DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL

In the case of	**Claim for**
A.H. (Appellant)	Supplementary Medical Insurance Benefits (Part B)
**** (Beneficiary)	**** (HIC Number)
MSPRC (Contractor)	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated March 30, 2009, concerning Medicare recovery of conditional payments made on the beneficiary's behalf following a motor vehicle accident on January 3, 2005, which ultimately resulted in a liability settlement. The ALJ determined that Medicare, as secondary payer, was entitled to recover $3,466.11 in principal, plus $144.44 in interest, in conditional payments made for medical care furnished to the beneficiary. 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 appellant's request for review and accompanying records are admitted as Exh. MAC-1.

The Council has considered the record and the appellant's exceptions. For the reasons and bases articulated herein, the Council concludes that the exceptions present no basis for changing the ALJ's action and adopts the ALJ's decision.

DISCUSSION

On January 3, 2005, the appellant was involved in an automobile accident. Emergency medical services (EMS) transported her to a hospital. Exh. 2 at 5. EMS noted the appellant's primary diagnosis as neck pain and secondary diagnosis as back pain. *Id*. EMS further documented that she had a "superficial laceration to [her right] large toe, and [complained of] right arm and shoulder pain, and neck and back pain upon palpitation." *Id*. at 8. EMS immobilized her neck and moved her by stretcher to the ambulance vehicle. *Id*. at 7. Upon admission to the hospital emergency department, the appellant was noted as having "neck, back, [right] shoulder, [and right] arm pain." *Id*. at 13. Subsequent testing revealed a large full thickness right rotator cuff tear, for which she underwent surgery on February 11, 2005. Exh. 3 at 18, 23-24.

In October 2006, the appellant received a settlement amount of $40,000.00 from Allstate Insurance Company. Exh. 1 at 1, 21, Exh. MAC-1 at 112-113. On December 14, 2007, the Medicare Secondary Payer Recovery Contractor (MSPRC) notified the appellant that Medicare was due $3,466.11, in conditional payments made for accident related medical expenses in accordance with 42 C.F.R. § 411.37. Exh. 1 at 23. The appellant requested that Medicare accept $2,000.00 in full satisfaction of the outstanding lien. Exh. 1 at 10, 15, 21-22. The appellant also requested the contractor reconsider its determination. Upon redetermination, the contractor found that all of the conditional payments were related to the automobile accident. The contractor determined that Medicare is owed $3,466.11 in principal and $144.44 in interest. Exh. 1 at 16. The Qualified Independent Contractor (QIC) affirmed the contractor's determination. The QIC found that there was insufficient documentation to support a conclusion that the medical services at issue were unrelated to the January 3, 2005, accident. *Id*. at 4-6.

The appellant consistently has maintained that Medicare should be reimbursed only a portion of the $3,466.11, because some of this amount constituted charges for medical care for conditions not related to the injury sustained on January 3, 2005. Specifically, during the proceedings below, the appellant asserted that she sustained a rotator cuff injury on January 3, 2005, and that Medicare is entitled to reimbursement for only the charges for medical care provided for that injury. The ALJ considered these arguments, hearing testimony, and the record

and found the arguments unpersuasive. Dec. at 3, 5-6. The ALJ found that "there is not enough evidence to substantiate [the] appellant's claim that the charges at issue in this case were unrelated to the injuries that gave rise to the settlement." Dec. at 5. Thus, the ALJ concluded that the appellant must reimburse Medicare for the conditional payments made on her behalf plus interest in accordance with Title XVIII of the Social Security Act. Dec. at 4-6.

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. Also pertinent is Medicare Secondary Payer Manual (MSPM), CMS Pub. 100-05, 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. Dec. at 6. Medicare is entitled to recover from settlement proceeds without regard to how the settlement agreement stipulates disbursements should be made, and even if the parties agree that a portion of the settlement proceeds is unrelated to the accident or injury.

The Council has considered the evidence submitted with the request for Council review, most of which are duplicate copies of medical records that were of record before the ALJ. The appellant, by counsel, determined which medical records are related to the January 3, 2005 accident, and which are not, by dividing the records into two groups, marking one group "accident related," and, the other, "not accident related." *See* Exh. MAC-1. In doing so, the appellant seems to be asserting that the records are self-evident. But merely grouping the medical records in such a manner lends little support to the appellant's position that only the charges associated with the care provided for the rotator cuff injury should be subject to recovery.

We also address the appellant's submittal of copies of two letters and an affidavit included with the request for Council review. All three submittals are dated (or, in the case of the affidavit, was executed) after the date of the ALJ's decision and apparently were prepared for the purposes of this request for review, at the request of the appellant's counsel. One is a letter dated May 18, 2009, written by the office manager for an orthopedist whose care the appellant asserts was not provided for injuries sustained on January 3, 2005, and addressed to the appellant's counsel. The office manager stated only that in November 2006, the appellant was seen for sciatica "that was not associated with nor a result of a motor vehicle accident." Exh. MAC-1 at 6. As for the affidavit, executed on May 17, 2009 (Exh. MAC-1 at 9-10), the affiant, J.S., a chiropractor, stated that he began treating the appellant for neck and other problems beginning in October 2006, but "never" for "any purported injuries that she sustained as a result of a motor vehicle accident on January 3, 2005." *Id.* at 9. Third, on May 21, 2009, another chiropractor wrote that the appellant was treated on various dates since February 2005 low back pain "following long rides back to *** from *** . . . brought on by sitting for too long of time." *Id.* at 5.

The Council has considered the record and concludes that the above submittals do not provide a basis for altering the ALJ's action. The appellant continues to assert that she suffered only a rotator cuff injury on January 3, 2005, and that the medical care provided for all other problems should not be subject to Medicare recovery. She emphasizes the dates of medical care purportedly unrelated to the January 3, 2005, accident (i.e., primarily in 2006), and seems to be asserting that the fact that such care was provided a year (or even later) following the January 3, 2005, automobile accident supports her position that the care was not provided for the January 3, 2005, injury. But, as we noted earlier (see in particular the first paragraph under the heading "DISCUSSION," above), the medical records dated on January 3, 2005, indicate that the appellant complained of neck and back pain. The appellant had her cervical spine immobilized that day. We note that many of the medical records of the appellant's care providers, particularly the chiropractic care records of J.S., indicate treatment for, among other things, cervical spine problems and neck pain, well after the date of the automobile accident. We do not find the appellant's argument persuasive based on a review of all of the medical records before us.

The Council adopts the ALJ's decision.

MEDICARE APPEALS COUNCIL

/s/ Susan S. Yim
Administrative Appeals Judge

Date: November 6, 2009