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STATE OF MICHIGAN

IN THE SUPREME COURT

Appeal from the Michigan Court of Appeals
The Hon. Michael F. Gadola, Michael J. Riordan, Mark T. Boonstra

SPINE SPECIALISTS OF MICHIGAN, PC,

Plaintiff- Appellant,

v

MEMBERSELECT INS. CO.,

Defendant-Appellee.

Supreme Court No. 165445
Court of Appeals No. 358296
Circuit Court No. 2020-003355-NF

_____/

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THE INSURANCE ALLIANCE OF MICHIGAN'S AMICUS CURIAE BRIEF

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STATEMENT OF APPELLATE JURISDICTION

Spine Specialists of Michigan, PC ("Plaintiff") seeks leave to appeal from the February 2, 2023 published Court of Appeals opinion in *Spine Specialists of Michigan, PC v MemberSelect Ins Co,* ___ Mich App ___; ___ NW2d ___ (2023) (Docket No. 358296). Amicus Curiae, the Insurance Alliance of Michigan ("IAM"),[1] does not believe that the Application satisfies MCR 7.305(B)(3) and (B)(5). Plaintiff points to the purported conflict between the Court of Appeals' decision in this case and *Encompass Healthcare, PLLC v Citizens Ins Co,* 344 Mich App 248, 252 n 1; 998 NW2d 751 (2022). **This conflict is an illusion.** *Spine Specialists* is directly on point and provides a substantive analysis of why the 2019 amendment to MCL 500.3145 cannot apply to expenses incurred before that date. *Encompass Healthcare,* on the other hand, mentions the issue in passing, in a footnote – consistent with the fact that this issue was never briefed or argued in that case.[2]

In contrast to the *Encompass Healthcare* footnote, every panel of the Court of Appeals that has substantively considered this issue has reached the same result as the *Spine Specialists* panel: merely filing after the amendment does not allow a claimant to invoke the new tolling language. See *Girimonte v Liberty Mutual Ins & Allstate Prop & Cas*, __ Mich App __; __ NW2d __ (2023)

[1] IAM states that no counsel for a party authored this brief in whole or in part, and no party or party's counsel made a monetary contribution intended to fund the preparation or submission of the brief. No person other than IAM, its members, or their counsel made such a monetary contribution.

[2] An opinion cannot create precedent as to "issues neither briefed nor argued…." *Quinton v General Motors Corp,* 453 Mich 63, 74; 551 NW2d 677 (1996) (opinion by Levin, J). "[P]ronouncements … without briefing and argument, are not stare decisis." *Id.* "The essential principles of stare decisis" include that "an issue of law must have been heard and decided," and if "an issue is not argued, or though argued is ignored by the court, or is reserved, the decision does not constitute a precedent to be followed…." *EEOC v Trabucco,* 791 F2d 1, 4 (CA 1, 1986) (citation omitted).

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(Docket No. 362128).[3] See also *Reid v Progressive Michigan Ins Co,* unpublished opinion per curiam of the Court of Appeals, issued March 9, 2023 (Docket No. 359412) (Ex. A); *Cherry v Progressive Marathon Ins Co,* unpublished opinion per curiam of the Court of Appeals, issued June 16, 2022 (Docket No. 357722) (Ex. B); *Mobile MRI Staffing, LLC v Meemic Ins Co,* unpublished opinion per curiam of the Court of Appeals, issued January 20, 2022 (Docket No. 355162) (Ex. C). But this is not just a matter of sifting through Court of Appeals decisions. The holdings in this case, *Health Partners, Reid, Cherry,* and *Mobile MRI Staffing* are all in harmony with this Court's holdings in *Andary v USAA Cas Ins Co,* 512 Mich 207, 256–257; 1 NW3d 186 (2023) and *Buhl v City of Oak Park*, 507 Mich 236; 968 NW2d 348 (2021), for reasons explained below.

[3] In that unanimous opinion, the panel sought to resolve the supposed conflict between *Encompass Healthcare* and *Spine Specialists.* Drawing guidance from *Health Partners, Inc v Progressive Mich Ins Co,* unpublished opinion per curiam of the Court of Appeals, issued March 9, 2023 (Docket No. 359096) (Ex. D), the *Girimonte* panel found that *Spine Specialists* "is directly applicable" and the "pre-amendment version of § 3145 applies to the claims at issue…." *Girimonte,* __ Mich App at __; slip op at 6. "That is, under *Spine Specialists*, the tolling provision in the current version of MCL 500.3145 does not apply to expenses that are incurred before June 11, 2019." *Girimonte,* __ Mich App at __; slip op at 7.

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INTRODUCTION AND STATEMENT OF THE AMICUS CURIAE

This is a provider suit for PIP[4] benefits under the No-Fault Act. In its November 22, 2023 "MOAA"[5] Order, this Court asked for briefing on "whether the Court of Appeals correctly held that the tolling provision of the one-year-back rule, MCL 500.3145(3), does not apply to claims for personal protection insurance no-fault benefits that accrued, MCL 500.3110(4), before the amendment to § 3145 took effect on June 11, 2019." *Spine Specialists of Michigan, PC v MemberSelect Ins Co,* 997 NW2d 45 (Mich, 2023). The Order invited amicus curiae briefs from multiple organizations including the Insurance Alliance of Michigan ("IAM"). *Id.*[6]

IAM represents the 2017 merger of The Insurance Institute of Michigan ("IIM") with the Michigan Insurance Coalition ("MIC"). IAM is a government affairs and public information association proud to represent property/casualty insurance companies and related organizations operating in Michigan.

IAM member companies provide insurance to approximately 94% of the automobile, 90% of the homeowners, and 60% of the commercial markets in Michigan. IAM's purpose is to serve the Michigan insurance industry and the insurance consumer as a central focal point for educational, media, legislative and public information on insurance issues. IAM serves as the official spokesperson for the property/casualty insurance industry in Michigan.

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[4] "What are commonly called 'PIP benefits' are actually personal protection insurance (PPI) benefits by statute." *Esurance Prop & Cas Ins Co v Michigan Assigned Claims Plan,* 507 Mich 498, 504 n 1; 968 NW2d 482 (2021). "However, lawyers and others call these benefits PIP benefits to distinguish them from property protection insurance benefits." *Id.*

[5] Mini-oral argument on application.

[6] On the same day, this Court also invited IAM to submit an amicus curiae brief in *Encompass Healthcare, PLLC v Citizens Ins Co*, 997 NW2d 37 (Mich, 2023). The second issue identified in that Order (Supreme Court No. 165321) is the same as the issue identified in the *Spine Specialists* MOAA Order. IAM therefore asks this Court to consider the arguments that follow in relation to both cases.

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IAM formulates its policy analyses on insurance issues in a consistent and deliberate manner. In conducting its policy analyses, IAM consistently applies the following core principles: (A) the legitimate role of the courts is the interpretation and application of the law as written, not the creation of new policy to augment, alter or conflict with statutes, regulations or contracts; (B) the natural commercial order arising out of consensual transactions between or among individuals and businesses is generally preferable to the imposition of government authority, regulation and laws designed to control commerce, limit choice, or effect preferred outcomes; and (C) commerce conducted by private individuals and businesses is generally preferable to commerce conducted by a governmental body.

This matter is of particular interest to IAM because if the Plaintiff's position were adopted, it would greatly expand the responsibilities and exposures of IAM's member companies. Otherwise stale PIP claims could be filed under the amended statute, with providers taking the position that tolling applies because there was never a formal denial of their claims (since insurers were under no obligation to issue such denials prior to June 11, 2019). To protect themselves, insurers would need to review closed files and issue formal denials for all claims where notice has been provided under MCL 500.3145(1), regardless of how long the claim has been inactive.

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STATEMENT OF THE QUESTION PRESENTED

I. Did the Court of Appeals correctly determine that a large portion of Plaintiff's bills were barred by the one-year-back rule, where the tolling language relied upon by the Plaintiff did not appear in MCL 500.3145 at the time the services were performed and any cause of action for those bills accrued?

Plaintiff-Appellant answers **"No."**

Defendant-Appellant MemberSelect answers **"Yes."**

Amicus Curiae Insurance Alliance of Michigan answers ***"Yes."***

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STATEMENT OF FACTS

IAM adopts the Statement of Facts contained set forth by the Court of Appeals, *Spine Specialists,* ___ Mich App at ___; slip op at 1-2.

STANDARD OF REVIEW

The decision below was to grant partial summary disposition to MemberSelect under MCR 2.116(C)(7). *Spine Specialists,* ___ Mich App at ___; slip op at 2. Decisions to grant or deny summary disposition under that subpart are reviewed on appeal *de novo*. *Id.*; *Jesperson v Auto Club Ins Ass'n*, 306 Mich App 632, 639-640; 858 NW2d 105 (2014).[7] This appeal also involves questions of statutory construction, which are likewise reviewed *de novo. Jesperson*, 306 Mich App at 639-640. Although this Court "reviews a decision to grant a motion for summary disposition *de novo*," this standard "does not authorize the Court to abandon its neutral role and become plaintiff's counsel." *Kaupp v Mourer-Foster, Inc,* 485 Mich 1033, 1035; 776 NW2d 893 (2010) (Corrigan, J., dissenting).

ARGUMENT

I. In this first-party no-fault action, the Court of Appeals correctly determined that a large portion of Plaintiff's bills were barred by the one-year-back rule, where the tolling language relied upon by the Plaintiff did not appear in MCL 500.3145 at the time the services were performed and any cause of action for those bills accrued. This outcome is consistent with this Court's decisions in *Andary* and *Buhl.*

The 2019 amendments to the No-Fault Act generally do not have any retroactive effect. See *Andary,* 512 Mich at 255. Spine Specialists suggests in its Application that *Andary* is distinguishable because *Andary* dealt with substantive rights, whereas the tolling language added

[7] Rev'd on other grounds, 499 Mich 29; 878 NW2d 799 (2016).

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to MCL 500.3145 is procedural.[8] But the one-year-back rule concerns a matter of substantive law, rather than procedure. This is demonstrated by the fact that federal courts, applying Michigan law in diversity, have repeatedly applied the one-year-back rule without question.[9] Regardless of *how* these decisions applied the one-year-back rule, that fact that they applied it at all demonstrates that it is a substantive rule.[10]

"[T]he one-year-back rule is not a statute of limitations in that it does not limit the period of time within which a claimant may file an action;" rather, the rule represents a statutory cap on damages a claimant is entitled to recover. *Joseph v Auto Club Ins Ass'n*, 491 Mich 200, 216; 815 NW2d 412 (2012). The one-year-back rule is substantive in nature, rather than procedural, because it reflects legislative policy considerations other than court practice and procedure. See *Zdrojewski v Murphy,* 254 Mich App 50, 82; 657 NW2d 721 (2002) (explaining that statutes capping damages in medical malpractice actions represent substantive law because the "purpose of the statutes is to control health care costs by reducing medical malpractice liability"). As explained in *Joseph,* 491 Mich at 220–221:

> **The one-year-back rule codifies an integral part of the legislative compromise that is the no-fault act**.... Given that Michigan is the only state with a no-fault automobile-injury

[8] At page 6 of its Application, Plaintiff seems to say that when an amendment is purely procedural, retroactivity is not even a relevant concept. See *Buhl,* 507 Mich at 253–257 (Viviano, J., concurring). Admittedly, there may be nuances to the definition of "retroactivity" that the lower courts did not deal with in *Spine Specialists*. However, Spine Specialists wants tolling because MemberSelect did not formally deny claims for services provided in April and May, 2019, even though there was no obligation to formally deny claims prior to June 11, 2019. That is a retroactive application under any formulation of the term. And again, this part of Justice Viviano's concurrence only speaks to amendments that are purely procedural – which this amendment is not for reasons explained elsewhere in this Brief.

[9] See *Am Med Sec, Inc v Auto Club Ins Ass'n of Michigan,* 238 F3d 743, 752 (CA 6, 2001); *Bartalino v Citizens Ins Co of the Midwest,* 526 F Supp 3d 277, 284 (ED Mich, 2021); *ZMC Pharmacy, LLC v State Farm Mut Auto Ins Co,* 307 F Supp 3d 661, 672 (ED Mich, 2018); *Buntea v State Farm Mut Auto Ins Co,* 467 F Supp 2d 740, 749 (ED Mich, 2006).

[10] "When a suit is before federal court pursuant to its diversity jurisdiction, it applies the substantive law of the state and federal procedural law." *Jackson v Ford Motor Co,* 842 F3d 902 (CA 6, 2016).

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> reparations scheme with mandatory, unlimited, lifetime medical benefits, the Legislature adopted a unique approach to defining the temporal limitations for filing suit without allowing open-ended liability or time-barring claims before they accrue. The Legislature addressed this problem by enacting the one-year-back rule, which limits recovery to losses incurred within one year before suit was filed. Thus, the creation of MCL 500.3145(1) was the Legislature's reasonable and simple approach to resolving the problem of allowing a reasonable amount of time for pursuing a claim while protecting the fiscal integrity of the no-fault system. (Emphasis added.)

The *Joseph* Court's description of the one-year-back rule is remarkably similar to the *Andary* Court's description of the fee schedule – as both ultimately operate to reduce the amount payable on PIP claims:

> The 2019 no-fault amendments at issue are almost entirely substantive in nature. Application of the 2019 amendments to individuals who had previously been injured and were already receiving PIP benefits would not operate in furtherance of a remedy or mode of procedure, given that the amendments create new monetary caps on compensable non-Medicare services and a new hourly limitation on how much reimbursable attendant care can be provided by an injured individual's family members. …[D]espite being framed as limitations on what providers can charge … application of the amendments … would substantively reduce the monetary amount … they have been receiving for medical services and care, which is a change in substance, not procedure. *Andary,* 512 Mich at 255 (cleaned up).

Because the 2019 amendment to the one-year-back rule is substantive, and not procedural, Plaintiff is unable to distinguish *Buhl*, 507 Mich at 236, which confirms that the date the cause of action accrued controls, not the filing date. In *Buhl*, an amendment that went into effect after the plaintiff's claim accrued, but before plaintiff filed her complaint, was not applicable.

Buhl calls for application of the four-part test articulated in *LaFontaine Saline, Inc v Chrysler Group, LLC,* 496 Mich 26; 852 NW2d 78 (2014). "First, we consider whether there

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is specific language providing for retroactive application." *Buhl,* 507 Mich at 244. "Second, in some situations, a statute is not regarded as operating retroactively merely because it relates to an antecedent event." *Id.* "Third, in determining retroactivity, we must keep in mind that retroactive laws impair vested rights acquired under existing laws or create new obligations or duties with respect to transactions or considerations already past." *Id.* "Finally, a remedial or procedural act not affecting vested rights may be given retroactive effect where the injury or claim is antecedent to the enactment of the statute." *Id.*

As it relates to § 3145, there is no specific language in the 2019 amendment providing for retroactive application. See *Andary,* 512 Mich at 248. "In the amended version of MCL 500.3145, the Legislature did not include language expressing its clear, direct, and unequivocal intent to apply this statute retroactively." *Cherry,* unpub op at 4 (cleaned up). "Simply put, no explicit or implicit reference to retroactivity exists in either the statute or the amendment." *Mobile MRI,* unpub op at 5 (citation omitted). So the first *LaFontaine* factor does not support Plaintiff's position.

The second *LaFontaine* factor is "irrelevant to this case because the amended version of MCL 500.3145 does not refer to an antecedent event." *Mobile MRI,* unpub op at 6. See also *Buhl,* 507 Mich at 244.

"According to the third *LaFontaine* factor, a statute or amendment may not be applied retroactively if doing so would take away or impair vested rights acquired under existing laws, or create a new obligation and impose a new duty, or attach a new disability with respect to transactions or considerations already past." *Buhl,* 507 Mich at 246 (cleaned up). Here the

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amendment to § 3145 impairs vested rights, albeit of the insurer and the insurance pool[11] rather than the "injured claimant": retroactive application of the new tolling language would, in this case, deprive MemberSelect of a one-year-back defense that was undoubtedly available to it when this provider's claims accrued. Therefore, as to MemberSelect, retroactive application would "create new obligations or duties with respect to transactions or considerations already past." *Buhl,* 507 Mich at 244. Plaintiff seems to be reading *Buhl* to say that statutory defenses *cannot* be provided retroactively – the city in *Buhl* could not gain an open and obvious defense after the plaintiff's injury – but they *can* be taken away retroactively. In other words, Plaintiff argues that a statutory amendment can only help, and never hurt, a claimant. This is not the law. See *Johnson v Pastoriza,* 491 Mich 417, 429-430; 818 NW2d 279 (2012) ("Statutes are presumed to apply prospectively" and this is "especially true when giving a statute retroactive operation will ... create a new liability in connection with a past transaction, *or invalidate a defense which was good when the statute was passed.*") (emphasis added).

As to the fourth factor, retroactive effect "*may* be given" if the "remedial or procedural" amendment does not affect "vested rights…." *Buhl,* 507 Mich at 244 (emphasis added). So, the fourth factor requires two things: that the third *LaFontaine* factor be met (i.e., that there is no impairment of "vested rights") *and* that the amendment be characterized as "remedial or procedural." When the third factor does not favor retroactivity, the Court can end its analysis; whether the amendment is remedial is of no consequence. *Buhl,* 507 Mich at 248 ("Although we disagree with the conclusion that MCL 691.1402a(5) satisfies the third *LaFontaine* factor *and could end our analysis here,* the Court of Appeals' creation of the so-called *Brewer*

[11] "Insurers … [have a] fiduciary duty to others in the insurance pool to not dissipate the pool's insurance fund reserves by paying unwarranted benefits…." *Cruz v State Farm Mut Auto Ins Co,* 466 Mich 588, 596; 648 NW2d 591 (2002).

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restoration rule introduces a new element to the fourth *LaFontaine* factor that merits further review.") (emphasis added).

Turing back to § 3145, the third (and in turn, the fourth) factor does not favor the Plaintiff's position because,

> …applying MCL 500.3145 retroactively would effectively allow plaintiff to rewrite history and would require defendant to go back in time and issue a formal denial of plaintiff's claim at a time when it was not required to do so. … Indeed, plaintiff's interpretation of MCL 500.3145 could have negative public policy effects. In particular, it could incentivize providers to resurrect long-dead claims and use the tolling provision of the amended statute to get a second bite at the apple.

Mobile MRI, unpub op at 7. Therefore, while the amendment might arguably be remedial, this cannot override the first and third *LaFontaine* factors and force a retroactive application that is not indicated in the statute's text, and that impairs vested rights. That was the gist of the "*Brewer* restoration rule"[12] that the Court of Appeals applied in *Buhl,* which this *Court* rejected. See *Buhl*, 507 Mich at 251.[13]

Moreover, all of these factors are meant to supplement – not supersede – general rules of statutory construction. *Id.* at 243-244. "The primary and overriding rule is that legislative intent governs." *Id.* at 243 (cleaned up). "All other rules of construction and operation are subservient to

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[12] See *Brewer v A.D. Transp Express, Inc,* 486 Mich 50; 782 NW2d 475 (2010).

[13] In *Health Partners*, unpub op at 5, the panel *suggested* that "the amendment to MCL 500.3145" could be characterized as remedial, so "remedial nature of the amendment" might arguably give it retroactive effect. What the panel seemed to have in mind here – through its discussion of *Devillers v Auto Club Ins Ass'n,* 473 Mich 562; 702 NW2d 539 (2005) and *Lewis v Detroit Auto Inter-Ins Exch,* 426 Mich 93; 393 NW2d 167 (1986) – was the "*Brewer* restoration rule" **which this Court rejected in *Buhl.*** In other words, the idea behind the *Health Partners* panel's comment presumably was: if the Legislature amended § 3145 as a rejection of *Devillers,* and with the intent to restore *Lewis,* then a legislative intent for retroactive application could be inferred. But that is not the law of this State. Rather, *Buhl* calls for application of the four-part test articulated in *LaFontaine*.

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this principle." *Id.* at 244 (citation omitted). That inquiry begins (and usually ends) "with the plain language of the statute." *Jesperson*, 499 Mich at 34. Plaintiff has not offered any textual support for retroactive application of the 2019 PA 21.

MCL 500.3145(1) is subject to ordinary rules of statutory interpretation. *Joseph,* 491 Mich at 205. "When interpreting statutory language, we begin with the plain language of the statute." *Jesperson*, 499 Mich at 34. "We must give effect to the Legislature's intent, and the best indicator of the Legislature's intent is the words used." *Id.* "[W]hen determining this intent we must give effect to every word, phrase, and clause in a statute and avoid an interpretation that renders nugatory or surplusage any part of a statute." *Id.*

"We must give the words of a statute their plain and ordinary meaning, and only where the statutory language is ambiguous may we look outside the statute to ascertain legislative intent." *People v Holder,* 483 Mich 168, 172; 767 NW2d 423 (2009). Courts may not "rewrite the plain statutory language and substitute [their] own policy decisions for those already made by the Legislature." *DiBenedetto v West Shore Hosp,* 461 Mich 394, 405; 605 NW2d 300 (2000). Courts have "no authority to add words or conditions to [a] statute." *Rowland v Washtenaw Co Rd Comm,* 477 Mich 197, 214 n 10; 731 NW2d 41 (2007).

"[T]he policy behind a statute cannot prevail over what the text actually says. The text must prevail." *Elezovic v Ford Motor Co,* 472 Mich 408, 421-422; 697 NW2d 851 (2005). "The Legislature is held to what it said. It is not for us to rework the statute. Our duty is to interpret the statute as written." *Id.* at 425. The "Legislature is free to make policy choices that, especially in controversial matters, some observers will inevitably think unwise"; any "dispute over the wisdom of a law … cannot give warrant to a court to overrule the people's Legislature." *Id.* (citation

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omitted). Even when "the Legislature's policy choice can be debated," the "judiciary is not the constitutional venue for such a debate." *Id.*

Or, as explained in *Cameron v Auto Club Ins Ass'n,* 476 Mich 55, 64; 718 NW2d 784 (2006), litigants cannot ask "that all the disciplines that judges, lawyers, and even lay people use for giving meaning to documents and distinguishing in a principled fashion between potentially conflicting instruments … be disregarded" so that courts can "raise our eyes from the tedious page, weigh who is the most compelling litigant, and 'effect legislative intent.'" Such arguments beg "the question … of why the words the Legislature used do not do that better than their efforts to find the 'real intent.'" *Id.* "Moreover, with a system of mandatory automobile no-fault insurance … it just may be, because of the economies required to make it work, that the Legislature's 'real intent' was to set up strict rules that can unfortunately, but unavoidably if you want no-fault insurance, produce some sad outcomes." *Id.*[14]

The text of § 3145 actually "contains two limitations on the time for filing suit and one limitation on the period for which benefits may be recovered." *Joseph,* 491 Mich at 207. "(1) An action for personal protection insurance [PIP] benefits must be commenced not later than one year after the date of accident, unless the insured gives written notice of injury or the insurer previously paid [PIP] benefits for the injury." *Joseph,* 491 Mich at 207. "(2) If notice has been given or payment has been made, the action may be commenced at any time within one year after the most recent loss was incurred." *Joseph,* 491 Mich at 207. "(3) Recovery is limited to losses incurred during the one year preceding commencement of the action." *Id.*

Put more succinctly, § 3145 "does two things. First, it provides that an action to collect PIP [personal injury protection] benefits must be commenced within one year after the date of the

[14] While *Cameron* was overruled by *Univ of Mich Regents v Titan Ins Co,* 488 Mich 893; 794 NW2d 570 (2010), it was expressly reinstated by *Joseph,* 491 Mich at 221.

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accident. … Second, it provides that a claimant may not recover benefits for losses incurred more than one year before the date the action was commenced." *Cameron,* 476 Mich at 92 (Cavanagh, J., dissenting). "The purpose of the one-year period of limitations is to encourage claimants or persons acting on their behalf to bring their claims to court while those claims are still fresh." *Id.* (citations omitted).

Under these principles, the Court of Appeals correctly determined that Plaintiff's claims for services performed prior in April and May of 2019 fail, under the version of the statute that was in effect when the accident occurred and when those expenses were incurred. Plaintiff's argument, with respect to those bills, rested entirely upon the post-June 11, 2019 version of the statute. Plaintiff argues that the amendment applies because it filed suit after the effective date. But this Court's reasoning in *Buhl*, 507 Mich at 240 confirms that it is the accrual date, not the filing date, that controls.

In *Buhl,* the "specific question before" this Court was "whether a GTLA[15] amendment that went into effect after plaintiff's claim accrued but before plaintiff filed her complaint can be retroactively applied." *Id.* The Court held "that the amended provision does not apply retroactively." *Id.* Rather, it could "only be applied to causes of action that accrued after the effective date of the amendment." *Id.* at 243. In so holding, the Court noted that the "amendment was given immediate effect without further elaboration" and made "no mention of whether it applies to a cause of action that had already accrued before its effective date." *Id.* at 245. The same is true of the 2019 amendment to § 3145. See *Andary,* 512 Mich at 248.

The Court in *Buhl* further noted that "because plaintiff's claim had already accrued … retroactive application of [the amendment] would effectively rewrite history as to the duty

[15] Governmental Tort Liability Act, MCL 691.1401 *et seq.*

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defendant owed plaintiff…." *Id.* at 246-247. An amendment generally cannot "create new obligations, impose new duties, or attach new disabilities with respect to transactions or considerations already past." *Id.* at 247 (citation omitted). This part of the *Buhl* majority opinion is also directly relevant here; before June 11, 2019, a no-fault carrier's ability to invoke the protection of the one-year-back rule was not in any way predicated on when "the insurer formally denie[d] the claim…," as it is under the current MCL 500.3145(3). Nor was there, prior to June 11, 2019, any exception to the one-year-back rule for "reasonable diligence." *Id*. See also *Devillers,* 473 Mich at 579.[16] The tolling and "reasonable diligence" language of the 2019 amendment created "new substantive dut[ies]" and "new substantive right[s] that did not previously exist," and therefore "should not be retroactively applied…." *Buhl*, 507 Mich at 247 (citation omitted).

