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A MEDICAL-LEGAL NEWSLETTER FOR PERSONAL INJURY ATTORNEYS BY DR. STEVEN W. SHAW

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## Hospital Liens, Medicare and Medicaid: Trouble Ahead?

Several years ago I was informed by an attorney that Danbury Hospital had put a lien on the liability carrier of his clients claim. He had looked into it and found that, not only were they able to do so but, they had Connecticut General Statutes to support their position. We discussed the potential dire consequences of the implementation of this approach on a broad scale and were grateful that it was only being used by a hospital outside of our geographic region. Well, over the past year or so we are seeing hospitals all across the State beginning the same practice. This will certainly challenge all of us in the future. This is further complicated by the language in the Medicare and Medicaid regulations which will potentially lead to even more problems ahead. In this newsletter I will review what I have learned so far.

Connecticut General Statute 49-73 allows hospitals to (a) lien the proceeds of any accident and liability insurance policy for the actual costs and materials provided. (b) Instruct the liability carrier to pay directly to the hospital the amount due (so long as all parties agree). What does this mean in practice? Well, if the Hospital or its agent discovers who the liability carrier is, they can place a lien on the file that directs the liability carrier to pay them the full amount billed, before you or your clients receive the settlement proceeds. If for example, a case settles for \$20,000 with a perfected hospital lien for \$9,000, your office would receive a check for \$11,000 which would be used for your fee, all remaining costs and specials. The remaining balance would be for the client.

Obviously, the hospital's position ahead of everyone is problematic and raises a whole list of other questions. Is the attorney entitled to their contingency fee on the entire settlement amount or the proceeds that are forwarded to them after the hospital is paid? Are attorneys informed ahead of time of the placement of the lien so they can take that into consideration when settling the claim and determining the value of the case? Do the hospital fees represent the usual, customary and reasonable fees that commercial carriers usually pay them for their services or are they inflated fees that are used solely for the purpose of cost shifting to payers that are foolish enough to pay the fee unchallenged?

Let's face it, while a hospital may charge \$15 for an aspirin, we all know that it's worth pennies on the open market. Hospitals often charge 5-10x the insurance reimbursed fee for operating room facilities knowing that the fees will never be paid at full fee by anyone (until now?). The same goes with surgical and non-surgical providers who bill multiples of the fees they are actually reimbursed in the hope of getting paid a reasonable fee by commercial carriers. The difference now is that, unlike doctors, hospitals have no incentive to negotiate fees with the attorney. With the application of CGS 49-73 they move to the top of the food chain. This elevated position puts everyone downstream in an untenable position.

You may be thinking that this will only be problematic for your uninsured patients because commercial carriers, Medicare and Medicaid are fee scheduled and therefore not subject to the ridiculously inflated fees charged by the hospitals. While that MAY be the case for commercial carriers (depending on the language of the specific contract), it is absolutely not the case for Medicare and Medicaid.

The Center for Medicare and Medicaid Services, Deficit Reduction Act, states that *"By law, the Medicaid program is the payer of last resort. If another insurer or program has the responsibility to pay for medical costs incurred by a Medicaid-eligible individual, that entity is generally required to pay all or part of the cost of the claim **prior** to Medicaid making any payment. This is known as "third party liability" or TPL. Third parties that may be liable to pay for services include*

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private health insurance, Medicare, employer-sponsored health insurance, settlements from a liability insurer, workers' compensation, long-term care insurance, and other State and Federal programs (unless specifically excluded by Federal statute). Third party payers are not responsible for reimbursing Medicaid for any services that are not covered under the Medicaid State plan" (**bold** added). Clearly, this indicates that if there is a case on a Medicaid insured plaintiff then the Medicaid providers (hospitals, doctors, therapists) have an obligation (perhaps an option?) to bill the third parties, which by their definition includes the liability carrier. Obviously, the hospital, now aware their State lien statute would rather be paid many multiples the Medicaid rate and would have no problem following this regulation.

What about Medicare? I have been given copies of collection letters sent to Connecticut attorneys on this topic. These letters reference the Medicare Secondary Payer Manual, Ch.2 §60 which refers to No-Fault payments. Since it was related to No-Fault claims and Connecticut is not a No-Fault State my initial impression was that it would not apply in Connecticut. Unfortunately, upon further reading of the Medicare Secondary Payer Manual, Ch.2, I came across §40 and §40-2. These two sections read as follows:

"§40 - Liability Insurance (Rev. 49, Issued: 04-07-06; Effective/Implementation: 05-08-06) Under §1862(b)(2) of the Act, (42 U.S.C. 1395y(b)(1)), **Medicare does not make payment for covered items or services to the extent that payment has been made, or can reasonably be expected to be made under a liability insurance policy or plan** (including a self-insured plan)...."

