STATE OF MICHIGAN

COURT OF APPEALS

BRONSON METHODIST HOSPITAL, Plaintiff-Appellee/Cross-Appellant, v HOME-OWNERS INSURANCE CO., Defendant-Appellant/Cross-Appellee.	FOR PUBLICATION February 16, 2012 9:00 a.m. No. 300566 Kalamazoo Circuit Court LC No. 2009-000539-NF
BRONSON METHODIST HOSPITAL, Plaintiff-Appellee/Cross-Appellant, v AUTO-OWNERS INSURANCE CO., Defendant-Appellant/Cross-Appellee.	No. 300567 Kalamazoo Circuit Court LC No. 2010-000034-NF

Before: HOEKSTRA, P.J., and K. F. KELLY and BECKERING, JJ.

PER CURIAM.

Defendants, Home-Owners Insurance Company (Home-Owners) and Auto-Owners Insurance Company (Auto-Owners), appeal as of right from a trial court order granting summary disposition in favor of plaintiff Bronson Methodist Hospital pursuant to MCR 2.116(C)(10) in these consolidated actions over the reasonableness of charges for surgical implant products billed to defendants' insureds under the no-fault act, MCL 500.3101 *et seq*. Plaintiff cross-appeals that portion of the trial court's order denying its motion for attorney fees under MCL 500.3148. We affirm in part and reverse in part. We find that, in accordance with defendants' clear statutory right and obligation to question the reasonableness of the fees, the no-fault act permits defendants to discover the wholesale costs to plaintiff of the surgical implant products for which the insureds were charged. Therefore, the trial court erred when it denied defendants' prior motion to compel discovery. Because of the error denying discovery, summary disposition was granted prematurely. We also stress that the ultimate burden of proof regarding the

reasonableness of the fees rests with the provider. Finally, we conclude that the attorney-fee penalty provision of the no-fault act was not triggered.

I. BASIC FACTS AND PROCEDURAL HISTORY

These consolidated appeals arise from disputes over the reasonableness of plaintiff's charges for surgical implant products provided to defendants' insureds, Gavin Powell and Hector Serrano-Ruiz, each of whom were treated at plaintiff hospital after suffering serious injuries in separate and unrelated automobile accidents. At issue is whether defendants are entitled to information pertaining to the cost of surgical implant products to plaintiff when determining whether the charges billed to defendants' insureds for those surgical implant products are "reasonable" under the no-fault act and, accordingly, whether that information is discoverable during the course of litigation over such charges.

Powell was injured on July 2, 2009, when the vehicle he was driving struck a tree. Serrano-Ruiz was injured on July 17, 2009, when the motorcycle he was driving was struck by another vehicle. Both Powell and Serrano-Ruiz suffered broken bones that were treated with surgical implant products, including screws and plates. Plaintiff's charges for the medical treatment afforded to Powell totaled $242,941.09, of which $61,237.50 was for "supply/implant" products; plaintiff's total charges for Serrano-Ruiz's medical treatment were $143,477.76, of which $28,810.00 was for "supply/implant" products. Auto-Owners is responsible for payment of the insurance proceeds for Powell's medical treatment; Home-Owners is responsible for payment of the insurance proceeds for Serrano-Ruiz's medical treatment. Plaintiff provided defendants with uniform billing forms, itemized statements, and medical records identifying the medical treatment provided to Powell and to Serrano-Ruiz, respectively. Defendants timely paid the portion of plaintiff's bills for all charges other than for the surgical implant products used to treat the two men. Defendants requested invoices showing the costs to plaintiff of those surgical implant products. Plaintiff refused to provide this information. Defendants did not pay the charges within the allotted statutory period, resulting in plaintiff filing the instant actions to recover the unpaid amounts, together with statutory interest and attorney fees.

Home-Owners admitted that it did not pay the $28,800 charge for surgical implant products and denied that such payment was due and owing because plaintiff failed to provide reasonable proof of the fact and amount of the loss and failed to comply with MCL 500.3158(2) in refusing to provide copies of the invoices showing the cost to plaintiff of the items billed as "supply implants." Absent such information, Home-Owners was unable to make a determination as to the reasonableness of the charges for the implants. Similarly, Auto-Owners admitted that it did not pay $61,237.50 for surgical implants because plaintiff failed to provide sufficient documentation as to the cost of treatment as required by MCL 500.3158(2) and failed to provide reasonable proof of the fact and amount of loss as required by MCL 500.3142 by refusing to provide copies of purchase invoices showing the cost to plaintiff of the items billed as "Supply/Implants in the amount of $61,237.50."

Defendants submitted discovery requests seeking information regarding: the wholesale costs to plaintiff of the surgical implant products at issue; plaintiff's "total revenue and operating expenses and the 'cost-to-charge ratio' which is derived from these numbers;" the percentages of plaintiff's patients that are uninsured or covered by no-fault insurance; the average annual

increase in plaintiff's charges over the last five years; and any billing manuals or guidelines used to prepare itemized charges or other billing documents. Plaintiff objected to defendants' discovery requests, arguing that the information sought was irrelevant to the claims asserted in plaintiff's complaints and that defendants were not entitled to the information sought because the "costs of treatment" to which defendants were entitled were the costs to the "injured person" of the medical care and treatment that person received, i.e., the charges incurred by the patient at plaintiff's hospital.

