BDB:DBS:jm

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

UNITED STATES OF AMERICA	:	
	:	
Plaintiff,	:	
v.	:	CIVIL NO.: 3:17-cv-1193
	:	
RICHARD C. ANGINO, ESQUIRE,	:	
	:	
ANGINO LAW FIRM, P.C. f/k/a	:	
Angino & Lutz P.C. f/k/a	:	
Angino & Rovner, P.C., and	:	
	:	
GLORIA TROSTLE, as Administratrix:		
of the ESTATE OF DAVID A.	:	
TROSTLE	:	
Defendants.	:	

FILED
SCRANTON
JUL - 7 2017
PER _____
DEPUTY CLERK

COMPLAINT

1. This is a civil action by the United States of America for declaratory judgment and money damages to recover amounts due and owing to the Centers for Medicare & Medicaid Services ("CMS"), a component of the United States Department of Health & Human Services, by virtue of charges the Medicare program paid on behalf of beneficiary David A. Trostle, but for which the Medicare program was not ultimately responsible.

PARTIES

2. Plaintiff is the United States of America.

3. Defendant Richard C. Angino, an attorney, represented Mr. Trostle in the matter entitled *David A. Trostle And Gloria L. Trostle v. Bloomfield Pharmacy, Inc., et al.*," No. 2013-527 in the Perry County Court of Common Pleas of Pennsylvania. Defendant Angino's office is located at 4503 North Front Street, Harrisburg, PA 17110-1799.

4. Defendant Angino Law Firm, P.C. is the current employer of Defendant Richard C. Angino and is located at 4503 North Front Street, Harrisburg, PA 17110-1799. Defendant Angino Law Firm, P.C. was formerly known as Angino & Lutz, P.C. (as of 2014) and Angino & Rovner, P.C. (1983-2014). Defendant Angino and the defendant law firms will be referred to herein as the Angino Defendants.

5. Defendant Gloria L. Trostle is the Administratrix of the estate of David A. Trostle. [1]

[1] Upon information and belief, Mr. Trostle's death was unrelated to the third-party payments at issue in this matter.

JURISDICTION AND VENUE

6. This Court has jurisdiction pursuant to 28 U.S.C. § 1345, 42 U.S.C. § 1395y(b)(2), and 42 C.F.R. Part 411. Venue is proper under 28 U.S.C. § 1391(b)(2), because a substantial part of the events giving rise to the claim in this action occurred in this District.

RELEVANT MEDICARE STATUTORY AND REGULATORY PROVISIONS

7. The Medicare program, which was enacted in 1965, is a federally funded program of health insurance for the aged, the disabled, and persons suffering from end stage renal disease. 42 U.S.C. §§ 1395 – 1395*lll* (the Medicare Act). The Secretary of HHS (the Secretary), acting through the Administrator of the CMS, has overall responsibility for the program.

8. In 1980, Congress enacted the Medicare Secondary Payer statute (MSPS), which requires insurers to make the primary payment for services rendered to Medicare beneficiaries, leaving the Medicare program to provide benefits only as a "secondary" payer. *See* 42 U.S.C. § 1395y(b).

9. The MSPS uses two mechanisms to protect Medicare funds and ensure that Medicare is the secondary payer. First, it prohibits Medicare from making payments for covered medical items and services if payment has already been made or can reasonably be expected to be made by another source, or "primary plan," such as the insurers that paid the settlement in this case. *See* 42 U.S.C. § 1395y(b)(2)(A)(ii). Second, when a primary plan cannot be expected to make payment promptly, the MSP provisions permit Medicare to pay – but conditions those payments on reimbursement after the primary plan makes payment. 42 U.S.C. § 1395y(b)(2)(B)(i). The payments Medicare makes in these circumstances are referred to as Conditional Payments.

10. Medicare has a right to recover Conditional Payments from either the primary plan or an entity that received payment from a primary plan. Such entities include beneficiaries and attorneys who represent them. 42 U.S.C. § 1395y(b)(2)(B)(ii); 42 C.F.R. § 411.24(g).

11. After a beneficiary reports a settlement to Medicare, the agency responds with notification of the amount of reimbursement due. *See e.g.*, Exhibit 1, CMS's Initial Determination dated August 14, 2014.

A beneficiary dissatisfied with Medicare's determination has the right to request a redetermination from the contractor who made the initial determination, then a reconsideration by a Qualified Independent Contractor (QIC), followed by a hearing before an Administrative Law Judge (ALJ), and a request that the Medicare Appeals Council (MAC) review the ALJ decision. 42 U.S.C. § 1395ff(b) and (c); 42 C.F.R. §§ 405.940, 405.960, 405.1000, 405.1100. An individual must obtain a decision from the MAC before suing Medicare in federal district court. 42 C.F.R. §§ 405.1130, 405.1136; 42 U.S.C. § 405(g). If an individual fails to timely appeal at any level of review, the most recent agency decision becomes binding. *See e.g.*, 42 C.F.R. §§ 405.958, 405.978, 405.1048, 405.1130.

FACTUAL ALLEGATIONS

12. On or about July 8, 2011, upon information and belief, a pharmacy dispensed the incorrect drug to Mr. Trostle, causing him to suffer lithium toxicity, which put him in a coma for two weeks and required a 66-day stay in various hospitals. Medicare paid $84,353.00 of the related medical charges.

13. In March 2013, the Angino Defendants informed Medicare that Mr. Trostle was pursuing a third-party claim related to the lithium toxicity, and asked Medicare to identify medical charges related to his injuries. Exhibit 2, Correspondence from Agino-Rovner dated March 28, 2013.

14. CMS responded with an interim amount of Conditional Payments of $725.00, and subsequently announced a second interim amount of $1,212.00. Exhibit 3, CMS Correspondence dated May 20, 2013, at 5; Exhibit 4, CMS Correspondence dated May 22, 2014, at 5. On both occasions, CMS informed Mr. Trostle that if the case involved ingestion, which Mr. Trostle's case did, the interim amount stated was incorrect, and requested that Mr. Trostle contact Medicare.

15. Upon information and belief, the Angino Defendants knew or should have known that Medicare paid more than $1,212.00 for the 66 days Mr. Trostle spent in the hospital related to the lithium toxicity.

16. The Angino Defendants proceeded to settlement of the personal injury case without contacting Medicare to determine whether the Conditional Payment amounts noted in CMS's letters were

accurate. The parties settled the claims for $225,000.00.

17. When the Angino Defendants reported the settlement, Medicare performed a further review of its paid claims, and identified $84,353.00 in medical charges related to the lithium toxicity. Exhibit 1, CMS's Initial Determination, dated August 14, 2014, at 7. Medicare reduced its claim by its share of the attorneys' fees and, in a letter dated August 14, 2014, notified the Angino Defendants and Mr. Trostle that it was due $53,295.00 from the settlement proceeds. *Id.* at 1. Medicare indicated that payment was due in 60 days.

18. Medicare's letter explained how to appeal Medicare's determination. *Id.* at 3-4, 12.

19. The Angino Defendants responded to Medicare's letter by arguing that Mr. Trostle was required to pay only $1,577.00. Exhibit 5, Trostle's Request for Redetermination, dated August 26, 2014. Medicare interpreted this letter as a request for redetermination – the first level of the administrative review process. 42 C.F.R. §§ 405.940 – 405.958.

