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Exhibit 1

Exhibit 1

21-004799-NI FILED IN MY OFFICE Cathy M. Garrett WAYNE COUNTY CLERK 2/23/2023 12:18 PM Moira Hartwell

APPLEBAUM & STONE, PLC
26777 Central Park Blvd, Suite 300
Southfield, MI 48076
(248) 233-5050

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STATE OF MICHIGAN
IN THE CIRCUIT COURT FOR THE COUNTY OF WAYNE

JOSEPH CANTY,

Plaintiff,

Case No. 21-004799-NI
Honorable Kathleen M. Mccarthy

v.

MICHAEL MASON,

Defendant.
_____/

Erik J. Stone (P55304)
Eric M. Noga (P83611)
APPLEBAUM & STONE, PLC
Attorneys for Plaintiff
26777 Central Park Boulevard, Ste 300
Southfield, Michigan 48076
(248) 233-5050 / FAX: (248) 359-8550
estone@applebaumstone.com
enoga@applebaumstone.com

Angela Esseily (P81816)
KRAMER CORBETT HARDING & DOMBROWSKI
Attorney for Defendant
PO Box 8084
Royal Oak, Michigan 48068-8084
313-237-5636 / 313-237-5732 (Fax)
aesseily@acg.aaa.com

_____/

ORDER GRANTING IN PART AND DENYING IN PART DEFENDANT'S MOTION FOR PARTIAL SUMMARY DISPOSITION

At a session of court held in the courthouse
in Detroit, Michigan, on 2/23/2023
Present: Honorable Kathleen M. Mccarthy
Circuit Court Judge

This matter having come before the Court on Motion of the Plaintiff, oral arguments being heard and the Court being otherwise fully advised in the premises;

IT IS HEREBY ORDERED that the Defendant's Motion is GRANTED IN PART and DENIED IN PART for the reasons stated on the record;

IT IS FURTHER ORDERED Plaintiff may claim all allowable expenses through this third party suit;

IT IS FURTHER ORDERED The Personal Injury Protection fee schedule does not apply to this third-party auto negligence cause of action.

IT IS FURTHER ORDERED Allowable expense claims are limited to "…reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation.", as under MCL 500.3107(1)(a).

IT IS SO ORDERED

THIS IS NOT A FINAL ORDER AND DOES NOT CLOSE THE CASE.

Date: 2/23/2023

/s/ Kathleen M. McCarthy 2/23/2023
HON. KATHLEEN M. MCCARTHY

Approved as to form; notice of entry waived:

APPLEBAUM & STONE, PLC

/s/ Eric M. Noga
ERIK J. STONE (P55304)
ERIC M. NOGA (P83611)
Attorney for Plaintiff
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(248) 233-5050 / Fax: (248) 359-8539
estone@applebaumstone.com
enoga@applebaumstone.com
Dated: February 23, 2022

KRAMER CORBETT HARDING & DOMBROWSKI

/s/ Angela Esseily
ANGELA ESSEILY (P81816)
Attorney for Defendant
PO Box 8084
Royal Oak, Michigan 48068-8084
313-237-5636 / 313-237-5732 (Fax)
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Exhibit 2

Exhibit 2

Register of Actions

Case No. 21-004799-NI

Party Information

Defendant	**Mason, Michael Chester**	**Attorneys** **Angela Esseily** *Retained* (313) 237-5636(W)
Plaintiff	**Canty, Joseph William**	**Erik J. Stone** *Retained* (248) 233-5050(W)

Events & Orders of the Court

	OTHER EVENTS AND HEARINGS
04/15/2021	**Complaint, Filed**
04/15/2021	**Service Review Scheduled**
04/15/2021	**Status Conference Scheduled**
04/15/2021	~~Case Filing Fee - Paid~~
05/11/2021	~~Service of Complaint, filed~~
05/11/2021	~~Proof of Service, Filed~~
05/25/2021	~~Proof of Service, Filed~~
05/25/2021	~~Jury Demand Filed & Fee Paid~~
05/25/2021	~~Answer to Complaint, Filed~~
06/14/2021	~~Answer to Affirmative Defenses, Filed~~
06/14/2021	~~Reliance on Jury Demand, Filed~~
06/14/2021	~~Proof of Service, Filed~~
07/15/2021	**Status Conference** (8:00 AM) (Judicial Officer Popke, Lita Masini) Result: Reviewed by Court
07/15/2021	~~Status Conference Scheduling Order, Signed and Filed~~
07/16/2021	~~Proof of Service, Filed~~
07/16/2021	~~Proof of Service, Filed~~
08/23/2021	**Case Reassigned**
09/20/2021	~~Proof of Service, Filed~~
09/20/2021	~~Proof of Service, Filed~~
09/20/2021	~~Miscellaneous Pleadings, Filed~~
09/20/2021	~~Miscellaneous Pleadings, Filed~~
09/20/2021	~~Proof of Service, Filed~~
09/20/2021	~~Proof of Service, Filed~~
09/20/2021	~~Notice of Taking Deposition, Filed~~
09/20/2021	~~Witness List, Filed~~
11/11/2021	~~Proof of Service, Filed~~
11/15/2021	~~Order Adjourning Mediation and Settlement Conference, S/F~~
11/15/2021	~~Notice of Taking Deposition, Filed~~
11/15/2021	~~Proof of Service, Filed~~
11/16/2021	~~Proof of Service, Filed~~
11/16/2021	~~Notice of Taking Deposition, Filed~~
12/09/2021	~~Witness List, Filed~~
12/09/2021	~~Proof of Service, Filed~~
12/20/2021	~~Proof of Service, Filed~~
12/20/2021	~~Witness List, Filed~~
01/25/2022	~~Notice of Taking Deposition, Filed~~
01/25/2022	~~Proof of Service, Filed~~
04/20/2022	**Case Evaluation - General Civil**
05/18/2022	**Case Evaluation - No Acceptance**
06/06/2022	**Settlement Conference** (9:00 AM) (Judicial Officer McCarthy, Kathleen M.) ~~Parties Present~~ *03/01/2022 Reset by Court to 06/01/2022* *06/01/2022 Reset by Court to 06/06/2022* Result: Held
10/04/2022	**Settlement Conference** (9:00 AM) (Judicial Officer McCarthy, Kathleen M.) Result: Held
10/04/2022	**Case Scheduled for Trial** (Judicial Officer: McCarthy, Kathleen M.)
10/05/2022	~~Order for Miscellaneous Action, Signed and Filed~~
10/25/2022	~~Motion for Summary Judgment/Disposition, Filed~~
10/25/2022	~~Proof of Service, Filed~~
11/07/2022	~~Praecipe, Filed~~ (Judicial Officer: McCarthy, Kathleen M.)
11/08/2022	~~Notice of Hearing, Filed~~
11/08/2022	~~Proof of Service, Filed~~
12/19/2022	~~Proof of Service, Filed~~
12/19/2022	~~Answer to Motion, Filed~~
01/03/2023	~~Reply to Brief, Filed~~
01/03/2023	~~Proof of Service, Filed~~

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01/04/2023	**Motion Hearing** (10:00 AM) (Judicial Officer McCarthy, Kathleen M.) Result: Held
01/04/2023	~~**Notice of Presentment**~~
01/04/2023	~~**Objection to 7-Day Order, Filed**~~
01/04/2023	~~**Proof of Service, Filed**~~
01/04/2023	~~**Notice of Hearing, Filed**~~
01/04/2023	**Motion Granted in Part/Denied in Part, Order to Follow** (Judicial Officer: McCarthy, Kathleen M.)
01/04/2023	~~**Proof of Service, Filed**~~
01/05/2023	~~**Proof of Service, Filed**~~
01/05/2023	~~**Notice of Hearing, Filed**~~
02/02/2023	~~**Praecipe, Filed**~~ (Judicial Officer: McCarthy, Kathleen M.)
02/02/2023	~~**Praecipe, Filed**~~ (Judicial Officer: McCarthy, Kathleen M.)
02/02/2023	~~**Notice of Hearing, Filed**~~
02/02/2023	~~**Proof of Service, Filed**~~
02/03/2023	~~**Reply to Brief, Filed**~~
02/03/2023	~~**Proof of Service, Filed**~~
02/03/2023	~~**Proof of Service, Filed**~~
02/07/2023	**Final Pre-Trial Conference** (9:00 AM) (Judicial Officer McCarthy, Kathleen M.) Result: Held
02/07/2023	**Motion Hearing** (9:00 AM) (Judicial Officer McCarthy, Kathleen M.) Result: Held
02/07/2023	**Motion Granted, Order to Follow** (Judicial Officer: McCarthy, Kathleen M.)
02/10/2023	~~**Motion for Stay of Proceedings, Filed**~~
02/10/2023	~~**Proof of Service, Filed**~~
02/10/2023	~~**Praecipe, Filed**~~ (Judicial Officer: McCarthy, Kathleen M.)
02/10/2023	~~**Proof of Service, Filed**~~
02/10/2023	~~**Notice of Hearing, Filed**~~
02/14/2023	~~**Proof of Service, Filed**~~
02/14/2023	~~**Objection, Filed**~~
02/15/2023	~~**Witness List, Filed**~~
02/15/2023	~~**Proof of Service, Filed**~~
02/15/2023	~~**Proof of Service, Filed**~~
02/15/2023	~~**Notice of Hearing, Filed**~~
02/21/2023	~~**Answer to Motion, Filed**~~
02/21/2023	~~**Proof of Service, Filed**~~
02/21/2023	~~**Answer to Motion, Filed**~~
02/21/2023	~~**Proof of Service, Filed**~~
02/21/2023	~~**Motion in Limine, Filed**~~
02/21/2023	~~**Proof of Service, Filed**~~
02/21/2023	~~**Miscellaneous Pleadings, Filed**~~
02/22/2023	~~**Praecipe, Filed**~~ (Judicial Officer: McCarthy, Kathleen M.)
02/22/2023	~~**Proof of Service, Filed**~~
02/22/2023	~~**Proof of Service, Filed**~~
02/23/2023	**Motion Hearing** (9:30 AM) (Judicial Officer McCarthy, Kathleen M.) Result: Held
02/23/2023	~~**Order Adjourning Trial, Signed and Filed**~~
02/23/2023	~~**Order Granting in Part/Denying in Part, Signed and Filed**~~
02/23/2023	~~**Proof of Service, Filed**~~
02/23/2023	~~**Proof of Service, Filed**~~
02/23/2023	~~**Proof of Service, Filed**~~
02/23/2023	~~**Notice of Hearing, Filed**~~
02/28/2023	*CANCELED* **Motion Hearing** (10:00 AM) (Judicial Officer McCarthy, Kathleen M.) *Case Disposed/Order Previously Entered*
03/06/2023	**Trial** (8:30 AM) (Judicial Officer McCarthy, Kathleen M.)
03/06/2023	**Motion Hearing** (9:00 AM) (Judicial Officer McCarthy, Kathleen M.)

Financial Information

Plaintiff Canty, Joseph William

	Total Financial Assessment			320.00
	Total Payments and Credits			320.00
	Balance Due as of 03/02/2023			**0.00**
04/15/2021	Transaction Assessment			175.00
04/15/2021	eFiling	Receipt # 2021-29974	Applebaum & Stone, PLC	(175.00)
05/26/2021	Transaction Assessment			85.00
05/26/2021	eFiling	Receipt # 2021-40545	Kramer, Corbett, Harding & Dombrowski	(85.00)
10/26/2022	Transaction Assessment			20.00
10/26/2022	eFiling	Receipt # 2022-76838	Kramer, Corbett, Harding & Dombrowski	(20.00)
02/10/2023	Transaction Assessment			20.00
02/10/2023	eFiling	Receipt # 2023-09947	Kramer, Corbett, Harding & Dombrowski	(20.00)
02/22/2023	Transaction Assessment			20.00
02/22/2023	eFiling	Receipt # 2023-11988	Kramer, Corbett, Harding & Dombrowski	(20.00)

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Exhibit 3

Exhibit 3

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STATE OF MICHIGAN
IN THE THIRD CIRCUIT COURT FOR THE COUNTY OF WAYNE

JOSEPH WILLIAM CANTY,

Plaintiff,

-vs-

MICHAEL CHESTER MASON,

Defendant.
_____/

Case No. 21-004799-NI

Honorable Kathleen McCarthy

DEFENDANT'S MOTION FOR PAYMENT OF MEDICAL BILLS

BEFORE THE HONORABLE Kathleen McCarthy,

Third Circuit Court, Civil Division

Detroit, Michigan on

Wednesday, January 4, 2023

APPEARANCES:

On Behalf of Plaintiff: **ERIK J. STONE** (P-55304)
26777 Central Park Blvd, #300
Southfield, MI 48076
(248) 233-5050

On Behalf of Defendant: **ANGELA ESSEILY** (P-81816)
P.O. Box 8084
Royal Oak, MI 48068
(313) 237-5636

REPORTED BY: SHELEE BEARD, CSR 5493
Official Court Reporter

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WITNESSES: **PAGE**

None

E X H I B I T S:

	INTRODUCED PAGE	**ADMITTED PAGE**
None Offered		

Detroit, Michigan

Wednesday, January 4, 2023

- - -

THE COURT: We're on the record on case number 2021-004799-NI.

Counsel for Plaintiff, your appearance, please.

MR. STONE: Erik Stone appearing on behalf of the Plaintiff.

THE COURT: Counsel for Defendant.

MS. ESSEILY: Angela Esseily appearing on behalf of Defendant.

THE COURT: Okay. So Defendant has filed a motion in this third party auto neg case because the Plaintiff in this case opted out of first party benefits.

In opting out of first party, he opted out of first party benefits, period. He then began treating with various providers and has not submitted the bill to Medicare.

Defendant maintains that all of these providers, except Medicare and ultimately in their final response indicate that Plaintiff does have a duty to mitigate.

Anything else for the record, Counsel

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for Defendant?

MS. ESSEILY: Yes, Judge, if I could just briefly.

I know you've read through all the briefs and gotten through everything. But I just want to emphasize that it has been ruled in the Court of Appeals that the duty to mitigate is not something that needs to be abrogated. It doesn't have to be written out into the law.

THE COURT: Common law duty.

MS. ESSEILY: Yeah. And the person wronged cannot recover for any damages as it relates to the failure to mitigate.

Additionally, even if this Court dos not find that mitigation is pertinent here, which I believe it absolutely is, at the end of the day, the Plaintiff must comply with 3135(C) which requires them to limit the pricing based on 3107 and 3157.

THE COURT: Okay. So those are two different issues.

MS. ESSEILY: Yes.

THE COURT: So let's break them down.

I agree with you that Plaintiff has a duty to mitigate. The whole purpose of the

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insurance reform in allowing someone to opt out was to guarantee that they had underlying insurance and/or that they were a qualified Medicare or Medicaid recipient.

And so even if it doesn't plainly state in the statute, it would defy common sense to indicate you have to have insurance or you have to have Medicare but you don't have to bill them.

Anything to add on that issue, Mr. Stone?

MR. STONE: Yes. I could like to counter the point --

THE COURT: Sure.

MR. STONE: That Medicare is not responsible for any no-fault or any damages arising out of an automobile motor vehicle accident.

I don't know who, I've even provided the Court rejections from Medicare on this saying they're not paying it because it arose out of a motor vehicle accident. Medicare is not responsible for this, Your Honor. You cannot --

THE COURT: I know your argument. And your argument is that if you're -- I don't know that's the case if you opt out because the

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insurance information that one of you provided, I think it was Ms. Esseily, clearly anticipated that Medicare costs were going to go up with this new opt out in auto insurance.

MR. STONE: But we provided this Court with documentation that it's been rejected by Medicare. That proves my point.

THE COURT: Okay. Hold on. I didn't see that.

MR. STONE: Lucid's billing which is 24,000 has been rejected by Medicare.

THE COURT: Only, what exhibit that is?

MR. STONE: I can't tell.

THE COURT: Hold on, don't over talk him. I just want to see what he's talking about first.

MS. ESSEILY: I apologize.

MR. STONE: And if I could continue my argument with regards to the Medicare.

THE COURT: Well, I think it makes a difference. I think you have to submit them to Medicare. And if Medicare rejects, then Medicare rejects. I think that's a different argument.

But I think you have an obligation to

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submit to his, either health insurance or Medicare with anticipated with the opt out.

MR. STONE: But if you don't, under the No-Fault law, you don't have to treat with anyone. You don't have to treat with Medicare. You don't have to treat with Medicaid. You could treat in Saudi Arabia if you wanted. Okay.

Why is there -- why would you be putting a bigger protection on someone who is not at fault, who opted out of no-fault? No fault does not even apply here. The word --

THE COURT: Because it's anticipated to be qualified to opt out, otherwise prior to the changes, you had to.

MR. STONE: But you don't have to go to someone who treats Medicare.

THE COURT: Well, in this case they did. And if they did, they have to submit them to Medicare.

MR. STONE: And only one of the places did, treats Medicare.

THE COURT: Go ahead and make a record. I'm not going to argue the point. Go ahead and make a record.

MR. STONE: Well, I'd like to know

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what your ruling is first, Your Honor.

THE COURT: My ruling is that you have, there's a common law duty to mitigate. You have an obligation to mitigate that the changes in the No-Fault law anticipated you could only opt out if you had qualified health insurance or you were a Medicare recipient.

Obviously that anticipation was that your health insurance or Medicare was going to be primary. And so that is my ruling.

You have a duty to mitigate. You must submit all of your bills in good faith to Medicare in this case.

MR. STONE: May I clarify?

What if the provider does accept or bill Medicare?

THE COURT: That's a secondary issue that Ms. Esseily, is it Esseily?

MS. ESSEILY: Esseily.

THE COURT: And her second argument is that he is then subject to a Medicare fee schedule; correct, that's your second argument, Ms. Esseily?

MS. ESSEILY: Yes, Judge. You'd still be required to submit the bills based on the

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statute of limitations, 3107, 3157.

THE COURT: In that case I disagree with you on that second part because I don't see anywhere in the statute that does require, as Mr. Stone said, to treat with a Medicare provider, unfortunately. It seems like it's a loophole in this new statute.

But I don't see any cases or anything in the statute that indicates that requirement.

So I have to deny that request. I think he has -- I'm ruling that it's granted in part and denied in part. He has to submit all of these bills in good faith to Medicare for payment. And anything above and beyond is the responsibility of the insurance company.

MR. STONE: Your Honor, may I make one other point here?

The ruling logically doesn't make sense because the provider in this case, if the person had, if Mr. Canty had no-fault insurance, would be getting the fee schedule and this hospital case would be 2 to 300 times the point of Medicare.

Since if he opts out and the provider now only gets Medicare rates. So yes, your ruling

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on the second part is correct. It shouldn't be capped at Medicare. But the provider now, is getting less, way less because you're allowing the bill -- You're not allowing the bill.

MS. ESSEILY: Judge, if I may reply?

THE COURT: I'm not sure what you just said, so you'll have to go through that. You have like four different providers. You got a provider that --

MR. STONE: Right. Let's say it's no-fault, Your Honor. And the Medicare bills, he goes to Medicare, he bills Medicare because all right, the provider bills Medicare, they get a fee schedule. No-fault would pay him two and a half times Medicare, 200 percent of Medicare.

We go to the third party case. That bill now is not 200 times Medicare. That's just the Medicare bill. So the provided is getting jobbed because there's no no-fault insurance. And that is fine but that isn't what they opted out of no-fault for.

They opted out to have their no-fault reduced, not the amount of damages or where they can go reduce. They opted out to have their -

THE COURT: You're arguing two

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different points. One is the person paying for no-fault. And again, they can only opt out if they have a qualified insurance.

And secondly, these providers that accept Medicare have already agreed to accept those reduced rates because they work under a Medicare fee agreement.

So I disagree with you.

MR. STONE: Okay. Then if Medicare rejects and in this case the other providers do not, have never billed, they're not associated with Medicare, those bills are still in then.

THE COURT: Right. You have to submit them if they accept Medicare. And then if anything, if they reject or anything over and above is subject to the third party case.

It doesn't make sense to me, honestly. But that's so far what the statute says. I imagine there'll be an amendment down the line. But that's how I view it.

MR. STONE: Thank you for your time today, Your Honor.

MS. ESSEILY: If I can just add one more thing --

THE COURT: Sure.

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MS. ESSEILY: For the record.

THE COURT: Sure.

MS. ESSEILY: To his reply, I mean, I think it should be noted that 3135(3)(c) 3107 and 3110 as allowable expenses and I think it goes, saying that it would lead to 3157. And I understand the Judge's point that this is, it's not necessarily mentioned in 3135(3)(c), however, I think it needs to be noted.

Additionally, even if, I mean in the case of Lucid's bill because he did note it, I just want to make it clear for the record.

My understanding is the Lucid bill was denied because they did not, they did not provide complete information for it to be completely processed through Medicare. It wasn't denied because they don't accept it.

And then lastly --

THE COURT: That was my point about saying that they have to be submitted in good faith. I agree with you, if there's something that's missing, that needs to be provided to get Medicare to pay for it. That is required on the Plaintiff to do that.

I don't know how you're going to word

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that in an order. That's why I said good faith submission with responding to them if they say there's a defect for something that can be easily cured.

You know, that gets into a Toussaint argument. I mean, you have kind of the same issue.

MS. ESSEILY: So I guess, just to clarify too for the order, I can, as far as the mitigation issue, that is granted. And then as far as the duty to submit these bills to Medicare, it's just in good faith.

Is that how you would like it worded?

THE COURT: I guess.

MS. ESSEILY: I just want to make sure that I'm not wording --

THE COURT: I was hoping that you're going to sound more eloquent than I was.

MS. ESSEILY: I know, I need to write it.

THE COURT: You work with that. Granted in part and denied in part because I don't think he has an obligation to treat with Medicare providers. I don't see that anywhere in the statute.

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MS. ESSEILY: Okay. And --

THE COURT: Appeal me. And then you'll get the Court of Appeals to decide this issue. I don't know.

MS. ESSEILY: I guess, Judge, I just want to clarify, my argument wasn't necessarily that he had to treat with Medicare.

THE COURT: Object to the fee schedule, yes.

