IN THE CIRCUIT COURT OF THE FIFTEENTH JUDICIAL CIRCUIT
IN AND FOR PALM BEACH COUNTY, FLORIDA
CIVIL DIVISION DIV: "AF"
CASE NO.: 2020CA001543AXX

CHRISTA HUMPHRIES,

Plaintiff,

vs.

LARRY ZUCCARI,

Defendant.
_____/

ORDER ON DEFENDANT'S MOTION *IN LIMINE* ON PLAINTIFF'S PAST MEDICAL EXPENSES

THIS CAUSE came before the Court on March 7, 2022 upon Defendant's Motion *in Limine* on Plaintiff's Past Medical Expenses ("Motion"), and the Court, having reviewed the Motion, the Plaintiff's Response in Opposition, having reviewed the court file and record, having heard argument of counsel, being familiar with the applicable law, and after being otherwise duly advised in the premises, finds as follows:

A. Factual Findings.

1. This is a personal injury action arising out of a December 7, 2018 auto accident.

2. Plaintiff seeks, among other damages, recovery of past medical expenses.

3. Plaintiff is enrolled in Medicare and was so enrolled at the time of the accident.

4. The following medical providers provided treatment to Plaintiff, submitted Plaintiff's bills to Medicare, and were paid by Medicare: (a) Jupiter Pain; (b) Resolute Pain; (c) Jupiter Outpatient; (d) MD Now; (e) Palm Beach Gardens Hospital; and (f) Good Sam Hospital.

5. Defendant seeks to limit evidence to the amounts Medicare paid for the treatment/services in past medical expenses for these six providers. Plaintiff agrees to this relief.

6. The following medical providers provided treatment to Plaintiff, did not opt-out of Medicare, and did not submit bills to Medicare: (a) Dr. Theofolis; (b) Dr. Contando; and (c) Advanced Diagnosis.

7. Defendant seeks to limit evidence to the amounts Medicare would have paid had Plaintiff's bills been submitted by these three providers to Medicare. Plaintiff opposes this relief.

B. Legal Analysis and Ruling.

1. Limitations on recoverable past medical expenses in a personal injury action.

It is Plaintiff's burden to present evidence proving a "specific and definite amount of economic damage," including those for past medical treatment. *United Auto. Ins. Co. v. Colon*, 990 So. 2d 1246, 1248 (Fla. 4th DCA 2008) (internal citations omitted). A personal injury plaintiff can recover compensatory or actual damages for the loss (designed to make the plaintiff whole) but cannot recover damages in excess of the amount that represents that actual loss sustained. *MCI WorldCom Network Servs., v. Mastec, Inc.*, 995 So. 2d 221, 223 (Fla. 2008); *Coop. Leasing, Inc. v. Johnson*, 872 So. 2d 956, 957-58 (Fla. 2d DCA 2004).

2. Medical providers participating in Medicare must accept Medicare rates unless they properly opt-out of the Medicare program.

Medicare was enacted as Title XVIII of the Social Security act and titled, "Health Insurance for the Aged and Disabled." 42 U.S.C. § 1395, *et. seq*. The Centers for Medicare & Medicaid Services ("CMS") administers the Medicare program and states as follows with regard to medical charges to beneficiaries for services covered by Medicare: "[I]f the provider bills Medicare, the provider must accept the Medicare approved amount as payment in full and may

charge beneficiaries only deductibles and coinsurance."[1]

> The Social Security Act and Section 1848(g)(4)(A) states in pertinent part: For services furnished on or after September 1, 1990, within 1 year after the date of providing a service for which payment is made under this part on a reasonable charge or fee schedule basis, a physician, supplier, or other person (or an employer or facility in the cases described in section 1842(b)(6)(A)
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> (i) shall complete and submit a claim for such service on a standard claim form specified by the Secretary to the carrier on behalf of a beneficiary; and
>
> (ii) may not impose any charge relating to completing and submitting such a form.