Moreover, any argument for retroactivity is weakened by the fact that, if Plaintiff's position were accepted, it would mean that the June 11, 2019 amendment breathed new life into bills that had been uncollectable for months when the new version of § 3145 took effect. "[A] limitations period cannot be construed retroactively to resurrect stale claims absent a clear statutory expression of … intent…." *Acosta v Trans Union, LLC*, 243 FRD 377, 387 (CD Cal, 2007). This is consistent with Michigan precedent, discussed above, holding that an amended statute generally "applies prospectively unless the Legislature has expressly or impliedly indicated its intention to give it retrospective effect." *Aztec Air Serv, Inc v Dept of Treasury,* 253 Mich App 227, 233; 654 NW2d 925 (2002). Again, this is "especially true when giving a statute retroactive operation will ... create a new liability in connection with a past transaction, *or invalidate a defense which was good when*

[16] In *Devillers,* 473 Mich at 564, the Court overruled case law that had allowed § 3145(1)'s "one-year statutory period" to be "tolled from the time a specific claim for benefits is filed to the date the insurer formally denies liability." In so holding, the Court noted that when prior case law made this tolling subject to a "reasonable diligence" exception, it "demonstrate[d] the fact that this Court ha[d] engaged in judicial legislation." *Id.* at 579 (citation omitted).

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the statute was passed." Johnson, 491 Mich at 429-430 (emphasis added).

Indeed, applying the amendment to resurrect stale claims would directly contradict the purpose of the one-year-back rule. Again, "[t]he purpose of the one-year period of limitations is to encourage claimants or persons acting on their behalf to bring their claims to court while those claims are still fresh." *Cameron,* 476 Mich at 92 (Cavanagh, J., dissenting). The fact pattern of *Health Partners* particularly illustrates the problem: under Plaintiff's proposed application of the amendment, if the *Health Partners* plaintiff had filed suit on March 11, 2019 (a year *earlier* than it actually did), it is undisputed that any claim for bills incurred between December 30, 2017 and March 10, 2018 would have been barred. But by waiting *an additional year* – until after the amendment took effect – those bills would be (if Plaintiff's position is accepted) back in play. This would reward claimants who delayed bringing their claims, rather than encouraging them to bring them while they are still fresh.

Plaintiff argues that the amendment to § 3145 "is no more than a procedural rule that tolls the one year back rule when no formal denial has been issued, effectively reinstating" *Lewis,* 426 Mich at 93. (Plaintiff's Supplemental Brief, pp 1-2.) But when *Lewis* was good law, federal courts applied it in diversity. *Norfolk & W Ry Co v Auto Club Ins Ass'n,* 894 F2d 838, 843 (CA 6, 1990); *Bomis v Metro Life Ins Co,* 970 F Supp 584, 588 (ED Mich, 1997); *Roberson v Metropolitan Life Ins Co,* 682 F Supp 907 (ED Mich, 1988). Federal courts sitting in diversity jurisdiction "are to apply state substantive law and federal procedural law." *Hanna v Plumer,* 380 US 460, 465; 85 S Ct 1136 (1965). The fact that judicial tolling under *Lewis* was applied in federal court confirms that is substantive rule of law. Indeed, since June 11, 2019 federal courts have assumed, without deciding, that § 3145(3) is a substantive rule of law that controls in diversity cases. *Allstate Ins Co v Performance Orthopedics of Michigan PLLC*, 2023 WL 6205425, at *12 (ED Mich, September

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21, 2023) (Ex. E); *Spann v Empire Fire & Marine Ins Co*, 2023 WL 5001447, at *14 (ED Mich, August 4, 2023) (Ex. F); *Moore v Auto Club Servs*, 2020 WL 2836326, at *4–5 (ED Mich, May 31, 2020) (Ex. G).

CONCLUSION AND REQUEST FOR RELIEF

"A statute presumptively has no retroactive application...." *Bd of Trustees of City of Pontiac Police v City of Pontiac*, 502 Mich 868; 912 NW2d 195, 198 (2018) (Zahra, J., dissenting). "As a general, almost invariable rule, a legislature makes law for the future, not for the past." *Id.* "A fundamental principle of jurisprudence holds that retroactive application of new law is usually unfair." *Id.* at 199 n 3.

Simply put, the Court of Appeals applied the correct version of the statute, as has every other Court of Appeals panel that has addressed the issue (the *Encompass Healthcare* panel did not consider the issue and therefore could not make precedent on this point[17]). This is because the statute in effect at the time a cause of action accrues governs that claim. See *Buhl*, 507 Mich at 240, 251.[18] For claims that had accrued[19] before 2019 PA 21 and 2019 PA 22 took effect, Plaintiff cannot invoke tolling or the "reasonable diligence" exception to the one-year-back rule for a very simple reason: Progressive was under no duty to "formally deny the claim" prior to June 11, 2019. Any result other than the one reached by the Court of Appeals in this case (and in *Reid, Health*

[17] See *Quinton,* 453 Mich at 74 (opinion by Levin, J).

[18] See also *Hill v GMAC,* 207 Mich App 504, 513-514; 525 NW2d 905 (1994) ("Michigan courts have followed the general rule that the relevant inquiry in determining the applicability of a statute is the date on which the cause of action arose."); *City of Marysville v Pate, Hirn & Bogue, Inc,* 196 Mich App 32, 36–37; 492 NW2d 481 (1992) ("[b]cause plaintiff's cause of action accrued before the amendment … the old" statute controlled).

[19] A no-fault provider's cause of action accrues when the services are provided, rather than the accident date. See *Executive Ambulatory Surgical Ctr, LLC v State Farm Mut Auto Ins Co*, 442 F Supp 3d 998, 1008–1009 (ED Mich, 2020) ("PIP benefits are 'payable' as loss 'accrues' and benefits payable accrue not when the injury occurs but as the allowable expense, work loss or survivor's loss is incurred.") (cleaned up).

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Partners, *Cherry,* and *Mobile MRI*) would give claimants the opportunity to resurrect stale claims. For these reasons, IAM respectfully asks this Court to deny leave or alternatively, affirm on a peremptory basis.

SECREST WARDLE

BY: **/s/Drew W. Broaddus**

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CERTIFICATE OF COMPLIANCE

I certify that this Brief contains 4,272 words. The word processing software that was used to generate the word count is Microsoft Word 365.

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EXHIBIT A

If this opinion indicates that it is "FOR PUBLICATION," it is subject to revision until final publication in the Michigan Appeals Reports.

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STATE OF MICHIGAN

COURT OF APPEALS

KRYSTYNA REID,

Plaintiff-Appellee,

v

PROGRESSIVE MICHIGAN INSURANCE COMPANY,

Defendant-Appellant.

UNPUBLISHED
March 9, 2023

No. 359412
Wayne Circuit Court
LC No. 20-014553-NF

Before: RICK, P.J., and M. J. KELLY and RIORDAN, JJ.

PER CURIAM.

Defendant appeals by leave granted[1] the order denying its motion for partial summary disposition of plaintiff's claims for personal protection insurance (PIP) benefits involving attendant care and replacement services under the no-fault act, MCL 500.3101 *et seq*. On appeal, defendant argues that the trial court erred by denying its motion for partial summary disposition because plaintiff's claims for attendant care and replacement services are barred by the one-year-back rule. Specifically, defendant argues that the preamendment version of MCL 500.3145 applies to this case because the accident occurred before the statute was amended.[2] Alternatively, defendant argues that plaintiff failed to pursue her claims for attendant care and replacement services with reasonable diligence. We reverse the trial court's order and remand to that court for further proceedings.

I. BACKGROUND

On May 24, 2019, plaintiff was injured in an automobile accident and had a no-fault insurance policy with defendant. Plaintiff incurred medical expenses, including for alleged receipt of attendant care and replacement services, as a result of the accident. Plaintiff sought payment

[1] *Reid v Progressive Mich Ins Co*, unpublished order of the Court of Appeals, entered March 17, 2022 (Docket No. 359412).

[2] The statute was amended effective June 11, 2019. See 2019 PA 21.

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from defendant for these PIP benefits. Defendant refused to pay plaintiff, and plaintiff filed this action on November 4, 2020.

Defendant moved for partial summary disposition of plaintiff's claims for benefits that were incurred before November 4, 2019, under MCR 2.116(C)(10) (no genuine issue of material fact), on the basis that some of her claims for benefits were barred by the one-year-back rule. Defendant argued: (1) the preamendment version of MCL 500.3145 generally controls plaintiff's claims for PIP benefits, and (2) there is no genuine issue of material fact that plaintiff is barred from recovering any PIP benefits incurred before November 4, 2019, under the preamendment version of MCL 500.3145. The trial court denied defendant's motion for partial summary disposition. Specifically, the trial court concluded that the amended version of MCL 500.3145 controls plaintiff's claims because plaintiff filed her complaint after the effective date of the amendment, and therefore, the tolling provision of MCL 500.3145(3) applies. This appeal followed.

II. STANDARDS OF REVIEW

This Court "review[s] de novo the interpretation and application of a statute as a question of law. If the language of a statute is clear, no further analysis is necessary or allowed." *Eggleston v Bio-Medical Applications of Detroit, Inc*, 468 Mich 29, 32; 658 NW2d 139 (2003). We also "review de novo a circuit court's decision on a motion for summary disposition." *Bonner v City of Brighton*, 495 Mich 209, 220; 848 NW2d 380 (2014). "In deciding whether to grant a motion for summary disposition pursuant to MCR 2.116(C)(10), a court must consider '[t]he affidavits, together with the pleadings, depositions, admissions, and documentary evidence then filed in the action or submitted by the parties' in the light most favorable to the nonmoving party." *Id*. at 220-221 (citation omitted). "Where the proffered evidence fails to establish a genuine issue regarding any material fact, the moving party is entitled to judgment as a matter of law." *Maiden v Rozwood*, 461 Mich 109, 120; 597 NW2d 817 (1999). A genuine issue of material fact exists "when reasonable minds can differ on an issue after viewing the record in the light most favorable to the nonmoving party." *Allison v AEW Capital Mgt, LLP*, 481 Mich 419, 425; 751 NW2d 8 (2008).

III. ANALYSIS

At the outset, there are essentially two issues we must resolve. First, whether the preamendment version of MCL 500.3145, see 2019 PA 21, applies to some or all plaintiff's claims for attendant care and replacement services. Second, to the extent that the current version of MCL 500.3145 applies to some or all of plaintiff's claims in that regard, whether there is a question of fact as to the applicability of the tolling provision in MCL 500.3145(3) to those claims.

Before the 2019 amendments, MCL 500.3145 stated, in relevant part:

> (1) An action for recovery of personal protection insurance benefits payable under this chapter for accidental bodily injury may not be commenced later than 1 year after the date of the accident causing the injury unless written notice of injury as provided herein has been given to the insurer within 1 year after the accident or unless the insurer has previously made a payment of personal protection insurance benefits for the injury. If the notice has been given or a payment has been made,

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> the action may be commenced at any time within 1 year after the most recent allowable expense, work loss or survivor's loss has been incurred. *However, the claimant may not recover benefits for any portion of the loss incurred more than 1 year before the date on which the action was commenced*. . . .
>
> (2) An action for recovery of property protection insurance benefits shall not be commenced later than 1 year after the accident. [Emphasis added.]

The italicized sentence of MCL 500.3145(1) is commonly referred to as the "one-year-back rule." See *Joseph v Auto Club Ins Ass'n*, 491 Mich 200, 208; 815 NW2d 412 (2012). It "is designed to limit the amount of benefits recoverable under the no-fault act to those losses occurring no more than one year before an action is brought." *Id*. at 203.

"Until 2005, Michigan courts interpreted the one-year-back rule to incorporate a judicially created tolling provision that remained in effect until a no-fault claim was formally denied by the insurer." *Encompass Healthcare, PLLC v Citizens Ins Co*, ___ Mich App ___; ___ NW2d ___ (2022) (Docket No. 357225); slip op at 5. See also *Lewis v Detroit Auto Inter-Ins Exch*, 426 Mich 93, 101; 393 NW2d 167 (1986), overruled by *Devillers v Auto Club Ins Ass'n*, 473 Mich 562; 702 NW2d 539 (2005) (concluding that the one-year-back rule of MCL 500.3145 is tolled from the date of a specific claim for benefits to the date of a formal denial of liability). Our Supreme Court's decision in *Devillers* discarded judicial tolling and held the one-year-back rule of MCL 500.3145(1) must be enforced as written, without a judicially created tolling provision. *Devillers*, 473 Mich at 586.

After the 2019 amendments, MCL 500.3145 states, in relevant part:

> (1) An action for recovery of personal protection insurance benefits payable under this chapter for an accidental bodily injury may not be commenced later than 1 year after the date of the accident that caused the injury unless written notice of injury as provided in subsection (4) has been given to the insurer within 1 year after the accident or unless the insurer has previously made a payment of personal protection insurance benefits for the injury.
>
> (2) Subject to subsection (3), if the notice has been given or a payment has been made, the action may be commenced at any time within 1 year after the most recent allowable expense, work loss, or survivor's loss has been incurred. However, the claimant may not recover benefits for any portion of the loss incurred more than 1 year before the date on which the action was commenced.
>
> (3) A period of limitations applicable under subsection (2) to the commencement of an action and the recovery of benefits is tolled from the date of a specific claim for payment of the benefits until the date the insurer formally denies the claim. This subsection does not apply if the person claiming the benefits fails to pursue the claim with reasonable diligence. [See 2019 PA 21.]

After 2019 PA 21 was enacted, this Court in *Encompass Healthcare, PLLC*, concluded that "these amendments to MCL 500.3145, particularly the addition of Subsection (3), act to supersede

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our Supreme Court's ruling in *Devillers* and return the state of law to that provided in *Lewis* and its progeny." *Encompass Healthcare, PLLC*, ___ Mich App at ___; slip op at 6-7.

In this case, the claims in dispute relate to alleged attendant care and replacement services provided to plaintiff after her accident on May 24, 2019. Defendant argues the preamendment version of MCL 500.3145 applies to all of plaintiff's claims because the accident from which these services arose occurred before the effective date of the no-fault amendments. However, "Michigan courts have followed the general rule that the relevant inquiry in determining the applicability of a statute is the date on which the cause of action arose." *Hill v Gen Motors Acceptance Corp*, 207 Mich App 504, 513-514; 525 NW2d 905 (1994). Under MCL 500.3110(4), "[p]ersonal protection insurance benefits payable for accidental bodily injury accrue not when the injury occurs but as the allowable expense, work loss or survivors' loss is incurred." Relatedly, "[a]n expense is incurred or a patient becomes liable when an agreement to pay is executed *and* treatment is received." *Bronson Health Care Group, Inc v USAA Cas Ins Co*, 335 Mich App 25, 35-36; 966 NW2d 393 (2020). Therefore, plaintiff's loss was incurred when she received attendant care and replacement services, and the claims for those services accrued at that time. The preamendment version of MCL 500.3145 applies to plaintiff's claims for attendant care and replacement services accruing before June 11, 2019, because the amendments became effective on that date. The trial court erred to the extent that it concluded otherwise. Plaintiff's claims accruing on or after June 11, 2019, are governed by the current version of MCL 500.3145, and are subject to the tolling provision in MCL 500.3145(3), if she made a specific claim for these services to defendant.

Accordingly, plaintiff's claims for attendant care and replacement services accruing before June 11, 2019, are barred by the one-year-back rule of the preamendment version of MCL 500.3145(1).

The next issue is whether there is a question of fact as to the applicability of the tolling provision in MCL 500.3145(3) to plaintiff's claims for attendant care and replacement services accruing on or after June 11, 2019. Defendant asserted that it never received a claim from plaintiff for attendant care and replacement services until after plaintiff filed her complaint on November 4, 2020. For her part, plaintiff failed to come forward with evidence showing submission of specific claims for payment of these benefits at any time before the complaint was filed. Instead, plaintiff speculates that she may have generally advised or indicated to defendant she needed attendant care and replacement services.

However, plaintiff's speculative or implied need for services is not the equivalent of notice of actual services rendered. In particular, MCL 500.3145(3) permits tolling "from the date of a *specific claim* for payment of the benefits until the date the insurer formally denies the claim." (Emphasis added.) In this instance, there is no evidence plaintiff submitted "a specific claim" as required by the statutory language. Use of the word "specific" indicates, in accordance with its common definition, being "precise, or particular" or "explicit or definite." *Random House Webster's College Dictionary* (2005). As such, plaintiff's mere implication that a particular type of service may be required or necessary, without proof of actual, documented evidence of the provision and receipt of such services is inadequate.

In other words, plaintiff was required to come forward with facts showing that there is a genuine issue as to whether she submitted her specific claims for replacement services and

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attendant care benefits to defendant during the relevant time period. "*Any* insured who incurs charges for services must present proof of those charges in order to establish, by a preponderance of evidence, that he is entitled to PIP benefits." *Douglas v Allstate Ins Co*, 492 Mich 241, 269; 821 NW2d 472 (2012). "This evidentiary requirement is most easily satisfied when an insured or a caregiver submits itemized statements, bills, contracts, or logs listing the nature of services provided with sufficient detail for the insurer to determine whether they are compensable." *Id*. Testimony may also satisfy this evidentiary requirement, provided the testimony allows a fact-finder to conclude that services were rendered. *Id*. at 270. However, "a claimant's failure to request reimbursement for allowable expenses in a timely fashion runs the risk that the one-year-back rule will limit the claimant's entitlement to benefits[.]" *Id*.

Based on the lower court record, it does not appear that plaintiff provided any evidence she made specific claims for payment of expenses actually incurred for attendant care and replacement services until after the filing of her complaint. Significantly, plaintiff does not dispute that she did not submit such claims to defendant before filing suit. Since plaintiff did not timely submit claims for attendant care and replacement services to defendant, there is nothing to toll under MCL 500.3145(3). Despite the availability of MCL 500.3145(3), plaintiff remains restricted by the one-year-back rule in regards to reimbursement. Ultimately, the tolling provision of MCL 500.3145(3) does not apply, and plaintiff cannot recover for attendant care or replacement services rendered between June 11, 2019, and November 3, 2019. See MCL 500.3145(2). As such, the trial court erred in denying defendant's motion for partial summary disposition.[3]

IV. CONCLUSION

The one-year-back rule bars plaintiff's claims for attendant care and replacement services that accrued before November 4, 2019, one year before plaintiff filed her complaint. Specifically, the preamendment version of MCL 500.3145(1) bars her claims that accrued before June 11, 2019, and the current version of that statute bars her claims that accrued between June 11, 2019, and November 3, 2019.

We reverse the trial court's denial of defendant's motion for partial summary disposition and remand to that court for further proceedings consistent with this opinion. We do not retain jurisdiction.

/s/ Michelle M. Rick
/s/ Michael J. Kelly
/s/ Michael J. Riordan

[3] On the basis of this ruling, we need not address defendant's unpreserved argument pertaining to whether plaintiff pursued her claims with "reasonable diligence."

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EXHIBIT B

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STATE OF MICHIGAN

COURT OF APPEALS

CHRISTOPHER LEE CHERRY,

Plaintiff-Appellant,

v

PROGRESSIVE MARATHON INSURANCE COMPANY,

Defendant-Appellee.

UNPUBLISHED
June 16, 2022

No. 357722
Wayne Circuit Court
LC No. 20-007437-NF

Before: LETICA, P.J., and K. F. KELLY and RIORDAN, JJ.

PER CURIAM.

In this case arising under the no-fault act, MCL 500.3101 *et seq*., plaintiff appeals as of right the order granting summary disposition under MCR 2.116(C)(7) and (10) to defendant, Progressive Marathon Insurance Company. We affirm.

I. BASIC FACTS AND PROCEDURAL HISTORY

Plaintiff was injured in an automobile accident on January 29, 2014. At the time of the accident, plaintiff's wife had an insurance policy with defendant. Plaintiff sought coverage from defendant for personal injury protection (PIP) benefits but the claim was denied. Specifically, defendant claimed that "material misrepresentations" were made at the time of the application for insurance. Ultimately, on July 13, 2016, plaintiff and defendant entered into a settlement agreement in which defendant paid plaintiff a sum of money in exchange for a release.[1]

Between April 4, 2017, and April 24, 2018, plaintiff received treatment from Dr. Lucia J. Zamorano for injuries allegedly related to the accident. Dr. Zamorano submitted invoices to defendant for her treatment of plaintiff. In response, defendant sent Dr. Zamorano a number of

[1] The parties do not submit that the terms of the release have any application to this appeal, and therefore, we do not address it.

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"explanation of benefits" letters ("EOBs") indicating the coverage amount was "$0.00." These EOBs also stated: "We have completed our investigation, which reveals that the policy was not in force for the above referenced accident. Therefore, payment for this service is denied."[2]

On June 12, 2020, plaintiff filed this litigation, claiming defendant breached its statutory duty to provide plaintiff with PIP coverage for his accident-related injuries. Defendant moved for summary disposition, contending plaintiff's suit was untimely under the preamendment and postamendment versions of MCL 500.3145 of the no-fault act. In response, plaintiff submitted that he never received a "formal denial" of the claim; accordingly, the claim was timely under the tolling provision of the postamendment version of the no-fault act. The trial court granted summary disposition, concluding that the EOBs constituted a formal denial, and therefore, plaintiff's suit was untimely because the tolling provision did not apply. The trial court also denied plaintiff's motion for reconsideration. This appeal followed.

II. STANDARDS OF REVIEW

A trial court's ruling on a motion for summary disposition is reviewed de novo. *Houston v Mint Group, LLC*, 335 Mich App 545, 557; 968 NW2d 9 (2021). Summary disposition is appropriate pursuant to MCR 2.116(C)(10) where there is "no genuine issue as to any material fact, and the moving party is entitled to judgment or partial judgment as a matter of law." MCR 2.116(C)(10).[3] When reviewing a motion for summary disposition challenged under MCR 2.116(C)(10), the court considers the affidavits, pleadings, depositions, admissions, and other admissible documentary evidence then filed in the action or submitted by the parties in the light most favorable to the nonmoving party. MCR 2.116(G)(4), (G)(5); *Buhl v City of Oak Park*, 507 Mich 236, 242; 968 NW2d 348 (2021). We review the trial court's decision on a motion for reconsideration for an abuse of discretion. *St John Macomb Oakland Hosp v State Farm Mut Auto Ins Co*, 318 Mich App 256, 261; 896 NW2d 85 (2016). The trial court abuses its discretion when its decision falls outside the range of reasonable and principled outcomes. *Id*.

Issues involving statutory interpretation present questions of law that are reviewed de novo. *Le Gassick v Univ of Mich Regents*, 330 Mich App 487, 495; 948 NW2d 452 (2019).

> The primary goal of statutory interpretation is to give effect to the intent of the Legislature. The most reliable evidence of legislative intent is the plain language of the statute. If the language of the statute is clear and unambiguous, it is presumed that the Legislature intended the meaning plainly expressed in the statute. The court's interpretation of a statute must give effect to every word, phrase, and clause. Further, an interpretation that would render any part of the statute surplusage or

[2] Specifically, the EOBs identified the explanation code "6676," and on page two of the EOBs, the text of the explanation code advised that the policy was no longer in effect, and therefore, the payment was denied.

[3] Because the parties presented and the trial court considered documentary evidence outside the pleadings, we treat the motion as having been granted under MCR 2.116(C)(10). See *Mino v Clio Sch Dist*, 255 Mich App 60, 63 n 2; 661 NW2d 586 (2000).

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> nugatory must be avoided. Common words and phrases are given their plain meaning as determined by the context in which the words are used, and a dictionary may be consulted to ascertain the meaning of an undefined word or phrase. In construing a legislative enactment we are not at liberty to choose a construction that implements any rational purpose but, rather, must choose the construction which implements the legislative purpose perceived from the language and the context in which it is used. [*Id*. at 495-496 (citations and quotations omitted).]

"Statutes are presumed to apply prospectively unless the Legislature clearly manifests the intent for retroactive application." *Buhl*, 507 Mich at 244; see also *George v Allstate Ins Co*, 329 Mich App 448, 451 n 3; 942 NW2d 628 (2019).

> Indeed, statutes and amended statutes are to be applied prospectively unless the Legislature manifests an intent to the contrary . . . . The Legislature's expression of an intent to have a statute apply retroactively must be clear, direct, and unequivocal as appears from the context of the statute itself. [*Davis v State Employees' Retirement Bd*, 272 Mich App 151, 155-156; 725 NW2d 56 (2006) (citations omitted).]

III. ANALYSIS

Plaintiff contends the trial court erred in granting defendant's motion for summary disposition because the trial court misinterpreted MCL 500.3145(3) of the postamendment version of the no-fault act, which includes a tolling provision. Specifically, he submits that the trial court failed to apply the tolling provision of MCL 500.3145(3), 2019 PA 21, which became effective on June 11, 2019, before plaintiff filed his complaint on June 12, 2020. We disagree. Because MCL 500.3145(3) contains no clear language indicating an intent to apply the amendment retroactively, plaintiff's challenge is without merit.

