DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-10-1929

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

The Administrative Law Judge (ALJ) issued a decision dated July 22, 2010, which concerned the appellant's/beneficiary's request for relief from liability under a Medicare Secondary Payer lien. The ALJ determined that the appellant was liable for the remaining three charges in the lien. The appellant has asked the Medicare Appeals Council to review this action. The appellant's request for review, which included additional supporting documentation, has been entered into the record as Exhibit (Exh.) MAC-1.

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).

As set forth below, the Council reverses the ALJ's decision.

BACKGROUND

The appellant's medical history includes reflex sympathetic dystrophy (RSD), cellulitis, abdominal wall hypesthesia, lumbar disc disease, and a mid-thigh amputation of his left leg. *See,*

e.g., Exh. 12 at 48, 57-58, 61. On July 6, 2007, the appellant was involved in an automobile accident resulting in injuries and related medical expenses. Medicare paid the appellant's accident-related medical expenses subject to a lien. On December 9, 2008, the appellant resolved his accident-related claim, receiving a $40,000 settlement. Exh. 5 at 11. On June 29, 2009, the MSPRC notified the appellant that Medicare had imposed a $40,000 lien for accident-related medical costs initially paid by Medicare. Exh. 9 at 30-34.

On August 25, 2009, the MSPRC issued a partially favorable redetermination, reducing the appellant's liability to $1,168.29. Exh. 14 at 67-69. On October 29, 2009, the Qualified Independent Contractor (QIC) issued a partially favorable reconsideration, removing two more charges from Medicare's lien. The QIC determined that charges for Dr. G.H. ($420.58), incurred on April 17, 2008, and Dr. M.H. ($300), incurred on April 10, 2008, will remain on the lien. Exh. 17 at 108-111. The QIC subsequently denied the appellant's request to reopen its reconsideration. Exh. 20 at 152-153.

The appellant requested a hearing before an ALJ seeking recovery of $625.56 plus interest. There, the appellant questioned three items which he indicated were still associated with the lien - the above identified charges for Dr. G.H. and Dr. M.H., as well as a March 7, 2008 charge from Dr. P.B. for $192. The appellant submitted a breakdown of the charges paid by his auto insurance carrier and asserted that all charges for Drs. M.H. and P.B. had been paid by his insurance carrier. However, he asserted that, for reasons he did not understand, while all other claims involving Dr. M.H. were removed from the lien, the April 10, 2008 charge was not. The appellant also noted that Dr. G.H.'s charge involved MRI treatment for a medical condition pre-dating and unrelated to the accident. Exh. 20 at 162-163.

On January 27, 2010, the ALJ conducted a hearing by telephone in which the appellant testified. Dec. at 2. Most of the hearing was devoted to determining how the appellant arrived at the $625.56 in dispute. The ALJ reasoned that the items in dispute were the charges for Drs. G.H. and M.H. The ALJ accepted that the "amount in dispute" as calculated by the appellant was based upon the appellant's belief that, on September 1, 2009, his automobile insurance carrier had paid the MSPRC $625.56 for reasons he did not entirely understand. ALJ Hearing CD. The ALJ's resolution of the case will be addressed in more detail below.

AUTHORITIES

Section 1862(b)(2)(A) of the Social Security Act (Act) specifies that Medicare will not pay for covered medical items and services to the extent that "payment has been or can be expected to be made under a workmen's compensation law or plan of the United States or a State or under a automobile or liability insurance policy or plan." When a Medicare payment is made that has been or can be expected to be covered by another third party payer, the Medicare payment is conditioned on the eventual repayment to the Medicare program when the beneficiary receives payment from the other payer. *See* section 1862(b)(2)(B) of the Act; 42 C.F.R. Part 411, subparts B and D.

The Centers for Medicare & Medicaid Services (CMS) has a direct right of action to recover any conditional payments from any entity responsible for making primary payment. 42 C.F.R. § 411.24(e). Further, CMS has a right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, state agency or private insurer that has received a primary payment. 42 C.F.R. § 411.24(g).

Regardless of how amounts may be designated in a liability award or settlement, *e.g.,* loss of consortium, special damages or pain and suffering, Medicare is entitled to be reimbursed for its payments from the proceeds of the award or settlement. Medicare Secondary Payer Manual (MSPM), CMS Pub. 100-05, Ch. 7, §§ 50.1 and 50.4.4.

ANALYSIS

The issue is whether the following three charges were properly included in the Medicare lien. We conclude that they were not, and should be moved from the lien.