MS. ESSEILY: Okay.

THE COURT: That's where I disagreed with you, that it's not subject to the fee, it's subject to the auto neg fee schedules. But it's not subject to the Medicare fee schedule if the provider isn't a Medicare recipient, isn't a Medicare provider, I mean.

MS. ESSEILY: Okay. But it would still be subject to the fee schedule based on 3107. Okay.

THE COURT: You're muted, Mr. Stone.

MR. STONE: What would be subject to the fee schedule?

THE COURT: Anything after the treatment date of the changes. Is there a fee schedule after June of 2019 or 2020?

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MR. STONE: And what about the excess that Medicare, that's beyond Medicare?

THE COURT: Right. Then that is the responsibility of the insurance company. That's what I've indicated.

But on Medicare, people that submit the Medicare, there should be any, they're agreeing to the Medicare rate so I don't know how there would be anything in excess. But -

MR. STONE: Well, the bills -- well, okay. They don't have to agree to the Medicare rates, that's the thing.

THE COURT: If they're a Medicare provider, they do. That's the contract that they signed up to accept Medicare.

MS. ESSEILY: At the end of the day, the providers were aware there was Medicare and they continued to treat. They could have --

THE COURT: Okay. I don't want to go back and forth. You have my ruling. Please submit an order.

MS. ESSEILY: Thank you, Judge.

THE COURT: All right.

Have a great day, guys.

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MS. ESSEILY: Thank you.

You as well.

THE COURT: Thanks.

- - -

(Whereupon proceedings concluded.)

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S T E N O G R A P H E R ' S C E R T I F I C A T E

STATE OF MICHIGAN)
) SS
COUNTY OF WAYNE)

I, **Shelee Beard**, CSR-5493, Certified Court Reporter in and for the Third Circuit Court, Wayne County, State of Michigan, do hereby certify that the foregoing pages 1 through 16 inclusive, was reduced to typewritten form by means of Computer-Assisted Transcription and comprise a true and accurate transcript of the proceedings in the above-entitled matter, on Wednesday, January 4, **2023.**

Shelee Beard

SHELEE BEARD, CSR-5493
Certified Court Reporter
Third Circuit Court
921 CAYMC
Detroit, MI 48226

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Exhibit 4

Exhibit 4

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF WAYNE

JOSEPH WILLIAM CANTY,

Plaintiff, Case No. 21-004799-NI

vs.

MICHAEL CHESTER MASON,

Defendant.

ZOOM Proceedings taken in the above-entitled matter before **HONORABLE KATHLEEN McCARTHY**, Third Judicial Circuit Court Judge, Detroit, Michigan, on February 7, 2023.

APPEARANCES:

On behalf of Plaintiff: MR. ERIK STONE (P55304)
26777 Central Pk. Blvd #300
Southfield, MI 48076

On behalf of Defendant: MS. ANGELA ESSEILY (P81816)
P.O. Box 8084
Royal Oak, MI 48068

Shelee Beard, CSR-5493
Official Court Reporter

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n/a	

Detroit, Michigan

February 7, 2023

- - -

THE COURT: I'm on the record on case number 2021-004799-NI. Counsel for Plaintiff, your appearance.

MR. STONE: Erik Stone appearing on behalf of plaintiff.

THE COURT: Counsel for Defense.

MS. ESSEILY: Angela Esseily appearing on behalf of defendant.

THE COURT: I know there's an issue regarding the hearing; it was a motion for summary. I had made a ruling. There's a dispute about the 7 day orders. Frankly, that got me researching this issue a little bit more, and I believe my ruling is incorrect. So in looking at this issue further because Medicare and Medicaid are exempt from the no fault statute, there is no duty to mitigate. Medicare is normally rejected if there's an auto accident because it's exempt under the federal court. So Mr. Stone, I believe, argued that and is correct in that ruling.

This is a third party case. Was there

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a -- There wasn't a first party because he opted out.

MR. STONE: Correct.

THE COURT: Under the third party case he just has to show what ever was charged by his providers was reasonable and necessary.

MS. ESSEILY: Judge if I could make a clear record on this based on the previous -- I mean, we were only here to clarify this order. It's still defendant's position the legislature intent was very clear here. They even quantified there would be increase in payment Medicare and Medicaid would be making on these no fault cases. At the end of the day, the whole point of the opt out was for the intent that people can take a deduction. He didn't have to do this opt out, and he chose to do it anyway. To penalize everyone around hundred him, we believe that's not the intent. He opted out the first party benefits here. There need to be a duty to mitigate based off that --

THE COURT: Here's your problem; if it had been a qualified health insurance plan, I agree with you, but Medicare is not a qualified health insurance plan, and the federal law has

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specifically exempted it. So you can disagree with me; I'm not going to argue with you. I have a right to revisit my opinions on my own motions; I have chosen to do that. And I found my previous ruling is in error, and there is no duty to mitigate. He couldn't even collect Medicare. If a bill went to Medicare, he had a duty to inform them that this was an auto accident. It's an affirmative duty so they can lien the file to the extent they paid for Medicare. His only duty is to make sure the bills are reasonable and necessary.

MS. ESSEILY: Judge, if you could allow me to make a full record for purposes of appeal. Plaintiff made a decision to accept a discounted rate by opting out of allowable expense coverage based on Medicaid part A and B coverage. I know this is going to be redundant, but the opt out as the legislature addresses would shift cost of certain medical expenses. Because plaintiff chose not to rely on the no fault system, he cannot just throw up his hand and assume alleged tortfeasor will absorb the cost.

The court of appeals previously ruled that you would still be able to mitigate despite

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it not be a codified -- it doesn't have to be codified in No-Fault Act, but there would still be a duty. That was in Bazzi V Citizens. Plaintiff can't just rack up medical cost and assume payment from an alleged tortfeasor when there could have been -- could have been a way to minimize those damages.

In this case, despite receiving an EOB denying claims from his auto carrier which is Liberty, they continue to bill and bill and bill without any intentional recourse. There was actually no attempt to mitigate. We have a bill that's been racked up with Northland nearly $200,000. Plaintiff's allegations that the right of plaintiff to treat wherever he wants, or the notion to treat no matter that benefits the tortfeasor entirely is missing the point. The duty to mitigate is not to benefit the tortfeasor rather to prevent needless accumulation of economic loss that could otherwise be avoided.

As far as the second issue relating to 3135 argument despite plaintiff's claiming no obligation to submit these bills, the legislature predicated opt out in insurance that the insureds had other means of coverage. I'm repeating that

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over and over. I think it worthy to be noted. If your Honor does not believe there's a duty to mitigate, I would like your Honor to still consider that the No-Fault Act has to be read as a whole and as such 3135 refers to a potential claimant allowable expenses. Plaintiff should still have those limits listed in 3107 to 3110, allowable expenses also includes. Allowable expenses means as well the fee schedule that was also written out in the statute 3157 subsection 2 of the statute

The plaintiff made the decision to disregard submissions to Medicare despite the election and despite asking over and over again, recover of allowable expenses should still be required to be mitigated. And there was a failure to do so here.

THE COURT: Thank you. You've made your record. I will add to my ruling that he is subject to the fee schedule under 3157. It specifically references Medicare. I don't know the dates of service of ur client. Go ahead.

MR. STONE: In the third party case he's not limited to fee schedule, that's only in the first party. That needs be clarified because

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that was Ms. Esseily's intention. She believed the fee schedule applies to all bills in the third-party case. The statute says anything but not limited to. There is no limit on third party. As far as him having a duty to mitigate, he opted out. This tortfeasor could very well have $50,000 policy. And then he would be stuck with all the automobile bills, or the accident bill, or the medical bills.

MS. ESSEILY: Your Honor, to Mr. Stone's point, if that were the case, plaintiff would have likely submitted all those bills to Medicare. As far as my 3157 argument, 3135 refers to allowable expenses. I believe that plaintiff would be subject to the fee schedule pursuant to the No-Fault Act that is provided. I understand this is a third-party case, but the legislature didn't abandon the notion of allowable expenses. It didn't abandon the way that it was intended to be, or the way it was written in the no-fault act. In fact, they refer, to -- If there was no intent for a third party and to base it off of the No-Fault Act, they would have never referred to allowable expenses.

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MR. STONE: One more thing, your Honor, if I may. If this were the case, we have a fee schedule that's 200 percent on. Therefore if you bill Medicare you would get Medicare rates where the fee scheduled is a heck of a lot more than Medicare rates. We went through Medicare to get an amount when no fault is 200 times that amount.

THE COURT: That's my point. What 3157 says she wants a fee schedule, then it's probably the same as what they're billing.

MR. STONE: The fee schedule is nowhere mentioned in 3135. There's no referenced statute that fee schedule applies in the third party case. This gentleman had a severe knee injury and went to Canada to have it operated on.

THE COURT: Hold on a second. 500.3157 says charges for treatment or training for injured person. It doesn't say it's limited to first-party cases.

MR. STONE: 3135 is the statute under the first party. Once you opt out, there's no PIP benefits. The fee schedule can't apply because there's no PIP benefits. That's the whole point of opting out.

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THE COURT: Give me a second. I've got to read 3135. Thank you. I just reviewed 500.3135. Again, I agree with plaintiff's position there's nothing in the statute that indicates that the fee schedule 3157 would apply on a third-party claim.

MS. ESSEILY: Your Honor, If I can just briefly respond to that, the -- I'm not arguing 3157 isn't noted in the statute. I don't think it necessarily makes sense to read 3135(3)(c) on its own. The entire No-Fault Act has to be read. It still says damages are allowable expenses and references 3157. It's not completely abandoning the notion that still following the No-Fault Act and still following the 3157 which is how we're now considering payments of bills. I don't think that was the legislature's intent.

THE COURT: I believe their intent was to help people of lower means to have affordable car insurance. People of lower means are identified by either being on Medicare, which means they're retired, and/or Medicaid, which means they're income eligible. In looking at the automobile code in conjunction with this makes perfect sense to me that this does not apply.

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The law is clear that Medicare is a separate government policy that does not get invoked when there's an auto policy in place.

That's my ruling. He obviously has an obligation to make sure his bills are reasonable and necessary. That's where we're at. I need an order, Mr. Stone, from you today indicating that the Court has revisited the issue on its own motion. And that's my ruling. And then you two have a final settlement conference, correct?

MS. ESSEILY: Yes. In considering the ruling, respectfully, your Honor --

THE COURT: It's not personal to me.

MS. ESSEILY: We're likely going to file a motion for reconsideration. I know the trial is less than a month. I -- my client may want to even appeal this. I think it's a good idea to adjourn the trial concerning the facts of bills. We have to be sure what bills should be included at trial. I think we'll benefit interest of judicial economy.

THE COURT: What is the amount of the policy in this case?

MS. ESSEILY: 250,000.

THE COURT: What are the amount of

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bills? Mr. Stone has a point; if the whole policy is used up paying medical providers then the client doesn't get anything for pain and suffering.

MS. ESSEILY: Your Honor, if reasonable and customary still applies, we can have some discussion about exactly what's been paid out on bill. It's a decent policy.

MR. STONE: Your Honor, that's to be determined by a jury.

THE COURT: Okay. Sure.

MR. STONE: For this bill I believe he should get 10,000 versus --

THE COURT: What are at amount of him current bills?

MR. STONE: I don't know. They're pretty extensive.

MS. ESSEILY: I think they're over 200.

MR. STONE: 250.

THE COURT: You're indicating you'll leave it to the jury to apportion.

MR. STONE: Correct.

THE COURT: That is the hazard of somebody not taking PIP coverage.

MR. STONE: Correct.

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MS. ESSEILY: Your Honor, what ever happens with this ruling maybe it's prevalent to see what happens before trial on this ruling in general.

THE COURT: You're free to file a motion for reconsideration. I need to know whether you filing an appeal. If it's filed, I'll cancel the trial. If it's not filed, I'm proceeding with the trial.

MS. ESSEILY: Okay.

THE COURT: All right.

(Whereupon proceedings concluded.)

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STATE OF MICHIGAN)
) SS
COUNTY OF WAYNE)

R E P O R T E R' S C E R T I F I C A T E

I, Shelee Beard, CSR-5493, do hereby certify that I have transcribed the **VIDEO** proceedings had in the above-entitled matter at the time and place hereinbefore set forth and that the foregoing is a true and correct transcript of proceedings.

/s/ Shelee Beard
Shelee D. Beard, CSR-5493
921 Coleman A. Young Municipal Center
Detroit, MI 48226
stenobeard@ymail.com

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Exhibit 5

Exhibit 5

Approved, SCAO | Original - Court; 1st Copy- Defendant | 2nd Copy - Plaintiff; 3rd Copy -Return

STATE OF MICHIGAN THIRD JUDICIAL CIRCUIT WAYNE COUNTY	SUMMONS	CASE NO. 21-004799-NI Hon.Lita Masini Popke

Court address : 2 Woodward Ave., Detroit MI 48226 | Court telephone no.: 313-224-2953

Plaintiff's name(s), address(es), and telephone no(s)		Defendant's name(s), address(es), and telephone no(s).
Canty, Joseph William	v	Mason, Michael Chester
Plaintiff's attorney, bar no., address, and telephone no Erik J. Stone 55304 26777 Central Park Blvd Ste 300 Southfield, MI 48076-4172		

Instructions: Check the items below that apply to you and provide any required information. Submit this form to the court clerk along with your complaint and, if necessary, a case inventory addendum (form MC 21). The summons section will be completed by the court clerk.

Domestic Relations Case

- ☐ There are no pending or resolved cases within the jurisdiction of the family division of the circuit court involving the family or family members of the person(s) who are the subject of the complaint.
- ☐ There is one or more pending or resolved cases within the jurisdiction of the family division of the circuit court involving the family or family members of the person(s) who are the subject of the complaint. I have separately filed a completed confidential case inventory (form MC 21) listing those cases.
- ☐ It is unknown if there are pending or resolved cases within the jurisdiction of the family division of the circuit court involving the family or family members of the person(s) who are the subject of the complaint.

Civil Case

- ☐ This is a business case in which all or part of the action includes a business or commercial dispute under MCL 600.8035
- ☐ MDHHS and a contracted health plan may have a right to recover expenses in this case. I certify that notice and a copy of the complaint will be provided to MDHHS and (if applicable) the contracted health plan in accordance with MCL 400.106(4).
- ☐ There is no other pending or resolved civil action arising out of the same transaction or occurrence as alleged in the complaint.
- ☐ A civil action between these parties or other parties arising out of the transaction or occurrence alleged in the complaint has

been previously filed in ☐ this court, ☐ _____ Court,

where it was given case number _____ and assigned to Judge _____.

The action ☐ remains ☐ is no longer pending.

Summons section completed by court clerk. **SUMMONS**

NOTICE TO THE DEFENDANT: In the name of the people of the State of Michigan you are notified:

1. You are being sued.
2. **YOU HAVE 21 DAYS** after receiving this summons and a copy of the complaint to **file a written answer with the court** and serve a copy on the other party **or take other lawful action with the court** (28 days if you were served by mail or you were served outside this state).
3. If you do not answer or take other action within the time allowed, judgment may be entered against you for the relief demanded in the complaint.
4. If you require special accommodations to use the court because of a disability or if you require a foreign language interpreter to help you fully participate in court proceedings, please contact the court immediately to make arrangements.

Issue date	Expiration date*	Court clerk
4/15/2021	7/15/2021	Laverne Chapman

Cathy M. Garrett- Wayne County Clerk.

*This summons is invalid unless served on or before its expiration date. This document must be sealed by the seal of the court.

MC 01 (9/19) **SUMMONS** MCR 1.109(D), MCR 2.102(B), MCR 2.103, MCR 2.104, MCR 2.105

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21-004799-NI FILED IN MY OFFICE Cathy M. Garrett WAYNE COUNTY CLERK 4/15/2021 10:20 AM Laverne Chapman

APPLEBAUM & STONE, PLC

STATE OF MICHIGAN
IN THE CIRCUIT COUNTY FOR THE COUNTY OF WAYNE
CIVIL DIVISION

JOSEPH WILLIAM CANTY,

Plaintiff,

v.

MICHAEL CHESTER MASON,

Defendant.
_____/

Case No. 21- -NI
Hon.

Erik J. Stone (P55304)
Eric M. Noga (P83611)
APPLEBAUM & STONE, PLC
Attorney for Plaintiff
26777 Central Park Boulevard, Suite 300
Southfield, Michigan 48076
(248) 233-5050 Fax: (248) 359-8550
enoga@applebaumstone.com
estone@applebaumstone.com
_____/

There is no other pending or resolved civil action arising out of the occurrence alleged in the Complaint.

COMPLAINT

NOW COMES Plaintiff, JOSEPH WILLIAM CANTY, by and through their undersigned counsel, and for their Complaint against Defendant, MICHAEL CHESTER MASON, and their agents, servants, representatives, or employees, either real or ostensible, and hereby respectfully represents unto this Honorable Court as follows:

PARTIES, JURISDICTION AND VENUE

1. Plaintiff, JOSEPH WILLIAM CANTY ("Plaintiff"), is a resident of Detroit, Wayne County, Michigan.

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2. Upon information and belief, Defendant, MICHAEL CHESTER MASON ("Michael Mason"), is a resident of Canton Township, Wayne County, Michigan.

3. The amount of controversy regarding Plaintiff's claims exceeds Twenty-Five Thousand Dollars ($25,000.00) and it is properly placed within this Court.

4. This Court has the power to declare the rights and other legal relations of an interested party seeking a declaratory judgment in a case of actual controversy within its jurisdiction.

5. This Court has jurisdiction over Plaintiff's claims since this Court would have jurisdiction of an action on the same claim or claims in which Plaintiff sought relief other than a declaratory judgment.

6. A declaratory judgment may be necessary to guide Plaintiff's future conduct in order to preserve their legal rights and, therefore, a case of actual controversy exists between Plaintiff and Defendant.

7. Plaintiff has standing, having suffered an actual or imminent invasion of a legally protected interest, which may be redressed by this Court.

8. Plaintiff has suffered, and continues to suffer, dire and imminent financial hardship by Defendant's wrongful acts.

9. Plaintiff is without an adequate remedy at law under the Michigan No-Fault Act.

10. All conditions precedent to recovery have been performed and/or have occurred.

11. Declaratory and/or equitable relief is sought.

GENERAL ALLEGATIONS

12. Plaintiff re-alleges and reincorporates by reference each of the preceding paragraphs as though fully set forth herein.

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13. On or about February 15, 2021, at approximately 6:35 a.m., Plaintiff was the owner and operator of a 2015 Chevrolet Malibu LT sedan four door motor vehicle bearing Michigan registration 0095K8.

14. At that time, Michael Mason was the owner and operator of a 2018 Lincoln Navigator Reserve Four Door Wagon Sport Utility motor vehicle bearing Michigan registration EFJ6900.

15. At that time, Plaintiff's vehicle was travelling in the 2nd to right lane on northbound Telegraph Road, north of the intersection with Schoolcraft Road, located in Redford Township, Wayne County, Michigan.

16. At that time and place, Michael Mason was travelling northbound on Telegraph Road, north of the intersection with Schoolcraft Road, in the right curb lane.

17. There were icy conditions on the roadway at the time Plaintiff and Michael Mason were travelling.

18. Plaintiff was not speeding or driving recklessly or negligently.

19. As Plaintiff travelled northbound on Schoolcraft Road, their vehicle hit a patch of ice and began to skid.

20. Michael Mason was travelling at speed too fast for the roadway conditions and was not maintaining an assured clear distance from Plaintiff's vehicle.

21. Michael Mason hit the same ice patch that Plaintiff's vehicle did, having not paid attention to the roadway or Plaintiff's vehicle.

22. Michael Mason's vehicle skidded until it struck the rear-end of Plaintiff's vehicle with substantial force.

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23. Plaintiff was improperly held at fault for the motor vehicle accident and did not lose control of their vehicle as the police reported Plaintiff did.

24. Michael Mason was at fault for the motor vehicle accident.

25. As a direct and proximate result of the motor vehicle accident and the negligence of Michael Mason, Plaintiff sustained accidental bodily injuries and required reasonable and necessary medical treatment, services, or accommodations.

COUNT TWO – AUTOMOBILE NEGLIGENCE AGAINST DEFENDANT MICHAEL CHESTER MASON

26. Plaintiff re-alleges and reincorporates by reference each of the preceding paragraphs as though fully set forth herein.

27. On the date and time aforesaid, Defendant Michael Mason owed duties to Plaintiff to operate said motor vehicle with reasonable care and caution under the Motor Vehicle Code of the State of Michigan, Ordinances of Redford Township, and the common law in such cases made and provided.

28. Defendant Michael Mason breached said duties owed to Plaintiff in at least one or more of the following particulars, so far as it is presently known:

a. operated said vehicle without having it under constant control.
b. failed to make proper observation and failed to observe the presence of other users of the road and/or failed to take timely or proper action on such observation as was made in order to avoid a collision.
c. operated said vehicle in a careless and heedless manner, without due regard for the rights and safety of others, particularly Plaintiff herein, and operated said vehicle without due care and circumspection and at a speed and in a manner so as to endanger or be likely to endanger persons and property in violation of Michigan Statute.

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d. failed to maintain the horn, brakes and other equipment of the motor vehicle in good working order as required by Michigan Statute, and/or failed to sound the horn of the vehicle or to apply the brakes when, in sufficient time to take such action, they saw or should have seen that it was necessary to avoid a collision.

e. failed to use ordinary care in the operation of a motor vehicle.

f. operated said vehicle in a reckless manner.

g. operated said vehicle while intoxicated and/or under the influence of intoxicating liquor with driving ability impaired in violation of Michigan Statute.

h. operated said vehicle at a speed in excess of the legal rate of speed posted or otherwise provided.

i. overtook and struck the rear of said vehicle proceeding in the same direction as it was lawfully [slowing down, stopped, proceeding} on said highway.

j. operated said vehicle at a careless and imprudent rate of speed greater than was reasonable and proper, having no due regard to the traffic, surface and width of said highway and of other conditions then existing, and operated the aforesaid vehicle at a speed greater than would permit it to be brought to a stop within the assured clear distance ahead, and failed to bring the vehicle to a stop within the assured clear distance ahead, in violation of Michigan Statute.

k. failed, upon approaching an open intersection, to yield the right-of-way to another vehicle simultaneously entering an open intersection from the right, in violation of Michigan Statute.

l. failed, upon approaching an open intersection, to yield the right-of-way to another vehicle which had already entered the intersection from a different highway, in violation of Michigan Statute.

m. failed, upon approaching an intersection where there was a sign bearing the message "yield right of way," to stop or slow to a reasonable speed and to yield the right-of-way to all traffic on the intersecting street which was so close as to constitute an immediate hazard, in violation of Michigan Statute.

