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Monthly Newsletter

May 2014

Message from James F. Hewson

This newsletter represents yet another new beginning for this 23 year old law firm. For years, all of the news we had to share was discussed over lunch, or coffee, or in each other's offices. Those few of us made all our news, and knew everything that was worth knowing about our practice. Look at us now; we need a newsletter. These are exciting and challenging times.

Inside This Issue

We have reached this new level by holding fast to our principles and our vision. We represent our clients with all of our creativity and skill, helping them to decide what amounts should be paid when they owe payment, and defending against the payment of any amount they don't owe. We have struck back against fraudulent providers and institutions, not only for the benefit of our clients, but for the good of our insureds who are entitled to receive the proper and best care that our clients provide for them. We have changed and helped explain the law through our appellate efforts, and continue to teach and share what we know for the good of the legal community at large. We have accomplished much.

But there is more to be done. Welcome to those of you who are new to us. Trust our vision and believe that what you do has positive and lasting impact. Believe, as I do, that we will continue to grow, not by pursuing growth, but by following the ideal that we are doing the right things for everyone concerned. We can continue to effect positive change through the legal system and through our efforts at trial. The future holds much promise if we work together, and remember where we came from.

- James F. Hewson
Partner, Hewson & Van Hellemont

Attorney Profile: Jerald Van Hellemont

In today's world of large-scale rings of insurance fraud, providing an aggressive defense for insurance companies requires the ability to adapt. The old adage of "thinking *outside* of the box" is no longer enough. Rather, according to Jerald Van Hellemont, attorneys now need to approach fraudulent insurance claims as if there isn't a box at all. With individuals and doctors constantly seeking out new methods to defraud insurance carriers, today's attorneys are required to come up with new and creative ideas to stop scams.

Jerald Van Hellemont has the experience and diverse background to do just that. He graduated from Wayne State University Law School with a Juris Doctor and was admitted to the State Bar of Michigan in 1980. He began his career as a general practitioner, handling probate matters, contract disputes, and insurance claims. His primary practice area became insurance defense with an emphasis on fire and casualty claims, including homeowners, no-fault, automobile theft, fire claims and various personal injury litigation cases.

In 1991, he was a founding partner of Hewson & Van Hellemont, P.C. The firm has been involved in the evaluation and investigation of claims, pre-litigation, and the defense and trial of litigated claims. Mr. Van Hellemont has practiced general civil and corporate litigation for local and national companies and included more than 150 civil jury trials. Additionally, Mr. Van Hellemont handles property law matters, rescission issues, policy drafting and opinions on insurance coverage. He is also counsel for the Michigan Chapter of the International Association of Special Investigative Units and has participated in management meetings and seminars with numerous insurance company clients and their special investigative units. Furthermore, he has participated and instructed in various seminars and classes for a number of insurance clients and insurance related organizations including the Michigan Chapter of the International Association of Special Investigative Units and MAVTI (Michigan Association of Vehicle Theft Investigators) in areas involving automobile theft, homeowners' claims, fire claims, subrogation, and other insurance topics.

News at Hewson & Van Hellemont P.C.

We would like to announce the addition of five new attorneys to our staff this month:

Andrew Franklin

Andrew Franklin graduated with a Bachelor of Arts in Criminal Justice from Michigan State University in 2002 and a Juris Doctorate from the University of Toledo College of Law in 2006. He was admitted to the Michigan Bar in 2012 and the Florida Bar in 2006 and is also a member of the Oakland County Bar Association.

Mr. Franklin served as an Assistant State Attorney for nearly six years. He began fighting fraud as the dedicated prosecutor for all insurance fraud cases originating in Broward County, Florida. He prosecuted worker's compensation fraud, property claims, PIP fraud, and multi-defendant staged accident rings.

Prior to joining Hewson & Van Hellemont, Mr. Franklin was a senior associate in an insurance defense firm handling first and third party claims. His practice was devoted to no-fault cases with an emphasis on fraudulent clinic operations.

