

TRAPS TO AVOID IN PERSONAL INJURY CASES:  
SUBROGATION AND LIENS

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Once a personal injury case has been settled, who besides the lawyer and client must be paid out of the settlement? Many different persons or entities may claim to have a lien, right of subrogation, or right to reimbursement from the proceeds from a personal injury settlement. Some of these claims may be enforceable, but as to others your client may have viable defenses which may reduce or eliminate them. Also, some entities, especially governmental entities, may not have actually notified you of any type of claim at all but may actually have a valid lien that must be honored. Too often, these issues are not addressed until after the case has already been settled with the tortfeasor's insurance carrier, causing, at best, significant delays before final resolution and at worst, additional liability for the client and/or lawyer. It is important to identify and address these issues as early in the process as possible so that they can be addressed accurately and at a time when the injured party has the most leverage in any settlement negotiations.

There are numerous potential areas where subrogation and lien issues can arise. However, certain types are certainly more common than others and this paper will address these more common ones in a way designed to give the general practitioner

the practical information needed to identify and handle them. The most common areas are: (1) claims for health coverage reimbursement (particularly those arising under ERISA health plans) (2) hospital/physicians practice liens, (3) Medicare liens, (3) Medicaid liens, (4) claims under the Federal Medical Care Recovery Act, and (4) Worker's Compensation liens.

### HEALTH COVERAGE REIMBURSEMENT CLAIMS/ERISA

Most health plans will contain language providing that if the plan pays for treatment for injuries caused by a third party, and the covered person recovers damages from that third party, plan is entitled to be reimbursed out of that recovery for what it paid. The extent to which these provisions are enforceable depends largely on whether the plan is based on insurance or if the plan is organized and self-funded by an employer under the Employee Retirement Income Security Act of 1974 (ERISA).

If the plan is funded by insurance, the plan's right to reimbursement is fairly limited. Under Georgia law, the benefit provider may only recover if the injured party has been "made whole", or "[t]he amount of the recovery exceeds the sum of all economic and noneconomic losses incurred as a result of the injury, exclusive of losses for which reimbursement is sought." O.C.G.A. § 33-24-56.1(b)(1).

However, if the health plan is an employee benefit plan organized under the Employee Retirement Income Security Act of 1974 (ERISA), O.C.G.A. § 33-24-

56.1 may be preempted by Federal law. However, while many health plans are organized under ERISA, Federal preemption does not apply to all such plans. If the plan is insurance based, state laws regulating insurance still apply and are not preempted. It is only if the plan is self-funded that Federal preemption applies. FMC Corp. v. Holliday, 498 U.S. 52 (1990).

The effect of this preemption is significant one when it comes to subrogation and reimbursement claims, to the detriment of the covered person. Equitable defenses to subrogation claims like the “made whole” doctrine or the “common fund” doctrine (which states that the plan should have to contribute to the plaintiff’s attorney’s fees and expenses by reducing its reimbursement claim on a pro rata basis) do not apply if the plan language affirmatively disclaims them. U.S. Airways v. McCutchen, 569 U.S. 88 (2013), see also Cagle v. Bruner, 112 F.3d 1510 (11<sup>th</sup> Cir. 1997).

Many times, the alleged lienholder will assert generally that the plan is “governed by ERISA.” It is still important to go further and find out, specifically, if the plan is self-funded. Begin by asking the alleged lienholder if they are self-funded. If they say yes, go further and ask for the plan language. (The client has a right to the plan language under 29 U.S.C. § 1024.) The plan will normally describe how it is funded. If it is funded through insurance, federal preemption does not apply.

However, if it is through the assets of the company, or through some type of trust mechanism, it probably is a self-funded ERISA plan.

Additionally, every ERISA plan is required to file a Form 5500 with the United States Department of Labor. A website, [Freeerisa.com](http://Freeerisa.com), gives access to all Form 5500's filed within the past two years. Section 9a of the Form 5500 describes how the plan is funded. If Section 9a indicates that the plan is funded only by the general assets of the sponsor or by a trust, it is a self-funded plan. On the other hand, if Section 9a indicates the plan is funded by only by insurance, it is not a self-funded plan.

Often, however, Section 9a has more than one entry. If it indicates the plan is funded both the general assets of the sponsor (or by a trust) AND by insurance, Schedule A to the form 5500 usually will provide further guidance. Often, there will be more than one Schedule A. On each one, examine part III(8) of the form for entry (a), health benefits. If there is an entry for health, and no separate entry for "stop-loss," it is an insured plan and state health insurance law applies. (However, if "stop-loss" is indicated, it is likely a self-funded plan.) If there is no Schedule A with an entry for health benefits, it is likely a self-funded plan. Even if it appears you are dealing with a self-funded plan, however, this does not end the inquiry. It is also important to review the actual subrogation language in the plan. If the plan simply asserts that it has a reimbursement right without specifying the

funds as to which that right applies, it is not enforceable. Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204 (2002). However, if the plan states that the right is recoverable “out of recovery from a third-party tortfeasor,” or uses similar language, it probably is enforceable. Sereboff v. Mid-Atlantic Medical Services, Inc., 547 U.S. 356 (2006). Also, if the plan language does not specifically disclaim any “made whole” or “common fund” doctrine defenses, under the U.S. Supreme Court’s decision in McCutchen these doctrines do apply, even if it is a self-funded plan.