Defendants later moved to compel discovery, asserting that the information sought was relevant to their determination of whether the charges billed were reasonable under the no-fault act. Pursuant to MCL 500.3158(2), plaintiff was required to provide insurers with information relating to the costs of treatment of the injured person, which, defendants argued, included the wholesale cost to the provider of the implant products for which the insured was charged. Defendants also asserted that MCR 2.302 required that plaintiff produce the requested information because it was relevant to the factual question of whether plaintiff's charges for the surgical implant products were "reasonable" within the meaning of the no-fault act. Defendants noted that they paid plaintiff the substantial portion of the total charges levied in each case and that the unpaid portions of plaintiff's bills related solely to charges for the surgical implant products for which defendants sought, and plaintiff refused to provide, underlying cost information. Defendants further asserted that whether plaintiff's charges are "reasonable" and whether plaintiff provided "reasonable proof" of the fact and amount of loss as required by the act was a determination to be made by the finder of fact, and was an issue to which the requested materials were relevant and discoverable.

Plaintiff opposed defendants' motions, again asserting that defendants were not entitled to the information sought. Plaintiff also moved for summary disposition under MCR 2.116(C)(9), on the basis that defendants had abdicated their duty to process the balance of plaintiff's claims in accordance with the no-fault act, instead seeking to use the discovery process to obtain information they were not entitled to obtain under the no-fault act – plaintiff's underlying – and often confidential – proprietary cost data. Plaintiff asserted that defendants could not merely refuse to process the claims; rather, defendants were required to fully process its claims by adopting a methodology for assessing the reasonableness of those claims. Further, plaintiff argued that the information about the "costs of treatment" that it was required to provide under MCL 500.3158(2) was the cost of treatment to the injured person, not the cost to the provider of providing the treatment.

At the hearing on the motions, defendants reiterated their position that the no-fault act required them to determine whether the charges assessed were reasonable and that MCL 500.3158(2) entitled them to documentation regarding the cost to plaintiff of the surgical implant products to make that determination. Defendants argued that by failing to provide that information, plaintiff had not met its burden of providing reasonable proof of loss under the act, so as to entitle it to payment for the surgical implant products. In response, plaintiff argued that by submitting a uniform billing form, an itemized statement, and the patient's medical records, it had met its burden in each case to provide defendants with reasonable proof of the amount of the loss under MCL 500.3142, but that, thereafter, defendants failed to evaluate the claims, pay what they believed to be reasonable, and deny what they believed to be excessive. Plaintiff argued that defendants were required to conduct an investigation to determine whether the charges were

reasonable by comparing costs among providers "similarly located geographically" for the products at issue. Plaintiff also asserted that allowing insurers to obtain providers' cost data would undermine the goals and objectives of the no-fault act and would cause that reparation system to come to a grinding halt. Plaintiff reiterated that all it is required to do is put the insurer on notice of the charges and the services provided to the insured, and that, once it does so, the insurer then has the obligation to go out and use whatever resources it has in the insurance industry to evaluate the reasonableness of the charges.

The trial court concluded that nothing in the no-fault statute required plaintiff to provide its cost of surgical implants and denied the discovery request. The trial court afforded defendants the opportunity to amend their answers to include allegations that plaintiff's charges were unreasonable. Following the court's ruling, defendants, through their audit consultant, CorVel Corporation, estimated a price at which the surgical implant products had been purchased and, based on those estimates, paid plaintiff $34,701.02 of the outstanding $61,237.50 charges related to Powell's treatment and $21,612.65 of the outstanding $28,800 charges related to Serrano-Ruiz's treatment. The payments were "calculated on a basis of cost of the product to the hospital plus 50%." As a result of the additional payments, the balances remaining in dispute were $26,536.48 for Powell's treatment and $7,187.05 for Serrano-Ruiz's treatment. Defendants amended their answers to plaintiff's complaints accordingly, to specifically deny the reasonableness of the outstanding charges for surgical implant products.

Plaintiff again moved for summary disposition, this time under MCR 2.116(C)(10), asserting that defendant's methodology for determining whether the charges for the surgical implants were reasonable was, itself, unreasonable as a matter of law. Plaintiff argued that calculating the reasonable rate of reimbursement based on one and one-half times the average wholesale implant cost, provided to defendants by a third-party auditing entity, was itself arbitrary and unreasonable as a matter of law under this Court's decision in *Advocacy Org for Patients Providers v Auto Club Ins Ass'n*, 257 Mich App 365, 370; 670 NW2d 569 (2003), aff'd in part 472 Mich 91 (2005) (*AOPP*). Plaintiff described defendants' methodology as mere guesswork. As it had previously, plaintiff argued that the only relevant consideration under the no-fault act is the amount of the provider's charges for medical services, and not the provider's cost of providing those services. The trial court granted plaintiff's motion for summary disposition, including penalty interest, but denied plaintiff's request for attorney fees because defendants' legal position was "based primarily on testing the legal waters, as opposed to testing the patience of this Court or the Plaintiff." Defendants now appeal as of right. Plaintiff cross appeals from that portion of the order that denied its request for attorney fees.