As noted, effective June 11, 2019, MCL 500.3145 was amended to state:

> (1) An action for recovery of personal protection insurance benefits payable under this chapter for an accidental bodily injury may not be commenced later than 1 year after the date of the accident that caused the injury unless written notice of injury as provided in subsection (4) has been given to the insurer within 1 year after the accident or unless the insurer has previously made a payment of personal protection insurance benefits for the injury.
>
> (2) Subject to subsection (3), if the notice has been given or a payment has been made, the action may be commenced at any time within 1 year after the most recent allowable expense, work loss, or survivor's loss has been incurred. However, the claimant may not recover benefits for any portion of the loss incurred more than 1 year before the date on which the action was commenced.
>
> (3) A period of limitations applicable under subsection (2) to the commencement of an action and the recovery of benefits is tolled from the date of a specific claim for payment of the benefits until the date the insurer formally denies

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> the claim. This subsection does not apply if the person claiming the benefits fails to pursue the claim with reasonable diligence.[4]
>
> (4) The notice of injury required by subsection (1) may be given to the insurer or any of its authorized agents by a person claiming to be entitled to benefits for the injury, or by someone in the person's behalf. The notice must give the name and address of the claimant and indicate in ordinary language the name of the person injured and the time, place, and nature of the person's injury.
>
> (5) An action for recovery of property protection insurance benefits may not be commenced later than 1 year after the accident.

In the amended version of MCL 500.3145, the Legislature did not include language expressing its "clear, direct, and unequivocal" intent to apply this statute retroactively. *Davis*, 272 Mich App at 156. Accordingly, the preamendment version of the no-fault act applies to the issues in this case. *Id*.[5]

The preamendment version of MCL 500.3145(1) did not contain a tolling provision and provided in pertinent part:

> (1) An action for recovery of personal protection insurance benefits payable under this chapter for accidental bodily injury may not be commenced later than 1 year after the date of the accident causing the injury unless written notice of injury as provided herein has been given to the insurer within 1 year after the accident or unless the insurer has previously made a payment of personal protection insurance benefits for the injury. If the notice has been given or a payment has been made, the action may be commenced at any time within 1 year after the most recent allowable expense, work loss or survivor's loss has been incurred. However, the

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[4] Plaintiff also submitted that the EOBs did not constitute a formal denial because they merely provided that the paid amount was "$0.00" and they were not addressed to plaintiff. However, the EOBs referenced the denial code of "6676" which reflected that an investigation occurred, it revealed that no policy was in force for the accident, and therefore, payment for the service was denied. The plain language of the statute does not require that the denial of the claim be sent to both the claimant and the insured. *Le Gassick*, 330 Mich App at 495-496. Plaintiff's submission of an affidavit that he did not receive a denial of his doctor's claim does not save his cause of action. The duty to interpret and apply the law applies to the courts, not the witnesses. See *Hottmann v Hottmann*, 226 Mich App 171, 179-180; 572 NW2d 259 (1997).

[5] Although not expressly stated, the trial court implied that it construed the postamendment version of MCL 500.3145 by stating that "no tolling" of the claims made to defendant occurred. Nonetheless, this Court will affirm an order where the trial court reaches the correct result, even for the wrong reason. See *Varela v Spanski*, 329 Mich App 58, 81; 941 NW2d 60 (2019).

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> claimant may not recover benefits for any portion of the loss incurred more than 1 year before the date on which the action was commenced.

In moving for summary disposition, defendant asserted that plaintiff failed to show the action "commenced at any time within 1 year after the most recent allowable expense . . . has been incurred." To substantiate this argument, defendant presented the EOBs showing plaintiff's most recent expense occurred on January 11, 2018.[6] Thus, under the plain language of MCL 500.3145(1), plaintiff should have brought suit by January 11, 2019, one year from the most recent expense. Because plaintiff filed suit on June 12, 2020, the claim was untimely under the statute.

Affirmed.

/s/ Anica Letica
/s/ Kirsten Frank Kelly
/s/ Michael J. Riordan

[6] Plaintiff did not present documentary evidence of later services provided to place services within the coverage period set forth in the preamendment version of MCL 500.3145(1).

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EXHIBIT C

If this opinion indicates that it is "FOR PUBLICATION," it is subject to revision until final publication in the Michigan Appeals Reports.

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STATE OF MICHIGAN

COURT OF APPEALS

MOBILE MRI STAFFING LLC, doing business as METRO MRI CENTER,

Plaintiff-Appellee,

v

MEEMIC INSURANCE COMPANY,

Defendant-Appellant.

UNPUBLISHED
January 20, 2022

No. 355162
Washtenaw Circuit Court
LC No. 20-000783-AV

Before: SAWYER, P.J., and SERVITTO and RICK, JJ.

PER CURIAM.

Defendant appeals by leave granted[1] the circuit court order denying defendant's application for leave to appeal the denial of its motion for summary disposition in the district court, because there was no "need for appellate review." We reverse.

I. FACTUAL BACKGROUND

On July 11, 2018, Sherita Minor was involved in a motor vehicle accident. Minor had no-fault insurance through defendant. On July 28, 2018, plaintiff took three magnetic resonance imaging (MRI) scans of Minor's back and charged $5,000 for each MRI. The parties do not dispute that Minor assigned her rights to pursue and collect benefits for the MRIs to plaintiff. On April 3, 2019, defendant paid $1,300 per MRI to plaintiff. On November 13, 2019, plaintiff filed a complaint against defendant in the 15th District Court seeking personal protection insurance (PIP) benefits of the full amount billed for the three MRIs. Defendant moved in the district court for summary disposition under MCR 2.116(C)(8) on June 3, 2020, arguing plaintiff's complaint, which was filed more than one year after the MRI expenses were incurred, violated the one-year-

[1] *Mobile MRI Staffing, LLC v Meemic Ins Co*, unpublished order of the Court of Appeals, entered January 27, 2021 (Docket No. 355162), p 1.

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back rule,[2] MCL 500.3145(1). A hearing was held in the district court on July 24, 2020. The district court denied summary disposition to defendant. Defendant applied for leave to appeal the July 24, 2020 order to the circuit court, which the circuit court denied because it was not persuaded that appellate review was warranted. This appeal followed.

II. STANDARD OF REVIEW

In Michigan, a party may move the court for summary disposition in their favor. MCR 2.116(B)(1). Such a motion must be supported by depositions, admissions, or other documentary evidence. MCR 2.116(G)(3), (4).

We review de novo a trial court's decision to grant or deny summary disposition. *Varela v Spanski*, 329 Mich App 58, 68; 941 NW2d 60 (2019). The de novo standard of review means that we review the issues independently, without deference to the trial court's decision. *Washington v Washington*, 283 Mich App 667, 671; 770 NW2d 908 (2009), citing *In re Contempt of Auto Club Ins Ass'n*, 243 Mich App 697, 714 n 33; 624 NW2d 443 (2000). A reviewing court must accept all well-pleaded factual allegations as true and consider the evidence in the light most favorable to the nonmoving party. *Dalley v Dykema Gossett, PLLC*, 287 Mich App 296, 304-305; 788 NW2d 679 (2010).

The district court denied defendant's motion for summary disposition under MCR 2.116(C)(8),[3] which allows a party to move for dismissal of an action where "[t]he opposing party has failed to state a claim on which relief can be granted." "A motion under MCR 2.116(C)(8) tests the *legal sufficiency* of a claim based on the factual allegations in the complaint." *El-Khalil v Oakwood Healthcare, Inc*, 504 Mich 152, 159- 160; 934 NW2d 665 (2019), citing *Feyz v Mercy Mem Hosp*, 475 Mich 663, 672; 719 NW2d 1 (2006). "When considering such a motion, a trial court must accept all factual allegations as true, deciding the motion on the pleadings alone." *El-Khalil*, 504 Mich at 160, citing *Bailey v Schaaf*, 494 Mich 595, 603; 835 NW2d 413 (2013); see also *Maiden v Rozwood*, 461 Mich 109, 119; 597 NW2d 817 (1999). However, "the mere statement of a pleader's conclusions, unsupported by allegations of fact, will not suffice to state a cause of action." *ETT Ambulance Serv Corp v Rockford Ambulance*, 204 Mich App 392, 395; 516 NW2d 498 (1994). "Summary disposition on the basis of [MCR 2.116](C)(8) should be granted only when the claim is so clearly unenforceable as a matter of law that no factual development

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[2] The one-year-back rule states that a plaintiff must provide notice to his or her insurer within one year of the accident if he or she wants to maintain a claim for PIP benefits. *Joseph v Auto Club Ins Ass'n*, 491 Mich 200, 203; 815 NW2d 412 (2012).

[3] Defendant argues in its brief on appeal that the district court's review of defendant's motion for summary disposition occurred under MCR 2.116(C)(10) rather than MCR 2.116(C)(8) because additional documents presented with plaintiff's response to defendant's motion for summary disposition appear to have been considered by the district court. This argument is incorrect because defendant's motion for summary disposition was filed under MCR 2.116(C)(8), and the district court's decision was based on the legal insufficiency of defendant's arguments, which falls directly within the purview of MCR 2.116(C)(8).

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could possibly justify a right of recovery." *Bedford v Witte*, 318 Mich App 60, 64; 896 NW2d 69 (2016), citing *Dalley*, 287 Mich App at 305; see also *Maiden*, 461 Mich at 119.

We also review de novo questions of statutory interpretation, including whether a statute applies retroactively. *Johnson v Pastoriza*, 491 Mich 417, 428-429; 818 NW2d 279 (2012); *In re Estate of Moukalled*, 269 Mich App 708, 713; 714 NW2d 400 (2006), citing *Roan v Murray*, 219 Mich App 562, 565; 556 NW2d 893 (1996). The de novo standard of review applies to our interpretation of both Michigan statutes and the Michigan Rules of Court. *State Farm Fire & Casualty Co v Corby Energy Servs, Inc*, 271 Mich App 480, 483; 722 NW2d 906 (2006); *Webb v Holzheuer*, 259 Mich App 389, 391; 674 NW2d 395 (2003).

III. LAW AND ANALYSIS

"The one-year-back rule is designed to limit the amount of benefits recoverable under the no-fault act to those losses occurring no more than one year before an action is brought." *Joseph v Auto Club Ins Ass'n*, 491 Mich 200, 203; 815 NW2d 412 (2012). Before it was amended in 2019, the statute read:

> An action for recovery of personal protection insurance benefits payable under this chapter for accidental bodily injury may not be commenced later than 1 year after the date of the accident causing the injury unless written notice of injury as provided herein has been given to the insurer within 1 year after the accident or unless the insurer has previously made a payment of personal protection insurance benefits for the injury. If the notice has been given or a payment has been made, the action may be commenced at any time within 1 year after the most recent allowable expense, work loss or survivor's loss has been incurred. However, *the claimant may not recover benefits for any portion of the loss incurred more than 1 year before the date on which the action was commenced* . . . . [MCL.500.3145(1) (emphasis added).]

MCL 500.3145 was amended by 2019 PA 21, effective June 11, 2019, and now states, in relevant part:

> (2) Subject to subsection (3), if the notice has been given or a payment has been made, the action may be commenced at any time within 1 year after the most recent allowable expense, work loss, or survivor's loss has been incurred. *However, the claimant may not recover benefits for any portion of the loss incurred more than 1 year before the date on which the action was commenced*.
>
> (3) A period of limitations applicable under subsection (2) to the commencement of an action and the recovery of benefits is tolled *from the date of a specific claim for payment of the benefits until the date the insurer formally denies the claim*. This subsection does not apply if the person claiming the benefits fails to pursue the claim with reasonable diligence. [MCL 500.3145(2), (3) (emphasis added).]

The amendments to MCL 500.3145 were to be given "immediate effect." 2019 PA 21.

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The Legislature's intent governs whether a statute applies retroactively or prospectively. *Johnson*, 491 Mich at 429. "Statutes are presumed to apply prospectively unless the Legislature clearly manifests the intent for retroactive application." *Id*. For instance, in MCL 141.1157, the Legislature stated the amended act "shall be applied retroactively . . . ." MCL 141.1157. Retroactive application, on the other hand, is not common or presumed. As our Supreme Court explained in *LaFontaine*:

> Retroactive application of legislation "presents problems of unfairness . . . because it can deprive citizens of legitimate expectations and upset settled transactions." We have therefore required that the Legislature make its intentions clear when it seeks to pass a law with retroactive effect. In determining whether a law has retroactive effect, we keep four principles in mind. First, we consider whether there is specific language providing for retroactive application. Second, in some situations, a statute is not regarded as operating retroactively merely because it relates to an antecedent event. Third, in determining retroactivity, we must keep in mind that retroactive laws impair vested rights acquired under existing laws or create new obligations or duties with respect to transactions or considerations already past. Finally, a remedial or procedural act not affecting vested rights may be given retroactive effect where the injury or claim is antecedent to the enactment of the statute. [*LaFontaine Saline, Inc v Chrysler Group, LLC*, 496 Mich 26, 38-39; 852 NW2d 78 (2014) (citation omitted).]

"Michigan courts have followed the general rule that the relevant inquiry in determining the applicability of a statute is the date on which the cause of action arose." *Hill v Gen Motors Acceptance Corp*, 207 Mich App 504, 513-514; 525 NW2d 905 (1994). "The substantive rights and liabilities of parties are determinable according to the law as it stood when the causes alleged by the plaintiff accrued." *Jones v Williams*, 172 Mich App 167, 171; 431 NW2d 419 (1988). Generally, a claim accrues at the time the wrong upon which the claim is based was done. MCL 600.5827. The "wrong" is the date on which the plaintiff is harmed. *Frank v Linkner*, 500 Mich 133, 147; 894 NW2d 574 (2017).

The issue in this case essentially boils down to whether the preamendment version of MCL 500.3145, or the amended version of MCL 500.3145, applies. If the preamendment version of the one-year-back rule applies in this case, then plaintiff's action must be dismissed as untimely. The claim accrued on July 28, 2018, when the three MRIs were taken, and plaintiff failed to file a complaint until November 13, 2019, over a year later. If, on the other hand, the amended version of the one-year-back rule applies, plaintiff's claim was timely, and the district court did not err in denying summary disposition. The one-year period did not begin until April 3, 2019, the date on which defendant denied full payment of the claim. Therefore, plaintiff's November 13, 2019 complaint was within the one-year period.

In holding the amended version of the one-year-back rule applied, the district court reasoned the lawsuit was "viable" on June 11, 2019, the date on which the amended version of the statute went into effect. Since the complaint was filed on November 13, 2019, less than a year after defendant submitted only partial payment to plaintiff, the complaint was timely. In sum, the district court found, because the one-year-back rule did not yet prohibit plaintiff's claim on June

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11, 2019, when the amended rule when into effect, the amended rule extended the timeframe within which plaintiff could file its complaint.

However, the district court's opinion answers only the surface-level question and fails to address the underlying issue of whether the provision in question operates retroactively—and why. The district court appears to have assumed the amended one-year-back rule operated retroactively, but failed to provide an explanation of its position. As noted above, the issue in this case is whether the preamendment version of MCL 500.3145, or the amended version of MCL 500.3145, applies, and the answer to that question depends on resolving the retroactivity question.

We conclude the district court and the circuit court erred. This conclusion is based on the foundational presumption in Michigan against retroactive application of legislation. *Johnson*, 491 Mich at 429. Instead, the presumption is for prospective application. "Statutes are presumed to apply prospectively unless the Legislature clearly manifests the intent for retroactive application." *Id*. Unlike MCL 141.1157, in which the Legislature clearly stated the amended act "shall be applied retroactively," there is no such language in MCL 500.3145 or 2019 PA 21. Simply put, no explicit or implicit reference to retroactivity exists in either the statute or the amendment. *Johnson*, 491 Mich at 432. And the "[u]se of the phrase 'immediate effect' does not at all suggest that a public act applies retroactively." *Id*. at 430. Therefore, in light of the presumption in favor of prospective application, the district court erred.

Plaintiff argues the relevant law is not the law in existence on the date the claim accrues, but rather the law in existence on the date the action was commenced. Plaintiff cites no law in support of this assertion, referencing only that the words "commencement of an action" are used in the legislation. Plaintiff argues the applicable law is therefore the amended version of the one-year-back rule, since the law in existence on November 13, 2019, was the amended statute. However, plaintiff and the district court fail to recognize that "the relevant inquiry in determining the applicability of a statute is the date on which the cause of action arose." *Hill*, 207 Mich App at 513-514; *Jones*, 172 Mich App at 171.

Generally, a claim accrues at the time the wrong upon which the claim is based was done. MCL 600.5827; *Frank*, 500 Mich at 147. In this case, the wrong upon which the claim is based was the partial payment of the medical expenses. This was the sole reason for plaintiff's complaint. We conclude that the "wrong" was done on April 3, 2019, the date on which defendant made the partial payment, which was over two months before the amended version of MCL 500.3145 went into effect. Even if the "wrong" is placed on April 8, 2019, the date on which plaintiff was notified of the partial payment, there still are more than two months between that date and the effective date of the amended rule. Additionally, even if the proper date of accrual is July 28, 2018, the date on which the medical expenses were assigned to plaintiff, there is still a significant amount of time between that date and June 11, 2019. Therefore, whether the claim accrued on July 28, 2018, April 3, 2019, or April 8, 2019, the law in effect at that time—and therefore the law that applies to this case—is the preamendment version of the one-year-back rule.

In *Bradfield v Estate of Burgess*, 62 Mich App 345, 351-352; 233 NW2d 541 (1975), we dealt with the very issue presented in this case: whether an amended version of a statute applied to a case in which the cause of action accrued before the amendment but the complaint was filed after the amendment. *Bradfield* involved a wrongful death claim that accrued on November 12, 1969,

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but was not filed until October 26, 1972. *Id*. at 346-347. In between those two dates, the statute, MCL 600.2922, was amended on March 30, 1972. *Id*. at 351-352. We concluded that the preamendment version of the statute controlled, stating: "Since statutes are to be given prospective effect exclusively unless a clear, unambiguous intent for retroactive application is expressed by the legislature, the amendment herein does not govern the instant action." *Id*. at 352. The same is true in this case. The preamendment version of the one-year-back rule applies because there is no "clear, unambiguous intent for retroactive application . . . expressed by the legislature . . . ." *Id*. at 352.

Plaintiff attempts to make an "intention by omission" argument. Plaintiff claims, had the Legislature intended for the amended MCL 500.3145 to be applied only prospectively, they would have said so. In plaintiff's view, the omission of such a statement means the Legislature intentionally chose to have the amended statute apply retroactively. This argument falls short, however, because plaintiff fails to recognize the fact that there is no need for an explicit statement regarding prospective application. Prospective application is presumed. *Nortley v Hurst*, 321 Mich App 566, 571; 908 NW2d 919 (2017). A statement is only needed for retroactive application, and there is no such statement in the legislation in this case. Plaintiff has it backward. Plaintiff's argument also runs into logical difficulties. The omission of one thing does not necessarily mean that its opposite is being intentionally endorsed.

Plaintiff also maintains the four *LaFontaine* factors for determining whether a statute has retroactive effect also support retroactive application. Plaintiff is incorrect. Those factors include:

> First, we consider whether there is specific language providing for retroactive application. Second, in some situations, a statute is not regarded as operating retroactively merely because it relates to an antecedent event. Third, in determining retroactivity, we must keep in mind that retroactive laws impair vested rights acquired under existing laws or create new obligations or duties with respect to transactions or considerations already past. Finally, a remedial or procedural act not affecting vested rights may be given retroactive effect where the injury or claim is antecedent to the enactment of the statute. [*LaFontaine*, 496 Mich at 38-39.]

Regarding the first factor, plaintiff argues that a reading of the "immediate effect" instruction in the context of the whole statute—particularly the lack of any language specifically excluding retroactive application—suggests retroactive application is appropriate. This argument again reverses the presumption under Michigan law. Contrary to plaintiff's position, the presumption is against retroactive application, and express language would be needed to make retroactive application possible. No such language exists in this case.

Regarding the second factor, plaintiff argues that whether the amended statute affects or references antecedent events like the incurring of medical expenses does not require a finding that the statute operates retroactively. We concur with defendant, however, that the second factor is irrelevant to this case because the amended version of MCL 500.3145 does not refer to an antecedent event.

Regarding the third and fourth factors, plaintiff argues the one-year-back rule must be applied retroactively because the amendment is procedural in nature and would not affect any

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vested rights. We again agree with defendant because applying MCL 500.3145 retroactively would effectively allow plaintiff to rewrite history and would require defendant to go back in time and issue a formal denial of plaintiff's claim at a time when it was not required to do so. Retroactive application would also make the one-year-back rule essentially meaningless by allowing plaintiff to bring its complaint beyond one year after the partial payment of the medical expenses. Instead, it is more likely that retroactive application is not warranted because plaintiff appears to have failed to "pursue the claim with reasonable diligence," MCL 500.3145(3). Indeed, plaintiff's interpretation of MCL 500.3145 could have negative public policy effects. In particular, it could incentivize providers to resurrect long-dead claims and use the tolling provision of the amended statute to get a second bite at the apple.

Plaintiff also argues, because there has been no formal denial of plaintiff's claim by defendant, plaintiff's claim is timely. This argument is a nonstarter, however, because the language regarding formal denial is only found in the amended version of MCL 500.3145, which, as we have determined, does not apply in this case.

For these reasons, the district court erred in denying summary disposition and the circuit court erred in denying defendant's application for leave to appeal.

IV. CONCLUSION

Reversed. Defendant may tax costs.

/s/ David H. Sawyer
/s/ Deborah A. Servitto
/s/ Michelle M. Rick

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EXHIBIT D

If this opinion indicates that it is "FOR PUBLICATION," it is subject to revision until final publication in the Michigan Appeals Reports.

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STATE OF MICHIGAN

COURT OF APPEALS

HEALTH PARTNERS, INC.,

Plaintiff-Appellee,

v

PROGRESSIVE MICHIGAN INSURANCE COMPANY,

Defendant-Appellant.

UNPUBLISHED
March 9, 2023

No. 359096
Ingham Circuit Court
LC No. 20-000168-NF

Before: PATEL, P.J., and BORRELLO and SHAPIRO, JJ.

PER CURIAM.

This Court recently held that the 2019 amendment to MCL 500.3145, which added a tolling provision to the one-year-back rule, does not apply retroactively. *Spine Specialists of Michigan, PC v MemberSelect Ins Co*, __ Mich App __; __ NW2d __ (2023) (Docket No. 358296). The dispute in this case concerns medical care that was provided more than one year before this action was commenced and before the effective date of the amendment. For this reason, the claims at issue in this interlocutory appeal are time barred. We reverse and remand for further proceedings consistent with this opinion.

I. BACKGROUND

The underlying facts are undisputed. In October 2017, Kenny Skoczylas was injured in a motor vehicle accident that rendered him a quadriplegic. Plaintiff Health Partners provided 24/7 home health aides and skilled nursing services for Kenny's injuries. The bills were then submitted to Defendant Progressive for payment. Progressive withheld payment for some of the claims. This appeal concerns claims that were submitted from December 30, 2017, through March 10, 2019.

In response to the claims submitted, Progressive issued "Explanation of Benefits" (EOB) statements that contained a provision inviting the insured to submit additional information. Health Partners argues that these EOBs were not a "formal denial" of the claims. Despite requesting and receiving further information, Progressive nonetheless did not pay the contested claims. On March 10, 2020, Kenny's legal guardian executed an assignment allowing Health Partners to file suit against Progressive for payment. Health Partners initiated suit the next day, on March 11, 2020.

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After initial discovery, Progressive moved for partial summary disposition under MCR 2.116(C)(7) and (C)(10). Progressive argued that any claim for benefits prior to March 11, 2019, was barred by the one-year-back rule, which provides that "the claimant may not recover benefits for any portion of the loss incurred more than 1 year before the date on which the action was commenced." MCL 500.3145(1).[1] Progressive further argued that the pre-2019 amended version of the statute is applicable to this case. Health Partners disagreed and argued that the amended version of MCL 500.3145 applied. Although the amended statute contains the same one-year back language, it additionally now tolls the one-year-back rule "until the date the insurer formally denies the claim." MCL 500.3145(3). Health partners asked the court to deny the motion because there were factual disputes as to whether Progressive formally denied the claims, thus tolling the application of the one-year-back rule under the amended statute. With tolling, the complaint was timely.

The trial court agreed that the amended statute applied and denied Progressive's motion for summary disposition. The court reasoned that there were genuine issues of material fact whether Progressive formally denied the at-issue claims, precluding summary disposition. The court denied a timely motion for reconsideration. Progressive filed an application for leave to appeal to this Court, which was granted.[2]

II. STANDARD OF REVIEW

We review de novo a trial court's ruling on a motion for summary disposition. *El-Khalil v Oakwood Healthcare, Inc*, 504 Mich 152, 159, 934 NW2d 665 (2019). We also review issues of statutory interpretation de novo. *People v Zajaczkowski*, 493 Mich 6, 12, 825 NW2d 554 (2012).

Under MCR 2.116(C)(7), summary disposition is warranted when a claim is barred by the applicable statute of limitations. *Al-Shimmari v Detroit Med Ctr*, 477 Mich 280, 288; 731 NW2d 29 (2007). Additional documentary evidence beyond the pleadings may be submitted by the parties, but is not required; if provided, such evidence must be considered. *Maiden v Rozwood*, 461 Mich 109, 119; 597 NW2d 817 (1999). Whether a statute of limitations applies in a case is a question of law we review de novo. *Ferndale v Florence Cement Co*, 269 Mich App 452, 457; 712 NW2d 522 (2006). In contrast, motions under MCR 2.116(C)(8) "test[ ] the legal sufficiency of a claim based on the factual allegations in the complaint." *El-Khalil*, 504 Mich at 159. "When considering such a motion, a trial court must accept all factual allegations as true, deciding the motion on the pleadings alone." *Id.* at 160.

