SMITH & BRINK
MICHIGAN QUARTERLY NEWSLETTER

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WELCOME

Welcome to Smith & Brink's Michigan Quarterly Newsletter. Smith & Brink is a national law firm with offices in Massachusetts, Michigan, New Jersey, New York, Pennsylvania, and Rhode Island that concentrates in complex civil litigation and anti-fraud work, including RICO, False Claims Act, healthcare, fraud recovery, class action, commercial, insurance litigation, and internal investigations. The goal of this newsletter is to inform our readers about recent court opinions in the area of Michigan no-fault insurance law, provide legal news pertaining to Michigan health insurance fraud, and to share recent updates about our Michigan office. We hope that you find the contents of this newsletter to be both informative and useful.

Sincerely,
The Smith & Brink Michigan Team

RECENT MICHIGAN COURT OPINIONS OF INTEREST

FRAUD

Recent Court of Appeals decisions on PIP cases involving fraud in the wake of *Bahri v IDS Prop Cas Ins Co*: evidence that specifically and directly contradicts representations made by a plaintiff in support of his/her claim for benefits warrants dismissal.

In *Bahri v IDS Prop Cas Ins Co*, 308 Mich App 420 (2014), the Court of Appeals upheld the trial court's dismissal of the plaintiff-insured's entire claim for benefits, based on the fraud provision contained in plaintiff's insurance policy, where there was no genuine issue of material fact that the plaintiff had committed fraud in submitting replacement care claims and that this fraud required that the plaintiff's entire claim be barred. In the wake of *Bahri*, the Michigan Court of Appeals has recently released several unpublished decisions addressing the dismissal, or attempted dismissal, of insured-plaintiff's claims for benefits due to fraud. These cases taken together stand for the proposition that a plaintiff is ineligible for benefits when an insurance company has evidence that directly and specifically contradicts representations made by an insured in support of his/her claim for benefits.

In *Thomas v Frankenmuth Mut Ins Co*, unpublished opinion per curiam of the Court

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of Appeals, issued July 12, 2016 (Docket No. 326744), plaintiff claimed PIP benefits, including transportation benefits. During the plaintiff's deposition, plaintiff denied ever driving an automobile during the six and one-half-month period following his motor vehicle accident. However, the insurance company obtained surveillance video showing plaintiff driving a motor vehicle several times on the same day that he availed himself of medical transportation services, which occurred during the relevant period following the accident. Further, when given the opportunity to explain his driving, plaintiff instead represented multiple times that he did not drive at all during this period. The Court of Appeals upheld the trial court's dismissal of plaintiff's entire PIP claim because the surveillance video "directly and specifically" contradicted representations made by plaintiff in support of his claim for transportation services, which warranted dismissal of plaintiff's claim based on both *Bahri* and the fraud provision contained in plaintiff's insurance policy.

In *Ward v State Farm Mut Auto Ins Co*, unpublished opinion per curiam of the Court of Appeals, issued September 15, 2016 (Docket No. 327018), plaintiff sought PIP benefits for medical expenses, attendant care, replacement services, and lost wages. Defendant sought summary disposition pursuant to *Bahri* based on false representations made by plaintiff regarding her claim for replacement services and her claim for lost wages. During her deposition, plaintiff testified that her friend came to her house every single day from September 30, 2013 through February 2, 2014 to perform household services that included cleaning plaintiff's house. However, during the friend's deposition, she testified that she never cleaned plaintiff's house and only took plaintiff shopping and drove plaintiff to her appointments. Further, defendant presented records from plaintiff's previous employer that established that plaintiff was fired from her job for misconduct and that her termination was not related to the accident at issue. With respect to the differing statements made by plaintiff and her friend regarding replacement services, the Court of Appeals held that "it is clear that reasonable minds would find this blatant inconsistency fatal to plaintiff's claim." Further, regarding the employment records that contradicted plaintiff's assertion that she had to leave work because of injuries sustained in the accident at issue, the Court held that "[d]ue to this clear documentary evidence, reasonable minds could not differ on the conclusion that plaintiff made a false statement with the intent to conceal a material fact from defendant in relation to her wage-loss claim." The Court of Appeals upheld the trial court's dismissal of plaintiff's entire claim for PIP benefits pursuant to *Bahri* and based on the language contained in the fraud provision of plaintiff's insurance policy.

