

**THE MOST COMMONLY ENCOUNTERED LIENS AND
SUBROGATION INTERESTS IN MEDICAL MALPRACTICE AND
NURSING HOME NEGLIGENCE CASES**

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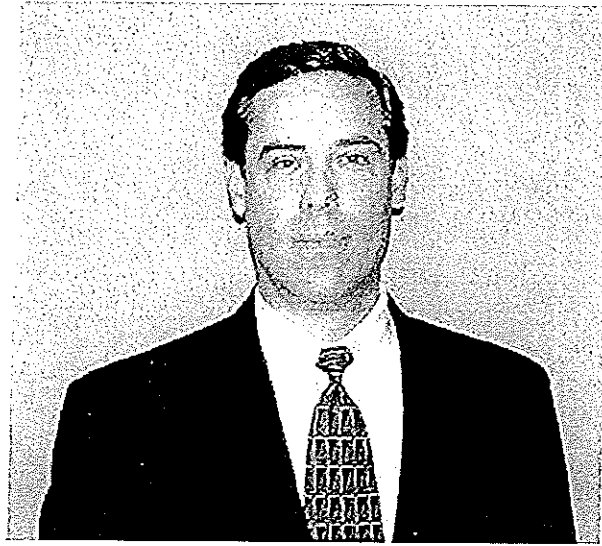
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THE MOST COMMONLY ENCOUNTERED LIENS AND SUBROGATION INTERESTS IN MEDICAL MALPRACTICE AND NURSING HOME NEGLIGENCE CASES

I. INTRODUCTION

You would think that giving away money would be easy! When dealing with liens and subrogation, however, it's just not that easy anymore.

Like most lawyers, I've never enjoyed dealing with subrogation interests and liens. Obtaining final lien totals is usually an extremely trying and exasperating experience. Glaciers move quicker than most lienholders – especially Medicare! It is usually necessary to repeatedly write and telephone lienholders to nudge them into providing you with final lien information and written itemizations of claims. And, it's a thankless job. I've never had a client that wanted to give a subrogee or lienholder any of their "hard fought" money. Moreover, I've never had a lienholder or subrogee say "thank you" after I lined their pockets. Nonetheless, processing liens is a necessary evil which, if done incorrectly, can subject you and your client to liability.

In this paper, I will provide some practical tips for efficiently handling liens that *most commonly* arise in plaintiffs' medical malpractice and nursing home negligence cases. This paper is by no means a review of *all* liens and subrogated interests that you might encounter in your practice. (For instance, virtually the only reference to ERISA in this paper occurs in this very sentence!) Along the way, I will throw in some black letter law to satisfy the diehards among you.¹

II. A FEW BASIC DEFINITIONS

A "lien" is defined as a legal right or interest that a creditor has in another's property, lasting usually

¹ I gratefully acknowledge Paul F. Waldner and his excellent paper entitled "Lienholders: The Pesky Parasites," which he presented at the Texas Trial Lawyers Association's 12th Annual Advanced Medical Malpractice Conference in 2001. With Mr. Waldner's permission, I have incorporated entire sections of his paper into mine.

For an in-depth discussion of liens and subrogation, I highly recommend an excellent treatise by Judith A. Kostura, entitled "Subrogation and Liens: Dividing the Recovery." Ms. Kostura presented this paper at the 2002 Texas Trial Lawyers Association Advanced Personal Injury Seminar. Ms. Kostura's paper contributed to my thought processes in writing this paper.

Finally, I thank Debra Davis of The Law Offices of Maloney & Maloney, P.C. for her valuable assistance in writing this paper. I have learned much about the practical aspects of handling liens from her.

until a debt or duty that it secures is satisfied. BLACK'S LAW DICTIONARY.

"Subrogation" is defined as the "substitution of one person in the place of another with reference to a lawful claim, demand, or right, so that he who is substituted succeeds to the rights of the other in relation to the debt or claim, and its rights, remedies, or securities." *Id.*

A "subrogee" is a "person who succeeds to the rights of another by subrogation," essentially, one who steps into the shoes of the party whom they have compensated. *Id.*

III. SOME GENERAL PRACTICAL TIPS

A. Identify Potential Lienholders

There are a variety of liens the cautious attorney should consider before taking a case, entering into a settlement, receiving a verdict, and/or disbursing money to clients. For instance, a plaintiff's attorney should determine whether any governmental and/or health insuring entities have paid health care claims for curative care rendered for the physical injuries that are the basis of the lawsuit. In a nursing home negligence case, this could include Medicare, Medicaid, TDHS, Veteran's Administration, and private health insurance, such as Humana or Secure Horizons/Pacificare. As all of these entities are potential lienholders, it is prudent to send all potential lienholders a letter requesting lien information on your client at the outset of the case.

B. Send a Letter to Potential Lienholders

Immediately after filing suit, a prudent plaintiff's lawyer may wish to send each potential lienholder a letter, via certified mail, return receipt requested, which informs the lienholder of the lawsuit and which requests the submission of any lien information. In the letter, the attorney should provide all information necessary to identify your client and the defendants, to include (as applicable):

- Full name;
- Date of birth
- Social Security number
- Address
- Date of loss
- Date of death
- Description of physical injury
- HIC/Medicare ID number
- Medicaid ID number
- Private Insurance Policy number
- Private Insurance Member ID number
- Full name of each defendant
- Address of each defendant

It is wise to attach a medical authorization to your notice of lien letter to each potential lienholder, signed by your client or his/her closest immediate surviving family member.

In the lienholder letter, you should also identify the dates of loss. Importantly, lienholders are NOT entitled to recover the expense of the negligent care that the Defendant provided which resulted in an injury to your client. For example, a lienholder is not entitled to recover the costs of a botched surgery that injured your client. Rather, the lienholder is only entitled to recover the expense of CURATIVE care or treatment subsequently provided to your client for the injury sustained during the botched surgery.

Therefore, the "dates of loss" that you reference in your notice of potential lien letters is usually not the same as the actual date of injury by the client. Instead, the "dates of loss" are the beginning and ending dates of the CURATIVE care rendered for the physical injury made the basis of the lawsuit. It is imperative to know when the curative care for your client's injury began/ended so that, when the lienholder provides you with an itemization of claims attributed to your client's "injury," you can readily identify which charges are relevant in your lawsuit.

