

# HOOK

## LAW CENTER

Comprehensive Planning.  
Lifelong Solutions.

We help families navigate the legal maze  
and implement plans to secure their futures.

Call today: 757-399-7506



## SPECIAL REPORT: Lien Resolution in Personal Injury Cases

---

Hook Law Center Offices:

295 Bendix Road, Suite 170, Virginia Beach, Virginia 23452  
5806 Harbour View Blvd., Suite 203, Suffolk, Virginia 23434  
[www.hooklawcenter.com](http://www.hooklawcenter.com)

Tel: 757-399-7506  
Fax: 757-397-1267

© 2014 Hook Law Center

When a personal injury settlement is being finalized, consideration should be given to resolving a number of liens. It is good practice to get information on the existence and amount of these liens early in the process, because this information may be helpful in settlement negotiations.

The types of liens that often arise in personal injury cases include the following:

- Medicaid Liens;
- Medicare Liens;
- Medicare Part D/Medicare Advantage;
- ERISA;
- State Worker's Compensation;
- Federal Employee Compensation Act;
- Hospital Liens;
- Veterans Administration Claims;
- Federal Employee Health Benefits Act;
- U.S. Medical Care Recovery Act;
- TRICARE Claims;
- Welfare Liens;
- Liens in Favor of the Commonwealth of Virginia and its Programs or Departments on Claims for Personal Injuries;
- Liens Against Recovery for Medical Treatment Provided to a Prisoner;
- Virginia Department of Behavioral Health and Developmental Services Liens; and
- Uninsured Medical Catastrophe Fund.

### **MEDICAID LIENS**

The Virginia Medicaid program is administered by the Department of Medical Assistance Services ("DMAS"). DMAS can be contacted through its website at [www.dmas.virginia.gov](http://www.dmas.virginia.gov) or at 600 East Broad Street, Richmond, Virginia 23219.

Plaintiffs' attorneys are often unfamiliar with the Medicaid laws in general and the *Ahlborn* case (*Ark. Dep't of Human Servs. v. Ahlborn*, 547 U.S. 268 (2006).) in particular.

Understanding Medicaid liens requires familiarity with two federal statutes.

- **Assignment to State.** As a condition of Medicaid eligibility, a Medicaid applicant is required to assign to the state any rights to payment of medical care from any third party. If the individual fails to pursue the claim, the state has the option of pursuing it. Often in a personal injury situation, the plaintiff's medical bills have been paid by Medicaid pending a determination of liability. Medicaid is required to be repaid from the proceeds of the tort recovery and imposes a lien against the

recovery. In addition, states require Medicaid applicants to cooperate with the state in identifying and providing assistance in pursuing any third party who may be liable to pay for care and services as a condition of receiving benefits.

- **Anti-Lien Statute.** Under federal law, no Medicaid lien may be imposed by a state on the property of an individual prior to his death, except pursuant to a court judgment for benefits incorrectly paid.

*Practice Tip: In resolving Medicaid liens, it is important to review carefully the statement for services rendered to be sure that the services being billed were actually performed and were related to the injury subject to the recovery.*

### **Extent of Lien**

There are a number of issues to be considered pertaining to the extent of the Medicaid lien:

- **Related to Injury.** The Medicaid lien affects only Medicaid expenses related to the injury. If an individual has been receiving medical assistance through the Medicaid program for medical conditions unrelated to the injury, then these do not have to be reimbursed out of the settlement. For example, a cerebral palsy victim may be receiving Medicaid and subsequently become involved in an automobile accident. Only the medical bills relating to the injury sustained in the automobile accident are subject to Medicaid recovery. Payments by Medicaid on account of the cerebral palsy are not subject to recovery because they were not caused by the acts of a third party and there is no third party liability. Medicaid officials may try to recover unrelated medical charges, unless the attorney for the individual with a disability identifies charges that are not related to the personal injury. Care should be exercised in this regard.
- **Payments Prior to Recovery.** The Medicaid lien only applies to payments made from the date of the injury to the date of the settlement, because these are the only expenses for which the third party is liable for reimbursement.
- **Pro Rata Share.** The significance of the *Ahlborn* case is that it is now clear: Medicaid's right to reimbursement attaches only to the portion of the settlement, judgment or award that represents payment for medical expenses and not for proceeds intended to cover other items, such as pain and suffering and loss of wages. Therefore, under *Ahlborn*, Medicaid may recover only a pro rata share of its claim, which is determined by the ratio that the settlement amount bears to the reasonable value of the total claim.

