alleged “claim” to recover from an insurer (to the extent it exists at all) depends entirely upon whether the insured has an underlying right to PIP benefits from the insurer. Accordingly, a provider’s “claim” is not “the claim of some other person”; it is instead the insured’s claim, and Section 3112’s discharge provision is simply not implicated under such circumstances.

Finally, the Court of Appeals misinterpreted MCL 500.3112 by making an apportionment proceeding the only route by which an insurer may discharge its liability with any certainty. The relevant statutory language is discretionary, providing that an application for apportionment “may” be filed. But the Court of Appeals held such an application is mandatory and the only way in which an insurer’s liability can be discharged with any certainty when the insurer is aware of the “claim of some other person.” While Section 3112 provides one “safe harbor” method of discharge, it is not the only way by which an insurer may discharge its liabilities. In reality, most no-fault disputes are resolved by settlement agreement and release, which this Court has recognized as essential to the no-fault system, and not by a Section 3112 apportionment order. But now, due to the Court of Appeals’ holding that when an insurer has been put on notice of a “claim” (but providers actually do not have any “claims”) of “some other person” (but provider “claims” are not those of some other person), the 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. Claims that were typically settled without court involvement now require apportionment proceedings, even if there was no dispute regarding the benefits owed or the amount to be paid. Any visit to a Michigan Circuit Court on motion day will show how these so-called “Covenant hearings” have clogged the court’s docket and added to the costs of litigation and the uncertainty of being able to settle what should be easily resolved no-fault cases. This results in delayed payment to injured persons, increases in litigation costs, further stresses on an already overburdened judicial system, and therefore simply cannot be what the Legislature intended. This Court should reverse.

## STATEMENT OF FACTS AND MATERIAL PROCEEDINGS

### I. THE NO-FAULT ACT

The No-Fault Act was created to address problems inherent in the liability system involving auto accidents, including long payment delays, high legal costs, and overburdened courts. See, e.g., *Shavers v Attorney General*, 402 Mich 554, 578-579; 267 NW2d 72 (1978). The goal of the no-fault insurance system was—and is—to provide victims of motor vehicle accidents with “assured, adequate, and prompt reparation for certain economic losses.” *Cruz v State Farm Mut Auto Ins Co*, 466 Mich 588, 595; 648 NW2d 591 (2002). A concomitant goal is keeping down the costs of both mandatory no-fault insurance and healthcare. See *Davey v DAIIE*, 414 Mich 1, 10; 322 NW2d 541 (1982) (while one objective of no-fault was providing an “assured, adequate and prompt recovery for certain economic losses arising from motor vehicle accidents . . . [w]e have also recognized a complementary legislative objective which is the containment of the premium costs of no-fault insurance”); *Tebo v Havlik*, 418 Mich 350, 367; 343 NW2d 181 (1984) (“[T]he Legislature made a trade-off. Those who were required to participate in the no-fault scheme gave up the possibility of redundant recoveries, but they were intended to receive the benefit of lower insurance rates.”); *Dean v Auto Club Ins Ass’n*, 139 Mich App 266, 274; 362 NW2d 247 (1984) (“The no-fault act was as concerned with the rising cost of healthcare as it was with providing an efficient system of automobile insurance.”); *Gooden v Transamerica Ins Corp*, 166 Mich App 793, 800; 420 NW2d 877 (1988) (“The basic goal of the no-fault insurance system is to provide individuals injured in motor vehicle accidents assured, adequate and prompt reparation for certain economic losses *at the lowest cost to the individual and the system.*”) (emphasis added); *Dolson v Sec’y of State*, 83 Mich App 596, 599; 269 NW2d 239 (1978) (same); *Spencer v Citizens Ins Co*, 239 Mich App 291, 300; 608 NW2d 113 (2000) (same).

The Legislature believed these goals could be most effectively achieved through a system of compulsory insurance, under which every Michigan motorist is required to purchase no-fault insurance or be unable to operate a vehicle legally in the state. Under this system, victims of motor vehicle accidents receive insurance benefits for their injuries as a substitute for their common-law remedy in tort. The act was “designed to minimize administrative delays and factual disputes that would interfere with achievement of the goal of expeditious compensation of damages suffered in motor vehicle accidents.” *Miller v State Farm Mut Auto Ins Co*, 410 Mich 538, 568; 302 NW2d 537 (1981). The “ability of insurers to settle claims is essential to meeting these goals.” *US Fid Ins & Guar Co v Mich Catastrophic Claims Ass’n*, 484 Mich 1, 25; 795 NW2d 101 (2009).

Under the No-Fault Act, a no-fault insurer is “liable to pay benefits for accidental bodily injury arising out of the ownership, operation, maintenance or use of a motor vehicle as a motor vehicle, subject to the provisions of this chapter [Chapter 31 of the Michigan Insurance Code].” MCL 500.3105. The No-Fault Act further provides that PIP benefits are payable only for certain expenses and/or work loss, including “[a]llowable expenses consisting of all reasonable charges incurred for reasonably necessary products, services and accommodations for *an injured person’s* care, recovery, or rehabilitation.” MCL 500.3107(1)(a) (emphasis added).

Section 3112 states:

Personal protection insurance 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. Payment by an insurer in good faith of personal protection insurance benefits, to or for the benefit of a person who it believes is entitled to the benefits, discharges the insurer’s liability to the extent of the payments unless the insurer has been notified in writing of the claim of some other person. If there is doubt about the proper person to receive the benefits or the proper apportionment among the persons entitled thereto, the insurer, the claimant or any other interested person may apply to

the circuit court for an appropriate order. The court may designate the payees and make an equitable apportionment, taking into account the relationship of the payees to the injured person and other factors as the court considers appropriate. In the absence of a court order directing otherwise the insurer may pay:

(a) To the dependents of the injured person, the personal protection insurance benefits accrued before his death without appointment of an administrator or executor.

(b) To the surviving spouse, the personal protection insurance benefits due any dependent children living with the spouse. [MCL 500.3112.]

Section 3114 provides, in pertinent part, that “a personal protection insurance policy . . . applies to accidental bodily injury to *the person named in the policy, the person’s spouse, and a relative of either* domiciled in the same household, if the injury arises from a motor vehicle accident.” MCL 500.3114(1) (emphasis added). Section 3114 also discusses the order of priority, providing:

*[A] person suffering accidental bodily injury arising from a motor vehicle accident while an occupant of a motor vehicle shall claim personal protection insurance benefits from insurers in the following order of priority: (a) The insurer of the owner or registrant of the vehicle occupied. (b) The insurer of the operator of the vehicle occupied. [MCL 500.3114(4) (emphasis added).]*

Finally, Section 3157 states:

A physician, hospital, clinic or other person or institution lawfully rendering treatment to an injured person for an accidental bodily injury covered by personal protection insurance, and a person or institution providing rehabilitative occupational training following the injury, may charge a reasonable amount for the products, services and accommodations rendered. The charge shall not exceed the amount the person or institution customarily charges for like products, services and accommodations in cases not involving insurance. [MCL 500.3157.]

## II. THE CURRENT DISPUTE

### A. Mr. Stockford's Accident; Release with State Farm; and the Circuit Court's Decision.

State Farm's insured, Jack Stockford, was injured in a June 20, 2011 motor vehicle accident. (Complaint, JA 2a-8a, ¶ 5, JA 4a.) Covenant provided medical services to Mr. Stockford on various dates through October 3, 2012. (*Id.*, ¶ 8.) Covenant billed State Farm in 2012 for the services rendered, but State Farm did not pay the bills. (*Id.*, ¶¶ 11, 14, JA 4a-5a.)

Mr. Stockford filed suit against State Farm on June 4, 2012 in Saginaw County Circuit Court for alleged accident-related PIP benefits. On April 2, 2013, Mr. Stockford entered into a release with State Farm. (Release Regarding Claim for Personal Protection Insurance Benefits Under Michigan No-Fault Automobile Act (JA 17a-20a.)) State Farm agreed to pay Mr. Stockford \$59,000 in exchange for a full and final release of State Farm "regarding all past and present claims incurred through January 10, 2013 for what are commonly referred to as first party benefits or personal injury protection benefits under the Michigan No-Fault Automobile Insurance law, arising from the June 20, 2011 accident . . . ." (Release, p. 1, JA 17a.) Mr. Stockford specifically agreed that the Release was a "complete release of [State Farm] regarding any and all past and present claims incurred through January 10, 2013, under the Michigan No-Fault Act the undersigned may have . . . including but not limited to allowable expenses, medical bills, . . . arising from the June 20, 2011 accident. . . ." (*Id.*, pp. 1-2, JA 17a-18a.) Mr. Stockford agreed to indemnify and hold State Farm harmless from "any liens or demands made by any provider," including, but not limited to, Blue Cross/Blue Shield, "Saginaw Covenant Medical Center," and others for services rendered to him in connection with any injuries resulting from the accident. (*Id.*, p. 3, JA 19a.) The Release concluded:

It is the express intention of the parties to this settlement that this Release be read as broadly as possible such that [State Farm] shall

have no further obligations or liability of any sort or nature to Jack H. Stockford, directly or indirectly, except as stated in this Release. The parties agree that the settlement payment referenced above is given as compensation in *full satisfaction for any and all claims for no-fault benefits incurred* through January 10, 2013, and for past, present and future wage loss claims under the Michigan Automobile No-Fault Act, and including but not limited to, attorney fees, costs and expenses. [*Id.*, pp. 3-4, JA 19a-20a (emphasis added).]

Covenant subsequently filed a Complaint against State Farm on April 25, 2013, in Kent County Circuit Court (later transferred to Saginaw County Circuit Court), alleging State Farm was required to reimburse Covenant for medical services rendered to Mr. Stockford in 2011 and 2012 because of the June 20, 2011 automobile accident. (JA 2a-8a.) State Farm filed a Motion for Summary Disposition pursuant to MCR 2.116(C)(7) and (C)(8) based on its release with Mr. Stockford. (JA 9a-31a.) The Circuit Court granted State Farm's motion on May 15, 2014, finding the Release to be dispositive. (Circuit Court Opinion and Order, JA 73a-79a.)

Specifically, the Circuit Court held that “[n]otwithstanding any argument as to a medical provider’s ability to pursue a direct action on a claim for the payment of no-fault benefits owed by an insurer, *such an action remains dependent on the insurer being obligated to pay benefits to the provider on behalf of the insured.*” (Circuit Court Opinion, p. 4, JA 76a) (emphasis added). The court, relying on the plain language of MCL 500.3112, found that any right a provider may enjoy under Section 3112 “flows solely from the fact that the provider is seeking benefits ‘payable . . . for the benefit of any injured person . . . .’” (*Id.*) It concluded:

No insurance benefits remain payable to or for the benefit of an insured under § 3112 when the claims have been settled by the insured and a valid release executed. That release ends the insurer’s obligation to pay benefits to or on behalf of its insured under its contract of insurance. [*Id.*]

The Circuit Court relied on *Michigan Head & Spine Institute, PC v State Farm Mut Auto Ins Co*, 299 Mich App 442; 830 NW2d 781 (2013), in which the Court of Appeals found that a

release signed by the insured discharged an insurer's liability to a provider. The Circuit Court rejected Covenant's argument that the fact that the notice of the provider's claim in *Michigan Head & Spine* was provided to the insurer *after* the release made the case factually distinguishable. Rather, the court noted that Section 3112 is only relevant to determining whether an insurer is "statutorily discharged of liability" under Section 3112 and that because the "insurer's liability . . . was terminated by the release [and] not by statute[.]" the *Michigan Head & Spine* court "took it as a given that existing entitlement to payment of no-fault benefits could be waived in exchange for a settlement." (Circuit Court Opinion, p. 55, JA 77a.) Thus, the Circuit Court concluded that a release covering existing and future claims is enforceable against a healthcare provider seeking to obtain payment on behalf of an insured.