Finally, in *Diallo v Nationwide Mut Fire Ins Co*, unpublished opinion per curiam of the Court of Appeals, issued November 15, 2016

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(Docket No. 328639), plaintiff's claim for PIP benefits included a claim for household services. Plaintiff submitted claims for household services from April to August of 2014 performed by plaintiff's husband. However, the insurance company obtained evidence from plaintiff's Facebook page that plaintiff was in Europe during this time period and it was undisputed that plaintiff's husband was not in Europe. During his deposition, plaintiff's husband testified that if he signed a household service form, he performed the services indicated on the form. Defendant then moved for summary disposition based on *Bahri* and the fraud provision contained in plaintiff's insurance policy. In response to the motion, plaintiff submitted an affidavit from plaintiff's husband stating that he actually believed that he was signing the household service forms for "any" provider, which would include the service provider plaintiff had while she was in Europe. The Court of Appeals upheld the trial court's dismissal of plaintiff's entire PIP claim based on *Bahri* and the fraud provision in plaintiff's insurance contract where plaintiff submitted household service forms where it was physically impossible for the services to be provided in the manner stated in the forms submitted. In response to the affidavit of plaintiff's husband, the Court held that parties "may not contrive factual issues merely by asserting the contrary in an affidavit after having given damaging testimony in a deposition."

Taken together, *Thomas*, *Ward*, and *Diallo* stand for the proposition that a plaintiff is precluded from benefits when there is evidence that directly and specifically contradicts representations made by a plaintiff in support of his/her claim for benefits.

However, in *Sampson v Jefferson*, unpublished opinion per curiam of the Court of Appeals, issued July 14, 2016 (Docket No. 326561), the Court of Appeals upheld a trial court's denial of a motion for summary disposition based on *Bahri* and the fraud provision in the plaintiff's insurance contract. In *Sampson*, plaintiff submitted a statement for household services for March 2013 that indicated that plaintiff's household services provider drove and ran errands for plaintiff. However, the form contained thirty-five (35) undated squares and each square contained different handwritten letters designating different services. Not every square contained the letters for driving or running errands. The insurance company submitted surveillance video from two different dates in March showing plaintiff driving and running errands. The Court of Appeals upheld the trial court's finding of genuine issues of material fact because it was possible that plaintiff's condition varied from day-to-day and the two (2) days of driving and running errands could have corresponded with two squares on the form where those activities were not indicated as being performed by the household service provider. Here, defendant was unable to produce evidence that directly

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and specifically contradicted representations made by plaintiff in support of his claim for benefits.

Abolishment of the "Innocent Third Party Rule"

In *Bazzi v Sentinel Ins Co*, __ Mich App __ (2016), the Court of Appeals held that if an insurer is able to establish that a no-fault insurance policy was obtained through fraud, then the insurer is entitled to rescind the policy and can deny the payment of benefits to innocent third parties. The Court's decision is significant because it effectively abolishes the "innocent third-party rule." Therefore, this case stands for the proposition that once an insurer establishes that its insured committed fraud, the insurer is no longer obligated to pay no-fault benefits to either the insured who committed the fraud or any innocent third parties, such as medical providers who seek to obtain no-fault benefits under the policy. After *Bazzi*, third parties, such as medical providers, are precluded from recovering no-fault benefits even if those same third parties were not in any way connected to the fraud perpetrated by the insured.

Security Bond

Substantial reason for imposing a security bond pursuant to MCR 2.109(A) exists where there is good reason to believe that a party's allegations are "groundless and unwarranted."

In *Oliver v State Farm Mut Auto Ins Co*, unpublished opinion per curiam, issued June 14, 2016 (Docket No. 326678), plaintiff's complaint sought no-fault benefits from an alleged hit-and-run accident. However, an engineering report obtained by the defendant insurer indicated that plaintiff's "collision scenario is not possible and is inconsistent with the physical evidence." Defendant requested that plaintiff post a bond for security for costs pursuant to MCR 2.109(A). The Court of Appeals upheld the trial court's requirement for a bond because there was good reason to believe that plaintiff's allegations were "groundless and unwarranted."

Sanctions

If a defendant requests sanctions pursuant to MCR 2.114 following the dismissal of plaintiff's claims due to fraud, the trial court commits error in denying the request for sanctions without conducting a reasonable inquiry into the legal and factual basis for sanctions.

