DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-10-125

In the case of	**Claim for**
M.B.C. (Appellant)	Medicare Secondary Payer
**** (Beneficiary)	**** (HIC Number)
Medicare Secondary Payer Recovery Contractor (Contractor)	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated September 22, 2009, concerning the beneficiary's possible liability for Medicare payments made for medical treatments received from December 29, 2006, through September 4, 2007, for an injury to the beneficiary's lower back. The ALJ determined that the beneficiary owes Medicare $1,147.74 for these payments.[1] The appellant beneficiary has asked the Medicare Appeals Council to review this action.

The Council reviews the ALJ's decision *de novo*. 42 C.F.R. § 405.1108(a). The Council will limit its review of the ALJ's action to the exceptions raised by the party in the request for review, unless the appellant is an unrepresented beneficiary. 42 C.F.R. § 405.1112(c). The beneficiary's request for review and its attachments will be made a part of the record as Exhibit (Exh.) MAC-1. For the reasons set forth below, the Council reverses the ALJ's decision.

[1] The ALJ's statement as to the amount claimed by the Medicare Secondary Payment Recovery Contractor (MSPRC) ($1,147.74) is based on the MSPRC's letter of December 12, 2008. Dec. at 1, *citing* Exh. 8 at 1. However, the MSPRC's Payment Recovery Form dated December 12, 2008, shows a balance of $1,350.27 in conditional payments. Exh. 1 at 15-16.

In her request for review, the appellant beneficiary contends that the medical services that she received on the dates at issue were for a lower back injury that she sustained at home in October 2006, and were not related to the job-based injuries for which she received a workers' compensation settlement, approved on February 21, 2008. *See* Exh. MAC-1. Therefore, she denies any indebtedness to Medicare for the payments it made for the dates of service at issue here. The appellant also contends that her private medical insurers (Carpenters/Blue Cross) made payment for all of the treatment she received in 2003 and 2004 for job-related injuries (to her neck, cervical spine, and upper extremities), and that she was not covered by Medicare at that time. *Id.* The records in the file, and the additional documentation that the appellant submitted during the appeals process, support the appellant's contentions.

In the following pages, the Council provides a summary of the beneficiary's workers' compensation injury and settlement, the lower back injury she sustained at home, and the procedural history of this case. On the basis of this information, the Council analyzes and explains why the beneficiary's medical treatment for her lower back (lumbar and sacral spine) injury could not have been paid for under her workers' compensation settlement (for cervical spine and bilateral upper extremities injuries). Because the two injuries are unrelated, the Medicare Secondary Payer recovery contractor erred by asking the beneficiary to repay Medicare for the sums Medicare paid to cover her lower back treatment.

Factual Background and Procedural History

The Workers' Compensation Injury and Surgery

On March 23, 2003, the appellant filed a workers' compensation claim as a result of cumulative trauma injury to her neck and upper extremities from her usual and customary repetitive activities as a forklift driver. Exh. 4 at 2. At the time she was fifty-four years old. In March 2004, she had surgery for neck and spinal injuries, including anterior cervical decompression and fusion, foraminotomy, bone spur excision, instrumentation at C5-6 and bone grafting. *Id.* Thereafter, she was treated with physical and occupational therapy, anti-inflammatory and muscle relaxant medication for the spine pain radiating to the shoulders, and for epicondylitis and carpal

tunnel syndrome. *Id.* In addition, she used a soft collar and wrist braces. *Id.* Her private insurer, Carpenters/Blue Cross, paid for these medical treatments. Testimony of the Appellant, CD Recording of ALJ Hearing, August 24, 2009; *see also* Exh. 19 at 18-20 (Account Activity for M*** B. C*** (from March 9, 2004, through December 3, 2004)). In 2003 and 2004 the appellant did not have Medicare coverage. She first began receiving Medicare on September 1, 2005. Testimony of Appellant, CD Recording of ALJ Hearing, August 24, 2009; *see also* Exh. MAC-1, Attachments (CMS Letter verifying the appellant's date of initial Medicare enrollment; copy of appellant's Medicare card with effective date of September 1, 2005).