Also, in your notice of potential lien letters to lienholders, it is important to provide a description of the physical injury(ies) made the basis of your lawsuit. This will enable each potential lienholder to search through their computer databases to specifically identify the claims paid by them for care related to your case and, ultimately, to provide you with an itemized list of claims and total lien amount.

Importantly, the description of physical injury contained in the letter to potential lienholders should track the allegations in your lawsuit. Conceivably, if you were to minimize the extent or severity of the injury sustained in an effort to reduce the amount of the lien related to your lawsuit, you and your client could be subject to fraud allegations. Unfortunately, this means that if you amend your Petition to allege new injuries suffered by your client, then you must also notify all lienholders of the additional injuries, so that the lienholders can determine if they incurred expenses related to curative treatment for the care of those injuries as well. This will result in delay in an already laborious and protracted process.

If you haven't received a verbal or written response or acknowledgement of any kind to your initial notice of potential lien letter after 68 weeks, you should telephone the lienholder to discuss the status of obtaining a final lien. Likelihood is, your letter got misdirected, is not being worked-up, or was put on a forgotten dust pile somewhere. A telephone call, followed by a confirming letter, may rectify that situation.

C. Create a Case File for Liens and Individual Folders for Each Lienholder

To stay organized, it's a good idea to maintain a case file for lien/subrogation correspondence in each of your cases. You may desire to maintain separate file folders for each lienholder as well. It is not uncommon for a good deal of correspondence to accumulate as to each lienholder.

I prefer to maintain subrogation correspondence to and from each lienholder chronologically, with the most recent correspondence on top. Typically, I file correspondence to/from the lienholder on the right side of the file folder. On the left side of the file folder, I maintain all of my attorney notes concerning liens, memos regarding discussions with clients on subro issues, interoffice e-mails, and interoffice memos regarding the handling of subro issues in each case.

D. Obtain a Written Itemization of Claims; Contest Unrelated Claims

It is important with all lienholders to obtain a written itemization of the claims that the lienholder is asserting against your case. Study the itemization of claims to make sure that each claim is indeed related to your case. If a claim is not related to your case, you should immediately contest the claim, in writing, and provide the lienholder with your rationale.

E. Obtain a Final Lien Total Verification

Prior to mediation and/or trial, ask all lienholders in writing for a final lien total. If you are unsure whether the lien total that you have is, indeed, a final lien total, you may wish to write a letter specifically requesting the lienholder to verify that the lien amount provided in their last letter is final. I often ask the lienholder to sign my letter under a "VERIFICATION" signature line. However, don't be surprised if the lienholder refuses to comply with this seemingly simple request. Unfortunately, many lienholders suffer from "commitment phobia."

F. Always Ask for a Reduction

Ask and you shall receive, or so you should. Most lienholders will negotiate their liens and will reduce them by some proportion in relation to your client's recovery, attorney's fees, and expenses.

G. Always Obtain a Release of Lien

To protect you and your client from subsequent liability, always obtain a release of lien. Without question, this is easier said than done. Medicare will not enter into a formal release, but will send a letter acknowledging "payment in full" of the amount owed.

To obtain a release from Medicaid and TDHS, you will need to send a proposed release along with your remittance of the lien payment. Otherwise, you

won't get one. Simply asking for a release in your payment remittance letter doesn't work, because neither TDHS nor Medicaid will expend the time to generate one.

Remember, when dealing with most lienholders, "the squeaky wheel gets the grease." If you're not squeaking, you're not likely to get the release.

IV. STATUTORY LIENS AND SUBROGATION INTERESTS

A. Medicare

1. Legal Authority -- The MSP Statute

When Medicare was first enacted in 1965, it was essentially the primary payer for medical services supplied to a beneficiary, even when such services were also covered by private insurance. Not surprisingly, in 1980, Congress responded to the "skyrocketing Medicare costs" by enacting the Medicare Secondary Payer ("MSP") statute, 42 U.S.C. § 1395y(b)(2), which requires Medicare to serve as the secondary payer when a beneficiary has other insurance that can pay or pays for medical expenses. The MSP statute thus requires Medicare beneficiaries to exhaust all available private insurance before resorting to Medicare coverage.

The federal agency that administers the Medicare program has changed its name. The agency formerly known as the Health Care Financing Administration (HCFA) is now known as the Center for Medicare/Medicaid Services (CMS).

Congress divided Medicare into two parts. Intermediaries administer Part A benefits, and carriers administer Part B benefits. When attempting to resolve a Medicare subrogation claim with respect to a personal injury recovery, one works with the intermediary.

Medicare claims to be a "super lien," superior to all other types of subrogation interests. In essence, the MSP statute states that Medicare will serve as a back-up insurance plan to cover that which is not paid for by a primary insurance plan. The MSP statute prohibits Medicare from making payments when it has notice that payments with respect to the injury could, or should, be paid by liability insurance. Medicare will also not pay a claim if "payment has been made or can reasonably be expected to be made *promptly* ... under a workmen's compensation law ... or under an automobile or *liability insurance policy or plan* (including a *self-insurance plan*) or under no fault insurance." 42 U.S.C. § 1395y(b)(2)(A) (emphasis added).

However, the MSP statute also *authorizes* Medicare to make *conditional* healthcare payments when a Medicare recipient already has coverage provided by a "*primary insurance plan*." 42 U.S.C. § 1395y(b)(2)(B). "A 'primary plan' is defined as a

group health insurance plan, or as any other type of insurance plan, such as workman's compensation law, liability insurance, or a self-insurance plan, that may reasonably be expected to pay for services *promptly*." *Thompson v. Goetzmann*, 315 F.3d 457 (5th Cir. Dec. 17, 2002)(emphasis added).

In the event that a *conditional* payment is made, the government has a right to sue "any entity which is required or responsible (directly or as a third-party administrator or otherwise) to make payment with respect to such item or service (or any portion thereof) under a primary plan ..., or against any other entity (including any physician or provider) that has received payment from that entity with respect to the item or service, and may join or intervene in any action related to the events that gave rise to the need for the item or service...." 42 U.S.C. § 1395y(b)(2)(B).

