STATE OF MICHIGAN

COURT OF APPEALS

KATE SPRAGUE, Individually and as Next Friend of RYAN SPRAGUE, a minor,	FOR PUBLICATION May 10, 2002 9:10 a.m.
Plaintiff-Appellee,	
v	No. 227400 Kalamazoo Circuit Court
FARMERS INSURANCE EXCHANGE,	LC No. 99-000720-AV
Defendant-Appellant.	Updated Copy August 16, 2002

Before: Owens, P.J., and Markey and Murray, JJ.

MURRAY, J.

Defendant appeals by leave granted the circuit court's reversal of the district court's order granting defendant's motion for summary disposition brought pursuant to MCR 2.116(C)(10). The issue presented in this case is one of first impression and requires us to determine whether, under the no-fault act, MCL 500.3101 *et seq*., a coordinated benefits clause in a contract of insurance relieves a no-fault insurer from liability for services received by an insured where those services were not offered by the health care provider and the insured did not first exhaust any available medical treatments offered by that same health care provider. We hold under the facts of this case that defendant is statutorily obligated to pay the "allowable expenses" incurred by plaintiff. Accordingly, we affirm the circuit court's decision and remand this case to the district court for further proceedings consistent with this opinion.

I. Basic Facts and Procedural History

The material facts are not in dispute. In November, 1997, plaintiff and her son Ryan[1] were injured in an automobile accident. At the time of the accident plaintiff had health care coverage through her employer with Physicians Health Plan (PHP), a health maintenance organization (HMO). Plaintiff also had no-fault automobile insurance with defendant. Plaintiff elected to coordinate these two insurance plans, thereby receiving a reduced premium for her no-fault insurance benefits. Ryan was an insured person under both plans.

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[1] Ms. Sprague and her son both received the chiropractic services at issue under the same set of circumstances and Ms. Sprague sued on her own behalf and on behalf of her son.

After the accident, plaintiff received treatment from her PHP primary care physician, Dr. Nayana Patel. Dr. Patel's physician's assistant first examined plaintiff, found her to have upper back strain, and placed plaintiff on pain medications. Almost one month later, plaintiff saw Dr. Patel, who diagnosed plaintiff with musculoskeletal neck pain. Dr. Patel continued the medications, scheduled plaintiff for physical therapy, and had her temporarily taken off work. After two weeks of physical therapy, plaintiff returned to Dr. Patel, indicating to him that most of the discomfort in her neck had subsided. After conferring, plaintiff and Dr. Patel decided that plaintiff could return to work. The record indicates, however, that plaintiff and Dr. Patel agreed that plaintiff would return for further treatment if she had additional problems.

Approximately one month later, plaintiff began treatment with a chiropractor. Plaintiff did not receive any referrals to a chiropractor from PHP, nor did she return to Dr. Patel or any other authorized PHP physician for any further treatment or medical services. Plaintiff subsequently submitted the chiropractor bills to PHP, which declined coverage on the basis that no PHP referral existed (a requirement of the PHP contract) and because chiropractic services were not covered by PHP.[2] Plaintiff then submitted the bills to defendant, which also denied coverage on the basis that plaintiff had not made reasonable efforts to obtain medical services from PHP. This suit followed.

In the district court, defendant filed a motion for summary disposition pursuant to MCR 2.116(C)(10), which the district court granted in a written opinion and order. Plaintiff appealed that decision to the circuit court, which upon review de novo reversed the entry of judgment for defendant and remanded to the district court for further proceedings. We granted leave to appeal, and we now affirm.

II. Standard of Review

We review de novo the trial court's decision on a motion for summary disposition. *Spiek v Dep't of Transportation,* 456 Mich 331, 337; 572 NW2d 201 (1998). A motion for summary disposition brought under MCR 2.116(C)(10) tests the factual support for a claim. *Id.* In recent years the Supreme Court has clarified the standards governing review of motions under this subrule:

> "In reviewing a motion for summary disposition brought under MCR 2.116(C)(10), a trial court considers affidavits, pleadings, depositions, admissions, and documentary evidence filed in the action or submitted by the parties, MCR 2.116(G)(5), in the light most favorable to the party opposing the motion. A trial court may grant a motion for summary disposition under MCR 2.116(C)(10) if the affidavits or other documentary evidence show that there is no genuine issue in respect to any material fact, and the moving party is entitled to judgment as a matter of law. MCR 2.116(C)(10), (G)(4).