20. Medicare considered Mr. Trostle's appeal and denied it, informing the Angino Defendants and Mr. Trostle of its redetermination decision. Exhibit 6, CMS's Redetermination Decision, dated October 15, 2014 at 1. Again, Medicare explained how to appeal the decision, notifying Mr. Trostle that he had 180 days, or until April 18, 2015, to write to Maximus Federal Services ("Maximus"), the Qualified Independent Contractor, to appeal the agency's decision. *Id.* at 1-2.

21. Defendants failed to file a timely appeal to Maximus. Consequently, the agency's redetermination decision became binding on Mr. Trostle. 42 C.F.R. § 405.958.

22. To date, this debt has not been paid.

23. Upon information and belief, Defendant Trostle or the Angino Defendants received payment of $225,000.00 from the primary plans. The MSPS and its implementing regulations therefore authorize the United States to recover the amount due Medicare from the Defendants. 42 U.S.C.A. § 1395y(b)(2)(B); 42 C.F.R. § 411.24(g).

24. Because this debt has not been repaid within the required sixty-day time period, CMS is also entitled to receive interest on this

debt under 42 U.S.C. §1395y(b)(2)(B) and 42 C.F.R. § 411.24(m)(2). The rate of interest accruing on this debt is 9.625% per year as provided for under 42 C.F.R. § 405.378(d) and CMS's Initial Determination dated August 14, 2014. Exhibit 1 at 4, § V.

25. Moreover, because the United States has expended litigation costs because the Angino Defendants and Defendant Trostle have opposed recovery of this debt, the United States will not pay its share of the attorney's fees and costs. Instead, in accordance with 42 C.F.R. § 411.37(e)(1), the principal amount of the debt is now the Conditional Payment amount of $84,353.00.

CAUSES OF ACTION

COUNT ONE

(Recovery of Medicare Secondary Payments 42 U.S.C. § 1395y(b)(2)(B); 42 C.F.R. § 411.24(g))

26. The United States brings this cause of action against all Defendants under the Medicare laws and regulations. 42 U.S.C. § 1395y(b)(2)(B); 42 C.F.R. § 411.24(g).

27. As detailed more fully in the allegations set forth above, which are incorporated herein, the Defendants are liable for a

Conditional Payment amount of $84,353.00, plus interest at the rate of 9.625% from August 14, 2014.

WHEREFORE, the United States of America respectfully requests that the Court (1) enter judgment in its favor declaring that the United States is entitled to reimbursement from Defendants for the medical charges Medicare paid on behalf of David Trostle related to the lithium toxicity he experienced in July 2011, as alleged hereinabove, (2) enter judgment in its favor in the amount of $84,353.00 plus interest at the rate of 9.625% from August 14, 2014, and (3) award such other relief as the Court may deem appropriate, including, but not limited to, costs.

Dated: July 7, 2017

Respectfully submitted,

BRUCE D. BRANDLER
United States Attorney

/s D. Brian Simpson
D. BRIAN SIMPSON
Assistant U.S. Attorney
Attorney I.D. No. OH 0071431
U.S. Attorney's Office
228 Walnut Street, Suite 220
Harrisburg, PA 17108-1754
Phone: 717-221-4482
Fax: 717-221-2246
D.Brian.Simpson@usdoj.gov

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150 S. Independence Mall West
Philadelphia, PA 19106-3499

3:17-cv-1193

CMS

COB&R
Coordination of Benefits and Recovery

August 14, 2014

94 2 SP 1 190
***SNGLP 720 R:94 T:2 P:2 PC:7 F:414702
ANGINO & ROVNER, P.C
4503 N FRONT ST
HARRISBURG, PA 17110-1799

COPY
For Information Only

August 14, 2014

94 2 SP 1 190
***SNGLP 720 R:94 T:2 P:2 PC:7 F:414702
DAVID A TROSTLE
[redacted]

RE: Beneficiary Name: TROSTLE, DAVID A
Medicare Number: [redacted]
Case Identification Number: [redacted]
Date of Incident: July 08, 2011
Demand Amount: $53,295.14

Dear DAVID A TROSTLE:

Please note that if we know that you have an attorney or other individual representing you in this matter, we are sending him/her a copy of this letter. If you have an attorney or other representative for this matter and his/her name is not shown as a "cc" at the end of this letter (indicating that he/she is receiving a copy), please contact us immediately. If you have any questions regarding this letter and are represented by an attorney or other individual in this matter, you may wish to talk to your representative and make sure that he/she has received a copy of this letter before contacting us.

4O20142200000400890

Exhibit 1

We are writing to you because we learned that you have made a liability claim relating to an accident, illness, injury, or incident occurring on or about July 08, 2011 and obtained a recovery. We have determined that you are required to repay the Medicare program $53,295.14 for the cost of medical care it paid relating to your liability recovery. (The term "recovery" includes a settlement, judgment, award, or any other type of recovery.)

Please read this entire letter, as it contains important information, including:

- An explanation of why you need to repay Medicare and the way we determined the amount you are required to repay (Parts I and II);
- Instructions for repaying Medicare if you agree that there has been an overpayment and accept the amount we have determined you owe. (Part III);
- Instructions for requesting waiver of recovery (for the full or a part of the amount of this demand) or appeal (if you disagree that an overpayment exists or with the amount of the overpayment we have determined you owe). (Part IV). Please note that Medicare will not initiate any recovery action while your request for waiver of recovery or appeal is pending;
- Interest charges that apply if you do not repay Medicare within sixty (60) days from the date of this letter and certain actions Medicare may decide to take if you fail to repay the amount you owe (Part V);
- Whom you should contact if you have questions about this letter (Part VI).

I. Why am I required to repay Medicare?

You are required to repay Medicare because Medicare paid for medical care you received related to your liability recovery. The Medicare Secondary Payer (MSP) law allows Medicare to pay for medical care received by a Medicare beneficiary who has or may have a liability claim. However, the law also requires Medicare to recover those payments if payment of a liability settlement, judgment, recovery, or award has been or could be made. Congress passed the MSP law because it wanted to make sure that the Medicare Trust Funds would have enough money to pay for medical care that beneficiaries may need in the future. Congress decided that, if a liability recovery was available to pay for a Medicare beneficiary's medical care, then that money should be used to pay for the care and any amounts already paid by Medicare should be refunded to the Medicare Trust Funds.

If you would like to read the MSP law, you can find it in Title 42 of the United States Code, Section 1395y(b)(2). You can also find the regulations that explain how the Medicare program recovers amounts it is owed under the MSP law in Title 42 of the Code of Federal Regulations, beginning at Section 411.20. You can also learn more about how the MSP law works by contacting your local Social Security office or by visiting www.medicare.gov

II. How did Medicare decide how much money I owe?

The Medicare program paid $84,353.11 for medical care related to your liability recovery. We have enclosed a list of the payments Medicare made related to your recovery with this letter. The Medicare program generally reduces the amount a Medicare beneficiary is required to repay to take into account the costs (such as attorney's fees) paid by the beneficiary to obtain his or her liability recovery. You can find the formula we use to decide how much the amount of this reduction should be at 42 C.F.R., sub-section 411.37. We have applied the formula and determined that the amount you owe Medicare is $53,295.14.

This letter relates only to money paid from your current recovery. If, in the future, you receive additional money from this liability recovery, or any other liability recovery, you must let us know.