The Lower Back Injury in October 2007

In October 2007 the appellant injured her lower back when she fell out of bed, onto her back and onto a footstool she kept next to the bed. *See* Exh. 14 at 1-3 (appellant's appeal memo to OMHA, June 29, 2009); *see also* Exh. 7 at 1 (appellant's letter to CMS, May 15, 2008); Exh. 12 at 1-12 (appellant's letter to the QIC Project Director, May 22, 2009 (attaching medical records from the hospital and the imaging of her lower back, lumbar and sacral vertebrae)). On November 29, 2006, the appellant went to the hospital emergency room for severe pain in her back and stomach. *Id.* The hospital physician diagnosed a urinary tract infection, and admitted and treated her. *Id.* After the hospital took x-rays of her lumbar and sacral spine and pelvis, and a CT scan of her lumbar spine, the hospital physician also diagnosed her with a "closed fracture, left transverse process, lumbar spine, resolving." Exh. 12 at 3-7. The hospital referred her to an orthopedist for follow up, and he prescribed treatment for her lower back in 2007.[2] *Id.* at 1; *see also* Exh. 19 at 22-23. Medicare paid for treatment on these dates of service. Exh. 1 at 4-7.[3]

[2] The orthopedist later noted that he did not see evidence of a fracture of her lumbar spine on the CT scan or x-rays taken at the hospital. Exh. 14 at 16-17.

[3] This treatment consisted of an additional visit with the orthopedist and use of a TENS (transcutaneous electrical nerve stimulation) unit that he prescribed. *See* Exh. 14 at 16-17; Exh. 1 at 15-16.

The Workers' Compensation Settlement

The appellant filed for workers' compensation after her neck, cervical, and upper extremity injuries were diagnosed. The process concluded with the approval of a settlement agreement signed by a California Workers' Compensation Appeals Board judge on February 21, 2008. Exh. 1 at 30-33. The first paragraph of the settlement agreement describes the appellant's employment-related injury as "cervical spine, bilateral upper extremities." Exh. 1 at 31. The third paragraph states, "This agreement is limited to settlement of the body parts, conditions, or systems and for the dates of injury [CT 3/28/03] set forth in Paragraph No. 1 despite any language to the contrary in this document or any addendum." In other words, the workers' compensation settlement only covered the injuries that the appellant had, as of March 28, 2003, to her cervical spine and bilateral upper extremities.

As part of the workers' compensation settlement agreement, the appellant set up and the Centers for Medicare and Medicaid Services (C.M.S.) reviewed a "Medicare Set-Aside Trust Fund," to be self-administered by the beneficiary. Exh. 1 at 30-33; Exh. 4 at 1-4. The beneficiary placed $18,740 of her workers' compensation settlement monies in this trust fund, to be used when she required further medical care because of the work-based injuries to her cervical spine, and bilateral upper extremities. *See* Pub. 100-5, Medicare Secondary Payer Manual (MSPM), Chapter 1, Sections 10.4 and 20; *see also* information at http://www.cms.hhs.gov/workerscompagencyservices/.

Procedural History of This Case

On May 12, 2008, a Medicare Secondary Payer Recovery Contractor (MSPRC) wrote to the appellant beneficiary, asking her to pay for the treatment for her back injury and her urinary tract infection (2006-2007), on the ground they were related to the injuries for which she received workers' compensation. Exh. 1 at 4-7. The appellant responded with a letter on May 15, 2008, explaining why the respective injuries were not related. *Id.* at 26-28. On redetermination, the MSPRC removed the hospital charges for the urinary tract infection and lower back injury, including multiple imaging of the lumbar spine and pelvis. Exh. 1 at 14-16. The appellant requested reconsideration, explaining again that the remaining charges for her lower back injury were

not related to her workers' compensation injuries. Exh. 9 at 1-2.

The Qualified Independent Contractor (QIC) denied the appellant's request for reconsideration. Exh. 11 at 1-6. Shortly thereafter, the appellant wrote again to the QIC, trying again to explain the difference between her workers' compensation-related injuries and the lower back injury resulting from her fall out of bed. Exh. 12 at 1. With this letter, she included copies of her hospital record. *Id.* at 3-12. The QIC declined to reopen. Exh. 13 at 1-2.