In *Moore v First National Rehabilitation*, unpublished opinion per curiam of the Court of Appeals, issued October 27, 2016 (Docket No. 327872), the trial court held that

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plaintiffs were not entitled to no-fault benefits based on the insurance policy's fraud provision. Defendant requested sanctions from both the plaintiff-insured and the plaintiff-transportation provider who both submitted claims that appeared to be not based in fact. The trial court denied the request for sanctions by simply stating, "Denying it, letting sleeping dogs lie." The Court of Appeals found that the trial court erred by denying the request for sanctions without conducting a reasonable inquiry into the legal and factual basis for sanctions.

CAUSATION

In proving that an accident caused injuries for a PIP claim, there is no requirement that a plaintiff show objective manifestations of his/her injury, but mere reliance on medical billing records and a plaintiff's deposition testimony is insufficient to establish causation.

In *Randall v State Farm Mut Auto Ins Co*, unpublished opinion per curiam of the Court of Appeals, issued June 21, 2016 (Docket No. 327292), the Court of Appeals reversed a trial court's grant of summary disposition based on a lack of causation. Defendant moved for summary disposition because all objective factors, including CT scans, MRIs, and X-Rays taken after the accident, were normal and indicated no injuries arising out of the accident at issue and the independent medical examinations (IMEs) performed on plaintiff indicated that plaintiff had no ongoing injuries that directly resulted from the accident. To oppose the motion, plaintiff presented evidence from her treating physicians who diagnosed her with a mild traumatic brain injury, post-concussive syndrome, migraine headaches, knots, swelling, and spasms in her neck, increased anxiety, and a temporomandibular disorder, which the physicians all believed were caused by the accident at issue. Defendant countered that all of these diagnoses were based on plaintiff's subjective complaints. The Court of Appeals held that the trial court erred in granting summary disposition because there is "no basis for concluding that [a] plaintiff [is] required to proffer evidence showing objective manifestation of her injuries in order to establish a genuine issue of material fact on the issue of causation." Instead, causation can be established by subjective complaints of pain as well as plaintiff's doctor's objective observations.

However, in *Lund v Travelers Indemnity Co of America*, unpublished opinion per curiam of the Court of Appeals, issued December 29, 2016 (Docket No. 330212), the only evidence plaintiff submitted in support of her assertion that her injuries were caused by the accident at issue, and were not pre-existing conditions, were medical billing records and her own deposition testimony. The Court of Appeals upheld the trial court's finding that this evidence was insufficient to survive summary disposition. The Court further stated that generally to prove a claim for no-fault benefits, a plaintiff must present competent expert testimony to establish a

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causal connection between medical treatment and injuries from the accident.

EXPERT WITNESS FEE

In a published opinion, the Court of Appeals held that the owner and treating physician from a plaintiff-provider is not entitled to an expert witness fee for his/her deposition.

In *Spine Specialists of Mich, PC v State Farm Mut Auto Ins Co*, __ Mich App __ (2016), defendant sought the deposition of Dr. Louis Radden, who owned Spine Specialists of Michigan and provided the treatment at issue. Dr. Radden refused to be deposed unless defendant paid him $5,000 for three (3) hours of testimony. The trial court lowered the fee to $1,000 for the first ninety (90) minutes and $1,000 for each hour thereafter. The Court of Appeals reversed, holding that Dr. Radden is an employee of plaintiff and is not entitled to a fee for testifying on its behalf.

The Court of Appeals explained that "[w]hile a party (or an employee of a party) with specialized knowledge may offer an expert opinion within his or her field, the court rules do not contemplate payment to a party offering an opinion on its own behalf." The Court further explained that the court rule requiring an expert witness fee applies to "experts who are third parties to the litigation; such experts examine the facts from a distance, offer opinions, and have no financial stake in the outcome other than receiving a court-approved witness fee." Dr. Radden, on the other hand, owned plaintiff-provider, would serve as its spokesperson at trial, and had a vested interest in the outcome of the case. Therefore, the Court held that he was not entitled to an expert witness fee.

UNLAWFULLY RENDERED TREATMENT

Unlicensed treatment is not lawfully rendered and is therefore not compensable under the No-Fault Act.

