DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-10-1650

In the case of	**Claim for**
F.G. (Appellant)	Medicare Secondary Payment (MSP) Recovery
**** (Beneficiary)	**** (HIC Number)
MSPRC (Contractor)	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated June 24, 2010, which concerned the recovery of conditional payments made by Medicare for medical treatment of injuries the beneficiary sustained in a fall on June 24, 2005. The ALJ determined that, because the beneficiary had received a liability settlement with respect to her injuries, she was required to repay Medicare for the conditional payments. The appellant timely filed a request for Medicare Appeals Council review of this action. In addition, by memorandum filed August 16, 2010, the Centers for Medicare & Medicaid Services (CMS) requested that the Council review this case on its own motion.

The Council admits the following documents into the record:

Exh. MAC-1	Request for Review, received 07/26/2010
Exh. MAC-2	Letter from the Council, dated 08/13/2010
Exh. MAC-3	Referral Memorandum, received 08/16/2010
Exh. MAC-4	Letter from Mr. G***, received 08/23/2010
Exh. MAC-5	Letter from Mr. L***, received 09/14/2010
Exh. MAC-6	Letter from Mr. G***, received 10/06/2010
Exh. MAC-7	Letter from Mr. G***, received 10/13/2010
Exh. MAC-8	Letter from Mr. G***, received 10/18/2010[1]

[1] Exh. MAC-8 was dated August 31, 2010, and was apparently mailed on or about that date, as Mr. L*** refers to it in his letter of September 14, 2010. *See* Exh. MAC-5. For reasons that are unclear, the Council did not receive

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 Council has considered the record and exceptions and has concluded that the exceptions do not provide a basis for changing the ALJ's action. Accordingly, for the reasons explained below, the Council adopts the ALJ decision.

LEGAL AUTHORITIES

The Medicare secondary payer principle is established by Section 1862(b)(2) of the Social Security Act (Act), which provides:

> (A) In General.— Payment under this subchapter may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that—
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> (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
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> (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 or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.
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> 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.
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> (B) Conditional payment
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> (i) Authority to make conditional payment.— The Secretary may make payment under this subchapter 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

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the original of the August 31 letter. Mr. G***'s office faxed a copy of the letter to the Council on October 18, 2010.

> 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.
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> (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 subchapter 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 appellant relies on the New Jersey collateral source statute codified at N.J.S.A. 2A:15-97 (hereafter "collateral source statute"). The statute provides, in pertinent part:

> In any civil action brought for personal injury or death, . . . if a plaintiff receives or is entitled to receive benefits for the injuries allegedly incurred from any other source other than a joint tortfeasor, the benefits, other than workers' compensation benefits or the proceeds from a life insurance policy, shall be disclosed to the court and the amount thereof which duplicates any benefit contained in the award shall be deducted from any award recovered by the plaintiff . . . .

The Medicare Secondary Payer Manual, CMS Pub. 100-5 (MSPM), 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[4] 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 designate 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, ch. 7, § 50.4.4.

BACKGROUND AND PROCEDURAL HISTORY

The appellant/beneficiary sustained injuries in a fall on June 24, 2005. Exh. 3, at 46. Medicare made conditional payments for the beneficiary's medical care totaling $28,502.24. Exh. 1, at 1. The appellant entered into a settlement agreement with the owner of the property on which she was injured. Exh. 3, at 46. The appellant settled her claims for $125,000. *Id.* Initially and on redetermination, the Medicare Secondary Payer Recovery Contractor (MSPRC) informed the appellant that she was obligated to repay to Medicare a principal amount of $18,885.64, plus $3,737.87 in interest, for a total of $22,623.51. Exh. 5, at 57.

The appellant, by counsel, sought reconsideration by a Qualified Independent Contractor (QIC). Counsel argued that Medicare's secondary payer recovery is barred because the appellant obtained an order from the Superior Court of New Jersey allocating the proceeds of the settlement "solely to recovery for bodily injury, disability, pain and suffering, emotional distress, and such non-economic and otherwise-uncompensated loss as plaintiff may have suffered." *See* Exh. 8, at 77. The Superior Court's order further stated "that no portion of the recovery obtained by plaintiff in this matter is attributable to medical expenses or other benefits compensated by a collateral source." *Id.*

The QIC concluded that the appellant was obligated to repay the conditional payments as calculated by the MSPRC. Exh. 7, at 71-

72. According to the QIC, the Superior Court's order was not a ruling on the merits of the case, within the meaning of the MSPM. *Id.* Further, the QIC determined that the New Jersey collateral source statute is preempted by federal law. *Id.*

The appellant requested a hearing before an ALJ. CMS also participated before the ALJ by submitting a position paper. *See* Exh. 13. The ALJ held a hearing by telephone on December 17, 2009. She issued her decision on June 24, 2010. Dec. at 2. The ALJ found that she need not defer to the Superior Court's allocation order because it was not a ruling on the merits of the case, within the meaning of the MSPM. Dec. at 12. Accordingly, she found the appellant was required to reimburse Medicare for its conditional payments.