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n. failed to obey the red light of the traffic control signal facing the vehicle, and failed to come to a stop before entering the intersection, and failed to remain standing until green was shown alone, in violation of Michigan Statute.

o. operated said vehicle on the left half of the highway in violation of Michigan Statute.

p. failed to approach for a right turn as close as practical to the right-hand curb or edge of the roadway and/or failed to make a right turn from the lane as close as practical to the right-hand curb or edge of the roadway in violation of Michigan Statute.

q. failed to observe traffic signals and/or signs placed on said highway, and failed to obey said traffic signals and/or signs.

r. failed to give any signal by hand, arm, mechanical or electrical means to signal or warn others that Defendant was going to [move his/her vehicle from one lane to another on the highway][turn right/left], in violation of Michigan Statute.

s. failed to drive the vehicle as nearly as practicable entirely within a single lane.

t. operated said vehicle from one lane to another lane of traffic without first ascertaining that such movement could be made safely.

u. failed to remain at the scene of a personal injury accident, provide information and give or offer assistance to the injured, in violation of Michigan Statute.

v. intending to turn left, did not yield the right-of-way to Plaintiff's vehicle, which was closely approaching from the opposite direction, in violation of Michigan Statute.

w. before turning left, did not ascertain that such movement could be made safely and did not give a warning signal to other drivers, in violation of Michigan Statute.

x. failed, upon approaching an intersection where there was a sign bearing the message "stop," to stop and yield the right-of-way to all traffic on the intersecting street, which was so close as to constitute an immediate hazard.

y. failed to obey the flashing red light of the traffic control signal facing Defendant, and failed to come to a stop before entering the intersection, and failed to remain stopped until all traffic on the intersecting street, which was so close as to constitute an immediate hazard, had passed.

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z. driving said vehicle upon the highway or other places open to the general public without lighted lamps and illuminating devices as required under the conditions then and there existing in violation of Michigan Statute.

aa. in other ways that may become known through discovery.

29. Plaintiff sustained personal injuries as a direct and proximate result of the negligence of Defendant Michael Mason.

30. As a direct result and proximate result of the negligence of Defendant Michael Mason, and/or their agents, servants and/or employees, either real or ostensible, Plaintiff has:

a. sustained severe bodily injuries which were painful disabling and necessitated medical care.

b. suffered shock and emotional damage.

c. sustained possible aggravation of pre-existing conditions and/or reactivation of dormant conditions.

d. was and/or may continue to be unable to attend to his usual affairs and daily activities including, but not limited to, household chores, and personal needs.

e. was and/or may continue to be unable to render services as formerly including, but not limited to, household chores, and personal needs.

f. suffered from a loss of enjoyment of life and/or was and may continue to be hampered in the enjoyment of the normal pursuit of life.

g. sustained injuries that are or may be permanent to the degree that Plaintiff suffered a loss in ability to earn money as before and may have impaired earning capacity in the future.

h. may continue to have pain and suffering in the future and impairment and disabilities as well as permanency.

i. suffered mental anguish.

j. suffered fright.

k. suffered from embarrassment and humiliation.

l. sustained any and all hedonic damages, both past and future.

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m. sustained injuries that are or may be permanent and may continue to have said damages in the future.

n. suffered excess economic damages, wage loss, and replacement services.

o. sustained damages that are past and future; and/or

p. sustained any other damages which are applicable, and which are recoverable pursuant to statute, case law, and Michigan Court Rules.

31. As a direct and proximate result of the negligence of Defendant Michael Mason and the resulting injuries to Plaintiff, they have sustained a serious impairment of a bodily function as an objectively manifested impairment of an important body function that affects a person's ability to lead their normal life, and/or a permanent, serious disfigurement and/or a serious neurological defect (closed-head injury).

32. In addition to aforementioned injuries sustained by Plaintiff as a direct and proximate result of their motor vehicle accident, Plaintiff required reasonable and necessary medical treatment with health care providers.

33. Defendant Michael Mason is liable to reimburse Plaintiff's claims for unpaid medical expenses incurred as a proximate result of their negligent motor vehicle operation.

34. Plaintiff has incurred unpaid medical expenses arising from medical treatment provided for their accidental bodily injuries arising from the use, operation, maintenance, or ownership of a motor vehicle as a motor vehicle.

35. Defendant Michael Mason is obligated to reimburse Plaintiff for unpaid medical expenses arising from their negligent motor vehicle operation.

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36. Defendant Michael Mason has unreasonably and unlawfully refused and/or neglected to compensate Plaintiff for their bodily injuries sustained as a result of Defendant's negligent motor vehicle operation or reimburse them for unpaid medical expenses.

37. Demand for payment and proof in support of the same has been made, but Defendant Michael Mason has refused or neglected to reimburse Plaintiff for medical expenses incurred as a result of Defendant's negligent motor vehicle operation.

38. More than thirty (30) days has passed since supplying Defendant Michael Mason with the documentation.

39. Defendant Michael Mason has failed, refused, or neglected, to reimburse Plaintiff for their medical expenses incurred as a result of receiving reasonable and necessary medical treatment.

40. Defendant Michael Mason owes Plaintiff reimbursement for medical expenses incurred as a result of Defendant's negligent motor vehicle operation.

41. Defendant Michael Mason's violation of their duties and obligations owed to Plaintiff has proximately caused Plaintiff to sustain damages.

42. Plaintiff is eligible and entitled to the relief requested herein.

WHEREFORE, Plaintiff prays for damages in their favor, and against Defendant Michael Mason, whatever amount Plaintiff is found to be entitled, together with interest, costs, actual attorneys' fees, and any other such just and equitable relief deemed reasonable and necessary.

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Respectfully submitted,

APPLEBAUM & STONE, PLC

BY: */s/ Erik J. Stone*

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Dated: April 15, 2021

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Exhibit 6

Exhibit 6

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Canty v. Mason

Court of Appeals of Michigan

October 4, 2024, Decided

No. 365327

Reporter
2024 Mich. App. LEXIS 7934 *

JOSEPH CANTY, Plaintiff-Appellee, v MICHAEL CHESTER MASON, Defendant-Appellant.

Notice: THIS OPINION IS UNCORRECTED AND SUBJECT TO REVISION BEFORE FINAL PUBLICATION IN THE MICHIGAN COURT OF APPEALS REPORTS.

Prior History: [*1] Wayne Circuit Court. LC No. 21-004799-NI.

Canty v. Mason, 2023 Mich. App. LEXIS 3121 (Mich. Ct. App., May 3, 2023)

Core Terms

expenses, coverage, mitigate, damages, fee schedule, benefits, medical expenses, limitations, summary disposition, tort damages, trial court, no-fault, providers, statutory provisions, prefatory, elected, insurance benefits, statutory language, tort action, insurance policy, incorporates, principles, provisions

Case Summary

Overview

HOLDINGS: [1]-Any damages recoverable by plaintiff under *MCL 500.3135(3)(c)* must constitute "allowable expenses" under *MCL 500.3107* to *MCL 500.3110*; [2]-The fee schedules in *MCL 500.3157* applied to his action; [3]-Common-law, mitigation-of-damages principles were also applicable; [4]-Under either *MCL 500.3109(1)* or common-law mitigation principles, defendant was entitled to a setoff for medical expenses that would have been covered by Medicare, and [5]-If necessary, the trier of fact must resolve whether any incurred expenses for services rendered by providers who did not accept Medicare were reasonably incurred for purposes of mitigating damages. With these guideposts in place, defendant was free to renew his motion for summary disposition should he be so inclined.

Outcome
Affirmed in part and reversed and remanded in part for further proceedings.

LexisNexis® Headnotes

Insurance Law > ... > No Fault Coverage > Personal Injury Protection > Medical Benefits

HN1 **Personal Injury Protection, Medical Benefits**

MCL 500.3157 contains fee schedules that limit a medical provider's reimbursement amount.

Civil Procedure > Appeals > Standards of Review > De Novo Review

Governments > Legislation > Interpretation

Civil Procedure > ... > Summary Judgment > Appellate Review > Standards of Review

HN2 **Standards of Review, De Novo Review**

The court reviews de novo a trial court's ruling on a motion for summary disposition. This court also reviews de novo issues of statutory construction. De novo

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review means that the court reviews the issues independently, with no required deference to the trial court.

Civil Procedure > Judgments > Summary Judgment > Burdens of Proof

Civil Procedure > Judgments > Summary Judgment > Entitlement as Matter of Law

Civil Procedure > ... > Summary Judgment > Entitlement as Matter of Law > Genuine Disputes

Civil Procedure > ... > Summary Judgment > Burdens of Proof > Nonmovant Persuasion & Proof

Civil Procedure > Judgments > Summary Judgment > Partial Summary Judgment

HN3 **Summary Judgment, Burdens of Proof**

In Anderson, this Court recited the principles that govern the analysis of a motion brought pursuant to MCR 2.116(C)(10): MCR 2.116(C)(10) provides that summary disposition is appropriate when, except as to the amount of damages, there is no genuine issue as to any material fact, and the moving party is entitled to judgment or partial judgment as a matter of law. A motion brought pursuant to MCR 2.116(C)(10) tests the factual support for a party's action. Affidavits, depositions, admissions, or other documentary evidence in support of the grounds asserted in the motion are required. when judgment is sought based on subrule (C)(10), MCR 2.116(G)(3)(b), and such evidence, along with the pleadings, must be considered by the court when ruling on the (C)(10) motion, MCR 2.116(G)(5). When a motion under subrule (C)(10) is made and supported., an adverse party may not rest upon the mere allegations or denials of his or her pleading, but must, by affidavits or as otherwise provided in this rule, set forth specific facts showing that there is a genuine issue for trial. MCR 2.116(G)(4).

Civil Procedure > ... > Summary Judgment > Supporting Materials > Affidavits

Civil Procedure > Judgments > Summary Judgment > Entitlement as Matter of Law

Civil Procedure > ... > Summary Judgment > Entitlement as Matter of Law > Genuine Disputes

Civil Procedure > ... > Summary Judgment > Appellate Review > Standards of Review

Civil Procedure > ... > Summary Judgment > Entitlement as Matter of Law > Appropriateness

HN4 **Supporting Materials, Affidavits**

A trial court may grant a motion for summary disposition under MCR 2.116(C)(10) if the pleadings, affidavits, and other documentary evidence, when viewed in a light most favorable to the nonmovant, show that there is no genuine issue with respect to any material fact. 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 might differ. The trial court is not permitted to assess credibility, weigh the evidence, or resolve factual disputes, and if material evidence conflicts, it is not appropriate to grant a motion for summary disposition under MCR 2.116(C)(10). Like the trial court's inquiry, when an appellate court reviews a motion for summary disposition, it makes all legitimate inferences in favor of the nonmoving party. Speculation is insufficient to create an issue of fact. A court may only consider substantively admissible evidence actually proffered by the parties when ruling on the motion.

Governments > Legislation > Interpretation

HN5 **Legislation, Interpretation**

With respect to the rules of statutory interpretation, this Court in observed: This Court's role in construing statutory language is to discern and ascertain the intent of the Legislature, which may reasonably be inferred from the words in the statute. The court must focus its analysis on the express language of the statute because it offers the most reliable evidence of legislative intent. When statutory language is clear and unambiguous, the court must apply the statute as written. A court is not permitted to read anything into an unambiguous statute that is not within the manifest intent of the Legislature. Furthermore, this Court may not rewrite the plain statutory language or substitute its own policy decisions

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for those decisions already made by the Legislature. Judicial construction of a statute is only permitted when statutory language is ambiguous. A statute is ambiguous when an irreconcilable conflict exists between statutory provisions or when a statute is equally susceptible to more than one meaning. When faced with two alternative reasonable interpretations of a word in a statute, we should give effect to the interpretation that more faithfully advances the legislative purpose behind the statute.

Insurance Law > ... > No Fault Coverage > Personal Injury Protection > Medical Benefits

HN6 **Personal Injury Protection, Medical Benefits**

With respect to MCL 500.3135(3)(c), an injured person with standard personal protection insurance (PIP) coverage under a no-fault insurance policy and an injured person who elected not to maintain such coverage and instead had a qualified-health-coverage (QHC) plan can both recover damages in a traditional tort action for allowable expenses as defined in MCL 500.3107 to MCL 500.3110. A distinction between these two individuals is that the person carrying PIP coverage under a no-fault policy is limited to recovering only amounts in "excess of" certain statutory limitations on the payment of PIP benefits, but recovery of allowable expenses by a person who elected not to maintain PIP coverage is "without limit." MCL 500.3135(3)(c).

Insurance Law > ... > Coverage > No Fault Coverage > Personal Injury Protection

HN7 **No Fault Coverage, Personal Injury Protection**

The "without limit" language of MCL 500.3135(3)(c) cannot be construed to mean that there are no parameters whatsoever on the amount of recovery. Rather, the "without limit" phrase, when read in context, simply means that the recovery of allowable expenses does not solely encompass amounts in excess of the statutory limitations, as is the case with respect to a party pursuing a tort action after no more personal protection insurance (PIP) benefits are available under a no-fault policy because the statutory limitations on coverage were met or exhausted.

Insurance Law > ... > Coverage > No Fault Coverage > Personal Injury Protection

HN8 **No Fault Coverage, Personal Injury Protection**

Under MCL 500.3107(1)(a), allowable expenses are defined as reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation.

Insurance Law > ... > Coverage > No Fault Coverage > Personal Injury Protection

HN9 **No Fault Coverage, Personal Injury Protection**

The introductory or prefatory language of MCL 500.3107(1) states that the provisions found within the statute, which includes the definition of allowable expenses, are subject to the exceptions and limitations in this chapter. And that chapter is Chapter 31 of the Insurance Code of 1956, MCL 500.100 et seq. Chapter 31 encompasses MCL 500.3157; therefore, MCL 500.3135(3)(c), by incorporating MCL 500.3107, necessarily also incorporates the fee schedules in MCL 500.3157.

Governments > Legislation > Interpretation

HN10 **Legislation, Interpretation**

The Legislature is presumed to be aware of and to have considered existing statutes when enacting new laws.

Governments > Legislation > Interpretation

HN11 **Legislation, Interpretation**

In construing statutory language, every word should be given meaning, and the court must avoid an interpretation that would render any part of a statute surplusage or nugatory.

Insurance Law > ... > Coverage > No Fault Coverage > Personal Injury Protection

HN12 **No Fault Coverage, Personal Injury Protection**

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The court recognizes that MCL 500.3107(1) limits the recovery of PIP benefits on the basis of any pertinent provisions in Chapter 31, but the prefatory language also necessarily places a limit on the calculation of recoverable allowable expenses. The recovery of personal protection insurance (PIP) benefits encompasses the recovery of compensation to pay for allowable expenses; the two are inextricably intertwined. If an expense is not an allowable expense, one cannot recover PIP benefits in relation to that expense. The court does not believe that there is a relevant distinction between PIP benefits and allowable expenses for purposes of employing Chapter 31 in relation to calculating damages under MCL 500.3135(3)(c).

Insurance Law > ... > Coverage > No Fault Coverage > Personal Injury Protection

Torts > Remedies > Damages > Reductions of Damages

HN13 **No Fault Coverage, Personal Injury Protection**

Mitigation of damages is a legal doctrine that seeks to minimize the economic harm arising from wrongdoing. It is incumbent on a person who has been harmed by the commission of a tort to use such means that are reasonable under the circumstances to minimize or mitigate the amount of damages. A person wronged by a tortfeasor is not entitled to recover for any item of damage that could have been avoided. This Court had held that because the no-fault act does not specifically abrogate the common-law principle that a plaintiff is obligated in a tort action to mitigate his or her damages, the defense remains viable. Moreover, and importantly, MCL 500.3135(3)(c) carves out an exception to the abolishment of tort liability arising from the ownership, maintenance, or use of a motor vehicle.

Insurance Law > ... > Coverage > No Fault Coverage > Personal Injury Protection

HN14 **No Fault Coverage, Personal Injury Protection**

MCL 500.3135(3)(c) incorporates MCL 500.3109(1), which provides that benefits provided or required to be provided under the laws of any state or the federal government shall be subtracted from benefits otherwise payable for the injury under this chapter. In general, Medicare healthcare benefits constitute benefits provided under the laws of the federal government. See 42 U.S.C.S. § 1395 et seq.

Counsel: For JOSEPH CANTY, Plaintiff - Appellee: ERIK J. STONE.

For MICHAEL CHESTER MASON, Defendant - Appellant: ERIN J. RODENHOUSE; MICHAEL J. COOK.

Judges: Before: MARKEY, P.J., and SWARTZLE and MARIANI, JJ. MARIANI, J. (concurring in part and dissenting in part).

Opinion

PER CURIAM.

In 2019, the Michigan Legislature made sweeping changes to the no-fault act, MCL 500.3101 et seq., through the enactment of 2019 PA 21 and 2019 PA 22. This appeal requires us to construe the interplay between several statutory provisions that were subject to amendment. Plaintiff, Joseph Canty, seeks to recover medical expenses incurred to treat injuries allegedly sustained in a motor-vehicle accident involving defendant, Michael Chester Mason. In pursuing the action, Canty is relying on the tort exception found in MCL 500.3135(3)(c), allowing recovery of "allowable expenses" by persons who elect not to maintain personal protection insurance (PIP) coverage under their automobile insurance policies. Canty was permitted to make that election because he has Medicare coverage; however, it was not used to pay for any of his accident-related medical expenses. Mason moved for partial summary disposition under MCR 2.116(C)(10), arguing that Canty's medical **[*2]** expenses had to be reasonable under MCL 500.3107(1)(a), that Canty had a duty to mitigate his damages by employing his Medicare coverage to pay the medical bills, and that the no-fault fee schedules in MCL 500.3157 apply to a suit brought under MCL 500.3135(3)(c). The trial court granted in part and denied in part Mason's motion for summary disposition. The court concluded that Canty's allowable medical expenses had to be reasonable, that he had no duty to mitigate damages by using his Medicare coverage, and that the fee schedules were inapplicable. Mason appeals by leave granted. We affirm in part and reverse in part.

I. BACKGROUND

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This case arose out of an automobile accident that occurred in February 2021. Canty filed a complaint against Mason, alleging that Mason negligently caused the accident by, in part, traveling too fast for conditions and failing to maintain proper distance, which resulted in Mason's vehicle skidding and rear-ending Canty's car. Canty alleged that he sustained physical injuries in the accident and, as a result, incurred medical expenses for treatment rendered by healthcare providers. Canty asserted that he had a statutory right to recover those expenses from Mason under MCL 500.3135(3)(c), which provides, in pertinent part: **[*3]**

> (3) Notwithstanding any other provision of law, tort liability arising from the ownership, maintenance, or use within this state of a motor vehicle with respect to which the security required by section 3101(1) was in effect is abolished except as to:
> * * *
>
> (c) Damages for allowable expenses, work loss, and survivor's loss *as defined in* sections 3107 to 3110, including all future allowable expenses and work loss, in excess of any applicable limit under section 3107c or the daily, monthly, and 3-year limitations contained in those sections, *or without limit for allowable expenses if an election to not maintain that coverage was made under* section 3107d or if an exclusion under section 3109a(2) applies. . . . [Emphasis added.[1]]

Canty was covered by an automobile insurance policy; however, he had "elect[ed] to not maintain coverage for [PIP] benefits payable under section 3107(1)(a)." MCL 500.3107d(1).[2] He was able to do so because he otherwise had "qualified health coverage," MCL 500.3107d(1), in the form of "parts A and B of the federal Medicare program," MCL 500.3107d(7)(b)(ii). We note that "[b]enefits provided or required to be provided under the laws of any state or the federal government shall be subtracted from the [PIP] benefits otherwise payable for the injury under this chapter." MCL 500.3109(1). ***HN1*** Additionally, relevant to this case and appeal, **[*4]** MCL 500.3157 contains fee schedules that limit a medical provider's reimbursement amount.

Subsequently, Mason moved for partial summary disposition under MCR 2.116(C)(10). He argued that the "without limit" nomenclature used in MCL 500.3135(3)(c) does not mean that there are no limits on Canty's recovery of allowable expenses.[3] Rather, the medical charges had to be reasonable and incurred for reasonably necessary services so as to be in compliance with the definition of "allowable expenses" in MCL 500.3107(1)(a), which provision is incorporated by express reference in MCL 500.3135(3)(c). Further, Mason contended that Canty and his healthcare providers had a duty to mitigate damages by utilizing Canty's Medicare coverage, which was not done. Mason maintained that Canty treated with many providers who accepted Medicare, yet Medicare was not billed for the services, nor were Medicare rates charged for the care and treatment. Mason asked the trial court to dismiss all claims for which Canty did not attempt to bill Medicare. He additionally argued that any recovery of allowable expenses is subject to the fee schedules in MCL 500.3157. In response, on the issue of mitigation, Canty argued that MCL 500.3135(3)(c) did not restrict his choice of medical providers, nor did it require him to submit claims **[*5]** to Medicare for purposes of his cause of action. Moreover, according to Canty, MCL 500.3135(3)(c) allows recovery "without limit" and does not reference or otherwise incorporate MCL 500.3157, thereby excluding application of the fee schedules.

Eventually, at a hearing to settle an order regarding a ruling made by the trial court from the bench on Mason's motion for summary disposition, the court entertained further argument on the motion and partially altered its prior ruling, which we need not explore. The trial court now ruled that Canty had no duty to mitigate damages or expenses "because Medicare and Medicaid are exempt from the no fault statute." The court further determined that Canty had to show that the charges by his medical providers were reasonable and necessary under MCL 500.3107(1)(a)'s definition of "allowable

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[1] We note that Canty also alleged a claim for noneconomic damages, asserting that he suffered a serious impairment of body function as a result of the accident. See MCL 500.3135(1) and (5).