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Jeremy Knox

Jeremy Knox graduated with honors from Michigan State University in 1997 and then attended Michigan State College of Law and graduated Magna Cum Laude in 2000. Mr. Knox is a member of the State Bar of Michigan and of the United States District Court for the Eastern and Western District of Michigan.

Prior to joining the Hewson & Van Hellemont, Mr. Knox represented hospitals, home health care companies and medical professionals. He has extensive litigation experience having tried cases all throughout the State of Michigan.

Patrick McGlinn

Patrick McGlinn graduated with a Bachelor of Arts degree, majoring in Political Science and Sociology, from Wayne State University in 1990. He graduated with his Juris Doctorate degree in 1994 from the University of Detroit Mercy School of Law. Mr. McGlinn is admitted to the State Bar of Michigan, the U.S. District Courts for the Eastern and Western Districts of Michigan, and the Sixth Circuit Court of Appeals.

Mr. McGlinn worked for the Michigan Attorney Grievance Commission as an investigating and litigating attorney for over 17 years with success. He is an adjunct professor at the University of Detroit Mercy School of Law, instructing Professional Responsibility and Prosecutorial Ethics. He served two terms as a district member on a State Bar Character and Fitness panel. Outside of work, he serves on the Four Corners Montessori Academy board of directors and spends time with his family.

Frederick Livingston

Frederick V. Livingston graduated from Wayne State University with a B.A. in Psychology in 2006. Mr. Livingston attended Wayne State Law School and graduated with a J.D. in 2011, he was admitted to the State Bar of Michigan Bar that same year. Mr. Livingston is a member of the Oakland County Bar Association and is also admitted to practice in all federal courts.

Prior to joining Hewson & Van Hellemont, P.C., Mr. Livingston represented individuals injured in automobile accidents and medical service providers. In his leisure time, Mr. Livingston enjoys spending time with family and attending sports events.

Additional News

We are happy to announce Stacey Heinonen, Danielle Haberstroh, and Jeffrey Coleman have been elevated from “C” shareholders to “B” shareholders within the company.

Legal News

The Affordable Care Act and Michigan's No-Fault Act

The Michigan Bar Journal March 2014 issue featured an article by Nelson P. Miller, a longtime no-fault practitioner in Michigan and professor at Thomas M. Cooley Law School in Grand Rapids. Miller predicts the Affordable Care Act's individual mandate requirement will likely allow no-fault insurers to setoff health insurance benefits rather than coordinating with a health insurance provider.

Michigan's No-Fault act specifically allows no-fault insurers to setoff against PIP benefits any other benefits "provided or required to be provided under the laws of any state or the federal government…" MCL 500.3109(1). This for instance, allowed no-fault insurers to set off both Social Security disability benefits and workers' compensation benefits so that amount was not paid in any work-loss benefits. Pursuant to MCL 500.3109a however, no-fault insurers cannot set off "other health and accident coverage," including health-insurance coverage. Rather, the no-fault insurer was required to coordinate its policy with the health-insurance coverage.

Michigan's appellate courts have already ruled that no-fault insurers can set off payments payable under insurances required by law. See *DeMeglio v Auto Club Ins Ass'n*, 449 Mich 33; 534 NW2d 665 (1995). According to Miller, it is likely that the Affordable Care Act's individual mandate will be treated similarly. As such, no-fault insurers will now be able to set off these benefits rather than coordinating them.

Miller cautions that a lot is left to be decided on this. The courts may interpret the individual mandate to not be "required at law" in the No-Fault sense or the legislature may exempt the individual mandate from the No-Fault Act's setoff provision. Over the next few years the impact of the Affordable Care Act on Michigan's No-Fault act will be decided by the courts and the legislature. Miller suggests attorneys should study the development of this new setoff issue in every first-party no-fault claim they see in the coming years.

Jaffer Odeh v. Auto Club Ins. Association

Michigan Court of Appeals

Unpublished Opinion - Docket No. 309647

(Mich Ct App March 13, 2014)

Affirming trial court's order dismissing plaintiff's claim that Auto Owners should be equitably estopped from invoking the one-year back rule after plaintiff invoked attorney client privilege and prevented Auto Owners from properly investigating the claim.