In support of its holding, the Circuit Court cited *Moody v Home Owners Ins Co*, 304 Mich App 415; 849 NW2d 31 (2014), which stated that providers' claims against an insurer "are completely derivative of and dependent on [the insured] having a valid claim of no-fault benefits against defendant." (*Id.*, p. 6, JA 78a.) The court also quoted *Moody's* holding that "the injured party may waive by agreement his or her claim against an insurer for no fault benefits, and a service provider is bound by the waiver" and "a service provider's remedy is to seek payment from the injured person." (*Id.*) Covenant appealed.

**B. The Court of Appeals' Decision.**

The Court of Appeals reversed, holding that "because [Covenant] provided written notice to State Farm regarding the medical services provided to Stockford, [Covenant] is entitled" to pursue its claim for medical bills, penalties, interests and costs. (COA Opinion, p. 2, JA 81a.) In reaching its conclusion, the court interpreted Section 3112 as follows:

MCL 500.3112 provides that if the insurer does not have notice in writing of any other claims to payment for a particular covered service, then a good faith payment to its insured is a discharge of

its liability for that service. However, the plain text of the statute provides that if the insurer has notice in writing of a third party's claim, then the insurer cannot discharge its liability to the third party simply by settling with its insured. Such a payment is not in good faith because the insurer is aware of a third party's right and seeks to extinguish it without providing notice to the affected third party. 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. That was not done in this case. Accordingly, pursuant to the plain language of the statute, because State Farm had notice in writing of Covenant Medical's claim, State Farm's payment to Stockford did not discharge its liability to Covenant Medical. [*Id.*, pp. 2-3, JA 81a-82a.]

The Court of Appeals distinguished *Mich Head & Spine*, holding that "where the relevant services were rendered and the insured received notice of the provider's claim *before* the settlement occurred, the payment and release does not extinguish the provider's rights." (*Id.*, p. 3, JA 82a, emphasis in original.)<sup>1</sup> While recognizing that "*Moody* made it clear that the source of a provider's right to no-fault benefits is based on the insured's right to benefits", the court nonetheless stated, "it is also well settled that a medical provider has independent standing to bring a claim against an insurer for the payment of no-fault benefits." (*Id.*), citing *Wyoming Chiropractic Health Clinic, PC v Auto-Owners Ins Co*, 308 Mich App 389; 864 NW2d 598 (2014); *Moody*; *Mich Head & Spine*; *Lakeland Neurocare Ctrs v State Farm Mutual Auto Ins*, 250 Mich App 35; 645 NW2d 59 (2002); and *Regents of Univ of Mich v State Farm Mut Ins Co*, 250 Mich App 719; 650 NW2d 129 (2002). The court then concluded, "while a provider's right to payment from the insurer is created by the right of the insured to benefits, an insured's agreement to release the insurer in exchange for a settlement, does not release the insurer as to the provider's noticed claims unless the insurer complies with MCL 500.3112." (*Id.*)

---

<sup>1</sup> The Court of Appeals did not state how it believed State Farm received written notice of Covenant's claim before settling with Mr. Stockford, presumably it was because Covenant had sent medical bills to State Farm.

C. **This Court Grants Leave to Appeal.**

State Farm filed an application for leave to appeal to this Court. This Court granted leave, directing the parties to brief the following issues:

- (1) Whether a healthcare provider has an independent or derivative claim against a no-fault insurer for no-fault benefits;
- (2) Whether a healthcare provider constitutes “some other person” within the meaning of the second sentence of MCL 500.3112; and
- (3) The extent to which a hearing is required by MCL 500.3112.

(May 27, 2016 Order.)

**STANDARD OF REVIEW**

The Court reviews the Court of Appeals’ ruling *de novo*, as this is the standard of review for both rulings on motions for summary disposition and issues of statutory interpretation. See, e.g., *DiPonio Constr Co, Inc v Rosati Masonry Co, Inc*, 246 Mich App 43, 46; 631 NW2d 59 (2001); *Stanton v City of Battle Creek*, 466 Mich 611, 614; 647 NW2d 508 (2002).

**ARGUMENT**

I. **THE COURT OF APPEALS’ DECISION IS DEPENDENT ON THE FAULTY PREMISE THAT HEALTHCARE PROVIDERS POSSESS A “CLAIM” FOR PIP BENEFITS.**

The No-Fault Act creates a right for *an injured person* involved in a motor vehicle accident to receive benefits under certain defined circumstances. See, e.g., MCL 500.3105, 500.3107, and 500.3112. The rights to such benefits created under the No-Fault Act belong solely to the injured person (or his or her dependents and survivors if the injured person is deceased), not healthcare providers. The fact that insurers *may* elect to pay the benefits owed to the injured person directly to healthcare providers for the benefit of the injured person does *not* create a “claim” for PIP benefits under the No-Fault Act for such providers, let alone a separate and independent “claim.”

Here, the injured person (Mr. Stockford) settled “any and all claims” for PIP benefits through a date certain by executing the Release. And yet, the “logic” of the Court of Appeals’ decision is that a provider’s “claim” to PIP benefits is completely independent of, and separate from, the injured person’s, as evidenced by its holding that the Release could not extinguish State Farm’s liability with respect to Covenant’s “noticed claims” without complying with Section 3112 (which the court then erroneously held means a mandatory apportionment hearing). (COA Opinion, p. 3, JA 82a.) The underlying premise is that the provider has a “claim” to PIP benefits that is independent of the injured person’s claim, *i.e.*, is a claim of “some other person.” The Court of Appeals did not analyze the language of the No-Fault Act when it made its broad proclamation. Instead, like other Court of Appeals panels before it, the panel here simply relied on so-called “well settled” law that providers “have independent standing to bring a claim against an insurer for the payment of no-fault benefits.” (*Id.*) The result is that courts, like the Court of Appeals here, have erroneously equated a healthcare providers’ *ability to receive payment* directly from a no-fault insurer for PIP benefits owed to an injured person (which extends to any third party provider, not just healthcare providers) with *the right to claim PIP benefits* directly from a no-fault insurer. The No-Fault Act, the case law, and general principles of contract law, simply do not provide for such a claim.<sup>2</sup>

---

<sup>2</sup> In *Chiropractors Rehabilitation Group v State Farm*, 313 Mich App 113; 881 NW2d 120 (2015)—the most recent case to find that providers have a right to PIP benefits—the Court of Appeals held that healthcare providers have standing to sue insurers in order to “enforce the provider’s right to be reimbursed for medical services rendered to an injured party . . . .” 313 Mich App at 124. State Farm filed an Application for Leave to Appeal the *Chiropractors Rehab* decision to this Court, which the Court has held in abeyance pending the outcome of this case. (July 26, 2016 Order in Case No. 152807.) Given that this Court’s May 27, 2016 Order granting leave in the instant case asked the parties to address “whether a healthcare provider has an independent or derivative claim against a no-fault insurer for no-fault benefits,” State Farm also addresses some of the errors of the *Chiropractors Rehab* decision in this Brief. In short, State Farm believes that the analysis presented here supports reversal in *Chiropractors Rehab* as well

A. **Healthcare Providers Do Not Have a “Claim” Against a No-Fault Insurer for PIP Benefits Under the No-Fault Act.**

When interpreting statutes, courts must “determine and effectuate the intent of the Legislature through reasonable construction in consideration of the purpose of the statute and the object sought to be accomplished.” *Frankenmuth Mut Ins Co v Marlette Homes*, 456 Mich 511, 515; 573 NW2d 611 (1998). Where statutory provisions all relate to the same subject matter, they must be read together to understand the Legislature’s intent. See, e.g., *Ameritech Mich v PSC (In re MCI)*, 460 Mich 396, 412; 596 NW2d 164 (1999).

This Court has stated that the goal of the No-Fault Act is “to compensate . . . a *limited class of persons* for economic losses sustained as a result of motor vehicle accidents. Under personal protection insurance, *benefits are made payable only to injured persons or surviving dependents of the injured person.*” *Belcher v Aetna Casualty & Surety Co*, 409 Mich 231, 243-244; 293 NW2d 594 (1980) (emphasis added). This Court’s statements in *Belcher* are consistent with the No-Fault Act’s language providing *rights* to injured persons, while specifying *obligations* of providers.

In particular, the No-Fault Act created a framework by which *persons injured in automobile accidents* are entitled to certain benefits. Numerous sections of the No-Fault Act discuss “persons” injured in accidents, and when such “persons” are entitled to benefits or when they may be recovered. Section 3114 identifies “person[s] suffering accidental bodily injury arising from a motor vehicle accident” as claimants for benefits. There is no reference in that Section to any other type of benefits claimant. MCL 500.3114(4). Similarly, Section 3145, setting forth the statute of limitations for claims under the Act, refers to “claimants” and “persons

---

as this case because healthcare providers have no “claim,” let alone standing to sue insurers for PIP benefits.

claiming to be entitled to benefits,” referring to injured persons and their survivors. MCL 500.3145. And Section 3112 states benefits are payable “to . . . an injured person” or “for the benefit of an injured person.” MCL 500.3112. It does not state that benefits are payable to a third party provider. There is a very real distinction between reading Section 3112 to say that “benefits are payable *to* healthcare providers providing services to injured persons” (which is essentially what the Court of Appeals’ decision holds) and that benefits are payable “for the benefit of an injured person” (which is what the statute provides). This distinction means the difference between having a “claim” for PIP benefits under the No-Fault Act and not.<sup>3</sup>

It is helpful to examine the most relevant statutory provisions—MCL 500.3105, 500.3107 and 500.3112—to understand why providers do not have a “claim” to PIP benefits under the No-Fault Act.