II. STANDARDS OF REVIEW

This Court reviews a trial court's ruling on a motion to compel discovery for an abuse of discretion. *Cabrera v Ekema*, 265 Mich App 402, 406; 695 NW2d 78 (2005).

We review a trial court's decision on a motion for summary disposition de novo, reviewing the record in the same manner as must the trial court to determine whether the movant was entitled to judgment as a matter of law. *Latham v Barton Malow Co*, 480 Mich 105, 111; 746 NW2d 868 (2008). A motion for summary disposition under MCR 2.116(C)(10) tests the factual sufficiency of the complaint. *Corley v Detroit Bd of Ed*, 470 Mich 274, 278; 681 NW2d

342 (2004). The moving party must specifically identify the matters that have no disputed factual issues, and it has the initial burden of supporting its position by affidavits, depositions, admissions, or other documentary evidence. MCR 2.116(G)(3)(b); MCR 2.116(G)(4); *Coblentz v Novi*, 475 Mich 558, 569; 719 NW2d 73 (2006). The party opposing the motion then has the burden of showing by evidentiary materials that a genuine issue of disputed material fact exists. MCR 2.116(G)(4); *Coblentz*, 475 Mich at 569. The existence of a disputed fact must be established by substantively admissible evidence, although the evidence need not be in admissible form. MCR 2.116(G)(6); *Maiden v Rozwood*, 461 Mich 109, 121; 597 NW2d 817 (1999). A genuine issue of material fact exists when the record, giving the benefit of reasonable doubt to the opposing party, leaves open an issue upon which reasonable minds could differ. *Allison v AEW Capital Mgt, LLP*, 481 Mich 419, 425; 751 NW2d 8 (2008).

We review de novo questions of statutory construction. *Feyz v Mercy Mem Hosp*, 475 Mich 663, 672; 719 NW2d 1 (2006). This Court's primary task in construing a statute is to discern and give effect to the intent of the Legislature. *Shinholster v Annapolis Hosp*, 471 Mich 540, 548–549; 685 NW2d 275 (2004). In so doing, the Court must begin with the language of the statute, ascertaining the intent that may reasonably be inferred from its language. *Lash v Traverse City*, 479 Mich 180, 187; 735 NW2d 628 (2007). It is axiomatic that the words contained in the statute provide the most reliable evidence of the Legislature's intent. *Kinder Morgan Mich, LLC v City of Jackson*, 277 Mich App 159, 163; 744 NW2d 184 (2007). The Legislature is presumed to have intended the meaning it plainly expressed and clear statutory language must be enforced as written. *Rowland v Washtenaw Co Rd Comm*, 477 Mich 197, 219; 731 NW2d 41 (2007); *Fluor Enterprises, Inc v Dep't of Treasury*, 477 Mich 170, 174; 730 NW2d 72 (2007). If the statutory language is clear and unambiguous, judicial construction is neither required nor permitted, and courts must apply the statute as written. *Lash*, 479 Mich at 187; *Rose Hill Ctr, Inc v Holly Twp*, 224 Mich App 28, 32; 568 NW2d 332 (1997). Only if a statute is ambiguous is judicial construction permitted. *Detroit City Council v Mayor of Detroit*, 283 Mich App 442, 449; 770 NW2d 117 (2009).

Finally, we review a trial court's decision whether to award attorney fees and under the no-fault act for an abuse of discretion. *Moore v Secura Ins*, 482 Mich 507, 516; 759 NW2d 833 (2008). An abuse of discretion occurs when the trial court's decision is outside the range of reasonable and principled outcomes. *Smith v Khouri*, 481 Mich 519, 526; 751 NW2d 472 (2008). "The trial court's decision about whether the insurer acted reasonably involves a mixed question of law and fact. What constitutes reasonableness is a question of law, but whether [a] defendant's denial of benefits is reasonable under the particular facts of the case is a question of fact." *Ross v Auto Club Group*, 481 Mich 1, 7; 748 NW2d 552 (2008). This Court reviews a trial court's factual findings for clear error. *Id.* A decision is clearly erroneous when the reviewing court is left with a definite and firm conviction that a mistake has been made. *Id.*

III. ANALYSIS

A. IS THE COST OF PROVIDING MEDICAL SERVICES AND PRODUCTS DISCOVERABLE UNDER MCL 500.3158(2), MCL 500.3159, AND MCR 2.302?