42 U.S.C. § 1395w-4(g)(4)(A)(i-ii).

"If the physician fails to submit a claim to the Medicare carrier on behalf of the beneficiary when one is required to be submitted the Secretary may impose sanctions." *Stewart v. Sullivan*, 816 F. Supp. 281, 284 (D.N.J. 1992). *See* 42 U.S.C. § 1395w-4(g)(4)(B)(i-ii).

Providers may elect *not* to bill Medicare under 42 U.S.C. § 1395a under limited circumstances if they properly "opt-out" of Medicare. Federal law requires providers to follow strict processes for opting out of the program. *See* 42 U.S.C. § 1395a; 42 C.F.R. §§ 405.405, 405.410, 405.420, 405.425 & 405.430. If the provider does not follow all requirements for opting out, a private contract requiring a patient to pay the full amount of the provider's charge for medical treatment is null and void. *See Medicare Benefit Policy Manual, Chapter 15 at 40.10, Failure to Properly Opt Out* (explaining that when either the private contract does not meet required specifications, or the practitioner fails to submit an opt-out affidavit, the contract is null and void and "[t]he physician/practitioner must submit claims to Medicare for all Medicare-covered items and services furnished to Medicare beneficiaries, including the items and services

[1] *Medicare Secondary Payer (MSP) Manual, Chapter 2 - MSP Provisions*, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/msp105c02.pdf

furnished under the nullified contracts.").[2] *See also* 42 C.F.R. §§ 405.405(c), (d); 405.430.

In this case, Plaintiff's providers were enrolled in the Medicare program and did not opt-out; they were required to accept Medicare rates for the services/treatment as a matter of law.

3. A plaintiff is not entitled to admit into evidence and recover more than what Medicare paid (or would pay) for medical expenses.

Medicare rates for treatment are generally less than those billed by health care providers. *See generally Bailey v. Rocky Mt. Holdings, LLC*, 889 F.3d 1259, 1271 n. 24 (11th Cir. 2018) (discussing Medicare rates for medical services). Nevertheless, "payment by Medicare requires the provider to whom payment is made to accept such amount in full satisfaction of the total charge even though the amount charged exceeds the amount paid by Medicare." *Thyssenkrupp Elevator Corp. v. Lasky*, 868 So. 2d 547, 549 (Fla. 4th DCA 2003).

The undiscounted excess medical charges cannot be admitted in evidence because it would result in a windfall to the Plaintiff by permitting recovery for past medical expenses for which she was never and will never be liable for. *Thyssenkrupp*, 868 So. 2d at 550. As the Court in *Cooperative Leasing, Inc*. stated:

> The issue in this case is the appropriate measure of compensatory damages for past medical expenses. "The objective of compensatory damages is to make the injured party whole to the extent that it is possible to measure his injury in terms of money." *Mercury Motors Express, Inc., v. Smith*, 393 So. 2d 545, 547 (Fla. 1981). "The primary basis for an award of damages is *compensation*." *Fisher v. City of Miami,* 172 So. 2d 455, 457 (Fla. 1965). In this case, Johnson sought to collect the "additional value of medical services reasonably made necessary" by the appellants. We conclude, however, that Johnson was not entitled to recover for medical expenses beyond those paid by Medicare because she never had any liability for those expenses and would have been made whole by an award limited to the amount that Medicare paid to her medical providers.

Coop. Leasing, Inc., 872 So. 2d at 957-58.

