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STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	IN THE NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON	)	CASE NO.: 2021-CP-10-03379
	)	
Carolina Neurosurgery & Orthopaedics, Inc.,	)	
	)	**ORDER GRANTING SUMMARY JUDGMENT**
Plaintiff,	)	
vs.	)	
	)	
Michael A. Maucher, Esq. and DeLuca & Maucher, LLP,	)	
	)	
Defendants.	)	

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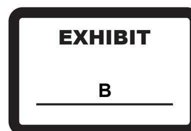

Plaintiff is a medical practice that treated a client of Defendants after the client sustained injuries in a car accident. When the amount of insurance proceeds recovered did not cover the client's medical bills with Plaintiff, Plaintiff sued the client and, separately in the present action, the client's attorney and law firm, seeking under multiple theories to recover those medical costs.

This matter came before the Court on March 31, 2025, for a hearing on Defendants' Motion for Summary Judgment. Attorney Thomas Pendarvis appeared on behalf of Plaintiff Carolina Neurosurgery & Orthopaedics, Inc., and Attorney Skyler Wilson appeared on behalf of Defendants Michael A. Maucher, Esq. and DeLuca & Maucher, LLP. After considering the memoranda of counsel filed prior to the hearing and arguments at the hearing, this Court GRANTS Summary Judgment to Defendants. Plaintiff's claims are preempted by a prior order of this Court and there are no genuine issues of material fact on one or more elements of each of Plaintiff's claims.

FINDINGS OF FACT

Defendants' Client was injured in a car accident on December 14, 2018. Shortly thereafter, he retained Defendants to pursue claims against the at-fault driver. Before the

accident, Client was a patient of Dr. Jason Highsmith and chose to return to Dr. Highsmith to treat the injuries he sustained in the car accident.

Upon Plaintiff's requests, Defendants sent Plaintiff a letter of protection on December 20, 2018, that stated:

> Please accept this correspondence as our Law Firm's agreement to protect any claim which you may have out of any settlement proceeds we may receive arising out of the incident referred to above. The above-named individual has been informed that, in the event of insufficient recovery, he remains personally responsible for your outstanding balance.

In order to receive treatment, Client executed Plaintiff's Financial Policy, under which the policy stated: "If you have insurance" that Plaintiff "will file with [the patient's] primary insurance." The Financial Policy also stated the patient may be responsible for all of part of the balance not paid by the insurance company. At the time, Client had primary health insurance through Blue Cross/Blue Shield. Defendants were not a party to the Financial Policy. Client then began receiving treatment with Plaintiff and Dr. Highsmith.

Afterwards, staff with Plaintiff and Defendants communicated about insurance. On January 21, 2019, Defendant's paralegal responded to an inquiry from Plaintiff's employee regarding the "limits" for Client. Defendants' paralegal explained the at-fault driver's carrier would not disclose its insurance limits, and stated: "Because [Client] carries $100,000.00 in Underinsured Motorist Coverage on his at-home policy with Safeco, and there is $1,000,000.00 in 'Occupational Accident Coverage' to pay bills and wages under the One Beacon Policy, we are not concerned that there will be enough over all coverage to pay the claim." But hours later the same day after learning Client needed surgery, Defendants' paralegal emailed Plaintiff's employee, requesting Plaintiff file with Client's private health insurance and that it was best "if we NOT do the treatment under an Assignment/Letter of Protection." Plaintiff's employee said "Okay thanks for the update."

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Defendants then sent Plaintiff a revised Letter of Protection on March 7, 2019, stating:

> Please accept this correspondence as our Law Firm's agreement to protect any portion of your bill not paid by private health insurance out of any settlement proceeds we may receive arising out of the incident referred to above. The above-named individual has been informed that, in the event of insufficient recovery, he remains personally responsible for your outstanding balance.

That same day, Client completed a Health Insurance Verification form for his upcoming surgery, providing Plaintiff with his BlueCross/BlueShield insurance information. Dr. Highsmith performed Client's first surgery on March 15, 2019 (First Surgery) and charged Client $58,697.41. On May 2, 2019, Dr. Highsmith performed additional surgery on Client, charging him an additional $62,451.87 (Second Surgery). In total, Plaintiff charged Client $125,409.28.

However, Plaintiff never filed claims with Client's private health insurance. Defendants' paralegal contacted Plaintiff's employee on January 3, 2020, reminding her of the Letters of Protection and that it appeared Client's health insurance did not pay any of Plaintiff's bills. Defendants' paralegal explained there was only $30,000 in coverage to pay the claim and they needed to discuss how to allocate that amount amongst everyone. Because Client was unable to pay for Plaintiff's services, Plaintiff sued client under its Financial Policy in May 2021, but resolved that case prior to trial.

Current Lawsuit & Procedural History

Plaintiff filed this action in July 2021, seeking to recover its medical costs directly from Defendants based on seven different claims. Defendants moved to dismiss Plaintiff's claims, which Judge Dickson granted in part, and the only remaining claims were for (1) breach of contract and (2) SCUTPA violation. That order made numerous findings of fact and conclusions of law that have not been appealed.