The primary issue on appeal is whether defendants are permitted by the no-fault act to discover the wholesale costs to plaintiff of surgical implant products used in treating defendants'

insureds when determining whether plaintiff's charges for those implant products are reasonable under the act. We find that, in accordance with defendants' clear statutory right and obligation to question the reasonableness of the fees, the no-fault act permits defendants to discover the wholesale costs to plaintiff of the surgical implant products for which the insureds were charged. We also stress that the ultimate burden of proof regarding the reasonableness of the fees rests with the provider.

The Michigan court rules establish "an open, broad discovery policy." *Cabrera*, 265 Mich App at 406–407; MCR 2.302. Discovery is permitted for any relevant matter, unless privileged. *Id.* However, "a trial court should also protect the interests of the party opposing discovery so as not to subject that party to excessive, abusive, or irrelevant discovery requests." *Id*.

The no-fault act provides a system of mandatory no-fault automobile insurance, which requires Michigan drivers to purchase personal protection insurance. MCL 500.3101 *et seq.* "Under personal protection insurance[,] an insurer is liable to pay 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." MCL 500.3105(1). MCL 500.3107(1)(a) provides that personal protection insurance benefits are payable for "allowable expenses consisting of all *reasonable charges* incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation." (Emphasis added.). Though "reasonable" is not defined, MCL 500.3157 instructs that:

> A physician, hospital, clinic or other person or institution lawfully rendering treatment to an injured person for an accidental bodily injury covered by personal protection insurance, and a person or institution providing rehabilitative occupational training following the injury, *may charge a reasonable amount for the products, services and accommodations rendered*. The charge shall not exceed the amount the person or institution customarily charges for like products, services and accommodations in cases not involving insurance. [Emphasis added.]

MCL 500.3158(2) further requires that:

> A physician, hospital, clinic or other medical institution providing, before or after an accidental bodily injury upon which a claim for personal protection insurance benefits is based, any product, service or accommodation in relation to that or any other injury, or in relation to a condition claimed to be connected with that or any other injury, if requested to do so by the insurer against whom the claim has been made, (a) *shall furnish forthwith a written report of the* history, condition, treatment and dates and *costs of treatment of the injured person* and (b) shall produce forthwith and permit inspection and copying of its records regarding the history, condition, treatment and dates and costs of treatment. [Emphasis added.]

Finally, MCL 500.3159 provides:

> In a *dispute regarding an insurer's right to discovery of facts about an injured person's* earnings or about his history, condition, treatment and dates and *costs of treatment*, a court may enter an order for the discovery. The order may be

> made only on motion for good cause shown and upon notice to all persons having an interest, and shall specify the time, place, manner, conditions and scope of the discovery. A court, in order to protect against annoyance, embarrassment or oppression, as justice requires, may enter an order refusing discovery or specifying conditions of discovery and may order payments of costs and expenses of the proceeding, including reasonable fees for the appearance of attorneys at the proceedings, as justice requires. [Emphasis added.]

Because benefits are payable as loss accrues, benefits are considered overdue "if not paid within 30 days after *an insurer receives reasonable proof of the fact and of the amount of loss sustained*." MCL 500.3142(2) (emphasis added). Similarly, "if the court finds that the insurer unreasonably refused to pay the claim or unreasonably delayed in making proper payment" an attorney's fee shall be a charged against the insurer in addition to the benefits recovered. MCL 500.3148(1).

Defendants argue that the cost to providers of the products used in treating an insured is an appropriate consideration in determining whether the charge for those products is reasonable and that the trial court erred by construing the phrase "cost of treatment" in MCL 500.3158(2) as referring only to the charges of the healthcare providers in their own billing to the patients, and not to documentation of the costs to the providers of products and materials used in that treatment.

In contrast, plaintiff argues that the cost of the surgical implant products, whether actual or estimated, was not a permissible consideration in determining whether plaintiff's charges were reasonable and that defendants' methodology is equivalent to a fee schedule, which is not authorized under the act; rather, the act contemplates only a "charge-to-charge" comparison. Plaintiff believes that defendants were limited in comparing plaintiff's charges to those of other similar providers for the same services.

The trial court concluded that defendants were not permitted to consider either plaintiff's costs for the surgical implant products or the average costs of those products to providers generally, as calculated by a third-party auditor. Instead, defendants are restricted to comparing plaintiff's charges with the charges of other similar providers for these products. We believe the trial court erred in so finding.