Other potential issues may arise when the client receives benefits under the Federal Employee Health Benefits Act (FEHBA). As would be anticipated, these plans are governed by Federal law and have enforceable subrogation rights. Conversely, with Georgia state employees, their benefits are subject to the “made whole” doctrine.

#### HOSPITAL/PHYSICIAN’S PRACTICE LIENS

Any time a personal injury client has been treated by a hospital, nursing home, physician practice, or traumatic burn care practice, there is a possibility of lien for the charges related to that treatment.

OCGA 44-14-470 provides that:

Any person, firm, hospital authority, or corporation operating a hospital, nursing home, or physician practice or providing traumatic burn care medical practice in this state shall have a lien for the reasonable charges for hospital, nursing home, physician practice, or traumatic burn care medical practice care and treatment of an injured person, which lien shall be upon any and all causes of action accruing to the person to whom the care was furnished or to the legal representative of such person on account of injuries giving rise to the causes of action and which necessitated the hospital, nursing home, physician practice, or provider of traumatic burn care medical practice care, subject, however, to any attorney's lien.

To perfect the lien, the hospital or physician's practice is required to do essentially two things. First, it must provide written notice of intent to file a lien to the patient and, to the best of the lienholder's knowledge, the persons, firms, corporations, and their insurers claimed to be liable, at least 15 days prior to filing. O.C.G.A. § 44-14-471(a)(1). Second, it must then file a verified statement of the lien with the clerk of superior court of the county where the lienholder is located and in the county where the patient resides. O.C.G.A. § 44-14-471(a)(2).

A hospital must file their lien statement within 75 days after the patient has been discharged from the facility. O.C.G.A. § 44-14-471(a)(2)(A). A physician's practice must file their statement within 90 days after the patient first sought treatment from the practice for the injury. O.C.G.A. § 44-14-471(a)(2)(B).

Checking the lien index used to require a trip to the courthouse in the county where the client resides (or where the hospital is located). However, it is now possible to check for the existence of these liens online at the website for the Georgia Superior Court's Cooperative Authority, GSCCCA.org. A single search costs \$5.00 for four hours of access, or a recurring monthly charge of \$11.95 allows for unlimited use.

The failure to timely comply with the notice and filing provisions invalidates the lien, with one exception: the lien is still valid "as to any person, firm, or corporation liable for the damages, which receives prior to the date of any release, covenant not to bring an action, or settlement, actual notice of a notice and filed statement . . . via hand delivery, certified mail, return receipt requested, or statutory overnight delivery with confirmation of receipt." O.C.G.A. § 44-14-471(b).

The fact the lien is subject any attorney's lien means simply that the plaintiff's attorney is entitled to have his or her fees and expenses paid first out of the settlement. However, it does not mean that the lienholder is required to reduce their lien to pay a pro rata share of the attorney's fees and litigation expenses the injured party incurred to recover damages. Watts v. Promina Health Systems, Inc., 242

Ga. App. 377. Also, the “made whole” doctrine does not apply to hospital or physician’s practice liens. Holland v. State Farm Mut. Auto. Ins. Co., 244 Ga. App. 583 (2000).

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Whether and to what extent providers will negotiate their liens varies a great deal from provider to provider. Probably the single greatest factor is the size of the recovery relative to the amount of the lien. The notice of lien will contain information about who to contact.

### MEDICARE LIENS

Anytime a client is aged 65 or over, or is disabled and receiving social security benefits, there is a substantial chance that Medicare has paid some or all of the client’s medical bills. If so, Medicare has a lien for any amounts they pay for treatment related to the event that is the subject of the personal injury claim. 42 U.S.C. § 1395. Medicare’s lien is sometimes referred to as a “super lien”, in that it is enforceable against the Medicare recipient, the defendant, the defendant’s

insurer, or even the plaintiff's attorney if the lien is not honored as part of the settlement. There are also strict reporting requirements for insurance carrier with substantial penalties for non-compliance. Because of this, insurance companies now are particularly sensitive to Medicare issues. Many will attempt to require funds necessary to satisfy Medicare claims be withheld from settlement funds and so that the lien can be satisfied directly.