2. Recent Case Law

a. *Thompson v. Goetzmann*

Recently, in *Thompson v. Goetzmann*, 315 F.3d 457 (5th Cir. Dec. 17, 2002), the government tested the power of its "super lien" by trying to expand the meaning of the term "self-insurance plan," in an effort to extract reimbursement out of a products liability suit settlement. This significant Fifth Circuit holding arguably affects Medicare's ability to assert liens against certain personal injury settlements!

In *Goetzmann*, the government sued a personal injury plaintiff (Lofin), her lawyer (Goetzmann), and the manufacturer of an artificial hip prosthesis (Zimmer), seeking reimbursement for Medicare expenditures related to Lofin's medical treatment. Medicare paid for Lofin's hip replacement surgery. When complications arose, Medicare paid for a second surgery and other medical treatment. All totaled, Medicare expended \$143,881.82 on Lofin's healthcare related to her hip. Lofin hired Goetzmann to sue Zimmer for products liability, alleging defective design of the hip prosthesis. The suit settled prior to trial for \$256,000. Goetzmann took 40% of the settlement proceeds in a contingency fee, and then disbursed the balance to Lofin. No part of the settlement was paid to insurance or Medicare.

The government filed suit under the Medicare Secondary Provider (MSP) statute, which authorizes the government to obtain reimbursement from a firm or entity that has a "self-insurance plan." The government insisted that Zimmer was "self-insured" for its liability to Lofin and, in settling the case, had ostensibly paid for Lofin's medical expenses, which had been originally paid for by the Medicare.

Zimmer moved for summary judgment, asserting that its tort settlement was not tantamount to maintaining a "self-insurance plan," as defined in the MSP statute. (Zimmer argued that the term "self-

insurance plan" does not automatically apply to alleged tortfeasors). In the alternative, Zimmer argued that its inability to pay for Loftin's medical treatment "promptly," as required by the MSP statute, precluded it from meeting the definition of a "self-insured plan." ("Promptly" is defined by HCFA regulations as payment within 120 days after the earlier of (1) the date the claim is filed; or (2) the date the service was provided or the patient was discharged from the hospital). The district court agreed, granting summary judgment and finding as a matter of law that Zimmer could not have "promptly" paid for Loftin's medical treatment, as the statute requires. Goetzmann and Loftin subsequently moved for summary judgment, which were also granted.

On appeal, the Fifth Circuit reasoned that the term "self-insurance plan" does not exist in a vacuum within the MSP statute. Rather, it is predicated on the term "primary plan." The Fifth Circuit stated that "the term 'primary plan' is pivotal to the applicability of the MSP statute -- its reimbursement provisions are not triggered unless a Medicare recipient's source of recovery meets the definition of 'primary plan.'" Although the term "self-insurance plan" is not defined in the MSP statute, the Fifth Circuit gave the term its ordinary meaning and stated that, in order to meet the definition of self-insurance, "an entity would have to engage in the same sorts of underwriting procedures that insurance companies employ; estimating likely losses during the period, setting up a mechanism for creating sufficient reserves to meet those losses as they occur, and usually, arranging for commercial insurance for losses in excess of some stated amount." *Goetzmann*, 315 F.3d at 463. The Fifth Circuit concluded that "it is wrong for the government to contend that an entity's negotiating of a single settlement with an individual plaintiff is sufficient, *in and of itself*, for such entity to be deemed as having a "self-insurance plan." *Id.* "The failure of Congress to include in the MSP statute a right of action for reimbursement of medical expenditures against tortfeasors indicates that this statute 'plainly intends to allow recovery only from an insurer.'" *Id.* at 464.

The Fifth Circuit concluded that Zimmer did not act under a "primary self-insurance plan" when it settled the products liability case with Loftin. The Fifth Circuit held that neither the products manufacturer (Zimmer), the plaintiff (Loftin), nor the plaintiff's attorney (Goetzmann) were required to reimburse the government under the MSP statute.

Although the Fifth Circuit ruled that the government was not entitled to reimbursement in this case under the MSP statute, the Fifth Circuit pointed

out that "the Medical Care Recovery Act ("MCRA")² explicitly provides the right of action that the government is attempting to read into the MSP statute. The MCRA expressly arms the government with a right to recover medical payments that it has made 'under circumstances creating tort liability upon some third person.' In such instances, the government may 'institute and prosecute legal proceedings against the third person who is liable for the injury or disease ... for the payment or reimbursement of medical expenses or lost pay." *Goetzmann*, 315 F.3d at 464.³

b. *Brown v. Thompson*

In *Brown v. Thompson*, 2003 WL 1477696 (E.D. Va., March 20, 2003), the federal district court of the Eastern District of Virginia disagreed with the Fifth Circuit's decision in *Goetzmann*. In *Brown*, the Plaintiff refused to reimburse Medicare following the settlement of a medical malpractice lawsuit. The Plaintiff alleged in the case that the Kaiser Urgent Care facility, which is owned and operated by the Kaiser Foundation Health Plan ("Kaiser"), failed to timely diagnose her condition and admit her to the hospital,

² The Medical Care Recovery Act ("MCRA") provides in pertinent part:

"In any case in which the United States is authorized or required by law to furnish or pay for hospital, medical, surgical, or dental care and treatment ... to a person who is injured or suffers a disease, ... under circumstances creating a tort liability upon some third person ... to pay damages therefore, the United States shall have a right to recover (independent of the rights of the injured or diseased person) from said third person, or that person's insurer, the reasonable value of the care and treatment so furnished, to be furnished, paid for, or to be paid for and shall, as to this right be subrogated to any right or claim that the injured or diseased person ... has against such third person...." 42 U.S.C. § 2651(a), Pub.L. No. 87-693, § 1, 76 Stat. 593 (1962), *as amended*.

³ *But see United States v. Phillip Morris, Inc.*, 116 F. Supp 2d 131 (D.D.C. 2000) ("The congressional intent in enacting MCRA in 1962--at which time Medicare did not exist and the Federal Employees Health Benefits Act ("FEHBA") was still in its infancy--was to provide a means for the Government to recover from third-party tortfeasors medical expenses it had furnished for (primarily military) employees. Applying the principles from a recent U.S. Supreme Court decision, *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 120 S.Ct. 1291, 146 L.Ed.2d 121 (2000), *this Court concludes that Congress did not intend that MCRA be used as a mechanism to recover Medicare or FEHBA costs.* The Court reaches this conclusion after examining the broad context in which MCRA has existed for 38 years--including its legislative history, the construction given it by those agencies charged with its interpretation, a body of longstanding state and federal case law, and its total non-enforcement by the Department of Justice for thirty-seven of those thirty-eight years" (emphasis added)).

which resulted in an emergent hospital admission for a perforated colon and sepsis. Medicare had made payments totaling \$59,047.13 for the Plaintiff's healthcare and sought reimbursement out of the \$285,000 settlement.