Both parties rely on our holding in *AOPP*, 257 Mich App 365. At issue in that case was "whether, under the language of the [no-fault] act, defendant insurance companies are required to pay the full amount charged as long as the charge constitutes a 'customary' one, or if defendants are entitled to independently review and audit the medical costs charged to their insureds to determine whether a particular charge is 'reasonable.'" *AOPP*, 257 Mich App at 372. Citing both § 3157 and § 3107, we noted that the amount an insurer is obligated to pay to a health care provider is limited to "a reasonable amount." We held:

> Under this statutory scheme, an insurer is not liable for any medical expense that is not both reasonable and necessary. *Hofmann v Auto Club Ins Ass'n*, 211 Mich App 55, 93-94; 535 NW2d 529 (1995), quoting *Nasser v Auto Club Ins Ass'n*, 435 Mich 33, 49-50; 457 NW2d 637 (1990). The reasonableness of the charge is an explicit and necessary element of a claimant's recovery against

> an insurer, and, accordingly, the burden of proof on this issue lies with the plaintiff. *Id.* "Where a plaintiff is unable to show that a particular, reasonable expense has been incurred for a reasonably necessary product and service, there can be no finding of a breach of the insurer's duty to pay that expense, and thus no finding of liability with regard to that expense." *Nasser*, [435 Mich] at 50.
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> As the United States Court of Appeals for the Sixth Circuit recognized, these statutory provisions leave open the questions of (1) what constitutes a reasonable charge, (2) who decides what is a reasonable charge, and (3) what criteria may be used to determine what is reasonable. See *Advocacy Organization for Patients & Providers (AOPP) v Auto Club Ins Ass'n*, 176 F3d 315, 320 (CA 6, 1999). [*AOPP*, 257 Mich App at 373-374.]

We rejected the provider's claim that insurers must pay all reasonable necessary medical expenses incurred for accidental bodily injuries as long as the charges did not exceed the amount the provider customarily charged for comparable services to patients *without* insurance. *Id.* at 375. While § 3157 specifically sets forth that a provider's charge "shall not exceed the amount customarily charged in cases not involving insurance," the language of the statute did not define what was "reasonable;" rather, the language simply placed a maximum on what a provider could charge in no-fault cases. "Thus, although § 3157 limits what can be charged, nowhere in that section does the Legislature indicate that a 'customary' charge is necessarily a 'reasonable' charge that must be reimbursed in full by the insurer." *Id.* at 376. Such a finding would be contrary to the purpose of the no-fault act. We noted:

> In fact, this Court in *McGill*, *supra*, discussed at length the policy considerations underlying the act in rejecting the plaintiffs' argument that the defendant insurers were required to pay the full amount of medical expenses billed by health-care providers:
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> > It is to be recalled that the public policy of this state is that "the existence of no-fault insurance shall not increase the cost of health care." Indeed, "[t]he no-fault act was as concerned with the rising cost of health care as it was with providing an efficient system of automobile insurance." To that end, the plain and ordinary language of § 3107 requiring no-fault insurance carriers to pay no more than reasonable medical expenses, clearly evinces the Legislature's intent to "place a check on health care providers who have 'no incentive to keep the doctor bill at a minimum.'"
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> > For the above reasons, we reject plaintiffs' argument that, pursuant to the no-fault act, defendants are obligated to pay the entire amount of plaintiffs' medical bills. *Such an interpretation would require insurance companies to accept health care providers' unilateral decisions regarding what constitutes reasonable medical expenses, effectively eliminating insurance companies' cost-policing function as contemplated by the no-fault act. This result would directly conflict with the Legislature's purpose in enacting the no-fault system in general and § 3107 in particular. "[I]t is clear that the Legislature did not intend for no-fault insurers to pay all*

> *claims submitted without reviewing the claims for lack of coverage, excessiveness, or fraud*." *Id.* at 407-408 (citations omitted; emphasis added). [*AOPP*, 257 Mich App at 378.]

Thus, insurers are *required* to challenge the reasonableness of charges and providers should expect no less. *Id.* at 378-379.

In concluding that insurers were only obligated to pay benefits for reasonable charges, we acknowledged that what was "reasonable" had yet to be defined. "[C]onsequently, insurers must determine in each instance whether a charge is reasonable in light of the service or product provided." *AOPP*, 257 Mich App at 379. Ultimately, the determination of what is a reasonable charge is for the trier of fact. *Id.* In a footnote, we acknowledged that the case had policy ramifications, but that those should not be overstated:

> We believe both sides overstate the effects of either side prevailing. Under the statute, plaintiffs necessarily make the initial determination of reasonableness by charging the insured for the services. Once plaintiffs charge the insured, the insurer then makes its own determination regarding what is reasonable and pays that amount to plaintiffs. Although, as plaintiffs argue, the cost-benefit analysis may cause fewer legal actions over the disputed amount, the fact-finder will ultimately decide what is reasonable. Whether this procedure is the best is a matter for the Legislature. [*Id.* at 379, n 4 (citations omitted).]

