DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-16-2671

In the case of	**Claim for**
T.P., surviving spouse, & J.P., C.P., & A.B., next of kin (Appellant)	Medicare Secondary Payer (MSP)
**** (Beneficiary)	**** (HIC Number)
Medicare Secondary Payer Recovery Contractor (Contractor)	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated February 5, 2016. The decision addresses whether Medicare can recover conditional payments that it made on behalf of the beneficiary (now deceased) for medical treatments, after the alleged failure of the beneficiary's physician to promptly diagnose prostate cancer. The ALJ concluded that Medicare is entitled to recover the conditional Medicare payments, less their procurement costs, for a total of approximately $171,537.04, plus interest, in accordance with the Medicare Secondary Payer statute.[1] The appellant 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.

[1] The ALJ indicates that the amount of conditional payments at issue, after subtracting procurement costs, was $171,537 (plus interest). Dec. at 2, 4, 12-13. The ALJ's decision also states that "over $177,000.00, with interest, claimed by Medicare as a secondary payer" is at issue. Dec. at 13. In Part II of this decision, below, the Council recalculates and corrects the amount of conditional payments owed, and explains its basis for doing so.

42 C.F.R. § 405.1112(c). The Council has entered the appellants' request for review and accompanying brief and attachments, received April 1, 2016, into the record as Exhibit (Exh.) MAC-1. The Council has also entered the appellants' request for escalation to federal district court into the record as Exh. MAC-2. The email summarizing the agreement that the Council would issue a decision within 30 days is made a part of the record as Exh. MAC-3.

The Council has considered the record and the exceptions in the appellant's request for review. For the reasons set forth below, the Council modifies the ALJ's decision in three respects: first, to provide additional reasons supporting the ALJ's determination that counsel for the appellants attempted to convert the mixed survival (medical malpractice) and wrongful death lawsuit into a pure wrongful death lawsuit in order to avoid Medicare's recovery of its conditional payments for medical care; second, to respond to the contentions the appellants advanced in their request for review; and third, to correctly allocate the amount recovered in the settlement between the medical malpractice action (the proceeds of which include medical expenses) and the wrongful death action (the proceeds of which do not include medical expenses).[2]

LEGAL AUTHORITIES

The Medicare Secondary Payer law is established by section 1862(b)(2) of the Social Security Act (Act), which provides as follows:

> (A) In General.— Payment under this title may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that—
>
> (i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or
>
> (ii) payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State or under an automobile

[2] The appellants in this Medicare administrative appeal (the beneficiary's spouse and three adult children) are represented by P.B. and D.N., the same attorneys who represented them in the medical malpractice and wrongful death lawsuit in Illinois state court, and in filing the motion in Illinois state court for approval of the settlement and distribution of the settlement proceeds. The Council refers to these attorneys as "counsel for the appellants" or "appellants' counsel."

> or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.
>
> In this subsection, the term “primary plan” means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen’s compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies. An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.
>
> (B) Conditional payment.—
>
> (i) 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) 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.
>
> (ii) Repayment required.— A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan’s responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient’s compromise, waiver, or release (whether or not there is a determination or admission 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. . . .

The Medicare regulations implementing the Medicare Secondary Payer statute are at 42 C.F.R. Part 411, Subparts B through H. Those regulations include the following provisions, *inter alia*:

> **Basis for conditional Medicare payment in liability cases.**
>
> * * *
>
> (b) Any conditional payment that CMS makes is conditioned on reimbursement to CMS in accordance with subpart B of this part.

42 C.F.R. § 411.52(b).

> **Basis for Medicare secondary payments.**
>
> *Basic rules.* (1) Medicare benefits are secondary to benefits payable by a primary payer even if State law or the primary payer states that its benefits are secondary to Medicare benefits or otherwise limits its payments to Medicare beneficiaries.

42 C.F.R. § 411.32(a).

The Medicare Secondary Payer Manual (MSPM), CMS Pub. 100-05, further provides:

> In general, Medicare policy requires recovering payments from liability awards or settlements, whether the settlement arises from a personal injury action or a survivor action, without regard to how the settlement agreement stipulates disbursement should be made. That includes situations in which the settlements do not expressly include damages for medical expenses. Since liability payments are usually based on the injured or deceased person's medical expenses, liability payments are considered to have been made "with respect to" medical services related to the injury even when the settlement does not expressly include an amount for medical expenses. To the extent that Medicare has paid for such services, the law obligates Medicare to seek recovery of its payments. The only situation in which Medicare recognizes allocations of liability payments to nonmedical losses is when payment is based on a court order on the merits of the case. If the court or other adjudicator of the merits specifically designates amounts that are for payment of pain and suffering or other amounts not related to medical services, Medicare will accept the Court's designation. Medicare does not seek recovery from portions of court awards that are designated as payment for losses other than medical services.

