Insurance Liens

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Insurance Liens

A. Standard Health Insurance Liens:

Health insurance liens are most often referred to as a “subrogated interest”. A health insurer that pays medical bills which arise out of an incident for which another party is responsible has a subrogated interest which may give them the right to have all or a portion of medical expenses paid by that party, reimbursed out of the settlement proceeds. With a standard subrogation agreement contained in a health insurance policy, in Wisconsin an insured must be made whole before the insurer may recover anything from the third-party claim. If the subrogated party is not satisfied with the amount offered by Plaintiff’s attorney in resolution of the subrogated interested, they have the right to request a Rimes hearing with the court. This right stems from the ruling in Rimes vs. State Farm Mutual Automobile Insurance Company, 316 N.W. 2d 348 (Wis. 1982). As a result of Rimes, a subrogated carrier can request a hearing, which in essence is a mini trial, for a court ruling whether plaintiff/claimant was made whole from the settlement. While this is an option, this is not something that I have seen occur very often, in fact, to my recollection, I am only aware of a Rimes hearing being requested in one case, but the case was resolved before the hearing. A Rimes hearing can be risky in that if the court finds that the plaintiff/claimant is not made whole, the subrogated carrier recovers nothing, and if the court finds that the plaintiff/claimant is made whole, the plaintiff/claimant must satisfy the whole subrogated amount. It tends to be in both parties’ best interest to come to a compromise.

B. Medicare Liens:

Medicare is the “secondary payor” and thus if Medicare makes payment of accident related medical expenses, they will require reimbursement. Medicare will likely receive notification of your client’s claims from three potential sources, (1) liability insurer; (2) first-party insurer (no-fault – med pay/PIP coverage), and (3) you (as attorney for the Medicare beneficiary). The liability insurer and no-fault carrier are required reporting entities and are required to identify that a personal injury claim exists. As a rule, in the role as the attorney for the injured party, we will also provide notification to Medicare to establish communication on behalf of the client. Absent our notification to Medicare, they will send all correspondence directly to the client, which can be overwhelming and extremely confusing for most clients. In our letter of retainer to Medicare we will ask that all communication from Medicare be directed to our attention.

In order for Medicare to comply with such a request, Proof of Representation/Consent To Release should be completed and provided with your letter of retainer. Medicare’s website does contain samples of the required documents, however, I have drafted my own form that contains all of Medicare’s requires. This is a form that I have every client on Medicare sign at our initial meeting. Providing this form to Medicare will allow you to communicate with Medicare for the entirety of your claim, which will be priceless to your client.

Once Medicare has received your letter of retainer and Proof of Representation/Consent to Release, you will receive an initial Medicare Secondary Payer Form for completion. This form requests identification of all insurance companies involved (liability and no-fault) as well as

for identification of the accident injuries. This is something that I will complete for my client and then forward to them for review and signature. Once signed, the form is sent on to Medicare which will prompt an initial Conditional Payment Report itemizing all medical expenses paid for which Medicare believes are related to the subject accident. Review this list carefully. If there are charges itemized on the Conditional Payment Report that are not related to the accident, I will immediately address that with Medicare, in writing. My preference is to send a detailed letter to Medicare setting forth my position and providing any documents that support my position that any alleged payments are not related to my client's claim. This can be addressed via telephone as well if that is your preference. The Conditional Payment Report will contain the appropriate address and phone number for Medicare that you will need to address your concerns.

Medicare now has an on-line Portal that is a great source in accessing your client's claim information. Your firm will need to set up an account with Medicare and then, once the appropriate Proof of Representation/Consent to Release documentation has been provided to Medicare, can access the claim files for your client. My favorite feature is being able to request updated Conditional Payment Reports.

Once you have reached a settlement of your claim, you must provide notice of settlement to Medicare which includes the following information:

- Amount of Settlement
- Date of Settlement
- Attorney Fees
- Attorney Costs (provide itemization of costs)

Insurance Type
Insurance Company
Injuries

In response, Medicare will provide a “final demand” amount. This amount will take into consideration a discount of sorts that Medicare will apply which basically gives your client credit for attorney fees and costs incurred. **Do not send any settlement proceeds to Medicare until you have received the final demand amount**. When making payment of Medicare’s lien, I send a cover letter and ask that Medicare’s file(s) be closed once payment is applied. Remember, Medicare may have two different files open for one accident, one for the liability claim and the other for the no-fault claim. I include both claim numbers and ask that both files be closed so that the client doesn’t run into any issues down the road due to one of the claims being left open inadvertently.

Once your case is placed in suit, all correspondence on Medicare’s claims will be with the U.S. Attorney’s office. You will need to provide the same settlement information to the U.S. Attorney’s office upon settlement; the only difference will be that they will obtain the final settlement amount from Medicare for you.

Remember to review Medicare’s itemized payments one last time prior to notification of settlement to be sure all payments are for treatment of “accident related injuries”.

In extreme cases, there can be an opportunity to ask Medicare to take a reduced amount. If you have a case where the injuries are

significant, but the available insurance proceeds are minimal, it is possible that Medicare will consider taking a reduction of their lien amount. This is a situation that would need to be negotiated with the U.S. Attorney's office. It is not something that happens on a regular basis, but is something your attorney may want to address if you find yourself in such a situation.