Statutory provision	MCL 500.3105	MCL 500.3107	MCL 500.3112
	Under personal protection insurance <b><u>an insurer is liable to pay</u></b> benefits for accidental bodily injury arising out of the ownership, operation, maintenance or use of	(1) Except as provided in subsection (2), personal protection insurance benefits <b><u>are payable for the following:</u></b>  (a) Allowable expenses consisting of <b><i>all reasonable charges incurred</i></b> for reasonably necessary products, services and	Personal protection insurance benefits are payable <b><u>to or for the benefit of an injured person</u></b> or, in case of his death, to or for the benefit of his dependents. Payment by an insurer in good faith of personal protection insurance benefits, to or for the benefit of a person who it believes

<sup>3</sup> Although “claim” is not defined in the No-Fault Act, the ordinary definition of the term sheds light on its meaning. In 1972 (the year MCL 500.3112 was passed), “claim” was defined to mean “1: *a demand for something due* or believed to be due <insurance claim> 2a: *a right or title to something* b: an assertion open to challenge <a claim of authenticity> 3: something claims, esp. a tract of land marked out by a settler or prospector.” Webster’s Intermediate Dictionary (1972) (emphasis added). See also *Pinckney Comm Schools v Continental Casualty Co*, 213 Mich App 521, 529; 540 NW2d 748 (1995) (noting that in other contexts Michigan courts have defined the word “claim” as “a demand of a right or alleged right; a calling on another for something due or asserted to be due”); Black’s Law Dictionary, 8th ed., p. 264-65 (defining “claim” to include the “assertion of an existing right; any right to payment or to an equitable remedy” or “[a] demand for money . . . to which one asserts a right.” Healthcare providers are owed nothing under, and have no rights under, the No-Fault Act. They therefore have no “claim” for PIP benefits.

	a motor vehicle as a motor vehicle, subject to the provisions of this chapter.	<p>accommodations <i>for an injured person's care, recovery, or rehabilitation.</i></p> <p>...</p> <p>(b) Work loss consisting of loss of income from work an injured person would have performed during the first 3 years after the date of the accident if he or she had not been injured. ...</p> <p>(c) Expenses not exceeding \$20.00 per day, <i>reasonably incurred in obtaining ordinary and necessary services in lieu of those that, if he or she had not been injured,</i> an injured person would have performed during the first 3 years after the date of the accident, not for income but for the benefit of himself or herself or of his or her dependent.</p>	<p>is entitled to the benefits, discharges the insurer's liability to the extent of the payments unless the insurer has been notified in writing of the claim of some other person. If there is doubt about the proper person to receive the benefits or the proper apportionment among the persons entitled thereto, the insurer, the claimant or any other interested person may apply to the circuit court for an appropriate order. The court may designate the payees and make an equitable apportionment, taking into account the relationship of the payees to the injured person and other factors as the court considers appropriate. In the absence of a court order directing otherwise the insurer may pay:</p> <p>(a) To the dependents of the injured person, the personal protection insurance benefits accrued before his death without appointment of an administrator or executor.</p> <p>(b) To the surviving spouse, the personal protection insurance benefits due any dependent children living with the spouse.</p>
Purpose	Defines liability of insurer	Defines what benefits are payable	Defines to whom benefits are payable and provides a "safe" method of discharge

To sum up, an insurer is liable (MCL 500.3105) to pay certain benefits for an injured person's care (MCL 500.3107). These benefits are payable either (1) to the injured person or (2) for the benefit of the injured person (MCL 500.3112). The clear legislative intent evidenced by the plain language of these provisions is that PIP benefits belong to an injured person, or, in the case of his or her death, the injured person's dependents. Nothing more, nothing less. And indeed, that is what this Court held in *Belcher*, 409 Mich at 243-244.

In defining what benefits are payable, Section 3107 provides that the “allowable expenses” are those “incurred” by the injured person. In the context of the No-Fault Act, the courts have defined “incurred” as “liable for.” See, e.g., *Proudfoot v State Farm Mut Auto Ins Co*, 469 Mich 476, 484; 673 NW2d 739 (2003). As *Bombalski v Auto Club Ins Ass’n*, 247 Mich App 536; 637 NW2d 251 (2001) stated:

This Court in *Shanafelt [v Allstate Ins Co*, 217 Mich App 625, 636; 552 NW2d 671 (1996)], addressed the defendant’s arguments that certain medical expenses were never incurred as contemplated by subsection 3107(1)(a). *The Court noted that Random House Webster’s College Dictionary (1995) defined “incur” as “to become liable for.” . . . See also Black’s Law Dictionary (7th ed), p 771, which similarly defines “incur” as “to suffer or bring on oneself (a liability or expense).”* The Court rejected the defendant’s suggestion that the plaintiff never incurred medical benefits because the plaintiff’s health insurer directly paid her medical bills. After quoting the definition of incur . . . , the Court reasoned that “obviously, plaintiff became liable for her medical expenses when she accepted medical treatment.” [*Bombalski*, 247 Mich App at 542 (emphasis added) (citations and quotation marks omitted).]

In other words, the injured person is the only person “incurring” recoverable costs. Healthcare providers are not “liable” to pay for the services that they themselves provided to the injured person and therefore do not “incur” recoverable benefits.

The No-Fault Act refers to providers in only two sections—MCL 500.3157 and 500.3158(2). Section 3157 limits the amount that providers may charge for treating an injured person.<sup>4</sup> And Section 3158(2) places an obligation on providers to, if requested by an insurer,

---

<sup>4</sup> Section 3157 provides:

A physician, hospital, clinic or other person or institution lawfully rendering treatment to an injured person for an accidental bodily injury covered by personal protection insurance, and a person or institution providing rehabilitative occupational training following the injury, may charge a reasonable amount for the products, services and accommodations rendered. The charge shall not

deliver certain reports regarding the condition, treatment, and dates and costs of treatment of the injured person, and permit inspection and copying of records.<sup>5</sup> Neither grants healthcare providers a “claim” to PIP benefits or the right to reimbursement from the insurer, as found in *Chiropractors Rehabilitation Group v State Farm*, 313 Mich App 113, 124; 881 NW2d 120 (2015). This does *not* mean that injured persons may not be liable to their providers for such expenses. It only means that the No-Fault Act focuses on the rights of injured persons covered by the Act, not on providers or other third parties who may be entitled to payment by injured persons.

Section 3112, the statute at the heart of this case, provides to whom PIP benefits may be paid; a “safe’ method of payment of benefits by insurers,” *Miller*, 410 Mich at 568; and for apportionment of survivor’s benefits. It states, in its entirety:

*Personal protection insurance 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. Payment by an insurer in good faith of personal protection insurance benefits, to or for the benefit of a person who it believes is entitled to the benefits, discharges the insurer’s liability to the extent of the payments unless the insurer*

---

exceed the amount the person or institution customarily charges for like products, services and accommodations in cases not involving insurance.

<sup>5</sup> Section 3158(2) provides:

A physician, hospital, clinic or other medical institution providing, before or after an accidental bodily injury upon which a claim for personal protection insurance benefits is based, any product, service or accommodation in relation to that or any other injury, or in relation to a condition claimed to be connected with that or any other injury, if requested to do so by the insurer against whom the claim has been made, (a) shall furnish forthwith a written report of the history, condition, treatment and dates and costs of treatment of the injured person and (b) shall produce forthwith and permit inspection and copying of its records regarding the history, condition, treatment and dates and costs of treatment.

has been notified in writing of the claim of some other person. If there is doubt about the proper person to receive the benefits or the proper apportionment among the persons entitled thereto, the insurer, the claimant or any other interested person may apply to the circuit court for an appropriate order. The court may designate the payees and make an equitable apportionment, taking into account the relationship of the payees to the injured person and other factors as the court considers appropriate. In the absence of a court order directing otherwise the insurer may pay:

(a) To the dependents of the injured person, the personal protection insurance benefits accrued before his death without appointment of an administrator or executor.

(b) To the surviving spouse, the personal protection insurance benefits due any dependent children living with the spouse. [MCL 500.3112 (emphasis added).]

A sentence-by-sentence review of this language shows that it does not expressly or impliedly give providers a claim for benefits.

The first sentence indicates a choice of alternatives for payment purposes. PIP benefits are payable to the injured person **or** for the benefit of the injured person. One or the other, not both. That an insurer may elect to pay a provider (who could be any third party providing PIP services, not just a healthcare provider) “for the benefit of an injured person” does not then mean that a provider has the right to claim entitlement to those very benefits, which—as numerous courts, including this Court, have held—belong to the injured party. See, e.g., *Belcher*, 409 Mich at 243-244; *Hatcher v State Farm*, 269 Mich App 596, 606; 712 NW2d 744 (2005) (“the right to benefits for attendant care services belongs to the injured person”); *In re Hales Estate*, 182 Mich App 55, 58; 451 NW2d 867 (1990) (“benefits payable under the no-fault act belong to the injured person”). Any other interpretation is directly contrary to the language and purpose of

the No-Fault Act because it would create a “right” for a third party that belongs only to the injured person.<sup>6</sup>

Put another way, Section 3112 authorizes the insurer to pay PIP benefits to the injured person or for his or her benefit, but does not convey ownership of those benefits to anyone else. Such an interpretation is supported by the framework of the No-Fault Act, which, as demonstrated above, provides that an insurer is liable (MCL 500.3105) to pay benefits for an injured person’s care (MCL 500.3107) and such benefits may be paid to the injured person himself or to a third party for the benefit of the injured person (MCL 500.3112). Nothing in the first sentence of Section 3112 can be construed as bestowing any right on the injured person’s creditor to PIP benefits. Just because a third may *receive* payment directly from an insurer for PIP benefits does not mean that third party has a statutory *entitlement* to such payment.

Nor does Section 3112’s second sentence grant providers any rights. Instead, as stated above, it provides a “safe” method of discharge by an insurer (*i.e.*, a statutory discharge). *Miller*, 410 Mich at 568. Specifically, it establishes that an insurer may statutorily discharge its liability to the extent of the payment if it makes a good faith payment to (or for the benefit of) a person who the insurer believes is entitled to the benefit. Since the PIP benefits belong to the injured person, the injured person is the only person to or for whom the allowable expenses are payable, and this sentence does not create any rights for providers.

---

<sup>6</sup> Indeed, “a plaintiff must assert his own legal rights and interests and cannot rest his claim to relief on the legal rights or interests of third parties.” *Barclae v Zarb*, 300 Mich App 455, 483; 834 NW2d 100 (2013), quoting *Fieger v Comm’r of Ins*, 174 Mich App 467, 471; 437 NW2d 271 (1988). It would be inappropriate under the real-party-in-interest rule for an injured person’s claim to be prosecuted by a healthcare provider because it is the injured person who, as discussed herein, owns the claim asserted. See *Rite-Way Refuse Disposal, Inc v Vanderploeg*, 161 Mich App 274, 278; 409 NW2d 804 (1987). This issue was raised in *Wyoming Chiropractic*, 308 Mich App at 391, but was not addressed by the Court of Appeals, which, as discussed below, erroneously found that providers had standing to sue no-fault insurers for PIP benefits.

As for Section 3112's third sentence, it discusses a method that the insurer can pursue if there is "doubt" as to the proper person to receive benefits. Such doubt only arises if there is a survivor's loss claimant involving a person not conclusively presumed to be a dependent under MCL 500.3110(1). The fact that Section 3112's remaining sentences specifically speak to survivor's losses supports the conclusion that all but the first sentence address survivor's losses.<sup>7</sup> Thus, the remainder of Section 3112 does not provide any entitlement to a "claim" of benefits for providers.<sup>8</sup>

In sum, there is no part of the Act that creates a right for providers, and no indication of any intention to confer rights on providers, to "claim" PIP benefits from insurers. Indeed, there is no express or implied "right" for any third party who may receive payment from a no-fault insurer for the benefit of an injured person to claim PIP benefits from the insurer.<sup>9</sup> That "claim"

---

<sup>7</sup> Section 3112's fourth sentence states a court may take "into account the relationship of the payees to the injured person" when apportioning benefits. Such language makes perfect sense within the context of survivor's losses where different dependents may be seeking payment, but does not make sense with respect to a provider. And the final two subsections of Section 3112 are explicitly related to survivor's losses when there is an absence of a court order (implying that the court order would address the same type of apportionment in the context of survivor's losses).

<sup>8</sup> Covenant argued in opposition to State Farm's Application for Leave that Section 3112's second sentence does not apply to survivor benefits because it states "payment by an insurer in good faith of *personal protection insurance benefits*" instead of "payment by an insurer in good faith of *survivor's loss benefits*." (Emphasis added). This argument is without merit. MCL 500.3108, which is the section of the No-Fault Act that specifically addresses survivor's loss benefits, does not itself use the phrase "survivor's loss benefits"—it states that "personal protection insurance benefits are payable for a survivor's loss . . . ." See also MCL 500.3110. In other words, the language used in the second sentence of Section 3112 is entirely consistent with the manner in which the Legislature addressed survivor's loss benefits in the No-Fault Act, as well as its use of the term "personal protection insurance benefits" throughout the Act. See MCL 500.3104, 500.3105, 500.3107, 500.3109, 500.3111, 500.3113, 500.3114, 500.3115, 500.3121, 500.3123, 500.3125, 500.3142, 500.3145, 500.3157.