MCR 2.116(C)(10) provides that summary disposition is appropriate when "[e]xcept as to the amount of damages, there is no genuine issue as to any material fact, and the moving party is entitled to judgment or partial judgment as a matter of law." A motion brought under MCR

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[1] The identical one-year back language is now contained within MCL 500.3145(2) following the 2019 amendment.

[2] *Health Partners, Inc v Progressive Michigan Ins Co*, unpublished order of the Court of Appeals, entered March 18, 2022 (Docket No. 359096).

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2.116(C)(10) tests the factual support for a party's action. *Pioneer State Mut Ins Co v Dells*, 301 Mich App 368, 377; 836 NW2d 257 (2013).

III. ANALYSIS

MCL 500.3145, known as the one-year-back rule, "is designed to limit the amount of benefits recoverable under the no-fault act to those losses occurring no more than one year before an action is brought." *Joseph v Auto Club Ins Ass'n*, 491 Mich 200, 203; 815 NW2d 412 (2012). "Until 2005, Michigan courts interpreted the one-year-back rule to incorporate a judicially created tolling provision that remained in effect until a no-fault claim was formally denied by the insurer." *Encompass Healthcare, PLLC v Citizens Ins Co*, ___ Mich App __; __ NW2d __ (2022) (Docket No. 357225); slip op at 5. "Our Supreme Court eradicated this judicial tolling of the one-year-back rule in *Devillers v Auto Club Ins Ass'n*, 473 Mich 562; 702 NW2d 539 (2005), holding that because the statute did not include a tolling mechanism, none could be engrafted." *Id.* at __; slip op at 1. "In 2019, however, the Legislature amended the no-fault act by adding a tolling provision. Now, the one-year-back period is tolled until the date of the insurer's formal denial of a claim." *Id.*

Before its amendment, MCL 500.3145(1), provided, in relevant part:

> An action for recovery of personal protection insurance benefits payable under this chapter for accidental bodily injury may not be commenced later than 1 year after the date of the accident causing the injury unless written notice of injury as provided herein has been given to the insurer within 1 year after the accident or unless the insurer has previously made a payment of personal protection insurance benefits for the injury. If the notice has been given or a payment has been made, the action may be commenced at any time within 1 year after the most recent allowable expense, work loss or survivor's loss has been incurred. However, the claimant may not recover benefits for any portion of the loss incurred more than 1 year before the date on which the action was commenced. . . .

MCL 500.3145 was amended by 2019 PA 21, effective June 11, 2019, and now provides, in relevant part:

> (2) Subject to subsection (3), if the notice has been given or a payment has been made, the action may be commenced at any time within 1 year after the most recent allowable expense, work loss, or survivor's loss has been incurred. However, the claimant may not recover benefits for any portion of the loss incurred more than 1 year before the date on which the action was commenced.
>
> (3) A period of limitations applicable under subsection (2) to the commencement of an action and the recovery of benefits is tolled from the date of a specific claim for payment of the benefits until the date the insurer formally denies the claim. This subsection does not apply if the person claiming the benefits fails to pursue the claim with reasonable diligence. [MCL 500.3145(2), (3).]

This appeal concerns bills for care that were incurred from December 30, 2017, through March 10, 2019; the complaint was filed on March 11, 2020. "PIP benefits accrue when they are

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incurred, MCL 500.3110(4), and are incurred when the insured receives medical treatment and becomes obligated to pay." *Spine Specialists,* __ Mich App at __; slip op at 5. It is therefore undisputed that the "loss incurred more than 1 year before the date on which the action was commenced." The issue in this case is whether Health Partners can rely on the tolling provision added in the amended version of § 3145, even though the bills were incurred before the effective date of the amendment.

This Court recently resolved this issue in *Spine Specialists*, and held that the amendments to § 3145 do not apply retroactively to claims that accrued before June 10, 2019, the effective date of the amendments. *Id.* at __; slip op at 5. Citing *Andary v USAA Casualty Ins Co*, __ Mich App __; __ NW2d __ (2022), this Court reasoned that "[i]n the absence of any Legislative statement of retroactive application, and in light of the presumption against retroactive application of a statutory amendment . . . the amendment to MCL 500.3145 does not apply retroactively." *Spine Specialists,* __ Mich App at __; slip op at 3-4.

Spine Specialists is directly applicable to the facts of this case and is binding. See MCR 7.215(C)(2). The pre-amendment version of § 3145 applies to the claims at issue here, which were incurred from December 2017 through March 10, 2019. Plaintiff cannot rely on the tolling provision in the amended statute and the at-issue claims are time barred.

Health Partners argues that this Court should not apply *Spine Specialists*, and, instead, relies on *Encompass Healthcare* for the proposition that the amended statute applies to losses incurred before June 10, 2019. Because *Encompass Healthcare* was released prior to *Spine Specialists*, Health Partners argues that it should control the outcome of this case. We disagree.

Encompass Healthcare, like *Spine Specialists*, and this case, dealt with medical care provided before June 10, 2019 (the effective date of the amended statute), the one-year-back rule, and the amended version of § 3145. The distinction, however, is that the parties in *Encompass Healthcare* did not dispute that the amended statute—with the tolling provision—applied. The tolling provision provides, in relevant part: "A period of limitations applicable under subsection (2) to the commencement of an action and the recovery of benefits is tolled from the date of a specific claim for payment of the benefits until the date the insurer formally denies the claim." MCL 500.3145(3). Because the parties did not raise it, this Court never reached the issue of retroactive application of the amended statute in *Encompass Healthcare*. Instead, the parties disputed, and this Court decided, whether the defendant had "formally denied" the plaintiff's claims. This Court held that the claims were never formally denied because the defendant "did not provide the explicit and unequivocal expression of finality required to constitute formal denials[.]" *Encompass Healthcare*, __ Mich App at __; slip op at 7. This Court concluded that, because there was never a formal denial, the one-year-back rule was tolled. *Id.* at __; slip op at 7.

Unlike the parties in *Encompass Healthcare*, the parties in *Spine Specialists* did raise the issue of whether the amended statute applies retroactively. We are bound by that decision.

We note that this Court concluded in *Encompass Healthcare* that the:

> amendments to MCL 500.3145, particularly the addition of Subsection (3), act to supersede our Supreme Court's ruling in *Devillers* and return the state of law to that

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> provided in *Lewis* [*v Detroit Auto Inter-Ins Exch*, 426 Mich 93; 393 NW2d 167 (1986)] and its progeny. Critically, the tolling exception adopted in MCL 500.3145(3) is identical to that embraced in the cases overruled, demonstrating the Legislature's intent to impose a tolling exception to the one-year-back rule in the form it existed before *Devillers*. [*Encompass Healthcare,* __ Mich App at __; slip op at 6-7.]

The impact of the amendment was to reinstate the judicial equitable tolling doctrine that was in place before *Devillers*. "Michigan courts have recognized that statutory amendments directed at a particular judicial decision can be remedial in nature by reinstating the state of the law as it existed prior to the judicial decision." *Encompass Healthcare,*__ Mich App at __; slip op at 4 (cleaned up). "[A] statute that can be characterized as merely remedial or procedural should generally be given retroactive application." *Buhl v City of Oak Park*, 507 Mich 236, 247; 968 NW2d 348 (2021).

Spine Specialists did not address the impact of the holding in *Encompass Healthcare* that the amendment to MCL 500.3145 is remedial in nature, or whether the remedial nature of the amendment makes it retroactive. We recognize that there is arguably some tension between the holding in *Spine Specialists* and *Encompass Healthcare*. This is, however, an issue for the Supreme Court to clarify.

We reverse and remand for further proceedings consistent with this opinion. We do not retain jurisdiction.

/s/ Sima G. Patel
/s/ Stephen L. Borrello
/s/ Douglas B. Shapiro

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EXHIBIT E

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2023 WL 6205425
Only the Westlaw citation is currently available.
United States District Court, E.D.
Michigan, Southern Division.

ALLSTATE INSURANCE COMPANY, et al., Plaintiffs/Counter-Defendants,

v.

PERFORMANCE ORTHOPEDICS OF MICHIGAN PLLC et al., Defendants/Counter-Plaintiffs.

2:20-CV-12008-TGB-EAS
|
Signed September 21, 2023

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Edward L. Ewald, Jr., Landis & Day, PLC, Wixom, MI, for Defendant/Counter-Plaintiff Dr. Namir David Zukkoor.

ORDER RESOLVING CROSS MOTIONS FOR SUMMARY JUDGMENT (ECF NOS. 100, 101)

TERRENCE G. BERG, UNITED STATES DISTRICT JUDGE

***1** In this lawsuit, Allstate Insurance Company and several associated insurers have sued nearly a dozen doctors, medical supply companies, surgical centers, and other medical providers for unjust enrichment, common-law fraud, and for violations of the Racketeer Influenced and Corrupt Organizations ("RICO") Act. All of the Defendants have settled or been dismissed except for Dr. Robert Swift and his company, Performance Orthopedics of Michigan.

Plaintiffs accuse Defendants Dr. Swift and Performance Orthopedics of attempting to bill them for services that were not performed or were medically unnecessary. These Defendants are also named as part of a larger corrupt scheme to defraud. Plaintiffs say that other providers double-billed them for services that Swift also claimed to have performed. They further charge that Swift's role was a necessary component of schemes to bill Plaintiffs for unnecessary treatments performed and medical equipment issued by others, because he wrote the prescriptions that other entities filled.

The parties have filed cross motions for summary judgment.

I. BACKGROUND

There were originally 11 Defendants in this case. Four were surgical centers or providers of neurological testing or other services: ISpine PLLC; Surgical Center of Southfield, LLC (also known as "Fountain View Surgery Center"); Northwest Neurology, P.C.; and Performance Orthopedics of Michigan PLLC. Three were "durable medical equipment" suppliers: BRR Medical Supply, Inc.; Gulf Coast Medical Service, LLC; and CCT Medical Supplies, Inc. There were also four individual Defendants: Dr. Stefan Pribil; Dr. Tessy Jenkins; Wesley Barber; and the remaining individual Defendant, Dr. Robert Swift.

Though nearly all of the Defendants have been dismissed, some background on the suit will be helpful to understand the remaining claims against Swift and Performance.

Plaintiff Allstate [1] accused the Defendants of operating as RICO enterprises. According to Allstate, the Defendants operated as a "cooperative," made up of the Defendant entities and certain members of their medical and nonmedical staff. Allstate brought seven RICO counts and seven RICO conspiracy counts. Each count identified one of the seven entity Defendants as a RICO "enterprise," and named several other Defendants as participating in that enterprise.

Allstate accuses the cooperative of submitting bills for services that either were never performed or were not medically necessary. Allstate says that the surgeon Defendants submitted charges for procedures that never happened. ECF No. 1, PageID.22–27. Allstate also maintains that multiple Defendants routinely submitted bills for the same procedure, service, or piece of medical equipment. *Id.* at PageID.28–37. Allstate also claims that some of the medical supplier Defendants issued prescribed medical equipment without the required license. *Id.* at PageID.37.

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***2** All Defendants have now been dismissed save for Performance and Dr. Swift. Swift and Performance are accused of participating in the ISpine enterprise, the Fountain View/Surgical Center of Southfield enterprise, the BRR enterprise, and the Gulf Coast enterprise. Swift is accused of participating in the Performance enterprise but, because of the way RICO claims must be pled to remain viable, Performance itself is not.

Robert Swift, D.O. is a Doctor of Osteopathy and the 100% owner of Performance Orthopedics of Michigan. Swift was also a part-owner and sat on the board of governors of the Surgical Center of Southfield, which operated under the name "Fountain View Surgery Center." Swift Dep., ECF No. 101-4, PageID.2586–88. As part of his operating agreement, Swift agreed to conduct at least 30% of his surgeries at the facility. *Id.* at PageID.2588.

Allstate accuses Swift of referring patients to ISpine for unnecessary evaluation and treatment. It also accuses him of scheduling and conducting unnecessary surgical procedures at Fountain View. It further accuses him of writing prescriptions for unnecessary "durable medical equipment" that were filled by BRR and Gulf Coast.

Allstate also accuses Swift, Fountain View, Performance —and the other entities that allegedly submitted bills— of fraudulent billing practices. ECF No. 1, PageID.64. Allstate says that Swift and Performance deviated from commonly accepted medical billing practices and committed fraud by "unbundling" medical services in their bills. *Id.* at PageID.65. "Unbundling" is the practice of billing separately for individual components of a procedure or pieces of equipment when those components or equipment are already integrated into the billing code for the procedure itself—a code that is also billed. [2] *Id.*

For example, Allstate says that Defendants billed for the act of "spinal exploration" while also billing for a comprehensive surgical procedure that would necessarily involve a spinal exploration. *Id.* According to Allstate, Defendants billed for supplies and ordinary equipment used during procedures while also billing for the procedures themselves. *Id.* at PageID.66. Allstate also says that all of the bills Defendants submitted dramatically inflated the costs of the procedures billed. *Id.* at PageID.71. Allstate maintains this was the case whether the procedures were necessary and actually performed, unnecessary and actually performed, or never performed at all.

Throughout the relevant period, Swift's billing was done by third-party medical billing companies. These experts reviewed Swift's notes from the procedures he performed and, nominally, were supposed to translate the surgery notices into billing codes and send those codes in bills to Allstate. Kayal Dep., ECF No. 101-12, PageID.2937. But according to two of the billers, Swift exercised significant control over what billing codes were ultimately submitted—much more than other doctors. *Id.* Indeed, the relationship between Swift and one of the billers broke down because of Swift's insistence that the billers submit the codes Swift had selected. Jones Dep., ECF No. 101-13, PageID.3018–20.

***3** In support of its motion, Allstate has submitted three expert reports. The first and second are by Doctors Robert Waltrip and James Cosgrove, respectively. *See* Waltrip Report, ECF No. 101-5; Cosgrove Report, ECF No. 101-6. Doctor Waltrip concluded, among other things, that "a majority" of the procedures for which Swift and Performance billed Allstate actually treated conditions unrelated to an auto accident. ECF No. 101-5, PageID.2628. Waltrip further found that billing records "frequently include billing codes for surgical procedures that were not actually performed according to the operative record." *Id.* at PageID.2629. Doctor Cosgrove reached similar conclusions.

The third report was by Tamera Rockholt, a nurse with expertise in medical billing. Rockholt reviewed 39 patients' bills submitted by Performance for services rendered by Swift and a medical assistant. Rockholt identified numerous instances in which Swift and Performance "upcoded" bills by using a billing code that corresponded to a more complex evaluation than the evaluation reflected in the visit notes. Rockholt Report, ECF No. 101-7, PageID.2829. And of the 14 surgical procedures she reviewed, Rockholt identified nine instances of unbundled billing and nine instances in which Performance used an unsupported code, meaning the provider's documentation was not consistent with the code's description. *Id.* at PageID.2827, 2829.

Defendants offered no competing expert report in response. However, Swift filed a supplemental declaration explaining his belief that, for each of the patients for whom Allstate actually paid bills, all treatment rendered was medically necessary and reasonable, and that the bills were "accurate descriptions of the services/procedures performed." Swift

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Supp. Decl., ECF No. 104-2, PageID.3364. Swift offers the same opinion about the bills for other patients that Allstate did not pay. *Id.* at PageID.3365. Allstate objects to this declaration, as will be discussed below.

II. ANALYSIS

A. Allstate's objection to Swift's supplemental declaration

Before reaching the merits of both sides' respective motions, the Court must address Allstate's objection to supplemental declaration filed by Defendant Swift. ECF No. 106. Allstate maintains that Swift's declaration is a disguised expert report. It argues that, because Swift was never identified as an expert witness, he may not offer expert testimony.

A party may object to the material supporting a motion for summary judgment on the basis that the facts it purports to contain cannot be presented in a form that would be admissible in evidence. Fed. R. Civ. P. 56(c)(2). Allstate says that Swift's expert opinion is inadmissible under Fed. R. Civ. P. 37(c)(1). That rule allows a court to exclude the testimony of a witness who was not disclosed as required by Rule 26.

The most recent scheduling order in this case, entered in December 2021, called for the exchange of expert reports by April 29, 2022, and the completion of all expert depositions by June 30, 2022. Stip. ECF No. 91, PageID.2127. Allstate submitted a witness list from the Defendants dated September 10, 2021. *See* Witness List, ECF No. 101-19. That list identifies Swift as a witness, but not as an expert. *Id.* at PageID.3196. It also indicates that Defendants may call "[e]xpert witnesses to be named in accordance with [the] court['s] scheduling order." *Id.*

Defendants do not dispute that they neither identified any expert witnesses nor disclosed an expert report from Swift. Rather, they appear to argue that no specific expert disclosure of Swift's opinions was required.

Rule 26(a)(2) governs the mandatory disclosure of expert witnesses. The rule contemplates two categories of experts: those who must provide a written report, and those who need not. A witness who is "retained or specially employed to provide expert testimony in the case" must provide an expert report. Fed. R. Civ. P. 26(a)(2)(B). So too must a witness "whose duties as the party's employee regularly involve giving expert testimony." *Id.* That written report must contain a complete statement of all opinions the witness will offer and the basis for them, the facts considered in forming them, any exhibits that will be used to support or summarize them, the witness's qualifications, a list of all other cases in which the witness has offered expert testimony in the last four years, and a statement of compensation. Fed. R. Civ. P. 26(a)(2)(B)(i–vi).

***4** A witness who is not specifically retained to offer expert testimony or whose duties do not regularly involve giving expert testimony need not provide such a report. Fed. R. Civ. P. 26(a)(2)(C). But a party must still provide a disclosure even for witnesses who need not provide a written report. That disclosure must state "the subject matter on which the witness is expected to present evidence" and "a summary of the facts and opinions to which the witness is expected to testify." Fed. R. Civ. P. 26(a)(2)(C)(i–ii).

Defendants have at least a colorable argument that Swift did not qualify as the sort of witness who would need to provide a written report.[3] Indeed, they devote virtually their entire response to this point.[4] But, as Allstate points out, Defendants ignore the central requirement of Rule 26(a)(2)(C): even if Swift was not required to produce a written report, Defendants were still obliged to identify him as an expert witness if they wished to present his opinion testimony and provide a summary of facts and opinions to which he was expected to testify. They did not do so.[5]

The question, then, is what remedy is appropriate for Defendants' failure to identify Swift as an expert witness. Allstate argues that Swift should be entirely precluded from testifying, either at trial or in support of a motion for summary judgment. Both sides agree that this would be tantamount to entering default judgment in favor of Plaintiffs and against the Defendants. Because many of the claims and defenses in this suit rise and fall on a difference of medical opinion, without a competing expert's testimony Defendants can point to no dispute of material fact. Defendants say that this sanction would be far too harsh.

Discovery sanctions are governed by Rule 37, which affords a court broad discretion in fashioning a sanction for failure to disclose a witness as required by Rule 26. The court may prohibit the witness from testifying or supplying evidence unless the failure was "substantially justified or is harmless." Fed. R. Civ. P. 37(c)(1). The Sixth Circuit weighs five factors when determining whether the violating party has met its burden to show that the nondisclosure was substantially

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justified or is harmless: (1) surprise to the party against whom the evidence would be offered; (2) ability of that party to cure the surprise; (3) extent to which allowing the evidence would disrupt the trial; (4) importance of the evidence; and (5) nondisclosing party's explanation for its failure to disclose the evidence. *Wade v. United States*, No. 21-10552, 2022 WL 19001837, at *2 (E.D. Mich. Dec. 19, 2022) (citing *Howe v. City of Akron*, 801 F.3d 718, 748 (6th Cir. 2015)).

***5** Or, "in addition to or instead of" that sanction, the court may "on motion and after giving an opportunity to be heard" order the payment of reasonable expenses caused by the failure, inform the jury of the party's failure, or impose other appropriate sanctions. Fed. R. Civ. P. 37(c)(1).

In support of its argument that Swift should be precluded from testifying at all, Allstate points to *Executive Ambulatory Surgical Center, LLC v. Allstate Fire & Casualty Insurance Co.*, 623 F. Supp. 3d 826 (E.D. Mich. 2022). There, Magistrate Judge Ivy determined that two physician expert witnesses were not required to produce full written reports, but should have been disclosed under Rule 26(a)(2)(C), and ordered the plaintiff to file an updated witness list reflecting the proper role of the witnesses.

But contrary to Allstate's description of that case, Judge Ivy did not bar the physician-owner of a surgical center from testifying because a disclosure was not made under Rule 26. Instead, Judge Ivy prohibited his testimony because, although the witness was competent to testify about the treatments he performed, he was not qualified as an expert on the whether the rates he charged were reasonable in light of the prevailing rate in the geographic area. *Id.* at 834.

Here, in the supplemental declaration, Swift offers his opinion concerning the validity of billing codes that he used. This kind of testimony veers over the line of mere factual observations and creeps into opinions or even legal conclusions reached from specialized knowledge. At the same time, as a physician, Swift occupies a hybrid position as a highly educated, medically trained professional, but also a lay witness who has personal work experience in applying the CPT codes. [6] It is not clear whether specialized knowledge of CPT codes is too remote from observations during surgery and other procedures that would not require disclosure as an expert. In some respects, Swift's testimony regarding how he applied the CPT codes may more appropriately be treated as the opinion of a lay witness under Fed. R. Evid. 701—it is based rationally on his perception; it will be helpful in providing a better understanding of his testimony and determining the facts, and it arguably is not based on the kind of scientific, technical, or specialized knowledge covered by Rule 702 (that is, based on "sufficient facts or data" and "the product of reliable principles and methods" that are reliably applied). *See* Fed. R. Evid. 701, 702. If Swift's testimony regarding his coding practices is lay opinion testimony, Defendants would not have been required to disclose him as an expert under Rule 26(a)(2).

And the Court also notes that Allstate deposed Swift on these very subjects: his experience with billing CPT codes generally, how he would apply them in certain hypothetical procedures, and why he applied them to specific patients. *See* Swift Dep., ECF No. 101-4, PageID.2444–55, 2534–60, 2597–98, 2602–09. Counsel did not explicitly state during the deposition whether they were treating Swift as an ordinary lay witness or as a full expert who had properly disclosed the topics to which they would testify.

***6** Ultimately, prohibiting Swift from testifying—a fact witness with direct knowledge of all the relevant claims and a party with a due process right to defend himself—is too harsh a sanction. It would be tantamount to entering default judgment in favor of Allstate. Allstate has not been irreparably prejudiced by Defendants' failure to disclose; no trial date has yet been set. *See, e.g., Heartland Rehab. Servs. v. Mekjian*, No. 06-11769, 2007 WL 1266352, at *1 (E.D. Mich. May 1, 2007). It is not clear why Defendants failed to disclose Swift timely as an expert but the record suggests it may simply have been an oversight. Allstate presents no evidence showing it was in bad faith. *See* *Howe*, 801 F.3d at 749 (finding that "Plaintiffs' late disclosure was more likely the result of negligence, confusion, and lack of information than underhanded gamesmanship"). Whatever minor prejudice Allstate suffers due to Defendants' delay in identifying Swift's opinion testimony, it may be readily cured by only considering Swift's testimony—both from his deposition on the record and supplemental declaration—as that of a lay witness for purposes of these cross-motions for summary judgment.

Therefore, Allstate's motion to strike this declaration will be granted in part and denied in part. Defendants will not be permitted to present any expert witnesses at trial, but Swift may testify as a treating physician regarding his observations and knowledge and may offer lay witness opinion testimony. If there are specific areas of testimony in the supplemental declaration that Allstate believes are

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inadmissible, Allstate may file a motion in limine seeking to exclude such statements, and may then address what it believes is the permissible scope of Swift's testimony.

In proceeding, parties should be mindful of the fact that these claims will likely turn on a dispute of medical necessity and reasonableness that, in all likelihood, will require resolution by a jury.

B. Defendants' motion for summary judgment

Defendants move for summary judgment on Allstate's RICO claims. To make out its civil RICO claims, Allstate must show "(1) conduct (2) of an enterprise (3) through a pattern (4) of racketeering activity." *Moon v. Harrison Piping Supply*, 465 F.3d 719, 723 (6th Cir. 2006) (citing *Sedima, S.P.R.L. v. Imrex Co.*, 473 U.S. 479, 496, 105 S.Ct. 3275, 87 L.Ed.2d 346 (1985)). Defendants challenge three of these elements. They say that the enterprises named in the complaint are not proper RICO enterprises. They contend that the Defendants did not conduct any of the enterprises' affairs, even if these enterprises are proper. Finally, they say that Allstate cannot meet the "racketeering activity" element, because Swift lacked the requisite intent to commit wire or mail fraud.

1. Whether Allstate has properly named an "enterprise" in each RICO count

Defendants argue that a RICO enterprise cannot consist of merely the named Defendants. ECF No. 100, PageID.2241. They argue that a "RICO enterprise alleged as an association-in-fact must be pled as existing separately from the Defendants' activity." *Id.*

As Allstate points out, all of the cases Defendants cite in their Response deal with "association-in-fact" RICO enterprises. An association-in-fact enterprise is a group associated for the common purpose of engaging in certain conduct rather than a distinct legal entity. *Boyle v. United States*, 556 U.S. 938, 944, 129 S.Ct. 2237, 173 L.Ed.2d 1265, (2009). To establish the existence of an association-in-fact, a plaintiff must show certain elements. But a plaintiff need not allege these elements of an association-in-fact enterprise when the alleged RICO enterprise is itself a distinct legal entity—such as a corporation. *In re ClassicStar Mare Lease Litig.*, 727 F.3d 473, 490 (6th Cir. 2013)

The enterprises alleged in the Complaint are not association-in-fact enterprises. Each count names a distinct legal entity: Counts I and II pertain to ISpine; Counts III and IV to Fountain View; Counts VII and VIII to Performance;[7] Counts IX and X to BRR; and Counts XI and XII to Gulf Coast. Because all five are corporations, limited liability companies, or other identifiable legal entities, Allstate need not resort to an association-in-fact theory.