After substantial discovery, Defendants moved for summary judgment in August 2023. Plaintiff, however, was granted leave to amend the complaint to alter its theories of recovery and

add claims for negligent misrepresentation and promissory estoppel. Plaintiff amended the complaint a second time, further changing its theories of recovery but leaving the four causes of action. The parties engaged in additional discovery and depositions, and Defendants' motion for summary judgment was rescheduled for a hearing before this Court. Defendants and Plaintiff each submitted memoranda supporting their positions, and the Court heard argument on March 31, 2025. This Court GRANTED Defendants summary judgment on April 3, 2025, and now issues its formal opinion.

STANDARD OF REVIEW

"Summary judgment is appropriate 'if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.'" *Russell v. Wachovia Bank, N.A.*, 353 S.C. 208, 217, 578 S.E.2d 329, 334 (2003) (quoting Rule 56(c), SCRCP). Summary judgment's purpose is to expedite the disposition of cases not requiring a fact finder. *Nakatsu v. Encompass Indem. Co.*, 390 S.C. 172, 177, 700 S.E.2d 283, 286 (Ct. App. 2010).

The burden of proof rests with the party seeking summary judgment; however, the non-moving party must make a showing sufficient to establish the existence of an essential element on which it will bear the burden to prove at trial. *Baughman v. Am. Tel. & Tel. Co*., 306 S.C. 101, 115, 410 S.E.2d 537, 545 (1991). In determining whether summary judgment is appropriate, the evidence is viewed in the light most favorable to the non-moving party. *Edgewater on Broad Creek Owners Ass'n, Inc. v. Ephesian Ventures, LLC,* 430 S.C. 400, 407, 845 S.E.2d 211, 214 (Ct. App. 2020).

The "mere scintilla" standard does not apply to defeat summary judgment, but instead the party must establish a genuine issue of material fact. *Kitchen Planners, LLC v. Friedman*, 440 S.C. 456, 463, 892 S.E.2d 297, 301 (2023). "A fact is material if it 'might affect the outcome of

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the suit under the governing law.'" *Libertarian Party of Va. v. Judd*, 718 F.3d 308, 313 (4th Cir. 2013) (quoting *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986)). A dispute is "genuine" if "a reasonable jury could return a verdict for the non-moving party." *Strothers v. City of Laurel*, 895 F.3d 317, 326 (4th Cir. 2018) (quoting *Anderson*, 477 U.S. at 248). It is not sufficient for a party to create an inference that is not reasonable or an issue of fact that is not genuine. *Town of Hollywood v. Floyd*, 403 S.C. 466, 477, 744 S.E.2d 161, 166 (2013).

CONCLUSIONS OF LAW

I. Plaintiff's claims are preempted by the unappealed findings of fact and conclusions of law in Judge Dickson's Order that are the law of the case.

Defendants argued that Judge Dickson's Order dismissing the majority of Plaintiff's claims preempted Plaintiff's remaining claims because the Order made multiple findings of fact and conclusions of law on central issues to the case that were not appealed. Plaintiff did not address Defendants' argument on the effect of the order in its brief or in arguments at the hearing. This Court agrees the Order preempts Plaintiff's claims.

"This State has a long-standing rule that one judge of the same court cannot overrule another." *Shirley's Iron Works, Inc. v. City of Union*, 403 S.C. 560, 573, 743 S.E.2d 778, 785 (2013). If a ruling is not appealed, whether it is wrong or right, it becomes the law of the case. *Id.* "The doctrine of the law of the case applies to an order or ruling which finally determines a substantial right." *Id.* (quoting *Weil v. Weil*, 299 S.C. 84, 89, 382 S.E.2d 471, 473 (Ct. App. 1989)). If the order, however, merely decides a point collateral to the issues of the case, it is not binding and can be reconsidered before a final order on the merits. *Id.*

Judge Dickson's Order is the law of the case. It decided a substantial right—dismissing Plaintiff's claims for (1) breach of contract accompanied by a fraudulent act; (2) fraud; (3) constructive fraud; (4) unjust enrichment and (5) negligence. The claims that were dismissed were based, in part, on allegations related to statements about insurance coverage. The Order

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made numerous findings of fact and conclusions of law that Plaintiff has not appealed. Because the Order ruled on important issues, not collateral issues, and was decided by Judge Dickson, this Court cannot overrule or modify the Order. Wrong or right, the Order is the law of the case.