The Manual goes on to explain:

"§40.2 - Billing in MSP Liability Insurance Situations (Rev. 49, Issued: 04-07-06; Effective/Implementation: 05-08-06)  
A – Intentionally omitted.

B – Billing Options and Requirements – Alternative Billing. Generally, providers, physicians, and other suppliers must bill liability insurance prior to the expiration of the prompt period rather than bill Medicare. **(The filing of an acceptable lien against a beneficiary's liability insurance settlement is considered billing the liability insurance.) ...**"

So it appears that your uninsured clients, as well as Medicare and Medicaid insured clients, who go to the Hospital may have an enforceable lien placed against their settlement or verdict proceeds. With that in mind, attorneys should consider and advise clients of the financial risks they are taking when going to a hospital emergency department for routine medical services that can otherwise be provided by a non-hospital based provider. Avoiding the hospital emergency department in cases of non-emergent and non-life threatening injuries will likely allow your clients to receive appropriate medical care in an outpatient setting that is equal to or perhaps even better than the care available in an emergency department setting. It certainly protects them from abusive and unreasonable fees which the hospital will likely not be willing to negotiate.

You should know that the hospital lien is only enforceable against the liability carrier and not your client. I have been told that on some instances the lien holder has sent a copy of the lien to the client's attorney. While it is possible that this is done as a courtesy, it is equally possible that they do it in the hope that the attorney may interpret it as a lien that he or his client is obligated to pay. It is my understanding that this is not the case.

I have downloaded some of these regulations, letters and statutes and posted them on my website along with this newsletter (<http://shawchiropractic.com/attorney/newsletters> ). These various statutes and regulations create more questions than answers. Of course, as a disclaimer, I am a doctor and not an attorney trained to read and interpret these regulations so I encourage each of you to read them on your own and make your own interpretation. In the mean time, we all must keep this in consideration before having our clients/patients receive medical services from a hospital when there may be, and usually will be, equal or better quality services available outside of the hospital system. Your feedback and comments are always welcome and appreciated. [Dr.Shaw@ShawChiropractic.com](mailto:Dr.Shaw@ShawChiropractic.com)

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# Deficit Reduction Act Important Facts for State Policymakers

December 11, 2007

## Third Party Liability in the Medicaid Program

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The Deficit Reduction Act of 2005 (DRA) made a number of changes intended to strengthen States' ability to identify and collect mistaken Medicaid payments from liable third party payers. The Centers for Medicare & Medicaid Services (CMS) has issued guidance to States on these changes. (A link to this guidance can be found below.)

### ***Background***

By law, the Medicaid program is the payer of last resort. If another insurer or program has the responsibility to pay for medical costs incurred by a Medicaid-eligible individual, that entity is generally required to pay all or part of the cost of the claim prior to Medicaid making any payment. This is known as "third party liability" or TPL. Third parties that may be liable to pay for services include private health insurance, Medicare, employer-sponsored health insurance, settlements from a liability insurer, workers' compensation, long-term care insurance, and other State and Federal programs (unless specifically excluded by Federal statute). Third party payers are not responsible for reimbursing Medicaid for any services that are not covered under the Medicaid State plan.

In general, if a State has determined that a potentially liable third party exists, it must attempt to ensure that the provider bills the third party first before sending the claim to Medicaid. This is known as "cost avoidance." Whenever a State has paid claims and subsequently discovers the existence of a liable third party it must attempt to recover the money from the liable third party. This is known as "pay and chase." States are required to cost-avoid claims, with a few specific exceptions which are identified in regulation. (For more information on TPL, a link to the CMS webpage can be found below.)

### ***How the DRA Strengthens Third Party Liability***

The DRA made several changes to the TPL provisions of the Medicaid statute. These changes are designed to enhance States' ability to identify third party resources that are legally responsible to pay claims primary to Medicaid in order to cost avoid and seek recoveries. Specifically, section 6035 of the DRA:

1. Clarifies which specific entities are considered "third parties" and "health insurers" that may be liable for paying a claim prior to Medicaid and prohibits those entities from discriminating against individuals on the basis of Medicaid eligibility; and
2. Requires States to pass laws that require health insurers:
  - To provide the State with coverage and eligibility data needed by the State to identify potentially liable third parties;
  - To honor the assignment to the State of a Medicaid recipient's right to payment by such insurers for health care items or services;
  - To refrain from denying payment of claims submitted by Medicaid based on procedural reasons.

# **Deficit Reduction Act Important Facts for State Policymakers**

December 11, 2007

## ***Clarification of “Third Parties”***

The DRA codifies the existing policy and clarifies that “third parties” include: self-insured plans; pharmacy benefits managers (PBMs); and “other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.”

