

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL

In the case of

Claim for

W.G.

Medicare Secondary Payer
(Parts A and B)

(Appellant)

(Beneficiary)

(HIC Number)

MSPRC

(Contractor)

(ALJ Appeal Number)

On April 27, 2009, the Administrative Law Judge (ALJ) issued a decision concerning Medicare recovery of conditional payments made on the beneficiary's behalf following an automobile accident on April 28, 2005. The ALJ determined that the beneficiary is not entitled to a waiver of any portion of the amount of \$10,618.87 plus accrued interest assessed by the Medicare Secondary Payer Recovery Contractor (MSPRC) for the conditional payments made by Medicare. The appellant, by counsel, has asked the Medicare Appeals Council (Council) to review this action.

The Council reviews the ALJ's decision *de novo*. 42 C.F.R. § 405.1108(a). The Council limits 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 admits the June 29, 2009, letter from the beneficiary's counsel and attachments as Exh. MAC-1. Counsel's October 19, 2009, supplemental filing is admitted as Exh. MAC-2. The Council has considered the record that was before the ALJ, as well as Exhs. MAC-1 and MAC-2. For the reasons and bases articulated herein, the Council concludes that the exceptions

present no basis for changing the ALJ's action. The Council adopts the ALJ's decision.

BACKGROUND AND PROCEDURAL HISTORY

The beneficiary was involved in a motor vehicle accident on April 28, 2005. On or about August 4, 2005, she suffered a fall. The issue before the Council is whether the beneficiary is entitled to a waiver of any portion of the \$10,618.87 plus interest as assessed by the MSPRC for conditional payments made on her behalf following the April 28, 2005 accident. The beneficiary's position is that only some of this amount should be subject to Medicare recovery because the medical expenses incurred following the August 2005 injury are wholly unrelated to those incurred following the April 2005 accident and the former should not be subject to Medicare recovery.

Initially, the MSPRC notified the appellant, by an October 25, 2007, letter, that Medicare had made \$21,442.42 in conditional payments. Exh. 1 at 61-66. On or about January 18, 2008, the beneficiary settled her personal injury claim for the amount of \$25,000. Exh. 1 at 35-37. On February 11, 2008, the MSPRC issued a letter informing the beneficiary that \$20,685.81 in conditional payments had been made and demanding a sum of \$12,796.49. Exh. 1 at 21-22. Then, on June 17, 2008, the MSPRC modified its prior determination, finding that some of the charges were not related to the April 28, 2005, accident. The MSPRC demanded a reduced sum of \$10,618.87 in principal and \$429.18 in interest. Exh. 1 at 16. On August 25, 2008, on reconsideration, Maximus Federal Services affirmed MSPRC's June 17, 2008, decision. Exh. 1 at 4.

The beneficiary, by counsel, requested ALJ review. Maximus submitted a position paper to the ALJ. Its position was that the beneficiary did not submit sufficient documentation to support the assertion that the charges for treatment included in Medicare's lien after August 4, 2005, were unrelated to the injuries sustained in the April 28, 2005, automobile accident. Exh. 5 at 4. The beneficiary responded with her own position paper. Exh. 6. The beneficiary stated that, on April 28, 2005, she had soft tissue injury to the left lower back and herniated disc, but not a fracture, citing a May 13, 2005 magnetic resonance imaging (MRI) report that does not specifically document a fracture. See Exh. 6 at 1, 5-7. The beneficiary had a syncopal episode on or about August 4, 2005, while bending

down, and fell on her buttocks. She sustained a compression fracture at L3. The beneficiary asserted that all charges related to the care provided for the August 4, 2005, fall are wholly unrelated to the April 28, 2005, vehicular accident and not subject to Medicare recovery. She further asserted that she had detrimentally relied on MSPRC's January 4, 2008 letter (Exh. 1 at 38-39), which she understood to mean that Medicare had made a total of \$379.90 in conditional payments, to reach a personal injury settlement for \$25,000.

The ALJ concluded that the appellant did not meet her burden to show that the Medicare lien includes charges unrelated to the April 28, 2005 accident. He also concluded that no waiver of the lien amount is warranted. Dec. at 7-8.

DISCUSSION

Before the Council, the appellant reasserts the arguments made and addressed below, and has submitted additional, new evidence in support of the request for review. The new evidence includes an August 5, 2005 radiology report indicating, among other things, L3 compression fracture, and Dr. W***'s August 8, 2005 "history and physical report." Of note are two opinion letters addressed to the appellant's counsel, one from S. B***, D.C., dated June 18, 2009, and, the other, from Dr. F. S***, dated June 22, 2009. Both Drs. B*** and S*** opined that the appellant had a fracture in the L3 spinal segment as a result of the August 2005, fall and not as a result of the April 2005 vehicular accident, and that the fracture and April 2005 injuries are not related.