As an initial matter, this Court recognizes the Order states it will not be "admissible" to prove facts or law for the "remaining claims of Breach of Contract and" SCUTPA. Defendants argued this language does not prevent the Court from finding the Order binding on Plaintiff's current claims because after the Order, Plaintiff twice amended its complaint and added claims. Specifically, Defendants argued that Plaintiff's breach of contract and SCUTPA claims were previously based on the letters of protection, but then were amended to be based on the email from Defendants' paralegal about insurance. Plaintiff did not respond to Defendants' argument in its brief or at the hearing. This Court agrees with Defendants and finds the Order applies to Plaintiff's altered claims of breach of contract and violation of SCUTPA, and also applies to the new claims for negligent misrepresentation and promissory estoppel.

This Court finds the following findings in the Order are the law of the case and preempt Plaintiff's claims:

- "as of January 21, 2019, Plaintiff was aware of the need to file claims for payment with Client's private health insurance." Order, ¶ 13.
- "as of March 7, 2019, Plaintiff was aware of the need to file claims for payment with Client's private health insurance first before seeking payment under the March 7, 2019 LOP." Order, ¶ 16.
- "Plaintiff never attempted to confirm its in-network status with Client's private health insurance carrier prior to rendering surgical services, or to file claims for payment with Client's private health insurance, as is required under Plaintiff's Financial Policy." Order, ¶ 17.
- "On April 29, 2019, D&M notified Plaintiff via email of the foregoing issues" (Order, ¶ 20), referring to Paragraph 19 that states it was determined the at-fault driver did not have sufficient insurance coverage, one policy was inapplicable, and the "additional policy was subject to subrogation only applicable after Client's primary private health insurance had been exhausted."
- "Despite receiving explicit instructions regarding claim submission and payment on several occasions prior to both surgeries, Plaintiff never attempted

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to file claims for Client's surgical services with Client's private health insurance. Order, ¶ 22.

- Under "Fraud" and "Availability of Insurance Coverage" finding Plaintiff was not entitled, by virtue of the parties' relationship to one another, to rely on Defendants' representations as to insurance coverage or intent to pay. Instead, Plaintiff was under an affirmative duty to use reasonable prudence and diligence to attempt to discover the truth of the representations." Order, ¶ 48.
- "While Bennett initially emailed Goodwine on January 21, 2019 and indicated 'we are not concerned that there will be enough overall coverage to pay the claim,' . . . she followed up that same day and notified Goodwine that all of Client's surgical treatment was to be filed with his private health insurance company, and that treatment should not proceed under an assignment or letter of protection." Order, ¶ 50.
- "as of January 21, 2019—approximately two (2) months before Client's First Surgery—Plaintiff had actual notice that . . . (2) Defendants did not intend to protect Plaintiff's claims out of any settlement proceeds from Client's personal injury claim; and (3) Plaintiff should file all claims for payment with Client's private health insurance company." Order, ¶ 52.
- "Bennett's email to Goodwine did not indicate any claims could or should be filed with Client's underinsured motorist carrier or his occupational accident carrier." Order, ¶ 53.
- Plaintiff "should have refused Bennett's instructions to file claims with Client's private health insurance company." Order, ¶ 54.
- "Plaintiff should have known the only potential avenue for payment would have been through Client's underinsured motorist and/or occupational accident policies." Order, ¶ 55.
- "Plaintiff, in the exercise of reasonable diligence, could and should have taken steps to obtain written confirmations of coverage from the underinsured motorist and occupational accident carriers themselves before furnishing costly surgical and other medical services to Client. Order, ¶ 56.
- "Plaintiff apparently instead chose to rely solely on Bennett's first January 21, 2019 email to Goodwine—expressing only an opinion on available coverage—which, as discussed above, Plaintiff had no right to rely on." Order, ¶ 57.

Plaintiff alleges four causes of action: (1) breach of contract; (2) SCUTPA violation; (3) negligent misrepresentation; and (4) promissory estoppel, all of which are preempted by the Order.

1. Plaintiff's breach of contract claim is preempted by the findings in the Order.

Plaintiff's breach of contract action is based on allegations that the parties "entered into a contract wherein Carolina Neurosurgery would provide medical services to the Lawyers' client

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based on the Lawyers' representations about insurance coverage." The Order finds that Plaintiff was on notice as of January 2019 of the need to seek payment from private health insurance, and that Defendants did not intend to protect any claims to insurance proceeds—*after* the statement about insurance proceeds and before any further letter of protection. The Order also finds Plaintiff was aware as of April 29, 2019, that the additional policy had a subrogation requirement and required filing with private health insurance first. Moreover, the Order clearly states Plaintiff had no right to rely on statements about coverage, the statement about insurance coverage was only an opinion, and Plaintiff needed to perform its own due diligence about the referenced policies and seek confirmations of coverage from the carriers before surgery.

To succeed on its breach of contract claim, Plaintiff would have to prove it agreed to provide medical services because Defendants made statements about insurance coverage. However, this conflicts with the Order's findings above that are the law of the case. Therefore, this Court grants Defendants summary judgment on Plaintiff's breach of contract claim.