In *Keys of Life v Auto-Owners Ins Co*, unpublished opinion per curiam of the Court of Appeals, issued December 27, 2016 (Docket No. 328227), the plaintiff-provider sought compensation for adult foster care services it provided to the insured. Defendant did not dispute that the insured required 24-hour attendant care. However, defendant provided evidence that plaintiff was not licensed to provide adult foster care services, as required by Michigan law. The trial court held that plaintiff lawfully rendered treatment. The Court of Appeals reversed and held that plaintiff unlawfully rendered treatment. The Court of Appeals held that the plain language of the No-Fault Act only affords compensation for lawfully rendered treatment, and when Michigan law requires licensing for treatment and the provider does not have such a license, the treatment provided is not lawfully rendered and is therefore not compensable under the No-Fault Act.

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ADEQUATE NOTICE OF CLAIM

Failure to give adequate notice of claim to insurer precludes insured from recovery of no-fault benefits.

In Bensen v Amerisure Ins, unpublished opinion per curiam of the Court of Appeals, issued May 24, 2016 (Docket No. 325319), the Court of Appeals agreed with the trial court in finding that an insured was not entitled to collect no-fault PIP benefits because the insured had not provided adequate notice of injury to the insurer. The Court found that the notice provided by the insured prior to litigation was deficient because it failed to include the location of the accident, and the notice did not provide a copy of the police report, nor did it contain the police report number. The notice also failed to provide the address or policy number for the insured. Despite the insurer's efforts to obtain additional information, the insured failed to provide the requested additional information. Therefore, the Court found that the insurer was not obligated to pay no-fault benefits since the insured's deficient notice of injury did not allow the insurer a fair opportunity to investigate the claim or to manage funds for potential settlement purposes prior to litigation.

UNLAWFUL TAKING OF VEHICLE

Recovery of no-fault benefits ruled to be permissible even if vehicle is taken unlawfully, so long as permission to use vehicle was given.

In *Monaco v Home-Owners Ins Co*, __ Mich App __ (2016), the Court of Appeals held a person injured in a motor vehicle accident is not barred from recovering no-fault benefits, even if the person seeking the benefits used a vehicle that he or she had "taken unlawfully." In other words, the Court found that no-fault benefits were payable to a person injured in an automobile accident even though that same person used the vehicle involved in the accident in violation of the law. Specifically, the Court found that although a 15-year-old girl took her parents' automobile unlawfully given her age and restricted license, the girl was still entitled to collect PIP benefits since she was covered under the terms of the policy, and her parents had given her permission, or consent, to "use" the automobile when the accident occurred.

EUO STATEMENTS

Statements given during EUO about unlawful taking of vehicle did not preclude recovery of no-fault benefits, where subsequent deposition testimony showed that the taking was lawful.

In *Detroit Med Ctr v Mich Prop & Cas Guaranty Ass'n*, unpublished opinion per curiam of the Court of Appeals, issued July 26, 2016 (Docket No. 326793), the Court of

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Appeals held that no-fault benefits were payable to a medical center, even though statements made during an examination under oath showed that the owner of the automobile involved in the motor vehicle accident had not given permission to the driver to take the vehicle at the time of the accident. The Court found that the statements made by the insured during the examination under oath did not preclude the payment of no-fault benefits, since the insured subsequently testified during a deposition that the automobile involved in the motor vehicle accident was not unlawfully taken. Specifically, the Court found that because the driver was able to provide an "explanation" for the "shift in her testimony," and since the driver was not a party to the case, the medical center could still attempt to collect no-fault benefits since the driver's deposition testimony showed that the driver had lawfully taken the automobile before the accident occurred.

DISMISSAL OF DERIVATIVE CLAIMS

If the court dismisses insured's no-fault lawsuit due to the insured's failure to comply with discovery orders, then all derivative claims for no-fault benefits related to the accident are also dismissed.

In *Dawoud v State Farm Mut Auto Ins Co*, __ Mich App __ (2016), the Court of Appeals held that dismissal of the insured's case due to failure to comply with discovery orders barred the claims of intervening medical providers from proceeding with their derivative claims. The Court found that the dismissal of the underlying insured's case due to the failure to comply with discovery orders was an adjudication on the merits, and if an insured's claim is substantively adjudicated on the merits, any derivative claims fail as well. The holding in this case is significant because innocent third parties, such as medical providers, are now precluded from recovery of no-fault benefits in the event that the underlying insured's case is dismissed for failure to comply with a trial court's discovery orders. Practically, this ruling now compels third parties, such as medical providers, to use their own efforts to ensure that the insured is diligently litigating his or her case, and that the insured is following all of the court's discovery orders.