III. If I accept this determination, how do I repay Medicare what I owe?

As stated, Medicare has calculated an overpayment of $53,295.14, with repayment requested within sixty (60) days of the date of this letter, August 14, 2014. Please send a check or money order for $53,295.14, made payable to Medicare, to us at the address listed at the end of this letter. Please make sure to include your name and Medicare number on the check or money order and include a copy of this letter with your payment.

The amount requested in this letter may not include payments received prior to the issuance of this demand letter dated August 14, 2014. Upon issuing a check, please deduct previous payments made to the Benefits Coordination & Recovery Center (BCRC) for the above referenced debt.

Please continue reading for information regarding your rights with respect to this overpayment and what happens if you do not repay Medicare timely (including the accrual and assessment of interest).

IV. What rights do I have if I disagree with the amount this letter says I owe or think that I should not have to repay Medicare for some other reason?

Right to Request a Waiver--You have the right to request that the Medicare program waive recovery of the amount you owe in full or in part. Your right to request a waiver is separate from your right to appeal our determination, and you may request both a waiver and an appeal at the same time. The Medicare program may waive recovery of the amount you owe if you can show that you meet both of the following conditions:

1. This overpayment (for purposes of requesting waiver of recovery, the amount you owe is considered an overpayment) was not your fault, because the information you

4Q2014220000040082

Exhibit 1

gave us with your claims for Medicare benefits was correct and complete as far as you knew; and when the Medicare payment was made, you thought that it was the right payment;

AND

2. Paying back this money would cause financial hardship or would be unfair for some other reason.

If you believe that both of these conditions apply to you, you should send us a letter that explains why you think you should receive a waiver of recovery of the amount you owe. If you request a waiver, we will send you a form asking for more specific information about your income, assets, expenses, and the reasons why you believe you should receive a waiver. Medicare will not initiate any recovery action while your request for waiver is pending. If we are unable to grant your request for a waiver, we will send you a letter that explains the reason(s) for our decision and the steps you will need to follow to appeal that decision if it is less than fully favorable to you.

Right to Appeal- You also have the right to appeal our determination if you disagree that you owe Medicare as explained in Part I of this letter, or if you disagree with the amount that you owe Medicare ($53,295.14) as explained in Part II of this letter. To file an appeal, you should send us a letter explaining why you think the amount you owe Medicare is incorrect and /or any reason(s) why you disagree with our determination. Medicare will not initiate any recovery action while your appeal request is pending. Once we receive your request, we will decide whether our determination that you must repay Medicare $53.295.14 is correct and send you a letter that explains the reasons for our decision. Our letter will also explain the steps you will need to follow to appeal that decision if it is less than fully favorable to you.

You have 120 days from receipt of this letter August 14, 2014 to file an appeal. We must assume that you received this letter within five (5) days of the date of the letter August 14, 2014unless you furnish us with proof of the contrary.

If you do not already have an attorney or other representative and you want help with your request for waiver or appeal, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your case. There are groups, such as lawyer referral service that can help you find a lawyer. There are also groups, such as legal aid services, that will provide free legal services if you qualify.

V. What happens if I do not repay Medicare the amount I owe?

If you do not repay Medicare in full by October 12, 2014, you will be required to pay interest on any remaining balance, from the date of this letter, at a rate of 9.625% per year as determined by

federal regulation If the debt is not fully resolved within 60 days of the date of this letter, interest is due and payable for each full 30 day period the debt remains unresolved. By law, all payments are applied to interest first, principal second. You can find the regulation that explains interest charges at 42 C.F.R., sub-section 411.24(m).

If you choose to appeal this determination or request a full or partial waiver of recovery, you may wish to repay Medicare the full amount or the amount you believe you owe within sixty (60) days of the date of this letter to avoid the assessment of interest. Interest accrues on any unpaid balance, which may include any amount you are determined to owe once a decision is reached on your request for waiver of recovery or appeal. If you receive a waiver of recovery or if you are successful in appealing our decision, Medicare will refund any excess amounts you have paid. Medicare will not initiate any recovery action while your request for waiver or appeal is pending.

If you can't repay Medicare in one payment, you may ask us to consider whether to allow you to pay in regular installments. If you make installment payments, you should be aware that your payments will be applied to any interest due first and then to the outstanding principal amount.

The provisions of the Debt Collection Improvement Act of 1996 apply to Medicare debt. Recovery actions may include collection by Treasury offset against any monies otherwise payable to the debtor by any agency of the United States (for example, tax refunds or federal benefits), among other collection methods. If Medicare intends to take collection action (including referral to Treasury), you will be provided with appropriate notice. This notice will include information concerning appropriate steps to avoid such actions.

VI. Who should I contact if I have questions about this letter?

If you have any questions concerning this matter, please call the BCRC at 1-855-798-2627 (TTY/TDD: 1-855-797-2627 for the hearing and speech impaired) or you may contact us in writing at the address below. If you contact us in writing, please be sure to include the beneficiary'sname, Medicare Health Insurance Claim Number (this is the number found on the beneficiary's red, white and blue Medicare card), and the date of the incident. Providing us with this information will help us respond more quickly to any questions you may have.

NGHP
PO BOX 138832
OKLAHOMA CITY, OK 73113

Sincerely,
BCRC

CC: ANGINO & ROVNER, P.C.

Enclosure: Payment Summary Form

47201422000004008

Exhibit 1

Payment Summary Form

Report Number: RMCAN - 5-5
Contractor: NGHP

Date: 08/14/2014
Time: 06:02:02

Beneficiary Name: TROSTLE, DAVID A
Beneficiary HICN: [redacted]

Case ID: [redacted]
Case Type: L – Liability
Date of Incident: 07/08/2013

TOS	ICN	Line #	Processing Contractor	Provider Name	Diagnosis Codes	From Date	To Date	Total Charges	Reimbursement Amount	Conditional Payment
20	[redacted]	0	52280	[redacted]	[redacted]	[redacted]	[redacted]	$17,821.22	$3,124.24	$3,124.24
20	[redacted]	0	12501	[redacted]	[redacted]	[redacted]	[redacted]	$16,447.55	$9,527.48	$9,527.48

[redacted] Exhibit 1

71	[redacted]	004	00882	[redacted]	$229.00	$55.02	$55.02
71	[redacted]	005	00882	[redacted]	$229.00	$55.02	$55.02
71	[redacted]	007	00882	[redacted]	$314.00	$80.19	$80.19

Sum of Total Charges:	$226,354.88
Total Conditional Charges:	$84,353.11

Exhibit 1

M 20140625 160550611 002 0056 1
150025914-0003893

angino-rovner

4503 North Front Street
Harrisburg, PA 17110-1799
Phone: (717) 238-6791
Fax: (717) 238-5610
www.angino-rovner.com
E-mail: rsadlock@angino-rovner.com

Richard C. Angino
David L. Lutz
Richard A. Sadlock
Daryl E. Christopher

Neil J. Rovner
Michael E. Kosik
Lisa M. Benzie
Kristen N. Sinisi

March 28, 2013

MSPRC-NGHP
PO Box 138832
Oklahoma City, OK 73113

RE: David A. Trostle
HIC # [redacted]
Date of Incident: 7/8/2011

To Whom it May Concern:

Enclosed you will find the Proof Of Representation and Consent To Release. Our office represents Mr. Trostle regarding his injuries suffered on July 8, 2011 and we are hereby requesting a Conditional Payment Account Summary at this time.