Item 1 - Services ($192) by Dr. P.B. (March 7, 2008)

During the hearing, the appellant and the ALJ agreed that there was no apparent issue regarding this charge because the appellant believed it had been resolved prior to the reconsideration and it was not addressed by the QIC. Nonetheless, the ALJ noted that the record included documentation from the provider hospital, *** Memorial Hospital, indicating a $184 insurance payment for a March 7, 2008 visit billed under HCPCS code 99214, which

concerns an office or outpatient visit for the evaluation and management of an established patient. The ALJ did not remove this item from the lien because the physician's name was not on the bill, the referenced date of loss on the bill was the date of the appellant's automobile accident, and the payment summary "provided by the insurance company did not reference the codes indicated by Dr. [P.B.]." Dec. at 11.

The appellant refers to the insurance carrier's payment summary for this $192 service, which indicated that Medicare paid $8 while the insurance carrier paid the remaining $184. The appellant asserts, although without supporting documentation, that the hospital explained its billing policy to him indicating that, "when Dr. [P.B.'s] bills are sent out, the payments are to be paid to the . . . Hospital." Exh. MAC-1 at 1-2.

The $184 charge should be removed from the lien. An internal use memorandum from the appellant's insurance company demonstrating that several ICD-9-CM[1] codes (724.2 – lumbago; V58.78 - aftercare following surgery of musculoskeletal system, not elsewhere classified; 722.52 – degeneration of lumbar or lumbrosacral intervertebral disc; and 733.90 – disorder of bone and cartilage, unspecified) were addressed in a March 7, 2008 visit billed under HCPCS code 99214. While the provider is identified as *** Memorial Hospital, the "Medical Specialty" line identifies a "General Practice," which is in accord with the nature of services provided by a physician, rather than a medical entity. The memorandum indicates that $184 of a $192 claim would be covered. Exh. 12 at 42. The Medicare claim "Payment Summary Form" identifies, by diagnosis codes, conditions addressed by Dr. P.B. on March 7, 2008. The Summary Form identifies a total charge of $192 and a conditional payment of $8. Exh. 14 at 65.

The ALJ's analysis does not fully appreciate the distinction between ICD and HCPCS codes. Generally, ICD codes identify medical conditions. However, HCPCS, the Healthcare Common Procedure Coding System, is a coding system developed by CMS (and based in part upon the American Medical Association's Current Procedural Terminology (CPT) system) for processing, screening, identifying, and paying Medicare claims. *See* 42

[1] Based upon the World Health Organization's Internal Classification of Diseases, the ICD-9-CM system "is designed for the classification of morbidity and mortality information for statistical purposes, and for the indexing of hospital records by disease and operations. . . ." ICD-9-CM for Physicians, Volumes 1&2 at iii (2008).

C.F.R. §§ 414.2 and 414.40. As noted in the instructions to the ICD-9-CM, these are distinct codes. Put simply, the ICD identifies a condition; HCPCS identifies a treatment for that condition.

The evidence provides sufficient support for the appellant's claims that all but the $8 in conditional payment for Dr. P.B.'s March 7, 2008 services should be removed from the Medicare lien.

Item 2 – Services ($420.58) by Dr. G.H. (April 17, 2008)

Before the ALJ, the appellant testified that his primary care physician (Dr. P.G.) ordered a thoracic spine MRI to address long-standing issues related to a hernia/hypesthesia across his abdominal wall. The MRI was "read" by Dr. G.H., a radiologist, whom the appellant never met. The appellant testified that this service was unrelated to his July 2007 automobile accident, and was routinely covered by Medicare, but the cost was included in the Medicare lien calculation. The appellant also testified that he spoke with MSPRC representatives to explain that this MRI was not related to the accident and that there is a difference between a thoracic MRI and a lower back MRI, but the MSPRC insisted this MRI was related to the auto accident. ALJ Hearing CD; *see also* Exh. 12 at 58.

The ALJ recounted that the service provided by Dr. G.H. on April 17, 2008, included an MRI of the thoracic spine without contrast. The ALJ noted that in an August 14, 2009 letter (Exhibit 12 at 61) Dr. P.G. listed the dates of service related to the appellant's RSD, which did not include April 17, 2008. Thus, the ALJ reasoned, the $420.58 charge could not be removed from the lien. Dec. at 11.