Plaintiff, Jaffer Odeh was badly injured in a motor vehicle accident in 1998. He filed a no-fault claim at the time and began receiving benefits from Auto Club. In 2009, Odeh sued Auto Club for attendant care and case management services that he alleged Auto Club had kept the availability of hidden from him in 1998.

Auto Club filed a motion for summary disposition arguing that the one-year back rule, MCL 500.3145(1), limited plaintiff's recovery only to damages for one year preceding the lawsuit. Odeh argued that Auto Owners incompletely explained his benefits to him and should be equitably estopped from asserting application of the one-year back rule. Auto Club sought discovery from Odeh's attorneys that handled his 1998 case in an attempt to examine if he was told of the availability of attendant care benefits at the time. Odeh invoked attorney-client privilege. Auto Club argued that it would be unfair to allow the plaintiff to assert lack of knowledge under an equitable estoppel theory while using attorney client privilege to prevent Auto Owners from discovering if the plaintiff had actually gained such knowledge. The trial court agreed with Auto Club and granted their motion for summary disposition on the plaintiff's equitable estoppel claim.

The appellate court agreed. "To prevent defendant from exploring the sources who may have informed plaintiff of his benefits is hardly equitable." A "mere assertion" that an insurer withheld information is insufficient for a court to invoke equitable powers to avoid a rule." They stated further that "the Michigan Supreme Court warned, courts are not permitted under the guise of equity to cast aside a constitutionally valid and plainly written statue." The narrow exception that allows a trial court to invoke their equitable power was not present in this case. "To hold otherwise would eviscerate the plain language of MCL 500.3145(1), as a mere assertion that defendant failed to inform a plaintiff of the full panoply of benefits would obliterate the one-year back rule.

The Order granting summary disposition for Auto Owners was affirmed.

Jerome Graham v. State Farm Mutual Automobile Ins. Company

Michigan Court of Appeals

Unpublished Opinion - Docket No. 313214
(Mich Ct App February 18, 2014)

Affirming the circuit court's dismissal of an action for uninsured motorist (UM) benefits brought a year after a settlement regarding PIP benefits, stemming from the same automobile accident.

Plaintiff, Jerome Graham, was in an automobile accident in 2009. In 2010, plaintiff brought a first-party PIP action against State Farm alleging he had not been fully reimbursed for medical services and household assistance resulting from his injuries. Additionally, he brought a negligence claim against the driver of the other vehicle. During the 2010 action, plaintiff learned that the other driver had been uninsured at the time of the accident because her policy had lapsed due to nonpayment. Plaintiff would go on to settle the PIP claim with State Farm and dismissed the claims against them with prejudice. One month later, the negligence action against the other driver was dismissed without prejudice.

In 2011, plaintiff brought a second action against State Farm, raising a claim for UM benefit in connection with the 2009 automobile accident. State Farm moved for summary disposition, arguing that the new action was barred because it should have been brought with the 2010 PIP action. The circuit court agreed and dismissed the claim, citing that the new claim was barred by res judicata, MCR 2.116(C)(7), and the compulsory joinder rule, MCR 2.203(A).

Res judicata "bars a second, subsequent action when (1) the prior action was decided on the merits, (2) both actions involve the same parties or their privities, and (3) the matter in the second case was, or could have been, resolved in the first." *Washington v Sinai Hosp of Greater Detroit*, 478 Mich 412, 418; NW2d 755 (2007). Plaintiff here did not contest the first two elements of res judicata.

Michigan courts have employed two alternative approaches in determining the third element, the "same evidence" and "same transaction" tests. "The transactional test provides that the assertion of different kinds of theories of relief still constitutes a single cause of action if a single group of operative facts gave rise to the assertion of relief." *Adair v Michigan*, 470 Mich 105, 124; 680 NW2d 386 (2004). Under the test, a "transaction" is to be "determined pragmatically, by considering whether the facts are related in time, space, origin or motivation, and whether they form a convenient trial unit." *Id* at 25.

