STATE OF MICHIGAN

COURT OF APPEALS

DANIEL BAMM,

Plaintiff-Appellee,

v

FARM BUREAU MUTUAL INSURANCE COMPANY,

Defendant-Appellant.

UNPUBLISHED
July 23, 2009

No. 278856
Washtenaw Circuit Court
LC No. 05-000209-NF

Before: Wilder, P.J., and Jansen and Owens, JJ.

PER CURIAM.

In this no-fault case, defendant appeals by right the trial court's order granting plaintiff's request for attorney fees following a jury trial. We affirm.

Defendant first argues that its delay in, and then denial of, payment of plaintiff's claim was reasonable because of plaintiff's preexisting back condition and because of plaintiff's delay in seeking medical treatment following the April 2004 accident. Defendant asserts that the trial court's contrary conclusion was error. We disagree. A trial court's decision to grant or deny attorney fees under the no-fault act[1] is reviewed for clear error. *Attard v Citizens Ins Co of America*, 237 Mich App 311, 316-317; 602 NW2d 633 (1999). A finding is clearly erroneous when this Court is left with the definite and firm conviction that a mistake has been made. *Amerisure Ins Co v Auto-Owners Ins Co*, 262 Mich App 10, 24; 684 NW2d 391 (2004).

MCL 500.3148(1) provides:

> An attorney is entitled to a reasonable fee for advising and representing a claimant in an action for personal or property protection insurance benefits which are overdue. The attorney's fee shall be a charge against the insurer in addition to the benefits recovered, if the court finds that the insurer unreasonably refused to pay the claim or unreasonably delayed in making proper payment.

[1] MCL 500.3101 *et seq.*

An insurer's delay in making payments under the no-fault act is not unreasonable if it is based on a legitimate question of statutory construction or factual uncertainty. *Attard*, 237 Mich App at 317. "[W]hen considering whether attorney fees are warranted under the no-fault act, the inquiry is not whether coverage is ultimately determined to exist, but whether the insurer's initial refusal to pay was reasonable." *Shanafelt v Allstate Ins Co*, 217 Mich App 625, 635; 552 NW2d 671 (1996). "When an insurer refuses to make or delays in making payment, a rebuttable presumption arises that places the burden on the insurer to justify the refusal or delay." *Attard*, 237 Mich App at 317.

Personal protection insurance (PIP) benefits are overdue "if not paid within 30 days after an insurer receives reasonable proof of the fact and the amount of loss sustained." MCL 500.3142(2). "[R]easonable proof" does not equate to definitive or exact proof. See *Williams v AAA Mich*, 250 Mich App 249, 267; 646 NW2d 476 (2002). Given plaintiff's previous back injury and herniated disk, there was reason for defendant to carefully evaluate plaintiff's medical records to determine if his current back problems were caused by the accident or if they predated it.

As noted above, the 30-day clock for determining whether PIP benefits are overdue begins to run after reasonable proof of the loss and the damages sustained is received. In this case, the clock started running when the relevant medical records were received showing that there was a new injury caused by the accident. However, defendant did not even attempt to obtain plaintiff's medical records until almost a full 30 days had passed from the time plaintiff first informed defendant of the accident. Then, once the request was made and defendant received the records, it appears that defendant still did not examine them in a timely fashion.

At the time defendant obtained the medical records and information, there was uncontradicted evidence, based on both doctors' reports and the MRI results, that plaintiff had a new disk hernaition after the April 2004 accident that had not been observed before the accident. There were multiple physicians' reports opining that this new herniation was likely caused by the trauma of the accident. While there was some dispute as to whether plaintiff had initially told his family doctor that he was involved in the accident, it was uncontested that he did seek treatment with a chiropractor shortly after the accident and that he then saw his own doctor several weeks after that. In sum, for the ten months before defendant had plaintiff examined by its own doctor, all of the existing medical evidence indicated that it was more probable than not that plaintiff's new herniation had been caused by the automobile accident. Given the multiple, uncontradicted reports indicating that the new injury had been caused by the accident, we conclude that defendant had more than reasonable proof to support plaintiff's claim.

Defendant contends that its denial of plaintiff's claim did not become "final" until its own doctor had received an opportunity to prepare a report in this case. But even if this report did provide sufficient reason to deny plaintiff's claim, defendant acted unreasonably by delaying for ten months and waiting until after litigation had already commenced to send plaintiff to its own physician. Furthermore, even after defendant's physician evaluated plaintiff, the findings of defendant's physician were ambiguous at best, and were apparently based more on the belief that plaintiff had not reported the accident to his own doctors than on any hard medical evidence.