[2] Although the insurance contract between plaintiff and PHP was not made a part of the lower court record, the parties agreed that PHP did not have a contractual obligation to provide chiropractic services.

> "In presenting a motion for summary disposition, the moving party has the initial burden of supporting its position by affidavits, depositions, admissions, or other documentary evidence. *Neubacher v Glove Furniture Rentals*, 205 Mich App 418, 420; 522 NW2d 335 (1994). The burden then shifts to the opposing party to establish that a genuine issue of disputed fact exists. *Id.* Where the burden of proof at trial on a dispositive issue rests on a nonmoving party, the nonmoving party may not rely on mere allegations or denials in pleadings, but must go beyond the pleadings to set forth specific facts showing that a genuine issue of material fact exists. *McCart v J Walter Thompson,* 437 Mich 109, 115; 469 NW2d 284 (1991). If the opposing party fails to present documentary evidence establishing the existence of a material factual dispute, the motion is properly granted. *McCormic v Auto Club Ins Ass'n,* 202 Mich App 233, 237; 507 NW2d 741 (1993)." [*Smith v Globe Life Ins Co,* 460 Mich 446, 454-455; 597 NW2d 28 (1999), quoting *Quinto v Cross & Peters Co,* 451 Mich 358, 362-363; 547 NW2d 314 (1996).]

"A litigant's mere pledge to establish an issue of fact at trial cannot survive summary disposition under MCR 2.116(C)(10)." *Maiden v Rozwood*, 461 Mich 109, 121; 597 NW2d 817 (1999). Instead, a litigant opposing a properly supported motion for summary disposition under this subrule must present substantively admissible evidence to the trial court before its decision on the motion, which creates a genuine issue of material fact. *Id.*

III. Analysis

By the time this case reached our Court, both sides were, in baseball jargon, "batting .500," because both had successfully convinced a different learned trial judge that their position was the legally correct one. Defendant argues on appeal, and the district court held, that under *Tousignant v Allstate Ins Co,* 444 Mich 301; 506 NW2d 844 (1993), plaintiff's failure to utilize reasonable efforts to obtain available medical treatment from PHP precluded her from obtaining from defendant the reasonable cost of her chiropractic services. Plaintiff, on the other hand, convinced the circuit court on review de novo to accept her argument, holding that *Tousignant* and its reasoning were not applicable and that because PHP did not provide chiropractic services, defendant was required under the act to pay for the reasonable costs of the chiropractic services.[3]

Although the parties have agreed throughout this proceeding that the outcome of this case is controlled by case law, we must first seek guidance from the statutory language itself. The statute is, after all, the "rule book" for deciding issues surrounding the awarding of benefits under the act. *Cruz v State Farm Mut Automobile Ins Co,* 241 Mich App 159, 164; 614 NW2d 689

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[3] On the basis of its holding on this issue, the circuit court remanded the case to the district court for a determination whether the chiropractic services were reasonably necessary as required by MCL 500.3107(1)(a).

(2000), lv gtd 464 Mich 873 (2001). Resolution of this dispute primarily involves application of three sections of the act, MCL 500.3105, 500.3107, and 500.3109a.[4]

Section 3105 contains the legislative liability determination that, subject to the other provisions of the act, "an insurer is liable to pay benefits for accidental bodily injury arising out of the ownership, operation, maintenance or use of a motor vehicle . . . ." MCL 500.3105(1). Subsection 3107(1)(a) sets forth the type of benefits a no-fault insurer is liable for under § 3105 and provides in pertinent part:

> (1) Except as provided in subsection (2), personal protection insurance benefits are payable for the following:
>
> (a) Allowable expenses consisting of all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation.

In *Nasser v Auto Club Ins Ass'n,* 435 Mich 33, 48-49; 457 NW2d 637 (1990), the Supreme Court described the interplay between the foregoing statutory provisions:

> Under § 3105 of the no-fault act, an insurer is "*liable* to pay [PIP] benefits for accidental bodily injury arising out of the ownership, operation, maintenance or use of a motor vehicle as a motor vehicle, *subject to the provisions of this chapter.*" (Emphasis added.) The relevant provision in this case is § 3107, which provides that PIP benefits are payable only for "[a]llowable expenses." Section 3107 defines allowable expenses as "consisting of all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation."