Plaintiff argued that the facts of the UM claim were different from those related to the PIP claim. The appellate court, however, ruled that a PIP claim and a UM claim arising from the same collision and involving the same parties are related in time, space, origin and motivation. In other words, the PIP and UM claims involved in this case met the same transaction test.

Plaintiff also relied on two cases, *Kaiser v Smith*, 188 Mich App 495; 470 NW2d 88 (1991), and *JAM Corp v AARO Disposal, Inc*, 461 Mich 161; 600 NW2d 617 (1999) but the court held that those cases did not apply to the current case because they involved statutory provisions that precluded giving res judicata effect to certain judgments. There was not a comparable provision applicable in this matter.

As such, the Court of Appeals upheld the circuit court's granting of State Farm's motion for summary disposition on res judicata grounds.

Wargo v. Ghafarloo, et al.

Michigan Court of Appeals

Unpublished Opinion – Docket No. 312331
(Mich Ct App January 30, 2014)

Michigan Court of Appeals granted physician's motion for summary disposition after plaintiff sought to impose liability on the physician after his patient blacked out and caused an automobile accident shortly after visiting the physician and complaining of blurry vision.

Defendant Jungels blacked out while operating an automobile and struck the Plaintiff, who was driving a motorcycle. Before the accident, Jungels saw his physician, Ghaffarlo, and he complained of blurriness in his one functional eye. During the drive home, however, the visibility in the eye became worse and led to the accident. Plaintiff sought to impose liability on Ghaffarloo on a theory that Jungels' condition made him a "dangerous man" which required Ghaffarloo to take steps to prevent him from causing any harm to a third party.

The Court ruled though that the symptoms that an elderly man like Jungels was exhibiting were not consistent with a "dangerous person" and further that Michigan law is clear that physicians are not liable as "highway accident insurers." For those reasons the Court of Appeals affirmed the granting of Ghaffarloo's motion for summary disposition.

Katrenia L. Blackburn v. Hastings Auto Parts, Inc., et al.

Michigan Court of Appeals

Unpublished Opinion – Docket No. 310916
(Mich Ct App April 8, 2014)

In a third-party auto no-fault case, conflicting evidence regarding the plaintiff's post-accident employment required a reversal of the trial court's decision granting defendant summary disposition.

Plaintiff Katrenia Blackburn was injured in a motor vehicle accident with a Hastings Auto Parts vehicle driven by Thomas Cupp. Plaintiff brought a third-party auto no-fault claim against defendants. Her doctor, Dr. Martin Kornblum, prescribed physical therapy, injections, and permanently disabled her from employment as a medical assistant.

Defendants only disputed whether the impairment affected plaintiff's general ability to lead her normal life. They presented State of Michigan documentation that showed the plaintiff received payment of approximately $200 for daycare services. Defendants

argued that the plaintiff's daycare services were far more strenuous than her prior work as a medical assistant. That assertion, however, was not supported in the record. The plaintiff was not deposed regarding the daycare activity, and no determination had been made regarding the degree and scope of the physical burden it placed upon her. Additionally, the defendants did not submit any further evidence of payment for daycare services besides this isolated instance. The appellate court ruled that the trial court erred by not allowing the conflicting evidence to be decided by a jury. The case was reversed and remanded.

Sara Rebecca Reese v. Auto-Owners Ins. Company

Michigan Court of Appeals

Unpublished Opinion – Docket No. 314210
(Mich Ct App March 18, 2014)

Affirming, in part, trial court's finding that the no-fault insurer was unreasonable in denying first-party benefits to plaintiff on basis that her injuries were the result of a pre-existing condition.

Auto-Owners Insurance did not pay the counseling and physical therapy bills that were submitted by plaintiff, Sara Reese, for treatment related to a motor-vehicle accident she had been in. The trial court granted plaintiff's motion for summary disposition and awarded attorney fees.

Auto-Owners argued on appeal that plaintiff had a pre-existing mental condition and her injuries and treatment may not have been related to the motor-vehicle accident. They argued that the trial court's decision to grant summary disposition was premature because discovery was not complete and new medical records might reveal that these injuries existed before the accident.