MSPM, Chapter 7, § 50.4.4.[3]

[3] CMS manuals are generally available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html. The Council notes that, as of the date of this decision, Chapter 7 of the MSPM is not posted on the CMS website, presumably because it is undergoing revision.

The MSPM also contains a provision stating that when a liability insurance payment is made pursuant to an action brought under a State's wrongful death statute, Medicare may recover from the payment only if the State statute permits recovery of medical expenses. MSPM, Chapter 7, § 50.5.4.1.1. This section of the MSPM also provides that if a State wrongful death statute does not permit recovering medical damages, Medicare has no claim to the wrongful death payments. *Id.*

Section 1870(c) of the Act permits waiver of the recovery of an overpayment when a beneficiary shows that he or she is "without fault" and that adjustment or recovery would either (1) defeat the purpose of Title II or XVIII of the Act, or (2) be against equity and good conscience. *See* 42 C.F.R. 405.355, 411.28; *see also* 42 C.F.R. part 405, subpart C; 20 C.F.R. §§ 404.506 - 404.509, 404.512.

The Illinois Wrongful Death Act, Chapter 740, Sections 180/0.01, 1, 2, and 2.1 of the Illinois Compiled Statutes (ILCS) provide for the surviving spouse and next of kin of a deceased person, whose death was caused by a wrongful act, neglect, or default, to bring an action against the person, company, or corporation liable for that wrongful act, neglect or default, and to recover fair and just compensation for the pecuniary injuries resulting from such death, including damages for grief, sorrow, and mental suffering.

Section 2 provides that the amount recovered in any such action shall be distributed by the court to each of the surviving spouse and next of kin, in the proportion, as determined by the court, that the percentage of dependency of each such person upon the deceased person bears to the sum of the percentages of dependency of all such persons upon the deceased person. Section 2 also provides that the amount recovered in every such action shall be for the exclusive benefit of the surviving spouse and next of kin. The court will conduct a hearing to determine the degree of dependency of each beneficiary of the action upon the decedent, and will calculate the amount of the damages to be awarded to each beneficiary.

BACKGROUND

The Medical Malpractice and Wrongful Death Lawsuit

The first of two main issues in this case is whether the appellants converted a lawsuit and settlement including both medical malpractice and wrongful death claims into a lawsuit and settlement including only wrongful death claims, in order to prevent Medicare from recovering any of the $253,546.73 in conditional payments it had made for the beneficiary's medical care under the Medicare Secondary Payer statute. In analyzing this issue, it is useful to review the history of the litigation resulting in the settlement here.

From 1997 through April 2007, G.P., the Medicare beneficiary (now deceased), received diagnostic testing (including testing for signs and symptoms of prostate cancer) ordered by his primary care physician, Dr. D.G. Exh. 2 at 7-13. On April 23, 2007, the beneficiary was diagnosed with prostate cancer. *Id.* at 11. On April 21, 2009, the beneficiary brought a lawsuit in Illinois state court against his primary care physician and his urologist (and their respective practice groups), alleging medical malpractice based on their failure to timely diagnose his prostate cancer. *See also* Exh. 5 at 5-9 (second amended complaint).[4]

Under Illinois law, a medical malpractice lawsuit includes claims for medical expenses. Under Medicare Secondary Payer law, Medicare may seek reimbursement for conditional medical payments it has made for medical care from monies recovered by the beneficiary for medical expenses. Section 1862(b)(2) of the Act.

From April 23, 2007, when the beneficiary's cancer was diagnosed, through his death on January 2, 2012, Medicare made

[4] The administrative record in this case does not contain a copy of the first complaint, or the first amended complaint, both filed in the malpractice lawsuit, because appellants' counsel did not submit these documents. *See* Exh. 5 at 5-6 (submitting only the second amended complaint). However, it is undisputed that the first complaint was a medical malpractice complaint and included a request for medical expenses, *inter alia,* as damages. It is also undisputed that the first amended complaint contained both the estate's survival claims (for medical malpractice), and also wrongful death claims on behalf of the beneficiary's next of kin (including his wife and three adult children).

conditional payments totaling $253,546.73 for the medical treatment of his cancer. Exh. 5 at 6, and 35-39.

Following the beneficiary's death in January 2012, his wife was appointed as a special administrator of his estate, and a first amended complaint was filed in the malpractice lawsuit. The first amended complaint included the estate's survival claims (for medical malpractice), and also added wrongful death claims on behalf of the beneficiary's next of kin (including his wife and three adult children). Exh. 5 at 6.

Under Illinois law, a survival action continues/includes legal claims, such as medical malpractice, that the decedent had a right to bring before he died, and is maintained and pursued on behalf of the decedent's estate. A wrongful death action in Illinois, on the other hand, is filed on behalf of a decedent's surviving spouse and next of kin, and includes claims for pecuniary injuries resulting from such death, including damages for grief, sorrow, and mental suffering. 740 ILCS 180. In Illinois, a wrongful death action does not include claims for medical expenses. *Id.; see also, e.g., Graul v. Adrian,* 32 Ill.2d 345 (1965).