If you have any questions, please feel free to contact our office.

Very truly yours,

Tiffany M. Herb, Paralegal to
Attorney Rich Sadlock

RAS/tmh
Enclosures

521872

Exhibit 2

MSPRC

Learn about your letter at www.msprc.info

CMS

May 20, 2013

4603 1 MB 0.405
***AUTO**MIXED AADC 720 R:4603 T:25 P:57 PC:3 F:190401
DAVID A TROSTLE
[redacted]

[redacted]

Beneficiary Name: TROSTLE, DAVID A
Medicare Number: [redacted]
Case Identification Number: [redacted]
Date of Incident: July 08, 2011

THIS IS NOT A BILL. DO NOT SEND PAYMENT AT THIS TIME.

Dear DAVID A TROSTLE:

If we know you have an attorney or other individual representing you in this matter, we are sending him/her a copy of this letter. If you have an attorney or other representative and his/her name is not shown as a "cc" at the end of this letter (indicating that he/she is receiving a copy), please contact us immediately.

This letter follows a previous letter notifying you and your attorney or representative of Medicare's priority right to recovery as defined under the Medicare Secondary Payer provision. This means that you may be required to reimburse Medicare for medical expenses related to your automobile, slip and fall, medical malpractice, or other type of liability claim.

As of the date of this letter, Medicare has identified $725.17 in conditional payments that we believe are associated with your claim. As an attachment to this letter, you will find a Payment Summary Form, which lists claims that add up to this total.. Please notify us in writing if you believe that the claims listed are incorrect or inaccurate. Please also provide a description of your injury. It helps us correct our records.

Please note: If the underlying claim involves ingestion, exposure, implantation, or other

MEDICARE SECONDARY PAYER RECOVERY
CONTRACTOR
PO BOX 138832
OKLAHOMA CITY, OK 73113

MSPRC

Learn about your letter at www.msprc.info

CMS

non-trauma based injury, this conditional payment amount will need to be revised. Please contact the MSPRC immediately with a description of the injury so that we may associate the appropriate claims with your case.

We have posted this conditional payment information under the "MyMSP" tab on the www.mymedicare.gov website. The information at www.mymedicare.gov will be updated regularly with any changes or newly processed claims.

Please be advised that the conditional payment amount listed above is an interim amount. We are still reviewing medical claims related to your case. The conditional payment amount (including a zero amount) is not a final amount. It will be updated once we receive settlement information from you.

C20131340005369S

Option to Self-Calculate Your Final Conditional Payment Amount Prior to Settlement

If you have experienced a physical trauma based injury, can demonstrate that you have completed treatment, and expect to receive a settlement of $25,000 or less, you may be able to participate in a new process that allows you to calculate your own FINAL conditional payment amount prior to settlement. Please visit www.msprc.info for additional details, including eligibility criteria, instructions on how and when to elect this option, and a special mailing address.

Has Your Case Settled?

If your case has settled, please provide us with a copy of:

1) The settlement agreement from the third party payer showing the total amount of the settlement, signed and dated, AND

2) Your closing statement reflecting the actual amount of the attorney's fees and cost (excluding medical bills)

Questions or Concerns?

If you have questions about this letter, you may call the Medicare Secondary Payer Recovery Contractor (MSPRC) at 1-866-677-7220 (TTY/TDD: 1-866-677-7294 for the hearing and speech impaired) or you may contact us in writing at the address below. If you contact us in writing, please be sure to include the beneficiary's name and Medicare health insurance claim number.

If you have an attorney or other representative, you may wish to contact him or her first.

MSPRC

Learn about your letter at www.msprc.info

CMS

Sincerely,
MSPRC

Enclosure: Payment Summary Form

MSPRC

Learn about your letter at www.msprc.info

CMS

Payment Summary Form

Report Number: RMCAN_5-5

Contractor: MEDICARE SECONDARY PAYER RECOVERY CONTRACTOR

Date: 05/20/20[redacted]

Time: [redacted]

[redacted]

TROSTLE, DAVID A

[redacted]

Case ID: [redacted]

Case Type [redacted]

Date of Incident 07/08/2011

TOS	ICN	Line #	Processing Contractor	Provider Name	Diagnosis Codes	From Date	To Date	Total Charges	Reimbursement Amount	Conditional Payment
71	[redacted]	006	00882	[redacted]	[redacted]	[redacted]	[redacted]	$126.00	$39.38	$39.38
71		004	00882					$125.00	$32.59	$32.59
71		005	00882					$125.00	$32.59	$32.59
71		006	00882					$125.00	$32.59	$32.59
71		007	00882					$125.00	$32.59	$32.59
71		008	00882					$125.00	$32.59	$32.59
71		009	00882					$125.00	$32.59	$32.59
71		010	00882					$125.00	$32.59	$32.59

[redacted]

4E20131340000S3695

Exhibit 3

MSPRC

Learn about your letter at www.msprc.info

CMS

71	[redacted]	011	00882	[redacted]	[redacted]	[redacted]	$125.00	$32.50	$32.50
71		001	00882				$339.00	$60.56	$60.56
71		002	00882				$1,771.00	$358.51	$358.51

Sum of Total Charges: $3,236.00

Total Conditional Charges: $725.17

Exhibit 3

(Page 5 of 5)

[redacted]

8F2013134000053695

CMS

COB&R Coordination of Benefits and Recovery

May 22, 2014

1949 1 MB 0.435
***AUTO**MIXED AADC 720 R:1949 T:15 P:21 PC:3 F:387101
DAVID A TROSTLE
[redacted]

[redacted]

Beneficiary Name: TROSTLE, DAVID A
Medicare Number: [redacted]
Case Identification Number: [redacted]
Date of Incident: July 08, 2011

THIS IS NOT A BILL. DO NOT SEND PAYMENT AT THIS TIME.

Dear DAVID A TROSTLE:

If we know you have an attorney or other individual representing you in this matter, we are sending him/her a copy of this letter. If you have an attorney or other representative and his/her name is not shown as a "cc" at the end of this letter (indicating that he/she is receiving a copy), please contact us immediately.

This letter follows a previous letter notifying you and your attorney or representative of Medicare's priority right to recovery as defined under the Medicare Secondary Payer provision. This means that you may be required to reimburse Medicare for medical expenses related to your automobile, slip and fall, medical malpractice, or other type of liability claim.

As of the date of this letter, Medicare has identified $1,212.32 in conditional payments that we believe are associated with your claim. As an attachment to this letter, you will find a Payment Summary Form, which lists claims that add up to this total. Please notify us in writing if you believe that the claims listed are incorrect or inaccurate. Please also provide a description of your injury. It helps us correct our records.

Please note: If the underlying claim involves ingestion, exposure, implantation, or other

Exhibit 4

non-trauma based injury, this conditional payment amount will need to be revised. Please contact the Benefits Coordination & Recovery Center (BCRC) immediately with a description of the injury so that we may associate the appropriate claims with your case.

We have posted this conditional payment information under the "MyMSP" tab on the www.mymedicare.gov website. The information at www.mymedicare.gov will be updated regularly with any changes or newly processed claims.