The appellate court agreed with the trial court that the plaintiff's neuropsychological evaluation was reasonably necessary. The determination of whether attorney fees are warranted under the no-fault act depends on whether the insurer's initial refusal to pay was unreasonable. The court ruled that plaintiff's neuropsychological evaluation was reasonably necessary and therefore the Auto-Owner's refusal to pay was unreasonable.

The appellate court held the trial court erred however, in finding there was no genuine issue of material fact that the plaintiff's physical therapy sessions were reasonably necessary. It held that it was debatable whether all of her physical ailments were related to the accident, and a remand for further proceedings was appropriate on that issue. The court stated that if the bills were ruled to be covered on remand, however, then the awarding of attorney's fees would be appropriate.

Dorian Carter v. Liberty Mutual Group

Michigan Court of Appeals

Unpublished Opinion – Docket No. 308884
(Mich Ct App March 18, 2014)

A jury verdict vacated because trial court committed reversible error in failing to give the jury a requested special instruction on fraudulent claims, resulting in unfair prejudice to defendant.

Defendant, Liberty Mutual Group, appealed jury trial verdict in favor of plaintiff and award of attorney fees to plaintiff.

Plaintiff, Dorain Carter, asserted he sustained injuries in a motor-vehicle accident in 2008 and initiated an action after his no-fault insurance provider, Liberty Mutual Group, refused to pay his PIP benefits.

The vast majority of the plaintiff's claims consisted of replacement service and attendant care service claims. The plaintiff, despite having not suffered catastrophic injuries, hired a case manager. The case manager was not a registered nurse or medical professional, but rather, was a disbarred attorney who sent out letters on other attorney's letterhead under the title of paralegal or case manager.

The plaintiff claimed his friend, Nelson Shaw, provided specific replacement and attendant care claims for him for eight to nine hours, every day for almost three years. The plaintiff went on three long vacations without Mr. Shaw during that time, but service logs still reported Mr. Shaw worked for the plaintiff during those time periods. Additionally, Mr. Shaw testified that he often did not work as long as the logs reported and the details of his actions were not always accurate. This, he said, was because the case manager prepared all of the forms, sometimes months after the dates he was signing for.

The plaintiff and Mr. Shaw argued that they did not commit any fraud and that any inconsistencies were the case manager's fault. The court reasoned that a principal and his agent share a legal identity and it is a fundamental rule that a principal is liable for the acts his agent commits with actual or apparent authority of the principal.

Liberty Mutual asserted fraud as an affirmative defense and requested the trial court provide the jury with a fraud instruction concerning the plaintiff's claim. They also requested a question concerning fraud be placed on the jury verdict form. The trial court denied both requests. Liberty Mutual submitted several special jury instructions regarding fraud but the trial court declined to give them to the jury.

The appellate court held that the trail court abused its discretion in finding that the instruction was not applicable to the facts of the case and erred in failing to give an instruction on fraud or misrepresentation when the evidence supported such an instruction.

Instructional error, however, only warrants reversal if it results in unfair prejudice inconsistent with substantial justice. If fraud had been found by the jury, the language of the insurance policy may have precluded Liberty Mutual from having to pay anything to the plaintiff. The appellate court noted that the jury's award was minimal on

replacement services and nothing was given for attendant care services and suggested the jury viewed the claims as fraudulent or at least excessive. With that in mind, the appellate court ordered the jury verdict be vacated and a new trial was ordered in which Liberty Mutual would have an instruction regarding fraud and misrepresentation given to the jury.

Bureau of Health Professions v. Bruce Devere Serven, D.C.,

Michigan Court of Appeals

Unpublished Opinion – Docket No. 311939
(Mich Ct App December 3, 2013)

A reversal of the Department of the Michigan Board of Chiropractic Disciplinary Subcommittee's findings of negligence and lack of good moral character, which resulted in respondent being placed on probation for one year.

Dr. Serven was contacted by State Farm Insurance Company to perform an Independent Chiropractor Examination (ICE) of a patient who was receiving chiropractic treatment. The patient had been in an automobile accident in 2004 and sought chiropractic treatment from HealthQuest in 2006. Respondent conducted the ICE and concluded that the patient's physical complaints were not causally related to the accident.