[2] https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

Original charges by health care providers, therefore, are irrelevant and inadmissible when the provider accepts payment from Medicare in full satisfaction of the charge. *See Thyssenkrupp*, 868 So. 2d at 551. "[I]t is error to permit a plaintiff to introduce into evidence (and to request from the jury) the gross amount of medical bills rather than the lesser amount actually paid as a governmental or charitable benefit in full settlement of those bills." *Matrisciani v. Garrison Prop. & Cas. Ins. Co*., 298 So. 3d 53, 59 (Fla. 4th DCA 2020) (citing *Thyssenkrupp*, *Boyd*, and *Coop. Leasing, Inc.*). *See also Dial v. Calusa Palms Master Ass'n*, 308 So. 3d 690 (Fla. 2d DCA 2020) (affirming decision limiting evidence of Plaintiff's past medical expenses to the Medicare bills that were tendered and paid); *Gulfstream Park Racing Ass'n v. Volin*, 326 So. 3d 1124 (Fla. 4th DCA 2021) (holding the circuit court erred in allowing Plaintiff to introduce evidence of the amount billed by medical providers ("phantom damages") instead of the discounted amount Medicare paid for past medical expenses).

Notably, Medicare is not a collateral source subject to reduction post-trial, pursuant to section 768.76, Florida Statues. "Section 768.79 excludes Medicare benefits as collateral sources because the federal government has a right to reimbursement . . . for payments it has made on [a plaintiff's] behalf." *Coop. Leasing, Inc*., 872 So. 2d at 960. *See also Matrisciani*, 298 So. 3d at 58; *Humana Medical Plan, Inc. v. Reale*, 180 So. 3d 195, 207 (Fla. 3d DCA 2015) (holding that section 768.76, Florida Statutes, excludes consideration of Medicare benefits as a collateral source).

The parties here agree that Plaintiff can only introduce into evidence (and recover), the past medical expenses in the amount paid by Medicare. Accordingly, Plaintiff may only introduce into evidence the discounted amounts Medicare paid for past medical expenses for the following providers: (a) Jupiter Pain; (b) Resolute Pain; (c) Jupiter Outpatient; (d) MD Now; (e)

Palm Beach Gardens Hospital; and (f) Good Sam Hospital.

Additionally, based on the facts and legal authority outlined above, the Court finds and concludes as follows: (1) Plaintiff bears the burden of proving a specific and definite amount of past medical expenses; (2) Plaintiff cannot recover in excess of the damages sustained; (3) Plaintiff was a Medicare beneficiary at all material times; (4) as a Medicare beneficiary, Plaintiff is not liable for reimbursement of any amount in excess of Medicare rates; (5) none of Plaintiff's health care providers opted-out of Medicare, and were, therefore, required by law to submit Plaintiff's bills to Medicare and accept Medicare rates as payment in full; (6) those providers who did not properly opt-out violated statutory law by not submitting Plaintiff's bills to Medicare; (7) the improper charges in excess of applicable Medicare rates are not recoverable either by the providers or Plaintiff; and (8) awarding Plaintiff anything above the Medicare rates would result in a wind-fall as over and above the amounts necessary to make Plaintiff whole. Accordingly, Plaintiff is precluded from introducing evidence as to the original charges beyond the corresponding Medicare rates for the same to establish past medical expenses.

4. Joerg applies only to *future* Medicare benefits, not *past* Medicare benefits.

Plaintiff relies on *Joerg v. State Farm Mutual Automobile Insurance Co.*, 176 So. 3d 1247 (Fla. 2015) in opposition to Defendant's Motion. The holding in *Joerg* is inapplicable because it only applies to *future* Medicare benefits, which are uncertain and for which Medicare retains a right of reimbursement. *Id.* at 1253. Defendant is not attempting to limit evidence as to future treatment potentially covered by Medicare. Defendant's motion pertained only to *past* medical treatment, which should have been paid for by Medicare. Instead, this issue is governed by *Coop. Leasing* and *Thyssenkrupp* both of which remain good law. *See Dial*, 308 So. 3d at 691 (determining that *Joerg* did not abrogate the evidentiary ruling in *Coop. Leasing*, and only

spoke to *future* Medicare benefits, not past benefits).

