United States Department of Labor
Employees' Compensation Appeals Board

P.C., Appellant	)	
and	)	**Docket No. 07-1691**
	)	**Issued: June 20, 2008**
ENVIRONMENTAL PROTECTION AGENCY, REGION II, Edison, NJ, Employer	)	

Appearances:
James M. Clancy, Esq., for the appellant
No appearance, for the Director

Oral Argument May 6, 2008

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On June 6, 2007 appellant filed a timely appeal from the February 22, 2007 merit decision of the Office of Workers' Compensation Programs, which denied a reduction of her third-party surplus. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the merits of the case.

ISSUE

The issue is whether compensation is payable for the medical expenses that were covered by appellant's private health insurance or by Medicare, thereby warranting a reduction in her third-party surplus.

FACTUAL HISTORY

Appellant, then a 33-year-old on-scene coordinator, filed a claim alleging that her exposure to fumes at the White Chemical Superfund site from August 30, 1990 to March 29, 1991 caused an injury in the performance of duty. The Office accepted her claim for aggravation

of asthma. The Office later accepted pseudotumor cerebri as consequential to her corticosteroid treatment for asthma. Appellant received compensation benefits.[1]

In 1992, appellant filed a third-party negligence claim arising out of her chemical exposure. In 1998, she received a settlement of $895,050.00. The Office notified her that she was required to reimburse the United States for the amount of compensation previously paid and that any additional compensation payable for the same injury would be credited against her third-party surplus.

In 2001, appellant's attorney submitted 560 pages representing "$199,000.00 worth of medicals related to the pseudotumor cerebri claim that have been submitted to the claimant's private health care insurer for payment as they would not have been compensable nor appropriate for payment by the Office due to the continuing third-party credits."[2] On May 21, 2002 the Office informed appellant: "Unfortunately, we are unable to process your request to reimburse Medicare for bills incurred by [you] for the reason that in order to secure reimbursement Medicare must submit all bills on the AMA standard billing form OWCP/HCFA 1500." Appellant's attorney continued to seek reduction of the third-party surplus to the extent that appellant submitted her medical bills through private insurance. On August 24, 2004 he stated that appellant was seeking a reduction of the surplus based upon after-incurred medical bills now totaling in excess of $500,000.00:

> "What makes no sense in this matter is that if [appellant] had submitted her after-incurred medical bills to OWCP for payment, they would have been denied and used to reduce the surplus. Thereafter she would have been free to submit them to either Medicare, Medicaid and/or private health insurance, Blue Cross/Blue Shield, for which she pays.
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> "The same result can be obtained by having the after-incurred medical bills submitted to private health insurance and then submitting those bills to OWCP for purposes of reimbursing the health insurance carrier. Of course, the OWCP would deny reimbursement to the carrier based upon the fact that there is still a third-party surplus. In either scenario, the result remains the same, just the route taken varies slightly."

On August 8, 2005 appellant wrote to the Office: "DOL [Department of Labor] claim examiners now say, the Regulations state that I must make the medical payments myself where the law says only that medical payments must be paid by the claimant. I got private insurance

[1] In another case, the Office accepted that appellant sustained a low back strain in the performance of duty. OWCP File No. 02-0626871.

[2] The submissions were largely Medicare Summary Notices explaining how much of the itemized expenses Medicare covered. The notices are marked "THIS IS NOT A BILL." Appellant's attorney argued that because the additional $199,000.00 in medical expenses was less than the third-party surplus, the Office would have had no statutory obligation to pay these expenses and never would have performed an audit of the medical bills to determine what would be payable as reasonable and necessary. "As such," the attorney argued, "OWCP would have simply denied these bills on a dollar-for-dollar basis. Therefore, at the present time, it is entirely appropriate to examine these bills on a dollar-for-dollar basis as a reduction in the total third-party credits."

and made those payments of medical bills from my private insurer." Appellant added: "We will not turn in any medical bills into DOL as we have private insurance to pay for them."

In a decision dated February 22, 2007, the Office denied a reduction of appellant's third-party surplus for medical bills not paid by her but by her private health insurance or Medicare. The Office informed appellant that it would reduce the surplus for medical expenses paid by her: "If you submit medical bills showing that they were paid by you, we will apply the amounts paid by you to the further reduction of the third-party surplus."