As a result of the ICE findings, State Farm cut off benefits to the patient and denied further claims for payment submitted by HealthQuest. Salvio Cozzetto, a chiropractor and part owner of HealthQuest filed a complaint against Dr. Serevn, claiming his findings had possibly caused harm to the patient's health. Eventually the Attorney General, on behalf of the petitioner, filed an administrative complaint against Dr. Serven and a disciplinary subcommittee handed down their findings of negligence and lack of good character from which Dr. Serven appealed.

The appellate court first ruled that Dr. Sevren could not be found negligent because he owed no duty of care to the patient nor HealthQuest. The duty he owed was owed to State Farm, the agency that had contacted him to conduct the ICE. The only other duty he owed was to "perform the examination in a manner not to cause physical harm to the examinee. " *Dyer v. Trachtman*, 470 Mich 45. Neither party alleged that respondent physically harmed the patient in any way.

Secondly, the court ruled that alleged statements made by respondent regarding HealthQuest's "track record" did not constitute a lack of good moral character. The comment was made during an informal interview in which the respondent was attempting to be candid with petitioner's investigator and honestly communicated his opinion, based on his experience with HealthQuest.

As such, the Michigan Court of Appeals found that the disciplinary subcommittee erred in their ruling and reversed and remanded the matter for expungement of respondent's record.

Anthony Johnson, et al. v. Titan Indemnity Company, et al.

Michigan Court of Appeals

Unpublished Opinion – Docket No. 308685
(Mich Ct App May 21, 2013)

Michigan Court of Appeals reversed and remanded a trial court ruling barring a hospital from intervening in a settlement agreement between a patient and his no-fault insurer and voiding a patient lien agreement between the hospital and the patient.

Anthony Johnson was a passenger in an automobile that was involved in an accident in August of 2008. Victoria General was the no-fault insurer of the automobile. Johnson suffered injuries that required professional medical treatment from several medical care providers including Southeast Michigan Surgical Hospital, who claimed Johnson's medical bill totaled $56,182.19. In August of 2009, Johnson sued Victoria General to recover his PIP benefits and shortly thereafter signed a "Patient Lien Agreement" with Southeast wherein he would grant the hospital a lien against all "judgments, settlements, or other recoveries, for any and all services provided."

In May of 2011, the parties proceeded to case evaluation and Johnson and Victoria General agreed to a settlement in which Johnson would receive $50,000. The settlement agreement was not placed on the record. Upon finding out about the settlement agreement, Southeast notified Johnson's attorney that he failed to include Southeast's bill at case evaluation. The next day, Southeast moved to intervene pursuant to MCR 2.209(A) and (B), arguing the parties would not adequately represent their right to recover from Victoria General. On September 30, 2011 the trial court granted Southeast's motion to intervene and two weeks later, following a settlement conference, the trial court ordered the reopening of the case.

Victoria General moved for reconsideration, arguing that Southeast was not entitled to intervene since they knew of the pending litigation before the case evaluation yet failed to become involved until after the parties agreed to settle. Southeast argued that they had no reason to suspect Johnson's counsel would fail to include their bill at case evaluation after they had supplied him with those documents prior to the case evaluation. The trial court granted Victoria General's motion for reconsideration and held that Southeast's patient lien was void because Southeast "sat on their rights."

Southeast appealed the ruling and the Court of Appeals concluded Southeast did have a right to intervene, pursuant to MCR 2.209(A)(3), and that the trial court erred as a matter of law in concluding otherwise. The appellate court ruled that Southeast had an interest in the "property or transaction" that was the subject of the underlying no-fault action and that the record did not support a finding that Southeast intentionally

delayed their motion to intervene by sitting on their rights. Rather, Southeast had a reasonable belief based on representations made by Johnson's attorney that their unpaid medical bill would be included at case evaluation. Further, upon discovering that their bill was not included, Southeast timely moved to intervene and their intervention would not have overcomplicated the proceedings.