5. The presence of Defendant's liability insurer as a potential primary payer is irrelevant.

Plaintiff argues Medicare is a secondary payer under federal law, and the presence of primary payer (in this case the Defendant's insurer) precludes Medicare from paying for Plaintiff's treatment. Initially, this is incorrect as Medicare *has* paid much of Plaintiff's past medical bills in this case. Additionally, regardless of whether there may be a primary payer, such entity's responsibility to pay has not been demonstrated. Even if it had been demonstrated, that would only mean the primary payer is responsible for reimbursing Medicare for Medicare's conditional payments made at the Medicare rates. In any event, the most Plaintiff could recover would be the rates charged by Medicare.

"The Medicare Secondary Payer statute ("MSP") . . . makes Medicare the secondary payer for medical services provided to Medicare beneficiaries whenever payment is available from another primary payer." *Glover v. Liggett Group, Inc.*, 459 F.3d 1304, 1306 (11th Cir. 2006). One such primary payer is an automobile or liability insurance policy or plan. *Id*. (citing 42 U.S.C. § 1395y(b)(2)(A)). *See also MSP Recovery Claims v. QBE Holdings, Inc*., 965 F.3d 1210, 1214 (11th Cir. 2020) ("Sometimes a third party has an obligation to pay for a beneficiary's healthcare costs, such as when a person enrolled in Medicare is injured in an automobile accident caused by another driver . . ."); *Cochran v. U.S. Health Care Fin. Admin*., 291 F.3d 775, 777 (11th Cir. 2002) (primary payer includes the private insurer of someone liable to the beneficiary).

"This means that if payment for covered services has been or is reasonably expected to be made by someone else, Medicare does not have to pay." *Glover* at 1306. But Medicare often makes conditional payments for covered services when the primary payer is not expected to pay

promptly. *Id*. "The way the system is set up the beneficiary gets the health care she needs, but Medicare is entitled to reimbursement if and when the primary payer pays her." *Cochran*, 291 F.3d at 777.

> Authority to make conditional payment. The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) [subpara. (A)] has not made or cannot reasonably be expected to make payment with respect to such item or service **promptly** (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.

42 U.S.C. § 1395y(b)(2)(B)(i) (emphasis added).

In that scenario, Medicare has a right of reimbursement from the primary payer. Reimbursement must occur if the primary payer "has or had a responsibility to make payment with respect to such item or service." *Glover* at *id*. (quoting 42 U.S.C. § 1395y(b)(2)(B)(ii)). Responsibility is demonstrated by "a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means." *Id*. In other words, "a separate adjudication or agreement." *MSP Recovery, LLC v. Allstate Ins. Co*., 835 F.3d 1351, 1361 (11th Cir. 2016) ("In *Glover*, we concluded that responsibility [to pay] must be demonstrated by 'a separate adjudication or agreement.'"). *See also Cochran*, 291 F.3d at 778 (reimbursement responsibility based on "judgments or settlements related to injuries for which Medicare paid medical costs, thereby casting the tortfeasor as the primary payer"). "That is why Medicare asks attorneys handling any related tort suits for its beneficiaries to supply the agency with a copy of the agreement setting out the share of the recovery they are to receive." *Id*.

In *Glover*, Plaintiff argued Defendants' (primary payers) responsibility to pay was demonstrated simply because Defendants were litigating a state court tort claim. *Glover*, 459 F.3d at 1308. The Eleventh Circuit rejected that argument. Defendants' responsibility to pay was not demonstrated simply by being a party to the tort litigation. Defendants were never adjudicated liable and never made a payment conditioned on a release of claims for the health care expenses caused by the tort. *Id*. at 1308. Defendants' responsibility to pay for items or services, therefore, was not demonstrated simply based on filing the underlying tort action or the subsequent action under the MSP to recover benefits. *Id*. at 1309. Until Defendants' responsibility to pay is demonstrated (e.g., by a judgment), there is no obligation to reimburse Medicare. *Id*. The Eleventh Circuit, in a different case, gave a real-world example:

> As with most complex concepts, a real-world example helps make the Act's contours more clear. Imagine a 65-year-old Medicare beneficiary who is injured when he slips on the wet floor of a supermarket and subsequently receives medical attention for his injuries. If the supermarket's negligence caused the man's injuries, the supermarket (or its liability insurance carrier) is ultimately responsible for his medical bills. But if the supermarket denies responsibility, litigation may be required to resolve the man's negligence claim, and he may not have the money to pay for his medical care in the meantime. Because this is a situation in which the supermarket cannot reasonably be expected to pay **promptly**, the Act allows Medicare to pay the man's medical bills on a conditional basis.
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> Now imagine that the man and the supermarket settle the negligence claim and that the supermarket's insurer pays the settlement funds to the man. To recoup the medical payments Medicare conditionally made, the Act allows the government to sue the insurer (which, because of the settlement, has been demonstrated to be the primary payer), the injured man (who is the recipient of a payment from the primary payment), or both of them. The government can, of course, recover only once, *see* 54 Fed. Reg. 41716, 41720 (Oct. 11, 1989) (the agency "will not pursue duplicate recoveries"), and if its recovery is against the insurer, the insurer can in turn sue the man to recover the payment it made to him, *see Shalala*, 23 F.3d at 418 n.4. *See also* 42 C.F.R. § 411.24(i)(1) ("If Medicare is not reimbursed as required . . . the primary payer must reimburse Medicare even though it has already reimbursed the beneficiary or other party.").

U.S. v. Stricker, 524 F. App'x. 500, 504 (11th Cir. 2013) (emphasis added). *See also Shapiro v. Sec'y of HHS*, No. 15-22151-Civ-COOKE/TORRES, 2017 U.S. Dist. LEXIS 42278, *6 (S.D. Fla. Mar. 23, 2017) (explaining tortfeasor's post-judgment and post-settlement responsibility to reimburse Medicare).

Additionally, 42 U.S.C. § 1395y(b)(2)(A) does not address whether providers may charge or bill a Medicare beneficiary in excess of Medicare rates or whether they may enter into a private contract with a beneficiary without first opting out of the Medicare program. Thus, health care providers remain legally restricted in the amounts they can charge Medicare beneficiaries regardless of whether those charges are ultimately paid by Medicare or a primary payer in the future.

In this lawsuit, regardless of whether there may be a primary payer, such entity's responsibility to pay has not been demonstrated. Such entity is not even a party to this lawsuit. And there is no judgment and no settlement in this case. The simple fact that an entity may insure the Defendant in this action does not demonstrate that entity's responsibility to pay for Plaintiff's medical expenses.

Moreover, even if Medicare *had* paid for Plaintiff's medical expenses, and even if—ultimately—an insurer is responsible to reimburse Medicare as the primary payer, the insurer would reimburse Medicare at the rates charged by Medicare. Absent properly opting-out of Medicare, nothing in 42 U.S.C. § 1395y suggests a provider can charge greater amounts than Medicare's rates. Further, the CMS guidelines again state: "[I]f the provider bills Medicare, the provider must accept the Medicare approved amount as payment in full and may charge beneficiaries only deductibles and coinsurance."

Thus, Plaintiff would still only incur actual medical expenses at the lower Medicare rates. And only those costs may be awarded to make the Plaintiff whole.

6. A Plaintiff also owes an obligation to submit medical bills to Medicare.

A Medicare beneficiary can submit his bills to Medicare if his physicians do not.[3] Doing so would mitigate the Plaintiff's damages.

> [T]he term "mitigation of damages" has no single meaning and is used by the courts to describe several different problems in the law of damages, the term as used herein encompasses those facts which tend to show that the conceded or assumed cause of action does not entitle the plaintiff to as large an amount of damages as would otherwise be recoverable. Specifically, the type of problem litigated herein involves the doctrine of avoidable consequences, or efforts to minimize damages, where the plaintiff reasonably could have avoided a part or all of the consequences of the defendant's wrongful act.

Parker v. Montgomery, 529 So. 2d 1145, 1147 (Fla. 1st DCA 1988) (concluding that "the concept of avoidable consequences or mitigation of damages is included within the . . . definition of comparative fault").