***7** Defendants also argue that a RICO enterprise cannot consist only of the named Defendants. *See* ECF No. 100, PageID.2241 (citing *Durant v. ServiceMaster Co.*, 159 F.Supp.2d. 977, 981–82 (E.D. Mich. 2001)). This appears to implicate RICO's "distinctness" requirement: if the alleged RICO enterprise is a corporation or other entity, the "person" against whom the RICO claim is asserted must be separate from the corporation or other entity that satisfies RICO's "enterprise" element.

The rule of *Durant* and the cases it rests upon is that a plaintiff may not sue a deep-pocketed corporation as a RICO defendant (the RICO "person") while simultaneously alleging that the corporation or the corporation collectively with its employees is *itself* the entity that satisfies RICO "enterprise" element. *See, e.g., Compound Prop. Mgmt. v. Build Realty, Inc.*, 462 F. Supp. 3d 839, 856 (S.D. Ohio 2020).

That was the issue in *Durant*; a plaintiff sued three corporations in a single count, naming each corporation individually as a RICO defendant or "person." *Durant*, 159 F. Supp. 2d at 981. The plaintiff further alleged that, collectively, all three corporations were a RICO "enterprise." As the *Durant* court explained, the same entity cannot be both the "person" and the "enterprise." *Id.* That is the issue discussed in *Durant* and its cited cases. *See Discon, Inc. v. NYNEX Corp.*, 93 F.3d 1055, 1063 (2d Cir. 1996) (naming three corporations collectively as an enterprise and one corporation as a defendant is not permissible) (vacated on other grounds, 525 U.S. 128, 119 S.Ct. 493, 142 L.Ed.2d 510 (1998)); *Manhattan Telecomm. Corp. v. DialAmerica Mktg.*, 156 F. Supp. 2d 376, 381 (S.D.N.Y. 2001).

The facts at hand are not analogous to *Durant, NYNEX*, or *DialAmerica.* Allstate has not sued a corporation as a RICO defendant while also naming it and its employees

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collectively as the RICO "enterprise." In each count, Allstate names one of the companies alleged to have participated in this scheme as the "enterprise," and names the other entities and individuals as Defendants. In each count, the corporation forming the "enterprise" is not itself named as a Defendant, so the concerns in *Durant* do not apply.

Swift may also argue that he is not sufficiently distinct from the Performance or Fountain View enterprises because he was an owner or part-owner of those entities. But the Sixth Circuit and Supreme Court have rejected that argument, explaining that the owner of a corporation who conducts the affairs of her corporation in a RICO-forbidden way is sufficiently distinct from the corporation itself. *Cedric Kushner Promotions, Ltd. v. King*, 533 U.S. 158, 163, 121 S.Ct. 2087, 150 L.Ed.2d 198 (2001).

2. Whether there is a genuine dispute of fact whether Swift and Performance conducted the affairs of the enterprises at issue

Defendants contend that Allstate has shown no evidence that Swift or Performance operated or managed the affairs of any of the other Defendants as part of a hierarchical structure, as required to establish RICO liability. Defendants point to the test set out in *Reves v. Ernst & Young*, 507 U.S. 170, 185, 113 S.Ct. 1163, 122 L.Ed.2d 525 (1993). There, the Supreme Court held that a person must participate in the "operation or management" of the enterprise to be held liable under RICO.

But RICO liability extends beyond those with "primary responsibility" for the enterprise's affairs; only "some part" in directing those affairs is required. *Ouwinga v. Benistar 419 Plan Servs.*, 694 F.3d 783, 792 (6th Cir. 2012). RICO liability is not limited to decision-makers; a person may "conduct" the affairs of a RICO enterprise by knowingly carrying out the enterprise's orders or by "continued endorsement of a fraudulent scheme." *Id.*

***8** First, there can be no serious dispute that Swift "conducted" the affairs of Performance, as he was its sole owner and manager. *See* ECF No. 101-4, PageID.2390. Swift avers that he had nothing to do with the billing practices of Fountain View, ISpine, or the durable medical equipment companies (BRR and Gulf Coast). As Allstate points out, courts elsewhere in this district have allowed RICO claims to proceed against doctors in similar circumstances.

In *State Farm Mutual Automobile Insurance Co. v. Physiomatrix, Inc.*, No. 12-11500, 2013 WL 509284, at *5 (E.D. Mich. Feb. 12, 2013), Judge O'Meara held that an insurer's RICO claim could proceed against a doctor who allegedly prescribed unnecessary physical therapy treatments that were rendered by a third-party clinic. The Court explained that the doctor had helped conduct the clinic enterprise because his role was essential to the fraudulent scheme; Michigan law requires a doctor's prescription before physical therapy services are rendered.

In *State Farm Mutual Automobile Insurance Co. v. Pointe Physical Therapy, LLC*, Judge Borman held that a prescribing physician could be liable for "conducting" a RICO enterprise premised on rendering unnecessary treatment. 107 F. Supp. 3d 772, 786–87 (E.D. Mich. 2015). This was because the physicians were a necessary component of the scheme: "without the Prescribing Clinics engaging the Prescribing Physicians to write the orders for the medically unnecessary services, ultimately provided by the Treatment Facilities who could not provide the services without orders from the Prescribing Clinics and Physicians, ... the goals of the enterprise could not be achieved." *Id.* at 786.

However, Swift's connection to ISpine and the DME suppliers appears too attenuated to support a conclusion that Swift or Performance "conducted" or conspired with those enterprises. Swift avers that he was casually acquainted with Dr. Stefan Pribil, ISpine's owner, having met him at Fountain View. Swift Decl., ECF No. 100-3, PageID.2266. He says that he never had any financial arrangement for referrals with ISpine or Dr. Pribil, and received only a "small number" of referrals. Wesley Barber, ISpine's administrator, testified that Dr. Pribil did not instruct ISpine staff to refer patients exclusively to Swift. Barber Dep., ECF No. 103-3, PageID.3296. Allstate does not point to any testimony suggesting an agreement or other relationship between Swift and ISpine, nor does Allstate identify patients who were referred to ISpine by Swift.

So too with the DME suppliers. Swift denied any financial relationship with BRR, Gulf Coast, or CCT. Swift Decl., ECF No. 100-3, PageID.2266–68. In response, Allstate supplies five prescriptions for durable medical equipment, four of which bear BRR letterhead. *See* ECF Nos. 103-4, 103-5. Allstate also points to the testimony of Candice Kayal, one of Swift's billers, and argues that she testified that Swift purchased certain equipment from CCT. However, that

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testimony is somewhat ambiguous upon a close review. *See* Kayal Dep., ECF No. 101-12, PageID.2952. It is not clear if Kayal understood "CCT" to be the name of the supplier, or of the devices themselves, given her testimony that she was "unaware" of where Swift purchased the devices. *Id.*

All of this is a far cry from the kinds of involvement that has been held sufficient to show that a medical provider "conducted" the affairs of an alleged RICO enterprise. In *Pointe Physical Therapy*, 107 F. Supp. 3d at 780, a central management group owned and controlled "prescribing clinics" and "treatment facilities." Those clinics hired doctors who prescribed unneeded physical therapy according to a "predetermined protocol that had no relation to the individual patient's needs or diagnoses." *Id.* That treatment was to be obtained universally at the treatment facilities.

***9** In *Physiomatrix*, the defendant doctor prescribed unnecessary physical therapy to be performed at the same defendant physical therapy clinics each time. 2013 WL 509284 at *5. And in *Allstate Ins. Co. v. Inscribed PLLC*, No. 19-13721, 2020 WL 5801186, at *2 (E.D. Mich. Sept. 29, 2020), the defendant physicians "required" their patients to fill prescriptions at the defendant pharmacy, and "arranged to have these unnecessary prescriptions filled" by the pharmacy in a quid-pro-quo agreement.

Swift's participation in the loose and sporadic practice of referrals that he and Barber described does not amount to the sort of systematic, tightly knit conduct of a RICO enterprise found in those cases. And Allstate has offered no testimony or evidence about a closer relationship than that. Allstate has not shown that Swift referred patients exclusively to ISpine for the sort of services ISpine provided. Nor has Allstate showed that, whenever Swift wrote prescriptions for durable medical equipment, he required that they be filled by one of the DME suppliers named here.

But the facts showing a connection to Fountain View are far more substantial. Swift was a partial owner of Fountain View and a member of its board of governors. He had an express agreement with Fountain View that he and Performance would use Fountain View's facilities to conduct at least 30% of his surgeries. And the surgery center could not have submitted its allegedly fraudulent bills without Swift agreeing to perform surgeries at its facilities. That is enough to allow a reasonable juror to conclude that Swift conducted the affairs of the Fountain View enterprise.

For these reasons, judgment will be entered in the Defendants' favor on the RICO claims against Swift and Performance premised on the ISpine, BRR, and Gulf Coast enterprises (Counts I, II, IX, X, XI, and XII), but not on the counts related to the Fountain View or Performance enterprises.

3. Whether there is a genuine dispute of fact that the enterprises engaged in racketeering activity

Defendants also argue that Allstate must prove that Swift and Performance had the specific intent to commit wire fraud to satisfy RICO's racketeering activity requirement.

To make out its RICO claims, Allstate must show that the enterprise engaged in a "course of racketeering activity": two or more predicate acts within a ten-year period. *Moon*, 465 F.3d at 723. Mail and wire fraud, indictable under 18 U.S.C. § 1341 and 1343, respectively, qualify as predicate acts. *Id.* Mail fraud has two elements: (1) a scheme to defraud; and (2) use of the mails to further that scheme. *Heinrich v. Waiting Angels Adoption Servs., Inc.*, 668 F.3d 393, 404 (6th Cir. 2012). The elements of wire fraud are the same, except the defendant must use the wires, not the mail, to further the scheme. *Id.* Only the first element, intent, is in dispute.

To make out the intent element, Allstate must show a plan or course of action by which the Defendants used false, deceptive, or fraudulent pretenses, representations, or promises to deprive Allstate of money. *Id.* Allstate must also show that the Defendants acted either with specific intent to defraud, or "with recklessness with respect to potentially misleading information." *Id.* (citing *United States v. DeSantis*, 134 F.3d 760, 764 (6th Cir. 1998)). Intent to defraud may be established by circumstantial evidence, or by inferences "drawn from examining the scheme itself which demonstrate that the scheme was reasonably calculated to deceive persons of ordinary prudence and comprehension." *United States v. Rayborn*, 495 F.3d 328, 338 (6th Cir. 2007) (internal quotation marks omitted).

***10** Allstate has offered ample evidence that the scheme was reasonably calculated to deceive it. Allstate's medical experts

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report that billing records from Swift and other alleged members of the enterprise include inappropriately selected billing codes, including those that reflect procedures that were never performed. The records also show that multiple bills were sometimes submitted for same service. Finally, the bills show—or at least, a reasonable juror who believed Allstate's experts' testimony could conclude that they show—a repeated pattern of prescribing medically unnecessary treatments and that all of this was reasonably calculated to deceive Allstate.

4. Whether the voluntary payment doctrine bars any of Allstate's claims

Finally, Defendants argue that they cannot be liable to Allstate at all because of "the doctrine of voluntary payment." They argue that when an insurer receives a claim arising under Michigan's no-fault insurance law, the insurer is obliged to investigate the reasonableness and necessity of the claim before paying. They say that Allstate was fully apprised of the facts of each claimant, and was entitled to—and often did—conduct its own investigation before paying on the claim.

Allstate responds that very nature of fraud is to misleadingly induce a person to hand over money to which the fraudster is not entitled. Allstate also argues that there is a dispute of fact whether or not it knew that the claims submitted were fraudulent. In response, Swift and Performance acknowledge that fraud can vitiate a defense of voluntary payment. But they employ circular logic by arguing that, because Allstate voluntarily paid the claims, there is no evidence of fraud.

Allstate has the better of the argument. In Michigan, a payment is only voluntary when made with full knowledge of the circumstances and without "artifice, fraud, or deception." *Pingree v. Mut. Gas Co.*, 107 Mich. 156, 158, 65 N.W. 6 (1895). A payment is not voluntary if it is induced by fraud. And a reasonable jury could conclude that one or more of the payments Allstate made to Swift and Performance were induced by fraud, and that Allstate was unaware of the bills' fraudulent nature. *See, e.g., Durant v. ServiceMaster Co.*, 159 F. Supp. 2d 977, 981 (E.D. Mich. 2001) (noting that the voluntary payment doctrine does not apply when payment is predicated on mistake of fact). For those reasons, the voluntary payment doctrine does not preclude Allstate's RICO claims.

C. Allstate's Motion for Summary Judgment

In its own motion, Allstate moves for summary judgment in its favor on Defendants' counterclaim. It also moves for judgment in its favor on its own claims for unjust enrichment, common law fraud, civil conspiracy, and declaratory judgment. Allstate further moves for summary judgment against Swift on its own RICO claims in Counts III, IV, VII, and VIII, and against both Swift and Performance on its RICO claims in Counts III and IV only. [8]

1. Whether Allstate is entitled to summary judgment on its own RICO claims or fraud-based claims

Both sides agree that intent to defraud is a necessary element of Allstate's civil conspiracy, common law fraud, and RICO claims. Defendants argue that it would be inappropriate to find that they intended to defraud Allstate as a matter of law, correctly pointing out that in the ordinary case, the "question of intent to defraud is a question of fact for the jury." *Steele v. Great Am. Ins. Co.*, 850 F.2d 692 (6th Cir. 1988) (unpublished table decision).

***11** Allstate replies that this is the rare case where the evidence of fraud is so strong that no reasonable juror could conclude that Defendants lacked the intent to defraud. They say that Defendants were clearly advised that their billing practices were improper, but continued to submit bills using those deceptive practices nonetheless.

After careful review of the testimony of the billing experts deposed in this case, the Court concludes that there is a genuine issue of material fact regarding Defendants' intent as to which reasonable jurors could differ. To be sure, the testimony of Allstate's billing expert Tamera Rockholt would likely be considered persuasive. *See generally*, ECF No. 101-7. A jury could easily accept Ms. Rockholt's conclusion that Defendants intentionally misused the billing codes and did so intending to defraud Allstate. But the question this motion asks is whether that conclusion is the *only* possible one that a reasonable juror could reach.

Dr. Swift insisted that there is an element of subjectivity to surgery coding: "[t]here's no ... two plus two equals four. It's variable based on what you do, how much work you do and how it's interpreted and how it's fixed." Swift Dep., ECF No. 101-4, PageID.2452. He also chalked up some of the instances of double billing identified by Allstate to billing mistakes. *Id.* at PageID. 2605, 2612–13. Similarly, Swift explained that he sometimes billed two instances of the same procedure for a single surgical session because of the complexity of the

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particular surgery. For example, he testified to his view and the view of some "billers and coders" that surgical procedures involving two "lateral portals" instead of one should actually be billed as two separate procedures. *Id.* at PageID.2603–04.

This testimony is supported by that of Candice Kayal, one of Swift and Performance's former billers. Kayal repeatedly insisted that it was not her testimony that Dr. Swift "forcefully intended" her to submit the wrong billing codes. Kayal Dep., ECF No. 101-12, PageID.2940. Rather, Kayal testified that Swift "believes he's always right." *Id.* She characterized the American Medical Association's guidelines on bundling as "suggestions." *Id.* at PageID.2942. She repeatedly testified that "surgery billing is very finicky." *Id.* at PageID.2948. She explained that there is an element of subjectivity to surgery coding: in some circumstances codes "are left up for interpretation because so much goes on within a surgery." *Id.* at PageID.2994.

Kayal further testified that the CPT guideline books created by the AMA are "guidelines." *Id.* at PageID.2976. A doctor contracted with Medicare or a traditional health insurer signs a "provider participating contract" agreeing to "take those guidelines as gospel." *Id.* But because doctors have no contracts with auto insurance carriers, strict adherence to CPT guidelines is "technically ... kind of gray." *Id.* at PageID.2977. Kayal explained her view that doctors who submit bills to auto insurers—like Dr. Swift—are not required to use CPT codes at all. As Ms. Kayal explained, the CMS rules and CPT codes "don't apply as 100 percent gospel" in the no-fault auto insurance context, though doctors "still like to use them as a guideline." *Id.* at PageID.2985. Kayal characterized the bundling rules as "voluntary." *Id.* at PageID.2990.

***12** Allstate responds that once Swift *chose* to use CPT codes to submit his bills, he was obligated to conform to the CMS and AMA guidelines that govern those codes.[9] Clearly, he did not do so. Indeed, Swift admits that he did not adhere strictly to the guidelines that govern the use of CPT codes. *See* Swift Dep., ECF No. 101-4, PageID.2445–46. He explained that he used CPT codes in his no-fault bills to maintain consistency with bills he submitted to health insurance companies, but that he expected Allstate to interpret the bill and surgical notes for itself notwithstanding the CPT codes Swift supplied. *Id.* at PageID.2446–49.

A jury could well conclude that in so doing, Swift intentionally defrauded Allstate. But given the countervailing evidence, a reasonable juror could also conclude that Swift's erroneous use of the CPT codes may not have been because of an intentional effort to defraud. A juror could conclude that Swift's billing practices were the product of a genuine but mistaken interpretation of the CPT codes, a good-faith dispute about their applicability to the surgeries at issue, an honest mistake, or purely reckless billing practices.

Though a jury could certainly conclude that Swift intended to defraud Allstate, they could also reject that interpretation of the facts. Accordingly, Allstate is not entitled to summary judgment on its fraud-based claims.

2. Whether portions of Defendants' counterclaim are time-barred

Allstate also argues that, medical evidence aside, some of Defendants' claims for payment are barred by a one-year limit that applies to certain no-fault benefits. *See* MCL § 500.3145. Allstate points out that the counterclaim in this suit was filed on November 9, 2020. Thus, it maintains, Defendants cannot recover for any service provided prior to November 9, 2019.

Before being sued by Allstate here, Swift and Performance had filed a number of suits in Michigan's state courts against Allstate for nonpayment. Some of those suits involved the same patients at issue in Defendants' counterclaim. To avoid litigating substantially related claims in multiple courts and cases, Defendants stipulated that they would dismiss all pending cases in other courts and pursue them as part of their counterclaim here. *See* Stip., ECF No. 49, PageID.1220. Allstate agreed that with respect to any portions of Defendants' counterclaim "for which separate litigation ha[d] already been filed, the date such litigation was filed" would govern any defenses pertaining to the one-year-back rule. *Id.* at PageID.1221. Neither side has identified which patients' claims, and thus what portion of Defendants' counterclaim, were subject to prior litigation.

Defendants also point out that the no-fault statute was amended in June 2019, and a tolling provision was added. Under that provision, the one-year limitations period for a specific claim is tolled until the date that an insurer "formally denies the claim." MCL § 500.3145. Allstate does not reply to this argument and does not explain when it "formally denied" any of the claims at issue. However, the 2019 amendments to the no-fault statute were not retroactive. *Spine Specialists of Michigan, PC v. MemberSelect Ins. Co.*, —— N.W.2d ——, 2022 WL 17073490, at *3–4 (Mich. Ct. App.

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Nov. 17, 2022). So that tolling provision applies only to claims for services performed on or after June 11, 2019.

***13** On the available record, the Court cannot determine which claims were subject to prior litigation. And Allstate has not explained when, if at all, it formally denied any claims that postdate the June 2019 amendments to the no-fault statute. Accordingly, the Court cannot decide with specificity which claims are subject to the one-year-back rule.

However, the Court can make the following determination. Claims for services rendered before November 9, 2019 are barred unless one of the following applies: (1) the claim was subject to prior litigation and thus falls under the parties' stipulation; (2) the claim was filed after the no-fault statute was amended on June 11, 2019 and Allstate did not formally deny the claim until after November 9, 2019.

3. Remaining claims (declaratory judgment, counterclaim, unjust enrichment)

The balance of Allstate's motion seeks dismissal of Defendants' counterclaim in its entirety as well as summary judgment in Allstate's favor on its own claim for unjust enrichment and its request for a declaratory judgment that it owes nothing to the Defendants.

In support of all three, Allstate argues that Defendants' failure to properly identify an expert dooms Defendants' claims and entitles Allstate to summary judgment on its own. Allstate is correct that the testimony of a medical expert is critical to all three claims. Defendants' claims and Allstate's declaratory relief claim are mirror images. Both depend on whether Defendants' bills were compensable under the no-fault act.

And, as Allstate points out, expert testimony is usually required to make out a claim of entitlement to no-fault benefits. Bills are only compensable under that law if they are for services to treat an injury arising out of a vehicle accident and are "reasonably necessary ... for an injured person's care, recovery, or rehabilitation." MCL §§ 500.3105, 500.3107(1)(a). Furthermore, a treating provider's bills must be for a "reasonable amount" and must not exceed the amount the provider "customarily charges for like treatment" in cases not involving insurance. MCL § 500.3157(1).

Determining whether these requirements have been met typically requires expert medical testimony. *See Lund v. Travelers Indem. Co. of Am.*, No. 330212, 2016 WL 7601903, at *4 (Mich. Ct. App. Dec. 29, 2016) (explaining that expert testimony "generally" required to "establish a causal connection between medical treatment and injuries from an accident"); *Galuten on behalf of Est. of Galuten v. Williamson Cnty. Hosp. Dist.*, No. 21-5007, 2021 WL 3043275, at *6 (6th Cir. July 20, 2021) (providing that Plaintiff was required to rebut expert testimony with their own expert when "issues turned on technical questions of medical judgment beyond the knowledge of a lay jury").

The same holds for Allstate's unjust enrichment claim. An insurer who pays for procedures later determined to be noncompensable may sue the medical provider on an unjust enrichment theory. *See, e.g., Allstate Ins. Co. v. Broe*, 2008 WL 3876188, at *17 (Mich. Ct. App. Aug. 21, 2008); *Citizens Ins. Co. of Am. v. Univ. Physician Grp.*, 319 Mich. App. 642, 651, 902 N.W.2d 896 (2017). Defendants concede that they received about $85,000 from Allstate for various procedures and patients.

Allstate's unjust enrichment claim turns on whether or not Defendants' retention of that money would be inequitable because the procedures at issue were medically unnecessary or not actually performed. That inquiry, in turn, depends on the same expert medical testimony relevant to the other claims discussed in this section. For the reasons discussed above, resolving this motion in Allstate's favor would be tantamount to entering a default judgment for Plaintiff against Defendants because they failed to timely disclose Swift as an expert. Such a draconian penalty is not justified here. Factually supported testimony from Swift that, in his opinion, the procedures were medically necessary, reasonable, and related to automotive accidents must be weighed against the testimony of Allstate's experts by a jury. Summary judgment on these remaining claims is therefore inappropriate at this time.

III. CONCLUSION

***14** In sum, Defendants' Motion for Summary Judgment is **GRANTED** as to:

- Count I (RICO, ISpine Enterprise),
- Count II (RICO Conspiracy, ISpine Enterprise),
- Count IX (RICO, BRR Medical Enterprise),
- Count X (RICO Conspiracy, BRR Medical Enterprise),

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- Count XI (RICO, Gulf Coast Enterprise), and
- Count XII (RICO Conspiracy, Gulf Coast Enterprise).

Defendants' Motion for Summary Judgment is **DENIED** as to:

- Count III (RICO, Fountain View Enterprise),
- Count IV (RICO Conspiracy, Fountain View Enterprise),
- Count VII (RICO, Performance Enterprise),
- Count VIII (RICO Conspiracy, Performance Enterprise),
- Count XV (Common Law Fraud),
- Count XVI (Civil Conspiracy),
- Count XVII (Payment Under Mistake of Fact),
- Count XVIII (Unjust Enrichment), and
- Count XIX (Declaratory Judgment).

Finally, Plaintiff Allstate's Motion for Summary Judgment is hereby **DENIED** as to Counts III, IV, VII, VIII, XV, XVI, XVIII, and XIX and Defendants' counterclaim (No-Fault Act Benefits).

IT IS SO ORDERED, this 21st day of September, 2023.

All Citations

Slip Copy, 2023 WL 6205425

Footnotes

1 Plaintiffs are five insurance companies under the Allstate umbrella. For simplicity, the Court will refer to the Plaintiffs as "Allstate" in the singular.

2 At issue in this case is the use of "Current Procedural Terminology" codes or "CPT codes." This is a comprehensive catalogue of all items, procedures, and services that a doctor might perform. CPT codes, which are promulgated by the American Medical Association ("AMA"), are a kind of universal shorthand that allow doctors, insurers, and others to refer to medical procedures in a standardized way.

3 Allstate contends that Swift's duties regularly involve giving expert testimony, and that Swift was therefore required to provide a full written report. The Court does not decide into which category of Rule 26(a)(2) Swift falls. Nevertheless, the general rule in the Sixth Circuit appears to be that a treating physician need not provide a written report, so long as the testimony does not stray beyond the physician's own treatment and diagnosis of the patient. *Fielden v. CSX Transp., Inc.*, 482 F.3d 866, 870-71 (6th Cir. 2007); *Avendt v. Covidien Inc.*, No. 11-15538, 2014 WL 7338727, at *4 (E.D. Mich. Dec. 20, 2014) (collecting cases).

4 Defendants also argue that Allstate deposed Swift fully once and was afforded the opportunity to depose Swift a second time as well, but elected not to. This is immaterial. Without advance knowledge that Swift planned to testify as an expert and a summary of his testimony, a second deposition focused on his yet-unknown expert testimony would have been of limited value.

5 "The application of the Rule 26 disclosure requirements depends on the substance of the treating physician's testimony rather than his or her status." *Hawkins v. Graceland*, 210 F.R.D. 210, 211 (W.D. Tenn. 2002) (collecting cases).