## Reasonable Value of the Claim

Cases settle for less than the full value of the claim where there are issues with respect to liability, or where the recovery is limited by the coverage of the insurance policy or by comparative fault or contributory negligence. Some states, by statute, require that the state be made a party to the action, and that the state may be involved in the settlement negotiation.

The issue now becomes how to value the entire case. What is the reasonable value of the entire claim? The *Ahlborn* court addressed the “risk of settlement manipulation” by reasoning that “the risk that parties to a tort suit will allocate away the state’s interest can be avoided by either obtaining the state’s advance agreement to an allocation or, if necessary, by submitting the matter to a court for a decision.” Alternatives for establishing the full value of the case may include the following:

- Medicaid stipulation. It may be possible, as in the *Ahlborn* case, to obtain a stipulation between the plaintiff and Medicaid as to the reasonable value of the claim. Post-*Ahlborn*, this may be unlikely.
- Defendant's stipulation. Although Medicaid may be unwilling to enter into a stipulation with respect to the fair value of the claim, the defendant may be willing to do so. It is questionable whether a state Medicaid agency would accept a stipulation between the plaintiff and the defendant, because such a stipulation may be easily manipulated after the case is settled.
- Expert witness. An expert witness may be obtained to write a report determining the fair value of the claim with reasons to support the conclusions. The expert witness may be a personal injury attorney with a solid reputation in the community. The expert witness report may be used in negotiating a settlement with Medicaid or admitted to a court as a basis for a court order.
- Court order. One may obtain a court order that allocates the settlement among various categories of damages. Any court hearing should be on notice to the state Medicaid agency.

## Negotiation of Medicaid Liens

Negotiation attempts should be directed to the office of the Attorney General. The Attorney General is vested with the authority to compromise the Medicaid lien for amounts less than \$250,000. Amounts exceeding \$250,000 must be submitted to the Governor for approval.

## MEDICARE LIENS

### **Statutory Lien**

The federal government has a statutory lien for payments made under the Medicare Secondary Payer Act (“MSP”). The Act provides that Medicare may not make payments when payment has been made or can reasonably be expected to be made promptly under worker’s compensation or automobile or liability insurance policies or plans (including a self-insured plan) or no-fault insurance. Any such payment shall be conditioned upon reimbursement from the primary plan.

### **Subrogation**

Where there is a “conditional payment,” the United States may bring an action against the primary plan responsible for payment, and “the United States shall be subrogated” for the payment of those expenses from the primary plan. If it is necessary for the Centers for Medicare and Medicaid Services (“CMS”) to take legal action to recover from the primary payer, then CMS may recover double damages.

### **Party Making Payment**

CMS has a direct right of action to recover from any entity responsible for making primary payment. This includes an employer, an insurance carrier, plan, or program, and a third party administrator.

### **Party Receiving Payment**

CMS also has a right of recovery from parties that receive third party payments. These include a beneficiary, provider, supplier, physician, attorney, state agency, or primary insurer that has received a third party payment.

### **Settlement**

There are three circumstances where Medicare claims may be waived in whole or in part or may be compromised:

1. The Federal Claims Collection Act provides that if the probability of recovery or the amount involved does not warrant pursuit of the claim, then there are grounds for compromise.
2. If the Secretary of Health and Human Services determines that the waiver is in the best interests of the Medicare program.
3. If recovery against a person who is without fault would defeat the purposes of Social Security or Medicare or would be against equity and good conscience, then there are grounds for a waiver.