2. Plaintiff's SCUTPA claim is preempted by the findings in the Order.

In its SCUTPA claim, Plaintiff asserts that Defendants "engaged in unfair or deceptive acts or practices of trade or commerce." In discovery, Plaintiff explained that the unfair or deceptive act was (1) making "representations, assurances, and promises to a healthcare provider that payments for elective surgical procedures . . . would be paid out of $1,100,000 of liability coverage." Plaintiff also asserted that it was unfair or deceptive "for a lawyer and a law firm to make false representations about email communications that never occurred"—referencing the April 29, 2019 email from Defendants' paralegal to Plaintiff's employee and alleging Plaintiff did not receive the email and did not know about it until after the surgeries were performed.

The Order explicitly finds that Plaintiff was notified of the April 29, 2019 email. Order, ¶¶ 19-20. Wrong or right, that finding is the law of the case and Plaintiff cannot now state it did not receive that email as a basis for SCUTPA liability.

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Further, the findings in the Order also preempt liability based on representations about insurance coverage. The Order finds that Plaintiff was on notice as of January 2019 of the need to seek payment from private health insurance, and that Defendants did not intend to protect any claims to insurance proceeds—*after* the statement about insurance proceeds and before any further letter of protection. Also, the Order finds Plaintiff was aware as of April 29, 2019, that the additional policy had a subrogation requirement and required filing with private health insurance first. According to the Order, Plaintiff had no right to rely on statements about coverage, the statement about insurance coverage was only an opinion, and Plaintiff needed to perform its own due diligence about the referenced policies and seek confirmations of coverage from the carriers before surgery.

It cannot be unfair and deceptive to make a statement of opinion on insurance limits that caused Plaintiff to provide services, when Plaintiff knew to seek payment from private health insurance instead of proceeding under a letter of protection or assignment immediately after the statement about limits, that Plaintiff agreed to, and Plaintiff had no right to rely on the statement. Therefore, this Court grants Defendants summary judgment on Plaintiff's claim for SCUTPA violation.

3. Plaintiff's claims for negligent misrepresentation and promissory estoppel are preempted by the findings in the Order.

Plaintiff alleges in the negligent misrepresentation claim that Defendants made false representations, and Plaintiff justifiably relied on those representations. Plaintiff alleges in its promissory estoppel claim that Defendants gave an "unambiguous promise" and assurances about "the availability of over $1 million in insurance coverage" and that Plaintiff reasonably relied on that promise. Reasonable reliance, of course, is an element of both claims. *See West v. Gladney*, 341 S.C. 127, 134, 533 S.E.2d 334, 337 (Ct. App. 2000) (listing the elements of negligent representation and including "the defendant owed a duty of care to see that he

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communicated truthful information to the plaintiff," "the plaintiff justifiably relied on the representation," and explaining reliance must be reasonable (quoting *AMA Management Corp. v. Strasburger*, 309 S.C. 213, 222, 420 S.E.2d 868, 874 (Ct. App. 1992));*Woods v. State*, 314 S.C. 501, 505, 431 S.E.2d 260, 263 (Ct. App. 1993) (including as element of promissory estoppel "reasonable reliance upon the promise by the party to whom the promise is made).

The findings in the Order, however, preempt any arguments that Plaintiff justifiably or reasonably relied on statements about coverage because the Order states Plaintiff did not have a right to rely on representations about coverage. Order, ¶ 48, ¶ 57. Further, the findings in the Order recognize Plaintiff had a duty to use reasonable diligence to discover the truth of the representations about coverage. Order, ¶ 48; ¶ 56. In addition, the Order finds the statement about insurance coverage was an opinion and, therefore, not a statement of fact. Because these rulings are the law of the case, but Plaintiff would need to prove the opposite to succeed on claims for negligent misrepresentation and promissory estoppel, the claims are preempted by the Order and this Court grants Defendants summary judgment on those claims.

II. Plaintiff cannot prove the necessary elements of breach of contract because, as a matter of law, there was no legally enforceable contract between Plaintiff and Defendants.

Initially, Plaintiff alleged the contract was based on the Letters of Protection. Then Plaintiff alleged in its Second Amended Complaint that it entered into a contract with Defendants wherein it "would provide medical services to the Lawyers' client based on the Lawyers' representations about coverage." In its memorandum in opposition to summary judgment, Plaintiff argued there is a genuine issue of material fact whether the agreement included an implied term about the availability of coverage. Defendants argued there was no contract because Defendants did not offer to pay for Client's medical bills if Plaintiff treated Client, and Plaintiff did not accept by providing medical services conditioned on a promise to pay the bills. This Court agrees with Defendants.

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To succeed on a breach of contract claim a plaintiff must establish (1) the existence of a contract; (2) its breach; and (3) the damages caused by the breach. *Branche Builders, Inc. v. Coggins*¸ 386 S.C. 43, 48, 686 S.E.2d 200, 202 (Ct. App. 2009). "The general rule is that for a breach of contract the [breaching party] is liable for whatever damages follow as a natural consequence and a proximate result of such breach." *S. Glass & Plastics Co. v. Kemper*, 399 S.C. 483, 492, 732 S.E.2d 205, 209 (Ct. App. 2012) (quoting *Fuller v. E. Fire & Cas. Ins. Co.*, 240 S.C. 75, 89, 124 S.E.2d 602, 610 (1962)).