DISCUSSION

Relying on the New Jersey collateral source statute, the appellant, through counsel, argues that, because Medicare had paid for the appellant's medical expenses, none of the appellant's settlement award may be attributed to such expenses. Counsel further argues that the Superior Court's allocation order is binding on the Medicare program. Counsel argues finally that, by refusing to defer to the Superior Court's allocation order because it was issued post-settlement, and not after a trial on the merits, the ALJ's decision frustrates public policy, which favors settlement.[2]

[2] The appellant additionally submitted to the Council a copy of the decision of the U.S. Court of Appeals for the Eleventh Circuit in *Bradley v. Sibelius,* No. 09-13765 (11th Cir. Sept. 29, 2010) (Exh. MAC-6) and a copy of a QIC reconsideration that purports to accept a New Jersey court's allocation of settlement proceeds to non-medical damages as precluding Medicare's recovery (Exh. MAC-7). In the *Bradley* case, the Eleventh Circuit held that Medicare must defer to a Florida probate court's allocation order distributing settlement proceeds primarily to the claims of the decedent's children for loss of parental companionship, rather than to the estate's claims for medical expenses, among other things. The Council does not find the *Bradley* case persuasive on the issues raised by the present case. The settling plaintiffs in *Bradley* (the beneficiary's children) had no relationship with Medicare and no liability for their father's medical expenses. Thus, they did not receive any direct benefit from Medicare's conditional payment of their father's medical expenses. By contrast, the appellant here is the injured party, whose medical expenses Medicare paid on a conditional basis. Were we to accept the appellant's position, she would, in essence, be unjustly enriched, as she has had the benefit of the medical care paid for by Medicare, and yet would retain the entire amount of the settlement, which was procured, at least in part, to satisfy her claim for damages, including her medical expenses. *See* Exh. 3, at 45-46. With regard to the QIC decision proffered by counsel, we observe that such an action is not precedential.

In its referral memorandum, CMS asks that the Council modify the ALJ's decision. CMS contends that the ALJ's decision did not sufficiently address whether the New Jersey collateral source statute can ever apply to Medicare and, if it did apply, whether it would be preempted by federal law.[3]

The ALJ did not err in concluding that the Superior Court's allocation order was not binding on Medicare because the order was not issued after a trial on the merits.[4] As the ALJ stated, this result is consistent with the guidance contained in the MSPM, as quoted above. The ALJ properly deferred to the MSPM, pursuant to 42 C.F.R. § 405.1062(a) (ALJs and the Council are not bound by CMS manual instructions, "but will give substantial deference to these policies if they are applicable to a particular case"). Further, while not necessary to her decision, the ALJ did observe that she was not persuaded that the New Jersey collateral source statute could supersede Medicare's right to recover its conditional payments. *See* Dec. at 12.

The appellant's argument that the result reached by the ALJ would thwart public policy by discouraging settlement is unconvincing. Requiring beneficiaries in the appellant's

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And, in any event, we do not have the complete record or facts of that case before us.

[3] CMS additionally asks that the Council supplement the record by admitting a copy of the Superior Court of New Jersey, Appellate Division's opinion in *Jackson v. Hudson Court, LLC, et al*, No. A-4755-08T1 (May 24, 2010). In that case, the Appellate Division concluded that the New Jersey collateral source statute does not apply to Medicare liens under the MSP provisions of the Act. In the Council's view, whether or not the Appellate Division's decision in *Jackson* was "admitted" as evidence is irrelevant. Court decisions are public records. CMS, or a party, is free to cite to any court decision in its submissions to the ALJ or to the Council. Attaching a copy of a cited decision for the adjudicator's convenience does not represent a proffer of evidence. A copy of the *Jackson* decision is present in the record; it was identified by the ALJ as Exh. 17. To the extent the ALJ ruled Exh. 17 inadmissible and excluded it, the ruling is harmless error.

[4] It is noteworthy that the New Jersey collateral source statute can similarly be read as applicable only in instances where a court (or jury) awards damages to a plaintiff after a trial on the merits. By its own terms, the statute requires that a collateral source of benefits be disclosed to the court, and directs the court to deduct any such benefits from the award of damages. While the Council can claim no expertise in the interpretation of New Jersey law, it seems unlikely that the New Jersey legislature intended the collateral source statute to be used by settling plaintiffs to shield their settlement proceeds from Medicare's right to recover conditional payments pursuant to the secondary payer provisions of the Social Security Act.

position to repay Medicare's conditional payments in no way discourages settlements. Rather, as counsel apparently did in the present case, a settling party must consider Medicare's right of recovery when negotiating a settlement amount. *See* Exh. 3, at 45-46.

For the reasons stated, the Council finds no error in the ALJ's decision. Accordingly, the Council adopts the ALJ's decision and declines to review the decision on the Council's own motion.

MEDICARE APPEALS COUNCIL

/s/ M. Susan Wiley
Administrative Appeals Judge

Date: October 20, 2010