CMS staff, through its central or regional offices, handles requests under situations one and two. Requests under situation three must be submitted to the Medicare Secondary Payer Recovery Contractor (“MSPRC”), the

Medicare recovery contractor ([www.msprc.info](http://www.msprc.info); MSPRC Auto/Liability – P.O. Box 33828, Detroit, Michigan, 48232-5828).

#### Waiver:

Waiver is a forgiveness of the party's obligation to satisfy Medicare claims and is possible under situation three above if collection of the claim would create a financial hardship by reducing the beneficiary's ability and sufficiency to meet the beneficiary's ordinary and necessary expenses. In evaluating the "against equity and good conscience" component, MSPRC reviews the totality of the circumstances of the case, specifically reviewing the degree to which Medicare contributed to and the beneficiary did not contribute to the overpayment. MSPRC also looks to see if repayment would cause undue hardship to the beneficiary as well as if the beneficiary was harmed by relying on erroneous Medicare payment. While waiver decisions based upon situation three are appealable, waiver decisions based upon the best interests of the Medicare program (situation two) are not.

#### Compromise:

A compromise is an acceptance of an amount less than the full debt owed to Medicare and may be granted if the beneficiary does not have either the present or prospective ability to pay the full amount. The decision to allow a compromise is based on several factors and is considered on a case by case basis. Only CMS has the ability to negotiate a settlement, and the acceptance of a settlement eliminates the individual's ability to appeal the remaining debt.

- Lump-Sum Compromise Settlement. Cases will be compromised where there is questionable liability. In such cases, counsel notifies Medicare of the strengths and weaknesses of the defendant's case in order to justify a reduction of the Medicare claim. The beneficiary is entitled to appeal an adverse decision on the beneficiary's request for waiver or compromise pursuant to section 1870(c) of the Social Security Act.

Where there is a "Lump-Sum Compromise Settlement" providing less than total compensation because of questionable liability, Medicare should review the compromise settlement prior to approval by the parties. As long as the settlement provides a reasonable amount for future medical expenses, Medicare will approve the settlement. If Medicare approves a settlement for less than the claimant's outstanding injury-related medical expenses, then Medicare applies the settlement proceeds to medical expenses in a coordinated fashion.

- Allocation of Damages Within the Settlement. Damages within the settlement are allocated for Medicare claim purposes among past medical expenses, compensatory damages, and pain and suffering. Only the portion of the recovery allocated to past medical expenses is available to satisfy the Medicare claim.

#### Hook Law Center Offices:

295 Bendix Road, Suite 170, Virginia Beach, Virginia 23452  
5806 Harbour View Blvd., Suite 203, Suffolk, Virginia 23434  
[www.hooklawcenter.com](http://www.hooklawcenter.com)

Tel: 757-399-7506  
Fax: 757-397-1267

© 2014 Hook Law Center

*Practice Tip: One way to reduce a Medicare lien would be by a court order allocating the settlement among the various components, including medical, after notice to Medicare.*

## **MEDICARE PART D/MEDICARE ADVANTAGE**

Medicare Part D provides prescription drug coverage to eligible beneficiaries. Medicare Part D is covered by the Prescription Drug Plans (PDP). PDP is similar to Medicare Managed Care Plans known as Medicare Advantage, and they have a separate right of recovery from Medicare. Both Medicare Part D and Medicare Managed Plan will need to initiate their own recovery efforts since they are not part of the traditional Medicare recovery effort.

It can be argued that Medicare Part D and Medicare Advantage do not have any lien rights against personal injury settlements, judgments or awards. This is not to say that they have no recovery rights. Any recovery rights are based in contract rather than the MSPs statute.

Technically, Medicare Part C Plans have the same right of reimbursement as traditional Medicare Parts A and B, but Medicare Part C Plans do not have lien rights. They are reimbursed according to the insurance contract and governing state law. The obligation to repay is set forth in federal law. "If a Medicare enrollee receives from a Medicare Advantage organization covered services that are also covered under State or Federal workers' compensation, any no-fault insurance or any liability insurance policy or plan...the MA organization may bill...to the Medicare enrollee to the extent he or she has been paid by the carrier, employer or entity for covered medical expenses."