MCL 500.3109a, in turn, requires a no-fault insurer to offer benefits coordination with health and accident coverage, which in turns affords the insured a lower premium. That section provides in pertinent part: "An insurer providing personal protection insurance benefits shall offer, at appropriately reduced premium rates, deductibles and exclusions reasonably *related to other health and accident coverage on the insured*." MCL 500.3109a (emphasis added).

In *Toth v AutoAlliance Int'l, Inc,* 246 Mich App 732, 737; 635 NW2d 62 (2001), this Court set forth the well-settled principles of statutory construction that are equally applicable in this case:

> The primary goal of judicial interpretation of statutes is to ascertain and give effect to the Legislature's intent. *Frankenmuth Mut Ins Co v Marlette*

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[4] We also recognize that the act is to be liberally construed in favor of coverage. *Putkamer v Transamerica Ins Corp of America*, 454 Mich 626, 631; 563 NW2d 683 (1997); *Gobler v Auto-Owners Ins Co,* 428 Mich 51, 61; 404 NW2d 199 (1987).

> *Homes, Inc,* 456 Mich 511, 515; 573 NW2d 611 (1998). If the plain and ordinary meaning of the statute is clear, judicial construction is neither necessary nor permitted. *Elia v Hazen*, 242 Mich App 374, 381; 619 NW2d 1 (2000). We may not speculate with regard to the probable intent of the Legislature beyond the words expressed in the statute. *In re Schnell,* 214 Mich App 304, 310; 543 NW2d 11 (1995). When reasonable minds may differ with respect to the meaning of a statute, the courts must look to the object of the statute, the harm it is designed to remedy, and apply a reasonable construction that best accomplishes the purpose of the statute. *Marquis v Hartford Accident & Indemnity* (*After Remand*), 444 Mich 638, 644; 513 NW2d 799 (1994).

It is well settled that MCL 500.3109a

> requires no-fault insurers to offer, at a reduced premium, personal injury protection benefits that are coordinated with benefits available from other health and accident coverage. The coordination of benefits clause serves to contain automobile insurance and health insurance costs while eliminating duplicative recovery. Under Michigan law, where no-fault coverage and health coverage are coordinated, the health insurer is primarily liable for plaintiff 's medical expenses. [*American Medical Security, Inc v Allstate Ins Co,* 235 Mich App 301, 303-304; 597 NW2d 244 (1999) (citations omitted)].

In *Tousignant*, *supra,* our Supreme Court held that "a no-fault insurer is not subject to liability for medical expenses that the insured's health care insurer is *required, under its contract, to pay for or provide*." *Tousignant, supra* at 303 (emphasis added). In that case, the plaintiff was examined and treated at a Health Alliance Plan (HAP) facility and released with instructions to return if her back or neck pain continued. The plaintiff apparently continued to suffer pain, but instead of returning to an HAP facility or physician, the plaintiff sought treatment from a physician other than an HAP physician. *Id.* at 305. In addition, the plaintiff obtained treatment from a dentist who was also not affiliated with HAP. The plaintiff then sought reimbursement from her automobile insurer for any non-HAP medical care. The automobile insurer informed the plaintiff that it would reimburse her only for medical care provided by a non-HAP physician pursuant to a referral from an HAP physician. *Id.*

After noting the legislative purposes underlying MCL 500.3109a, and the general limitation of choice available from HMOs, the Supreme Court held that where "the no-fault insured's employer chooses to provide health insurance, or the no-fault insured chooses to obtain health insurance, from an HMO, *and the no-fault insured chooses to coordinate* no-fault and health coverages, the no-fault insured has, in effect, thereby agreed to relinquish choice of physician and facility." *Tousignant, supra* at 310 (emphasis in original).