Kaiser did not have liability insurance, but was self-insured. The Plaintiff asserted that Medicare was not entitled to reimbursement under the MSP statute because her medical malpractice settlement was not "made promptly" (for the same reasons argued in *Goetzmann*). The federal district court disagreed. The court stated that "this construction misreads the statute and is at odds with the statute's obvious and sensible purpose of ensuring that Medicare is a secondary payer only after Medicare beneficiaries have exhausted their private insurance." *Brown*, 2003 WL 1477696 at *4.

Essentially, the court in *Brown* focused on the phrase "payment has been made ... under a ... liability insurance policy or plan (including a self-insured plan)", and downplayed the importance of the phrase "payment ... can reasonably be expected to be made promptly ... under a ... liability insurance policy or plan (including a self-insured plan)." The federal district court in *Brown* stated that the Fifth Circuit in *Goetzmann* focused "too narrowly on the 'prompt payment' requirement." *Brown*, 2003 WL 1477696 at *5.

c. The Potential Effect of *Goetzmann* and *Brown*?

The potential effect of the *Goetzmann* and *Brown* decisions are significant. Although the Virginia federal district court in *Brown* disagreed with the result that the Fifth Circuit reached in *Goetzmann*, the common ground of both cases is that Medicare's right to reimbursement under the MSP statute is not automatic.

In the nursing home industry, for example, more and more facilities are going "bare" (i.e. without liability insurance coverage). The way I interpret *Goetzmann* and *Brown*, if you settle with a nursing home defendant that is "bare," and the nursing home defendant does not have a plan of self-insurance in place, and the nursing home defendant uses its general assets to fund the settlement, then Medicare has no right to reimbursement from the settlement proceeds! "Indeed, to hold otherwise would render 'every tortfeasor that used its general assets to fund a tort settlement with persons who had received federal health care benefits...potentially liable under the MSPS.'" *Brown v. Thompson*, 2003 WL 1477696 at *7 (quoting *In re Orthopedic Bone Screw Products Liability Litigation*, 202 F.R.D. 154, 165 (E.D. Pa. 2001)).

However, there are many attorneys in the country that read the *Goetzmann* case much more broadly. These attorneys argue that *Goetzmann* largely erodes

Medicare's ability to assert a lien against personal injury settlements. This is because they read *Goetzmann* to stand for the proposition that, since virtually no case settles within 120 days of the earlier of the provision of the service or the filing of the claim with the insurer, then, in most cases, payment will not be "made promptly." They argue that, if payment is not made promptly, then Medicare has no right to reimbursement under the MSP statute.

For more information on this issue, I recommend that you access Benjamin W. Glass, III's website at <http://www.vamedmal.com/mainpages/docs.cfm> (after accessing the website, it is necessary for you to e-mail Mr. Glass and obtain a username and password to enter). On this website, Mr. Glass, a lawyer from Virginia, has posted most all of the on-point cases, several motions and briefs, and an excellent paper on the subject entitled, "Are Lawyers Who Reimburse Medicare Out of Tort Settlements Committing Malpractice?"

3. Practical Tips To Handle Medicare Liens

Assuming that the "prompt payment" argument in *Goetzmann* does not relegate Medicare reimbursement to an obscure footnote in the annals of jurisprudence, the following are some practical tips for handling Medicare liens:

a. Requirement to Notify Medicare

You must notify Medicare of your client's litigation pursuant to 42 C.F.R. §§ 411.24 and 411.26.

b. Telephone Medicare Coordination of Benefits (COB)

Prior to sending any notice of potential lien letter to Medicare, you must first telephone the Medicare Coordination of Benefits ("COB") office in New York, New York, to request that COB create a file (set up the claim) on their computer database regarding your specific case. When placing this call, you must provide COB with an HIC/MEDICARE ID number, as Medicare can not set up a claim without one. (Your client's HIC/MEDICARE ID number can usually be found on the "face sheet" of your client's medical records. If you cannot locate the number in the medical record, ask your client or his/her surviving family members for this information). COB will also ask for your client's name, the date(s) of loss, the address of the client, the physical injury made the basis of your lawsuit, AND the name of the liability carrier of the Defendant. (If you do not know the name of the Defendant's liability carrier, most COB agents will accept the name and address of the Defendant). COB's address and phone number are:

MEDICARE Coordination of Benefits
MSP Claim Investigation Project
Post Office Box 5041
New York, New York 10274-5041
Telephone No. (800) 999-1118

After COB takes this information from you on the phone, COB will tell you to expect to receive written acknowledgement in about 15 days.

c. Consent to Release and Medicare Trauma Code Development Forms

Usually, when COB sends a written acknowledgment of your claim, COB will also send you a "Consent to Release" (Medical Authorization) form and a "Medicare Trauma Code Development" form. Your client must sign the medical authorization form to authorize Medicare to communicate with you (the law firm) about the case and to provide you with medical/billing/lien information about your client. You must complete the "Medicare Trauma Code Development" form in as much detail as possible and return it to COB ASAP.

d. Notification of Lead Contractor

Soon after you return to COB the signed "Consent to Release" medical authorization form and "Medicare Trauma Code Development" form, COB will send you a two-sided document that reflects which Medicare contracting entity (name and address) has been assigned by COB to act as the "lead contractor" in your specific case. When you get this document, this is when you immediately send your written notice of potential lien letter to whichever Medicare contracting entity that COB has appointed to act as the "lead contractor."

The "lead contractor" is the office that actually obtains and compiles all claims related to your lawsuit and calculates the final lien total to be asserted by Medicare. To do this, the "lead contractor" contacts other Medicare contracting entities that it determines may have paid claims relevant to your client's case, and asks these other contracting entities to provide claims information and a total that are attributable to your client's case.

