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Case Study

## Courts are Not Permitted to Deduct Medicare “Write-Offs” from Jury Awards

— by Jeffrey D. Eberhard

**Claims Pointer:** Medical services provided to an injured person that are “written-off” under Medicare qualify as economic damages that the court cannot deduct from a plaintiff’s total jury award. However, a defendant can submit evidence to prove that the amount of medical expenses claimed is excessive, and therefore unreasonable.

Whenever a plaintiff suffers an injury and recovers damages from both a defendant and a third party for the exact same injury, the defendant contends that the plaintiff is recovering more compensation than he or she actually suffered and is being unjustly enriched. Last year the decision in *White v. Jubitz Corp.*, by the Oregon Court of Appeals dealt a huge blow against defendants when the court held that plaintiffs are entitled to recover the full amount of medical expenses, even if a large portion of those expenses were waived or “written-off” under Medicare. 219 Or App 62, 182 P3d 215 (2008). However, defendants were encouraged when the Oregon Supreme court granted review. Unfortunately, the October 2009 Oregon Supreme Court decision in *White v. Jubitz Corp.*, was not the holding defendants had wanted to hear. No. A128617, in the Supreme Court of the State of Oregon (October 15, 2009).

Plaintiff, George White, was over 65 years old when he was injured after falling off a stool that collapsed beneath him while sitting at a bar. Plaintiff sued the bar owner for his injuries and the jury awarded him \$37,600 in economic damages—approximately the total amount of his medical bills. Because of his age, Plaintiff qualified for Medicare. In accordance with federal law, Medicare paid \$13,400 of Plaintiff’s medical bills and the medical providers accepted that amount as payment in full. The medical providers “wrote-off” the remainder of his medical bills. Defendant made sev-

eral motions challenging Plaintiff’s right to recover the “written-off” damages. The trial court denied Defendant’s motions and the court of appeals affirmed the trial court’s rulings. Defendant appealed to the Oregon Supreme Court.

Appealing to the Oregon Supreme Court, Defendant argued that ORS 31.580 prohibits “double recovery.” Defendant also argued that because Plaintiff had no obligation to reimburse Medicare for the “written-off” amounts, the trial court was not precluded from deducting the “write-offs” from the jury award. The Oregon Supreme Court rejected Defendant’s arguments and held that ORS 31.580 does not prevent a plaintiff from receiving a double recovery. Rather, the court explained that when a plaintiff receives an award for injuries from the injury-causing party as well as a third party, ORS 31.580 grants a trial court some discretion on reducing the plaintiff’s judgment award by how much the plaintiff will receive from the third party. However, the trial court’s discretion is limited under ORS 31.580 if the third party benefits are federal Social Security benefits. The Oregon Supreme Court, agreeing with the court of appeals, held Medicare benefits are “federal Social Security benefits.” Thus, trial courts are prevented from reducing the jury award by the amount “written-off” under the Medicare benefits.

Hope, however, is not lost for insurers. The Oregon Supreme Court also held that insurers of defendants can still present evidence questioning the reasonableness of medical expenses at trial. In the present case this was not helpful because Defendant had stipulated that the medical bills were reasonable. Thus the court concluded Defendant was bound to the jury’s determination and award. Although contesting the reasonableness of medical bills may seem a small conciliation after this decision, Tami Rockholt, President of Health Cost Management Company out of Beaverton, Oregon, sees this holding as an opportunity for insurers. Rockholt firmly believes “there are several avenues worth pursuing that can reduce the total medical bills in order to ascertain the real ‘reasonable value’ for the medical expenses,” which could lower an insurer’s liability. Rockholt explained that “a very high percentage of hospital and other provider bills’ include inflated final costs of medical expenses. For example, some

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bills include un-bundled charges; up-coded charges; charges for services not rendered; and duplicate charges. A careful professional review of the bills and corresponding medical records can often reduce the total amount of medical bills by 20% to 50% or more.”

So, although plaintiffs may recover economic damages for benefits that are “written-off” under Medi-

care, by obtaining a medical professional’s opinion, insurers may reduce their liability by contesting the reasonableness of medical expenses provided to the injured plaintiff. ❖

— Full case is available at: [www.publications.ojd.state.or.us/S056015.htm](http://www.publications.ojd.state.or.us/S056015.htm)

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Medical Notes

### Freud’s “The Uncanny”: Clinical Perspectives

Article provided by Health Cost Management

*Abridged from an Original Article by Ronald Turco, MD*

Freud published his paper “The Uncanny” in fall of 1919. This paper shows his developing thoughts on the ego, and relates to two main issues. The first issue covers theories like repetition compulsion, reemergence of repressed conflict, and the concept of doubling. Freud applies these theories to traumatic unconscious experiences. The paper is clearly linked to trauma and birth anxiety. The second issue is of contemporary clinical importance. Psychoanalytic thinking encompasses somatization disorders including personality death, personality change, and body dysmorphic disorders. Uncanny experiences can occur when repressed memories of a trauma emerge.

“The Uncanny” relates to what is frightening or horrific, precisely because it is not known and familiar. Throughout the paper, Freud associates uncanniness with blindness. He explains that these uncanny states of mind can even cause doubts as to whether animate beings are actually alive. Freud likens this to being robbed of one’s eyes. As a coping mechanism, doubling is discussed (the perception of living two separate lives with possible evil intent). Man’s capability of self-observation and self-criticism render this concept possible and even tempting. Freud discusses the factor of repetition, a concept which later developed into repetition com-

pulsion. Unconscious minds find comfort in repetition, and it is very clearly expressed in the impulses of small children and neurotic patients. Whatever reminds us of this inner repeating compulsion is perceived as uncanny. In contemporary psychoanalytic treatment, the compulsion to repeat is an attempt to master a trauma. The compulsion to repeat is powerful enough to overrule the pleasure principle.