[2] MCL 500.3107(1)(a) provides that PIP benefits are payable for, in part, "[a]llowable expenses consisting of reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation."

[3] Mason posited that the phrase "without limit" in MCL 500.3135(3)(c) simply references the fact that there is no PIP coverage limit to exhaust before seeking damages from a tortfeasor, and not that an injured party is entitled to unlimited expenses from the tortfeasor.

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expenses." Thus, the charges and expenses were not without some limit. But the trial court also found that the fee schedules in MCL 500.3157 do not apply to Canty's action brought under MCL 500.3135(3)(c). The court entered an order granting in part and denying in part Mason's motion for summary disposition. Mason appeals by leave granted. *Canty v Mason*, unpublished order of the Court of Appeals, entered August 28, 2023 (Docket No. 365327, 2023 Mich. App. LEXIS 6164). **[*6]**

II. ANALYSIS

A. STANDARD OF REVIEW

HN2 We review de novo a trial court's ruling on a motion for summary disposition. Champine v Dep't of Transp, 509 Mich 447, 452; 983 NW2d 741 (2022). This Court also reviews de novo issues of statutory construction. Estes v Titus, 481 Mich 573, 578-579; 751 NW2d 493 (2008). De novo review "means that we review the issues independently, with no required deference to the trial court." People v Beck, 504 Mich 605, 618; 939 NW2d 213 (2019).

B. SUMMARY DISPOSITION PRINCIPLES — MCR 2.116(C)(10)

HN3 In Anderson v Transdev Servs, Inc, 341 Mich App 501, 506-507; 991 NW2d 230 (2022), this Court recited the principles that govern the analysis of a motion brought pursuant to MCR 2.116(C)(10):

> MCR 2.116(C)(10) provides that summary disposition is appropriate when, "[e]xcept as to the amount of damages, there is no genuine issue as to any material fact, and the moving party is entitled to judgment or partial judgment as a matter of law." A motion brought pursuant to MCR 2.116(C)(10) tests the factual support for a party's action. "Affidavits, depositions, admissions, or other documentary evidence in support of the grounds asserted in the motion are required . . . when judgment is sought based on subrule (C)(10)," MCR 2.116(G)(3)(b), and such evidence, along with the pleadings, must be considered by the court when ruling on the (C)(10) motion, MCR 2.116(G)(5). "When a motion under subrule (C)(10) is made and supported . . ., an adverse party may not rest upon the mere allegations or denials of his or her pleading, but must, by affidavits or as otherwise **[*7]** provided in this rule, set forth specific facts showing that there is a genuine issue for trial." MCR 2.116(G)(4).
>
> **HN4** A trial court may grant a motion for summary disposition under MCR 2.116(C)(10) if the pleadings, affidavits, and other documentary evidence, when viewed in a light most favorable to the nonmovant, show that there is no genuine issue with respect to any material fact. 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 might differ. The trial court is not permitted to assess credibility, weigh the evidence, or resolve factual disputes, and if material evidence conflicts, it is not appropriate to grant a motion for summary disposition under MCR 2.116(C)(10). Like the trial court's inquiry, when an appellate court reviews a motion for summary disposition, it makes all legitimate inferences in favor of the nonmoving party. Speculation is insufficient to create an issue of fact. A court may only consider substantively admissible evidence actually proffered by the parties when ruling on the motion. [Quotation marks, citations, and brackets omitted.]

C. RULES OF STATUTORY CONSTRUCTION

HN5 With respect to the rules **[*8]** of statutory interpretation, this Court in Slis v Michigan, 332 Mich App 312, 335-336; 956 NW2d 569 (2020), observed:

> This Court's role in construing statutory language is to discern and ascertain the intent of the Legislature, which may reasonably be inferred from the words in the statute. We must focus our analysis on the express language of the statute because it offers the most reliable evidence of legislative intent. When statutory language is clear and unambiguous, we must apply the statute as written. A court is not permitted to read anything into an unambiguous statute that is not within the manifest intent of the Legislature. Furthermore, this Court may not rewrite the plain statutory language or substitute its own policy decisions for those decisions already made by the Legislature.
>
> Judicial construction of a statute is only permitted when statutory language is ambiguous. A statute is ambiguous when an irreconcilable conflict exists between statutory provisions or when a statute is equally susceptible to more than one meaning. When faced with two alternative reasonable interpretations of a word in a statute, we should give effect to the interpretation that more faithfully advances the legislative purpose behind the statute. [Quotation **[*9]** marks and citations

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omitted.]

D. DISCUSSION AND RESOLUTION

Abiding by the plain and unambiguous language of the various statutory provisions implicated in this case and the uncontroverted caselaw on mitigation of damages, we conclude that resolution of this appeal is fairly straightforward. ***HN6*** With respect to MCL 500.3135(3)(c), an injured person with standard PIP coverage under a no-fault insurance policy *and* an injured person who elected not to maintain such coverage and instead had a qualified-health-coverage (QHC) plan can both recover damages in a traditional tort action for "allowable expenses" as defined in MCL 500.3107 to MCL 500.3110. A distinction between these two individuals is that the person carrying PIP coverage under a no-fault policy is limited to recovering only amounts in "excess of" certain statutory limitations on the payment of PIP benefits, but recovery of allowable expenses by a person who elected not to maintain PIP coverage is "without limit." MCL 500.3135(3)(c). ***HN7*** We conclude that the "without limit" language of MCL 500.3135(3)(c) cannot be construed to mean that there are no parameters whatsoever on the amount of recovery. Rather, the "without limit" phrase, when read in context, simply means that the recovery of allowable expenses does **[*10]** not solely encompass amounts in excess of the statutory limitations, as is the case with respect to a party pursuing a tort action after no more PIP benefits are available under a no-fault policy because the statutory limitations on coverage were met or exhausted. In other words, a person in Canty's shoes who elected not to have PIP coverage through an auto insurance policy can recover *dollar one* in allowable expenses from the tortfeasor.[4] The "without limit" terminology in MCL 500.3135(3)(c) cannot be viewed in a vacuum, and the grammatical structure of Subsection (3)(c) supports our interpretation of the provision.

Furthermore, under MCL 500.3135(3)(c), the "allowable expenses" available to Canty, if successful in his tort action, are those defined in MCL 500.3107 to MCL 500.3110. ***HN8*** And, as noted earlier, under MCL 500.3107(1)(a), "allowable expenses" are defined as "reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation."[5] We therefore conclude that the trial court properly ruled that MCL 500.3107(1)(a) limits any recovery by Canty under MCL 500.3135(3)(c) to those expenses that were reasonable and that were for reasonably necessary services.[6]

The next issue posed in this case is whether the fee schedules in MCL 500.3157 apply to a tort **[*11]** action under MCL 500.3135(3)(c). MCL 500.3135(3)(c), while referencing and incorporating MCL 500.3107 to MCL 500.3110, makes no express mention of MCL 500.3157. ***HN9*** But the introductory or prefatory language of MCL 500.3107(1) states that the provisions found within the statute, which includes the definition of "allowable expenses," are "[s]ubject to the exceptions and limitations in this chapter[.]" And that chapter is Chapter 31 of the Insurance Code of 1956, MCL 500.100 et seq. Chapter 31 encompasses MCL 500.3157; therefore, MCL 500.3135(3)(c), by incorporating MCL 500.3107, necessarily also incorporates the fee schedules in MCL 500.3157, making them applicable to this case. Accordingly, the trial court erred by ruling that the fee schedules cannot be applied to limit Canty's recovery.

Our concurring-dissenting colleague disagrees with our analysis and resolution of the issue concerning the fee schedules in MCL 500.3157. He argues that the Legislature did not expressly identify MCL 500.3157 in the language of the tort-damages provision, MCL 500.3135(3)(c); therefore, we should not construe MCL 500.3135(3)(c) as if the Legislature had done so. We respectfully disagree. ***HN10*** The Legislature is presumed to be aware of and to have considered existing statutes when enacting new laws. See Milne v Robinson, 513 Mich 1, 18; 6 NW3d 40 (2024). We must thus assume that when the Legislature crafted MCL 500.3135(3)(c), which expressly references MCL 500.3107, it knew quite well that MCL 500.3107 placed restrictions on the amount of recoverable allowable expenses **[*12]** through limitations and exceptions found in Chapter 31, including the fee schedules.

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[4] This proposition is subject to our holding regarding the duty to mitigate damages.

[5] Our Supreme Court has "recognized that the plain language of this provision imposes four requirements that a . . . claimant must prove before recovering benefits for allowable expenses: (1) the expense must be for an injured person's care, recovery, or rehabilitation, (2) the expense must be reasonably necessary, (3) the expense must be incurred, and (4) the charge must be reasonable." Douglas v Allstate Ins Co, 492 Mich 241, 259; 821 NW2d 472 (2012).

[6] There are additional qualifiers, criteria, and exceptions in MCL 500.3107 to MCL 500.3110 for purposes of identifying allowable expenses that are recoverable under MCL 500.3135(3)(c).

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Effectively, the Legislature did indeed identify MCL 500.3157 as a statutory provision that is to be considered for purposes of setting tort damages under MCL 500.3135(3)(c).

The concurrence/dissent asserts that our interpretation disregards the legislatively-chosen range specifically targeted in MCL 500.3135(3)(c), i.e., MCL 500.3107 to MCL 500.3110, improperly expanding the range to incorporate all of Chapter 31, which the Legislature could have stated outright in MCL 500.3135(3)(c) had that been its intent. We again disagree. First, for the reasons discussed above, we conclude that if MCL 500.3157 is not taken into consideration, the plain and unambiguous language of MCL 500.3107(1) referencing Chapter 31, as incorporated by MCL 500.3135(3)(c), is not being honored and is, instead, rendered surplusage and nugatory. See Empire Iron Mining Partnership v Tilden Twp, 337 Mich App 579, 586; 977 NW2d 128 (2021) **HN11** (in construing statutory language, every word should be given meaning, and we must avoid an interpretation that would render any part of a statute surplusage or nugatory). Moreover, folding Chapter 31 into the definition of "allowable expenses" does not implicate each and every provision in Chapter 31, but only those few that would restrict or limit the amount of allowable expenses, such as MCL 500.3157.

The concurrence/dissent **[*13]** also contends that the prefatory language of MCL 500.3107(1) that references Chapter 31 pertains to the availability of insurance or PIP benefits, while MCL 500.3135(3)(c) concerns the availability of tort damages. Therefore, the prefatory language is inapplicable in relation to MCL 500.3135(3)(c). But the same can be said with respect to the definition of "allowable expenses" in MCL 500.3107(1)(a): it regards the availability of insurance or PIP benefits, yet there is no dispute, and the concurrence/dissent agrees, that it also sets the parameters of tort damages available under MCL 500.3135(3)(c).[7]

The final question concerns mitigation of damages, which requires us to also consider the impact of the setoff language in MCL 500.3109(1). **HN13** "Mitigation of damages is a legal doctrine that seeks to minimize the economic harm arising from wrongdoing." Morris v Clawson Tank Co, 459 Mich 256, 263; 587 NW2d 253 (1998). It is incumbent on a person who has been harmed by the commission of a tort to use such means that are reasonable under the circumstances to minimize or mitigate the amount of damages. *Id.* A person wronged by a tortfeasor is not entitled to recover for any item of damage that could have been avoided. Id. at 263-264.

This Court had held that because the no-fault act does not specifically abrogate the common-law principle that **[*14]** a plaintiff is obligated in a tort action to mitigate his or her damages, the defense remains viable. Lee v Detroit Med Ctr, 285 Mich App 51, 67; 775 NW2d 326 (2009); Bak v Citizens Ins Co of America, 199 Mich App 730, 737-738; 503 NW2d 94 (1993).[8] Moreover, and importantly, MCL 500.3135(3)(c) carves out an exception to the abolishment of tort liability arising from the ownership, maintenance, or use of a motor vehicle. Consequently, Canty's lawsuit *is a true tort action*. Thus, the doctrine of mitigation of damages is applicable.

We reject the trial court's finding or suggestion that Medicare benefits cannot be taken into consideration on the issue of mitigation of damages because such benefits were not available to cover Canty's medical expenses given that the case arises out of the no-fault act and Medicare is exempt from the act. In John Hancock Prop & Cas Ins Cos v Blue Cross & Blue Shield of Mich, 437 Mich 368, 373; 471 NW2d 541 (1991), the Michigan Supreme Court, citing 42 USC 1395y(b)(2)(A) (Medicare secondary payer), which is part of the Omnibus Reconciliation Act of 1980, stated:

> A federal statute provides that Medicare benefits are not payable where the medical expense is covered under an automobile insurance policy or plan or under no-fault insurance. The federal statute thus allocates to automobile insurers the primary burden of paying the medical expense,

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[7] **HN12** We recognize that MCL 500.3107(1) limits the recovery of *PIP benefits* on the basis of any pertinent provisions in Chapter 31, but the prefatory language also necessarily places a limit on the calculation of recoverable *allowable expenses*. The recovery of PIP benefits encompasses the recovery of compensation to pay for allowable expenses; the two are inextricably intertwined. If an expense is not an allowable expense, one cannot recover PIP benefits in relation to that expense. We do not believe that there is a relevant distinction between PIP benefits and allowable expenses for purposes of employing Chapter 31 in relation to calculating damages under MCL 500.3135(3)(c).

[8] The Supreme Court in Marquis v Hartford Accident & Indemnity, 444 Mich 638, 651; 513 NW2d 799 (1994), voiced its approval of the Bak decision on the mitigation-of-damages issue in the context of the no-fault act.

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> arising out of automobile accidents, of persons covered by the Medicare program.

In this case, Canty did not have PIP coverage for allowable **[*15]** medical expenses through an automobile insurance policy or no-fault insurance plan because he had healthcare coverage under parts A and B of Medicare, as expressly permitted by the Legislature under MCL 500.3107d(1) and (7)(b)(ii). The trial court's ruling circumvents the legislative goal of allowing motorists to opt out of PIP coverage where they have QHC through Medicare, leaving the motorist without any medical coverage for injuries sustained in a motor-vehicle accident. Accordingly, federal law did not prohibit Canty from receiving Medicare benefits for medical expenses incurred as a result of the accident.

HN14 Furthermore, MCL 500.3135(3)(c) incorporates MCL 500.3109(1), which, as quoted earlier, provides that "[b]enefits provided *or required to be provided* under the laws of any state *or the federal government* shall be subtracted from . . . benefits otherwise payable for the injury under this chapter." (Emphasis added.) In general, Medicare healthcare benefits constitute benefits provided under the laws of the federal government. See 42 USC 1395 et seq. And Canty has Medicare coverage. Apparently, no Medicare benefits have been provided to or on behalf of Canty in relation to medical expenses incurred as a result of the accident. Therefore, the question becomes **[*16]** whether Medicare benefits would have been *required to be provided* to him or his providers had any of the pertinent medical bills been submitted to Medicare for payment. And to that extent, Mason is entitled to a setoff under MCL 500.3109(1) for purposes of any damage calculation on a finding of liability. We would also reach that same conclusion solely under common-law mitigation principles because the failure to seek payment from Medicare would not have been reasonable as a matter of law if the medical provider accepted Medicare.[9]

III. CONCLUSION

We conclude (1) that any damages recoverable by Canty under MCL 500.3135(3)(c) must constitute "allowable expenses" under MCL 500.3107 to MCL 500.3110, (2) that the fee schedules in MCL 500.3157 apply to Canty's action, (3) that common-law, mitigation-of-damages principles are also applicable, (4) that under either MCL 500.3109(1) or common-law mitigation principles, Mason is entitled to a setoff for medical expenses that would have been covered by Medicare, and (5) that, if necessary, the trier of fact must resolve whether any incurred expenses for services rendered by providers who did not accept Medicare were reasonably incurred for purposes of mitigating damages. With these guideposts in place, Mason is free to renew his motion **[*17]** for summary disposition should he be so inclined.

We affirm in part and reverse and remand in part for further proceedings consistent with this opinion. We do not retain jurisdiction. We decline to tax costs under MCR 7.219.

/s/ Jane E. Markey

/s/ Brock A. Swartzle

Concur by: Philip P. Mariani (In Part)

Dissent by: Philip P. Mariani (In Part)

Dissent

MARIANI, J. (*concurring in part and dissenting in part*).

I agree with the majority's conclusions that (1) per MCL 500.3135(3)(c)'s incorporation of the "allowable expenses" definition in MCL 500.3107(1)(a), Canty's tort-damages claim for medical expenses comprises "reasonable charges incurred for reasonably necessary products, services and accommodations"; and (2) the trial court erred by concluding that no duty to mitigate applies his claim. I respectfully disagree, however, with the majority's conclusion that the fee schedule set forth in MCL 500.3157 applies to a tort-damages claim under MCL 500.3135(3)(c).

As the majority aptly explains, Canty's tort-damages claim is proceeding under MCL 500.3135(3)(c), which preserves from abolition by the no-fault act third-party tort liability for certain damages—namely, as relevant here, "[d]amages for allowable expenses . . . as defined in sections 3107 to 3110[.]" The Legislature thus expressly identified a discrete range of statutory

[9] We wish to make clear that if Canty received pertinent medical services and treatment from a provider who did not accept Medicare, those expenses might still be recoverable. In that situation, the issue to be resolved by the trier of fact in relation to mitigation would concern whether it was reasonable under all of the surrounding circumstances for Canty to see a provider who did not accept Medicare.

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provisions **[*18]** to define the scope of these available tort damages; MCL 500.3157 is not within it, nor does that provision itself say otherwise. Of course, the Legislature could have expressly identified MCL 500.3157 to help define the scope of these damages, as it did with the other handful of statutory sections it designated for the task. The Legislature chose not to, however, and I do not believe MCL 500.3135(3)(c) should be read as if it had.

The majority grounds its conclusion otherwise on MCL 500.3107, which is one of the provisions expressly identified in MCL 500.3135(3)(c). Section 3107 contains a subsection specifically defining the term "allowable expenses," and I certainly agree that, when the Legislature said "[d]amages for allowable expenses . . . as defined in section[] 3107," it meant to adopt that specific definition to help delineate the scope of tort damages preserved via MCL 500.3135(3)(c). But I do not see in the statutory language an intent to apply MCL 500.3157 to those tort damages as well. The majority finds such intent in Section 3107's general prefatory language, which states, "Subject to the exceptions and limitations in this chapter, and subject to chapter 31A, personal protection insurance benefits are payable for the following"—with the section then proceeding to provide specific definitions of various things, **[*19]** including allowable expenses. "[T]his chapter" is Chapter 31 of the Insurance Code, which spans all of MCL 500.3101 through MCL 500.3179. The majority reasons that, because MCL 500.3157 is among "the exceptions and limitations in" Chapter 31, it is a part of what MCL 500.3135(3)(c) incorporated when referring to Section 3107—a conclusion that presumably would hold for any other potentially relevant "exceptions and limitations" in Chapter 31 as well.

I struggle to square this reading with Section 3135(3)(c)'s plain language. As noted, the Legislature, in Section 3135(3)(c), expressly chose to designate a narrow and specific range of statutory provisions within Chapter 31—Sections 3107 to 3110—to define the scope of available tort damages. The majority's interpretation of Section 3107, however, effectively reads that designated range out of the statute. Rather than being defined by the specific sections of Chapter 31 that the Legislature expressly identified, tort damages under MCL 500.3135(3)(c) are instead defined—and limited—by every potentially applicable provision in Chapter 31. That reading strikes me as at odds with MCL 500.3135(3)(c)'s plain language, and leaves the Legislature's specifically chosen range of provisions without due meaning or effect.

Nor, in my view, do MCL 500.3107's own plain terms require that reading. Instead, I read "[s]ubject to the exceptions **[*20]** and limitations in this chapter" not to define allowable expenses per se—and thus be a part of what MCL 500.3135(3)(c) means when it speaks of those expenses "as defined by section[] 3107"—but instead to attach to and modify the language that immediately follows it: "personal protection insurance benefits are payable for the following." In other words, Section 3107's prefatory language, by its own terms, helps define what insurance benefits are payable, making clear that the payability of those benefits is subject to the exceptions and limitations of the rest of Chapter 31.[1] MCL 500.3135(3)(c), however, pertains not to the payability of insurance benefits, but to liability for tort damages—a distinction that is at the core of MCL 500.3135(3)(c), and that places that subsection to the side of what MCL 500.3107's prefatory language is addressing. In my view, MCL 500.3107's prefatory language certainly has meaning—just, by its plain terms, for something distinct (the payability of insurance benefits) from what MCL 500.3135(3)(c) specifically addresses and defines (available tort damages).

Correspondingly, in MCL 500.3135(3)(c), the Legislature did not simply say that the tort damages available for allowable expenses are "as defined in this chapter," or are the same as what are payable for insurance benefits under Chapter 31, **[*21]** or something to that effect. Instead, it was much more targeted and precise, carving out from Chapter 31 a discrete and expressly circumscribed range of provisions to mark the bounds of allowable expenses that can be pursued as tort damages. MCL 500.3157 is not among those legislatively chosen provisions, and I would not read it into them.[2]

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[1] And this makes good sense, given that the payability of benefits is what Chapter 31 largely deals with—including MCL 500.3157, which speaks in terms of payment for treatment of injuries "covered by personal protection insurance."

[2] Furthermore, that the scope of available tort damages may, as a result, be different than the scope of payable insurance benefits does not strike me as interpretively odd or concerning, given the fundamental difference in character between tort damages and insurance benefits (and with it, the different policy judgments that the Legislature may have brought to bear on them—that, for instance, it could strike the right cost-savings balance by imposing a fee schedule on the benefits that can be recovered via first-party claims but not on the tort damages that can be pursued via third-party lawsuits).

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In sum, I would conclude that *MCL 500.3135(3)(c)* does not incorporate *MCL 500.3157*'s fee schedule into its defined scope of available tort damages, as that reading, in my view, best reflects and effectuates the plain terms of the relevant statutory provisions. Accordingly, I respectfully dissent from the majority in that regard.