Prior to approximately January 2001, and COB's involvement in Medicare's lien gathering process, the notice of potential lien letters were always sent directly to the Texas Medicare contracting office: TrailBlazer Health Enterprises, L.L.C., Post Office Box 9020, Denison, Texas 75021, Telephone No. (903) 463-0641, Fax No. (903) 463-0642.

Although the process has changed, it is likely that, if the health care was provided in Texas and the client was a resident of Texas, COB will appoint TrailBlazer

Health Enterprises, L.L.C. to act as "lead contractor" in the bulk of your cases.

e. "Chain of Authority" Documentation

When sending Medicare your notice of potential letter, it is prudent to also provide Medicare with "chain of authority" documentation. Providing Medicare with "chain of authority" documentation, at the outset, will avoid potential serious delay in dealing with Medicare later.

"Chain of authority" documentation are documents you must provide to Medicare when a client is unable to sign his/her own medical authorization form or is not acting directly for himself/herself in the lawsuit. In nursing home cases, because of the age, infirmity, or death of clients, this scenario occurs often.

Examples of "chain of authority" documentation include:

As to a living but incapacitated client:

- Power of Attorney, in which the client has authorized someone else (likely his next of kin) to act on his/her behalf in legal/business matters; or
- Order Appointing Guardianship (as to a client who has been declared legally incompetent).

As to a deceased client:

- Last Will and Testament (where the client sets out who has been named to act as Independent Executor of his/her Estate).
- Probate Court Order Appointing Dependent/Independent Administrator

Of course, whoever is named in any of these documents as your client's legal representative needs to sign the Medicare-proscribed Consent to Release form.

It may also be necessary for you to provide Medicare with a copy of the Contingency Fee Contract signed by your client or their surviving legal representative, evidencing your client's retention of your law firm to represent them in the litigation at issue.

f. Expect Delay!

In the last few years, TrailBlazer – Medicare has operated on its stated intent or policy of responding to subrogation-related correspondence it receives within a 60-day window. This allegedly means that, on the 60th day after the date Medicare received your subrogation-related correspondence on a case, Medicare will

actually pick up the letter to work it up in some way (meaningful or not!).

Significantly, however, for the past two years, TrailBlazer – Medicare's response window has been outside 100 days, and in some cases, even longer than 150 days! Recently, Medicare reiterated its intent or policy to return to responding to subrogation-related correspondence within the 60-day window time frame. (I'm holding my breath!)

To my knowledge, TrailBlazer-Medicare is still adhering to the policy of only accepting subrogation-related telephone calls during certain hours of the work day, i.e., 10:00 a.m. to 12:00 p.m. and 1:00 p.m. to 3:00 p.m., Monday through Friday.

g. Who to Call to Complain

If you are having difficulty dealing with any Medicare contracting entity, or are unable, after an unreasonably lengthy period, to get Medicare to provide you with a final lien total, then I suggest that you call Medicare's "troubleshooter", Ms. Sally Stalcup, of the Center for Medicare and Medicaid Services ("CMS") office in Dallas, Texas. Ms. Stalcup's telephone number is (214) 767-6415.

h. Always Request a Lien Reduction

It is prudent to always request a reduction of sizeable lien amounts. With Medicare, any requests for reduction of the final lien amount must be in writing. Medicare will bear its pro-rata share of the "procurement costs," including legal fees and expenses, incurred by the plaintiff in obtaining the third party recovery. It will not bear any share of the procurement fees in collecting from an automobile no-fault insurance policy or no-fault premises medical payments coverage, unless the attorney was instrumental in obtaining those no-fault benefits for the plaintiff.

Medicare utilizes a "Recovery Sheet" to calculate the portion of procurement costs to be borne by Medicare. I recommend that you complete a "Recovery Sheet" and send it to Medicare along with your letter requesting a lien reduction. Medicare will undoubtedly ignore your Recovery Sheet calculations and prepare their own. However, it will communicate your expectations to Medicare, as well as provide you with some estimation as to what Medicare is likely to do.

When requesting a lien reduction from Medicare, you must provide Medicare with the total amount of your client's gross recovery in the case (by settlement or jury verdict), the total amount of your attorney's fees (as determined by the percentage allowed under your Contingency Fee contract), and the total amount of the costs expended by your firm in handling the case.

Note: Presently, in light of the Fifth Circuit decision in *Goetzmann*, Medicare is refusing to process any requests for reduction of liens for procurement costs.

i. Payment

Once Medicare has notified you of the total subrogation lien amount it is asserting, and if you have already settled the case, you have 60 days to remit payment to Medicare or your client will be assessed penalty and interest fees/charges. See 42 C.F.R. § 411.24(h).

j. Penalties for Failing to Reimburse

An attorney should not attempt to avoid informing Medicare of a personal injury recovery in the hopes that Medicare will not discover it. Medicare has six years in which to seek reimbursement after it learns that it was not reimbursed. Medicare can recover double the amount of its claim if it takes legal action.

k. Obtain a Release

When you mail your lien payment to Medicare, always request a Release. Upon receipt of payment, Medicare always affords itself one more careful "look-see" to make sure they have collected all that they can. When they receive the payment from you, prior to sending a Release to you, Medicare always sends a letter stating that the payment you sent may not be sufficient to fully "extinguish" the lien debt and, accordingly, Medicare is holding onto the payment pending further investigation of the claims. Upon conclusion of their final case review, Medicare will then send a letter releasing any interest that it has in your case.

B. Medicaid

1. Legal Authority

Unlike Medicare, one may not recover Medicaid absent need. Medicaid provides medical assistance for families with dependent children and aged, blind, or disabled individuals who lack sufficient income and resources to meet the costs of necessary medical services. Medicaid's subrogation rights in Texas are found in section 32.003 of the Texas Human Resources Code.

The filing of an application for Medicaid benefits constitutes an assignment to Medicaid of the applicant's right of recovery from: (a) personal insurance; (b) another person for personal injury caused by such other person's negligence or wrong; and (c) other sources. TEX. HUM. RES. CODE ANN. § 32.033(a) (Vernon 2001). Section 12.036 of the Health & Safety Code confers upon the Texas Department of Health the authority to pursue and collect a subrogation interest in favor of the state.