Please be advised that the conditional payment amount listed above is an interim amount. We are still reviewing medical claims related to your case. The conditional payment amount (including a zero amount) is not a final amount. It will be updated once we receive settlement information from you.

452014136000029754

Option to Self-Calculate Your Final Conditional Payment Amount Prior to Settlement

If you have experienced a physical trauma based injury, can demonstrate that you have completed treatment, and expect to receive a settlement of $25,000 or less, you may be able to participate in a new process that allows you to calculate your own FINAL conditional payment amount prior to settlement. Please visit www.CMS.gov for additional details, including eligibility criteria, instructions on how and when to elect this option, and a special mailing address.

Has Your Case Settled?

If your case has settled, please provide us with a copy of:

1) The settlement agreement from the third party payer showing the total amount of the settlement, signed and dated, AND

2) Your closing statement reflecting the actual amount of the attorney's fees and cost (excluding medical bills)

Questions or Concerns?

If you have questions about this letter, you may call the BCRC at 1-855-798-2627 (TTY/TDD: 1-855-797-2627 for the hearing and speech impaired) or you may contact us in writing at the address below. If you contact us in writing, please be sure to include the beneficiary's name and Medicare health insurance claim number.

If you have an attorney or other representative, you may wish to contact him or her first.

Sincerely,
BCRC

CC: RICHARD SADLOCK

Enclosure: Payment Summary Form

Exhibit 4

Payment Summary Form

Report Number: RMCAN - 5-5
Contractor: NGHP

Date:: 05/22/2014
Time: 06:14:24
Page 4 of 5

Beneficiary Name: TROSTLE, DAVID A
Beneficiary HICN: [redacted]

Case ID: [redacted]
Case Type: L Liability
Date of Incident: 07/08/2011

TOS	ICN	Line #	Processing Contractor	Provider Name	Diagnosis Codes	From Date	To Date	Total Charges	Reimbursement Amount	Conditional Payment
71	[redacted]	1006	00882	[redacted]	[redacted]	[redacted]	[redacted]	$126.00	$39.38	$39.38
71		004	00882	[redacted]	[redacted]	[redacted]	[redacted]	$125.00	$32.59	$32.59
71		005	00882					$125.00	$32.59	$32.59
71		006	00882					$125.00	$32.59	$32.59
71		007	00882					$125.00	$32.59	$32.59
71		008	00882					$125.00	$32.59	$32.59
71		009	00882					$125.00	$32.59	$32.59
71		010	00882					$125.00	$32.59	$32.59

[redacted]
47201413600029754

Exhibit 4

(Page 4 of 10)

CMS

COB&R
Coordination of Benefits and Recovery

71	[redacted]	011	00882	[redacted]	$125.00	$32.59	$32.59
71		001	00887		$339.00	$66.56	$66.56
71		002	00882		$1,771.00	$358.51	$358.51
71		004	00882		$0.00	$0.00	$0.00
71		006	00882		$0.00	$0.00	$0.00
71		001	00882		$198.00	$31.42	$31.42
71		001	00882		$63.00	$12.09	$12.09
71		001	00882		$628.00	$259.77	$259.77
71		002	00882		$441.00	$163.42	$163.42
71		002	00882		$97.00	$0.00	$0.00
71		005	00882		$0.01	$0.00	$0.00
71		003	00882		$40.00	$20.45	$20.45

Sum of Total Charges: $4,703.01

Total Conditional Charges: $1,212.32

Exhibit 4

[redacted]

8820141380000029754

CMS

COB&R
Coordination of Benefits and Recovery

May 22, 2014

1955 I MB 0.435
***AUTO**MIXED AADC 720 R:1955 T:15 P:21 PC:3 F:387101
RICHARD SADLOCK
4503 N FRONT ST
HARRISBURG, PA 17110-1708

COPY
For Information Only

May 22, 2014

1955 I MB 0.435
***AUTO**MIXED AADC 720 R:1955 T:15 P:21 PC:3 F:387101
DAVID A TROSTLE
[redacted]

S20141360002925

Beneficiary Name: TROSTLE, DAVID A
Medicare Number: [redacted]
Case Identification Number: [redacted]
Date of Incident: July 08, 2011

THIS IS NOT A BILL. DO NOT SEND PAYMENT AT THIS TIME.

Dear DAVID A TROSTLE:

If we know you have an attorney or other individual representing you in this matter, we are sending him/her a copy of this letter. If you have an attorney or other representative and his/her name is not shown as a "cc" at the end of this letter (indicating that he/she is receiving a copy), please contact us immediately.

This letter follows a previous letter notifying you and your attorney or representative of

Exhibit 4

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As of the date of this letter, Medicare has identified $1,212.32 in conditional payments that we believe are associated with your claim. As an attachment to this letter, you will find a Payment Summary Form, which lists claims that add up to this total. Please notify us in writing if you believe that the claims listed are incorrect or inaccurate. Please also provide a description of your injury. It helps us correct our records.

Please note: If the underlying claim involves ingestion, exposure, implantation, or other non-trauma based injury, this conditional payment amount will need to be revised. Please contact the Benefits Coordination & Recovery Center (BCRC) immediately with a description of the injury so that we may associate the appropriate claims with your case.

1720141380002975S

We have posted this conditional payment information under the "MyMSP" tab on the www.mymedicare.gov website. The information at www.mymedicare.gov will be updated regularly with any changes or newly processed claims.

Please be advised that the conditional payment amount listed above is an interim amount. We are still reviewing medical claims related to your case. The conditional payment amount (including a zero amount) is not a final amount. It will be updated once we receive settlement information from you.

Option to Self-Calculate Your Final Conditional Payment Amount Prior to Settlement

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Has Your Case Settled?

If your case has settled, please provide us with a copy of:

1) The settlement agreement from the third party payer showing the total amount of the settlement, signed and dated, AND

2) Your closing statement reflecting the actual amount of the attorney's fees and cost (excluding medical bills)

Questions or Concerns?

If you have questions about this letter, you may call the BCRC at 1-855-798-2627 (TTY/TDD: 1-855-797-2627 for the hearing and speech impaired) or you may contact us in writing at the address below. If you contact us in writing, please be sure to include the beneficiary'sname and Medicare health insurance claim number.

If you have an attorney or other representative, you may wish to contact him or her first.

Sincerely,
BCRC

CC: RICHARD SADLOCK

Enclosure: Payment Summary Form

Exhibit 4

Payment Summary Form

Report Number: RMCAN - 5-5

Contractor: NGHP

Date: 05/22/2014

Time: 06:14:24

Beneficiary Name: TROSTLE, DAVID A

Beneficiary HICN: [redacted]

Case ID: [redacted]

Case Type: L = Liability

Date of Incident: 07/08/2011

TOS	ICN	Line #	Processing Contractor	Provider Name	Diagnosis Codes	From Date	To Date	Total Charges	Reimbursement Amount	Conditional Payment
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71		004	00882					$125.00	$32.59	$32.59
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71		006	00882					$125.00	$32.59	$32.59
71		007	00882					$125.00	$32.59	$32.59
71		008	00882					$125.00	$32.59	$32.59
71		009	00882					$125.00	$32.59	$32.59
71		010	00882					$125.00	$32.59	$32.59

[redacted]

4V20141360000029755

Exhibit 4

CMS

COB&R

71	[redacted]	011	00882	[redacted]	[redacted]	[redacted]	$125.00	$32.59	$32.59
71		001	00882				$339.00	$66.56	$66.56
71		002	00882				$1,771.00	$358.51	$358.51
71		004	00882				$0.00	$0.00	$0.00
71		006	00882				$0.00	$0.00	$0.00
71		001	00882				$198.00	$31.42	$31.42
71		001	00882				$63.00	$12.09	$12.09
71		001	00882				$628.00	$259.77	$259.77
71		002	00882				$441.00	$163.42	$163.42
71		002	00882				$97.00	$0.00	$0.00
71		005	00882				$0.01	$0.00	$0.00
71		003	00882				$40.00	$20.45	$20.45

Sum of Total Charges: $4,703.01

Total Conditional Charges: $1,212.32

Exhibit 4

(Page 10 of 16)

Page 5 of 5

[redacted]

81201413600002975S

M 20140829 150550611 002 0054 1
15002914-0003693

ANGINO & LUTZ, P.C.

