STATE OF MICHIGAN

COURT OF APPEALS

EDWARD W. SPARROW HOSPITAL, Plaintiff-Appellant,	UNPUBLISHED March 23, 2006
v	No. 258503 Ingham Circuit Court
SINAS DRAMIS BRAKE BOUGHTON & MCINTYRE, P.C., Defendant-Appellee.	LC No. 03-000264-NZ

Before: Smolenski, P.J., Whitbeck, C.J., and O'Connell, J.

PER CURIAM.

Plaintiff appeals as of right from an order of the trial court denying plaintiff's motion for summary disposition under MCR 2.116(10). The trial court dismissed plaintiff's claims, ruling that defendant could not have converted money belonging to plaintiff by retaining a portion of its client's settlement as attorney fees. The trial court also found that plaintiff lost any claim when it accepted payment in full from Medicare. We affirm.

This litigation concerns a no-fault auto insurance settlement relating to a collision between a vehicle and a pedestrian that occurred on June 2, 2001. The pedestrian suffered unspecified injuries, including a catastrophic brain injury, and was treated at plaintiff's hospital and released on August 3, 2001. Prior to the accident the patient had suffered from schizophrenia, and, at the time of the accident, all facts indicated that the patient had been attempting to injure himself by running directly into the vehicle on foot. Thus, when the no-fault insurer denied liability, plaintiff billed Medicare. There is no indication that plaintiff initially questioned this denial of no-fault benefits. Plaintiff erroneously billed Medicare as the primary insurer, even though the Medicare secondary payer statute, 42 USC 1395y, required plaintiff either to bill the insurer as the primary payer and Medicare as secondary or to bill Medicare conditionally. Medicare paid a little over $100,000 for the patient's care, which plaintiff accepted. However, plaintiff allegedly expended an additional $140,000 in medical services that were not reimbursed.

After Medicare paid for the patient's treatment, the patient signed a contingency agreement with defendant, and defendant challenged the no-fault insurer's presumption that the patient had been attempting suicide and ultimately settled with the insurer. On June 24, 2002, after settlement was reached, plaintiff contacted the no-fault insurer, which informed plaintiff of the settlement. From the settlement proceeds, defendant reimbursed Medicare and eventually

reimbursed plaintiff about $105,000, but withheld roughly $35,000 in attorney fees (one quarter of the payment). Plaintiff then brought suit against defendant for conversion and sought summary disposition, but the trial court ultimately ruled that plaintiff had accepted the Medicare payment as payment in full and had no claim to the settlement proceeds.

We review de novo a grant of summary disposition. *Wilcoxon v Minnesota Mining & Mfg Co*, 235 Mich App 347, 357; 597 NW2d 250 (1999). A motion brought under MCR 2.116(C)(10) tests the factual basis for a claim, so we review "the affidavits, pleadings, depositions, or any other documentary evidence presented by the parties in the light most favorable to the nonmoving party, affording all reasonable inferences to the nonmovant, to determine whether the moving party is entitled to judgment as a matter of law." *Knauff v Oscoda Co Drain Comm'r*, 240 Mich App 485, 488; 618 NW2d 1 (2000).

Plaintiff first argues that nothing in the Medicare no-charge statute, 42 USC 1395cc(a)(1)(A), precludes it from seeking no-fault settlement benefits. The statute requires providers to agree "not to charge . . . any individual or any other person for items or services for which such individual is entitled to have payment made under this title . . . ." 42 USC 1395cc(a)(1)(A)(i). The statute prevents providers from pursuing claims for the difference between the providers' actual expenses and the amount they receive from Medicare. However, once it is affirmatively established that the patient never had a right to Medicare coverage, CFR 411.35 permits a provider to collect from the patient the amount he receives for expenses that exceeded the amount Medicare paid. Nevertheless, there is a split in authority over whether a provider may pursue unpaid expenses after accepting payment from Medicare. Compare *Rybicki v Hartley*, 792 F2d 260 (CA 1, 1986), with *Smith v Farmers Ins Exch*, 9 P3d 335, 340 (Colo, 2000). Fortunately, we need not mend this rift to affirm the trial court's ultimate conclusion in this case.

As an initial matter, the trial court correctly dismissed plaintiff's count of statutory conversion because this case has nothing to do with the destruction of real property. MCL 600.2919.[1] The trial court also correctly described the legal backdrop for analyzing plaintiff's claim for common law conversion. "In the civil context, conversion is defined as any distinct act of domain wrongfully exerted over another's personal property in denial of or inconsistent with the rights therein." *Foremost Ins Co v Allstate Ins Co*, 439 Mich 378, 391; 486 NW2d 600 (1992). For a plaintiff to prevail on a claim of conversion of money, "the defendant must have an obligation to return the specific money entrusted to his care." *Head v Phillips Camper Sales & Rental, Inc*, 234 Mich App 94, 111; 593 NW2d 595 (1999). These rules prevent litigants from asserting conversion on every unpaid claim they seek to pursue. Without the rules, conversion would lie whenever a defendant is ultimately found liable for any debt, breach, or injury, when the defendant's only wrong was to require the plaintiff to prove damages and obtain judgment in a legal proceeding.

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[1] Although we understand that plaintiff's complaint was probably referring to MCL 600.2919a, plaintiff failed to amend its complaint or otherwise explain the defect in the face of defendant's opposition to this claim.

Although plaintiff's unpaid medical expenses establish a legal right of payment from the patient and may establish an equitable right such as a lien in the insurance proceeds, nothing in the record demonstrated that plaintiff attempted to attach or enforce its lien against the proceeds or made any effort to pursue the patient. Instead, it sued the patient's attorneys. The record demonstrates that plaintiff billed Medicare as the primary insurer and did not pursue the no fault insurer until over one year had passed since the date of the accident. Despite numerous procedural errors, its own lax approach to its insurance billing, and the fact that it had already "written off" the discrepancy as bad debt, plaintiff sought to recover all its unpaid expenses. Such a recovery would ignore defendant's legal efforts and sanction an inequitable windfall. While this renders tenuous any equitable claim in the insurance proceeds, a claim of absolute ownership is indefensible. The insurer paid the patient according to its insurance contract with him. Plaintiff has never argued that this money was paid to the patient as plaintiff's agent or trustee, so the money was the patient's, not plaintiff's, and plaintiff fails to present any legal or factual reason to find otherwise. In sum, although plaintiff *could* have sought reimbursement from the patient, a cause of action is not money in hand, and it certainly cannot be evidence that defendant held plaintiff's money. Because plaintiff failed to demonstrate that it ever had a possessory right to the specific money defendant held, the trial court correctly dismissed plaintiff's conversion claim.

Affirmed.

/s/ William C. Whitbeck
/s/ Peter D. O'Connell

I concur in result only.

/s/ Michael R. Smolenski