6 "Treating physicians ... can testify as ordinary witnesses without disclosure as experts if the essence of the testimony is factual. Thus, even though Dr. Feck has specialized knowledge, to the extent that Dr. Feck is

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testifying as an ordinary witness, disclosure as an expert was unnecessary." *Oaks v. Wiley Sanders Truck Lines*, No. 07-45, 2008 U.S. WL 11344846, at *2 (E.D. Ky. Oct. 29, 2008).

7 Swift is named as a Defendant in the Performance enterprise counts (Counts VII and VIII), but Performance itself is not.

8 Counts III and IV involve the "Fountain View Enterprise," while Counts VII and VIII involve the "Performance Orthopedics Enterprise." Allstate does not move for summary judgment in its favor on the counts involving the ISpine enterprise (Counts I and II) or durable medical equipment supplier enterprises (Counts IX–XII).

9 Allstate also suggests that CPT-code billing *is* required in the no-fault context. For that proposition Allstate cites 45 C.F.R. § 162.1000(a), which provides that a "covered entity" must use CPT codes when "conducting a transaction covered by" 45 C.F.R. Part 162. But Allstate does not explain why Performance or Swift are "covered entities" or whether the no-fault transactions at issue were "covered" by Part 162. Allstate also points to a recent decision of the Michigan Court of Appeals, *Mich. Ambulatory Surgical Ctr. v. Liberty Mut. Ins. Co.*, No. 356082, 2022 WL 2188480, at *1 (Mich. Ct. App. June 16, 2022). But while Allstate is correct that the Court of Appeals confirmed that CPT codes are relevant in the no-fault context, nothing in that opinion appears to require their use.

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EXHIBIT F

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KeyCite Blue Flag – Appeal Notification
Appeal Filed by ELIJAH SPANN v. EMPIRE FIRE & MARINE INSURANCE CO., ET AL, 6th Cir., September 1, 2023

2023 WL 5001447
Only the Westlaw citation is currently available.
United States District Court, E.D. Michigan, Southern Division.

Elijah Dequon SPANN, Plaintiff,
v.
EMPIRE FIRE AND MARINE INSURANCE COMPANY and Allstate Insurance Company, Defendants,
Empire Fire and Marine Insurance Company, Cross-Plaintiff,
v.
Allstate Insurance Company, Cross-Defendant.

Case No. 21-cv-11036
|
Signed August 4, 2023

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OPINION AND ORDER (1) GRANTING IN PART AND DENYING IN PART DEFENDANT EMPIRE FIRE AND MARINE INSURANCE COMPANY'S MOTION FOR SUMMARY JUDGMENT AGAINST PLAINTIFF AND ALLSTATE INSURANCE COMPANY (ECF NO. 24), AND (2) GRANTING ALLSTATE'S MOTION FOR SUMMARY JUDGMENT AGAINST PLAINTIFF AND EMPIRE FIRE AND MARINE INSURANCE COMPANY (ECF NO. 55)

Paul D. Borman, United States District Judge

***1** This case involves Plaintiff Elijah Spann's claims against Defendants Empire Fire and Marine Insurance Company (Empire) and Allstate Insurance Company (Allstate) for the payment of personal injury protection (PIP) benefits under the Michigan No-Fault Act, Mich. Comp. Laws § 500.3101, *et seq.*, stemming from a July 29, 2019 motor vehicle accident, and Cross-Plaintiff Empire's claim against Cross-Defendant Allstate seeking reimbursement of benefits Empire paid to and on behalf of Spann under the No-Fault Act.

Now before the Court are Empire's and Allstate's Motions for Summary Judgment. Empire states that it is now undisputed that Spann was logged into a digital transportation network (Uber) when the July 29, 2019, accident occurred, and that neither the applicable Empire insurance policy nor the Michigan No-Fault Act requires Empire to provide PIP benefits for an accident that occurred when Spann was logged into a digital transportation network. Empire argues that there is no genuine issue of material fact that the Empire insurance policy does not provide coverage for Spann's July 29, 2019, automobile accident, and that Allstate must reimburse Empire for PIP benefits that Empire previously paid to or on behalf of Spann. Empire's motion for summary judgment is fully briefed, including supplemental briefing following additional discovery with respect to Defendant Allstate.

Allstate argues in its motion for summary judgment that the claims asserted against it by both Spann and Empire are time-barred under the Michigan No-Fault Act's one-year statute of limitations because of Spann's failure to give written notice of his alleged injuries to Allstate within one year of his accident, and barred by the No-Fault Act's one-year-back rule that bars claims for losses incurred more than one year before the action was commenced. Allstate's motion has also been fully briefed.

The Court held a hearing on both motions for summary judgment on August 2, 2023, at which counsel for Plaintiff and both Defendants appeared.

For the reasons that follow, the Court GRANTS IN PART AND DENIES IN PART Defendant Empire Fire and Marine Insurance Company's Motion for Summary Judgment Against Plaintiff and Allstate (ECF No. 24), and GRANTS Allstate's Motion for Summary Judgment Against Plaintiff and Empire (ECF No. 55).

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I. FACTUAL AND PROCEDURAL BACKGROUND

A. Factual Background

On July 29, 2019, Plaintiff Elijah Spann was involved in a motor vehicle accident while he was driving a 2019 Chevrolet Malibu that was owned or leased by Maven Drive LLC, a car sharing business launched by General Motors that rented vehicles to individuals for personal use and to "gig workers" for rideshare and delivery work. The 2019 Chevrolet Malibu was insured by Defendant Empire Fire and Marine Insurance Company (Empire).

1. The Empire insurance policy

The Empire insurance policy that covered the 2019 Chevrolet Malibu driven by Spann defines covered vehicles as expressly excluding vehicles while "operated by a person logged into a 'digital transportation network,' [ ]or while the 'auto' is being used to transport persons for hire." (ECF No. 26, Empire Policy (filed under seal), PageID.681.) "Digital transportation network" is defined as "any online-enabled application, software, website or system offered or utilized by a 'transportation network company' that enables the pre-arrangement of rides." (*Id.*) "Transportation network company" is "an entity that uses a 'digital transportation network' to enable the connection of drivers and passengers for 'ride-sharing' purposes." (*Id.*) "Ride-sharing" means "transportation in a personal 'auto' of the driver that is pre-arranged using a 'digital transportation network.' " (*Id.*) Empire explains that this includes, but is not limited to, Uber.

***2** As explained further below, Uber procured insurance from Allstate for its Michigan drivers when they are logged into Uber's network. Thus, Allstate is responsible for the payment of PIP benefits under Michigan's No Fault Act when drivers are logged into Uber's network.

2. Spann's request for PIP benefits from Empire

Before litigation involving Spann's PIP benefits commenced, Uber responded to an August 30, 2019, email from a claims specialist with ESIS/General Motors Claims Unit, Empire's third party claims administrator, notifying Uber of "an incident involving a 2019 Chevrolet Malibu" and inquiring as to whether Spann was logged into Uber's digital transportation network when the accident occurred. Uber responded to that email on September 2, 2019, stating "we can confirm that the driver was not logged into the application when the loss occurred." (ECF No. 24-7, 9/3/2017 Email, PageID.587-88.)

After litigation commenced in a separate action against Empire for PIP benefits by one of Spann's providers, Uber produced records in response to Empire's February 9, 2021, subpoena, again indicating that Spann was not logged into the Uber digital transportation network at the time of the July 29, 2019, accident. (ECF No. 24-7, Elizabeth Favaro Aff. ¶¶ 8-9, PageID.582.) (ECF No. 27, Uber records (under seal).)

However, in Spann's August 3, 2021, written discovery responses in this case, he admitted that he was logged into a digital transportation network (Uber) at the time of the accident "in a prearranged ride." (ECF No. 24-7, Spann's discovery responses, PageID.622.)

After receiving Spann's August 3, 2021, discovery responses, Empire contacted Uber yet again to re-confirm that it had no record of activity by Spann on Uber's application at the time of the accident on July 29, 2019. (ECF No. 24-7, Favaro Aff. ¶ 12, PageID.583.) In response to that inquiry, Uber responded on August 24, 2021, and for the first time produced records showing that Spann was indeed logged into Uber's application at the time of the accident. (ECF No. 28, Uber records (under seal).)

Thus, under the terms of the applicable insurance policies, Empire's policy does not provide coverage for Spann's July 29, 2019, accident, as he was logged into the Uber application at the time of the accident, and Allstate's policy would provide coverage, if claims for benefits under the Allstate policy are timely brought.

Empire states that it has received requests for payment of medical treatment, wage loss, and replacement services for and on behalf of Spann totaling more than $377,000. (ECF No. 24-2, Empire's Payment Log.) Before Uber finally informed Empire on August 24, 2021, that Spann was logged into Uber's digital transportation network at the time of the July 29, 2019, accident, Empire had paid $225,776.65 to Spann's medical providers and replacement service providers, as well as for wage loss to Spann. At the summary judgment hearing, counsel for Empire stated that it was not seeking payment in this case for provider claims subject to other

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litigation, and that it is now seeking reimbursement in this case for $192,989.11 it has paid to or on behalf of Spann.

3. The Allstate insurance policy

Uber procured insurance from Allstate for its Michigan drivers when they are logged into Uber's network. (ECF No. 24-4, Allstate discovery responses, PageID.554.)

***3** Allstate first received notice of Spann's July 19, 2019, accident on February 6, 2020, when ESIS/General Motors Claims Unit representative Sean Kelly electronically notified Uber of the accident, and Uber forwarded that notice to Allstate, which was received by Allstate's liability adjuster Erin Contreras. (ECF No. 55-2, Contreras Aff. ¶ 3, PageID.1366.) Allstate then opened a claim file for the matter. (*Id.* ¶ 4.) It is part of Allstate's regular business practice to include in a claim file copies of any and all notices, emails, letters, communications, bills, invoices, medical records, summaries of the contents of conversations, oral statements, or other material related to the accident. (*Id.*)

The February 6, 2020 "First Notice of Loss" indicated that the vehicle was not "being used for transportation as a Ride of Hire such as Uber of Lyft," (ECF No. 55-3, First Notice of Loss, PageID. 1372), which the parties now acknowledge is incorrect. That Notice indicates that there were no fatalities but otherwise does not contain any indication regarding whether there were any injuries to the person(s) involved in the accident. (*Id.* PageID.1374-75.)

Contreras, the Allstate liability adjuster, asserts that she investigated the Spann accident claim to determine what liability Allstate might have. (ECF No. 55-2, Contreras Aff. ¶ 6, PageID.1366-67.) She avers that she and another liability adjuster made several attempts to contact Spann through the contact information Spann provided to Uber, including calling and emailing Spann, but that Spann never responded to Allstate's communications. (*Id.* ¶ 7, PageID.1367.)

Contreras also obtained a copy of the police report for Spann's accident. (*Id.* ¶ 8, PageID.1367.) The July 29, 2019, police report states that Spann "refused" an ambulance or hospital and listed "0" under injury. (ECF No. 55-5, Police Report, PageID.1385.)

On February 21, 2020, Contreras spoke by telephone to an attorney representing Spann. (ECF No. 55-2, Contreras Aff. ¶ 9, PageID.1367.) Contreras placed a summary of that conversation in the claim file. (ECF No. 55-6, Claim file excerpt, PageID.1387.) According to the summary, Spann's attorney stated that Spann was not at fault for the accident, and that another insurer, Progressive, had accepted full responsibility for the accident. (*Id.*) The summary makes no mention of any statement or inquiry regarding any injuries.

On February 25, 2020, Contreras received the results of an Insurance Services Office Inc. (ISO) search for any insurance claims related to Spann's July 29, 2019, accident, and the search showed no matching claims for Spann. (ECF No. 55-2, Contreras Aff. ¶ 10, PageID.1367.) Contreras asserted that because Allstate had received no information that Spann was injured in the accident, she concluded her investigation of Spann's accident and did not open a PIP claim. (*Id.* ¶ 11, PageID.1367.) Contreras explained that it was Allstate's policy to open a PIP claim with respect to an accident only if it receives notice of possible injuries caused by the accident. (*Id.*)

According to Allstate, it did not receive any bills, liens, notices of any kind by Spann or on his behalf, or any other information that Spann was injured in the July 29, 2019, accident until over two years later, on October 25, 2021, when it was served with a lawsuit in a separate action by one of Spann's medical providers, Michigan Head and Spine Institute. (ECF No. 55-7, Hubert Aff. ¶ 11, PageID. 1393) (ECF No. 55-9, Claim file excerpt, PageID.1394-95.)

Allstate asserts that Spann first asserted a claim against Allstate seeking payment of No-Fault Act benefits on April 13, 2022, the date Spann filed his First Amended Complaint naming Allstate as a defendant in this case. Empire first asserted a cross-claim against Allstate on May 2, 2022.

B. Procedural History

1. The pleadings

***4** Spann filed this civil action against Defendant Empire in the Wayne County Circuit Court on February 18, 2021, alleging denial of PIP benefits under the Michigan No-Fault Act allegedly arising out of the July 29, 2019, motor vehicle accident. (ECF No. 1-2, Compl., PageID.11-15.) On May 6, 2021, Defendant Empire timely removed this case to this Court based on diversity jurisdiction. (ECF No. 1, Notice of Removal, PageID.1-6.)

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Spann filed his First Amended Complaint, adding Allstate as a Defendant, on April 13, 2022. (ECF No. 17, First Am. Compl.) Spann alleges that both Empire and Allstate have unreasonably denied or delayed payment of PIP benefits under Michigan's No-Fault Act.

On May 2, 2022, Empire filed an Answer to Spann's First Amended Complaint, and a Cross-Claim against Allstate. (ECF No. 19, Empire Answer/Cross-Complaint.) Empire asserts that its Policy does not provide coverage when vehicles are used to transport persons for hire or when the driver is logged into the Uber "digital transportation network," as it now knows Spann was, and thus Spann is not covered by the Empire policy for the July 29, 2019, accident. Empire asserts that Spann is instead covered by the Allstate insurance policy procured by Uber. Empire seeks reimbursement from Allstate for PIP benefits Empire has paid to and on behalf of Spann.

On June 1, 2022, Cross-Defendant Allstate filed its Answer to Empire's Cross-Claim (ECF No. 22, Cross-Defendant Allstate Answer), and on July 12, 2022, Defendant Allstate filed its Answer to Spann's First Amended Complaint. (ECF No. 35, Allstate Answer.)

2. Empire's Motion for Summary Judgment (ECF No. 24)

On June 3, 2022, Empire filed its Motion for Summary Judgment against Spann and Allstate. (ECF No. 24, Empire Mot.) Empire argues that there is no genuine issue of material fact that Uber's insurer, Allstate – not Empire – is obligated to pay Spann's PIP benefits because Spann was logged into Uber's digital transportation network when the July 29, 2019, accident occurred. Empire asserts that its policy does not cover Spann's PIP benefits, and Allstate must reimburse Empire for PIP benefits that Empire previously paid to or on behalf of Spann.

Spann did not file a Response in opposition to Empire's Motion for Summary Judgment.

Cross-Defendant Allstate filed a Response in opposition to Empire's Motion for Summary Judgment on June 27, 2022. (ECF No. 32, Allstate Resp.) Allstate argues that it did not have notice of Spann's injury within one year of the July 29, 2019, accident, and thus any subrogation claims by Empire are barred by the one-year statute of limitations and the one-year-back notice requirements under Mich. Comp. Laws 500.3145.

Empire filed a Reply brief in support of its summary judgment motion on July 11, 2022 (ECF No. 33), and also filed a Motion to Reopen Discovery that same day. (ECF No. 34.) Because Allstate joined this case after the close of discovery, the Court granted Empire's Motion to Reopen Discovery and reopened discovery "for the limited purpose of conducting depositions of Allstate's witnesses, Jessica Hubert and Erin Contreras, and to serve requests for production of documents on Allstate related to Allstate's notice defense." (ECF No. 36, Order.)

Following the close of the limited discovery, and pursuant to the Court's order allowing supplemental briefs, Empire filed a supplemental brief in support of its motion for summary judgment on February 2, 2023 (ECF No. 53), and Allstate filed a response to that supplemental brief on February 13, 2023 (ECF No. 54).

3. Allstate's Motion for Summary Judgment (ECF No. 55)

***5** On February 13, 2023, Allstate filed its Motion for Summary Judgment against Spann and Cross-Plaintiff Empire. (ECF No. 55, Allstate Mot.) Allstate argues that Spann's and Empire's claims for PIP benefits are time-barred under Michigan's No Fault Act by Spann's failure to give written notice of the nature of his injuries within one year of his accident, and by the one-year-back rule that bars claims for losses incurred more than one year before the date the action was commenced, under Mich. Comp. Laws 500.3145.

Spann did not file a Response in opposition to Allstate's motion for summary judgment.

On March 6, 2023, Empire filed its Response in opposition to Allstate's motion for summary judgment. (ECF No. 56, Empire Resp.) Empire argues that its recoupment claims are not claims for PIP benefits under the Michigan No Fault Act, and thus are not barred by Act's one year statute of limitations or its one-year-back rule and are instead subject to Michigan's six-year "catch-all" statute of limitations.

Allstate filed a Reply brief in support of its Motion for Summary Judgment on March 14, 2023. (ECF No. 57,

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Allstate Reply.) Allstate argues that Empire is seeking payment of No-Fault benefits, and thus its subrogation claim is barred by the No-Fault Act's statute of limitations and one-year-back rule.

II. LEGAL STANDARD

Summary judgment is appropriate where the moving party demonstrates that there is no genuine dispute as to any material fact. *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986); Fed. R. Civ. P. 56(a). "A fact is 'material' for purposes of a motion for summary judgment where proof of that fact 'would have [the] effect of establishing or refuting one of the essential elements of a cause of action or defense asserted by the parties.' " *Dekarske v. Fed. Exp. Corp.*, 294 F.R.D. 68, 77 (E.D. Mich. 2013) (quoting *Kendall v. Hoover Co.*, 751 F.2d 171, 174 (6th Cir. 1984)). A dispute is genuine "if the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-48 (1986).

"In deciding a motion for summary judgment, the court must draw all reasonable inferences in favor of the nonmoving party." *Perry v. Jaguar of Troy*, 353 F.3d 510, 513 (6th Cir. 2003) (citing *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986)). At the same time, the non-movant must produce enough evidence to allow a reasonable jury to find in his or her favor by a preponderance of the evidence, *Anderson*, 477 U.S. at 252, and "[t]he 'mere possibility' of a factual dispute does not suffice to create a triable case." *Combs v. Int'l Ins. Co.*, 354 F.3d 568, 576 (6th Cir. 2004) (quoting *Gregg v. Allen–Bradley Co.*, 801 F.2d 859, 863 (6th Cir. 1986)). Instead, "the non-moving party must be able to show sufficient probative evidence [that] would permit a finding in [his] favor on more than mere speculation, conjecture, or fantasy." *Arendale v. City of Memphis*, 519 F.3d 587, 601 (6th Cir. 2008) (quoting *Lewis v. Philip Morris Inc.*, 355 F.3d 515, 533 (6th Cir. 2004)). "The test is whether the party bearing the burden of proof has presented a jury question as to each element in the case. The plaintiff must present more than a mere scintilla of the evidence. To support his or her position, he or she must present evidence on which the trier of fact could find for the plaintiff." *Davis v. McCourt*, 226 F.3d 506, 511 (6th Cir. 2000) (internal quotation marks and citations omitted). " 'The central issue is whether the evidence presents a sufficient disagreement to require submission to a jury or whether it is so one-sided that one party must prevail as a matter of law.' " *Binay v. Bettendorf*, 601 F.3d 640, 646 (6th Cir. 2010) (quoting *In re Calumet Farm, Inc.*, 398 F.3d 555, 558 (6th Cir. 2005)). That evidence must be capable of presentation in a form that would be admissible at trial. *See Alexander v. CareSource*, 576 F.3d 551, 558–59 (6th Cir. 2009).

III. ANALYSIS

A. Spann's Claims Against Empire are Dismissed Because the Empire Insurance Policy Does Not Provide Coverage When Spann Was Logged Into a Digital Transportation Network at the Time of the Accident

***6** It is undisputed that Spann was logged into a digital transportation network when the July 29, 2019, accident occurred. It is further undisputed that Empire's Policy expressly excludes coverage for automobiles while "operated by a person logged into a 'digital transportation network.' " Empire's policy harmonizes with the Michigan No-Fault Act, which allows insurers to exclude coverage for PIP benefits while a driver is logged into a digital transportation network. *See* Mich. Comp. Laws 500.3017(1) (eliminating the insurance requirement when a driver "is logged into a transportation network company's digital network or while a transportation network company driver is providing a prearranged ride."). [1]

Thus, because the Empire insurance policy did not provide coverage for the 2019 Chevrolet Malibu when Spann was logged into the Uber network at the time of the July 29, 2019 accident, the policy does not provide PIP benefits to Spann for that accident, and Spann therefore is not entitled to PIP benefits from Empire. *See Pioneer State Mut. Ins. Co. v. Dells*, 301 Mich. App. 368, 378 (2013) ("A court cannot hold an insurance company liable for a risk that it did not assume.") (citing *Henderson v. State Farm Fire & Cas. Co.*, 460 Mich. 348, 354 (1999)).

Spann did not file a response to Empire's motion for summary judgment, and thus he has waived any opposition. When a plaintiff "fails to address [a claim] in response to a motion for

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summary judgment," the claim is deemed waived. *Haddad v. Sec'y, U.S. Dept. of Homeland Sec.*, 610 F. App'x 567, 568-69 (6th Cir. 2015) (quoting *Brown v. VHS of Mich., Inc.*, 545 F. App'x 368, 372 (6th Cir. 2013)). Where claims are so waived, district courts in this Circuit grant summary judgment as a matter of course. *See, e.g., Mahindra & Mahindra Ltd. v. FCA US LLC*, 503 F. Supp. 3d 542, 554 (E.D. Mich. 2020) (holding plaintiff entitled to summary judgment because defendant failed to substantively respond to plaintiff's arguments); *Design Basics, LLC v. Chelsea Lumber Co.*, 977 F. Supp. 2d 714, 737 (E.D. Mich. 2013) (failure to respond to an argument in a dispositive motion "is grounds for the court to deem opposition waived"); *Burress v. City of Franklin, Tenn.*, 809 F. Supp. 2d 795, 809 (M.D. Tenn. 2011) ("The plaintiff's leaving these claims wholly unaddressed and unsupported leads the Court to conclude that the plaintiff no longer wishes to pursue them."); *Dage v. Time Warner Cable*, 395 F. Supp. 2d 668, 679 (S.D. Ohio 2005) ("The Court finds that Plaintiff has abandoned any claim to FMLA relief on a theory of retaliatory harassment by failing to address this theory in responsive briefing.").

Because the undisputed facts show that Empire is not obligated to pay Spann's PIP benefits arising out of the July 29, 2019, motor vehicle accident, Empire's motion for summary judgment as to Plaintiff Spann will be granted and Spann's claims against Empire are dismissed with prejudice.

B. Allstate's Policy Provided Coverage for the 2019 Chevrolet Malibu While Spann was Logged Into Uber's Digital Transportation Network

As discussed above, it is now undisputed that Spann was logged into Uber's digital transportation network at the time of the July 29, 2019, accident.

***7** The Michigan Limousine, Taxicab, and Transportation Network Company Act requires transportation network companies to maintain automobile insurance on personal vehicles, including personal protection and property protection insurance, while the driver is logged into the company's digital network or engaged in a prearranged ride for the company. *See* Mich. Comp. Laws 257.2123. As required by that Act, Uber procured the Allstate Insurance Policy, which provided PIP benefits to Spann when he was logged into Uber's digital transportation network.

Allstate argues, however, that Spann's and Empire's claims against it are barred by the No-Fault Act's one year statute of limitations and one-year-back rule.

C. Spann's Claims Against Allstate for PIP Benefits are Time Barred

Allstate argues that Spann's claims against it are barred by the Michigan No-Fault Act's one-year statute of limitations at Mich. Comp. Laws 500.3145(1).

The Michigan No-Fault Act provides that:

> An action for recovery of personal protection insurance benefits payable under this chapter for an accidental bodily injury may not be commenced later than 1 year after the date of the accident that caused the injury *unless written notice of injury as provided in subsection (4)* has been given to the insurer within 1 year after the accident or unless the insurer has previously made a payment of personal protection insurance benefits for the injury.

Mich. Comp. Laws 500.3145(1) (emphasis added).

The Act further provides:

> The notice of injury required by subsection (1) may be given to the insurer or any of its authorized agents by a person claiming to be entitled to benefits for the injury, or by someone in the person's behalf. *The notice must give the name and address of the claimant and indicate in ordinary language the name of the person injured and the time, place, and nature of the person's injury.*

Mich. Comp. Laws 500.3145(4) (emphasis added).

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Accordingly, the No-Fault Act imposes a one-year statute of limitations from the date of an insured's accident to commence an action for recovery of PIP benefits, subject to two potential exceptions: (1) a "notice" exception, which avoids the statute of limitations if a statutorily-sufficient "written notice of injury ... has been given to the insurer within one year after the accident," and (2) a "payment" exception, which avoids the statute of limitations if "the insurer has previously made payment of personal protection insurance benefits for the injury." *Perkovic v. Zurich American Ins. Co.*, 500 Mich. 44, 50 (2017). The No-Fault Act is remedial in nature and thus "courts must liberally construe [the Act's] provisions in favor of the persons who are its intended beneficiaries." *Frierson v. W. American Ins. Co.*, 261 Mich. App. 732, 734 (2004) (quotation marks and citation omitted). "Further, courts should not abandon common sense when construing a statute." *Id.* (quotation marks and citation omitted).