<sup>9</sup> Although standing is not an express issue in this case, this supports a finding that healthcare providers (or, again, any third party seeking payment under Section 3112 "for the benefit of" the injured person) lack standing to bring an action for PIP benefits against a no-fault

belongs to the injured person and his or her dependents. If the Legislature intended to create a right for providers of no-fault services to bring claims against no-fault carriers, it could have so provided, yet it did not.

**B. The Case Law Relied Upon by the Court of Appeals Does Not Analyze the No-Fault Act.**

The concept of a provider’s “claim” for benefits under the No-Fault Act is based on cases in which the courts did not actually analyze the issue. The idea originated in *Lakeland*, in which the provider, not the injured person, brought the lawsuit. But the issue of a provider’s right of action was *not decided* in that case, rather, it was just not disputed. “In this case, defendant did not dispute that plaintiff had the legal right to commence this action for payment of medical services rendered to defendant’s insured.” *Lakeland*, 250 Mich App at 37. The only issue on appeal was whether the provider could enforce the penalty interest and attorney fees provisions of the No-Fault Act. Despite the fact that the issue of a healthcare provider’s “right” to make a claim was not before the *Lakeland* court, subsequent courts, including the Court of Appeals in the instant case, have erroneously attributed such a conclusion to *Lakeland* and treated *Lakeland* as precedent for such a “right.”

Similarly, in *Regents*, the court stated in passing, in a section explaining why the tolling provision of MCL 600.5821(4) applied to negate the one-year-back rule of MCL 500.3145(1), that providers have “direct claims for personal protection insurance benefits.” 250 Mich App at 733, citing *LaMothe v Auto Club Ins Ass’n*, 214 Mich App 577, 585-586; 543 NW2d 42 (1995) and *Munson Medical Center v Auto Club Ins Ass’n*, 218 Mich App 375, 381; 554 NW2d 49

---

insurer. The Court of Appeals in *Chiropractors Rehab* found that healthcare providers had a “right to be reimbursed” under Section 3112 and therefore satisfied the standing test set forth in *Lansing Schools Ed Ass’n v Lansing Bd of Ed*, 487 Mich 349, 372; 792 NW2d 686 (2010). *Chiropractors Rehab*, 313 Mich App at 124. As shown herein, however, Section 3112 simply does not grant providers any “rights,” and certainly not a “right to be reimbursed.”

(1996). The *Regents* court did not perform a statutory analysis to support this claim. Moreover, neither of the cases cited by *Regents* involved the right of providers to a claim for benefits.

In *LaMothe*, the insurer refused to pay the entirety of the provider's bill on the ground that it was unreasonably high, but agreed to defend and hold the insured harmless against any action by the provider. 214 Mich App at 583-584. Likewise, in *Munson*, the defendant insurer agreed to be sued by the plaintiff provider over the reasonableness of the provider's charges. The Court of Appeals stated, "[the insurer's] obligation to pay and [the provider's] right to be paid for the injureds' no-fault medical expenses arise pursuant to MCL 500.3105, 500.3107, and 500.3157 . . . ." *Munson*, 218 Mich App at 381. But the provider's right to claim PIP benefits from a no-fault insurer or a provider's standing or ability to sue was not an issue in that case—the insurer actually agreed to be sued by the provider because the only issue was the reasonableness of the charges. Although the court used the term "right" in its opinion, the more accurate description would have been "ability to receive payment," in accordance with the plain language of Section 3112. The *Munson* court's imprecise choice of words does not create a "right" where none exists in the statute, and the court's passing description of the No-Fault Act cannot be considered support for a provider's "claim" to PIP benefits or a right to sue a no-fault insurer, especially when that was not an issue in the case. A case is not controlling precedent as to an issue not actually considered. See, e.g., *Sizemore v Smock*, 430 Mich 283, 291 n 15; 422 NW2d 666 (1988); *In re Fitch Drain*, 346 Mich 81, 90; 77 NW2d 450 (1956). Thus, the discussion in *Munson* (or lack thereof) of a provider's "right" was not the result of a statutory analysis, but rather, a passing remark using inaccurate language.

In *Michigan Head & Spine*, the Court of Appeals again made a passing remark about a provider's "independent" cause of action, citing *Lakeland*. *Michigan Head & Spine*, 299 Mich

App at 447. The only issue in that case, however, was whether an insured's release barred a provider's claim for services rendered after the release was executed. *Id.* at 448. Therefore, the passage in question was *dictum*. Similarly, in the course of explaining that a provider's claim against an insurer is completely dependent on the validity of an insured's claim—and therefore *not*, as prior courts had carelessly stated, independent—*Moody* mentioned that providers may bring a cause of action against a no-fault insurer, again citing *Lakeland*. *Moody*, 304 Mich App at 442. Again, the passage was *dictum*, the issue having been neither argued nor substantively addressed in the *Moody* opinion.

In sum, the cases relied on by the Court of Appeals for the proposition that it is “well settled” that providers have “independent standing to bring a claim against an insurer for the payment of no-fault benefits”, (JA 82a), were built on a house of sand. In the first few, the provider's right to benefits or to bring a cause of action for the same were either not questioned or had been agreed to by the insurer. Those cases were then cited for the proposition that a provider has a direct right of action against an insurer for PIP benefits, without these later courts actually analyzing the No-Fault Act itself, and this concept thus became a self-fulfilling prophecy. The harmful effect of these cases is evident in *Wyoming Chiropractic*, *Chiropractors Rehab*, and this case.

*Wyoming Chiropractic* also misread and misapplied the case law on which it relied. That court erroneously found that *Munson* held a provider had a “right to be paid for the injureds' no-fault medical expenses” under MCL 500.3112. *Wyoming Chiropractic*, 308 Mich App at 393. As discussed above, *Munson* cannot be considered support for a provider's right to bring a first-party claim against a no-fault insurer for PIP benefits. *Wyoming Chiropractic* also found that in *Lakeland*:

This Court analyzed the plain language of MCL 500.3112 and determined that the plaintiff was entitled to prompt payment because the plaintiff brought a claim for PIP benefits “for the benefit of” the injured individual when the plaintiff submitted a claim for PIP benefits to the defendant. [*Wyoming Chiropractic*, 308 Mich App at 394.]

*Lakeland*, however, actually said:

Further, contrary to the trial court’s conclusion, the fact that plaintiff was not the injured person is not dispositive. MCL 500.3112 specifically contemplates the payment of benefits to someone other than the injured person as reflected by its inclusion of the phrase “benefits are payable to or for the benefit of an injured person” and by its discharge of an insurer’s liability upon payment made in good faith to a payee “who it believes is entitled to the benefits....” As a result, it is common practice for insurers to directly reimburse health care providers for services rendered to their insureds.... Moreover, MCL 500.3142 does not limit the right to seek penalty interest solely to the injured person and if the Legislature intended to limit the penalty interest provision, it could have done so. [250 Mich App at 39-40.]

Pursuant to the foregoing language, *Lakeland* noted that Section 3112 *contemplates* the payment of benefits directly to a third party on behalf of the injured person. This is not the same as that third party being *entitled to* those benefits. And as discussed above, the question in *Lakeland* was whether, as a litigant, the provider was entitled to no-fault penalty interest, not whether the provider had the right to commence an action—which “the defendant did not dispute” in that case—or whether a provider had a “claim” against a no-fault insurer for PIP benefits.

*Wyoming Chiropractic* also stated that in *Regents* the Court of Appeals noted that “[a]lthough plaintiffs may have derivative claims, they also have direct claims for personal protection insurance benefits.” *Wyoming Chiropractic*, 308 Mich App at 395. *Regents*, however, never really analyzed the No-Fault Act, but simply cited *Munson* and *LaMothe*, in which the insurers agreed to litigate directly against the provider and which therefore are not appropriate support. *Regents*, 250 Mich App at 733. Finally, *Wyoming Chiropractic* cited *Michigan Head &*

*Spine*, which (as discussed above) merely cited *Lakeland* as support for the statement that Section 3112 “creates an independent cause of action for healthcare providers.” *Michigan Head & Spine*, 299 Mich App at 448 n 1. Again, no statutory analysis was undertaken.

As shown in the previous section, nothing in the No-Fault Act provides that healthcare providers have a claim against no-fault insurers for PIP benefits. That is why, in support of such a concept, providers—and the Court of Appeals in our case—point only to the cases discussed above. None of those cases, however, provide tenable support for such a conclusion. Plaintiff cannot point to any decision from this Court, as this Court has not—until now—weighed in on the issue. What this Court *has* decided is directly contrary to the idea of providers having such a “claim.” Unlike the cases discussed above, this Court in *Belcher* actually analyzed the statute. It then stated this proposition twice: “under [PIP], benefits are made payable *only* to injured persons or surviving dependents of the injured person,” *Belcher*, 409 Mich at 243-244 (emphasis added); and “[PIP] benefits are payable to *two* separate recipient categories: an ‘injured person’ or ‘his dependents’.” (*Id.* at 247) (emphasis added). Similarly, the Court of Appeals stated in *Hatcher*, 269 Mich App at 606, “the right to benefits . . . belongs to the injured person”; and *In re Hales Estate*, 182 Mich App at 58, “benefits payable under the no-fault act belong to the injured person.” In sum, the “well settled” law on whether providers have a “claim” under the No-Fault Act for PIP benefits, entitling them to bring actions against insurers, are simply devoid of the statutory analysis required to make such conclusions. As explained above, analyzing the actual language of the No-Fault Act shows that no such claim exists.

**C. Providers Have No Contractual Right to a Claim.**

The only other possible basis on which a provider could claim a right to PIP benefits would be contractual. But it is undisputed that only the insured has the contractual relationship with the insurer and that providers are not parties to such agreements. In other states, providers

have tried to argue they have standing to sue insurers as third party beneficiaries. No Michigan court has so held, which is not surprising, as such an argument would fail.<sup>10</sup>

MCL 600.1405 allows for suits by third party beneficiaries. It states, in pertinent part:

Any person for whose benefit a promise is made by way of contract, as hereinafter defined, has the same right to enforce said promise that he would have had if the said promise had been made directly to him as the promisee.

(1) A promise shall be construed to have been made for the benefit of a person whenever the promisor of said promise has undertaken to give or to do or refrain from doing something *directly to or for said person*. [Emphasis added.]