According to appellants' counsel, in the fall of 2012, appellants entered into a tentative settlement of the lawsuit for $250,000 plus costs, with the beneficiary's primary care physician (Dr. D.G.) and his practice group. Exh. 5 at 6; Exh. 2 at 83-83. These defendants were then dismissed from the case. Exh. 5 at 6. However, also according to appellants' counsel, that settlement fell through, and Dr. D.G. and his practice group were reinstated as defendants in the case on September 11, 2013. *Id.*

On September 23, 2013, the Illinois state court granted a motion to dismiss for failure to state a claim filed by the beneficiary's urologist and his practice group. Exh. 5 at 6. The beneficiary's primary care physician and his practice group remained as defendants in the case. *Id.* The court granted leave for the plaintiffs to file a second amended complaint. *Id.* However, according to appellants' counsel, they did not file that complaint "due to a ministerial oversight." *Id.*

Also according to the appellants' counsel, "the parties continued to discuss settlement, and a settlement was reached in December, 2013 for $258,664.10, of which the next of kin would receive $175,000.00 and the remainder [would go] towards

attorneys fees and case related expenses." Exh. 5 at 6-7. This settlement amount was the same as the settlement amount that the same parties had tentatively arrived at in the fall of 2012, for the lawsuit including both the estate's survival claims (for medical malpractice), and also wrongful death claims on behalf of the beneficiary's next of kin. Exh. 2 at 83-84.

Once the settlement was reached, counsel for the appellants prepared the documents necessary to file the settlement with the Illinois state court and to request a distribution of the proceeds among the next of kin, pursuant to Illinois law (740 ILCS 180/2). Exh. 5 at 11-16. Two weeks later, appellants' counsel apparently realized that they had failed to file a second amended complaint after earlier receiving leave of court to do so. Appellants' counsel sought and received leave of court a second time to file a second amended complaint. Exh. 5 at 7, 27. The second amended complaint that counsel prepared and filed *replaced* the first amended complaint which had included both the estate's survival claims (for medical malpractice) and the wrongful death claims with a complaint containing wrongful death claims *only* and requesting damages which they stated were "in excess of" $100,000. *Id.* at 28-34.

Appellant's counsel also prepared and filed with the Illinois court a "Motion to Approve Settlement and Distribution, to Confirm That Settlement is Made Exclusively Pursuant to the Wrongful Death Act, and to Dismiss" (motion to approve settlement) and an accompanying proposed Order. Exh. 5 at 11-16, 91-93. The motion asserted that the $250,000.00 settlement should be ascribed wholly to damages in the wrongful death action. For example, the motion stated:

> 7. . . . [T]he settlement should be apportioned 100% to the Wrongful Death claim.
> * * *
> 13. Because this matter was settled exclusively under the Illinois Wrongful Death Act, which does not allow Medicare or other liens to attach, Medicare does not have a cognizable claim for medical expenses against the settlement proceeds allocated to the next of kin in this matter.

Id. at 12, 14. However, appellants' counsel did not document, in any way, these assertions that the matter was settled "exclusively under the Illinois Wrongful Death Act," and that Medicare did not have a cognizable claim to recover conditional

payments for medical care. Nor did appellants' counsel mention or explain the fact that the settlement recovery ($250,000 plus costs) was the same as the settlement it had almost obtained earlier for a lawsuit that combined the medical malpractice and wrongful death claims.

Nevertheless, in the motion, appellants' counsel explained why it was asking the Illinois court to enter an order stating that the case was "settled exclusively under the Illinois Wrongful Death Act," as follows:

> 15. According to Medicare, several steps must be taken before it will even consider waiving its lien. First, the matter must settle exclusively under the Illinois Wrongful Death Act, as Medicare can rightfully attach its lien to any monies allocated to satisfy damages brought under the Survival Act. * * *
>
> 16. Thus, in order to commence the process of requesting Medicare to waive its lien, the Estate needs this Court to enter a written order memorializing that this matter was settled exclusively under the Illinois Wrongful Death Act. Until that time, Medicare's claim for $247,687.82 will remain.
>
> 17. Despite the foregoing legal support, there is absolutely no guarantee that Medicare will waive its lien completely. If Medicare refuses to waive its lien, an action would have to be pursued against Medicare in federal court. A written order memorializing that this matter was settled under the Illinois Wrongful Death Act will assist the parties in litigating the Medicare claim in federal court.

Exh. 5 at 14-16.