The concept of the evil eye is an uncanny and widespread form of superstition. The origin of the evil eye has been dated back to early classical texts from Europe and elsewhere. It is commonly believed that the evil eye holds the power of witching or enchanting people. In Italian American communities, there are evil eye specialists who have become experienced healers and are familiar removing the curse of the evil eye. These treatments are performed in a religious context in hopes of disabling the evil eye’s ability to cause both physical and psychiatric illnesses. People often find death and dying uncanny. Freud describes the uncanny as something secretly familiar which has undergone repression and then returned. He argues that extreme coincidence seems to confirm previously discarded beliefs. Traumatic changes in one’s body can produce uncanny feelings. When the uncanny arises from infantile complexes, an actual repression and return of the repressed content is what occurs, not a cessation of belief in the reality of such content. Some inexplicable experiences occur when repressed complexes are revived. Freud emphasizes that a great deal that is not uncanny in fiction would be so if it happened in real life and also that there are many more ways

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of creating uncanny effects in fiction than there are in life. It is very important to separate fact from fiction in the uncanny. The uncanny is viewed in the same light as the return of the repressed in neurosis.

Freud's work is valuable for understanding self-image anxiety reactions. In physically traumatized patients such as amputees, the uncanny due to changed bodily perception complicates rehabilitation. Some patients feel like completely different people after being in an accident and having facial reconstructive surgery. In these instances there may be a reemergence of earlier repressed body image anxiety issues. Patients experience intense anxiety and depression secondary to their physical complications. They require sophisticated otoneurological studies. These patients may avoid open spaces, withdraw from friends and suffer humiliation in the workplace. Some patients' perceptions even go awry. This can create the illusion that, for example, animate objects are inanimate, or unfamiliar people are familiar. Internalizing images may lead to patients having uncanny feelings of being taken over or possessed. These maladaptive defensive operations indicate the state of trauma in the psyche and must not be mistaken for psychosis.

Catherine Feigelson discusses the issue of the uncanny from a different perspective. Her context is what she calls personality death. She writes that every human being is a survivor of some type of loss and she discusses patients who have had traumatic brain damage. Her perspective on the state of mind produced in the healthy partner of a head injured person. In a sense, the partner has been stranded with a psychological stranger who is physically recognizable, but personality-deceased. She discusses Freud's perspective of the anxiety of the uncanny involving something on the border of what we know and don't know. How can a mentally disabled patient be half-there and half not-there? She discusses uncanny anxiety of the ego in attempts to protect oneself from feelings of hatred towards the object. This, of course, would include guilt for this hatred. There is the initial shock at the change, the uncanny feelings, a sense of a need for rescuing, and what Feigelson terms the malignant turn towards hopelessness and rage interwoven with endless mourning. The actual patients may say something is missing and they feel remote in the

context of the housing of their own bodies. In this regard, Freud's perception of the familiar and unfamiliar manifests itself in an eerie feeling in such patients. The patient's ego attempts to cope as best as it can but ultimately the patient experiences a considerable amount of anxiety. Such patients are likely to harbor resentment.

In working with victims themselves, to what extent the patient has malignant introjects determines the prognosis for a resolution of this discrepancy in body image alteration. Sometimes the patient has a hallucination in which he sees himself as he was before trauma. Communication is sensed more often than actually heard and frequently accompanied by feelings of sadness and mourning. These are called autoscopic phenomena, and have been attributed to brain lesions particularly in the parietal-temporal-occipital area. An extreme form of this syndrome is the Capgras Syndrome, in which a patient believes that important individual in their life has been replaced by an exact double. This impersonator can often be a victim of violence from the patient with the Capgras Syndrome. Sometimes patients experience the doubling phenomenon due to their inability to accept the extreme defectiveness that they sense about their bodies. It is a coping mechanism. The instinctual conflict is seen as involving a stranger rather than the self but this does not solve the problem of the anxiety generated. It has been suggested that double of a traumatized patient is articulated with tendrils of uncanny sensation. Trauma is defined by the totality of the assault, experienced somatically as well as cognitively, threatening disorganization of the sense of self and the sense of the world within which the self exists. The individual cannot adapt to, absorb, or long tolerate uncanny feelings, such are the residues of dissociation. A closely related phenomenon to issues of the uncanny involves the body dysmorphic disorder, which is a condition characterized by an intense preoccupation with an imagined or slight defect in physical appearance. While this is not the same as the doubling effect, there does appear to be similar somatosensory disturbances. The basal ganglia are associated with both types of disturbances

It is important to call attention to the sense of the uncanny as originally postulated by Freud as applicable in contemporary medical practice to a variety

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of physical and mental syndromes. Most notably, the distortion in body image associated with a significant trauma is the underlying basis of the sense of uncanniness that such patients experience. The resolution of this dichotomy is dependent upon the therapist's awareness and understanding of the somatosensory issues the patient is struggling with as well as the mirroring elements of the transference. An awareness of these syndromes is the first

step toward instituting appropriate treatment. We are introduced to the uncanny as the experience of sudden, undifferentiated anxiety so severe that it triggers the dissociative process. While this perspective differs somewhat from Freud's, it is practical in terms of treatment. It allows us to focus on the immediate and the repressed and to link the internal and external. ❖

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