/s/ Philip P. Mariani

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Exhibit 7

Exhibit 7

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Medicare Secondary Payer (MSP) Manual
Chapter 2 - MSP Provisions

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(Rev. 12436; Issued: 12-28-23)

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The purpose of Pub. 100-05, Chapter 2 is for the Centers for Medicare & Medicaid Services (CMS) to provide detailed information regarding the MSP provisions, and the relationship of MSP to other laws. This information can assist the A/B Medicare Administrative Contractors (MACs) (Part A), A/B MACs (Part B), or A/B MACs (Part HHH) (collectively referred to as A/B MACs) and Durable Medical Equipment MACs (DME MACs)with responses to questions from providers, physicians and other suppliers, attorneys, employers, and other payers.

10 -MSP Provisions for Working Aged Individuals

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Pursuant to 42 CFR § 411.100, and further specified in § 411.170 and § 411.172, Medicare pays secondary to GHP coverage for individuals age 65 or over if the GHP coverage is by virtue of the individual's current employment status or the current employment status of the individual's spouse. Health insurance plans for retirees or the spouses of retirees do not meet this condition and are not primary to Medicare. The law requires employers (as defined in Pub. 100-05, Chapter 1) to offer to their employees age 65 or over and to the age 65 or over spouses of employees of any age the same coverage as they offer to employees and employees' spouses under age 65. For example, a plan may not provide benefits that are less for individuals age 65 or over or charge policyholders premiums that are higher for individuals age 65 or over since this would create an incentive for these individuals to reject the GHP coverage and make Medicare the primary payer. This provision applies whether or not the individual age 65 or over is entitled to Medicare. This equal benefit rule applies to coverage offered to full-time and part-time employees. CMS accepts that an individual attains a particular age on the day preceding his or her birthday.

Medicare beneficiaries who have current employment status are free to reject employer plan coverage, in which case they retain Medicare as their primary coverage in accordance with 42 CFR § 411.172. If the employee or spouse refuses the plan Medicare is primary payer for that individual; and the plan may not offer that individual coverage complementary to Medicare. The requirements for employer compliance with the MSP provisions may differ in some respects from the requirements for compliance with the Age Discrimination in Employment Act (ADEA). For example, the ADEA law applies only to employees, while the Medicare provision applies also to self-employed individuals. Employers may not sponsor or contribute to individual Medigap or Medicare supplement policies for beneficiaries who have or whose spouse has current employment status, as outlined in 42 CFR § 411.108.

Where a GHP is primary payer, but does not pay in full for the services, secondary Medicare benefits may be paid to supplement the amount it paid for Medicare-covered services. If a GHP denies payment for services because they are not covered by the plan as a plan benefit bought for all covered individuals, primary Medicare benefits may be paid if the services are covered by Medicare. Primary Medicare benefits may NOT be paid if the plan denies payment because the plan does not cover the service for primary payment when provided to Medicare beneficiaries. (See 42 CFR § 411.108.)

A GHP's decision to pay or deny a claim because the services are or are not medically necessary is not binding on Medicare. A/B MACs and DME MACs evaluate claims under existing guidelines derived from the law and regulations to assure that Medicare covers the

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services regardless of any employer plan involvement.

A/B MACs and DME MACs assume for developing claims and the requirement that GHPs be billed before Medicare that, in the absence of evidence to the contrary, an employer in whose health plan a beneficiary is enrolled because of employment meets the definition of employer and employs at least 20 people. The A/B MACS or DME MAC refers an employer's allegation that the 20-employee requirement is not met to the MSP contractor for coordination of benefits.

A/B MACs and DME MACs must refer a multi-employer plan's (a plan sponsored by or contributed to by two or more employers or employee organizations) statement identifying specific members as employees of employers of fewer than 20 employees, as a basis for making Medicare primary payer, to the MSP contractor for coordination of benefits. Refer to the Employer Exception (SEE) provisions process on the following link: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/EmployerServices/Small-Employer-Exception

NOTE: The request to exempt is done on a prospective basis.

10.1 - Individuals Subject to Limitations on Payment

(Rev. 11755, Issued :12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Medicare pays secondary for Part A and Part B benefits for an individual who:

- Is age 65 or over;
- Is entitled to Part A (hospital insurance) on the basis of the individual's own Social Security or Railroad Retirement earnings record, or Federal quarters of coverage, or the earnings record or the Federal quarters of coverage of another person; and
- Is covered on the basis of individual's own current employment status or the current employment status of the individual's spouse.

Re-employed Retirees and Annuitants

If a retiree or annuitant returns to work even for temporary periods, the employer is required to provide the same coverage under the same conditions that the employer furnishes to other similarly situated employees (i.e., non-retirees). Medicare is the secondary payer to the GHP that the employer provides to the re-employed retiree even if the premiums for coverage in the plan are paid from a retirement pension or fund. Medicare is also secondary payer for individuals associated with the employer in a business relationship such as consultants who are former employees, if the employer provides insurance coverage for other such individuals. (See 42 CFR §411.172(d))

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10.2 - Individuals Not Subject to the Limitation on Payment

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

The MSP provision for working aged does not apply to:

- Individuals enrolled in Part B only;
- Individuals enrolled in Part A on the basis of a monthly premium;
- Anyone who is under age 65. (Medicare is secondary to LGHPs that cover at least one employer of 100 or more employees for certain disabled individuals under age 65.);
- Individuals covered by a health plan other than a GHP as defined above, e.g., one that is purchased by the individual privately, and not as a member of a group, and for which payment is not made through an employer;
- Employees of employers of fewer than 20 employees who are covered by a single employer plan;
- Retired beneficiaries who are covered by GHPs as a result of past employment and who do not have GHP coverage as the result of their own or a spouse's current employment status;
- Individuals enrolled in single employer GHPs of employers with fewer than 20 employees;
- Members of multi-employer plans whom the plan identified as employees of employers with fewer than 20 employees, provided the plan formally elected to exempt the plan from making primary payment for employees and spouses of employees of specifically identified employers with fewer than 20 employees;
- Domestic partners who are given “spousal” coverage by the GHP; or
- Former spouses who have Federal Employees Health Benefit (FEHB) coverage under the Spouse Equity Act

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10.3 - The 20-or-More Employees Requirement

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

The working aged MSP provision applies only to GHPs of employers with 20 or more employees and to multi-employer and multiple employer GHPs in which at least one employer employs 20 or more employees. See 42 CFR § 411.100(a)(1)(i). 42 CFR § 411.170(a)(2)(i) which specifies this requirement is met if an employer has 20 or more full-time and/or part-time employees for each working day in each of 20 or more calendar weeks in the current or preceding year. An employer is considered to have 20 or more employees for each working day of a particular week if the employer has at least 20 full-time or part-time employees on its employment rolls each working day of that week. This condition is met as long as the total number of individuals on the employer's rolls adds up to at least 20 regardless of the number of employees who work or who are expected to report for work on a particular day. Self-employed individuals participating in a GHP are not counted as employees for purposes of determining if the 20-or-more employee requirement is met. An individual is considered to be on the employment rolls even if the employee does not work on a particular day. An employer may not have different employment rolls for different days reflecting those scheduled.

Where an employer does not have 20 or more employees in the preceding year, it is required to offer its employees and spouses age 65 or over primary coverage beginning with the point in time at which the employer had 20 or more employees on each working day of 20 calendar weeks of the current year. The employer is then required to offer primary coverage for the remainder of that year and throughout the following year even if the number of employees drops below 20 after the employer has met the requirement.

The 20-or-more employees requirement must be met at the time the individual receives the services for which Medicare benefits are claimed. During the time the employer has met the 20-or- more employees requirement in the current year or in the preceding calendar year, the GHP is primary payer. An employer that meets this requirement must provide primary coverage even if less than 20 employees participate in the GHP.

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10.4 – Working Aged Exception for Small Employers in Multi-Employer Group Health Plans (GHPs)

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

A multi-employer GHP having at least one employer participating that has at least one employer with 20 or more employees may **prospectively** request to except employees (and their spouses) of identified employers with fewer than 20 employees from the working aged provision. The small employer provision of the MSP statute can be found at 42 U.S.C. 1395y(b)(1)(A)(iii) and 42 CFR 411.172(b). Under this provision, multi-employer GHPs may elect Medicare as the primary payer for services provided to working aged Medicare beneficiaries covered through qualified employers participating in the plan that have fewer than 20 employees. These employees and their spouses are not subject to the working aged provision once an exception has been granted as long as the employer continues to meet the requirements for the exception.

Be advised that it is the GHP's responsibility to provide written updates of any information that may affect the original exception request (updates should include identification of any employees not previously identified as well as information on any terminated coverage issues, etc.) to the MSP Contractor as soon as any changes take place.

All requests for exceptions from the multi-employer plan/administrator of the small employer shall be submitted to the MSP Contractor. A/B MACs and DME MACs having received a request or an update to a previous request shall forward these requests within 14 calendar days of receipt to the MSP Contractor. Please refer to the following link to identify the appropriate contact: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Contacts/Contacts-page.

The MSP contractor shall not make an exception for beneficiaries entitled to Medicare based on permanent kidney failure (End-Stage Renal Disease) or Disability.

The MSP Contractor shall only grant requests on a prospective basis.
Detailed information regarding the Small Employer Exception and requirements for requesting an exception can be found on the CMS Web site at: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/EmployerServices/Small-Employer-Exception

10.5 - Rules Defining Employees Covered by GHPs and Large Group Health Plans (LGHPs)

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

[See 42 CFR § 411.104 regarding current employment status]

A. Current Employment Status

An individual has current employment status if the individual is:

- Actively working as an employee, is the employer (including a self-employed person), or is associated with the employer in a business relationship; or
- The individual is not actively working and is receiving disability benefits from an

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employer for up to 6 months (the first 6 months of employer disability benefits are subject to FICA taxes); or not actively working but meets **all** of the following conditions:

- Retains employment rights in the industry;
- His or her employment terminated by the employer if the employer provides the coverage or has not had his/her membership in the employee organization terminated if the employee organization provides the coverage;
- Is not receiving disability benefits from an employer for more than 6 months;
- Is not receiving Social Security disability benefits, and
- Has employment-based GHP coverage that is not COBRA continuation coverage. [See 29 U.S.C. 1161-1168.]

A person aged 65 or older and receiving disability payments from an employer is considered to have current employment status if such payments are subject to taxes under FICA. Employer disability payments are subject to FICA tax for the first six months of disability after the last calendar month in which the employee worked for that employer.

EXAMPLE: Adam Green stopped working because of disability in December 2021 at age 63. His employer began paying him disability payments January 2022. Since disability payments are taxed under FICA for 6 months after the last month in which the employee worked, Medicare is the secondary payer through June 2022. Beginning with July 2022, Medicare becomes the primary payer as the disability payments are no longer considered wages under FICA.

B. Retain Employment Rights [See 42 CFR § 411.104(b)]

Persons who retain employment rights include but are not limited to:

- Those who are furloughed, temporarily laid off, or who are on sick leave;
- Teachers and seasonal workers who normally do not work throughout the year;
- Those who have health coverage that extends beyond or between active employment periods (e.g., based on an "hours bank" arrangement). (Active union members in certain trades and industries (e.g., construction) often have "hours bank" coverage); and
- Those who take an employer-approved temporary leave of absence for any reason. Temporary leaves of absence include, but are not limited to, periods when an individual qualifies for short-term or long-term medical disability.

C. Coverage by Virtue of Current Employment [See 42 CFR § 411.104(c)]

An individual has coverage as a result of current employment status with an employer

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if the individual has:

- GHP or LGHP coverage based on employment, including coverage based on a certain number of hours worked for that employer or a certain level of commissions earned from work for that employer at any time; and

- Current employment status with that employer, as defined above.

10.5.1 - Clarification of Current Employment Status for Specific Groups
(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

[See 42 CFR § 411.104 for references to employment status of specific groups]

A. Member of Religious Order [See 42 CFR § 411.104(e)]

A member of a religious order whose members are required to take a vow of poverty is not considered to have current employment status with the religious order if the services he/she performs as a member of the order are considered employment by the order for Social Security purposes only. This is because the religious order elected Social Security coverage for its members under section 3121(r) of the Internal Revenue **Member of Religious Order** Code. Thus, Medicare is primary payer to any group health coverage provided by the religious order.

This exception applies only to members of religious orders who have taken a vow of poverty. It does not apply to clergy or to any member of a religious order who has not taken a vow of poverty or to lay employees of the order. This exception applies not only to services performed for the order itself (such as administrative, housekeeping, and religious services), but also to services performed at the direction of the order for employers outside of the order, provided that the outside employer does not provide the member of the religious order with its own GHP coverage. A member of a religious order has current employment status with the outside employer as a result of providing services on behalf of the outside employer (an ongoing business relationship exists). If the outside employer provides GHP coverage to the member of the religious order on the basis of that current employment status relationship, the usual MSP rules apply.

Medicare is the secondary payer to the GHP of the outside employer if the outside employer has the requisite number of employees.

EXAMPLE 1:

Sister Mary Agnes is a member of a religious order where members are required to take a vow of poverty. Sister Mary Agnes was assigned to teach at a church school in the Diocese of the Metropolis. The Diocese does not provide GHP coverage to

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Sister Mary Agnes. The only group health coverage available to Sister Mary Agnes is provided by the religious order. Medicare is the primary payer for services provided to Sister Mary Agnes.

EXAMPLE 2:

Sister Mary Teresa is a member of a religious order whose members are not required to take a vow of poverty. Sister Mary Teresa was assigned to teach at a church school in the Diocese of Smallville. On the basis of her teaching relationship with the Diocese of Smallville, the Diocese provides GHP coverage to Sister Mary Teresa. The GHP provided by the Diocese of Smallville is the primary payer and Medicare is the secondary payer for services provided to Sister Mary Teresa.

A/B MACs and DME MACs should note that the exemption only applies to the working aged and disability provisions that base a GHP's obligation to be a primary payer on a current employment status relationship. The exception does not apply to the ESRD, workers compensation, or liability and no-fault provisions.

B. Insurance Agents

The following guidelines apply in determining the status of insurance agents.

A self-employed insurance agent is considered to have coverage based on current employment status if the agent:

1. Has an "active agent" relationship with the company; or

2. Has a "retired agent" relationship with the company and has reached the "earning threshold" of $400 or more pursuant to §211(b) of the Act. The fact that a self-employed insurance agent is authorized to represent the company, e.g., to write policies on behalf of the company, does not itself imply current employment status.

C. Senior Federal Judges

Senior Federal judges are retired judges of the U.S. court system and the Tax Court. They may continue to adjudicate cases, but they are entitled to full salary as a retirement benefit whether or not they perform judicial services for the Government. By law, the remuneration they receive as senior judges is not considered wages for Social Security retirement offset purposes. Since they are considered retired for Social Security purposes, they are not considered to have current employment status for purposes of the working aged and disability provisions.

D. Volunteers

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Volunteers are considered to have current employment status when they perform services or are available to perform services for an employer and receive remuneration for their services. For example, for purposes of §1862(b) of the Act, AmeriCorps members in the Volunteers In Service To America program (VISTA) are considered to have current employment status since they receive remuneration from the Federal Government. Also, remuneration may be of a monetary or nonmonetary nature. Benefits, including health benefits that a volunteer receives, are considered remuneration.

E. Directors of Corporations

Directors of corporations (i.e., persons serving on a Board of Directors of a corporation who are not officers of the corporation) are self-employed. (Officers of a corporation are employees.) Directors who receive remuneration for serving on a board are considered to have current employment status. Remuneration may be of a monetary or nonmonetary nature. Benefits, including health benefits that a corporation provides to a board member, are considered remuneration if they are subject to FICA taxes under the IRC.

Directors who receive no remuneration for serving on the Board (unpaid directors) are not considered to have current employment status. However, remuneration may consist of deferred compensation (i.e., amounts earned but not payable until some future date usually when the individual reaches age 70 and is no longer subject to the Social Security retirement test). A director receiving deferred compensation is considered to have current employment status only while serving as a director. (See subsection F.)

F. Individuals Receiving Delayed Compensation Payments Subject to FICA Taxes
[See 42 CFR § 411.104(f)]

An individual who is not working is not considered to have current employment status solely on the basis of receiving delayed compensation payments for previous periods of work even though those payments are subject to FICA taxes (or would be subject to FICA taxes if the employer were not exempt from paying those taxes). For example, an individual who is not working and in 2021 receives payments subject to FICA taxes for work performed in 2020 is not considered to be an employee in 2021 solely on the basis of receiving those payments.

G. Leased Employees

Leased employees (as defined in §414(n)(2) of the IRC) are treated as employees of the recipient. The term "leased employee" means any person who is not an employee of the recipient of the services but who provides services to the recipient if the:

- Services are provided based on an agreement between the recipient and any other person (i.e., the leasing organization);

- Person has performed such services for the recipient on a substantially full-time basis for at least 1 year. (In general, an employee who works 30 hours or more is considered to be full time.); and

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- Services are of a type historically performed in the business field of the recipient by employees. An example of a leased employee is an employee of a temporary agency who is assigned to work full time for at least one year doing bookkeeping for an accounting firm.

In implementing these provisions, CMS relies on the regulations and decisions made by the Secretary of the Treasury. Specific questions relating to application of these provisions may be directed to CMS.

H. Re-employed Retirees and Annuitants

If a retiree or annuitant returns to work even for temporary periods, the employer is required to provide the same coverage under the same conditions that is furnished to other employees (i.e., non-retirees). Thus, an employer is required to provide primary coverage for a re-employed retiree if the amount of work the individual performs (based on hours, productivity, etc.) would be sufficient to earn the employee coverage from the employer had the employee not retired. The GHP or LGHP coverage is primary to Medicare because of the current employment status. This rule applies even if the:

- Plan is the same plan that previously provided coverage to the individual retiree or annuitant;
- Premiums for the plan are paid from a retirement pension or fund; or
- Re-employed retiree pays the entire premium.

I. Coverage for Self-Employed Individuals [See 42 CFR § 411.104(d)]

When Medicare is secondary payer, the employer is not required to provide GHP coverage to self-employed individuals. However, if an employer subject to the MSP provisions provides coverage to a self-employed individual (including owners, a consultant, or a contractor), the employer may not take into account the individual's Medicare entitlement (i.e., the GHP must pay primary to Medicare). Also see 42 CFR § 411.104(d).

10.6 - Aggregation Rules Applicable to Determine the Employer Size

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

The size of the employer is a factor in determining whether Medicare is secondary or primary payer under the working aged and disability provisions of the law. For MSP purposes, the employer is the legal entity that employs the employees. For example, the employer may be an individual, a partnership, or a corporation. Ordinarily, the identity of that entity is clear.

There are situations, however, when it is not clear which corporation or individual is the employing entity for MSP purposes. For example, when a corporation is owned or controlled by another corporation, it must be decided which corporation is the employer.

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Similarly, when related individuals each have businesses and each claim to be a separate employer with either fewer than 20 or fewer than 100 employees, it must be decided whether the individuals are separate employers or a single employer.

The MSP law contains the following rules for determining the size of the employer under the MSP for the aged and disabled provisions. [See 42 CFR § 411.106]

A. Single Employers

Single employers under Section §52 of the IRC are defined as follows:

- All employers that are treated as single employers under subsections (a) or (b) of §52 of the IRC are treated as single employers;

- Section 52(a) of the IRC provides that all employees of all corporations that are members of the same controlled group of corporations are treated as if employed by a single employer; and,

- Section 52(b) of the IRC provides that all employees of trades or businesses (whether or not incorporated), e.g., employees of partnerships or proprietorships that are under common control, shall be treated as employed by a single employer.

In general, two or more individuals or corporations are considered to be separate employers under §52(a) or (b) of the IRC if they file separate income tax returns. Two or more individuals are considered to be a single employer if they file a consolidated tax return.

When there is a question about the tax status of a particular employer that claims to have fewer employees than the 20 or 100 employee thresholds, A/B MACs and DME MACs must request the employer to submit copies of its most recent tax return to resolve the question.

B. Affiliated Service Groups

All employees of the members of an affiliated service group (as defined in Section 414(m) of the IRC) are treated as employed by a single employer.

C. Treatment of Religious Organizations

CMS does not aggregate religious organizations for MSP purposes. Incorporated parishes and churches that are part of a church-wide organization, such as a diocese or synod, are considered to be individual employers. A GHP or LGHP for employees of such parishes or churches is considered to be a multi-employer GHP. (See §10.3 and §10.4 of this chapter, for policies regarding multi-employer GHPs in which at least one participating employer employs 20 or 100 or more employees respectively.)

10.7 - Effect of GHPs Payments on Deductible, Coinsurance, and Utilization

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

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Expenses that serve to meet the beneficiary's Part A or Part B cash and blood deductibles, if Medicare were primary payer, are credited to those deductibles even if the expenses are reimbursed by a GHP. This is true even if the GHP paid the entire bill and there is no secondary Medicare benefit payable. If a GHP paid for Medicare covered expenses in whole or in part, the Part B deductible is credited on the basis of the Medicare fee schedule amount rather than the amount paid by the GHP. Also, GHP payments to a provider are applied to satisfy a beneficiary's obligation to pay a Part A or Part B coinsurance amount. However, GHP payments are credited to deductibles before being used to satisfy the coinsurance.

Where no Medicare secondary benefit is payable, no utilization is charged the beneficiary. Where a Medicare secondary payment is made, the A/B MAC charges the beneficiary with utilization. These procedures are applicable for calculating utilization for stays for which Medicare is secondary only for a portion of the stay.

Expenses for which payments are made and Medicare conditional payments are recovered from no-fault or liability insurance are credited toward the deductible amounts for both Parts A and B. Also, no-fault and liability payments are applied to satisfy a beneficiary's obligation to pay Part A or Part B coinsurance amounts. No-fault and liability payments are credited to deductibles before being used to satisfy the coinsurance. For services provided prior to November 13, 1989, payments by the primary payer are not counted toward the Medicare deductible. The discharge date is used for determining when a provider furnished the services.