Approximately one month after the motion was filed, the Illinois court signed the order requested, worded exactly as appellants' counsel had drafted it, stating, *inter alia*:

> 2. 100% of the settlement is apportioned to plaintiff's wrongful death claim.
> * * *
> 6. This matter is settled exclusively under the Illinois Wrongful Death Act, 740 ILCS 180/1 *et al.,* under which the settlement proceeds are not part of the estate of the

> deceased [the beneficiary], but rather belong to the surviving spouse and next of kin of the deceased.

Exh. 5 at 91-93. The administrative record does not reflect whether the Illinois court held a hearing; and if so, what transpired. The record does reflect that appellants' counsel had notified counsel for CMS of the date on which the state court hearing was scheduled, and invited him to participate. Exh. 5 at 81-82. Counsel for CMS did not participate. Exh. MAC-1 at 3.

Medicare's Conditional Payments

The administrative record does not identify the exact date on which Medicare representatives first provided appellants' counsel with an account of Medicare's conditional payments, or first requested recovery of those payments. However, correspondence that the appellants' counsel submitted for the record indicates that by September 3, 2013 (three months before the appellants' settlement of the lawsuit) appellants' counsel and an attorney representing the Department of Health and Human Services were communicating about the possibility of settling Medicare's claim for recovery of the conditional payments. Exh. 5 at 81-82; *see also id.* at 83-83 (similar correspondence concerning settlement). However, they failed to reach agreement about the amount of such a settlement. *Id.*

Following settlement of the lawsuit, on January 27, 2014, the Medicare Secondary Payer Recovery Contractor (MSPRC) sent the beneficiary's estate a letter requesting repayment of $171,537.04 in Medicare's conditional payments for the decedent's medical care. Exh. 5 at 35-80 (attaching a list with details of the conditional payments). The letter explained that Medicare had made $253,546.73 in conditional payments, and had reduced that amount by the costs (such as attorney's fees) paid by the beneficiary to obtain a recovery in the lawsuit. *Id.* at 36.

Appellants' requested a redetermination, but for eleven months the MSPRC did not respond. Exh. 5 at 7-8, 95-96. Next, appellants filed a declaratory judgment action in the U.S. District Court for the Northern District of Illinois, seeking a declaration that Medicare does not have a right to obtain reimbursement from the settlement of an Illinois wrongful death claim, and arguing that the exhaustion of administrative remedies requirement had been waived by MSPRC's failure to

respond to the redetermination request. *Id.* at 108-18*; see also* Exh. 5 at 110-18.

Three months later, MSPRC issued a redetermination, and the lawsuit was subsequently dismissed. Exh. 5 at 119-21, 122. In its redetermination, MSPRC summarily denied the appellants' request, stating that "the claims listed on your payment summary form are related to your liability insurance . . . settlement . . ., so we are upholding Medicare's recovery claim . . . . *Id.* at 119-21.

On reconsideration, the Qualified Independent Contractor (QIC) upheld MSPRC's right to recover, on the ground that the documentation did not demonstrate that the medical services were not related to the settlement received. Exh. 1 at 1-23. The QIC reconsideration also stated that according to Medicare's records, the beneficiary had a liability plan effective March 1, 1996, through September 11, 2012, and the liability plan should be billed for the services. *Id.* at 22. This is an apparent error. The record does not include any other references to or information about such a liability plan, and the ALJ made a finding that the appellants had no information regarding the alleged liability plan that the QIC referred to. Dec. at 4-5.

The appellants requested an ALJ hearing, which the ALJ conducted by telephone on January 6, 2016. ALJ Hearing. The appellants were represented by their counsel, who largely reiterated the legal arguments they had already advanced, asserting that the settlement was made pursuant to wrongful death claims and not pursuant to medical malpractice claims. *Id.* at 10:06 to 10:13 a.m. Thus, the appellants asserted, no part of the settlement was available to repay any of Medicare's conditional payments. *Id.* At the beginning of the hearing, however, appellants' counsel stated (possibly inadvertently):

> The parties settled the *medical malpractice lawsuit* for a total of $258,664.10. On December 30, 2013, plaintiff filed a motion to approve the settlement and to confirm that the settlement was made exclusively pursuant to the Wrongful Death Act. CMS was given notice of this motion, and invited to intervene in the lawsuit as it is allowed to do so under 42 U.S.C. § 2651(d).

Id. at 10:06 to 10:08 a.m. (emphasis added). Neither the appellants' counsel nor the ALJ commented on the fact that the

appellants' counsel had described the lawsuit as a "medical malpractice lawsuit," although they were contending that the action was a wrongful death lawsuit and not a medical malpractice lawsuit. *Id.*

During the hearing, the ALJ asked if there was a written agreement formalizing the settlement (apart from the motion asking the Illinois court to approve the settlement). ALJ Hearing at 10:21 a.m. The appellant's counsel responded that he thought there was a general release, and would supply it for the record. *Id.* at 10:22 to 10:23 a.m. However, following the hearing, both he and his co-counsel submitted affidavits stating that neither they nor their opposing counsel had been able to locate a written settlement agreement. Exh. 6 at 4, 5-9.