## ***Requiring Third Parties to Provide Data to States***

The DRA also directs States, as a condition of receiving Federal Financial Participation (FFP), to have laws in effect that require health insurers to provide the State with eligibility and coverage information in order:

- To identify potentially liable third parties;
- To properly avoid payments for services covered under the State plan when another party is liable for payment; and
- To recover payments from liable third parties.

## ***Third Parties’ Requirement to Reimburse States Appropriately***

Prior to the DRA, States were already required to have laws in effect that gave the State the rights of the Medicaid recipient to reimbursement by any other party that was liable for payment. However, payers sometimes denied Medicaid claims based on procedural requirements (e.g., rejecting a claim because it was not billed at the “point of sale,” was not in a particular claim format, or was not billed timely). The DRA strengthens the statute by requiring States to enact laws that require third parties:

- To accept the State’s right of recovery (in other words, the right to payment from such party for an item or service for which Medicaid has made payment); and
- To process and, if appropriate, reimburse Medicaid to the same extent that the third party would have been liable had it been properly billed at the point of sale.

It is important to note that third parties are not required to reimburse States for items or services which are not covered under the State plan. In addition, States still have a responsibility to provide proper documentation when submitting claims to third parties in order to confirm that the covered service for which the third party is liable was actually provided.

## ***Additional Information***

The provisions of section 6035 of the DRA were effective January 1, 2006, except where States are required to pass laws in order to comply with the new rules.

The State Medicaid Director Letter and Questions and Answers on the DRA provisions on TPL:  
<http://www.cms.hhs.gov/SMDL/SMD/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=1&sortOrder=descending&itemID=CMS1190482&intNumPerPage=10>

The CMS TPL webpage:  
<http://www.cms.hhs.gov/ThirdPartyLiability/>

**Sec. 49-73. Liens on accident and liability policies in favor of hospitals and ambulance services. Service of process on insurer and defendant.**

(a) Any 1. hospital, 2. ambulance, or 3. any hospital owned/operated by a municipality or the state, which furnished MEDICAL CARE to any patient injured IN AN accident [not covered by the Workers' Compensation Act] HAS A LIEN ON THE PROCEEDS of any accident and liability INSURANCE POLICY issued by any company authorized to do business in this state, which proceeds may be due such patient, either directly or indirectly, to the extent of the actual cost of such service and materials, **provided** such hospital or ambulance owner, or, in the case of the state, the Department of Administrative Services (*how about in the case of a municipality? I guess there aren't any more of them*), after the commencement of rendering of such service or providing of such materials and before payment by the insurance company, **serves written notice upon the insurance company** by registered or certified mail at its principal home office or any branch office, if the company issuing the policy is located within this state, **and upon the Insurance Commissioner of this state by registered or certified mail**, if the insurance company is located without the state. The notice shall be in duplicate and shall contain the name of the injured person, if known, the name of the company or companies issuing the policy and the amount expended and an estimate of the amount to be expended in the services rendered to or the materials provided for the patient.

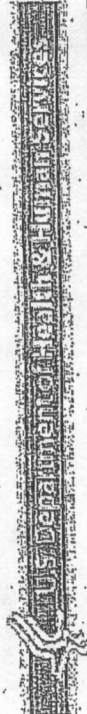
(b) Whenever the liability of the company or companies, either directly or indirectly, to the patient has been fixed, **the insurance company shall pay directly to the hospital or ambulance owner**, or, in the case of the state, **to the Department of Administrative Services**, the amount due it, provided the amount shall be agreed upon by all of the parties interested. A receipt by the hospital or ambulance owner, operator, association, partnership, corporation or division is evidence of payment of such amount by such company or companies on account of their liability to the insured.

(c) If the interested parties do not agree concerning the amount due the hospital or ambulance owner, operator, association, partnership, corporation or division, either party may bring an action of interpleader in the judicial district in which the hospital or ambulance owner, operator, association, partnership or corporation involved is located or, in the case of the state, in the judicial district of Hartford.

(d) When an insurance company located outside the state is a defendant [in an interpleader action?], service of process may be made on the Insurance Commissioner of this state, as set forth in section 38a-25. When any such defendant is a nonresident person who has been a patient in any hospital in this state or has used the services of such ambulance owner, operator, association, partnership or corporation, that person shall be conclusively presumed, by virtue of his admission as a patient in the hospital or use of the services of the ambulance owner, operator, association, partnership or corporation, to have appointed the Secretary of the State as his agent for service of process in any action of interpleader under the provisions of this section, arising out of his treatment as such patient or because of such service, and for no other purpose. Service shall be made by delivering to and leaving with the secretary or some person designated by him to receive the process in his office two copies thereof and by paying to him the sum of five dollars. The secretary shall forthwith send by registered or certified mail one of the copies of the

process to the defendant at his last-known address and shall keep a record of all process so served on him.