ATTORNEY'S FEES NOT WARRANTED

Medical records and opinions of doctors provided insurer with reasonable grounds to deny claim for no-fault benefits so that attorney's fees were not warranted.

In *Affiliated Diagnostics of Oakland v Farmers Ins Exch*, unpublished opinion per curiam of the Court of Appeals, issued May 26, 2016 (Docket No. 325873), the Court of Appeals held that an insurer satisfied its burden of establishing that its refusal to pay its insured was based on *bona fide* and legitimate factual uncertainties. The holding was based upon the facts that the insured's claims representative recommended sending the insured to an independent medical doctor because the accident was low impact, the

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insured's primary care doctor did not recommend further treatment, there were significant inconsistencies in the medical records, and because of the length of time between the accident and the insured's treatment. Thus, based on the medical records and the opinions of doctors, the Court found that the insurer had *bona fide* factual uncertainties and therefore the insurer's decision to deny the payment of no-fault benefits was found by the Court to be reasonable. Since the denial of no-fault benefits was reasonable, no attorney's fees were awarded to the insured.

COORDINATED BENEFITS

Medical provider was not required to appeal heath insurer's medical necessity determination before seeking no-fault benefits under a coordinated policy.

In *St. John Macomb Oakland Hosp v State Farm Mut Auto Ins Co*, __ Mich App __ (2016), the Court held that pursuant to a coordinated no-fault and health insurance policy, a medical provider could seek payment from the no-fault insurer since the medical provider first made reasonable efforts to obtain payment from the health insurer. The health insurer made a medical necessity determination regarding the insured, but the Court found that the medical provider was not required to appeal the medical necessity determination in order to establish that it made reasonable efforts to obtain payments that were available from the health insurer. Thus, the Court ruled that the medical provider was permitted to recover no-fault benefits, even though it failed to challenge the medical necessity determination made by the health insurer.

EVIDENCE OF PRIOR LAWSUITS

Evidence of prior lawsuits admissible to show that insured engaged in a scheme to defraud insurer.

In *Williams v State Farm Mut Auto Ins Co*, unpublished opinion per curiam of the Court of Appeals, issued November 10, 2016 (Docket No. 326008), the Court of Appeals held that an insurer could introduce evidence of the insured's prior automobile lawsuits to show that the automobile accident at issue never occurred and that the alleged accident was part of an ongoing scheme by the insured to defraud the insurance company. The Court held that the risk of unfair prejudice from mentioning the prior lawsuits at trial did not substantially outweigh the probative value of the evidence, since the insured conceded that evidence of the accidents and past injures were admissible, and the pattern of accidents was relevant to the insurer's theory that the insured was engaged in an ongoing scheme to defraud the insurer.

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LEGAL NEWS

In January 2017, a Birmingham, Michigan neurosurgeon, Dr. Aria Sabit, was sentenced to nearly twenty (20) years in prison for his role in a $2.8 million dollar insurance fraud scheme in which he performed unnecessary spinal surgeries on patients. Dr. Sabit owned and operated the Michigan Brain and Spine Physicians Group, which was located in multiple cities in the Detroit area. In connection with his guilty plea, Dr. Sabit admitted that he convinced over a dozen of his patients to undergo spinal fusion surgeries that he never performed. Despite the fact that he did not perform the surgeries, Dr. Sabit filed insurance claims with Medicare, Medicaid, and private insurance providers seeking payment for the surgeries.

MICHIGAN OFFICE UPDATES

Smith & Brink's Michigan office has recently obtained multiple summary disposition rulings in favor of its clients in various Michigan state courts. Specifically, Smith & Brink obtained summary disposition dismissing entire cases in multiple matters where the insured was unlawfully solicited.

Additionally, in September 2016, Smith & Brink was represented at the State Bar of Michigan's Health Care Law Section Annual Meeting.

CLOSING REMARKS

Thank you for reading our newsletter. Please contact us if you would like further information or explanation regarding any of the contents in this newsletter or other matters involving Michigan law. Please also contact us if you wish to discuss ways in which our firm can be of value to you and your organization. We can be reached by phone at (734) 521-9000, and you can find a list of our Michigan attorneys by going to www.smithbrink.com.

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