"The necessary elements of a contract are an offer, acceptance, and valuable consideration." *Sauner v. Pub. Serv. Auth. of S.C.*, 354 S.C. 397, 406, 581 S.E.2d 161, 166 (2003). "An offer is the manifestation of willingness to enter into a bargain, so made as to justify another person in understanding that his assent to that bargain is invited and will conclude it." *Carolina Amusement Co. v. Connecticut Nat'l Life Ins. Co.*, 313 S.C. 215, 437 S.E.2d 122 (Ct. App. 1993) (quoting Restatement (Second) of Contracts § 24 (1981)). A valid offer "identifies the bargained for exchange and creates a power of acceptance in the offeree." *Id.* "To be binding, an offer must be definite. *Prescott v. Farmers Tel. Co-op., Inc.*, 335 S.C. 330, 336–37, 516 S.E.2d 923, 926 (1999). Also, it must "be one which is intended of itself to create legal relations on acceptance." *Id.*(quoting *McLaurin v. Hamer*, 165 S.C. 411, 420, 164 S.E. 2, 5 (1932)).

"Acceptance of an offer is a manifestation of assent to the terms thereof made by the offeree in a manner invited or required by the offer." *Electro-Lab of Aiken, Inc. v. Sharp Constr. Co. of Sumter*, 357 S.C. 363, 369, 593 S.E.2d 170, 173 (Ct. App. 2004) (quoting Restatement (Second) of Contracts § 50 (1981)). "A typical contract contains mutual promises and is created by an acceptance constituting a return promise by the offeree." *Id.* "Moreover, a contract only arises when there is an actual agreement by the parties in which the parties demonstrate a mutual intent to be bound." *Id.*

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Construing the facts and reasonable inferences in Plaintiff's favor, there is no genuine issue of material fact that there was no legally enforceable contract between Defendants and Plaintiff whereby Plaintiff agreed to provide medical services to Client in return for a promise on the availability of coverage, or that Defendants would be personally responsible for Client's medical bills.

The language in the Letters of Protection and the emails on insurance coverage did not include an offer that Defendants would pay for Client's medical costs. The December 20, 2018 letter stated the law firm agreed "protect any claim which you may have out of any settlement proceeds we may receive arising out of the incident" and that the Client "has been informed that, in the event of insufficient recovery, he remains personally responsible for your outstanding balance." Thus, prior to discussion of insurance coverage, Plaintiff was on notice of the potential of an insufficient recovery in settlement proceeds and that the agreement was limited to protection out of settlement proceeds received.

The January 21, 2019 emails did not include, or imply, a promise that Defendants agreed to be responsible for Client's medical costs. According to the medical bills, Plaintiff was already treating Client when it inquired about "limits" for the client on January 21, 2019. Defendants' paralegal explained she did not know the limits of the at-fault driver, but that Client had $100,000 in UIM coverage on a Safeco Policy and carried $1,000,000 in "Occupational Accident Coverage" on a One Beacon policy, and that Defendants were "not concerned that there will be enough over all coverage to pay the claim." However, hours later the same day, Defendants' paralegal informed Plaintiff that Defendants just learned that Client needed surgery and all of Client's treatment should be filed with his private health insurance company. Further, that it "would be best for everyone involved if we NOT do the treatment under an Assignment/Letter of Protection." Plaintiff's employee responded, "Okay thanks for the update."

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The language in the email referencing insurance coverage cannot be construed as an offer that Defendants would agree to pay for Client's medical bills out of that specific coverage. The language is not definite, and does not "identify the bargained for exchange" and create "a power of acceptance" in Plaintiff. The language does not contain a bargained for exchange identifying what Plaintiff is giving in exchange for insurance coverage representations. The language does not create a power of acceptance because it does not identify what Plaintiff would need to do (or refrain from doing) in order to accept. Without language identifying the bargained for exchange, there can be no contract. Also, without language identifying what Plaintiff would need to do to accept, there can be no offer and no contract.

In the context of the prior letter of protection explaining Client would be personally responsible in the event of an insufficient recovery, Plaintiff's Financial Policy reflecting the same language, that Plaintiff was already providing services to Client, and a retraction of any assignment or letter of protection mere hours after referencing insurance, there is no genuine issue of material fact and there was no offer.

Even if the statement about coverage could be construed as an offer, Plaintiff did not communicate any acceptance in the manner invited or required by the offer. The offer did not identify that Plaintiff could accept by providing treatment and, regardless, Plaintiff was already providing services to Client before the email exchange about coverage and Defendants' paralegal immediately contacted Plaintiff's employee about obtaining payment through insurance before any further services were rendered.