In light of defendant's unreasonable delay in attempting to obtain plaintiff's records, the unanimous opinion of the initial treating physicians that it was more probable than not that the

new herniation was caused by the accident, and the untimely and ambiguous report of defendant's physician, the trial court properly determined that the insurer's initial refusal to pay was unreasonable. See *Shanafelt*, 217 Mich App at 635. We cannot conclude that the trial court clearly erred by finding that defendant's refusal to timely pay plaintiff's claim was unreasonable or by awarding attorney fees under the no-fault act. *Attard*, 237 Mich App at 316-317.

Nor do we conclude that our Supreme Court's decision in *Moore v Secura Ins*, 482 Mich 507; 759 NW2d 833 (2008), mandates a contrary result. In contrast to the facts of *Moore*, where the plaintiff apparently consulted only one physician whose "records do not reflect whether he attributed plaintiff's inability to work to her accident-related injuries or her preexisting osteoarthritis," *id*. at 513, at least three doctors in the present case clearly opined that plaintiff had sustained a new disk injury as a result of the April 2004 automobile accident. Moreover, unlike the situation presented in *Moore*, where the independent medical evaluation (IME) doctor clearly and unambiguously opined that the "plaintiff had severe osteoarthritic degeneration in both knees that predated the accident, and that the accident had not exacerbated plaintiff's underlying osteoarthritis," *id*., the physician retained by defendant in the case at bar merely stated that the MRI results were inconclusive, that plaintiff's condition may have been degenerative in nature, that he could not "attribute the progression of degenerative changes to one single event" such as a car accident, and that his findings were based at least in part on the fact that "[plaintiff] didn't even seek medical attention at the time." This simply is not the type of case in which the insurance company was faced with a "tie" between its own doctors and the plaintiff's doctors. See *id*. at 522. The weight of the medical evidence in this case suggested that plaintiff's new disk herniation had been caused by the automobile accident. As our Supreme Court noted in *Moore*, "an insurer acts at its own risk in terminating benefits in the face of conflicting medical reports." *Id*.

Defendant next argues that, even if attorney fees were warranted, the trial court abused its discretion by granting over $95,000 in attorney fees. We disagree. A trial court's determination of the reasonableness of an attorney fee award is reviewed for an abuse of discretion. *Wood v DAIIE*, 413 Mich 573, 588; 321 NW2d 653 (1982). Six factors to be considered when assessing the reasonableness of an attorney fee are:

> "'(1) the professional standing and experience of the attorney; (2) the skill, time and labor involved; (3) the amount in question and the results achieved; (4) the difficulty of the case; (5) the expenses incurred; and (6) the nature and length of the professional relationship with the client.'" [*Id*. (citations omitted)].

"[T]he trial court is not limited to these factors and need not detail its finding with regard to each specific factor." *Bloemsma v Auto Club*, 190 Mich App 686, 689; 476 NW2d 487 (1991). A contingency fee agreement may be considered as one factor in determining the reasonableness of a fee, but it is not by itself determinative. *Hartman v Associated Truck Lines*, 178 Mich App 426, 430-431; 444 NW2d 159 (1989); *In re Estate of L'Esperance*, 131 Mich App 496, 502; 346 NW2d 578 (1984).

Under the six *Wood* factors, it is clear that plaintiff's attorney was of high professional standing and experience and that he expended a great deal of skill, time, and labor on this case. Defendant argues that the attorney fees granted in this case were disproportionately high because the fees actually awarded greatly exceeded the recovery amount of approximately $20,000. But

as plaintiff points out, that $20,000 amount does not include the cost of a future back operation, which was also awarded to plaintiff, and which plaintiff claims could exceed $50,000. Defendant also makes much of the fact that there was an original contingency fee agreement between plaintiff and his counsel. But as noted above, the existence of a contingency fee agreement is not itself dispositive when calculating reasonable attorney fees under the no-fault act. *Estate of L'Esperance*, 131 Mich App at 502.

Because there was no dispute as to the number of hours plaintiff's attorney spent on this case, or that those hours were necessary, the only issue remaining was the hourly rate charged. Defendant has provided no authority or argument as to why $350 an hour for an experienced and skilled attorney is so high as to be an abuse of discretion. See *University Rehabilitation Alliance, Inc v Farm Bureau Gen Ins Co of Michigan*, 279 Mich App 691, 702; 760 NW2d 574 (2008). Given the large number of hours worked on this case over several years and the experience and standing of plaintiff's attorney, we simply cannot say that the amount of attorney fees ultimately awarded for plaintiff in this case constituted an abuse of discretion. *Wood*, 413 Mich at 588.