Additionally, the appellate court also found the trial court erred in concluding there was a binding settlement agreement between Johnson and Victoria General. The record showed that the parties had negotiated the terms but the settlement agreement had not been placed on the record or signed by Johnson. Lastly, based on their above findings, the appellate court also ruled that the trial court erred in voiding Southeast's patient lien.

The case was reversed and remanded for further proceedings.

Nationwide Mutual Fire Ins. Co v. McDermott, et al.

Eastern District Court of Michigan

Case No. 12-11863 - September 10, 2013

Insurer sought to recover payment made to defendant after discovering new information on the causation of a house fire. The court ruled a jury must determine if the insurer knew the true circumstances when they paid the claim and were barred from recovery by the voluntary payment doctrine.

Mathews, a medical marijuana patient, set up a laboratory in McDermott's basement to produce a concentrated marijuana extract. When sampling some of the extract, butane flames ignited, resulting in a blaze that caused more than $160,000 in damage. Nationwide insurance paid the claim but later sued to get the money back claiming that had they known the circumstances, they would have denied the claim for two reasons – (1) the fire was not accidental, and (2) it was caused by an increased hazard within Mathew's control. Nationwide moved for summary judgment.

Under the voluntary payment doctrine, a voluntary payment may not be recovered by the payor. A "voluntary payment" is one made with a full knowledge of all the circumstances upon which it is demanded, and without artifice, fraud, or deception. *Pingree v. Mut. Gas Co.,* 65 N.W. 6, 7 (Mich. 1895). A voluntary payment, if made under a mistake of a material fact, may be recovered even if it was the result of a lack of investigation and the question of whether or not the claim was paid with sufficient information is a question of fact. *Montgomery Ward & Co. v. Williams,* 47 N.W.2d 607, 611 (Mich. 1951).

McDermott presented a report that was generated before Nationwide made payments that disclosed the nature of events that led to the fire. Nationwide claimed the payment was a mistake and that they did not have knowledge of the true facts but could offer no evidence to support their contention. Because Nationwide had not carried its burden and because McDermott offered evidence to the contrary, the Court denied Nationwide's motion for summary judgment and left the question of whether the payments were voluntary to be answered by the jury.

Mary Schildgen v. Allstate Ins. Company

Michigan Court of Appeals

Unpublished Opinion – Docket No. 311339
(Mich Ct App November 19, 2013)

Affirming trial court's order granting summary disposition to State Farm after defendant failed to present any genuine issue of material fact regarding her obligation to meet the clear and unambiguous reporting procedures of her uninsured motorist policy.

Plaintiff contracted to provide Defendant with uninsured motorist coverage. The policy required defendant to notify the police within twenty-four hours of any hit-and-run accident and to notify Plaintiff within thirty days of any such accident.

The trial court found no genuine issue of material fact that defendant did not comply with these requirements. As such, they granted State Farm's motion for summary disposition. Defendant appealed.

On appeal, defendant argued that factual issues existed as to whether she "reported" the accident in compliance with her policy. However, when the reporting requirement is clear and unambiguous, the provision only may be understood in one way. In other words, when the policy language is clear the courts must give terms within the policy their plain meanings and not create ambiguity where none existed before. There is no evidence that the defendant "reported" the accident to either party within the required timeframe. Defendant merely asked the police department what their reporting procedure was, but did not actually file a report within 24 hours. The court did not address the sufficiency of defendant's "reporting" to State Farm. Failure to properly report the accident to the police department within twenty-four hours constituted failure to comply with a condition precedent to State Farm's duty to provide uninsured motorist coverage. As such, the defendant had no cause of action against the insurer and the granting of State Farm's motion for summary disposition was affirmed.

Emily Kincaid v. Robert Croskey, et al.

Michigan Court of Appeals

Unpublished Opinion – Docket No. 310148
(Mich Ct App November 21, 2013)

Court of Appeals vacated an order by the trial court granting discovery of personal financial documents of physicians performing independent medical examinations (IMEs) for defendant.