The ALJ's decision, issued February 5, 2016, determined that Medicare is entitled to recover conditional payments for the deceased beneficiary's medical care from the settlement proceeds, in the amount of $202,306.45 (which included interest). Dec. at 19-20. The ALJ did state that Medicare cannot recover its conditional payments from settlements made pursuant to the Illinois Wrongful Death Act, because those wrongful death recoveries are designated for a decedent's next of kin to compensate them for losses related to non-medical expenses (such as grief and loss of consortium). Dec. at 14-15. However, the ALJ found that the appellants had attempted to convert a lawsuit that combined medical malpractice and wrongful death claims into a pure wrongful death lawsuit in order to prevent Medicare from recovering any of its conditional payments. *Id.* at 17-19. Therefore, the ALJ determined that the appellants could not claim that the settlement was solely for the wrongful death claims and unavailable to reimburse Medicare. *Id.* The ALJ also rejected the appellants' contention that the Illinois court's order approving the settlement was an order "on the merits" as that term is used in the Medicare Secondary Payer Manual (MSPM). *Id.* at 16-17; *see* MSPM, Ch. 7, § 50.4.4. Finally, the ALJ determined that the appellants were not eligible for a waiver, because Medicare's recovery of its conditional payments would not be against equity and good conscience, and the documentation did not support a waiver under section 1870 of the Social Security Act. *Id.* at 19.

The appellants filed a request for review by the Council, and when ninety days had elapsed, requested that the appeal be escalated to federal district court as provided by 42 C.F.R.

§ 1132(a). Exhs. MAC-1 and MAC-2. Following the escalation request, representatives of the appellant and the Council agreed that the Council would issue a decision within 30 days. Exh. MAC-3.

In their request for Council review, the appellants contend that the settlement was solely for a wrongful death action, and that under Illinois law the proceeds cannot be used to repay Medicare's conditional payments for medical care. Exh. MAC-1. The appellants also contend that the language that they inserted in the settlement order (later signed by the Illinois court) stating that the case was settled exclusively under the Illinois Wrongful Death Act was a determination "on the merits of the case," precluding Medicare Secondary Payer recovery. *Id.* at 2-3. Appellants assert that Medicare cannot claim any recovery from the proceeds of a wrongful death settlement, because those funds belong to the beneficiary's next of kin to compensate them for non-medical losses. *Id.* at 2, *citing Bradley v. Sebelius,* 621 F.3d 1330, 1338 (11th Cir. 2010). Further, the appellants contend that the ALJ erred in finding that they had attempted to convert a lawsuit that combined medical malpractice and wrongful death claims into a pure wrongful death lawsuit in order to prevent Medicare from recovering any of its conditional payments. *Id.* at 3. On this point, appellants contend that this issue should have been raised by a Medicare representative appearing at the Illinois state court hearing on the settlement, and since that was not done, Medicare has waived any objection to terms of the state court order. *Id.*

DISCUSSION

I. Appellants' Responsibility for Repayment of Medicare's Conditional Payments for Medical Care

The purpose of the Medicare Secondary Payer statute, enacted by Congress in 1980 and amended several times since, was to help control escalating Medicare costs, by requiring that Medicare serve as a secondary payer when a beneficiary has overlapping insurance coverage, or similar sources of payment for medical expenses, such as a recovery from a lawsuit or a settlement for medical damages. *See* Section 1862(a)(2) of the Act, *see also United States v. Baxter Int'l., Inc.,* 345 F.3d 866, 874-75 (11th Cir. 2003); *Taransky v. Secretary of U.S. Dept. of H.H.S.,* 760 F.3d 307, 310 (3d Cir. 2014).

Under the Medicare Secondary Payer statute, when a Medicare beneficiary suffers an injury covered by a group health plan or liability, workers' compensation, automobile, no-fault, or self-insurance (by an entity that engages in a business, trade, or profession), Medicare will conditionally pay for the beneficiary's medical expenses but is entitled to reimbursement from the beneficiary for these conditional payments. Section 1862(b)(2) of the Act. As explained in more detail below, in this case Medicare made conditional payments for medical treatment of the beneficiary's cancer, totaling approximately $253,546.73 over four and one-half years. Exh. 5 at 6, 35-80.

The beneficiary filed a medical malpractice lawsuit seeking damages (including medical expenses) from his primary care physician and his urologist, and their respective practice groups. Exh. 5 at 6. Following the beneficiary's death in January 2012, the appellants' counsel continued to litigate the medical malpractice claims (as a survival action under Illinois law), and amended the complaint in the action to also include wrongful death claims. *Id.*

In the fall of 2012, appellants' counsel negotiated a settlement of the lawsuit with the appellant's primary care physician, including the survival/medical malpractice claims and the wrongful death claims, for an amount totaling $250,000 plus costs. Exh. 5 at 6; Exh. 2 at 83-84. However, that settlement fell through, and the appellant's primary care physician and his practice group were reinstated as defendants in the case on September 11, 2013. Exh. 5 at 6.