Ultimately, in order to find there was a contract, there would need to be a definite offer that Defendants agreed to be responsible for the medical bills if Plaintiff provided treatment to Client. The only reasonable inference is that Defendants did not offer to be responsible for Client's medical bills if Plaintiff agreed to provide medical services to Client, and Plaintiff did not accept that offer and provide medical service to Client based on that offer. Without that offer

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and acceptance, there is no contract, and this Court grants Defendants summary judgment on Plaintiff's breach of contract claim.

III. Defendants did not violate the South Carolina Unfair Trade Practices Act because Defendants were not engaged in a "trade or commerce" with Plaintiff.

Defendants argued, among other things, that this Court should grant summary judgment because Defendants were not engaged in trade or commerce with Plaintiff. Plaintiff argued this Court should deny summary judgment "because there are disputes on whether the Defendants' suspect 'email' attempting to alter the record on what was communicated about the Letters of Protection constitute unfair or deceptive acts." This Court agrees with Defendants.

SCUTPA makes unlawful "unfair or deceptive acts or practices in the conduct of any trade or commerce." S.C. Code Ann. § 39-5-20(a). To state a claim under SCUTPA, a plaintiff must show "(1) the defendant engaged in an unfair or deceptive act in the conduct of trade or commerce; (2) the unfair or deceptive act affected [the] public interest; and (3) the plaintiff suffered monetary or property loss as a result of the defendant's unfair or deceptive act(s)." *Health Promotion Specialists, LLC v. S.C. Bd. of Dentistry*, 403 S.C. 623, 638, 743 S.E.2d 808, 816 (2013) (quoting *Wright v. Craft*, 372 S.C. 1, 23, 640 S.E.2d 486, 498 (Ct. App. 2006)).

Under the Act, "trade or commerce" includes "the advertising, offering for sale, sale or distribution of any services and any property, tangible or intangible, real, personal or mixed, and any other article, commodity or thing of value wherever situate." S.C. Code Ann. § 39-5-10(b). These terms make clear the Act applies "to business and consumer transactions." *Health Promotion Specialists, LLC*, 403 S.C. at 638, 743 S.E.2d at 816 (2013). "Furthermore, by its very definition, 'trade or commerce' involves '’[e]very business occupation carried on for subsistence or profit and involving the elements of bargain and sale, barter, exchange, or traffic." *Id.* (quoting *Black's Law Dictionary* (9th ed. 2009)). For example, our supreme court determined the Board of Dentistry was not engaged in trade or commerce under the act when it

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promulgated a regulation because it was not involved in the "advertisement, sale, or distribution of services or property within a business context." *Health Promotion Specialists, LLC*, 403 S.C. at 639, 743 S.E.2d at 816. The court also discussed how the act can apply to professional services, which the regulation governed, but it still was not within the ambit of SCUTPA because it did not involve the sale of those services. *Id.* at 639 n.13, 743 S.E.2d at 816 n.13.

Construing the facts and reasonable inferences in Plaintiff's favor, there is no genuine issue of material fact that Defendants were not engaged in trade or commerce with Plaintiff in a business context when the representations were made. Defendants were not selling professional services to Plaintiff, and the communication were not related to the "advertisement, sale, or distribution of services or property" to Plaintiff. Plaintiff gave nothing in response to the representations. Because Defendants were not engaged in trade or commerce with Plaintiff when the representations occurred, Plaintiff's SCUTPA claim fails, and this Court grants Defendants summary judgment on that claim.

IV. Plaintiff cannot prove the necessary elements of negligent misrepresentation because Plaintiff cannot establish Defendants made a false statement to Plaintiff or that Plaintiff actually relied on those statements.

Defendants argue there is no genuine issue of material fact and summary judgment is appropriate, because they did not make a false statement of fact regarding insurance to Plaintiff or that Plaintiff actually relied on any statements of Defendants. Plaintiff argues there are genuine issues of material fact on every element of its negligent misrepresentation claim, specifically that "Defendants made statements about insurance coverage that were either inaccurate or inadequately investigated." Further, Plaintiff argues there is evidence that Carolina Neurosurgery reasonably relied on Defendants' representations about insurance coverage. This Court agrees with Defendants.

To prevail on a cause of action for negligent misrepresentation as it relates to a pecuniary loss, a plaintiff must prove: (1) the defendant made a false representation to the plaintiff; (2) the

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defendant had a pecuniary interest in making the statement; (3) the defendant owed a duty of care to see that he communicated truthful information to the plaintiff; (4) the defendant breached that duty by failing to exercise due care; (5) the plaintiff justifiably relied on the representation; and (6) the plaintiff suffered a pecuniary loss as a result of his reliance upon that representation. *Ama Management Corp v. Strasburger*, 309 S.C. 213, 420 S.E.2d 868 (1992). For the tort of negligent misrepresentation, "the element of 'false misrepresentation' cannot be premised upon an omission or silence of a party." *Allegro, Inc. v. Scully*, 409 S.C. 392, 419, 762 S.E.2d 54, 68 (Ct. App. 2014), *rev'd in part on other grounds*, 418 S.C. 24, 791 S.E.2d 140 (2016).