Affirmed.

/s/ Kathleen Jansen
/s/ Donald S. Owens

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WILDER, J., (*dissenting).*

Defendant appeals as of right an order granting plaintiff attorney fees following a jury trial. This personal protection insurance case arose under Michigan's no-fault act, after plaintiff's involvement in an automobile accident in April 2004. Defendant argues that the trial court clearly erred in awarding attorneys' fees to plaintiff, because any delay in paying benefits to the plaintiff arose from a legitimate factual dispute regarding whether plaintiff's post-accident back injury symptoms were caused by the accident, or may have been natural degenerative changes from his significant pre-accident back problems. I agree with the defendant's arguments, and therefore respectfully dissent.

MCL 500.3142 provides that "personal protection insurance benefits are overdue if not paid within 30 days after an insurer receives reasonable proof of the fact and of the amount of loss sustained." "Attorney fees are payable only on overdue benefits for which the insurer has unreasonably refused to pay or unreasonably delayed in paying." *Prousfoor v State Farm Mut Ins Co,* 469 Mich 476, 485; 673 NW2d 739 (2003); *Beach v State Farm Mut Auto Ins Co,* 216 Mich App. 612, 628; 550 NW2d 580 (1996).

"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 the defendant's denial or benefits is reasonable under the particular facts of the case is a question of fact." *Moore v Secura Ins,* 482 Mich 507, 516; 759 NW2d 833 (2008) (internal quotation marks and citation omitted). We review questions of law, such as statutory interpretation, de novo, but review findings of fact for clear error. *Id*. Further, we review the amount of a trial court's award of attorney fees and costs for an abuse of discretion. *Id*., citing *Smith v Khouri*, 481 Mich 519, 526; 751 NW2d 472 (2008).

While acknowledging that defendant had reason to "carefully evaluate plaintiff's medical records to determine if his current back problems were caused by the [April 2004 automobile] accident or if they predated it," the majority nevertheless concludes, first, that defendant unreasonably delayed in obtaining plaintiff's medical records and, second, that based on the reports of plaintiff's initial treating physicians, defendant had "more than reasonable proof" to support plaintiff's claim. On the basis of these findings, the majority further concludes that the defendant has, therefore, failed to overcome the rebuttable presumption that its delay and ultimate refusal to pay was unreasonable. I disagree with the majority's characterization of the record.

The accident occurred on April 12, 2004. According to defendants activity log, on September 21, 2004, five months post-accident, plaintiff's girlfriend, Laurie Bedore (whose car plaintiff was driving, and under whose policy he would make a claim), first spoke with defendant's claim representative, Karen Phillipich, regarding the accident. There is no evidence that plaintiff, or his girlfriend, ever contacted defendant before September 21, 2004. According to the activity log, in the September 21, 2004, conversation, Bedore told Phillipich that plaintiff was her boyfriend, and a resident of her household. Bedore also told Phillipich that, before the accident, plaintiff was treating with Dr. Siddiqui for a herniated disk in his back, sustained as a result of a work injury. Thus, in the initial report of the accident, the circumstances as reported to defendant immediately raised a potential question of injury causation. Accordingly, Phillipich told Bedore that before defendant could pay personal protection insurance benefits, she, Phillipich, would need to determine whether plaintiff suffered a new injury in the April automobile accident.

About one week later, on October 1, 2004, Phillipich spoke with plaintiff directly on the telephone. Plaintiff reiterated that he had had a previous low back injury (a herniated disc), and had treated with Dr. Kotecha before the accident. He also told Phillipich that he had had physical therapy before the accident. Plaintiff said that, after the April automobile accident, he felt pain all day, and treated with Dr. Siddiqui. Not until a full three weeks later, on October 22, 2004, did defendant receive plaintiff's application for personal protection insurance coverage. In the application, plaintiff claimed that the "accident caused me to thrust forward and made a pop sound in my lower back."

Two weeks later, on November 5, 2004, defendant requested the medical records from Dr. Siddiqui of the Center for Family Health. On November 10, 2004, Phillipich received a telephone call from plaintiff. Plaintiff related that, before the accident, on November 3, 2004, he had undergone a magnetic resonance imaging (MRI), and that the results had shown a multitude of conditions in the lumbar spine, including a disc herniation at L4-L5.