Allstate asserts that Spann first filed suit against it on April 13, 2022, more than two years after the date of his accident on July 29, 2019, and thus well past the No-Fault Act's one-year statute of limitations. Allstate argues that the summary judgment evidence here shows that neither of the two exceptions to the one-year limitation on commencing a No-Fault action is available to revive Spann's untimely claim, asserting:

(1) Allstate first received notice of Spann's alleged motor vehicle accident on February 6, 2020, more than six months after it occurred, at which time it opened a claim for the matter and began an investigation but was not advised that Spann had any injuries at that time. (ECF No. 55-2, Contreras Aff. ¶ 3, PageID. 1366).

***8** (2) Allstate repeatedly and unsuccessfully sought to contact Spann to obtain a statement and information about the accident in February 2020. (*Id.* ¶ 7, PageID.1367).

(3) In February 2020, Allstate obtained a copy of a police report that showed there were no injuries from Spann's accident. (*Id.* ¶ 8) (ECF No. 55-5, Police Report, PageID. 1385).

(4) An Allstate representative spoke to Spann's attorney in February 2020 but, as reflected in the contemporaneous claim file notes made by Allstate's representative summarizing the conversation, the attorney did not report any injuries to Allstate. (ECF No. 55-2, Contreras Aff. ¶ 9, PageID. 1367) (ECF No. 55-6, Claim File excerpt, PageID. 1387).

(5) Allstate did not open a PIP claim with respect to Spann's injuries in February 2020, which it would have done had it been notified of any injuries caused by the accident at that time. (ECF No. 55-2, Contreras Aff. ¶ 11, PageID.1367-68).

(6) Allstate received no other information about Spann's accident, including any information about any alleged injuries to Spann, until October 25, 2021, when it was served with a lawsuit by Michigan Head and Spine Institute. (ECF No. 55-7, Hubert Aff. ¶ 11, PageID. 1393) (ECF No. 55-8, Claim File excerpt, PageID.1394-95).

(ECF No. 55, Allstate Mot., PageID.1349-50.)

Spann did not file a response to Allstate's motion for summary judgment, and thus has waived any opposition to it. As explained above, when a plaintiff "fails to address [a claim] in response to a motion for summary judgment," the claim is deemed waived, *Haddad*, 610 F. App'x at 568-69, and where claims are so waived, district courts in this Circuit grant summary judgment as a matter of course. *See, e.g., Mahindra & Mahindra Ltd.*, 503 F. Supp. 3d at 554 (holding plaintiff entitled to summary judgment because defendant failed to substantively respond to plaintiff's arguments).

Accordingly, the Court grants Allstate's motion for summary judgment against Spann and dismisses Spann's claims against Allstate with prejudice.

D. Empire's Claims Against Allstate are Time Barred

Allstate argues that Empire's claims are barred by the one-year statute of limitations, just as Spann's are. Empire argues in response that it is not seeking No-Fault benefits, and thus its claims against Allstate are not time-barred. The Court agrees with Allstate.

1. Empire is Seeking No-Fault benefits from Allstate

Empire first argues that its claims against Allstate are not barred by the No-Fault Act's one-year limitations period because it is not seeking benefits under the No-Fault Act from Allstate. Empire contends that because it had no obligations under the No-Fault Act to Spann (because he was logged

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into the Uber digital transportation network at the time of the accident), its payments to and on behalf of Spann were not paid under the No-Fault Act and Empire is asserting "only common law rights of recovery[.]" (ECF No. 56, Empire Resp., PageID.1441-44.) Empire argues that its claim is properly viewed as a claim for recoupment, governed by the catch-all six-year statute of limitations in Mich. Comp. Laws 600.5813. (*Id.*)

The Court is unpersuaded by Empire's argument and finds instead that Empire is seeking No-Fault benefits from Allstate.

***9** Empire asserts three claims against Allstate in its cross-complaint: (1) subrogation; (2) recoupment; and (3) a declaratory judgment that Allstate is required to pay Spann's PIP benefits. (ECF No. 19, Empire Cross-Complaint, PageID.112-14.) In these claims, Empire "seeks an Order requiring Allstate to reimburse Empire for PIP benefits that Empire has paid to and on behalf of [Spann], as well as costs, interest and attorney fees, and any other relief as the Court deems appropriate," and "to pay additional benefits allegedly incurred by [Spann] and future PIP benefits." (*Id.*) [2]

The Michigan Court of Appeals has held that "when a plaintiff insurance company mistakenly pays no-fault benefits, while another defendant insurance company had the obligation to pay the benefits in the first place because of it having a higher priority in the no-fault statutory scheme, the plaintiff's claim for reimbursement from the defendant is one of subrogation, and the limitations period in MCL 500.3145(1) applies." *Suburban Mobility Auth. for Reg'l Transp. v. Auto Club Ins. Ass'n*, No. 324132, 2016 WL 191923, at *2 (Mich. Ct. App. Jan. 14, 2016) (citing *Titan Ins. v. North Pointe Ins.*, 270 Mich. App. 339, 343-44 (2006)). That is precisely the claim Empire asserts here against Allstate. *See Button v. Progressive Mich. Ins. Co.*, Nos. 314836, 319312, 2014 WL 4375729, at *3 (Mich. Ct. App. Sept. 4, 2014) (holding that the action by an insurer who mistakenly paid benefits on behalf of an injured party against the priority payee, "even to the extent labeled a common-law claim for reimbursement for mistaken payments, is subject to the one-year-back rule[ ]" in 500.3154(1)). "[T]he statute does not provide, as it could have, a separate limitations period in the event of mistake." *Id.* (citing *Titan Ins.*, 270 Mich. App. at 347). "A no-fault insurer's claim for reimbursement on a subrogation theory is subject to the one-year statute of limitations set forth by MCL 500.3145(1), as unyielding as that rule may be." *Titan Ins. Co. v. State Farm Mut. Auto. Ins. Co.*, No. 321112, 2015 WL 4746240, at *3 (Mich. Ct. App. Aug. 11, 2015) (citing *Titan Ins.*, 270 Mich. App. at 343).

In a subrogation action, the subrogee [Empire] "stands in the shoes of the subrogor [Spann] and acquires no greater rights than those possessed by the subrogor." *Yerkovich v. AAA*, 461 Mich. 732, 737 (2000). Empire argues that its claim here is different because its policy did not provide coverage for Spann while he was logged into the Uber application. However, "just because [Spann] was not entitled to no-fault benefits from [Empire], [Empire's] subsequent payment of benefits and its attempt to recoup those expenses from [Allstate] do not transform its claim into something other than subrogation." *Suburban Mobility*, 2016 WL 191923, at *3.

***10** Thus, Empire here stands in the shoes of Spann, and it is entitled to no greater rights against Allstate than Spann has. Allstate argues that just as Spann's claims against Allstate are barred by the one-year limitations period of the Michigan No Fault Act, so are Empire's subrogation claims.

The Court finds that there is no dispute that Empire is seeking reimbursement of No-Fault benefits from Allstate. Empire's belated discovery that its Policy did not provide coverage for the July 29, 2019 accident, because of Uber's failure to timely provide evidence to Empire that Spann was in fact logged into Uber's digital transportation network at the time of the accident, does not save Empire's subrogation claim against Allstate. *See* *Titan Ins.*, 270 Mich. App. at 344-45 ("Belated discovery of the existence of the primary insurer does not operate to equitably toll the statute of limitations.").

Empire relies in part on *Madden v. Employers Insurance of Wausau*, 168 Mich. App. 33 (1988), as supporting its argument that its request for the recovery of no-fault benefits paid by mistake is not an action for subrogation and therefore does not implicate Mich. Comp. Laws 500.3145(1). However, *Madden* was issued before November 1, 1990, and is not binding pursuant to MCR 7.215(J)(1), which provides that "[a] panel of the Court of Appeals must follow the rule of law established by a prior published decision of the Court of Appeals issued on or after November 1, 1990, that has not been reversed or modified by the Supreme Court, or by a special panel of the Court of Appeals as provided in this rule."

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Further, subsequent, published decisions by the Michigan Court of Appeals have considered, and rejected, *Madden*, and held that the one-year statute of limitations properly applied when an insurer is suing another insurer on the basis that it paid benefits by mistake for which the defendant insurer was liable. *See, e.g.,* *Titan*, 270 Mich. App. at 343-44 (explaining that whatever label was attached to a claim by plaintiff, "actions between no-fault insurers for recovery of monies mistakenly paid by the secondary insurer" were claims of subrogation and subject to the limitations period in Mich. Comp. Laws 500.3145(1)); *Amerisure Cos. v. State Farm Mut. Auto. Ins. Co.*, 222 Mich. App. 97, 102-03 (1997) (rejecting *Madden* and holding that "actions between no-fault insurers for recovery of monies mistakenly paid by the secondary insurer" were claims of subrogation and subject to the limitations period in Mich. Comp. Laws 500.3145(1)); *see also Suburban Mobility*, 2016 WL 191923, at *3 (recognizing that *Madden*'s holding has been rejected). [3]

***11** The Court determines the nature of Empire's claims by looking at the nature of the claim that Spann would have against Allstate. *Progressive Mich. Auto. Ins. Co. v. Nat'l Cas. Co.*, No. 14-13859, 2015 WL 6082088, at 3 (E.D. Mich. Oct. 15, 2015) ("The nature of the lawsuit by a no-fault carrier in a subrogation action is determined by looking at the nature of the claim that the insured would have against the primary insure[r]") (citation omitted); *Auto Club Ins. Ass'n v. New York Life Ins. Co.*, 440 Mich. 126, 135 (1992). Here, that would be a claim for PIP benefits, and it is governed by the No-Fault Act's one-year statute of limitations. *See* *American Med. Sec., Inc. v. Auto Club Ins. of Michigan*, 238 F.3d 743, 751 (6th Cir. 2001) ("Simply put, *Titan* reiterated and confirmed what the Michigan courts have consistently held: that § 3145 applies to reimbursement suits between no-fault insurers."); *Progressive*, 2015 WL 6082088, at *3 ("As Davis's claim against National would have been for benefits under Michigan's no-fault act, Progressive's subrogation action is a no-fault claim as well.").

2. Empire's claims against Allstate are barred by the No-Fault Act's one-year statute of limitations

Allstate argues that Spann did not provide the timely and appropriate statutory written notice of injury under the No-Fault Act. The No Fault Act provides that the notice must be in writing and "shall give the name and address of the claimant and indicate in ordinary language the name of the person injured and the time, place *and nature of his injury.*" Mich. Comp. Laws 500.3145(1) (emphasis added). The statute, however, "does not mandate any particular format for this notice, nor does it require language "explicitly indicating a possible claim for benefits." *Perkovic*, 500 Mich. at 53-54 (noting that the Legislature could have elected to include such language in the statute, but it did not). Instead, substantial compliance with the purpose of Mich. Comp. Laws 500.3145(1) is sufficient to preserve a claim for No-Fault benefits. *Id.* at 52. And the statute only requires "the kind of notice that an ordinary layperson can provide." *Dillon v. State Farm Mut. Auto. Ins. Co.*, 501 Mich. 915 (2017) (explaining that simply providing "[a] description of symptoms that are traceable to a diagnosed injury" will suffice as notice of the "nature of the injury"). However, the statute requires more than mere notice that the claimant was "physically injured" – it must describe the nature of the injuries, which "refers to an injury's inherent characteristics." *Id.*

Allstate argues that the summary judgment evidence here establishes that it did not receive written notice of the nature of Spann's injuries within one year of the date of his accident. As discussed above, Allstate asserts that the summary judgment evidence demonstrates:

(1) Allstate first received notice of Spann's alleged motor vehicle accident on February 6, 2020, more than six months after it occurred, at which time it opened a claim for the matter and began an investigation but was not advised that Spann had any injuries at that time. (ECF No. 55-2, Contreras Aff. ¶ 3, PageID. 1366).

(2) Allstate repeatedly and unsuccessfully sought to contact Spann to obtain a statement and information about the accident in February 2020. (*Id.* ¶ 7, PageID.1367).

(3) In February 2020, Allstate obtained a copy of a July 29, 2019, police report that showed there were no injuries from Spann's accident. (*Id.* ¶ 8) (ECF No. 55-5, Police Report, PageID. 1385).

(4) An Allstate representative spoke to Spann's attorney in February 2020 but, as reflected in the contemporaneous claim file notes made by Allstate's representative summarizing the conversation, the attorney did not report any injuries to Allstate. (ECF No. 55-2, Contreras

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Aff. ¶ 9, PageID. 1367) (ECF No. 55-6, Claim File excerpt, PageID. 1387).

***12** (5) Allstate did not open a PIP claim with respect to Spann's injuries in February 2020, which it would have done had it been notified of any injuries caused by the accident at that time. (ECF No. 55-2, Contreras Aff. ¶ 11, PageID.1367-68).

(6) Allstate received no other information about Spann's accident, including any information about any alleged injuries to Spann, until October 25, 2021, when it was served with a lawsuit by Michigan Head and Spine Institute. (ECF No. 55-7, Hubert Aff. ¶ 11, PageID. 1393) (ECF No. 55-8, Claim File excerpt, PageID.1394-95).

(ECF No. 55, Allstate Mot., PageID.1349-50.)

Empire argues in its Response brief that a genuine issue of material fact exists regarding whether Allstate had notice of the injury. (ECF No. 56, Empire Resp., PageID.1445-46.) Empire contends that: (1) Contreras's February 6, 2020, email asked Spann to call her to "provide a statement and discuss the injuries and damages," (2) Allstate's electronic record flagged for "Injury and Compensation," and (3) Contreras's conversation with Spann's attorney on February 21, 2020, to discuss liability and Allstate's involvement, all together create an issue of fact as to notice. (*Id.*) Empire asserts that all of this activity occurred within one year of Spann's accident and "evince, at a minimum, a disputed factual question on whether Allstate had notice of Spann's injuries." (*Id.*) Empire does not explain, however, how any of these documents or communications constitute statutorily-sufficient written notice of the "nature" of Spann's claimed injuries within one year of the accident.

The Court finds that there is no summary judgment evidence that Allstate had the requisite statutory written notice of the "nature" of Spann's alleged injuries arising from the July 29, 2019, motor vehicle accident within one year of the accident. The February 6, 2020, notice Allstate received from the ESIS/General Motors Claim Unit representative did not mention any injuries. (ECF No. 55-2, Contreras Aff. ¶ 3, PageID.1366.) Allstate's form "First Notice of Loss Snapshot" only indicates no fatalities under the "Injury Details" portion of the notice but is otherwise silent regarding injuries. (ECF No. 55-3, First Notice of Loss Snapshot, PageID.1374-75.) Allstate obtained a copy of the July 29, 2019, police report, which also did not indicate any injuries, and which stated that Spann "appeared normal" and refused an ambulance and the hospital. (ECF No. 55-5, Police Report, PageID.1385.) And, there was no report of any injuries to Spann when Contreras spoke to Spann's attorney in February 2020. (ECF No. 55-6, Claim File excerpt, PageID.1387.) Thus, there is no summary judgment evidence of written notice to Allstate of any injury to Spann from the July 29, 2019, accident, much less notice of the "nature" of any alleged injury.

Contrary to Empire's argument, Allstate's February 6, 2020, email to Spann and Allstate's electronic "Participant" record do not provide summary judgment evidence supporting the requisite statutory notice under the No-Fault Act. The email asks Spann to contact Contreras "to provide a statement and discuss the injuries and damages." However, even construing that email liberally to imply that Allstate had notice of potential injuries from the accident, "merely providing notice that [he] was *physically* injured" is not enough under the Act and "ignores the requirement that the notice describe the 'nature of [his] injury.' " *Dillon*, 501 Mich. 915.

***13** Similarly, Allstate's electronic record with a checkmark by "Injury and Compensation" provides no indication as to the "nature" of Spann's claimed injuries. As the Michigan Supreme Court explained, "[i]f the Legislature had intended for notice of general physical injury to suffice, it would have stopped at 'notice of injury.' " *Id.*

The Michigan Court of Appeals' decision in *Morrissette v. Indian Harbor Insurance Company*, No. 359503, 2022 WL 17072815 (Mich. Ct. App. Nov. 17, 2022), though unpublished is instructive. In *Morrissette*, the plaintiff allegedly sustained injuries in a January 29, 2019, motor vehicle accident while operating her 2009 Ford Escape as a driver for Lyft. *Id.* at *1. Plaintiff did not immediately seek medical attention, and she reported the accident to Lyft. Plaintiff subsequently applied for PIP benefits through her insurer, AAA, and then filed suit against AAA following its denial of benefits. *Id.* The trial court granted AAA's motion for summary judgment because of a business pursuits exclusion in AAA's policy. *Id.* The plaintiff did not identify defendant Indian Harbor Insurance Company as Lyft's insurer until her litigation with AAA had commenced. *Id.* The plaintiff then filed her complaint against Indian Harbor on July 27, 2020, more than one year after the date of the accident. *Id.* The trial court granted Indian Harbor's motion for summary judgment, finding that the plaintiff's claims were time barred under Mich. Comp. Laws 500.3145(1)

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because written notice of the injury was not furnished to Indian Harbor within one year of the accident. *Id.*

On appeal, the Michigan Court of Appeals affirmed, finding that the plaintiff's timely notice to her insurer, AAA, and her employer, Lyft, did not constitute notice to defendant Indian Harbor for the purposes of Mich. Comp. Laws 500.3145. *Id.* at *3. The Court of Appeals stated that "plaintiff failed to demonstrate how a contractual relationship between defendant insurer and its insured, Lyft, would establish an agency relationship within the meaning of the statute and thus constitute notice to the insurer. *Id.* (citing *Boss v. Wolverine Ins. Co.*, 123 Mich. App. 175, 177 (1983) (holding that absent evidence that an agency relationship had been created between defendant insurer and its insured, notice provided by an injured plaintiff to his employer, the insured, did not constitute notice to the insurer)).

The Michigan Court of Appeals further held that the plaintiff failed to allege any unusual circumstances providing a basis to invoke judicial equitable powers as a means to disregard the plain language of Mich. Comp. Laws 500.3145(1). *Id.* at *4. The court stated that the plaintiff "had not cited any fraud, mutual mistake, or other conduct *by defendant [insurer]* that could have induced her action or inaction," and that her "inability to identify defendant [insurer] as the correct insurer also does not warrant tolling. *Id.* (emphasis added).

In this case, there is no evidence that Spann, or anyone else, timely provided statutorily sufficient written notice to Allstate of *any* injuries arising from the July 29, 2019, accident, much less notice of the "nature" of any claimed injuries. Accordingly, the Court finds that Spann's, and thus Empire's, claims against Allstate are barred by the applicable statute of limitations and dismisses those claims with prejudice.

***14** Allstate also argues that the "payment" exception to the No-Fault Act's one-year statute of limitations does not apply because Allstate had not received, let alone paid, any claims for PIP benefits to or for the benefit of Spann prior to being brought into this lawsuit. (ECF No. 55, Allstate Mot., PageID.1351-52.) Allstate asserts that, to the extent Spann or Empire argue that Allstate's February 2022 settlement of a separate provider lawsuit filed against it somehow revives claims that are already time-barred, that claim fails. Allstate contends that a payment of a settlement of a lawsuit, based on several factors, including the cost of litigation, interest, and potential attorney fees, is not a "payment of [PIP] benefits for the injury" under the No-Fault Act. Allstate argues that a settlement payment made after other claims are already time-barred does not resuscitate those time-barred claims. Allstate explained that it chose to settle one provider action more than a year and a half after Spann's ability to assert claims for PIP benefits already were time-barred. Allstate argues that Spann and Empire cite no authority for the proposition that by paying a small settlement in separate litigation Allstate is required by the Michigan No-Fault Act to pay claims that were previously time-barred.

Empire does not respond to this argument in its Response to Allstate's motion for summary judgment. However, Empire asserts in its Motion for Summary Judgment that "Allstate recognized its obligation to pay Spann's PIP benefits by settling with another Spann provider after Empire provided the Uber records to Allstate's counsel in a case filed against both Empire and Allstate." (ECF No. 24, Empire Mot., PageID.525 (citing ECF No. 24-5, Stipulated Order of Dismissal in *MMT Integrative Services v. Empire, et al.*, Case No. 21-01970-GC (44th Judicial District Court of Michigan), PageID.572-73).) Empire further contends in its Reply brief to its motion for summary judgment that Allstate's February 24, 2022, payment of a settlement in that action with another of Spann's providers satisfies the "payment" exception to the No-Fault Act's statute of limitations. (ECF No. 33, Empire Reply, PageID.1045-46.) Empire however cites no authority for the proposition that a settlement constitutes "payment of [PIP] benefits for the injury" under the No-Fault Act.

Without any information regarding the claims in the state court litigation or the terms of any settlement, and without any supporting case law, the Court finds that Empire has not provided sufficient summary judgment evidence of a "payment of [PIP] benefits" by Allstate for Spann's alleged injuries sufficient to meet the "payment exception" to the one-year statute of limitations in a No-Fault action.

In any event, even if Allstate's February 2022 settlement payment could be considered a "payment of [PIP] benefits for the injury" of Spann under Mich. Comp. Laws 500.3145(1), the Court finds that Empire's claims against Allstate nevertheless are barred by the No-Fault Act's one-year-back rule, as discussed next.

E. Empire's Claims Against Allstate are Barred by the One-Year Back Rule

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Allstate argues that, even if the No-Fault Act's statute of limitations did not bar Empire's claims, Empire would still be prohibited from asserting its claims against Allstate in this case by the No-Fault Act's "one-year-back rule" which provides:

> [I]f the notice has been given or a payment has been made, the action may be commenced at any time within 1 year after the most recent allowable expense, work loss, or survivor's loss has been incurred. However, the claimant may not recover benefits for any portion of the loss incurred more than 1 year before the date on which the action was commenced.

Mich. Comp. Laws 500.3145(2). Thus, the one-year-back rule limits recovery in an action for PIP benefits to those losses incurred within one year preceding the commencement of an action to recover such benefits. *Button*, 2014 WL 4375729, at *3 (citing *Devillers v. Auto Club Ins. Ass'n*, 473 Mich. 562, 574 (2005)). This rule applies to a subrogation claim. *Id.*; *Titan*, 270 Mich. App. at 346-47. Further, the one-year-back rule is not subject to judicial tolling, and it " 'draws a strict line, which must be followed even with unfair results.' " *State Farm Mut. Auto. Ins. Co. v. Travelers Indem. Co. of Conn.*, No. 1:19-cv-653, 2020 WL 5588771, at *2 (W.D. Mich. Sept. 4, 2020) (quoting *Bronson Methodist Hosp. v. Allstate Ins. Co.*, 286 Mich. App. 219, 229 (2009)). And, the one-year-back rule "appl[ies] to insurance companies who 'stand in the shoes' of a claimant, as occurs when one insurance company seeks reimbursement for no-fault benefits that should have been paid by another." *Titan Ins. Co.*, 2015 WL 4746240, at *1.

***15** Allstate argues that the "one-year-back rule" applies to No-Fault claims by an insured and to subrogation claims brought by one insurer against another. (ECF No. 55, Allstate Mot., PageID.1356, citing *Titan Ins.*, 270 Mich. App. at 345-46.) Allstate contends that all of the services at issue in Empire's cross-complaint are services allegedly incurred between August 2019 and December 2020. (*Id.* citing ECF No. 24-2, Empire Payment Log, PageID.542-47.)[4] All of those dates are more than one year before this action was commenced against Allstate, whether the Court considers the filing of Spann's First Amended Complaint on April 13, 2022, or Empire's cross-complaint on May 2, 2022.

Empire argues in its Response brief only that the one-year-back rule does not apply to bar its claim against Allstate because it contends that its claim is not for the recovery of PIP benefits. (ECF No. 56, Empire Resp., PageID.1446.)

However, as discussed above, Empire's claims against Allstate are equitable subrogation claims in which Empire stands in the shoes of Spann and its claims are subject to the strictures of the Michigan No-Fault Act. It does not matter what label Empire attaches to its claims, it is seeking to recover No-Fault benefits from Allstate. Indeed, in its cross-complaint, Empire asserts that "Allstate is liable to Empire for all PIP benefits Empire paid to and on behalf of Plaintiff," and that Empire "seeks an Order requiring Allstate to reimburse Empire for PIP benefits that Empire has paid." (ECF No. 19, Empire Cross-Complaint, ¶ 25, PageID.113.)

Thus, the Court finds that Empire's claims against Allstate, even if not time barred by the No-Fault Act's one-year statute of limitations, are barred by the Michigan No-Fault Act's one-year-back rule. *See State Farm Mut. Auto. Ins. Co.*, 2020 WL 5588771, at *2 ("The one-year back rule in § 500.3145(1) prevents State Farm from recovering benefits from Travelers that State Farm paid prior to July 10, 2018, to the individuals involved in the automobile accident giving rise to this lawsuit."); *Progressive Mich. Auto. Ins. Co.*, 2015 WL 6082088, at *4 (finding insurer's claim for reimbursement barred by the one-year-back rule).

F. Res Judicata

Finally, both Allstate and Empire argue that rulings by a Michigan state district court act as res judicata to the claims asserted here. (ECF No. 55, Allstate Mot., PageID. 1357) (ECF No. 56, Empire Resp. PageID.1443, 1447.) Specifically, Allstate argues that the Michigan state district court's September 13, 2022, ruling that claims for No-Fault benefits against Allstate related to Spann's accident were barred by the one-year statute of limitation acts as res judicata here. (ECF No. 55-10, Order, PageID.1430-31.) However, prior to issuing that decision, the same state district court granted Empire's motion for summary judgment against Allstate on June 2, 2022, (without any opinion or substantive explanation for the decision) and ordered Allstate to reimburse certain amounts Empire had paid to one of

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Spann's providers, Michigan Head & Spine. (ECF No. 56-5, Order, PageID.1551-52.) Empire argues that this order acts as res judicata.