RICHARD C. ANGINO
RCA@ANGINOLUTZ.COM

DAVID L. LUTZ
DLUTZ@ANGINOLUTZ.COM

August 26, 2014

CMS
Centers for Medicare & Medicaid
NGHP
PO Box 138832
Oklahoma City, OK 73113

Re: David A. Trostle
Case ID No. [redacted]
HIC No.: [redacted]
Date of Injury: 07/08/11

Dear Sir or Madam:

I am attorney for David A. Trostle and I am responding to your communication of August 14, 2014, demanding $53,295.14.

We notified you of our representation of Mr. Trostle by later dated March 28, 2013, copy of letter, Consent to Release and Proof of Representation forms enclosed.

On May 10, 2013, you acknowledged our office as representation, copy of letter enclosed.

On May 13, 2013, you sent out a form letter noting "if we know that you have a lawyer or other person representing you, we have sent him or her a courtesy copy of this letter and you will see him or her listed as a "cc" at the end of this letter." Angino & Rovner was listed and received a copy per cc.

On August 11, 2013, you confirmed original documentation previously sent on May 20, 2013, "as of this letter, Medicare has identified $725.17 in conditional payments that we believe are associated with your claim. As an attachment to this letter you will find a Payment Summary Form which list claims that add up to this total. Please notify us in writing if you believe that the claims listed are incorrect or inaccurate. Please also provide a description of your injury if it helps us correct our records." Copy of letter and enclosure supporting Medicare payments of 10/21/2011.

4503 NORTH FRONT STREET HARRISBURG, PA 17110-1799 PHONE: (717) 238-6791 FAX: (717) 238-3610
WWW.ANGINOLUTZ.COM

M 20140829 150550611 092 0058 1
1s0892514-0003493

As of May 22, 2014, you verified a sum of total charges of $4,703.01, and conditional charges of $1,212.32, copy enclosed.

Relying upon your May 22, 2014, confirmation of total billings from the date of the incident July 8, 2011, through February 25, 2014, we settled this case for $225,000.00.

We settled the case for $225,000.00 based upon your assurance of May 22, 2014, and the assurance of the Tricare lien claim of $40,586.37, but agreed to accept $26,809.54 as full payment. On July 15, 2014, we faxed to you Final Settlement Detail Document indicating the total settlement of $225,000.00, Med-Pay or PIP of $1,577.50, Attorney Fee of $78,750.00, Procurement Expenses Paid by the Beneficiary of $4,092.40 and the Date the Case Was Settled of 7/9/2014. Copy of documents enclosed. Following the settlement, your August 14, 2014, notice to Mr. Trostle demands $53,295.14.

Mr. Trostle does not have a legal obligation to pay $53,295.14. His obligation is to pay only $1,577.50. After receiving your August 14, 2014, demand we called your office and there was no explanation for the change from May 22, 2014, of $1,212.32 to $53,295.14. We relied upon the May 22, 2014, confirmation to settle the case. We will rely upon that letter to refuse to pay any additional amount.

Very truly yours,

Richard C. Angino

RCA/mam

enclosures

4503 North Front Street Harrisburg, PA 17110-1799 Phone: (717) 238-6791 Fax: (717) 238-9610
www.anginolutz.com

Exhibit 5

October 15, 2014

322 1 MB 0.435
***AUTO**MIXED AADC 720 R:322 T:5 P:5 PC:5 F:435301
ANGINO & LUTZ, P.C.
4503 N FRONT ST
HARRISBURG, PA 17110-1708

Beneficiary Name: DAVID TROSTLE
Medicare Number: [redacted]
Entitlement Date: [redacted]
Date of Incident: July 08, 2011
Case Identification Number: [redacted]
Document Control Number: 15082914-0003693

Dear ANGINO & LUTZ, P.C.:

This letter is in response to your August 28, 2014 request to appeal our initial determination of the amount/existence of Medicare's recovery claim. In your appeal request you stated that there are claims on the payment summary form unrelated to your case.

Individuals not involved in the original decision have reviewed your case. They have determined the claims listed on your payment summary form are related to your liability insurance (including self-insurance) settlement, judgment, award, or other payment, so we are upholding Medicare's recovery claim stated in our demand letter dated August 14, 2014.

The **amount due** through October 13, 2014 is **$53,295.14**. (The principal amount is $53,295.14 and the interest amount is $0.00.) Please pay this amount by October 12, 2014.

Please make your check payable to Medicare, include a copy of this letter, and mail both to the Benefits Coordination & Recovery Center (BCRC) address on the bottom of this page. If payment in full is not received by October 12, 2014, the amount due, including interest, will be $54,150.08. Please be advised that interest will continue accruing, and will be assessed every 30 days thereafter until the balance is paid in full.

If you disagree with this decision, you can request "reconsideration", the next level of appeal.

Reconsideration is a new and impartial review performed by a Qualified Independent Contractor. To exercise your right to reconsideration, you must file a request in writing within 180 days of getting this letter. Fill out the enclosed Reconsideration Request Information Sheet, or a similarly formatted letter, and explain why you disagree with this determination. Also enclose both a copy of this letter and any additional evidence you wish to submit. Under special circumstances, you may ask for more time to request reconsideration.

Send your request for reconsideration or a request for additional time to:

Maximus Federal Services Part A East
3750 Monroe Avenue, Suite 701
Pittsford, NY 14534-1302

1400000000154405401

Please note that only evidence you submit in your reconsideration request can be considered for any further appeal, unless you can show good cause why any other evidence was not submitted previously.

If we know that you have an attorney or other individual representing you in this matter, then we are sending him/her a copy of this letter. If you have an attorney or other representative for this matter and his/her name is not shown as a "cc" at the end of this letter (indicating that he/she is receiving a copy), please call the Benefits Coordination & Recovery Center (BCRC) immediately at 1-855-798-2627 (TTY/TDD: 1-855-797-2627 for the hearing and speech impaired). You may wish to talk to your representative before contacting us, if you have any questions about this letter.

If you do not already have an attorney or other representative, you or someone you name to act for you may file the reconsideration request. You can name a relative, friend, advocate, attorney, doctor or someone else. To do this, you and the person you are naming to act for you must sign, date and send us a statement authorizing that person as your representative, along with your reconsideration request.

You can contact your State Health Insurance Assistance Program (SHIP) for questions about payment denials and appeals. For information on how to contact your local SHIP, call 1-800-MEDICARE (1-800-633-4227).