2. Practical Tips To Handle Medicaid Liens

a. Requirements to Notify

(i) 25 Tex. Admin. Code § 354.2313 (2002)

Pursuant to 25 Tex. Admin. Code § 354.2313(a), an applicant or recipient of Medicaid benefits has a duty to inform Medicaid of the following:

- any pending or unsettled claim for injuries for which a claim for medical services has or will be submitted to Medicaid for payment;
- the name/address of any attorney hired to represent the applicant or recipient in any claim for injuries;
- the identity of any third party health insurer or third party who is or may be responsible for paying for health coverage (e.g., name, relationship to insured, policyholder, policy number, dates of coverage, date of accident or injury).

You (as the recipient's attorney) must notify Medicaid of any of the above-listed "resources" within 60 days of learning of or discovering the existence of the "resource."

(ii) 25 Tex. Admin. Code § 354.2315(a) (2002)

Pursuant to 25 Tex. Admin. Code § 354.2315(a)(2002), you (as the recipient's attorney) must notify Medicaid of your client's third party claim for personal injury damages within 45 days of the date that you are retained, or within 45 days from the date that a potential third party is identified.

The notice should include:

- the name/address and identifying information of the recipient (date of birth and/or Social Security or Medicaid identification number);
- the name/address of the third party from whom a claim for injuries is being asserted; and
- the name/address of health care providers who have asserted a claim for payment for medical services for which a third party may be liable.

This information should be supplemented as necessary. The applicant's intentional failure to give notice as required by statute is a Class C misdemeanor.

b. Authorization

You should attach an authorization, signed by the recipient (or the recipient's power of attorney) to your notice to Medicaid. See 25 Tex. Admin Code § 354.2315(b)(2002).

c. Who to Contact

Medicaid utilizes a contracting collection agent for the collection of benefits reimbursement. All of your correspondence and communication should be directed to:

National Heritage Insurance Company
ATTN: Tort/Subrogation Department
12545 Riata Vista Circle
Austin, Texas 78727
Telephone No. (800) 846-7307
Fax No. (512) 514-4225

You should always reference your client's Medicaid I.D. number on your notice of potential lien letter, as well as on all of your subsequent correspondence to Medicaid.

d. Always Request a Lien Reduction

Again, ask and you shall receive. To obtain a reduction of Medicaid's asserted lien, reference 25 Tex. Admin. Code Ann. § 354.2332(b) and (c), which authorizes a reduction of lien for costs and attorney's fees. Specifically, this statute authorizes Medicaid to reduce its lien by paying attorney's fees in the amount of 15% of the entire amount recovered for Medicaid. Further, the statute authorizes Medicaid to reduce its lien by paying prorata expenses not to exceed 10% of the entire amount recovered for Medicaid.

When requesting a lien reduction from Medicaid, you are required to provide the total amount of your client's monetary recovery in the case (by settlement or jury verdict), and to provide a summary (maximum one page total in length) of your law firm's costs expended in handling the case. The summary of expenses should itemize expenses by type and include a total expense amount, and the expense summary must be signed by the attorney of record. Medicaid will not authorize a reduction for costs expended unless you provide them with the expense summary with your letter requesting the lien reduction. They frown upon receiving lengthy expense itemizations, in lieu of an expense summary. In fact, they have been known to totally refuse to accept a lengthy expense itemization in lieu of an expense summary.

e. Notify Social Security of Change in Client's Unearned Income

If your client is alive at the time of the final distribution of funds, and your client is a recipient of Supplemental Security Income, via Medicaid, you must notify the Social Security Administration office that processes your client's SSI payments of the change in your client's financial resources or unearned income as a result of the personal injury recovery. See 20 CFR § 416.710, et seq. This may impact your

client's ability to continue to receive SSI benefits. You should notify your client of this as well, preferably at the outset of the case. Implementing a Special Needs Trust to safeguard your client's SSI benefits does not excuse you from having to notify the Social Security Administration office of your client's net monetary recovery from the lawsuit.

C. Texas Department Of Human Services ("TDHS")

1. Legal Authority

The Texas Department of Human Services ("TDHS") pays for some care-related expenses that a nursing home resident receives via the Medicaid program. (Note: This is separate from Medicaid claims paid to other health care providers, like doctors and hospitals). TDHS has the right to assert a lien for care that it has paid for. Title XIX of the Federal Social Security Act requires reimbursement by liable third parties when Medicaid funds have been paid. The Texas Human Services Code, section 32.033, establishes automatic assignment of the Medicaid recipient's right of recovery from personal insurance and other sources to TDHS as a condition of eligibility.

2. Practical Tips to Handle TDHS Liens

a. Requirement to Notify

As with Medicaid, you must notify TDHS of your client's lawsuit. The following is the contact information for TDHS:

Texas Department of Human Services
ATTN: Ms. Gayle Sandoval, Supervisor, PBS
Recovery Unit [Y948]
Post Office Box 149081
Austin, Texas 78714-9081
Telephone No. (512) 490-4680
Fax No. (512) 490-4667

If one is available, you should always reference your client's Medicaid ID number on your notice of potential lien letter, as well as on all of your subsequent correspondence to TDHS.

b. Always Request a Lien Reduction

To obtain a lien reduction from TDHS-Medicaid (for costs expended and attorney's fees), you must do so through Barry Browning, TDHS's Assistant General Counsel. His address/phone numbers are as follows:

Barry Browning, Esq.
Assistant General Counsel
Texas Department of Human Services
Post Office Box 149030
Austin, Texas 78714-9030

Telephone No. (512) 438-3126
Fax No. (512) 438-3747

It will help you to note that TDHS only has a lien right to recover the difference in Medicaid-related monies expended by TDHS for your client's care/treatment at a nursing home, due to a change in your client's TILE rating, as a direct result of the injury your client sustained, which is the basis of your lawsuit. Therefore, you should look for a difference amount on the itemization of claims TDHS provides to you reflecting their final lien total, as being the amount of the lien you must repay.

To obtain a reduction of TDHS' asserted lien, you only have to request one in writing in general terms.

c. Obtain a Release of Lien

Release of lien documents are obtained through Barry Browning, at the above address, as well. Remember, to obtain a release from Medicaid and TDHS, you will need to send a proposed release along with your remittance of the lien payment.