Allstate explains in its Reply brief that these two rulings are clearly inconsistent, and Allstate is appealing the state district court's grant of summary judgment against it. Counsel for the parties subsequently explained at the August 2, 2023, summary judgment hearing that the Wayne County Circuit Court has since ruled in Allstate's favor, and that the decisions have now been appealed by Empire to the Michigan Court of Appeals, which appeal remains pending.

***16** The Court declines to afford res judicata or collateral estoppel to either Empire or Allstate. Courts use the doctrine of res judicata to prevent multiple suits litigating the same cause of action. *Washington v. Sinai Hosp. of Greater Detroit*, 478 Mich. 412, 418 (2007). It bars a subsequent action when (1) the prior action was decided on the merits, (2) both actions involve the same parties or their privies, and (3) the claims in the second case were, or could have been, resolved in the first case. *Adair v. Michigan*, 470 Mich. 105, 121 (2004). "If the same facts or evidence would sustain both, the two actions are the same for the purpose of res judicata." *Peterson Novelties, Inc. v. Berkley*, 259 Mich. App. 1, 11 (2003) (citations omitted).

For collateral estoppel to apply, three elements must be satisfied: "(1) a question of fact essential to the judgment must have been actually litigated and determined by a valid and final judgment; (2) the parties or privies must have had a full [and fair] opportunity to litigate the issue; and (3) there must be mutuality of estoppel." *Monat v. State Farm Ins. Co.*, 469 Mich. 679, 682-684 (2004) (internal quotation marks and citations omitted). The party seeking the benefit of preclusion bears the burden of proof. *See Browning v. Levy*, 283 F.3d 761, 771-72 (6th Cir. 2002); *Winget v. JP Morgan Chase Bank, N.A.*, 537 F.3d 565, 572 (6th Cir. 2008) ("The party asserting the defense of res *judicata* bears the burden of proof.").

The parties have not met their burden here. Without a substantive opinion from the state courts explaining the facts and evidence considered by the state courts, the specific findings of the courts, and the bases of the inconsistent rulings granting the dismissal and summary judgment, this Court cannot know what issues the state courts considered and the bases for the rulings. Empire in fact argues in its Response to Allstate's motion for summary judgment that there is no evidence that the payments sought in the state court action are in fact the same payments sought to be recovered here, and that "the overwhelming majority of the payments sought to be recovered in this case have **nothing to do** with Michigan Head and Spine." (ECF No. 56, Empire Resp., PageID.1446-47 (emphasis in original).)

The Court therefore declines to afford res judicata or collateral estoppel to either Empire or Allstate.

IV. CONCLUSION

For the reasons set forth above, the Court **GRANTS IN PART AND DENIES IN PART** Defendant Empire Fire and Marine Insurance Company's Motion for Summary Judgment (ECF No. 24), and **GRANTS** Allstate's Motion for Summary Judgment (ECF No. 55).

Specifically, the Court **GRANTS** both Empire's Motion for Summary Judgment and Allstate's Motion for Summary Judgment as to Plaintiff Spann, and **DISMISSES** Plaintiff Spann's claims against both Defendants **WITH PREJUDICE**.

The Court **DENIES** Empire's Motion for Summary Judgment as to Defendant/Cross-Defendant Allstate, and **GRANTS** Allstate's Motion for Summary Judgment as to Defendant/Cross-Plaintiff Empire, and **DISMISSES** Empire's cross-claim against Allstate **WITH PREJUDICE**.

IT IS SO ORDERED.

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Footnotes

1 As discussed more fully *infra*, digital transportation network company drivers are not left without PIP coverage because the Michigan Limousine, Taxicab, and Transportation Network Company Act requires transportation network companies to maintain automobile insurance on personal vehicles, including personal protection and property protection insurance, while the driver is logged into the company's digital network or engaged in a prearranged ride for the company. *See* Mich. Comp. Laws 257.2123.

2 As Allstate correctly asserts in its Motion for Summary Judgment, Empire's declaratory judgment claim – seeking a declaratory judgment that "Allstate is the responsible insurer for all of [Spann's] PIP benefits related to the alleged accident," is plainly barred by Spann's failure to give written notice of his injuries to Allstate within one year of his accident, as found *infra*, as Empire cannot obtain a declaratory judgment that Allstate must pay claims for PIP benefits to Spann that Spann himself cannot assert. (*See* ECF No. 55, Allstate Mot., PageID.1355-56.) Because Allstate is entitled to summary judgment on Spann's claims for payment of PIP benefits, Empire cannot be entitled to a judgment declaring that Allstate is required to pay PIP benefits to Spann, and this claim is dismissed.

3 The additional cases Empire relies on in its Response brief do not support a different finding. In *Auto Club Insurance Association v. New York Life Insurance Company*, 440 Mich. 126 (1992), the No-Fault insurer was entitled to the benefit of the six-year statute of limitations applicable to ERISA health plans when claiming payment from the group medical plan, because that is the same claim the subrogor claimant would have had. In *Hofmann v. Auto Club Insurance Association*, 211 Mich. App. 55, 117-18 (1995), the no-fault insurer sought to recover payments to medical providers for overcharges and charges outside the scope of chiropractic *from those medical providers*, in other words non-PIP payments and not from another no-fault insurer. The *Hofmann* court held that because none of the counterclaims for reimbursement from the recipients of payments involve actions for the recovery of no-fault benefits that are "payable under [the Act]," the No-Fault Act's one year statute of limitations did not apply.

4 Counsel for Empire clarified at the August 2, 2023, hearing on Defendants' motions for summary judgment that Empire is no longer seeking recovery of PIP benefits paid to certain of Spann's providers that are separately litigating claims related to Spann's July 29, 2019, accident. Specifically, Empire no longer seeks recovery of PIP benefits paid to the following providers: Michigan Head and Spine; Spine Specialists; ZMC Pharmacy; and, Farmbrook/Wook.

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EXHIBIT G

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2020 WL 2836326
Only the Westlaw citation is currently available.
United States District Court, E.D. Michigan, Southern Division.

Nancy MOORE, et al., Plaintiffs,
v.
AUTO CLUB SERVICES, et al., Defendants.

Case No: 19-10403
|
Signed 05/31/2020

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ORDER GRANTING IN PART AND DENYING IN PART DEFENDANTS' MOTION TO DISMISS [ECF No. 11]

DENISE PAGE HOOD, UNITED STATES DISTRICT JUDGE

I. INTRODUCTION

***1** Plaintiffs filed this 28 U.S.C. § 1332(d)(2) Class Action Complaint ("Complaint") on February 8, 2019, alleging that Defendants underpaid the proper amount of attendant care benefits owed to the members of the class under Subsection 3107(1)(a) of the Michigan Automobile No-Fault Insurance Act (the "Act"). On April 18, 2019, Defendants collectively filed a Rule 12(b)(6) Motion to Dismiss. [ECF No. 11] Defendants' Motion to Dismiss has been fully briefed, and the Court held a hearing on July 24, 2019 regarding the Motion to Dismiss. [1] At the hearing, the parties agreed that the Court should address only two of the issues in the Motion to Dismiss and that Plaintiffs' could file an amended complaint with respect to the remaining claims and issues. The Court entered a Stipulated Order Regarding Defendants' Motion to Dismiss setting forth that agreement. ECF No. 27.

The Stipulated Order provided that the Court was to decide, and this Order addresses, the following two issues:

1. Whether the One-Year-Back Rule bars claims for damages incurred prior to February 8, 2018 and is not subject to tolling; and

2. Whether Count IV should be dismissed because Michigan does not recognize a claim for bad faith breach of contract.

The Stipulated Order provided that the Court was dismissing without prejudice the following six arguments contained in Motion to Dismiss and gave Plaintiffs the right to file an amended complaint relating to those arguments:

> Argument I. – Plaintiffs fail to state plausible claims or establish Article III standing by lumping all Defendants together in violation of FRCP 8;
>
> Argument III. – Plaintiffs' fraudulent concealment theory fails as a matter of law;
>
> Argument IV. – Plaintiffs failed to plead fraudulent concealment with specificity as required under FRCP 9(b);
>
> Argument V.A. – The claim for breach of implied covenant of good faith and fair dealing should be dismissed; and
>
> Argument V.C. – Plaintiffs failed to plead the elements of unjust enrichment (Count III) and there is an express written contract between the parties governing the same subject matter arguments contained in Defendants' Brief in Support of Motion to Dismiss.

Plaintiffs filed an amended complaint two weeks later. *See* ECF No. 28.

For the reasons that follow, the Court grants in part and denies in part Defendants' Motion to Dismiss.

II. BACKGROUND

A. Plaintiffs

The three named Plaintiffs have sued on behalf of themselves and request that they be representatives of a class. ECF No. 1 at ¶64. These three individuals will be collectively referred

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to as "Plaintiffs" and, when appropriate, the class will be referred to as "Plaintiff Class."

***2** Plaintiffs currently have no-fault personal injury protection ("PIP") claims filed with Defendants and are receiving attendant care benefits. ECF No. 1 at ¶35. All Plaintiffs have been receiving these benefits at least since 2005. ECF No. 1 at ¶¶15-17. Each of the Plaintiffs' attendant care benefits are being used to pay for family provided attendant care. ECF No. 1 at ¶1. All allegations in the Complaint are based on Defendants' alleged "systematic underpayment of family provided/non-agency provided attendant care benefits ("Benefits") through the use of a series of reports [referred to as the "P&M Surveys" that] they [Defendants] falsely claimed were valid surveys of commercial agency payment rates for attendant care providers." ECF No. 1 at ¶7.

Plaintiffs' PIP claims have been adjusted by Defendants. ECF No. 1 at ¶¶15-17. Plaintiffs allege Defendants relied on the P&M Surveys to determine class benefits for their family provided attendant care services and adjusted Plaintiffs' claims. ECF No. 1 at ¶36. Plaintiffs allege that Defendants' use of the P&M Surveys was improper and injured Plaintiffs by causing them to receive less money for their family provided attendant care benefits. ECF No. 1 at ¶7.

Litigation and discovery by Defendants in a prior case revealed that the P&M Surveys were created under the direction of a lawyer and Vice President at AAA. ECF No. 1 at ¶50. Testimony in that case, by the creator of the P&M Surveys, revealed the survey "lacked valid statistical authority." ECF No. 1 at ¶52. Other testimony, by the director of casualty claims for AAA, acknowledged that the rates in the P&M Surveys were not adjusted after 2011 and that the company used previous P&M Surveys to determine class benefits. ECF No. 1 at ¶54.

As individuals and as class representatives, Plaintiffs have filed a four-count Complaint against all Defendants: (1) Count I – violation of the Act; (2) Count II – breach of contract and breach of implied covenant of good faith and fair dealings; (3) Count III – unjust enrichment; and (4) Count IV - bad faith breach of contract.

B. Plaintiff Class

Plaintiffs seek to establish a representative class under FRCP 23(a) for all individuals who received attendant care benefits from Defendants for the Class Period either at: (1) a "home health aide rate;" or (2) a "higher than a home health aide rate." ECF No. 1 at ¶64. Plaintiffs also bring suit on behalf of the sub-class of individuals who received benefits from Defendants during the Class Period while residents of states that provided for bad faith claims. ECF No. 1 at ¶64. Plaintiffs have pleaded facts sufficient to meet the requirements of a class action suit as outlined by FRCP 23(a) and FRCP 23(b). See ECF No. 1 at ¶¶63-94.

The "Class Period" covered by the claim is in dispute. Plaintiffs allege that Defendants committed fraud by concealing their use of P&M Surveys. Plaintiffs assert that, because of the alleged fraudulent action by the Defendants, Michigan's no-fault one-year back rule should be tolled for two years with respect to Plaintiffs' claims.

III. APPLICABLE LAW & ANALYSIS

A Rule 12(b)(6) motion to dismiss tests the legal sufficiency of the plaintiff's complaint. The Court must accept all well-pleaded factual allegations as true and review the complaint in the light most favorable to the plaintiff. *Eidson v. Tennessee Dep't of Children's Servs.*, 510 F.3d 631, 634 (6th Cir. 2007); *Kottmyer v. Maas*, 436 F.3d 684, 688 (6th Cir. 2006).

As a general rule, to survive a motion to dismiss, the complaint must state sufficient "facts to state a claim to relief that is plausible on its face." *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 570, 127 S.Ct. 1955, 167 L.Ed.2d 929 (2007). The complaint must demonstrate more than a sheer possibility that the defendant's conduct was unlawful. *Id.* at 556, 127 S.Ct. 1955. Claims comprised of "labels and conclusions, and a formulaic recitation of the elements of a cause of action will not do." *Id.* at 555, 127 S.Ct. 1955. Rather, "[a] claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Ashcroft v. Iqbal*, 556 U.S. 662, 678, 129 S.Ct. 1937, 173 L.Ed.2d 868 (2009).

IV. ANALYSIS

A. Effect of One-year-back Rule in PIP Cases of Fraudulent Concealment

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***3** Defendants argue that MCL 500.3145 ("one-year-back rule") is not subject to tolling based on MCL 600.5855 ("fraudulent concealment") because the two statutes have independent functions. Defendants argue the one-year-back rule functions as a "damage-limiting provision" that determines the amount of recoverable damages, and the fraudulent concealment statute functions to determine when a claim can be brought by a plaintiff. ECF No. 11, PgID 75-77. Due to the independent functions of the two statutes, Defendants argue that the damages period for the Plaintiffs' PIP claims cannot be extended two years based on Plaintiffs' allegations of fraudulent concealment. *Id.* at 75. Defendants state, "The Complaint was filed on February 8, 2019, so all alleged damages prior to February 8, 2018 are barred." *Id.*

Defendants rely on four Michigan cases that held Michigan's one-year-back rule was not subject to tolling based on: (a) a minority/insanity statute (*Joseph* and *Cameron*); (b) a political subdivisions statute (*Liptow*); or (c) the tolling provision of MCL 600.5856 (*Farm Bureau*). *See Joseph v. Auto Club Ins Ass'n*, 491 Mich. 200, 203, 815 N.W.2d 412 (2012); *Cameron v. Auto Club Ins Ass'n*, 476 Mich. 55, 72, 718 N.W.2d 784 (2006); *Liptow v. State Farm Mut Auto Ins Co.*, 272 Mich. App. 544, 549, 726 N.W.2d 442 (2006); *Attendant Care Companies v. Farm Bureau Gen. Ins. Co. of Michigan*, No. 340205, 2018 WL 6252058, at *7 (Mich. Ct App, November 29, 2018). Defendants also cite a case where the court dismissed an alleged fraudulent concealment claim by a plaintiff. *Basirico v. State Farm Mut. Auto. Ins. Co.*, No. 05-CV-74691, 2007 WL 1520770, at *1, 2006 U.S. Dist. LEXIS 87761, at *42 (E.D. Mich. 2006).

Plaintiffs argue that the one-year-back rule is subject to tolling in cases where defendants have a claim of fraud pleaded against them. ECF No. 17 PgID 123. Plaintiffs state "a fraud action may be maintained against no-fault insurers as long as the separate and distinct elements of fraud are pleaded and proved." *Id.* at 127, 718 N.W.2d 784. Plaintiffs insist they have properly pleaded fraudulent concealment in the Complaint, such that their claim period should be tolled by two years. *Id.* at 124, 718 N.W.2d 784. Plaintiffs rely on a Michigan Supreme Court case holding that the one-year-back rule did not apply to an "independent" fraud claim that arose from a no-fault claim. *Cooper v. Auto Club Ins Ass'n*, 481 Mich. 399, 405, 751 N.W.2d 443 (2008). Plaintiffs maintain fraud claims allow tolling, but also acknowledge courts have not addressed how the one-year-back rule applies specifically to a claim of fraudulent concealment. ECF No. 17 PgID 126.

MCL 500.3145(2) provides that "the [insurance] claimant may not recover benefits for any portion of the loss incurred more than 1 year before the date on which the action was commenced." This one-year-back rule limits recovery of PIP benefits. PIP benefits include "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). The "one-year-back-rule applies only to actions brought under the no-fault act." *Cooper*, 481 Mich. at 405, 751 N.W.2d 443. In *Cooper,* the Michigan Supreme Court found "because fraud claims are independent of and distinct from no-fault claims, the one-year-back rule of the no fault act simply does not apply" to fraud claims. *Id. at* 450, 751 N.W.2d 443. "Where fraudulent conduct results in the loss, or reduced payment, of PIP benefits, plaintiffs are entitled to seek damages for their entire loss, including the equivalent of the no-fault benefits." *Id.* at 413, 751 N.W.2d 443. "Therefore, where an insured's claim arises not out of the insurer's mere failure to pay no-fault benefits, but out of the insurer's fraudulent misrepresentations, which might have ultimately led to payment of reduced no-fault benefits to the insureds, the courts are faced with a fraud claim, as opposed to a no-fault claim." *Id. at* 412, 751 N.W.2d 443. "Trial courts should exercise special care in assessing these types of fraud claims ... [because] fraud must be pleaded with particularity." *Id. at* 414, 751 N.W.2d 443 referencing MCR 2.112(B)(1).

***4** The Court rejects Defendants' argument that Plaintiffs' damages are limited by the one-year-back rule. Plaintiffs have pleaded that the Defendants committed fraudulent concealment by not disclosing the use of the P&M Surveys that caused Plaintiffs injury, ECF No. 1 ¶¶ 61-62, and therefore pleaded a fraud claim such that the "one-year-back rule ... simply does not apply." *Cooper*, 481 Mich. 399 at 450, 751 N.W.2d 443. As the *Cooper* court recognized, "a common-law cause of action for fraud is not subject to the one-year-back rule." *Id.* at 445, 751 N.W.2d 443.

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If Plaintiffs plead their fraudulent concealment claim with particularity,[2] the damages period for the Plaintiffs' PIP claims are not limited by the one-year-back rule.

Defendants' reliance on *Joseph*, *Cameron*, *Liptow*, and *Farm Bureau* is not persuasive because none of the cases involve allegations of fraud against a defendant. *Joseph*, 491 Mich. at 414, 817 N.W.2d 528; *Cameron*, 476 Mich. at 74, 718 N.W.2d 784; *Liptow*, 272 Mich.App. at 445, 726 N.W.2d 83; *Farm Bureau*, 2018 WL 6252058 at *7. *Basirico* also does not support their argument, as the court noted that "it remains possible for [plaintiff] to develop a factual record at trial that would support recovery under these non-contractual claims for damages other than damages for the recovery of no-fault insurance benefits." *Basirico*, 2007 WL 1520770, at *1, 2006 U.S. Dist. LEXIS 87761, at *42. This ruling contravenes Defendants' argument that the one-year-back rule will apply to Plaintiffs' claim despite Plaintiffs' allegations of fraud.

For the reasons stated above, the Court concludes that the one-year-back rule does not apply to PIP claims when a plaintiff properly alleges their injury is a result of fraudulent concealment.

The Court also notes that the parties filed supplemental briefs to address whether an amendment to M.C.L. § 500.3145 that became effective on June 11, 2019 constituted the intent of the Michigan Legislature to convert the one-year-back-rule to a statute of limitation or leave it as a limitation on damages. At issue is the following new subsection:

> (3) A period of limitations applicable under subsection (2) to the commencement of an action and the recovery of benefits is tolled from the date of a specific claim for payment of the benefits until the date the insurer formally denies the claim. This subsection does not apply if the person claiming the benefits fails to pursue the claim with reasonable diligence.

M.C.L. § 500.3145(3). Plaintiffs argue that the amendment constitutes a statute of limitations because the language used in the new provision was "A period of limitations ..." Plaintiffs do not cite anything in the legislative history of the amendment to indicate that the Michigan Legislature intended that the amendment be a statute of limitations.

Defendants contend that limitation on damages provision in M.C.L. § 500.3145(2), as recognized by the courts, has not changed. *See* M.C.L. § 500.3145(2) (which includes the unchanged provision, "However, the claimant may not recover benefits for any portion of the loss incurred more than 1 year before the date on which the action was commenced."). Defendants rely on *Van Emon v. State Farm Mut. Auto. Ins. Co.*, No. 05-72638, 2007 WL 275882, at *8 (E.D. Mich. Jan. 26, 2007) ("recovery of no-fault [attendant care] benefits, no matter the theory of recovery, will be limited as a matter of law under [M.C.L.] § 500.3145(1)"); and *VHS of Michigan, Inc. v. Farm Bureau Gen. Ins. Co. of Michigan*, No. 344583, 2019 WL 3436566, at *3 (Mich. Ct. App. July 30, 2019).

***5** The language of M.C.L. § 500.3145 related to the limitation on damages ("However, the claimant may not recover benefits for any portion of the loss incurred more than 1 year before the date on which the action was commenced," M.C.L. § 500.3145(2)) remains intact and there is no indication that the intent of the amendment noted by Plaintiffs was to change that section or the recognized (and conceded) interpretation by the courts. The Court therefore concludes that the amendment does not change the bar on recovery of losses incurred more than one year prior to the date the lawsuit was filed (which is February 8, 2018) and has no impact on the one-year-back rule argument.

B Count IV - Bad Faith Breach of Contract

Defendants contend that Plaintiffs' bad faith breach of contract claim should be dismissed because "Michigan law applies and Michigan does not recognize an independent tort of bad faith breach of contract." ECF No. 11, PgID 88. Defendants acknowledge that Plaintiffs want to apply Nevada law because one of the Plaintiffs is a resident of Nevada. *Id.* Defendants maintain that Michigan choice-of-law rules should apply because: (1) at the time of accident all Plaintiffs were Michigan residents; (2) all Plaintiffs' accidents occurred in Michigan; (3) all Plaintiffs had Michigan insurance

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policies; and (4) all Defendants are Michigan entities. ECF No. 11, PgID 88-89. *See Magda v. Auto Club Ins. Ass'n*, No. 14-12144, 2015 WL 13036945, at 5 (E.D. Mich. Apr. 28, 2015) (Michigan law would apply despite the plaintiff in the case being a thirty-year resident of Florida).

Plaintiffs argue that there is no choice of law issue in the case because there is "no conflict of laws." ECF No. 17 PgID 136. Plaintiffs argue their "bad faith breach of contract claim [is] only on behalf of a state law subclass" and that because "these class members' bad faith claims are sufficiently similar, or identical, the criteria for a sub-class under Rule 23 is met and warranted." ECF No. 17 PgID 136. Plaintiffs also argue that Defendants' reliance on *Magda* is misplaced because *Magda* involved a situation where the state laws conflicted. In this case, Plaintiffs argue, the laws of Nevada and Michigan can be applied without conflict. Plaintiffs do not cite any case law to support their argument.

"When deciding matters of supplemental jurisdiction, a federal court must apply the substantive law of the forum state in which it sits, including the forum state's choice-of-law rules." *Menuskin v. Williams,* 145 F.3d 755, 761 (6th Cir. 1998). Under Michigan law, a tort claim is governed by the law of the forum unless a "rational reason" exists to displace it. *Watkins & Son Pet Supplies v. Iams Co.,* 254 F.3d 607 (6th Cir. 2001) (quoting *Olmstead v. Anderson,* 428 Mich. 1, 29–30, 400 N.W.2d 292 (1987)).

The Court grants Defendants' motion to dismiss Plaintiffs' bad faith breach of contract because Michigan's interest predominates. Plaintiffs have failed to make an argument that supports Nevada's interest in having their law applied. Plaintiffs' argument is limited to how both laws can be applied in a way that does not conflict, and that is not a rational reason to displace Michigan law.

Michigan has an interest in governing and applying Michigan laws to both its residents and entities in the state of Michigan. Because all Plaintiffs and Defendants are currently domiciled or were domiciled in Michigan at some point, Michigan interest predominates. The Michigan Legislature has decided not to recognize the claim of bad faith breach of contract, and Michigan has an interest in ensuring that the Defendants, who are Michigan entities, are not (if found liable) penalized under the laws of another state. The subclass of Plaintiffs who take residence in other states are also members of the larger Plaintiff Class. Therefore, if the Plaintiff Class is successful, all members of the class will benefit from a remedy under Michigan laws.

***6** For the reasons stated above, the Court dismisses Plaintiffs' bad faith breach of contract claim.

V. CONCLUSION

Accordingly,

IT IS ORDERED that Defendants' Motion to Dismiss [ECF No. 11] is GRANTED IN PART and DENIED IN PART.

IT IS FURTHER ORDERED that Defendants' Motion to Dismiss is GRANTED with respect to Plaintiffs' bad faith breach of contract claim (Count IV of Plaintiffs' Complaint).

IT IS FURTHER ORDERED that Defendants' Motion to Dismiss is DENIED with respect to Plaintiffs' remaining claims (Counts I-III of Plaintiffs' Complaint).

IT IS ORDERED.

All Citations

Not Reported in Fed. Supp., 2020 WL 2836326

Footnotes

1 Two days before the hearing, Plaintiffs filed a Notice of Supplemental Authority. [ECF No. 24] Defendants immediately filed a Motion for Leave to File Response to Plaintiffs' Notice of Supplemental Authority. [ECF No. 25] The Court grants Defendants' Motion for Leave to File Response, and the Court has reviewed and considered the parties' arguments in both of those filings in determining the one-year back rule issue addressed in this Order.

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2 Pursuant to the parties' Stipulated Order Regarding Defendants' Motion to Dismiss, ECF No. 27, Plaintiffs were permitted to amend their Complaint with respect to – and the Court would not address arguments in the Motion to Dismiss regarding – Plaintiffs' fraudulent concealment claim.

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