Construing the facts and inferences in the light most favorable to Plaintiff, there is no genuine issue of material fact and Defendants did not make an affirmative misrepresentation of fact to Plaintiff. Plaintiff takes issue with Defendants' paralegal mentioning the insurance policies in response to Plaintiff's employee inquiring about limits. The statements Defendants' paralegal made in the email were not false. Defendants' employee replied to Plaintiff's employee's email, telling Plaintiff's employee she did not know what the at-fault party's liability insurance was—a true statement. Defendants' employee stated that Client "carried" a policy with Safeco with $100,000 in UIM and One Beacon Policy for "Occupational Accident Coverage" for $1,000,000—a true statement that remained true. Client had those policies in effect when Defendants' paralegal communicated with Plaintiff's employee. In addition, Defendants' paralegal mentioned that they were "not concerned that there will be enough overall coverage to pay the claim." This statement was true at the time made and only an opinion about their concern about coverage.

Further, even though Defendants' employee said they were "not concerned", she followed up that same day after she found out that Client needed surgery, explaining to Plaintiff's employee that all of Client's surgical treatment was to be filed with his private health insurance company, and that the treatment should not proceed under an assignment or Letter of

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Protection. As Defendants testified, this shows that Defendants were concerned about coverage. Thus, Plaintiff knew after any statements about policies, that it was to process payment through the private health insurer—not the UIM policy or occupational policy limits. Also, Plaintiff's employee responded to Defendants' paralegal's request to submit claims to insurance, saying "Okay thanks for the update." Moreover, during Plaintiff's lawsuit, One Beacon's successor accepted coverage and paid an amount for each of Plaintiff's services provided Client according to the Explanation of Benefits, albeit at a reduced amount. Thus, it would be true that Client's One Beacon policy provided coverage. Because there is no genuine issue of material facts that the statements on which Plaintiff relies for its negligent misrepresentation were true when made, there is no false statement, and this Court finds summary judgment appropriate.

Additionally, there is no genuine issue of material fact that Plaintiff did not actually rely on any of Defendants' representations to provide services to Client. Plaintiff has a financial policy that said the Client was responsible for the bill and Dr. Highsmith testified he relies on that financial policy. Dr. Highsmith also testified that coverages do not affect his treatment recommendation. Moreover, Dr. Highsmith testified that he did not know whether he saw the email from Defendants' paralegal referencing insurance policies prior to providing services to Client, and further that the substance of the emails about coverage were not relevant to Client's medical care. He also testified that, in a situation where a patient needs surgery and he doesn't know anything about what insurance coverage is, he would still provide the surgery; and Client needed the surgery.

Even construing the evidence and reasonable inferences in Plaintiff's favor, the only reasonable inference from the evidence is that the statements Plaintiff takes issues with were true and that Plaintiff did not actually, reasonably, or justifiably rely on statements about insurance coverage to provide medical care to Client. Accordingly, this Court grants Defendants summary judgment on Plaintiff's negligent misrepresentation claim.

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V. Plaintiff cannot prove the necessary elements for promissory estoppel because there is no evidence that Defendants made an unambiguous promise that insurance coverages would be available to pay for Client's medical bills.

Defendants argued that summary judgment is appropriate on Plaintiff's claim for promissory estoppel because there is no evidence of any unambiguous promise to pay for Client's medical bills out of specific insurance coverages if Plaintiff provided Client services. Plaintiff did not directly address this argument in its memorandum or at the hearing. This Court agrees with Defendants.

"The elements of promissory estoppel are:

> (1) the presence of a promise unambiguous in its terms; (2) reasonable reliance upon the promise by the party to whom the promise is made; (3) the reliance is expected and foreseeable by the party who makes the promise; and (4) the party to whom the promise is made must sustain injury in reliance on the promise.

Rushing v. McKinney, 370 S.C. 280, 295, 633 S.E.2d 917, 925 (Ct. App. 2006) (quoting *Woods v. State,* 314 S.C. 501, 505, 431 S.E.2d 260, 263 (Ct. App. 1993)).

Construing the facts and reasonable inferences in Plaintiff's favor, there is no genuine issue of material fact that Defendants did not make an unambiguous promise to pay for Clients medical bills out of specific coverages. In its Complaint, Plaintiff alleged Defendants "made [an] unambiguous promise and gave unambiguous assurances to [Plaintiff] concerning the availability of over $1 million in insurance coverage for the medical services [Plaintiff] was to provide to" the Client.