This Court has repeatedly held that the highlighted language means that “[o]nly intended beneficiaries, not incidental beneficiaries, may enforce a contract . . . .” *Schmalfeldt v North Pointe Ins Co*, 469 Mich 422, 429; 670 NW2d 651 (2003). See also *Koenig v City of South Haven*, 460 Mich 667, 676-677; 597 NW2d 99 (1999) (“[S]ection 1405 does not empower just any person who benefits from a contract to enforce it. Rather, it states that a person is a third-

---

<sup>10</sup> This argument has not helped the providers in the other jurisdictions either. See, e.g., *United States v Allstate Ins Co*, 754 F2d 662, 666 (CA 6, 1985) (finding plaintiff medical services provider could not sue the auto insurer for payment, holding that the fact that the Kentucky no-fault statute allowed an insurer to pay a provider directly “makes the provider an optional payee or incidental beneficiary of no-fault policies in order to facilitate the insured person’s receipt of benefits, and does not make the provider a third party beneficiary with a right to enforce the insurance contract”); *Ludmer v Erie Ins Exchange*, 295 Pa Super 404, 408-409; 441 A2d 1295 (1982) (“The scheme of the [Pa] No-Fault Act itself, and the contract between the parties in the instant action, certainly do not preclude direct payment to a service provider by an insurance company. Ordinarily, such a course is efficient and sensible. It is not mandated, however, and the ordinary and prudent scheme of the law of contracts is not abrogated by the No-Fault Act. We cannot find that a service provider becomes a third party beneficiary of the contract . . . and thus the real party in interest, merely upon the allegation that he has rendered services to the insured and presented a bill for those services to the insurer.”); *Parrish Chiropractic Ctrs, PC v Progressive Cas Ins Co*, 874 P2d 1049, 1056-1057 (Colo 1994) (plaintiff provider “is only an incidental beneficiary of the . . . policy and, as such, is not entitled to recovery in a direct action to enforce the terms of that policy”); *Elsner v Farmers Ins Group*, 364 Ark 393, 397; 220 SW3d 633 (2005) (plaintiff treater was “merely incidental beneficiary [of auto insurance policy] who does not possess the right to bring a direct action” against insurer).

party beneficiary of a contract only when the promisor undertakes an obligation ‘directly’ to or for the person.”)<sup>11</sup>

It simply cannot be said that a no-fault insurer promises to do anything “directly to or for” a provider. Nothing in the typical policy makes any such suggestion, nor does the Act. To the contrary, by providing that benefits can be paid “to or for the benefit of” an injured person, the Act makes clear that it is the injured persons, the insureds, who are the direct beneficiaries of no-fault policies. Providers have no statutory, common law, or contractual claims for PIP benefits. There is simply no indication of a legislative intent to give providers any rights under the No-Fault Act, let alone the right to bring lawsuits, and certainly not the right to bring lawsuits that can stand alone.

Providers *do* have a contractual relationship with the injured person. They will not be left without a remedy if this Court finds, as it should, that they have no claim against the insurer. A provider’s remedy is to pursue payment from the person to whom they rendered the services. That person can then pursue a claim from their insurer. The insured then takes part of the proceeds he gets, if any, from his dispute with the insurance company, whether it be by settlement or judgment, to pay the providers’ bills, at an amount he and the provider have negotiated (as is done in other types of personal injury cases). Each party can sue only the person with whom they have a legally cognizable relationship, which only makes sense. Looking at it from another angle, if a provider treats a patient for problems or a condition caused by anything *other* than a motor vehicle accident in Michigan, and the bill is not paid, the provider must pursue the patient for payment. There is no reason a provider should be given extra rights simply because of the underlying incident that caused the need for treatment.

---

<sup>11</sup> See also Brief of Amici Curiae Insurance Institute of Michigan and Michigan Insurance Coalition in Support of the Application for Leave to Appeal in this matter, pp. 13-19.

**D. Even Assuming Providers Have a Claim Against No-Fault Insurers, Such a Claim Would Be a Derivative Claim at Best.**

Even assuming, *arguendo*, that providers have a claim against insurers for PIP benefits, such claim would be derivative and not an independent claim that would constitute the “claim” of “some other person.”<sup>12</sup> Black’s Law Dictionary (10th ed) (p. 887), defines “independent” as “not subject to the control or influence of another” and “not dependent or contingent on something else.” And it defines “derivative” as “something that has developed from or been produced by something else” and “derivative action” as “a lawsuit arising from an injury to another person . . . .” (p. 538). Assuming *arguendo* that a provider has a claim for PIP benefits, that “claim” is “dependent upon” the validity of the PIP claim of the injured person treated by the provider, and “arises from an injury to another person.” Clearly, any such “claim” is—at best—a derivative one.

Indeed, courts finding the existence of a provider claim have recognized that such claim is derivative of the injured person’s claims. See, e.g., *Bahri v IDS Property Cas Ins Co*, 308 Mich App 420, 424; 864 NW2d 609 (2014) (provider “stood in the shoes of the named insured, if [the insured] cannot recover benefits, neither can [the provider]”); *TBCI, PC v State Farm Mut Auto Ins Co*, 289 Mich App 39, 44; 795 NW2d 229 (2010) (provider was “essentially standing in the shoes” of the insured). And, relatedly, a provider’s eligibility is completely dependent upon the injured person’s eligibility. *Bahri*, 308 Mich App at 424. The Court of Appeals recently articulated this in *Moody*:

While the providers may bring an independent cause of action against a no-fault insurer, *the providers’ claims against Home Owners are completely derivative of and dependent on Moody’s having a valid claim of no-fault benefits against Home Owners. Specifically, the providers’ claims are dependent on establishing*

---

<sup>12</sup> See *infra* for further discussion of “some other person.”

Moody's claim that he suffered "accidental bodily injury arising out of the . . . use of a motor vehicle," MCL 500.3105(1), that they provided "reasonably necessary products, services and accommodations for [Moody's] care, recovery, or rehabilitation," MCL 500.3107(1)(a), and that at the time of the accident, Moody was "domiciled in the same household" as his father who was insured by Home Owners, MCL 500.3114(1). The providers' and Moody's claims with respect to the requisites of Home Owners' liability are therefore identical. Because there is an identity between Moody's claims and those of the providers and because the claims were consolidated for trial, we consider them merged for the purpose of determining the amount in controversy under MCL 600.8301(1). [304 Mich App at 440-441 (emphasis added).]

Strangely, the Court of Appeals here acknowledged that "a provider's right to no-fault benefits is based on the insured's right to benefits." It nonetheless then found that providers have "independent standing" to bring a claim against an insurer. (COA Opinion, p. 3, JA 82a.) A claim "based on" the rights of another is derivative, at best.

This proposition was most recently reiterated in two different cases. First, in *Michigan Head & Spine Institute PC ("MHSI") v State Farm Mutual Auto Ins Co*, unpublished opinion of Court of Appeals, issued January 21, 2016 (Docket No. 324245) (attached as Ex. A),<sup>13</sup> the insured first sued State Farm for unpaid medical bills, including those of MHSI. A jury found that State Farm did not owe the insured any more payments. The Court of Appeals then upheld the dismissal of MHSI's separate suit against State Farm as barred by *res judicata*, even though MHSI's bills had not been presented to the jury, because they could have been. The court cited numerous cases, including *TCBI* and *Moody*, for the proposition that "a healthcare provider seeking payment under a no-fault insurance policy stands in privity with an injured party who previously brought a lawsuit against the insurer attempting to claim benefits under the same

---

<sup>13</sup>State Farm is citing this unpublished decision as it is unaware of a published decision involving similar facts and it shows the result of the Court of Appeals' decision in the instant case.

policy” and “by seeking payment from State Farm, MHSI stands in [the insured’s] shoes.” (Ex. A, pp. 3-4.) The court concluded that “State Farm should not be faced with the costs and vexation of additional litigation, and the interests of judicial economy will be served by the application of res judicata to preclude MHSI’s lawsuit.” (*Id.*, p. 5.)

Thus, under the Court of Appeals’ logic in that case and our case, if an insurer settles a PIP lawsuit with an insured (which includes known provider bills) and obtains a dismissal with prejudice, that does *not* bar a later suit by such known provider; but a jury verdict in favor of the insurer *does*. Such a result hardly promotes judicial economy or consistency. There should be no difference based on how the insured’s claim is resolved; either way, the outcome should be the same.

In *Clark v Progressive Ins Co*, 309 Mich App 387; 872 NW2d 730 (2015), the plaintiff sued Progressive for PIP benefits and agreed to settle for \$78,000 “for all benefits to date.” *Id.* at 392. The insurer knew, but plaintiff’s counsel was unaware, that plaintiff had incurred prior medical expenses totaling \$28,942. In support of a subsequent provider lawsuit, plaintiff’s counsel argued he would not have settled for that amount if he had been aware of the bill. The Court of Appeals rejected plaintiff’s argument that Progressive was obligated to inform her counsel of the bill and reversed the trial court’s ruling that the \$28,942 claim was not part of the settlement and could be separately pursued:

Progressive . . . is in an adversarial position with plaintiff, and, as such, has every right to protect its interests and to expect that courts will uphold a settlement freely entered into by the parties. Progressive paid to buy its peace, not to advise plaintiff and her lawyer on how to settle a case. Were we to accept the proposition advanced by plaintiff, we would undermine the finality of settlements, and, perhaps, place opposing counsel in the untenable and conflicted position of advising two parties: his client on how best to settle a claim, and his opponent on what claims to include

in a settlement. This we cannot and will not do. [*Clark*, 309 Mich App at 402.]

Here, the Court of Appeals did precisely what the *Clark* court refused to do—undermine the finality of a settlement with the insured, who has the authority to fully resolve his claim.

If providers have a claim to PIP benefits at all, such a claim would be wholly derivative of the injured person’s claim for benefits. Although described in a different context, the derivative nature of loss of consortium claims is informative. “The main action in a personal injury case lies with the injured party. Others seeking recovery thereunder for additional effects of the injury on them do not stand independently nor separately from the injured party as they once did, but instead take derivative rights from the success of that party in the original action.” *Morse v Deschaine*, 13 Mich App 101, 104-105; 163 NW2d 693 (1968) (citations omitted). See also *Moss v Pacquing*, 183 Mich App 574, 583; 455 NW2d 339 (1990) (if original claim for medical malpractice fails, so must the consortium claim, as it “is clearly derivative of his injured spouse’s claim. His recovery for loss of consortium stands or falls upon her recovery of damages.”). If a plaintiff cannot prove, for example, their cause of action for negligence, his or her spouse cannot take a second bite at the apple and try again to prove this in connection with a consortium claim. Similarly, in *Jozwiak v Northern Mich Hosps*, 207 Mich App 161, 167-168; 524 NW2d 250 (1994), the court held that an action brought by the injured person’s children was derivative and if an arbitration agreement signed by the injured person’s guardian was valid, it would also bind the children.

This concept only makes sense in our context. There is no reason for a provider to potentially have *more* rights than the insured; rather, the provider’s rights (again, if any) are dependent upon those of the injured person. If the injured person is not entitled to benefits, then neither is the provider. If an injured person cannot recover a claim because the service was not

reasonably necessary, then neither can the provider. If an injured person cannot recover a claim because he committed fraud in connection with the claim, and the policy is voided, then neither can the provider. The same logic should hold when it comes to releases—if an injured person cannot recover a claim because he signed a release, then neither can the provider; if the injured person settled their claims with the insurance company, extinguishing their right to any further payment, then the provider’s right to receive payment is also extinguished.

**II. THE COURT OF APPEALS’ DECISION MISINTERPRETS SECTION 3112—PROVIDERS DO NOT PRESENT “CLAIMS OF SOME OTHER PERSON” WITHIN THAT SECTION, AND HEARINGS ARE NOT REQUIRED BEFORE CLAIMS CAN BE SETTLED WITH INSUREDS.**

The Court of Appeals’ finding regarding provider rights was coupled with a flawed interpretation of Section 3112. Although State Farm firmly believes that healthcare providers like Covenant do not have a claim for the payment of benefits against a no-fault insurer, even if this Court finds that such a right exists, the Court of Appeals’ interpretation of Section 3112 is wrong and should be reversed. To begin with, Section 3112 provides *one* avenue through which an insurer may discharge its liability; but it is not the only avenue by which a liability may be extinguished, and other avenues include settlement with the insured. Second, a healthcare provider does not present the “claim of some other person” within the meaning of MCL 500.3112; indeed, as discussed above, a provider’s “claim” (if one even exists) is derivative of, and the provider “stands in the shoes of,” the insured. Finally, under the plain language of the statute, a hearing is not required before an insurer and its insured can settle their claims. All-in-all, the Court of Appeals’ interpretation of Section 3112 simply does not comport with the plain language of the statute or the goals of the No-Fault Act.