The Medicare statute says, "The eligible organization may...charge or authorize the provider of such services to charge...such member to the extent that the member has been paid under such law, plan, or policy for such services." While traditional Medicare has an automatic statutory right of recovery, the Medicare Advantage Plans have only a right to recover but no statutory claim. While Medicare must be given affirmative notice of a third party liability claim, there is no such requirement for Medicare Advantage Plans. CMS maintains records of all third party liability claims involving traditional Medicare recipients, but CMS does not maintain similar records for Medicare Advantage Plan recipients. There's no single source through which to verify coverage, payments or reimbursement rates.

It is important in settling a claim involving a Medicare Advantage Plan to be aware that there may be a Medicare lien for the traditional Medicare Parts A and B for conditional payments made under the Medicare Secondary Payer Act, as well as a right of recovery for Medicare Advantage for payments made by the MA Plan. In resolving a Medicare Advantage claim, the attorney should contact the MA provider requesting a claims itemization and should include a Health Insurance Portability and Accountability Act (HIPAA) release. The

attorney should also request a copy of the Summary Plan Description (SPD). The plan's right of recovery should be assessed and negotiated based on the subrogation language found in the SPD and governing law.

## **ERISA**

There are two types of private medical insurance subrogation and they are handled in different ways. The first type of private insurance is through an Employee Retirement Income Security Act (ERISA) plan. The other is non-ERISA. ERISA plans are governed by the ERISA statute. Non-ERISA subrogation is governed by state law.

ERISA was enacted in 1974, and most medical plans provided by employers fall under the terms of ERISA. These plans may have liens against tort recoveries.

The website [www.freeerisa.com](http://www.freeerisa.com) makes company Form 5500 filings available for viewing. These filings provide insight into plan funding as well as the plan administrator's name and address to which to request the summary plan description.

### **Appropriate Equitable Relief**

Relief under ERISA is based on equitable principles, rather than legal relief, in the form of money damages for breach of contract.

### **ERISA Qualification**

To qualify as an ERISA plan, a plan must be:

- A plan, funded program;
- Established or maintained by an employer or employee organization, or both;
- For the purpose of providing medical, surgical, hospital care, sickness, accident, disability, or other encumbered benefits stated in ERISA to participants or their beneficiaries.

It is clear that a medical insurance policy covering a self-employed person and spouse does not constitute an ERISA plan. In addition, ERISA does not apply to church, government or farm plans or self-pay insurance contracts.

### **Plan Language**

An ERISA plan can recover for damages received from third parties where the plan language clearly establishes such a right (*Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006).). The *Sereboff* court did not address the issue of a "make whole doctrine," because it was not property before the court. Since an ERISA

plan's right to reimbursement is based in equity, it is subject to equitable defenses based upon a strict reading of the actual contract language.

### **Specific Identifiable Fund**

The Plan's right of recovery must be against a specific, identifiable fund, such as the tort recovery as opposed to a claim against the general assets of the plaintiff. Such a claim against general assets would be a claim at law, rather than in equity.

### **Derivative Claims**

An ERISA lien is enforceable against the settlement of the injured beneficiary on whose behalf benefits are paid, but it is likely unenforceable against the derivative claims of others related to the incident.

### **Wrongful Death**

State law often protects wrongful death claims from subrogation, so allocating more to wrongful death and less to the survival claim may reduce the lien. Also, the survival claim may be subject to federal or state estate or inheritance taxes. Medicare and Medicaid can collect even from wrongful death, because federal law preempts state law.

### **Loss of Consortium**

Allocation of loss of consortium claims to those who do not have responsibility for medical bills, such as a spouse or child of the injured party, may avoid or reduce the healthcare lien.