The *Tousignant* holding does not, however, resolve the issue before us because the *Tousignant* Court repeatedly emphasized that it was addressing the situation where the insured utilized the services of a medical care provider for services that the insured's health insurer had already contractually agreed to provide to the insured. For example, the Court's specific holding was "that a no-fault insurer is not subject to liability for medical expense that the insured's health

care insurer is *required, under its contract, to pay for or provide.*" *Id.* at 303 (emphasis added). The Court also noted several times in its opinion that the plaintiff was not alleging that the necessary medical care was "unavailable or of inadequate quality" at HAP facilities. *Id.* at 303, n 2, 305. Additionally, the Court explained its conclusion by stating that coordination provisions in a contract requires the insured "to obtain payment and services from the health insurer *to the extent of the health coverage available from the health insurer.*" *Id.* at 307 (emphasis added). Finally, the Court amplified its holding by noting that the policy of precluding duplicative recovery would be ineffectual if an insured could obtain from the no-fault insurer "medical expense *obtainable*" from the health insurer. *Id.* at 308 (emphasis added).

As the foregoing discussion amply illustrates, the *Tousignant* Court's holding was premised on the significant fact that the services utilized by the insured were already "obtainable" and "available" from the health insurer, as the primary insurer, under the contract held by the insured. Therefore, to order the no-fault insurer to pay for benefits that the health care provider was already contractually bound to provide would allow for duplicative recovery and excessive health care costs. Hence, the contractual coordination provision precluded the plaintiff's recovery in that case. This point is further illustrated in *Booth v Auto-Owners Ins Co,* 224 Mich App 724, 734-735; 569 NW2d 903 (1997), as follows:

> In *Tousignant* and *Owens*, the Supreme Court held that by choosing to coordinate health care coverage, the insureds agreed in effect to avail themselves of the *coverage provided*, *Owens, supra* at 321, and relinquish choices of physician and facility, *where the coverage is provided* by a health maintenance organization as in *Tousignant, supra* at 310. [Emphasis added.]

Hence, under *Tousignant* and *Owens* a party who holds a contract containing a coordinated benefits clause is required first to utilize the health care provider for services offered by that health care provider, but is able to seek reimbursement for "allowable expenses" that were not contractually required to be provided by the health care provider. MCL 500.3105, 500.3107, 500.3109a. In other words, because the services received by plaintiff in this case were not required by contract to be provided by PHP, they were not subject to the coordination of benefits clause. As such, the general liability provision of the act, MCL 500.3105, applies to defendant's obligation to plaintiff under the act.[5]

Although we are somewhat sympathetic to defendant's position that plaintiff never gave PHP an opportunity to complete the medical services instituted, i.e., physical therapy, plaintiff's

[5] We reject the invitation from amicus to rely on a House Analysis of the house bill that led to the act, and the minutes of the Committee on Insurance from 1974, as evidence of the legislative purpose of the statute. Such "evidence" is of no value with respect to what the Legislature, rather than committee members or administrative staff, believed to be the purpose of the proposed statute. *People v Pfaffle,* 246 Mich App 282, 301-302; 632 NW2d 162 (2001); *In re Complaint of Michigan Cable Telecommunications Ass'n,* 241 Mich App 344, 372-373; 615 NW2d 255 (2000). Instead, we rely on the words actually utilized by the Legislature in §§ 3105, 3107, and 3109a in coming to our conclusion. We also note that defendant has not alleged that any provision of the act other than § 3109a applies to this case.

actions in that regard do not address whether defendant is liable for the services because of a coordinated benefits clause. Rather, whether plaintiff was reasonable in failing to return to PHP for continued physical therapy, and instead unilaterally engaging the services of a chiropractor, addresses the second statutory consideration in determining the extent, if any, of defendant's obligation: Whether plaintiff incurred an "allowable expense" and, in particular, whether the chiropractic services were "reasonably necessary services." MCL 500.3107(1)(a). It is plaintiff's burden to prove that the services were reasonably necessary, *Owens, supra* at 324, and that issue should be resolved by the trier of fact[6] in light of PHP's stated desire to continue with physical therapy if plaintiff's problems persisted. As the circuit court noted, this issue was never addressed by the district court in light of its holding on the coordination issue. We believe, as did the circuit court, that this issue must be addressed in the first instance by the district court.

We affirm the circuit court's decision and remand to the district court for proceedings consistent with this opinion.

/s/ Christopher M. Murray
/s/ Donald S. Owens
/s/ Jane E. Markey

[6] This statement should not be construed as foreclosing resolution of this issue by way of a motion for summary disposition should the evidence and proceedings so warrant.