On November 17, 2004, Phillipich sent plaintiff a letter stating that defendant was investigating the claim because defendant had not yet been able to obtain documentation to establish that the injuries claimed were related to the April automobile accident. The letter requested "[d]ocumentation to support proof of residency on" the date of the accident; and "[c]omplete name, [a]ddress and phone numbers of all medical facilities that you have treated with for five years preceding the accident." Finally, the letter concluded: "Based on the above, Farm Bureau is denying your Personal Injury Benefits at this time . . . . Please provide the requested documentation to expedite the process." At trial, Phillipich testified that she sent this

denial letter because on November 17, 2004, she still did not have plaintiff's medical records to verify that the claimed injury was a result of the MVA.

Phillipich testified at trial that after sending the denial letter to plaintiff, she received a letter from plaintiff's attorney, dated November 15, 2004 (two days before Phillipich's denial letter). With plaintiff's counsel's letter were two MRI reports. One report concerned an MRI of plaintiff's back after he suffered a lifting injury at work, and was prepared on June 20, 2003, well before the accident. This MRI revealed degenerating discs at L3-4, L4-5, and L5-S1, and further indicated (1) left foraminal disc herniation at L5-S1, with impingement on the left L5 nerve root; and (2) protruding disc material at the L3-4 and L4-5 levels. The second MRI report was dated November 3, 2004, six months after the April automobile accident, and revealed (1) degenerative changes in the low lumbar spine, notably from L3-4 through L5-S1; (2) mild spinal stenosis at L3-4 and L4-5; (3) moderate neutral foraminal narrowing on the right at L4-5, and on the left at L5-S1; (4) a small disc herniation along the left posterior disc at L4-5; (5) a small amount of extruded disc material extending inferiorly from the disc along the left posterior aspect of L5; (6) extension of herniated disc toward the medial margin of the left L4-5 neural foramen; and (7) asymmetric compromise of the left lateral recess containing the L5 nerve root at the level of the L4-5 disc.

Phillipich testified that, after reviewing these MRI films, she recognized that the new MRI showed a new disc herniation at L4-5, but still wanted to obtain all of plaintiff's medical records, both before and after the accident, before making any further determination regarding the claim. On November 21, 2004, Phillipich responded to plaintiff's counsel's letter. In this letter, Phillipich directed plaintiff's counsel to her denial letter sent to plaintiff. Phillipich testified that when she sent this letter to plaintiff's counsel, she was waiting for the records from the Center for Family Health concerning Dr. Siddiqui's treatment of plaintiff.

While Phillipich was waiting for Dr. Siddiqui's records, on November 22, 2004, plaintiff faxed to Phillipich a list of his medical providers before and after the April 2004 automobile accident. On December 5, 2004, Defendant sent affidavits to obtain the medical records from Dr. Siddiqui, Dr. Kotecha, Northwest Chiropractic, and Dr. Chodoroff of Chelsea Back Care.

The following day, defendant received Dr. Chodoroff's records. Dr. Chodoroff had not examined plaintiff until seven months after the accident (November 9, 2004). Dr. Chodoroff's chart indicated that *plaintiff was moving an entertainment center, and injured his back, feeling a pop* (the same description plaintiff used concerning the injury he alleged occurred during the April automobile accident). Dr. Chodoroff's report indicated that, after the lifting injury, plaintiff experienced persistent pain, and developed left lower-extremity pain; that plaintiff sought treatment with Dr. Siddiqui; that an MRI revealed protruding discs at L3-4 and L4-5, with a foraminal disc herniation on the left at L5-S1; that Dr. Kotecha performed three lumbar epidural steroid injections, and physical therapy was done for three weeks. Dr. Chodoroff's report referenced a mid-June 2004 motor vehicle accident. Dr. Chodoroff concluded that he did not have medical records to corroborate plaintiff's history, beyond the imaging studies he referenced. Phillipich testified at trial that Dr. Chodoroff's report gave her one more reason to doubt whether plaintiff's claimed medical expenses were related to an April 2004 automobile accident.

On January 14, 2005, Phillipich left plaintiff a voicemail, indicating that she had not yet received medical records from Dr. Siddiqui, Dr. Kotecha, and Northwest Chiropractic, and that, without those records, the investigation was still ongoing. Later in January 2005, defendant received Dr. Kotecha's medical records, according to Phillipich's trial testimony. These records indicated that Dr. Kotecha treated plaintiff after the 2003 work injury. In September, October and November of 2003, Dr. Kotecha performed lumbar epidural steroid blocks on plaintiff. After the first injection, plaintiff told Dr. Kotecha that it helped to alleviate the pain. But after the last injection, plaintiff told Dr. Kotecha that the injection did not help as much, and that he wished to proceed with surgery.

The records further revealed that plaintiff was scheduled to have surgery on January 29, 2004 (2 ½ months before the automobile accident at issue here). Dr. Kotecha had planned to perform an L4-L5 decompression, with pedicle screw fixation of L4 to S1, and cage fixation at L5-L1, but plaintiff failed to appear for the surgery, claiming that he had the flu.