The Court of Appeals interpreted the second sentence of Section 3112<sup>14</sup> to mean that “if the insurer has notice in writing of a third party’s claim, then the insurer *cannot* discharge its liability to the third party simply by settling with its insured.” (COA Opinion, p. 2, JA 81a) (emphasis added). Continuing, the court found “[s]uch a payment is not in good faith because the insurer is aware of a third party’s right and seeks to extinguish it without providing notice to the affected party. 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.” (*Id.*, pp. 2-3, JA 81a-82a) (emphasis added). The Court of Appeals’ interpretation requiring no-fault insurers to apply to the Circuit Court for an apportionment order every time it receives any written correspondence, bill, or other “notice” from a medical provider or any other “person” before it makes a payment to the insured is incorrect because: (a) a statutory discharge is not the only way to discharge an insurer’s liability; (b) a provider claim is not “the claim of some other person”; and (c) Section 3112 does not mandate an apportionment hearing.

**A. A Statutory Discharge Is Not the Only Way to Discharge an Insurer’s Liability, Even if the Insurer Has “Notice” of a Third Party’s Claim.**

The plain language of the statute does not provide that the *only* way an insurer may discharge its liability to pay PIP benefits is through Section 3112, even if it receives “notice”<sup>15</sup> of

---

<sup>14</sup> That sentence reads, “Payment by an insurer in good faith of personal protection insurance benefits, to or for the benefit of a person who it believes is entitled to the benefits, discharges the insurer’s liability to the extent of the payments unless the insurer has been notified in writing of the claim of some other person.” MCL 500.3112.

<sup>15</sup> The Court of Appeals did not directly address the concept of what constitutes “notif[ication] in writing,” but implicitly found that Covenant’s medical bills sent to State Farm constituted notice for purposes of Section 3112. If not reversed, the Court of Appeals’ decision could be read to mean that any time an insurer receives any piece of paper (or electronic correspondence) that identifies the injured person and provides information that indicates a third party believes it is owed some payment by the injured person for covered services, the insurer could not settle with the injured person, but would need to round up every potential “claimant” and apply to the Circuit Court for an apportionment order. Such result completely defeats the

a third party's claim. As this Court has previously recognized, Section 3112 provides a "'safe' method" of payment. *Miller*, 410 Mich at 568. In other words, Section 3112 provides how an insurer may *statutorily* discharge its liability to pay PIP benefits—by making a good faith payment to a person who it believes is entitled to the benefits so long as the insurer has not been notified in writing of the claim of some other person. The statute does not state that it is the *only* way by which an insurer may discharge its liabilities. More accurately, it provides *one* safe way by which an insurer can do so, even if it ultimately makes a payment to the wrong person.

For example, if an injured person succumbs to his or her injuries and an insurer makes survivor payments to Dependent X, who the insurer believes is entitled to the benefits, and then Dependent Y comes forward to claim benefits, the insurer has no liability to Dependent Y to the extent of the payments made to Dependent X, regardless of whether Dependent X was actually entitled to the benefits. However, if Dependent Y had notified the insurer in writing of its claim before the insurer made the payment to Dependent X, the insurer could not argue that its liability was *statutorily* discharged (the insurer could still defend against Dependent Y's claim in court by arguing that it had no liability to pay Dependent Y; it just could not rely on Section 3112 to claim its liability was *statutorily* discharged).

---

purpose of the No-Fault Act.

Illustrative of yet another problem with the Court of Appeals' opinion, *Covenant* argued below that "notice" under Section 3112 should be the same as "notice" under MCL 500.3145. (*Covenant's* Brief on Appeal, p 5.) But the Court of Appeals recently held that medical bills alone may not satisfy the "notice" requirements of MCL 500.3145, even if a bill is "sufficient in content," because the notice must also fulfill the purposes of the statute. *Perkovic v Zurich American Ins Co*, 312 Mich App 244, 258; 876 NW2d 839 (2015). Because a medical bill sent directly to the insurer is to obtain payment *for the benefit of the injured person*, not to give notice of the "claim" of the provider, for Section 3112 purposes, simply providing a bill cannot reasonably be viewed as sufficient to put an insurer on notice of the claim of "some other person." See also *Heikkinen v Aetna Cas & Sur Co*, 124 Mich App 459, 461; 335 NW2d 3 (1981) ("Notice encompasses something more than words typed on a piece of paper.").

The fact that Section 3112 does not preclude discharge through settlements or releases, regardless of third party claims, comports with this Court's recognition that the ability to settle no-fault cases is "essential" to meeting the goals of the No-Fault Act. *US Fid Ins & Guar Co*, 484 Mich at 25. If a Section 3112 apportionment order is the only way that an insurer can discharge its liabilities, settlements will become much more costly and time-consuming.

Case law, moreover, provides that executing a broad release, like the Release in this case, discharges an insurer's liability. *Michigan Head & Spine* held that an insurer's liability may be discharged via a release with the injured person and such a release operates as a bar to a provider's claim for benefits under Section 3112:

This Court has recognized that the language in MCL 500.3112 "specifically contemplates the payment of benefits to someone other than the injured person . . . ." *Lakeland Neurocare Ctrs v State Farm Mut Auto Ins Co*, 250 Mich App 35, 39; 645 NW2d 59 (2002). "As a result, it is common practice for insurers to directly reimburse health care providers for services rendered to their insureds." *Id.* It is well established that an injured person entitled to no-fault benefits may waive that entitlement and release an insurer from payment of future benefits in exchange for a settlement. *Lewis v Aetna Casualty & Surety Co*, 109 Mich App 136, 140; 311 NW2d 317 (1981). The issue presented in this case is whether an insured's release bars a healthcare provider's claim for payment for medical services rendered to the insured after the release was executed. [*Michigan Head & Spine*, 299 Mich App at 447-448 (emphasis added).]

The court then determined that, based on ordinary contract principles, "the plain language [of the release] demonstrates that, in exchange for defendant's payment of \$35,000, the parties intended to discharge defendant's liability altogether, including its liability for future medical services. The language of the release is clear and unambiguous, and the parties' intent, expressed in the release, governs its scope." *Id.* at 448-449.

In this case, much like the release in *Michigan Head & Spine*, Mr. Stockford and State Farm entered into a very clear and unambiguous release under which, in exchange for State

Farm's payment of \$59,000, the parties intended to discharge State Farm's liability altogether. Indeed, it is difficult to imagine clearer language on this point than that contained in the Release.

It is understood and agreed that this full and final release is a complete release of [State Farm] regarding any and all past and present claims incurred through January 10, 2013, under the Michigan No-Fault Act the undersigned may have under the Michigan Automobile No-Fault Act, including but not limited to allowable expenses, medical bills, attendant care, medical mileage, work loss, replacement services, attorney fees, interest and costs arising from the June 20, 2011 accident alleged in the complaint.

\* \* \*

The parties agree that the settlement payment referenced above is given as compensation in full satisfaction for any and all claims for no-fault benefits incurred through January 10, 2013, and for past, present and future wage loss claims under the Michigan Automobile No-Fault Act, and including but not limited to, attorney fees, costs and expenses. [(Release, pp. 1, 3, JA 17a, 19a.)]

The Court of Appeals distinguished *Michigan Head & Spine* on the grounds that the issue there was whether the insured's release barred a healthcare provider's claim for services rendered *after* the release was executed, as opposed to here, where Covenant sent bills to State Farm *before* the Release was executed. (COA Opinion, p. 3, JA 82a.) This is a distinction without a difference. As the Circuit Court correctly pointed out, written notice under Section 3112 "is only relevant to determining whether an insurer is *statutorily* discharged of liability under Section 3112 to the extent that it paid a claim for benefits in good faith." (Circuit Court Opinion, p. 5, JA 77a) (emphasis added). The insurer's liability in *Michigan Head & Spine* — and in the instant case—was terminated by the release, not by the statute. *Michigan Head & Spine* expressly acknowledged that an injured person is entitled to waive his or her entitlement to benefits and release an insurer for liability for same in exchange for a settlement payment. The court therefore held that a settlement and release covering existing and future claims for benefits

was enforceable against a medical provider seeking to obtain payment on behalf of the insured. In other words, the second sentence of Section 3112 did not come into play because the insurer was relying on a contractual release, and not the “safe” statutory discharge. Similarly, *Clark* held that the insurer had the right to expect that the court would uphold a settlement. Whether the case involves future medical bills (like in *Michigan Head & Spine*) or disputed past bills (like here), if the injured person executes an agreement that releases the insurer of liability for such claims, that release is dispositive as to the insurer’s liability.<sup>16</sup>

Two other cases buttress this conclusion. In *Moody*, the Court of Appeals found that an injured person “may waive by agreement his or her claim against an insurer for no-fault benefits, and a service provider is bound by the waiver.” 304 Mich App at 443. And in *Miller v Citizens Ins Co*, 490 Mich 904; 804 NW2d 740 (2011), the injured person and insurer entered into a settlement agreement that included the costs of medical treatments. Although in that case the primary issue was whether a provider, who did not bring its own claim for benefits, was liable for attorney fees to the insured person’s attorney, this Court made clear that in the event of such a settlement, a provider still had recourse against the injured person, as discussed above. *Id.* at 904. “The circuit court’s order of dismissal pursuant to the settlement agreement did not have the effect of extinguishing the [provider’s] right to collect the remainder of its bill from plaintiff.” *Id.*<sup>17</sup>

---

<sup>16</sup> This conclusion comports with the No-Fault Act, which provides that PIP benefits belong to the injured person and his or her dependents, not to healthcare providers or other third party service providers.

<sup>17</sup> Covenant claimed in its Brief Opposing State Farm’s Application for Leave to Appeal that *Miller* held that a settlement between the injured person and the insurer does not extinguish “the provider’s claims,” meaning, any claims the provider may have against the insurer. (Brief in Opposition, p. 14.) But this Court’s order only said the settlement “did not have the effect of extinguishing the [provider’s] right to collect the remainder of its bill from plaintiff,” 490 Mich at 904 (emphasis added), with the plaintiff in that case being the injured person.

Discharge by release has been long acknowledged by Michigan courts as one permissible route by which an insurer may discharge its liabilities (and an integral route at that) and Section 3112 should have no effect on that method. Section 3112 simply states that if an insurer makes a payment in good faith to a person the insurer believes is entitled to such payment, the insurer's liability is discharged to the extent of that payment. If, however, the insurer is notified in writing of the claim of some other person before it makes a good faith payment, the statute does not provide automatic protection for the insurer. It does not mean that the liability cannot otherwise be discharged (by release, for example), it just means that it is not *statutorily* discharged. Once Mr. Stockford released State Farm for all claims incurred through January 10, 2013, State Farm was no longer liable to make payments for such claims, including to Covenant. If a third party, such as Covenant, believes it is entitled to payment after such a release is executed, that party must seek such payment from the injured person.

**B. A Provider Claim Is Not a "Claim of Some Other Person".**

The Court of Appeals' reading of Section 3112 necessarily, and erroneously, assumes that if an insurer had written notice of a provider's bill, such notice was "the claim of some other person." The "claim" of a provider, however, is no such thing. As discussed at length above, healthcare providers do not have a "claim" for PIP benefits, so for that reason alone, Section 3112's statutory discharge provision is not implicated. Should this Court disagree and find that providers have a "claim" for benefits, such claim is still not the claim of "some other person" because, as shown above, the claim would be derivative of the injured person, and the provider "stands in the shoes of" the insured. If the provider stands in the shoes of the injured person, its "claims" are those of the injured person, and not the claims of "some other."