LEGAL PRECEDENT

Under section 8103 of the Federal Employees' Compensation Act (Act) or FECA, the United States shall furnish to an employee who is injured while in the performance of duty, the services, appliances and supplies prescribed or recommended by a qualified physician, which the Secretary of Labor considers likely to cure, give relief, reduce the degree of the period of any disability or aid in lessening the amount of any monthly compensation.[3] An employee claiming reimbursement of medical expenses should submit an itemized bill.[4] If an employee has paid bills for medical, surgical or dental services, supplies or appliances due to an injury sustained in the performance of duty, she may submit an itemized bill on the Health Insurance Claim Form, HCFA 1500 or OWCP 1500, together with a medical report to the Office for consideration.[5] The bill must be accompanied by evidence that the provider received payment for the service from the employee and a statement of the amount paid. Acceptable evidence that payment was received includes, but is not limited to, a signed statement by the provider, a mechanical stamp or other device showing receipt of payment, a copy of the employee's canceled check (both front and back) or a copy of the employee's credit card receipt.[6] The Office will not accept copies of bills for reimbursement unless they bear the original signature of the provider, with evidence of payment.[7]

If an injury or death for which compensation is payable is caused under circumstances creating a legal liability in a person other than the United States to pay damages and a beneficiary entitled to compensation from the United States for that injury or death receives money or other property in satisfaction of that liability as a result of suit or settlement by her or in her behalf, the beneficiary, after deducting therefrom the costs of suit and a reasonable attorney's fee, shall refund to the United States the amount of compensation paid by the United States and credit any surplus on future payments of compensation payable to her for the same

[3] 5 U.S.C. § 8103(a).

[4] 20 C.F.R. § 10.335.

[5] *Id*. at § 10.802(a).

[6] *Id*. at § 10.802(a)(2).

[7] *Id*. at § 10.802(d).

injury. If compensation has not been paid to the beneficiary, she shall credit the money or property on compensation payable to her by the United States for the same injury.[8]

After the refund owed to the United States is calculated, FECA beneficiary retains any surplus remaining and this amount is credited, dollar for dollar, against future compensation for the same injury. The Office will resume the payment of compensation only after FECA beneficiary has been awarded compensation which exceeds the amount of the surplus.[9]

Where a beneficiary has received a third-party recovery resulting in a surplus, compensation payments are calculated and continue to be charged against the surplus, as are medical expenses that have been paid by the claimant and submitted for reimbursement. Claimants should be encouraged to submit reimbursement requests for medical expenses as they are incurred, even though the amounts paid for such expenses will result in reduction of the surplus, rather than actual payment of additional benefits.[10]

There are no provisions in the Act or the regulations for payment to an injured employee of medical and other expenses incurred but not actually paid by the employee.[11] Where private insurance pays for all medical expenses incurred with respect to the work injury, payment of additional benefits under section 8103 would result in a windfall for the employee and such is not the intent of the Act.[12]

ANALYSIS

Appellant's position that the Office should reduce her third-party surplus is, for all practical purposes, a claim for additional compensation under the Act.[13] The Office's February 22, 2007 decision denying the requested reduction is a final decision that the Board has jurisdiction to review.[14] The Board has no jurisdiction to determine whether the Office must reimburse appellant's private health insurance or Medicare for the insurance benefits she received. That is a matter between BlueCross BlueShield and Medicare on the one hand and the

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[8] 5 U.S.C. § 8132; *see David R. Gilmer*, 34 ECAB 1342, 1346 (1983) (the principle underlying the obligation of an employee to reimburse the employer for its compensation outlay once a recovery is made against the responsible tortfeasor is to prevent a double recovery by the employee).

[9] 20 C.F.R. § 711.

[10] Federal (FECA) Procedure Manual, Part 2 -- Claims, *FECA Third-Party Subrogation Guidelines*, Chapter 2.1100.10.b(3) (March 2006).

[11] *Anna Palestro (Vincent Palestro)*, 15 ECAB 595 (1964).

[12] *Jerrold L. Hudson*, 33 ECAB 1095 (1982). *See generally* 6 Arthur Larson & Lex K. Larson Larson's *Workers' Compensation* Law Chapter 110 (May 2000) (the theory of third-party actions and the policy of avoiding double recovery).