Services for which Medicare conditional payments are recovered from liability or no-fault insurance are not counted against the number of inpatient care days available to the beneficiary. If an individual is hospitalized twice in the same benefit period and Medicare recovers its payment from a no-fault or liability insurance for the first hospitalization, the first hospitalization would not be charged to the beneficiary. See CFR 42 § 411.30 and 411.33

EXAMPLE 1:

An individual who previously had not met any of the $233 Part B deductible incurred $233 in charges for which the GHP paid $200. The Medicare fee schedule amount was $233. No Medicare benefits are payable. The individual is credited with $233 toward the Part B cash deductible.

The beneficiary can be charged $33. (The $233 fee schedule amount minus the sum of the $200 primary payment plus the $0 Medicare payment).

EXAMPLE 2:

An individual who previously had met $100 of the $233 Part B deductible incurred $150 in charges that were paid in full by the GHP. The Medicare fee schedule amount was $150. No Medicare benefits are payable. The individual is credited with an additional $150 toward the Part B cash deductible and now has satisfied the Medicare deductible.

The physician cannot bill the beneficiary because the sum total of the primary payment ($150) and the Medicare payment ($0) meets the fee schedule amount of ($150).

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10.7.1 - Crediting Deductible for Non-Inpatient Psychiatric Services
(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

The Part B deductible for non-inpatient psychiatric services is credited on the basis of the Medicare fee schedule amount. There is no annual limit on incurred expenses for non-inpatient psychiatric services.

EXAMPLE 1:

An individual received non-inpatient psychiatric services for which a physician charged $250. The $233 Part B deductible had not been met. The GHP allowed $100 and paid $100. The Medicare fee schedule amount is $210.

A. Actual charge by the physician minus the third-party payment: $250 - $100 = $150.

B. The Medicare payment is determined in the usual manner: $210 - $233 = 0 x .80 = $0.

C. Medicare's allowable charge of $210 (which is higher than GHP's allowed amount of $200) minus GHPs payment of $100 equals $110.

Medicare pays $0 (lowest of amounts in steps A, B, or C).

The beneficiary can be charged $110 (the $210 fee schedule amount minus the sum of the $100 primary payment plus the $0 Medicare payment). The unmet Part B deductible is credited with $210. The beneficiary still must meet $13 of the annual Part B deductible before Medicare benefits become payable.

EXAMPLE 2:

An individual received non-inpatient psychiatric services for which the physician charged $250. None of the individual's Part B deductible had been met. The GHP allowed charges in full and paid $250. The Medicare fee schedule amount for the services was
$200. No Medicare secondary benefit is payable since the GHP paid charges in full. The $233 Part B deductible is credited by the first $200 of the fee schedule amount.

The beneficiary cannot be billed by the physician because the sum total of the primary payment ($250) and the Medicare payment ($0) exceeds the fee schedule amount ($200).

EXAMPLE 3:

An individual received non-inpatient psychiatric services from a physician for which the physician charged $500. None of the individual's $233 Part B deductible had been met. A GHP allowed charges in full and paid $400 (80 percent of the $500). The Medicare fee schedule amount for the services was also $500. The $233 Part B deductible is credited in full. The Medicare secondary benefit calculated is $100.

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The physician cannot bill the beneficiary because the sum total of the primary payment ($400) and the Medicare secondary payment ($100) equals the Medicare fee schedule amount.

10.8 - Beneficiary's Rights and Responsibility
(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

A. Beneficiary's Responsibility with Respect to GHPs that are Primary to Medicare

The A/B MACs and DME MACs shall not make any Medicare payment if the beneficiary has not filed a claim or cooperated fully with the provider, physician or other supplier or the GHP. Also, the A/B MACs and DME MACs will not make any Medicare payments until the beneficiary has exhausted the entire claims process. Conditional benefits are not payable if payment cannot be made under the GHP because the beneficiary failed to file a proper claim (See §100 of this chapter for definition of proper claim) unless the failure to file a proper claim is due to mental or physical incapacity of the beneficiary. [See CFR 42 § 411.165, 411.175 and 411.206]. A beneficiary need not file any appeal if not inclined to do so.

B. Beneficiary's Right to Take Legal Action Against A GHP

Section 1862(b)(3)(A) of the Act provides that any claimant (including a beneficiary, provider, physician, or supplier) has the right to take legal action against, and to collect double damages from a GHP, that fails to pay primary benefits for services covered by the GHP. Any claimant, also, has the right to take legal action against, and to collect double damages from, a no-fault or liability insurer that fails to pay primary benefits for services covered by the no-fault or liability insurer where required to do so under §1862(b) of the Act.

20 -MSP Provisions for End-Stage Renal Disease (ESRD) Beneficiaries
(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Pursuant to 42 CFR § 411.162, Medicare is secondary payer to GHPs for individuals eligible for, or entitled to Medicare Part A based on ESRD during a coordination period described below. This provision applies regardless of the number of employees employed by the employer and regardless of whether the individual or other family member has current employment status. The ESRD provision applies to former as well as to current employees. This provision applies where an individual is eligible for Medicare based on ESRD and where an individual is entitled to Medicare based on ESRD. An individual who has ESRD but who has not filed an application for entitlement to Medicare on that basis is eligible for Medicare based on ESRD for purposes of §20.1.1 or §20.1.3 if the individual meets the other requirements.

In general, §13561(c)(2) and (3) of OBRA 1993 provided that plans must pay primary benefits during the coordination period regardless of whether the individual is also entitled to Medicare on another basis. (See §20.1.3 for dual entitlement provisions. Specifically, see §20.1.3.B, which discusses the dual entitlement provision under which a GHP remains secondary to Medicare during the

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30-month coordination period and litigation challenging that provision.)

This provision applies to all Medicare-covered items and services furnished to beneficiaries who are in the 30-month period, including services for non-ESRD treatment and services required by kidney donors in cases of transplantation. This limitation applies for claims processing for items or services furnished to ESRD beneficiaries who are in their 30-months of eligibility or entitlement on the basis of ESRD.

20.1 - Determining the 30 Month Coordination Period During Which Medicare May Be Secondary Payer

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

If Medicare was not the primary payer for an individual on the basis of age or disability at the time the individual became eligible for or entitled to Medicare on the basis of ESRD, Medicare is secondary payer to GHPs for items and services furnished during a period of up to 30 consecutive months, which begins with the earlier of:

- The month in which a regular course of renal dialysis is initiated, or
- If the patient undergoes a course of self-dialysis training the first day of the month in which the training occurred, or
- If an individual who received a kidney transplant, the first month in which the individual became entitled.

NOTE: In the rare case of an untimely application by an individual who receives a transplant, the 30-month period could begin with the first month in which the individual would have been eligible for or entitled to Medicare benefits if a timely application had been filed. It is not necessary to consider this possibility absent a specific indication, e.g., information that the transplant occurred before the first month of eligibility or entitlement. If further development is required, the contractor should contact the SSO.

When the 30-month period begins before the month the individual becomes eligible for or entitled to Medicare, A/B MACs and DME MACs pay secondary benefits for the portion of the period during which the individual is eligible or entitled. The latter is the coordination period. Medicare entitlement usually begins with the third month after the month in which the individual starts a regular course of dialysis.

20.1.1 - Duration of Coordination Period

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

The coordination period is a period that begins with the earlier of the first month of entitlement to or eligibility for Medicare Part A based on ESRD. Eligibility refers to the first month the individual would have become entitled to Medicare Part A on the basis of ESRD if he/she had filed an application for such benefits.

The Balanced Budget Act (BBA) of 1997, extended the coordination period from 18 months to 30 months.

Eligibility refers to the first month the individual would have become entitled to

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Medicare Part A on the basis of ESRD if an application were filed for such benefits. In the rare case of an untimely application by an individual, the coordination period could begin with the first month in which the individual would have been entitled to Medicare benefits if a timely application had been filed. It is not necessary to consider this possibility absent a specific indication, e.g., information that the transplant occurred before the first month of entitlement. If further development is required, A/B MACs and DME MACs contact the RO.

When the coordination period begins before the month the individual becomes entitled to Medicare, the A/B MACs and DME MACs pay secondary benefits for the portion of the period during which the individual is entitled. Medicare entitlement usually begins with the third month after the month in which the individual starts a regular course of dialysis. However, for individuals who undertake a course in self-dialysis training or who receive a kidney transplant during the 3-month waiting period, Medicare may be the secondary payer for up to the first 30 months of the individual's entitlement.

Individuals eligible for Medicare on the basis on ESRD cannot enroll for Part B during a Special Enrollment Period (SEP)SEP, but can defer entitlement to both Part A and B and file an initial application later, usually at the end of the coordination period.

More examples illustrating when Medicare pays secondary in cases of ESRD entitlement and eligibility are found at 42 CFR § 411.162(d).

20.1.2 - Determination for Subsequent Periods of ESRD Eligibility

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

20.1.3 - Dual Eligibility/Entitlement Situations

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

If an individual also becomes entitled to Medicare based on age 65 or disability after being entitled based on ESRD, the coordination period continues for the remainder of the 30-months if Medicare was properly the secondary payer at the time of the dual entitlement. See 42 CFR § 411.163.

When an individual is eligible for, or entitled to Medicare Part A based on ESRD and also entitled on the basis of age or disability, the coordination of benefits is described below.

Except as provided in subsection B, GHPs are subject to a 30-month coordination period for any plan enrollee eligible for, or entitled to Medicare Part A based on ESRD, regardless of whether that individual also is entitled to Medicare on the basis of age or disability. The 30-month period coincides with the first 30 months of ESRD-based Part A Medicare eligibility or entitlement. (Under previous law, Medicare automatically became the primary payer at the point of dual Medicare eligibility/entitlement.) As long as dual eligibility/entitlement exists, the ESRD MSP provision applies exclusively. Medicare becomes the primary payer after the 30th month of ESRD-based eligibility/entitlement even though plan coverage may be in effect by reason of current employment status.
That is, the working aged MSP provisions and the disability MSP provisions do not

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apply to individuals who are entitled on the basis of ESRD during or after the 30-month coordination period.

Subsection A, below, deals with coordination periods governed by present law and provides examples. Subsection B specifies the circumstances under which the ESRD MSP provision does not apply in dual entitlement situations and provides an example. Subsection C deals with circumstances in which Medicare continues to be primary when an individual is entitled to Medicare based on age or disability and then ESRD with no GHP coverage, but obtains GHP coverage during the coordination period and provides an example. Subsection D deals with the effect of the cessation of dual entitlement.

A - Circumstances in Which Medicare Continues to be Secondary After Aged or Disabled Beneficiary Becomes Eligible for, or Entitled to Medicare on the Basis of ESRD

Medicare is secondary payer during the first 30 months of ESRD-based eligibility and entitlement and becomes primary payer after the 30th month of ESRD-based eligibility or entitlement if Medicare was not properly primary prior to ESRD-based eligibility. (Refer to subsection B below if Medicare is properly primary.)

EXAMPLE 1

Mr. C, who is 67 years old and entitled to Medicare on the basis of age, has GHP coverage by virtue of current employment status. Mr. C is diagnosed as having ESRD and begins a course of maintenance dialysis at an ESRD facility on June 27, 2020. Effective September 1, 2020, Mr. C is eligible for Medicare on the basis of ESRD. Medicare, which was secondary because Mr. C's GHP coverage was by virtue of current employment, continues to be secondary payer through February 2023, the 30th month of ESRD-based eligibility, and becomes primary payer beginning March 2023.

EXAMPLE 2

Mr. D retired at age 62 and maintained GHP coverage as a retiree. In January 2020 at the age of 64, Mr. D became entitled to Medicare based on ESRD. Seven months into the 30-month coordination period (July 2020), Mr. D turned age 65. The coordination period continues without regard to age-based entitlement with the retirement plan continuing to pay primary benefits through June 2023, the 30th month of ESRD-based entitlement. Thereafter, Medicare becomes the primary payer beginning July 2023.

EXAMPLE 3

Mr. Edwards retired at age 62 and maintained GHP coverage as a retiree. In July 2020, he simultaneously became eligible for Medicare based on ESRD (maintenance dialysis began in April 2020) and entitled based on age. The retirement plan must pay benefits primary to Medicare from July 2020 through December 2022, the first 30 months of ESRD-based eligibility. Medicare becomes the primary payer beginning January 2023.

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B - Circumstances in Which Medicare Continues to be Primary After Aged or Disabled Beneficiary Becomes Eligible on Basis of ESRD

Medicare remains the primary payer when an individual becomes eligible for Medicare based on ESRD if both of the following conditions are met:

- The individual is already entitled to Medicare on the basis of age or disability when he/she becomes eligible on the basis of ESRD, and

- The MSP prohibition against "taking into account" age-based or disability-based entitlement does not apply because plan coverage was not "by virtue of current employment status" or the employer had fewer than 20 employees (in the case of the aged) or fewer than 100 employees (in the case of the disabled).

The plan may continue to pay benefits secondary to Medicare under this subsection. However, the plan may not differentiate in the services covered and the payments made between persons who have ESRD and those who do not.

EXAMPLE 1

Mrs. G, who is 67 years of age, is retired. She has GHP retirement coverage through her former employer. Her plan permissibly took into account her age-based Medicare entitlement when she retired and is paying benefits secondary to Medicare. Mrs. G subsequently develops ESRD and begins a course of maintenance dialysis in October 2020. She automatically becomes eligible for Medicare based on ESRD effective January 1, 2021. The plan continues to be secondary on the basis of Mrs. G's age-based entitlement as long as the plan does not differentiate in the services it provides to Mrs. G and does not do anything else that would constitute "taking into account" her ESRD-based eligibility.

C – Circumstances in Which Medicare Continues to be Primary When Individual is Entitled to Medicare Based on Age or Disability and then ESRD with no GHP Coverage but Obtains GHP Coverage During the Coordination Period

If Medicare is the proper primary payer for services when eligibility for Medicare based on ESRD is established, Medicare remains the primary payer (during the coordination period and afterwards). Medicare is considered to be the primary payer when Medicare is the only payer or Medicare is legally obligated to be the primary payer to any GHP coverage.

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EXAMPLE 1

Mr. Z is 67 years old and has Medicare based on age. He has no GHP coverage. Mr. Z develops ESRD and begins a course in maintenance dialysis and becomes eligible for Medicare based on ESRD which triggers the 30-month coordination period. However, Mr. Z has no GHP coverage and Medicare continues as the primary payer. In the 6th month of the coordination period Mr. Z obtains coverage through his wife's GHP. Since Medicare was the proper primary payer when eligibility for ESRD was established, Medicare remains the primary payer.

D - Dual Eligibility/Entitlement Ceases

If ESRD-based eligibility or entitlement ceases in accordance with the Medicare Pub. 100-01, Medicare General Information, Eligibility and Entitlement, Chapter 2, §10.4, Medicare is the primary payer unless plan coverage is in effect by virtue of current employment status, and the provisions of §§10 and 20 or 30 apply.

More examples illustrating the coordination of benefits in cases of dual entitlement are found at 42 CFR § 411.163(c).

20.1.4– Summary Chart for ESRD-MSP Rules and Dually Entitled Medicare Beneficiaries

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Rule: If Medicare is the proper primary payer for services when eligibility for Medicare based on ESRD is established, Medicare remains the primary payer (during the coordination period and afterwards). Medicare is considered to be the primary payer when Medicare is the only payer or Medicare is legally obligated to be the primary payer to any GHP coverage. Otherwise, Medicare is secondary to any GHP coverage that may exist during the ESRD coordination period.

BASIS OF MEDICAL ELIGIBILITY AND GHP COVERAGE	APPLICATION OF RULE
ESRD Only	Medicare secondary to any GHP coverage.
Age or Disability entitlement and GHP coverage precede ESRD eligibility with Medicare primary	Medicare primary to any GHP coverage.
Age or Disability entitlement and GHP coverage precede ESRD eligibility with Medicare secondary	Medicare secondary to any GHP coverage.
Age or Disability entitlement and ESRD eligibility occur on same day	Medicare secondary to any GHP coverage at time of ESRD eligibility or obtained later.
ESRD eligibility precedes entitlement based on Age or Disability	Medicare secondary to any GHP coverage.
Age or Disability entitlement and NO GHP coverage precedes ESRD eligibility	Medicare primary to any GHP coverage.

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20.2 - Effect of ESRD MSP on Consolidated Omnibus Budget Reconciliation Act (COBRA)

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

A. General

The COBRA requires that certain GHPs offer continuation of plan coverage for 18 to 36 months after the occurrence of certain qualifying events, including loss of employment or reduction of employment hours. Those are events that otherwise would result in loss of GHP coverage unless the individual is given the opportunity to elect and does elect to continue plan coverage at his/her own expense.

On June 8, 1998, the Supreme Court in "Geissal v. Moore Medical Corp." invalidated the COBRA continuation of health care coverage regulations with respect to when a GHP may terminate COBRA coverage. The court ruled that individuals who obtain other coverage (including Medicare) on or before the COBRA election date are permitted to continue this coverage along with COBRA. Thus, where ESRD-based Medicare Part A entitlement predates the COBRA qualifying event, the plan is obligated to offer COBRA coverage for a qualifying event such as termination of employment. To the extent the period of COBRA coverage overlaps the ESRD MSP coordination period, COBRA is primary and the employer plan has no discretion to terminate COBRA because of the ESRD-based Medicare entitlement. Those individuals who obtain other coverage (including Medicare) after the COBRA election date can be terminated from COBRA coverage. This means that where COBRA coverage came first, the employer may terminate existing COBRA coverage under its health plan when Medicare entitlement occurs. Where COBRA expressly permits termination of continuation coverage upon entitlement to Medicare there is one exception. The exception is that the plan may not terminate continuation coverage of an individual (and the individual's qualified dependents) if the individual retires on or before the date the employer substantially eliminates regular plan coverage by filing for Chapter 11, Bankruptcy. (See 26 U.S.C. 4980B(g)(1)(D), 29 U.S.C. 1162(2)(D), and 1167(3)(C).)

B. Medicare is Secondary to COBRA Coverage

To the extent COBRA coverage overlaps the 30-month ESRD MSP coordination period, Medicare is secondary payer for benefits that a GHP:

- Is required to keep in effect under the COBRA continuation requirements where Medicare entitlement occurs first; or
- Is required to keep in effect under the COBRA continuation requirements even after the individual becomes entitled to Medicare based on ESRD (i.e., the bankruptcy situation as described in subsection A above); or

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- Voluntarily keeps in effect after the individual becomes entitled to Medicare on the basis of ESRD even though not obligated to do so under the COBRA provisions. [See 42 CFR § 411.162(a)(3)]

30 - MSP Provision for Disabled Beneficiaries

Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Pursuant to 42 CFR § 411.204, Medicare is secondary payer to LGHPs for individuals under age 65 entitled to Medicare on the basis of disability and whose LGHP coverage is based on the individual's current employment status or the current employment status of a family member. (See Pub. 100-05, Chapter 1 for definition.)

Under the law, a LGHP may not "take into account" that such an individual is eligible for, or receives, Medicare benefits based on disability. Apply the instructions in this chapter when processing claims where Medicare is secondary payer for disabled individuals. Where those sections refer to a GHP of 20 or more employees, substitute the term "large group health plan" as defined in Pub. 100-05, Chapter 1 to apply them to disabled individuals.

30.1 - Individuals Not Subject to MSP Provision

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Medicare is **not** secondary under the MSP provision for disabled individuals:

- Who work or whose family member works for employers having fewer than 100 employees unless the GHP is a multi-employer plan in which at least one employer of 100 or more employees participates;

- Covered by an LGHP as a result of past employment (e.g., as a retired former employee or as the spouse of a retired former employee) and whose coverage is not also based on current employment status of their own or a family members current employment status;

- Covered by a health plan other than an LGHP (e.g., one that is purchased by the individual privately and not through an employer);

- Who have FEHB coverage under the Spouse Equity Act;

- Enrolled in Part B only; or

- Enrolled in Part A on the basis of a monthly premium.

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30.2 - The 100 or More Employees Requirement

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

The Medicare as secondary for the disabled provision applies only to LGHPs that cover employees of at least one employer that employed 100 or more full-time and/or part-time employees on 50 percent or more of its business days during the previous calendar year.

Medicare is secondary for all employees enrolled in the plan if a plan is a multi- employer plan, such as a union plan which covers employees of some small employers and also employees of at least one employer that meets the 100-or- more employee requirement, including those that work for small employers. The exception discussed in this chapter, with respect to the working aged provision, does not apply to the Medicare as secondary for the disabled provision. An employer will be considered to employ 100 or more employees on a particular day if the employer has at least 100 full-time or part-time employees on his/her employment rolls on that day. This condition is met as long as the total number of individuals on the employer's rolls adds up to at least 100 regardless of the number of employees who work or who are expected to report for work on that day.

Self-employed individuals who participate in an LGHP are not counted as employees for purposes of determining if the 100-or-more employee requirement is met. If an employer does not meet the 100-or-more employees requirement in a particular year, the employer may offer employees coverage that is secondary to Medicare during the following year. If the employer meets the 100-or-more employee requirement at any time during the current year, the employer is required to provide employees with coverage that is primary to Medicare during the following year.

30.3 - Disabled Individuals Who Return to Work

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

If a disabled individual who has LGHP coverage based on prior service to the employer returns to work, the coverage is considered to be by virtue of current employment status if the employer provides coverage to similarly situated individuals who are not disabled. Similarly situated individuals are individuals who work in the same category of employment and who perform the same amount of work. Such services may be based, for example, on the number of hours worked or the amount of earnings. [See 42 CFR § 411.104 for current employment status regulations.]

30.4 - Dually Entitled Individuals

(Rev.11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

If a disabled individual is also eligible for, or entitled to Medicare under the ESRD provisions, follow the rules in §20.1.3 under which Medicare is the secondary payer for the applicable 30-month coordination period.

40 - Liability Insurance

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

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Under (42 U.S.C. 1395y(b)(2)), and outlined in 42 CFR § 411.50, Medicare does not make payment for covered items or services to the extent that payment has been made, or can reasonably be expected to be made under a liability insurance policy or plan (including a self-insured plan). Under certain circumstances, Medicare may make conditional payments if the liability insurance will not pay or will not pay promptly. Conditional payments are conditioned on reimbursement to the Medicare program to the extent that payment with respect to the same items or services has been made, or could be made, under a liability insurance policy or plan (including a self-insured plan).