The appellant filed a request for an ALJ hearing, with a more detailed written explanation of the difference between her workers' compensation-related injuries and the lower back injury, and attached a copy of the report from the orthopedist to whom she had been referred. Exh. 14 at 1-3, 16-17. The ALJ upheld the QIC's determination that the appellant must refund Medicare $1,147.74 for the dates of service still at issue, on the ground that she had not produced sufficient documentation. The appellant then filed this request for review by the Medicare Appeals Council.

Analysis

The issue in this case is whether the beneficiary received Medicare coverage for medical treatment that could reasonably have been paid for under her California workers' compensation settlement, and therefore should be required to reimburse Medicare from the trust fund set up as part of that settlement. Section 1862(b)(2)(A)(ii) of the Social Security Act (Act) provides, in relevant part, that Medicare payments may not be made with respect to any item or service to the extent that payment has been made or can reasonably be made under a workmen's compensation law or plan of the United States or a State. If it is determined that Medicare has paid for items or services that can be or could have been paid under workers' compensation, then the Medicare payment constitutes an overpayment. Pub. 100-05, MSPM, Chapter 1, Sections 10.4 and 10.4.1.

In this case, medical services can be or could have been paid for under the appellant's workers' compensation settlement (and from her Medicare Set-Aside Trust Fund) if the medical expenses were related to the injury or disease that was the basis for the workers' compensation settlement. 42 C.F.R. § 411.46. More

specifically, if the medical services the appellant received from December 29, 2006, through September 4, 2007, for her lower back injury were related to the cervical spine and bilateral upper extremity injuries she suffered as a result of her forklift work, then she may be required to repay Medicare for the $1,350.27 that Medicare has paid for those services.

However, the appellant has demonstrated that the medical services for her lower back injury were not related to her earlier cervical spine and bilateral upper extremity injuries, for several reasons. The earlier injuries sustained in 2003, which were attributable to her job duties, were in her neck and cervical spine area. In contrast, the 2006 injury is in her lower back and lumbar and sacral spine area. Second, the injuries occurred at different points in time. The orthopedist's report of December 7, 2006, examining the later injury (from the fall at home), states, "The patient has had prior severe pain in her back, which has resolved." Exh. 14 at 16.

Third, the cause of her lower back injury was a fall from bed onto an uneven surface (the floor and a footstool), on her back. *See* Exh. 14 at 6 (hospital emergency department record of the fall off her bed); *see also* Exh. 7 at 1 (appellant's letter to CMS, May 15, 2008); Exh. 12 at 1-12 (appellant's letter to the QIC Project Director, May 22, 2009 (attaching medical records)); and Exh. 14 at 1-3 (appellant's appeal memo to OMHA, June 29, 2009). The fall that caused her lower back injury is not related to any cervical spine injuries that were the subject of her workers' compensation settlement, nor is it related to any injuries for which she seeking either workers' compensation or other remuneration. For all of these reasons, the Council determines that the medical services for the appellant's lower back injury (from December 29, 2006, through September 4, 2007) were not related to the workers' compensation injuries and could not have been paid for under her workers' compensation settlement.[4]

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[4] It would appear that the Medicare Secondary Payer recovery contractor in this case may have assumed initially that the services the beneficiary received for her lower back injury were related to the earlier workers' compensation injuries because one of the five ICD-9 codes appearing on the Workers Compensation Medicare Set-Aside Review form (724.2 – Lumbago: low back pain, low back syndrome, lumbalgia) is the same as one of the five ICD-9 codes appearing on the Medicare billing statements for the lower back injury treatment. *Compare* Exh. 4 at 1 *with* Exh. 1 at 15-16. However, as explained above, the California Workers' Compensation Settlement contains an explicit

DECISION

For the foregoing reasons, the Council reverses the ALJ's decision, and determines that the appellant is not liable to Medicare for the costs of medical services provided from December 29, 2006, through September 4, 2007, identified on the MSPRC's Payment Summary Form dated December 12, 2008 (Exh. 1 at 15-16) and the chart attached to this decision (Attachment A).

MEDICARE APPEALS COUNCIL

/s/ M. Susan Wiley
Administrative Appeals Judge

/s/ Susan S. Yim
Administrative Appeals Judge

Date: March 19, 2010

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limitation of the injury definition to "cervical spine, bilateral upper extremities."