Naturally, "plaintiffs may challenge defendants' failure to fully reimburse them for medical bills as a violation of the act, but they have the burden of establishing the reasonableness of the charges in order to impose liability on the insurer" and "the question whether expenses are reasonable is for the jury to decide." *Id.* at 380. Thus, "[i]f plaintiffs disagree with a defendant's assessment of reasonableness, they have the right to contest the amount of such payment and must prove by a preponderance of the evidence that the expenses were both reasonable and necessary." *Id.*[1]

While *AOPP* supports an insurer's practice of determining the reasonableness of a provider's charges for surgical implant products by comparing those charges to the amounts charged for those products by other, similar providers, *AOPP* does not suggest that this is the *only* permissible approach under the act. In *AOPP*, we specifically declined to "delineate the permissible factors" that defendants may consider when determining whether a charge is reasonable, while specifically rejecting the notion that providers are permitted to "unilaterally

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[1] Following our decision in *AOPP*, our Supreme Court granted the provider's application for leave to appeal, directing "defendants to explain in detail the computations they use in determining whether a particular charge meets the '80th percentile test.'" *Advocacy Org for Patients Providers v Auto Club Ins Ass'n*, 470 Mich 881; 682 NW2d 87 (2004). Thereafter, the Supreme Court affirmed the case in a memorandum opinion for the reason that "we agree with the Court of Appeals resolution of this issue." *Advocacy Org for Patients Providers v Auto Club Ins Ass'n*, 472 Mich 91; 693 NW2d 358 (2005).

determine the 'reasonable' charge to be paid by the insurer" by way of their customary charges, or that the act should be interpreted in a manner that effectively eliminates the cost-policing function of insurance companies as contemplated by the no-fault act. *Id.* at 379-380. To limit assessing the reasonableness of provider charges based solely on a comparison of such charges among similar providers, would be to leave the determination of reasonableness solely in the hands of providers, as a collective group, and would abrogate the cost-policing function of no-fault insurers, contrary to the intention of the Legislature. Accordingly, defendants' ability to assess the reasonableness of provider charges is not limited to a comparison of customary charges among similar providers. Rather, the act contemplates that, as happened here, insurers will assess the reasonableness of a provider's charges, paying that portion deemed reasonable, with the provider having the prerogative to then challenge the insurer's decision not to pay the entire charge submitted, by filing suit. Once an action is filed, the provider has the burden of proving, by a preponderance of the evidence, the reasonableness of its charges. *AOPP*, 257 Mich App at 379-380. The parties are free to introduce evidence to the fact-finder as to the reasonableness of plaintiff's charges. Plaintiff is free to argue that its charges are in line with those of other similar providers for the surgical implant products at issue here, and defendant may respond by asserting that plaintiff's mark-up over that average wholesale costs of those products renders the charges excessive. But ultimately, the burden of proof is on the provider to show how and why the charges are reasonable.

In keeping with the insurers' obligation to determine the reasonableness of a provider's charges, we believe that defendants were entitled to discover the wholesale cost of the surgical implant products for which the insureds were charged. The no-fault act permits defendants to discover plaintiff's "costs of treatment *of* the injured person" not the "costs of treatment *to* the injured person," which presumably are plaintiff's "customary charges." Accordingly, defendants are permitted to consider the cost *to plaintiff* of providing that treatment and not merely the cost of treatment as billed by the provider to the injured person when evaluating the reasonableness of the charges submitted for payment. We recognize that permitting insurers access to a provider's cost information could open the door to nearly unlimited inquiry into the business operations of a provider, including into such concerns as employee wages and benefits. However, we explicitly limit our ruling to the sort of durable medical supply products at issue here, which are billed separately and distinctly from other treatment services and which defendants represent (and plaintiff has not disputed) require little or no handling or storage by a provider. Here, the surgical implants are stand-alone items that can be easily quantified. Plaintiff must come forward with evidence to convince a jury that charges for the durable medical equipment were reasonable.

We find further support in our recent opinion *Hardrick v Auto Club Ins Ass'n*, ___ Mich App ___; ___ NW2d ___ (Docket Nos. 294875, 298661, and 299070, decided December 1, 2011). At issue in that case was the reasonable rate for family-provided attendant care services under MCL 500.3107(1)(a). The plaintiff believed that agency rates constituted a material and probative measure of the general value of attendant care services; whereas the insurance company claimed that agency rates were irrelevant to establish the reasonable rate for unlicensed, family-provided care. Instead, the insurance company argued, the reasonable rate should have been based on a similar worker's wage, which would not include an agency's overhead and additional expenses not related to the worker's wages. *Id.* at slip op p 6. We found that, while rates charged by an agency to provide attendant care services were not *dispositive* of

the reasonable rate chargeable by a relative caregiver, they were certainly a relevant consideration for the jury in deciding what was a "reasonable rate." *Id.* at slip op p 8. Finding that the trial court properly rejected the insurance company's attempt to exclude the evidence, we explained:

> Here, the question presented is not whether an agency rate is per se reasonable under the circumstances, but whether evidence of an agency rate may assist a jury in determining a reasonable charge for family-provided attendant care services. The fact that an agency charges a certain rate for precisely the same services that [the] parents provide does not prove that the rate should apply to the parents' services. However, an agency rate for attendant care services, routinely paid by a no-fault carrier, is a piece of evidence that "throw[s] some light, however faint," on the reasonableness of a charge for attendant care services. In other words, an agency rate supplies one measure of the value of attendant care and is worthy of a jury's consideration. A jury may ultimately decide that an agency rate carries less weight than the rate charged by an independent contractor, or no weight at all. But the fact that different charges for the same service exist in the marketplace hardly renders one charge irrelevant as a matter of law. [*Id.* at slip op p 9 (citations omitted).]