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### Third Party Liability

#### Overview

#### Overview

Third Party Liability (TPL) refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a State plan. The Medicaid program by law is intended to be the payer of last resort; that is, all other available third party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid. Examples of third parties which may be liable to pay for services include private health insurance, Medicare, employment-related health insurance, court-ordered health insurance derived by noncustodial parents, court judgements or settlements from a liability insurer, workers' compensation, first party probate-estate recoveries, long-term care insurance, and other State and Federal programs (unless specifically excluded by Federal statute).

Individuals eligible for Medicaid assign their rights to third party payments to the State Medicaid agency. States are required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the State plan. Once States have determined that a potentially liable third party exists, the State is required to either "cost avoid" or "pay and chase" claims. Cost avoidance is where the provider of services bills and collects from liable third parties before sending the claim to Medicaid. Pay and chase is utilized when the State Medicaid agency pays the medical bills and then attempts to recover from liable third parties. States are generally required to cost avoid claims unless they have a waiver approved by CMS which allows them to use the pay and chase method.

#### Important Information for Plan Sponsors

There are provisions of Federal law that affect the way plan sponsors deal with pharmacy claims submitted by State Medicaid agencies. Plan sponsors often are not aware that employees and/or their dependents for whom the employer is providing health coverage are also enrolled in Medicaid. Such situations can occur when a child is covered through a non-custodial parent's employer-based plan and is also covered by Medicaid through the custodial parent. As the primary payer, in such situations, plan sponsors are responsible for ensuring appropriate consideration of the state's claim for reimbursement. For more information, download

# CARDON OUTREACH™

June 11, 2013

Re: Our Client: [REDACTED]  
Patient: [REDACTED]  
Treatment Dates: [REDACTED]  
Balance: [REDACTED]  
Claim No.  
Insured:

Dear Attorney [REDACTED]

As you know, Cardon Outreach is a business associate of The Hospital of Central Connecticut New Britain. Pursuant to our contract with the Hospital, we provide third party liability reimbursement services, including assisting with the filing and enforcement of their hospital liens as allowed by the Connecticut Hospital Lien Statute, Conn. Gen. Stat. 49-73.

We are writing in response to your request to bill Medicare for the medical services provided to [REDACTED]. Medicare Secondary Payer rules preclude Medicare payments for services to the extent that payment has been made or can reasonably be expected to be made from certain third parties, including no-fault insurance and liability insurance.

With regard to no-fault insurance, the Medicare Secondary Payer Manual, Ch. 2, §60 instructs as follows:

Under §1862(b)(2) of the Act, (42 U.S.C. 1395y(b)(1)), Medicare does not make payment for covered items or services to the extent that payment has been made, or can reasonably be expected to be made under no-fault insurance. Medicare is secondary to no-fault insurance even if State law or a private contract of insurance stipulates that its benefits are secondary to Medicare benefits or otherwise limits its payments to Medicare beneficiaries.

Rules pertaining to liability insurance are similar:

Generally, providers, physicians, and other suppliers must bill liability insurance prior to the expiration of the promptly period rather than bill Medicare. (The filing of an acceptable lien against a beneficiary's liability insurance settlement is considered billing the liability insurance.) Promptly means payment within 120 days after the earlier of: 1) the date the claim is filed with an insurer or a lien is filed against a potential liability settlement; or 2) the date the service was furnished or, in the case of inpatient hospital services, the date of discharge) rather than bill Medicare. Following expiration of the



# CARDON OUTREACH™

promptly period, or if demonstrated (e.g., a bill/claim that had been submitted but not paid) that liability insurance will not pay during the promptly period, a provider, physician, or other supplier may either:

- bill Medicare for payment and withdraw all claims/liens against the liability insurance/beneficiary's liability insurance settlement (liens may be maintained for services not covered by Medicare and for Medicare deductibles and coinsurance); or
- maintain all claims/liens against the liability insurance/beneficiary's liability insurance settlement.

Medicare Secondary Payer Manual, Ch. 2, §40.2.

Based on the foregoing, we believe it is proper to pursue the liable party prior to billing Medicare in this case. If you are aware of any authority to the contrary, please let us know.

If you have further questions or concerns regarding this issue, I am happy to put you in touch with our counsel.

Sincerely,

  
TPL Specialist

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8610 South Sandy Parkway, Suite 100  
Sandy, Utah 84070