If you want copies of statutes, regulations, policies, and/or manual instructions we used to arrive at this decision, or if you have other questions, please call the BCRC at 1-855-798-2627 (TTY/TDD: 1-855-797-2627 for the hearing and speech impaired).

Sincerely,

BCRC Case Analyst

CC: DAVID TROSTLE

JAX

Enclosure: Reconsideration Request Information Sheet
Payment Summary Form

Exhibit 6

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

COB&R
Coordination of Benefits and Recovery

Reconsideration Request Form

Directions: If you wish to appeal this decision, please fill out the information below. *At a minimum, items marked with an asterisk (*) must be completed.* To help us serve you better, please include a copy of our cover letter with your Reconsideration Request Information Sheet, and any other supporting material, and mail to:

Maximus Federal Services Part A East
3750 Monroe Avenue, Suite 701
Pittsford, NY 14534-1302

* 1. Name of Beneficiary: _____

* 2. Medicare Number: _____

3. Case Identification Number: _____

* 4. Item or service you wish to appeal: _____

* 5. Date of the service: From ___/___/___ To ___/___/___

6. Does this appeal involve an overpayment? Yes ☐ No ☐

* 7. Why do you disagree? Or what are your reason for your appeal?
(Attach additional pages, if necessary.)

_____

8. You may also include any supporting material to assist your appeal. Examples of supporting materials include:

- Medical Records
- Copy of the Claim
- Certificate of Medical Necessity
- Office Records/Progress Notes
- Treatment Plan

9. Person Appealing: Beneficiary ☐ Representative ☐

* 10. Address of the Person Appealing: _____

_____

* 11. Printed Name of the Person Appealing: _____

* 12. Signature of the Person Appealing: _____

Contractor Number	Redetermination Number:

Exhibit 6

CMS

COB&R
Coordination of Benefits and Recovery

October 15, 2014

319 1 MB 0.435
***AUTO**MIXED AADC 720 R:319 T:5 P:5 PC:5 F:435301
DAVID TROSTLE
[redacted]

COPY
For Information Only

[redacted]

470000000015440541

October 15, 2014

319 1 MB 0.435
***AUTO**MIXED AADC 720 R:319 T:5 P:5 PC:5 F:435301
ANGINO & LUTZ, P.C.
4503 N FRONT ST
HARRISBURG, PA 17110-1708

Beneficiary Name: [redacted]
Medicare Number: [redacted]
Entitlement Date: [redacted]
Date of Incident: [redacted] 08, 2011
Case Identification Number: [redacted] 5082914-0003693

Dear ANGINO & LUTZ, P.C.:

This letter is in response to your August 28, 2014 request to appeal our initial determination of the amount/existence of Medicare's recovery claim. In your appeal request you stated that there are claims on the payment summary form unrelated to your case.

Individuals not involved in the original decision have reviewed your case. They have determined the claims listed on your payment summary form are related to your liability insurance (including

self-insurance) settlement, judgment, award, or other payment, so we are upholding Medicare's recovery claim stated in our demand letter dated August 14, 2014.

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If you disagree with this decision, you can request "reconsideration", the next level of appeal. Reconsideration is a new and impartial review performed by a Qualified Independent Contractor. To exercise your right to reconsideration, you must file a request in writing within 180 days of getting this letter. Fill out the enclosed Reconsideration Request Information Sheet, or a similarly formatted letter, and explain why you disagree with this determination. Also enclose both a copy of this letter and any additional evidence you wish to submit. Under special circumstances, you may ask for more time to request reconsideration.

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If we know that you have an attorney or other individual representing you in this matter, then we are sending him/her a copy of this letter. If you have an attorney or other representative for this matter and his/her name is not shown as a "cc" at the end of this letter (indicating that he/she is receiving a copy), please call the Benefits Coordination & Recovery Center (BCRC) immediately at 1-855-798-2627 (TTY/TDD: 1-855-797-2627 for the hearing and speech impaired). You may wish to talk to your representative before contacting us, if you have any questions about this letter.

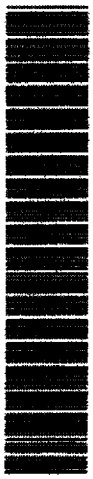
If you do not already have an attorney or other representative, you or someone you name to act

Exhibit 6

for you may file the reconsideration request. You can name a relative, friend, advocate, attorney, doctor or someone else. To do this, you and the person you are naming to act for you must sign, date and send us a statement authorizing that person as your representative, along with your reconsideration request.

You can contact your State Health Insurance Assistance Program (SHIP) for questions about payment denials and appeals. For information on how to contact your local SHIP, call 1-800-MEDICARE (1-800-633-4227).

If you want copies of statutes, regulations, policies, and/or manual instructions we used to arrive at this decision, or if you have other questions, please call the BCRC at 1-855-798-2627 (TTY/TDD: 1-855-797-2627 for the hearing and speech impaired).



Sincerely,

BCRC Case Analyst

CC: DAVID TROSTLE

JAX

Enclosure: Reconsideration Request Information Sheet
Payment Summary Form

Exhibit 6

CMS

COB&R Coordination of Benefits and Recovery

Reconsideration Request Form

Directions: If you wish to appeal this decision, please fill out the information below. *At a minimum, items marked with an asterisk (*) must be completed.* To help us serve you better, please include a copy of our cover letter with your Reconsideration Request Information Sheet, and any other supporting material, and mail to:

Maximus Federal Services Part A East
3750 Monroe Avenue, Suite 701
Pittsford, NY 14534-1302

* 1. Name of Beneficiary: _____

* 2. Medicare Number: _____

3. Case Identification Number: _____

* 4. Item or service you wish to appeal: _____

* 5. Date of the service: From ___/___/___ To ___/___/___

6. Does this appeal involve an overpayment? Yes ☐ No ☐

* 7. Why do you disagree? Or what are your reason for your appeal?
(Attach additional pages, if necessary.)

_____

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- Copy of the Claim
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- Treatment Plan

9. Person Appealing: Beneficiary ☐ Representative ☐

* 10. Address of the Person Appealing: _____

_____

* 11. Printed Name of the Person Appealing: _____

* 12. Signature of the Person Appealing: _____

Contractor Number	Redetermination Number:

Exhibit 6

JS 44 (Rev. 06/17)

CIVIL COVER SHEET 3:17-cv-1193

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS

UNITED STATES OF AMERICA

(b) County of Residence of First Listed Plaintiff _____
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*
AUSA D. Brian Simpson, United States Attorney's Office MDPA
228 Walnut Street, Harrisburg, PA 17108
(717)221-4482

DEFENDANTS

Richard Angino, Esquire, Angino Law Firm, P.C. f/k/a Angino & Lutz, P.C. f/k/a Angino & Rovner, P.C., and Gloria Trostle, as Administratrix of the Estate of David A. Trostle,
County of Residence of First Listed Defendant Dauphin
(IN U.S. PLAINTIFF CASES ONLY)
NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*
Richard C. Angino, Esquire, Angino Law Firm
4503 N Front St, Harrisburg, PA 17110
(717) 238-6791

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ☒ 1 U.S. Government Plaintiff
- ☐ 3 Federal Question *(U.S. Government Not a Party)*
- ☐ 2 U.S. Government Defendant
- ☐ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*
(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☒ 1	Incorporated *or* Principal Place of Business In This State	☒ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

Click here for: Nature of Suit Code Descriptions.