Medicare lien claims are handled by the Center for Medicare and Medicaid Services (CMS). The process to deal with these claims can be a lengthy one, so it is important to notify CMS as soon as possible. Begin by faxing a letter of representation notifying them of the claim and with your client's authorization for you to receive medical information to 405-869-3309. CMS will then send you a form with relevant claim information and ask you to make any corrections or additions. Once this is done, they will send you (and the client) a "Rights and Responsibilities" letter, which will include their claim number. This will allow you to access the claim on the CMS website and handle the claim on line.

CMS will maintain a "Conditional Payment amount", which is the amount that Medicare is currently claiming it paid for treatment related to the incident at issue. It is possible to dispute these amounts (through the website), and it is often necessary to do so. In addition to maintaining this on the website, CMS will send a "Conditional Payment Letter" with this amount.

Once you are ready to resolve and pay the lien, request a “Final Payment Letter.” Do not request this until you are ready to completely resolve, because you will only have 60 days to pay before interest starts accruing. However, when you are ready to request the final amount, it is at that point that CMS will apply any reductions for attorney’s fees, etc.

### MEDICAID LIENS

Similar to Medicare, Medicaid has a lien for any care for the charges for any care it has provided. However, rather than being administered by the Federal Government, Medicare is administered by the state. In Georgia, it is administered by the through the Georgia Department of Community Health. O.C.G.A. § 49-4-149 “The Department of Community Health shall have a lien for the charges for medical care and treatment provided a medical assistance recipient upon any moneys or other property accruing to the recipient to whom such care was furnished or to his legal representatives as a result of sickness, injury, disease, disability, or death, due to the liability of a third party, which necessitated the medical care.” Attorneys are required to notify the department anytime they initiate an action to recover in a case where the client has expenses covered by Medicaid. O.C.G.A. § 9-2-21.

The Georgia Department of Community Health has contracted with an agency called HMS to handle its subrogation claims. Their website is [hms.com/ga](http://hms.com/ga). The subrogation unit can also be contacted by mail, fax, or phone at:

Georgia Department of Community Health  
Subrogation Unit  
900 Circle 75 Parkway  
Suite 650  
Atlanta, GA 30339  
Phone: 678-564-1163  
Fax: 885-46703970

While the “made whole” and “common fund” doctrines do not apply to Medicaid lien claims, as a general matter the DCH and HMS will negotiate these claims, especially when the recovery is low in relation to the medical expenses.

#### CLAIMS UNDER THE FEDERAL MEDICAL CARE RECOVERY ACT

Pursuant to the Federal Medical Care Recovery Act, 42 U.S.C. § 2651 et seq. “In any case in which the United States is authorized or required by law to furnish or pay for [health care] to a person who is injured or suffers a disease . . . under circumstances creating tort liability upon some person, the United States shall have a right to recover (independent of the rights of the injured or diseased person) from said third person . . . the reasonable value of the care and treatment . . . and shall . . . be subrogated to any right or claim that [the injured party] has against such third person[.]” 42 USC § 2651.

Claims under this act typically arise when the client is in the military, is a military retiree, is a dependent of a service member or retiree, or receives VA benefits. A service member, retiree, or dependent may have received care at a private facility which was paid for by Tri-Care, or they may have received treatment from a military facility directly. VA recipients typically receive care at a VA facility, but they do occasionally receive benefits at another facility that is paid for by the VA. The handling of a claim under the FMCRA is time-consuming. It is important to start early or final settlement can be significantly delayed. When the treatment at issue was provided at a military or VA facility, you must actually request that a bill be generated. The forms for this are included on the VA website. For the military, you generally must work through the JAG office where the military member is stationed.

The “made whole” and “common fund” doctrines do not apply to claims under the FMCRA. However, reductions generally will be granted when not granting one will place an undue burden on the injured party.

#### WORKER’S COMPENSATION SUBROGATION

O.C.G.A. § 34-9-11.1 gives an employer and an employer’s insurer a subrogation lien for benefits paid under the Georgia Worker’s Compensation Act. The employer or insurer has the right to intervene in the injured party’s tort claim to enforce their lien, and if the employee has not filed an action within one year, the

employer or insurer may actually institute an action, into which the injured party has the right to intervene. O.C.G.A. § 34-9-11.1 However, the worker's compensation lien is only permitted if the injured party has been "fully compensated for all economic and non-economic losses." Id. Also, a worker's compensation lien does not apply to UM benefits. Stewart v. Auto-Owners Ins. Co., 230 Ga. App. 265 (1998).

Beware, however, of claims arising under the Federal Employee's Compensation Act. As with most Federal claims, an enforceable subrogation right exists as to which the "made whole" and "common fund" doctrines do not apply. Also, be cognizant of the fact that your client's claim might arise under the worker's compensation laws of another state. In that case, that state's law applies and the employer may have a much stronger subrogation claim.