If the settlement in the fall of 2012 had been completed and approved by the Illinois state court, the $250,000 would have been allocated between the survival/medical malpractice claims and the wrongful death claims. In that event, Medicare would have been legally entitled to recover some of its conditional payments for the beneficiary's medical care from the amount allocated to the survival/medical malpractice claims.

Approximately one year later, in December 2013, the appellants again reached a settlement with the appellant's primary care physician and his practice group, again for $250,000 plus costs, and again while the first amended complaint in the pending lawsuit contained both survival/medical malpractice claims and wrongful death claims. Again, both Illinois law and federal Medicare law provide for the settlement proceeds to be allocated

between the survival/medical malpractice claims and the wrongful death claims. Therefore, Medicare would have recovered some or all of its conditional payments from the amount allocated to the survival/medical malpractice claims.

Instead, counsel for the appellants took steps to restructure the lawsuit and the settlement in order to facilitate a claim that the lawsuit and settlement were solely for wrongful death claims, in an effort to maximize the appellants' recovery and prevent Medicare from recovering its conditional payments. First, as explained above in the Background section, appellants' counsel represented to the Illinois state court that the case had been settled "exclusively under the Illinois Wrongful Death Act." Appellants' counsel also requested that the state court:

> . . . enter a written order memorializing that this matter was settled exclusively under the Illinois Wrongful Death Act. Until that time, Medicare's claim for $247,687.82 will remain.

Notably, appellants' counsel made this request in a motion filed with the court while the complaint in the lawsuit (the first amended complaint) contained claims for both survival/medical malpractice and wrongful death. *Compare* Exh. 5 at 11 (motion to approve settlement filed December 30, 2013) *with* Exh. 5 at 28 (second amended complaint filed January 13, 2014 to replace the first amended complaint).

Then, according to appellants' counsel, approximately two weeks later (in January 2014), they discovered their "ministerial oversight" in failing to file a second amended complaint. Exh. 5 at 7. They asked the court for leave to file a second amended complaint. *Id.* When leave was granted, they used that opportunity to eliminate the survival/malpractice claims from the lawsuit, instead filing a second amended complaint with only wrongful death claims. Exh. 5 at 27 (leave to file a second amended complaint); Exh. 5 at 28-34 (second amended complaint filed). The complaint included two claims, each "in excess of" $50,000. *Id.* The appellants have not provided any reason for changing their lawsuit to one exclusively for wrongful death, and dropping the survival/medical malpractice claims, other than the explanation provided in their motion to the Illinois state court --- that they needed to alter the action in order to avoid Medicare's claim for reimbursement of the conditional payments. Exh. 5 at 13-16. Nor have the appellants explained the relationship between the settlement they negotiated in the fall

of 2012 for $250,000 for both medical malpractice and wrongful death claims and the $250,000 settlement they negotiated in December 2013, which they now claim was entirely for wrongful death claims (although, as noted above, the complaint of record at the time of the settlement discussion and agreement contained both medical malpractice and wrongful death claims). Nor have the appellants explained why, after negotiating a $250,000 settlement, they drafted and filed a second amended complaint specifying only that their claims were worth "in excess of" $100,000. Exh. 5 at 28-34.

Moreover, statements by the appellants' counsel contradict their characterization of the case that they settled as one "exclusively under the Illinois Wrongful Death Act." At the ALJ hearing on January 6, 2016, appellants' counsel (D.N.) stated in his opening description of the case:

> The parties settled the *medical malpractice lawsuit* for a total of $258,664.10. On December 30, 2013, plaintiff filed a motion to approve the settlement and to confirm that the settlement was made exclusively pursuant to the Wrongful Death Act.

ALJ Hearing at 10:06 to 10:08 a.m. In other words, appellants' counsel thought that they were settling a medical malpractice lawsuit (which had become a survivor action with the death of the plaintiff). However, they were asking the Illinois state court to state that the settlement was made exclusively under the Wrongful Death Act, in order to prevent Medicare from seeking reimbursement for conditional payments for medical care.

Appellants contend that when the Illinois state court entered the order as they had requested, characterizing the lawsuit and settlement as "exclusively under the Illinois Wrongful Death Act," the court made a ruling on the merits of the case. Exh. MAC-1. Specifically, the appellants argue that:

> The February 3, 2014 [Illinois state court] order was made on the merits of the case, and governs the apportionment and distribution of the settlement proceeds. Because 100% of the settlement proceeds were apportioned to the wrongful death claims of the beneficiary's next of kin, CMS and Medicare have no claim to the settlement proceeds.