In March 2005, defendant was *still* waiting for medical records from Dr. Siddiqui and Northwest Chiropractic, according to the activity log. Plaintiff then commenced this action.

Plaintiff began treating with Dr. Jon Wardner in May 2005. On June 7, 2005, Dr. Wardner wrote plaintiff's counsel a letter, opining that the April 2004 automobile accident was a significant cause of the changes seen on the second MRI. Defendant then requested an IME. On August 30, 2005, Dr. Phillip Friedman examined plaintiff. In his initial report, Dr. Friedman was inconclusive, but he requested a side-by-side review of the MRIs. When this side-by-side review was completed, Dr. Friedman concluded that the evidence did not support any causal relationship between the disc herniation, and the April 2004 automobile accident. Dr. Friedman further concluded that, if plaintiff had surgery for his low back, it would be the exact same surgery as the one Dr. Kotecha was scheduled to perform at the end of January 2004, shortly before the automobile accident. Following receipt of and based on Dr. Friedman's report, defendant issued a final denial of plaintiff's claim.

I would conclude that this chronology, rather than demonstrating "more than reasonable proof" that plaintiff's injury was due to the April 2004 automobile accident, raised significant questions about the causation of plaintiff's back injury, and justified further inquiry by defendant. The record demonstrates that defendant exercised prudence in its investigation, and promptly responded to every communication from plaintiff or plaintiff's representatives. Dr. Kotecha's records, not received until January 2005, validated defendant's initial concern, derived from the oral representations of Bedore and plaintiff about plaintiff's treatment with Dr. Siddiqui, that plaintiff's back injury may not have been caused by the automobile accident but instead predated the accident. Especially because Dr. Kotecha's records show that plaintiff had a pre-existing back injury that required surgery, in my judgment, defendant was entitled to receive Dr. Siddiqui's records before it can be considered to have unduly delayed in responding to plaintiff's claim, since plaintiff told defendant that he treated with Dr. Siddiqui immediately following the April 2004 automobile accident. Importantly, Dr. Siddiqui's records, which were not received until after this action was commenced, contained no mention of an automobile

accident until just before plaintiff filed his claim with defendant, despite the fact that plaintiff treated with Dr. Siddiqui at the Center for Family Health on three different occasions after the April 2004 automobile accident.[1]

Thus, contrary to the majority's conclusion, the fact that plaintiff's attorney gave defendant proof that plaintiff suffered a new herniation after his June 2003 MRI report is *not* proof that the herniation was caused by the April 2004 automobile accident. Defendant was entitled to gather relevant medical records to address the legitimate question of causation, particularly when those records show inconsistencies in what plaintiff reported to his treating physicians about the cause of his back injuries (it is apparent that the back injury plaintiff reported to Dr. Chodoroff was suffered when he was moving an entertainment center would not be covered by PIP benefits).

Additionally, as noted by defendant in arguing below that it had a reasonable basis to deny plaintiff's claim, the jury's verdict validated the caution with which it approached the evaluation of plaintiff's claim by awarding plaintiff only a fraction of the wage loss he sought[2] and limiting defendant's obligation to pay for plaintiff's future medical care to surgery only (i.e., no future coverage for doctor's visits, physical therapy, wage loss, aide care or evaluations). The jury's rejection of 85% of plaintiff's wage loss claim, and its limitation of plaintiff's future medical coverage to the cost of the surgery only, highlights that there was, in fact, a bona fide question pursued by the defendant about the causation of plaintiff's back injury.

Given the evident inconsistencies between plaintiff's claim of injury as the result of the April 2004 automobile accident, and plaintiff's medical records which revealed that he had a significant back injury before the accident that required surgery and a post-accident back injury resulting from moving his entertainment center, and that he failed for 6 months to even mention the automobile accident to his primary treating physician, I would conclude that, pursuant to *Moore*, *supra* at 522, defendant acted reasonably given the existing bona fide factual dispute of causation by continuing to gather *all* of plaintiff's medical records and by seeking an IME before ultimately denying plaintiff's claim. As such, I would reverse and hold that the trial court's finding that defendant unreasonably delayed or denied payment, although it had not received the records of the physician with whom plaintiff claimed to treat immediately after the accident, was clear error.

/s/ Kurtis T. Wilder

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[1] Moreover, as noted by defendant's counsel, Dr. Chodoroff's records show that plaintiff identified the wrong date as the date of the accident.

[2] Plaintiff sought $66,164 in wage loss, and the jury awarded him only $10,000.