D. Veteran's Administration ("V.A.")

1. Legal Authority

The Veterans Administration has a statutory subrogation interest pursuant to the Federal Medical Care Recovery Act, 42 U.S.C. 2651. The V.A. may obtain reimbursement out of the recovery from the plaintiff's personal injury lawsuit, the plaintiff's Personal Injury Protection (PIP), the plaintiff's workman's compensation benefits, or any health plan contract.

2. Practical Tips Regarding Handling V.A. Liens

a. How to Contact the V.A.

To reach the regional office, contact:

Department of Veterans Affairs
Office of Regional Counsel (02)
4800 Memorial Drive, Building 12
Waco, Texas 76711
Main Telephone No. (254) 754-9300
Fax No. (254) 754-9310
Additional Fax No. (254) 754-9344

b. Amend Your Petition

After you send a notice of potential lien letter to the V.A., the V.A. will likely want to strike a deal with you (the plaintiff's attorney). The V.A. will offer to present your client's V.A. doctors and nurses for informal meetings, depositions, and trial, and provide certified copies of medical records, if you will protect the V.A.'s interest by amending Plaintiff's petition to assert the following:

"As a result of the Plaintiff's injuries, he has received and will continue to receive medical care furnished by the United States of America. The Plaintiff, for the sole use and benefit of the United States of America under the provisions of 42 U.S.C. 2561, et seq, and with its express consent, asserts a claim for the reasonable value of said past and future care."

Since the V.A. has a solid right to reimbursement, the plaintiff's attorney loses nothing and gains much by striking this "bargain" with the V.A.

c. Always Request a Lien Reduction

The V.A. is usually willing to reduce its lien in order to enable the veteran to be fairly compensated for his injuries. In doing so, the V.A. does not enter into any formal calculations and does not formally consider procurement costs. However, the V.A. does tend to employ equitable principles in an effort to make the veteran whole.

E. Hospital Liens

1. Legal Authority

The Texas Hospital Lien Statute, TEX. PROP. CODE ANN. § 55.001 et seq. (Vernon 1996), provides hospitals an additional method of securing payment for medical services. The legislature's intent was to provide hospitals with a separate cause of action to satisfy their liens. The lien to which a hospital is entitled attaches to the patient's right of action against a third party for negligently causing the personal injuries for which he or she was treated. The lien also attaches to money paid as a result of a claim or lawsuit for personal injuries sustained by a patient in an accident.

2. Important Facts

Here are some important facts to know regarding the statute:

- a. Look for a hospital lien in the deed records of the county where the medical services were rendered—the hospital must file its lien there. For the lien to attach, the hospital must file the lien with the county clerk before money is paid to an entitled person because of the injury. TEX. PROP. CODE ANN. § 55.005(a) (Vernon 1996).
- b. Hospital liens attach to causes of action, judgments, and proceeds of settlements. *Id.* at §§ 55.003(a)(1)(2)(3).
- c. For the lien to attach, the individual must be admitted to a hospital not later than 72 hours after the accident. A hospital cannot perfect a lien against the judgment or settlement of

any claims if the injured person initially comes in for treatment 72 hours or more after the accident. *Id.* at § 55.002(a).

- d. The lien extends to both the admitting hospital and any hospital to which the individual is transferred for treatment of the same injury. *Id.* at § 55.002(b).
- e. Hospital liens do not attach to certain claims brought under Texas workers' compensation laws. *Id.* at § 55.003(b)(1). One must look at the parties involved and claims made to determine whether a hospital lien attaches to that action. If an injured person brings a claim against his or her employer or workers' compensation carrier for workers' compensation benefits and is found to have suffered a compensable injury under the Workers' Compensation Act, the hospital's right to recover for treatment of the employee is wholly governed by the provisions of the Workers' Compensation Act, not on its hospital lien. If the patient did not suffer a compensable injury under the workers' compensation laws, the hospital retains its rights under the Hospital Lien Statute. Further, if the injured employee sues a third party for causing the non-compensable injury, the hospital may maintain a lien on that third-party lawsuit. *McCollum v. Baylor Univ. Med. Ctr.*, 697 S.W.2d 22, 25–26 (Tex. App.—Dallas 1985, no writ).
- f. While survival proceeds are subject to a hospital lien, wrongful death damages are not. *Tarrant County Hosp. Dist. v. Jones*, 664 S.W.2d 191, 194–95 (Tex. App.—Fort Worth 1984, writ ref'd n.r.e.).
- g. The lien does not cover charges for other services that exceed a "reasonable and regular rate" for the services. *Id.* at § 55.004(d)(1). The lien covers the first 100 days of the injured individual's hospitalization. *Id.* at § 55.004(b).
- h. The limitations period for the hospital's cause of action is four years from the date of the settlement or judgment. *Baylor Univ. Med. Ctr. v. Borders*, 581 S.W.2d 731, 732–34 (Tex. Civ. App.—Dallas 1979, writ ref'd n.r.e.).
- i. A hospital is not required to shoulder any part of the plaintiff lawyer's charges for services rendered resulting in collection on a hospital lien through a third-party lawsuit. The rationale is that plaintiffs' attorneys are performing services they are obligated to their clients to perform and the benefit to the hospital is incidental. *Bashara v. Baptist*

- Mem'l Hosp. Sys.*, 685 S.W.2d 307-310 (Tex. 1985).
- j. All persons involved in a settlement may be liable if a lien is not satisfied. Though a hospital can bring a claim against the injured patient seeking satisfaction of a lien, cases have held that insurance companies and defendants who pay the injured party also remain responsible to the hospital for unpaid bills. *Borders*, 581 S.W.2d at 733-34; *Baylor Univ. Med. Ctr. v. Travelers Ins. Co.*, 587 S.W.2d 501, 501 (Tex. Civ. App.—Dallas 1979, writ ref'd n.r.e.); *Republic Ins. Co. v. Shotwell*, 407 S.W.2d 864, 867 (Tex. Civ. App.—Amarillo 1966, writ ref'd n.r.e.).
 - k. In the 2001 session of the legislature, Sec. 55.004 of the Property Code was amended to include the bills of certain physicians within the lien. Within that amendment, sec. 55.004(a) added a definition of "emergency hospital care" to include care that the average prudent layperson would believe was necessary to treat "a serious medical problem of recent onset or severity." Section 55.004(b) grants the lien for the first 100 days of hospitalization but, under sec. 55.004(d)(1) the lien does not extend to charges that "exceed a reasonable and regular rate for the services. Section 55.004 now allows the physician to claim a lien (which the hospital may file on the physician's behalf) for the reasonable and necessary charges within the first seven days of hospitalization. However, if the physician "has accepted benefits or payment under a private medical indemnity plan or program, regardless of whether the benefits or payment equals the full amount of the physician's charges for those services" or if the injured person "has coverage under a private medical indemnity plan or program from which the physician is entitled to recover payment for the physician's services under an assignment of benefits or similar right" or if the physician is a member of the state legislature, then the physician's fees are not covered by the lien.