The email on which Plaintiff relies, however, does not contain an unambiguous promise that the insurance proceeds would be available to pay for the medical services. In the email, Defendants' employee stated that Client "carried" a policy with Safeco with $100,000 in UIM and One Beacon Policy for "Occupational Accident Coverage" for $1,000,000. Those statements were truthful representations of the policies Client had. In addition, Defendants' paralegal stated they were "not concerned that there will be enough overall coverage to pay the

claim." Bennett's statement that *she was not concerned* about coverage is not tantamount to an unambiguous promise that those coverages were available to pay for Plaintiff's medical services. Further, Defendants' paralegal responded again to Plaintiff's employee two hours later after she discovered the Client needed surgery, and told Plaintiff to bill Client's health insurance, and that it would be better not to provide services under an assignment or letter of protection. Plaintiff's employee agreed. Because there is no genuine issue of material fact that there was no unambiguous promise that coverages would pay for Plaintiff's services, this Court grants Defendants summary judgment on Plaintiff's promissory estoppel claim.

ORDERED, ADJUDGED, and DECREED that Defendants' Motion for Summary Judgment is hereby GRANTED.

____
The Honorable Jessica A. Salvini
Presiding Judge, Ninth Judicial Circuit

Charleston, South Carolina

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Charleston Common Pleas

Case Caption: Carolina Neurosurgery & Orthopedics Inc VS Michael A Maucher , defendant, et al

Case Number: 2021CP1003379

Type: Order/Summary Judgment

So Ordered

Jessica A. Salvini

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FORM 4

STATE OF SOUTH CAROLINA
COUNTY OF Charleston
IN THE COURT OF COMMON PLEAS

JUDGMENT IN A CIVIL CASE

CASE NO. 2021CP1003379

Carolina Neurosurgery & Orthopedics Inc
PLAINTIFF(S)

Michael A Maucher et al
DEFENDANT(S)

DISPOSITION TYPE (CHECK ONE)

☐ **JURY VERDICT**. This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.

☑ **DECISION BY THE COURT**. This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.

☐ **ACTION DISMISSED** (*CHECK REASON*): ☐ Rule 12(b), SCRCP; ☐ Rule 41(a), SCRCP (Vol. Nonsuit); ☐ Rule 43(k), SCRCP (Settled);
☐ Other

☐ **ACTION STRICKEN** (*CHECK REASON*): ☐ Rule 40(j), SCRCP; ☐ Bankruptcy;
☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award;
☐ Other

☐ **STAYED DUE TO BANKRUPTCY**

☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT** (*CHECK APPLICABLE BOX*):
☐ Affirmed; ☐ Reversed; ☐ Remanded;
☐ Other

NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

IT IS ORDERED AND ADJUDGED: ☐ See attached order (formal order to follow) ☑ Statement of Judgment by the Court:

Statement of Judgment on the following page.

ORDER INFORMATION

This order ☐ ends ☑ does not end the case.

☑ See Page 2 for additional information.

For Clerk of Court Office Use Only

This judgment was electronically entered by the Clerk of Court as reflected on the Electronic Time Stamp, and a copy mailed first class to any party not proceeding in the Electronic Filing System on 04/03/2025 .

NAMES OF TRADITIONAL FILERS SERVED BY MAIL

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Court Reporter:

E-Filing Note: The date of Entry of Judgment is the same date as reflected on the Electronic File Stamp and the clerk's entering of the date of judgment above is not required in those counties. The clerk will mail a copy of the judgment to parties who are not E-Filers or who are appearing pro se. See Rule 77(d), SCRCP.

This matter was before the Court on March 31, 2025. Thomas Pendarvis appeared on behalf of Plaintiff and Skyler Wilson appeared on behalf of Defendants. Defendants Michael A. Maucher, Esq. and Deluca & Maucher, LLP's Motion for Summary Judgment is granted.

The Court finds that Plaintiff's breach of contract, revised SCUPTA, negligent misrepresentation, and promissory estoppel claims are all preempted by the findings in the Order granting Defendant's Motion to Dismiss.

In addition, the Court finds that Plaintiff cannot prove the necessary elements for each claim. Specifically the Court finds the following:

1.Plaintiff's cannot prove the necessary elements of a breach of contract claim because there was no legally enforceable contract between Plaintiff and Defendant;

2.Defendants did not violate the South Carolina Unfair Trade Practices Act as Defendants were not engaged in a "trade or commerce" with Plaintiff;

3.Plaintiff's cannot prove the necessary elements of negligent misrepresentation because Plaintiff cannot establish Defendants made a false statement to Plaintiff or that Plaintiff actually relied on those statements; and

4.Plaintiff cannot prove the necessary elements for promissory estoppel because there is no evidence that Defendant made unambiguous promise to pay for Client's medical bills.

Therefore, Defendants' Motion for Summary Judgment is granted. Defendants' counsel shall prepare a more formal order within twenty (20) days.

IT IS SO ORDERED.

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Charleston Common Pleas

Case Caption: Carolina Neurosurgery & Orthopedics Inc VS Michael A Maucher , defendant, et al

Case Number: 2021CP1003379

Type: Order/Electronic Form 4

So Ordered

Jessica A. Salvini

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