40.1 - Medicare's Recovery Rights

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Pursuant to 42 CFR § 411.24 and with reference to 42 CFR Subpart D, Medicare has a statutory direct right of recovery from the liability insurance as well as any entity that has received payment directly or indirectly from the proceeds of a liability insurance payment. Medicare's recovery rights take precedence over the claims of any other party, including Medicaid. Medicare's recovery right is superior to other entities including Medicaid because Medicare's direct right of recovery is explicitly prescribed in Federal law and other entities' recovery rights are based on either State law or subrogation rights.

In addition to its direct rights of recovery, Medicare has subrogation rights. "Subrogation" literally means the substitution of one person or entity for another. If Medicare exercises its subrogation rights, Medicare is a claimant against the responsible party and the liability insurer to the extent that Medicare has made payments to or on behalf of the beneficiary for services related to claims against the alleged tortfeasor (and the alleged tortfeasor's liability insurance). Medicare can be a party to any claim by a beneficiary or other entity against an alleged tortfeasor and/or his/her liability insurance and can participate in negotiations concerning the total liability insurance payment and the amount to be repaid to Medicare.

40.2 - Billing in MSP Liability Insurance Situations

(Rev. 12436: Issued: 12-28-23: Effective: 01-29-24; Implementation: 01-29-24)

A - Difference Between Liability Insurance and Other Primary Plans

Liability insurance differs from the other insurance policies or plans that, under §1862(b) of the Act, are primary to Medicare. In the case of other types of insurance that are primary to Medicare, i.e., no-fault insurance, GHPs, and WC, the insurance has a contractual obligation to pay for medical services provided to the covered/injured person. Liability insurance, however, has a contractual obligation to compensate the alleged tortfeasor for any damages the alleged tortfeasor must pay to an injured party.

Pursuant to §1862(b)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395y(b)(2)(A)(ii)), Medicare is precluded from making payment where payment "has been made, or can reasonably be expected to be made..." under liability insurance (including self- insurance), no-fault insurance, or a workers' compensation law or plan, hereafter, referred to as Non-Group Health Plan (NGHP). Where Ongoing Responsibility of Medicals (ORM) has been reported, the primary plan has assumed responsibility to pay, on an ongoing basis, for certain medical care related to the NGHP claim. Consequently, Medicare is not permitted to make payment for such associated claims absent documentation that the ORM has terminated or is otherwise exhausted.

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See IOM 100-05, Chapter 5, Section 20.4 for detailed instructions regarding ORM.

B – Billing Options and Requirements – Alternative Billing

Generally, providers, physicians, and other suppliers must bill liability insurance prior to the expiration of the promptly period rather than bill Medicare. (The filing of an acceptable lien against a beneficiary's liability insurance settlement is considered billing the liability insurance.) As specified in 42 CFR § 411.50, promptly means payment within 120 days after the earlier of: 1) the date the claim is filed with an insurer or a lien is filed against a potential liability settlement; or 2) the date the service was furnished or, in the case of inpatient hospital services, the date of discharge) rather than bill Medicare. Following expiration of the promptly period, or if demonstrated (e.g., a bill/claim that had been submitted but not paid and the liability insurer indicates, on the claim, the reason why the claim is not being paid. Note: If the reason for primary payer denial is not identified on the claim, the A/B MAC or DME MAC denies/rejects the claim). If liability insurance will not pay during the promptly period, a provider, physician, or other supplier may either:

- Bill Medicare for payment and withdraw all claims/liens against the liability insurance/beneficiary's liability insurance settlement (liens may be maintained for services not covered by Medicare and for Medicare deductibles and coinsurance); or

- Maintain all claims/liens against the liability insurance/beneficiary's liability insurance settlement.

C – Special Rule for Oregon [See 42 CFR § 411.54(d)(2)]

As a result of a court order, providers, physicians, and other suppliers in Oregon:

- May either (i.e., double billing is not permitted) bill Medicare or bill liability insurance (the filing of a lien against a beneficiary's liability insurance settlement is considered billing the liability insurance) if the liability insurer pays within 120 days after the earlier of the following dates:

    - The date the provider or supplier files a claim with the insurer or places a lien against a potential liability settlement; or

    - The date the services were provided or, in the case of inpatient hospital services, the date of discharge.

- Must withdraw claims/liens against the liability insurance/beneficiary's liability insurance settlement following expiration of the 120-day period and bill Medicare.

However, CMS will not terminate the provider agreement of a provider that does not comply with the court order if that provider is following the procedures outlined in B above.

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D – Charges to Beneficiaries

Provider Charges to Beneficiaries for Services Covered By Medicare

The following applies to providers that participate in Medicare, emergency hospitals that do not participate in Medicare, and foreign hospitals with an election to bill Medicare:

- If the provider bills Medicare, the provider must accept the Medicare approved amount as payment in full and may charge beneficiaries only deductibles and coinsurance.

- If the provider pursues liability insurance, the provider may charge beneficiaries actual charges, up to the amount of the proceeds of the liability insurance less applicable procurement costs, but may not collect payment from the beneficiary until after the proceeds of the liability insurance are available to the beneficiary.

Physician and Other Supplier Charges to Beneficiaries for Services Covered By Medicare

The following applies to physicians and other suppliers who participate in Medicare:

- If the physician or other supplier bills Medicare, the physician or other supplier must accept the Medicare approved amount as payment in full and may charge beneficiaries only deductibles and coinsurance.

- If the physician or other supplier pursues liability insurance, the physician or other supplier may charge beneficiaries actual charges, up to the amount of the proceeds of the liability insurance less applicable procurement costs, but may not collect payment from the beneficiary until after the proceeds of the liability insurance are available to the beneficiary.

The following applies to physicians and other suppliers who do not participate in Medicare and who submit or would be required to submit an assigned claim:

- If the physician or other supplier bills Medicare, the physician or other supplier must accept the Medicare approved amount as payment in full and may charge beneficiaries only deductibles and coinsurance.

- If the physician or other supplier pursues liability insurance, the physician or other supplier may charge beneficiaries actual charges, up to the amount of the proceeds of the liability insurance less applicable procurement costs, but may not collect payment from the beneficiary until after the proceeds of the liability insurance are available to the beneficiary.

- Physicians and other suppliers (with the exception of DMEPOS suppliers) who do not participate in Medicare and who submit an unassigned claim may charge beneficiaries no more than the limiting charge and may collect payment without regard to whether the liability insurance is available to the beneficiary.

Physicians and other suppliers who do not participate in Medicare, do not submit an

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unassigned claim, and are not required to submit an assigned claim if they submitted a claim to Medicare, may pursue liability insurance but the amount may not exceed the limiting charge.

Charges to Beneficiaries for Services Not Covered by Medicare

- For services for which there is no Medicare coverage available regardless of who furnishes them, providers, physicians, and other suppliers may charge and collect actual charges from beneficiaries without regard to whether the proceeds of the liability insurance are available to the beneficiary.

- For services of foreign hospitals that have no election to bill Medicare, providers may charge and collect actual charges from beneficiaries without regard to whether the proceeds of the liability insurance are available to the beneficiary.

- For services of foreign physicians and other suppliers, the physician or other supplier may charge and collect actual charges from beneficiaries without regard to whether the proceeds of the liability insurance are available to the beneficiary.

E – Provider, Physician, or Other Supplier Bills Medicare and Maintains Claim/Lien Against the Liability Insurance/Beneficiary's Liability Insurance Settlement

As cited above in B, providers, physicians, and other suppliers must withdraw all claims/liens against liability insurance/beneficiary's liability insurance settlement (except for claims related to services not covered by Medicare and for Medicare deductibles and coinsurance) when they bill Medicare. A/B MACs and DME MACs may learn of a situation where the provider, physician, or other supplier billed Medicare but did not withdraw the claim/lien. In such situations, A/B MACs and DME MACs must:

- Advise the provider, physician, or other supplier and beneficiary that the act of billing Medicare limits the payment that the provider, physician, or other supplier may receive for the services billed to the Medicare approved amount. This applies even if Medicare did not pay the claim or the provider, physician, or other supplier refunded the Medicare payment to Medicare.

- If the provider, physician, or other supplier collected on a claim/lien after billing Medicare, advise the provider, physician, or other supplier and beneficiary that:
    - The provider, physician, or other supplier must refund the Medicare payment in instances where the amount collected on the claim/lien is for the full charges of the claim/lien and the Medicare payment is greater than or equal to the full charges of the claim/lien and greater than or equal to the amount collected on the claim/lien (see example one below for an illustration of this policy); or

    - The provider, physician, or other supplier must refund the lesser of the amount collected on the claim/lien or the Medicare payment in instances where the amount collected on the claim/lien is less than

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the full charges of the claim/lien due to policy limits (see example two below for an illustration of this policy); and

- The provider, physician, or other supplier must refund to the beneficiary the difference between the amount collected on the claim/lien and the Medicare payment if the provider, physician, or other supplier received payment for services not covered by Medicare and for Medicare deductibles and coinsurance (see example three below for an illustration of this policy); or

- The provider, physician, or other supplier must refund to the beneficiary the difference between the amount collected on the claim/lien and the Medicare payment less any amounts due from the beneficiary for services not covered by Medicare and for Medicare deductibles and coinsurance (see example four below for an illustration of this policy).

- *Nothing within this manual, or the respective regulations cited herein, prevents a provider, physician, or other supplier, from maintaining a claim or lien against the liability insurance or beneficiary's liability insurance settlement once the Medicare timely filing period has lapsed.*

EXAMPLES

EXAMPLE 1: Charges from the facility are $5,000. Medicare is billed. The facility receives $8,000 from Medicare. The facility receives $5,000 from the liability insurance. The facility must repay Medicare $8,000.

EXAMPLE 2: Charges from the facility are $150,000. Medicare is billed. The facility receives $110,000 from Medicare. The facility receives $100,000 (due to policy limits) from the liability insurance. The facility must repay Medicare $100,000.

EXAMPLE 3: Charges from the facility are $1,000. Medicare is billed. The Medicare allowable is $800.00. The Medicare deductible has been satisfied. The Medicare coinsurance of $160.00 has been paid. There are no charges for non-covered Medicare services. The facility receives $640.00 from Medicare. The facility receives $1,000 from the liability insurance. The facility must repay Medicare $640.00 and send $360.00 to the Medicare beneficiary.

EXAMPLE 4: Charges from the facility are $1,000. Medicare is billed. The Medicare allowable is $800.00. The Medicare deducible has been satisfied. The Medicare coinsurance of $160.00 has not been paid. There are $50.00 in charges for non-covered Medicare services. The facility receives $640.00 from Medicare. The facility receives $1,000 from the liability insurance. The facility must repay Medicare $640.00. The facility may retain $210.00 for the unpaid Medicare coinsurance and charges for the non-covered Medicare services. The facility must send to the Medicare beneficiary the remainder of the liability insurance payment ($150.00).

F – Permissible Liens

The MSP provisions do not create lien rights when those rights do not exist under State

law. Where permitted by State law, a provider, physician, or other supplier may file a lien for full charges against a beneficiary's liability settlement. (A lien against a beneficiary will be considered a lien against a liability settlement if there is a binding agreement that the lien will only be enforced if there is a settlement and will be withdrawn otherwise.)

- The provider, physician, or other supplier may enforce a permissible lien up to the lesser of the amount of the settlement and charges for the services incorporated in the lien. The provider, physician, or other supplier may not charge interest, lien filing, and administrative fees to the beneficiary or against the lien.

50 - Workers' Compensation (WC)

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

A - General

Under §1862(b)(2) of the Act, (42 U.S.C. 1395y(b)(2)), and outlined in 42 CFR § 411.40, payment under Medicare may not be made for any items and services to the extent that payment has been made or can reasonably be expected to be made for such items or services under a WC law or plan of the United States or any State. If it is determined that Medicare has paid for items or services that can be or could have been paid for under WC, the Medicare payment constitutes an overpayment.

This limitation also applies to the WC plans of the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands. It also applies to the Federal WC

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plans provided under the Federal Employees' Compensation Act, the U.S. Longshoremen's and Harbor Workers' Compensation Act and its extensions, and the Federal Coal Mine Health and Safety Act of 1969 as amended (the Federal Black Lung Program).

These Federal programs provide WC protection for Federal Civil Service employees and certain other categories of employees not covered, or not adequately covered, under State WC programs, for example:

- Coal miners totally disabled due to pneumoconiosis;
- Maritime workers (with the exception of seamen);
- Employees of companies performing overseas contracts with the United States government;
- Employees of American companies who are injured in an armed conflict;
- Employees paid from non-appropriated Federal funds (such as employees of post- exchanges);
- Offshore oil field workers; and
- Qualified claimants under the Department of Labor’s Energy Employees Occupational Illness Compensation Program.

The Federal Employers' Liability Act, which covers merchant seamen and employees of interstate railroads, is not a WC law or plan for purposes of this exclusion. Similarly, some States have employers' liability acts. These also are not considered WC acts for purposes of this exclusion. However, they are considered liability insurance and the MSP liability rules apply.

All WC acts require that the employer furnish the employee with necessary medical and hospital services, medicines, transportation, apparatus, nursing care, and other necessary restorative items and services. However, in some States there are limits to the amount of medical and hospital care provided. For specific information regarding the WC plan of a particular State or territory, contact the appropriate agency of that State or territory. If payment for services cannot be made by WC because they were furnished by a source not authorized by WC, such services can be paid for by Medicare.

The beneficiary is responsible for taking whatever action is necessary to obtain payment under WC where payment under that system can reasonably be expected (e.g., timely filing a claim, furnishing all necessary information). If failure to take proper and timely action results in a loss of WC benefits, Medicare benefits are not payable to the extent that payment could reasonably have been expected under WC.

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B. - Workers' Compensation Medicare Set-Aside Arrangements (WCMSAs)

A WCMSA is an agreement between CMS and the CMS beneficiary surrounding the allocation of funds from a workers' compensation (WC) settlement, judgment or award for future medical and/or future prescription drug expenses related to the WC injury and/or illness/disease. A WCMSA identifies the conditions that must be met before Medicare will resume primary payment of all settled WC injuries or illnesses. Where a WC settlement specifies that a portion of the settlement is for future medical care, Medicare may not pay for future medical and/or prescription drug services until the administrator of the WCMSA allocated funds provides evidence that payments were made appropriately for services that Medicare would otherwise reimburse and that the funds deposited in the WCMSA account were appropriately exhausted (disbursed only for services related to the WC injury or illness/disease). In addition, Medicare will not pay conditionally for diagnosis codes related to the set-aside occurrence. Once the set-aside amount is exhausted and accurately accounted for as set forth in the following sections, Medicare will pay primary for future Medicare covered medical and/or prescription drug expenses related to the WC injury or illness/disease. For additional information on WCMSAs, please visit the following website on CMS.gov: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Workers-Compensation-Medicare-Set-Aside-Arrangements/WCMSA-Overview. The WCMSA Reference Guide, located in the Downloads section, details the CMS WCMSA approval process used by CMS while serving as a reference for those choosing to submit a WCMSA for CMS approval.

NOTE: There are situations where WCMSA benefits may terminate, or deplete, during a beneficiary's provider facility stay or upon a physician's visit and a residual payment is due. Under these circumstances Medicare may make a residual Medicare secondary payment. The term "residual payment" is defined as: a payment Medicare makes on a claim where available funds have been exhausted from the WCMSA benefit or responsibility for payment terminates mid-service. The shared systems, the A/B MACs, and DME MACs may pay this residual secondary payment by sending the primary payer amounts to the MSPPAY module and calculate Medicare's payment if such services are covered and reimbursable by Medicare.

50.1 50.1 - **Effect of Payments Under WC Plan**

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

No Medicare payment may be made if WC has paid an amount:

- Which equals or exceeds the gross amount payable by Medicare;
- Which equals or exceeds the provider's charges for Medicare covered services; or
- The provider, physician or other supplier is either obligated to accept, or voluntarily accepts, a primary plan's payment as full payment.

NOTE: In general, WC medical benefits constitute a service benefit, i.e., the payment constitutes full discharge of the patient's liability for services. In such cases, providers are obligated to accept the WC payment as payment in full, and no secondary Medicare benefits are payable. If WC pays for Medicare covered services and under the WC law or plan the provider is not obligated to accept the payment as payment in full, Medicare

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secondary benefits may be payable as described in Pub. 100-05, Chapter 5. If the beneficiary has an open WCMSA on CWF, Medicare will not make any payment related to the WC accident or injury.

A - Secondary Medicare Payments

When a primary plan's payment for Medicare covered services is less than the provider's charges for those services and less than the gross amount payable by Medicare, and the provider does not accept and is not obligated to accept the primary plan's payment as full payment, then Medicare secondary payment can be made as appropriate. In general, the Medicare secondary payment is the least of:

- The Medicare gross payable amount minus the amount paid by the primary plan for Medicare covered services; or,
- The gross amount payable by Medicare minus the applicable deductible and/or coinsurance amount; or
- The provider's charges (or an amount less than the charges that the provider is obligated to accept as payment in full) minus any applicable deductible or coinsurance amounts; or
- The provider's charges (or an amount less than the charges that the provider is obligated to accept as payment in full), minus the amount paid by the primary plan for Medicare covered services.

NOTE: Medicare uses the amount the provider is obligated to accept as payment in full when:

1. The provider is obligated to accept an amount that is less than its charges (e.g., under the terms of a preferred provider agreement), and
2. The primary payer pays less than charges and less than the amount the provider is obligated to accept as payment in full for reasons other than failure to file a proper claim (e.g., because of the imposition of a primary payer deductible and/or copayment).

In the absence of a lower amount that the provider is obligated to accept as payment in full, the amount of the provider's actual charges is used in determining Medicare's secondary payment.

If WC pays a physician's or other supplier's full charges for medical services or pays a lesser amount based on its reasonable charge screen or fee schedule which must be accepted as payment in full, secondary Medicare benefits may not be paid to supplement the amount paid by WC. In addition, the physician or other supplier cannot charge the beneficiary or any other party for the services. This is because WC medical benefits constitute a service benefit, i.e., the payment constitutes full discharge of the patient's liability for the services.

B - Workers' Compensation Does Not Pay for All Services

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As stated in 42 CFR § 411.40(b)(2), where WC does not cover and therefore pay for all services furnished to a beneficiary, Medicare benefits may be paid for those services. For example, the services of a physician not authorized to furnish medical care under WC, may be reimbursed under Medicare. However, where a WCMSA exists, CMS may not pay for any treatments, services or medications related to the settled injury or illness until the fund administrator demonstrates complete and total exhaustion of the WCMSA funds, regardless of whether the treatment, service or medication might not have been covered under the WC plan.

C - Charges Included Non-Work Related Items or Services

If WC does not pay all of the charges because only a portion of the services is compensable, i.e., the patient received services for a condition which was not work related concurrently with services which were work-related, Medicare benefits may be paid to the extent that the services are not covered by any other source which is primary to Medicare. A physician/supplier is permitted under WC law to charge an individual or the individual's insurer for services that are not work related. (See 42 CFR § 411.43(d)).

D - WC Cases Involving Liability Claims

Most State laws provide that, if an employee is injured at work due to the negligent act of a third party, the employee cannot receive payments from both WC and the third party for the same injury. If the individual is covered by a GHP and is age 65 or over, or is eligible or entitled to Medicare based on ESRD and covered by a GHP, or is under age 65 and has LGHP coverage and entitled to Medicare based on disability, the GHP may also be primary to Medicare. Generally, WC benefits are paid while the third party claim is pending. However, once a settlement of the third party claim is reached or an award has been made, WC may recover the benefits it paid from the third party settlement and may deny any future claims for that injury up to the amount of the liability payment made to the individual.

If WC does not pay for services or recovers benefits it previously paid for services solely because a third party is determined to be liable, Medicare is not secondary under this provision, to the extent of the nonpayment or recovery by WC. However, Medicare may be secondary for services covered under the liability insurance provision. Consider these cases under the policies within this chapter and Pub. 100-05, Chapter 7.

E - Possible Coverage of Work Related Services Under No-Fault Insurance or Group Health Plan

Where services are covered in part by WC and also under no-fault insurance, WC pays first, the no-fault insurance pays second and Medicare would be the residual payer. If the individual is covered by a GHP and is age 65 or over; or is under age 65 and entitled to Medicare solely because of ESRD, or is entitled as an active individual, including the member of the family of such individual, who is entitled to benefits on the basis of disability, the employer plan coverage may also be primary to Medicare.

Accordingly, whenever WC pays in part for services, and the physician or other supplier does not accept and is not obligated to accept such payment as payment in full, and there

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is information which indicates that the services may also be reimbursable under no-fault insurance or under a GHP, the A/B MAC or DME MAC follows the instructions in Pub. 100-05, Chapter 5.

If there is no coverage under no-fault insurance, but another insurer is shown on the bill, and there is indication of primary GHP coverage under §10, §20, or §30, the other insurer is to be billed for the services not paid for by WC. The other insurer is billed because, in the case of a beneficiary who is injured on the job and who is covered by private health insurance, it is assumed that the individual is employed and that the other insurance is a GHP.

If the services provided to the Medicare beneficiary are not related to an automobile accident (see §60) and there is no indication of primary group health plan coverage under §10 or §20, Medicare may pay benefits for the services not covered under WC.

F - Workers' Compensation Pays Only for Services of Certain Physicians

In some States, physicians' services are covered under WC only if furnished by a physician selected by the employer or the WC carrier or if furnished by a member of a panel of physicians authorized to furnish care in WC cases. In such cases, if the individual engages the services of another physician (for whose services the individual is not entitled to receive WC benefits), Medicare payment for such services is not precluded.

G - Contested Workers' Compensation Claims

An employee may appeal the refusal of an employer to pay WC benefits, or an employer may appeal the award of benefits to an employee by the WC agency. Such appeals are generally heard by a hearing officer or judge of the agency, with further appeal from such decision to the WC agency or appeals board and from there to the courts. Sometimes contested claims are settled by compromise agreement between the parties with the approval of the WC agency.