The appellant asserts that Dr. P.G.'s August 14, 2009 letter is referring to the appellant's "hospitalizations . . . in 2007-2008 and office visits with Dr. [P.G.] which were not related to my motor vehicle accident of July 6, 2007." The appellant further notes that, in that same letter, Dr. P.G. indicates that "care regarding that accident was rendered by Dr. [M.H.]. This [Dr. P.G.'s August 14, 2009] letter has nothing to do with any services rendered by Radiologist . . . [Dr. G.H.] . . . That is why there was no mention of any date of services by Radiologist Dr. [G.H.] in that letter." Exh. MAC-1 at 2.

The Council finds the evidence and the appellant's testimony on this issue persuasive. Dr. P.G.'s August 12, 2009 letter

recounts the appellant's medical history pertaining to RSD (possibly originating from a motor vehicle accident twenty years earlier) and the subsequent amputation of his left leg. Dr. P.G. identified Dr. M.H. "of ***, Florida" as the physician treating the appellant for the injuries sustained in the July 2007 accident. Further, Dr. P.G. indicates that the care provided to the appellant at *** General Hospital was not related to the July 2007 auto accident. Exh. 12 at 61. The record also contains treatment notes from Dr. G.H. supporting the appellant's contention that he underwent an MRI on his thoracic/spine consistent with concerns about a possible hernia. Exh. 12 at 54, 57-58.

The $420.58 charge shall be removed from the Medicare lien.

Item 3 – Services ($300) by Dr. M.H. (April 10, 2008)

Before the ALJ, the appellant asserted that this charge was not paid by Medicare and thus should not be included in the lien. The appellant also noted that all other charges related to Dr. M.H. had been resolved between his insurance carrier and the MSPRC and expressed confusion as to why this charge was in the lien. ALJ Hearing CD. The ALJ recounted Dr. P.G.'s August 14, 2009 letter (Exhibit 12 at 61) stating that Dr. M.H. treated the appellant for the July 2007 accident. The ALJ noted that Dr. P.G. "does not reference . . . [this date] of service as being related to the . . . [appellant's] RSD. Further, the ALJ also found that the appellant's documentation shows a different code of service (HCPCS code 64475, for injection, anesthetic agent and/or steroid, paravertebral facet joint) than those listed on the Medicare Payment Summary Form (ICD codes 72885 - muscle spasm; 7202 - sacroiliitis, not elsewhere classified; and 7242 - lumbago). Therefore, the ALJ concluded, the April 10, 2008 charge was properly included in the lien. Dec. at 11.

The appellant asserts that although Dr. M.H. was referenced in Dr. P.G.'s August 14th letter, Dr. P.G.'s intent "was to clarify the care rendered to me at the *** General Hospital in 2007-2008 . . . That is why he [Dr. P.G.] did not make any reference to any dates [on which] Dr. [M.H.] rendered services." Exh. MAC-1 at 3. The appellant continues, citing billing documentation of record to support his position that Medicare denied Dr. M.H.'s charge for April 10, 2008, thereby precluding inclusion of that charge in Medicare's lien. *Id.* at 3-4.

The record supports the appellant's position. It is understandable that an ICD code may appear on one document and a HCPCS (CPT) code on another, yet both may refer to the same event on the same date of service. In that context, the September 23, 2008, Medicare Summary Notice identifies Dr. M.H.'s April 10, 2008 service (HCPCS code 64475) as not medically necessary and the $300 charge as not covered by Medicare. The Notice addresses no other April 10, 2008 service provided by Dr. M.H. *See* Exh. 24 at 170-171. Similarly, the Payment Summary Form identifies Dr. M.H.'s $300 charge for April 10, 2008 as having $0.00 "Reimbursed Amount" and a $0.00 "Conditional Payment." *See* Exh. 20 at 161. The record clearly indicates that Dr. M.H.'s $300 charge for services performed on April 10, 2008 was not reimbursed by Medicare. Accordingly, this charge should be removed from the lien.

DECISION

The Council finds that the following three charges shall be removed from the Medicare lien assessed against the appellant relative to his July 6, 2007 automobile accident.

Dr. P.B. - March 7, 2008 ($184 out of $192);
Dr. G.H. – April 17, 2008 ($420.58); and
Dr. M.H. - April 10, 2008 ($300).

MEDICARE APPEALS COUNCIL

/s/ Susan S. Yim
Administrative Appeals Judge

/s/Constance B. Tobias, Chair
Departmental Appeals Board

Date: June 28, 2011