Similarly, in this case, the issue of plaintiff's actual cost for surgical implants is but one piece of information that a jury might find relevant in determining whether plaintiff's charges were reasonable. *Hardrick* stresses what we have already discussed at length – the jury is charged with the responsibility of determining the reasonableness of plaintiff's charges. Because actual costs to plaintiff would most certainly "throw some light on" the reasonableness of the charges, the trial court should have compelled plaintiff to provide the information.

Hardrick also confirms the notion that a hospital's itemized bills and records do not, standing alone, satisfy the "reasonableness" requirement. We analogized a "charge" to an attorney's bill for services. When an attorney seeks a court order for payment of a "reasonable attorney fee," he may not simply provide a bill; he must also demonstrate that the bill was reasonable by looking at more than his actual "wage." *Hardrick,* slip op pp 11-12. We explained:

> Given that many factors influence the determination of a "reasonable charge" for attendant care services, a jury may consider a provider's wage as one piece of evidence relevant to this calculation. We view the reasonableness inquiry as encompassing any evidence bearing on fair compensation for the particular services rendered. The principles supporting the relevancy of agency rates equally support the relevancy of other evidence. For example, [the expert] testified that an agency would pay its employees less than the $25 to $45 hourly rate charged to the patient. Evidence of the employee's hourly wage "throw[s] some light, however faint" on the reasonableness of a charge for attendant care services. [The insurance company] correctly notes that the jury should hear such evidence to more fully and accurately calculate a reasonable rate for the services rendered.

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> Limiting a family members "reasonable charge" to a wage ignores [] other costs. In the end, the Legislature commanded that no-fault insurers pay a "reasonable charge" for attendant care services, thereby consigning to a jury the necessary economic value choices.
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> None of the evidence proffered by [either party], or even mentioned by this Court, is *dispositive* of the reasonable charge issue. Rather, the evidence provides a collage of factors affecting the reasonable rate that may be charged by Hardrick's parents for the services they provide. [*Id.* at slip op pp 13-14.]

Similarly, plaintiff's actual cost for the surgical implants is not dispositive on the issue of whether their charges were reasonable; however, the actual cost of the durable medical equipment is certainly a piece of the overall "collage of factors affecting the reasonable rate" of plaintiff's charges. Again, it cannot be overstated that, when factually disputed, the reasonableness of the charges is a question of fact for the jury to determine. The jury can only make such a determination if it has been provided with all relevant and probative evidence.

Accordingly, given our conclusion that defendants were entitled to discover the actual costs of the surgical implant products to plaintiff under §§ 3158 and 3159, the trial court erred when it denied defendants' motion to compel discovery. Because of the error, it follows that summary disposition in plaintiff's favor was prematurely and improvidently granted, as discussed further below.

B. DID THE TRIAL COURT ERR IN GRANTING PLAINTIFF SUMMARY DISPOSITION?

Defendants argue that, considering the cost data presented by defendants, which is a permissible consideration under the no-fault act in determining reasonableness, and considering plaintiff's lack of admissible evidence supporting the reasonableness of its charges, a rationale fact-finder could conclude that plaintiff's charges for surgical implant products were not reasonable and, therefore, summary disposition in plaintiff's favor was not warranted. We agree.

Plaintiff sought summary disposition on the basis that defendants' methodology in determining that plaintiff's charges for the surgical implant products were excessive was arbitrary and unreasonable. Plaintiff did not proffer anything to support its assertion that its charges were reasonable, nor did it offer any evidence as to how its charges compared with those of similar providers for the same products. Instead, plaintiff claims that when it established and submitted its charges to defendants it necessarily made the determination as to the reasonableness of those charges, thus shifting the burden to defendants to employ a reasonable methodology to challenge the validity of plaintiff's charges. Thus, plaintiff argues, defendants carried the burden of legitimately auditing plaintiff's charges under the no-fault act and, when they failed to do so, they failed to create a triable issue for the jury. We disagree.

Plaintiff's position is at odds with established case law. The burden of proof as to the reasonableness of its fees lies with plaintiff. *Hofmann*, 211 Mich App at 93-94, quoting *Nasser*,

435 Mich at 49-50. "[I]t is the insurance company that has the right to deny a claim (or part of a claim) for unreasonableness under Section 3107. The *insured* then has the burden to prove that the charges are in fact reasonable." *USF&G*, 484 Mich at 18. Moreover, as the moving party plaintiff bore the burden of establishing the absence of any genuine issue as to this material fact in the first instance. MCR 2.116(G)(4); *Coblentz*, 475 Mich at 569. Plaintiff had to provide the trial court with some basis for concluding that its charges were reasonable and that there was no factual issue for trial, despite defendants' arguments otherwise. Plaintiff wholly failed to do this. Considering that this Court has explicitly held that a provider's customary charges are not necessarily reasonable, *AOPP*, 257 Mich App at 377, the mere fact that plaintiff believed its charges to be reasonable does not make it so. Accordingly, there was no basis for the trial court to conclude that plaintiff's charges were necessarily reasonable under the no-fault act. Hence, summary disposition was improvidently granted.