Emily Kincaid, plaintiff-appellee, was on-duty as a city of Detroit police officer who was injured after the police vehicle she occupied

struck another vehicle that had pulled into the roadway. The vehicle that the police officers struck was driven by Robert Croskey and owned by Wolpin Company, doing business as Tri-County Beverage Company. Exam Works, on behalf of defendants, Croskey and Wolpin Company, conducted IMEs of Kincaid.

Exam Works, a nonparty, appealed the trial court's order granting discovery to plaintiff of financial and ownership documentation pertaining to Exam Works and the two physicians who performed the IMEs on plaintiff for defendants. Specifically, the trial court permitted the disclosure of income and financial information involving the physicians and Exam Works, which was limited in duration but not restricted to the examinations performed on the plaintiff alone, and included gross income figures that the physicians received from defense medical examinations with Exam Works.

The appellate court stated that discovery of documents from a nonparty is limited to depositions, MCR 2.302(B)(4)(i),(ii), whether it involves the actual taking of testimony or not, MCR 2.305(A)(3), and written requests for production, MCR 2.310(B)(2). Plaintiff focused on the language in MCR 2.302(B)(4)(a)(iii) that permitted the trial court to "order *further* discovery by other means..." (emphasis added). The appellate court, however, reasoned that the language of the subsection must be read with the language of preceding subsections. When read in that manner, the sub rule suggests that a litigant must first depose an expert and only then may seek alternative means of discovery from the court.

While alternative means of discovery, such as the submission of interrogatories to nonparty expert witnesses, are not precluded by court rules, the use of such alternative methods necessitates the existence of "exceptional" or "compelling" circumstances. The appellate court ruled that such circumstances did not exist in this case. The extent of Exam Works practices in performing defense work and the amount of compensation they have received for such work could have easily been discovered through depositions. It was unnecessary for plaintiff to obtain the detailed financial records of the Exam Works physicians to determine this.

Universal Rehabilitation Services, Inc. (Soukaina Sobh) v. State Farm

Oakland County Circuit Court

Unpublished Opinion – Docket No. 314273
(Mich Ct App April 11, 2013)

Granting of defendant's motion for summary disposition due to the failure of a critical party to participate in discovery.

Universal Rehabilitation Services, a medical service provider, sued the no-fault insurer, State Farm, for payment of first party no-fault insurance benefits regarding services purportedly rendered to non-party Soukaina Sobh. Universal's complaint alleged claims for breach of contract and declaratory relief based on allegations that the defendant unreasonably refused or unreasonably delayed in making payments. The court heard State Farm's motion for summary disposition based on Sobh's repeated failure to participate in discovery on the underlying nature of her injuries and treatment. The court ruled that since the serial violation of discovery deprived State Farm of any meaningful ability to defend the case, summary disposition was appropriate.

The court characterized Sobh's failure to participate in discovery as not being temporary or inadvertent. Among her failures, she breached her statutory duty under MCL 500.3151 to submit to an IME, breached her contractual duties under State Farm's insurance policy to provide proof of the fact and of the amount of the loss and failed, or refused, to comply with a duly served subpoena for her deposition as well as a show-cause order to appear.

Universal admitted, for purposes of the motion for summary disposition, that Sobh had breached her statutory and contractual obligations, but maintained that the instant action was not dependent on Sobh's action or inaction as she was not a party in the lawsuit. The court however concluded that Universal's own pleading established that Sobh was critical to the action. The court stated that undisputed evidence showed State Farm had been attempting to investigate the legitimacy of Sobh's injury claim since August 2011 – long before the lawsuit was filed – but that she repeatedly and consistently failed or refused to cooperate. Further, they stated that State Farm's conduct had been entirely consistent with its statutory rights under MCL 500.3151 and its contractual rights under policy provisions condoned by MCL 500.3151. Additionally, Universal was unable to pinpoint any facts to establish their allegations that State Farm had been unreasonable in refusing or delaying proper payments. Lastly, Universal failed to prove their claim that reasonable proof for full payment of all personal protection insurance benefits had been supplied to State Farm under MCL 500.3107(1) or that Universal's services were "reasonably necessary" for a motor vehicle related accident.

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