Id. at 3. In asserting that the Illinois state court order approving the settlement was "on the merits of the case," appellants refer to the terms of section 50.4.4 in Chapter 7 of the MSPM. This section states that in general, Medicare policy requires recovering payments from liability awards or settlements in personal injury and survival actions, without regard to how the settlement stipulates disbursement should be made. *Id.* However, the section also states:

> *The only situation in which Medicare recognizes allocations of liability payments to nonmedical losses is when payment is based on a court order on the merits of the case.* If the court or other adjudicator of the merits specifically designates amounts that are for payment of pain and suffering or other amounts not related to medical services, Medicare will accept the Court's designation. Medicare does not seek recovery from portions of court awards that are designated as payment for losses other than medical services.

Id. (emphasis added).

However, the order that appellants' counsel drafted, and the state court judge signed, stating that the case was settled exclusively under the Illinois Wrongful Death Act, was not a court order on the merits of the case, for multiple reasons. First, the case had never been litigated (except insofar as a state court judge had granted the urologist's motion to dismiss for failure to state a claim). As a result, the order approving the settlement had nothing to do with the merits of the case. Second, there is no indication in the order, or any materials appellants' counsel submitted, that the state court judge who signed the order was familiar with the history of the lawsuit or the settlement negotiations. For example, from the appellant's written motion, it does not appear that they informed the state court judge that the litigation was filed, pursued, and previously settled based on medical malpractice claims as well as wrongful death claims. *See* Exh. 5 at 11-16 (motion to approve settlement). Third, in support of their request that the state court judge sign an order characterizing the case and the settlement as "exclusively under the Illinois Wrongful Death Act," the appellants represented that this was necessary in order to prevent Medicare from recovering any of its conditional payments. *Id.* at 13-16.

For these reasons, the Council rejects the appellants' contention that the Illinois state court's approval of the order stating that the lawsuit and settlement were "exclusively under the Wrongful Death Act" was an order on the merits of the case. In this respect, recent federal court case law is instructive. In *Taransky v. Secretary of U.S. Dept. of H.H.S.,* the U.S. Court of Appeals for the Third Circuit upheld the Council's determination in another Medicare Secondary Payer case that a state court judge's entry of an order drafted by counsel approving a settlement was not a court order "on the merits." 760 F.3d 307, 318-20 (2014). As the court in *Taransky* explained, "A court order is 'on the merits' when it is 'delivered after the court has heard and evaluated the evidence and the parties' substantive arguments." *Id.* at 318 (citations omitted). An order is on the merits when a state court has made a decision that finally resolved the claim, and resolved it on the basis of substance. *Id.* (citations omitted).

However, in *Taransky* as in the instant case, the state court did not adjudicate any substantive issue in the primary lawsuit. Instead, the state court was asked only for an order approving and allocating the settlement, in order to obtain documentation to use in opposing Medicare's request for repayment of conditional payments for medical care. *Id.* Moreover, as the court in *Taransky* pointed out, the process was one in which the state court rubber stamped the appellants' request. *Id.* at 18-19. The state court in this case also rubber stamped the appellants' request for settlement approval and an allocation to wrongful death claims only. *See* Exh. 5 at 11-16 (motion) and at 91-93 (order). In both cases, the resulting order is not one made by a judge on the merits. *Id.*

The appellants also assert that if Medicare disagreed with their efforts to re-characterize the lawsuit and settlement as involving only wrongful death claims, a Medicare representative should have intervened in the Illinois state court proceedings to object to approval of the settlement. Exh. MAC-1 at 3. Because no representative of Medicare did so, appellants argue that Medicare has waived any right to object that the allocation was incorrect. *Id.* However, neither the Medicare Secondary Payer statute nor its implementing regulations require CMS to intervene in state court proceedings when settlement approval motions are filed. *See also Taransky,* 760 F.3d 319. Moreover, from a procedural perspective, it would not have been difficult for the appellants' counsel to provide the Illinois state court with a fair and accurate description of this malpractice and

wrongful death litigation and settlement. This is not the kind of litigation step that typically requires opposing counsel. However, it appears that the appellants' counsel may not have provided the Illinois state court with a complete history of the litigation and settlement. Appellants' counsel were, however, candid about their reason for doing so --- to avoid Medicare's recovery of conditional payments.

On this set of facts, the Council agrees with the ALJ that the appellants attempted to convert a combined survival/medical malpractice and wrongful death case into an exclusively wrongful death case, in order to prevent Medicare from recovering any of its conditional payments for the decedents' medical care. Dec. at 17-20. The Council also agrees with the ALJ that on this record, the appellants, who have the burden of proof, have not met their burden of establishing that the amounts awarded under the settlement did not include recovery for medical expenses, subject to recoupment by Medicare. *Id.* at 19.