## **STATE WORKER'S COMPENSATION**

Where there is a state worker's compensation claim and also a third party liability case and the third party liability case settles, there is a worker's compensation lien against the third party liability proceeds. Frequently the worker's compensation lien is negotiable because the worker's compensation carrier is anxious to get the plaintiff off its books. If an injured employee or this employee's personal representative receives the proceeds of a settlement or verdict and the employer's lien has not yet been satisfied, then the employer has the right to recover its lien either as a credit against future benefits or through a civil action against the injured employee or this employee's personal representative.

Because worker's compensation liens sometimes contain amounts for administrative expenses, it is important to review first a detailed statement of expenses and remove inappropriate ones prior to taking a pro-rata reduction for attorney's fees.

No compromise settlement shall be made by the employer in the exercise of a right of subrogation without first obtaining the approval of the Virginia Worker's Compensation Commission and the injured employee or the personal representative or dependents of the deceased employee.

### **FEDERAL EMPLOYEES COMPENSATION ACT**

The Federal Employees Compensation Act (FECA) is the federal equivalent of state worker's compensation. It covers benefits under the Longshore and Harbor Worker's Compensation Act and the Federal Employees Compensation Act. Essentially, the federal government has a lien under either of these two acts.

### **HOSPITAL LIENS**

Every hospital, nursing home, licensed physician, registered nurse, registered physical therapist, pharmacy, or ambulance service shall have a lien for services rendered, by way of treatment, service, or care, to any person who shall have sustained personal injuries in an accident as a result of negligence or alleged negligence of any other person. The lien shall be for the amount of a just and reasonable charge for the service tendered, not exceeding \$2000 in the case of a hospital or nursing home, \$500 for each physician, nurse, physical therapist, or pharmacy, and \$200 for each ambulance service. These liens are difficult, if not impossible, to negotiate.

### **VETERANS ADMINISTRATION CLAIMS**

The Veterans Administration (VA) has a right of recovery against a third party when the VA pays for medical treatment on behalf of the veteran or the veteran's family. The VA has a lien in favor of the United States against any recovery the veteran or the veteran's family subsequently receives from a third party for the same treatment.

#### **Extent of Right of Recovery**

In any case where the veteran is furnished care or services for a non-service-connected disability, the United States has a right to recover or collect reasonable charges for such care or services from a third party to the extent that the veteran (or the provider of the care or services) would be eligible to receive payment for such care or services from such third party, if the care or services had not been furnished by a department or agency of the United States.

### **FEDERAL EMPLOYEE HEALTH BENEFITS ACT**

Federal Employee Health Benefit Act (FEHBA) provides group health insurance benefits to federal employees. The federal government enters into private contracts with insurance carriers. The federal statute does not contain lien language, but most plans contain subrogation or reimbursement provisions.

## **U.S. MEDICAL CARE RECOVERY ACT**

The U.S. Medical Care Recovery Act (MCRA) applies in all cases in which the United States provides or pays for medical care for a person injured in a third party liability case. Under MCRA the government has a right to recover, either directly or indirectly, the value of medical treatment for which it pays or provides.

The federal government may require an injured person to assign the injured person's claim to the government if the injured person does not pursue the claim.

### **TRICARE CLAIMS**

TRICARE claims are covered under the Federal Medical Care Recovery Act (FMCRA). The right of recovery includes care that may be received by the beneficiary at the uniformed services facility or under TRICARE, or both. Each branch of the service has a slightly different model agreement that must be signed when private counsel is asserting a separate cause of action to recover for injury-related care paid by TRICARE/CHAMPUS on a contingent basis.

### **WELFARE LIENS**

The Commonwealth of Virginia or any of its political subdivisions may not claim, levy or attach a lien against the real and personal property of a person as a condition of eligibility for public assistance or social services; or to recover such aid following the death of an applicant or recipient, except applicants for or recipients of long-term care nursing facility benefits paid by the Department of Medical Assistance Services. The Commonwealth of Virginia, however, is able to seek reimbursement for costs incurred for care and maintenance provided to an applicant of the Federal Supplemental Security Income program during the application period when the applicant becomes retroactively eligible. Also, the Commonwealth of Virginia may seek reimbursement for public assistance paid through the Temporary Assistance for Needy Families program while the family attempts to dispose of the property and resources that cause the family to be in excess of the state's allowable reserve.