Both comparative fault and avoidable consequences make recovery dependent on the plaintiff's proper care of the protection of her own interests and both require she act as a reasonable person under the circumstances. *Ridley v. Safety Kleen Corp*., 693 So. 2d 934, 942 (Fla. 1996). "Accordingly, if some of the damages incurred could have reasonably been avoided by the plaintiff, [this] doctrine prevents those damages from being added to the amount of damages recoverable." *Id.*; *See also Sys. Components Corp. v. Fla. DOT*, 14 So. 3d 967, 982 (Fla. 2009).

[3] See https://www.medicare.gov/claims-and-appeals/file-a-claim/file-a-claim.html

7. Public policy favors limiting a plaintiff to recover only Medicare's reimbursement rates.

Not only does federal law require the providers accept Medicare, but public policy favors requiring providers accept Medicare reimbursement rates for Medicare enrolled patient/plaintiffs. Judge Thomas H. Barkdull, III issued a comprehensive order on this issue. In granting Defendant's motion to limit evidence of medical expenses to Medicare rates—where Plaintiff's providers were required but did not submit Plaintiff's bills to Medicare—he explained the public policy reasons in support of his decision:

> The particular danger that is sought to be avoided are situations where patients/plaintiffs, who are Medicare beneficiaries and who have filed suit against an alleged tortfeasor, receive medical treatment from providers who would otherwise accept Medicare reimbursement rates but decline to submit bills for treatment through Medicare in these litigation cases so that they may charge and claim full value for their treatment. All too frequently, these plaintiffs, who, by virtue of being Medicare recipients, are recognized as being at-risk population due either to seniority or disability, are left with exorbitant medical bills when they are unsuccessful in litigation.
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> Based on this long standing established public policy, this Court finds that in addition to the federal regulations which govern how participating physicians and practitioners are permitted to charge and contract with beneficiaries, there is a legitimate government interest in protecting the elderly community and other beneficiaries from being charged in excess of Medicare reimbursement rates and in properly and thoroughly advising plaintiff-patients of the perils of permitting their providers to bill outside of the Medicare reimbursement schedules. These public policy concerns support this Court's ruling.

Richardson v. Wal-Mart Stores, Inc., No. 2014-CA-015197 (Fla. 15th Cir. Ct., Dec 13, 2017) (Order on Re-Hearing on Wal-Mart Stores, Inc.'s Motion to Limit Medical Bills Provided Under Letters of Protection).

The purpose behind Title XVIII of the Social Security Act, the administration of the Medicare program by CMS, and the case law cited above, is thwarted by permitting Plaintiff to recover in excess of Medicare rates when the services/treatment is required by law to be limited

to Medicare rates. Plaintiff's health care providers here are only legally permitted to charge Plaintiff in the amounts established by the Medicare program. Plaintiff, therefore, is only responsible for that amount, which would represent Plaintiff's compensatory damages. If a defendant can only be liable for Plaintiff's compensatory damages for past medical expenses, it would contravene public policy for said defendant be held liable for an amount greater than what Plaintiff would ever be responsible for paying. **WHEREFORE**, it is hereby

ORDERED and ADJUDGED that Defendant's Motion is **GRANTED**. Plaintiff may only introduce into evidence (and recover) the amounts of past medical expenses paid by Medicare for the following providers: (a) Jupiter Pain; (b) Resolute Pain; (c) Jupiter Outpatient; (d) MD Now; (e) Palm Beach Gardens Hospital; and (f) Good Sam Hospital. Plaintiff may only introduce into evidence (and recover) the Medicare rates for her past medical expenses billed by the following providers: (a) Dr. Theofolis; (b) Dr. Contando; and (c) Advanced Diagnosis.

DONE and ORDERED in Chambers, at West Palm Beach, Palm Beach County, Florida, this _____ day of May, 2022.

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John S. Kastrenakes
Circuit Judge

JOHN S. KASTRENKES
Circuit Judge

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