[13] *Harry E. Schnackenberg*, 30 ECAB 887, 890 (1979).

[14] 20 C.F.R. § 501.2(c) (the Board has jurisdiction to consider and decide appeals from the final decision of the Office in any case arising under the Act).

Office on the other. It does not involve a determination with respect to "claims of employees."[15] The Board's jurisdiction extends only to appellant's claim that compensation is payable to her for certain medical expenses, thereby warranting a reduction in her third-party surplus.

Section 8132 of the Act requires appellant "to credit any surplus on future payments of compensation that are payable" to her for the same injury. The question, therefore, is whether compensation is payable under section 8103 of the Act for the medical expenses that were paid by appellant's private health insurance or by Medicare.

The law on this point is settled. There are no provisions in the Act or the regulations for payment to an injured employee of medical and other expenses incurred but not actually paid by the employee. In the case of *Anna Palestro (Vincent Palestro)*[16] the Board interpreted the regulatory language "paid by an injured employee" to mean actually paid by the employee, not by private insurance. Where BlueCross BlueShield, the deceased husband's insurance carrier, paid a $411.68 hospital charge, the Board found that appellant was not entitled to reimbursement of this amount by the Office, as neither she nor the deceased employee paid the charge. In the case of *Jerrold L. Hudson*,[17] where private insurance reimbursed the claimant for $5,287.78 of his medical expenses, which totaled $6,280.72, the Board found that the Office properly reimbursed the claimant only for the balance of $992.94, which the employee paid.

Under the federal regulations implementing the Act, when it comes to determining whether "an employee has paid bills" for medical, surgical or dental services, supplies or appliances due to an injury sustained in the performance of duty[18] or whether the provider received payment for the service "from the employee,"[19] the Office will not reimburse an employee for medical expenses paid by the employee's private health insurance or by Medicare. Office procedures indicating that medical expenses will be charged against the surplus if they have been paid by the claimant are consistent with the Board's interpretation of the implementing regulations.

Appellant makes no distinction between herself and her private health insurance, but the distinction must be made to prevent a windfall to her from the Employees' Compensation Fund. To the extent that insurance discharges her liability for medical expenses incurred, she is made whole. If the Office were then to send her a check for the same sum that BlueCross BlueShield and Medicare paid to her health care providers, she would be enriched, which is not the intent of the Act. Indeed, appellant would find herself equally enriched by a reduction of her third-party surplus, not because she received an actual payment of additional benefits, but because her liability to the United States under section 8132 of the Act would be reduced by the amount of compensation payable. It is only when the claimant makes the payment herself that she is

[15] 5 U.S.C. § 8149; *Glenn E. Erickson*, 25 ECAB 9, 16 (1973).

[16] *Supra* note 11.

[17] *Supra* note 12.

[18] *See supra* text accompanying note 5.

[19] *See supra* text accompanying note 6.

eligible for reimbursement of those medical expenses or for a reduction of her third-party surplus.

Appellant's attorney argued that if appellant had submitted her after-incurred medical bills to the Office for payment, they would have been denied and used to reduce her surplus. Whether the Office would have denied those bills is a matter of speculation. The Office has broad discretion under section 8103 in approving services provided under the Act.[20] Further, the Office will not reduce a third-party surplus for medical bills that are denied. Again, section 8132 of the Act requires appellant to credit any surplus on future payments of compensation that are "*payable*" to her for the same injury. (Emphasis in the original.) So the Office will reduce her surplus for medical expenses only when it determines, in its discretion, that compensation is payable under section 8103.

The Board will affirm the Office's February 22, 2007 decision denying a reduction in appellant's third-party surplus for medical expenses paid by her private health insurance or by Medicare. Because appellant did not make these payments herself, she is not eligible for reimbursement. And because compensation is not payable to her for these expenses, her third-party surplus is not credited under section 8132 of the Act.

CONCLUSION

The Board finds that compensation is not payable for the medical expenses that were paid by appellant's private health insurance or by Medicare. The Office properly denied the requested reduction of her third-party surplus.

[20] *Daniel Wietchy*, 34 ECAB 670, 672 (1983).

ORDER

IT IS HEREBY ORDERED THAT the February 22, 2007 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 20, 2008
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board