Medicare Set-Aside is only applicable in a case where your client is currently a Medicare recipient or is likely to become a Medicare recipient in the relatively near future. A Medicare Set-Aside is an amount of money from settlement funds that is "set-aside" for future medical care. These funds are put into a special account called a Medicare Set-Aside Account or MSA Account.

The Medicare Set-Aside rules seem to be in a constant state of flux. However, we have recently been made aware that there seems to be a push for CMS to put into place a formal review system and track cases that do not have MSA's and potentially deny treatment. If you and your attorney find yourself in a situation where you are questioning whether a Medicare Set-Aside is required, your best bet would be to speak with a special needs planner in your area that is familiar with the Medicare Set-Aside requirements.

If your client has completed all accident related care prior to settlement, a set-aside should not be a concern. However, it is in your client's best interest to obtain documentation from his/her medical provider that accident related treatment has been completed and no future treatment for the accident injury is necessary. In fact, we are currently dealing with some insurance companies that will require it

before they wrap up settlement of the claim. The easiest way to accomplish this is for your client to meet with their doctor one final time and have the medical provider note that treatment has been completed and the client is being released from care in the final medical note.

At the end of the day, use common sense. If your client is on Medicare and it is foreseeable that they are going to require ongoing care into the future for injuries sustained in the accident for which you are obtaining a settlement, you need to be sure that steps are taken to protect Medicare's future interests. As indicated previously, the best way to be sure you are compliant with Medicare's set-aside rules is to enlist the assistance of a special needs planner that has experience dealing with Medicare set-asides.

Finally, it is important that your client have a clear understanding that if they seek future treatment that is in any way similar to that treatment received for their accident injuries, Medicare could potentially flag those treatments and deny payment. Have a plan in place in the event that occurs so that they are not unduly stressed by such incidents. We always make sure that our clients know that if anything like this should come up with Medicare, to just give us a call and we can look into it for them. In the majority of cases, the treatment is clearly not related to the prior accident treatment, and a simple phone call with Medicare can straighten it out, and can put your client at ease.

C. Medicaid Liens:

As with Medicare, Medicaid also has the right to be reimbursed in full. You will want to provide Medicaid with your letter of retainer, along with a signed Medical Authorization from your client. Medicaid will request that you complete a claim form with information regarding responsible party; insurance available; accident details, and claimed injuries. Medicaid will then provide you with an initial list of payments they have made on behalf of your client. Again, go over this list in great detail to be sure all claimed payments are for accident related injuries. As with Medicare, if you identify unrelated treatment, you should contact the Medicaid representative and ask that any unrelated charges be removed.

Upon resolution of our client's claim, contact your Medicaid representative for a final lien amount and request an updated itemization. Once again, review the payment history in detail to be sure all claimed payments are for accident related treatment.

D. ERISA Health Insurance Liens:

Health insurance liens of self-funded plans established under ERISA (Employee Retirement Income Security Act of 1974) are afforded greater protection than a standard health insurance lien. While some ERISA plans call for full reimbursement of their lien, some do not. If a health insurer is claiming ERISA status, you will want to be sure to obtain their plan language and provide it to your attorney for his/her review.

If it is determined that the health insurance provider does have ERISA status, it is important to note that in the file so your attorney is aware

of that at the time of resolution. This is something that I will note on the Subro Settlement Memo previously referenced.

E. Med Pay/PIP

Medical Payments Coverage (Med Pay) under an automobile insurance policy (and some premise policies) pays for medical expenses of an insured and/his/her passenger (guest) after an accident. This can also apply if the insured or family member is a pedestrian or bicyclist.

Personal Injury Protection (PIP) coverages pays benefits for medical expenses and wage loss incurred by the insured or passengers in an accident. PIP coverage is required in several states.

You will need to know which applies to the state in which you practice or from which the applicable coverage in your case is issued. It may be that your accident occurred in one state but that the policy of the covered vehicle was issued in a different state. The limits of med pay/PIP coverage vary from state to state.

Many states apply the Made Whole Doctrine to Med Pay/PIP coverage. What this means is that the claimant must be deemed whole from the liability settlement before the Med Pay/PIP carrier is reimbursed for their payments. However, some States also hold that the Made Whole Doctrine can be overridden by appropriate plan language.

It is crucial to identify whether you are dealing with Med Pay or PIP coverage, and what the law of your state are with respect to reimbursement. If the Made Whole Doctrine applies, that allows you

the ability to negotiate with the Med Pay/PIP carrier to either take a reduction or waive their interest altogether.

In Wisconsin, we have Med Pay and the Made Whole Doctrine applies, which cannot be overridden with policy language. If there is a dispute between the insured and the med pay insurer, a *Rimes* hearing can be requested, and each side can argue their case to a judge

F. Miscellaneous:

No matter the type of lien or subrogated interest you are dealing with, it is important to be sure that the claims being made are for accident related charges only. I cannot stress enough the importance of reviewing the bills and/or payment histories carefully for all claimed liens or subrogated interests.

Oftentimes, a medical provider will identify that they have balances for treatment not related to the accident. While it is not accident related, I will still pass this information on to the client. Some clients will prefer to have those balances paid from the settlement proceeds just to clear any credit issues, especially if they make a decent recovery. This is all up to the client but I like to at least give them the information and let them weigh their options.

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