In general, a decision by a State WC agency on a contested claim, or a compromise settlement that has been approved by the agency should be accepted as a basis for applying the WC exclusion, except where the settlement did not make reasonable provision for payment under WC of all work-related medical expenses. Thus, where an individual has been denied WC benefits for a particular illness or injury, the A/B MAC or DME MAC allows claims for treatment of that condition unless the decision or settlement is clearly inconsistent with the medical facts and applicable State law and has the effect of shifting to the Medicare program liability for medical expenses which are the responsibility of the State WC program. Where it is clear that an attempt was made to shift responsibility to the Medicare program, the A/B MAC or DME MAC denies the Medicare claim. The conclusions should be explained in detail in the denial notice and state that the beneficiary may wish to request a reopening under the WC law.

60 - No-Fault Insurance

Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Under §1862(b)(2) of the Act, (42 U.S.C. 1395y(b)(1)), Medicare does not make payment

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for covered items or services to the extent that payment has been made, or can reasonably be expected to be made under no-fault insurance. Medicare is secondary to no-fault insurance even if State law or a private contract of insurance stipulates that its benefits are secondary to Medicare benefits or otherwise limits its payments to Medicare beneficiaries. Under certain circumstances, Medicare may make conditional payments if the no-fault insurance will not pay or will not pay promptly (i.e., 120 days after receipt of the claim). Conditional payments are conditioned on reimbursement to the Medicare program to the extent that payment with respect to the same items or services has been made, or could be made, under no-fault insurance.

If services are covered under no-fault insurance, that insurance must be billed first. If the insurance does not pay all of the charges, a claim for secondary Medicare benefits can be submitted. Medicare can pay for services related to an accident if benefits are not available under the individual's no-fault insurance coverage because that insurance has paid maximum benefits for the accident on items or services not covered by Medicare or on non-medical items such as lost wages.

The question in each case involving accident-related medical expenses is whether no-fault benefits can be paid for these particular services. If so, the no-fault insurance is primary. If not, Medicare may be primary. Primary Medicare benefits cannot be paid merely because the beneficiary wants to save insurance benefits to pay for future services or for non-covered medical services or non-medical services. Since no-fault insurance benefits would be available in that situation, they must be used before Medicare can be billed.

If there is an indication that the individual has filed, or intends to file a liability claim against a party that allegedly caused an injury, the A/B MAC or DME MAC follows the procedures related to MSP liability insurance situations once the no-fault insurance is exhausted.

Pursuant to §1862(b)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395y(b)(2)(A)(ii)), Medicare is precluded from making payment where payment "has been made, or can reasonably be expected to be made..." under liability insurance (including self-insurance), no-fault insurance, or a workers' compensation law or plan, hereafter, referred to as Non-Group Health Plan (NGHP). Where Ongoing Responsibility of Medicals (ORM) has been reported, the primary plan has assumed responsibility to pay, on an ongoing basis, for certain medical care related to the NGHP claim. Consequently, Medicare is not permitted to make payment for such associated claims absent documentation that the ORM has terminated or is otherwise exhausted. See IOM 100-05, Chapter 5, Section 20.4 for detailed instructions regarding ORM.

60.1 – Medicare's Recovery Rights

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Medicare has a statutory direct right of recovery from the no-fault insurance as well as any entity that has received payment directly or indirectly from the proceeds of a no-fault insurance payment. Medicare's recovery rights take precedence over the claims of any other party, including Medicaid. Medicare's recovery right is superior to other entities including Medicaid because Medicare's direct right of recovery is explicitly prescribed in Federal law and other entities' recovery rights are based on either State law or subrogation

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rights.

In addition to its direct rights of recovery, Medicare also has subrogation rights. "Subrogation" literally means the substitution of one person or entity for another. If Medicare exercises its subrogation rights, Medicare is a claimant against the no-fault insurer to the extent that Medicare has made payments to or on behalf of the beneficiary for services related to claims against the no-fault insurer. Medicare can be a party to any claim by a beneficiary or other entity against no-fault insurance and can participate in negotiations concerning the total no-fault insurance payment and the amount to be repaid to Medicare.

70 – Interest on MSP Recovery Claims

(Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Section 1862(b)(2)(B)(i) of the Social Security Act (the Act) and 42 C.F.R. 411.24(m) provide express authority to assess interest on MSP debts. Interest is calculated on the MSP debts using the method applicable to Non-MSP Medicare overpayments and underpayments as stated in 42 C.F.R. 405.378. For Medicare overpayments and underpayments and MSP debts, interest is calculated in full 30-day periods. Interest instructions for Medicare overpayments and underpayments are found in Chapter 4, Pub. 100-06, Medicare Financial Management Manual.

80 – Prohibitions Applicable to Employers Offering GHP Coverage

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

80.1- Financial Incentives

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

An employer or other entity is prohibited from offering Medicare beneficiaries financial or other benefits as incentives not to enroll in or to terminate enrollment in a GHP or LGHP that is or would be primary to Medicare, pursuant to 42 CFR § 411.103. This prohibition precludes the offering of benefits to Medicare beneficiaries that are alternatives to the employer's primary plan (e.g., prescription drugs) unless the beneficiary has primary coverage other than Medicare. An example would be primary plan coverage through his/her own or a spouse's employer. This rule applies even if the payments or benefits are offered to all other individuals who are eligible for coverage under the plan. It is a violation of the Medicare law every time a prohibited offer is made regardless of whether it is oral or in writing. Any entity that violates the prohibition is subject to a civil money penalty of up to $5,000 for each violation

80.2 - Discrimination in Offering Equal Benefits for Older and Younger Employees and Spouses

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Section 1862(b)(1)(A)(i)(II) of the Act provides that GHPs of employers of 20 or more employees must provide to any employee or spouse age 65 or older the same benefits under the same conditions that they provide to employees and spouses under 65 if those 65 or older are covered under the plan on the basis of the individual's current employment status or the current employment status of a spouse of any age. The requirement applies regardless of whether the individual or spouse 65 or older is entitled to Medicare. (See 42

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CFR § 411.100 and 102.)

80.3 - Differentiation for ESRD

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

A GHP may not take into account that an individual is eligible for or entitled to Medicare benefits on the basis of ESRD during a coordination period described earlier in this chapter. The following are examples of potential taking into account the Medicare eligibility or entitlement of ESRD patients:

- The plan does not cover routine maintenance dialysis services or kidney transplants;
- The plan excludes benefits, makes itself secondary to government benefits, or charges a higher premium for individuals with ESRD;
- The plan imposes limitations on benefits for persons with ESRD which are not applicable to others, e.g., a higher deductible or coinsurance, a longer waiting period or a lower annual or lifetime benefit limit.

Section 1862(b)(1)(C)(ii) of the Act provides that GHPs may not differentiate in the benefits they provide between individuals who do not have ESRD and other individuals covered under the plan on the basis of the existence of ESRD, the need for renal dialysis, or in any other manner. Actions that constitute differentiation in plan benefits (and that may also constitute "taking into account" Medicare eligibility or entitlement) include, but are not limited to, the following:

- Terminating coverage of individuals with ESRD for reasons that would not be a basis for terminating individuals who do not have ESRD;
- Imposing benefit limitations (such as less comprehensive health plan coverage, reductions in benefits, exclusion of benefits, a higher deductible or coinsurance, a longer waiting period, a lower annual or lifetime benefit limit, or more restrictive preexisting illness limitations) on persons who have ESRD but not on others enrolled in the plan;
- Charging individuals with ESRD higher premiums;
- Paying providers/suppliers less for services furnished to individuals who have ESRD than for the same services furnished to those who do not have ESRD, such as paying 80 percent of the Medicare rate for renal dialysis on behalf of a plan enrollee who has ESRD and the usual, reasonable, and customary charge for renal dialysis on behalf of an enrollee who does not have ESRD; and
- Failing to cover routine maintenance dialysis or kidney transplants when a plan covers other dialysis services or other organ transplants.

A plan is not prohibited from limited covered utilization of a particular service as long as the limitation applies uniformly to all plan enrollees. For instance, if a plan limits its coverage of renal dialysis sessions to 30 per year for all plan enrollees, the plan would not be differentiating in the benefits it provides between plan enrollees who have ESRD

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and those who do not.

80.3.1- Paying Benefits Secondary to Medicare

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

The nondifferentiation provision does not prohibit a plan from paying benefits secondary to Medicare after the coordination period. However, a plan may not otherwise differentiate, as described in §70.2 and §70.3, in the benefits it provides.

EXAMPLE 1:

Mr. Smith works for employer A and he and his wife are covered through employer A's GHP (Plan A)**.** Neither is eligible for Medicare nor has ESRD. Mrs. Smith works for employer B and is also covered by employer B's plan (Plan B). Plan A is more comprehensive than Plan B and covers certain items and services, such as prescription drugs, which Plan B does not cover. If Mrs. Smith obtains a medical service, Plan B pays primary and Plan A pays secondary. That is, Plan A covers Plan B copayment amounts and items and services that Plan A covers but that Plan B does not.

Mr. Jones also works for employer A and he and his wife are covered by Plan A. Mrs. Jones does not have other GHP coverage. Mrs. Jones develops ESRD and becomes entitled to Medicare on that basis. Plan A pays primary to Medicare during the first 30 months of Medicare entitlement based on ESRD. When Medicare becomes the primary payer, the plan converts Mrs. Jones' coverage to a Medicare supplemental policy. That policy pays Medicare's deductible and coinsurance amounts but does not pay for items and services not covered by Medicare which Plan A would have covered. That conversion is impermissible because the plan is providing a lower level of coverage for Mrs. Jones who has ESRD than it provides for Mrs. Smith who does not. In other words, if Plan A pays secondary to primary payers other than Medicare, it must provide the same level of secondary benefits when Medicare is primary in order to comply with the nondifferentiation provision.

80.4 - Taking Into Account Medicare Entitlement

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Sections 1862(b)(1)(A), (B), and (C) of the Act provide that GHPs and LGHPs may not take into account that an individual is entitled to Medicare in any of the following situations:

- Beneficiaries age 65 or older who are covered by a GHP (of employers who employ at least 20 employees) by virtue of the individual's current employment status or the current employment status of a spouse of any age (see Chapter 2, §10);

- Beneficiaries who are eligible for or entitled to Medicare on the basis of ESRD and who are covered by a GHP (without regard to the number of individuals employed and regardless of current employment status) during the first 30 months of ESRD-based Medicare eligibility or entitlement (See Pub. 100-05, Chapter 2, §20); or

- Beneficiaries under age 65 who are entitled to Medicare on the basis of disability

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and who are covered under a LGHP (i.e., a plan of an employer who employs at least 100 employees) and are covered under the plan by virtue of the individual's or a family member's current employment status. (See Pub. 100-05, Chapter 2, §30)

A. Examples of Actions that Constitute "Taking Into Account" Medicare Entitlement

Actions by GHPs or LGHPs that constitute taking into account that an individual is entitled to Medicare on the basis of ESRD, age, or disability (or eligible on the basis of ESRD) include, but are not limited to, the following:

- Failing to pay primary benefits;

- Offering to individuals entitled to Medicare coverage that is secondary to Medicare;

- Terminating coverage because the individual has become entitled to Medicare, except as permitted under COBRA continuation coverage provisions (see 26 U.S.C. Section 4980B(f)(2)(B)(iv); 29 U.S.C. Section 1162(2)(D); and 42 U.S.C. Section 300bb-2 (2)(D));

- In the case of a LGHP, denying or terminating coverage because an individual is entitled to Medicare on the basis of disability without denying or terminating coverage for similarly situated disabled individuals who do not meet the Social Security definition of disability;

- Imposing limitations (such as providing less comprehensive health care coverage, excluding benefits, reducing benefits, charging higher deductibles or coinsurance, or providing for lower annual or lifetime benefit limits or more restrictive preexisting illness limitations) on benefits for a Medicare-entitled individual that do not apply to others enrolled in the plan;

- Charging the Medicare-entitled individual higher premiums;

- Requiring a Medicare-entitled individual to wait longer for coverage to begin;

- Paying providers and suppliers no more than the Medicare payment rate for services furnished to a Medicare beneficiary but making payments at a higher rate for the same services to an enrollee who is not entitled to Medicare;

- Providing misleading or incomplete information that could have the effect of inducing a Medicare-entitled individual to reject the employer plan, thereby making Medicare the primary payer. (An example of this would be informing the beneficiary of the right to accept or reject the employer plan but failing to inform the individual that if he/she rejects the plan, the plan will not be permitted to provide or pay for secondary benefits.);

- Including in its health insurance cards, claims forms, or brochures distributed to beneficiaries, providers, and suppliers instructions to bill Medicare first for services furnished to Medicare beneficiaries without stipulating that such action may be taken only when Medicare is the primary payer; and

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- Refusing to enroll an individual for whom Medicare would be secondary payer when enrollment is available to similarly situated individuals for whom Medicare would not be secondary payer.

80.5 - Permissible Distinctions in Coverage Allowed a GHP or LGHP
(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

A plan is not prohibited from limiting covered utilization of a particular service as long as the limitation applies uniformly to all plan enrollees. For instance, if a plan limits its coverage of renal dialysis sessions to 30 per year for all plan enrollees, the plan would not be differentiating in the benefits it provides between plan enrollees who have ESRD and those who do not.

If a GHP or LGHP makes benefit distinctions between various categories of individuals (distinctions unrelated to the fact that an individual is entitled to Medicare but based, for instance, on length of time employed, occupation, or marital status), the GHP or LGHP plan may make the same distinctions between the same categories of individuals entitled to Medicare whose plan coverage is based on current employment status. For example, if a GHP or LGHP does not offer coverage to employees who have worked less than one year and who are not entitled to Medicare on the basis of disability or age, the GHP or LGHP is not required to offer coverage to employees who have worked less than one year and who are entitled to Medicare on the basis of disability or age.

- A GHP or LGHP may pay benefits secondary to Medicare for an aged or disabled beneficiary who has current employment status if the employer employs fewer than 20 or 100 employees, respectively.

- A GHP or LGHP may pay benefits secondary to Medicare for an aged or disabled beneficiary who has current employment status if the plan coverage is COBRA continuation coverage because of reduced hours of work. Medicare is primary payer for this beneficiary because, although he/she has current employment status, the GHP or LGHP coverage is by reason of the COBRA law rather than by virtue of current employment status.

- A GHP may terminate COBRA continuation coverage of an individual who becomes entitled to Medicare on the basis of ESRD when permitted under the COBRA provisions. The only exception in the COBRA law (see 29 U.S.C.1162(2)(D)(ii)) prohibits GHPs from terminating COBRA coverage for retirees and dependents who are entitled to Medicare when the employee retired before the employer effectively terminated the regular plan coverage by filing for bankruptcy.

90 - Actions Resulting from GHP or LGHP Nonconformance
(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

A. Determination [See 42 CFR § 411.110]

A determination of nonconformance is a CMS determination that a GHP or LGHP is a nonconforming plan as provided in this section. The CMS may make a finding of nonconformance for any GHP or LGHP that at any time during a calendar year fails to

comply with any of the following statutory provisions:

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- The prohibition against taking into account that a beneficiary who is covered or seeks to be covered under the plan is entitled to Medicare on the basis of ESRD, age, or disability or eligible on the basis of ESRD (see §70.4 above);

- The equal benefits clause for the working aged (see §70.5 above);

- The non-differentiation clause for individuals with ESRD (see §70.3 above); or

- The obligation to refund conditional Medicare primary payments.

The CMS may make a finding of nonconformance for a GHP or LGHP that fails to provide correct, complete, and timely information, either voluntarily or in response to a CMS request, on the plan's primary payment obligation with respect to a given beneficiary if that failure contributes to:

- Medicare mistakenly making a primary payment; or

- A delay or foreclosure of CMS's ability to recover a mistaken primary payment.

If CMS determines that a GHP fails to comply with the provision that prohibits taking into account entitlement to Medicare (see §70.4 above) in a particular year, the GHP is nonconforming for that year. If, in a subsequent year, that plan fails to repay the resulting mistaken primary payments, the plan is also nonconforming for the subsequent year. For example, if a plan paid secondary for the working aged in 2019, that plan was nonconforming for 2019. If in 2022 CMS identifies mistaken primary payments attributable to the 2019 violation and the plan refuses to repay, it is also nonconforming for 2022.

B. Starting Dates for Determination of Nonconformance [See 42 CFR § 411.114]

The CMS's authority to determine nonconformance of GHPs and LGHPs begins on the following dates:

- January 1, 1987, for MSP provisions that affect the disabled;

- December 20, 1989, for MSP provisions that affect ESRD beneficiaries and the working aged; and

- August 10, 1993, for failure to refund mistaken Medicare primary payments.

C. Notice to GHP or LGHP of Determination of Nonconformance [See 42 CFR § 411.115(a)]

If central office determines that a GHP or a LGHP is nonconforming with respect to a particular calendar year, CMS will mail a written notice to the plan with the following:

- The determination;

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- The basis for the determination;
- The right of the parties to request a hearing. (The Parties are the GHP or LGHP for which CMS determined the nonconformance and any employers or employee organizations that contributed to the plan during the calendar year for which CMS determined nonconformance.);
- An explanation of the procedure for requesting a hearing;
- The tax that may be assessed by the IRS in accordance with §5000 of the IRC; and

The fact that, if none of the parties requests a hearing within 65 days from the date on the notice, the determination is binding on all parties unless it is reopened.

The notice also states that the plan must submit to CMS, within 30 days from the date on its notice, the names and addresses of all employers and employee organizations that contributed to the plan during the calendar year for which CMS has determined nonconformance.

D. Notice to Contributing Employers and Employee Organizations [See CFR 42 §v 411.115(b)]

The CMS mails written notice of the determination, including all the information specified in subsection C, above, to all contributing employers and employee organizations already known to CMS or identified by the plan in accordance with subsection C. Employer and employee organizations have 65 days from the date of their notice to request a hearing.

E. Penalties

Any entity that violates the prohibition described in subsection A is subject to a civil money penalty of up to $5,000 for each violation.

If CMS Central Office determines that a plan has been a nonconforming GHP in a particular year, it refers its determination, including the identity of the contributors that it has identified, to the IRS, but only after the parties have exhausted all appeal rights with respect to the determination. Section 5000 of the Internal Revenue Code of 1986 imposes an excise tax penalty on employers and employee organizations that contribute to nonconforming GHPs. They are taxed 25 percent of the employer's or employee organization's expenses incurred during the calendar year for each GHP (conforming as well as nonconforming) to which they contribute. This tax penalty does not apply to Federal and other governmental employers. The IRS administers Section 5000 of the IRC, which imposes the tax on employers (other than governmental entities) or employee organizations that contribute to a nonconforming GHP mentioned in §80.

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100 - GHP or LGHP Actions to Document Conformance

(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

A GHP or LGHP may be required to demonstrate that it has complied with the MSP prohibitions and requirements, set forth in §70 of this chapter, and to submit supporting documentation. If the GHP or LGHP fails to provide acceptable documentation, the GHP or LGHP could be found to be nonconforming. The A/B MAC or DME MAC must notify the RO and furnish complete information.

A. Examples

The following are examples of acceptable documentation:

- A copy of the employer's plan or policy that specifies the services covered, conditions of coverage, and benefit levels and limitations with respect to persons entitled to Medicare on the basis of ESRD, age, or disability for whom Medicare is secondary payer, as compared to the provisions applicable to other enrollees and potential enrollees; and

- An explanation of the plan's allegation that it does not owe CMS any amount CMS claims the plan owes as refund for conditional or mistaken Medicare primary payments. The plan must include all information requested by the A/B MAC or DME MAC.

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Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R12436MSP	12/28/2023	Update to Internet Only Manual 100-05, Chapter 2, Section 40.2 to Clarify the Liability Insurance Settlement Provisions	01/20/2024	13475
R11755MSP	12/21/2022	Significant Updates to Internet Only Manual (IOM) Publication (Pub.) 100-05 Medicare Secondary Payer (MSP) Manual, Chapters 1 and 2	01/23/2023	13000
R118MSP	04/28/2016	Individuals Not Subject to the Limitation on Medicare Secondary Payment (MSP)	05/31/2016	9576
R113MSP	08/06/2015	Instructions for the Shared Systems and Medicare Administrative Contractors (MACs) to follow when a Medicare Residual Payment must be Paid on Workers' Compensation Medicare Set-aside Arrangement (WCMSA) or for Ongoing Responsibility of Medicals (ORM) Non-Group Health Plan (NGHP) Medicare Secondary Payer (MSP) Claims	01/04/2016	9009
R65MSP	03/20/2009	New Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Workers Compensation Medicare Set-Aside Arrangements (WCMSAs) to Stop Conditional Payments	04/06/2009/ 07/06/2009	5371
R64MSP	01/09/2009	New Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Workers Compensation Medicare Set-Aside Arrangements (WCMSAs) to Stop Conditional Payments - Rescinded and replaced by Transmittal 65	04/06/2009/ 07/06/2009	5371
R49MSP	04/07/2006	Manualizing Long-Standing Medicare Secondary Payer (MSP) Policy	05/08/2006	4024
R45MSP	12/16/2005	Interest on MSP Debts	01/17/2006	4125

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R33MSP	08/12/2005	Working Aged Exception for Small Employers in Multi-Employer Group Health Plans (GHPs)	05/20/2005	3768
R28MSP	04/28/2005	Working Aged Exception for Small Employers in Multi-Employer Group Health Plans (GHPs)	05/20/2005	3768
R25MSP	02/25/2005	Changes Included in the Medicare Modernization Act (MMA)	04/25/2005	3219
R18MSP	08/27/2004	Application of Medicare Secondary Payer Provisions for the Working Aged, Disabled Former Spouses and Certain Family Members with Coverage Under the Federal Employees Health Benefits (FEHB) Program	11/29/2004	3120
R02MSP	10/17/2003	Individuals Not Subject to the Limitation on Payment	04/01/2004	2252
R01MSP	10/01/2003	Initial Issuance of Manual	N/A	N/A

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