Therefore, the Council determines that because the appellants settled a combined survival/medical malpractice and wrongful death lawsuit for $250,000 (plus $8,664.10 in costs), Medicare can recover some of its conditional payments for the decedent's medical care from the part of the settlement representing recovery on the medical malpractice claims.

II. Allocating the Settlement Between Medicare and the Appellants

The ALJ held that Medicare was entitled to recover the full amount of its claim (after subtracting the costs of procuring a recovery), that is, $192,049.98, plus applicable interest. Dec. at 19-20. However, the Council has arrived at a different determination of the amount of Medicare's recovery, and the amount allocable to the next of kin for settlement of the wrongful death claims.

Based on the litigation history and the facts explained above, the Council finds that the $250,000 (plus $8,664.10 in costs) settlement that the appellants recovered included $100,000 for the wrongful death claims (based on the $100,000 figure that the appellants' counsel stated for the wrongful death claims in the second amended complaint), and $150,000 in medical expenses for the medical malpractice claims. Both times that the parties in the lawsuit discussed and arrived at a settlement, the lawsuit was based on a complaint that included both wrongful death and

medical malpractice claims. Shortly after the second settlement discussions, the appellants' counsel filed the second amended complaint stating that the wrongful death claims (including damages for loss of consortium) were "in excess of" $100,000, but did not provide any further specification of these damages). Exh. 5 at 28-34. The appellants also contracted for and paid attorneys fees in the amount of $75,000, reducing the total amount available for distribution from the settlement to approximately $175,000. Exh. 5 at 12, 17.

As noted above, Medicare may recover conditional payments made for the beneficiary's medical care from the part of the settlement made for the medical expense claims in the medical malpractice action (approximately $150,000 out of $250,000, or 60% of the settlement). Section 1862(b)(2) of the Act. However, because of the way in which wrongful death actions are defined under Illinois law, Medicare may not recover conditional payments from the part of the settlement made for damages owing to the beneficiary's spouse and next of kin in the wrongful death action (approximately $100,000 out of $250,000, or 40% of the settlement). 740 ILCS 180 (Illinois Wrongful Death Act); *see also Bradley v. Sebelius,* 621 F.3d 1330 (11th Cir. 2010); *Denekas v. Shalala,* 943 F.Supp. 1073 (S.D. Iowa 1996).

Medicare made conditional payments in the amount of $258,664.10, and may recover from up to sixty percent of the total settlement (less the appellant's costs to obtain (or procure) that part of the settlement). In this case, the appellant's procurement costs for the entire settlement were $75,000 in attorneys' fees and $8,664.10 in court and related costs, for a total of $83,664.10. Medicare is responsible for paying sixty percent of those fees and costs, which amounts to $50,198.46. Therefore, these procurement costs are subtracted from Medicare's share of the settlement, as follows:

$ 155,198.46 (60% of $258,664.10)
- 50,198.46_ (procurement costs)
$ 105,000.00 Medicare's recovery

Therefore Medicare may recover $105,000.00 from the settlement proceeds for the conditional payments that it made for the beneficiary's medical care.

The appellants are responsible for paying forty percent of the attorneys fees and costs, which amounts to $33,465.64 in

procurement costs. These procurement costs are subtracted from the appellants' share of the settlement, as follows:

$ 103,465.64	(40% of $258,664.10)
- 33,465.64	(procurement costs)
$ 70,000.00	Appellant's recovery

The record reflects that counsel for the appellants have received $75,000.00 in attorneys fees and $8,664.10 in costs.

The appellants are also responsible for paying interest on Medicare's share of the recovery ($105,000), from sixty days after the date when the Medicare Secondary Payer Recovery Contractor (MSPRC) notified them of their financial obligation. The MSPRC should recalculate the amount of interest owing for the applicable time period, based on the sum of $105,000 owed for conditional Medicare payments, applying the correct provisions for calculating interest.

III. Waiver

The ALJ also determined that the appellants are not entitled to a waiver of Medicare's recovery of its conditional payments, pursuant to section 1870 of the Act. The appellants have not objected to this part of the ALJ's decision, and so the Council does not disturb it.

DECISION

For the foregoing reasons, the Medicare Appeals Council concurs in the ALJ's determination that the appellants attempted to convert a lawsuit including both survival/medical malpractice claims and wrongful death claims to a lawsuit solely for wrongful death claims, in an effort to avoid responsibility for reimbursing Medicare for the conditional payments it made for medical care furnished to the deceased beneficiary.

The Council further determines that the appellants are responsible for repaying Medicare for conditional payments in

the amount of $105,000, plus applicable interest to be recalculated upon implementation of this decision.

The ALJ’s decision is modified accordingly.

MEDICARE APPEALS COUNCIL

/s/ Gilde Morrisson
Administrative Appeals Judge

/s/ Deborah S. Samenow
Administrative Appeals Judge

Date: August 16, 2017