The definition of "other" highlights this distinction. Webster's Intermediate Dictionary (1972) defined "other" to include "being the ones distinct from those first mentioned." In the

context of Section 3112, the “claim of some other person” means the claim of a person distinct from the person the insurer believes is entitled to benefits. In this case, the only person entitled (statutorily and contractually) to PIP benefits was Mr. Stockford. Because Covenant’s “claim” for payment can only be construed under the No-Fault Act as Mr. Stockford’s claim for benefits, there is no “other” person implicated.

In addition, the second sentence of Section 3112 really speaks to survivor’s loss benefits, which is why the claim of “some other person” does not make sense in the context of providers. Doubt as to the proper person to receive such benefits only arises if there is a survivor’s loss claimant presumed to be a dependent under MCL 500.3110(1).

Although the Court of Appeals acknowledged *Moody* and the fact that the source of a provider’s so-called “right” to PIP benefits is based on the insured’s right, it then found that because other Michigan cases stated that a provider has “independent standing” to bring a claim, the injured person cannot release the insurer from liability through a settlement unless the insurer complies with Section 3112. (COA Opinion, p. 3, JA 82a.) This conclusion is legally inconsistent. The Court of Appeals’ decision is the first case to find that a provider’s claim is one of “some other person,” independent of the claim of the injured person. When a provider submits its bills to an insurer, it does so “for the benefit of the injured person,” as that is the only way under Section 3112 anyone other than the injured person is able to receive payment of benefits. Any claim that a provider has to PIP benefits, if one exists at all, is entirely dependent upon and tied to the injured person. In short, the “claim” (if any) of a provider is not the “claim” of “some other person” under Section 3112.

C. **Section 3112 Does Not Mandate Applying to the Circuit Court Even if There Is a Dispute Over the Proper Person to Receive Payment.**

Finally, even if one could read Section 3112 to mean that an insurer cannot discharge its liabilities without a court order once it receives notice from “some other person” (which is not consistent with the statute’s plain language), and a provider is “some other person” (which it is not), it still does not *mandate* that the insurer apply to the Circuit Court to resolve a dispute, as the Court of Appeals held. Section 3112 states:

If there is doubt about the proper person to receive the benefits or the proper apportionment among the persons entitled thereto, the insurer, the claimant or any other interested person *may apply to the circuit court* for an appropriate order. The court may designate the payees and make an equitable apportionment, taking into account the relationship of the payees to the injured person and other factors as the court considers appropriate. In the absence of a court order directing otherwise the insurer may pay: [discussing survivors]. [Emphasis added.]

It is well established that “the term ‘may’ is permissive, as opposed to the term ‘shall,’ which is considered ‘mandatory.’” See, e.g., *Manuel v Gill*, 481 Mich 637, 647; 753 NW2d 48 (2008). Thus, even if Section 3112 applied to this set of circumstances, the plain language of the statute does not “require” an insurer to apply to the Circuit Court, as the Court of Appeals held. (COA Opinion, p. 2, JA 81a.) Indeed, the last sentence of the statute acknowledges that it is acceptable for there to be an absence of a court order. And the remainder of the statute makes clear that the hearing is a procedure that the insurer *may* invoke when it comes to determining who gets what in terms of survivor benefits, *or* it can allocate them as the statute goes on to provide. As is the case with the rest of the statute, there is not one word here about providers.

That the Circuit Court process is not mandatory makes sense given the goals of the No-Fault Act (*i.e.*, lower legal costs, decreased burden on judicial system, and prompt payment) as well as the fact that, as discussed above, Section 3112 does not provide the only way in which

liabilities may be discharged but simply provides a “safe method” by which insurers may proceed if they receive notice of the claim of some other person.

**D. The Court of Appeals’ Decision Is Contrary to the Goals of the No-Fault Act.**

Last, but not least, are the policy ramifications of the Court of Appeals’ opinion. The judicial system is bowing under the weight of the number of PIP cases that have been, and continue to be, filed against no-fault insurers. The plaintiffs are not only the insureds, but myriad providers, all of whom often bring suits in different courts, resulting in numerous lawsuits in different courts over one accident.<sup>18</sup> This is the mess created by *Lakeland* and its ill-thought-out progeny. The current case then made matters worse by limiting the ability of insurers to settle the claims brought by their insureds. Instead, insurers must now determine from whom it has received bills or notice of services provided, treat those as “claims of some other person,” notify all of those people, and ask the Circuit Court to conduct a hearing on the “apportionment” of the settlement proceeds before a claim can be resolved.<sup>19</sup> That many of the provider “claimants” may choose not to be so bound, or that the Circuit Court will be unable to

---

<sup>18</sup> See Brief of Amicus Curiae Auto Club Insurance Ass’n in Support of Application for Leave to Appeal (“AAA amicus brief”), p. 1, stating that as of September 2013, two insurers—State Farm and AAA—had over 1,000 pending cases filed against them directly by healthcare providers. Appendix F to AAA’s amicus brief contains an affidavit averring that, as of June 2013, State Farm had 317 claims that had parallel litigation with suits by both the insured and providers. Similarly, Appendix G states that as of September 2013, 27 percent of the suits against AAA were suits filed by providers. Things have not gotten any better since.

<sup>19</sup> In Appendix E to AAA’s amicus brief, James Hoehner of AAA indicates that for one claim he was trying to settle, he had to notify 37 different providers of the apportionment hearing. He also indicates that Circuit Court judges have not been consistent in their application of the Court of Appeals’ rule, with some judges not hearing the apportionment motions and others disagreeing with the type of notice that must be given by the insurer to the providers.

bind them if they have their own litigation pending elsewhere (such as, is most often the case, in district court), was not considered by the Court of Appeals.<sup>20</sup>

This does *not* provide assured reparation to accident victims. This does *not* provide prompt reparation to accident victims. This does *not* keep the costs of No-Fault insurance down. This does *not* keep down healthcare costs. And this does *not* lessen the burden on the judicial system. It does entirely the opposite of each.

**CONCLUSION AND RELIEF REQUESTED**

Defendant-Appellant requests that this Court reverse the Court of Appeals' opinion, reinstate the Circuit Court opinion and order, and grant such other relief as is just and proper.

Respectfully submitted,

DYKEMA GOSSETT PLLC

Dated: August 11, 2016

By: /s/ Jill M. Wheaton

Jill M. Wheaton (P49921)  
Courtney F. Kissel (P74179)  
Dykema Gossett PLLC  
2723 S. State St., Suite 400  
Ann Arbor, MI 48104  
(734) 214-7629  
jwheaton@dykema.com  
Attorneys for Defendant-Appellant

---

<sup>20</sup> Indeed, under the Court of Appeals' decision, apportionment proceedings will be required on every claim, whether it is resolved by pre- or post-litigation settlement, case evaluation, or jury verdict.

**INDEX TO EXHIBITS**

- A. *Michigan Head & Spine Institute PC v State Farm Mutual Auto Ins Co*, unpublished decision of Court of Appeals, issued January 21, 2016 (Docket No. 324245).

**CERTIFICATE OF SERVICE**

On August 11, 2016 I e-filed this Brief on Appeal with the Michigan Supreme Court which will serve copies on all counsel of record.

By: /s/ Jill M. Wheaton  
Jill M. Wheaton (P49921)  
Dykema Gossett PLLC  
2723 S. State St., Suite 400  
Ann Arbor, MI 48104  
(734) 214-7629  
jwheaton@dykema.com

4853-2596-8950.1  
ID\WHEATON, JILL - 095876\002245

**1**

STATE OF MICHIGAN  
COURT OF APPEALS

---

MICHIGAN HEAD & SPINE INSTITUTE PC,  
Plaintiff-Appellant,

UNPUBLISHED  
January 21, 2016

v

STATE FARM MUTUAL AUTO INS CO,  
Defendant-Appellee.

No. 324245  
Wayne Circuit Court  
LC No. 13-004938-CZ

---

Before: STEPHENS, P.J., and HOEKSTRA and SERVITTO, JJ.

PER CURIAM.

In this action under the No-Fault Act, MCL 500.3101 *et seq.*, plaintiff Michigan Head & Spine Institute, P.C. (MHSI) filed the present lawsuit against defendant State Farm Mutual Auto Insurance (State Farm), seeking payment for medical services provided to Ashford Garley. The trial court granted summary disposition to State Farm under MCR 2.116(C)(7) based on the conclusion that MHSI's claims were precluded under the doctrines of res judicata and collateral estoppel by a prior federal action brought by Garley against State Farm. At the same time, the trial court denied MHSI's motion for partial summary disposition. MHSI now appeals as of right. Because res judicata bars MHSI's current claims, we affirm.

On December 15, 2011, Garley sustained bodily injury in a motor vehicle accident, after which he obtained medical services from several healthcare providers, including MHSI. Specifically, MHSI provided Garley with services between March 22, 2012 and May 23, 2012. At the time of Garley's accident, Garley's wife had a policy with State Farm, and it is undisputed that State Farm is highest in priority with respect to providing Garley with no-fault benefits. Nonetheless, State Farm failed to pay all of Garley's medical bills, including bills submitted by MHSI.

On August 13, 2012, Garley personally filed suit against State Farm in Wayne County Circuit Court, seeking benefits under the no-fault act. This case was later removed to federal court, and it ultimately resulted in a jury verdict in favor of State Farm in June of 2014. In particular, the jury concluded that Garley had sustained bodily injury in an auto accident, resulting in allowable expenses; but, the jury nonetheless determined that State Farm owed Garley \$0. As part of a question submitted to the federal court, the jury explained: "we think all bills related to the accident have been paid and no more money is owed." Notably, MHSI was not a party to Garley's lawsuit and Garley did not specifically request payment of MHSI's bills.

However, it is uncontested that MHSI's treatment of Garley was considered during the federal action insofar as MHSI's medical records pertaining to Garley were introduced into evidence.

MHSI filed the present lawsuit in state district court, seeking payment of Garley's bills under the no-fault act. The case was later transferred to circuit court because the amount in controversy exceeded the district court's \$25,000 jurisdictional limit. Thereafter, State Farm moved for summary disposition under MCR 2.116(C)(7) based on the applicability of res judicata and/or collateral estoppel. According to State Farm, MHSI stood in privity with Garley because MHSI sought no-fault benefits on behalf of Garley and such a claim was precluded because the question of State Farm's liability had been previously litigated in Garley's action against State Farm. MHSI opposed State Farm's motion and filed its own motion for partial summary disposition based on the application of res judicata and collateral estoppel. Although MHSI asserted that its claims were not precluded by the verdict in Garley's case, MHSI nonetheless asserted that portions of the jury's verdict should have a preclusive effect in this case. That is, in its motion for partial summary disposition, MHSI maintained that the jury verdict form in Garley's case demonstrated that the jury had concluded that (1) Garley had sustained accidental bodily injury arising out of the operation of a motor vehicle and that (2) Garley had incurred allowable expenses arising out of that accident.

Following a hearing, the trial court denied MHSI's motion for partial summary disposition and entered summary disposition in favor of State Farm under MCR 2.116(C)(7). The trial court concluded that State Farm was entitled to summary disposition for the reasons stated in State Farm's motion, i.e., based on the application of res judicata and collateral estoppel. MHSI now appeals as of right.