### **LIENS IN FAVOR OF THE COMMONWEALTH AND ITS PROGRAMS OR DEPARTMENTS ON CLAIMS FOR PERSONAL INJURIES**

When a person sustains injuries and receives treatment in any hospital or nursing home, receives medical treatment from a physician or care from a registered nurse, or receives pharmaceutical goods or medical device or apparatus which is paid for pursuant to the programs of the Department of Medical Assistance Services (including Medicaid), the Maternal and Child Health Program, or the Children's Specialty Services Program, or provided at or paid for by any hospital or rehabilitation center operated by the Commonwealth of Virginia, the Department of Rehabilitative Services, or any state institution of higher education, the Commonwealth of Virginia shall have a lien for the total amount paid.

Additionally, the Commonwealth of Virginia or DMAS also has a lien for any funds which may be due the individual from insurance proceeds received under the individual's own insurance coverage or through an uninsured or underinsured coverage endorsement.

The Code of Virginia sets out an order of priority for these liens and also designates that they may be compromised or settled by the Attorney General.

### **LIENS AGAINST RECOVERY FOR MEDICAL TREATMENT PROVIDED TO A PRISONER**

In a personal injury action brought for injuries or death suffered by a prisoner in a state or local facility, the Commonwealth of Virginia or locality has a lien against any recovery by settlement or verdict for all expenses it has incurred for medical, surgical, and hospital treatment, as well as for supplies provided to the prisoner during the injury treatment.

### **VIRGINIA DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES LIENS**

The Virginia Department of Behavioral Health and Developmental Services has a lien against an individual who has been admitted to a state facility or is the subject of counseling or receives treatment at a state facility. The amount of expenses for which an individual is liable shall not exceed the average cost for the particular type of service rendered, as determined by the Department, but in no event will recovery be permitted for amounts more than five years past due. The Department will investigate the individual's ability to pay, including present and future needs of the individual and the individual's dependents and may agree to accept an amount lower than cost.

If an individual who is receiving or formerly received public or private mental health, mental retardation, or substance abuse treatment or habilitation services dies, then the individual's estate is liable for charges remaining unpaid and not more than five years past due. If upon the individual's death the individual possessed real or personal property from which reimbursement may be had, then the Department has a lien against that property.

### **UNINSURED MEDICAL CATASTROPHE FUND**

The Virginia Uninsured Medical Catastrophe Fund (UMCF) was established in 1999 to provide funds for uninsured individuals who need treatment for a life-threatening illness or injury. UMCF is mainly funded by voluntary contributions from taxpayers who designate that a part of their tax refunds go to UNCF. Fund disbursement requires that: 1) a provider can be found who is willing to accept the UMCF contract, 2) funds are available, 3) the individual has an approved treatment plan, and 4) the individual meets the eligibility rules. To

be eligible, the individual must be a United States citizen and a Virginia resident. The individual must also have income under 300% of the poverty level, have a life-threatening illness or injury, and be uninsured for the treatment. The treatment plan must not be open-ended. There is no provision for a lien against funds disbursed as part of the UMCF.

#### ABOUT THIS HANDOUT

This guide is provided as a courtesy to help you recognize potential estate planning issues. It is not intended as a substitute for legal advice. It is distributed with the understanding that if you need legal advice, you will seek the services of a competent elder law attorney. While every precaution has been taken to make this explanation accurate, we assume no responsibility for errors or omissions, or for damages resulting from the use of the information in this explanation.



Hook Law Center focuses its practice on estate and tax planning, planning for long-term care and aging, retirement and investment advice, trust and estate administration and probate, guardianships for those unable to make sound decisions, and the unique situations associated with special needs.

Learn more about the Hook Law Center at [www.HookLawCenter.com](http://www.HookLawCenter.com).