C. DID THE TRIAL COURT ERR IN REFUSING TO AWARD ATTORNEY FEES UNDER MCL 500.3148?

In its cross-appeal, plaintiff argues that the trial court clearly erred by failing to award plaintiff its attorney fees after defendants refused to pay for the surgical implants. We disagree.

The no-fault act provides for an award of reasonable attorney fees when an insurer unreasonably withholds benefits. MCL 500.3148(1). Our Supreme Court has held:

> MCL 500.3148(1) establishes two prerequisites for the award of attorney fees. First, the benefits must be overdue, meaning '"not paid within 30 days after [the] insurer receives reasonable proof of the fact and of the amount of loss sustained." MCL 500.3142(2). Second, in postjudgment proceedings, the trial court must find that the insurer "unreasonably refused to pay the claim or unreasonably delayed in making proper payment." Therefore, assigning the words in MCL 500.3142 and MCL 500.3148 their common and ordinary meaning, attorney fees are payable only on overdue benefits for which the insurer has unreasonably refused to pay or unreasonably delayed in paying." *Proudfoot v State Farm Mut Ins Co*, 469 Mich 476, 485; 673 NW2d 739 (2003) (emphasis omitted). [*Moore*, 482 Mich at 517.]

"The purpose of the no-fault act's attorney-fee penalty provision is to ensure prompt payment to the insured." *Ross v Auto Club Group*, 481 Mich 1, 11; 748 NW2d 552 (2008). Therefore, when an insurer refuses or delays payment of PIP benefits, it has the burden of justifying its refusal or delay under MCL 500.3148(1). *Id.* When benefits initially denied or delayed are later determined to be payable, "a rebuttable presumption arises that places the burden on the insurer to justify the refusal or delay." *Attard v Citizens Ins Co of America*, 237 Mich App 311, 317; 602 NW2d 633 (1999). However, a refusal to pay or a delay in payment "is not unreasonable if it is based on a legitimate question of statutory construction, constitutional law, or factual uncertainty." *Id*. The determinative factor "is not whether the insurer ultimately is held responsible for benefits, but whether its initial refusal to pay was unreasonable." *Id*.

Defendants asserted below, as they do here, that the refusal to pay the full amount of plaintiff's charges for surgical implant products was based on both a legitimate question of

statutory construction and factual uncertainty as to the reasonableness of those charges. The trial court determined that defendants conduct was based on a legitimate question of statutory construction. We agree and find that the trial court did not abuse its discretion by declining to award plaintiff attorney fees.

As discussed above, an insurer is not foreclosed from assessing the reasonableness of a provider's charges merely because those charges are the provider's customary charges; rather, insurers have a duty under the act to "audit and challenge the reasonableness" of charges submitted for payment. Thus, defendants were required to assess the reasonableness of plaintiff's charges for surgical implant products. In *AOPP*, this Court found it unnecessary to "delineate the permissible factors for determining what is 'reasonable.'" *Id.* at 379. Consequently, at the time defendants received plaintiff's billings, the permissible factors available for defendants' consideration in evaluating the reasonableness of the charges for surgical implant products submitted by plaintiff remained undefined by either the no-fault act or the case law interpreting and construing it. Defendants requested that plaintiff provide information regarding the wholesale cost of these durable medical products for consideration in determining whether plaintiff's charges to defendants' insureds for those products were reasonable. Considering that § 3158(2) requires that, upon defendants' request, plaintiffs provide defendants with "a written report of the . . . costs of treatment of the injured person" and that plaintiffs "produce forthwith and permit inspection and copying of its records regarding . . . costs of treatment," and considering further a complete absence of case law construing this phrase, the trial court did not clearly err by concluding that defendants denial of full payment was premised on a legitimate question of statutory construction. "An insurer's initial refusal to pay benefits under Michigan's no-fault insurance statutes can be deemed reasonable even though it is later determined that the insurer was required to pay those benefits." *Moore*, 482 Mich at 525. Even if it is later established that defendants are obligated to pay the full amount of plaintiff's fees, we believe that their actions thus far in paying only the undisputed portions of the bills were reasonable under the circumstances and the attorney-fee penalty provision of the no-fault act was not triggered.

Because we find that the no-fault act permits defendants to discover the wholesale costs to plaintiff of the surgical implant products for which the insureds were charged, we reverse that portion of the trial court's order that granted plaintiff summary disposition, affirm that portion of the trial court's order that denied plaintiff's request for attorneys fees, and remand for further proceedings. We do not retain jurisdiction.

/s/ Joel P. Hoekstra
/s/ Kirsten Frank Kelly
/s/ Jane M. Beckering