F. Private Health Insurance Companies

1. Legal Authority

A private health insurance entity, which provided health care coverage benefits to your client following the injury made the basis of your lawsuit, may have a contractual right of subrogation pursuant to a provision that may be contained in their health insurance policy.

2. Practical Tips To Handle Insurance Subrogation

a. Requirement to Notify

If your client has received private insurance benefits for medical care related to an injury, there may be a provision in the insurance contract that mandates that you notify the carrier of any third party action that you are bringing to recover damages for injuries sustained by the insured. If you do not initially have access to the insurance policy, the safe practice is to send private insurance carriers a notice of potential lien letter.

b. Request Copy of Applicable Insurance Policy/Plan

In your notice of potential lien letter to a private health insurance entity, you should always ask for a copy of your client's health insurance policy/plan that was in effect during the date(s) of loss referenced in your letter. Upon receipt, study this policy! This is the only way you can determine whether the private health insuring entity actually has a contractual right of subrogation recovery in connection with your particular case. Insurance companies do not have a right of subrogation absent a contract or agreement that allows for one. See *TAC v. Matagorda County*, 52 S.W.3d 128 (Tex. 2001).

c. Beware of Reimbursement Agreements

Often, after receiving your notice of potential lien letter, a private health insurance company will respond by demanding that your client sign an onerous Reimbursement Agreement. It is rarely in your client's best interest to sign.

These reimbursement agreements are usually worded in such a way as to essentially ignore your client's right to be "made whole" and/or to be reimbursed for procurement costs in accordance with *Esparza v. Scott & White Health Plan*, 909 S.W.2d 548 (Tex. App.—Austin 1995, writ denied). Typically, the reimbursement agreements foreclose any opportunity that your client may have to negotiate a reduction of the lien amount. The reimbursement agreements also tend to abrogate jury findings, by mandating reimbursement to the private health insuring entity based upon the total sum recovered, regardless of how damages are allocated by the jury. In some instances, the reimbursement agreements specifically subordinate the insured's other family members, who are covered under the same policy, from recovering on their individual claims, such as for loss of consortium, until after the insurance company is reimbursed in full. Some of these reimbursement agreements also interfere with the settlement of the case, by requiring the tortfeasor to make payment directly to the private health insuring entity, bypassing the insured and the insured's attorney! Finally, most reimbursement

agreements are objectionable in that they provide that, if litigation is necessary to enforce the agreement, then your client will be responsible for the insurance company's costs and attorney's fees.

Private health insuring entities will also use duress in an effort to force your client to sign their reimbursement agreement. Oftentimes, the insurance company threatens to stop payment for treatment of the injuries made the basis of the suit unless your client signs the reimbursement agreement. They will also threaten not to provide you with any subrogation lien information or amounts unless and until your client signs the reimbursement agreement.

You should notify, in writing, the private health insuring entity of the unethical and inappropriate nature of their demands. Using the "savings clause" of ERISA, 29 U.S.C. 1144(b)(2)(A), argue that the "made whole" doctrine and the "common fund" doctrine are not preempted by ERISA and that your client is entitled to a lien reduction, regardless of whether your client signs the reimbursement agreement. In addition, argue that the reimbursement agreement is contrary to equitable common law regulation of insurance plans in the state of Texas, which is also not preempted by ERISA. If possible, try to work with the private health insurer's legal department to draft a reimbursement agreement that is consistent with your client's rights.

d. Humana and Secure Horizons/Pacificare

If an individual qualifies for Medicare, that individual can enroll in a Medical replacement plan, like Humana Gold Plus or Secure Horizons/Pacificare. These health care plans stand in Medicare's shoes and provide to plan members the benefits that Medicare would have provided. In addition, the plans provide additional benefits that Medicare would not have provided, under the theory that a for-profit company is more efficient than the federal government. In nursing home cases, it is not uncommon for your client to be a member of a Medicare replacement plan, like Humana or Secure Horizons/Pacificare.

Humana's contracting collection agent is Healthcare Recoveries, Inc., and may be reached at the following address:

Healthcare Recoveries, Inc.
Post Office Box 37440
Louisville, Kentucky 40233
Phone Nos. (800) 685-0419 (Lorie Sebastian);
(800) 405-0956 (Tracy Wilson)
Fax No. (502) 454-1291

Secure Horizons/Pacificare's contracting collection agent is Primax Recoveries, Inc., and may be reached at the following address:

Primax Recoveries, Inc.
ATTN: Third Party Liability/Subrogation Dept.
Post Office Box 4003
Schaumburg, IL 60168-4003
Telephone No. 1-800-442-2911

When corresponding to either of these contractors, you should always reference your client's Policy number, Group ID number, and Member ID number.

e. Always Request a Lien Reduction

If the lien asserted by any private health insuring entity is sizeable, it is advisable to always request a reduction of the final lien amount asserted (for costs expended and attorney's fees), pursuant to *Lancer Corp. v. Murillo*, 909 S.W.2d 122 (Tex. App.—San Antonio 1995, no writ).

V. CONCLUSION

Timely and proper handling of subrogation interests and liens in medical malpractice and nursing home negligence cases entails a lot of perseverance, patience, and paperwork. Delay in timely notifying lienholders of a case and uncertainty about the dates of loss and/or the injuries in question will negatively impact your ability to timely obtain final lien totals. Without final lien totals, a final distribution of the settlement proceeds cannot occur. This invariably results in dissatisfied clients and a case that perpetually drags-on. Although much about the timing of processing liens is out of the Plaintiff's lawyer's control, it is possible for a Plaintiff's lawyer to ensure that any delay is not attributable to her. Sadly, it's just not that easy to give away money anymore!