CONTRACT
- ☐ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☒ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

REAL PROPERTY
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

TORTS

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury
- ☐ 362 Personal Injury - Medical Malpractice

PERSONAL INJURY
- ☐ 365 Personal Injury - Product Liability
- ☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

CIVIL RIGHTS
- ☐ 440 Other Civil Rights
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing/ Accommodations
- ☐ 445 Amer. w/Disabilities - Employment
- ☐ 446 Amer. w/Disabilities - Other
- ☐ 448 Education

PRISONER PETITIONS

Habeas Corpus:
- ☐ 463 Alien Detainee
- ☐ 510 Motions to Vacate Sentence
- ☐ 530 General
- ☐ 535 Death Penalty

Other:
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition
- ☐ 560 Civil Detainee - Conditions of Confinement

FORFEITURE/PENALTY
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 690 Other

LABOR
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Management Relations
- ☐ 740 Railway Labor Act
- ☐ 751 Family and Medical Leave Act
- ☐ 790 Other Labor Litigation
- ☐ 791 Employee Retirement Income Security Act

IMMIGRATION
- ☐ 462 Naturalization Application
- ☐ 465 Other Immigration Actions

BANKRUPTCY
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 835 Patent - Abbreviated New Drug Application
- ☐ 840 Trademark

SOCIAL SECURITY
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

FEDERAL TAX SUITS
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS—Third Party 26 USC 7609

OTHER STATUTES
- ☐ 375 False Claims Act
- ☐ 376 Qui Tam (31 USC 3729(a))
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 480 Consumer Credit
- ☐ 490 Cable/Sat TV
- ☐ 850 Securities/Commodities/ Exchange
- ☐ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 893 Environmental Matters
- ☐ 895 Freedom of Information Act
- ☐ 896 Arbitration
- ☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ☐ 950 Constitutionality of State Statutes

V. ORIGIN *(Place an "X" in One Box Only)*

☒ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from Another District *(specify)* ☐ 6 Multidistrict Litigation - Transfer ☐ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing *(Do not cite jurisdictional statutes unless diversity)*:
42 U.S.C. 1395y(b)(2)

Brief description of cause:
Recover on a Medicare Secondary Payer claim

VII. REQUESTED IN COMPLAINT:

☐ CHECK IF THIS IS A CLASS ACTION UNDER RULE 23, F.R.Cv.P.

DEMAND $ 84,353.00 plus interest CHECK YES only if demanded in complaint:

JURY DEMAND: ☐ Yes ☐ No

VIII. RELATED CASE(S) IF ANY

(See instructions): JUDGE William W. Caldwell DOCKET NUMBER 16-cv-00156

DATE July 7, 2017

SIGNATURE OF ATTORNEY OF RECORD /s D. Brian Simpson

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____

INSTRUCTIONS FOR ATTORNEYS COMPLETING CIVIL COVER SHEET FORM JS 44

Authority For Civil Cover Sheet

The JS 44 civil cover sheet and the information contained herein neither replaces nor supplements the filings and service of pleading or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. Consequently, a civil cover sheet is submitted to the Clerk of Court for each civil complaint filed. The attorney filing a case should complete the form as follows:

I.(a) Plaintiffs-Defendants. Enter names (last, first, middle initial) of plaintiff and defendant. If the plaintiff or defendant is a government agency, use only the full name or standard abbreviations. If the plaintiff or defendant is an official within a government agency, identify first the agency and then the official, giving both name and title.

(b) County of Residence. For each civil case filed, except U.S. plaintiff cases, enter the name of the county where the first listed plaintiff resides at the time of filing. In U.S. plaintiff cases, enter the name of the county in which the first listed defendant resides at the time of filing. (NOTE: In land condemnation cases, the county of residence of the "defendant" is the location of the tract of land involved.)

(c) Attorneys. Enter the firm name, address, telephone number, and attorney of record. If there are several attorneys, list them on an attachment, noting in this section "(see attachment)".

II. Jurisdiction. The basis of jurisdiction is set forth under Rule 8(a), F.R.Cv.P., which requires that jurisdictions be shown in pleadings. Place an "X" in one of the boxes. If there is more than one basis of jurisdiction, precedence is given in the order shown below.
United States plaintiff. (1) Jurisdiction based on 28 U.S.C. 1345 and 1348. Suits by agencies and officers of the United States are included here.
United States defendant. (2) When the plaintiff is suing the United States, its officers or agencies, place an "X" in this box.
Federal question. (3) This refers to suits under 28 U.S.C. 1331, where jurisdiction arises under the Constitution of the United States, an amendment to the Constitution, an act of Congress or a treaty of the United States. In cases where the U.S. is a party, the U.S. plaintiff or defendant code takes precedence, and box 1 or 2 should be marked.
Diversity of citizenship. (4) This refers to suits under 28 U.S.C. 1332, where parties are citizens of different states. When Box 4 is checked, the citizenship of the different parties must be checked. (See Section III below; **NOTE: federal question actions take precedence over diversity cases.**)

III. Residence (citizenship) of Principal Parties. This section of the JS 44 is to be completed if diversity of citizenship was indicated above. Mark this section for each principal party.

IV. Nature of Suit. Place an "X" in the appropriate box. If there are multiple nature of suit codes associated with the case, pick the nature of suit code that is most applicable. Click here for: Nature of Suit Code Descriptions.

V. Origin. Place an "X" in one of the seven boxes.
Original Proceedings. (1) Cases which originate in the United States district courts.
Removed from State Court. (2) Proceedings initiated in state courts may be removed to the district courts under Title 28 U.S.C., Section 1441. When the petition for removal is granted, check this box.
Remanded from Appellate Court. (3) Check this box for cases remanded to the district court for further action. Use the date of remand as the filing date.
Reinstated or Reopened. (4) Check this box for cases reinstated or reopened in the district court. Use the reopening date as the filing date.
Transferred from Another District. (5) For cases transferred under Title 28 U.S.C. Section 1404(a). Do not use this for within district transfers or multidistrict litigation transfers.
Multidistrict Litigation – Transfer. (6) Check this box when a multidistrict case is transferred into the district under authority of Title 28 U.S.C. Section 1407.
Multidistrict Litigation – Direct File. (8) Check this box when a multidistrict case is filed in the same district as the Master MDL docket.
PLEASE NOTE THAT THERE IS NOT AN ORIGIN CODE 7. Origin Code 7 was used for historical records and is no longer relevant due to changes in statue.

VI. Cause of Action. Report the civil statute directly related to the cause of action and give a brief description of the cause. **Do not cite jurisdictional statutes unless diversity.** Example: U.S. Civil Statute: 47 USC 553 Brief Description: Unauthorized reception of cable service

VII. Requested in Complaint. Class Action. Place an "X" in this box if you are filing a class action under Rule 23, F.R.Cv.P.
Demand. In this space enter the actual dollar amount being demanded or indicate other demand, such as a preliminary injunction.
Jury Demand. Check the appropriate box to indicate whether or not a jury is being demanded.

VIII. Related Cases. This section of the JS 44 is used to reference related pending cases, if any. If there are related pending cases, insert the docket numbers and the corresponding judge names for such cases.

Date and Attorney Signature. Date and sign the civil cover sheet.