In general, Medicare policy requires recovery of 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. Medicare Secondary Payer Manual (MSPM), CMS Pub. 100-05, Ch. 7, section

50.4.4. Also pertinent is MSPM, Ch. 7, section 50.4.5, which provides, in relevant part:

In some cases, the amount of the overpayment is questioned on the grounds that services included in the calculation were for preexisting conditions and should be omitted from the overpayment calculation.

When a beneficiary has filed suit for accident-related services, including services relating to exacerbation of an underlying condition as the basis for the complaint, the total amount of Medicare's payments should be used to calculate the amount of Medicare's recovery. The fact that the settlement or other documentation provides that all parties considered such services to be unrelated to the accident or injuries does not justify omitting them from Medicare's recovery.

Id.

In the Council's view, the MSPM provision quoted above supports a conclusion that all medical expenses are presumptively included in a settlement amount. The Council finds no ALJ error in placing the burden of proof on the appellant to demonstrate otherwise and agrees with the ALJ that the appellant has not met that burden in this case. Medicare is entitled to recover from settlement proceeds even if the parties agree that a portion of the settlement proceeds is unrelated to the accident or injury.

The Council has considered the record, and in particular, the new evidence submitted with the request for review (June 2009 opinion letters of Drs. B*** and W***), as well as Dr. A***'s November 4, 2005 opinion (Exh. 6 at 50) that he "cannot comment on whether [the beneficiary's] automobile accident had anything to do with her subsequent fracture or if it [referring to the automobile accident] would have left her with deficits that would have resulted in her fall." The Council finds no basis for altering the ALJ's finding that: "A review of the diagnoses does not show that the services that remain on the payment summary form are . . . unrelated to the injury that gave rise to the settlement." Dec. at 7. The Council also notes that the settlement statement for the personal injury claim associated with the April 2005 vehicular accident (Exh. 1 at 35) includes medical expenses incurred after the August 2005 syncope and fall. It is inconsistent that counsel would include the medical

expenses incurred after August 2005 to obtain a personal injury settlement from State Farm Insurance Companies for the April 2005 vehicular accident and then assert that the expenses incurred in and after August 2005 should be entirely excluded for the purposes of calculating the appropriate Medicare lien amount.

Waiver of Recovery

Before the Council, the appellant states that she underwent hip surgery in 2009, and her current living and medical expenses are such that repaying Medicare would pose a financial hardship and would be against equity and good conscience. Exh. MAC-2. We note that the appellant did not specifically raise the issue of financial hardship during the prior proceedings, including before the ALJ. Her argument for waiver below was that she had detrimentally relied on MSPRC's statement in January 2008, that \$379.90 constituted conditional payments made on her behalf and that she took this statement into consideration in settling her personal injury claim for \$25,000. She seems to be reasserting this argument before the Council. See Exh. MAC-2.

The ALJ rejected the appellant's "detrimental reliance" argument as unpersuasive and determined that the asserted reliance on the MSPRC's January 2008 statement was "inappropriate." Dec. at 7. The Council agrees. The MSPRC's January 4, 2008, letter states:

Currently, Medicare has paid \$379.90 in conditional payments related to your claim. Attached you/your attorney will find a listing of claims that comprise this total. Please take a look at this listing and let us know if you/your attorney disagree . . . *Please be advised that we are still investigating this case file to obtain any other outstanding Medicare conditional payments. Therefore, the enclosed listing of current conditional payments (including a response of a zero amount) is not a final listing and will need to be updated once we receive final settlement information from you.*

Exh. 1 at 39 (emphasis added). The letter included as an enclosure a 7-page payment summary dated January 4, 2008, listing conditional payments of \$17,165.64 made to date. *Id.* at 40-47. In her January 23, 2008, letter (Record at 306) responding to MSPRC's January 4, 2008, letter, the appellant acknowledged that the lien "to date is \$379.90," and asked for a

reduction of the lien amount. Based on a review of the MSPRC's and appellant's correspondence, it is evident that Medicare made conditional payments well in excess of \$379.90, and the appellant was made aware that \$379.90 did not constitute MSPRC's final determination as to the amount of the Medicare lien.

As for the "financial hardship" argument, the Council concludes that no waiver is warranted based on this argument. As stated, the appellant's only argument is that her *present* financial circumstances are such that it would be difficult for her to repay the Medicare lien amount. See Exh. MAC-1. However, for the purposes of a waiver of the overpayment amount under section 1870(c) of the Social Security Act, repayment of the Medicare conditional payments must be the circumstance that causes the financial hardship. See MSPM, Ch. 7, sections 50.6.2 and 50.6.5.3. That is not demonstrated to be the case here. We find that requiring the appellant to reimburse Medicare in this case is not against equity and good conscience.

The Council adopts the ALJ's decision.

MEDICARE APPEALS COUNCIL

/s/ Susan S. Yim
Administrative Appeals Judge

Date: November 10, 2009