On appeal, MHSI argues that the trial court erred by granting summary disposition to State Farm and by denying MHSI's motion for partial summary disposition. According to MHSI, neither res judicata nor collateral estoppel entitle State Farm to summary disposition because MHSI was not a party to Garley's federal action and the issue of State Farm's liability with respect to MHSI's bills in particular was not actually litigated during the federal suit. Further, MHSI maintains that partial summary disposition should have been granted to MHSI because the jury actually determined that Garley suffered bodily injury arising from a motor vehicle accident that resulted in allowable expenses.

"This Court reviews de novo a trial court's decision to grant summary disposition." *Burkhardt v Bailey*, 260 Mich App 636, 646; 680 NW2d 453 (2004). Under MCR 2.116(C)(7), dismissal of an action is appropriate because a claim is barred by a "prior judgment." See *RDM Holdings, LTD v Contl Plastics Co*, 281 Mich App 678, 687; 762 NW2d 529 (2008). The application of legal doctrines, such as res judicata and collateral estoppel, is reviewed de novo. *Estes v Titus*, 481 Mich 573, 578-579; 751 NW2d 493 (2008).

Simply stated, res judicata prevents "multiple suits litigating the same cause of action." *Adair v State*, 470 Mich 105, 121; 680 NW2d 386 (2004). Res judicata is a judicially created doctrine designed to "relieve parties of the cost and vexation of multiple lawsuits, conserve judicial resources, and, by preventing inconsistent decisions, encourage reliance on adjudication." *Pierson Sand & Gravel, Inc v Keeler Brass Co*, 460 Mich 372, 380; 596 NW2d 153 (1999) (quotation marks and citation omitted). Under this doctrine, a subsequent action is

barred when “(1) the prior action was decided on the merits, (2) the decree in the prior action was a final decision, (3) the matter contested in the second case was or could have been resolved in the first, and (4) both actions involved the same parties or their privies.” *Richards v Tibaldi*, 272 Mich App 522, 531; 726 NW2d 770 (2006). Res judicata has been broadly applied to bar “not only claims already litigated, but also every claim arising from the same transaction that the parties, exercising reasonable diligence, could have raised but did not.” *Adair*, 470 Mich at 121.

In this case, the parties do not dispute that Garley’s federal lawsuit was decided on the merits and that it resulted in a final decision in State Farm’s favor. Instead, MHSI argues that res judicata should not apply because MHSI was not a party to Garley’s actions and because MHSI’s bills were not submitted to the jury, meaning that the jury did not actually consider whether State Farm owed MHSI payment for services provided. These arguments implicate the issues of privity and whether MHSI’s claims were, or could have been, raised in Garley’s lawsuit.

With regard to privity, “[t]o be in privity is to be so identified in interest with another party that the first litigant represents the same legal right that the later litigant is trying to assert.” *Id.* at 122. “The outer limit of the doctrine traditionally requires both a ‘substantial identity of interests’ and a ‘working functional relationship’ in which the interests of the nonparty are presented and protected by the party in the litigation.” *Id.* (quotation marks and citation omitted). Previously, this Court has specifically concluded that a healthcare provider, seeking payment under a no-fault insurance policy, stands in privity with an injured party who previously brought a lawsuit attempting to claim no-fault benefits under the same policy. *TBCI*, 289 Mich App at 44. In *TBCI*, this Court explained:

[The healthcare provider], by seeking coverage under the policy, is now essentially standing in the shoes of [the insured]. Being in such a position, there is also no question that [the healthcare provider], although not a party to the first case, was a “privity” of [the insured]. [*Id.*]

As *TBCI* makes plain, in the case of healthcare providers and injured parties seeking benefits under a no-fault insurance policy, both the injured party and the healthcare provider share a common identity of interests in enforcing the provisions of the no-fault act and obtaining benefits under the policy. See generally MCL 500.3112; *Wyoming Chiropractic Health Clinic, PC v Auto-Owners Ins Co*, 308 Mich App 389, 397; 864 NW2d 598 (2014); *Mich Head & Spine Inst, PC v State Farm Mut Auto Ins Co*, 299 Mich App 442, 447; 830 NW2d 781 (2013). That is, while a healthcare provider has independent standing to bring a lawsuit against a no-fault insurer, the fact remains that there is an “interdependence between the claims of a healthcare provider and an injured party,” such that “a healthcare provider’s eligibility to recover medical expenses is dependent upon the injured party’s eligibility for no-fault benefits under the insurance policy.” *Chiropractors Rehab Group, PC v State Farm Mut Auto Ins Co*, \_\_\_ Mich App \_\_\_, \_\_\_; \_\_\_ NW2d \_\_\_ (2015), slip op at 8-9. See also *Moody v Home Owners Ins Co*, 304 Mich App 415, 440; 849 NW2d 31 (2014). For this reason, a healthcare provider seeking payment under a no-fault insurance policy stands in privity with an injured party who previously brought a lawsuit against the insurer attempting to claim benefits under the same policy. See *TBCI*, 289 Mich App at 44.

It follows that in this case, MHSI stands in privity with Garley. Both MHSI and Garley sought benefits under the same no-fault insurance policy. Both MHSI and Garley have a

common interest in obtaining a judgment against State Farm under this policy and, in particular, they have an interest in obtaining an award of medical costs arising from Garley's accident on December 15, 2011. They both share an interest in showing that Garley was injured in this accident and that he incurred allowable expenses payable by State Farm in accordance with the no-fault act. Indeed, MHSI's entitlement to payment is dependent on Garley's eligibility for no-fault benefits under the insurance policy. See *Chiropractors Rehab Group, PC*, slip op at 8-9. In short, by seeking payment from State Farm, MHSI stands in Garley's shoes and therefore stands in privity with Garley. See *TBCI*, 289 Mich App at 44.

Aside from the issue of privity, MHSI emphasizes on appeal that its bills were not specifically submitted to the jury for actual consideration and that, because the jury did not specifically reject payment of MHSI's bills, res judicata cannot apply. Although it appears that MHSI's bills were not introduced at Garley's trial, the fact remains that the jury did in fact conclude that Garley could recover nothing from State Farm. That is, the jury did consider the broader issue of State Farm's liability under the policy and the jury rejected Garley's claim for no fault benefits, meaning that MHSI, as Garley's privy, cannot relitigate this issue. See *Adair*, 470 Mich at 121. Cf. *TBCI*, 289 Mich App at 44.

Moreover, to the extent MHSI's particular bills were not introduced, this fact is not dispositive because these bills *could* have been submitted to the jury during Garley's action. In this respect, Michigan follows a broad approach to the application of res judicata, and it will be applied to bar "not only claims already litigated, but also every claim arising from the same transaction that the parties, exercising reasonable diligence, could have raised but did not." *Adair*, 470 Mich at 121. To determine whether a claim could have been raised in a previous action, courts apply the "same transactional test." *Id.* at 123-125. Under this test, "[w]hether a factual grouping constitutes a transaction for purposes of res judicata is to be determined pragmatically, by considering whether the facts are related in *time, space, origin or motivation*, [and] whether they form a convenient trial unit. . . ." *Id.* at 125 (quotation omitted). "If the new claim or claims arise from the same group of operative facts as the previously litigated claim or claims, even if there are variations in the evidence needed to support the theories of recovery, [this Court] will treat the claims as the same and res judicata will apply." *Green v Ziegelman*, 310 Mich App 436, \_\_; \_\_ NW2d \_\_ (2015), slip op at 5.

In this case, the same group of operative facts underlying Garley's lawsuit give rise to MHSI's current claims for payment of MHSI's bills. Both cases rest on Garley's entitlement to coverage under the State Farm no-fault policy, and in particular Garley's entitlement to benefits for payment of medical care. In both cases, Garley and MHSI assert a right to coverage based on injuries Garley sustained in an automobile accident in December of 2011. All the medical costs at issue in MHSI's case, which Garley incurred before May of 2012, arose before Garley filed his lawsuit in August of 2012. Cf. *Elser v Auto-Owners Ins Co*, 253 Mich App 64, 69; 654 NW2d 99 (2002). Moreover, all of MHSI's medical records pertaining to Garley were in fact introduced into evidence during Garley's trial. Given that the claims at issue clearly arise from the same operative facts, Garley plainly could have sought payment of MHSI's medical bills during his trial and, if MHSI felt its interests were not being adequately protected, MHSI could

have intervened in Garley's lawsuit to protect its rights.<sup>1</sup> See MCR 2.209; see also *Richards*, 272 Mich App at 531-532 ("The matter could have been resolved in the first suit had plaintiff added defendants as parties or had defendants intervened in the action."); *Tomalis v Tradesmen's Nat Bank of New Haven*, 19 Mich App 592, 594; 173 NW2d 259 (1969). In short, viewed pragmatically, MHSI's medical bills could easily have been addressed during Garley's federal lawsuit for no-fault benefits against State Farm.

In sum, res judicata applies in this case because Garley's lawsuit resulted in a final decision on the merits in State Farm's favor, MHSI is Garley's privy, the jury rejected Garley's claim for benefits, and State Farm's obligations with respect to the payment of MHSI's bills in particular could have been addressed during the previous litigation. See *Richards*, 272 Mich App at 531. In these circumstances, State Farm should not be faced with the costs and vexation of additional litigation, and the interests of judicial economy will be served by the application of res judicata to preclude MHSI's lawsuit. See *Pierson Sand & Gravel, Inc*, 460 Mich at 380.

Having determined that the trial court properly granted State Farm's motion for summary disposition based on the application of res judicata, we need not decide whether collateral estoppel also entitled State Farm to summary disposition and we need not consider MHSI's arguments regarding its motion for partial summary disposition.

Finally, we note briefly that MHSI argues that application of res judicata in this case will deprive MHSI of due process and its statutory right to reimbursement of medical expenses under MCL 500.3112. These issues are unpreserved because MHSI failed to raise them in the trial court, and they are improperly presented to this Court because they have not been included in MHSI's statement of the questions presented. Consequently, these issues need not be decided. See *Hines v Volkswagen of Am, Inc*, 265 Mich App 432, 443; 695 NW2d 84 (2005); *Bouverette v Westinghouse Elec Corp*, 245 Mich App 391, 404; 628 NW2d 86 (2001).

In any event, these arguments are without merit. Although it is true that MHSI has standing to pursue claims for no-fault benefits under MCL 500.3112, this does not obviate the privity that exists between MHSI and Garley by virtue of their shared interests in obtaining benefits from State Farm, nor does it overcome the fact that MHSI's bills could have been presented during Garley's action. Thus, MHSI's standing under MCL 500.3112 does not prevent application of res judicata. Rather, if anything, MHSI's standing underscores MHSI's ability and failure to intervene in Garley's lawsuit. Likewise, with regard to due process, MHSI has not shown that application of the doctrine of res judicata violates principles of due process. As discussed, there was a shared identity of interests between MHSI and Garley, and this shared identity of interests would generally ensure that MHSI's rights were adequately protected. See *Beyer v Verizon N Inc*, 270 Mich App 424, 435; 715 NW2d 328 (2006). Moreover, if MHSI felt

---

<sup>1</sup> There has been no assertion that MHSI was unaware of Garley's lawsuit. Moreover, in September of 2012, while Garley's suit was ongoing, State Farm moved for summary disposition in the district court against MHSI based on the suit that had been filed by Garley. Clearly, by that time at the latest, almost 2 years before the conclusion of Garley's suit, MHSI knew of Garley's lawsuit and could have taken steps to intervene.

its interests were not adequately represented by Garley, it should have intervened in Garley's action against State Farm. See MCR 2.209. MHSI's failure to do so does not demonstrate a deprivation of due process.

Affirmed.

/s/ Cynthia Diane Stephens  
/s/ Joel P. Hoekstra  
/s/ Deborah A. Servitto